RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: army

CASE NUMBER: PD201000021 SEPARATION DATE: 20051115

BOARD DATE: 20110114

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an Army Reservist, CW2, 250N, Network Management, medically separated from the Army in 2005 after over 16 years of combined service. The medical basis for the separation was Bell’s Palsy (facial nerve) and Chronic Radiating Low Back Pain (LBP). The CI was diagnosed with Bell’s Palsy in February 2004 and treated with medications. He continued to have mouth problems, daily headaches, abnormal blinking of his right eye, dry eye, jaw twitching, abnormal sensations in his right external auditory canal and pain below the neck line. The neurologist reported that this condition was stable with anomalous re-innervation which caused the secondary symptoms. The CI injured his back in 1992 and was diagnosed with lumbo-sacral strain. Symptoms were documented for one year without radiation or any abnormal spine imaging noted. In September 2004, the CI’s back pain increased/re-started and was associated with new onset of radiating symptoms manifested by numbness in the right leg and right foot and “episodic shooting needles and pin pains” down his leg. An X-ray showed a tiny spur at L-4. Surgery was not recommended and he was treated with medication. As he did not respond adequately to perform within his military occupational specialty or participate in a physical fitness test, he was issued a permanent P-3, L-3, E-3 profile and underwent a Medical Evaluation Board (MEB). Bell’s palsy and Chronic Radiating Low Back Pain were addressed in the narrative summary (NARSUM) and forwarded to the Informal Physical Evaluation Board (IPEB) on the DA Form 3947 as medically unacceptable IAW AR 40-501. Eight other conditions, as identified in the rating chart below, were forwarded on the DA Form 3947 as medically acceptable conditions IAW AR 40-501. Additional conditions supported in the Disability Evaluation System (DES) packet, but not forwarded for IPEB adjudication on the DA Form 3947, are discussed below. The IPEB found the LBP condition to be unfitting and “existed prior to service” (EPTS) and therefore not eligible for compensation, with no other unfitting or compensable condition. The CI appealed the IPEB’s decision, and the Formal PEB (FPEB) upheld the LBP as unfitting, but non-compensable, and made a determination that Bell’s palsy was unfitting, rated at 10%. There were no further appeals and the CI was therefore separated with a 10% disability rating.

CI CONTENTION: The CI states: ‘’VA rating of 30% for the same condition the Army gave me 10%, in addition to other conditions pending the VA compensation.” As a matter of policy, all service conditions are reviewed by the Board for their potential contribution to its rating recommendations.

RATING COMPARISON:

|  |  |
| --- | --- |
| **Service FPEB – Dated 20051021** | **VA (8 Mo. After Separation) – All Effective 20051227** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Bell’s Palsy | 8399-8307 | 10% | Bell’s Palsy w/right sided partial paralysis | 8205 | 30% | 20060707 |
| Chronic radiating LBP | 5299-5237 | Not Compensable | LBP Syndrome | NSC |
| Hypertension | Not Unfitting | Hypertension | 7101 | 0% | 20060707 |
| Hypercholesterolemia | Not Unfitting | Hypercholesterolemia, | NSC |
| Herpetic Whitlow | Not Unfitting | Herpetic Whitlow Disease | NSC |
| Hip, Knee, Shoulder, Wrist Pain | Not Unfitting | Left Hip & Right Hip … | NSC |
| Left & Right Knee … | NSC |
| Left Shoulder Injury | NSC |
| Neck pain | Not Unfitting | Cervical DDD | NSC |
| Left Shoulder | Not Unfitting | Left Shoulder Injury  | NSC |
| ↓No Additional MEB Entries↓ | Tinnitus, Hearing Loss, Hx Radiating Pain, GERD (2009) | NSC |
| **TOTAL Combined: 10%** | **TOTAL Combined (*Includes Non-PEB Conditions*): 30%** |

ANALYSIS SUMMARY:

Bell’s Palsy Condition. The FPEB disability description included “improper closing of the right eye, dry eye syndrome, frequent right sided headaches and facial pain, with other symptoms attributed to anomalous regeneration of the seventh cranial nerve.” The NARSUM and neurologic specialty exams indicated Bell’s Palsy noted to be symptomatic and stable with anomalous innervations leading to secondary neuropathic pain (of the right face and ear canal) and near daily headaches. The CI wore a right eye patch, and had complaints of co-contraction of several muscles simultaneously which included tearing and a runny nose when he tried to eat. He also had “problems with his right eye drying out because at times when he is working, especially using the computer, his eye doesn't blink so he has to continuously use eye drops.” The examiner noted twitching and blinking of the right eye throughout the exam. Regarding testing of other aspects of the cranial nerves, no other anomalies were noted (normal pupils / vision / extra-ocular muscles, facial expressions, motor strength of all facial / tongue / swallowing / gag / shoulder shrug, normal hearing and facial sensation exams). The post-separation VA exam indicated similar complaints with the addition of flares of facial paralysis with stress without well documented physical findings. The FPEB’s coding of 8399-8307 was analogous to Neuritis of the seventh (facial) cranial nerve (CN VII) as incomplete moderate (10%). The VA coding was for incomplete, severe paralysis of the fifth (trigeminal) cranial nerve (CN V; 30%). The bulk of the CI’s symptoms were attributable only to the seventh (facial) cranial nerve; however, the pain symptoms may overlap with the fifth (trigeminal) cranial nerve and speculatively could be “analogous” to Tic douloureux (Trigeminal neuralgia, a facial pain condition). The Board considered the provisions of §4.123 Neuritis, and §4.124 Neuralgia, as well as the special VASRD consideration for Tic douloureux, a facial pain condition for potential analogous coding. From the record, it is clear that any paralytic component to the CI’s condition was from the CN VII, not the CN V. The lacrimation component (tears) and improper closing of the right eye leading to dry eye are also attributable to the facial nerve. However, the facial pain, ear canal pain, and secondary headaches are atypical for the facial nerve and are more analogous to trigeminal neuralgia CN V. These pain symptoms were attributed to anomalous nerve regeneration from the Bell’s Palsy. It is noted that the VA used the code 8205 (CN V) at 30% for incomplete, severe paralysis of the Trigeminal nerve [CN V] based on a mixture of poorly documented CN VII paralysis, the mis-characterization of the Bells’s Palsy as secondary to a CN V neuropathy, and overlap with CN V distribution of pain. The Board noted that there were consistent documentations of symptoms proximate to the date of separation: near daily headaches, abnormal sensation and pain of the right face, right ear canal pain, frequent right eye blinking and abnormal tearing/dry eye, abnormal right eyelid closing, and otherwise normal exams for muscle strength. The Board agreed that CN V paralysis was not documented and the moderate threshold for combined CN VII neuralgia and/or paralysis was exceeded. The Board considered that the symptoms attributed to anomalous regeneration of the CN VII potentially mimicked CN V pain. The deliberations focused on coding of 8405-8307 Neuralgia of CN V pain with CN VII eye symptoms as incomplete, severe (30%); versus 8399-8307 (Neuritis CN VII) as incomplete, severe (20%). After due deliberation, the Board determined that the CI’s symptom complex best fits 8399-8307 (Neuritis CN VII) as incomplete, severe (20%).

Chronic Radiating Low Back Pain. The crux of the LBP rating is any linkage of the CI’s 2004 LBP to an injury sustained in a fall while on AD in 1992; or, if the LBP was not related to the fall and only normal progression on an underlying condition without service aggravation. IAW DODI 1332.38, E3.P4.5.3., Prior Service Impairments:

“Any medical condition incurred or aggravated during one period of service or authorized training in any of the Armed Forces that recurs or is aggravated during later service or authorized training, regardless of the time between, should normally be considered incurred in the line of duty provided the condition or subsequent aggravation was not the result of the member's misconduct or willful negligence. In those cases in which the service member reverts to a civilian status after the condition is incurred, the service member must prove by a preponderance of evidence that the medical condition was incurred or aggravated in the line of duty and was not due to intentional misconduct or willful negligence.”

The CI had well documented onset of LBP in 1992, diagnosed as lumbo-sacral strain, while on AD after falling ~5' off a tracked vehicle and was seen again with LBP complaints one year later in 1993. The CI stated that the LBP persisted. However, there is no documentation of duty limitations for LBP or further visits in the record. There was an increase in symptoms and onset of new radicular symptoms (pain and numbness of right leg) in September 2004 without intervening, acute trauma, while he was on drill status. Imaging revealed an L-4 spur and on MRI mild L5-S1 disk protrusion was noted. The NARSUM (16 months after his last active tour), revealed mild tenderness to the lower lumbar area, and flexion of 90°/combined 220° (normal 90°/240°), with normal reflexes and referenced normal electrophysiologic studies. Physical therapy comprehensive ROMs for the hips and knees indicated mild (0.5” thigh; 0.25” calf) girth difference in the right lower extremity, mild decrease in reflexes on the right knee and ankle (1+ vs. 2+ opposite side), and a normal gait. There was no evidence of an unfitting or ratable radiculopathy. The CI was able to heel and toe walk without difficulty. He had continuous problems with back pain with radiculopathy unresponsive to prednisone tapers and pain medications. Surgery was not recommended. The LBP, numbness and tingling in his right leg prevented him from performing the physical aspects of his soldiering duties per the FPEB. The FPEB adjudicated that LBP was an unfitting EPTS condition and non-compensable:

“Chronic radiating low back pain with onset in 1990 while on active duty. Not unfitting at time Soldier left last active duty tour in Apr 04. Subjective radicular symptoms have increased since Soldier left active duty. Imaging essentially normal and nerve conduction times on EMG, normal. Exam shows full motion and no tenderness. Normal posture and gait, and no clinical signs of unfitting radiculopathy. Back pain and profile prevent effective duty in PMOS. The present symptoms represent natural progression of a condition that was not unfitting at the time of your release from active duty, and there is no documentation of permanent aggravation resulting from subsequent military duty Your current state of unfitness is the result of natural progression in a civilian (drilling reserve) status, therefore, the condition is not compensable.”

