RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXXXX BRANCH OF SERVICE: Army

CASE NUMBER: PD1100042 SEPARATION DATE: 20090614

BOARD DATE: 20120123

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was a Reserve SSG/E-6 (91K, Medical Laboratory Specialist), medically separated for chronic low back pain (LBP) secondary to degenerative disc disease (DDD) and left sided herniation. The CI had a long history of LBP (since at least the early 1990’s) with no traumatic history. His pain radiated to his left thigh. Magnetic resonance imaging (MRI) revealed DDD at L5-S1 with herniation and nerve root impingement. His treatment included rest, activity modification, epidural steroid injections, radiofrequency ablation, chiropractic care, and pain management including narcotic medications. 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 P3/U3/L3 profile and underwent a Medical Evaluation Board (MEB). Chronic low back pain, bilateral cubital tunnel syndrome (arm neuropathy), and obstructive sleep apnea (OSA) were forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501. No other conditions appeared on the MEB’s submission. Other conditions included in the Disability Evaluation System (DES) file are discussed below. The PEB adjudicated the LBP condition as unfitting, rated 10%, with likely application of the United States Army Physical Disability Agency (USAPDA) pain policy and Veterans’ Administration Schedule for Rating Disabilities (VASRD). The CI appealed for a Formal PEB (FPEB) which reaffirmed the PEB determinations. He was granted Continuation on Active Reserve Duty in order to achieve his 20-year retirement. The CI elected to transfer to the Retired Reserve awaiting pay at age 60 in lieu of disability separation with severance pay, with a separation date of 14 June 2009.

CI CONTENTION: “The formal PEB and subsequent appeal did not properly include all disqualifying conditions. Furthermore, the disqualifying condition I was boarded on was not properly rated.”

RATING COMPARISON:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Service FPEB – Dated 20061214** | | | **VA (19 Mo. Pre-Separation) – All Effective Date 20081007** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Chronic LBP Secondary to DDD & L Sided Herniation | 5243 | 10% | DDD, L5-S1 w/ Radicular Nerve Pain | 5003-5237 | 20%\* | 20071127 |
| Bilateral Cubital Tunnel Syndrome | Not Unfitting | | R Ulnar Neuropathy | 8515 | 10% | 20071127 |
| L Ulnar Neuropathy | 8515 | 10% | 20071127 |
| Obstructive Sleep Apnea | Not Unfitting | | Obstructive Sleep Apnea | 6847 | 50% | 20071206 |
| ↓No Additional MEB/PEB Entries↓ | | | Depression | 9434 | 30% | 20071127 |
| Cervical Spine DDD | 5237 | 10% | 20071127 |
| GERD | 7346 | 10% | 20071127 |
| L Knee Chondromalacia | 5299-5019 | 10% | 20081010 |
| 0% x 4/Not Service Connected x 5 | | | 20071127 |
| **Combined: 10%** | | | **Combined: 80%\*** | | | |

\*LBP 5003-5237 rated 10% from 20031008 to 20041129; temporary increase to 100% 20070719-20070901, then to 20% effective 20081007 (combined 80%)

ANALYSIS SUMMARY: The Board acknowledges the CI’s contention for Service ratings for other conditions documented at the time of separation. The Board wishes to clarify that the mere presence of a diagnosis, in and of itself, is not sufficient to render a condition unfitting and ratable. 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 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.

There was a significant difference in the CI’s condition at the time of FPEB adjudication (14 December 2006) and the final date of separation of 14 June 2009 (30 months later). IAW DoDI 6040.44, the Board adjudicated the case based on the CI’s condition at the date of final separation (14 June 2009).

