RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: air force

CASE NUMBER: PD1000004 SEPARATION DATE: 20060127

BOARD DATE: 20110526

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty Technical Sergeant (3C071, Comm/Computer System Operations Craftsman) medically separated for a back condition (degenerative disc disease [DDD] with radiculopathy, status post L4-5 discectomy and fusion, with normal neurological and range of motion [ROM] examination). He did not respond adequately to treatment and was unable to perform physically demanding aspects of his Air Force specialty, or meet physical fitness standards. He was issued a 4T profile and underwent a Medical Evaluation Board (MEB). DDD with radiculopathy, status post L4-5 discectomy and fusion, with normal neurological and ROM examination was forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AFI 48-123. Four other conditions, as identified in the rating chart below, were forwarded on the MEB submission as medically acceptable conditions. The Informal PEB (IPEB) adjudicated the back condition as unfitting, rated 10%, with application of DoDI 1332.39 and Veterans’ Administration Schedule for Rating Disabilities (VASRD). The CI appealed to the Formal PEB, and was then medically separated with a 10% disability rating.

CI CONTENTION: “I believe my case was unfairly determined, considering all of the facts of my medical history and Air Force service. I joined the USAF on 4 Jan 1996 with a clean bill of health, having completed all physical testing at the MEPS in Indianapolis, IN in August 1995. Having no lumbar issues in basic training or the first portion of my technical school, my school (B-52 Weapon loader) began focusing on working with and lifting the bomb bay doors. These doors are extremely heavy (l was told about 2,000 Ibs; I could not locate an actual weight). After training with the doors for a few weeks, I began to have my first lower extremity numbness in my right foot. The doctor I visited seemed unconcerned and told me that my boot was probably too tight. I believed that opinion, but had no improvement after following his advice of loosening my boot. I finished tech school, continuing my weapons loading training (to include the bomb bay door), and then PCS'd to Barksdale AFB. Within the first week, I notified my supervisors of my numbness and intent to have it seen; the next morning, I woke to NO right foot numbness but now with LEFT foot numbness and a left foot drop. I began a two-month series of tests (EMG, MRI, CAT scan, etc...) resulting in my first surgery. I now believe I could have benefited from therapy and traction (and not going back to lifting after the first doctor visit in Tech school...), instead of a rather quick decision for surgery. Post-op, there was; no physical therapy prescribed; I was simply seen by my doctor a few times and deemed recovered. I went on to have sciatic pain (mostly left leg, some right) starting in 1998, continuing through my two spinal fusions in June 2004 and February 2006, and indeed continue to struggle with today. As I understand the systems, my rating (and VA rating) is based solely on range of movement in my spine, pain not being a factor. This seems as unfair as my first doctor misdiagnosing my symptoms and possibly preventing me from having to endure 3 surgeries and an early medical separation from the USAF instead of a full career.” He elaborates no specific contentions regarding rating or coding and mentions no additionally contended conditions.

RATING COMPARISON:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Service FPEB – Dated 20051212** | | | **VA (3 Wks. Pre Separation) – All Effective Date 20060128** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| DDD w/Radiculopathy, S/P L4-5 Discectomy and Fusion with Normal Neurological and ROM Examination | 5241 | 10% | S/P L3-4 Fusion, L4-5 Fusion Revision and L5-S1 Fusion | 5243 | 20% | STR |
| Peroneal Nerve…Assoc. w/S/P L4-3 Fusion…. | 8523-8522 | 20% | STR |
| Tension Headaches | CAT II | | Headaches | 7336 | 0% | 20071013 |
| GERD | CAT II | | GERD | 7399-7346 | 0% | 20071013 |
| Hypothyroidism | CAT II | | Hypothyroidism | 7903 | 10% | STR |
| CTS | CAT II | | Bilateral CTS | 8715-8515 | 0% | STR |
| ↓No Additional MEB/PEB Entries↓ | | | 0% x 3/Not Service Connected x 1 | | | STR |
| **Combined: 10%** | | | **Combined: 40%** | | | |

