RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: AIR FORCE

CASE NUMBER: PD0900419 BOARD DATE: 20091104

SEPARATION DATE: 20090629

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SUMMARY OF CASE: This covered individual (CI) was TSgt/E-6, Air Transportation Craftsman medically separated from the Air Force Reserves in 2009 after more than 13 years active duty and 35 years of combined service. The medical basis for the separation was Cervical Spondylosis Status Post Spinal Fusion.

The CI injured his back and neck while loading a plane with heavy equipment when he was stationed in Turkey in April 2007. He experienced back pain, neck pain and right army radiculopathy. He was diagnosed with Cervical Spondylotic Myelopathy, Cervical Herniated Nucleus Pulposus C3/4, C4/5, and C5/6, and Right C6 Radiculopathy. He had decompression surgery with fusion of C3-4, C4-5, and C5-6 for cervical stenosis in October 2007. He initially improved after surgery but he later had profound worsening of symptoms in all four extremities.

The CI’s condition significantly worsened between June 2008 and the time of his separation in June 2009 and this is documented in both VA and military treatment records. The Air Force Informal Physical Evaluation Board (PEB) documents list the condition as Cervical Spondylosis status post Spinal Fusion. It is not clear why the diagnosis was altered and the myelopathy was not included.

Appropriate therapy failed to alleviate his symptoms and he was referred to the Air Force Physical Evaluation Board (PEB). In December 2008 the Informal PEB determined he was unfit for continued military service and rated his condition at 20% for 5241 Cervical Spondylosis Status Post Spinal Fusion. He requested a Formal PEB and contended that his back pain should also be rated. The FPEB noted the CI’s High Year of Tenure date of 1 Oct 2008, which placed him within a presumptive period since 1 Oct 2007. The Board concluded, based on the evidence of record, that his cervical condition overcame the presumption of fitness. The Board found this was an unfitting condition and is best rated at 20%. He appealed to the Secretary of the Air Force Personnel Council (SAFPC) and contended for permanent retirement. In a memorandum dated 20090417 the SAFPC concluded the CI’s lower back pain did not overcome the presumption of fitness and concurred with the disposition recommended by the previous boards. The SAFPC agreed that the CI’s neck condition did overcome the presumption of fitness standard and as the CI agreed to this aspect of the case, did not adjudicate this aspect of the case. The CI was subsequently separated with a 20% disability for 5241 Cervical Spondylosis Status Post Spinal Fusion using the Veterans Affairs Schedule for Ratings Disabilities (VASRD) and applicable Air Force and Department of Defense regulations. He was not separated from the Reserves until after the SAFPC appeal was completed.

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CI CONTENTION: “The rating from the board does not take into account other conditions that have been triggered from the cervical spondylosis status post spinal fusion. In Feb 2009 an MRI performed demonstrated lumbar degenerative disc disease. In the board’s decision they also state that ‘The DES compensates disabilities when they cause or contribute to career termination,’ then they go on to say that they ‘have determined that you are physically unfit for continued military service’ so they are acknowledging that my condition makes me unfit. Because of my condition I will not be able to return to my previous job either. Also now have trouble sitting or standing for a period of time. My leg falls asleep; I have to used a walker. VA has size me up for a wheelchair, they have sent me some safety equipment for my home bath room.”

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RATING COMPARISON:

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Previous Determinations** | | | | | | | | |
| **Service** | | | | **VA** (Exam 12-18 months pre-separation) | | | | |
| **PEB Condition** | **Code** | **Rating** | **Date** | **Condition** | **Code** | **Rating** | **Exam Date** | **Effective date** |
| Cervical Spondylosis Status Post Spinal Fusion | 5241 | 20% | 20090417 | Postoperative Cervical Spondylosis With Intervertebral Disc Syndrome | 5243 | 20%  100%  20% | 20071106 | **20070811**  20071018  20080401 |
| Lumbosacral Degenerative Disc Disease With Chronic Pain | 5243 | CAT II | 20090417 | Surgical Scar At Anterior Aspect Of Neck | 7800 | 10% | 20071116 | **20070811** |
|  |  |  |  | Radiculopathy Of The Right Upper Extremity | 8615 | 10% | 20071116 | **20070811** |
|  |  |  |  | Tender Scar At Anterior Aspect Of Neck | 7804 | 10% | 20071116 | 20071018 |
|  |  |  |  | Right Lower Extremity Spasticity Associated With Postoperative Cervical Spondylosis W/Intervertebral Disc Syndrome | 8520 | 10% | Treatment record review | 20081116 |
|  |  |  |  | Neurogenic Bladder Associated W/Postoperative Cervical Spondylosis With Intervertebral Disc Syndrome | 7542 | 0% | Treatment record review | 20090108 |
|  |  |  |  | Post Traumatic Stress Disorder | 9411 | 30% | 20080719 | 20080613 |
|  |  |  |  | Fractured Radius Of The Left Wrist | 5099-5010 | 0% | 20071106 | **20070811** |
|  |  |  |  | Postoperative Right Hydrocele | 7599-7523 | 0% | 20071106 | **20070811** |
|  |  |  |  | Tender Scar In Right Groin Area | 7804 | 0% | 20071116 | **20070811** |
| **TOTAL Combined: 20%** | | | | **TOTAL Combined (*incl non-PEB Dxs)*: 40**% from 20070811  **100**% from 20071018  **50**% from 20080401  **60**% from 20080613  **70%** from 20081116  **All with bilateral factor of 1.9 for codes 8615, 5010** | | | | |

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ANALYSIS SUMMARY:

The CI injured his back and neck while loading a plane with heavy equipment when he was stationed in Turkey in April 2007. He had severe pain in his back and neck and paresthesias radiating to the right arm along his biceps and volar surface of his lower forearm into the last four fingers. He was referred to physical therapy and then had X-rays and MRI done in July 2007. This revealed severe central canal stenosis at C3-4 through C5-6 along with herniated discs and severe spinal cord deformity. The MRI also showed T2 signal hyperintensity on MRI consistent with gliosis, edema, or myelomalacia. He was diagnosed with Cervical Spondylotic Myelopathy and scheduled for surgery. He did well initially after cervical decompression and fusion of C3-4, C4-5, and C5-6 for cervical stenosis in October 2007 and had physical therapy as part of his rehabilitation. A Navy Neurosurgeon outpatient note of 20080604 documented improved right upper extremity (RUE) strength to the point of being neurologically intact. Some notes state he did not develop back and lower extremity symptoms until after the surgery. However, on a visit 20070604 he complained of neck and low back pain; this was after the injury and prior to the surgery. Subsequent lumbar MRI showed mild disc bulges at L3-4 and L4-5 with mild central canal stenosis and mild bilateral foraminal narrowing but in December 2008 VA neurosurgery stated there was no impingement of neural elements and surgery was not indicated. A cervical MRI done after surgery showed some osteophytes at C3-4 and C4-5 but the hardware was in good position and the spine was in good alignment. Surgery was anatomically successful and no revision was indicated but the spinal cord was injured and persistent symptoms remained as described above. The VA neurosurgeon stated he had residual myelomalacia. This condition generally includes gradual onset of motor and sensory deficits like the CI had.

A Neurosurgery addendum was done in March 2008 and the Medical Evaluation Board (MEB) Narrative Summary (NARSUM) was done in August 2008. These evaluations along with the CI’s service treatment records demonstrate initial improvements in the symptoms of his Cervical Spondylotic Myelopathy and Right C6 Radiculopathy through June 2008. The CI was also diagnosed with Cervical Herniated Nucleus Pulposus C3/4, C4/5, and C5/6. However, the CI’s condition profoundlyly worsened between June 2008 and the time of his separation in June 2009 and this is documented in both VA and military treatment records. The Air Force Informal Physical Evaluation Board (PEB) documents list the condition as Cervical Spondylosis Status Post Spinal Fusion. It is not clear why the diagnosis was altered and the myelopathy was not included.

