RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: army

CASE NUMBER: PD1001218 SEPARATION DATE: 20050408

BOARD DATE: 20120112

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SGT/E5 (92A, Automated Logistical Specialist), medically separated for lumbar spine, bilateral ankle, and migraine headache conditions. The CI suffered a heart attack in June 2004 while deployed to Korea. He was treated in theater with coronary angioplasty and stenting; after recuperation, was cleared to redeploy for a Medical Evaluation Board (MEB). He was referred for a 180-day trial of duty for the coronary artery condition (IAW AR 40-150); but, chronic conditions of back pain, bilateral ankle pain, and migraine headaches surfaced acutely during the MEB process and he responded inadequately to treatment. He was unable to fulfill the physical demands of his Military Occupational Specialty (MOS) or meet physical fitness standards and was issued permanent P3 and L3 profiles. Coronary artery disease, migraine headaches, mechanical low back pain, compression fractures of T11 and T12, bilateral ankle osteoarthritis, and right ankle instability were forwarded to the Informal Physical Evaluation Board (IPEB) as six separate medically unacceptable conditions IAW AR 40-501. Additionally, hypertension and hyperlipidemia were forwarded as medically acceptable conditions. Other conditions included in the Disability Evaluation System (DES) file will be discussed below. The IPEB combined the chronic low back pain and T11/T12 compression fractures as one unfitting condition, rated 10%; combined the bilateral ankle osteoarthritis and right ankle instability as one unfitting condition, rated 10%; and, adjudicated migraine headaches as unfitting, rated 0%. All ratings cited criteria from the Veterans Administration Schedule for Rating Disabilities (VASRD). The coronary artery disease, hypertension, and hyperlipidemia conditions were determined to be not unfitting. The CI appealed to the Formal PEB (FPEB), which affirmed the findings of the IPEB; and, the CI was medically separated with a 20% combined disability rating.

CI CONTENTION: The CI states: “Was rated at 10% for back, 10% for ankles, 0% for migraines, and nothing for heart attack with stent and asthma. Had permanent profiles for heart attack and migraines, but did not receive proper ratings for either. Went to Washington State to appeal initial rating and my legal representative did nothing to help my appeal. Asthma was listed as bronchial spasms so I could deploy but later rated by the VA as asthma. I had 14 years, 7 months of active duty when separated. Was granted tax exempt for combat related injuries. Also new law expands severance pay to 19 years. I was calculated at 12 years.” The CI 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 FPEB – Dated 20050119** | **VA (1 Mo. Pre Separation) – All Effective Date 20050409** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Chronic Low Back Pain | 5299-5237 | 10% | Lumbar Strain | 5020-5237 | 10% | 20050311 |
| Radiculopathy, LLE | 8599-8520 | 10% | 20050311 |
| Bilateral Ankle Pain and Instability | 5003 | 10% | Residuals of Left Ankle Sprain | 5299-5271 | 10% | 20050311 |
| Residuals of Right Ankle Sprain | 5299-5271 | 10% | 20050311 |
| Migraine Headaches | 8100 | 0% | Migraine Headaches | 8100 | 0% | 20050311 |
| Coronary Artery Disease | Not Unfitting | Coronary Artery Disease | 7006-7005 | 10% | 20050311 |
| Hypertension | Not Unfitting | Hypertension | 7101 | 10% | 20050311 |
| Hyperlipidemia | Not Unfitting | No VA Entry | 20050311 |
| ↓No Additional MEB/PEB Entries↓ | Reactive Airway Disease | 6699-6602 | 10% | 20050311 |
| 0% x 3/Not Service Connected x 1 | 20050311 |
| **Combined: 20%** | **Combined: 50% (Incorporating BLF)** |

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 wishes to clarify that it is subject to the same laws for Service disability entitlements as those under which the military 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 all service connected conditions without regard to fitness 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. Additionally, the Board acknowledges the CI’s assertion that his legal representation was inadequate; but, 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 further acknowledges the CI’s assertion that revised laws related to severance pay may not have been applied to his case. By law, Board authority is limited to making recommendation on correcting disability determinations. The actual correction of records and consequential entitlement determinations is the responsibility of the applicable Secretary and Accounting service. The applicant's request will of course remain with the application as it is processed. 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.

