RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: xxxxxxxxxx BRANCH OF SERVICE: Army

CASE NUMBER: PD1100344 SEPARATION DATE: 20051005

BOARD DATE: 20120423

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was a National Guard SGT/E-5 (51R, Interior Electrician), medically separated for chronic low back pain (LBP) and left shoulder pain*.* He had a long history of LBP without any specific injury or precipitating event. The CI’s left shoulder pain also began without any specific injury or precipitating event about a year prior to separation. There was no indication for surgical intervention for either condition, and despite conservative treatment the CI was unable to fully perform within his Military Occupational Specialty (MOS) or meet physical fitness standards. He was issued a permanent U3/L3 profile and underwent a Medical Evaluation Board (MEB). Chronic LBP and chronic left shoulder pain were forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501. No other conditions appeared on the MEB’s submission. Other conditions included in the Disability Evaluation System (DES) file will be discussed below. The PEB adjudicated the chronic LBP condition as existing prior to service (EPTS) but compensable under 10 U.S.C. 1207A, rated 10% IAW the Veterans Administration Schedule for Rating Disabilities (VASRD); and adjudicated the chronic left shoulder pain condition as unfitting, rated 0% with application of the US Army Physical Disability Agency (USAPDA) pain policy. The CI made no appeals, and was medically separated with a 10% combined disability rating.

CI CONTENTION: “While I was on Medical Hold at Ft. Bragg, NC, receiving treatment for my lower back and chronic left shoulder pains, I had been sent to receive treatment from a private physician, (Dr. Joel Greenberg), for cervical/neck pains. My packet had been sent up to the Physical Disability Board and I was not able to include the cervical/neck diagnosis in the disability report. I had to have surgery on my cervical/neck to remove and replace two disks and remove some spurs. The cervical/neck problems should have been one of the injuries on the documents sent to the Medical Board. The VA awarded me compensation for; lower back 40%, left shoulder 20%, cervical/neck 10% which is on appeal. The Physical Disability Board only awarded me 10% for my lower back and 0% for my shoulder. Inmy opinion, both awards should have been higher and my cervical/neck problem should have been included for consideration of a fair percentage.” 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:

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| --- | --- |
| **Service PEB – Dated 20050830** | **VA (~8 Mo. After Separation) – All Effective 20051006** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Chronic Low Back Pain | 5237 | 10% | Lumbar Spine Condition | 5237 | 40% | 20060612 |
| Chronic Left Shoulder Pain | 5099 5003 | 0% | Left Shoulder Strain | 5201 | 20% | 20060612 |
| ↓No Additional MEB/PEB Entries↓ | Tinnitus | 6260 | 10% | 20060612 |
| Cervical Spine Condition | 5242 | 10% | 20060612 |
| Hypertension | 7101 | 10% | 20060612 |
| 0% x 2/Not Service-Connected x 1 | 20060612 |
| **Combined: 10%** | **Combined: 70%** |

\* VA initial rating for low back pain in 1989 and rated at 40% (5292) effective 20021122

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 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 also acknowledges the CI's contention suggesting that 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 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.

Chronic Low Back Pain. The CI had a history of intermittent LBP dated to the mid 1980s. He had a series of VA ratings for his low back condition dating to 1989, and had most recently been rated at 40% based on a December 2002 exam. His symptoms became more constant upon his activation in 2003. At no time did the CI complain of radicular symptoms attributable to the thoracolumbar spine. MRI of the lumbar spine showed a broad-based disc protrusion at L4-5 which “encroaches upon the lateral recesses and deforms anterior thecal sac.” This was judged not to be amenable to surgical intervention.

There were two VASRD compliant goniometric range-of-motion (ROM) evaluations, 1 non-VARSD compliant goniometric ROM evaluation, and several non-goniometric evaluations in evidence, with documentation of additional ratable criteria, which the Board weighed in arriving at its rating recommendation.

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| Thoracolumbar ROM | Ortho – 4 Mo. Pre Sep | PT – 3 Mo. Pre Sep | VA C&P –8 Mo. Post Sep |
| Flexion 0-90⁰ normal | 50⁰ | (37, 37, 38) 35⁰ | 0⁰-60⁰ |
| Combined 240⁰ normal | 200⁰ | 135⁰ | 210⁰ |
| Comments | ROM “is full,” able to touch toes; demonstrated forward flexion 50 degrees; Normal contour, no spasm, no tenderness | PROM 90⁰ flexion | Normal gait, no spasm |
| §4.71a Rating | 10%-20%\* | 20% | 20% |

\* See text below.

