RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: ARMY

CASE NUMBER: PD0900071 BOARD DATE: 20100202

SEPARATION DATE: 20060602

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SUMMARY OF CASE: This covered individual (CI) was a Captain, O3, Engineer Officer, 21A, medically separated from the Army in 2006 after 5+ years of service. The medical basis for the separation was chronic cervical and thoracic pain secondary to myofascial pain syndrome. The CI's cervical and thoracic pain was present since 1999 surgery for Arnold Chiari malformation (suboccipital decompression of a congenital condition). The CI's physical conditioning and functional activity limitations restricted her from being able to accomplish the duties of her MOS and she was referred to an MEB. The Chronic cervicalgia and chronic thoracic pain were determined to be medically unacceptable IAW AR 40-501. All other conditions (adjustment disorder, thoracic radiculopathy, cervical radiculopathy, cystitis and chronic left shoulder pain) were noted to meet medical retention standards. The CI was referred to the PEB, and found unfit for a condition that was "neither service incurred nor permanently aggravated by military service." On appeal to the FPEB, the CI's condition was Service connected and the CI was found unfit for Cervical and thoracic pain secondary to myofascial pain syndrome and separated with a 0% disability coded 5021 Myositis and rated under the USAPDA pain policy as slight and occasional.

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CI CONTENTION: The CI states: “VA awarded 40% for limited range of motion with chronic strain, thoracolumbar spine, 20% for limited range of motion with instability, C3-C4, C4-C5, cervical spine: overall rating 70%.”

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RATING COMPARISON:

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Service FPEB** | | | | **VA (8 Mo. after Separation)** | | | | |
| **Unfitting Conditions** | **Code** | **Rating** | **Date** | **Condition** | **Code** | **Rating** | **Exam** | **Effective** |
| Cervical and thoracic pain secondary to myofascial pain syndrome | 5099-5021 | **0%** | 20060503 | Thoracolumbar Spine, chronic strain w/limited ROM | 5237 | **40%** | 20070222 | 20060603 |
| Cervical Spine instability w/ limited ROM | 5237 | **20%** | 20070222 | 20060603 |
| **Additional Conditions**  **(list all PEB conditions)** | **PEB** | **DES**  **(If Yes, List Where: NARSUM, H&P, Etc)** | | **Condition**  **(list all VA compensable conditions)** | **Code** | **Rating** | **Exam** | **Effective** |
| Adjustment Disorder with anxiety | Not Unfit | NARSUM | | Anxiety Disorder |  | 10% then  30% | 20070130  20080616 | 20060603  20080502 |
| Thoracic radiculopathy | Not Unfit | NARSUM | | Hypesthesia, left leg | 8599-8520 | 10% | 20070222 | 20060603 |
| Cervical Radiculopathy | Not Unfit | NARSUM | | Hypesthesia, left arm | 8599-8517 | 0% | 20070222 | 20060603 |
| Cystitis | Not Unfit | NARSUM | |  |  |  |  |  |
| Left Shoulder Pain | Not Unfit | NARSUM | |  |  |  |  |  |
| Arnold Chiari | Not Unfit | NARSUM | | Arnold Chiari malformation with chronic headaches s/p decompression craniectomy |  | NSC | 20070130 & 20070222 |  |
|  |  |  | | Exercised induced asthma | 6699-6602 | 0% | 20070130 | 20060603 |
|  |  |  | | Irritable Bowel Syndrome |  | NSC | 20080616 |  |
|  |  |  | | Chronic fatigue syndrome |  | NSC |  |  |
|  |  |  | | Asbestos exposure |  | NSC |  |  |
| **TOTAL Combined: 0%** | | | | **TOTAL Combined (*Includes Non-PEB Conditions*):**  **60% from 20060603**  **70% from 20080502** | | | | |

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ANALYSIS SUMMARY: The CI underwent surgery to repair her congenital Arnold Chiari in 1999 for headaches and subsequently developed cervical and thoracolumbar pain that limited her ability to accomplish common Soldier tasks. The military exams documented both spine segments with muscle spasm and painful motion, but had no formal ROM exams documented within the last 2 years of service. The CI's sensory radiculopathy (upper and lower) did not interfere with duty and were found to be meet retention standards and to be not unfitting. The cervical and thoracic spine imaging studies from the service were negative. The exam from the VA was accomplished 8 months post separation with no intervening trauma. The VA documented abnormal cervical spine imaging showed subluxation of the C3-4 and C4-5 level and thoracolumbar scoliosis. ROMs were pain limited to Cervical: 30˚/190˚, and Thoracolumbar 30˚/140˚.

