RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXXXXXXXXX BRANCH OF SERVICE: air force

CASE NUMBER: PD1100403 SEPARATION DATE: 20070319

BOARD DATE: 20120404

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SSgt/E-5 (2F071, Fuels Resource Controller) medically separated for chronic low back pain. The condition was present for several years and was not associated with a surgical indication. 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 an L4 profile and underwent a Medical Evaluation Board (MEB). Chronic low back pain was forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AFI 48-123. No other conditions appeared on the MEB’s submission. The PEB adjudicated the chronic low back pain with minimal annular bulge at L4-5 and L5-S1 condition as unfitting, rated 20% IAW the Veterans Administration Schedule for Rating Disabilities (VASRD). The CI made no appeals and was medically separated with a 20% disability rating.

CI CONTENTION: The CI states: “I was given a lumbar spine rating from the Department of Veterans affairs of 40 percent and a cumulative total of 80 percent.” 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:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Service PEB – Dated 20070131** | | | **VA (1 Mo. After Separation) – All Effective 20070320** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Chronic Low Back Pain | 5243 | 20% | Lumbar Spine Deg. Disease | 5242 | 10%\* | 20070413 |
| ↓No Additional MEB Entries↓ | | | Obstructive Sleep Apnea | 6847 | 50% | 20070413 |
| Gastroesophageal Reflux | 7346 | 10%\*\* | 20070413 |
| Cervical Spine Deg. Disease | 5242 | 10% | 20070413 |
| Chronic Cephalgia | 8100 | NSC\*\*\* | 20070413 |
| Not Service Connected x 4 | | | 20070413 |
| **Combined: 20%** | | | **Combined: 60%** | | | |

\*VA’s 10% rating decision on 24 August 2007 was changed to 40% on 20 April 2009, based on exam 20071025 effective 20 March 2007. \*\*VA’s 10% rating decision on 24 August 2007 changed to 30% on 20 April 2009, effective 20 March 2007. \*\*\*VA’s denial of chronic Cephalgia on 24 August 2007 changed to 10% on 20 April 2009, effective 20 March 2007

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.

Back Condition. Although there were a few clinical encounters between 2003 and 2004 for thoracic back pain, the first entry addressing low back pain was a 3 August 2006 note by a physical therapy (PT) back school, which stated that the condition was present for more than 2 years. A chiropractic note on 14 August 2006 stated that there was no history of lower back trauma but that he experienced a recent flare up when laying his daughter down. He denied radiating pain to the lower extremities at that time. A PT note the following day indicated that left buttock pain associated with the lumbar pain was present. There were two goniometric range-of-motion (ROM) evaluations in evidence which the Board weighed in arriving at its rating recommendation. Both of these exams are summarized in the chart below.

|  |  |  |
| --- | --- | --- |
| Thoracolumbar ROM | PT ~ 3 Mo. Pre-Sep | VA C&P ~ 7 Mo. After Sep\* |
| Flexion 90⁰ normal | 55⁰ (62,56,55) | 30⁰\* |
| Combined 240⁰ normal | 175⁰ | 140⁰\* |
| Comments | Lumbar spasm | Normal gait, painful motion. |
| §4.71a Rating | 20% | 40% |

\*C&P exam on 13 April 2007 did not include flexion and extension. These were added on 25 October 2007.

