RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: army

CASE NUMBER: PD110008 SEPARATION DATE: 20090529

BOARD DATE: 20120301

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SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty Army Soldier; E4/SPC (25B, Signal Corps) medically separated for degenerative arthritis, lumbar spine with bilateral L6 (sic) pars interarticularis defects. This was the CI’s second medical separation for his back condition. The CI was given a waiver for reenlistment, but then reinjured his back during simulated combat training. He did not respond adequately to treatment and was unable to perform within his Military Occupational Specialty (MOS) or meet physical fitness standards. He was issued a permanent L3 profile and underwent a Medical Evaluation Board (MEB). Chronic low back pain, secondary to bilateral L5 pars interatricularis defect and disc bulges at L4-S1 with electrodiagnostic evidence of right lumbar radiculitis, was forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501, chapter 3, paragraph 3-39. Five other conditions, as identified in the rating chart below, were forwarded on the MEB submission as medically acceptable conditions along with one other, alcohol dependence, identified as not ratable. Other conditions included in the Disability Evaluation System (DES) packet will be discussed below. The PEB adjudicated the degenerative arthritis, lumbar spine with bilateral L6 (sic) pars interarticularis defects as unfitting, rated 10%, with application of the Veterans’ Administration Schedule for Rating Disabilities (VASRD). It also adjudicated four conditions as not unfitting and meeting medical retention standards as well as two as not ratable, as charted below. The CI made no appeals, and was medically separated with a 10% disability rating.

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CI CONTENTION: The CI states: “Request that Transient Alteration of awareness (Seizure Disorder) be rated as TBI; unfitting with the appropriate rating percentage. Request that the diagnosis of Anxiety Disorder and Insomnia be correctly rated as PTSD; unfitting with the appropriate rating percentage. Request that IBS be rated nexus to PTSD; unfitting and appropriately rated. Request the right lumbar radiculitis be rated as unfitting with the appropriate rating percentage.”

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RATING COMPARISON:

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| --- | --- | --- | --- | --- | --- | --- |
| **Service IPEB – Dated 20090127** | | | **VA (1 & 3 Mo. After Separation) – All Effective 20090530** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Lumbar Degenerative Arthritis, w/Bil pars interarticularis Defects. | 5242 | 10% | Lumbar Strain w/Radiculopathy | 5237 | 10% | 20090722 |
| Transient Alteration of Awareness | Not Unfitting | | Seizure Disorder | Not Service Connected | | |
| Anxiety Disorder | PTSD\* | 9411 | 50% | 20100125 |
| Insomnia |
| Specified Sedative/Hypnotic/  Anxiolytic Abuse | Not Ratable | |
| Alcohol Dependence |
| IBS | Not Unfitting | | IBS | 7319 | 30% | 20090630 |
| ↓No Additional MEB/PEB Entries↓ | | | Cervical Strain /Radiculopathy | 5237 | 20% | 20090722 |
| TBI w/Post-Traumatic Migraine | 8045 | 10% | 20090825 |
| Tinnitus\*\* | 6260 | 10%; | 20100115 |
| 0% x 0/Not Service Connected x 8 | | | 20090630 |
| **Combined: 10%** | | | **Combined: 80%\*\*\*** | | | |

\*Initially rated 30% as cyclothymic disorder, anxiety disorder and depression, coded 9431, with Cyclothymic Disorder, 9431, as Active Psychosis, SC for Treatment Only; \*\*Initially, NSC; \*\*\*Initial combined rating 70%. All changes retroactive to separation.

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ANALYSIS SUMMARY: The 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. 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 for military service 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 the 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 notes that the presence of a diagnosis, in and of itself, is not sufficient to render a condition unfitting and ratable. 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. Furthermore, a “crystal ball” requirement is not imposed on the service PEB’s by the Board and the 12-month window specified in DoDI 6040.44 is appropriate for rating comparisons but not for new developments after separation. The Board notes that some of the conditions adjudicated as service-connected and rated for disability by the VA, had their onset in the first enlistment. The CI was allowed to re-enlist after he was medically separated for back pain despite the history of these issues. This is considered by the Board to be prima facie evidence that the conditions were “not unfitting at re-enlistment; rather, these conditions met both accession and retention standards at the time of re-enlistment. Therefore, for an unfitting adjudication, evidence of service-aggravation and deterioration during the second enlistment must be present.