Commander's Statement 20060206: CPT Rouse is a 26 year old Engineer Officer serving as a Battalion S4. Her current PULHESS is 23111 due to Arnold Chiari Malformation and Thoracic Radiculopathy, both of which according to her medical advisors are rare but treatable conditions. These medical conditions severely limit her physical conditioning to cardio at own pace and distance, upper body conditioning as tolerated, and a modified PT test. Her functional activity limitations include not wearing a Kevlar or Individual Body Armor (IBA) for extended periods of time, not able to carry a fighting load, and not able to construct an individual fighting position.

**Condition 1: Cervical and thoracic pain secondary to myofascial pain syndrome.**

**FPEB (20060503):** Chronic cervical and thoracic pain secondary to myofascial pain syndrome present since fall at Fort Benning in 2002. Had surgery for Arnold Chiari malformation (suboccipital decompression) in 1999, but recovered fully, subsequently completing all physical requirements and graduating from USMA, BOLC prototype course and Engineer Officer basic course. Met all commissioning requirements and standards. Unable to fully perform in PMOS due to chronic pain. Loss of spinal motion is due to pain alone, no radiculopathy or muscle spasm. Rated under USAPDA pain policy as slight and occasional. (MEBD Dx 1, 2, NARSUM, FP)

**IPEB (20060412):** Chronic cervical and thoracic pain secondary to myofascial pain syndrome present since surgery for Arnold Chiari malformation (suboccipital decompression in 1999). Unable to fully perform in PMOS due to chronic pain that existed prior to commissioning without evidence of permanent service aggravation. Loss of spinal motion is due to pain alone, no radiculopathy or muscle spasm. Your unfitting condition is found to be neither service incurred nor permanently aggravated by military service. Your impairment originated while not entitled to basic pay, and has increased only to the extent of its accepted normal and natural progress, therefore there is no permanent service aggravation. Because your condition was not service incurred or permanently aggravated, you are ineligible for disability compensation and are therefore separated without disability benefits.

**MEB Diagnoses**: 1) Chronic cervicalgia. 2) Chronic thoracic pain. 3) She meets retention criteria for all other diagnoses.

**NARSUM (20060316):** Exam occurred 28 Feb 2006. CHIEF COMPLAINT: Chronic neck pain and back pain. HISTORY OF PRESENT ILLNESS: The patient is a 26-year-old Caucasian Service member who was initially seen in July 2003 after demobilizing from Iraq when she presented with complaints of generalized arthralgias with nonspecified numbness and tingling in upper and lower extremities. She gave a history of Arnold-Chiari syndrome, status post decompression in 1999 and has since had chronic headaches for which she has been followed by the neurological service. She underwent extensive workup to rule out vasculitis, in addition to a repeat MRI to rule out any postoperative complications which were all essentially negative. She began to complain of cervical and thoracic spinal pain not amenable to nonsteroidal anti-inflammatories. Her prior plain radiograph of her T-spine revealed only normal changes. MRl of her T-spine was performed in March 2004 which was also within normal limits. Throughout this period she was sent to a chiropractor on base, who was able to administer chiropractic treatments over the course of about 3 months without significant improvement. Continued to treat her pain with nonsteroidal antiinf1ammatories, in addition to muscle relaxants, namely Flexeril and at times Valium. She had some improvement in her symptoms but had recurrence and pain so was referred to the Pain Clinic in April 2004. The Pain Clinic administered multiple steroid injections and also stopped Flexeril and started her on Skelaxin but the patient did not note any significant improvements in her condition. She followed up with her neurosurgical service at Brooke Army Medical Center (BAMC) where her Arnold Chiari decompression was performed wherein she was evaluated and noted to have had difficulty and persistent myofascial muscular pain and deconditioning as a result of her Arnold-Chiari decompression surgery. She underwent physical and medical rehabilitation without significant improvement and followed up with me here at Fort Leonard Wood. She also underwent continuous physical therapy but she continued to complain of persistent cervical and thoracic back pain. Her ability to perform extreme physical activities has been inhibited due to her persistent complaints. She is unable to wear her Kevlar or individual body armor for extended periods of time and has failed to carry a fighting load effectively. Her commanding officer stated she is unable to be assigned to a FORSCOM unit due to her inability to deploy to the theater and as such this Medical Evaluation Board was instituted by myself due to failure to progress despite maximal treatment for her symptoms.

