RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXXXXXXXXX BRANCH OF SERVICE: Army

CASE NUMBER: PD1000377 SEPARATION DATE: 20060925

BOARD DATE: 20120402

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was a National Guard Soldier, SGT/E-5(11B/88M, Infantry/Truck Driver), medically separated for cervical spondylosis, w/o neurologic abnormality and lumbago, w/o neurologic abnormality*.* He initially injured his back in a training accident during mobilization training. He did not respond adequately to treatment and was unable to perform within his Military Occupational Specialty (MOS) or meet physical fitness standards. He was issued a permanent U3/L3, and temporary P3 profile, put in a medical hold company and underwent a Medical Evaluation Board (MEB). Cervical spondylosis and lumbago were forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501. Seven other conditions, as identified in the rating chart below, were forwarded on the MEB submission as medically acceptable conditions. The PEB adjudicated the cervical spondylosis, w/o neurologic abnormality and lumbago, w/o neurologic abnormality as unfitting, rated 0% and 0% respectively, with application of the US Army Physical Disability Agency (USAPDA) pain policy. The other seven conditions were determined to be not unfitting and not rated. The CI non-concurred with the PEB, waived a formal hearing, did not submit a written appeal, and was then medically separated with a 0% combined disability rating.

CI CONTENTION: The CI states: “I was not rated for my stroke, cervicalgia or vertigo which are individually debilitating and occupationally limiting. Because of my injuries, I was not able to continue in my MOS as 11B and 88M. My MEB physician mistakenly concluded that my stroke was and old injury and existed prior to active duty activation. However, active duty medical records noted that my stroke was not old and was responsible for my new onset seizures, migraine headaches, nauseu, tinnitus, vertigo, fatigue and general poor state of health. They state that they were not able to determine when it happened in any detail. My PCM noted that retrospectively, my heat injury probably induced mystroke and resultant neurological problems. Additionally my active duty Neurologist noted that my migraines were secondary to my seizures. There exists no clinical evidence that my conditions or stroke existed prior to my service. Contrarily, my good state of health as evidenced by both my activation physical and my prior employers performance letter supports my assertions. I had suffered a gross decline in health which has greatly impaired my ability to seek employment since separation. Likewise, it isnoted in my medical records that I suffered a neck injury after dismounting from a truck in full battle gear. I have suffered chronic radiculopathies, cervicalgia and lumbar pain since that time. Contrary to the Army's 0% disability rating, the VA has rated me at 50% and I am receiving 100% Social Security Disability. My condition has not appreciably changed for the better or worse since my military separation. Previous to my injury and as a civilian, I drove semi-truck for 14 years. I was required to undergo a physical every 2 years. I consistently passed my physicals. Because of my injuries, I failed my physical immediately after mymilitary separation. Specifically, the use of anti seizure medication, and my inability to both lift over 20 pounds or sit for long periods of time due to my lumbar and cervical injuries prevented me from returning to my previous civilian employment. In addition to these occupational limitations, these injuries have significantly impacted my personal life. Consistent with my complaints while on active duty, I am still unable to tolerate heat for more than twenty to thirty minutes without feeling nauseous and dizzy. In addition to this, I experience weekly exacerbation of my condition which requires me to lay down and rest for up to a few days. Again, this is consistent with symptoms I complained of while on active duty. It is difficult for me to do simple chores such as mowing my lawn or manual lubor. During active duty, I was told, because of my seizures and vertigo, to not bathe without someone else present, climb up on ladders, or do any thing where I might fall or cause serious injury to myself. I have been fully compliant with my VA medical care. I am still actively treated for seizures, headaches, nausea, fatigue and vertigo. I am still taking pain medications for my spinal injuries. The only conditions which has worsened since separation is my carpal tunnel syndrome and depression. I requested a personal aquaintence, who is a military physician and familiar with the medical board process, to review my medical records and assist me with this appeal request during his off duty time. I have attached his memorandum. Thank you for your consideration.” In addition to the referenced memorandum, he additionally lists a rating of 30% for depression anxiety, which he was being treated for while on Medical Hold.

