RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: Air force

CASE NUMBER: PD1000737 SEPARATION DATE: 20070122

BOARD DATE: 20111117

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SSgt/E-5 (1CO52, Aviation Resource Manager) medically separated for a lumbar spine condition. He did not respond adequately to treatment and was unable to perform within his career field or meet physical fitness standards. He was issued a P4 profile and underwent a Medical Evaluation Board (MEB). Chronic low back pain and asthma were forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AFI 48-123. Additional conditions supported in the Disability Evaluation System (DES) file are discussed below, but were not forwarded for PEB adjudication on the AF Form 618. The Informal PEB (IPEB) adjudicated the lumbar degenerative disc disease condition as unfitting, rated 10% with presumptive application of DoDI 1332.39 and the Veterans Administration Schedule for Rating Disabilities (VASRD); asthma as Category II (conditions that can be unfitting but are not currently compensable or ratable); and overweight and adjustment disorder with anxious mood as Category III (conditions that are not separately unfitting and not compensable or ratable). The CI made no appeals and was medically separated with a 10% disability rating.

CI CONTENTION: “A ten percent (10%) rating does not accurately reflect the limitations placed on me due to the pain I endure and the significant limitation in range of motion that I experience. Please review my medical records, it is my opinion that they will illustrate that the initial rating was significantly lower than it should have been. And although I was diagnosed with sleep apnea (CPAP), and asthma it [*sic*] was not considered.” He elaborates no specific contentions regarding rating or coding and mentions no additionally contended conditions.

RATING COMPARISON:

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| --- | --- | --- | --- | --- | --- | --- |
| **Service IPEB – Dated 20061201** | | | **VA (2 Mo. After Separation) – All Effective 20070123** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Degenerative Disc Disease | 5243 | 10% | Degenerative Disc Disease | 5242-5237 | 10% | 20070309 |
| Asthma | Cat II | | Asthma | 6602 | 30% | 20070309 |
| Overweight, BMI 29 | Cat III | | No VA Entry | | | |
| Adjustment Disorder | Cat III | | Anxiety Disorder | 9413 | 10% | 20070324 |
| ↓No Additional MEB Entries↓ | | | Obstructive Sleep Apnea | 6847 | 50% | 20070309 |
| Bilateral Tinnitus | 6260 | 10% | 20070324 |
| Left Knee Patellofemoral Syndrome | 5010-5260 | 10% | 20070309 |
| 0% x 2 / Not Service Connected x 2 | | | 20070309 |
| **Combined: 10%** | | | **Combined: 80%** | | | |

ANALYSIS SUMMARY: The Board acknowledges the sentiment expressed in the CI’s application regarding the significant impairment with which his service-incurred condition continues to burden him. The Board wishes to clarify that it is subject to the same laws for service disability entitlements as those under which the DES operates. 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. That role and authority is granted by Congress to the Department of Veteran Affairs (VA), operating under a different set of laws (Title 38, United States Code). The Board evaluates VA evidence proximal to separation in arriving at its recommendations, but its authority resides in evaluating the fairness of DES fitness decisions and rating determinations for disability at the time of separation. The Board also acknowledges the CI’s contention for service ratings for other conditions documented at the time of separation, and notes that its recommendations in that regard must also comply with the same governance.