PAST MEDICAL HISTORY: 1. Adjustment disorder with anxiety. 2. Arnold-Chiari malformation, status post decompression in 1999 without any significant complications at this time. Her working diagnosis is that she has chronic myofascial deconditioning since surgery. 3. Thoracic radiculopathy without radiographic evidence of pathology. 4. Cervical radiculopathy without radiographic evidence of pathology. 5. Cystitis without any current sequelae.

Musculoskeletal: No gross upper or lower extremity abnormalities. She had some focal tenderness over the thoracic and cervical spine especially with rotation along the vertical plane. There was some myofascial pain with palpation of this region. No edema of upper or lower extremities.

X-RAY DATA: 1. November 2002: T-spine series within normal limits. Left shoulder series plain radiograph suggested possible increased acromiohumeral distance suggesting possibility of impingement. 2. December 2002: MRI of the left shoulder did not reveal any conclusive evidence for impingement. 3. August 2003: MRI of the brain showed post suboccipital craniotomy for decompression of Chiari Type I malformation; otherwise, unremarkable. 4. March 2004: MRI of the T-spine, L-spine and C-spine was essentially unremarkable. 5. August 2004: MRI of the brain without any significant changes with good flow in the anterior and posterior portions to the cord at the foramen magnum on CSF flow study. 6. September 2005:Repeat MRI of the brain confirmed suboccipital craniotomy for Chiari Type I malformation without any significant pathology.

DIAGNOSES:

1. Chronic cervicalgia. In accordance with Army Regulation 40-50.1, Chapter 3-39h, due to nonradicular pain involving the cervical, thoracic and lumbosacral spine.

2. Chronic thoracic pain. In accordance with Army Regulation 40-501, Chapter 3-39h, for which she fails to meet retention criteria.

3. She meets retention criteria for all the other diagnoses.

**Service Treatment records:** The only formal ROM degree measurements found in the file from the Service were completed in 2003 and are in the chart below.

On a 20040428 exam, the lumbar exam notes pain with extension and says there is some relief with flexion. Cervical exam notes range of motion is normal.

An exam dated 4 June 2004 notes that the AROM for the lumbar is decreased by 25% in extension and lateral flexion. The cervical spine was noted to be okay

20041012 note indicated “cervical FROM” and trunk FAROM. TTP was noted.

20050328 note stated Trunk AROM WNL.

20050201 cervical spine showed full range of motion. Thoracolumbar range of motion was normal but pain elicited by flexion and extension.

**VA:** Using evaluations completed 20070130 and 20070222, 8 months post separation from the Army, the Veterans Administration (VA) rated this disability as limited range of motion with chronic strain thoracolumbar spine at 40% and limited range of motion with instability, C3-4, C4-5, cervical spine at 20%.

