RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXXXXXXX BRANCH OF SERVICE: AIR FORCE

CASE NUMBER: PD1100401 SEPARATION DATE: 20060515

BOARD DATE: 20120614

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SRA/E-4 (3E051, Electrical Journeyman), medically separated for chronic left shoulder instability. He did not respond adequately to treatment and was unable to perform within his Air Force Specialty (AFS) or meet physical fitness standards. He was issued a permanent U4 profile and referred for a Medical Evaluation Board (MEB). Chronic left shoulder pain and instability and chronic low back pain (LBP) were forwarded to the Physical Evaluation Board (PEB) as conditions that contribute or may contribute to make the qualifications for worldwide duty questionable IAW AFI 48-123. The MEB forwarded no other conditions for PEB adjudication. The PEB adjudicated the chronic left shoulder instability condition as unfitting, rated 20% with application of the Veterans Administration Schedule for Rating Disabilities (VASRD). The intermittent back pain condition was determined to be not unfitting. The CI appealed to the Formal PEB (FPEB) and the Secretary of the Air Force Personnel Council (SAFPC) and was medically separated with a 20% combined disability rating.

CI CONTENTION: “1) Degenerative Changes of lumbosacral spine not considered in MEB, please refer to item 13. 2) I believe based on VA Rating Decision within one year of discharge these additional conditions should be considered for this request. Please refer to Item 14. I am currently rated for 20% residuals of Left Shoulder Injury, S/P 4 Surgical Repair. Within one year following discharge I was rated by the VA at 70%; the ratings included: 30% Chronic Allergic Rhinitis, 20% Residuals of Left Shoulder Injury, S/P 4 Surgical Repair, 20% Degenerative Changes Lumbosacral Spine, S/P Fusion at L5-S1. 10% Irritable Bowel Syndrome with Gastroesophageal Reflux Disease; 10% Degenerative Changes Cervical Spine; 10% Tinnitus, 0% Bilateral Hearing Loss, 0% Surgical Scar Left Shoulder, 0% Scars Residual of Mole Removals on Abdomen, 0% Surgical Scar Lower Back, % Cystic Acne with Residual Scarring. \* Consideration of PTSD 50% of which I was diagnosed in November of 2006 however stressors report were not verifiable at the time and later conceded on 1/28/2010.”

SCOPE OF REVIEW: The Board wishes to clarify that the scope of its review as defined in DoDI 6040.44, Enclosure 3, paragraph 5.e.(2) is limited to those conditions which were determined by the PEB to be specifically unfitting for continued military service; or, when requested by the CI, those condition(s) “identified but not determined to be unfitting by the PEB.” The ratings for unfitting conditions will be reviewed in all cases. The Intermittent back pain associated with mild degenerative disc disease condition requested for consideration and the unfitting chronic left shoulder instability, status post four surgeries condition meet the criteria prescribed in DoDI 6040.44 for Board purview, and are accordingly addressed below. The other requested conditions and remaining conditions rated by the Department of Veterans’ Affairs (DVA) at separation and listed on the DA Form 294 are not within the Board’s purview. Any conditions or contention not requested in this application, or otherwise outside the Board’s defined scope of review, remain eligible for future consideration by the Air Force Board for Correction of Military Records (AFBCMR).

RATING COMPARISON:

|  |  |
| --- | --- |
| **Service Sec AF Pers. Council – Dated 20060310** | **VA (5 Mos. Post-Separation) – All Effective Date 20060516** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Chronic Left Shoulder Instability | 5202 | 20% | Residuals of Left Shoulder Injury, s/p 4 Surgical Repairs | 5210 | 20% | 20061026 |
| Chronic Low Back Pain | Not Unfitting | Degenerative Changes, Lumbosacral Spine, s/p Fusion at L5-S1 | 5243 | 20% | 20061026 |
| ↓No Additional MEB/PEB Entries↓ | Degenerative Changes, Cervical Spine | 5243 | 10% | 20061026 |
| Chronic Allergic Rhinitis w/Sinusitis | 6510-6522 | 30% | 20061026 |
| Tinnitus | 6260 | 10% | 20061026 |
| GERD | 7346 | 10% | 20061026 |
| 0% X 5 / Not Service-Connected x 12 |  |
| **Combined: 20%** | **Combined: 70%** |

