RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: Army

CASE NUMBER: PD1001227 SEPARATION DATE: 20071121

BOARD DATE: 20120207

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SFC/E7 (31B, Military Police), medically separated for a low back condition and a shoulder condition. The CI’s back pain and shoulder pain started insidiously about five years and fifteen months prior to separation, respectively. Both conditions were treated conservatively with physical therapy, medication, and epidural steroid injections without extended relief of his symptoms; and surgery, at the time of the MEB, was not considered an option. He was unable to fully perform within his Military Occupational Specialty (MOS) or meet physical fitness standards. He was issued permanent P3, U3, and L3 profiles and underwent a Medical Evaluation Board (MEB). Low back pain with radiculopathy, right shoulder pain, asthma, and sleep apnea were forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501. Two other conditions, obesity and bee sting allergy, were forwarded on the MEB’s DA Form 3847 submission as medically acceptable conditions. These latter two conditions are not ratable conditions under Department of Defense (DoD) or Department of Veterans’ Affairs (DVA) regulations and will not be discussed further. Other conditions included in the Disability Evaluation System (DES) packet will be discussed below. The PEB adjudicated the chronic low back pain and chronic right shoulder pain conditions as unfitting, rated 10% and 0%, respectively; with likely and specified application of the US Army Physical Disability Agency (USAPDA) pain policy, respectively. The asthma and sleep apnea were determined to be not unfitting. The CI made no appeals and was medically separated with a 10% combined disability rating.

CI CONTENTION: The CI states: “The PEB only rated lumbar spine at 10% however, the other conditions that VARO rated was a major concern. I feel this PEB rating is unjust and unfair. Please see award letter date 3/14/2010. I were [sic] service connected for Sleep Apnea @50%, Right Shoulder @10%, and Asthma@ 10%. However, these chronic problems were annotated on Physical Evaluation Board Proceedings, however, was not given a rating. The statement for sleep apnea states that electricity for CPAP machine should be available in theater …. Please review my PEB and reconsider for TDRL.”

RATING COMPARISON:

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| **Service IPEB – Dated 20070907** | | | **VA (1 Mo. After Separation) – All Effective Date 20071122** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Chronic Low Back Pain | 5299-5243 | 10% | DDD Lumbar | 5237 | 10% | 20071217 |
| Chronic R Shoulder Pain | 5099-5003 | 0% | R Shoulder Tendonitis | 5299-5024 | 10% | 20071217 |
| Asthma | Not Unfitting | | Asthma | 6602 | 10% | 20071219 |
| Sleep Apnea | Not Unfitting | | Sleep Apnea | 6847 | 50% | 20071219 |
| Obesity | Not Unfitting | | No VA Entry | | | 20071219 |
| Bee Sting Allergy | Not Unfitting | | No VA Entry | | | 20071219 |
| ↓No Additional MEB/PEB Entries↓ | | | 0% x 0/Not Service Connected x 0 | | | 20071219 |
| **Combined: 10%** | | | **Combined: 60%** | | | |

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 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 DVA, operating under a different set of laws (Title 38, United States Code), is empowered to compensate all service connected conditions and to periodically reevaluate said conditions for the purpose of adjusting the Veteran’s disability rating should the degree of impairment vary over time.

The Board also notes that the CI in his contention requests that he be reconsidered for the Temporary Disability Retired List (TDRL). By law, the Board authority is limited to making recommendations on correcting disability determinations. TDRL is not authorized for disabilities rated under 30%. It was considered that the CI was actually requesting a medical retirement and/or rating of 30% or greater. The Board will review all evidence at hand to assess the fairness of PEB fitness and rating determinations, compared to the Veterans Administration Schedule for Rating Disabilities (VASRD) standards, based on severity at the time of separation.

Chronic Low Back Pain. There were two goniometric range-of-motion (ROM) evaluations in evidence, as shown in the chart below, which the Board weighed in arriving at its rating recommendation.