Lumbar Spine Condition. The CI’s injured his back and sacrum in a jumping exercise in 1994 and was treated conservatively. He was on jump status for five years and incurred repetitive re-injuries to his back such that, at the time of separation, he was experiencing daily pain and stiffness in the back which was limiting activities; and, also reported occasional pain and tingling of the left leg. The orthopedic addendum to the narrative summary (NARSUM) documented muscle spasm in the paraspinous muscles, a normal distal neurological examination to both lower extremities, and range-of-motion (ROM) as shown in the goniometric table below. The orthopedic surgeon opined that the CI “is not a surgical candidate at this time.” The pre-separation VA Compensation and Pension (C&P) examination noted daily pain with occasional radiation to the left foot, which was worse with lifting, running and physical training exercises. The VA examiner documented tenderness over the L3 to L5 vertebrae, paraspinous spasm, negative straight leg raise, and normal gait. Lumbar spine x-rays showed mild (< 50% loss of height) compression deformities at T11 and T12 and multiple osteophytes (indicative of degenerative spine disease).

There were two goniometric ROM evaluations in evidence, with documentation of all ratable criteria, which the Board weighed in arriving at its rating recommendation.

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| ROM – Thoracolumbar Spine | MEB (5 Mo. Pre-Sep) | VA C&P (1 Mo. Post-Sep) |
| Flexion (Normal 90⁰)  | 75⁰ | 80⁰ |
| Combined (Normal 240⁰) | Incomplete | 185⁰ |
| Comments | Spasm | Spasm; normal gait. |
| §4.71a Rating | 10% | 10% |

Both evaluations are consistent with a rating of 10% IAW VASRD §4.71a; although, only the VA evaluation is fully compliant with VASRD §4.46 (accurate measurement) given that a full set of combined measurements was not provided by the MEB. There was no documentation by either examiner of abnormal gait or spinal contour which would meet 20% criteria independently of ROM measurements. Although radicular symptoms were in evidence, and a sciatic peripheral nerve rating was conferred by the VA, the symptoms were confined to intermittent radiating pain and subjective paresthesias. 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. The pain component of a radiculopathy is subsumed under the general spine rating as specified in §4.71a. The sensory component in this case has no functional implications and there is no documentation of objective weakness. All evidence considered, there is not reasonable doubt in the CI’s favor supporting a change from the PEB’s adjudication of the lumbar spine condition.

Bilateral Ankle Condition. The CI’s ankle conditions were the result of recurrent ankle sprains while in the service. The orthopedic addendum noted that the CI had difficulty walking on uneven ground; and, had frequent sprains (right more so than left) requiring him to wear a tightly laced boot or shoe. The exam demonstrated an “extremely loose” right ankle with a 2+ anterior drawer and a 1+ lateral tilt, mild swelling, and decreased (3/5) peroneal strength. The left ankle demonstrated equivalent findings, except for insignificant instability. Ankle X-rays demonstrated bilateral degenerative changes. The orthopedist made diagnoses of bilateral ankle osteoarthritis and significant right ankle instability. The pre-separation VA C&P examination likewise noted increased pain with negotiating uneven terrain. Exam findings were tenderness over both lateral malleoli with no crepitance in either ankle; and, the diagnosis was bilateral ankle sprain, status post avulsion fracture of the right ankle. The ROM and exam findings from the Service and pre-separation VA evaluations are summarized in the chart below.

