RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXX BRANCH OF SERVICE: Army

CASE NUMBER: PD1100466 SEPARATION DATE: 20020611

BOARD DATE: 20120404

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty member, E-6 SSgt (95B30 / Military Police), medically separated for chronic back pain and leg pain. Despite intense conservative and surgical treatment, he did not respond adequately 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). Status-post L3-1 decompression and fusion for degenerative disc disease (DDD) was forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501. No other conditions appeared on the MEB submission. Other conditions included in the Disability Evaluation System (DES) packet will be discussed below. The PEB adjudicated the back pain condition as unfitting, rated 10%, with probable application of the Veterans’ Administration Schedule for Rating Disabilities (VASRD). The CI appealed to a Formal PEB (FPEB) which rated the back condition at 20%. He filed a rebuttal to the FPEB findings which was declined and forwarded on to the US Army Physical Disability Agency (USPDA) for review. The CI made no further appeals and was then medically separated with a 20% combined disability rating.

CI CONTENTION: The CI stated “At the time of discharge and even to this date I am unable to walk without assistance of a cane, Canadian crutches or even the use of a walker. My legs will give out on me and I have consistent chronic pain. On 2/1997, I was medevac from Womack Army Medical to Walter Reed Army Medical. I had back surgery. On 6/1997, they had to redo my back surgery again, leaving less than 10% of my disk. Still having tremendous pain in my lower back and both legs and having to walk with assistance; the doctor's decided to fuse my whole lower back. This was done on 4/2001 at Bethesda Naval Hospital. On 12/2003 I had a nerve stimulator implant which was done at UNC Hospital. To help with my chronic pain I had a morphine pump installed and they replaced the battery on the nerve stimulator. This was done at UPMC Hospital on 11/2010. Due to me being on the morphine pump I have to wear a CPAC while I am sleeping to help me breath. Upon being discharged and treated at the VA I was diagnosed with having a mental disorder due to chronic back pain and I have to see a therapist for this and I am currently on medication. I continue to be treated by the doctors because my testicles hurt. I was informed that due to the medication that I am on for my chronic back pain, which my testosterone levels have dropped to a dangerous level. I am treated with injection. I developed a mass in my left breast because of this and it had to be removed. I have to take medication to help me sleep because of the pain that I experience due to my back. I have been rated 100% disabled from the VA. My medical records are at Fayetteville, NC V A, Clarksburg, WV, V A and Pittsburgh, PA, VA. The only two civilian doctors that I saw were at UNC Chapel Hill, NC and UPMC in Pittsburgh, PA.”

RATING COMPARISON:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Service FPEB – Dated 20020206** | | | **VA (2 Mo. Pre Separation) – All Effective Date 20020612** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Chronic Back & Leg Pain | 5299-5293 | 20% | Postoperative Residuals, DDD, Lumbosacral Spine | 5293-5292 | 60%\* | 20020403 |
| ↓No Additional MEB/PEB Entries↓ | | | Depression | 9440 | 50% | 20020403 |
| R Carpal Tunnel Syndrome | 8515 | 30% | 20020403 |
| Stress Changes Left Shoulder | 5099 5003 | 10% | 20020403 |
| Tinnitus | 6260 | 10% | 20020403 |
| Left Parotidectomy Scar | 7344 7800 | 10% | 20020403 |
| Left Carpal Tunnel Syndrome | 8515 | 10% | 20020403 |
| Scar Mid –Back | 7804 | 0%\*8 | 20020403 |
| 0% x 4/NSC x 9 | | | 20020403 |
| **Combined: 20%** | | | **Combined: 90%** | | | |