The CI was first evaluated in the VA spinal cord injury clinic in August 2008 after a referral from the VA neurosurgeon. A comprehensive exam showed decreased strength in the RUE and right lower extremity (RLE) and decreased sensation to both light touch and pinprick in the RUE from C4 to S5 dermatomes. A repeat exam in January 2009 showed similar motor defects but also new sensory deficits in the left upper extremity (LUE) from C3 to S5 dermatomes and increased sensory deficits in the RUE at C2 and C3 dermatomes and the absence of sensation at C7 and C8 dermatomes. The deficits resulted from the myelopathy, damage to the spinal cord itself, not to peripheral nerve roots. See attached chart. Urodynamic studies documented a neurogenic bladder and the CI had symptoms of urgency and retention. However, the CI had inconsistent reports of incontinence, no mention of requirement for use of absorbent material, and post void residual was 20cc.

The CI had symptoms of myelopathy in all four extremities. This was documented by the abnormal signal on MRI and characteristic signs and symptoms. He had sharp, shooting neuropathic pain from the neck to his upper extremities that is not related to movement or position, pain in his lower back and right leg especially with sitting or standing for long periods of time, numbness in soles of both feet at night, slight weakness of right upper extremity (dominant hand) and right lower extremity, spasticity and hyperreflexia, stiffness of upper and lower extremities especially in the morning and after periods of inactivity, episodes of his right leg giving out, persistent sensory impairments, neurogenic bladder documented on urodynamic study in Jan 2009, some deep tendon reflexes (DTRs) absent, some hyperreflexic, and antalgic gait favoring right lower extremity. His symptoms significantly interfered with his ability to ambulate. His gait was repeatedly documented in both VA and military records as wide-based, slow, and antalgic and multiple falls were reported. While the CI had been using a cane to ambulate (prescribed in Sept 2008), he was prescribed a walker in Jan 2009 as a result of increased tone and pain interfering with balance and ability to ambulate for increased distances. On his application to the PDBR, the CI stated he was in the process of obtaining a wheelchair from the VA. The CI also was treated in the pain management clinic and physical therapy with multiple treatment modalities in addition to medication.

The initial VA rating was based on a diagnosis similar to the one used by the IPEB and it did not include myelopathy. The VA rating examination was done in November 2007, only one month after the CI’s spinal fusion surgery and nineteen months prior to the CI’s separation. At this time the CI had symptoms of right upper extremity radiculopathy. A review of his VA treatment records from June 2008 through January 2009 resulted in the addition of a 10% rating for Right Lower Extremity Spasticity and a 0% rating for Neurogenic Bladder. Also, the 10% rating for the right upper extremity radiculopathy was continued. No Compensation and Pension (C&P) examination was performed. It is not clear why the VA rater failed to realize the profound impairments documented in the CI’s VA treatment records and rate appropriately for the CI’s level of functional limitation. In particular, the rater seems to have missed the evaluations from the spinal cord injury clinic in August 2008 and January 2009 documenting widespread signs and symptoms of spinal cord dysfunction that worsened over time, including the prescription of a walker as described above. Perhaps if a full C&P examination had been completed, a more appropriate rating would have resulted.

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BOARD FINDINGS: IAW DoDI 6040.44, the PDBR used the Veteran’s Affairs Schedule of Rating Disabilities (VASRD) as the most favorable basis for rating. After careful consideration of all available information, the Board concluded by simple majority that the CI’s condition is appropriately rated at a combined 80% with 20% for 5241 Cervical Spondylotic Myelopathy Status Post Spinal Fusion C3-6 using the VASRD general rating formula for diseases and injuries of the spine, 40% for 5241-8513 Right (Dominant) Upper Extremity Motor And Sensory Radiculopathy associated with Cervical Spondylotic Myelopathy Status Post Spinal Fusion C3-6, 40% for 5241-8520 Right Lower Extremity Motor And Sensory Radiculopathy with Spasticity (Associated with Cervical Spondylotic Myelopathy Status Post Spinal Fusion C3-6) Requiring Walker for Ambulation, 10% for 5241-8520 Left Lower Extremity Sensory Radiculopathy associated with Cervical Spondylotic Myelopathy Status Post Spinal Fusion C3-6. This includes the bilateral factor of 4.6 for 8520.

The Board unanimously agreed that the CI’s condition is accurately classified as Cervical Spondylotic Myelopathy Status Post Spinal Fusion as stated in the MEB NARSUM and the STR. His neck condition is appropriately rated at 20% based on cervical flexion limited by pain at 20 degrees.

