RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: ARMY

CASE NUMBER: PD0900251 BOARD DATE: 20090917

SEPARATION DATE: 20060401

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SUMMARY OF CASE: This covered individual (CI) was a Guard NCO medically separated from the Army in 2006 after 17 years of combined service. The medical basis for the separation was a back condition. He was a truck driver and had a history of back pain dating to 2000. It was exacerbated by duty requirements of a 2003 Kuwait deployment. An MRI revealed L5/S1 spondylosis. It was associated with bilateral lower extremity radicular symptoms, although electromyelography (EMG) studies were normal. He was not a surgical candidate, and did not respond well enough to conservative management for continued performance in his MOS. He unsuccessfully petitioned to continue his Guard service, and underwent a MEB. The MEB determined that his lumbar condition was not medically acceptable, and referred him to the PEB. In addition to the back condition, the CI was diagnosed with right acromioclavicular joint arthritis, for which he underwent an open distal clavicle resection in September 2004. It was evaluated by orthopedics during the MEB, and judged to be medically acceptable. The CI was being treated on an outpatient basis during the MEB for diagnosed PTSD. Substrates were from his Kuwait and earlier Desert Storm deployments. It was evaluated by psychiatry during the MEB, and judged to be medically acceptable. The CI had numerous other conditions forwarded on his MEB Form 3947 (see rating table), all designated as medically acceptable. The CI appealed the findings of the informal PEB, requesting additional disability for lower extremity neuropathies, the right shoulder condition and PTSD. A formal PEB, consistent with the informal adjudication, found the CI unfit solely for his back condition and he was separated at 10% disability.

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CI CONTENTION: The CI’s application cites the disparity between the service and VA ratings, without more specific contentions.

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RATING COMPARISON:

|  |  |
| --- | --- |
| **Service PEB** | **VA (3 Mo. after Separation)** |
| **Condition** | **Code** | **Rating** | **Date** | **Condition** | **Code** | **Rating** | **Exam** | **Effective** |
| CHRONIC LOW BACK PAIN, DUE TO LUMBAR SPONDYLOSIS… | 5242 | 10% | 20050620 | BACK INJURY, LUMBAR SPINE | 5292 | NSC | 20020712(Civilian records) | 20030313 |
| RIGHT SHOULDER PAIN S/P CLAVICLE RESECT… | FIT | 20050620 | RIGHT SHOULDER PAIN S/P CLAVICLE RESECT. | 5203 | 10% | 2006071 | 20060402 |
| PTSD | FIT | 20050620 | PTSD | 9411 | 30% | 20060622 | 20060402 |
| MIGRAINE HEADACHE | FIT | 20050620 | MIGRAINE HEADACHE | 8100 | 10% | 20060622 | 19940602 |
| GLAUCOMA | FIT | 20050620 | NOT NOTED IN RATING DECISIONS. |
| RECURRENT SINUSITIS | FIT | 20050620 | SINUSITIS | 6513 | NSC | 20060622 | 20060402 |
| DENTAL CARIES | FIT | 20050620 | DENTAL CARIES | 9913 | NSC | 20060622 | 20060402 |
| NORMOCYT. ANEMIA | FIT | 20050620 | NORMOCYT. ANEMIA | 7700 | 0% | 20060622 | 20060402 |
| DISHYDROTIC RASH | FIT | 20050620 | DISHYDROTIC …RUEDISHYDROTIC …LUE | 78067806 | 0%0% | 20060622 | 20060402 |
| CERVICAL SPONDYLOSIS | FIT | 20050620 | BACK INJURY, CERVICAL SPINE  | 5010-5242 | NSC | 20020712(Civilian) | 20030313 |
| NO ENTRY ON DA 3947.Diagnoses reported in civilian physician letter to USAPDA. | LUE …NEUROPATHYRUE …NEUROPATHYLLE …NEUROPATHYRLE …NEUROPATHY | 8516851685218521 | 10%10%10%10% | Various prior exams cited. | 20060402 |
| NO ADDITIONAL DA 3947 ENTRIES. | NON-PEB X 2 |  |  |
| **TOTAL Combined: 10%** | **TOTAL Combined (*Includes Non-PEB Conditions*): 70%**   |

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ANALYSIS SUMMARY:

Back Condition. The lumbar spine condition was not rated by the VA because it had been determined to be not service connected (NSC). Service connection was denied in a 2003 rating decision. This cited civilian records documenting onset of the complaint in 2002, well after separation from his prior service. All subsequent rating decisions have carried the condition as NSC, including those following the 2006 separation. For rating purposes, the single back exam in evidence is that described in the NARSUM. The VA orthopedic rating examinations addressed the extremity conditions, but not the range-of-motion (ROM) of the spine. Of note, the VA general medical rating examination documented an antalgic gait as well as the use of a cane. The indication for the cane or cause of the antalgic gait was not elaborated. The VA orthopedist’s examination stated that he did not use assistive devices, but did not comment on gait. The MEB exam documented a normal ROM (Flexion > 90⁰, Total > 240⁰) and lumbar tenderness. The exam did not remark on gait. There were no other concurrent examinations remarking on the gait in the service or VA records. The only Board issue affecting the thoracolumbar rating is whether to apply antalgic gait to the spine rating as a 20% criterion. This would be an easier decision if the MEB examiner had documented a normal gait, although it is probable that an abnormal gait would have been documented. Also given that there was no compromise in ROM, which would commonly accompany gait disturbance, there is dubious justification for applying a finding from a single unrelated examination several months later to achieve a higher spine rating. Even mindful of §4.3 (reasonable doubt), the Board cannot recommend a change in the PEB rating of the back condition. The PEB coding is accurate and there is no evidence of influence of the USAPDA pain policy on adjudication.