Lumbar Spine Condition. The CI’s first episode of back pain occurred in December 1999 lifting furniture. He re-injured his low back in February 2001 while loading pallets. Recurrence in 2002 was associated with more severe pain and evidence of nerve root impingement. Due to ongoing restrictive profiles, an MEB was performed in 2004 which led to the recommendation for continued medical observation and a repeat MEB at a later date. He continued to have intermittent back pain treated with physical therapy, a steroid injection and pain medication. Ongoing symptoms prevented him from participating in fitness testing for over two years prior to his second MEB in 2006. The narrative summary (NARSUM) examiner noted recent recurrence of right lumbar pain with pain radiating to the right buttock. Martial arts training was beneficial and he was pain free for nine months prior to the exacerbation. Physical examination revealed a normal gait but was silent regarding posture and spinal contour. Tenderness of the right lumbar paraspinal muscles was present. Full range of motion (ROM) was reported but measurements were not in evidence. Sensation and deep tendon reflexes were normal. Right leg strength was three out of five (normal is five out of five) but this was ascertained to be due to pain rather than actual muscle weakness due to radiculopathy. Straight leg raise testing was negative bilaterally. Magnetic resonance imaging showed broad-based disc bulge and facet hypertrophy at L4-5 and L5-S1, and some S1 nerve root impingement bilaterally. The VA compensation and pension (C&P) examiner, two months after separation, reported that pain was present “all the time” and that pain flares occurred once per week and lasted over a day. Walking, running, standing for five minutes or sitting for ten minutes caused pain flares. Pain occasionally radiated to the top of his right thigh. Non-narcotic pain medication was helpful and use of assistive devices was not required. Physical examination revealed a normal gait. There was no ankylosis, but muscle spasm was present. A positive straight leg raise was present on the right but muscle strength, sensation and deep tendon reflexes were normal. Lumbar ROM measurements revealed flexion of 90⁰ (normal 90⁰) and combined ROM of 220⁰ (normal 240⁰). There was no loss of ROM with repetition or additional limitation due to pain.

The PEB and VA chose different coding options for the condition, but this did not bear on rating. The PEB rating reflected presumptive application of DoDI 1332.39 since lumbar ROM was not measured as required by the VASRD, but its 10% determination was consistent with application of §4.59 (painful motion) or §4.40 (pain with use). The limitation of combined motion reported on the C&P exam was compensable at 10%, although the VA justified the rating with application of §4.59. The Board deliberated whether a higher rating could be achieved under the formula for rating intervertebral disc disease based on incapacitating episodes. However, not even the minimum rating under that formula was met.

The Board also considered if additional disability rating was justified for peripheral nerve impairment. There is little support in the service record for clinically significant radiculopathy. Although intermittent episodes of radiating pain were noted, and a magnetic resonance imaging showed minimal S1 nerve root impingement, there was no evidence on multiple exams of muscle weakness due to neuropathy. The presence of functional impairment with a direct impact on fitness is the key determinant in the Board’s decision to recommend any condition for rating as additionally unfitting. While the CI may have suffered additional pain from the nerve involvement, this is subsumed under the general spine rating criteria, which specifically states “with or without symptoms such as pain (whether or not it radiates).” Therefore, the critical decision is whether or not there was a significant motor weakness which would impact duty-specific activities. There is no evidence in this case that motor weakness existed to any degree that could be described as functionally impairing. The Board therefore concludes that additional disability rating was not justified on this basis.

Contended Obstructive Sleep Apnea. The CI first complained of sleep difficulty during the MEB process. The sleep clinic record indicates loud snoring as the main complaint. Based on a sleep study, the specialist’s assessment (30 October 2006) was moderate obstructive sleep apnea (OSA). Continuous positive airway pressure (CPAP) treatment was started in November 2006 (two months prior to separation), but a follow up study to assess effectiveness is not in evidence. However, a 30 October 2006 sleep clinic note indicates the CI did not experience excessive daytime sleepiness fatigue or tiredness during the daytime. The C&P examiner stated that the CPAP helped some with the symptoms, though he still experienced some sleepiness during the day. PEBs across the services do not routinely find OSA, with or without CPAP requirement, unfitting if symptoms are controlled and functioning is unimpaired. The burden of providing CPAP in field and deployed environments is not considered to be a critical factor with the common availability of portable generators and sanitary facilities. The OSA condition was not profiled and was not implicated in the commander’s statement. This condition was reviewed by the action officer and considered by the Board. It was determined that it could not be argued as unfitting and subject to separation rating.