The CI contended that his back pain and lower extremity symptoms should also be rated as they were triggered by his neck condition. The SAFPC determined that his back pain did not overcome the presumption of fitness and this Board has no evidence to overturn this decision. However, the CI’s lower extremity problems are a result of his cervical myelopathy, not his lumbar degenerative disc disease. The myelopathy affects the spinal cord itself, not the peripheral nerves as they exit the neural foramina of the spinal column. The myelopathy has been determined to be unfitting and therefore the lower extremity symptoms will be rated as part of this unfitting condition.

A majority of the Board agreed that the fitness of each extremity should be evaluated prior to rating or alternatively that the disability related to each extremity should be evaluated to determine its degree of contribution to overall unfitness prior to rating. The Board determined that the functional limitations of the right upper and right lower extremities could be considered separately unfitting and both significantly contributed to the CI’s overall unfitness. The Board also determined that the functional limitations of the left lower extremity significantly contributed to the CI’s overall unfitness. The functional limitations of left upper extremity could not be considered either separately unfitting or as a significant contribution to the overall unfitness. Therefore the right upper and lower extremities and the left lower extremity are rated. When applying the peripheral nerve ratings, ‘incomplete paralysis’ indicates a degree of lost or impaired function substantially less than the type pictured for complete paralysis given with each nerve, whether due to varied level of the nerve lesion or to partial regeneration. When the involvement is wholly sensory, the rating should be for the mild, or at most, the moderate degree (VASRD paragraph §4.124a)

The right upper extremity rating of 5241-8513 Right (Dominant) Upper Extremity Motor and Sensory Radiculopathy associated with Cervical Spondylotic Myelopathy Status Post Spinal Fusion C3-6 at 40% is based on Incomplete Paralysis characterized as moderate on the dominant side. The CI had decreased strength (4/5) from C5 to T1, absence of biceps and brachioradialis reflexes, decreased (1+) triceps reflex, positive Hoffman sign, impaired pin prick sensation from C2 to C6 and T1, and absence of pinprick sensation from C7 to C8. The CI also had symptoms of weakness, stiffness, and sharp, shooting neuropathic pain rated 8 to 9 out of 10. A 20090113 Kinesiology consult demonstrated right shoulder flexion limited to 80 degrees with active motion and abduction limited to 130 degrees with passive motion and 90 degrees with active motion. Under VASRD code 5201, this limited shoulder range of motion (ROM) would rate at 20%. However, the rating for radiculopathy is 40% and radiculopathy more accurately describes the disability. According to VASRD paragraph §4.55 Principles of combined ratings for muscle injuries, we cannot rate for both radiculopathy and muscle injury unless the injuries affect entirely different functions and they do not. Also according to VASRD paragraph §4.7 Higher of two evaluations we should rate using the peripheral nerve code as it gives a higher rating.

The right lower extremity rating of 5241-8520 Right Lower Extremity Motor and Sensory Radiculopathy (associated with Cervical Spondylotic Myelopathy Status Post Spinal Fusion C3-6) Requiring Walker for Ambulation at 40% is based on Incomplete Paralysis characterized as moderately severe. The CI had significant difficulties ambulating secondary to motor and sensory deficits in his right lower extremity. From late June 2008 the STI recorded a wide based, slow antalgic gait. He was initially prescribed a cane in September 2008 and then was prescribed a walker in January 2009. His contention states that at the time of application, he was in the process of obtaining a wheelchair from the VA. He had spasticity in his right leg and was unable to dorsiflex his right foot due to tone. His right leg would also ‘give way’ and he reporting falling multiple times as a result of this. The CI also had symptoms of weakness, stiffness, and sharp, shooting neuropathic pain rated 8 to 9 out of 10. He had decreased strength (4/5) from L5 to S1, normal ankle reflex, hyperreflexia at the knee, positive babinski, and impaired pin prick sensation from L1 to S5.