\*5243 20% increased to 100% effective 20060215 for convalescence s/p surgery; decreased to 10% effective 20060601; \*8523-8522 20% decreased to 0% effective 20060215 (date of surgery)

ANALYSIS SUMMARY: The Board acknowledges the sentiment expressed in the CI’s application regarding the significant impact that his service-incurred condition has had on his quality of life. However, the military services, by law, can only rate and compensate for those conditions that were found unfitting for continued military service based on the severity of the condition at the time of separation and not based on possible future changes. The VA, however, can rate and compensate all service connected conditions without regard to their impact on performance of military duties. The VA can also increase or decrease ratings based on the changing severity of each condition over time. The Board’s role is confined to the review of medical records and all evidence at hand to assess the fairness of PEB rating determinations compared to VASRD standards, as well as the fairness of PEB fitness adjudications at the time of separation. It is noted for the record that the Board has neither the jurisdiction nor authority to scrutinize or render opinions in reference to the CI’s statements in the application regarding medical care or suspected DES improprieties in the processing of his case. The Board’s role is confined to the review of medical records and all evidence at hand to assess the fairness of PEB rating determinations compared to VASRD standards, as well as the fairness of PEB fitness adjudications.

Degenerative Disc Disease with Radiculopathy, Status Post L4-5 Discectomy and Fusion with Normal Neurological and ROM Examination. The CI experienced chronic low back pain since 1996 associated with recurrent interverterbral disc herniation and residuals of back surgery. In September 1996 he underwent left L4-5 discectomy and laminectomy for a left L4-5 herniated disc with left L5 radiculopathy (pain and left foot drop). Following recovery from his first surgery, he was cross-trained from weapons loading to communications computer operation and functioned well at his job, with intermittent low back pain requiring periodic conservative treatment. In June 2004 he underwent right L4-5 discectomy and laminectomy with L4-5 interbody fusion for recurrent L4-5 intervertebral disc herniation to the right side associated with right L5 radiculopathy (pain and weak extensor hallicus longus muscle). Although initially improved, he experienced worsened chronic low back pain in December 2004 interfering with participation in the Air Force fitness program. A pain clinic evaluation in July 2005 noted exacerbation of low back pain by activity, and prolonged sitting or standing with pain radiating to the sides of both legs. On examination, the thoracolumbar spine flexed to 80° and extended to 5°. The gait was normal and lower extremity strength was intact by toe and heel walking. Achilles tendon reflexes were absent, consistent with the history of herniated discs (as was electromyography [EMG] in November 2005, showing bilateral L5 changes) but sensory examination was intact. Conservative treatment including injections was without significant improvement, and he was referred for MEB. The MEB narrative summary (NARSUM) approximately October 2005 noted similar report of pain exacerbated by physical activity, sitting for long periods of time and cold weather. The examination reported normal gait, full ROM of the back without muscle atrophy, and intact motor function of lower extremities. There was subjective decreased sensation on both lateral legs. After the MEB and IPEB, magnetic resonance imaging (MRI) and computed tomography (CT) scanning demonstrated a left paracentral disc herniation at L3-4. A pain clinic examination on November 28, 2005 was unchanged from the July 2005 examination. Two weeks prior to separation, a neurosurgery evaluation on January 11, 2006 demonstrated an antalgic gait and positive root irritation testing on the left with intact motor strength and sensory function of the lower extremities. Two weeks after separation, the CI underwent a third back surgery (L3-4 discectomy laminectomy and three-level fusion of L3-4, L4-5 and L5-S1). A June 2006 neurosurgery clinic note five months after separation reported the CI was doing well, with intact motor strength and sensation, occasional brief sciatic pain into the buttocks and thigh, not interfering with routine functioning. The PEBs rated the CI’s back condition 10% based on the NARSUM and service records in evidence at the time (flexion to 80°, normal strength, normal gait), while the VA’s 20% rating at the time of separation was additionally based on the January 2006 neurosurgery note documenting an antalgic gait (20% for muscle spasm, severe enough to alter gait). The VA also granted a 20% rating for radiculopathy (peroneal nerve based on EMG report). Following a period of post-operative convalescence with a temporary rating of 100% (effective the day of surgery), the VA re-adjudicated the CI’s back condition to 10% and the rating for radiculopathy to 0% based on the treating neurosurgeon’s examination.

