RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: marine corps

CASE NUMBER: PD1001106 SEPARATION DATE: 20090429

BOARD DATE: 20120402

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was a Reserve Gunnery Sergeant/E7 (0629/Radio Chief), medically separated for chronic neck pain. Despite conservative and surgical intervention, the neck condition did not respond adequately to treatment to fully perform within his Military Occupational Specialty (MOS) or meet physical fitness standards. Brachial neuritis or radiculitis NOS, cervicalgia and lumbago were forwarded to the Physical Evaluation Board (PEB) as medically unacceptable SECNAVINST 1850.4E. No other conditions were forwarded on the MEB submission. The PEB adjudicated the chronic neck pain condition as unfitting, rated 20%, with application of SECNAVINST 1850.4E. Right C6 and C7 radiculopathy, s/p right posterior micro-foraminotomy at C5-6 and C6-7 and tension headaches were adjudicated as category II conditions, contributing to the unfitting condition but not separately unfitting. Lumbar spine pain was adjudicated as a category III condition, not unfitting or contributing to the unfitting condition. The CI made no appeals and was medically separated with a 20% combined disability rating.

CI CONTENTION: The CI states: ‘’Given the complexity of my condition at the time of my physical evaluation and the on-going treatment that I have had to sustain after service, I believe that I should have been medically retired from service rather than medically separated from service as I was.” He submits VA rating decision letters and a contention for inclusion of all service connected conditions is implied.

RATING COMPARISON:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Service PEB – Dated 20090305** | | | **VA ( Pre and Post Separation) – Effective Dates vary\*** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Chronic Neck Pain | 5242 | 20% | Cervical Spine DDD S/p Micro foraminotomy | 5242 | 20% | 20100304 |
| Posterior Micro-foraminotomy | Related Cat II Diagnosis | |
| Right C6 and C7 Radiculopathy | Related Cat II Diagnosis | | Right Shoulder Radiculopathy | 8510 | 40% | 20100304 |
| Tension Headaches | Related Cat II Diagnosis | | Tension Headache | 8199-8100 | 50% | 20100405 |
| Lumbar Spine Pain | Not Unfitting | | Not VA Rated | | | |
| ↓No Additional MEB/PEB Entries↓ | | | Left Knee DJD | 5003-5260 | 10% | 20080709 |
| Right Knee DJD | 5003-5260 | 10% | 20080929 |
| 0% 1 / Not Service Connected 5 | | | 20080109 |
| **Combined: 20%** | | | **Combined: 80%** | | | |

\*Multiple rating changes and recoding over multiple VARDs. Rating table reflects the final rating and code applied which was also the only VARD accomplished after separation.

ANALYSIS SUMMARY: The Disability Evaluation System (DES) is responsible for maintaining a fit and vital fighting force. 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. 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 nor for conditions determined to be service-connected by the Department of Veterans’ Affairs (DVA) but not determined to be unfitting by the PEB. However the DVA, operating under a different set of laws (Title 38, United States Code), is empowered to compensate all 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’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, based on severity at the time of separation. It must also judge the fairness of PEB fitness adjudications based on the fitness consequences of conditions as they existed at the time of separation. 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.