The left lower extremity rating of 5241-8520 Left Lower Extremity Sensory Radiculopathy associated with Cervical Spondylotic Myelopathy Status Post Spinal Fusion C3-6 at 10% is based on Incomplete Paralysis characterized as mild. No decreased strength was noted on examination but stiffness and sharp, shooting neuropathic pain rated 8 to 9 out of 10 were present. The CI had normal ankle reflex, hyperreflexia at the knee, positive babinski, and impaired pin prick sensation from L1 to S5. While this leg did not demonstrate spasticity or ‘give way’, the Board was unable to separate the CI’s left lower extremity problems from his difficulties in ambulation and determined that the left lower extremity significantly contributed to his difficulty walking and his overall disability.

A majority of the Board agreed that the fitness of the Neurogenic Bladder condition should be evaluated prior to rating or alternatively that the disability related to Neurogenic Bladder should be evaluated to determine its degree of contribution to overall unfitness prior to rating. The CI did have neurogenic bladder documented with urodynamic studies. However, his post void residual was only 20cc and he did not have urinary incontinence and did not require the use of absorbent material. The Board opined this condition cannot be considered separately unfitting or as significantly contributing to the CI’s overall disability.

The Board determined that the condition Lumbar Degenerative Disc Disease does not overcome the presumption of fitness and is not considered unfitting. The other conditions rated by the VA were not included in the DES package and cannot be considered by the PDBR. These include Post Traumatic Stress Disorder, Fractured Left Radius, Hydrocele, and Scars.

The single voter for dissent (who recommended rating the disabilities of all four extremities and neurogenic bladder as part of the overall unfitting condition of myelopathy) submitted an attached 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 |
| CERVICAL SPONDYLOTIC MYELOPATHY STATUS POST SPINAL FUSION C3-6 | 5241 | 20% |
| RIGHT (DOMINANT) UPPER EXTREMITY MOTOR AND SENSORY RADICULOPATHY ASSOCIATED WITH CERVICAL SPONDYLOTIC MYELOPATHY STATUS POST SPINAL FUSION C3-6 | 5241-8513 | 40% |
| RIGHT LOWER EXTREMITY MOTOR AND SENSORY RADICULOPATHY WITH SPASTICITY (ASSOCIATED WITH CERVICAL SPONDYLOTIC MYELOPATHY STATUS POST SPINAL FUSION C3-6) REQUIRING WALKER FOR AMBULATION | 5241-8520 | 40% |
| LEFT LOWER EXTREMITY SENSORY RADICULOPATHY ASSOCIATED WITH CERVICAL SPONDYLOTIC MYELOPATHY STATUS POST SPINAL FUSION C3-6 | 5241-8520 | 10% |
| COMBINED | 80% |

Bilateral Factor of 4.6

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090624, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

