RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: ARMY

CASE NUMBER: PD1100168 SEPARATION DATE: 20090817

BOARD DATE: 20120105

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SGT/E-5 (25Q, Communications Specialist) medically separated for anxiety disorder and low back pain. Neither condition responded adequately to treatment nor was he unable to perform without restrictions within his Military Occupational Specialty (MOS) or meet physical fitness standards. He was issued a permanent L3/S3 profile and underwent a Medical Evaluation Board (MEB). Anxiety and depression, and low back pain were forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501. Additional conditions supported in the Disability Evaluation System (DES) file are discussed below, but were not forwarded for PEB adjudication on the DA Form 3947. The Informal PEB (IPEB) adjudicated the anxiety disorder condition and lumbosacral strain condition as unfitting, rated 10% each IAW with the Veterans Administration Schedule for Rating Disabilities (VASRD). The CI made no appeals and was medically separated with a 20% combined disability rating.

CI CONTENTION: The CI elaborates no specific contentions regarding rating or coding and mentions no additionally contended conditions.

RATING COMPARISON:

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| --- | --- | --- | --- | --- | --- | --- |
| **Service IPEB – Dated 20090511** | | | **VA (1 Wk. After Separation) – All Effective 20090818** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Anxiety Disorder | 9413 | 10% | PTSD With Major Depression | 9411 | 50% | 20090826 |
| Lumbosacral Strain | 5299-5237 | 10% | Low Back Condition | 5237 | NSC | No Exam |
| ↓No Additional MEB Entries↓ | | | 0% x 0 | | | 20090826 |
| **Combined: 20%** | | | **Combined: 50%** | | | |

ANALYSIS SUMMARY:

Mental Health Condition. Service treatment records and VA Compensation and Pension (C&P) examination reflect onset of symptoms following deployment during which the CI reported exposure to combat and a diagnosis of posttraumatic stress disorder (PTSD). The PEB adjudication occurred after the promulgation of the National Defense Authorization Act (NDAA) 2008 mandate for DOD adherence to VASRD §4.129. The salient question before the Board is whether the CI’s psychiatric condition meets the §4.129 definition of “a mental disorder that develops in service as a result of a highly stressful event [that] is severe enough to bring about the Veteran’s release from active military service.” Should the Board decide that §4.129 is applicable in this case, then, IAW DoDI 6040.44 and DoD guidance the Board is obligated to recommend a minimum 50% rating for a retroactive six month period on the Temporary Disability Retired List (TDRL). The Board must then determine the most appropriate fit with VASRD §4.130 criteria at six months for its permanent rating recommendation.

