RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: usaf

CASE NUMBER: PD0900193 BOARD DATE: 20091112

SEPARATION DATE: 20060922

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SUMMARY OF CASE: This covered individual (CI) was a Captain Services Officer who was medically separated from the Air Force in 2006 after 14 years of service. The medical basis for the separation was Lower Back Pain and Left Shoulder Impingement.

This CI served almost ten years as an Allergy Technician and achieved the rank of Staff Sergeant (E5). After a break in service of less than one year she returned to service and became a Services Officer. During her initial term of service she received treatment for low back pain and left shoulder rotator cuff injury and chronic impingement. Symptoms from both problems had resolved prior to her return to service. The CI was injured during Officer Training School in 2002 when she fell from the top beam of one of the obstacles on the obstacle course and landed on her buttocks and back. She had severe back pain with bilateral pars fractures at L5 and spondylolisthesis was also noted. Conservative therapy failed to alleviate her symptoms and a L5-S1 posterior spinal fusion was done in March 2004. However, she continued to have back pain and radiculopathy and eventually had a second surgery in October 2005. This surgery revised the prior spinal fusion at L5-S1 using both anterior and posterior approaches. Her back symptoms were minimal but her orthopedic surgeon stated that she would most likely have significant problems if exposed to the rigors of deployment and of normal active duty service. She had no injury to her shoulder but her pain resolved with physical therapy in her first term of service. In January 2002 her shoulder was evaluated by orthopedics and she was cleared for Officer Training School. At that time she had a normal shoulder exam and was 100% asymptomatic. Her left shoulder symptoms returned in her second term of service. An MRI done 20060615 showed a partial thickness rotator cuff tear (supraspinatus), impingement, and a type III acromium. At the time of the Medical Evaluation Board (MEB) Narrative Summary (NARSUM) in August 2006 she was currently in physical therapy and the plan was to have arthroscopy if conservative measures did not lead to resolution of symptoms.

The CI was referred to the Air Force Physical Evaluation Board (PEB). The Informal PEB determined she was unfit for continued military service and she was then separated with a 20% disability using the Veterans Affairs Schedule for Ratings Disabilities (VASRD) and applicable Service and Department of Defense regulations.

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CI CONTENTION: The CI states: “The rating should be changed because I believe I was not rated correctly for the conditions that were originally listed on my AF Form 356 dtd 6 Sep 06. I had a herniated disc and vertebrae fracture in my lower back which was incurred from a fall I had at OTS. I had two spinal fusions and a disc replacement surgery to correct the situation; however, I'm still having low back pain that has spread throughout my whole back and neck.”

“Also it has been noted in my VA records that I now have scoliosis. My AF Form 356 states that I have chronic pain in my left shoulder; this statement is partially true. I have an impingement syndrome and a partial rotator's cuff which was documented in my service records. I had surgery for this condition in December 06 (paid for by the Air Force). I'm still seeing the VA for my back and my shoulder as I'm still having problems.”

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RATING COMPARISON:

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| --- |
| **Previous Determinations**  |
| **Service** | **VA** (Exam 4 months post-discharge) |
| **PEB Condition** | **Code** | **Rating** | **Date** | **Condition** | **Code** | **Rating** | **Exam Date** | **Effective date** |
| Chronic Low Back Pain, Status-Post Posterior Fusion L5-S 1 | 5241 | 10% | **20060906** | Spinal Stenosis At L4-5 with Severe Right L4-5Neuroforaminal Narrowing; Disc Bulge at L5-S1 Level; Episodes of Musculoskeletal Back Strain [Predischarge Exam] | 5299-5240 | 10% | 20070119 | **20060916** |
| Chronic Pain Left Shoulder, Impingement Syndrome | 5304 | 10% | **20060906** | Left Shoulder Partial Rotator Cuff Tear andImpingement Syndrome | 5201-5019 | 10% | 20070119 | **20060916** |
|  |  |  |  | Dysthymic Disorder with Anxiety Symptoms (Claimed as Anxiety Disorder) | 9433 | 30% | 20070111 | **20060916** |
|  |  |  |  | 9 Other Conditions  |  | 0% |  |  |
|  |  |  |  | 7 Other Conditions  |  | **NSC** |  |  |
| **TOTAL Combined: 20%** | **TOTAL Combined (*incl non-PEB Dxs)*: 40**% from 20060916   |