Low Back Pain. There were three post-operative thoracolumbar spine evaluations proximate to separation, including three goniometric range of motion (ROM) evaluations, in evidence which the Board weighed in arriving at its rating recommendation. These exams are summarized in the chart below. The bold vertical line in the chart indicates the time of surgery.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Goniometric ROM - Thoracolumbar | MEB (H&P) ~ 35 Mo. Pre-Sep | MEB (PT) ~ 35 Mo. Pre-Sep | NARSUM ~ 33 Mo. Pre-Sep | VA C&P ~ 19 Mo. Pre-Sep | VA Primary Care ~ 19 Mo. Pre-Sep | VA C&P ~ 8 Mo. Pre-Sep |
| Flex (0-90) | “ROM limited – decreased flexion, extension, rotation, and lateral flexion” | (15,15,15) 15⁰ | No ROMs reported | 80⁰ | 50⁰ | (59) 60⁰ |
| Ext (0-30) | (15,10,10) 10⁰ | 20⁰ | 15⁰ | 15⁰ |
| R Lat Flex (0-30) | (15,15,10) 15⁰ | 30⁰ | 15⁰ | 30⁰ |
| L Lat Flex 0-30) | (10,10,10) 10⁰ | 30⁰ | 15⁰ | 30⁰ |
| R Rotation (0-30) | (20,20,20) 20⁰ | 30⁰ | 15⁰ | 30⁰ |
| L Rotation (0-30) | (20,25,20) 20⁰ | 30⁰ | 15⁰ | 30⁰ |
| COMBINED (240) | 90⁰ | 220⁰ | 135⁰ | 195⁰ |
| Comment:  **Surgery after FPEB; at ~ 23 Mo. Pre-Sep** | Pain elicited by ROM, TTP, gait antalgic (uses cane), neg SLR, sensory deficit L thigh, motor 5/5, reflexes - L knee 3+, others 2+ | CI “reports all motion is painful” | TTP, rises stiffly from chair, requires cane for balance, give way weakness LLE, neg SLR, no spasm, motor 5/5, sensory intact, DTRs normal; 3/5 Waddell’s | Antalgic gait, Increase in pain from start to finish all ROMs, TTP, no spasm or guarding, no further limitation after 3 reps, posture normal; (incapacitation x 30 days after surgery); neuro normal | Mild reversal of lumbar lordosis, increased tone, TTP, scar, neg SLR bilat (90⁰), neuro normal (MMT>4/5 UE & LE), able to walk on heels & toes | TTP, “increased pain with all movements,” antalgic gait, one cane for ambulatory aid, normal curvature, neg SLR bilat, no additional loss with 3 repetitions, neuro normal |
| §4.71a Rating | ≥20% | 40% | ≥20%  (PEB 10%) | 10%-20%  (VA 10%) | 20% | 20%  (VA 20%) |

The MEB physical exam, 35 months pre-separation, noted reduced ROM in all planes, but did not quantify. The examiner also noted painful motion, tenderness, antalgic gait (using cane), decreased sensation to light touch of the left anterior and lateral thigh, and mild hyper-reflexia of the left knee. Straight leg raise was negative, and motor evaluation was normal. The physical therapy (PT) evaluation accompanying the MEB, also 35 months pre-separation, was a ROM-only exam, and reported significantly reduced (and painful) ROMs meeting the 40% criteria IAW the General Rating Formula for Diseases and Injuries of the Spine, VASRD §4.71a. The narrative summary (NARSUM), 33 months pre-separation, did not report ROMs, but noted tenderness to palpation, the CI required a cane “for balance,” and rose “quite stiffly from the chair.” Muscle spasm was notably absent, straight leg raise was negative, and neurological evaluation was normal, including motor strength (5/5), although the examiner noted “give way weakness” in the left lower extremity, presumably due to pain. The examiner also reported the presence of three of five Waddell signs. MRIrevealed DDD at L5-S1 with herniation to the left, indenting the left S1 nerve root.

The VA Compensation and Pension (C&P) exam, 19 months pre-separation, reported the CI underwent surgery at 23 months pre-separation, with a microdiskectomy and partial laminectomy. The examiner reported mildly reduced ROMs (meeting the 10% criteria), painful motion, tenderness, and antalgic gait, but he specifically noted absence of spasm, guarding, and abnormal posture. Neurological evaluation was normal. The examiner noted no additional limitation after three repetitions. The CI reported 30 days of incapacitation following the surgery*;* this was considered in the VA §4.30 (convalescent rating) 100% rating from 19 July 2007 to – 1 September 2007. There was no indication of physician prescribed bed rest meeting the 5243 provisions for incapacitating episodes outside of the post-surgical period.

A VA primary care note the same day as the 19-month pre-separation VA exam, reported ROM deficits meeting the 20% criteria, mild reversal of lumbar lordosis, increased muscle tone, tenderness, and an old well-healed lumbar scar. Negative findings included normal neurological evaluation (although motor testing was not detailed, reporting “>4/5 throughout upper and lower extremities,” negative straight leg raises bilaterally (to 90⁰), and ability to walk on heels and toes.

