RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: army

CASE NUMBER: PD0900072 BOARD DATE: 20091014

SEPARATION DATE: 20080117

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SUMMARY OF CASE: This covered individual (CI) was a Captain Air Defense Artilleryman who was medically separated from the Army in 2008 after 5.5 years of service. The medical basis for the separation was Lower Back Pain (LBP) and Depression. The CI injured his lower back in 2004 and subsequently underwent surgery on 20070205. He continued to have significant post-surgical LBP and had left leg radiculopathy and left foot drop. The CI also had onset of Major depressive disorder in 2006 secondary to multiple familial, occupational and medical stresses and the CI was on multiple psychotropic medications. He continued to have significant LBP, became dependent on narcotic medications and was treated for opioid dependence. The CI was referred to the PEB, found unfit and separated at 20% disability.

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CI CONTENTION: “The spinal injury, including the surgery for this injury, have rendered this former servicemember disabled to the point of being rated 100 percent unemployable through the Department of Veterans Affairs and fully disabled through the Social Security Administration. The servicemember was also diagnosed with and rated for a Major Depressive Disorder which has not changed. These disabling conditions, along with the necessary medications for the pain and depression associated with these conditions, is why this rating should be reviewed by the PDBR. These were life changing, as well as career changing/ending injuries/disabilities. Thank you.”

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RATING COMPARISON:

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Previous Determinations** | | | | | | | | |
| **Service** | | | | **VA** Exams 2 days (LBP) and 1 month (MH) post-discharge | | | | |
| **PEB Condition** | **Code** | **Rating** | **Date** | **Condition** | **Code** | **Rating** | **Exam Date** | **Effective date** |
| Fusion of the lower back resulting in lower back pain and limitation of range of motion secondary to pain with no mechanical block to range of motion noted. (see text) | 5241 | 10% | **20071218** | Residuals, Intervertebral Disc Syndrome, IDA Status Post L5-S1Fusion with Laminectomy And Discectomy, Lumbar Spine | 5243 | 20%  then  40% | **20080119**  **20080505** | **20080118**  from  **20080415** |
|  |  |  |  | Radiculopathy, Left Leg | 8599-8520 | 10% | **20080119** | **20080118** |
| Major depressive disorder (see text) | 9434 | 10% | **20071218** | Major Depressive Disorder with Anxiety | 9434 | 30% | **20080204** | **20080118** |
| Dx 3, opioid dependence, does not constitute a physical (see text) | Not ratable |  |  |  |  |  |  |  |
|  |  |  |  | Left Ankle Sprain with Degenerative Changes | 5010-5271 | 10% | **20080119** | **20080118** |
|  |  |  |  | 4 other Conditions |  | 0% | **20080119** | **20080118** |
|  |  |  |  | 3 Conditions |  | NSC |  |  |
| **TOTAL Combined: 20%** | | | | **TOTAL Combined (*incl non-PEB Dxs)*: 60%** from **20080118**  **70%** from **20080415**  Individual Unemployability Granted from April 15, 2008 | | | | |

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**ANALYSIS SUMMARY:** The CI's LBP and use of pain medicines, major depressive disorder with psychotropic medications, and opioid dependence appear to be inter-related. There was no indication that any illicit substances were used. The PEB disability descriptions were:

**5241 (LBP)** "Fusion of the lower back resulting in lower back pain and limitation of range of motion secondary to pain with no mechanical block to range of motion noted. The Soldier had an L5-S1 fusion with laminectomy and discectomy in February 2007. Physical examination was remarkable for tenderness to palpation and a range of motion (ROM) limited by pain. Soldier cannot move 2 miles with a fighting combat load."

**9434 (Depression)** "Major depressive disorder with onset in 2006 secondary to multiple familial, occupational and medical stresses for which Soldier takes multiple psychotropic medications. Soldier has occupational and social impairment due to mild or transient symptoms which decrease work efficiency and ability to perform occupation tasks only during periods of significant stress. Soldier cannot carry or fire his assigned weapon. Soldier is competent to manage legal, financial and medical affairs."

**Not ratable** "Dx 3, opioid dependence, does not constitute a physical disability and is not ratable in the absence of an underlying ratable causative disorder as specified in DoDI 1332.38, November 14, 1996."

