RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXXXX. BRANCH OF SERVICE: coast Guard

CASE NUMBER: PD1000344 SEPARATION DATE: 20060804

BOARD DATE: 20111129

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty YN2/E-5 medically separated for intervertebral disc syndrome. He did not respond adequately to treatment and was unable to perform within his military rating or meet physical fitness standards and underwent a Disability Evaluation Board (DEB). Intervertebral disc syndrome was forwarded to the Physical Evaluation Board (PEB) as medically unacceptable. The Informal PEB (IPEB) adjudicated the intervertebral disc syndrome condition as unfitting, rated 20%, with application of the Veterans’ Administration Schedule for Rating Disabilities (VASRD). The Formal PEB concurred on appeal and the CI was medically separated with a 20% disability rating.

CI CONTENTION: “CPEB decision to discharge me with a 20% disability rating for Intervertebral Disk Syndrome was based on one visual assessment made by a Physician’s Assistant, who was conducting her first medical review for separation. Attached are numerous reports from Teche Regional Medical Center-Physical Therapy, with measurements that were taken using both a goniometer and inclinometer over various periods.” Additionally the CI lists his VA ratings for right and left knee osteoarthritis.

RATING COMPARISON:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Service IPEB – Dated 20060328** | | | **VA (5 Mo. After Separation) – All Effective Date 20060805** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Intervetebral Disc Syndrome | 5243 | 20% | Lumbar Strain with DDD | 5243 | 0%\* | 20070303 |
| ↓No Additional MEB/PEB Entries↓ | | | L Knee Osteoarthritis | 5010-5261 | 10% | 20060930 |
| R Knee Osteoarthritis | 5010-5261 | 10% | 20060930 |
| 0% x 1/Not Service Connected x 3 | | |  |
| **Combined: 20%** | | | **Combined: 50%** | | | |

\*VARD 20080404 increased to 40% effective the day after separation.

ANALYSIS SUMMARY: 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 VA Schedule for Rating Disabilities (VASRD) standards, as well as the fairness of PEB fitness adjudications at the time of separation.

Intervertebral Disc Syndrome. The CI had a history of chronic low back pain that worsened in the year preceding the DEB. A magnetic resonance imaging scanning in October 2005 demonstrated degenerative disc disease at L3-4, with small posterior herniation and L4-5 with bulging disc, without nerve root involvement. The VASRD general rating formula for diseases and injuries of the spine relies on thoracolumbar range of motion (ROM). The CI contends the ROM reported in the narrative summary was not accurate because the examiner was an inexperienced physician assistant who estimated the ROM based on a visual assessment rather than use of a goniometer or inclinometer. He contends the ROM results provided by Teche Regional Medical Center physical therapy are accurate and should be used in determining a VASRD disability rating. Except for the 27 January 2006 ROM results, the ROM measurements reported by Teche Regional Medical Center (TRMC) physical therapy were lumbar ROMs, not thoracolumbar ROMs. TRMC physical therapy performed lumbar ROMs in accordance with the AMA guideline (American Medical Association Guides to the Evaluation of Permanent Impairment; presumed to be fifth edition) which directs separate measurements for each segment of the spine using a dual inclinometer method, i.e., thoracic segment separately from the lumbar segment. The AMA method also involves subtraction of sacral movement that is part of the VASRD thoracolumbar ROM. VARSD rating guidance under the general rule for rating spinal conditions uses the combined thoracic and lumbar ROM measured from the vertical. Therefore, lumbar ROMs reported by TRMC physical therapy are not equivalent to thoracolumbar ROM, and do not directly correlate with ratings using the VASRD general rating formula. The TRMC physical therapy ROM work sheets did not include a measurement of thoracic spine ROM that could be combined with the lumbar ROM to provide values that would more nearly approximate the thoracolumbar ROM for rating using the VASRD.

Due to the significant differences between the narrative summary ROM and 27 January 2006 TRMC physical therapy thoracolumbar ROM, the Board carefully reviewed all examinations to develop a consistent picture of the CI’s back condition. A summary follows:

* At the neurosurgery evaluation on 25 March 2005, there was a history of intermittent low back pain for six years that had recently become progressively worse. There were no radicular symptoms; strength was normal (5/5); the CI was able to heel and toe walk; sensation was intact; and examination testing for nerve root irritation was negative. Although a goniometric ROM was not reported, the neurosurgeon stated the CI had a “full ROM of the lumbar spine.”
* At the 30 April 2005 TRMC physical therapy encounter during an acute exacerbation of low back pain, the lumber ROM was 27 degrees in flexion, which is approximately 50% of normal (normal lumbar flexion is 60 degrees).
* At the 21 July 2005 clinic encounter with his physician, he could flex forward until his fingers were 8” to floor, which is approximately 60 to 70 degrees of thoracolumbar flexion for a man of the same height with average arm span (CI is 72” tall).
* A 29 July 2005 TRMC physical therapy encounter records lumbar flexion of 60° which is normal, but with reduced lumbar extension (13°) and lumbar side bending (19° and 17°).
* Clinic encounters in August and October 2005 recorded ROM was “decreased” without other descriptors that reflect the amount.
* A TRMC physical therapy appointment on 1 December 2005 recorded lumbar flexions of 26, 28 and 35 degrees, in accordance with the AMA Guide. This examination also recorded the sacral inclinometer readings, as well as the straight leg raise readings. According to the AMA Guide, the validity of a lumbar ROM examination is questionable when the tightest straight leg raise movement exceeds the combined sacral flexion plus extension by more than 15 degrees; it was exceeded by 35 degrees.
* At the 15 December 2005 neurosurgery follow up, the CI reported that he was unable to perform full military duties due to his back pain. The surgeon wrote:

I asked him once again whether he feels that his symptoms in his back are severe enough to warrant undergoing lumbar fusion surgery and he states that he does not feel that they are. They do impact on many of his daily activities but he states that they really are not particularly severe. He has an achy pain in his back during the day and some difficulty with sleeping at night, but not what he would call unremitting, severe lower back pain. He stated definitively today that he is not interested in surgery to eradicate the level of pain that he is experiencing.

* The MEB narrative summary (undated, but service treatment record entry for MEB physical examination is dated 21 December 2005) records “lumbar spine” flexion of “around” 45 degrees. It is not clear if the examiner was referring to lumbar segment motion or combined thoracolumbar motion. The IPEB (28 March 2006) based its VASRD rating on the narrative summary ROM.
* A 20 January 2006 TRMC physical therapy appointment two weeks after an emergency room visit for a flare of back pain recorded a lumbar flexion of 17 degrees.
* A TRMC physical therapy appointment on 27 January 2006, expressly for measurement of thoracolumbar ROM in accordance with the VASRD, recorded thoracolumbar flexions of 25, 25 and 28 degrees (after exercise) that are essentially no different than the lumbar ROM measurements (that exclude thoracic ROM) from 1 December 2005, both without documentary evidence of an acute exacerbation of back pain. Both of these later ROMs were not different from an April 2005 lumbar flexion that was in the setting of an acute exacerbation.
* At a 26 April 2006 follow up appointment with his physician (no acute flare), he could flex reaching his fingers to the level of his knees, which is approximately 45 degree of thoracolumbar flexion (although the examiner stated 10 to 15 degrees not consistent with the observed movement).
* During an acute exacerbation of low back pain on 1 June 2006, the physical therapist recorded a lumbar flexion of 15 degrees (similar to a 21 January 2006 value close to the time of a documented acute flare).
* At the VA compensation and pension (C&P) examination of the spine, seven months after separation, the recorded thoracolumbar ROM was 20 degrees in all planes. The C&P examiner did not believe the ROM results were valid and recorded the CI gave an “extremely poor effort” during ROM testing. Reportedly, the CI did not provide full participation because of “fear of pain.” Based on this examination, the VA initially adjudicated a zero percent rating. On appeal, the VA assigned a 40% rating based on the TRMC ROM examinations.

Although different examiners at different times described the CI’s ROM in different terms or by different methodology, the Board concluded there was a consistent picture and sufficient evidence to make a rating recommendation IAW the VASRD. The preponderance of evidence does not support that the impairment is consistent with a VASRD rating of 40%. Although the VASRD requires the use of ROM (or incapacitating episodes for intervertebral disc syndrome) in determining the impairment of spinal conditions, this is not in isolation from the evidence of the other details of the medical evaluation and clinical impression. While the 27 January 2006 TRMC physical therapy examination reports thoracolumbar flexion limited to 25 to 30 degrees, the overall findings do not support this degree of restriction or impairment during the times between acute exacerbations. The Board noted that the thoracolumbar ROM was consistently in the range consistent with the 20% rating (greater than 30 degrees but not more than 60 degrees) in between acute exacerbations and during non-compensation examinations. The TRMC physical therapy thoracolumbar ROM recorded 27 January 2006 (25 to 28 degrees after exercise) was not consistent with a thoracolumbar ROM that would be suggested by the TRMC physical therapy lumbar ROM values from 1 December 2005 (25 to 30 degrees) or April 2005 (27 degrees). The April 2005 TRMC physical therapy lumbar flexion was measured during an acute flare of back pain and was similar to the December 2005 values. Although the CI was seen in the emergency room on 4 January 2005 for exacerbation of his back pain, between the 1 December 2005 and 27 January 2006 TRMC examinations, there is no evidence of injury or incident that would have caused the CI’s back condition to become permanently worse. The lumbar flexion recorded on 1 December 2005 (ranged from 25° to 35°) is 42% to 58% of predicted normal lumbar flexion of 60°. Applying this proportional loss to the normal thoracolumbar ROM of 90 degrees would yield 40 to 50 degrees and would assume a similar proportional loss of motion in the non-diseased thoracic spine. This is within the same ROM reported by the narrative summary examiner and is consistent with the 20% rating under the VASRD general rating formula for diseases and injuries of the spine. Applying the proportional loss of lumbar ROM to the entire thoracolumbar ROM would be expected to overestimate the decrease of thoracolumbar ROM since there was no documented thoracic spine disease and the thoracic spine ROM would be assumed to be normal. Since there was no thoracic spine disease, a normal thoracic ROM (45 degrees) added to the 1 December 2005 TRMC measured lumbar ROM (25 to 30 degrees) would exceed the 30 degree threshold for the 40% VASRD rating, and possibly more nearly approximate the 10% rating with a combined lumbar flexion plus a normal thoracic flexion greater than 60 degrees. The Board also noted that at the time of the 1 December 2005 TRMC physical therapy ROM measurement, the tightest straight leg ROM exceeded the sum of sacral flexion and extension by more than 15 degrees (by 31 to 36 degrees), which suggests a under reported lumbar ROM.

