RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: Army

CASE NUMBER: PD1100410 SEPARATION DATE: 20070527

BOARD DATE: 20120123

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SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was a Reserve PFC/ E-3 (92Y, Supply), medically separated for chronic low back pain (LBP) with right L5 radiculopathy. The CI initially presented with LBP in October 2004 when he injured both his right ankle and lower back while running on rocks from a mortar attack. The CI’s symptoms were aggravated by wearing body armor and doing heavy lifting. In December 2004, the CI sought treatment for worsening of low back, right leg, and ankle pain. The therapist placed the CI in a CAM walker (walking boot) and referred him for his back problem to the USAF hospital in Balad for medication and therapy. Because there was no improvement, the CI was transferred to Landstuhl Regional Medical Center and then based on the findings of a magnetic resonance image (MRI), he was transferred to Walter Reed Army Medical Center where he underwent an L5-S1 spinal fusion in March 2005. Despite extensive therapy and surgical treatment the CI did not respond adequately 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 residual low back pain with chronic L5 radiculopathy following surgery to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501. Right peroneal nerve neuropathy, manifested by incomplete foot drop, as identified in the rating chart below, was forwarded on the MEB submission as a medically acceptable condition. The PEB, November 2006, adjudicated the chronic LBP with chronic right L5 radiculopathy condition as unfitting, rated 20% with application of the Department of Defense Instruction (DoDI) 1332.39 and the Veterans Administration Schedule for Rating Disabilities (VASRD), respectively. This PEB determined the right peroneal nerve neuropathy was not unfitting and therefore no rating was applied. The US Army Physical Disability Agency (USAPDA) returned the case to the PEB stating the medical evidence did not support a 20% rating based on the range of motion (ROM) examination. USAPDA also requested the PEB determine if some element of the back condition existed prior to service (EPTS). The PEB completed an informal reconsideration of the evidence on 6 February 2007 and determined there was no EPTS element to the back condition and the ROM examination warranted a 10% rating. It also determined the right peroneal nerve neuropathy was not unfitting. The CI filed a “request for continuation on active duty” (COAD) stating that his disability resulted from combat or an act of terrorism; however the US Army Human Resources Command denied this request. The CI was medically separated with a 10% combined disability rating.

CI CONTENTION: “(1) Soldier should have been medically retired instead of discharged. Soldier’s condition with his spine enabled him to continue his active status. Soldier has: (1) Right lower leg radiculopathy (2) Lumbar spine spondylolisthesis with spondylolysis status post Harington Strauss Fixation. Soldier had a spinal fusion done to his L-5/S-1 to his back while he was at Walter Reed’s Army Hospital in the year of 2005.” He elaborates no specific contentions regarding rating or coding and mentions no additionally contended conditions.

RATING COMPARISON:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Service IPEB – Dated 20070206** | | | **VA (5 Mo. After Separation) – All Effective Date 20070529** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Chronic LBP with Chronic Right L5 Radiculopathy | 5241 | 10% | Lumbar Spine Spondylolisthesis with Spondylolysis status post status Harrington Strauss Fixation from L3 to S1 | 5241 | 20% | 20070920 |
| Right Peroneal Nerve Neuropathy, Manifested By Incomplete Foot Drop | Not Unfitting | | Right Lower Leg Radiculopathy | 8521 | 40%\* | 20070920 |
| ↓No Additional MEB/PEB Entries↓ | | | 0% X 0 / NSC X 1 | | | 20070920 |
| **Combined: 10%** | | | **Combined: 50%\*\*** | | | |

\* VA also granted entitlement to special monthly compensation based on loss of use of one foot effective 20070529.

\*\* Bilateral Tinnitus coded 6260 added effective 20100907; total rating increased to 60%.

ANALYSIS SUMMARY: The Board acknowledges the CI’s contention that suggests Service ratings should have been conferred for the neck condition 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 (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 DVA 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 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 Low Back Pain with Right L5 Radiculopathy Condition. There were two goniometric ROM evaluations and one non-goniometric ROM evaluation in evidence which the Board weighed in arriving at its rating recommendation. These three exams are summarized in the chart below.

