RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: Army

CASE NUMBER: PD1001174 SEPARATION DATE: 20060309

BOARD DATE: 20120112

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was a National Guard SPC/E-4 (11B, Infantryman), medically separated for a lumbar spine condition. The CI sustained a series of injuries to the lower back starting in 1993 with progressive worsening of his symptoms up to and during his deployment to Iraq in 2005. His evaluation after redeployment yielded a diagnosis of multi-level lumbar disc disease. Surgical intervention was not elected; and, he did not respond adequately to a trial of conservative measures to fully perform within his Military Occupational Specialty (MOS) or meet physical fitness standards. He was issued a permanent L3 profile and referred for a Medical Evaluation Board (MEB). Back pain with bulging intervertebral disks was 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’s DA Form 3947 submission as medically acceptable conditions. Other conditions included in the Disability Evaluation System (DES) file will be discussed below. The PEB adjudicated the lumbar spine condition as unfitting, rated 10%, with presumptive application of the US Army Physical Disability Agency (USAPDA) pain policy. The remaining conditions were determined to be not unfitting. An initial appeal for a Formal PEB was withdrawn and the CI was medically separated with a 10% disability rating.

CI CONTENTION: The CI states: “Unfair treatment/decision. I didn’t have a chance to appear before the board for "all" of my medical conditions due to unfair treatment by my chain of command. I missed my flight and was threatened by my chain of command with an article 15/court martial and was given a discharge option of honorable. Without any bad remarks on my file, I was scared and didn’t understand my rights or know where else to turn so I took that option and was honorably discharged. All these conditions I have are still bothering me up to the present time and it was caused during the time I served in the military. Some conditions aggravated during the time I deployed to Iraq. I believe that I will have a much higher rating than what I was given which is 10% for my back. I would like to be rated for other medical conditions as well. These conditions bother me every day and it prevent me from getting a job. I have a family to support. Especially my school age children. I appreciate your decision to reconsider my rating by reviewing “all” of my medical conditions.” He additionally lists all of his VA conditions and ratings as per the rating chart below. A contention for their inclusion in the separation rating is therefore implied.

RATING COMPARISON:

|  |  |
| --- | --- |
| **Service IPEB – Dated 20060316** | **VA (5 Mos. Post-Separation) – All Effective 20060310** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Chronic Low Back Pain | 5299-5237 | 10% | DJD Lumbar Spine | 5242 | 40% | 20060810 |
| Shoulder Pain | Not Unfitting | Arthritis AC Joint, R Shoulder | 5201-5010 | 0% | 20060810 |
| Disability of the Right Shoulder | 5201 | NSC | 20060810 |
| Plantar Fasciitis | Not Unfitting | Plantar Fasciitis, Right Foot | 5010-5284 | 10% | 20060810 |
| Plantar Fasciitis, Left Foot | 5284 | NSC | 20060810 |
| Nephrolithiasis | Not Unfitting | Bilateral Nephrolithiasis and Proteinuria w/ Hypertension | 7508 | 30% | 20060810 |
| Hypertension | Not Unfitting |
| Depression | Not Unfitting | Depression/Anxiety | 9435 | NSC | 20060810 |
| Tinnitus | Not Unfitting | Tinnitus | 6260 | 10% | 20060810 |
| Obesity | Not Unfitting | No VA Entry | 20060810 |
| ↓No Additional MEB/PEB Entries↓ | R Knee Strain | 5260 | 10% | 20060810 |
| R Ankle Sprain | 5010-5271 | 20% | 20060810 |
| L Ankle Sprain | 5010-5271 | 20% | 20060810 |
| DJD Cervical Spine | 5242 | 20% | 20060810 |
| 0% x 1 / Not Service Connected x 9 | 20060810 |
| **Combined: 10%** | **Combined: 90% (Incorporating BLF)** |

ANALYSIS SUMMARY: The Board acknowledges the sentiment expressed in the CI’s application regarding the significant impairment with which his service-incurred condition has had on his current earning ability and quality of life. 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 Veterans’ Affairs (DVA), operating under a different set of laws (Title 38, United States Code). The Board evaluates DVA 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 further 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 comply with the same governance. 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 DVA, however, 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 his degree of impairment vary over time. Lastly, the Board acknowledges the CI’s assertions that unfair treatment by his chain of command may have impacted the outcome of his medical board. It is noted for the record that the Board has neither the jurisdiction nor authority to scrutinize or render opinions in reference to asserted Service improprieties in the disposition of a case. 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 Veterans Administration Schedule for Rating Disabilities (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.

