RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXXXX BRANCH OF SERVICE: Army

CASE NUMBER: PD1100434 SEPARATION DATE: 20020823

BOARD DATE: 20120703

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SPC/E-4 (56M10/Chaplain Assistant), medically separated for a lumbar spine condition*.* He suffered a torsion injury to his back during basic training, resulting in persistent pain which worsened during subsequent duty in Korea. He was diagnosed with L5/S1 disk disease, and underwent a laminectomy in 2001. His surgical outcome was poor; and, persistent symptoms included intractable severe pain, right foot drop, fecal urgency, and erectile dysfunction. The CI’s condition could not be adequately rehabilitated to meet the physical requirements of his Military Occupational Specialty (MOS) or satisfy physical fitness standards. He was consequently issued a permanent L3 profile and referred for a Medical Evaluation Board (MEB). The lumbar spine condition, characterized as separate “chronic low back” and “status post L5-S1 diskectomy” diagnoses, were forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501. The CI submitted a rebuttal to the MEB asserting that there were associated conditions of bilateral radicular symptoms, right foot drop, and loss of bowel control. The additional conditions were specifically evaluated based on this appeal; but, could not be confirmed by electrodiagnostic testing or by a gastroenterology consultant; and, no additional conditions were added to the MEB’s DA Form 3947 submission. The PEB adjudicated “chronic low back pain (LBP)” as unfitting, and further noted “rectal symptoms related to myofascial pain without evidence of residual radiculopathy” in its DA Form 199 description of the condition. It was rated 10%, citing “characteristic pain on motion” from the Veterans Administration Schedule for Rating Disabilities (VASRD) then in effect. The CI disagreed with this finding, but the PEB’s determination was affirmed upon review by the US Army Physical Disability Agency (USAPDA); and, he was medically separated with a 10% disability rating.

CI CONTENTION: “I request review and correction of the erroneous findings and rating in my medical discharge. The evidence absolutely shows the Army deliberately reduced my percentile rating of disability to evade awarding retirement benefits in my case. I ask to have my medical disability rating audited and the correct disability rating awarded.” The CI attached a 5-page statement pleading to his application which was reviewed by the Board and considered in its recommendations. The statement affirms a contention for additional ratings for right foot drop, bowel urgency, and an associated mental health disorder; it details the CI’s current physical limitations and occupational compromise; it alleges incompetent Service medical care; and, it cites verbal supporting medical opinions by Service physicians which were not entered in the medical record.

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. Consideration for rating of right foot drop and bowel dysfunction, as requested, was judged by the Board to fall within the DoDI 6040.44 prescribed scope; since, these associated conditions were specifically included in the PEB’s description of the unfitting spine condition. The mental health disorder, or any other conditions or contention outside the Board’s defined scope of review, remain eligible for future consideration by the Army Board for the Correction of Military Records (ABCMR).

RATING COMPARISON:

|  |  |
| --- | --- |
| **Service PEB – Dated 20020604** | **VA (1 Mo. Pre-Separation) – All Effective Date 20020824** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Chronic Low Back Pain | 5295 | 10% | Status Post L4-5 [*sic*] Diskectomy\* | 5293 | 60% | 20020710 |
| No Additional MEB/PEB Entries | Right Ankle Ligamentous Laxity | 5271 | 10% | 20020710 |
| Mood Disorder | 9435 | 0% | 20020710 |
| 0% x 1 / Not Service-Connected x 2 | 20020710 |
| **Combined: 10%** | **Combined: 60%** |

\* Incorporating bowel urgency, right foot drop, sexual dysfunction, and bilateral leg numbness.

ANALYSIS SUMMARY: The Board acknowledges the sentiment expressed in the CI’s application regarding the significant impairment with which his service-connected 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 Disability Evaluation System (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 evaluates DVA evidence proximate to separation in arriving at its recommendations, but its authority resides in evaluating the fairness of fitness decisions and rating determinations for disability at the time of separation. The Board also must note that, in reference to its recommendations regarding the neurological conditions associated with his unfitting lumbar disk disease (as elaborated above), it must comply with the same governance. While the DES considers all of the service member's medical conditions, compensation can only be offered for those medical conditions that cut short the 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 his degree of impairment vary over time. Finally, the Board acknowledges the CI’s assertions that his medical care was substandard and that his disability ratings were intentionally minimized; but, must note for the record that it has neither the jurisdiction nor authority to scrutinize or render opinions in reference to such allegations. The Board’s role is confined to the review of medical records and all evidence at hand to assess the fairness of rating and fitness determinations at separation, as elaborated above.