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ANALYSIS SUMMARY:

Condition 1: Spinal Stenosis, Herniated Nucleus Pulposus, and Spondylolisthesis status post Two Spinal Fusion Surgeries L5-S1

During her initial term of service she received treatment for low back pain. After a break in service of less than one year she returned to service and became a Services Officer. She filed a disability claim for back pain during her break in service and received a VA rating of 10% for Spinal Stenosis at L4-5 with severe right L4-5 Neuroforaminal narrowing; disc bulge at L5-S1 level; episodes of musculoskeletal back strain. The rating was discontinued when she returned to active duty and then reapplied after her separation from service in September 2006 at the same 10%. The CI was injured during Officer Training School in 2002 when she fell from the top beam of one of the obstacles on the obstacle course and landed on her buttocks and back. She had severe back pain with bilateral pars fractures at L5 and spondylolisthesis was also noted. Conservative therapy failed to alleviate her symptoms and a L5-S1 posterior spinal fusion was done in March 2004. However, she continued to have back pain and radiculopathy and eventually had a second surgery in October 2005. This surgery revised the prior spinal fusion at L5-S1 using both anterior and posterior approaches and autograft. She initially did well and at six months after the second surgery she reported complete resolution of the radiculopathy and significant improvement of the back pain, rating 1/10 at most. She was not taking any medication for back pain. Her orthopedic surgeon noted in April 2006 that while she had improved significantly, she should not be exposed to the rigors of deployment or even the normal rigors of active duty service as she is predisposed to further spinal problems and would likely have additional problems at the L4-5 segment in the future that would require additional surgeries. After the April 2006 evaluation she experienced increased low back pain that occasionally radiated down her left leg. This was treated with over the counter pain medications three to four times a week. There was no objective evidence of radiculopathy in the NARSUM, the orthopedic addendum, or 20070119 VA examination.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| MovementThoracolumbar | Normal ROM | ROM VA20010411 | ROM Mil20060616\* | ROM VA20070119\*\* | ROM VA20090126# |
| Flex | 0-90 | 90 | 77 (75)  | 90 | 70 |
| Ext | 0-30 | 20 | 7 (5)  | 20 | 10 |
| R Lat flex | 0-30 | 20 | 22 (20) | 20 | 20 |
| L lat flex | 0-30 | 20 | 21 (20) | 20 | 20 |
| R rotation | 0-30 | 30 | 21 (20)  | 35 (30) | 15 |
| L rotation | 0-30 | 30 | 45 (30 ) | 35 (30) | 15 |
| COMBINED |  240 | 210 | 170 | 210 | 150 |
|  |  | No painful motion today |  |  |  |
|  |  | MRI 20010424L5-S1 disc narrowed; Moderate spinal stenosis L4-5 with severe right L4-5 neuroforaminal narrowing | MRI 20040219 Disc herniation L5-S1 |  |  |

*\* Flexion and extension limits due to physical limits with some pain. Right rotation limit due to physical limit. Right and left lateral flexion and Left rotation limit due to pain alone.*

*\*\* All limits secondary to pain. No additional loss of range of motion due to pain, fatigue, weakness, or lack of endurance was shown following repetition.*

*# All limits secondary to pain. The joint function of the spine is additionally limited by the following after repetitive use: pain and pain has the major functional impact. It is not additionally limited by the following after repetitive use: fatigue, weakness, lack of endurance and incoordination. There is no additional limitation in degree.*

VA:

Using an evaluation completed four months after the time of separation from the Service, the Veterans Administration (VA) rated this disability as 5299-5240 Spinal Stenosis at L4-5 with Severe Right L4-5 Neuroforaminal Narrowing; Disc Bulge at L5-S1 Level; Episodes of Musculoskeletal Back Strain at 10%. The diagnosis was unchanged from the rating determined during the CI’s break in service. This rating was based on the range of motion (ROM) measurements documented above, absence of muscle spasm or guarding severe enough to result in an abnormal gait or abnormal spinal contour, and lack of objective evidence of radiculopathy. Radiographs demonstrated scoliosis, exaggerated lumbar lordosis, and sacralization and all were considered congenital and not the result of guarding or spasm.

