RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: Air Force

CASE NUMBER: PD0900403 BOARD DATE: 20091021

SEPARATION DATE: 20071015

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SUMMARY OF CASE: This covered individual (CI) was a Staff Sergeant Fuels Craftsman medically separated from the Air Force in 2007 after more than thirteen years of service. The medical basis for the separation was Neck Pain with Radiculopathy.

History of Present Illness: While deployed to Bahrain in 2001 he injured his right shoulder and neck while helping to move a fuel bladder. He had immediate onset of moderate pain which progressed to severe pain in his right shoulder and neck that evening. He did not note any special swelling or ecchymosis. He was treated with pain medication which helped somewhat. He was treated conservatively while deployed and returned as scheduled in Feb 2002. He continued to have intermittent shoulder and neck pain which would increase when he was more physically active. In the fall of 2005 he was referred to physical therapy and when his pain did not resolve an MRI was done and he was referred to orthopedics (Dr. B---) in December 2005 for assessment of his right shoulder problems. He was diagnosed with right shoulder impingement with rotator cuff tendinopathy, right trapezius fibrositis with tender point areas, and limited C-Spine ROM with possible underlying occult radicular symptoms. Dr. B--- referred him to physical therapy for an impingement program to treat his tendinopathy. The plan was to re-evaluate after a course of physical therapy as is the normal treatment course for rotator cuff injuries. However, the CI never returned to orthopedics for a re-evaluation while on active duty. CI was instead referred by his primary care manager to neurosurgery (Dr. Sc---) in December 2005 after a cervical MRI demonstrated minimal bulging of intervertebral disks C3-4, C5-6, and C6-7 without evidence of overt disk herniation within the spinal canal, and slight indentation of the anterolateral margin of the dural sac on the right at C5-6 and C6-7. The neurosurgeon noted some weakness of the right biceps and no biceps reflex on the right. He thought the CI might have an entrapment neuropathy of C6 and C7 and obtained EMG studies. The EMG was completely normal in January 2006 and at a follow-up visit in February 2006, Dr. Sc--- stated there was no evidence of a cervical radiculopathy and no surgical problems. He opined that the CI’s problem was a shoulder problem and he recommended follow-up with pain management and orthopedics. The CI was subsequently referred to pain management and physical medicine and rehab and in July 2006 received a second opinion from a different neurosurgeon (Dr. S---). However, he never saw an orthopedic surgeon for his shoulder. He underwent multiple treatments including right occipital nerve and right suprascapular nerve blocks, chiropractic care, physical therapy, cervical traction, ultrasound, TENS, RS stimulator, and cervical epidural steroid injections most of which brought some temporary relief (1-2 weeks) but nothing significantly decreased his pain. Dr. S--- obtained a cervical CT myelogram on 20060831 which showed diffuse degenerative changes, mild foraminal narrowing secondary to osteophytes at C5-6 bilaterally, and mild right neural foraminal narrowing at C2-3 and C3-4 as well as a small disc herniation at C3-4. At a visit on 20060906, the CI reported pain in his neck that starts in his trapezius, goes down into his right scapula and up into his occiput. Dr. S--- did not find any cause for cervical surgery and recommended follow-up in the pain clinic. CI never had follow-up for shoulder impingement before separation and all of his care remained focused on his neck. When no objective findings consistent with radiculopathy were noted the possibility of embellishment was suggested.

Appropriate therapy failed to alleviate his symptoms and he was referred to the Air Force Physical Evaluation Board (PEB). The Informal PEB (IPEB) determined he was unfit for continued military service. The CI requested a Formal PEB (FPEB) to consider returning him to duty but the FPEB concurred with the IPEB and he was then separated with a 10% disability for 5243 Neck Pain with Radiculopathy using the Veterans Affairs Schedule for Ratings Disabilities (VASRD) and applicable Air Force and Department of Defense regulations. The CI also appealed to the Air Force Personnel Council (AFPC) contending he should be returned to duty. The AFPC concurred with the decision of the FPEB and the CI then appealed to the Board of Correction for Military Records (BCMR) requesting military retirement and correction of administrative errors on his DD214. The BCMR concurred with the AFPC in matters concerning the medical separation. The diagnosis of shoulder impingement or rotator cuff injury was not evaluated by the IPEB, the FPEB, the AFPC, or the BCMR.