Lumbar Spine Condition. The CI suffered a forceful twisting injury to his back during basic training in December 2000. X-rays were normal and he was treated conservatively without lasting resolution of his back pain. His pain worsened a few months after a subsequent assignment to Korea, and magnetic resonance imaging (MRI) revealed an L5/S1 disk protrusion with right neural encroachment. He underwent diskectomy in June 2001 (per the CI’s statement, by an inexperienced Korean army surgeon whose technique was overly aggressive). His pain was reported to have worsened with surgery, and was associated with right leg radiation and the neurological symptoms addressed later. A post-surgical MRI, performed 5 months prior to separation, revealed “no evidence of recurrent disk herniation,” left foraminal narrowing at L5/S1, and fibrotic tissue at the right margin of L5/S1. The narrative summary (NARSUM) described “near constant” pain, and noted ambulation with the use of a cane and “markedly guarding his low back and limping.” The NARSUM referenced range-of-motion (ROM) measurements by physical therapy (PT) which recorded flexion of 30⁰ (normal 90⁰) and significantly diminished extension and lateral flexion as well. A physical medicine (PM) consult from a few months earlier recorded a flexion of 90⁰. The NARSUM physical exam documented “minimal palpable muscle spasm” and neurological findings to be discussed later. The examiner also documented “magnification of response to palpation” and “increased axial pain with minimal vertex loading.” The VA Compensation and Pension (C&P) examination, performed prior to separation, did not characterize the severity of the pain, but stated that it was exacerbated by “any spine motion at all.” The VA physical examination noted a markedly antalgic gait, normal spinal curvature, and a minimally tender surgical scar; not commenting on spasm. Lumbosacral ROM was described as “markedly limited” by pain with flexion of “essentially” 30⁰ and a combined ROM of 90⁰ (normal 240⁰).

The Board directs attention to its rating recommendation based on the above evidence. The 2002 VASRD coding and rating standards for the spine, which were in effect at the time of separation, were changed to the current §4.71a rating standards in 2004. For the reader’s convenience, the 2002 rating codes under discussion in this case are excerpted below.

