RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXX BRANCH OF SERVICE: usmc

CASE NUMBER: PD09-00567 SEPARATION DATE: 20090830

BOARD DATE: 20110120

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty Lance Corporal/E3 (0351, Assaultman), medically separated from the USMC in 2009. The medical basis for the separation was Lumbago (back pain/LBP). The CI first noticed back pain in January 2008 while deployed to Iraq. He sought treatment while deployed and was able to complete the deployment. Upon returning to CONUS, he sought further care which consisted of physical therapy, three epidural steroid injections (ESI), a facet block (injection for pain relief), acupuncture, and narcotic pain medications. He had engaged in pain management and had an orthopedic consultation, but declined operative intervention as it was not likely to improve his condition. Magnetic resonance imaging (MRI) demonstrated facet joint hypertrophy, with L4-L5 and T11-12 disc protrusions. Despite complaints of right leg numbness, electrodiagnostic study conducted November 2008 was normal with no evidence of radiculopathy. He did not respond adequately to perform within his military occupational specialty or participate in a physical fitness test, and was placed on several periods of limited duty (LIMDU) prior to undergoing a Medical Evaluation Board (MEB). Back pain (Lumbago, displacement of lumbar intervertebral disc without myelopathy and other symptoms referable to the back) were addressed in the narrative summary (NARSUM) and forwarded to the Physical Evaluation Board (PEB) on the NAVMED 6100/1. No other conditions appeared on the MEB’s NAVMED 6100/1. Other conditions included in the NARSUM and Disability Evaluation System (DES) packet will be discussed below. The PEB adjudicated the lumbago condition as unfitting, rated at 20% with associated back diagnoses as (Category 2). The CI made no appeals, and was then medically separated with a 20% disability rating.

CI CONTENTION: The CI states: ‘’I feel that I am more disabled than 20% (not all symptoms were taken into consideration). I was injured due to a deployment, but was told it was not combat related. New symptoms have occurred because of my injury and its effects.” As a matter of policy, all service conditions are reviewed by the Board for their potential contribution to its rating recommendations.

RATING COMPARISON:

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| **Service IPEB – Dated 20090630** | **VA (3.5 Mo. after Separation) – All Effective 20090831** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Lumbago | 5237 | 20% | Thoracic Disc Herniation & Lumbar Disc Bulge | 5243 | 40% | 20091218 |
| - | Facet Syndrome | Category 2 |
| - | Bulging Disc (L4-L5)(T11-T12) | Category 2 |
| ↓No Additional MEB Entries↓ | RLE Radiculpathy  | 8520 | 20% | 20100414 |
| LLE radiculopathy | 8520 | 10% | 20100414 |
| Depressive disorder … | 9499-9432 | 30% | 20091218 |
| Tinnitus | 6260 | 10% | 20100304 |
| Irritable Bowel Syndrome | 7319 | 10% | 20100414 |
| Cervical; Hearing; Chg smell/taste, TBI, Migraine HA, PTSD | NSC |
| **TOTAL Combined: 20%** | **TOTAL Combined (*Includes Non-PEB Conditions*): 80%** |

ANALYSIS SUMMARY: We note the applicant implicitly asks the Board for changing his back condition to “combat-related.” By law the Board authority is limited to making recommendation on correcting disability determinations. The actual categorization of injuries/illnesses as combat related is the responsibility of the applicable Secretary. The applicant's request will of course remain with the application as it is processed. The Board also acknowledges the sentiment expressed in the CI’s application regarding the significant impact that his service-incurred condition has had on his current earning ability and quality of life. It is a fact, however, that the DES has neither the role nor the authority to compensate service members for anticipated future severity or potential complications of conditions resulting in medical separation. This role and authority is granted by Congress to the Veterans Administration. A ‘crystal ball’ requirement is not imposed on the service PEB’s by the Board; and, the 12 month window specified in DoDI 6040.44 is appropriate for rating comparisons but not for new developments after separation for increased rating.

