RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: xxxxxxxxxxxx BRANCH OF SERVICE: air force

CASE NUMBER: PD1100089 SEPARATION DATE: 20030509

BOARD DATE: 20111213

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SSgt/E-5 (2T051, Traffic Management Journeyman) medically separated for low back pain, status post diskectomy and fusion L4-S1, associated with lumbar spondylolysis and degenerative disk disease*.* His symptoms of low back pain with radiation down both legs began in 1999, after lifting cargo while stationed in Korea. Radiologic studies revealed two-level DDD (L4-5 and L5-S1) and bilateral pars interarticularis defects at L5. His treatment included medications, physical therapy, chiropractic care, and surgery (laminectomy L4 and L5; fusion L4-S1), and post-operative rehabilitative care, without significant improvement. He did not respond adequately to treatment and was unable to perform within his career field or meet physical fitness standards. He was issued a U4 profile and underwent a Medical Evaluation Board (MEB). Low back pain, lumbar spondylolysis and lumbar degenerative disc disease and chronic right knee pain were forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AFI 48-123. The PEB adjudicated the low back pain condition as unfitting, rated 20%, with application of DoD Veterans’ Administration Schedule for Rating Disabilities (VASRD) guidelines. The CI did not appeal and was medically separated with a 20% disability rating.

CI CONTENTION: “I was medically separated after the surgery I had made my back and back pain worse than it ever was. Since my unsuccessful surgery my back and ensuing pain from surgery has significantly worsened to where now I have constant pain at a level of 8-9 out of 10 daily. To try to combat this daily pain, I take 6-8 Oxycodone daily as well as applying a Fentanyl 50MCG/HR patch to my body every 2 days. I keep each patch on for 3 days. My anal fissure that I was diagnosed with in 1998 while stationed in ROK has also worsened because the narcotics dry my stool out and constipate me. I also have ongoing problems with my prostate, 2 of my VA health providers believe the reason that I have this pain and constant feeling of needing to urinate is because of my Oxycodone use. My right knee that I had surgery on and my left knee that Dr. C--- wanted me to have the same surgery on constantly hurt also. My right knee has a throbbing pain and buckles or gives out on me 1-2 times a weeks and my left knee buckles on me 2-3 times a month. My right wrist has pain in it that radiates into my fingers 2-3 times a month and usually always after typing for 5-10 minutes. My back pain has severely complicated my life. I am unable to play with my children, play any sports, do many nominal tasks, stand or sit for longer than 10-15 minutes at a time because of these disabilities. I typically will crawl up my stairs 3-4 times a week because of this pain. From Nov 08 to Aug 09 I lost 4 jobs because my back pain was causing me to miss significant days of work, during this time I was a manager at XXX's GMC dealership, a salesman at Lakeside Auto brokers and B & E Motors, and a financial rep at Northwestern Mutual Financial Network (NMFN). I haven't help [sic] a steady job since NMFN because of my disabilities. I am unable to obtain health insurance from any company unless I can get a job that offers group health coverage. A chiropractor I see believes that most of my pain came from improper care after surgery.” He additionally lists all of his VA conditions and ratings as per the rating chart below. A contention for their inclusion in the separation rating is therefore implied.

RATING COMPARISON:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Service IPEB – Dated 20030102** | | | **VA (1 Mo. After Separation) – All Effective Date 20030510** | | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** | |
| Low Back Pain S/P Diskectomy & Fusion L4-S1... | 5295 | 20% | Low Back Strain, S/P Diskectomy & Fusion L4-S1 | 5295\* | 20%\* | 20030619 | |
| Chronic R Knee Pain | Category II | | R Knee Strain, S/P … (*surgery*) | 5257-5261 | 10% | 20030619 | |
| Overweight | Category III | | No Corresponding VA Entry | | | | |
| ↓No Additional MEB/PEB Entries↓ | | | L Ear Tinnitus | 6260 | 10% | | 20030619 |
| L Knee Patellofemoral Syndr. | 5099-5019 | 10%\* | | 20030619 |
| 0% x 4/Not Service Connected x 2 | | | | 20030619 |
| **Combined: 20%** | | | **Combined: 40%\*** | | | | |

LBP 5295 changed to 5242-5243 and increased to 40% (combined 60%) effective 20070912; Left Knee 5099-5019 originally 0% changed to 10% in DRO Decision 20041012, and code later changed to 5260-5014 in VARD 20110222