**Rating Decision (20070828):** 1. Service connection for limited range of motion with instability, C3-C4, C4-C5, cervical spine. 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. 38 C.F.R. 4.7. Although Physical Evaluation Board findings showed that your chronic cervical and thoracic pain was secondary to myofascial pain syndrome, VA finding showed instability of the cervical spine with limited range of motion, and chronic sprain, with scoliosis thoracolumbar spine, with limited range of motion which warrant the higher evaluation. Hypesthesia, bilateral upper and bilateral lower extremities, secondary to Arnold-Chiari decompression surgery are evaluated separately. We have granted service connection for limited range of motion with instability, C3-C4, C4-C5, cervical spine, effective June 3, 2006, the day following separation from active duty. Service Medical Board findings showed that you were seen in July 2003, following deployment to Iraq, when you presented with complaints of generalized arthralgias with nonspecified numbness and tingling in the bilateral upper and lower extremities. You gave a history of Arnold-Chiari syndrome status post decompression in 1999, and chronic headaches. You underwent extensive workup to rule out vasculitis, in addition to a repeat MRI to rule out postoperative complications, which were all essentially negative. You began to complain of cervical and thoracic spinal pain which was not amenable to nonsteroidal antiinflammatories. Plain radiograph, and MRI of the thoracic spine were within normal limits. You received chiropractic treated over a 3 month period without significant improvement. You continued treated with nonsteroidal antiinflammatories, in addition to muscle relaxant, Flexeril, and at times Valium. You had some improvement in your symptoms, but had recurrence of pain, and you were referred to the Pain Clinic in April 2004. Multiple steroid injections were administered, and Flexeril was stopped, and you were started on Skelaxin, but you did not note any significant improvement. You followed up with your neurosurgical service at Brooke Army Medical Center, and you were again evaluated and found to have persistent myofascial muscular pain and deconditioning secondary to your Arnold-Chiari decompression surgery. You underwent physical and medical rehabilitation without significant improvement. During continuous physical therapy you complained of persistent cervical and thoracic back pain. Your ability to perform extreme physical activities became inhibited, and due to you inability to carry a fighting load, your commanding officer determined that you were unable to be assigned to a FORSCOM unit and deployed. A Medical Board was instituted despite maximal treatment for your symptoms. Physical Evaluation Board findings showed that you were found to be medically unfit to perform the duties of your primary MOS, and you were separated with disability severance pay. A cervical spine X-ray in January 2007, showed subluxation at C3-C4 and C4-C5. A 20 percent evaluation is assigned for limited forward flexion of the cervical spine, because VA examination found history of neck and back pain which began in 2002, which you associated with a fall during training. You were treated with Methocarbamol. You also complained of pain in both arms, left greater than right (evaluated separately). You denied assistive devices for ambulation, and you have no limitations on walking. You have difficulty lifting, pushing, and pulling abilities due to neck and shoulder pain. Kneeling, squatting, and stooping are limited due to neck pain. Sitting and traveling in a car are limited to about 1 hour. You said that you have difficulty sleeping due to neck discomfort. Clinical findings showed examination of the cervical spine found tenderness on palpation of the entire cervical and upper thoracic paravertebral musculature. Shoulder depression test was negative bilaterally, but you did complain of neck pain with that maneuver. Cervical spine range of motion examination, with repetitive testing, showed forward flexion was limited to 30 degrees; extension was limited to 20 degrees; bilateral lateral flexion each were limited to 25 degrees; bilateral rotations were each limited to 45 degrees; combined range of motion of the cervical spine limited to 190 degrees; and no additional limitations were found due to repetitive testing (38 CFR 4.40 and 4.45). A slight flattening of the thoracic kyphosis was noted. The examiner noted that your cervical spine ranges of motion are diminished due to complaint of pain. Neurological examination found long glove hypesthesia of the left arm. Diagnoses was cervical spine instability with radicular irritation to the left arm. The criteria for rating diseases and injuries of the spine apply with or without symptoms such as pain (whether or not it radiates), stiffness, or aching in the area of the spine affected by residuals of injury or disease. In order to assign the next higher evaluation of 30 percent, there must be objective evidence of forward flexion of the cervical spine of 15 degrees or less; or, favorable ankylosis of the entire cervical spine, which was not shown by the evidence of record.