Contended Asthma. Symptoms suggestive of asthma began approximately one year prior to separation; however, there were occasional clinic visits for symptoms suggestive of asthma over several years. A chest computed tomography scan 13 April 2006 was normal and pulmonary function testing on 7 August 2006 showed findings of mild obstruction that improved with bronchodilator, interpreted as “probably consistent with asthma.” The CI was treated with maintenance and rescue inhaler medication, and on occasion was prescribed steroids for increased symptoms on three occasions. Examinations during symptoms were usually noted for absence of wheezing, normal peak flow, and normal oxygen levels. Clinic notes reflect release from clinic, without limitations. Approximately two weeks prior to separation, he was hospitalized for one day for an asthma exacerbation which was quickly controlled with additional medication. The C&P examiner reported that exposure to pets and smoke or cutting the grass caused wheezing and trouble breathing requiring use of rescue medication. Preventive inhaled medication was not mentioned. Pulmonary physical exam was normal. The asthma condition was not profiled and was not implicated in the commander’s statement. After due deliberation in consideration of the totality of the evidence, the Board concluded that there was insufficient cause to recommend a change from the PEB fitness adjudication for the asthma condition.

Other PEB Conditions. The other condition adjudicated as not unfitting by the PEB was adjustment disorder with anxious mood. The CI first presented with anxiety symptoms in April 2006 which stemmed specifically from a difficult situation with a co-worker. Brief treatment with psychotropic medication was not helpful. A psychiatric NARSUM addendum recorded a completely normal mental status examination and stated that there was no impairment for further military service, and no impairment for civilian, social, and industrial adaptability. His psychiatric profile remained S1. A note from a mental health provider 13 December 2006 (one month prior to separation) stated, “Client is stable, no further need of LSSC [Life Skills] care.” This condition was not profiled, was not implicated in the commander’s statement or noted as failing retention standards. It was reviewed by the action officer and considered by the Board. There was no indication from the record that this condition significantly interfered with satisfactory duty performance. All evidence considered, there is not reasonable doubt in the CI’s favor supporting recharacterization of the PEB fitness adjudication for the stated conditions. The PEB also adjudicated overweight as not separately unfitting. Overweight is a condition that itself does not constitute a physical disability. The Board therefore has no reasonable basis for recommending this condition as additionally unfitting for separation rating.

Remaining Conditions. Other conditions identified in the DES file were hypertension, hyperlipidemia, allergies and problems hearing. Several additional non-acute conditions or medical complaints were also documented. None of these conditions were clinically or occupationally significant during the MEB period, none carried attached profiles and none 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. Additionally left knee patellofemoral syndrome, bilateral tinnitus and gastroenteritis were noted in the VA rating decision proximal to separation, but were not documented in the DES file. 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.

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 DoDI 1332.39 for rating lumbar degenerative disc disease was operant in this case and the condition was adjudicated independently of that instruction by the Board. In the matter of the lumbar degenerative disc disease condition and IAW VASRD §4.71a, the Board unanimously recommends no change in the PEB adjudication. In the matter of the OSA condition, the Board unanimously agrees that it cannot recommend a finding of unfit for additional rating at separation. In the matter of the asthma and adjustment disorder conditions, the Board unanimously recommends no change from the PEB adjudications as not unfitting. In the matter of the hypertension, hyperlipidemia, allergies and hearing 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. 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 therefore recommends that there be no recharacterization of the CI’s disability and separation determination.

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| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Lumbar Degenerative Disc Disease | 5243 | 10% |
| **COMBINED** | **10%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20100120, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans' Affairs Treatment Record

President

Physical Disability Board of Review

SAF/MRB

1500 West Perimeter Road, Suite 3700

Joint Base Andrews MD 20762

Reference your application submitted under the provisions of DoDI 6040.44 (Section 1554, 10 USC), PDBR Case Number PD-2010-00737.

After careful consideration of your application and treatment records, the Physical Disability Board of Review determined that the rating assigned at the time of final disposition of your disability evaluation system processing was appropriate. Accordingly, the Board recommended no re-characterization or modification of your separation with severance pay.

I have carefully reviewed the evidence of record and the recommendation of the Board. I concur with that finding and their conclusion that re-characterization of your separation is not warranted. Accordingly, I accept their recommendation that your application be denied.

Sincerely,

Director

Air Force Review Boards Agency

Attachment:

Record of Proceedings