Condition 2: Left Shoulder

The CI had treatment for left shoulder pain during her first term of service and had received a cortisone injection in her left shoulder in March 2001 for chronic impingement syndrome with good relief for three months. Her pain gradually returned but after a physical therapy rehabilitation program in June 2001 her symptoms resolved. During her break in service she filed a VA claim for Left shoulder impingement and left rotator cuff injury. However, her VA evaluation was performed in April 2001 and she was pain free and had a normal exam at that time. Service connection was denied based on lack of current symptoms. In January 2002 she was evaluated by orthopedics and was cleared for Officer Training School. At that time she had a normal exam and was 100% asymptomatic. Her left shoulder symptoms returned in her second term of service. An MRI done 20060615 showed a partial thickness rotator cuff tear (supraspinatus), impingement, and a type III acromium. An evaluation by a civilian orthopedic surgeon on 20060630 documented a partial thickness rotator cuff tear with instability/impingement left shoulder. This evaluation noted ‘On exam of the left shoulder, the patient has mild anterior and inferior instability mild sulcus sign. She has noted apprehension with excessive external rotation, approximately 110 degrees. I am able to sublux her about 20 to 30 degrees, anterior and inferior. She has tenderness over the anterior lateral acromion with positive rotator cuff weakness. Negative painful arc of motion, negative modified speed's, positive empty can. Skin sensation and distal pulses are intact. The right shoulder reveals mild anterior instability, good strength.’ She received a steroid injection and her physical therapy was continued. The plan was to have arthroscopy if conservative measures did not lead to resolution of symptoms. She was re-evaluated by orthopedics and surgery was scheduled for 17 August 2006. However, on 16 August her primary care manager instructed the CI to cancel the surgery because “This is considered an elective surgery and will not be approved.” Three months after separation the CI had a subacromial decompression Mumford procedure and debridement of the partial tear of the supraspinatus.

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| --- | --- | --- | --- | --- | --- |
| Left Shoulder (dominant)Movement | Normal | ROM VA20010411 | ROM Mil20060616 | ROM VA20070119\* | ROM VA20090126# |
| Flex | 180 | 180 | 120 | 180 | 120 |
| Extension |  |  |  59 |  |  |
| Abduction | 180 | 180 | 139 (140) | 110 | 100 |
| Internal Rotation |  90 |  90 |  66 (65) |  90 |  70 |
| External Rotation |  90 |  90 |  86 (85) |  90 |  50 |
|  |  | 1 month after steroid injection | Limited by pain | Limited by pain; 1 month after surgery | Limited by pain |

**\*** No additional loss of range of motion was shown due to pain, fatigue, weakness, or lack of endurance following repetition.

# On the left, the joint function is additionally limited by the following after repetitive use: pain and pain has the major functional impact. The joint function on the left is not additionally limited by the following after repetitive use: fatigue, weakness, lack of endurance and incoordination. There is no additional limitation in degree.

VA:

Using an evaluation completed four months after the time of separation from Service, the Veterans Administration (VA) rated this disability as 5201-5019 Left Shoulder Partial Rotator Cuff Tear and Impingement Syndrome at 10%.

The CI filed a VA claim for her left shoulder during her break in service but had full range of motion and was pain-free on the day of her VA examination. In a rating decision dated 20010914 service connection for history of a left shoulder impingement and left rotator cuff injury was denied based on lack of current symptoms. CI had received cortisone shot approximately one month prior to C&P examination. VA did acknowledge treatment for left shoulder pain while in service.

