RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXXXXXXX BRANCH OF SERVICE: Army

CASE NUMBER: PD1100268 SEPARATION DATE: 20040918

BOARD DATE: 20120409

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was a Reserve SGT/E-5 (92A, Unit Supply Specialist), medically separated for chronic low back pain (LBP)*.* The CI had a long history of LBP with a flare during his deployment that lead to his early redeployment. 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 L3 profile and underwent a Medical Evaluation Board (MEB). The MEB forwarded LBP with subjective radiculopathy to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501. No other conditions appeared on the MEB submission. Other conditions included in the Disability Evaluation System (DES) packet will be discussed below. The PEB adjudicated the chronic LBP condition as unfitting, rated 10% with application of the US Army Regulation 635-40 paragraph B-29e. The CI appealed to the Formal PEB (FPEB) which upheld the PEB adjudication. The case was also reviewed by the US Army Physical Disability Agency (USAPDA) and they administratively changed the disability rating code from 5299-5237 to 5237 without a change in the rating percentage. The CI made no further appeals and was then medically separated with a 10% disability rating.

CI CONTENTION: “Request review my records for possible medical retirement.” Under item 14, he additionally elaborates “I have since went before VA Medical Board they awarded 40% for my back, because I could not back to work due to my condition—also awarded individual unemployability I have been dealing with depression. I deal with back problem on daily Basic. Take med. given to me by VA.” Spelling and grammar errors are left intact.

RATING COMPARISON:

|  |  |
| --- | --- |
| **FPEB (Admin Correction) – Dated 20040407** | **VA – All Effective 20040919** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Chronic Low Back Pain | 5237 | 10% | DDD, Lumbosacral Spine at L4-5 and L5-S1 Levels | 5234 | 40%\* | 20030530, 20061130 |
| ↓No Additional MEB/PEB Entries↓ | S/P Fracture Right Wrist | 5215 | 10% | 20030530 |
| 0% x 0/Not Service-Connected x 0 |
| **Combined: 10%** | **Combined: 50%\*\*** |

\*Initially rated at 20% but increased to 40% effective 20040919 with a Decision Review Officer Decision dated 20081023.

\*\*Increased to 80% effective 20070201 after addition of Depression (associated with Degenerative Disc Disease) 9434 rated 70%.

ANALYSIS SUMMARY: The Board acknowledges the sentiment expressed in the CI’s application regarding the significant impairment with which his service-aggravated condition continues to burden him. It is a fact, however, that 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. This role and authority is granted by Congress to the Department of Veterans’ Affairs (DVA). The DVA, operating under a different set of laws (Title 38, United States Code), 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. The Board utilizes VA evidence proximal to separation in arriving at its recommendations; and, DoDI 6040.44 defines a 12-month interval for special consideration of post-separation evidence. The Board’s authority as defined in DoDI 6044.40, however, resides in evaluating the fairness of DES fitness determinations and rating decisions for disability at the time of separation. Post-separation evidence therefore is probative only to the extent that it reasonably reflects the disability and fitness implications at the time of separation.

Unfitting Condition: Low Back Pain. The CI has a longstanding history of LBP with his first documented visit in 1975, a year after enlistment. He responded to conservative management with no further visits noted in the records available for review until 1980. He was seen by an orthopedist who noted that he was lifting some heavy steel at his civilian job and developed severe LBP and right hip pain with exacerbation from cough, sneeze or strain. It was also noted that he had been pain free since the episode in 1975 until the re-injury. He had pain which radiated down the right lower extremity (RLE) to the outside of his foot. He complained that the entire leg felt weak and also of numbness of the lateral 2-3 toes, but no bowel or bladder incontinence. Significant lumbosacral spasm was noted as well as pain with any motion. Weakness of the right gastrocnemius muscle and an absent right Achilles reflex were noted. He was thought to have disc disease with S1 “nerve root compromise on the right.” The record also documents that he sought compensation from his company unsuccessfully. Imaging was normal and he was again managed conservatively. He was next seen in 1994 after moving a water buffalo with re-injury. He was treated with medications and 72 hours quarters with apparent resolution of his symptoms. He was next seen May 2002 while deployed to Qatar. He presented with a 7-10 day history of LBP after increased exercise without specific injury. He failed conservative management and an MRI reportedly showed a herniated nucleus pulposus (HNP) at “L5-S1.” The MRI report is not in the records available for review, but was apparently obtained on the economy in Qatar. He was re-deployed on 18 June 2002 and seen by both an orthopedist and a neurologist on 20 June 2002. At the orthopedic exam he noted that this was the first episode of LBP in his lifetime and that there was a stocking distribution of paresthesias from the knee down in the RLE. Onset was described as insidious. Motor and DTR exams were normal and no bowel or bladder incontinence was noted. MRI showed an anterior L5-S1 disc bulge and degenerative disc disease (DDD) L4-5 and L5-S1.

