RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXXXXXX BRANCH OF SERVICE: Army

CASE NUMBER: PD1100415 SEPARATION DATE: 20040721

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 (51B, Carpenter and Masonry), medically separated for chronic low back pain (LBP) and obstructive sleep apnea (OSA). The CI sustained an injury to his lower back during 1980 and in May 2003, while deployed to Iraq, he was diagnosed with lower back muscle strain due to increased lifting, twisting and wearing of the load bearing vest (LBV). He also reported gasping for breath at night while asleep, feeling tired and requiring mid-day naps. 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 P3L3 profile and underwent a Medical Evaluation Board (MEB). Chronic LBP and OSA were forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501. Four other conditions, as identified in the rating chart below, were forwarded on the MEB submission as medically acceptable conditions. The PEB adjudicated the chronic LBP and OSA conditions as unfitting, rated 10% and 0% respectively; 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 elected severance pay in lieu of transfer to the retired list awaiting retired pay at age 60.

CI CONTENTION: The CI states: “buys to National Guard Did not look at my medical issues, such as hearing loss, tinnitus, left eye corneal erosion, both knee’s, sleep apnea.” 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 20040530** | **VA (1 Mo. After Separation) – All Effective Date 20040722** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Chronic Low Back Pain | 5243 | 10% | Left Paracentral Disk Protrusion At L5-S1 And Disk Bulge At Annular Tear At L4-5 | 5243 | 10%\* | 20040823 |
| Sleep Apnea | 6847 | 0% | Sleep Apnea | 6847 | 50% | 20040819 |
| Bilateral Knee Degenerative | Not Unfitting | Degenerative Joint Disease, Right Knee | 5003 | 10% | 20040823 |
| Degenerative Joint Disease, Left Knee, Status Post Menisectomy | 5003 | 10% | 20040823 |
| Hearing Loss | Not Unfitting | Right Ear Sensorineural Hearing Loss | 6100 | NSC | 20040819 |
| Gastroesophageal Reflux Disease | Not Unfitting | Gastroesophageal Reflux Disease | 7023-7346 | 10% | 20040819 |
| Recent Right Shoulder Surgery | Not Unfitting | Rotator Cuff Impingement Syndrome, Status Post Right Rotator Cuff Repair | 5201 | 20% | 20040819 |
| Surgical Scar, Right Shoulder | 7804 | 10% | 20040819 |
| ↓No Additional MEB/PEB Entries↓ | Cervical Strain With Degenerative Joint Disease | 5003-5237 | 30% | 20040819 |
| Left Eye Corneal Erosion | 6009 | 10% | 20040819 |
| Tinnitus | 6260 | 10% | 20040819 |
| 0% x 2/Not Service-Connected x 4 | 20040819 |
| **Combined: 10%** | **Combined: 90%** |

\* VA rating based on exam most proximate to date of permanent separation.

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 Department of Veterans’ Affairs (DVA) but not determined to be unfitting by the PEB. However the DVA, 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. It must also judge the fairness of PEB fitness adjudications based on the fitness consequences of conditions as they existed at the time of separation. The Board’s threshold for countering DES 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. Furthermore, a “crystal ball” requirement is not imposed on the service PEB’s by the Board; and, the 12-month window specified in DoDI 6040.44 is appropriate for rating comparisons but not for new developments after separation.

Chronic Low Back Pain Condition. The CI had a history of recurrent LBP with degenerative disc disease (DDD) at L5-S1 prior to mobilization. The CI developed recurrent back pain in June 2003 while being medically evacuated for a knee injury. There was no specific injury to the back, but strenuous duties were recorded. There were no complaints of radiating pain or leg weakness. Magnetic resonance imaging (MRI), demonstrated DDD at L4-5 and L5-S1 with a disc protrusion contacting the left S1 nerve root. A clinic encounter for a week of LBP in January 2004 documented flexion of 90 degrees. The MEB narrative summary (NARSUM) examination on 25 March 2004 recorded there was chronic back pain limiting activities, but no current use of medication. There were no radicular complaints or weakness. On examination, thoracolumbar range-of-motion (ROM) with three repetitions was flexion 60 degrees, extension 25 degrees, left lateral flexion 20 degrees, right lateral flexion 24 degrees, left rotation 45 degrees, and right rotation 45 degrees, with painful motion. Straight leg testing was normal (negative for radicular symptoms), and strength was normal. There was some decreased sensation in both legs. The orthopedic MEB NARSUM dated 2 April 2004, documented forward flexion reaching finger tips to six inches from the floor, which nearly approximates 90 degrees in an individual of the same height (73”). No lumbar spasm was present. Strength was normal. The left ankle reflex was decreased and there was decreased sensation in the left S1 distribution. Straight leg raising was negative and strength was normal. At the time of the VA general medical Compensation and Pension (C&P) examination, on 19 August 2004, a month after separation, the thoracolumbar spine flexed to 90 degrees with pain at 60 degrees. Gait was antalgic apparently due to the left knee. Strength was normal. Four days later, at the VA joint C&P examination, on 23 August 2004, the thoracolumbar spine flexed to 45 degrees, extended 15 degrees, laterally flexed 20 degrees and rotated 35 degrees. Muscle spasm was noted on this examination, gait was antalgic, and strength was normal. A VA clinic encounter in December 2004 recorded complaint of occasional LBP without radiation, numbness or weakness. Gait and station were normal. The PEB and VA chose the 5243 code (intervertebral disc syndrome) and rated the back condition 10%. The Board noted the variability in reported thoracolumbar range of motion. A January 2004 clinic encounter during a flare of LBP and the April 2004 orthopedic NARSUM indicated normal or near normal motion without muscle spasm while the March 2004 MEB examination recorded significantly reduced ROM.