**5292** Spine, limitation of motion of, lumbar:

Severe ………………………………………………………..……….………….... 40

Moderate …………………………………….……………….…….…………...…. 20

Slight ………………………………………………………..……………….…..….10

**5293** Intervertebral disc syndrome:

Pronounced; with persistent symptoms compatible with: sciatic

 neuropathy with characteristic pain and demonstrable muscle

 spasm, absent ankle jerk, or other neurological findings appropriate

 to site of diseased disc, little intermittent relief ………………..….……….….. 60

Severe; recurring attacks, with intermittent relief ……………..…….………..….…40

Moderate; recurring attacks ……………………………………………............…...20

Mild ……………………………………………………………..…………….….…10

Postoperative, cured ……………………………………………..……………....…..0

**5295** Lumbosacral strain:

Severe; with listing of whole' spine to opposite side, positive

Goldthwaite's sign, marked limitation of forward bending in

standing position, loss of lateral motion with osteo-arthritic

changes, or narrowing or irregularity of joint space, or some

 of the above with abnormal mobility on forced motion ……………….......... 40

With muscle spasm on extreme forward bending, loss of lateral spine

motion, unilateral, in standing' position ...……………...……..………….….. 20

With characteristic pain on motion ………………………………..……....………. 10

With slight subjective symptoms only …………..…………...………………....….. 0

The PEB’s 10% rating under code 5295 is supported by the criteria of that code, since the specific criteria for the higher ratings were not in evidence. The Board, IAW VASRD §4.7 (higher of two evaluations), must nevertheless examine the applicability of codes which would achieve a higher rating. The VA achieved its 60% rating under code 5293, and a diagnosis of intervertebral disc syndrome can be derived from the clinical evidence. The rating criteria and the VA rating decision (specifically citing foot drop, bowel urgency, sexual dysfunction, and bilateral leg numbness) make it clear that the attendant neurologic symptoms were given full weight and their linkage to spinal neuropathy was fully conceded in support of that rating. All members agreed; however, that both the equivocal clinical evidence (addressed below) and the DES rule set (addressed above) dissuades the Board from supporting a disability rating recommendation on this basis. It was concluded that a rating for the additional conditions must be separately considered both for fitness and linkage to spinal neuropathy (as is forthcoming). Although arguments for both the 40% and 20% ratings under code 5293 can be made, a good deal of speculation is required in establishing the presence or temporal characteristics of any “attacks” rated by those criteria. At the time of the above referenced PM consult which documented normal flexion, it is clear that no “attack” was in progress; and, it is unlikely that the subsequent clinical period around the time of the MEB and VA rating evaluations represented one protracted attack. Members agreed, therefore, that ROM limitation rated under code 5292 provides the most quantifiable basis for the Board’s recommendation. All members agreed that the “slight” 10% rating under code 5292 is not a fair characterization of the ROM limitation in evidence. Deliberation ensued regarding “moderate” (20%) vs. “severe” (40%) characterizations. The 30⁰ flexion and the diminished ROM in all planes as documented by the MEB PT and VA C&P evaluators prior to separation, would argue for characterizing the ROM limitations as “severe;” if, full probative value is assigned to that evidence. It may be argued; however, that the ROM measurements obtained specifically for rating purposes are tempered by the markedly disparate normal flexion documented during the preceding period. No intervening injury or other clinical aggravation was documented; and, the recorded ROM values were derived from subjectively reported pain thresholds in the express context of providing a basis for disability rating; thus subject to loss of objectivity. It was also noted that the collateral physical findings (minimal or no spasm or tenderness; normal curvature) did not correlate with significant ROM limitations as measured. After considerable deliberation, members agreed that since a flexion of 30⁰ is the currently defined threshold for a 40% rating based on ROM limitation, it would be a reasonable threshold for assigning the higher “severe” rating under the more non-specific rating scheme for code 5292 which forces a judgment call on the part of the rater. Member consensus was that the probative value reservations just expressed would require full concession to support a 40% recommendation under code 5292; and, that the baseline ROM limitation was reasonably closer to “moderate” than to “severe.” Therefore, considering the preponderance of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a disability rating of 20% for the lumbar spine condition under code 5292.

Right Foot Drop Condition. The NARSUM did not specifically address foot drop, but on rebuttal the MEB obtained a thorough evaluation of this symptom. The NARSUM did note an absent right Achilles reflex (L5/S1 nerve root) and “a possible mild degree of ankle dorsiflexor weakness on the right.” The MEB neurology consultant noted that “the right foot becomes weak the more he walks,” and several clinical entries (as well as the CI himself in his rebuttal letter) document the onset of foot drop and bilateral leg numbness with exertional activities; not as a baseline. The neurologist’s physical exam documented “came in walking with a limp on the right side … but with minimally decreased dorsiflexion on the right side when compared to the left.” Specifically “giveway weakness” (reflects voluntary or pain-mediated loss of effort) estimated at 4/5 was documented for right dorsiflexion. Reflexes were recorded as normal. An electromyelogram (EMG) was obtained and the interpretation stated, “There is no Edx [electrodiagnostic] evidence for a right L5-S1 lumbosacral radiculopathy. Clinically, the above findings are not consistent with the patient’s symptoms. He may be experiencing severe myofascial pain complicated with muscle imbalances, but he would need another evaluation in order to assess for those conditions.” The last post-operative neurosurgical note, 14 months prior to separation, recorded normal strength and reflexes; the PM consultation, 9 months prior to separation, recorded “plantar flexion/dorsiflexion” and normal reflexes. The VA C&P examination performed prior to separation is excerpted below.

He demonstrated right foot drop, dragging the right foot … The neurologic examination of the lower extremities was unremarkable for deep tendon reflexes or motor abnormalities. The motor examination was somewhat limited by production of back pain on extension and flexion at the knee and also he was unable to dorsiflex at the right foot. There was no muscular atrophy appreciated on inspection of the anterior tibialis on the right. The leg circumferences at the midcalf were symmetric. The sensory examination was significant for a diminished pinprick in the L4-5 [surgical disk was L5/S1] distribution and to a lesser degree at S1 on the right, normal on the left.