Back Condition. All of the CI’s lower back MEB diagnoses [Lumbago, Facet Syndrome, Bulging Disc (L4-L5)(T11-T12)] and all back symptoms were considered in a single back rating IAW Veterans Administration Schedule for Rating Disabilities (VASRD) §4.71a. There were two goniometric range-of-motion (ROM) evaluations in evidence which the Board weighed in arriving at its rating recommendation. Both of these exams are summarized in the chart below, along with an orthopedic consultant’s exam.

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| Thoracolumbar | Separation Date: 20090830 |
| Goniometric ROM | MEB PT -20090323 | Ortho – 20090428\* | VA C&P -20091218 |
| Flexion 0-90⁰ normal | 0⁰-75⁰ | 0⁰-15⁰ | 0⁰-15⁰ |
| Combined 240⁰ normal | 195⁰ | -- | 90⁰ |
| §4.71a Rating | 10% | 40% | 40% |
| Comments | +TTP and spasm; abnormal motion; pain with motion | \*Non-goniometric; pain limited; Ext 0⁰-10⁰; +R L5 decreased sensation; tender R L4-5 & R SI jt; +R SLR  | + tender, spasm, SLR bilat; levoscoliosis; motor sym; dec RLE light touch & vibration  |

The CI had non-duty limiting subjective right leg numbness and also had right lower extremity radiating pain symptoms. However, the numbness was intermittent and not to the level to interfere with duty. Symptoms such as pain (whether or not it radiates), stiffness, or aching in the area of the spine affected by residuals of injury or disease is rated IAW the General Rating Formula for Diseases and Injuries of the Spine. There was no evidence of non-pain radiculopathy by electrophysiological studies (EMG/NCV was normal). There was therefore no evidence of ratable peripheral nerve impairment in this case. The CI met or exceeded a number of the 20% rating criteria. Despite hospital emergency room visits, the NMA statement of “being placed SIQ (sick in quarters) on several different occasions” and the CI’s reportedly being told to stay at home due to his command not wanting him to drive while on narcotics; there was insufficient evidence in the record to support “incapacitating episodes having a total duration of at least 4 weeks but less than 6 weeks during the past 12 months” for a higher (40%) rating under code 5243 outside of the General Rating Formula. Therefore, rating deliberations in this case focused on whether the pain-limited forward flexion of the thoracolumbar spine was “greater than 30 degrees but not greater than 60 degrees” (20%); or “30 degrees or less” (40%). The MEB physical therapy ROMs were five months pre-separation and did not support a higher rating. The Board noted numerous other notes related to the back flexion that were not complete or ratable, that preceded the MEB ROMs indicated were to “50% flexion.” There were rare notes that indicated either 75% flexion or flexion limited to 30 degrees. However, an orthopedic consultation performed four months pre-separation indicated forward flexion of only 15 degrees without a complete goniometric exam for all planes of movement: “He is able to forward-flex from approximately 0 to 15 degrees, limited by pain. He is able to extend from about 0 to 10 degrees, limited by pain.” There was a single VA clinical note that indicated positive Waddell’s that were not noted anywhere else in the VA or service record. The VA rating examination performed four months post-separation indicated forward flexion limited to 15 degrees. The VA exam was the most comprehensive, closest to separation, and adjudged to have the highest probative value. The Board considered that the CI had numerous clinical visits; multiple non-surgical treatment modalities for his back pain (ESIs, TENS, facet injection, physical therapy, back brace, acupuncture, and pain management), abnormal spine imaging consistent with symptoms, flares of symptoms including not-unfitting radicular symptoms, and long-term narcotic medications. The flares and indications of “good days and bad days” with lower back conditions was considered. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), §4.6 (evaluation of evidence) and §4.7 (higher of two evaluations); the Board recommends a separation rating of 40% for the back condition. All evidence considered, there is not reasonable doubt in the CI’s favor supporting addition of right lower extremity radiculopathy as an unfitting condition for separation rating.

