RECORD OF PROCEEDINGS WITH MINORITY OPINION

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: ARMY

CASE NUMBER: PD0900148 BOARD DATE: 20100415

SEPARATION DATE: 20070706

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SUMMARY OF CASE: This covered individual (CI) was a Guard SSG, Attack Helicopter Repair, medically separated from the Army in 2007 after 23 years of combined service. The medical bases for the separation were cervical and lumbar spine conditions. He experienced an onset of neck and back pain handling cargo three weeks after arrival in theater for a 2006 Operation Iraqi Freedom (OIF) deployment. He was placed on light duty until a return home on Rest and Recuperation (R&R) one month later where he sought further medical care. He returned to Iraq, but was promptly sent to Kuwait for physical therapy (PT) where a cervical Magnetic Resonance Imaging (MRI) was obtained. Multilevel degenerative changes ‘consistent with chronic discogenic pathology’ was demonstrated and he was transferred to Landstuhl. Conservative measures, including epidural injections, were unsuccessful in allowing him to return to theater and he was medically evacuated. He remained on active duty Medical Hold status and was further evaluated and treated at a CONUS Hub facility. A lumbar MRI at that time demonstrated degenerative changes and three-level disc disease at the L2-L5 levels. A repeat cervical MRI demonstrated degenerative changes and spinal stenosis at the C3-C7 levels (indeterminate disc abnormalities). There are intermittent and variable radicular symptoms in evidence, but no consistent radiculopathy or any neurological deficits on exam. Surgical options were discussed, but deferred. He did not respond adequately to continued conservative measures to perform within his military occupational specialty (MOS) or participate in the Army Physical Fitness Test (APFT). He was issued permanent U3 and L3 profiles and underwent a Medical Evaluation Board (MEB). The cervical and lumbar conditions were forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501. Depression and right foot conditions were addressed in the narrative summary (NARSUM) and forwarded to the PEB on the DA Form 3947. Both were designated as within AR 40-501 standards. Additional conditions supported in the Disability Evaluation System (DES) packet are discussed below, but were not forwarded for PEB adjudication. The PEB found the CI unfit only for the neck and back conditions, rated 10% each, and he was medically separated with a combined disability rating of 20%.

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CI CONTENTION: The CI states: ‘I was given a 30% Disability Rating from the VA for my unfitting conditions. I would like the PDBR to change the current 20% to 30% and consider the Veterans Administration Schedule for Rating Disabilities (VASRD) that the VA uses for disability ratings given to veterans. I do not feel that I received any compensation for my injuries in IRAQ.’ He notes his other VA-rated conditions on the application, but does not specifically contend for service ratings for them.

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RATING COMPARISON:

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Service PEB – Dated 20070614** | | | **VA (Pre-Separation) – All Effective 20070707** | | | | | |
| **Condition** | **Code** | **Rating** | **Condition** | | | **Code** | **Rating** | **Exam** |
| Chronic Neck Pain… | 5299-5237 | 10% | Degen. Arthritis, Cervical | | | 5242 | 10% | 20070509 |
| Low Back Pain… | 5299-5237 | 10% | Bulging Disc, Thoracolumbar | | 5299-5242 | | 20% | 20070509 |
| Depression | Not Unfitting | | Depression | | | 9434 | 30% | 20070508 |
| Right Foot Pain | Not Unfitting | | Exostosis, Right Foot | 5299-5281 | | | 10% | 20070509 |
| ↓No Additional DA Form 3947 Entries.↓ | | | Asthma | | | 6602 | 30% | 20070509 |
| Non-PEB X 7 | | | | | 20070509 |

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ANALYSIS SUMMARY:

The Board wishes to note that the probative value and reliability of a CI’s stated medical history and subjective elements of physical examinations in evidence are generally accepted and unchallenged. However, the Board must assign limitations to that principle in some cases. This is such a case. There are numerous examples of conflicting, implausible and frankly contradicted histories throughout the medical files. VA rating examinations for post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI), for example, contain accounts of events and injuries that were extraordinarily unlikely given the limited combat exposure as described in the summary. There are four different accounts for a concussive injury, different accounts of the reason for medical evacuation, a stated history that ‘he was injured in an explosion that threw the veteran several feet in the air’ and many other examples beyond the scope of this narrative. In addition to the implausibility based on the limited deployment exposure, it should be noted that 1) no combat awards are documented on the DD 214, 2) medical records from OIF are in evidence with no corroboration of any trauma, 3) the Post-Deployment Health Assessment was negative for any combat exposure or fear of being killed, and 4) no such injuries or events were documented by military providers at any point during the MEB period. In light of the above observations and others not included, the Board, regretfully, takes the position that the CI’s credibility as a medical historian and his reliability as an examinee for the subjective elements of the rating examinations are questionable and cannot therefore be given full weight for purposes of the ensuing recommendations.

