RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: ARMY

CASE NUMBER: PD0900137 BOARD DATE: 20100916

SEPARATION DATE: 20070410

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SUMMARY OF CASE: This covered individual (CI) was a National Guard SPC, E4 (MOS 62B, Vehicle Mechanic) medically separated from the Army in 2007 after 3 years of combined service. The medical bases for the separation were chronic lumbar and cervical spine conditions. The CI injured his back and neck in 2004 as a result of falling from a truck during training for an OIF mobilization. His injuries failed to improve satisfactorily to permit deployment and he was retained in medical hold for further management. During this period he developed left leg weakness and incontinence as well. A magnetic resonance imaging (MRI) and EMG (nerve conduction study) of the cervical spine were both normal. A lumbar MRI demonstrated disc protrusion at L4/5 and the EMG suggested a mild L5/S1 neuropathy. He was evaluated by neurosurgery and was not a surgical candidate. He reported aggravation of his condition with a trial of physical therapy. Further conservative measures, including epidural injections, also failed to restore him to full MOS function. He was placed on permanent U-3/L-3 profiles and referred for a Medical Evaluation Board (MEB). During the MEB period, the CI additionally developed significant psychiatric symptoms (anxiety, agitation, sleep disturbance, hyperarousal) that were complicated by concurrent alcohol and substance abuse. He was managed by Behavioral Health and received an S-3 profile. The psychiatric issues will be addressed in detail below. The lumbar and cervical spine conditions were forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501. Substance abuse and alcohol dependence were forwarded as medically unacceptable psychiatric conditions. Five other MEB conditions, as identified in the rating chart below, were forwarded on the DA Form 3947 as medically acceptable conditions. Other conditions included in the narrative summary (NARSUM) and Disability Evaluation System (DES) packet will be discussed below, but were not forwarded on the DA Form 3947. The lumbar condition (rated 20%) and the cervical condition (rated 0%) were adjudicated as the only unfitting and ratable conditions by the informal PEB. The psychiatric conditions were adjudicated as non-compensable under DoDI 1332.38. The CI did not appeal for a formal PEB and was thus medically separated with a combined disability rating of 20%.

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CI CONTENTION: The application states: “The Department of Veterans Affairs rated the member at 40% and 30% for the same conditions rated 20% and 0% by the Army.” He additionally lists all of his VA conditions and ratings (which include PTSD rated 70%) as noted in the rating chart below. A contention for their inclusion in the separation rating is therefore implied.

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RATING COMPARISON:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Service PEB – Dated 20070330** | | | **VA (~5 Mo. after Separation) – All Effective 20070411** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Chronic Low Back Pain | 5237 | 20% | Low Back Sprain | 5237 | 40% | 20070918 |
| Incontinence A/W LBP | 7599-7517 | 40% | 20070918 |
| Chronic Neck Pain | 5237 | 0% | Cervical Radiculopathy | 5237 | 30% | 20070918 |
| Substance Abuse … | Not Compensable | | Post Traumatic Stress Disorder | 9411 | 70% | 20070924 |
| Alcohol Dependence … | Not Compensable | |
| Right Ankle Sprain | Not Unfitting | | Right Ankle Sprain | 5271 | 20% | 20070918 |
| Left Knee Sprain | Not Unfitting | | Left Knee Sprain | 5257 | 10% | 20070918 |
| Allergic Rhinitis | Not Unfitting | | Allergic Rhinitis | 6522 | 0% | 20070918 |
| Asthma | Not Unfitting | | No VA Code | | | 20070918 |
| Carpal Tunnel Syndrome (CTS) | Not Unfitting | | L Wrist CTS | 8514 | 20% | 20070918 |
| R Wrist CTS | 8514 | 20% | 20070918 |
| No Additional DA Form 3947 Entries. | | | Non-PEB X 5 / NSC X 1 | | | 20070918 |
| **TOTAL Combined: 20%** | | | **TOTAL Combined (*Includes Non-PEB Conditions*): 100%** | | | |

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ANALYSIS SUMMARY:

Lumbar and Cervical Spine Conditions. The appropriate ratings for the thoracolumbar and cervical conditions are better considered in concert since their goniometric range-of-motion (ROM) measurements were performed concurrently on each of three separate examinations in evidence. These examinations are summarized in the chart below.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Goniometric ROM | MEB – 20060412 | | MEB – 20061114 | | VA C&P – 20070918 | |
| Lumbar | Cervical | Lumbar | Cervical | Lumbar | Cervical |
| Flexion | 37⁰ | 30⁰ | 60⁰ | 30⁰ | 30⁰ | 20⁰ |
| Combined | Incomplete | 189⁰ | 133⁰ | 145⁰ | 80⁰ | 90⁰ |
| §4.71a Rating | 20% | 20% | 20% | 20% | 40% | 20% |

As noted above, ROM values from the MEB are derived from two separate examinations. The PEB’s DA Form 199 quoted those from the later exam. This exam also listed abnormal gait and contour which was acknowledged on the DA Form 199. Either of these examinations would be rated 20% IAW §4.71a for both the cervical and lumbar conditions. The PEB rating was derived from the US Army Physical Disability Agency (USAPDA) pain policy. The ROM values reported by the VA examiner, 5 months after separation, are significantly worse than those reported by the MEB dated 5 months before separation. There is no record of recurrent injury or other development in explanation of the marked impairment reflected by the VA measurements. The values reported were derived from reported pain threshold with motion and the examiner stated, “Patient could not cooperate fully with this examination which is somewhat unsatisfactory”. The Board therefore assigns a higher probative value to the MEB data as a basis for its recommendations. Based on the evidence from those exams as discussed above, the Board recommends a 20% rating for both spine conditions. The Board is in agreement with the 5237 code chosen for both conditions by the PEB and the VA.

Neuropathies. It is unclear if the left sciatic neuropathy initially documented during the MEB course was associated with any clear physical exam evidence of motor weakness. The MEB examiner noted “decreased sensation” in the L5/S1 dermatome and a “slightly reduced” Achilles’ reflex. No motor deficits were documented. The VA rating examiner stated “Both lower extremities are very weak.” His exam, however, elaborated only the details of pain with motion; it did not document motor or sensory testing of any muscle groups. Furthermore all of the VA examiner’s entries, including tendon reflexes, reflected symmetric findings for a unilateral condition. The most comprehensive and highest probative value examination for upper and lower motor function was provided by a civilian neurosurgeon consulted by the MEB. This stated “normal, symmetric power in all muscle groups without atrophy” and “reflexes were 2/4 and normal throughout the upper and lower extremities”. The CI was noted to use a crutch or cane because of reported weakness and falling. There are no notes verifying that it was a prescribed or indicated. It is also noted that he was using a back brace, knee sleeve, ankle splint, bilateral wrist splints and a cervical soft collar. This raises the question of valid indications for the utilization of so many orthopedic appliances. The sciatic neuropathy was not covered under the L-3 profile and it was not separately coded and rated by the VA. There was no evidence of cervical nerve root compromise on the MRI; the EMG “showed no cervical radiculopathy, however there did appear to be mild carpal tunnel syndrome [CTS] more so on the right side”. As with the lower extremities, there is no convincing evidence by physical examination that there was significant motor impairment associated with the upper extremity condition(s). Only the cervical spine condition was covered under the U-3 profile and the MEB physician’s opinion was that the bilateral CTS was within AR 40-501 retention standards.

The presence of functional impairment with a direct impact on fitness is a crucial factor in the Board’s decision to recommend any condition for rating as additionally unfitting. There is not adequate evidence that the motor or sensory deficits associated with either the sciatic neuropathy or the bilateral CTS conditions satisfy this requirement. There is not therefore reasonable doubt in the CI’s favor for recommending left sciatic neuropathy as an additional unfitting condition or for recommending a change in the PEB’s adjudication of bilateral CTS as not unfitting.

Urinary Incontinence. The VA medical opinion that urinary incontinence was associated with L4/5 disc disease is not consistent with nerve innervation to the bladder. Even if the link were established, there is no convincing argument that the incontinence was unfitting. The CI was followed by urology during the MEB. The last note (one month prior to separation) stated that there had been no episodes of incontinence for the last six months and “no restrictions associated with voiding complaints”. Although the CI was wearing absorbent pads and reported a severity of symptoms meeting 40% rating criteria by the time of the VA examination, he had apparently reported a resolution of the symptoms at the time of separation. There is not reasonable doubt in the CI’s favor for adding urinary incontinence as an unfitting condition for separation rating.