President

Physical Disability Board of Review

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | **Motor** | | | | **Sensory (Pin Prick)** | | | | | |
| 20080804 | | **20090106** | | 20080804 | | | | **20090106** | |
| Right | Left | Right | Left | Right | | left | | Right | left |
| C2 |  | |  |  |  |  | 2 | | 2 | | 1 | 2 |
| C3 |  | |  |  |  |  | 2 | | 2 | | 1 | 1 |
| C4 |  | |  |  |  |  | 1 | | 2 | | 1 | 1 |
| C5 | Elbow Flex | | 5 | 5 | 4 | 5 | 1 | | 2 | | 1 | 1 |
| C6 | Wrist Ext | | 5 | 5 | 4 | 5 | 1 | | 2 | | 1 | 1 |
| C7 | Elbow Ext | | 4 | 5 | 4 | 5 | 1 | | 2 | | 0 | 1 |
| C8 | Finger Flexors | | 4 | 5 | 4 | 5 | 1 | | 2 | | 0 | 1 |
| T1 | Finger Abductors | | 4 | 5 | 4 | 5 | 1 | | 2 | | 1 | 1 |
| T2 |  | |  |  |  |  | 1 | | 2 | | 1 | 1 |
| T3 |  | |  |  |  |  | 1 | | 2 | | 1 | 1 |
| T4 |  | |  |  |  |  | 1 | | 2 | | 1 | 1 |
| T5 |  | |  |  |  |  | 1 | | 2 | | 1 | 1 |
| T6 |  | |  |  |  |  | 1 | | 2 | | 1 | 1 |
| T7 |  | |  |  |  |  | 1 | | 2 | | 1 | 1 |
| T8 |  | |  |  |  |  | 1 | | 2 | | 1 | 1 |
| T9 |  | |  |  |  |  | 1 | | 2 | | 1 | 1 |
| T10 |  | |  |  |  |  | 1 | | 2 | | 1 | 1 |
| T11 |  | |  |  |  |  | 1 | | 2 | | 1 | 1 |
| T12 |  | |  |  |  |  | 1 | | 2 | | 1 | 1 |
| L1 |  | |  |  |  |  | 1 | | 2 | | 1 | 1 |
| L2 | Hip Flex | | 4 | 5 | 4 | 5 | 1 | | 2 | | 1 | 1 |
| L3 | Knee Ext | | 4 | 5 | 4 | 5 | 1 | | 2 | | 1 | 1 |
| L4 | Ankle Dorsiflex | | 3 | 5 | 4 | 5 | 1 | | 2 | | 1 | 1 |
| L5 | Long Toe Ext | | 3 | 5 | 4 | 5 | 1 | | 2 | | 1 | 1 |
| S1 | Ankle Plantarflex | | 3 | 5 | 4 | 5 | 1 | | 2 | | 1 | 1 |
| S2 |  | |  |  |  |  | 1 | | 2 | | 1 | 1 |
| S3 |  | |  |  |  |  | 1 | | 2 | | 1 | 1 |
| S4-5 |  | |  |  |  |  | 1 | | 2 | | 1 | 1 |
|  |  | | 39 | 50 | 40 | 50 | 30 | | 56 | | 27 | 30 |
| max |  | | 50 | 50 | 50 | 50 | 56 | | 56 | | 56 | 56 |
|  |  | | 89/100 | | 90/100 | | 86/112 | | | | 57/112 | |
|  | | | | | | | | | | | | |
| **Motor** | | | | | | | | **Sensory** | | | | |
| 0 | | total paralysis | | | | | | 0 | | Absent | | |
| 1 | | palpable or visible contraction | | | | | | 1 | | Impaired | | |
| 2 | | active movement gravity eliminated | | | | | | 2 | | Normal | | |
| 3 | | active movement against gravity | | | | | | NT | | Not Testable | | |
| 4 | | active movement against some resistance | | | | | |  | | | | |
| 5 | | active movement with full resistance | | | | | |
| NT | | Not testable | | | | | |

MINORITY OPINION

It is this Board Member’s opinion that the Board’s decision to rate only those residuals of an unfitting condition that either could be considered separately unfitting or significantly contributed to the covered individual’s (CI) overall disability is in conflict with DoDI 6040.44 as updated 20090602 and the 20081014 NDAA Memo (including enclosure 7). These documents specify that all medical conditions determined to be unfitting independently or due to combined effect, to include in combination with an independently unfitting condition shall be rated using the Department of Veterans Affairs Schedule for Rating Disabilities (VASRD). A specific amount or degree of contribution to overall disability is not required to rate conditions or residuals considered unfitting due to combined effect.

The CI has cervical spondylotic myelopathy with characteristic signs and symptoms in all four extremities and a neurogenic bladder. The myelopathy has been determined to be an unfitting condition. It is the combined effect of all the residuals of myelopathy that make the CI unfit so all should be rated.

The Board determined that only those residuals of the cervical spondylotic myelopathy that either could be considered separately unfitting or **significantly** contributed to the CI’s overall unfitness would be rated. This resulted in rating three of extremities but not the left upper extremity or the neurogenic bladder.

This Board Member agrees with the ratings percentages that were applied by the Board. However ratings for the left upper extremity and the neurogenic bladder should be added.

The left upper extremity rating of 5241-8513 Left Upper Extremity Sensory Radiculopathy associated with Cervical Spondylotic Myelopathy Status Post Spinal Fusion C3-6 at 20% is based on Incomplete Paralysis characterized as mild on the non-dominant side. The CI had absence of triceps and brachioradialis reflexes, decreased (1+) biceps reflex, and impaired pin prick sensation from C3 to T1. The CI also had symptoms of weakness, stiffness, and sharp, shooting neuropathic pain rated 8 to 9 out of 10. A 20090113 Kinesiology consult demonstrated left shoulder flexion limited to 80 degrees with active motion. Under VASRD code 5201, this limited shoulder range of motion (ROM) would rate at 20%. This rating is the same as the rating for radiculopathy but radiculopathy more accurately describes the disability. According to VASRD paragraph §4.55 Principles of combined ratings for muscle injuries, we cannot rate for both radiculopathy and muscle injury unless the injuries affect entirely different functions

and they do not. Therefore only the 20% rating for radiculopathy is applied.