Cervical Condition. The PEB DA Form 199 invoked application of the US Army Physical Disability Agency (USAPDA) pain policy for rating this condition. The NARSUM referenced a PT goniometric exam (4/3/07) for spine range-of-motion (ROM) evaluation. An additional PT goniometric examination as part of routine intake was performed in close proximity. These two examinations and the pre-separation VA rating examination are summarized in the chart below.

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| --- | --- | --- | --- |
| Cervical ROM | P.T. – 2/14/07 | P.T. – 4/3/07 | VA C&P – 5/9/07 |
| Flexion | 50⁰ | 30⁰ | 35⁰ |
| Combined | 285⁰ | 210⁰ | 245⁰ |
| §4.71a Rating | 10% | 20% | 10% |

The NARSUM and VA examiner documented spasm and tenderness; neither documented abnormal gait or contour. Both exams documented pain as the end-point of measurement, with the VA measuring pain on repetition as well. The VA examiner made an ambiguous notation suggesting a 5° deduction for ROM’s after repetition. If applied this would result in 20% §4.71a rating. It was obviously not applied by the VA rater, and the Board agreed that the entry was not definitive enough to justify a recommendation on that basis. These findings are tempered with several informal ROM notations in the MEB records documenting ‘normal’ or ‘full’ ROM. A detailed examination in a neurosurgical consult, although not providing measurements, stated, ‘*Flexion and extension of the neck is within normal limits.*’ Of further note, a VA entry two months after separation stated ‘*Exercise routine - He will get on treadmill walk 5 mins then jog 2 miles on the treadmill - does 4x a week. He lifts weights and does push-ups, other resistance exercise.*’ The measurement of ROM reflecting pain with motion is dependent on the examinee’s reported pain with scant ability by the examiner to objectively confirm it. The MEB rating PT examination and the VA rating examinations were both subject to invalid influence in that regard. The incidental entry from an unrelated VA examination regarding exercise capabilities is not consistent with the spinal impairment reflected on the formal rating ROM examinations. All of these factors, coupled with the overall probative value concerns already elaborated, significantly constrains the reasonable doubt necessary to recommend a more favorable 20% cervical rating in this case. There was no evidence of ratable peripheral nerve impairment. The Board therefore recommends no recharacterization of the PEB adjudication for the cervical spine condition.

Thoracolumbar Condition. The PEB DA Form 199 invoked application of the USAPDA pain policy for rating this condition. There was no separate PT evaluation for thoracolumbar ROM measurements as with the cervical condition. The MEB PT and VA examinations are charted below.

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| --- | --- | --- |
| Thoracolumbar ROM | P.T. – 4/3/07 | VA C&P – 5/9/07 |
| Flexion | 85⁰ | 50⁰ |
| Combined | 250⁰ | 100⁰ |
| §4.71a Rating | 10% | 20% |

Both exams documented spasm and tenderness; neither documented abnormal gait or contour. Both exams documented pain as the end-point of measurement. The same ambiguous 5° deduction note was also entered on the VA thoracolumbar exam, but had no rating implications in this instance. Informal ROM exams and the neurosurgical consult note are equivalent to the comments above for the cervical condition. The caveat noted in the incidental VA note regarding exercise habits is equally applicable to the thoracolumbar rating. The reasonable doubt necessary to default to the most favorable examination for a rating recommendation is mitigated on the same basis as elaborated for the cervical condition. There was no evidence of ratable peripheral nerve impairment. The Board therefore recommends no recharacterization of the PEB adjudication for the lumbar spine condition.

Other DA Form 3947 Conditions (Depression, R Foot Condition). The CI was diagnosed with non-specific depressive disorder shortly prior to separation. He first presented to Behavioral Health less than four months prior to separation. He manifested no acute psychiatric features and was placed on an anti-depressant. Serial mental status examinations were normal. His Axis I PTSD diagnosis did not evolve until after separation. The Criterion A stressor applied by the VA was stated as, ‘The patient reports nightmares and flashbacks about his injury in the service. This basically involves him injuring his back and neck when a pallet came loose from a plane and hit him.’ A psychiatrist’s statement to the MEB specified ‘His condition does not disqualify him for continued military service and will not require submission of a medical board addendum.’ A psychiatric condition was not noted in the Commander’s statement and no mental impairments were described by the Commander or in enlisted evaluation reports. The physical profile was S1 without weapon restriction. There is not reasonable doubt in the CI’s favor supporting recharacterization of the PEB fitness adjudication for the psychiatric condition.

Although the DA Form 3947 forwarded right foot pain as a medically acceptable condition, it was not elaborated in the NARSUM nor is it entirely clear in the service record what condition was being referred to. There are two podiatry visits in evidence during the MEB period, but they were for a bilateral congenital foot deformity. The MEB physical also documented a bilateral hammer toe condition. The VA rating examiner yielded a diagnosis of exostosis (bone spur) of the right foot for which he was rated 10%. This was based on a six month history of pain. A service x-ray of the foot was normal. The VA exam stated ‘He does not have any limitation with standing and walking. He does not require any type of support with his shoes.’ A foot condition was not noted on the profile or in the Commander’s statement. There is not reasonable doubt in the CI’s favor supporting recharacterization of the PEB fitness adjudication for the right foot condition.