He was thought to have a possible atypical radiculopathy of the RLE. At the neurology evaluation, the CI stated that he had injured himself in the mailroom and that conservative management had been unsuccessful. He also noted RLE weakness and, upon awakening, numbness of the right 4th and 5th toes. His motor exam was normal except for RLE and right upper extremity (RUE) “give way weakness,” an indication of non-organic etiology for the deficit. Deep tendon reflexes (DTRs) were normal and sensation diminished in an L5-S1 distribution. Straight leg raise (SLR) on the right was positive. He was referred to physical therapy (PT) where he noted that he had gradual onset of symptoms which worsened on 11 May 2002 when he awoke with RLE symptoms. He was treated both in the clinic and with a home exercise program (HEP) and noted to have a L5-S1 HNP with a “supratentorial overlay.” He was seen again in orthopedics on 2 August 2003 and noted to have persistent pain, good range-of-motion (ROM) with a diminished right ankle jerk reflex and motor exam of the RLE. He was referred to neurosurgery where a normal motor, sensory and DTR exam was noted. The examiner opined that the CI had “DDD with a slight bulge at 5-1 but nothing that I think is of surgical significance. I don’t think it is related to an injury and it appears to me to be degenerative in nature.” An orthopedic exam 3 days later showed a decreased S1 reflex, decreased sensation at S1 and 4+/5 S1 motor exam. An electromyogram/nerve conduction velocity (EMG/NCV) study done 3 weeks later was negative for a right lumbosacral radiculopathy. He was determined to not be a surgical candidate and then referred by the orthopedist to pain management where his exam was normal including ROM other than a diminished right Achilles reflex. He was treated with continued medications and epidural steroid injections (ESI) with only temporary relief and it was determined that he should be referred to MEB for persistent LBP. The Board notes that during the MEB period, the CI continued to be seen in the pain management clinic and had multiple additional ESIs. There were four goniometric ROM evaluations in evidence, with documentation of additional ratable criteria, which the Board weighed in arriving at its rating recommendation.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Thoracolumbar ROM | VA C&P 16 months Pre-Separation20030530 | PT for MEB 8 Months Pre-Separation20040115  | Disability H&P3 Months Post-Separation20041229  | VA C&P 26 Months Post-Separation20061130 |
| Flexion 0-90⁰ normal | 70⁰ | 10⁰ (20°, 25°, 10°) | About 20° | 20⁰ |
| Combined 240⁰ normal | 210⁰ | 125⁰ | Not measured | 110⁰ |
| Comments | Lumbar spasm and mild limp to the right; not able to walk on heels but is able to go up and down on his toes; no motor weakness; reflexes 2+; no incontinence | Rest of exam done 20030916: Moderate tenderness to palpation; no true SLR; some give-way weakness in right foot and leg and upper extremity but no true motor weakness; decreased sensation in non-anatomic stocking and glove distribution; MRI had mild disc bulge at L5-S1 | Unable to dorsiflex right great toe; no sensation in L5 dermatome on the right; positive SLR on right; normal strength in the left lower extremity; some slight muscle atrophy in the right lower extremity; not able to walk on toes or heels | Motor and SLR normal. No atrophy. Antalgic gait and used cane |
| §4.71a Rating | 20%  | 40% | 40% | 40%  |