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| Goniometric ROM - Thoracolumbar | MEB ~ 5 Mo. Pre-Sep  (20070619) | VA C&P ~ 1 Mo. After-Sep  (20071219) |
| Flex (0-90⁰) | 55, 56 59 (55⁰) | 70⁰ |
| COMBINED (240⁰) | 175⁰ | 200⁰ |
| Comment | Tenderness, painful motion, +left SLR; motor and sensory normal; ROM limits due to pain, not mechanical limit; ROMs confirmed at ~ 3 Mo. Pre-Sep | Tenderness; -SLR; motor/sens/reflexes normal |
| §4.71a Rating | 20% (PEB 10%) | 10% |

Spine formulae note (4) applied to rounding

There was no consistent evidence in the record of gait or contour abnormalities, and there was no evidence for ankylosis or incapacitating episodes. There was no motor radiculopathy, and the sensory radicular pain was intermittent and principally on the left down the back of the leg. An imaging study showed disk bulges at L4-5 and L5-S1 causing neuroforaminal narrowing, right greater than left, and an annular tear at L5-S1. Evaluations included the pain management clinic and prior treatments included three epidural steroid injections, physical therapy, transcutaneous electrical nerve stimulation (TENS), and medication. The CI was determined to not be a candidate for surgery. It is obvious that there is a ROM disparity between the two charted examinations, with significant implications regarding the Board's rating recommendation. The Board thus carefully deliberated its probative value assignment to these conflicting evaluations, and carefully reviewed the service file (STR) and record for any additional corroborating evidence. There were no objective ROM determinations prior to separation to corroborate the MEB findings, but there were soft findings to both support and counter either exam. Orthopedic entries 11 months and eight months prior to separation describe ROM as being “slightly” decreased in all planes secondary to pain. Some STR notes regarding CI activities indicated normal sports activities which may imply mild ROM limits. An orthopedic note seven months prior to separation documented a “hunched over gait.” The orthopedic NARSUM done five months prior to separation documented that the CI was in “minimal to moderate distress throughout the exam” and charted complete ROMs with three repetitions of forward flexion not greater than 60 degrees (as above). The orthopedist indicated that the “soldier’s complaints are consistent with his physical exam and radiologic findings.” The PEB-requested orthopedic MEB addendum, 3 months prior to separation, indicated that the ROMs measured by physical therapy for the NARSUM had been retested in the orthopedic clinic and that ROM limits were due to pain versus mechanical limits, and the orthopedist did not indicate that any changes in the ROMs (charted above) were recommended. The Board deliberated on the probative values of the different ROM examinations looking at the records of evidence in their entirety, including the timing of the exams, level of examiner, completeness and detail of documentation. The Board majority determined that both exams had equivalent probative value.

The Board directs its attention to its rating recommendations based on the evidence just described. The PEB rated the condition using analogous VASRD code 5299-5243 (intervertebral disc syndrome) as 10% based on tenderness of the paraspinous muscles. The documented ROM of 59⁰ of forward flexion stated on the DA form 199 would have justified a 20% rating IAW VASRD §4.71a. The VA rated the condition using VASRD code 5237 (lumbosacral strain) as 10% based on spinal forward flexion of 70⁰ IAW with VASRD §4.71a. The Board determined that there was no evidence for ankylosis or incapacitating episodes which would have justified a rating higher than 20% under the general rating formula for diseases and injuries of the spine IAW VASRD §4.71a. There was also no evidence for a ratable, linked-to-fitness, peripheral nerve impairment in this case. The radicular component consisted primarily of pain, which is subsumed under the general spine rating. The Board also considered the degree of functional loss resulting from this condition as implied by the commander’s statement that the CI “can’t fire a weapon, do PT, or stand and instruct, his primary responsibility.” After due deliberation, considering all of the evidence, including the waxing and waning nature of the back pain, the history of treatment interventions, and the CI’s overall disability, and mindful of VASRD §4.3 (reasonable doubt), §4.7 (higher of two evaluations), and §4.40 (functional loss), the Board majority recommends a separation rating of 20% for the thoracolumbar spine condition.