ANALYSIS SUMMARY: The Disability Evaluation System (DES) is responsible for maintaining a fit and vital fighting force. 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 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 nor for conditions determined to be service-connected by the VA but not determined to be unfitting by the PEB. However the VA, operating under a different set of laws (Title 38, United States Code), 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. The Board’s role is confined to the review of medical records and all evidence at hand to assess the fairness of PEB rating determinations, compared to VASRD standards, based on severity at the time of separation. 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 to 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.

Chronic Left Shoulder Instability. The right handed CI had a history of chronic left shoulder instability and pain for which he underwent surgery in November 2000, April 2002, December 2003 and June 2005. At the time of his fourth surgery he was placed on medical hold due to his scheduled date of separation in August 2005. Following placement on medical hold, an MEB was initiated. The MEB narrative summary (NARSUM) following his fourth surgery documented persistent pain and instability. Range-of-motion (ROM) was reported as full active ROM with pain at 90 degrees of elevation. Orthopedic examination 16 January 2006 documented continued left shoulder instability and advised continued physical therapy. At the time of his appeal to the FPEB, the CI submitted new ROM results dated 9 February 2006 (flexion 37 degrees, abduction 31 degrees) that were inconsistent with prior examinations or the VA Compensation and Pension (C&P) examination performed on 26 October 2005, 5 months after separation. The VA C&P examination noted the shoulder was “without significant atrophy,” flexed to 80 degrees and abducted to 50 degrees. The VA rated the left shoulder condition 20% based on limitation of motion (5201) while the PEB adjudicated a 20% rating based on instability of the left shoulder under VASRD diagnostic code 5202. The ROM results from the NARSUM would not support a minimum rating but a minimum 10% rating would be supported by application of §4.59 (painful motion) or §4.40 (functional impairment). The ROM examination results after the MEB NARSUM would not result in a compensable rating higher than the 20% rating adjudicated by the PEB under the diagnostic code for instability (5202). After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board concluded that there was insufficient cause to recommend a change in the PEB adjudication for the left shoulder condition.

Contended PEB Conditions. The contended conditions adjudicated as not unfitting by the PEB was intermittent back pain associated with mild degenerative disc disease. The Board’s first charge with respect to these conditions is an assessment of the appropriateness of the PEB’s fitness adjudications. The Board’s threshold for countering fitness determinations is higher than the VASRD §4.3 (reasonable doubt) standard used for its rating recommendations, but remains adherent to the DoDI 6040.44 “fair and equitable” standard. The MEB NARSUM records CI report of intermittent LBP since a fall in 1999 however service treatment records (STR) are silent regarding care for back pain until 2004. The CI checked “No” to back problems on a June 2003 health assessment form, and checked “No” a question regarding a history of recurrent back pain or any back problem on the DD Form 2807, *Report of Medical History*, in October 2003. A 4 May 2004 VA C&P examination, performed prior to approval of the CI’s request for enlistment extension, recorded a report of intermittent LBP for 4 years which occurred 3 to 4 times per week lasting 30 minutes without radiation. On examination, there was full active ROM, with normal neurologic examination, negative straight leg raising and normal gait. A CT scan of the lumbosacral spine performed on 10 May 2004 disclosed annular bulging of the discs at L4-5 and L5-S1 (less at L3-4) accompanied by “some compromise” in neural foramina bilaterally at L5-S1. A clinic appointment 26 May 2004 recorded intermittent back pain without radiation, and the examination was indicated as normal. The CI’s enlistment extension request was approved and he participated in a CONUS deployment with his unit. An 8 December 2004 occupational health examination noted the CT scan showing bulging discs at L4-5 L5-S1 and recorded the CI experienced back pain from time to time. The CI presented for care of back pain in January 2005 and was treated with medication and physical therapy. A 16 February 2005 physical therapy appointment notes improved symptoms and indicated no loss of lumbar motion on examination. An 11 March 2005 clinic appointment records that physical therapy and medication had “improved his back pain significantly.” There are physical therapy record entries to May 2005 indicating no problems after which the STR is silent for care of back pain until after the PEB. Medical hold was approved for completion of treatment for his left shoulder condition and the CI underwent left shoulder surgery in June 2005 followed by MEB evaluation. The MEB NARSUM notes a history of mechanical LBP with degenerative disc disease that “occasionally does limit his activities, but for the most part is tolerable.”