An orthopedic addendum (on 13 June 2005) for the MEB narrative summary (NARSUM) dated 4 months prior to separation recorded normal contour, absence of spasm, and normal motor and sensory findings in the lower extremities. The ROM was measured at 50⁰ of forward flexion, but there was conflicting evidence within the exam. The examiner stated: “ROM of the lumbar spine is full. The patient is able to touch his toes, demonstration with forward flexion of 50 degrees and extension of 30 degrees. Lateral rotation is 45 degrees bilaterally and lateral flexion is 45 degrees bilaterally.”

A service treatment record (STR) clinical note on 12 July 2005 documented a stiff gait with paravertebral spasm and ROM limited by pain. Formal ROM measurements by physical therapy were conducted a week later (on 19 July 2005) are charted above. These active ROM measurements reflected pain limited ROMs, without mechanical limitations and concurrently measured passive ROMs were normal. A discharge PT treatment note of 28 July 2005 indicated ROM “WNL – c/o pain at end ROM” without specific measurements, or noting active, passive or repetitive testing.

At the VA Compensation & Pension (C&P) exam 8 months after separation (on 12 June 2006), the CI reported no difficulties with his usual daily activities due to back pain. The examiner recorded a normal gait and normal spinal contour without spasm. ROM was to 60⁰ in forward flexion and normal in all other planes. Repetitive testing increased the pain without changing the ROM or fatigability. The lower extremity motor and sensory exams were normal.

All measured active ROMs documented “Forward flexion of the thoracolumbar spine greater than 30 degrees but not greater than 60 degrees” which met the 20% rating criteria. The clinical notes were mixed on pain and occasional spasm without additional formal ROMs, and some “FROM” entries indicating “full” ROM. The orthopedic exam comments decreased the probative value of the measured ROM for that exam, and did not address DeLuca criteria. There was no evidence of unfitting peripheral nerve impairment or documentation of incapacitating episodes. The PEB and VA chose the same coding option for the condition. The PEB’s DA Form 199 indicated that the PEB judged the back pain condition to have existed prior to service, but was unfitting and compensable IAW 10 U.S.C. 1207A (8 years of active service rule). The PEB stated “soldier can forward flex to 90 degrees” which was a documented passive ROM and IAW Army guidance in effect at the time. Given the absence of other ratable findings, this suggests that the assigned 10% rating may have been IAW the USAPDA pain policy or IAW VASRD §4.59. The VA cited C&P exam evidence consistent with a 20% rating in support of its decision to maintain the CI’s prior 40% rating. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a service disability rating of 20% for the back pain condition.

Chronic Left Shoulder Pain. The right-handed CI noted the sudden onset of left shoulder pain upon awakening one morning with no history of trauma or injury. No pathology amenable to surgical intervention was identified. There were two goniometric ROM evaluations in evidence, with documentation of additional ratable criteria, which the Board weighed in arriving at its rating recommendation.

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| L Shoulder ROM | Ortho – 4 Mo Pre-Sep20050613 | PT – 3 Mo Pre-Sep20050719 | VA C&P –8 Mo. Post Sep20060612 |
| Abduction 180⁰ normal | 110⁰ | (93, 93, 93) 93⁰ | 75⁰ |
| Flexion 180⁰ normal | 125⁰ | (91, 91, 91) 91⁰ | 100⁰ |
| Comments | No weakness, instability | Passive ROMs 95⁰ abd. and 93⁰ flex. | No weakness, instability |
| §4.71a Rating | 10% | 10%-20% | 20% |

The orthopedic addendum to the NARSUM revealed decreased ROM of the left shoulder in flexion and abduction. There was no evidence of instability, and no motor or sensory abnormalities of the upper extremities. An examination by a consulted civilian neurologist (on 24 May 2005) showed a full ROM of the left shoulder with crepitus and discomfort on motion. A treatment note on 20050616 documented “objective L shoulder: unable to abduct beyond 90 deg, + apprehension sign, - subscapularis liftoff sign, + empty can sign.” Physical therapy ROMs (on 19 July 2005) accomplished for the MEB are charted above. The formal PT ROM measurements for the MEB also showed limitations of active and passive ROM. Treatment note on 12 September 2005 indicated left shoulder and left neck pain with radiation into both hands with intermittent hand numbness. An examination by a consulted civilian neurosurgeon (on 14 August 2006) 10 months after separation also showed a “full ROM” of the left shoulder with a normal motor and sensory exam; it appeared that the neurologist considered the CI’s significant cervical spondylosis and herniated cervical discs the etiology of the shoulder pain and intermittent bilateral upper extremity radicular symptoms. NOTE: CI had a cervical fusion 11 months after separation (on 12 September 2006), for neck and shoulder pains.