Unfitting Conditions: Lumbar degenerative arthritis with L5 pars interarticularis defect. The CI was previously medically separated from military service for low back pain on 5 January 2007. The initial injury was from squats and later aggravated by weight lifting and a road march (the Board notes that later in the record, it states that he injured himself in 2004 while deployed during a fall while on patrol, from carrying a fuel jug, following an RPG attack, or striking his back against the stryker rail when the driver accelerating during an attack). An MRI in 2006 showed a L4-5 herniated disc propulsus (HNP) with L5 nerve root impingement. He failed conservative management including epidural steroid injections (ESI) and chronic narcotic medications. He was determined not to be a good surgical candidate and separated with 10% disability 5 January 2007. In July 2007, the CI applied for reenlistment. At the time of his enlistment medical examination, July 2007, he reported he had experienced no back pain for 6 months. Examination by an orthopedic surgeon recorded CI report of no pain, and demonstrated full range-of-motion (ROM) on examination. Based on the orthopedic examination, the CI was granted a waiver for reenlistment and re-entered active duty on 6 September 2007. Six days later, on 13 September 2007, the CI presented to clinic with complaint of chronic low back pain for three years; he was prescribed Percocet (Oxycodone) and referred to physical medicine. It was recommended that he not perform sit-ups. A repeat MRI on 11 December 2007 revealed a bulge of the L4-5 disc with bilateral neural forminal narrowing, but without cord compression. No comment on nerve root compression was made. Pain continued despite further conservative treatment including facet injections and narcotics. A CT scan, 4 February 2008, demonstrated disc bulges at L4-5 and L5-S1 without significant canal stenosis. The spinal nerve roots were surrounded by fat in the neuroforamina indicating absence of compression by the bulging inter-vertebral discs. The CT scan also showed an L5 pars interarticularis defect without significant listhesis of L5 on S1. Clinically, this latter finding was concluded to be congenital by the orthopedic spine surgeon. An electromyogram/nerve conduction velocity (EMG/NCV) study was positive for a right lumbar radiculitis. There were two goniometric ROM evaluations in evidence, with documentation of additional ratable criteria, which the Board weighed in arriving at its rating recommendation.

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| Goniometric ROM - Thoracolumbar | MEB ~ 8 Mo. Pre-Sep | VA C&P ~ 2 Mo. After-Sep |
| Flex (0-90) | 90⁰ | 90⁰ |
| Ext (0-30) | 30⁰ (pain @28) | 10⁰ |
| R Lat Flex (0-30) | 30⁰ (pain @ 30) | 30⁰ |
| L Lat Flex 0-30) | 30⁰ (pain @ 26) | 30⁰ |
| R Rotation (0-30) | 30⁰ (pain @30) | 30⁰ |
| L Rotation (0-30) | 30⁰ (pain@38) | 30⁰ |
| COMBINED (240) | 240⁰ | 220⁰ |
| Comment | 1. ROM limited by pain  2. Muscle Spasm | Numbness of right and left great toe and heel. |
| §4.71a Rating | 10% (§4.59) | 10% |

The MEB narrative summary, dictated 15 January 2009, was based on an exam dated 28 September 2008, eight months prior to separation. The narrative summary (NARSUM) examiner noted there CI had not been pain free for four ½ years. Deep tendon reflexes (DTR) sensory and the motor exams were normal and no atrophy noted. Spasm of the parathoracic muscles was noted, but the spine had normal contour. Gait and station were normal. Straight leg raise (SLR) was positive at 60 degrees on the right and 45 on the left. The VA C&P exam was two months after separation. It noted that his back pain started after a RPG explosion (2004) and that he also had neck pain. The CI also complained of numbness of the right and left great toes. Deep tendon reflexes were absent in the lower extremities, but motor strength normal. The PEB and VA both rated the back condition at 10% disability, but coded it differently. The VA utilized code 5237 for lumbosacral or cervical strain whereas the PEB coded the back as 5242, degenerative arthritis of the spine. The Board notes that the exams support no more that the 10% awarded under these two codes. The Board also considered coding under 5243 for intervertebral disc syndrome utilizing incapacitation. At the time of the MEB NARSUM examination the CI reported flare ups every other month requiring bed rest for two to three days. Physical medicine and rehabilitation treatment records repeatedly document report of intermittent radicular pain in the L5 distribution lasting two hours that occurred once every other month. Service treatment record (STR) show that the CI was placed on quarters for 24 hours twice in the two years prior to separation which would rate at 0% disability offering no advantage to the CI. All evidence considered, there is not reasonable doubt in the CI’s favor supporting re-characterization of the PEB fitness adjudication for the back condition.