The VA C&P exam, utilized for the VA decision most proximate to separation, was done for an increase in the disability for the back on 30 May 2003, almost 16 months prior to separation. An initial claim in 1980 had been determined to be non-service connected (NSC) because he had no chronic condition at that time. He was noted to walk without aids and to have a normal gait. He stated that the pain recurred while running. He did use a back brace at work. Sensory exam was not documented. Motor exam and DTRs were normal as was a bilateral SLR. Incontinence was denied. Imaging was normal. A 20% disability rating was awarded for spasm and an abnormal gait. It was coded 5243, intervertebral disc syndrome. A de novo review of this condition was completed in April 2005 and the 20% rating was continued. However, upon further appeal, the VA increased the disability rating to 40% effective 19 September 2004, the day after separation from service. This rating decision cited VA C&P examinations of 30 November 2006 and 10 January 2008 and testimony from 31 January 2007 as supporting this decision.

The MEB exam was accomplished 4 November 2003, over 10 months prior to separation. No additional trauma was noted between the MEB and 2003 C&P exams. Sensation was noted to be decreased throughout the RLE in a stocking distribution (non-anatomic). Tenderness to palpation was noted, right>left, about the lumbar spine. The motor exam was diminished to 4/5 on the right due to “give way” weakness. No true positive SLR was noted. The ROM was measured separately on 15 January 2004 (8 months prior to separation) and noted in the chart above. The CI was also noted to have a non-anatomic distribution of sensory loss of the RUE and this was considered 1 positive Waddell’s sign out of a possible 5. The MEB H&P done in September 2003 also noted thoracolumbar flexion not greater than 20 degrees. The FPEB awarded 10% disability coded 5299-5237, lumbosacral strain. They specifically cited US Army Regulation 635-40 paragraph B-29e which states rating for loss of joint motion can only be awarded where a mechanical basis for limited motion is found. The USAPDA administratively changed the VASRD code to 5237 alone but did not change the rating. While no mechanical basis for the limited ROM existed, the VASRD does not require a mechanical basis and recognizes pain-limited motion as productive of disability.

The Board notes a significant difference in exams between the VA and MEB. Both examinations contain full goniometric measurements of active ROM. However, the MEB examination is closer in time to the date of separation and it is therefore afforded a higher probative value. There is no indication of embellishment of ROM limitations noted in any examination in the record and all examinations after the MEB NARSUM examination showed thoracolumbar flexion less than or equal to 30 degrees. This included a disability evaluation completed in December 2004 and two additional C&P examinations accomplished long after separation. The disability evaluation examinations of December 2004 may have been completed as part of an evaluation for social security disability. There is evidence in the record of the CI notifying the VA he had received social security disability benefits. At the 30 November 2006 C&P, the CI was noted to use a cane and to have an antalgic gait. ROM was limited due to pain and is noted below. There was no muscle spasm or atrophy. SLR, DTR and motor exams were normal as was imaging. He had no incapacitating episodes at this exam or at the 10 January 2008 exam. On the 2008 exam, he again was noted to use a cane and had an antalgic gait. Thoracolumbar flexion was limited by pain to 30 degrees. Motor, sensory and DTR exams were normal and there was neither atrophy nor spasm noted. SLR was negative. A CT showed a small posterior bulge at L5-S1 with a small left paramedian disc herniation.

The Board utilizes VA evidence proximal to separation in arriving at its recommendations as well as other available clinical evidence. DoDI 6040.44 defines a 12-month interval for special consideration to post-separation evidence. The Board’s authority as defined in DoDI 6040.44, however, resides in evaluating the fairness of DES fitness determinations and rating decisions for disability at the time of separation. Post-separation evidence therefore is probative only to the extent that it reasonably reflects the disability and fitness implications at the time of separation. In this case, the CI first had radiculopathy noted by an orthopedist in 1980, 24 years prior to separation, following an injury at his civilian workplace. The Board notes that while the CI initially improved after this injury, the symptoms present were similar to those seen much later which lead to the PEB. The Board also notes that various examiners commented on a non-organic stocking distribution of sensory disturbance.