**Rating Decision (20070828):** **Service connection for limited range of motion with chronic strain, thoracolumbar spine.** We have granted service connection [or limited range of motion with chronic strain, thoracolumbar spine, effective June 3,2006, the day following separation from active duty. 38 C.F.R. §4.7. Service Medical Board findings showed that you complained of thoracic spine pain which was not amenable to nonsteroidal antiinflammatories, and numbness and tingling of the bilateral lower extremities. During continuous physical therapy you complained of persistent thoracic back pain. Physical Evaluation Board findings showed that you were found to be medically unfit to perform the duties of your primary MOS, and you were separated with disability severance pay. A 40 percent evaluation is assigned for limited range of motion with chronic strain, thoracolumbar spine because VA examination found history of neck and back pain which occurred in 2002, which you associated with a fall during training. You were treated with Methocarbamol. You also complained of numbness, left leg. You denied assistive devices for ambulation, and you have no limitations on walking. Standing causes pain the low back and upper back. Sitting or traveling in a car are limited to about one hour. Clinical findings showed a normal gait. A slight flattening of the thoracic kyphosis and increase in lumbar lordosis was noted. The entire thoracolumbar and paravertebral musculature was tender to palpation. Thoracolumbar spine range of motion examination, with repetitive testing, showed forward flexion was limited to 30 degrees; extension was limited to 10 degrees; bilateral lateral flexions were each limited to 20 degrees; bilateral rotations were nOffi1al to 30 degrees; combined thoracolumbar spine range of motion was limited to 140 degrees; and no additioI1allimitations were found due to repetitive testing (38 CFR 4.40 and 4.45). Straight leg raises were positive at 70 degrees bilaterally. Neurological examination found long stocking hypesthesia, left leg (evaluated separately). No motor deficit was found, and deep tendon reflexes were symmetrical bilaterally at +1. The examiner noted that your lumbar spine ranges of motion are diminished due to complaint of pain. Thoracolumbar X-ray showed scoliosis, otherwise normal. Diagnosis was limited range of motion with chronic sprain, thoracolumbar spine. The criteria for rating diseases and injuries of the spine apply with or without symptoms such as pain (whether or not it radiates), stiffness, or aching in the area of the spine affected by residuals of injury or disease. In order to assign the next higher evaluation of 50 percent there must be objective evidence of unfavorable ankylosis of the entire thoracolumbar spine, which was not shown by the evidence of record.

**C&P Exam (20070222):** PE: This is an alert female who appears in no acute distress. She ambulates without a limp. She gets on and off the examining table with ease. She turns from aide to side with ease. CERVICAL SPINE: There is tenderness on palpation of the entire cervical and upper thoracic paravertebral musculature. Shoulder depression test is negative bilaterally, but she does complain of neck pain on the maneuver. Range of motion of her cervical spine is as follows: Flexion is 30 degrees of a normal 45 degrees. Extension is 20 degrees of normal 45 degrees. Side bending is 25 degrees to each side of a normal 45 degrees. Rotation is 45 degrees to each side of a normal 80 degrees. NEUROLOGICAL: There is no evidence of any atrophy of either upper extremity. She has a long glove hypesthesia of the left arm. There is no evidence of any motor deficit of the upper extremities. Deep tendon reflexes of the upper extremities are present and symmetric bilaterally at +2. THORACOLUMBAR SPINE: There is flattening of the thoracic kyphosis and increase in the lumbar lordosis. She has tenderness on palpation of the entire thoracolumbar and paravertebral musculature. Range of motion of the thoracolumbar spine is as follows. Flexion is 30 degrees of a normal 90 degrees extension is 10 degrees of a normal 30 degrees, side bending is 20 degrees to each side of a normal 30 degrees. Thoracolumbar rotation is 30 degrees to each side of a normal 45 degrees. NEUROLOGICAL: Straight leg raising can be carried to 70 degrees bilaterally with posterior thigh pain elicited. There is a long stocking hypesthesia of the left leg. There is no evidence of any motor deficit of either lower extremity. Deep tendon reflexes of the lower extremit1is are present and symmetrical bilaterally +1. There is no evidence of pathologic reflexes. She tandem toe and heel walks without difficulty. The veteran's cervical and lumbar spine range of motion and strength are diminished due to complaint of pain on attempt at repetitive motion testing. The extent and degree of which is not possible to determine due to the extreme subjectivity of the exercise. The veteran's cervical spine x-rays showed subluxation of the C3-4 and C4-5 level indicating instability of the whole segments. The thoracolumbar x rays showed scoliosis but otherwise reported as normal. DIAGNOSIS: l. Instability of the C3-4 and C4-5 levels with radicular irritation to the left arm. 2. The long stocking and long glove hypesthesia is most likely secondary to the history of the Chiari malformation surgery in 1999. 3. Chronic thoracolumbar sprain.