Anxiety Disorder / Contended PTSD. The CI first sought care in the mental health clinic (MHC) in February 2006 for insomnia during his first enlistment. It was noted that there were domestic issues related to the poor health of his wife and that he was in the MEB process. He was diagnosed with anxiety disorder not otherwise specified (NOS) and also with a phase of life problem. He did have an exacerbation of symptoms following the deaths of two service members he knew in Iraq and also a “flashback.” He was started on an anti-depressant with improvement in his symptoms. At no point were duty limitations levied nor is there a record of any profile other than an S1. On the exit history from his first enlistment, he noted panic attacks and worry which were attributed to his pending transition to civilian life. After discharge, the CI sought and obtained a waiver to re-enlist reporting his back pain had resolved. On his re-enlistment medical pre-screen, he denied any periods of unconsciousness, head injury or headache. These and other mental health issues were also denied on the medical history. On the DD Form 2807, completed by the CI on 26 July 2007, the CI checked “no” in response to questions 17a., d, e. f. g, regarding a history of nervous trouble of any sort (anxiety or panic attacks), frequent trouble sleeping, received counseling of any type, depression or excessive worry, been evaluated or treated for a mental condition. Shortly after his return to active duty, he again developed chronic pain, insomnia, and anxiety disorder and was also noted to have a cyclothymic disorder. He was released without limitations at each visit, though. However, 30 July 2008, one year prior to separation, he was transferred to a VA hospital for psychiatric care following a two week admission to a different institution. The CI stated that he had been “huffing” Endust and that he had PTSD with flashbacks to Iraq. He was noted to be an “extremely inconsistent historian” and to exhibit medication seeking behavior (opioids and benzodiazepines). While admitted, he became intoxicated during an unauthorized absence. At discharge he was thought to have an adjustment disorder with depressed mood and a custer B personality. Rule out diagnoses (diagnostic considerations not established) included PTSD, malingering, and an anti-social or borderline personality. A follow on psychiatric exam 13 August 2008 was significant for a diagnosis of anxiety disorder NOS, substance abuse and a recommendation for administrative separation for unsuitability under Chapter 5, AR 635-200 (personality disorder). Two days later, a psychiatric evaluation by a different physician noted that the CI “tended to minimize his responsibility,” that the CI stated that he “had not slept in four days” yet noted that the CI had a normal mental status exam (MSE); this was inconsistent with the history of sleep deprivation. He was diagnosed with alcohol and psychoactive substance dependence. Neither evaluator imposed duty limitations. At the MEB narrative summary dictated 15 January 2009, three and a half months prior to separation, the only mental health diagnosis is anxiety disorder which was determined to be medically acceptable by the MEB and to be not unfitting by the PEB. His profile was S1, which it remained consistently during the first and second enlistments. The undated commander’s letter does not note duty limitations secondary to mental health issues. There is no record of further care specifically for mental health issues prior to separation or after separation until 18 October 2010, over 16 months after separation. However, that visit does note that he had been in ongoing care since separation and that an additional diagnosis of bipolar disorder was made. He stated that he had no legal history prior to the military, but the CI states elsewhere in the record that he did have legal issues while in high school. A VA Compensation and Pension (C&P) examination was performed 25 January 2010, eight months after separation and nine months prior to the above visit. The history provided to this examiner notes that he had been wounded in combat and had loss of consciousness (LOC). The CI was deployed to Iraq November 2003 to November 2004 during his first enlistment however there is no service record of being wounded in combat. As noted above, this is in contrast to the history the CI reported on the separation examination in May 2006, the re-enlistment pre-screen history and DD Form 2807-2, and enlistment examination DD Form 2807-1 in July 2007. In fact, there is neither contemporaneous record of combat injury nor award of a Purple Heart. He also noted two prior suicide attempts, although in contemporaneous records of the one documented overdose, from “huffing,” he denied suicidal ideation and the concern of malingering was raised. The Board also noted that he denied a family history of psychiatric issues, although elsewhere he stated that both parents had psychiatric illnesses. A MSE was remarkable only for a depressed mood and dysphoric affect. He was otherwise noted to be coherent, organized, relevant, non-delusional, without suicidal or homicidal ideation, without auditory or visual hallucinations, normal speech, to be alert and oriented, memory and concentration were normal, and insight and judgment intact. A Global Assessment of Function (GAF) of 55 was assigned; this is indicative of moderate symptoms or difficulty in social and occupational functioning. The Board considered both the GAF and the fact that the VA awarded a disability rating of 50% based on symptoms and history reported by the CI at the time of this examination, eight months after separation. The Board noted that the history provided was not supported by the record; rather, it is frequently contradicted by the record. It also noted that the CI retained a S1 profile throughout his military career (both enlistments) and that the MSE was relatively unremarkable. The Board also noted the question of malingering raised at the hospital admission for huffing and the annotation of an “extremely inconsistent” history during that admission. While the diagnosis of PTSD was raised as a possibility while on active duty and possibly made during his psychiatric admission at the civilian hospital prior to transfer to the VA (but this cannot be substantiated), the diagnosis was not formally made until after separation and was based on reported history which is not supported by the evidence of service records. The MEB determined that his anxiety was medically acceptable and the PEB determined it to be not unfitting. The commander did not cite duty impairment from a mental health condition. All evidence considered, there is not reasonable doubt in the CI’s favor supporting re-characterization of the PEB fitness adjudication of not unfitting for anxiety (PTSD) to a separately unfitting condition at the time of separation.

