RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: ARMY

CASE NUMBER: PD0900105 BOARD DATE: 20100325

SEPARATION DATE: 20030518

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SUMMARY OF CASE: This covered individual (CI) was an active duty SGT (Calvary Scout) medically separated from the Army in 2003 after 7 years of service. The medical basis for the separation was a back condition with radiculopathy. He developed back pain with left lower extremity radicular pain in 2002 during field duty. His pain worsened over time and he developed numbness and weakness in the leg. A Magnetic Resonance Imaging (MRI) demonstrated L5/S1 disc protrusion to the left. He was treated with traction, epidural injections and other conservative measures without adequate relief. Surgical options were discussed, but deferred. He was placed on a permanent L3 profile and confined to desk duty. He underwent a Medical Evaluation Board (MEB) which forwarded the lumbar disc disease and radiculopathy as a single condition to the Physical Evaluation Board (PEB) and noted as medically unacceptable IAW AR 40-501. Other medical conditions identified by the MEB were acne, gastroesophageal reflux (GERD) and a benign intention tremor. These were forwarded on the DA Form 3947 as within AR 40-501 standards. The PEB found the CI unfit for lumbar disc disease and the radiculopathy rated separately at 10% each. The other three conditions were adjudicated as not unfitting and the CI was medically separated with a combined disability rating of 20%.

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CI CONTENTION: The CI states: ‘I was a little confused and disappointed with the MEB when I received 10% from the Army and for the same injuries I received 50% from the VA. I am not asking for more disability, I just do not understand how the two institutions could be so far apart on the same conditions. Thank you for help in this matter.’ His statement elaborates the current pain and limitations with his back and radiculopathy. He also notes a bilateral knee condition as service connected.

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RATING COMPARISON:

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| --- | --- |
| **Service PEB – Dated 20030321** | **VA (Pre-Separation) – All Effective 20030519** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Herniated L-5-S1 Disc… | 5293-5295 | 10% | Lumbar Spine, Degenerative Disc Disease… | 5293-5292 | 20% | 20030425 |
| Residual Radiculopathy… | 5293-8260 | 10% | Radiculitis… | 8520 | 20% | 20030425 |
| Acne | Not Unfitting | No VA Rating. | 20030425 |
| GERD | Not Unfitting | GERD | 7399-7346 | 0% | 20030425 |
| Benign Intention Tremor | Not Unfitting | Benign Intention Tremor | 8105 | 10% | 20030425 |
| ↓No Additional DA 3947 Entries.↓ | L Knee DJD | 5010-5284 | 10% | 20030425 |
| Non-PEB X 1 / NSC X 2 | 20030425 |
| **TOTAL Combined: 20%** | **TOTAL Combined (*Includes Non-PEB Conditions*): 50%**   |

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ANALYSIS SUMMARY:

Lumbar Spine Condition. The back condition was rated IAW the 2003 Veterans Administration Schedule for Rating Disabilities (VASRD) standards which are no longer in effect. The current spine formula is based on range-of-motion (ROM) measurements and therefore more objective. The 2003 ratings were based on the examiner’s or rater’s opinion as to whether the disability was mild, moderate or severe. The MEB and VA examinations were similar, thus the different ratings were based on the PEB opinion that disability was mild (10%) vs. the VA rater’s opinion that disability was moderate (20%). Many cases rated under the old rules do not provide the ROM criteria required for rating under the current formula. In these cases, the Board must base its recommendation solely on its own opinion as to severity of disability. This case, however, does document all elements required to rate under current VASRD §4.71a spine rating criteria. Although a default to the VASRD criteria in effect at the time is mandated by DoDI 6040.44, the Board sees no reason why current criteria cannot be used as a guide to its recommendation regarding estimated disability under the old standards. Since the objective elements applied to our recommendations for the majority of our back cases are present in this case, it allows us to use the same ‘yardstick’ for purposes of uniformity and equity.

There are two ROM examinations documented by the MEB. The one in the orthopedist’s narrative summary (NARSUM) documented flexion of 80°, extension 10° and lateral flexion of 25° right and left. Since rotations were not documented, a combined rating is unobtainable. The Internal Medicine addendum to the NARSUM, however, contained a separate full set of ROM measurements. This documented flexion of 85° and combined ROM of 235°. The pre-separation VA examination included goniometry measurements after ‘three Deluca repetitions’. These were flexion of 65° and combined ROM of 205°. None of the examinations documented abnormal gait or contour which would achieve a 20% rating under current standards. All of these examinations yield a 10% rating under the existing §4.71a formula which underpins the majority of Board recommendations for back cases. The Board also evaluated application of the 2003 VASRD codes and ratings with disregard to the current standards and the uniformity rationale as elaborated above. The 5295 code applied by the PEB was commonly used during that period. The 20% rating for 5295 required ‘muscle spasm on extreme forward bending, loss of lateral spine motion, unilateral, in standing position’. The CI’s condition clearly did not meet that threshold, and the PEB rating was consistent with the code. The VA applied the 5292 code for limitation of spine motion. The minimally impaired ROM’s in evidence are not a convincing foundation for the ‘moderate’ limitation of motion required for a 20% rating. The Board therefore cannot support a 20% rating under the 5292 code. The Board considered rating under the 5293 code for intervertebral disc syndrome. It is a fit with the pathology, but the 5293 rating criteria subsume the impairment from the radiculopathy. A 20% rating for ‘moderate, recurring attacks’ could be justified under 5293; but, after due deliberation, the Board did not believe it was justified to apply the 20% rating and still add a peripheral nerve rating. Since combining the PEB’s two 10% ratings into a single 20% rating would be of no total benefit to the CI, the Board sees no reason for recommending this coding option. All evidence considered, the 5295 code applied by the PEB is the best choice but a higher rating cannot be justified under this code. There is not reasonable doubt in the CI’s favor for recommending a change in the PEB’s code and rating for the lumbar spine condition.