The Board considered the different rating options for the CI which best represents the level of permanent disability at separation. It noted that the sensory exam was non-anatomic and that the motor and DTRs, while variable, tended to be normal. The significant limitation in ROM documented on the MEB NARSUM examination, remained present for years as documented on VA C&P examinations in 2006 and 2008 without any evidence that questioned the validity of this clinical finding.

After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a separation rating of 40% for the back condition. The Board considered the findings proximate to separation, but also reviewed the examinations more distant to separation to gain a picture of the actual permanent disability. It noted that the ROM limitation found on the MEB exam, the disability evaluation of December 2004, and the 2006 VA C&P exam were all consistent with each other and with a 40% evaluation. The Board also noted that the CI did have an antalgic gait and used a cane on a regular basis independent of the ROM findings. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a separation rating of 40% for the back condition as best representing the permanent disability at separation.

Additionally, the CI reported pain radiating into his right leg and foot as well as intermittent numbness. However, examinations documented inconsistent findings and the CI had an EMG that did not support of finding of a radiculopathy. There is no evidence of any true muscle weakness at the time of separation and the give-way weakness noted on the MEB NARSUM examination is most likely attributable to pain. 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 pain component of a radiculopathy is subsumed under the general spine rating as specified in §4.71a. The sensory component in this case has no functional implications. As no evidence of functional impairment exists in this case, the Board cannot support a recommendation for additional rating based on peripheral nerve impairment.

Contended conditions. The CI contends for depression under item 14. The Board notes that this was not part of the DES and that the first visit for mental health issues was almost a year after separation. 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. However, this condition remains eligible for adjudication by the Army Board of Correction for Military Records (ABCMR).

Remaining Conditions. Other conditions identified in the DES file were trouble sleeping, sinusitis, GERD, neck pain, shoulder pain, knee pain, and ankle pain. None of these conditions were clinically or 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. Additionally, right wrist fracture and several other non-acute conditions were noted in the VA 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. As discussed above, PEB reliance on the US Army Regulation 635-40 paragraph B-29e for rating chronic LBP was operant in this case and the condition was adjudicated independently of that policy regulation by the Board. In the matter of the chronic LBP condition, the Board, by simple majority, recommends a disability rating of 40% coded 5237 IAW VASRD §4.71a. The single voter for dissent (who recommended rating 5237 at 20%) did not elect to submit a minority opinion. In the matter of the depression, trouble sleeping, sinusitis, GERD, neck pain, shoulder pain, knee pain, and ankle pain, 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 and that the discharge with severance pay be recharacterized to reflect permanent disability retirement, effective as of the date of his prior medical separation:

|  |  |  |
| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Chronic Low Back Pain | 5237 | 40% |
| **COMBINED** | **40%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110406, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans Affairs Treatment Record

 XXXXXXXXXXXX

 President

 Physical Disability Board of Review

SFMR-RB

MEMORANDUM FOR Commander, US Army Physical Disability Agency

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

SUBJECT: Department of Defense Physical Disability Board of Review Recommendation

for XXXXXXXXXXXX, AR20120008233 (PD201100268)

1. Under the authority of Title 10, United States Code, section 1554(a), I approve the enclosed recommendation of the Department of Defense Physical Disability Board of Review (DoD PDBR) pertaining to the individual named in the subject line above to recharacterize the individual’s separation as a permanent disability retirement with the combined disability rating of 40% effective the date of the individual’s original medical separation for disability with severance pay.

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:

 a. Providing a correction to the individual’s separation document showing that the individual was separated by reason of permanent disability retirement effective the date of the original medical separation for disability with severance pay.

 b. Providing orders showing that the individual was retired with permanent disability effective the date of the original medical separation for disability with severance pay.

 c. Adjusting pay and allowances accordingly. Pay and allowance adjustment will account for recoupment of severance pay, and payment of permanent retired pay at 40% effective the date of the original medical separation for disability with severance pay.

 d. Affording the individual the opportunity to elect Survivor Benefit Plan (SBP) and medical TRICARE retiree options.

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 CATHERINE C. MITRANO

 Deputy Assistant Secretary

 (Army Review Boards)

CF:

( ) DoD PDBR

( ) DVA