Other PEB Conditions. The other conditions forwarded by the MEB and adjudicated as not unfitting by the PEB were transient alteration of awareness, anxiety disorder, insomnia, and irritable bowel syndrome (IBS). Alcohol dependence and specified sedative/hypnotic/anxiolytic abuse were conditions not constituting physical disabilities IAW DoDI 1332.38 (E5.1.2.9.1). Anxiety disorder and insomnia were discussed above under PTSD. The Board noted the MEB comment that the transient alterations of consciousness were most likely secondary to anxiety and/or medication/substance effects. Review of the record supports this conclusion. The Board also noted that this was also attributed to insomnia by some examiners and that the VA determined this condition, under a discussion of possible seizure disorder, to be not service-connected as there was no clinical diagnosis. Although the MEB determined the IBS to be medically acceptable, the record does not show that there were any visits for this condition although the CI was seen for gastroenteritis and a viral syndrome. 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 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 also asserts that compensable ratings should be considered for right lumbar radiculitis. The PEB specifically noted that this was not unfitting. 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. No motor impairment was in evidence. Since no evidence of functional impairment exists in this case, the Board cannot support a recommendation for additional rating based on peripheral nerve impairment. He also requested that the transient alteration of awareness be rated as TBI and that the anxiety, insomnia and IBS be considered as PTSD. These conditions have already been considered by the Board. The Board again notes that there was no record of duty impairment from any condition other than the back pain in the commander’s assessment. The CI was placed on a profile for the back pain. He was also put on a profile limiting weapons access while under evaluation for the transient alteration of awareness during evaluation for a seizure disorder. The Board notes that this diagnosis of a seizure disorder was not confirmed and also notes the documented substance abuse. All of 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 viral hepatitis, gastrointestinal ulcers, coughing up blood, breathing trouble, blurred vision, right elbow and wrist pain, numbness in hands, blood while using bathroom, memory loss, and nausea. Several additional non-acute conditions or medical complaints were also documented. None of these conditions were clinically 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, cervical musculo-ligamentous strain with radiculopathy, TBI with posttraumatic migraine headaches and several other non-acute conditions 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. The Board specifically notes that at the time of the separation examination DD Form 2807-1 (undated) but examiner dated 4 May 2006, the CI checked “no” to question 15.c. and 15.g. regarding history of head injury, memory loss or amnesia, a period of unconsciousness or concussion. On the medical pre-screen of medical history report, DD Form 2807-2, completed by the CI on 25 July 2007, the CI checked “no” in response to questions 2.a.(10), 2.a.(14) regarding having had periods of unconsciousness, head injury resulting in skull fracture, concussion, loss of consciousness, headaches, etc. On the report of medical history, DD Form 2807-1, completed by the CI on 26 July 2007, the CI checked “no” to question 15.c. and 15.g. regarding history of head injury, memory loss or amnesia, a period of unconsciousness or concussion. The CI report to the VA of TBI while deployed is not supported by the record or the CI’s prior history on multiple documents. The Board therefore has no reasonable basis for recommending any additional unfitting conditions for separation rating.

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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 back condition, the Board recommends no re-characterization of the PEB adjudication. In the matter of the transient alteration of awareness, anxiety disorder, insomnia, and an irritable bowel syndrome (IBS), the Board unanimously recommends no change from the PEB adjudications as not unfitting. In the matter of the alcohol dependence and specified sedative, hypnotic, anxiolytic abuse, the Board recommends no change in the PEB adjudication as not unfitting (and IAW DoDI 1332.38). In the matter of the viral hepatitis, gastrointestinal ulcers, coughing up blood, breathing trouble, blurred vision, right elbow and wrist pain, numbness in hands, blood while using bathroom, memory loss, and nausea or any other condition 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** |
| Degenerative Arthritis of The Spine | 5242 | 10% |
| **COMBINED** | **10%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20101207 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 for

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 and hereby deny the individual’s application.

This decision is final. The individual concerned, counsel (if any), and any Members of Congress who have shown interest in this application have been notified of this decision by mail.

BY ORDER OF THE SECRETARY OF THE ARMY:

Encl

Deputy Assistant Secretary

(Army Review Boards)