Chronic Neck Pain, Right C6-& Radiculopathy, Status Post Right Posterior Microforamenotomy at C5-6 and C6-7: The CI developed chronic and episodic neck pain radiating into the right upper extremity associated with an injury while deployed to Iraq in 2006. Non-surgical treatment did not improve his symptoms and he underwent right C5-6 and C6-7 microdiscectomies and C5/C6 foraminotomies on 14 July 2008 at the VA medical center. The MEB narrative was dictated 25 November 2008, 5 months prior to separation and 4 months after surgery. The right hand dominant CI reported daily neck pain and spasm with decreased ROM of his neck and radiation of pain into his lower back. He noted intermittent paresthesias of the right upper extremity, but stated that this was improved from his pre-operative state. He was restricted from lifting greater than 10 pounds. He denied weakness of the upper or lower extremities and had normal bowel and bladder function. On exam, he was noted to have a normal gait, normal heel and toes walking and could jump in place without difficulty. The neck incision was well healed. Cervical spine range-of-motion (ROM) was reduced and uncomfortable, but no goniometric measurements were recorded. Deep tendon reflexes (DTRs) and motor function was normal. Sensation was altered to light touch in all distributions of the right hand. There was no muscle atrophy and signs of spinal cord compression were absent. The assessment was that he had primarily musculoskeletal pain involving the cervical spine with some lumbosacral spasm. It was noted that he might be a candidate for further surgery if his symptoms persisted and that he had not reached maximal medical improvement. The PEB found the neck pain condition unfitting rated 20%. The radiculopathy was determined to be a category II condition, contributing to the unfitting neck condition but not separately unfitting or ratable. A VA Compensation and Pension (C&P) examination 29 September 2008, 3 months before the MEB, documented cervical spine ROM of flexion 20 degrees, extension 20 degrees, right lateral flexion 28 degrees, left lateral flexion 20 degrees, right rotation 40 degrees, left rotation 39 degrees (combined 170 degrees). There was no further decrease after repetitive use. There was tenderness without muscle spasm. Right arm pain due to radiculopathy was recorded which limited use of the right arm. Examination recorded normal muscle bulk, strength and tone with intact, reflexes that were normal and symmetric. A 12 November pain clinic encounter recorded that strength coordination and reflexes were normal. During a VA C&P examination on 4 March 2010, 10 months after separation, the CI reported increased neck pain with right upper extremity pain for which injections had not been helpful. Paresthesias of the fourth and fifth digits of the right hand was noted as well as the radial three digits of the left hand (the CI had carpal tunnel syndrome on the left, though, for which he had surgery). He noted that he missed work once a week when his neck was “bad.” On examination, his gait was normal and scar noted to be well healed. Cervical spine ROM was flexion 20 degrees, extension 5 degrees, left rotation 10 degrees; right rotation 20 degrees, left lateral bending 15 degrees, and right lateral bending 10 degrees (combine 80 degrees). There was pain with motion. Sensation was noted to be intact except for decreased light touch in the C7-8 distribution. Deep tendon reflexes were noted to be absent in both right and left upper extremities. Motor strength was slightly reduced in the right triceps, but otherwise intact. No muscle atrophy was noted. Imaging again showed foraminal narrowing and multi-level cervical DDD. A month later, the CI was evaluated in the neurology clinic for headaches on 5 April 2010. This examination documented intact, symmetric normal deep tendon reflexes in all four extremities, normal motor function and tone in all four extremities without atrophy and normal sensation in all tested dermatomes. Gait was normal. The PEB and VA both adjudicated the chronic neck pain as 20% disabling and coded it 5242, degenerative arthritis of the spine. Although ROM was not documented in the MEB NARSUM, Board members agreed that the 20% rating assigned by the PEB was consistent with the ROM documented at the time of the C&P examinations before the MEB and 10 months after separation. The Board considered if a higher rating could be awarded under code 5243 for incapacitating episodes, but noted that the CI did not have a record of “physician prescribed bed rest” as required prior to separation. The C&P examiner (10 months after separation) did note that the CI would need to leave once a week when the neck pain was bad, did not indicate how often it was this bad. The Board notes that the VA considered and rejected this coding option.