The NARSUM examination recorded a non-tender back, ROM that was mildly limited in extension and lateral bending (flexion 90 degrees, extension 6 degrees, left lateral flexion 15 degrees, right lateral flexion 20 degrees, left rotation 37 degrees, right rotation 32 degrees), and intact strength and reflexes. The examiner commented that the back condition could cause off and on pain that may require intermittent duty restrictions. The MEB referred chronic left shoulder pain and instability, and chronic LBP to the PEB. The PEB concluded the back pain condition was not unfitting for continued military service based on the evidence of the NARSUM and the STR. A 27 December 2005 clinic appointment documents that the CI’s back “stiffens up at times” without complaint of weakness. Neurologic examination was normal. A positive left straight leg raise and report of a shock going down the right leg prompted imaging by MRI. The MRI, performed on 29 December 2005 demonstrated minimal disc bulges at L3-4 and L4-5 with mild facet hypertrophy, and L5-S1 disc desiccation, bulging, facet hypertrophy. The L5-S1 disc bulge extended laterally to right with mild neuroforaminal narrowing but without definite nerve root impingement. A 12 January 2006 clinic appointment records complaint of “electric shocks down the legs at times”, and constant back pain. The Board made note of concurrent complaint of neck pain associated with arm numbness not supported by the evidence of cervical spine imaging (mild disc degeneration without evidence of disc herniation or stenosis), that was attributed to a neck injury in a fall in 1999 that was not corroborated by primary medical documentation prior to the time of the MEB. The CI appealed to the FPEB on 7 January 2006, contending for addition of his back condition as an unfitting condition for rating. The FPEB noted the MEB NARSUM and the recent MRI consistent with “minimal” degenerative changes and concluded the back condition was not unfitting. The CI was evaluated by a civilian neurosurgeon on 1 February 2006. The CI reported he injured his back in a fall of 45 feet in 1999. He reported he did not lose consciousness but was in a dissociative state and was seen in the emergency department. The primary STR from that time does not corroborate the fall or a head or back injury (records do document a left shoulder strain when the CI slipped while climbing a pole and caught himself with his left arm, and a shoulder injury playing football). Back pain was characterized as mild radiating to the right buttock that worsened with lifting, sitting in one position for more than 30 minutes, and with prolonged walking. There were intermittent shooting pains down both legs to the knees, left more than right shooting pain that occurred approximately two or three times per week and lasted for 5 minutes. The CI denied associated leg weakness. There was decreased movement that was not further characterized. Tight muscles on the right side were noted, but gait was normal, strength was normal, and straight leg raising was negative.