Similarly, the 19 August 2004 C&P examination indicated normal or near normal thoracolumbar range of motion while 4 days later, the 23 August 2004 C&P examination recorded significantly reduced ROM. There is no record of recurrent injury or other development to explain the decreases in ROM; however, the second C&P examination noted muscle spasm. In its 10% rating, the VA cited the results of the earlier C&P examination. The Board carefully considered the whole record in order to develop a consistent picture of the CI’s back condition and agreed in this case that the preponderance of evidence reflected a flexion of greater than 60 degrees. Board members agreed the condition most nearly approximated the 10% rating based on the preponderance of evidence of all examinations considered in their totality as well as the known pathology. The Board deliberated whether a higher rating could be achieved under the formula for rating intervertebral disc disease based on incapacitating episodes. However, there was no evidence of incapacitating episodes due to intervertebral disc disease that would meet the criteria for a minimum rating under the alternative formula for incapacitating episodes due to intervertebral disease. The Board also considered if additional disability rating was justified for peripheral nerve impairment due to radiculopathy. MRI demonstrated a disc protrusion contacting the left S1 nerve root and a decreased left ankle reflex and decreased sensation in the left S1 distribution was documented. However, there was no radicular pain, and strength was normal on all examinations. 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 pain from the nerve involvement, this is subsumed under the general spine rating criteria, which specifically states “with or without symptoms such as pain (whether or not it radiates).” Therefore the critical decision is whether or not there was a significant motor weakness which would impact military occupation specific activities. While the reported mild sensory changes and decreased Achilles tendon reflex were consistent with a mild radiculopathy, they were not impairing of functioning and would not be considered separately unfitting. Motor strength testing was consistently normal. The Board therefore concludes that additional disability rating was not justified on this basis. After due deliberation, in consideration of the totality of the evidence, and IAW §4.3 (reasonable doubt), the Board concluded that there was insufficient cause to recommend a change from the PEB fitness adjudication for the LBP condition.

Obstructive Sleep Apnea. The CI developed sleep problems with daytime sleepiness and was diagnosed with severe OSA by sleep study in December 2003. Use of continuous positive airway pressure device (CPAP) was deemed medically necessary. Although application of CPAP controlled his condition, the PEB determined the condition was unfitting for continued military service in his MOS. The PEB’s DA Form 199 assigned a 0% rating under DODI 1332.39 (E2.A1.2.21), and based the fitness adjudication solely on field impediments to the use of CPAP. Contemporary PEBs across all of the services no longer consider OSA to be unfitting solely on this basis, but the Board, by legal opinion and firm precedent, does not make contrary recommendations to a PEB determination that a condition was unfitting. VASRD §4.97 mandates a minimum rating of 50% under 6847 for OSA requiring a breathing assistance device. In consideration of this evidence, and IAW DoDI 6040.44, the Board must recommend a separation rating of 50% for the OSA condition.

