RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME:

CASE NUMBER: PD1100202 BRANCH OF SERVICE: Army

BOARD DATE: 20120222 SEPARATION DATE: 20071219

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SGT/E-5 (25P/Microwave Systems Operator/Maintainer), medically separated for a low back condition. The CI first noted back pain in 1999 related to a lifting injury. Worsening pain and spasm over the years resulted in specialty evaluation and imaging studies that identified arthritic and discogenic changes in the lumbar spine. Surgical intervention was not recommended and the CI did not respond adequately to aggressive conservative management to fully perform within her Military Occupational Specialty (MOS). She was issued a permanent L3 profile and underwent a Medical Evaluation Board (MEB). Chronic low back pain was forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501. No other conditions appeared on the MEB’s DA Form 3947 submission. Other conditions included in the Disability Evaluation System (DES) packet will be discussed below. The PEB adjudicated the low back condition as a lumbosacral strain, unfitting, rated 0%, with application of the Veterans Administration Schedule for Rating Disabilities (VASRD). The CI made no appeals and was medically separated with a 0% disability rating.

CI CONTENTION: The CI states: “I was separated for chronic lower back pain, when in fact, I had multiple diagnosed medical conditions related to my back to include: degenerative disc disease, chronic upper back muscle spasms, osteopenia, osteo-arthritis and peripheral neuropathy, lower right extremity. The conditions occurred during and were a direct result of military service and are well documented in my military medical records. The conditions were, and still are, debilitating and prevented me from continuing in my military career and retiring, as I had planned.” She elaborates no specific contentions regarding rating or coding and mentions no additionally contended conditions.

RATING COMPARISON:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Service IPEB – Dated 20071001** | | | **VA (7 Mo. After Separation) – All Effective Date 20071220** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Lumbosacral Strain | 5237 | 0% | DDD L-Spine w/ Intervertebral Disc Syndrome | 5242 | 10% | 20080723 |
| Peripheral Neuropathy, R Lower Ext | 8599-8520 | 10% | 20080723 |
| Peripheral Neuropathy, L Lower Ext | 8599-8520 | 10% | 20080723 |
| ↓No Additional MEB/PEB Entries↓ | | | Bilateral Pes Planus w/ Hammertoes Deformity | 5276 | 30% | 20000912 |
| Upper Airway Resistance Syndrome | 6899-6847 | 30% | 20080723 |
| Status-Post Vaginal Hysterectomy | 7618 | 30% | 20080723 |
| Right Wrist Tendonitis | 5299-5024 | 10% | 20080723 |
| Left Wrist Tendonitis | 5299-5024 | 10% | 20080723 |
| Right Ankle Strain | 5299-5024 | 10% | 20080723 |
| Cervical Strain | 5237 | 10% | 20080723 |
| Cystocele w/ Stress Incontinence | 7512 | 10% | 20080723 |
| Herpes Simplex Virus, Recurrent | 7899-7806 | 10% | 20080723 |
| Carpal Tunnel Syndrome, R Upper Ext | 8599-8515 | 10% | 20080723 |
| Bipolar Disorder | 9432 | 10% | 20080610 |
| 0% x 4/Not Service Connected x 9 | | | 20080723 |
| **Combined: 0%** | | | **Combined: 90% (Incorporating Bilateral Factor)** | | | |

ANALYSIS SUMMARY: The Board acknowledges the sentiment expressed in the CI’s application regarding the significant impairment with which her service-incurred condition continues to burden her. The Board wishes to clarify that it is subject to the same laws for service disability entitlements as those under which the 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 DVA evidence proximal 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 suggesting that service ratings should have been conferred for other conditions documented at the time of separation and for conditions not diagnosed while in the service (but later determined to be service connected by the DVA). 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 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.

Thoracolumbar Spine Condition. The CI first noted back pain in 1999 related to a lifting injury. She was treated conservatively with resolution of pain. She reinjured her back six months later and then continued to have episodic back pain extending into her right leg from 1999-2004. These episodes occurred every 2-3 months but she did not lose time from work until 2007, the time of her narrative summary (NARSUM), wherein the evaluator noted she had lost 12 work days because of back pain. She had had a permanent L2 profile for right hip pain and was able to pass an Army physical fitness test (APFT) with the walk one month prior to the NARSUM. She was issued a L3 profile for her back due to her inability to perform required military tasks mandating her MEB. These tasks included inability to: move with a fighting load at least two miles, construct an individual fighting position, run three to five second rushes under direct and indirect fire, and deploy. She was still authorized to do an AFPT alternate walk, swim, or bike along with sit-ups and push-ups. She was treated with conservative treatment to include medications, physical therapy, chiropractic therapy, pain management and injections and was not considered a surgical candidate. Her commander’s statement did not corroborate the 12 day work loss and and further documented “in her years at this unit, she has adequately performed her duties and her medical condition has had minimal impact on her performance.”