A pain management specialist on 21 August 2006 (7 months prior to separation) reported that the CI experienced low back pain for the past few years. A recent exacerbation was due to his daughter jumping on his back, resulting in daily, constant pain in the central lumbar area that worsened with driving and prolonged standing. Radicular symptoms were denied. Medication and physical therapy were not helpful. His physical exam revealed a normal gait, lumbar flexion of 75 degrees and full lumbar extension. Some right paravertebral tenderness was present. Straight leg raise testing was recorded as positive bilaterally. Motor strength, sensory and deep tendon reflex (DTR) testing were normal. Magnetic resonance imaging (MRI) showed minimal annular bulge at L4-5 and L5-S1 without nerve root impingement or spinal stenosis. Epidural steroid and right lumbar facet joint injection treatments were not helpful. A brief undated NARSUM exam noted lumbar spasm and normal motor strength. Although the examiner thought that surgical intervention was planned, the CI did not have surgery. A Compensation and Pension (C&P) examination performed on 13 April 2007 (one month after separation) noted that low back pain began in 2001. Pain was described as constant and radiated to the right buttock and the left posterior knee. Symptoms were exacerbated by bending over, twisting or lateral bending and by cold or rainy weather. Rest, heating pads, massage and Ultram (pain medication) were helpful. Walking was limited to a mile and standing to 15 minutes. A physician reportedly placed the CI on bed rest once (for 3 days) during the preceding year. Examination revealed normal posture and gait. Some lumbar flattening was present. Repetitive lumbar motion did not result in additional loss of motion. Motor and sensory exams were normal while an absent right knee DTR was noted. The VA assigned a 10% rating based on this examination. Because this examination did not contain complete goniometric ROM assessments, a repeat exam 7 months after separation provided the missing flexion and extension measurements upon which the VA based its 40% rating. The PEB and VA chose different coding options for the condition, but this did not bear on rating. Under the 5243 code (intervertebral disc syndrome) used by the PEB, the 20% rating was justified by limitation of flexion. There is no evidence that DoD or service specific regulations or policies were applied.

Using the 5242 code (degenerative arthritis of the spine), the VA initially assigned a 10% rating for painful motion. After a complete ROM assessment was obtained at the second VA exam, the rating was changed to 40% based on limited flexion. The ROM values reported by the VA examiner 7 months after separation were significantly worse than those reported by the MEB dated 3 months before separation. There is no record of recurrent injury or other development in explanation of the more marked impairment reflected by the VA measurements. It was agreed therefore, that higher probative value should be assigned to the measurements used by the PEB, which were closer to separation and more consistent with outpatient clinical evaluations in the service treatment record (STR). The Board deliberated whether a higher rating could be achieved under the formula for rating intervertebral disc disease based on incapacitating episodes. However, not even the minimum rating under that formula was met. The preponderance of evidence in this case supports no greater than a 20% rating under the VASRD spine formula. The Board also considered if additional disability was justified for the pain that radiated to the left lower extremity as reported by the VA examiner. While the pain specialist noted positive SLR testing and the C&P examiner reported an absent right knee DTR, all other neurologic findings were normal and MRI evaluation showed no evidence of nerve impingement. The presence of functional impairment with a direct impact on fitness is the key determinant in the Board’s decision to recommend any condition for rating as additionally unfitting. While the CI may have suffered additional lower extremity symptoms related to his back condition, this is subsumed under the general spine rating criteria, which specifically states “with or without symptoms such as pain (whether or not it radiates).” There is no evidence in this case of functional impairment attributable to peripheral neuropathy. The Board therefore, concludes that additional disability rating was not justified on this basis. All evidence considered, there is not reasonable doubt in the CI’s favor supporting a change from the PEB’s rating decision for the low back condition.

