RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: xxxxxxxx BRANCH OF SERVICE: Army

CASE NUMBER: PD1100251 SEPARATION DATE: 20070629

BOARD DATE: 20120403

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was a National Guard SGT/E-5 (88M20/Motor Transport Operations), medically separated for chronic neck pain secondary to degenerative arthritis and multilevel degenerative disc disease (DDD). In June 2004, while deployed to Iraq, the CI developed symptoms of chronic neck pain, aggravated by wear of his Kevlar helmet and his full combat load. He was medically evacuated out of theater for further evaluation of his symptoms in December 2004, but then returned to Iraq to complete the deployment with his unit. Upon redeployment to CONUS in June 2005, the CI began physical therapy treatment with traction and use of a transcutaneous electrical nerve stimulation unit. Despite conservative treatment, his symptoms did not improve and neurosurgery evaluation determined that he was not a surgical candidate. He did not respond adequately to treatment and was unable to perform within his Military Occupational Specialty (MOS). He was issued a permanent U3/L2/H2 profile and underwent a Medical Evaluation Board (MEB). “Chronic neck pain with DDD without radiculopathy/myelopathy” was forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501. Seven other conditions, as identified in the rating chart below, were forwarded on the MEB submission as meeting retention standards. The PEB adjudicated the chronic neck pain (secondary to degenerative arthritis and multilevel DDD) condition as unfitting, rated 10%; with likely application of the US Army Physical Disability Agency (USAPDA) pain policy. The CI appealed to a Formal PEB (FPEB) and requested continuance on active Reserve (COAR) status, but subsequently withdrew both requests. He was medically separated with a 10% combined disability rating.

CI CONTENTION: “The Army only gave me 10% for the chronic neck pain associated with the degenerative dise disease. As the V.A. has awarded me 20%. And the Army does not recognize the 20% for the left hand neuropathy. Also with a truck driving MOS can the Army provide 120-V electric power for my C-PAP while I'm in the field, and or battlefield.”

RATING COMPARISON:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Service Revised PEB – Dated 20070705** | | | **VA (3 Mo. After Separation) – All Effective Date 20070630** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Chronic Neck Pain …DDD | 5242 | 10% | Cervical Spine DDD | 5243 | 20% | 20070919 |
| LUE Neuropathy … Cervical DDD | 8514 | 20% | 20070919 |
| Right Trochanteric Bursitis | Not Unfitting | | Right Hip Bursitis | 5019 | 10% | 20070919 |
| Right RPPS | Not Unfitting | | Right Knee RPPS | 5299-5261 | 0% | 20070919 |
| Depressive Disorder | Not Unfitting | | Major Depression | 9434 | 10% | 20070920 |
| Morton Neuroma, R Foot | Not Unfitting | | Morton’s Neuroma R Foot | 5279 | 10% | 20070919 |
| Neuritis, Left Foot | Not Unfitting | | L Foot Condition | 8524 | NSC | 20070919 |
| Left Subclavian Stenosis | Not Unfitting | | L Subclavian Stenosis | 8099-8008 | 0% | 20070919 |
| Mild OSA | Not Unfitting | | Sleep Apnea | 6847 | 50% | 20070919 |
| ↓No Additional MEB/PEB Entries↓ | | | Tinnitus | 6260 | 10% | 20070822 |
| Hiatal Hernia | 7346 | 10% | 20070919 |
| 0% x 1/Not Service-Connected x 1 | | | 20070919 |
| **Combined: 10%** | | | **Combined: 80%** | | | |

ANALYSIS SUMMARY: The Board acknowledges the CI’s contention that suggests service ratings should have been conferred for other conditions documented at the time of separation. 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. 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, operating under a different set of laws (Title 38, United States Code), is empowered to compensate all service-connected conditions and to periodically reevaluate said conditions for the purpose of adjusting the Veteran’s disability rating should the degree of impairment vary over time.