SEPARATION DATE: 20060602

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| --- | --- | --- | --- |
| Movement  **Thoracolumbar** | Normal ROM | ROM Mil | ROM VA  20070222 |
| Flex | 0-**90** | **No degree measures available in STR.** | 30 |
| Ext | 0-**30** | 10 |
| R Lat flex | 0-**30** | 20 |
| L lat flex | 0-**30** | 20 |
| R rotation | 0-**30** | 30 |
| L rotation | 0-**30** | 30 |
| COMBINED | **240** | 140 |

SEPARATION DATE: 20060602

|  |  |  |  |
| --- | --- | --- | --- |
| Movement  **Cervical** | Normal ROM | ROM Mil  ***20031028*** | ROM VA  20070222 |
| Flex | 0-**45** | 60 | 30 |
| Ext | 0-**45** | 70 | 20 |
| R Lat flex | 0-**45** | 45 | 25 |
| L lat flex | 0-**45** | 45 | 25 |
| R rotation | 0-**80** | 80 | 45 |
| L rotation | 0-**80** | 80 | 45 |
| COMBINED | **340** | 340 | 190 |

**Discussion:** In regards to the Cervical Radiculopathy (VA Hypesthesia, left arm) and Thoracic radiculopathy (VA Hypesthesia, left leg) they were found as meeting retention standards by the MEB and as not unfitting by the FPEB. The radiculopathies were glove or stocking-like. There was no evidence in the STR via profile restriction, NARSUM, or Commander's statement that any radiculopathy interfered with the performance of duties. The radiculopathies are therefore not separately ratable. The only complete formal (measured degrees) spine ROMs in the STR were cervical from 20031028. There were no military formal ROM measurements proximate to the date of separation. The preponderance of the military exams stated FROM, but also included statements of demonstrated painful motion of both cervical and thoracolumbar segments with tenderness and occasional thoracolumbar spasm. At least one exam noted painful motion "at extremes of motion", without noted degrees; however, most did not annotate at what ROM pain began. Military exams did not comment on fatigue, or incoordination, or decreased ROM or increased pain with repetition. There was a positive Romberg noted on a single exam and NCV testing was negative. Gait was normal. In the STR the cervical and thoracolumbar spine segments were without radiographic evidence of significant pathology as of Mar 2004 spine MRI or 2002 spine X-rays. There were no military spine radiographs proximate to discharge in the record.

As noted frequently in this type of case, it is difficult to retrospectively determine pain-limited ROM from military exams accomplished during the period where the USAPDA pain policy was in effect. Army ratings were solely on mechanical limitations of motion and did not comprehensively consider pain-limited motion in ratings; providers did not clearly address the degree of motion of onset of pain or other Deluca criteria in their examination details. The VA exams were accomplished 8 months post separation without any intervening injury. The VA imaging studies were markedly different from the military imaging (~2 and 4 yrs prior to separation) and showed abnormalities in both spine segments. The VA cervical spine X-ray in January 2007, showed subluxation at C3-C4 and C4-C5 and thoracolumbar spine showed scoliosis. Cervical spine range of motion examination, with repetitive testing, showed forward flexion was limited to 30 degrees; combined range of motion of the cervical spine limited to 190 degrees. The exam was 8 months post separation and there was no intervening trauma. The VA exam was much more detailed on measurement of onset of pain limited motion and addressed the DeLuca criteria. The VA rating noted the provisions of §4.7 "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." The VA exam was much more detailed on measurement of onset of pain limited motion; however, it was accomplished 8 months post-separation and given the CI's overall physical deconditioning, the post-separation decreased ROM, of the "core" thoracolumbar spine segment, may have been due to worsening of CI's condition. This deconditioning is much less likely to occur in the cervical region. In this specific case, given the CI's entire STR and imaging for the cervical spine segment, and IAW §4.3 resolution of reasonable doubt, the VA's ROM evaluation should be used for rating the CI's cervical spine condition as 5021-5237 at 20% for "forward flexion of the cervical spine greater than 15 degrees but not greater than 30 degrees." In the case of the CI's thoracolumbar condition, the STR documented multiple exams that placed the VA's extremely pain-limited ROM exam in question as to reflecting the true disability picture at the time of separation and neither §4.7, or §4.3 should be applied to the thoracolumbar spine condition. The VA imaging of non-measured thoracolumbar scoliosis was noted in light of the significant tenderness and ROM limitations as part of the worsening of CI's thoracolumbar condition and not applicable to the time of separation. The CI's thoracolumbar condition should therefore be rated absent the USAPDA pain policy as 5021-5237 at 10% IAW §4.59 Painful motion. All evidence considered and IAW VASRD §4.3, reasonable doubt is resolved in favor of the CI in recommending separating the cervical and thoracolumbar spine into two separate ratings for pain-limited motion. The Cervical spine condition rating of 5021-5237 at 20% for forward flexion of the cervical spine not greater than 30 degrees and the thoracolumbar spine condition rating of 5021-5237 at 10% for painful motion IAW §4.59.