Other Conditions. In addition to the conditions already discussed, the CI listed multiple other conditions or complaints on the MEB physical. Some are not relevant for Board consideration as additionally unfitting, but some merit scrutiny. None of these conditions were covered by physical profile or noted in the Commander’s statement. The CI related an intermittent history of wheezing associated with exercise for which he periodically used an inhaler. He related the onset to toxic fume exposure in Iraq per a VA note. His MEB medication list does not include a bronchodilator or other asthma medications. There are no emergency or primary care visits for respiratory symptoms during the MEB period. The profile was P1. Bilateral hearing impairment was mentioned. It was not service connected by the VA and audiometric findings were not compensable. The profile was H1. The CI had a prior history of right shoulder injury and arthroscopy. There is no evidence of issues with it until a complaint of right shoulder pain on the MEB physical. No abnormal shoulder exams or active complaints are in evidence during the MEB period otherwise. Similar observations are applicable to left knee and right ankle complaints on the MEB physical. Acid reflux (GERD) was noted on the physical. Although the condition was rated 10% by the VA, the rating examiner described no active symptoms or treatment. Headaches and dizziness were reported on the physical. These surfaced in conjunction with a TBI claim to the VA, but were not clinically active during the MEB period. The CI was diagnosed with obstructive sleep apnea (OSA) less than two months prior to separation. OSA was not noted in the NARSUM, mentioned on the MEB physical or contended to the PEB. The same is true of the PTSD diagnosis. 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. The OSA, PTSD and any contended conditions not covered above remain eligible for Army Board of Correction for Military Records (ABCMR) 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. As discussed above, PEB reliance on the USAPDA pain policy for rating the cervical and lumbar conditions was operant in this case and the conditions were adjudicated independently of that policy by the Board. In the matter of the cervical condition and IAW VASRD §4.71a, the Board unanimously recommends no change in the PEB adjudication. In the matter of the thoracolumbar condition and IAW VASRD §4.71a, the Board by a 2:1 vote recommends no change in the PEB adjudication. The single voter for dissent (who recommended adopting the VA rating of 20%) submitted the addended minority opinion. In the matter of the depression and right foot conditions, the Board unanimously recommends no recharacterization of the PEB adjudication as not unfitting. In the matter of the asthma, bilateral hearing impairment, right shoulder condition, left knee condition, right ankle condition, acid reflux, headache condition 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.

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 20090210, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

MINORITY OPINION

I non-concur with the Majority’s decision and contend that the CI should receive a 30% combined disability for 10% (Neck 5242) and 20% (Back 5242):

1. I believe the CI’s Military and VA (Neck and Back) ROM examinations should be considered independently of his personal military and medical accounts. Although there is some evidence that possible invalid historical information was provided to VA examiners by the CI, the assumption that this would extend to exaggerating physical findings is overly speculative. The exam evidence speaks for itself. (See ROM tables below).
2. None of the physicians or medical providers who examined the CI either during service or after separation made any notations indicating that the CI was exaggerating any of his physical symptoms. In the absence of evidence indicating that the CI’s back condition is less severe than the objective examination evidence, the evidence must be taken at face value. It is also illogical that the CI would exaggerate cervical and lumbar ROM differently on separate examinations as the majority opinion in this case would imply. (See ROM tables below).
3. Only the VA ROM (Neck and Back) examinations clearly denote to which ‘degree that pain occurs’. The most complete examination has to warrant the most probative value. In this case, the VA examinations were the only complete examinations in the CI’s file.

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| Cervical ROM | P.T. – 2/14/07 | P.T. – 4/3/07 | VA C&P – 5/9/07 |
| Flexion | 50⁰ | 30⁰ | 35⁰ degree that pain occurs |
| Combined | 285⁰ | 210⁰ | 245⁰ |
| §4.71a Rating | 10% | 20% | 10% |
| Comments | - No exaggeration noted  - Utilize goniometer for “Rotation” ROM only | - No exaggeration noted  - Utilize goniometer & inclinometer | - No exaggeration noted  - Utilized goniometer  - Degree that pain occurs |

|  |  |  |
| --- | --- | --- |
| Thoracolumbar ROM | P.T. – 4/3/07 | VA C&P – 5/9/07 |
| Flexion | 85⁰ | 50⁰ |
| Combined | 250⁰ | 100⁰ |
| §4.71a Rating | 10% | 20% |
| Comments | - No exaggeration noted  - Utilize goniometer & inclinometer  - Active ROM limited by pain | - No exaggeration noted  - Utilized goniometer  - Degree that pain occurs |

1. Whatever the conclusion regarding the validity of some VA conditions or ratings, they are not the focus of the Board’s recommendations. There is sufficient reasonable doubt in the CI’s favor supporting valid exam findings for his unfitting spinal conditions. These findings support the ratings recommended in this opinion.