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| --- | --- | --- |
| ROM – L/R Ankle | MEB (5 Mo. Pre-Sep) | VA C&P (1 Mo. Post-Sep) |
| Right | Left | Right | Left |
| Dorsiflexion (Normal 20⁰) | 30⁰ | 30⁰ | 10⁰ | 10⁰ |
| Plantar Flexion (Normal 45⁰) | 30⁰ | 30⁰ | 45⁰ | 45⁰ |
| Comments | Instability  | No painful motion. | No painful motion or instability documented. |

The Board directs its attention to its rating recommendation(s) based on the evidence presented above. It is obvious that there is a clear disparity between the ROM examinations. At the time of the MEB there is normal *dorsiflexion*, and at the time of the VA C&P exam there is normal *plantar* *flexion*; and, there is no documentation of re-injury or other exacerbating event in the four month interval between these evaluations accounting for the conflicting ROM impairments in the opposite planes noted by the different examiners. Furthermore, there were no outpatient entries in the Service file for the 12-month period prior to separation for corroborating either set of findings. It was concluded that the more focused and comprehensive specialty examination provided in the MEB’s orthopedic addendum should be assigned the preponderance of probative value for purposes of the rating recommendation.

With the above evidence and probative value conclusion in mind, the Board directed its attention to its rating recommendation(s) for the ankle condition(s). The PEB combined the bilateral ankle pathology as a single unfitting condition, coded analogously to 5003 (supported by x-ray evidence for degenerative arthritis in both joints) and rated 10% for two major joints (appropriate to 5003). The FPEB’s DA Form 199 cited “full range of motion,” although plantar flexion was reduced by 33%; and, cited “slight instability,” although the description in the orthopedic addendum (elaborated above) challenges that characterization. The VA rated the right and left ankle conditions separately, coded analogously as 5299-5271 (ankle, limited motion), each rated at 10%. It must be noted that there is no VASRD defined ROM threshold for compensable loss of motion for the ankle. Code 5271 (the only ROM-based code for the ankle) cites 10% for ‘moderate’ and 20% for ‘marked’ limitation of motion. The VA obviously judged the 50% reduction in dorsiflexion (per the C&P measurements) to constitute ‘moderate’ limitation of motion; and, had no C&P evidence for the right ankle instability to consider. If the Board recommends the 5271 code, it must consider whether the 33% reduction in plantar flexion (via the probative MEB exam as previously established) constitutes a ‘moderate’ limitation of motion; or, if this degree of ROM impairment is slight or less significant, i.e., non-compensable, based on ROM’s.

The Board first considered the applicability of the PEB’s bilateral rating under 5003. While the radiographic findings demonstrated bilateral degenerative changes for both ankles, the Board concluded that that the unfitting disability in this case was clearly the ligamental pathology (especially the joint instability of the right ankle) and not degenerative arthritis. The Board next considered the VA’s approach of separate compensable ratings under 5271 for limitation of motion. It was agreed, however, that the modest ROM limitation evidenced in the more probative MEB orthopedic evaluation would constitute at most ‘slight’ (i.e., non-compensable) limitation of motion. All members ultimately agreed that the most reasonable approach to rating Service disability was separate ankle ratings which encompassed the right ligamental instability and bilateral modest ROM limitations constituting the functional impairment in evidence. The Board notes there is no precise §4.71a code for ankle instability; but, agreed with the action officer’s assessment that *analogous* coding under 5262 (tibia and fibula, impairment of), which encompasses contiguous knee or ankle ‘disability’, captures the right ankle instability in evidence. This yields a compensable 10% rating for the right ankle coded 5299-5262.

The Board next considered appropriate coding and rating for the left ankle. A consensus of members believed that the left ankle was not, in fact, independently unfitting; but, it was concurred that the PEB adjudication, as a VASRD-derived bilateral rating, imposed a separately unfitting Service determination in this case; and, by policy and firm precedent, the Board does not counter a Service fitness adjudication favorable to the member. Since the objective instability of the left ankle was insignificant, it was agreed that the 5299-5262 approach as elaborated for the right ankle could not be supported for the left ankle. A separate compensable rating under a 5003 based code, 5024 (tenosynovitis) in this case, was discussed and rejected on the same basis as that discussed above for not applying the PEB’s 5003 approach. It was thus concluded that the only appropriate code for rating the left ankle was analogously to 5271 (limitation of motion). As previously elaborated, it was agreed that the ROM impairment itself is not compensable. It was agreed that application of §4.59 (painful motion) was specifically excluded by both the MEB and VA examinations; and, further agreed that application of §4.40 (functional loss) could not be supported by the clinical histories in evidence (especially in light of the skepticism that there was unfitting impairment based solely on the left ankle as elaborated above). All members agreed, therefore, that there was inadequate support for any §4.71a pathway to a separately compensable Service disability rating for the left ankle. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a 10% Service disability rating for the right ankle condition, coded 5299-5262; and, a 0% Service disability rating for the left ankle condition, coded 5299-5271.