Chronic Right Shoulder Pain. The record indicates the CI was right hand dominant. There were two goniometric RO) evaluations in evidence which the Board weighed in arriving at its rating recommendation. Both of these exams are summarized in the chart below.

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| Goniometric ROM – L/R Shoulder | MEB ~ 5 Mo. Pre-Sep  (20070619) | VA C&P ~ 1 Mo. After-Sep  (20071219) |
| Flexion (0-180) | 129, 134. 135⁰ | 160⁰ |
| Abduction (0-180) | 121, 126, 124⁰ | 150⁰ |
| Comment | Painful motion | Painful motion with effort |
| §4.71a Rating | 10%\* (PEB 0%) | 10%\* |

\*Conceding painful motion

Both exams indicated painful motion of the shoulder and ROM well past the 90⁰ abduction or forward flexion level. There was no indication of instability, subluxation, weakness or dislocations. Imaging was normal. Although the PEB disability description indicated abduction limited by pain to 26⁰, the source ROMs (charted above) was used for rating and indicated a PEB typographic error for 126⁰. As to the rating recommendation, the VA rated the condition using analogous VASRD code 5299-5024 (Tenosynovitis) at 10% based on painful or limited motion of a major joint IAW with VASRD §4.71a. The PEB rated the condition using analogous VASRD code 5099-5003 (degenerative arthritis) at 0%, “rated for pain, moderate/intermittent” indicative of the USAPDA pain policy. Based on the evidence at separation of non-compensable ROM impairment and painful motion, the Board determined that a minimum compensable rating of 10% for the shoulder condition is justified IAW VASRD §4.71a and with application of VASRD §4.59 (painful motion). There was no clinical and/or radiologic evidence in the examinations done proximate to separation that suggested ankylosis, loss of the humeral head, nonunion, malunion, fibrous union, deformity, nonunion or dislocation of the scapula, or recurrent dislocations of the humerus that would have justified any code with higher rating potential. Ideal coding would be analogous to 5024 (tenosynovitis) as there was no bony abnormalities of the shoulder. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a separation rating of 10% for the chronic right shoulder pain condition, coded as 5299-5024.

Other PEB Conditions. The other potentially ratable conditions forwarded by the MEB and adjudicated as not unfitting by the PEB were asthma and obstructive sleep apnea (OSA). 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 asthma and the OSA were first identified in December 2006 (11 months prior to separation) when the CI’s wife witnessed him having an apnea episode and his examiner noted that the CI was wheezing. As a result, the CI underwent a sleep study in January 2007 and was diagnosed with OSA and subsequently was started on a continuous positive airway pressure (CPAP) device in February 2007. The CI reported significant improvement on his CPAP, indicating that he only awakened a couple times a month related to an apneic episode. The MEB examiner opined that the condition failed to meet retention standards because the use of CPAP interfered with deployment to austere environments where electricity was not available. Routinely, however, OSA is not considered unfitting solely on the basis of field and operational impediments to the use of CPAP. There is no evidence in this case that OSA was associated with any unfitting impairments not corrected by CPAP. The PEB’s fitness adjudication was therefore expected and reasonable. All evidence considered, there is not reasonable doubt in the CI’s favor supporting recharacterization of the PEB fitness adjudication for OSA.

