RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: ARMY

CASE NUMBER: PD0900156 BOARD DATE: 20100225

SEPARATION DATE: 20050106

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SUMMARY OF CASE: This covered individual (CI) was an active duty NCO (artillery) medically separated from the Army in 2005 after 10 years of service. The medical bases for the separation were a neck injury and sinusitis. He sustained a whiplash and penetrating shrapnel injury to his neck when his vehicle was struck by a rocket propelled grenade during an Operation Iraqi Freedom (OIF) deployment in 2003. He was stabilized and medically evacuated, requiring ventilator support for several days. The shrapnel fragment was lodged adjacent to a vertebra and not amendable to surgical removal. He suffered continued neck pain and swallowing dysfunction. He underwent an extended trial of physical therapy, pain management, epidural injections, speech therapy and other rehabilitative measures. He also developed recurrent sinusitis and underwent nasal turbinate surgery which was complicated by a septal perforation. He was unable to resume the rigorous physical requirements of his military occupational specialty (MOS), received a permanent U3 profile and referred for a medical evaluation board (MEB). The neck pain and sinusitis conditions were forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR-40-501. He was also suspected of a rheumatologic disorder and had a positive ANA titer, although not a specifically diagnosed disease, by the specialty consultant. This was forwarded to the PEB on the DA Form 3947 as a medically acceptable condition. Additional conditions supported in the Disability Evaluation System (DES) packet are discussed below, but were not forwarded for PEB adjudication. An informal PEB found the CI unfit for the neck and sinus conditions, rated 10% each. This was upheld by a formal PEB and by the US Army Physical Disability Agency (USAPDA) on appeal. The CI was medically separated with a total disability rating of 20%.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CI CONTENTION: The CI states: ‘Rated only for shrapnel in neck. Denied rating for following that occurred with injury: Hyoid Fracture, Scars from injury, mild to moderate dysphagia, concussion blast injury, and severe chronic pain due to muscle injury (shrapnel and glass protruding into right anterior of neck. I was informed by the PEB that the VA will rate these findings and that it was insufficient for a claim to support my neck injury.’

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RATING COMPARISON:

|  |  |
| --- | --- |
| **Service PEB** | **VA (22 Mo. after Separation) – All Effective 20050107** |
| **Condition** | **Code** | **Rating** | **Date** | **Condition** | **Code** | **Rating** | **Exam** |
| Chronic Neck Pain… | 5237 | 10% | 20041021 | Residuals Shrapnel Wound, Neck… | 5323 | 10% | 20061118 |
| Surgical Scar…Neck | 7804 | 10% | 20061118 |
| Chronic Pan Sinusitis… | 6510 | 10% | 20041021 | Nasoseptal Perforation with Chronic Rhinosinusitis | 6502-6510 | 10% | 20061118 |
| Positive ANA Titer | Not Unfitting | 20041021 | Positive ANA Titer  | 5099-5002 | NSC | 20061118 |
| No Additional DA 3947 Entries. | Non-PEB X 1 | 20061118 |
| **TOTAL Combined: 20%** | **TOTAL Combined (*Includes Non-PEB Conditions*): 30%**   |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ANALYSIS SUMMARY:

It is noted for the record that the Board recognizes the significant interval (22 months) between the date of separation and the VA evaluation. DoDI 6040.44, under which the Board operates, specifies a 12 month interval for special consideration to VA findings. This does not mean that the VA information was disregarded, as it was a valuable source for clinical information and opinions relevant to the Board’s evaluation. In matters germane to the severity and disability at the time of separation, however, the information in the service treatment record (STR) was assigned proportionately more probative value as a basis for the Board’s rating recommendations.