The neurosurgeon recommended physical therapy but “briefly” discussed surgery as an option for improving pain symptoms (“…fusion operation can help some people; the expected results are about 60% get anywhere from 60-80% better, about 30% get just a little better 20-30%, and 10% stay about the same.”). On 10 March 2005, SAFPC considered the CI’s appeal of the FPEB decision. The CI submitted a ROM examination reporting severe limitation in all planes of motion that was not consistent with prior examinations, or a physical therapy examination a week later (some loss of extension consistent with prior examinations and no loss of flexion or side movement). SAFPC upheld the decisions of the prior Boards and the CI was discharged with severance pay on 15 May 2006. After the SAFPC decision and prior to separation, the CI underwent elective discogram (civilian) on 23 March 2006 to evaluate whether the source of back pain was related to disc disease. Injections produced no pain at the L3-4 or L4-5 discs. Injection at the L5-S1 disc produced burning pain that was characterized as “not a significant amount of pain with injection.” Imaging indicated the L5-S1 disc was “severely degenerated” with annular tears allowing for leakage of contrast. The CI elected to undergo back surgery which was performed on 24 April 2006, 3 weeks before separation. The Board noted that the CI was on medical hold for treatment of the left shoulder condition beginning in May 2005 and was on continuous medical restrictions from strenuous activities from that time until separation (physical profile serial reports from 3 May 2005 directed no pole climbing, no lifting >20 pounds, no sit-ups, no push-ups, and no running). There were no injuries after placement on medical hold and the CI was not performing strenuous duties due to the shoulder condition that would cause worsening of the back condition. The results of the December 2005 MRI were similar to the CT scan in May 2004 demonstrating annular bulges without disc herniation. Prior to placement on medical hold for the shoulder condition, the CI was performing duties without impairment related to the back condition. The neurosurgery evaluation of 1 February 2006 did not describe symptoms that were significantly different from those reported prior to placement on medical hold for the shoulder condition. The surgery performed in April 2006, just prior to separation was elective, performed for chronic symptoms, and was not authorized in accordance with AFI 41-210.

The Board considered DoDI 1332.38 and AFI 36-3212 that states if a member has performed his or her duty satisfactorily prior referral into the DES or within the 12 months before a scheduled separation or retirement, a presumption of fitness is established. This presumption applies whether the member was referred to a PEB as a result of nondisability retirement or separation processing. This presumption of fitness can be overcome only if clear and convincing evidence to the contrary is established by a preponderance of evidence that one of the following exists: within the presumptive period an acute, grave illness or injury occurs that would prevent the member from performing further duty, if he or she were not separating or retiring, or a serious deterioration of a previously diagnosed condition occurs that would prevent the member from performing further duty immediately prior to or concurrent with the processing for normal separation or retirement. The Board concluded that there was not a serious deterioration of the CI’s chronic back condition to the degree that would prevent further performance of duty. Although the elective back surgery was not authorized by AFPC, the Board also noted that medical hold was not appropriate for the chronic back condition or performance of elective surgery. The back condition was reviewed by the action officer and considered by the Board. After due deliberation in consideration of the preponderance of the evidence, the Board concluded that there was insufficient cause to recommend a change in the PEB fitness determination for the back pain condition, and, therefore, no additional disability ratings can be recommended.

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. In the matter of the chronic left shoulder instability condition and IAW VASRD §4.71a, the Board unanimously recommends no change in the PEB adjudication. In the matter of the contended chronic LBP condition, the Board unanimously recommends no change from the PEB determinations as not unfitting. There were no other conditions within the Board’s scope of review for consideration.

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

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| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Chronic Left Shoulder Instability, Status Post Four Surgeries | 5202 | 20% |
| **COMBINED** | **20%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110516, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans’ Affairs Treatment Record

 Director of Operations

 Physical Disability Board of Review

SAF/MRB

1500 West Perimeter Road, Suite 3700

Joint Base Andrews MD 20762

XXXXXXXXXX

Dear XXXXXXXXXX:

 Reference your application submitted under the provisions of DoDI 6040.44 (Title 10 U.S.C. §1554a), PDBR Case Number PD-2011-00401

 After careful consideration of your application and treatment records, the Physical Disability Board of Review determined that the rating assigned at the time of final disposition of your disability evaluation system processing was appropriate. Accordingly, the Board recommended no re-characterization or modification of your separation with severance pay.

 I have carefully reviewed the evidence of record and the recommendation of the Board. I concur with that finding and their conclusion that re-characterization of your separation is not warranted. Accordingly, I accept their recommendation that your application be denied.

 Sincerely,

Director

Air Force Review Boards Agency

Attachment:

Record of Proceedings