RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: Army

CASE NUMBER: PD0900219 BOARD DATE: 20100525

SEPARATION DATE: 20020515

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SUMMARY OF CASE: This covered individual (CI) was an active duty SFC (Surveyor/82D) medically separated from the Army in 2005 after 15 years of service. The medical basis for the separation was a cervical spine condition with unilateral shoulder and upper extremity involvement.

It is essential to provide an early clarification in this case to avoid confusion. The narrative summary (NARSUM) summary section incorrectly identified the left shoulder and upper extremity as the affected side. This error flowed onto the Medical Evaluation Board (MEB)’s DA Form 3947 and the Physical Evaluation Board (PEB)’s DA Form 199. Preceding text in the NARSUM, the VA documentation and the service treatment record (STR) all make it clear that both the myofascial condition and the cervical nerve root pathology evidenced in this case affected the right upper extremity (RUE). There was no significant left upper extremity (LUE) involvement and the CI is right handed.

The NARSUM states that the CI developed neck and right upper back pain while weight-lifting, although the STR reports onset of neck pain with a soccer injury in 1999. Whatever the precipitating event, he was left with persistent neck and radiating right shoulder pain. This was managed conservatively and never fully resolved, resulting in temporary profiles. An MRI was obtained in 2001 which demonstrated mild degenerative changes and spondylosis at the C3-6 levels. There was a mild disc protrusion encroaching on the right C4/5 foramina. An EMG (nerve conduction study) a few months earlier had shown some right biceps and deltoid changes consistent with reinvervation (nerve healing after damage). A neurosurgeon opined that he was not a surgical candidate and conservative measures were continued. Although the CI was able to perform very well within his military occupational specialty (MOS), he was unable to fulfill basic soldiering requirements and was placed on a permanent U-3 profile. His Commander petitioned an MOS/Medical Retention Boards (MMRB) to allow him to remain on active duty, but he was referred for a MEB. The MEB forwarded two separate cervical-related conditions (one reflecting the spondylosis and disc pathology and another designated as ‘chronic neck pain’) plus a myofascial condition of the RUE (listed as LUE) to the PEB as medically unacceptable IAW AR 40-501. No other conditions were forwarded for PEB adjudication on the DA Form 3947. The PEB combined the cervical and RUE (listed as LUE) myofascial conditions as a single unfitting condition, coded analogously to 5003 and rated 10%. The CI was thus medically separated with a total disability rating of 10%.

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CI CONTENTION: The CI states: ‘The disability rating I received from the Army for "pain, constant and slight" is part of larger problem. The areas that cause the pain should have been awarded.’ He goes on to elaborate why he believes that more than one condition should have been rated and questions why he was not found fit. The application lists all four of the VA conditions and ratings listed in the rating chart below. A contention for their inclusion in the separation rating is therefore implied.

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RATING COMPARISON:

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| **Service PEB – Dated 20020313** | **VA (5 Mo. after Separation) – All Effective 20020516** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Chronic Pain, Neck … Left Upper Trapezius …Myofascial Pain Syndrome.  | 5099-5003 | 10% | R Shoulder Pain and Weakness | 8510 | 20% | 20021023 |
| Cervical Spondylosis | 5010-5290 | 10% | 20021023 |
| ↓No Additional DA Form 3947 Entries.↓ | Tinnitus | 6260 | 10% | 20021023 |
| IBS with GERD | 7346-7319 | 10% | 20021023 |
| Non-PEB X 8 / NSC X 1 | 20021023 |
| **TOTAL Combined: 10%** | **TOTAL Combined (*Includes Non-PEB Conditions*): 40%**   |

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ANALYSIS SUMMARY:

The Board first evaluated the PEB coding approach of combining the conditions under the single analogous 5003 code. The PEB invoked the US Army Physical Disability Agency (USAPDA) pain policy and may have also relied on AR 635.40 (B.24 f.) for not applying separately compensable Veterans Administration Schedule for Rating Disabilities (VASRD) codes. In cases such as this one where the combined conditions may be considered as separately compensable IAW VASRD §4.71a, the Board must individually consider each condition in its recommendations. This is consistent as well with the VA rating decision. It should be noted that the combination of the separately listed DA Form 3947 cervical conditions into a single rating is appropriate since separate VASRD ratings are not possible.

Cervical Condition. The primary unfitting pathology in this case was cervical spondylosis with disc disease. Although it did not prohibit routine performance of the CI’s MOS, it interfered with the use of Kevlar and flak. The spinal condition was therefore distinctly unfitting, and merits a separate rating under the cervical spine code as applied by the VA. The §4.71a cervical rating preceded the contemporary VASRD general spine rating formula based primarily on goniometric range-of-motion measurements. The applicable 5290 code in the 2002 VASRD simply designates mild, moderate and severe limitations rated 10%, 20%, and 30% respectively. The range-of-motion (ROM)’s provided in the NARSUM were flexion >45⁰ and combined ROM 315⁰; those provided in the VA rating examination were flexion 45⁰ and extension 30⁰. These measurements are close to normal. The VA rating assignment was 10% for mild. The rating under contemporary §4.71a standards would also be 10%. The Board therefore recommends that the cervical spine condition be separately coded 5290 and separately rated 10%.