\*100% 20030911 – 20040101; \*\*Increase Scar Mid-Back to 10% effective 20040101

ANALYSIS SUMMARY: The Board makes note that some of the CI’s contended conditions are derived from Department of Veterans’ Affairs (DVA) evaluations performed after separation, diagnosing conditions which were not addressed by the PEB. By policy and precedent the Board has limited its jurisdiction for recommending unadjudicated conditions as unfitting and subject to additional separation rating to those conditions which are evidenced in the core DES file. The core DES file consists of the MEB referral document (DA Form 3947), the PEB adjudication document (DA Form 199), the narrative summary (NARSUM) (including any addendums or referenced examinations), the MEB physical exam, the commander’s statement, the physical profile(s), and any written appeals or internal DES correspondence. Contended conditions which are not eligible for Board recommendations on this basis remain eligible for submission to the Army Board for Corrections of Military Records (ABCMR). The Board further notes that the presence of a diagnosis, in and of itself, is not sufficient to render a condition unfitting and ratable. 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 DVA, operating under a different set of laws (Title 38, United States Code), is empowered to periodically re-evaluate Veterans for the purpose of adjusting the disability rating should the degree of impairment vary over time. Finally, the Board notes that the 2002 Veteran Administration Schedule for Rating Disabilities (VASRD) standards for the spine, which were in effect at the time of separation, were changed to the current §4.71a rating standards in 2004. The 2002 standards for rating based on range-of-motion (ROM) impairment were subject to the rater’s opinion regarding degree of severity, whereas the current standards specify rating thresholds in degrees of ROM impairment. When older cases have goniometric measurements in evidence and when the VASRD 2002 code 5292 (for limitation of motion, lumbar spine) is applicable, the Board reconciles (to the extent possible) its opinion regarding degree of severity for 5292 with the objective thresholds specified in the current §4.71a general rating formula for the spine. This promotes uniformity of its recommendations for different cases from the same period and more conformity across dates of separation, without sacrificing compliance with the DoDI 6040.44 requirement for rating IAW the VASRD in effect at the time of separation. The Board received additional medical documentation submitted by the CI relating to his back condition and surgery from November 2011. This evidence was reviewed by all members of the Board.

Chronic Back & Leg Pain: The CI first presented with low back pain (LBP) in July 1996 without a history of trauma. The CI was diagnosed with a herniated intervertebral disc at L4-5 and subsequently underwent surgery (right L4-5 hemilaminectomy with discectomy and foraminotomy) in February 1997, and again in June 1997. Recurrent disc disease in 2000, herniated discs at L4-5 and L5-S1 with multilevel DDD culminated in more definitive but extensive surgery in April 2001, L3-5 laminectomy with L3-S1 posterior spinal fusion. The 7 August 2001 neurosurgery reflected satisfactory progress post-operatively. The CI had full strength in the legs but had not been doing any bending since he was still in the post-operative brace. He ambulated stiffly due to pain. The neurosurgeon did not anticipate the CI would be able to perform military duties and initiated an MEB and dictated the NARSUM. Imaging demonstrated good fusion with good position of the hardware without evidence of failure of the repair. There were three goniometric ROM measurements proximate to separation. These are in the table below.

|  |  |  |  |
| --- | --- | --- | --- |
| Goniometric ROM - Thoracolumbar | PT ~ 10 Mo. Pre-Sep | PT ~ 4 Mo. Pre-Sep | VA C&P~ 2 Mo. Pre-Sep |
| Flex (90⁰) | 60-70⁰ | 30⁰ (60⁰ passive) | 5⁰ |
| Ext (30⁰) | 0-5⁰ | 10⁰ (15⁰ passive) | 5⁰ |
| R Lat Flex (30⁰) |  | 15⁰ | 20⁰ |
| L Lat Flex (30⁰) |  | 15⁰ | 20⁰ |
| R Rotation (30⁰) |  | 30⁰ (35⁰) | 15⁰ |
| L Rotation (30⁰) |  | 30⁰ (35⁰) | 10⁰ |
| Combined (240⁰) |  | 130⁰ | 75⁰ |
| Comment | Four months post-op and one week out of back brace. | Obtained after IPEB for appeal to FPEB. | Normal gait.  No Muscle spasm.  Strength intact.  Reflexes intact. |
| 4.71a Rating\* | 10% | 20% | 40% |

\*VASRD rules in effect at the time; diagnostic code 5292, limitation of motion (slight, moderate, severe).