Other Conditions. Regarding the other DA 3947 conditions, the CI had various service connected conditions rated at 0% or NSC by the VA, but her only additional compensable ratings were for Anxiety Disorder and Hypesthesia, left leg. Hyperesthesia, left leg was discussed as a thoracolumbar radiculopathy in Condition #1 above and is not unfitting. Anxiety Disorder was specifically addressed by the FPEB and adjudged as not unfitting. There were no duty limitations due to any mental Health related symptoms on profile or Commander's statement. All evidence considered there is not reasonable doubt in the CI’s favor supporting recharacterization of the PEB fitness adjudication for the Anxiety Disorder or radiculopathy conditions. The Board therefore, has no reasonable basis for recommending any additional unfitting conditions for separation rating.

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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. As discussed above, PEB reliance on the USAPDA pain policy for rating the cervical and thoracolumbar conditions was operant in this case and the condition was adjudicated independently of that policy by the Board. In the matter of the Cervical and Thoracic pain secondary to myofascial pain syndrome condition, the Board unanimously recommends separately rating each spinal segment with ratings of Cervical spine strain with myofascial pain syndrome, 5021-5237 at 20% and Thoracolumbar strain with myofascial pain syndrome coded 5021-5237 at 10% IAW VASRD §4.71a. The Board adjudged that the CI's Cervical and Thoracolumbar spine segments each had painful motion. There was prolonged discussion of the specific pain-limited ROMs for each segment as the STR did not provide ROMs specifying degrees of motion for onset of pain and the case was adjudicated by the FPEB under the USAPDA pain policy. The STR contained multiple complaints of Cervical and Thoracolumbar painful motion and the CI did not have demonstrated "mechanical limitation of motion." The VA exam was 8 months post-separation and demonstrated significantly restricted pain limited ROMs and abnormal spine imaging of both the Cervical and thoracolumbar segments. It was adjudged unlikely that the cervical condition had significantly worsened post discharge especially given the VA cervical spine imaging abnormalities. Therefore, IAW §4.3 resolution of reasonable doubt and, §4.7 higher of two evaluations, the VA ROM limits for the Cervical spine were used for rating the cervical spine as 5021-5237 at 20% for forward flexion of the cervical spine not greater than 30 degrees. The Thoracolumbar spine imaging showed non-measured scoliosis with exam findings dramatically different than the CI's disability picture at discharge. It was therefore adjudged that neither §4.7, or §4.3 should be applied to the post separation thoracolumbar spine examination. The Thoracolumbar condition should therefore be rated on painful motion as documented in the STR and it should be coded as 5021-5237 at 10% IAW §4.59 Painful motion.

In the matter of the adjustment disorder, thoracic radiculopathy, cervical radiculopathy, cystitis and chronic left shoulder pain conditions, or any other medical conditions eligible for Board consideration; the Board unanimously agrees that it cannot recommend any findings of unfit for additional rating at separation. The other diagnoses; Exercised induced asthma, Irritable Bowel Syndrome, Chronic fatigue syndrome, and Asbestos exposure, noted by the VA were not mentioned in the Disability Evaluation System (DES) package and are therefore outside the scope of the Board. The CI retains the right to request her service Board of Correction for Military Records (ABCMR) to consider adding these conditions as unfitting.

The Board voted unanimously to rate the CI as Cervical spine strain with myofascial pain syndrome as 5021-5237 at 20% and Thoracolumbar strain with myofascial pain syndrome as 5021-5237 at 10% with no additional unfitting conditions.

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RECOMMENDATION: The Board recommends that the CI’s prior determination be modified as follows and that the discharge with severance pay be recharacterized to reflect permanent disability retirement, effective as of the date of her prior medical separation.

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| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Cervical spine strain with myofascial pain syndrome | 5021-5237 | 20% |
| Thoracolumbar strain with myofascial pain syndrome | 5021-5237 | 10% |
| **COMBINED** | **30%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090123, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