Neck Injury. The cervical pathology is somewhat intertwined, but is clinically associated with two components. One is the direct tissue damage from the shrapnel missile and sequelae of the retained fragment. The other is a myofascial and cervical strain injury from the whiplash mechanism. Both contributed to pain, spasm and loss of mobility. This is evident in numerous STR entries, was opined by consultants and is reflected in the VA rating examination and subsequent VA records. The narrative summary (NARSUM) and DA Form 3947 forwarded the condition as ‘Chronic neck pain with decreased range of motion secondary to whiplash injury and penetrating trauma to the right anterior neck, with retained shrapnel fragment.’ The PEB’s DA Form 199 paraphrased the condition, inserting ‘status post whiplash injury and shrapnel wound’ in the description. The VA rating decision characterized it only as ‘shrapnel wound, neck’. This mixed etiology is manifested by the separate coding approaches in the PEB and VA determinations. The PEB rated for the musculoskeletal component under the Veterans Administration Schedule for Rating Disability (VASRD) spine formula, but the VA rated for the tissue injury under a muscle code. The Board, however, recognizes that there are two conditions that do not necessarily have to be rolled into one. It is conceded that separate rating determinations and separate fitness adjudications are difficult with such overlapping of findings and symptoms. Rating involves negotiating a thorny path around pyramiding, and separation of the fitness implications is fraught with speculation. What is clear, however, is that the overall disability picture at separation is too severe to be encompassed by the VASRD prescription under any single applicable code. The NARSUM and a letter to the MEB from the CI’s pain specialist make it clear that the functional impairments were relatively severe. There was constant moderately severe pain and physical limitations compromising both quality of life and occupational options. In a MEB addendum, responding to a PEB request for clarification of ‘the service member’s present condition with regard to chronic pain’, the physician stated, ‘It does significantly interfere with the service member’s activities of daily living.’ The letter from the pain specialist stated, ‘I consider the injury to be severely limiting to him.’ In addition the CI had continued swallowing impairment, forcing rigorous dietary habits in order to maintain his weight.

It is clear that the PEB entertained coding for the muscle injury. The following is excerpted from the PEB’s reply to the CI’s appeal.

The Board considered all possible ways to rate your neck and used the one that gave you the highest rating, 10% based on range of motion. The Board is specifically precluded from rating spine conditions for pain by Physical Disability Agency Policy/Guidance Memorandum #13, and a rating based on nerve or muscle groups would only be 0%, as there is no significant loss of muscle tissue or function.

Although the PEB acknowledged application of the USAPDA pain policy to the VASRD spine rating, the 10% determination would have been unaffected by rating strictly IAW VASRD §4.71a. The conclusion that a muscle code rating would be 0% is not necessarily true as elaborated below. The Board quarrels primarily, however, with the overall notion that only a single most favorable code could be applied. This is premised on the assumption that there was only one condition for the DA Form 199 entry ‘whiplash injury and shrapnel wound’. That assumption is open to challenge, as already discussed.

The Board directs its attention to the shrapnel wound and the PEB conclusion that there was no compensable muscle injury. First it is noted that there is no difference between the current and the 2005 VASRD §4.56 and §4.73 language. §4.56 states ‘A through-and-through injury with muscle damage shall be evaluated as no less than a moderate injury for each group of muscles damaged.’ Although the CI’s shrapnel injury was not associated with an exit wound, the path of the missile tract is self-apparent and constitutes a *de facto* through-and-through injury. The entry wound was in the right antero-lateral neck and the shrapnel was lodged abutting the contralateral aspect of the 3rd cervical vertebra. The missile tract therefore traversed two VASRD-coded muscle groups. These are elaborated in the following VASRD excerpts.

**5322** Group XXII. Function: Rotary and forward movements of the head; respiration; deglutition. Muscles of the front of the neck: (Lateral, supra-, and infrahyoid group.) (1) Trapezius (clavicular insertion); (2) sternocleidomastoid; (3) the ‘hyoid’ muscles;

(4) sternothyroid; (5) digastric.

**5323** Group XXIII. Function: Movements of the head; fixation of shoulder movements. Muscles of the side and back of the neck: Suboccipital; lateral vertebral and anterior vertebral muscles.

Rating for both is:

Severe ---------------------30

Moderately Severe ----------20

Moderate -------------------10

Slight ----------------------0

Painful motion was well documented for both muscle groups by the NARSUM and numerous other entries in the STR. An ‘anatomic barrier’ to lateral movement of the neck was documented in the NARSUM. Logically this would imply scarring and limitation of movement affecting Group XXIII. A ‘weak’ shoulder shrug was documented in physical therapy and specialty notes in the STR and by the VA examiner. This would imply muscle weakness attributable to Group XXIII. A fractured hyoid bone and swallowing impairment are directly linked to Group XXII. Thus, the Board sees no contradiction to coding the shrapnel muscle injury separately under both codes. This is not only grounded in §4.56 but supported separately on a clinical basis as just elaborated, thereby avoiding pyramiding in its own right. The lowest compensable ‘moderate’ rating assigned by §4.56 is also justified independently by the disabilities just elaborated. The Board therefore finds reasonable doubt in the CI’s favor for recommending separate codes and ratings, 5323 rated 10% and 5322 rated 10%, for the shrapnel injury.