A second VA C&P exam, eight months pre-separation, reported reduced forward flexion (meeting the 20% criteria), tenderness, “increased pain with all movements,” and an antalgic gait with use of a cane to assist ambulation. Negative findings included normal curvature; negative straight leg raises bilaterally; normal neurological evaluation; and no additional loss with repetitions. Post-operative VA outpatient notes indicate the CI had persistent pain following his surgery, and was diagnosed with post-laminectomy syndrome (failed back syndrome) 14 months pre-separation, requiring narcotic medications which provided minimal relief. He continued to use a cane or crutches due to pain, had a slight limp, and had a normal neurological evaluation. No post-separation VA outpatient notes were included in the record; however a VA rating decision 23 months post-separation showed no changes in the VA rating (20%) for the CI’s back condition.

The FPEB rated the back condition at 10% with likely application of the USAPDA pain policy stating, “Chronic low back pain secondary to degenerative disc disease and left sided herniation; without motor neurologic deficit; positive tenderness; range of motion limited by pain. There is no spasm or guarding on exam to cause an antalgic gait. The soldier requires a cane because of pain and weakness.” However, all of the Service exams have reduced probative value for separation rating, since they were pre-operative, and were greater than 12 months pre-separation. The only exam within 12 months of separation would rate 20% IAW VASRD §4.71a. The radiologic evidence of disc pathology and nerve root impingement supports the coding of 5243 (intervertebral disc syndrome). After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a separation rating of 20% for the low back condition, coded 5243.

LBP Condition (Radiculopathy). The CI endorsed episodic radiation of his pain into his left leg, subjective weakness of his left leg, and numbness of the left thigh region. Any pain-radiculopathy is considered above under the CI’s primary unfitting lumbosacral condition IAW the General Rating Formula for Diseases and Injuries of the Spine, “With or without symptoms such as pain (whether or not it radiates), stiffness, or aching in the area of the spine affected by residuals of injury or disease.” There was evidence of sensory deficits (light touch decreased over anterior and lateral thigh) without evidence of disability due to sensory loss. With the exception of the “give way weakness” reported in the NARSUM (likely due to pain), lower extremity motor function was normal throughout the pre-separation record, without atrophy or foot drop. Also, the MEB history reported normal nerve conduction studies, with no evidence of lumbosacral radiculopathy. All post-operative neurological evaluations were normal. This leaves no grounds for Board recommendation of an additionally unfitting neuropathy. All evidence considered, there is not reasonable doubt in the CI’s favor supporting addition of any lower extremity radiculopathy as an unfitting condition for separation rating.

Other PEB Conditions. The other conditions forwarded by the MEB and adjudicated as not unfitting by the PEB were bilateral cubital tunnel syndrome and OSA. Both of these conditions were profiled (P3 and U3, respectively), and both were noted as failing retention standards. Neither condition was directly implicated in the commander’s statement, which only noted “several medical limitations,” a restrictive profile that “precluded him being assigned any duties,” and that during his limited time at the medical retention processing unit, his performance had been “minimal.” Both conditions were reviewed by the action officer and considered by the Board.

An orthopedic addendum to the NARSUM, 33 months pre-separation, noted the CI had two surgeries on his right elbow (submuscular ulnar nerve transposition in 2003, removal of suture knots and debridement in 2005), but had persistent elbow pain. On exam, the only positive findings were mild tenderness over the medial epicondyle, and a well healed scar over the medial elbow. Elbow ROMs were full. The examiner noted that the CI’s primary condition for his MEB was his back, and that his upper extremity conditions would not be expected to interfere with his activities of daily living (in contrast to his back condition), or to interfere with light clerical work. The MEB history, 35 months pre-separation, indicated that the most recent nerve conduction studies showed no evidence for focal neuropathy. On exam there was full ROM with painful ROM, and tenderness/hypersensitivity noted. The CI’s U3 profile restriction indicated, “Lifting, Gripping, Pushing, Pulling, and carrying with the right hand as tolerated.”