The Board next considered whether the radiculopathy condition was separately unfitting and ratable. The PEB determined the radiculopathy to be a category II condition which contributed to the unfitting neck condition but was not separately unfitting. The VA initially awarded 20% for mild loss of function, apparently based on the sensory deficits recorded in a C&P 3 months after surgery. The VA subsequently awarded 40% based on the 4 March 2010 examination 10 months after separation in which the CI was noted to have absent reflexes in both arms and diminished sensation in the right C7-8 distribution and slightly reduced right triceps strength. The Board notes that the reflex and motor exam were normal on the MEB evaluation and that sensation was altered only for the right hand. A pain clinic examination 12 November 2009, 5 months after separation, documented normal strength, coordination and reflexes, and an evaluation by a neurologist a month after the March 2010 VA C&P was completely normal (normal strength, intact reflexes, normal tone, no fasciculations, no atrophy). As it was performed by a neurologist and is more consistent with other examinations, it is assigned a higher probative value of the two C&P exams. It is also more remote from surgery and therefore considered to be a better reflection of the permanent condition. It is clear from the MEB narrative that the primary duty limitation was from pain and the commander’s assessment indicates that the unfitting condition was the inability to deploy; in garrison, “his contribution has been outstanding.” His limitation in lifting and from physical fitness training was secondary to the neck injury and surgery, not the sensory deficit. Board precedent is that a functional impairment tied to fitness is required to support a recommendation for addition of a peripheral nerve rating at separation. 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).” The sensory component in this case has no functional implications. The motor impairment was either absent or relatively minor and cannot be linked to physical impairment. Since no evidence of functional impairment exists in this case, the Board cannot support a recommendation for additional rating for radiculopathy. All evidence considered, there is not reasonable doubt in the CI’s favor supporting recharacterization of the PEB fitness adjudication for the right C6-7 radiculopathy. All evidence considered, there is not reasonable doubt in the CI’s favor supporting a change from the PEB’s rating decision for the chronic neck pain condition.

Other PEB Conditions. The other condition forwarded by the MEB and adjudicated as not unfitting by the PEB was lumbar spine pain. 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. It was reviewed by the action officer and considered by the Board. The CI completed a post-deployment health assessment form on 27 September 2006 and checked no to problems with his back, joints, or numbness tingling in hands or feet. At the time of the medical examination on 10 October 2006, the CI checked “no” to question 12.c on the DD Form 807 regarding recurrent back pain or any back problem. The CI was released from active duty 30 November 2006. At the time of a civilian rheumatology evaluation of knee pain on 6 August 2007, the CI denied problems with back pain. The CI reported back pain following neck surgery. This condition was not profiled or implicated in the non-medical assessment (NMA). There was no indication from the record that this condition significantly interfered with satisfactory performance of MOS duty requirements. All evidence considered, there is not reasonable doubt in the CI’s favor supporting recharacterization of the PEB fitness adjudication for the low back pain.