Chronic Neck Pain Condition. There were three cervical spine evaluations in evidence, two with goniometric range-of-motion (ROM) measurements, which the Board weighed in arriving at its rating recommendation. These were a physical therapy (PT) response to treatment evaluation, the MEB examination with PT ROM measurements and the VA Compensation and Pension (C&P) examination. The exam findings are summarized in the table below.

|  |  |  |  |
| --- | --- | --- | --- |
| Separation Date: 20070629 | | | |
| Goniometric ROM – Cervical | PT ~ 12 Mo. Pre-Sep  (20060613) | MEB/PT ~ 9 Mo. Pre-Sep  (20060919) | VA C&P ~ 3 Mo. After-Sep  (20070919) |
| Flex (0-45) | 30⁰ | 35⁰, 35⁰, 40⁰ (35⁰) | 30⁰ |
| Ext (0-45) | 25⁰ | 35⁰ | 45⁰ |
| R Lat Flex (0-45) | 20⁰ | 25⁰ | 45⁰ |
| L Lat Flex (0-45) | 15⁰ | 25⁰ | 30⁰ |
| R Rotation (0-80) | 60⁰ | 20⁰, 20⁰, 25⁰ (20⁰) | 80⁰ |
| L Rotation (0-80) | 40⁰ | 25⁰ | 60⁰ |
| COMBINED (340) | 190⁰ | 165⁰ | 290⁰ |
| Comment | Some improvement in numbness but no change in pain with traction -Traction tx discontinued | Pain at limits of ROM, tenderness of lower C-spine; negative Spurling; intact DTRs and no motor deficits; numbness L hand of medial thumb and lateral index finger (DD 2808) | Normal gait and posture; no spasm or ankylosis; pain at limits of ROM; joint function additionally limited by pain after repetitive use but no additional loss of ROM; sensory deficit LUE; 2+ reflexes BUE; normal hand strength. |
| §4.71a Rating | 20% | 20% (PEB – 10%) | 20% |

At the MEB exam, the CI complained of neck pain radiating to the left upper extremity. All three examinations documented similar degrees of limitation of cervical spine flexion, and all documented limitation of the combined ROM of the cervical spine. Both the MEB exam and the VA C&P exam noted pain at the limits of ROM. Additionally, the MEB exam documented tenderness of the cervical spine with no motor deficits and a negative Spurling test. At the VA C&P exam, joint function was additionally limited by pain after repetitive use, but did not result in additional loss of ROM. The CI had a normal gait and posture, and there was no spasm or ankylosis. The C&P examiner also documented a sensory deficit of the left lateral forearm, left thumb and left index finger. Reflexes were normal and bilateral hand strength was normal. Plain films of the cervical spine were remarkable for multi-level cervical spondylosis with degenerative changes primarily at C5-C6 and C6-C7 with disk space narrowing. MRI findings documented a posterior disk osteophyte complex at C5-C6 resulting in moderate right-sided foraminal narrowing and moderate canal stenosis.

The MEB examiner noted worsening of the CI’s neck pain symptoms with wear of the Kevlar helmet, wear of the armored vest and performance of any impact activities. Additionally, the neck pain caused extreme difficulty riding and driving over rough, uneven terrain, as well as performing overhead work and keeping the head and neck extended. The examiner concluded that the prognosis for improvement was fair to poor and opined that symptoms “will likely increase with time and age due to the degenerative nature of the condition.” The permanent profile detailed, “no running, no jumping, no sit-ups or lifting greater than 50 pounds, no wearing of rucksack armored vest or full combat load, no ruckmarching, alternate APFT.” The PEB noted that “pain and profile restrictions prevent full duty function.”

The PEB and the VA chose similar coding for the condition, but arrived at different rating recommendations. Both codes rate based upon the general rating formula for diseases and injuries of the spine. The PEB coded for degenerative arthritis of the spine and rated 10% based upon “Full ROM with pain on motion, no radiculopathy or spasm.” There was no rating deduction for existing prior to service (EPTS-UND). The VA coded for intervertebral disc syndrome and rated 20% based upon forward flexion of the cervical spine of greater than 15 degrees but not greater than 30 degrees. There was no documentation of incapacitating episodes to justify rating based upon that criteria.