**LBP:** The CI injured his back with a fall in 2004. The CI did not improve with conservative treatment of oral medications, Pain Management and steroid injections. Orthopedic surgery was delayed due to the death of his father and the CI was using narcotics (Fentanyl patches combined with MS Contin) for pain control. The CI underwent L5-S1 fusion laminectomy and discectomy 20070205, with post-surgical episodes of dropped foot wherein he had left lower extremity weakness causing him to fall several times. The CI noted increased LBP following surgery, complained of weakness in his left lower extremity from the left buttocks down to his foot, and was on narcotic pain medication. The CI returned to the Pain Clinic and was started on methadone which decreased his memory and attention at work. The CI became tolerant to narcotics and underwent substance abuse treatment without long-lasting success. The NARSUM exam (signed 20071114; 20071106/07 dtd) stated: "This service member is right handed. He appeared alert and oriented and in no acute distress. Examination of the back revealed a symmetrical back. Palpation of the spine revealed moderate to severe tenderness to palpation in the midline in the spinous processes starting in the lumbar spine area. The surgical incisional scar was well healed with no signs of overt infection. There was no crepitus on palpation of the spine. No palpable masses on palpation of the spine. Of note, there was very mild paraspinous muscle tenderness to palpation without acute muscle spasms. The patient had marked pain with attempts to flex the spine even at 20 degrees of flexion. Pain was relieved with extending the back and standing upright. The patient experienced marked pain with attempts at lateral flexion of the spine in either direction. The service member had experienced weakness in the left lower extremity when walking on the heels however he was able to plantar flex without difficulty and walk on his tip toes. Otherwise he had normal strength in the lower extremities on examination. He exhibited equal bilateral deep tendon reflexes at the patella and the ankle jerk and ankle bilaterally. The patient had no demonstrable numbness or loss of sensation in the lower extremities." Lumbar CT 20070420 revealed postoperative laminectomy at L5 with inter-peduncle fixation at LS-S1. The formal ROMs of 20071130 demonstrated an average of three measurements for flexion 35˚; combined 135˚.

The VA exam of 20080119 (2 days post-discharge) was rated at 20% without access to Service Treatment Records. Exam noted limited and painful ROM status post L5-S1 Fusion with Laminectomy and Discectomy of the Lumbar Spine. The CI reported pain and stiffness with walking, standing, running, and climbing stairs and pain with increased activities. The summary noted: "You wear a back brace for support and use a cane to assist with walking. Exam noted radiation of pain on movement, muscle spasms, and tenderness. The LS ROM was flexion to 65 degrees, extension to 10 degrees right/left lateral flexion to 10 degrees, and right/left rotation to 20 degrees. Your combined range of motion was 115 degrees *(possible math error; appears to be 135˚ combined: see table*). Motor strength and tone were normal in both lower extremities. However, light touch sensation in the left foot was diminished. There was no heat, redness, swelling, or effusion. There was no weakness, laxity, instability, lack of endurance, incoordination, or ankylosis. It was noted that there was no decrease in the range of motion additionally limited by pain, fatigue, weakness, or lack of endurance following repetitive use. An evaluation of 20 percent is granted because there is documentation that the combined range of motion of the thoracolumbar spine is not greater than 120 degrees. [NOTE: Although there appears to be a math error in the VA's rating rationale for the exam of 20080119 (combined ROM should be 135˚ vice 115˚), this does not appear to be substantive as the exam noted abnormal gait, use of an assistive devise and required assistance with clothes (socks) which would have still met the criteria for a 20% rating.] The portion of this exam for the left lower extremity and radicular symptoms also noted significant left leg weakness and that the CI had fallen several times, resulting in further injuries to his left foot. The CI had tender / healing left fourth and fifth metatarsals and his left foot was slightly weaker on flexion than the right foot.

VA exam of 20080505 (4 months post discharge) led to an increased the LBP rating to 40% effective 20080415. The exam noted constant severe LBP, radiating to the front of the left leg to the toes, frequent weakness that sometimes causes a fall. The CI was taking Vicodin for pain, which usually did not give any relief, and had some side effects of sleepiness. The CI wore a back brace constantly, occasionally using a cane and described significant disability. ROM limits were Flexion 35˚/combined 145˚. The rater stated" Although you do not meet the criteria for 40 percent, 38 CFR 4.40 and 4.45 allows consideration of functional loss due to painful motion and stiffness with repeated motion. Since you demonstrate painful motion, and stiffness with repeated motion, the 40 percent evaluation is assigned."