A rating of 0% for neurogenic bladder 5241-7542 is based on the lack of evidence for urinary or stress incontinence that required the wearing of absorbent material. The CI had symptoms of urgency and hesitancy and had urodynamic studies that documented neurogenic bladder. However, the post void residual was 20cc and there was no evidence of obstructive symptomatology requiring dilatation one to two times per year.

RECOMMENDATION: This Board Member 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. The bilateral factor 7.4 is applied.

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| --- | --- | --- |
| Unfitting Condition | VASRD Code | Rating |
| CERVICAL SPONDYLOTIC MYELOPATHY STATUS POST SPINAL FUSION C3-6 | 5241 | 20% |
| RIGHT (DOMINANT) UPPER EXTREMITY MOTOR AND SENSORY RADICULOPATHY ASSOCIATED WITH CERVICAL SPONDYLOTIC MYELOPATHY STATUS POST SPINAL FUSION C3-6 | 5241-8513 | 40% |
| LEFT UPPER EXTREMITY SENSORY RADICULOPATHY ASSOCIATED WITH CERVICAL SPONDYLOTIC MYELOPATHY STATUS POST SPINAL FUSION C3-6 | 5241-8513 | 20% |
| RIGHT LOWER EXTREMITY MOTOR AND SENSORY RADICULOPATHY WITH SPASTICITY (ASSOCIATED WITH CERVICAL SPONDYLOTIC MYELOPATHY STATUS POST SPINAL FUSION C3-6) REQUIRING WALKER FOR AMBULATION | 5241-8520 | 40% |
| LEFT LOWER EXTREMITY SENSORY RADICULOPATHY ASSOCIATED WITH CERVICAL SPONDYLOTIC MYELOPATHY STATUS POST SPINAL FUSION C3-6 | 5241-8520 | 10% |
| NEUROGENIC BLADDER ASSOCIATED WITH CERVICAL SPONDYLOTIC MYELOPATHY STATUS POST SPINAL FUSION C3-6 | 5241-7542 | 0% |
| COMBINED | 90% |

Bilateral factor of 7.4 added

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-2009-00419.

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.

The Board majority recommended a combined disability rating of 80% rather than 20% while the minority member recommended a combined rating of 90%. I have carefully reviewed the evidence of record, the recommendation of the Board and the minority opinion and I concur with the finding and recommendation of the board majority 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

PDBR PD-2009-00419

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) and Section 1552, Title 10, United States Code (70A Stat. 116) it is directed that:

The pertinent military records of the Department of the Air Force relating to XXXXXXXXX be corrected to show that:

a.  The diagnoses in his finding of unfitness were cervical spondylotic myelopathy status post spinal fusion C3-6, rather than cervical spondylosis status post spinal fusion, VASRD code 5241, rated at 20%; right (dominant) upper extremity motor and sensory radiculopathy associated with cervical spondylotic myelopathy status post spinal fusion C3-6, VASRD code 5241-8513, rated at 40%; right lower extremity motor and sensory radiculopathy with spasticity (associated with cervical spondylotic myelopathy status post spinal fusion C3-6) requiring walker for ambulation, VASRD code 5241-8520, rated at 40%; and left lower extremity sensory radiculopathy associated with cervical spondylotic myelopathy status post spinal fusion C3-6, VASRD code 5241-8520, rated at 10%; with a combined rating of 80%.

b.  On 27 June 2009, he elected spouse-only coverage under the Survivor Benefit Plan (SBP) based on full retired pay, naming XXXXXXXXX as the eligible spouse beneficiary.

c.  He was not discharged on 28 June 2009 with entitlement to disability severance pay; rather, on that date he was relieved from active duty and on 29 June 2009 his name was placed on the Permanent Disability Retired List.

Director

Air Force Review Boards Agency