Lumbar Spine Condition. The CI suffered an initial training injury to his back in 1993, and suffered various duty-related re-injuries after that. He fell down some stairs during his 2005 deployment to Iraq and was put on quarters for the duration of the tour. Imaging studies included a magnetic resonance imaging (MRI) that showed early degenerative disc disease at L4-5 and multilevel lumbar disc bulging that slightly narrowed the neural foramina and a normal nuclear bone scan. There were three goniometric ranges of motion (ROM) evaluations in evidence, with documentation of active ROM (AROM), passive ROM (PROM), and additional ratable criteria. The measured goniometric evaluations are summarized in the chart below. The Board also considered non-goniometric (although probative) ROM evaluations which are discussed in the ensuing narrative.

|  |  |  |  |
| --- | --- | --- | --- |
| ROM – Thoracolumbar Spine | MEB ~4 Mo. Pre-Sep | MEB ~4 Mo. Pre-Sep | VA C&P ~5 Mo. Post-Sep |
| Flexion (Normal 90⁰)  | 20⁰ | 45⁰ | 11⁰ |
| Combined (Normal 240⁰) | 115⁰ | 155⁰ | 50⁰ |
| Comments | AROM | PROM | Painful motion; positive DeLuca |
| §4.71a Rating | 40% | 20% | 40% |

The MEB narrative summary (NARSUM) documented pain of moderate intensity that radiated to the left knee and was aggravated by hard labor, sitting, bending, lifting, and lying down. The examination documented spinal tenderness, paravertebral muscle spasm, pain with extension of the back, a positive left straight leg raise, and other positive chiropractic provocative tests. Neurological exam was normal. The post-separation VA Compensation and Pension (C&P) examination documented a slow but normal gait and normal posture; noting the use of a cane and inability to lie down for examination. The cane was issued by the VA three months after separation, and was not in use during military service. The C&P ROMs charted above reflect De Luca criteria after repetitions.

Both the MEB’s AROM exam and the VA’s ROM exam were consistent with a rating of 40% IAW VASRD §4.71a if based strictly on ROM criteria. The MEB’s PROM examination was consistent with a 20% rating. In general, the Board applies AROM measurements to its recommendations; but, there is additional evidence in this case not reflected in the data above. There is ample documentation in outpatient clinical notes that observed AROM remained grossly normal up until the period of the MEB’s physical therapy (PT) rating measurements. There are notes reflecting pain, guarding and spasm (10% criteria); and, two entries reflecting antalgic gait and lordosis (20% criteria); but, AROM was characterized as ‘full’ or ‘WNL’ (within normal limits). An evaluation by a Family Practice physician four months prior to separation noted a flexion of 45⁰ and lateral rotation as full. An evaluation by PT in the same time period documented painful motion, but “lumbar AROM WNL.” There are additionally numerous entries in both the Service treatment record (STR) and subsequent VA records which challenge the probative value of the ROM based on subjective pain threshold and reasonable effort. A PT note four and a half months prior to separation documented, “after several attempts at getting a clear picture of patient’s back history, the patient admitted to wanting to leave the military.” At the same encounter, it was documented that the “patient states that he does not take his meds or do his exercises because he doesn’t like when people in his unit pick on him.” Two weeks later, the same PT examiner documented an unexplained increase in severity, and the CI’s reported inability to perform the same physical maneuvers observed on the recent preceding visit. Detailed examples were provided, which included an increase of back pain with five seconds of manual distraction of the left leg; and, the therapist documented a discussion with the CI’s primary care physician regarding “possible exaggerated responses.” Additonally, there were various entries in the VA records within 12 months of separation which similarly documented exaggeration of symptoms, pain out of proportion to exam, poor effort, and non-compliance with the treatment plan. As an example, one examiner documented that the CI “moaned and groaned throughout the exam;” and, frankly stated in the CI’s report that he “seems to be able to handle his pain with ibuprofen, which is disproportionate to the amount of pain he expressed today.” It is also noted that 13 months post separation, after the final lumbar spine disability rating, the VA records documented improvement of lumbar ROMs to approximately 50% of normal. This is consistent with the MEB evidence outside the context of disability rating; and, in line with the PROM recorded in the MEB’s goniometric evaluation. In addition to substantially documented non-compliance, the Board must also weigh the factor that the majority of Service and VA examiners characterized the CI’s obesity as “morbid.” Marked obesity is a non-ratable factor which affects both severity of symptoms and validity of ROMs in spine conditions. In this case, the obesity preceded the spine condition and was not a result of the condition; and, further the CI was non-compliant with a weight reduction program.

Board members engaged in protracted deliberation regarding probative value assignment and a fair rating recommendation in this case. As to the severe ROM limitations documented at the VA rating examination, especially in light of the evidence just presented, the Board must consider that VA C&P evaluations rest on ROM measurements which rely predominantly on subjective pain thresholds plainly linked to financial incentive; thus, intrinsically subject to some loss of objectivity. There is no documented injury or other aggravation in explanation of the worse severity, and new requirement for a cane to assist ambulation, as noted by the VA rating examiner. The Board therefore agreed that the MEB ROM evaluation carried the most probative value; but, in light of the mitigating psychological factors and expressed incentive to terminate military service, all members agreed that the PROM measurements provided the most valid criteria for purposes of its recommendation. These ROM criteria, as well as conceding the §4.71a criteria of abnormal gait and contour (from the probative outpatient evidence), support a 20% rating without regard to the PEB-applied USAPDA pain policy. After due deliberation, considering the preponderance of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a separation rating of 20% for the lumbar spine condition. The action officer prefers the 5242 (degenerative spine) code for its clinical specificity.