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| Movement  **Thoracolumbar** | Normal ROM | ROM Mil  Avg of 3 (Calc)  **20070727** | ROM Mil PAIN  Avg of 3 (Calc)  **20071130** | ROM VA PAIN  **20080119** | ROM VA PAIN  **20080505** |
| Flex | 0-**90** | 6 (5) | 35 (**35**) | 65 | 0-**35** |
| Ext | 0-**30** | 12 (10) | 20 (20) | 10 | 0-15 |
| R Lat flex | 0-**30** | 9 (10) | 17 (15) | 10 | 0-20 |
| L lat flex | 0-**30** | 16 (15) | 16 (15) | 10 | 0-20 |
| R rotation | 0-**30** | 14 (15) | 31 (30) | 20 | 0-30 |
| L rotation | 0-**30** | 10 (10) | 22 (20) | 20 | 0-30 |
| COMBINED | **240** | 65 | **135** | 135 (**RD *115***) | 145 |
| Surgery 20070205 |  | **< 6 months post-op** | **NARSUM 20071114: tender 'marked pain at 20˚ flexion'** | **abnormal gait**; **required assist with clothes** | **abnormal gait; spasms**  §4.40 and §4.45 |

Absent the pain rule, the 20071114 NARSUM limitation of "marked pain with attempts to flex the spine even at 20 degrees of flexion" would meet the 40% rating criteria. The more detailed repetitive PT ROMs accomplished 2 weeks later showed flexion 35˚ and would rate at 20%. The VA exam of 20080119 with abnormal gait and requiring assistance rated at 20%. The VA exam 4 months post discharge met the 20% flexion criteria and was rated at 40% IAW §4.40 Functional loss and §4.45 The Joints.

The CI's thoracolumbar spine condition should be rated at 40% using either the military NARSUM for pain-limited forward flexion (20˚), or the CI's overall musculoskeletal disability related to the lumbosacral spine IAW §4.40 Functional loss and §4.45 The Joints. There is strong evidence from the NARSUM and subsequent VA exams that the CI's disability is better represented by the 40% rating level due to §4.40 Functional loss as demonstrated by severe pain, use of an assistive device (cane), incoordination, high levels of pain medications required, and radicular non-pain symptoms and signs. Use of §4.45 The Joints parts (c) weakened movement and (e) incoordination were also well documented in the NARSUM and VA exams within 4 months of separation without intervening trauma or indicators of worsening. As the CI's non-pain radicular sensory and neurologic losses (foot drop and weakness in the left lower extremity when walking on the heels) were unlikely to be separately unfitting and ratable, it is most reasonable to combine them into a higher back rating of 40%.

**Depression:**  The MEB psychiatrist's addendum of 20071116 comprehensively noted the CI's history of depressive symptoms from Feb 2006, familial and legal stressors (death of father, aunt, and grandfather) loss of Company Command position (Mar 07), back pain and narcotic use leading to tolerance/dependence and two substance abuse treatment programs, with continued concerns over seeking narcotics from physician sources. Past alcohol use and family history of depression were noted. In Oct 2006 the CI had increased anxiety which was marked by episodes of shortness of breath. "The patient was overwhelmed by numerous stressors, his father's death, potential for MEB due to his LBP, job responsibilities and marital difficulties." The CI was seeing a pain specialist who prescribed Skelaxin, Neurontin and methadone for his continuing postoperative pain. The CI developed fears about someone breaking into his house while sleeping. These fears were significant enough for the patient to sleep with his door shut and locked and with a firearm. In Jun 2007 the CI's grandfather died which worsened his depression. The CI had a declining work performance and had received several negative counselings and appeared to be intoxicated at work and in Aug 2007 the CI's command referred him to Substance Abuse Rehabilitation Division (SARD) because he seemed intoxicated, which was likely due to prescribed medications. "(The CI) was confronted on the fact that it seemed that he was going out of his way to obtain narcotic pain medication and that he had developed an addiction to these medications. Arrangements were made to have the patient admitted to Inpatient Detox…" In Oct 2007 the CI was having significant marital problems, was assigned to the Warrior Transition Unit and was also enrolled in a VA Substance-Abuse Treatment Program – Intensive Outpatient Program. He had significant conflicts with the Hospital Command over issues of his accountability at the VA Program and the possibility that he again was obtaining pain medications from an outside physician. The CI was enrolled at a third substance abuse program at the time of the NARSUM (20071116). The psychiatrist's PRESENT CONDITION and FUNCTIONAL STATUS is quoted below:

"(The CI) continues to struggle with his depressive symptoms which are related at his unresolved issues surrounding his father's death. However, because of his back pain and consequent use of narcotic analgesics he has developed an opioid dependence. This has become a significant feature in his presentation and has complicated his course of depression. The patient has had significant work related difficulties mainly in the form of declining work performance. He has been through an inpatient detoxification program and a Veterans Administration outpatient program. Despite this, sobriety remains a challenge for the patient. His depression has been difficult to treat and has also caused difficulties in his ability to function at work and in his marriage. He has been tried on various antidepressants without lasting results. His use of substances has not allowed him to effectively deal with his depression and his bereavement. This will likely continue to be a source of difficulty for him. He will need intensive treatment for his opioid addiction and his concurrent regular treatment for depression. His depressive treatment must consist of medication management and psychotherapy. The undersigned believes that the success of his treatment for his depression depends on his commitment to sobriety. As such his prognosis is guarded. Initially the undersigned believed that this depression did not require disposition through medical channels however given his level of psychosocial dysfunction a formal Medical Evaluation Board addendum has been written."

The VA exam of 20080204 (<1 month post-discharge) diagnosed Major Depressive Disorder with Anxiety and was rated at 30%. The CI reported diminished interest and participation in activities; poor memory; persistent feelings of detachment and estrangement from others; poor sleeping pattern; intrusive thoughts; irritability; easily startled; anxiousness; depression; poor concentration; hopelessness; and lack of interest. Exam showed mood was depressed and affect was mood congruent; memory was slightly impaired for immediate information. The examiner noted moderate to considerable symptoms associated with major depressive disorder. The examiner estimated his level of disability to be in the moderate to considerable range and moderately impaired social adaptability and interactions with others. His Global Assessment of Functioning (GAF) score was 54. The VA rated this exam at 30% noting mood was depressed; an inability in establishing and maintaining effective work, social relationships; a GAF of 54 and addressed that although some of the 50% criteria were demonstrated that the CI's overall disability picture more closely approximates the 30 percent evaluation.

The psychiatry NARSUM addendum noted a level of psychosocial dysfunction that clearly adversely impacted the CI's ability to work and the CI's marriage over an extended period of time. The complicating issues of seeking pain medications cannot easily be removed from the picture of the CI's disability. However, the opioid dependence/tolerance and substance abuse treatments were distinctly tied to the CI's non-psychiatric medical condition (LBP) pain medication and psychotropic medication use. The initial VA rating and exam did not have the history of opioid dependence or treatment and separately rated the CI at 30%. There is no way short of pure speculation to deduct for opioid dependence as "not ratable" for its contribution to the CI's mental health disability. Due to the length of the CI's symptoms and occupational and social difficulties, absent DoDI guidance and IAW the VASRD in effect at the time, CI's MH diagnosis should be rated at 30% for Occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks (although generally functioning satisfactorily, with routine behavior, self-care, and conversation normal) due to his symptoms.

**Radiculopathy, Left Leg:** The military treatment record documented post-surgical (Feb 2007 L5-S1 fusion with laminectomy and discectomy) foot drop that resolved to the point where the residual was noted in the NARSUM as "weakness in the left lower extremity when walking on the heels however he was able to plantar flex without difficulty and walk on his tip toes. Otherwise he had normal strength in the lower extremities on examination. He exhibited equal bilateral deep tendon reflexes at the patella and the ankle jerk and ankle bilaterally. The patient had no demonstrable numbness or loss of sensation in the lower extremities."

The VA exam, 2 days post-discharge, noted (claimed left leg pain and numbness due to back) that the CI reported numbness, pain, and tingling down the left leg to the foot. The examiner noted that the CI had significant left leg weakness and had fallen several times, resulting in further injuries to his left foot with documented healing fractures of the left third and fourth metatarsals. The CI also had slight loss of sensation to the (left) foot and the left foot was slightly weaker on flexion than the right foot.

This condition was noted in the DES package. However, it is unlikely to have been separately unfitting and is difficult to separate from a fitness aspect from the LBP condition above. In this case, it is best considered and rated under the CI's lumbosacral spine condition as discussed above IAW §4.40 Functional loss and §4.45 The Joints, with additional consideration of VASRD §4.7 (higher of 2 evaluations).