RATING COMPARISON:

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| --- | --- |
| **Service PEB – Dated 20060818** | **VA (6 Mo. Pre Separation) – All Effective Date 20060926** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Cervical Spondylosis, w/o Neurologic Abnormality | 5299-5237 | 0% | DDD, Cervical Spine | 5010-5243 | 10%\* | 20060329 |
| Lumbago, w/o Neurologic Abnormality | 5299-5237 | 0% | DDD, Lumbar Spine | 5010-5243 | 10% | 20060329 |
| Seizure Disorder w/Syncopal Episodes | Not Unfitting | Epilspsy | 8911 | 10% | 20060329 |
| Remote History of Cerebrovascular Accident w/no Residual Effects | Not Unfitting | Heart Condition | 7005 | NSC | 20060329 |
| Stroke | 8099-8046 | NSC | 20060329 |
| History of Heat Injury and Heat Stroke w/no Residual Effects | Not Unfitting | Residuals of Heat Exposure | 8999-8911 | NSC | 20060329 |
| Migraine Headaches | Not Unfitting | Migraine Headache | 8100 | 0% | 20060329 |
| Atypical Chest Pain | Not Unfitting | No VA Entry |  |  |  |
| Hypertension | Not Unfitting | Hypertension | 7101 | 0% | 20060329 |
| Benign Prostatic Hyperplasia | Not Unfitting | Benign Prostatic Hypertrophy | 7527 | 0% | 20060329 |
| ↓No Additional MEB/PEB Entries↓ | Tinnitus | 6260 | 10% | 20060329 |
| Major Depressive Disorder | 9434 | 30%\* | 20070223 |
| 0% x 2/Not Service Connected x 3 | 20060329 |
| **Combined: 0%** | **Combined: 50%\*** |

\*MDD increased to 70% effective 20090908 (combined 70%) and to 100% with Cervical Spine increased to 20%, effective 20100410 (combined 100%) [DRO and Board of Veterans’ Appeals documentation from 2008/9 and 2010]

ANALYSIS SUMMARY: The Board acknowledges the CI’s contention that suggests service ratings should have been conferred for other conditions documented at the time of separation. The Board notes that the presence of a diagnosis, in and of itself, is not sufficient to render a condition unfitting and ratable. The Board wishes to clarify that it is subject to the same laws for service disability entitlements as those under which the Disability Evaluation System (DES) operates. While the DES considers all of the service member's medical conditions, compensation can only be offered for those medical conditions that cut short a service member’s career, and then only to the degree of severity present at the time of final disposition. However, the Department of Veterans’ Affairs (DVA), operating under a different set of laws (Title 38, United States Code), is empowered to compensate service-connected conditions and to periodically re-evaluate said conditions for the purpose of adjusting the Veteran’s disability rating should the degree of impairment vary over time. The Board utilizes VA evidence proximal to separation in arriving at its recommendations; and, DoDI 6040.44 defines a 12-month interval for special consideration to post-separation evidence. The Board’s authority as defined in DoDI 6044.40, however, resides in evaluating the fairness of DES fitness determinations and rating decisions for disability at the time of separation. Post-separation evidence therefore is probative only to the extent that it reasonably reflects the disability and fitness implications at the time of separation.

Neck and Back Conditions (Cervical Spondylosis, w/o Neurologic Abnormality and Lumbago, w/o Neurologic Abnormality): The neck (cervical) and thoracolumbar (back) spine conditions were well documented in the record which included detailed treatment and duty limitation discussions. There were two goniometric range-of-motion (ROM) evaluations in evidence, with documentation of additional ratable criteria, which the Board weighed in arriving at its rating recommendation. Although three exams are charted below, it is most likely that there were only two independent ROM evaluations since it is almost certain that the MEB exam and VA pre-separation exam was the same exam: DD 2808 item 44 stated “see VA Dictation,” the measured ROMs were the same in the narrative summary (NARSUM) and VA rating decision (VARD), and the VARD stated “in March 2006 a medical evaluation board (MEB) and VA predischarge examination was conducted.” There were slight differences in the NARSUM and VARD comments which are included below. The additional ROM exam is a physical therapy (PT) ROM accomplished after the NARSUM, but prior to the MEB and PEB. The PT note and VARD delineate that reported ROMs were expressed as active/passive ROM. The cervical ROMs in the VARD were stated as: “Physical examination demonstrated active/passive ROM of the cervical spine with flexion of 20/45, extension of 35/45, bilateral lateral flexion 35/45, left rotation of 40/80 and right rotation of 70/80 degrees.” Active ROMs are charted IAW VASRD §4.71a.