The 10% rating determined after her second separation was based on the ROM limited by pain as documented in the chart above. The limited ROM exceeds the limitation required for the minimal compensable rating under VASRD 5201 as the CI has greater than 90 degrees of flexion and abduction of her left shoulder. However she does have decreased ROM secondary to pain and is rated for painful motion IAW VASRD §4.59 Painful Motion. This paragraph states: ‘The intent of the schedule is to recognize painful motion with joint or periarticular pathology as productive of disability.’ The VA commonly uses VASRD 5201-5019 to rate rotator cuff injuries. VASRD 5304 is also an acceptable analogous code for rotator cuff injuries.

The CI did have a subsequent worsening of her left shoulder condition noted on a VA evaluation dated 20090126 that documented decreased sensation in her left arm in the distribution of the median nerve. However, all evaluations done at the time of separation documented normal neurologic examinations. As this was not present at the time of separation, the Board cannot consider this information in rating the CI’s shoulder.

Condition 3: Dysthymic Disorder with Anxiety Symptoms

There is no mention of any mental illness in Commander’s letter or in any part of the DES package and therefore the PDBR cannot adjudicate this condition. The CI retains the right to request reconsideration from the Air Force Board of Corrections of Military Records (AFBCMR) to address adding this condition as unfitting.

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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. After careful consideration of all available information, the Board unanimously concluded that the CI’s condition is appropriately rated at a combined 20% with 10% for 5241 Spinal Stenosis, Spondylolisthesis, Bilateral Pars Fractures at L5, and Herniated Nucleus Pulposus Status Post Two Spinal Fusion Surgeries L5-S1 using the VASRD general rating formula for diseases and injuries of the spine and 10% for 5304 Left Shoulder (Dominant) Partial Rotator Cuff Tear and Impingement Syndrome.

The CI received the same rating percentages from the Air Force PEB and the VA for her back and left shoulder conditions. However, the coding and diagnostic wording was different. From the CI’s contention, it appears that she thought the Air Force did not fully adjudicate all aspects of her conditions, specifically a herniated disc, bilateral vertebral pars fractures of L5, scoliosis, and partial rotator cuff tear. Although these conditions were not all specifically listed in the diagnostic wording of either the AF PEB or the VA, all of these conditions were considered by both the AF PEB and the VA. Rating determinations are based on functional limitations and not on specific diagnoses. Regardless of the reason for limited range of motion (ROM) of the spine, the disability rating for back conditions is determined by applying the general rating formula for diseases and injuries of the spine. The AF PEB and the VA both applied this general rating formula and appropriately rated her back condition at 10%. This Board also considered all of the CI’s back conditions, applied the general rating formula for diseases and injuries of the spine, and independently determined the rating should be 10%. The 10% rating is based on forward flexion of the thoracolumbar spine greater than 60 degrees but not greater than 85 degrees and the absence of muscle spasm or guarding severe enough to result in an abnormal spinal contour such as scoliosis, reversed lordosis, or abnormal kyphosis. While the CI had scoliosis, exaggerated lumbar lordosis, and sacralization documented on radiograph, none of these resulted from muscle spasm or guarding and all were considered congenital. This Board recommends changing the diagnostic wording to reflect all of the CI’s back conditions to demonstrate all were considered in the rating.