The CI was first treated for depression in May 2007, several months after completing a deployment to Iraq. Experiences reported during that deployment included exposure to mortar fire and seeing wounded and dead soldiers, however the CI identified family relationships and work as his primary stressors. Treatment with medication and counseling resulted in sufficient improvement that, by August 2007, he was considered qualified for another deployment (September 2007 – May 2008). There were no traumatic events during the second deployment. While deployed he received an Article 15 and experienced recurrent symptoms of depression. He reportedly purposefully harmed himself apparently in an attempt to garner chain of command support for return home. However, he was returned from the deployment early due alarming symptoms indicating neurologic spine problems that were not shown on subsequent evaluation (see below). Psychological symptoms at the time of his return were exacerbated by his wife leaving him, and included sleeping difficulty, depressed mood, irritability and anxiety. He was diagnosed with an anxiety disorder and treated with multiple medications. By late 2008 his symptoms had improved so much that he discontinued his medications on his own, but on 3 December 2008 the CI presented with recurrent symptoms and stated: “I stopped all my medications. That was a bad idea.” He re-started them with subsequent improvement in symptoms. The MEB narrative summary (NARSUM) examiner (general medical, 21 March 2009) reported an absence of panic attacks, but reported daily mild to moderate depression with diminished sleep, nightmares, and episodes of intense anxiety. The psychiatric NARSUM examiner (15 December 2008, updated 21 April 2009, four months prior to separation) reported mild to moderate depressed mood, daily anxiety, diminished sleep, nightmares, apathy and low energy. The CI claimed suicidal thoughts on a weekly basis. He lived alone and considered most of his relationships to be poor. Four psychotropic medications and a fifth medication for sleep were listed; however, a 4 August 2009 clinic note records CI report he had not been taking medications for the prior five months, indicating the CI was not on medications at the time of the MEB NARSUM. Mental status examination (MSE) revealed normal mood, affect, speech, memory and thought processes. There was no evidence of delusions or hallucinations and no current suicidal or homicidal ideation. Three different psychiatric inventories revealed scores in the severe range for depression symptoms, severe range for anxiety symptoms and severe range for PTSD symptoms. It is noted however that the actual inventories are dated 15 December 2008, less than two weeks after the CI re-started his medications and do not represent symptoms in the treated state. The mental health NARSUM examiner’s impression was that, despite some progress with treatment, the CI continued to experience significant psychiatric symptoms. The diagnosis was anxiety disorder. Impairment for military duty was considered “marked” and impairment for social and industrial adaptability “definite.” The Global Assessment of Functioning (GAF) was 65 (connoting mild symptoms or some difficulty in social, occupational, or school functioning, but generally functioning pretty well, has some meaningful interpersonal relationships). The psychiatric MEB NARSUM examiner stated that she did not have the commander’s statement or commander corroboration of occupational functioning. The commander’s statement on 21 April 2009 reported the CI was working in his MOS full time and could complete non-field type duties. The commander indicated that there was occasional interference with workplace relationships due to irritability, occasional difficulties with reduced reliability and productivity. The commander noted difficulty establishing or maintaining effective work relationships however he observed that loss of motivation and difficulties with work relationships followed the Article 15 punishment and that the behavior that led to the punishment also disrupted work place relationships. He noted the CI was able to make reasonable decisions with occasional difficulty with complex decisions. A termination summary from the mental health clinic, 3 August 2009, listed four current psychiatric medications, but it is not clear if the interviewer confirmed that the medications were being taken or if they were simply derived from an electronic medication list. Mood and sleep were noted to be improved, but anxiety increased. At a VA clinic visit on 4 August 2009 (one day after the mental health clinic termination summary visit and two weeks prior to separation) the CI stated he had been off of his medications for five months because of “problems obtaining them through the Army” (a problem that was not noted in service treatment records). He reported that the most stressful event encountered during his deployment was witnessing a man brought out of a humvee who was missing an arm and a leg. He did not witness the traumatic event itself. His next most traumatic event was being almost hit by shrapnel from a mortar explosion. Symptom history included frequent night-time awakening, and awakening with a racing heart and night sweats once or twice per week. He experienced intrusive thoughts very infrequently but panic attacks occurred two to three times per week. Obsessive or compulsive symptoms were present, but these pre-dated his deployment. He reported that since his recent reconciliation with his wife his depression had diminished. At the time of the VA C&P examination (26 August 2009, one week after separation), symptoms were the same or somewhat worse that at the time of the MEB. The CI had been off of medications for several months, had only re-started one of them three weeks prior to the C&P exam and was noticing some mild positive effects. Sleep was poor and he was very nervous most of the time. He remained socially isolated, did not like crowds and his wife accompanied him most places. He was unemployed but was only recently separated from the service. He stated that intense anxiety and avoidance made working in most jobs intolerable. He sometimes felt apathetic. Depressed mood, anxiety and insomnia occurred daily, and nightmares and night sweats were three times per week. He experienced exaggerated startle, hypervigilance and panic attacks that occurred only in public places. He denied flashbacks. He reported mild memory loss that required use of a planner. The MSE revealed no impairment in thought processes or communication, no delusions or hallucinations, and no homicidal or suicidal thoughts. Orientation and speech were normal. Memory, although reported as mildly impaired, was not tested. The assessment was PTSD with major depression which resulted in deficiencies in most areas. The GAF was 55 (connoting moderate symptoms or moderate difficulty in functioning). At a VA clinic evaluation on 5 October 2009 (six weeks after separation) the CI reported “I’m happier that I have been” but he remained unemployed. He still was anxious “all the time” and was not sleeping well. The provider stated that the medication the CI began three weeks prior to the C&P exam was not helping the symptoms of anxiety and depression. He also denied ever having a panic attack. Nightmares were occurring approximately twice per month. He still avoided crowds and denied flashbacks. His depression occurred twice per week and was of a mild intensity. He denied feelings of worthlessness or guilt, but did feel hopeless and helpless twice per month. The GAF was 55. The examiner observed that the CI lacked motivation to comply with psychiatric treatment.