The Board directs attention to its recommendation based on the above evidence. The action officer opines that there are several clinical features in this case which raise doubt with linking right foot drop to lumbar radiculopathy in this case. The provocation of the neurological symptoms by physical exertion is not consistent with nerve root compromise, which should yield a fixed deficit. Although EMG measurements may fail to capture subtle peripheral nerve damage, it should not fail to demonstrate a nerve root etiology of the frank foot drop under rating consideration. The physical findings described above in multiple examinations are inconsistent and equivocal. Some degree of fine sensory deficit is the only physical finding consistently demonstrated, and could be the type of impairment missed by EMG. The motor findings were all equivocal. Some were outside the L5/S1 dermatome and there are expressed opinions that they were more likely mediated by pain. The absent Achilles reflex (stressed in the CI’s statement) was only recorded once in the NARSUM, and a diminished spinal reflex does not necessarily correlate with motor weakness or other functional deficit. The well documented and measured absence of calf atrophy recorded by the VA examiner is fairly conclusive that there was no long standing weakness significant enough to produce persistent foot drop. Although foot drop was consistently demonstrated and a corrective brace was prescribed, the etiology of the foot drop appears elusive. If the basis of the foot drop was voluntary guarding from the pain (a reasonable hypothesis), then pain is subsumed in the spine rating itself; and, cannot be the basis for a separate rating without violation of VASRD §4.14 (avoidance of pyramiding). The code 5293 criteria forming the basis for the VA rating must necessarily be rooted in a premise that they were neurologically mediated. Furthermore, firm Board precedence requires a functional impairment tied to fitness to support a recommendation for addition of a peripheral nerve rating to disability in spine cases; even if lumbar radiculopathy is conceded as a diagnosis in this case. Since the pain component is not separately ratable (as established above) and the sensory component in this case has no functional implications, a Board rating recommendation would have to rest on motor weakness. Motor weakness of the magnitude rated by the VA would clearly have adverse fitness implications, but members deliberated whether there was adequate objective evidence of motor weakness to support a positive recommendation on this basis. After considerable deliberation it was agreed that the preponderance of the evidence did not support a conclusion that there was unfitting objective motor weakness; and, the Board finds insufficient cause to recommend additional disability rating for the contended foot drop condition.

Bowel Dysfunction Condition. As with the foot drop condition, the bowel control issue was not addressed in the NARSUM; but, was subsequently evaluated by the MEB. The gastroenterology consultant stated that his bowel symptoms “consist of fecal urgency, which comes on usually during increased activity, such as bike riding or other activity.” The physical exam noted normal sphincter tone, but “somewhat of a decreased maximal squeeze pressure when the patient attempted to maximally squeeze the anal sphincter he winced from LBP.” The consultant concluded that the CI’s “bowel changes are related to his back problems and may be a complication of his lower back surgery with possible pudendal nerve damage.” This opinion preceded the EMG which did not demonstrate the postulated nerve etiology, and the final MEB opinion (response to rebuttal) was that “your rectal frequency was likely related to pain.” The VA C&P examiner prior to separation, documented the presence of associated “bowel urgency,” but did not provide relevant exam findings or an opinion regarding neurological origin.

The Board directs attention to its recommendation based on the above evidence. As with the foot drop condition, the action officer does not find convincing evidence of a direct spinal neurological link to the symptom. The EMG evidence is not conclusive enough with this entity, however, to preclude that possibility. As with the foot drop, it also appears to have been associated with exertional factors rather than a constant complaint. The gastroenterologist’s physical findings are somewhat suggestive that back pain (rationally worsened by exertion) was the precipitant factor. Regardless of etiology, the Board must establish a link to fitness in support of any positive recommendation. The necessity of seeking bowel relief during exertional activities has some general soldiering implications, but would not reasonably prohibit performance within the CI’s day-to-day MOS duties. The commander’s statement documented that he had “done an outstanding job” with the non-strenuous duties to which he was assigned. Even if the condition were conceded as unfitting, the Board must note that, in the absence of bowel incontinence, a compensable rating for the condition cannot be achieved under available VASRD codes outside the VA’s code 5293 linked rating. 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 additional disability rating for the bowel dysfunction condition.

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 lumbar spine condition, the Board by a vote of 2:1 recommends a disability rating of 20%, coded 5292 IAW VASRD §4.71a. The single voter for dissent (who recommended a code 5292 rating of 40%) did not elect to submit a minority opinion. In the matter of the contended right foot drop condition, the Board unanimously agrees that it cannot recommend it for additional disability rating. In the matter of the contended bowel dysfunction condition, the Board unanimously agrees that it cannot recommend it for additional disability rating. There were no other conditions within the Board’s scope of review for consideration.

RECOMMENDATION: The Board recommends that the CI’s prior determination be modified as follows, effective as of the date of his prior medical separation:

|  |  |  |
| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Lumbar Disc Disease, L5/S1 | 5292 | 20% |
| **COMBINED** | **20%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110518, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans’ Affairs Treatment Record

 XXXXXXXXXXXXXXXXX

 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 XXXXXXXXXXXXXXXX, AR20120012285 (PD201100434)

1. I have reviewed the enclosed Department of Defense Physical Disability Board of Review (DoD PDBR) recommendation and record of proceedings pertaining to the subject individual. Under the authority of Title 10, United States Code, section 1554a, I accept the Board’s recommendation to modify the individual’s disability rating to 20% without recharacterization of the individual’s separation. This decision is final.

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.

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 XXXXXXXXXXXXXXXXXXXX

 Deputy Assistant Secretary

 (Army Review Boards)

CF:

( ) DoD PDBR

( ) DVA