The MEB NARSUM, dated 7 August 2001, 10 months prior to separation, recorded report of persistent pain which was unchanged by the most recent procedure. The incision was noted to be well healed, motor strength normal, and gait and station normal. Some spasm was present. A 14 August 2001 physical therapy note records a report of a 50% reduction in leg and back pain since before the surgery. A goniometric ROM by physical therapy on 14 August 2001, performed one week after the back brace was discontinued, was 60 to 70 degrees of flexion and 5 degrees of extension (values for rotation and lateral flexion were not recorded). A second NARSUM dated 22 January 2002, was submitted to the FPEB at the request of the CI. Examination again showed mild paravertebral muscle spasm, decreased ROM with normal motor strength. An antalgic gait was observed at the time of this examination. Another goniometric ROM was performed 13 February 2002 that was submitted in support of reconsideration of the FPEB decision showed a dramatic decrease in range of motion that was not otherwise explained by a new injury, complication, or change in clinical pathology. The VA Compensation and Pension (C&P) examination, dated 3 April 2002, 2 months prior to separation, noted that the CI had issues with sleeping secondary to pain for the past year. He could not run and had to modify his sitting. Walking was also painful and limited to two blocks in relative comfort. On exam, it was noted that the surgical scar did not interfere with the wear of clothing. Both gait and posture were normal and no assistive device in use. Sensation, motor and deep tendon reflex exams were all normal. There was a loss of lordosis, but no spasm or atrophy. Straight leg raising caused pain at 15 degrees on the right and 20 degrees on the left. ROM, again showed an additional dramatic decrease that was not otherwise explained by a new injury, complication, or change in clinical pathology. The commander’s letter reported the CI walked with a limp and had problems performing everyday military activities and was precluded from taking part in most military activities. The Non-Commissioned Officer (NCO) evaluation report closing September 2001 reflected excellent performance of administrative duties as the rear operations/plans NCO, and battalion ammunition NCO. A 6 May 2002 primary care appointment recorded good results with recent changes in narcotic pain medication. On examination, the CI was in no apparent discomfort, strength and reflexes were normal, ROM was decreased but not quantified.

The PEB and VA chose different coding options and assigned different disability ratings. The PEB utilized code 5295, lumbosacral strain, and rated the back at 10% (characteristic pain on motion). The FPEB used code 5293, analogous to intervertebral disc syndrome, and rated at 20% (moderate, recurring attacks). The VA chose 5293-5292, intervertebral disc syndrome and limitation of lumbar motion, and rated the back at 40% for severe limitation of motion. This was subsequently increased to 60% effective retroactively at a de novo review in November 2003 considered under old VASRD rule 5293 (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). This subsequent increase to 60% also considered a VA examination from 18 September 2003 showing objective neurologic findings of absent ankle reflex and abnormal sensory examination more than a year after separation. The Board must correlate the above clinical data with the 2002 rating schedule (applicable diagnostic codes include: 5292 limitation of lumbar spine motion; 5293 intervertebral disc syndrome; and 5295 lumbosacral strain).

The Board considered rating using the 5292 code for limitation of motion and noted the April 2002 VA C&P ROM measurements. It notes that the limitation in ROM was significantly different that those obtained previously by physical therapy in February 2002 and August 2001 and was not consistent with the normal gait and posture, and absence of muscle spasm noted on the same examination, or the known pathology. The Board also considered the February 2002 physical therapy ROM measurements. This examination was performed in the context of appealing his disability rating and the ROM recorded was dramatically decreased from the physical therapy examination in August 2001 without intervening injury, complication or change in underlying pathology. In its assignment of probative value to the disparate exams, the Board must acknowledge that compensation spine examinations may predispose a lowered pain threshold since the examinee is generally quite aware that the severity of symptoms and pain tolerance on ROM is directly correlated with the resulting rating and financial gain. The measurement of ROM reflecting pain with motion is dependent on the examinee’s reported pain with scant ability by the examiner to objectively confirm it. Upon deliberation the Board agreed in this case that the preponderance of evidence, considering both physical therapy examinations in the context of the known pathology, that rating under diagnostic code 5292 for limitation of motion most nearly approximates the 10% rating and does not warrant a rating higher than 20% for moderate limitation of motion providing no benefit to the CI. The Board next considered the rating under diagnostic codes 5293, intervertebral disc syndrome, and 5295, lumbosacral strain. The Board noted that 5295 (lumbar strain) does not describe the underlying medical condition as closely as the 5293 code (intervertebral disc syndrome), and concluded that the service medical records and MEB NARSUM do not describe findings that support a rating higher than 20% under the 5295 code. The Board then considered the rating under 5293. The Board considered the chronic back pain radiating into the leg requiring narcotic pain medication, and the resulting physical limitations. The Board also took into consideration the commander’s letter citing his observation the CI was in obvious pain at work and often had to leave work early. While there was radiating pain, there was no weakness of loss of reflexes. Prior to separation, medication was indicated to provide good relief of pain. The Board also noted the post-separation worsening of the CI’s back condition. The majority of Board members concluded the preponderance of evidence prior to separation more nearly approximated the 40% rating than the 20% rating under diagnostic code 5293. All Board members agreed the preponderance of evidence prior to separation did not approach the 60% rating. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a separation rating of 40% for the back condition coded 5293.