Other PEB Conditions. The other conditions forwarded by the MEB and adjudicated as not unfitting by the PEB were hypertension, shoulder pain, plantar fasciitis, nephrolithiasis (kidney stones), tinnitus, depression, and obesity. 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.

The right shoulder suffered a grade II acromioclavicular separation and required temporary profiles, but did not result in a permanent profile. In June 2005 the CI was seen by the physical medicine and rehabilitation clinic for his back condition, during which the examiner noted that he was able to do pushups with only minimal pain. There was no mention of any limitations related to the shoulder condition, and the CI reported that he was ready to return to duty. Additionally, the NARSUM documented a normal upper extremity exam. The profile at separation was U1. The VA C&P examiner mentioned nothing regarding the shoulder condition, prompting the non-compensable rating conferred by the VA.

Plantar fasciitis of the right foot was identified during the MEB exam. The CI was placed on light duty for 15 days (three months prior to separation), but was not permanently profiled for this condition. The kidney stone condition was successfully treated with lithotripsy and surgery, with no sequealae. Hypertension with proteinuria was evaluated by a nephrologist in 2004. This consultant recommended a release from active duty; but, this recommendation was not pursued, and did not result in a permanent profile or referral to a medical board. Blood pressure was poorly controlled at separation due to documented non-compliance, with failure to follow exercise, diet and weight loss recommendations. Tinnitus was evaluated by an otolaryngologist three months prior to separation, who documented normal findings except for scarring of the right eardrum and a normal hearing evaluation. No further treatment or duty limitations were prescribed.

A psychiatric addendum was attached to the NARSUM addressing the CI’s diagnosis of depression. The CI self-referred to mental health in October 2004 because he had become chronically irritable, angry, and suffered from insomnia. He described fatique and low energy, but not subjective depression. It was determined that he had no psychological trauma from being deployed and no symptoms consistent with posttraumatic stress disorder (PTSD). He was diagnosed by the examiner with an adjustment disorder with mixed disturbance of emotions and conduct. The examiner opined that the CI “does not have a mental illness of such severity as to render him not fit for full duty. His adjustment disorder is resolving with therapy and is expected to be fully resolved by discharge from active duty.” The VA post-separation psychiatric examiner diagnosed the CI with a borderline personality disorder; found no evidence for PTSD or independent diagnoses of depression or anxiety; and, considered that any symptoms of depression or anxiety would have been seen as secondary to his personality disorder. Adjustment disorder, personality disorder and obesity (as discussed above) do not constitute ratable disabilities.

All of the above conditions were reviewed by the action officer and considered by the Board. None were profiled at separation and all were judged by the MEB to meet retention standards. There was no indication from the record that any of these conditions significantly interfered with satisfactory duty performance. All evidence considered, there is not reasonable doubt in the CI’s favor supporting a change in the PEB fitness adjudication for any of the stated conditions.

Other Contended Conditions. The CI’s application asserts that compensable ratings should be considered for right knee, bilateral ankle, and cervical spine conditions. The ankle conditions were the result of sprains that occurred in 2004 while playing basketball; radiographs showed degenerative changes but no fractures. The MEB physical documented a normal lower extremity exam. There was no evidence in the STR related to the knee and cervical spine conditions. None of these conditions were significantly clinically or occupationally active 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. There was no 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.

Remaining Conditions. Other conditions identified in the DES file were prostatitis, headaches, and umbilical hernia. Several additional non-acute conditions or medical complaints were also documented. None of these conditions were significantly clinically or occupationally active 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, no other conditions were service connected with a compensable rating by the VA within twelve months of separation or contended by the CI. 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. As discussed above, PEB reliance on the USAPDA pain policy for rating the lumbar spine condition was operant in this case and the condition was adjudicated independently of that policy and regulation by the Board. In the matter of the lumbar spine condition, the Board unanimously recommends a rating of 20% coded 5242 IAW VASRD §4.71a. In the matter of the shoulder pain, plantar fasciitis, nephrolithiasis, hypertension, tinnitus, depression, and obesity conditions; the Board unanimously recommends no change from the PEB adjudications as not unfitting. In the matter of the right knee, bilateral ankle, cervical spine, prostatitis, headaches, umbilical hernia, or any other conditions eligible for Board consideration; the Board unanimously agrees that it cannot recommend any finding 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** |
| Lumbar Degenerative Spine and Disc Disease | 5242 | 20% |
| **COMBINED** | **20%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20101007, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans' Affairs Treatment Record