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| Goniometric ROM –Lumbar & Cervical | MEB ~ 6 Mo. Pre-Sep(20060321) | VA C&P ~ 6 Mo. Pre-Sep(20060329) | PT ~ 3 Mo. Pre-Sep(20060607) |
| Lumbar | Cervical | Lumbar | Cervical | Lumbar | Cervical |
| Flexion | 90⁰ | 20⁰ | 90⁰ | 20⁰ | 90⁰ | 20⁰ |
| Combined | 240⁰ | 205⁰ | 240⁰ | 205⁰ | 190⁰ | 240⁰ |
| Comment: VARD normals-Lumbar (90/240)Cervical (45/340) | No tender, no spasm, motor 5/5, normal gait and stance, SLR negative, no sensory deficits | No tender, no spasm, motor 5/5 | No tender, no spasm, motor 5/5, normal gait and stance, SLR negative; MRI degenerative disc process; pain constant and moderate | No tender, no spasm, motor 5/5; pain on motion | Ext limited to pain in B LE | Flex limited to pain and tingling into L UE |
| §4.71a Rating | 0%-10% | 20% | 0-10% (VA 10%) | 20% (VA 10%) | 10% (PEB 0%) | 20% (PEB 0%) |

The Board carefully reviewed all evidentiary information available. The PEB and VA choice of disability codes use the same general spine rating criteria for determining rating level.

 Back Condition (Lumbago, w/o Neurologic Abnormality). There was abnormal imaging of the thoracolumbar spine with lumbar mild to moderate degenerative disk changes, but no frank evidence of a herniated disc. The PEB disability description stated “thoracolumbar ROM limited by pain.” The physical therapy (PT) exam met the ROM criteria for a 10% rating based on limitation of thoracolumbar motion, and the history of radiating pain on motion met the tenants of §4.59 (painful motion) and §4.40 (functional loss). There was no evidence of incapacitating pain episodes that would warrant a higher rating under VASRD code 5243 (intervertebral disc syndrome). No exam in evidence documented an abnormal gait or spinal contour. The Board majority adjudged the MEB/VA exam as the highest probative value for rating, and during that exam there was no objective evidence of painful motion. After due deliberation, the Board majority recommends no change from the PEB 0% rating.

 Neck Condition (Cervical Spondylosis, w/o Neurologic Abnormality). There was abnormal imaging of the cervical spine segment with mild degenerative disk disease (DDD) and anterior and posterior spondylosis. All of the cervical spine active ROM evaluations fit the VASRD criteria for a 20% rating based on limitation of cervical spine motion greater than 15 degrees but not greater than 30 degrees. After due deliberation, considering all of the evidence, the Board recommends a service disability rating of 20% for the cervical (neck) condition.

 Cervical or Thoracolumbar Radiculopathy: The Board considered whether additional service rating could be recommended under a peripheral nerve code, for the residual bilateral lower extremity pain (sciatic) radiculopathy or the neck-motion induced left upper extremity pain and tingling at separation. Firm Board precedent requires a functional impairment tied to fitness to support a recommendation for addition of a peripheral nerve rating to service disability in spine cases. The pain component of a radiculopathy is subsumed under the general spine rating as specified in §4.71a. The sensory component in this case (left arm transient tinglinging without a fixed sensory deficit) had no functional implications, and no motor weakness was in evidence. Since no evidence of functional impairment exists in this case, the Board cannot support a recommendation for additional service rating based on peripheral nerve impairment.

Other PEB Conditions. The other conditions forwarded by the MEB and adjudicated as not unfitting by the PEB were seizure disorder w/syncopal episodes, remote history of cerebrovascular accident w/no residual effects, history of heat injury and heat stroke w/no residual effects, migraine headaches, atypical chest pain, hypertension and benign prostatic hyperplasia. The Board’s main charge in respect to these conditions is an assessment of the appropriateness of the PEB’s fitness adjudication. The Board’s threshold for countering DES fitness determinations is higher than the VASRD §4.3 (reasonable doubt) standard used for its rating recommendations, but remains adherent to the DoDI 6040.44 “fair and equitable” standard. In addition to the unfitting neck and back conditions discussed above, the profile also listed seizures as a “temp P3” restriction with “T-3: Patient is not allowed to swim, bike, operate any machinery or drive due to seizures.” The commander’s statement did not specify what limitations or conditions impaired duty performance. Any impact of an “existed prior to active duty activation” (EPTS) determination is only considered for unfitting conditions.