The Board discussed the diagnosis of an apparent new disc protrusion with radicular pain symptoms coincident with the MEB and PEB. Although the apparent worsening of the condition in the two months prior to separation may have merited consideration for retention on active duty status for treatment and convalescence, it is not within the authority of the Board to recommend this option. The majority of the Board concluded the evidence of pre-separation worsening, which was not available to the PEB in this case, should be taken into consideration in the permanent separation rating, especially in light of post-separation evidence which reflects on the severity of the condition at the time of separation. Therefore, the majority of the Board concluded that the CI’s back condition most nearly approximated the 20% rating IAW the VASRD general rating formula for spine diseases based on antalgic gait (20% for muscle spasm, severe enough to alter gait). The Board also considered a rating using the VASRD formula based on incapacitating episodes due to intervertebral disc syndrome (5243). The criteria are based on the number of incapacitating episodes in the prior 12 months requiring bed rest prescribed by a physician. No service treatment records were identified that documented physician directed bed rest. The VA provided a separate rating for the associated radiculopathy coded as peroneal neuropathy (8523-8522). The Board considered whether the CI’s radiculopathy was separately unfitting, warranting a disability rating at the time of separation. While the reported mild sensory changes and loss of Achilles tendon reflexes were consistent with the CI’s known L5 radiculopathy, they were not impairing of functioning and would not be considered separately unfitting. Motor strength testing was consistently normal (including the neurosurgery evaluation at the time of separation) and evidence of the record reflects that pain was the reason the CI was unable to perform all the functions of his military specialty. VASRD rating criteria under the general rating formula for diseases and injuries of the spine takes into account pain, whether it radiates or not. All evidence considered, there is not reasonable doubt in the CI’s favor supporting addition of lumbar radiculopathy as an unfitting condition for separation rating. The Board also noted the CI’s contention at the time of the FPEB for rating under muscle function. There was no loss of muscle function and the Board concurred with the FPEB’s determination. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a separation rating of 20% for the lumbar DDD status post discectomy and fusion (5241).

Remaining Conditions. Other conditions identified in the Disability Evaluation System (DES) file were tension headaches, gastroesophageal reflux disease (GERD), hypothyroidism, hemorrhoids and bilateral carpal tunnel syndrome. Several additional non-acute conditions or medical complaints were also documented. None of these conditions were significantly clinically or occupationally active during the MEB period, carried attached profiles, or were implicated in the commander’s statement. These conditions were reviewed by the action officer and considered by the Board. It was determined that none could be argued as unfitting and subject to separation rating. No other conditions were service connected with a compensable rating by the VA within twelve months of separation or contended by the CI. The Board therefore has no reasonable basis for recommending any additional unfitting conditions for separation rating.

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 adjudication. In the matter of the back condition (DDD with radiculopathy, status post L4-5 discectomy and fusion) and IAW VASRD §4.71a, and §4.3, the Board recommends, by a vote of 2:1, a rating of 20% coded 5241. The single voter for dissent (who recommended no modification of the PEB adjudication) did not elect to submit a minority opinion. In the matter of the left L5 radiculopathy, the Board unanimously agrees that it cannot recommend a finding of unfit for additional rating at separation. In the matter of any other medical conditions eligible for Board consideration, the Board unanimously agrees that it cannot recommend any findings of unfit for additional rating at separation.

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** |
| DDD w/Radiculopathy, S/P L4-5 Discectomy and Fusion: | 5241 | 20% |
| **COMBINED** | **20%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20091230, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

Deputy Director

Physical Disability Board of Review