Radiographs and MRI of the shoulder were normal. Electrodiagnostic studies were also normal. At the VA C&P exam there was no interval history of further injury of the left shoulder. The examiner recorded normal strength and sensation in the upper extremities, and no evidence of instability of the left shoulder. ROMs were markedly diminished as charted above. Repetitive motion testing did increase the pain, but did not change the ROM or cause fatigability.

The Board discussed the possibility that the CI’s left shoulder pain was due to cervical pathology versus left shoulder joint pathology, but adjudged that there was most probably overlap and that the left shoulder pain was best rated under the PEB’s unfitting shoulder diagnosis.

The PEB and VA chose different coding options for the condition. The PEB’s DA Form 199 reflected likely application of the USAPDA pain policy for rating, and its 0% determination was not consistent with §4.71a standards. Although no definite pathology was identified in the left shoulder, the preponderance of evidence in the STR supports the MEB examiner’s findings of diminished ROM. It is obvious that there is a clear disparity between the ROM examinations, with significant implications regarding the Board's rating recommendation. The preponderance of the evidence supported pain-limited motion IAW VASRD 5003 or application of VASRD §4.59 (painful motion) for a minimum 10% rating coded as analogous to 5024 (tenosynovitis). The Board deliberated on if there was sufficient reasonable doubt IAW VASRD §4.3, and in consideration of VASRD §4.40 (functional loss) to adjudge that the CI’s left shoulder condition was closer to the VASRD 5201 code 20% criteria of “limitation of motion at shoulder level.” The Board adjudged the PT exam had the greatest probative value for rating at separation. There was no clinical and/or radiologic evidence that suggested ankylosis, loss of the humeral head, nonunion, malunion, fibrous union, deformity, nonunion or dislocation of the scapula, or recurrent dislocations of the humerus that would have justified any alternate shoulder code with higher rating potential. After due deliberation, considering all of the evidence, the Board majority recommends a separation rating of 10% for the left shoulder condition.

Other Contended Conditions. The CI’s application asserts that a compensable rating should be considered for neck pain. The CI reported that neck pain began suddenly without injury in September 2004. The CI had left shoulder and left neck pain with radiation into both hands with intermittent hand numbness. His evaluation included consultations with both a civilian neurologist and neurosurgeon. The neurologist recorded a normal ROM exam of the neck and a normal neurologic exam. An electrodiagnostic study was normal. MRI showed diffuse degenerative changes, severe cervical spondylitic disease and disc bulges at C5-6 and C6-7. As discussed above, the CI had a cervical fusion on 12 September 2006, 11 months after separation for neck and shoulder pains. The neck pain condition did not carry an attached profile, was not implicated in the commander’s statement, and was not judged to be medically unacceptable. As discussed above, the right shoulder pain rating would include any radicular pain from the cervical condition. The neck and intermittent hand numbness 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 this condition interfered with duty performance to a degree that could be argued as unfitting. The Board determined therefore that the neck and intermittent hand numbness conditions were not subject to service disability rating.

Remaining Conditions. Other conditions identified in the DES file were sinus problems, tinnitus, psoriasis, left wrist cyst, high blood pressure, difficult sleeping, and diverticulitis. Several additional non-acute conditions or medical complaints were also documented. 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. No other conditions were service-connected with a compensable rating by the VA within 12 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. As discussed above, PEB reliance on the USAPDA pain policy for rating shoulder pain was operant in this case and the condition was adjudicated independently of that policy by the Board. In the matter of the chronic back pain condition and IAW VASRD §4.71a, the Board unanimously recommends a rating of 20% coded 5237. In the matter of the left shoulder condition, the Board by a simple majority recommends a rating of 10% coded 5099-5024. The single voter for dissent (who recommended adopting the VA rating 5201 at 20%) did not elect to submit a minority opinion. In the matter of the neck pain and intermittent hand numbness conditions, the Board unanimously agrees that it cannot recommend a finding of unfit for additional rating at separation. In the matter of the sinus problems, tinnitus, psoriasis, left wrist cyst, high blood pressure, difficult sleeping, and diverticulitis 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 and that the discharge with severance pay be recharacterized to reflect permanent disability retirement, effective as of the date of his prior medical separation.

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| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Chronic Low Back Pain | 5237 | 20% |
| Left Shoulder Strain | 5099-5024 | 10% |
| **COMBINED** | **30%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110427, 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, AR20120008648 (PD201100344)

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 30% 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 30% 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 XXXXXXXXX

 Deputy Assistant Secretary

 (Army Review Boards)

CF:

( ) DoD PDBR

( ) DVA