The Board directs its attention to the question of §4.129 applicability and the rating recommendation based on the evidence just described. The Board noted that the stresses of deployment to a combat zone, although considerable under the best of circumstances, do not automatically equate to the §4.129 standard of “a highly stressful event” or to Criterion A stressors for PTSD – a typical mental disorder for which the provisions of §4.129 would apply. The Board also considered that multiple symptoms of PTSD were documented in the service record and that the VA C&P examiner did diagnose PTSD, implying that he believed that Criterion A stressors as well as other diagnostic features were present. The Board debated if there was reasonable evidence that the history, symptoms, and clinical findings described in the above psychiatric examinations were connected to the stresses he experienced in combat during his first deployment. Board members agreed that the CI’s symptoms could not be clearly linked to the reported traumatic stressors, and that the CI’s psychological symptoms developed in the context of marital problems and disciplinary actions. Therefore, §4.129 is not applicable in this case.

The Board now turns its attention to the rating recommendation. The PEB’s 10% rating was based on a conclusion that symptoms were controlled with medication and that he was employed full time in his MOS. The Board debated the severity of his symptoms at the time of the MEB NARSUM. Service treatment records reflected a good response to medication prior to the MEB NARSUM, with worsened symptoms prompting request to restart medications in December 2008. The April 2009 psychiatry MEB NARSUM gave the impression that the reported significant symptoms were despite taking multiple medications at that time; however, subsequent VA clinic treatment record of 4 August 2009 documented CI report he had not taken medication for five months, extending back to March 2009. The reported symptoms suggested occupational impairment consistent with a 30% rating (occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks although generally functioning satisfactorily). However the MSE was normal with normal mood, affect, memory, and speech. Further, the examining NARSUM psychologist did not have corroborating information from the commander or the commander’s statement available. The commander’s statement provided evidence of occupational functioning consistent with a 10% rating (mild or transient symptoms which decrease work efficiency and ability to perform occupational tasks only during periods of significant stress). The VA assigned a 50% rating but the Board did not see evidence of the “occupational and social impairment with reduced reliability and productivity” required for that rating. While the symptoms reported at the C&P examination were more consistent with a 30% rating (occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks although generally functioning satisfactorily), the final VA clinical assessment in evidence (six weeks after separation) more closely describes a 10% rating at which time the CI had been on medication for a few weeks. The Board considered that the CI was not compliant with medications and that he missed scheduled counseling sessions. Although it should be conceded that these issues are at least partially attributable to the psychiatric condition itself, the rating recommendation is intended to reflect the severity of the condition in a more stable and treated state. The Board was further challenged by some inconsistencies in the record, for example the reports of panic attack frequency (two to three times per week versus never), improved mood and sleep reported at the termination summary yet informing a VA examiner the following day that he had been out of medications for five months, and alleged difficulty in obtaining medications. The Board also noted back symptoms and limited motion unsupported by objective findings. The Board is left to consider, therefore, that the CI’s accounts of his symptoms and their severity, which constitute most of the psychiatric evidence, are subject to probative value compromise. In such cases, the Board leans more heavily on the well-grounded evidence such as actual performance and functioning, objective elements of the mental status examination and symptoms which are consistently reported and compatible with clinical expectations. In so doing, the Board remains cognizant of VASRD §4.3 (reasonable doubt) and favorably concedes matters which it cannot opine to a “more likely than not” standard. All of the evidence, bolstering and reducing support for the higher rating, was debated. The majority of the Board failed, on balance, to find adequate reasonable doubt favoring the CI in support of a recommendation for the higher rating. All evidence considered, there is not reasonable doubt in the CI’s favor supporting a change from the PEB’s rating decision for the anxiety disorder condition.