The Board directs its attention to the whiplash injury and spine rating. The 287⁰ combined range of motion (ROM) quoted in the DA Form 199 supports a 10% cervical spine rating IAW §4.71a. Other ROM exams in the STR are also consistent with a 10% rating. Consideration for the addition of a spine rating to the muscle codes poses a quandary, however. The ROM impairment, just ‘tipping the scale’ for a 10% rating as it is, was to a significant extent due to the muscle damage and retained shrapnel. This functional impairment should be subsumed under the muscle code ratings, although it is not a required element to sustain them. The pain consultant believed that the spasm was a consequence of scarring and retained foreign body. It is, of course, impossible to apportion decrements of ROM to that mechanism versus myofascial injury from whiplash. This introduces an unacceptable degree of speculation in defense of a compensable rating for the whiplash injury. Likewise, a Board recommendation that myofascial strain would be independently unfitting, minus the shrapnel injury, is unduly speculative. It is clear that the VA found no compensable cervical strain injury, albeit nearly two years later. The Action Officer, although only to a more likely than not standard, opines that the myofascial strain component would not have rendered the CI unfit for further service. This is especially likely given the degree of motivation evident in the CI’s record. After due deliberation, the Board agreed that the dual muscle code rating accounted for all of the CI’s compensable disability related to the neck injury. No additional code for further rating can be recommended. It is noted in passing that a 10% rating for cervical myofascial strain would have no effect on the combined rating recommendation in this case.

Sinusitis. This condition was associated with a congenital deviation of the nasal septum and persistent allergic rhinitis. The CI suffered recurrent episodes of sinusitis and underwent a septoplasty in 2004. The surgery was complicated by a septal perforation, thought to be a consequence of vasculitis secondary to undiagnosed rheumatologic disease. This left him with constant nasal crusting and required prophylactic antibiotics. The condition was chiefly unfitting because it was incompatible with the use of NBC gear. The PEB’s 6510 code for pan-sinusitis is accurate and was rated IAW the general rating formula for sinusitis in §4.97. There is no evidence of any incapacitating episodes as defined under the formula, although the 10% requirement for 3-6 incapacitating episodes a year is evidenced in the STR. The VA examiner stated ‘he has never been incapacitated’ from the condition, and the 10% rating was applied. Consideration was given to additional application of code 6502 for septal deviation, but the VASRD specifies it for ‘traumatic only’ (not congenital) and the degree of airflow obstruction for a compensable (10%) rating was dubiously present. It would also be difficult to justify that septal deviation was a significant factor in the use of a gas mask. All evidence considered, there is not reasonable doubt in the CI’s favor supporting recharacterization of the PEB coding or rating adjudication for the sinusitis condition.

Rheumatologic Disorder and Other Conditions. ANA (anti-nuclear antibody) is a very non-specific marker for rheumatologic and autoimmune disorders. It was ordered because of the clinical suspicion regarding the post-op septal perforation as noted above. A rheumatologist opined that there was no diagnosable disorder and recommended monitoring only. The VA records document repeat testing as negative. The VA did not service connect the condition because there was no associated disease. There is no reasonable doubt in the CI’s favor supporting recharacterization of the PEB fitness adjudication for this condition.

The only relevant additional conditions documented in the DES packet were surgical removal of a ganglion cyst from the right wrist, history of back problems and recurrent headaches. The wrist condition was asymptomatic and coded only for the scar by the VA (0%). The back problem appeared to be resolved at the time of separation. It was not mentioned in the Commander’s statement and the physical profile was L1. The headaches were associated with the sinus and cervical conditions. They were not coded by the VA, mentioned in the Commander’s statement or noted on the physical profile. There is nothing in evidence suggesting that they were unfitting. The Board, therefore, has no reasonable basis for recommending any additional unfitting conditions for separation rating.

The VA granted a 10% rating for a left knee condition, reported as an injury related to the OIF incident. The CI denied knee problems on the MEB physical and there are no STR entries noting the knee problem as an active condition at separation. 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 knee injury and any contended conditions not covered above remain eligible for Army Board for Correction of Military Records (ABMCR) consideration.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 neck condition was operant in this case and the condition was adjudicated independently of that policy by the Board. In the matter of the cervical shrapnel injury and whiplash condition, the Board unanimously recommends that it be rated for two separate unfitting conditions as follows: injury to muscle group XXII coded 5322 and rated 10%; and, injury to muscle group XXIII coded 5323 and rated 10%; both IAW VASRD §4.56 and §4.73. In the matter of the sinusitis condition and IAW VASRD §4.97, the Board unanimously recommends no change in the PEB adjudication. In the matter of the right wrist condition, history of low back pain, 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 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.

|  |  |  |
| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Neck Shrapnel Injury to Muscle Group XXII | 5322 | 10% |
| Neck Shrapnel Injury and Retained Fragment to Muscle Group XXIII | 5323 | 10% |
| Chronic Pan-Sinusitis | 6510 | 10% |
| **COMBINED** | **30%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090106, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