Other PEB Conditions. Four other conditions were forwarded by the MEB as meeting retention standards and adjudicated as not unfitting by the PEB were bilateral knee condition, hearing loss, gastroesophageal reflux disease, and recent right shoulder surgery. The CI had a history of right knee surgery in approximately 1997 for a medial meniscus tear. While deployed to Kuwait, he injured the left knee playing football in April 2003. MRI disclosed a torn medial meniscus. In July 2003 he underwent arthroscopic surgery, with partial medial meniscectomy, of the left knee. The post-operative course was unremarkable. Upon follow-up examination on 5 January 2004, the CI noted intermittent pain with overuse. On examination, there was full ROM, and normal gait. There was crepitus noted of the knees, left more than right. At the time of the orthopedic MEB NARSUM, there was persisting pain. On examination, there was full ROM, without effusion. There was no instability. The orthopedic surgeon did not indicate the knee condition did not meet retention standards. The 5 May 2004 MEB NARSUM recorded CI report of pain with any running and walking more than half a mile. Both knees extended fully. The left knee flexed 100 degrees and the right knee flexed 110 degrees. The commander’s letter documented predominantly duty limitations due to back pain and mentioned there was occasional knee pain. The MEB concluded the knee condition met retention standards. At the time of the C&P examinations after separation, the CI walked with an antalgic gait favoring the left extremity. Range of motion was similar to the MEB examination. Patellar compression tests were positive for patellofemoral pain.

A VA clinic encounter on 22 December 2004 noted occasional joint discomfort and knee discomfort. On examination, gait was observed as normal. Four years after separation, the CI underwent partial left knee replacement, and five years after separation, partial right knee replacement. All evidence considered, there is not sufficient evidence to overcome reasonable doubt in the CI’s favor supporting recharacterization of the PEB fitness adjudication for the bilateral knee condition. The CI developed the gradual onset of right shoulder pain in 2003. MRI revealed degenerative joint disease of the acromioclavicular joint and a possible rotator cuff tear and labral tear. The CI underwent arthroscopic surgery of the shoulder in February 2004. Arthroscopic examination demonstrated that there was no rotator cuff tear. An acromioplasty of the right shoulder was performed for impingement syndrome. At the time of the MEB NARSUMs, the CI was still recovering from surgery. A physical therapy follow up examination 18 May 2004 recorded full range of motion with normal strength. A follow up orthopedic examination 21 June 2004 recorded normal range of motion except for 10 degrees loss from full abduction. The C&P examination similarly documented near normal ROM (abduction and flexion 160 degrees). There was tenderness but strength was normal. The CI had hearing loss for which a H2 profile was issued. An H2 profile is not disqualifying for continued military duty. Gastroesophageal reflux disease (GERD) was controlled with medication. None of these conditions were noted as failing retention standards in the MEB referral to the PEB. All were reviewed by the action officer and considered by the Board. There was no indication from the record that any of these conditions significantly interfered with satisfactory duty performance. All evidence considered, there is not reasonable doubt in the CI’s favor supporting recharacterization of the PEB fitness adjudication for any of the stated conditions.

Other Contended Conditions. The CI’s application asserts that compensable ratings should be considered for, tinnitus, and left eye corneal erosion. All of these conditions were reviewed by the action officer and considered by the Board. There was no evidence for concluding that any of these conditions interfered with duty performance to a degree that could be argued as unfitting. The Board determined therefore that none of the stated conditions were subject to service disability rating.

Remaining Conditions. Other conditions identified in the DES file were nasal passage corrected and internal hemorrhoids removed. 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. Additionally, cervical strain with degenerative joint disease was noted in the VA rating decision proximal to separation, but was not documented in the DES file. No complaint of neck pain was documented in the MEB history and physical examination, and neck pain was not a documented in service treatment records. A cervical spine X-ray was normal in April 2004, obtained for evaluation of shoulder pain. 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. Even if its presence in the DES file is conceded, there was no evidence for concluding that the cervical spine condition interfered with duty performance to a degree that could be argued as unfitting. 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 DoDI 1332.39 for rating the OSA condition was operant in this case and the condition was adjudicated independently of that instruction by the Board. In the matter of the chronic low back pain disorder and IAW VASRD §4.71a, the Board unanimously recommends no change in the PEB adjudication. In the matter of the OSA condition, the Board unanimously recommends a rating of 50% coded 6847 IAW VASRD §4.100. In the matter of the bilateral knee condition, hearing loss, GERD, recent right shoulder surgery, 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. 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 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 | 5243 | 10% |
| Obstructive Sleep Apnea | 6847 | 50% |
| **COMBINED** | **60%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110517, 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 /), 2900 Crystal Drive, Suite 300, Arlington, VA 22202

SUBJECT: Department of Defense Physical Disability Board of Review Recommendation

for XXXXXXXXXXX, AR20120008203 (PD201100415)

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 60% 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 60% 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 XXXXXXXXXXX

 Deputy Assistant Secretary

 (Army Review Boards)

CF:

( ) DoD PDBR

( ) DVA