Other Contended Conditions. The CI contends for consideration of tension headaches due to traumatic brain injury, and degenerative joint disease with patellofemoral syndrome of both knees. Headaches and knee condition are noted in the MEB NARSUM and MEB history and physical examination, and the CI reported traumatic brain injury in his 10 January 2009 letter of rebuttal to the MEB. Service treatment record (STR) reflect that the CI sought medical care on 5 July 2006 complaining of persistent hearing loss in the right ear and difficulty with balance since exposure to an IED blast that was reported to have detonated 10 feet away while the CI was in a HMMWV. The CI reported experiencing ringing in the right ear and right foot pain at the time of the IED blast and was seen by his unit corpsman. At the time of this medical evaluation (5 July 2006) there was no report of loss of consciousness, current tinnitus, persisting foot pain, headache, or neck pain. The neurologic examination was normal. Hearing loss due to IED blast was diagnosed. On follow up medical evaluation on 13 July 2006, there was complaint only of persisting hearing loss in the right ear and episodic balance problem with normal neurologic examination. The CI completed a post deployment health assessment form on 27 September 2006 and checked no to problems with headaches. He checked yes to problems with problems with feeling dizzy, fainting, light headedness, difficulty remembering, and ringing in ears. At the time of a 10 October 2006 medical examination, the CI completed DD Form 2807 and checked “no” to frequent or severe headache, dizziness or fainting spells, a period of unconsciousness or concussion, nervous trouble of any sort (anxiety panic attacks,) loss of memory or amnesia, frequent trouble sleeping, depression or excessive worry. He checked yes to ear trouble and hearing loss and wrote “loss of hearing due to IED incident.” The CI completed another post deployment health assessment on 13 April 2007 and did not indicate problems with headaches, ringing in the ears, dizziness or memory problems. A December 2007 VA TBI evaluation concluded resolved mild TBI and attributed headaches to chronic neck pain. A January 2008 audiology evaluation recorded that the ringing in the ears had resolved and audiogram and speech recognition testing was normal. At the time of the MEB history and physical examination, 9 December 2008, the CI checked “no” regarding a head injury, memory loss or amnesia, a period of unconsciousness or concussion. He checked “yes” to frequent or severe headaches. The MEB did not list headaches as a medically unacceptable condition and the service treatment record (STR) is silent for visits for headaches. He was not profiled or placed on LIMDU for the headaches. The CI’s DD 214 for the period of active service ending 30 November 2006 does not list a Purple Heart medal or Combat Action Ribbon. The commander does not cite headaches or other problems that might be attributed to a TBI as contributing to duty impairment. The CI’s in garrison duty performance was characterized as outstanding including operating a systems control center or as the acting First Sergeant. All evidence considered, there is not reasonable doubt in the CI’s favor supporting recharacterization of the PEB fitness adjudication for the headache condition as category II and adding headaches or TBI as a separately unfitting condition. The CI had a period of restricted duty from March 2007 to September 2007 due to knee pain diagnosed as degenerative joint disease with patellofemoral syndrome. A physical therapy encounter dated 17 September 2007 records that the CI was running up to three miles, two to three times per week. He was returned to full duty 20 September 2007. The knee condition was not clinically active during the MEB period and was reported to be asymptomatic by the MEB NARSUM examiner.

Remaining Conditions. Other conditions identified in the DES file were the following: shortness of breath, chronic cough, hearing loss, frequent indigestion or heartburn, chest pain, and sleep disturbance. Several additional non-acute conditions or medical complaints were also documented. The chest pain was determined to be non-cardiac. A stress test in July 2008 was normal, and pulmonary functions were normal. There were no entries in the STR for visits related to heartburn, or sleep disturbance. While mild hearing loss was documented, the CI met retention standards. There was no additional VA conditions, but the Board notes that the VA determined the hearing loss, heart condition, TBI and sleep conditions to not be service-connected and that the heartburn was rated at 0% disability. 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 the adjudication. In the matter of the chronic neck pain and IAW VASRD §4.71a, the Board unanimously recommends no change in the PEB adjudication. In the matter of the right C6 and C7 radiculopathy condition, the Board unanimously recommends no change in the PEB adjudication as not separately unfitting. In the matter of the tension headaches and low back pain conditions, the Board unanimously agrees that it cannot recommend a finding of unfit for additional rating at separation. In the matter of the shortness of breath, chronic cough, hearing loss, left and right knee pain, frequent indigestion or heartburn, chest pain, sleep disturbance, and TBI 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, therefore, recommends that there be no recharacterization of the CI’s disability and separation determination, as follows:

|  |  |  |
| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Chronic Neck Pain | 5242 | 20% |
| **COMBINED** | **20%** |

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

The following documentary evidence was considered:

Exhibit A. DD Form 294 dated 20100913, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans' Affairs Treatment Record

President Physical Disability Board of Review

MEMORANDUM FOR DIRECTOR, SECRETARY OF THE NAVY COUNCIL OF REVIEW

BOARDS

Subj: PHYSICAL DISABILITY BOARD OF REVIEW (PDBR) RECOMMENDATIONS

Ref: (a) DoDI 6040.44

(b) CORB letter dtd 12 Apr 12

In accordance with reference (a), I have reviewed the cases forwarded by reference (b), and, for the reasons provided in their forwarding memorandum, approve the recommendations of the PDBR the following individuals’ records not be corrected to reflect a change in either characterization of separation or in the disability rating previously assigned by the Department of the Navy’s Physical Evaluation Board:

Assistant General Counsel

(Manpower & Reserve Affairs)