The CI had an initial diagnosis and hospitalization for seizure condition in April 2006. Neurologist exam indicated postictal state and electroencephalogram showed abnormal postictal seizure activity. The CI had a an abnormal MRI showing “probable remote ischemic event or injury.” The CI was on chronic medication and had “not had any further syncopal episodes or seizures since being treated with seizure medication.” Treatment notes following the NARSUM, and closer to the date of separation, indicated the seizure condition was stable. The profile restrictions were indicated as temporary and are usual for a new diagnosis of seizure until medication has proven effective in seizure prevention (commonly 1 year). After separation records through 2010 indicated good seizure control on medication. The remote history of cerebrovascular accident w/no residual effects was based on imaging abnormality and each claimed residual was separately considered. The history of heat injury and heat stroke w/no residual effects did indicate a righer risk of recurrence and probable geographic restrictions. There was scant evidence of recurrent prostrating attacks for the migraine headache condition. Atypical chest pain was not debilitating and hypertension and benign prostatic hyperplasia had no symptoms that were to the level of being unfitting. After due deliberation in consideration of the preponderance of the evidence, the Board concluded that there was insufficient cause (preponderance of evidence) to recommend a change in the PEB not unfitting adjudications for the seizure disorder remote history of cerebrovascular accident w/no residual effects, history of heat injury and heat stroke w/no residual effects, migraine headaches, atypical chest pain, hypertension and benign prostatic hyperplasia.

Other Contended Conditions and Remaining Conditions. Since the MEB and the VA exam were the same exam and the MEB DD Forms 2807 and 2808 indicated “see VA dictation,” all conditions mentioned in the VA dictation (C&P exam) were considered as mentioned in the DES file. Tinnitus, major depressive disorder and carpal tunnel syndrome were the only VA rated or contended conditions not included in the discussion above. With regard to tinnitus (ringing in the ears), there was no evidence that the CI had any impairment in hearing or speech discrimination to the level of interfering with duty. With regard to major depressive disorder, the NARSUM diagnosis was depression and anxiety treated with medication (Ativan and Lexapro). The CI had an S1 profile and only sleep disturbance, which was related to pain rather than a mental disorder, was a significant symptom potentially attributable to a mental disorder. Right wrist carpal tunnel was rated at 0% by the VA and the CI indicated that his conditions that “worsened since separation is my carpal tunnel syndrome and depression.” There was no indication of any wrist condition adversely impacting duty performance. All of these conditions were reviewed by the action officer and considered by the Board. There was insufficient evidence for concluding that any of the conditions 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. As discussed above, PEB reliance on the USAPDA pain policy for rating the neck and back conditions was operant in this case and the conditions were adjudicated independently of that policy by the Board. In the matter of the cervical (neck) condition, the Board unanimously recommends a service disability rating of 20%, coded 5299-5237 IAW VASRD §4.71a. In the matter of the lumbago (back) condition and IAW VASRD §4.71a, the Board by a vote of 2:1 recommends no change in the PEB 0% adjudication. The single voter for dissent (who recommended rating at 10%) submitted the addended minority opinion. In the matter of the seizure disorder, history of cerebrovascular accident, history of heat injury and heat stroke, migraine headaches, atypical chest pain, hypertension and benign prostatic hyperplasia conditions, the Board unanimously recommends no change from the PEB adjudications as not unfitting. In the matter of the contended tinnitus, depression/major depressive disorder and carpal tunnel syndrome conditions, the Board unanimously agrees that it cannot recommend a finding of unfit for additional service disability rating. The Board unanimously agrees that there were no other conditions eligible for Board consideration which could be recommended as unfitting for additional service disability rating.

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** |
| Cervical Spondylosis, w/o Abnormality | 5299-5237 | 20% |
| Lumbago, w/o Neurologic Abnormality | 5299-5237 | 0% |
| **COMBINED** | **20%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20100409, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans Affairs Treatment Record.