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CI CONTENTION: “I had 13 years 8 months and 25 days Active Duty. I was discharged for medical condition but I have always contended I should have retired from service.”

“I feel that I should have been retired as opposed to being medically discharged. I do not believe I was properly informed regarding the discharge I was to receive. I feel I was improperly advised during my separation and believe my situation warranted retirement vs. separation. I respectfully request your review of my separation.”

“I could not immediately apply for VA compensation nor any other benefits immediately upon discharge in October of 2007 as I did not have a DD214 until March 2008. I then applied for VA comp and health benefits. My VA disability comp was awarded retroactive to the day following my discharge 10/16/2007.”

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RATING COMPARISON:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Previous Determinations** | | | | | | | | |
| **Service** | | | | **VA** | | | | |
| **PEB Condition** | **Code** | **Rating** | **Date** | **Condition** | **Code** | **Rating** | **Exam Date** | **Effective date** |
| Neck Pain with Radiculopathy, with Minimal Bulging of Discs at C3-4, C5-6, and C6-7 | 5243 | 10% | 20070516 | Cervical Spine Injury With Chronic Strain (Claimed As Neck Injury) | 5237 | 20% | 20081105 | 20071016 |
|  |  |  |  | Rotator Cuff Injury, Right Shoulder With Degenerative Changes, AC Joint & Scapulocostal Syndrome Claimed As Arthritis, Right Shoulder, With Inflamed Rotator Cuff | 5201 | 20%  100%  20% | 20081105  20090310  20090601 | 20071016  20090310  20090601 |
|  |  |  |  | Tinnitus | 6260 | 10% | 20081105 | 20071016 |
|  |  |  |  | Ingrown Great Toenail, Right Foot, Postoperative With Residuals | 5299-5280 | 0% | 20081105 | 20071016 |
|  |  |  |  | Migraine Headaches | 8100 | 0% | 20081105 | 20071016 |
|  |  |  |  | Plus 2 |  | NSC |  |  |
| **TOTAL Combined: 10%** | | | | **TOTAL Combined (*incl non-PEB Dxs)*: 40% from 20071016**  **100% from 20090310**  **40% from 20090601** | | | | |

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**ANALYSIS:**

**Neck Pain (with Radiculopathy)**

**IPEB (20070516):** Your medical condition prevents you from reasonably performing the duties of your office, grade, rank, or rating. The Informal Physical Evaluation Board finds you unfit and recommends discharge with severance pay with a disability rating of 10% IAW Department of Defense and Veterans Administration Schedule for Rating Disabilities guidelines. The Board notes that you have normal strength of the upper extremities. You are unable to lift more than 30 pounds and have been assigned administrative-type tasks since Jan 06.

**FPEB (20070702):**

The member's contention was for a recommendation for return to duty. The member was diagnosed with neck pain with radiculopathy, with minimal bulging of discs at C3-4, C5-6, and C6-7. The FPEB finds the member unfit. Following a regimen of physical therapy, the member testified his condition has improved and he has returned to full duties in his primary job as of Mar 07. The board reviewed a letter written by the member's Section Chief which addresses his supervisory skills and duties but does not indicate any flightline duties specific to his AFSC. The board acknowledges the member's progress since beginning new physical therapy, however, it does not deem the member fully fit to continue his primary duties. The member remains on physical profile. Based on the evidence presented the Board recommends Discharge with Severance Pay at a compensable rating of 10%.

Military NARSUM examination of 20070516 documented ‘FROM of neck, although slow movements’ and no C-spine tenderness to palpation. There was no mention of absence or presence of pain with movement, effect of repetitive motion, or specific degrees of movement. All reflexes were noted to be 2/4 or normal. No sensory examination was noted. Motor examination was documents as 5/5 strength in bilateral arms with hand grip, finger abduction, wrist flexion/extension, elbow flexion/extension, and in deltoids.

