RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: ARMY

CASE NUMBER: PD0900249 BOARD DATE: 20090820

SEPARATION DATE: 20080916

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SUMMARY OF CASE: This covered individual (CI) was an NCO medically separated from the Army in 2008 after 12 years of service. The medical basis for the separation was a back condition. The back was initially injured in a parachute jump in 1996. There was persistent back pain throughout the rest of his Army career requiring temporary profiles, medication and physical therapy. An MRI demonstrated disc disease and degenerative changes at several levels. He was not a surgical candidate and eventually could not meet the requirements of his infantry MOS. He underwent an MEB evaluation, during which he was evaluated for several other conditions. These included migraine headaches, for which he had a history dating to his youth. Neurology was consulted and followed him during the MEB process. The severity and frequency varied, and he was on different trials of medication regimens. The CI also suffered from chronic cervical degenerative disease. This was quiescent during the initial MEB process, but flared shortly before the PEB convened. The CI developed obstructive sleep apnea (OSA) which was also not diagnosed until late in the MEB process. Additionally, the CI was evaluated by the MEB for various other orthopedic and medical conditions as enumerated in the rating chart below. The informal PEB found the CI found unfit for his back condition only, rated 20%. On appeal, a formal PEB concurred with the same adjudication and the CI was separated at 20% disability.

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CI CONTENTION: The CI contention simply stated, ‘V.A. Rating of February 2, 2009 and for migraine headaches.’

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RATING COMPARISON:

|  |  |
| --- | --- |
| **Service PEB** | **VA (Pre- Separation)** |
| **PEB Condition** | **Code** | **Rating** | **Date** | **Condition** | **Code** | **Rating** | **Exam** | **Effective** |
| SPINAL STENOSIS | 5238 | 20% | 20080818 | DDD, THORACO-LUMBAR SPINE, WITHINTERVERTEBRAL DISC SYNDROME | 5243 | 20% | 20080716 20080721 | 20080918 |
| MIGRAINE HEADACHES | FIT | - | 20080818 | MIGRAINE HEADACHES | 8100 | 30% | 20080716 20080721 | 220080918 |
| BILATERAL HEARING LOSS | FIT | - | 20080818 | BILATERAL HEARING LOSS | 6100 | 0% | 20080716 20080721 | 20080918 |
| BILATERAL KNEE PAIN | FIT | - | 20080818 | BILATERAL KNEE STRAIN | 5260 | 0% | 20080716 20080721 | 20080918 |
| RIGHT PLANTAR FASCIITIS | FIT | - | 20080818 | PLANTAR FASCIITIS, RIGHT FOOT | 5099-5020 | 10% | 20080716 20080721 | 20080918 |
| RIGHT SHOULDER PAIN | FIT | - | 20080818 | TENDONITIS, RIGHT SHOULDER | 5201-5024 | 10% | 20080716 20080721 | 20080918 |
| HYPERTENSION | FIT | - | 20080818 | HYPERTENSION | 7101 | 10% | 20080716 20080721 | 20080918 |
| HYPOTHYROIDISM | FIT | - | 20080818 | HYPOTHYROIDISM | 7903 | 10% | 20080716 20080721 | 20080918 |
| HYPERLIPIDEMIA | FIT | - | 20080818 | NOT RATED |  |  |  |  |
| ELEVATED TRANSAMINASE | FIT | - | 20080818 | NOT RATED |  |  |  |  |
| NO DA 3947 ENTRY |  |  |  | CERVICAL STRAIN | 5237 | 10% | 20080716 20080721 | 20080918 |
| NO DA 3947 ENTRY |  |  |  | OSA | 6847 | 50% | 20080505 | 20080918 |
|  |  |  |  | NON-PEB X 3 |  |  |  |  |
| **TOTAL Combined: 20 %** | **TOTAL Combined (*incl non-PEB Dxs*): 90%**   |

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ANALYSIS SUMMARY:

Back Rating. The PEB and VA ratings for the back are equivalent, under different (but equally applicable) codes. The PEB thoracolumbar rating was based on goniometric range-of-motion (ROM) measurements by Physical Therapy, as quoted in the NARSUM. This yielded flexion 45⁰/total 165⁰. Pain vs. mechanical end-points are specified, such that there is no indication that the rating was unduly influenced by the USAPDA pain policy. An informal earlier ROM entry noted flexion of 90⁰, ‘with difficulty’. The concurrent VA rating exam yielded flexion 50⁰/total 200⁰. Since the PEB rating was IAW §4.71a and based on the most abnormal ROM, it is judged to be appropriate and fair.