Right Shoulder Condition. The CI was evaluated by orthopedics during the MEB specifically for his shoulder condition. The orthopedic addendum noted pain with overhead activities and shifting gears in his truck, and inability to do push-ups or heavy lifting. Although other planes of motion were normal, external rotation was limited to 45⁰. The shoulder profile was extended for 3 months, but the orthopedist opined that his shoulder ‘should allow him to return to his MOS’. The addendum did not render an opinion specific to AR 40-501, although the MEB deemed the condition medically acceptable. The VA orthopedic examination noted similar activity restrictions, and some modest reductions of ROM with repetition. The Commander’s statement noted the lifting requirements of the MOS, and specifically mentioned the shoulder pain as a limitation. Separation was effected in advance of the Army orthopedist’s timeline for anticipated improvement, and the VA examination occurred at about the time the CI was expected to resume MOS activities. The VA exam implies that the Army orthopedist’s prognosis was too optimistic. On balance there is more evidence in support of the shoulder condition as unfitting than there is to the contrary. IAW VASRD §4.3 (reasonable doubt), the fairest Board recommendation is to add the shoulder as an unfitting condition, coded 5299-5203 and rated 10%.

PTSD. An Axis I diagnosis of PTSD was well established by the service prior to separation. He was being treated on an outpatient basis with an anti-depressant and sleep medication. The MEB psychiatrist opined that there was no social or industrial impairment and that IAW AR 40-501 ‘from a purely psychiatric standpoint [the CI] is medically acceptable to remain in the military and to continue performing his MOS’. The Commander’s statement cited only the orthopedic limitations to his MOS requirements and noted that he was performing administrative duties. His medical profile was S1. The CI’s USADA appeal related that his marriage was suffering and that ‘lack of sleep is affecting my daily performance’, but did not state or imply that he was unable to function at work. The VA rating psychiatrist noted that the CI was currently unable to resume his prior work as a commercial truck driver, but specifically related it to his orthopedic conditions. The VA examiner did assign a poor Global Assessment of Functioning (GAF = 50) score which would imply occupational impairment, but this does not correlate well with the rest of the clinical picture and is a non-specific indicator. Clinical notes and letters from civilian mental health providers were also available. These documented typical and moderately severe PTSD symptoms, but provided no specific information regarding occupational impact. All evidence considered, there is not reasonable doubt in the CI’s favor supporting a change in the PEB adjudication of PTSD as not unfitting.

Migraine. The CI’s migraine condition was noted in the NARSUM and addressed in a neurological addendum. The neurologist noted an average of 2 incapacitating episodes a year, specifically noting that, regarding MOS, severe headaches required him to ‘pull the truck over and cease all activity’. The addendum recommended a trial of prophylactic medication, but specified ‘the soldier is fit for duty’. The Commander’s statement or medical profiles did not implicate headaches as unfitting. Even if added as an unfitting condition at separation, the frequency of incapacitating episodes noted would rate 0%. All evidence considered, there is not reasonable doubt in the CI’s favor supporting a change in the PEB adjudication of migraine headache as not unfitting.

Other Conditions. The MEB also identified cervical spondylosis as a medically acceptable condition. The VA carried the cervical condition as NSC, similar to the back. The language in the Commander’s statement was broad enough to encompass the cervical condition, although the medical U2 profile (reflecting the shoulder condition) would not imply that the neck was unfitting per se. The CI’s USAPDA appeal specified only the shoulder condition as interfering with his work activities. All evidence considered, there is not reasonable doubt in the CI’s favor supporting a change in the PEB adjudication of either migraine or cervical spondylosis as not unfitting. The CI’s neuropathies were also considered for their potential as additionally unfitting. The CI eventually received VA ratings for bilateral upper and lower extremity neuropathies, retroactively effected to his date of separation. This resulted from a lengthy process of VA and U.S. Court appeals. The NARSUM and the MEB physical exam noted bilateral leg radicular pain and paresthesias. EMG was normal, however, as were physical examinations. The STR and the VA rating examinations documented normal motor strength and reflexes. There was therefore not reasonably an unfitting motor component of the radiculopathies. The sensory component would not have impacted function and the pain component, to the extent present, is subsumed under the general spine rating. There is no documentation of any significant upper extremity neuropathies in the STR or VA rating exams proximate to separation. When the VA eventually awarded the neuropathy ratings, they were not conclusively linked to the spine pathology. There are, therefore, no good grounds for a Board recommendation of any extremity neuropathies as additionally unfitting. None of the CI’s additional medical conditions have any potential for link to fitness.

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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, the Board unanimously recommends no recharacterization of the PEB coding or rating. In the matter of the right shoulder condition, the Board unanimously recommends that it be added as an additionally unfitting condition for separation rating; coded 5299-5203 and rated 10% IAW VASRD §4.71a. In the matter of the migraine headache, cervical spondylosis, extremity neuropathies and all of the CI’s other medical conditions, the Board unanimously agrees that it cannot recommend a finding of unfit for additional 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** |
| CHRONIC LOW BACK PAIN DUE TO LUMBAR SPONDYLOSIS | 5242 | 10% |
| RIGHT SHOULDER PAIN STATUS-POST CLAVICLE RESECTION | 5299-5203 | 10% |
| **COMBINED** | **20%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090318, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