Low Back Condition. There were two goniometric range-of-motion (ROM) evaluations as well as non-goniometric examinations in evidence which the Board weighed in arriving at its rating recommendation. These examinations are summarized in the chart below.

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| Goniometric ROM - Thoracolumbar | MEB H&P ~12 Mos. Pre-Sep | MEB ~ 5 Mo. Pre-Sep | PT 20090427 ~ 4Mo. Pre-Sep | MEB Re-evaluation ~ 3 Mo. Pre-Sep |
| Flexion 0-90⁰ normal | “Full” | 10⁰ | “Full” | 65⁰ |
| Combined 240⁰ normal | “Full” | 180⁰ | “Full” | 185⁰ |
| Comments | Tenderness | Tenderness | Normal gait. |  |
| §4.71a Rating | 0% | 40%\* | 0% | 10% |

\*Based on flexion component

Although the CI experienced ongoing low back discomfort since 2004, he experienced a flare of back pain 12 May 2008 when a ten to fifteen pound box fell approximately two feet onto his back. Low back pain and associated urinary incontinence symptoms and radiation of pain to the left lower extremity with numbness resulted in urgent medical evacuation from his deployed location. Examiners recorded a three year history of intermittent pop with pain in the back associated with numbness in the legs and previous problems in the past with urinary control. Urinary symptoms resolved but constant pain and occasional radiation of pain to the left leg persisted. The NARSUM examiner (20 March 2009, five months before separation) reported a “normal appearance” of the back. Tenderness was present in the mid-lumbar region. ROM was markedly reduced. Straight leg raise testing (SLR) was positive on the left, but deep tendon reflexes and muscle strength were normal. X-rays showed a moderate lumbar scoliosis, but this was consistent with previous evaluations noting a congenital or developmental scoliosis. Magnetic resonance imaging (MRI) showed mild left facet hypertrophy at L4-5 with mild neuroforaminal narrowing. However, electrodiagnostic studies showed no evidence of radiculopathy. Clinic encounters from June and July 2008 showed full ROM. An MEB history and physical examination 4 August 2008 also documented full ROM. Service treatment records do not document an intervening injury to explain the dramatic decrease in thoracolumbar ROM at the time of the 20 March 2009 NARSUM examination. A physical therapy (PT) follow-up visit on 27 April 2009 noted a normal gait, normal squat, full active ROM of the lumbar spine and negative SLR, normal strength and reflexes. Another MEB exam was performed 8 May 2009 for the purpose of obtaining repeat ROM measurements. It was reported at this exam that the CI’s pain was worse than at the time of the NARSUM exam. The examiner reported normal movements from sitting to standing and normal ambulation. A mild scoliosis was present. Localized tenderness and isolated spasm were present at the L-1 level. This examiner noted that the ROM measurements obtained were “reproducible” and then, after the examination, proceeded to estimate a reduction in ROM that should be applied due to pain based on the CI’s report that “backward flexion and left lateral flexion are usually problematic.” An estimated reduction of flexion by an additional 10⁰ (to 55⁰ from 65⁰), extension by an additional 5⁰ and left lateral flexion by an additional 5⁰ was suggested. This would have resulted in a combined ROM of 165⁰. The commander’s statement indicated the CI was performing duties in his MOS but could not perform field duties, range duties or wear field gear. The Board notes that the CI failed to appear for a VA rating exam (and was therefore denied service connection), so there is no post-separation ROM evidence for comparison. However at two follow-up VA clinic visits within six weeks of separation, he reported that his back pain severity was a “one” and a “two” (on a 1-10 severity scale), and he declined any treatment for his back pain at those clinic encounters. The PEB’s 10% rating, based on reduction of flexion, normal gait and the presence of tenderness was IAW VASRD §4.71a criteria. Limited combined ROM also supported a 10% rating. The Board likewise relied more heavily on the second MEB exam in its rating recommendation, which was further supported by the April 2009 PT examination showing full range of motion. The rather dramatic reduction in flexion recorded at the NARSUM exam was not consistent with other concurrent objective findings or known pathology, while the second MEB exam was more detailed and more proximal to separation. The Board considered if the scoliosis in evidence warranted a higher rating, but noted that this finding was not secondary to muscle spasm as required under the 20% rating, but rather was consistent with a developmental scoliosis. The Board members further agreed that the reduction in ROM values due to reported pain suggested by the second MEB examiner should not be applied. Any such reduction should be objectively measured, and the fact that the actual recorded measurements were “reproducible” suggests that reduction in ROM attributable to pain was in fact not present. The preponderance of evidence in this case supports no greater than a 10% rating under the VASRD spine formula.