|  |  |  |  |
| --- | --- | --- | --- |
| Goniometric ROM – Thoracolumbar | MEB ~ 9 Mo. Pre-Sep  20060828 | DD Form 2808~ 8 Mo. Pre-Sep  20060808 | VA C&P ~4 Mo. After-Sep  20070920 |
| Flex (0-90) | 60⁰ | No goniometrics | 50⁰ |
| Ext (0-30) | 10⁰ | No goniometrics | 18(20)⁰ |
| R Lat Flex (0-30) | 30⁰ | No goniometrics | 15⁰ |
| L Lat Flex 0-30) | 40⁰ | No goniometrics | 15⁰ |
| R Rotation (0-30) | 30⁰ | No goniometrics | 15⁰ |
| L Rotation (0-30) | 45⁰ | No goniometrics | 15⁰ |
| COMBINED (240) | 215⁰ |  | 130⁰ |
| Electromyelogram (EMG) 20060713 chronic right L5 motor radiculopathy | Some increase in upper lumbar lordosis; chronic LBP Thoracic spine hypkyphotic; Right thoracolumbar curve convex to right; ROM is decreased; asymmetric gait-leans to right; uses cane; Right ankle dorsiflexion/plantar flexion 4/5; peroneal strength 4/5; calf atrophy right 34 cm left 35cm;toe extensors/great toe 3/5; ankle foot orthosis(which helps hold his foot up when he walks); Gastrocnemius strength 4/5 motor; Testing difficult-give way weakness; pin prick intact; straight leg raising(SLR) 60 degrees limited by Right lower extremity(RLE) and back pain; Right leg length 1.5cm shorter than left; Lumbar scoliosis | Tenderness to palpation Lumbar area; decreased strength right foot; decreased pinprick; tender along lateral side right thigh  (NOTE TO BOARD- very difficult to read notes on this form in CPF pg 60) | Antalgic and unsteady gait; All ROM’s with pain; increased pain on ROM x3 repetitions but no decrease in ROM; Mild to moderate fatigue, weakness and lack of endurance with repetitive testing x3;Unable to stand on toes due to right ankle weakness; motor strength 4+/5 in right leg and 5/5 in left leg and bilateral upper extremities, hip flexion 4+/5 on right and 5+ on left; Achilles tendon reflexes absent; heel lift in right shoe; Right leg 3/8 inch shorter; using cane; Listing to the left side; + SLR 30 degrees to the RLE |
| §4.71a Rating | 20% (MEB 10%) |  | 20% |
| §4.24a Rating (Nerve) | 30% | 10-20% | 40% (VA rating) |

An MRI in February 2005, demonstrated Grade 2 anterolisthesis of L5 on S1 with likely pars defects producing moderate bilateral neural foraminal narrowing at L5-S1. The CI was diagnosed with spondylolysis/spondylolisthesis L5-S1 Grade 2 with associate lumbar scoliosis and unrehabilitated ankle foot strain and was referred to an orthopedic surgeon. The CI underwent a spinal fusion at L5-S1 in March 2005. Postoperatively, the CI had a urethral tear during the course of initial catheter insertion and required a catheter for one month. He continued with physical therapy, however he developed pain radiating down the right leg to the foot and had continued LBP. An EMG done in July 2006 indicated chronic right L5 radiculopathy. A computed tomography (CT) myelogram later in the month, noted enterolisthesis (anterolisthesis) of the L5 vertebral body on S1.

The MEB narrative summary (NARSUM) examination nine months prior to separation documented that the CI walked with an antalgic gait; required a cane for ambulation; required an ankle foot orthosis (AFO), and had mild foot drop. The CI had pain which extended from the center of his low back to his right anterior thigh and to the dorsum of the foot and toes which interfered with sleep and was aggravated by activities such as walking and required narcotic medication (Percocet) twice daily with some relief. The examiner noted some increase in upper lumbar lordosis; thoracic spine hypkyphotic; right thoracolumbar curve convex to right; and ROM was decreased. The right leg was 1.5cm shorter than the left, there was right calf atrophy with right 34 cm and left 35cm, and motor weakness was present as described in the chart above. Physical therapy had fitted him with an AFO which helped hold his foot up when he walked. At the MEB medical examination eight months prior to separation, the examiner noted tenderness to palpation in the lumbar area; decreased strength of the right foot; decreased pinprick; and tenderness along lateral side right thigh. This examination did not include any goniometric measurements.

The VA Compensation & Pension (C&P) examination four months after separation indicated chronic LBP with weakness, stiffness and spasm; numbness and tingling that radiated to his right foot on a continuous basis (lateral aspect right lower extremity); and pain flares. He required the use of the AFO and a cane for ambulation. The exam also noted inability to stand for more than five minutes; inability to walk more than one half a block; unsteadiness-he reported falling twice over the prior twelve months; functional abnormalities with bending and stooping; increased problems with heavy lifting, pushing or pulling; inability to run; and increased problems changing from sitting to standing. The examiner noted increased pain, mild to moderate fatigue, weakness and lack of endurance on ROM after three repetitions but no decrease in ROM. The examiner also noted the motor abnormalities in the chart above, absent Achilles tendon reflex, a heel lift in right shoe, leg length discrepancy with listing to the left side, and positive straight leg raise (SLR) 30 degrees to the right lower extremity.

The PEB and the VA chose the same disability code 5241 (spinal fusion) however the PEB rated the condition at 10% and the VA rated it 20%. The General Rating Formula for Diseases and Injuries of the Spine considers the CI’s pain symptoms “with or without symptoms such as pain (whether or not it radiates), stiffness or aching in the area of the spine affected by residuals of injury or disease.” All exams proximate to separation met the 20% rating criteria for “forward flexion of the thoracolumbar spine greater than 30 degrees but not greater than 60 degrees.” The CI had chronic LBP, antalgic gait, decreased ROM with pain and still required the use of a cane for ambulation at the VA C&P exam. 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 LBP condition coded 5241.