Other Contended Conditions: The CI’s application asserts that compensable ratings should be considered for the following conditions: testicular condition (hypotestosteronism), sleep disturbance and post-separation use of CPAP (continuous positive airway pressure for sleep apnea), breast mass, mental disorder (depression). There is no mention of CPAP, testosterone replacement or breast mass in the DES or service treatment record (STR). These are therefore outside the review authority of the Board. The sleep disturbance noted was secondary to pain and treated with medications. It 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 none of the stated conditions were subject to service disability rating.

Remaining Conditions: Additional conditions identified in the DES file were the following conditions: loss of hearing, left shoulder numbness/bursitis of the left shoulder; knee pain, right inguinal hernia repair, tumor removal from left ear and cheek, tinea pedis, hematemesis and hematochezia. Several additional non-acute conditions or medical complaints were also documented. None of these conditions were clinically or occupationally significant during the MEB period, none carried attached profiles (the left knee was profiled temporarily 12 years prior to separation) 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, bilateral tinnitus, bilateral carpal tunnel syndrome, scars and several other non-acute conditions were noted in the VA rating decision proximal to 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.

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 low back pain and leg pain condition, and IAW VASRD §4.71a and §4.7 the Board recommends, by a vote of 2:1, a rating of 40% coded 5293. The single voter for dissent (who recommended no modification of the PEB adjudication) submitted the addended minority opinion. In the matter of the sleep disturbance, loss of hearing, left shoulder numbness/bursitis of the left shoulder; knee pain, right inguinal hernia repair, tumor removal from left ear and cheek, tinea pedis, hematemesis and hematochezia or any other condition 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:

|  |  |  |
| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Chronic Back Pain and Leg Pain | 5293 | 40% |
| **COMBINED** | **40%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110625, w/atchs.

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans' Affairs Treatment Record

XXXXXXXXXX

President Physical Disability Board of Review

Minority Opinion

The minority voter concluded the preponderance of evidence prior to separation more nearly approximated the 20% rating (moderate; recurring attacks) than the 40% rating (severe; recurring attacks, with intermittent relief) under 5293 (intervertebral disc syndrome). While there was chronic pain, there were no objective neurologic findings of weakness or loss of reflexes, and STRs prior to separation indicated reasonable pain control with a moderate pain rating. The NCO evaluation report closing September 2001 reflected excellent performance of administrative duties as the rear operations/plans NCO, and Battalion Ammunition NCO and further stated that the CI worked long shifts of 12 hours. The second NARSUM for the FPEB recommended limiting work days to 8 hours. The C&P examiner, 3 April 2002, wrote “In general, he can sustain heavy physical activities without immediate distress.” The minority voter concludes the preponderance of evidence supports the FPEB rating of 20%.

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 XXXXXXXXXX, AR20120007052 (PD2011-00466)

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 reject the Board’s recommendation and accept the Board’s minority opinion as accurate that the applicant’s final Physical Evaluation Board disability rating remains unchanged. There is insufficient justification to support the Board’s recommendation in accordance with Army and Department of Defense regulations. Additionally, the majority did not find support in the service medical records for a rating for back pain greater than 10% for VASRD code 5292 or greater than 20% for 5295. They concluded that the preponderance of evidence prior to separation supported a rating of 40% for code 5293. In this determination they used the same disability rating criteria that the PEB used (based on incapacitating episodes) and did not offer any evidence to justify a modification from 20% to 40%, citing only the commander's letter which was also used by the PEB in their determination.

2. This decision is final. The individual concerned, counsel (if any), and any Members of Congress who have shown interest in this application have been notified of this decision by mail.

BY ORDER OF THE SECRETARY OF THE ARMY:

Encl XXXXXXXXX

Deputy Assistant Secretary

(Army Review Boards)

CF:

( ) DoD PDBR

( ) DVA