The CI was not in a protected status and had less than 8 years of active service. There was no indication of misconduct or willful negligence. The VA denied service connection due to missing exams, until 4+ years after separation with a medical opinion at that remove that the LBP condition (and cervical condition) had stabilized in 2006 (motorcycle crash of 2007) and was non-service connected based on medical opinion of “less likely as not (less than 50/50 probability) caused by or a result of lumbar and cervical paravertebral muscle strains.” The Board noted that while there is evidence of an injury to the lower back in the 1992-3 time frame, there was no subsequent history of LBP until September 2004. While the Board did not agree with the details of the PEB rationale, the conclusion of not-service aggravated or incurred was substantiated by the record and medical opinion. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board determined that the LBP condition did not meet the intent of DODI 1332.38, E3.P4.5.3., Prior Service Impairments, and should not be considered service incurred or aggravated. In the matter of the LBP condition and IAW VASRD §4.71a, the Board unanimously recommends no change in the PEB adjudication of non-compensable at separation.

Other DA Form 3947 Conditions (Hypertension; Hypercholesterolemia; Herpetic Whitlow; Hip, Knee, Shoulder and Wrist Pain; Neck Pain and Left Shoulder Pain). The Commander’s letter specifically cites the Herpetic Whitlow as a duty limitation and mentions the neck and joints without comment on duty impairment. However, it was most likely written while the CI was in a drill status and not on active status. None of these conditions were profiled after 20030712. The VA determined the neck, left shoulder, left and right knees, left and right hips, and herpetic whitlow to be non-service connected. Hypercholesterolemia is a laboratory finding and not ratable. The hypertension was well controlled with medications and rated at 0% by the VA. Review of the records shows no visits for any of these conditions in the two years leading up to the final active tour except for a right thigh strain in 2002. These conditions were judged to be within AR 40-501 standards. All evidence considered, there is not reasonable doubt in the CI’s favor supporting re-characterization of the PEB fitness adjudication for these conditions.

Other DES Mentioned Conditions (Eye [PRK], Rectal Bleeding, Pain in Chest, Migraine Headaches and Allergic Rhinitis). PRK is an elective eye surgery to correct refractive error. It was done while in drill status and there is no evidence of other than a good outcome. There is no documentation of rectal bleeding or chest pain in the records other than the MEB history. Migraine headaches are only mentioned in the Commander’s letter. Allergic rhinitis was noted in 2002 in an assessment for a food allergy. None of these conditions were profiled. No other conditions were service connected with a compensable rating by the VA within twelve months of separation. All evidence considered, there is not reasonable doubt in the CI’s favor supporting addition of any of these as an unfitting condition for separation rating.

Other Conditions. The VA also considered radiating pain (other than lumbo-sacral), tinnitus, and bilateral hearing loss in the rating decision dated 20070816, 21 months after separation. All were found to be non-service connected. There is no record of these conditions causing duty limitations and the hearing had an H-1 profile. 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. These and any contended conditions not covered above remain eligible for Army Board for Correction of Military Records (ABCMR) consideration.

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. In the matter of the Bell’s Palsy and anomalous CN regeneration condition, the Board recommends by a vote of 2:1 a rating of 20% coded 8399-8307 (Neuritis CN VII as incomplete, severe) IAW VASRD §4.124a. The single voter for dissent (who recommended a rating of 30% coded 8499-8405 [Neuralgia of CN V distribution with CN VII eye symptoms as incomplete, severe] IAW VASRD §4.124a.) did not elect to submit a minority opinion. In the matter of the LBP condition and IAW VASRD §4.71a, the Board unanimously recommends no change in the PEB adjudication of non-compensable at separation. In the matter of the Hypertension, Hypercholesterolemia, Herpetic Whitlow, Hip, Knee Shoulder and Wrist Pain, Neck Pain, Left Shoulder Pain, PRK, Rectal bleeding, Pain in Chest, Migraine Headaches and Allergic Rhinitis conditions or 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.

|  |  |  |
| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Bell’s Palsy with Anomalous Nerve Regeneration | 8399-8307 | 20% |
| **COMBINED** | **20%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20091231, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