Migraine. In the CI’s appeal for a formal PEB, he made a cogent argument that the migraine should have been found unfitting. This included an occasional inability to drive, the ongoing need for medications and concerns regarding incapacitating episodes in combat as an 11B. The CI suffered an escalation of his chronic migraines during the MEB process, which he himself acknowledged were probably triggered by the inherent stress of the circumstance. He was responding favorably to his latest treatment regimen approaching the PEB timeline. His appeal stated, and a neurologist note corroborated, a frequency of about 3 incapacitating episodes a month going into the PEB. He was hospitalized once during the MEB process for a migraine with focal neurological symptoms. There was complete resolution with an overnight observation, and this represented the only ER visit for migraine found in the record. His neurology consultation stated, ‘Patient acknowledges difficulty performing his duties at work when his headaches or associated visual dysfunction are severe’, but went on to state that he met retention standards IAW AR 40-501. A subsequent neurology follow-up note stated, ‘SM does not feel HA’s interfere significantly with duty, though acknowledges that he would be unable to use weapons if he should develop a significant HA with associated visual dysfunction.’ A month later a civilian consultant note stated, ‘Symptoms are now described as moderate to debilitating; when he is afflicted with the most severe symptoms he is incapacitated.’ Specifically, AR 40-501 (2-26e) regarding migraine headaches states, ‘History of recurrent headaches...that interfere with normal function...or of such severity to require prescription medications, are disqualifying.’ It is established that the CI was on two prophylactic migraine medications (non-narcotic) at the time of separation and concurrent with the specialty opinion that the headaches were not disqualifying. Neither the Commander’s statement nor the medical profiles implicate migraines as unfitting. Conceding that the infallible capacity to drive is not a rigid MOS requirement, two questions arise relevant to an argument for unfitness: 1) Does an average of one incapacitating episode every 10 days constitute overall unfitness for an infantryman? 2) Does dependence on non-narcotic migraine prophylactic medications constitute on its face a medically unacceptable headache condition IAW AR 40-501? If the answer to either is ‘yes’, then a finding of unfitness (or placement on TDRL) was the appropriate PEB action in this case. The BOARD faces the fact, however, that the answers were ‘no’ by the specialty consultant, MEB, informal PEB and formal PEB. In light of this layered review and expertise, the BOARD cannot sustain a reasonable recommendation for opposing the Army’s assessment that the headaches were not unfitting.

Neck. The CI’s cervical condition was chronic and related to the same spinal degenerative process underlying his unfitting back condition. There are no entries of clinical significance regarding the neck until late in the MEB process (about a month prior to the PEB). He underwent physical therapy and conservative management. The initial NARSUM noted that it ‘has not caused any significant limitations’, but it was not entered on the DA 3947. The PEB did obtain a formal MEB evaluation for neck pain 3 days before the PEB convened. An addendum documented a good medical review and exam, deemed it to be a self-limited exacerbation and opined that it met retention standards. The VA rating examiner (one week prior to the PEB) noted a 1 month history of neck pain ‘which has not resulted in any incapacitation’, although he added the functional impairment ‘can’t shoot in prone position’. The MEB addendum stated ‘There is no need to issue a new permanent profile’, and it remained U1. Due presumably to its last minute appearance, the cervical condition did not appear as a separate adjudication on the PEB Form 199. The documentation in the MEB addendum, however, satisfies the requirement that the condition was properly evaluated and does not support a reasonable BOARD recommendation as additionally unfitting.

Other Conditions. In addition to those discussed above, the MEB forwarded 8 other conditions as meeting retention standards. All were adjudicated fit by both PEB’s. All were covered in the initial NARSUM and noted on the DA 3947 except OSA, which was diagnosed on a sleep study 3 months before the PEB. The CI’s appeal for a formal PEB included a request for adding the condition to the DA 199. Since it had not forwarded from the MEB or yet documented in available medical records, it was mentioned, but not added as an adjudicated condition on the DA 199. OSA was not reflected in the commander’s statement or medical profile. The condition was not especially severe or atypical. Per common PEB practice across the services, there is no reason to suspect that a formal adjudication of OSA would have been unfitting. There is no firm basis, therefore, for this BOARD to recommend it as additionally unfitting. All of the CI’s other orthopedic and medical conditions were reviewed in the service and VA records for implications regarding fitness. None met any reasonable threshold for challenging the MEB’s and PEB’s expertise in these decisions. None can be supported as additional unfitting recommendations by the BOARD.

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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. The Board did not surmise from the record or PEB ruling in this case that any prerogatives outside the VASRD were exercised. In the matter of the back condition, it was unanimously concluded that the PEB rating is fair and IAW VASRD §4.71a. In the matter of the migraine headache condition, the Board unanimously concluded that our threshold for opposing the PEB expertise in its fitness adjudication was not reached and that it cannot be recommended as additionally unfitting. In the matter of the neck condition, it was unanimously concluded that it was adequately addressed in the MEB addendum and consistent with a transient exacerbation not meriting Board recommendation as additionally unfitting. In the matter of the OSA, it was concluded that, although not formally adjudicated by the PEB, it would not be expected to merit a finding of unfitness by common PEB practice. The Board was in unanimous agreement that OSA cannot be recommended as additionally unfitting. There was likewise unanimous agreement that all of the CI’s other orthopedic and medical conditions were fairly adjudicated by the Army as not unfitting.

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RECOMMENDATION: The Board therefore recommends that there be no re-characterization of the CI’s disability and separation determination.

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090316, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