While the term partial rotator cuff tear was not included in the AF PEB diagnostic wording, review of the records demonstrate the PEB was likely aware of this condition and considered it when determining the disability rating. The VASRD code 5304 is routinely used by the AF PEB as an analogous code to rate rotator cuff injuries. The VA included the wording and arrived at the same disability rating although they used a different code. The VA considers either 5304 or 5201-5019 as appropriate analogous codes for rating rotator cuff injuries. This Board independently rated the CI’s shoulder condition, considered both the impingement syndrome and the partial rotator cuff tear, and arrived at the same disability rating of 10%. The 10% rating is based on painful motion of the shoulder joint IAW VASRD paragraph §4.59 Painful Motion. The CI’s limited range of shoulder motion did not meet the minimum compensable level for VASRD 5201 Arm, limited motion of, which requires motion limited to the level of the shoulder, or 90 degrees of flexion or abduction. On various examinations, the CI was able to flex her left shoulder to either 120 or 180 degrees and abduct her left shoulder to 140 or 110 degrees. The motion is limited by pain and is appropriately rated as analogous to moderate impairment of Group IV muscles under VASRD 5304. This muscle group includes supraspinatus, infraspinatous, teres minor, subscapularis, and coracobrachialis muscles. A moderate impairment on the dominant side is rated at 10%. Whether the disability rating uses 5304 or 5201-5019, the 10% rating is warranted. This Board recommends changing the diagnostic wording to reflect both of the CI’s shoulder conditions, impingement and partial rotator cuff tear to demonstrate both were considered in the rating.

In addition to the back and shoulder conditions, the VA also rated 9433 Dysthymic Disorder with Anxiety Symptoms. However, examining this condition is outside the scope of this Board. Internal policy previously agreed to by the PDBR is that only conditions specifically noted in the DES submission (MEB physical, NARSUM and PEB documents) are reasonable for Board recommendation as additionally unfitting for service disability rating. With this precedence, the CI retains the right to request reconsideration from their Service BCMR to address adding this condition as unfitting.

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RECOMMENDATION: The Board recommends that the CI’s prior determination be modified as follows, effective as of the date of the CI’s prior medical separation.

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| --- | --- | --- |
| Unfitting Condition | VASRD Code | Rating |
| Spinal Stenosis, Spondylolisthesis, Bilateral Pars Fractures at L5, and Herniated Nucleus Pulposus Status Post Two Spinal Fusion Surgeries L5-S1 | 5241 | 10% |
| Left Shoulder (Dominant) Partial Rotator Cuff Tear and Impingement Syndrome | 5304 | 10% |
| Combined | 20% |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090225, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

 President

 Physical Disability Board of Review

SAF/MRB

1535 Command Drive, Suite E-302

Andrews AFB, MD 20762-7002

 Reference your application submitted under the provisions of DoDI 6040.44 (Section 1554, 10 USC), PDBR Case Number PD-2009-00193.

 After careful consideration of your application and treatment records, the Physical Disability Board of Review determined that the rating assigned at the time of final disposition of your disability evaluation system processing was appropriate under the guidelines of the Veterans Administration Schedule for Rating Disabilities and that your separation with severance pay should remain unchanged. However, the Board recommended modification of the description of your condition to a narrative that provides a more accurate depiction.

 I have carefully reviewed the evidence of record and the recommendation of the Board. I concur with that finding, accept their recommendation and direct that your records be corrected as set forth in the attached copy of a Memorandum for the Chief of Staff, United States Air Force. The office responsible for making the correction will inform you when your records have been changed.

 Sincerely

Director

Air Force Review Boards Agency

Attachments:

1. Directive

2. Record of Proceedings

cc:

SAF/MRBR

DFAS-IN

PDBR PD-2009-00193

MEMORANDUM FOR THE CHIEF OF STAFF

 Having received and considered the recommendation of the Physical Disability Board of Review and under the authority of Section 1554, Title 10, United States Code (122 Stat. 466) it is directed that:

 The pertinent military records of the Department of the Air Force relating XXXXXXXXXX be corrected to show that the AF Form 356, *Findings and Recommended Disposition of USAF Physical Evaluation Board*, dated 6 September 2006, be corrected in Section 9 (A) to reflect "1. Spinal Stenosis, Spondylolisthesis, Bilateral Pars Fractures at L5, and Herniated Nucleus Pulposus Status Post Two Spinal Fusion Surgeries L5-S1" rather than "1. Chronic Low Back Pain, Status-Post Posterios Fusion L5-S1;" and "2. Left Shoulder (Dominant) Partial Rotator Cuff Tear and Impingement Syndrome" rather than "2. Chronic Pain Left Shoulder, Impingement Syndrome."

 JOE G. LINEBERGER

 Director

 Air Force Review Boards Agency