The NARSUM, completed by an orthopedic surgeon, documented pain as her major problem, rated at 2/10 on a good day and 8/10 on a bad day. She medicated with non-steriodals and muscle relaxants if her pain was 5/10 and added a narcotic for two to three days if her pain flare approached 7/10. Sitting and standing for more than two hours worsened her pain. The clinical exam of the thoracolumbar spine documented normal gait, straight leg raise, and neurological examination (sensory, motor, and reflexes) to the lower extremities; and no evidence for tenderness, muscle spasm, guarding, or abnormal spinal contour. All Waddell’s signs were negative. Magnetic resonance imaging (MRI) studies demonstrated discogenic disease at the L1-2 and L4-L5 levels with no evidence of acute disc herniation or significant spinal stenosis and some anterior osteophytic formation. The VA Compensation and Pension (C&P) examination noted a similar historic account as the NARSUM and specifically documented her conditions did not result in any incapacitation and that she could function with medication. The clinical exam documented tenderness of the thoracic and lumbar paraspinal muscles; normal gait, posture, and straight leg raise; and no evidence for spasm, incapacitation, or ankylosis. The neurologic examination was positive for sensory deficits of the right and left lateral thighs and symmetrically diminished patellar and ankle reflexes bilaterally. There were no electrodiagnostic studies in evidence to review. The goniometric range-of-motion (ROM) evaluations in evidence which the Board weighed in arriving at its rating recommendation are summarized in the chart below.

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| Goniometric ROM - Thoracolumbar | NARSUM ~ 6 Mo. Pre-Sep  (20070628) | VA C&P ~ 7 Mo. After-Sep  (20080723) |
| Flex (0-90) | (69⁰) 70° | 90⁰ |
| COMBINED (240) | 220⁰ | 240⁰ |
| Comment |  | Painful motion |
| §4.71a Rating | 10% | 10% |

The Board directs its attention to its rating recommendations based on the evidence just described. The PEB and VA chose different coding options for the condition which did not bear on rating; but the Board agreed that the code chosen by the VA, 5242 (Degenerative arthritis of the spine), was more representative of the clinical pathology related to the CI’s condition. Applying the general rating formula for diseases and injuries of the spine, the ROM findings of the MEB NARSUM examination were consistent with a rating of 10% IAW VASRD §4.71a. The PEB likely determined a combined range of motion of 292° by using the average of three passive ROM measurements in each plane of motion. The values were not truncated to the normal values as indicated in the VASRD. This number is greater than the total possible 240° documented in the VASRD. This method does not take motion limited by pain into consideration. Using active measurements accounts for pain limited ROM. Standard rating practice utilizes active motion measurements and uses the lowest value when multiple measurements are available. However, even if the 292° combined range of motion was correct, flexion is still limited to 70°, painful motion is present, and a 10% rating is warranted. The Board considered the VASRD formula for rating intervertebral disc syndrome based on incapacitating episodes and invoked the VASRD definition for incapacitating episodes which requires “bed rest prescribed by a physician and treatment by a physician.” There is no evidentiary support for a conclusion that the periods of work loss were medically directed or supervised; and, all members agreed that no higher rating can be recommended under this formula than can be achieved under the §4.71a general rating formula for diseases and injuries of the spine. With regards to the general rating formula for diseases and injuries of the spine there was no evidence of spasm, guarding, abnormal gait, abnormal spinal contour, ankylosis, or incapacitating episodes to justify a higher rating than 10%.

The Board noted the VA rated the sensory loss in the right and left thighs with diminished reflexes as right and left leg peripheral neuropathy analogous tothe sciatic nerve IAW §4.124a schedule of ratings–neurological conditions and convulsive disorders. These findings were not documented in the MEB NARSUM. 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 radicular component in evidence in this case consisted primarily of pain, which is subsumed under the general spine rating, and decreased sensation. There was no objective evidence for functional impairment related to motor deficits and the sensory component had no functional implications. Therefore, there was no evidence of ratable peripheral nerve impairment to justify additional rating. The Board, therefore, does not find reasonable doubt favoring a recommendation for additional service rating on this basis. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a separation rating of 10% for the thoracolumbar spine condition coded as 5242, as discussed above.

Remaining Conditions. Other conditions identified in the DES file were chronic vaginitis, hysterectomy, gastroesophageal reflux disease (GERD), osteopenia, anxiety disorder, bipolar disorder, alcohol abuse, wrist pain and numbness, left hip pain, foot, sleep disorder, toe problems, and urinary incontinence. Several additional non-acute conditions or medical complaints were also documented. The CI suffered a left hip stress fracture in 1996 in basic training which required surgical repair and resulted in a permanent L3 profile which was downgraded four months later to an L2 restricting her to an alternate aerobic AFPT walk event. The other conditions did not carry attached profiles, and none were implicated in the commander’s statement. None of these conditions were of clinical or occupational significance during the MEB period. 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, upper airway resistance syndrome, cervical strain, herpes simplex virus, right ankle strain, 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 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 thoracolumbar spine condition, the Board unanimously recommends a rating of 10% coded 5242 IAW VASRD §4.71a. In the matter of the bilateral lower extremity peripheral neuropathy, chronic vaginitis, hysterectomy, GERD, osteopenia, anxiety disorder, bipolar disorder, alcohol abuse, wrist pain and numbness, right hip pain, foot and toe problems, sleep disorder, urinary incontinence 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 her prior medical separation:

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| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Degenerative Disc Disease, Lumbar Spine | 5242 | 10% |
| **COMBINED** | **10%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110401, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans Affairs Treatment Record

President

Physical Disability Board of Review

SFMR-RB

MEMORANDUM FOR Commander, US Army Physical Disability Agency

SUBJECT: Department of Defense Physical Disability Board of Review Recommendation

1. 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 10% 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:

Encl

Deputy Assistant Secretary

(Army Review Boards)