Associated Right Upper Extremity Condition. The Board must first consider the issue of a fitness recommendation for the RUE impairment, having de-coupled it from the rating for the unfitting cervical condition. In one sense, the PEB adjudicated it as unfitting by including it as part of the unfitting condition. In analyzing the intrinsic impairment for appropriately coding and rating the RUE condition, however, the Board was left with a questionable basis for arguing that the RUE component was indeed separately unfitting. The latitude for recommending a determination of not unfitting for a condition adjudicated as unfitting by the PEB is countenanced under DoDI 6040.44 as long as the combined separation rating is not lowered. By precedent and legal opinion, the Board does not exercise that latitude except in cases such as this one where conditions combined under one rating by the PEB are ‘un-bundled’ by the Board. Two sources of confusion in this case are the actual etiology of the RUE impairment and conflicting examinations for the degree of impairment. The MEB forwarded the condition as myofascial in etiology, and deemed the myofascial condition to be medically unacceptable IAW AR 40-501. The VA coded and rated it as a peripheral neuropathy. The NARSUM made the myofascial diagnosis on the basis of trapezial and paraspinal spasm and trigger points which were not described by the VA examiner several months later or in earlier examinations in the STR. The Action Officer questions if the condition was actually a transient exacerbation of contiguous spasm in response to nerve root irritation. The NARSUM stated, ‘He has episodes of right upper arm pain which appears to be function [sp] in nature. It only occurs when he does something with his right arm. It occurs anytime he lifts his arm in abduction more than 90 degrees reaching above his head.’ The VA examiner only stated, ‘He gives a history of treatment for spondylosis of the cervical spine with some involvement of the nerve root at the right shoulder.’ The VA physical examination further stated that ‘He could abduct both shoulders from 0 to 180 without difficulty.’ Both the NARSUM and VA examinations noted some mild dermatomal sensory impairment to pin prick (which would not bear on fitness). The NARSUM stated that the CI reported subjective weakness of the right arm, but documented normal 5/5 motor testing of all groups and normal reflexes. The neurosurgical addendum to the NARSUM also documented a normal motor and reflex examination, and opined ‘intermittent right C5 and C6 nerve root irritation, no evidence of myelopathy, no radicular pain’. The VA examiner did not provide a detailed motor or reflex exam, but stated ‘There was some decreased strength in the grip on the right hand and felt to be due to the shoulder involvement.’ This variable clinical information is also tempered by the fact that only the cervical condition was profiled. There were no profile limitations or functional impacts listed in the NARSUM which would be specific to shoulder or arm impairment, and the Commanders’ statements (which emphasized what the CI *could* do rather than his limitations) covered only cervical spondylosis.

The Action Officer opines that there were separate myofascial and peripheral neuropathy conditions, at least at the time of the NARSUM physical examination, which made separate contributions to the RUE impairment in this case. Their impact on fitness should therefore be considered separately and in combination. Unless the decreased grip strength noted by the VA examiner and the subjective weakness mentioned in the NARSUM are emphasized, there was not an unfitting peripheral nerve impairment in this case. The equivocal motor impairment is countered by the NARSUM examination, MEB neurosurgical addendum and other examinations in the STR. Unless the pain at 90⁰ abduction documented in the NARSUM is emphasized, there was not unfitting shoulder joint impairment. No other joint pathology in the arm was evidenced. Shoulder imaging and work-up was pursued early in the course with normal results. Other shoulder examinations in the STR, as with the VA examination, do not document any ROM impairment of the shoulder. The overall functional limitation imposed jointly by both conditions is not supported as unfitting in the physical profile, APFT performance or the Commanders’ statements.

The Board deliberated at length if there was an unfitting RUE impairment in this case, be it a radiculopathy, a shoulder joint impairment or both in combination. The Board concluded that, all evidence considered, there is not reasonable doubt in the CI’s favor supporting addition of the cervical radiculopathy and/or the right shoulder joint impairment as unfitting for separation rating.

Other Conditions. The only contended additional conditions and the only other ones which received compensable VA ratings are tinnitus and ‘irritable bowel syndrome with gastroesophageal reflux disorder’. Neither tinnitus nor the GI conditions were noted in the NARSUM or by the CI or examiner on 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 DES. Both of these conditions remain eligible for ABCMR consideration, although the H1 profile and the lack of acute GI symptoms would be formidable barriers to a conclusion that either was unfitting. Several other relatively minor medical conditions were identified in the NARSUM and MEB physical. They had no connection with fitness and are not relevant for Board consideration as additionally unfitting and ratable. A few additional conditions were noted in the VA rating decision, but were not documented in the DES packet. The Board, therefore, has no reasonable basis for recommending any additional unfitting conditions for separation rating.

The Board concludes in acknowledging the CI’s contention that he should have been found fit overall for continued service. Three of his Commanding Officers shared that opinion. The MMRB or PEB rationales for concluding otherwise are not in evidence, although deployability concerns are likely. Whether or not the Army’s decision was appropriate, and irrespective of its opinion thereof, the Board is not empowered to provide a recommendation for retroactive relief.

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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 and possibly on AR 635.40 for rating the cervical and right upper myofascial conditions was operant in this case and the conditions were adjudicated independently of that policy and regulation by the Board. In the matter of the cervical spine condition, the Board unanimously recommends a rating of 10% coded 5290 IAW VASRD §4.71a. In the matter of the right shoulder myofascial condition, the Board unanimously agrees that it cannot recommend a finding of unfit for additional rating at separation. In the matter of the right upper extremity radiculopathy condition, the Board unanimously agrees that it cannot recommend a finding of unfit for additional rating at separation. The Board unanimously agrees that there were no other conditions eligible for Board consideration which could be recommended as additionally unfitting for rating at separation.

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

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| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Cervical Spondylosis with Degenerative Spine and Disc Disease | 5290 | 10% |
| Right Trapezial and Paraspinal Myofascial Pain Syndrome | Not Unfitting,Not Rated |
| Cervical Radiculopathy, Right Upper Extremity | Not Unfitting,Not Rated |
| **COMBINED** | **10%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090305, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