In its assignment of probative value to the disparate exams, the Board must acknowledge that disability compensation examinations may predispose a lowered pain threshold since the examinee is generally quite aware that the severity of symptoms and pain tolerance on ROM is directly correlated with the resulting rating and financial gain. The measurement of ROM reflecting pain with motion is dependent on the examinee’s reported pain, with scant ability by the examiner to objectively confirm it. Based on the preponderance of evidence, the Board concluded that the CI’s back ROM most nearly approximated the 20% rating for thoracolumbar ROM, flexion greater than 30 degrees but not more than 60 degrees.

The Board considered rating under incapacitating episodes for intervertebral disc syndrome. A 29 July 2005 physical therapy encounter records CI report of two to four episodes of severe pain per year. There were 5 to 6 exacerbations of low back pain for which the CI sought acute medical care documented in the 18 months before separation (dates are 30 April 2005, 5-11 October 2005, 4 January 2006, 3 March 2006, 23 March 2006, and 1 June 2006). However, there was not bed rest prescribed by a physician. At the 26 April 2006 routine clinic appointment, the CI requested a couple of days off just to lie around and rest his back, but there was not an acute exacerbation; however, the physician wrote only for continuation of current medications. The Board concluded the preponderance of evidence did not support a higher rating using this alternate formula providing no additional benefit to the CI. Although an electromyography indicated possible radiculopathy, there were no objective findings on examination of radiculopathy. 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. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends no change to the separation rating of 20% adjudicated by the PEB for the CI’s back condition.

Other Contended Conditions. The CI listed the VA ratings for right and left knee osteoarthritis and a contention for consideration for compensable ratings is implied. At the joint C&P examination two months after separation, the CI reported two to three years of knee pain with stairs, symptoms of giving way, and flare ups of knee pain twice per month, lasting two days. A single medical encounter prior to separation in February 2005 for left anterior knee pain is recorded as normal. The knee condition was reviewed by the action officer and considered by the Board. There was no evidence for concluding that the knee condition interfered with duty performance to a degree that could be argued as unfitting. The Board determined therefore that none of the stated conditions were subject to Service disability 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 the adjudication. In the matter of the intervertebral disc syndrome and IAW VASRD §4.71a, the Board unanimously recommends no change in the PEB adjudication at separation. In the matter of right and left knee osteoarthritis, 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 therefore recommends that there be no recharacterization of the CI’s disability and separation determination, as follows:

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| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Intervertebral Disc Syndrome | 5243 | 20% |
| **COMBINED** | **20%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20100403 w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

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President

Physical Disability Board of Review

U.S. Department of

Homeland Security

United States

Coast **Guard**

Dear XXXXXXXXXX

**Commandant**

**United States Coast Guard**

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MAR 1 2012

I am the Designated Decision Authority for the Coast Guard on applications submitted to the

Department of Defense Physical Disability Board of Review (DoD PDBR). In your case (Case

Number PD-2010-00344), I accept the recommendation of the DoD PDBR with no

recharacterization of separation or modification of the disability rating. Enclosed is a copy of the

Board's recommendation and record of proceedings for your information.

A copy of this decision has also been provided to the DoD PDBR and the Department of

Veterans Affairs.

If you have any further questions, please contact the Coast Guard Personnel Service Center at

Rear Admiral, U.S. Coast Guard

Assistant Commandant for Human Resources

Enclosures: (1) PDBR President memo dated December 8, 2011