ANALYSIS SUMMARY: The Board acknowledges the sentiment expressed in the CI’s application regarding the significant impairment with which his service-incurred condition continues to burden him. The Board wishes to clarify that it is subject to the same laws for service disability entitlements as those under which the Disability Evaluation System (DES) operates. The DES has neither the role nor the authority to compensate service members for anticipated future severity or potential complications of conditions resulting in medical separation. That role and authority is granted by Congress to the Department of Veterans’ Affairs (DVA), operating under a different set of laws (Title 38, United States Code). The Board evaluates VA evidence proximate to separation in arriving at its recommendations, but its authority resides in evaluating the fairness of DES fitness decisions and rating determinations for disability at the time of separation. The Board also acknowledges the CI’s contention for service ratings for other conditions documented at the time of separation and notes that its recommendations in that regard must also comply with the same governance. While the DES considers all of the service member's medical conditions, compensation can only be offered for those medical conditions that cut short a service member’s career, and then only to the degree of severity present at the time of final disposition. The DVA, however, is empowered to compensate service connected conditions and to periodically re-evaluate said conditions for the purpose of adjusting the veteran’s disability rating should the degree of impairment vary over time.

Low Back Condition. The back condition must be rated IAW 2003 VASRD standards, following VASRD changes of 23 September 2002 to criteria of 5293 intervertebral disc syndrome, and before the VASRD change of 26 September 2003 when the current spine criteria became effective. The 2003 VASRD had three spine segments identified, while the current VASRD combines thoracic (dorsal) and lumbar into a single spine segment for rating. The 2003 ratings were based on the examiner’s or rater’s opinions as to whether the disability was mild, moderate or severe (5291, 5292, 5293), or based on the presence or absence of clinical signs and radiological findings such as pain, abnormal posture, positive Goldthwaite’s sign, limitation of forward or lateral bending, osteoarthritic changes, and muscle spasm (5295). Of specific note in this case is that the older VASRD spine criteria did not have the current General Rating Formula for Diseases and Injuries of the Spine inclusion of “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.” Additionally, the VASRD criteria prior to 23 September 2002 used substantially different criteria for code 5293 for intervertebral disc syndrome which specifically included neuropathy and pain with assessment of frequency of attacks and relief; however, they are not applicable to this case given the date of separation (28 March 2003).

5285 Vertebra, fracture of, residuals:

With cord involvement, bedridden, or requiring

long leg braces ............................................. 100

Consider special monthly compensation; with

lesser involvements rate for limited motion,

nerve paralysis.

Without cord involvement; abnormal mobility requiring

neck brace (jury mast) ....................................... 60

In other cases rate in accordance with definite

limited motion or muscle spasm, adding 10

percent for demonstrable deformity of vertebral body.

NOTE: Both under ankylosis and limited motion,

ratings should not be assigned for more than

one segment by reason of involvement of only

the first or last vertebrae of an adjacent segment.

5291 Spine, limitation of motion of, dorsal:

Severe........................................................ 10

Moderate...................................................... 10

Slight........................................................ 0

5292 Spine, limitation of motion of, lumbar:

Severe ....................................................... 40

Moderate ..................................................... 20

Slight ....................................................... 10

5293 Intervertebral disc syndrome:

Evaluate intervertebral disc syndrome (preoperatively or

postoperatively) either on the total duration of

incapacitating episodes over the past 12 months or by

combining under Sec. 4.25 separate evaluations of its

chronic orthopedic and neurologic manifestations along with

evaluations for all other disabilities, whichever method

results in the higher evaluation. …

***(deleted portion of 5293 was not applicable to this case and is equivalent to current VASRD 5243 spine formula criteria)***

5294 Sacro-iliac injury and weakness:

5295 Lumbosacral strain:

Severe; with listing of whole spine to opposite side, positive

Goldthwaite's sign, marked limitation of forward bending in

standing position, loss of lateral motion with osteoarthritic

changes, or narrowing or irregularity of joint

space, or some of the above with abnormal mobility on forced

motion....................................................... 40

With muscle spasm on extreme forward bending, loss of lateral

spine motion, unilateral, in standing position............... 20

With characteristic pain on motion............................ 10

With slight subjective symptoms only.......................... 0

There were three post-operative spine examinations, including incomplete 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.