All exams met the 20% rating criteria for ROMs. The Board noted that the degree of limitation of cervical spine flexion documented in the physical therapy note and at the VA C&P exam meets the criteria for the 20% rating’s “forward flexion of the cervical spine greater than 15 degrees but not greater than 30 degrees.”

The MEB exam documented three measurements for each ROM as noted in the chart. Board precedent, IAW VASRD §4.71a and congruent with VA rating practice, is to round to the nearest five degrees and to utilize the lowest of multiple measurements for rating purposes. The MEB exam’s degree of limitation of combined ROM therefore meets the criteria for the higher 20% rating’s “the combined ROM of the cervical spine not greater than 170 degrees.” The Board considered the CI’s functional limitations and duty restrictions, as well as the cervical ROM limitations documented in all exam, and concluded that the CI’s overall disability picture more closely approximates the criteria for the 20% rating.

Radiculopathy Condition. The CI was right-handed and complained of neck pain radiating to the left arm and constant numbness in the left arm, thumb and index finger. The CI had multiple electromyogram studies of the left upper extremity; March 2005 normal, September 2005 mild cubital tunnel syndrome, and March 2006 normal (“showed no evidence of carpal tunnel syndrome, thoracic outlet syndrome or damage in the innervation of any C5-C8 myotomes”). MEB exam documented pain and numbness on the left hand of “medial thumb and lateral index finger.” Neurosurgical evaluation confirmed diminished sensation in a C7 type distribution in the left upper extremity, but motor strength and reflexes were normal. The VA exam documented similar left upper extremity findings of normal motor and reflex exams with “sensory deficit of left lateral forearm, left thumb and left index finger.”

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 commander’s statement specified that he was unable to evaluate the CI’s functioning and the CI was working out of his MOS. There was no evidence of dropping items, inadvertent injury to the left hand/fingers, restriction from driving, or other functional impairments from the partial hand numbness. The pain component of a radiculopathy is subsumed under the general spine rating as specified in §4.71a. The Board noted the left hand symptoms may have overlapped in etiology with the CI’s left subclavian artery stenosis, but attributed all hand symptoms to the peripheral nerve category when determining fitness implications for a radiculopathy. The sensory component in this case had no functional implications. There was no motor impairment that could be linked to significant physical impairment. Since no evidence of functional impairment exists in this case, the Board cannot support a recommendation for additional rating based on peripheral nerve impairment. 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 chronic neck pain condition, and not unfitting for any peripheral nerve condition.

Other PEB Conditions. The other conditions forwarded by the MEB and adjudicated as not unfitting by the PEB were right greater trochanteric bursitis (hip), right retropatellar pain syndrome (knee), depressive disorder, Morton neuroma (right foot), neuritis (left foot), left subclavian stenosis (with steal syndrome) and mild obstructive sleep apnea (OSA). The CI complained of occasional pain in the right hip and right knee and had had some temporary profiles which included the right knee condition. The MEB examiner commented that the hip and knee symptoms were relieved with physical therapy, rest and use of non-narcotic medication (Ibuprofen). The examiner noted an excellent prognosis and concluded that the CI “is able to do his MOS in regards to his knee and hip pain.” The CI was diagnosed with depression and started on the anti-depressant Celexa shortly after return from deployment. During the MEB psychiatric evaluation, the CI reported that his depressive symptoms had improved with medication. The psychiatric examiner noted that the CI had not required hospitalization and had never been profiled for psychiatric reasons. The diagnosis was Depressive disorder, in remission, and the examiner concluded that there was no impairment for further military duty. The CI was diagnosed with a Morton’s neuroma in the right foot and a possible neuroma in the left foot. The right foot condition required treatment with steroid injections and did result in some temporary profile restrictions. In January 2005, podiatry noted that the foot pain condition was nearly resolved and the CI was released back to work without restrictions. The podiatry MEB exam documented that the CI was able to perform his MOS and could return to duty from the standpoint of his podiatric diagnoses.