Radiculopathy. Although not confirmed by electromyogram (EMG) (nerve conduction study), there is no question that the CI suffered from a left L5/S1 (sciatic) radiculopathy. In splitting out and separately rating it, the PEB acknowledged that the additional impairment caused by the peripheral nerve involvement was separately unfitting. The 8520 rating criteria for sciatic nerve impairment are unchanged from 2003. As with the spine rating, the nerve rating differed between the PEB and the VA based on opinion as to whether there was mild (10%) or moderate (20%) incomplete paralysis. There are four detailed neurologic examinations in evidence from which to assess the severity of the neuropathy. The MEB orthopedist described intact sensation, 5/5 motor strength of all lower extremity groups and 2+ symmetric tendon reflexes. The MEB internist noted decreased sensation in the S1 dermatome, ‘very mild’ weakness of left foot dorsiflexion and symmetric 2+ reflexes. A civilian spine surgeon was consulted by the MEB. His exam noted intact sensation, 5/5 strength in all groups but an absent Achilles reflex on the left. This consult stated ‘At this point, he believes that his weakness has plateaued and he has not gotten any weaker in his left leg. He also states that the majority of his discomfort is back pain related and not related to leg pain.’ The VA rating examiner documented a normal motor examination but did not detail a sensory exam or annotate tendon reflexes. Although not supported by exam findings, he concluded ‘The L5-S1 sensorimotor findings on the left lower extremity do demonstrate a dominant component of sensory and also likely component of motor distribution, chronic recurrent lumbar radiculitis.’ Note was made in several exams and in the VA rating decision that there was atrophy of the left calf. The NARSUM noted only a half centimeter and the VA exam a half inch difference in measured circumference. These objective findings do not indicate that there was significant muscle atrophy, nor would any be expected on the basis of the motor examinations in evidence.

The overall conclusion that may be surmised from the evidence detailed above is that the peripheral neuropathy was mostly sensory in nature. That would not appear to be a constant dense numbness. Some mild weakness to forceful step-off on the left foot can also be assumed. Certainly the radicular pain should not be discounted, but the spine surgeon’s note implies that this was fairly mild at the time of separation. The Board has applied the sciatic neuropathy rating to numerous prior cases, and functional impairment from motor weakness is the usual determinant for moderate or higher rating recommendations. The only functional limitations attributable to motor weakness that can be surmised in this case would involve competitive sports, protracted climbing or other activities not related to usual occupations or activities of daily life. The Board, therefore, does not find reasonable doubt in the CI’s favor to support a recommendation for a higher rating than that adjudicated by the PEB for the lumbar radiculopathy.

Other DA Form 3947 Conditions (Acne, GERD, Benign Intention Tremor). The acne condition has no link to fitness and is therefore not relevant for Board consideration. The GERD did not require daily medication and was not associated with episodes of protracted pain or vomiting. No reasonable argument can be made that it was unfitting. The benign intention tremor was described on the MEB physical as an intermittent symptom for the past 1½ years and by the VA examiner as ‘minimal’ without complications. It was not specifically diagnosed or treated at the time of separation. There is no evidence that it interfered with Military Occupational Specialty (MOS) duties or that it was involved with marksmanship or other soldiering requirements. All three of these conditions were judged to be within AR 40-501 standards by the MEB and were appropriately adjudicated as not unfitting by the PEB.

Other Conditions. No other medical conditions were covered in the NARSUM. The MEB physical addressed a history of bronchitis, a history of nosebleeds, a previous metatarsal fracture of the left foot and a complaint of motion sickness. None of these conditions were under active treatment during the MEB period and they were not noted in the Commander’s statement or physical profile. No link to fitness is in evidence for any of them. The CI mentioned bilateral knee pain in his contention and the VA provided a compensable (10%) rating for his left knee at the time of separation. There was no indication of active treatment for a knee condition at the time of separation and no mention of one in the NARSUM or any PEB documents. It was not noted by the CI or the examiner at the time of the MEB physical. The Board does not have the authority under DoDI 6040.44 to render fitness or rating recommendations for any conditions not considered by the Disability Evaluation System (DES). The knee condition or any contended conditions not covered above remain eligible for Army Board for Correction of Military Records (ABMCR) consideration.

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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 lumbar spine condition and IAW VASRD §4.71a, the Board unanimously recommends no change in the PEB adjudication. In the matter of the lumbar radiculopathy condition and IAW VASRD §4.124a, the Board unanimously recommends no change in the PEB adjudication. In the matter of the acne, gastroesophageal reflux and benign intention tremor conditions, the Board unanimously recommends no recharacterization of the PEB adjudication as not unfitting. In the matter of the bronchitis, nosebleeds, metatarsal fracture of the left foot, motion sickness 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.

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RECOMMENDATION: The Board therefore recommends that there be no recharacterization of the CI’s disability and separation determination.

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090202, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