Other Conditions. The right lower extremity radiculopathy was noted in the DES file and included in the discussion and rating consideration above. The VA additionally rated the following conditions at 10% or greater within 12 months of separation: Left lower extremity radiculopathy, depressive disorder, tinnitus, and Irritable Bowel Syndrome (IBS). However, none of these conditions were noted in the DES package. 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. The left lower extremity radiculopathy, depressive disorder, tinnitus, IBS and any contended conditions not covered above remain eligible for Board for Corrections of Naval Records (BCNR) consideration. The Board therefore has no basis for consideration of any other conditions eligible for additional rating at separation

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. The Board was unsure if there was PEB reliance on SECNAVINST 1850.4E for rating the back condition was operant in this case, and the condition was adjudicated independently of that regulation by the Board. In the matter of the back condition, the Board, by a vote of 2:1 recommends a rating of 40% coded 5237 IAW VASRD §4.71a. The single voter for dissent (who recommended a 20% rating) submitted the addended minority opinion. In the matter of the right lower 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.

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 his prior medical separation.

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| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Lumbago, Facet Syndrome, and Bulging Disc (L4-L5)(T11-T12)  | 5237 | 40% |
| **COMBINED** | **40%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090914, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

 Deputy Director

 Physical Disability Board of Review

MEMORANDUM FOR DIRECTOR, SECRETARY OF THE NAVY COUNCIL OF REVIEW BOARDS

Subj: PHYSICAL DISABILITY BOARD OF REVIEW (PDBR) RECOMMENDATION ICO XX, FORMER USMC, XXX XX XXXX

Ref: (a) DoDI 6040.44

 (b) PDBR ltr dtd 22 Feb 11

 I have reviewed the subject case pursuant to reference (a) and, for the reasons set forth in reference (b), I approve the recommendation of the Physical Disability Board of Review Mr. XXXX’s records not be corrected to reflect a change in either his characterization of separation or in the disability rating previously assigned by the Department of the Navy’s Physical Evaluation Board.

 Principal Deputy

 Assistant Secretary of the Navy

 (Manpower & Reserve Affairs)

Minority Opinion

The VA and the Service used different codes, but both used the same general rating formula for diseases and injuries of the spine (based on range of motion [ROM]), and there are several documented ROMs in evidence for the Board to consider. The MEB PT exam done on 23 Mar 2009 measured active flexion of the lumbosacral spine as 75 degrees on three of three attempts. These would be compensable at the 10% level using the general rating formula. Prior to this the CI had measurements done on 30 Jan 2009, where his lumbar spine flexion was 50%, and on 02 Feb 2009 there was a reduction in ROM which was mainly limited into extension due to pain. Then on 03 Feb 2009 his flexion went to 50% before onset of pain. Lastly, on 09 Feb 2009 lumbar motion was assessed as flexion 50%. Any one of these (non-goniometric measurement) ROMs (assuming 50% = 45⁰) would have rated closer to 20%, in agreement with the Service PEB (for painful motion greater than 30 degrees, but not greater than 60 degrees). Then one month later, 28 Apr 2009, the ROMs were dramatically reduced with flexion from approximately 0-15 degrees (non-goniometric measurement) by an orthopedic surgeon consult. Three months post separation at the VA C&P exam, the ROMs were again dramatically reduced with flexion at 0-15 degrees. Such a drastic reduction of range of motion cannot, in my mind, be attributed to normal progression of the condition, and there were no injuries, surgeries or other facts in evidence that might suggest how or why the ROMs could have worsened so quickly. Additionally, I find no reason to dispute or discount the measurements and findings of the MEB PT ROM examination done on 23 Mar 2009, which were consistent with several others taken in the same timeframe. I assign a higher probative value to the MEB exam measurements, over the C&P exam measurements which were not consistent with the well documented history. I recommend no recharacterization (5237 at 20%) as a fair and accurate rating of his condition and disability at the time of separation.