VA examination of 20081105 documented severe muscle spasms from the occiput to C7 in addition to active ROM limited by pain described in the chart below with no change with passive ROM or following repetitive motion. Neurologic exam was noted to be normal except for strength of muscle bundles 1-6 (upper extremities) were 4/5 on the right and 5/5 on the left. Sensory exam was normal to light touch, pin prick, vibratory, and proprioception.

|  |  |  |
| --- | --- | --- |
| **Cervical** | Normal  ROM | VA ROM Exam  20081105  (13 Months After Separation) |
| Flex | 0-45 | 35 |
| Ext | 0-45 | 45 |
| R Lat flex | 0-45 | 35 |
| L lat flex | 0-45 | 35 |
| R rotation | 0-80 | 40 |
| L rotation | 0-80 | 50 |
| COMBINED  TOTAL | 340 | 240 |

**MRI 20051215**: Minimal bulging of intervertebral disks at C3-4, C5-6, and C6-7 without evidence of overt disk herniation within the spinal canal. Clinical correlation needed for right C6 and/or C7 nerve root radiculopathy.

**EMG 20060131**: Completely normal

**CT with myelogram 20060831**: Diffuse degenerative changes; anterior mass effect at C3-4 and C5-6; slightly decreased filling of nerve root sleeves at C6-7 bilaterally and C5-6 on the left. CT: ant mass effect on thecal sac mild at C2-3 and some at C3-4 on the right (may be small disc herniation); neural foraminal narrowing mild right at C2-3, some right C3-4, mild bilateral at C5-6 secondary to some osteophyte formation. No significant central canal or neural foraminal narrowing at C6-7, C7-T1, or T1-2.

Although there was no objective evidence of a cervical radiculopathy and two neurosurgeons determined the CI did not have any indication for surgery, the IPEB determined the CI was unfit due to the condition of 5243 Neck Pain with Radiculopathy, with Minimal Bulging of discs at C3-4, C5-6, and C6-7. This was rated at 10% by the PEB, presumably for painful motion IAW with VASRD paragraph 4.59. The VA documented limited ROM exam would warrant a 10% rating under the General Rating Formula for Diseases and Injuries of the Spine. However, they rated his neck pain as 5237 Cervical Spine Injury with Chronic Strain at 20% because he also had significant muscle spasms of 4+/4 in his neck and muscle tightness from the occiput to C7. The VA rated his shoulder as a separate condition as described below.

**Right Shoulder Pain/Impingement:**

The shoulder impingement is unfitting as it precludes the CI from lifting anything over 30 lbs as required by his job and weapons training/firing. His AFSC is physically demanding and requires lifting heavy objects, pulling and extending fuel hoses, etc. If his neck pain were not present, he would still not be able to perform the duties of his AFSC. Limitations are described in Commander’s letter.

The CI was evaluated by orthopedics on 20051207 for shoulder pain. He reported approximately ten episodes of major problems over the previous four years. He had increased problems when using his arm and was unable to lift weights or do his fitness activities and test. At the time of this examination, he complained of severe stabbing pain over his right trapezius and superior shoulder, limited ROM, and numbness into his shoulder, arm, and neck. His pain was 8-9 out of 10. Physical examination by the orthopedic surgeon demonstrated limited C-spine ROM with rotation and lateral bending to the right. There was tenderness to palpation and appearance of tightness over the right trapezius. There was also tenderness over the right parascapular musculature, mild to moderate tenderness over the AC joint, moderate to marked tenderness over the subacromial space. No neurologic deficit was noted in the right hand or fingers. Shoulder ROM was limited, passive more than active and there was a definite weakness of abduction and external rotation. Previous X-Rays showed slight narrowing of the AC joint. MRI of 20051026 showed mild degenerative changes of the AC joint and tendinopathy of supraspinatous and infraspinatous tendons with no identifiable tear. Cervical spine X-Rays were obtained which showed some flattening of the normal cervical lordosis but no foraminal narrowing. Diagnosis was right shoulder impingement with rotator cuff tendinopathy, limited C-spine ROM with possible underlying occult radicular symptoms, and right trapezius fibrositis with tender point areas.