 XXXXX

 President

 Physical Disability Board of Review

MINORITY OPINION. The action officer strongly non-concurs with the majority’s decision to rate the CI’s Lumbago (back) condition at 0%, and agreed with the cervical (neck) 20% rating. The majority 0% back rating was based on the combined VA/MEB exam (6 Mo. Pre-Sep; 29 March 2006), and completely discounted the physical therapy (PT) ROM exam (3 Mo. Pre-Sep; 7 June 2006) and other evidence of record for painful back motion. The verbatim PEB disability description was:

“LUMBAGO, WITHOUT NEUROLOGIC ABNORMALITY. THORACOLUMBAR RANGE OF MOTION LIMITED BY PAIN. (MEBD DIAG 2, NARSUM, PT RANGE OF MOTION EVAL, FT CAMPBELL C&P EVAL, DA FORM 3349)”

The PEB disability description specified that there was ROM limited by pain and that the PEB used the PT exam (which was closer to the date of separation) as their rating exam. Absent application of the USAPDA pain policy, the PEB disability description alone (ROM limited by pain) would meet the 10% rating criteria with application of §4.59, painful motion. The ratable goniometric PT exam (combined ROM 190⁰ [normal 240⁰]) would meet the 10% general spine formula criteria of “combined ROM of the thoracolumbar spine greater than 120 degrees but not greater than 235 degrees.”

It is conceded that the VA C&P/initial MEB exam, in isolation, may be rated at 0% without a clear and unmistakable error in VASRD application, even though the VA rated that exam at 10% and reasonable doubt could be applied for a 10% rating. However, the PT exam was closer to the date of separation, and followed a hospitalization for seizure disorder (generalized) which may have exacerbated the back condition. The PT exam was used by the service for rating and aligned with the record of evidence of use of a TENS unit; pain clinic and chiropractic treatments; a lumbar epidural steroid injection; and multiple complaints of lower extremity radicular pain on motion or following activity. The PT exam had the highest probative value and would clearly and unmistakably be rated at 10% IAW VASRD §4.71a.

It is certainly not IAW §4.3 (resolution of reasonable doubt) to discount the PEB-rated exam in favor of an exam more remote from separation that could support a lower rating, as reasonable doubt can only be “resolved in favor of the claimant.” The record clearly justifies a 10% back rating with consideration of §4.3 (resolution of reasonable doubt), §4.7 (Higher of two evaluations), and §4.40 (functional loss). The CI’s thoracolumbar spine condition should be rated at the 10% level, coded 5299-5237.

I respectfully submit to the secretary that a fair rating recommendation for this soldier is 20% for the neck condition and 10% for the back condition; and that the CI’s prior determination of discharge with severance pay be recharacterized to reflect permanent disability retirement, as follows.

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| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Cervical Spondylosis, w/o Abnormality | 5299-5237 | 20% |
| Lumbago, w/o Neurologic Abnormality | 5299-5237 | 10% |
| **COMBINED** | **30%** |

MEMORANDUM FOR Commander, US Army Physical Disability Agency

(TAPD-ZB /), 2900 Crystal Drive, Arlington, VA 22022

SUBJECT: Department of Defense Physical Disability Board of Review Recommendation

for xxxxxxxxxxxxx, AR20120007060 (PD201000377)

1. I have reviewed the enclosed Department of Defense Physical Disability Board of Review (DoD PDBR) recommendation and record of proceedings pertaining to the subject individual. Under the authority of Title 10, United States Code, section 1554a, I accept the Board’s recommendation to modify the individual’s disability rating to 20% without recharacterization of the individual’s separation. This decision is final.

2. I direct that all the Department of the Army records of the individual concerned be corrected accordingly no later than 120 days from the date of this memorandum.

3. I request that a copy of the corrections and any related correspondence be provided to the individual concerned, counsel (if any), any Members of Congress who have shown interest, and to the Army Review Boards Agency with a copy of this memorandum without enclosures.

 BY ORDER OF THE SECRETARY OF THE ARMY:

Encl xxxxxxxxxxxxxxx

 Deputy Assistant Secretary

 (Army Review Boards)

CF:

( ) DoD PDBR

( ) DVA