Other Contended Conditions. The CI’s application implies that compensable ratings should be considered for obstructive sleep apnea (OSA), gastroesophageal reflux disease (GERD), degenerative disc disease of the cervical spine and chronic cephalgia (claimed as migraine headaches). OSA was first suspected in 2002 when a sleep study was ordered for symptoms of severe snoring, daytime somnolence and observed apneas. There were no subsequent STR entries regarding this condition. At the C&P exam, a review of systems was positive for sleep apnea and the diagnosis was confirmed by a subsequent sleep study. Although the CI did not claim the condition, the VA awarded a 50% rating based on the need for CPAP treatment. PEBs across the services do not routinely find OSA, with or without CPAP requirement, unfitting if symptoms are controlled and functioning is unimpaired. The burden of providing CPAP in field and deployed environments is not considered to be a critical factor with the common availability of portable generators and sanitary facilities. In this case, sleep difficulty was not indicated on a post-deployment survey (10 June 2006), and it was not identified as a problem on the final periodic health assessment (PHA - 29 June 2006). Performance reports described occupational functioning that was “superior” in addition to noting careful and meticulous scrutiny of accounts and documents, attention to detail, and participation in off-duty voluntary events. The OSA condition was not profiled and was not implicated in the commander’s statement. This condition was reviewed by the action officer and considered by the Board. There was no evidence for concluding that it interfered with duty performance to a degree that could be argued as unfitting. The Board determined therefore that the condition was not subject to service disability rating. GERD symptoms, manifested by chest pain, first presented in 2001. After an emergency room visit in 2002 for the same condition, a laboratory test for Helicobacter pylori (a bacterial infection that causes gastric and duodenal symptoms) was positive. The record was silent regarding this condition until an outpatient note on 9 May 2005 reported a several year history of acid reflux. A prescription for Aciphex was requested, which the CI indicated “works great” when taken daily. At that visit the CI stated he never received treatment for H. pylori infection and had never had an endoscopy performed. He was given the prescription, H. pylori testing was again ordered and one month follow-up discussed. Except for annotating on the 29 June 2006 PHA that he took Aciphex for heartburn, there are no further notes in the STR about this condition. The C&P examiner (April 2007) recorded a history of intermittent symptoms with remissions, and that the CI was currently taking no medication. The presence of daily heartburn symptoms and regurgitation of food was also noted. An H. pylori test was positive and the CI subsequently received antibiotic treatment for it in 2008. The GERD condition was not profiled and was not implicated in the commander’s statement. This condition was reviewed by the action officer and considered by the Board. There was no evidence for concluding that it interfered with duty performance to a degree that could be argued as unfitting. The Board determined therefore that the condition was not subject to service disability rating. Cervical spine degenerative disc disease was discovered on an MRI on 15 September 2006 that was ordered by the pain management specialist to evaluate complaints of neck pain and bilateral upper extremity numbness. A small osteophyte caused moderate right neuroforaminal encroachment at C5-6; however, a subsequent electrophysiologic study (EMG) was normal. The C&P examiner stated that symptoms began in 2006 and that there was no history of injury or of incapacitating episodes of pain. The cervical spine condition was not profiled and was not implicated in the commander’s statement. This condition was reviewed by the action officer and considered by the Board. There was no evidence for concluding that it interfered with duty performance to a degree that could be argued as unfitting. The Board determined therefore that the condition was not subject to service disability rating. Headache symptoms were first indicated on the post-deployment survey in June 2006, but no details were described. At a 12 September 2006 clinic visit the CI complained of constant dull ache in the back of his head due to neck pain that was relieved by sleep. He was given pain medication at that visit. The C&P examiner stated that headaches began in 2006 and reported that they lasted 30 minutes if he took medication and two hours if he did not. Headaches were not considered to be prostrating and did not prevent the performance of ordinary activities. The headache condition was not profiled and was not implicated in the commander’s statement. This condition was reviewed by the action officer and considered by the Board. There was no evidence for concluding that it interfered with duty performance to a degree that could be argued as unfitting. The Board determined therefore that the condition was not subject to service disability rating.

Remaining Conditions. No other conditions were noted in the NARSUM, or found elsewhere 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 thus has no 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 chronic low back pain condition and IAW VASRD §4.71a, the Board unanimously recommends no change in the PEB adjudication. In the matter of the OSA, GERD, migraine headache, and cervical spine degenerative disc disease, the Board unanimously agrees that it cannot recommend a finding of unfit for additional rating at separation. The Board unanimously agrees that there were no other conditions eligible for Board consideration which could be recommended as additionally unfitting for rating at separation.

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

|  |  |  |
| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Chronic Low Back Pain | 5243 | 20% |
| **COMBINED** | **20%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110426, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans' Affairs Treatment Record

XXXXXXXXXXXXXXXXXXXXXXXXXXX

President

Physical Disability Board of Review

SAF/MRB

1500 West Perimeter Road, Suite 3700

Joint Base Andrews MD 20762

Dear XXXXXXXXXXXX:

Reference your application submitted under the provisions of DoDI 6040.44 (Title 10 U.S.C. §  1554a), PDBR Case Number PD-2011-00403

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,

XXXXXXXXXXXXXX

Director

Air Force Review Boards Agency

Attachment:

Record of Proceedings