Using an evaluation completed twelve and one half months after the time of separation from the Air Force, the Veterans Administration (VA) rated this disability as 5201 Rotator Cuff Injury, Right Shoulder with Degenerative Changes, AC Joint & Scapulocostal Syndrome Claimed as Arthritis, Right Shoulder, with Inflamed Rotator Cuff at 20%. A 20% rating was assigned for limitation of arm motion midway between side and shoulder level or for limitation of arm motion at shoulder level. The VA examination on 20081105 documented Pain to palpation of the right shoulder, painful motion of right shoulder, and crepitation in right shoulder. The right shoulder was one inch lower than the left shoulder. The neurologic exam was normal except strength of muscle bundles 1-6 was 4/5 on the right and 5/5 on the left. Sensory exam was normal and included light touch, pin prick, vibratory and proprioception. The ROM is in the chart below as is the orthopedic exam from December 2005.

RIGHT SHOULDER:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Movement | Normal ROM | Ortho Exam  20051207 | | NARSUM  20070320 | VA Exam  20081105 | |
|  |  | Active | Passive |  | Active | Passive |
| Forward Elevation (Flexion) | 0 - 180 | 85  (limited by pain) | 160 |  | 90 | 90 |
| Abduction | 0 - 180 | 70  (limited by pain) | 140 |  | 90 | 90 |
| External Rotation | 0 - 90 |  |  |  | 90 | 90 |
| Internal Rotation | 0 - 90 |  |  |  | 55 | 55 |
|  |  | Mild to moderate tenderness over AC joint; moderate to marked tenderness over subacromial space | No mention of pain; no mechanical limitation | FROM although slow | All limits secondary to pain; No change with repetitive emotion; right shoulder one inch lower than left | |

After the December 2005 orthopedic consult, CI never had follow-up for shoulder impingement before separation and all of his care prior to his separation remained focused on his neck. When no objective findings consistent with radiculopathy were noted the possibility of embellishment was suggested. In reality, the symptoms in his shoulder and arm were more likely than not related to his right shoulder impingement that occurred subsequent to his injury in 2001. This abnormality was ultimately proven when CI had right shoulder arthroscopic surgery at the VA in March 2009, eighteen months after he separated. The diagnosis was made in December 2005 and CI was properly sent for physical therapy specific for impingement. However, after physical therapy failed to address the problem, the CI was never referred back to orthopedics for evaluation of surgical treatment of his right shoulder impingement. The active ROM exam from Dec 2005 is very similar to the VA exam of 20081105 and is also consistent with the findings at arthroscopy in March 2009. The CI underwent a right glenohumoral arthroscopy and arthroscopic subacromial decompression in March 2009 a few months after his VA evaluation. No rotator cuff tear was noted and the post-operative diagnosis was right shoulder impingement. The intervening NARSUM exam of 20070320 is inconsistent with the two other exams but it merely states “full range of motion, although slow with movements in his neck and shoulders”, no individual measurements are listed and there is no mention of pain with motion or the effect of repetitive emotion. This exam is not complete and therefore less probative value is placed on this exam.

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**Analysis Summary**:

The CI did not receive his DD214 until five months after he separated and he filed a VA claim when he received it. This delay resulted in his initial VA examinations being completed thirteen months after separation. The Board is instructed to consider all VA examinations, especially those completed within twelve months of separation. Since the delay in obtaining VA evaluation was outside the control of the CI, the Board considered his VA examinations as if they had occurred within twelve months of separation.

CI injured his right shoulder, right trapezius, and his neck in 2001 while lifting/pulling a fuel bladder with others. He had intermittent problems for several years and sought care intermittently. He received appropriate initial care for his shoulder in December 2005 but did not receive appropriate follow-up care which should have included evaluation for possible surgical intervention if/when physical therapy did not lead to resolution of his rotator cuff injury and shoulder impingement. His shoulder problem was entirely eclipsed by an extremely thorough search for evidence of a cervical radiculopathy as an explanation for his shoulder symptoms. However, there is no physical evidence of the presence of a radiculopathy. The NARSUM mentions the shoulder problem but neither the IPEB nor FPEB rated it. The NARSUM labeled the CI’s neck pain as cervical radiculopathy when there is no evidence any radiculopathy existed and it is not clear if this was meant to encompass the CI’s shoulder condition.