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. However, the motor impairment was significant in this case and can be linked to significant physical impairment. As there is good evidence of functional impairment, the Board must consider a recommendation for additional rating based on peripheral nerve impairment. Rating under peripheral nerve codes entails a judgment call regarding the severity of incomplete paralysis, especially the mild vs. moderate distinction. A rigid assessment could require 3/5 or worse strength testing to merit the moderate rating. More liberal rating applies any objective motor impairment or atrophy as a threshold for the moderate designation. By precedent, the Board threshold for a “moderate” peripheral nerve rating requires some functionally significant motor and/or sensory impairment.

The PEB adjudicated the right peroneal nerve neuropathy, manifested by mild incomplete foot drop condition as not unfitting however; there is ample documentation in the service treatment record (STR) of the mild incomplete foot drop as interfering with the CI’s daily activities. The Board noted this condition could have resulted from nerve root impingment associated with the spine condition, as a direct result of the ankle injury that occurred at the time of the initial back injury, or from a combination of the two. It is not possible to determine which injury is responsible. However, regardless of the mechanism of injury functional impairment did result. The EMG study of July 2006 clearly documents a chronic right L5 radiculopathy and is consistent with physical findings. The MEB examiner noted that the CI had constant tingling to the lateral aspect of the right lower extremity; weakness and fatigue; a right foot drop secondary to peroneal nerve injury; an AFO was required to hold the foot up to allow for walking along with a cane to provide balance; the right leg was 1.5 cm shorter and a right heel lift was required to assist with balance; there was right calf atrophy; and an inability to stand on toes due to right ankle weakness. The DD Form 2808 noted decreased strength in the right foot and the VA C&P exam indicated mechanical and functional disability and continued need for an AFO, cane, and heel lift to offset the CI’s chronic imbalance and unsteadiness. This condition significantly affected the CI’s ability to ambulate and required the use of three assistive devices: AFO, cane, and heel cup. He also required adaptive equipment to drive a car. He was unable to run at all as indicatied on his permanent profile and could only walk for short distances without taking a break. He was unsteady and had occasional falls.

The VA rated this as a complete paralysis with a 40%. The CI had decreased strength, muscle atrophy, loss of reflexes, sensory disturbances, and constant pain. However, he did not have a complete foot drop or complete loss of motor functioning in his right foot. The examinations present in the record for review do not support a 40% rating. VASRD §4.123 notes: neuritis, cranial or peripheral--characterized by loss of reflexes, muscle atrophy, sensory disturbances, and constant pain at times excruciating--is to be rated on the scale provided for injury of the nerve involved, with a maximum equal to severe, incomplete, paralysis. The radiculopathy present in this case can best be described as severe. Additionally, the VA granted the CI an “entitlement to automobile and adaptive equipment” based on the permanent loss of use of the right foot. Although it is not clear why the VA rated this condition at 40%, it may have been due to this requirement. After due deliberation, the Board agreed that the preponderance of the evidence with regard to the functional impairment of the right peroneal nerve neuropathy, manifested by mild incomplete foot drop condition favors its recommendation as an additionally unfitting condition for separation rating. It is appropriately coded 8521 and rated 30% IAW VASRD §4.124a.

Other Contended Conditions. The CI’s application asserts that compensable ratings should be considered for right lower leg radiculopathy and lumbar spine spondylolisthesis with spondylolysis status post Harrington Strauss fixation. All of these conditions were included in the chronic LBP with right L5 radiculopathy condition discussion above.

Remaining Conditions. Other conditions identified in the DES file were sciatica, right foot pain, and microscopic hematuria. Several additional non-acute conditions or medical complaints were also documented. None of these conditions were significantly clinically or occupationally active separate from the conditions described above 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. Tinnitus and gastroesophageal reflux disease (GERD) were also noted in VA rating decisions after 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.

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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 LBP with right L5 radiculopathy condition, the Board unanimously recommends a permanent Service disability rating of 20%, coded 5241 IAW VASRD §4.71a. In the matter of the right peroneal nerve neuropathy, manifested by mild incomplete foot drop condition, the Board unanimously recommends that it be added as an additionally unfitting condition for separation rating, coded 8521 and rated 30% IAW VASRD §4.124a. In the matter of the sciatica, right foot pain, microscopic hematuria, tinnitus and GERD 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 LBP with Right L5 Radiculopathy | 5241 | 20% |
| Right Peroneal Nerve Neuropathy, Manifested By Incomplete Foot Drop | 8521 | 30% |
| **COMBINED** | **40%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110511, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans’ Affairs Treatment Record

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 XXXXXXXXXXXXXX (PD201100410)

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:

Deputy Assistant Secretary

(Army Review Boards)

CF:

( ) DoD PDBR

( ) DVA