**Opioid dependence:** As the PEB noted, "opioid dependence, does not constitute a physical disability and is not ratable in the absence of an underlying ratable causative disorder as specified in DoDI 1332.38, November 14, 1996." However, this condition was integrally related to the CI's two ratable diagnoses (LBP, Depression) and any disability attributed to opioid dependence should be considered within the rating for those diagnoses.

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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 PDBR to the extent they were inconsistent with the VASRD in effect at the time of the adjudication. The PEB 10% rating for 5241 "Fusion of the lower back resulting in lower back pain and limitation of range of motion secondary to pain with no mechanical block to range of motion noted" was most likely due to application of the USAPDA Pain policy, in conflict with the PDBR DoDI cited above. The Board also determined that the CI's radicular symptoms, left foot flexion weakness, incoordination, and need for significant pain medications contributed substantially to the CI's overall disability so that the overall thoracolumbar disability was not adequately reflected in a 20% rating using limited flexion alone. The individual components of that disability are not amendable to separate coding and rating without pushing the threshold for separately unfitting. Given these factors, and that a higher rating is defensible independently IAW VASRD §4.40 and §4.45, the Board, therefore, agreed by a simple majority that the proper rating for the CI’s 5241 back condition was 40%. IAW VASRD §4.3, reasonable doubt is resolved in favor of the CI in recommending a separation rating of 40% for the LBP condition. The 10% PEB Mental Health rating was most likely based on DoDI 1332.39 (E2.A1.5) in conflict with the PDBR DoDI cited above. Absent DoDI 1332.39, and using only the VASRD in effect at the time, the clinical picture would have met criteria for a 30% rating using either the military or VA examinations. The Board, therefore, was in unanimous agreement that the proper rating for the CI’s 9434 Major Depressive Disorder was 30%. The Board unanimously agreed that opioid dependence was not separately ratable and any disability due to that condition was appropriately considered in the CI's ratable diagnoses.

The Board voted by simple majority to rate the CI at 40% for 5241 Fusion of the lower back resulting in lower back pain and limitation of range of motion and function; and at 30% for Major Depressive Disorder. The single voter for dissent (who recommended adopting the VA rating 5241 at 20% and 9434 at 30%) elected not to submit a minority opinion.

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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 the CI’s prior medical separation.

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| --- | --- | --- |
| Unfitting Condition | VASRD Code | Rating |
| Fusion of the lower back resulting in lower back pain and limitation of range of motion AND FUNCTION | 5241 | 40% |
| Major depressive disorder | 9434 | 30% |
| Combined | 60% |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090119, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

SFMR-RB

**DEPARTMENT OF THE ARMY**

ARMY REVIEW BOARDS AGENCY

1901 SOUTH BELL STREET 2ND FLOOR

ARLINGTON, VA 22202-4508

02 NOV 2009

MEMORANDUM THRU Commander, US Army Physical Disability Agency

(TAPD-ZB /), WRAMC, Building 7, Washington, D.C. 20307-5001

FOR US Army Review Boards Agency Support Division, st. Louis (SFMR-RBR-SL),

9700 Page Avenue, St. Louis, MO 63132-5200

SUBJECT: Department of Defense Physical Disability Board of Review Recommendation

for XXXXXXXXXXX, AR20090018394 (PD200900072)

1. Under the authority of Title 10, United States Code, section 1554(a), I approve the

enclosed recommendation of the Department of Defense Physical Disability Board of

Review (000 PDBR) pertaining to the individual named in the subject line above to

recharacterize the individual's separation as a disability retirement with the combined

disability rating of 60% effective the date of the individual's original medical separation

for disability with severance pay.

2. I direct that all the Department of the Army records of the individual concerned be

corrected as shown in the 000 PDBR recommendation letter and record of proceedings

and the pay and allowances adjusted accordingly no later than 120 days from the date

of this memorandum. Pay and allowance adjustment will account for recoupment of

severance pay and provide payment of permanent retired pay at 60% effective the date

of the individual's original medical separation for disability. The individual will be

afforded the opportunity to elect Survivor Benefit Plan (SBP) and medical TRICARE

retiree options.

3. I request that a copy of the corrections and-anyrelated correspondence be provided

to the individual concerned, counsel (if any), any Members of Congress who have

shown interest, and to the Army Review Boards Agency.

BY ORDER OF THE SECRETARY OF THE ARMY:

Encl