The shoulder impingement is unfitting as it (along with his neck pain) precluded him from lifting anything over 30 lbs as required by his job and weapons training/firing. His AFSC is physically demanding and requires lifting heavy objects, pulling and extending fuel hoses, etc. If his neck pain were not present, he would still not be able to perform the duties of his AFSC as described in the Commander’s letter. The shoulder range of motion (ROM) exams from Dec 2005 and Nov 2008 are almost identical and are in contrast with the NARSUM exam which is less complete. More probative value is placed on the Dec 2005 and the VA exam of Nov 2008 because they are more complete. The VA exam did not result from a worsening of the CI’s condition but rather its persistence due to lack of clinical attention. There is no evidence of an intervening injury between the two examinations. The shoulder surgery done in 2009 demonstrates the impingement that was clinically suspected with the exams of Dec 2005 and Nov 2008 as well as the shoulder MRI of December 2005.

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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 concluded by simple majority that the CI’s condition is appropriately rated at a combined 30% with 20% for 5201 Right Shoulder Impingement and 10% for 5237 Cervical Spine Injury with Chronic Strain using the VASRD General Rating Formula for Diseases and Injuries of the Spine.

The Board unanimously opined the condition of Right Shoulder Impingement was unfitting and appropriately rated using VASRD 5201 Arm, limitation of motion of for the Major joint as the CI is right handed. Using the orthopedic examination of December 2005 and the VA examination of November 2008, which both show right shoulder flexion and abduction limited to shoulder level (90 degrees) or less, a majority of the Board determined this condition warrants a 20% rating. The Board opined that the VA examination of November 2008 which was done more than 12 months after separation more likely than not accurately represented the CI’s shoulder condition at the time of separation and did not result from a worsening of his condition over time. The almost identical orthopedic examination from December 2005 was considered sufficient evidence to make this determination.

The Board also unanimously determined the CI’s limited cervical spine ROM with flexion limited to 35 degrees and combined cervical ROM of 240 warrants a 10% rating using the VASRD General Rating Formula for Diseases and Injuries of the Spine. The presence of muscle spasm, although severe, does not satisfy the criteria for a 20% rating.

The other diagnoses rated by the VA (tinnitus, ingrown toenail, and migraine headache) were not mentioned in the DES package and could not be considered by the Board.

The single voter for dissent (who agreed the shoulder impingement was unfitting but recommended rating 5201 Right Shoulder Impingement at 10%) elected not to submit a minority opinion.

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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 the CI’s prior medical separation.

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| --- | --- | --- |
| Unfitting Condition | VASRD Code | Rating |
| right shoulder impingement | 5201 | 20% |
| cervical spine injury with chronic strain | 5237 | 10% |
| Combined | 30% |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090529, 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-2009-00403.

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 not appropriate under the guidelines of the Veterans Administration Schedule for Rating Disabilities. Accordingly, the Board recommended your separation be re-characterized to reflect disability retirement, rather than separation with severance pay.

I have carefully reviewed the evidence of record and the recommendation of the Board. I concur with that finding, accept their recommendation and determined that your records should be corrected accordingly. The office responsible for making the correction will inform you when your records have been changed.

As a result of the aforementioned correction, you are entitled by law to elect coverage under the Survivor Benefit Plan (SBP). Upon receipt of this letter you must contact the Air Force Personnel Center at 1-800-531-7502 to make arrangements to obtain an SBP briefing prior to rendering an election. If a valid election is not received within 30 days from the date of this letter, you will not be enrolled in the SBP program. Unless at the time of your separation, you were married or had an eligible dependent child, in such a case, failure to render an election will result in automatic enrollment.

Sincerely

Director

Air Force Review Boards Agency

Attachment:

Record of Proceedings

cc:

SAF/MRBR

DFAS-IN