Migraine Headaches. The neurologic addendum to the NARSUM documented that the CI “since 1996, has had a continuous non-changing headache pattern;” and, continued with the following excerpts.

During service-member’s one visit to the Neurology Service on 29 September 2004, he noted a slightly less frequency recently ... notes previous significant MOS interference where he has actually had to leave work due to severe prostration one to two times per week. For his current headache pattern he uses Excedrin Migraine, which can fully resolve the headache if taken at onset. He notes six to seven recent Emergency Department visits.

It is difficult to reconcile a now-improved headache pattern, with the current degree of occupational interference as stated, with satisfactory completion of years of preceding active duty when the severity was continuously even worse. No rationale for this incongruity is provided in the neurologic addendum or elsewhere in the service treatment record (STR). Other than the one referenced MEB clinic visit (not itself in evidence), there is no evidence in the STR for a clinically active migraine condition or for outpatient management of a headache condition during the 12 months preceding separation. There are, in fact, only three entries in the STR documenting rescue treatment of migraine: two in 2002 and one in 2000. None of these are probative to the VASRD 4.124a defined rating interval. The CI’s profile did specifically direct that during a prostrating headache, he be allowed to rest or seek medical attention; so it could be speculated that the CI may not have sought medical care for treatment of his headaches, but rather exercised his profile option of resting only. It would be atypical however for a headache pattern of such severity, and associated with such frequent duty loss, to continue without medical consultation or supervision. The commander’s statement did not document either migraine headaches or work loss; noting only the physical MOS limitations inherent to the orthopedic conditions. The pre-separation VA C&P examination added no additional information.

Based on the above evidence, the Board directs its attention to a rating recommendation for the migraine headache condition. Migraine headaches are rated under code 8100 which hinges on the frequency of ‘prostrating’ attacks; and, it is incumbent on the Board to apply DoDI 6040.44-compliant and uniform criteria which would define a recurrent migraine episode as ‘prostrating’ and ratable. Under DoDI 6040.44, the Board is directed to: “use the VASRD in arriving at its recommendations, along with all applicable statutes, and any directives in effect at the time of the contested separation (to the extent they do not conflict with the VASRD in effect at the time of the contested separation).” Since the VASRD does not provide a definition of ‘prostrating’, it can be argued that the Board is directed to apply the DoDI 1332.39 definition (i.e., the Service member must stop what he is doing and seek medical attention). The Board, by precedence, has not required rigid proof of medical attention for each and every episode to characterize it as prostrating; but, does require reasonably convincing evidence that rated attacks force the abandonment of work (or current activity) to treat the migraine, although allowing for self-management under medical supervision. The Board carefully considered the historical and subjective data presented, but was ultimately confronted by the paucity of objective evidence or even corroborating subjective evidence that a reasonable threshold for supporting any prostrating attacks was met in this case. The lowest compensable rating under 8100 requires at least infrequent (one every two months) prostrating attacks. The Board concluded that, while the evidence supported frequent occurrence of headaches, it did not support the lowest compensable rating under 8100. This is the same conclusion reached by the PEB and the VA. All evidence considered, there is not reasonable doubt in the CI’s favor supporting a change from the PEB’s adjudication of the migraine headache condition.