Psychiatric Condition. The psychiatric picture is somewhat confusing, and is clouded by concurrent alcohol and substance abuse. The MEB psychiatrist (5 months prior to separation) opined an Axis I diagnosis of adjustment disorder. Predicated on continued abstinence from drugs and alcohol, his judgment was that the CI was fit for duty (albeit confined to CONUS). Prior Behavioral Health Notes reflect labile symptoms and sometimes conflicting histories. The CI had earlier reported duty in “classified operations” as a basis for his symptoms, which was investigated and established as untrue. His VA diagnosis of PTSD is open to challenge. The Criterion A stressor cited was the emotional trauma of the service injury (fall from the truck). The reported history was that the CI was “in and out of consciousness” and could not recall the duration of hospitalization. No loss of consciousness or initial medical care beyond ER evaluation and discharge is documented in the service record. The Action Officer opines that DSM IV criteria for PTSD were inaccurately assigned by the VA and that a service connected diagnosis of PTSD is not established for purposes of the Board’s recommendations. Substance abuse cannot be reasonably ascribed to a psychiatric disorder in this case, and a compensable psychiatric condition independent of the non-compensable drug and alcohol use is difficult to identify. Although the psychiatric S-3 profile was not lifted in the interval between the MEB psychiatric opinion and separation, the Commander’s statement noted only physical impairments to performance. It in fact states “interaction well, but sometimes quiet … worked well with little supervision … interact well with others”. The Board deliberated if a compensable psychiatric condition (diagnosis of depression from earlier MEB opinions, coded 9434, rated 30% derived from the MEB psychiatric addendum) should be recommended as an additionally unfitting condition for separation rating. After consideration of all the evidence, the Board agreed that there was not reasonable doubt in the CI’s favor to support said recommendation.

Other DA Form 3947 Conditions (Right Ankle Sprain, Left knee Sprain, Allergic Rhinitis and Asthma). These conditions were all 1) judged by the MEB to be within AR 40-501 standards; 2) not profiled at separation; and, 3) not implicated as unfitting in the Commander’s statement. The ankle condition was without x-ray abnormality and had been managed by physical therapy and temporary profiles. It was stable and not under active treatment at separation. The pain from the knee condition was documented in the NARSUM as having resolved. The asthma condition was controlled on medication and documented in the NARSUM as “does not interfere with his activities”. The rhinitis condition was treated with a nasal spray with “good control of the symptoms” per the NARSUM. There is thus no convincing rationale that any of these four conditions could be considered unfitting. All evidence considered, there is not reasonable doubt in the CI’s favor supporting recharacterization of the PEB fitness adjudications for any of these conditions.

Other Conditions. The only condition not discussed above which was documented in the DES packet was erectile dysfunction. This was noted to be “multifactorial” by the MEB urologist and obviously does not bear on fitness. The only other conditions identified by the VA at separation were tinnitus, hearing loss (0% rating) and temporomandibular joint dysfunction (0% rating). The Board does not have the authority under DoDI 6040.44 to render fitness or rating recommendations for any conditions not considered by the DES. All of these latter conditions service connected by the VA remain eligible for ABMCR consideration. The Board has no reasonable basis for recommending any additional unfitting condition for separation rating.

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BOARD FINDINGS: lAW 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. As discussed above, PEB reliance on the USAPDA pain policy for rating the spine conditions was operant in this case and they were adjudicated independently of that policy by the Board. 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 cervical spine condition, the Board unanimously recommends a rating of 20% coded 5237 IAW VASRD §4.71a. In the matter of any of the neuropathy conditions, including sciatic radiculopathy or carpal tunnel syndromes, the Board unanimously agrees that it cannot recommend any finding of unfit for additional rating at separation. In the matter of the urinary incontinence condition, the Board unanimously agrees that it cannot recommend a finding of unfit for additional rating at separation. In the matter of any psychiatric condition, the Board unanimously agrees that it cannot recommend a finding of unfit for additional rating at separation. In the matter of the right ankle, left knee, asthma and allergic rhinitis conditions, the Board unanimously recommends no recharacterization of the PEB adjudication as not unfitting. In the matter of the erectile dysfunction 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 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 his prior medical separation.

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| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Chronic Low Back Pain | 5237 | 20% |
| Chronic Neck Pain | 5237 | 20% |
| **COMBINED** | **40%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090204, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