|  |  |  |  |
| --- | --- | --- | --- |
| ROM - Thoracolumbar | Neurosurg ~ 6 Mo. Pre-Sep | MEB ~ 5 Mo. Pre-Sep | VA C&P ~ 1 Mo. Post-Sep |
| Flex (0-90) | “limited flexion and extension…due to pain” | 60⁰ | [68] (68⁰) 70⁰ |
| Ext (0-30) |  | - | [20] 25⁰ |
| R Lat Flex (0-30) |  | - | [15] 30⁰ |
| L Lat Flex 0-30) |  | - | [20] 25⁰ |
| Combined (240)\* |  | Min 60⁰, Max 210⁰ | Min 125⁰, Max 210⁰ |
| Comment: \*No measures of R/L rotation (0-30) in exams | TTP, ambulates without difficulty, reflexes diminished (1+ in L knee, 0 in ankles), sensation intact in feet | Mild guarding, TTP, “ambulates w/ mild stiffened back appearance,” able to walk on heels and toes, neg SLR, neuro normal; See imagining in text | Pain with all ROMs; SLR pos bilat at 45⁰; well healed scar; loss of flex 22⁰, ext 10⁰, L lat 15⁰, R lat 10⁰; ROM w/ no change against resistance; neuro normal; [#] above are summary ROMs |
| §4.71a Rating (May 2003) | 10-20% | 20%-30% (PEB 20%) | 10%-30% (VA 20%) |

The neurosurgery addendum to the MEB, six months pre-separation, reported “limited flexion and extension…due to pain,” tenderness to palpation, and diminished lower extremity reflexes, in the left knee and bilateral ankles. Sensation was intact in the feet, and the CI ambulated “without difficulty.” Radiographs showed surgical hardware in place, with no movement on flexion or extension, and a fusion mass present bilaterally. The narrative summary (NARSUM), five months pre-separation, documented limited flexion, mild guarding, gait with “mild stiffened back appearance,” and tenderness to palpation. The remainder of the exam was normal, with negative straight leg raise, normal heel and toe walking, and normal neurological evaluation. Radiological studies revealed post-surgical changes, with two of the pedicle screws piercing the anterior cortex, question of a fracture of the S1 metal bar (later studies showed hardware intact), and degenerative disc disease at L4-5 and L5-S1 without spinal canal impingement or neuroforaminal compromise.

The VA exam, one month post-separation, noted persistent ROM deficits with pain on motion, positive straight leg raises bilaterally at 45 degrees, a well-healed scar, and normal neurological evaluation. The examiner’s summary of ROMs in the chart above was from the physical exam section of the C&P exam and was slightly different than the summary area ROMs (no ratable difference), which stated, “Loss of flexion of 22 degrees, extension of 10 degrees, left lateral flexion of 15 degrees and right lateral flexion of 10 degrees.” Although remote from separation, the Board noted that four subsequent VA exams at 38, 55, 77, and 87 months post-separation showed significantly greater ROM deficits than those recorded proximate to separation, meeting the 40% criteria IAW the May 2003 VASRD as well as the current VASRD. Two of the exams recorded spasm and gait abnormalities. Radiologic studies demonstrated degenerative disc disease at L4-5, and confirmed the surgical hardware was intact. The DVA increased the CI’s rating for the low back condition to 40% based on the 55-month post-separation exam. This was considered a post-separation worsening of the CI’s condition, and not indicative of the CI’s condition at separation.

The Board evaluated the above data with application of the pre-September 2003 (post September 2002) VASRD codes and rating criteria without consideration of the previous or current VASRD standards. The NARSUM exam supports the PEB’s single-code 20% rating decision. The Board noted that the record clearly indicates the CI had spondylolysis, which is a fracture of the vertebral pars interarticularis, and radiological studies showed successful fusion of the L4 to S1 vertebrae, with surgical hardware in place, which could be argued as being a “demonstrable deformity of vertebral body,” and warranting an additional (adding) 10% under 5285, residuals of vertebral fracture. There was no indication in the record of loss of vertebral body height, or other deformity of the body of the vertebra, only of the posterior portion of the vertebra (the lamina). The Board majority concluded the evidence did not support additional coding under 5285. None of the exams proximate to separation would rate higher than 20% under any of the applicable coding options. All evidence considered, there is not reasonable doubt in the CI’s favor supporting a change from the PEB’s rating decision for the low back condition.