Other PEB Conditions. The other conditions forwarded by the MEB and adjudicated as not unfitting by the PEB were coronary artery disease, hypertension, and hyperlipidemia. The Board’s main charge in respect to these conditions is an assessment of the appropriateness of the PEB’s fitness adjudications. 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 MEB was initiated because of the heart attack from coronary disease. The CI was treated appropriately and was stable on cardioprotective medications at the time of separation. Follow-up studies to include an electrocardiogram, graded exercise tolerance test (full Bruce protocol), and a transthoracic echocardiogram were normal and revealed no evidence of residual cardiac dysfunction. The CI was placed on a trial of duty as authorized by regulation; and, based on the above evidence, the formal PEB determined that the coronary artery condition was not itself unfitting at the time of separation. All Board members agreed with that conclusion.

The CI had been diagnosed with hypertension six years prior to separation and was started on medication. Normal blood pressures on the MEB physical and VA examinations validated that his blood pressure was in good control at the time of separation. The hyperlipidemia was stable on medication, and the condition in itself does not constitute a disability (as per the VA decision). None of these conditions were profiled, implicated in the commander’s statement or noted as failing retention standards. All were reviewed by the action officer and considered by the Board. There was no indication from the record that any of these conditions 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 any of the stated conditions.

Other Contended Conditions. The CI’s application asserts that a compensable rating should be considered for asthma. The CI first developed respiratory symptoms, attributed to reactive airway disease, in 1993. Pulmonary function tests (PFT) were reported as being borderline for obstructive airway disease. In 1996, the CI was precluded from specialized flight duty because of the borderline PFT; but, that evaluation showed no significant decrease in lung function with exercise. A repeat PFT, to include a methacholine challenge test, was completed in 2003 and reported as normal; and, a cardiopulmonary stress test later that same year was negative for exercise induced asthma. The CI’s Internist in Korea, who initiated the MEB, documented the extensive asthma workup noted above; and, concluded that there was “no evidence of chronic obstructive pulmonary disease.” All evidence considered, there is not reasonable doubt in the CI’s favor supporting addition of asthma as an unfitting condition for separation rating.

Remaining Conditions. Other conditions identified in the DES file were gastroesophageal reflux disease, umbilical hernia, bronchitis, and depression. Several additional non-acute conditions or medical complaints were also documented. None of these conditions were of clinical or occupational significance 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. 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. The Board did not surmise from the record or PEB ruling in this case that any prerogatives outside the VASRD were exercised. In the matter of the lumbar spine condition and IAW VASRD §4.71a, the Board unanimously recommends no change in the PEB adjudication. In the matter of the bilateral ankle condition the Board unanimously recommends that it be rated for two separate unfitting conditions as follows: chronic right ankle sprain with instability coded 5299-5262 and rated 10%, and chronic left ankle sprain coded 5299-5271 and rated 0%; both IAW VASRD §4.71a. In the matter of the migraine headache condition and IAW VASRD 4.124a, the Board unanimously recommends no change in the PEB adjudication. In the matter of the coronary artery disease, hypertension, and hyperlipidemia conditions, the Board unanimously recommends no change from the PEB adjudications as not unfitting. In the matter of the contended asthma condition, the Board unanimously agrees that it cannot recommend a finding of unfit for additional rating at separation. In the matter of the gastroesophageal reflux disease, umbilical hernia, bronchitis, and depression 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 recommends that the CI’s prior determination be modified as follows, effective as of the date of his prior medical separation:

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| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Chronic Low Back Pain | 5299-5237 | 10% |
| Chronic Right Ankle Sprain with Instability | 5299-5262 | 10% |
| Chronic Left Ankle Sprain | 5299-5271 | 0%  |
| Migraine Headaches | 8100 | 0% |
| **COMBINED** | **20%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20101103, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans' Affairs Treatment Record

SFMR-RB

MEMORANDUM FOR Commander, US Army Physical Disability Agency

Crystal Drive, Suite 300, Arlington, VA 22202

SUBJECT: Department of Defense Physical Disability Board of Review Recommendation

for (PD201001218)

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 description without modification of the combined rating or 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

CF:

( ) DoD PDBR

( ) DVA