The Board also considered if additional disability was justified for the pain that radiated to the left leg and foot numbness. While the NARSUM examiner noted positive SLR testing on the left, all other neurologic findings were normal and electrodiagnostic testing showed no evidence of radiculopathy. The presence of functional impairment with a direct impact on fitness is the key determinant in the Board’s decision to recommend any condition for rating as additionally unfitting. While the CI may have suffered additional lower extremity symptoms related to his back condition, this is subsumed under the general spine rating criteria, which specifically states “with or without symptoms such as pain (whether or not it radiates).” There is no evidence in this case of functional impairment attributable to peripheral neuropathy. The Board therefore concludes that additional disability rating was not justified on this basis. 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.

Remaining Conditions. Other conditions identified in the DES file were shortness of breath, heartburn, elbow stiffness and headaches. Several additional non-acute conditions or medical complaints were also documented. None of these conditions were clinically active 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 anxiety condition and IAW VASRD §4.130, the Board, by a vote of 2:1, recommends no change in the PEB adjudication. The single voter for dissent (who recommends a rating of 30%) submitted the addended minority opinion. In the matter of the lumbosacral strain condition and IAW VASRD §4.71a, the Board unanimously recommends no change in the PEB adjudication. In the matter of the shortness of breath, heartburn, elbow stiffness and headache 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. The Board unanimously agrees that there were no other conditions eligible for Board consideration which could be recommended as additionally unfitting for rating at separation.

RECOMMENDATION: The Board therefore recommends that there be no recharacterization of the CI’s disability and separation determination.

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| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Anxiety Disorder | 9413 | 10% |
| Lumbosacral Strain | 5299-5237 | 10% |
| **COMBINED** | **20%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110328, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans' Affairs Treatment Record

Minority Opinion

The minority member concludes the evidence of the record supports a 30% rating for the mental condition. At the time of the MEB, despite taking multiple medications, he continued to experience significant symptoms that were more consistent with a 30% rating (occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks although generally functioning satisfactorily) including daily mild to moderate depressed mood and anxiety, irritability, sleep disturbance, nightmares, decreased concentration, passive suicidal thoughts without plan, and decreased motivation (apathy) that made it difficult for him to put effort into his work. His irritability impaired work relationships and social relationships were recorded as impaired. The examining psychiatrist estimated his impairment for civilian occupational functioning as “definite” connoting a moderate impairment. The C&P examination one week after separation also documented moderately severe symptoms including moderate depression, moderate to severe anxiety, panic attacks, social isolation, sleep disturbance, lack of motivation, avoidance of crowds, exaggerated startle response, hypervigilance, and mild memory impairment. The examiner estimated functioning as moderately impaired. The commander’s statement, cited by the PEB and Board majority, was somewhat vague, reflected problems with motivation and irritability, and concluded with the commander’s recommendation against retention. Although the Board majority cited some inconsistencies in the record, a reasonably consistent pattern of moderate symptoms that impaired occupational and social functioning that exceeded the 10% level and more nearly approximated the 30% rating were evidenced in the MEB NARSUM and C&P examination. The minority member concludes the evidence of the record at least as likely as not, supports the 30% rating and that the 30% rating is appropriate based on the evidence with application of §4.3 reasonable doubt and §4.7 higher of two ratings.

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