Low Back Condition (Radiculopathy). There was no evidence of unfitting peripheral nerve impairment in this case. The CI endorsed radiation of his pain down both legs. All exams proximate to separation showed normal sensory and motor function in the lower extremities. The neurosurgery addendum, six months pre-separation, recorded diminished ankle and left knee reflexes, but those reflexes were normal in the exams more proximate to separation. There was no report of atrophy, foot drop, bowel or bladder dysfunction or neurologically-related gait abnormalities (NARSUM noted, “ambulation with mild stiffened back appearance,” but normal heel and toe walking). This leaves no grounds for a 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 adjudicated by the PEB were chronic right knee pain (adjudicated as Category II) and overweight (adjudicated as Category III). The CI underwent right knee arthroscopic surgery 27 months pre-separation, and was temporarily profiled (L4) for his knee until 24 months pre-separation. No subsequent knee profiles were seen in the record. Chronic right knee pain was forwarded to the PEB for adjudication. The NARSUM reported full right knee ROM, no effusion, and no instability. Service treatment record entries proximate to separation revealed the CI had full ROM of the right knee without effusion, and no mention of instability. The VA exam one month post-separation reported non-compensable (absent painful motion) ROM decrements (-6 to 110 degrees), no effusion, and no instability. Neither of these conditions was implicated in the commander’s statement. Both were reviewed by the action officer and considered by the Board. Although it is possible that impairment from the right knee condition was overshadowed by the low back condition, that possibility is unduly speculative as the basis for a Board fitness recommendation. There was no indication from the record that either of these conditions significantly interfered with satisfactory performance of duty requirements proximate to separation. All evidence considered, there is not reasonable doubt in the CI’s favor supporting recharacterization of the PEB fitness adjudication for either of these conditions.

Other Contended Conditions. The CI’s application asserts that compensable ratings should be considered for left ear tinnitus (VA 10%), and left knee patellofemoral pain syndrome (VA 10%), anal fissure (VA 0% for hemorrhoids with anal fissure; increased to 20% (19 September 2008), prostate condition, right wrist pain (VA 0%), and tinea cruris and tinea pedis (VA 0%). The left ear tinnitus, left knee condition, anal fissure, prostate condition, and tinea cruris condition 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 right wrist condition and tinea pedis condition (which was assessed in the NARSUM as eczematous dermatitis of the left foot) were reviewed by the action officer and considered by the Board. There was no evidence for concluding that either 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.

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 DoD guidelines for rating the low back condition was operant in this case and the condition was adjudicated independently of those guidelines by the Board. In the matter of the low back condition and IAW VASRD §4.71a, the Board, by a vote of 2:1, recommends no change in the PEB adjudication. The single voter for dissent (who recommended a rating of 30% coded 5285-5295 IAW VASRD §4.71a) did not elect to submit a minority opinion. In the matter of the right knee pain and overweight conditions, the Board unanimously recommends no change from the PEB adjudications as Category I and II, respectively. In the matter of the right wrist pain, tinea pedis, and left foot eczematous dermatitis 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 therefore recommends that there be no recharacterization of the CI’s disability and separation determination, as follows:

|  |  |  |
| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Low Back Pain, S/P Diskectomy and Fusion, L4-S1 | 5295 | 20% |
| **COMBINED** | **20%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110302, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

President

Physical Disability Board of Review

SAF/MRB

1500 West Perimeter Road, Suite 3700

Joint Base Andrews MD 20762

Dear xxxxxxxxxxx:

Reference your application submitted under the provisions of DoDI 6040.44 (Section 1554, 10 USC), PDBR Case Number PD-2011-00089.

After careful consideration of your application and treatment records, the Physical Disability Board of Review determined that the rating assigned at the time of final disposition of your disability evaluation system processing was appropriate. Accordingly, the Board recommended no re-characterization or modification of your separation with severance pay.

I have carefully reviewed the evidence of record and the recommendation of the Board. I concur with that finding and their conclusion that re-characterization of your separation is not warranted. Accordingly, I accept their recommendation that your application be denied.

Sincerely,

Director

Air Force Review Boards Agency

Attachment:

Record of Proceedings