As relates to the asthma, the CI underwent pulmonary fuction testing in January 2001 and was shown to have a minimal obstructive lung defect with mild response to bronchodilator treatments. He was initially started on an as needed inhalational bronchodilator medication (Albuterol); but, within a month, was started on a twice a day inhalational anti-inflammatory medication (Advair). His primary complaint was shortness of breath with exertion such that he had to premedicate with Albuterol prior to physical exercise. His symptoms were intermittent such that he could be awakened twice weekly with shortness of breath or coughing, but he could go with no symptoms for several weeks. The CI, on one documented asthma questionnaire in the evidence of record, rated his athma such that it was considered “well controlled.” The NARSUM documented that the CI had not required the use of any oral steroids to treat his condition and that he had had only one emergency room visit for his asthma. His medications at the time of the NARSUM were Albuterol and Advair which was validated by the medication profiles included in his records of evidence. The asthma was added to the permanent profile at the time of the NARSUM, but was not implicated in the commander’s statement. There was nothing in the profile limitations that was specifically related to the asthma; however, the NARSUM examiner did document a subjective impact on both activities of daily living as well as activities of his primary MOS. The NARSUM examiner opined that the asthma condition failed to meet retention standards because it interfered with satisfactory performance of duty and results in inability to meet the standard for the timed two mile run despite medications. However, the PEB determined that the condition did not prevent the CI from performing his MOS duties and that he could wear a protective mask.

The Board deliberated the fitness of this condition. Since there was nothing documenting any functional impairment from the asthma in the service treatment record for the five months after the date of the NARSUM, since the commander’s statement did not implicate asthma as a limiting condition, and since encounters in the VA treatment record within the first four months post separation indicated that the condition was in good control, the Board determined that the asthma condition did not significantly interfere with satisfactory duty performance. All evidence considered, there is not a preponderance of evidence in the CI’s favor supporting recharacterization of the PEB fitness adjudication for any of the stated conditions.

Remaining Conditions. One other condition, high frequency hearing loss in the left ear, was identified in the DES file. This condition was not of clinical or occupational significance during the MEB period, carried no attached profiles, 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. No other conditions were service connected with a compensable rating by the VA within 12 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 the back and shoulder conditions was operant in this case and the condition was adjudicated independently of that policy by the Board. In the matter of the chronic low back pain condition, the Board by a 2:1 vote recommends a rating of 20%, coded 5299-5243 IAW VASRD §4.71a. The single voter for dissent (who recommended application of the same code, rated 10%) did not elect to submit a minority opinion. In the matter of the chronic right shoulder pain condition, the Board unanimously recommends a rating of 10% coded 5299-5024 IAW VASRD §4.71a. In the matter of the asthma and the OSA conditions, the Board unanimously recommends no change from the PEB adjudications as not unfitting. In the matter of the high frequency hearing loss 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 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** |
| Chronic Low Back Pain | 5299-5243 | 20% |
| Chronic Right Shoulder Pain | 5299-5024 | 10% |
| **COMBINED** | **30%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20101119, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans Affairs Treatment Record

President

Physical Disability Board of Review

SFMR-RB

MEMORANDUM FOR Commander, US Army Physical Disability Agency

SUBJECT: Department of Defense Physical Disability Board of Review Recommendation

1. Under the authority of Title 10, United States Code, section 1554(a), I approve the enclosed recommendation of the Department of Defense Physical Disability Board of Review (DoD PDBR) pertaining to the individual named in the subject line above to recharacterize the individual’s separation as a permanent disability retirement with the combined disability rating of 30% effective the date of the individual’s original medical separation for disability with severance pay.

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:

a. Providing a correction to the individual’s separation document showing that the individual was separated by reason of permanent disability retirement effective the date of the original medical separation for disability with severance pay.

b. Providing orders showing that the individual was retired with permanent disability effective the date of the original medical separation for disability with severance pay.

c. Adjusting pay and allowances accordingly. Pay and allowance adjustment will account for recoupment of severance pay, and payment of permanent retired pay at 30% effective the date of the original medical separation for disability with severance pay.

d. Affording the individual the opportunity to elect Survivor Benefit Plan (SBP) and medical TRICARE retiree options.

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

Deputy Assistant Secretary

(Army Review Boards)