The CI was diagnosed with left subclavian artery stenosis and left subclavian steal syndrome due to complaints of aching and fatigue in the left arm and numbness and tingling in the left thumb and fingers. At the time of the MEB vascular evaluation, the CI denied any central nervous system symptoms to include vision loss, dizziness or facial droop. The CI initially declined surgery; however, in December 2006 (a month after the MEB and 7 months prior to separation) he underwent placement of a stent in the left subclavian artery due to complaints of imbalance and exertional fatigue in the left upper extremity. The immediate post-procedure angiogram documented resolution of the left subclavian artery stenosis and resolution of the subclavian steal phenomenon. A subsequent civilian cardiology visit in December 2006 noted some persistent symptoms of dizziness on standing. A cerebrovascular ultrasound performed at that visit documented a 50 – 75% stenosis of the left subclavian artery and was suggestive of a latent vertebral to subclavian steal syndrome. The CI complained of ongoing symptoms of vertigo and memory loss in his appeal to the MEB (December 20, 2006), however, by the time of the C&P exam (3 months after separation) he denied any symptoms or limitations. The Board notes that it is not uncommon for members to be separated for an established unfitting condition with pending treatment issues for conditions unrelated to the reason for a MEB. The service’s responsibility in such cases is to assure that there are no safety concerns with transfer of care, not to see all conditions through to their maximal resolution. When assessing the fitness implications of these collateral conditions, the PEB acknowledges that the member is not remaining on active duty for other reasons. It must therefore anticipate the typical clinical course and expected impact on long-term MOS performance. The Board must judge the fairness of the PEB’s fitness adjudication in such cases on the basis of that principle, not on the particulars in effect on the day of separation.

The CI was diagnosed with mild OSA that was treated with continuous positive airway pressure (CPAP). Routinely OSA is not considered unfitting solely on the basis of field and operational impediments to the use of CPAP. There is no evidence in this case that OSA was associated with any unfitting impairments not corrected by CPAP. The PEB’s fitness adjudication was therefore expected and reasonable.

None of the discussed conditions was permanently profiled, implicated in the commander’s statement or noted as failing retention standards. All conditions 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 duty performance. All evidence considered, there is not a preponderance of evidence 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 asserts that compensable ratings should be considered for left hand neuropathy and OSA. As discussed above, these conditions were reviewed by the action officer and considered by the Board. There was not a preponderance of evidence in the CI’s favor for concluding that either condition interfered with duty performance to a degree that could be argued as unfitting. The Board determined therefore that neither the left hand neuropathy nor the OSA conditions are subject to service disability rating.

Remaining Conditions. One other condition identified in the VARD proximal to separation and documented in the DES file was hiatal hernia (listed as gastroesophageal reflux disease [GERD] in the DES). Several additional non-acute conditions or medical complaints were also documented in the MEB history and physical. None of these conditions were significantly clinically or occupationally 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. Additionally the condition of tinnitus was noted in the VARD proximal to separation, but was 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. As discussed above, PEB reliance on the USAPDA pain policy for rating the chronic neck pain condition was operant in this case and the condition was adjudicated independently of that policy regulation by the Board. In the matter of the chronic neck pain condition, the Board unanimously recommends a permanent service disability rating of 20%, coded 5242 IAW VASRD §4.71a. In the matter of the right greater trochanteric bursitis, right retropatellar pain syndrome, depressive disorder, Morton neuroma (right foot), neuritis (left foot), left subclavian stenosis (with steal syndrome) and mild obstructive sleep apnea conditions, the Board unanimously recommends no change from the PEB adjudications as not unfitting. In the matter of left hand neuropathy condition, the Board unanimously agrees that it cannot recommend a finding of unfit for additional rating at separation. In the matter of the hiatal hernia 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 medical separation:

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| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Chronic Neck Pain | 5242 | 20% |
| **COMBINED** | **20%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20100406, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans Affairs Treatment Record

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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 XXXXXXXXXX, AR20120008231 (PD201100251)

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:

Encl XXXXXXXXX

Deputy Assistant Secretary

(Army Review Boards)

CF:

( ) DoD PDBR

( ) DVA