The VA C&P exam, 19 months pre-separation, noted the CI remained employed as a blood bank technician, with adjustment of his duty assignments, and stated the CI was “unable to function in his previous occupational environment active duty Army, but is able to function in a less physically demanding environment with limitation in lifting not greater than 25 lb, no walking greater than ½ mile, no prolonged standing greater than 30 min.” Although the examiner did not specifically comment on the elbows, he stated all four extremities were normal, exam of the hands was normal, and neurologic evaluation was normal, including motor function, sensory function, and reflexes.

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 Board could not find evidence in the commander’s statement or elsewhere in the Service file that documented a preponderance of evidence that the bilateral cubital tunnel syndrome condition, absent the back condition, precluded duty performance.

Regarding the OSA condition, the MEB history reported a polysomnogram conducted 36 months pre-separation identified severe OSA, with an apnea-hypopnea index of 55, and adequate continuous positive air pressure (CPAP) titration at 11 cm of water pressure. The CI was scheduled to receive his CPAP machine the following week (34 months pre-separation). A psychiatry memo to the PEB dated two months later (32 months pre-separation) reported the CI’s CPAP had “not been working due to fit problems with the mask,” and cited “definite” resulting impairment. The CI’s appeal to the PEB suggested he had excessive daytime sleepiness; however, the PEB’s response stated the CI’s OSA was “controllable with CPAP, and therefore does not render you unfit for that condition.” AR 40-501 directs referral to MEB for OSA that “cannot be corrected with medical therapy, nasal continuous positive airway pressure (CPAP), [etc.]…,” and allows for a 12-month trial of CPAP prior to any fitness determination. The CI had apparently received his CPAP machine only two months prior to the MEB, and had not realized the full benefit of it due to “fit problems with the mask.” A VA exam 18 months pre-separation noted the CI was still on CPAP, but did not give further details regarding response to treatment or daytime sleepiness.

The PEB’s disability description for OSA stated “There is no evidence of interference with performance of his duties if he were to seek proper adjustment or alteration of the type of device used.” This appeared to either consider non-compliance or was speculative. The Board deliberated concerning the fitness of OSA and considered the duty restrictions at the time of the commander’s statement and profile were prior to a sufficient period of treatment with CPAP; however, by the time of separation there was no evidence of ongoing excessive daytime somnolence or any interference in work performance from sleep-related conditions. Routinely OSA is not considered unfitting solely on the basis of field and operational impediments to the use of CPAP. By the time of permanent separation there was no evidence in this case that OSA was associated with any unfitting impairments not corrected by CPAP. All evidence considered, there is not reasonable doubt in the CI’s favor supporting recharacterization of the PEB fitness adjudication for the OSA condition.

All evidence considered, there is not sufficient evidence in the CI’s favor supporting recharacterization of the FPEB fitness adjudication for either the bilateral cubital tunnel syndrome or the OSA conditions.

Remaining Conditions. Other conditions identified in the DES file were depression (VA 30%), cervical disc disease (VA 10%), gastroesophageal reflux disease (VA 10%), bronchitis, seasonal allergies, bilateral knee pain with bursitis, supraventricular tachycardia (with radioablation 1998), left ventricular hypertrophy, hypertension, hyperlipidemia, anxiety, erectile dysfunction, and hemorrhoids. Several additional non-acute conditions or medical complaints were also documented. None of these conditions were occupationally 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. 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 LBP condition was operant in this case and the condition was adjudicated independently of that policy by the Board. In the matter of the LBP condition, the Board unanimously recommends a rating of 20% coded 5243 IAW VASRD §4.71a. In the matter of the bilateral cubital tunnel syndrome and OSA conditions, the Board unanimously recommends no change from the PEB adjudications as not unfitting. In the matter of the depression, cervical disc disease, gastroesophageal reflux disease 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 separation:

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| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Chronic Low Back Pain Secondary to DDD & Left Sided Herniation | 5243 | 20% |
| **COMBINED** | **20%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20100121, 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

(TAPD-ZB /), 2900 Crystal Drive, Suite 300, Arlington, VA 22202

SUBJECT: Department of Defense Physical Disability Board of Review Recommendation

for XXXXXXXXXXXXXXXXXXXXX (PD201100042)

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 rating to 20% without 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:

Deputy Assistant Secretary

(Army Review Boards)

CF:

( ) DoD PDBR

( ) DVA