RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXXX BRANCH OF SERVICE: Army

CASE NUMBER: PD1100467 SEPARATION DATE: 20080413

BOARD DATE: 20120125

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SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty member, SGT/E-5 (42A, Human Resources Specialist), medically separated for chronic low back pain and migraine headaches. The CI reported the onset of her back pain in 2004 with an insidious onset without an inciting event after which the pain started. The migraines existed prior to service (EPTS), but the CI was headache free until she deployed in 2005 and the headaches were found to be Service aggravated. The CI did not respond adequately to treatment and was unable to perform within her Military Occupational Specialty (MOS) or meet physical fitness standards. The CI was issued a permanent P3, L3 profile and underwent a Medical Evaluation Board (MEB). The MEB forwarded “chronic low back pain with sacroiliac joint (SI) yysfunction and headache syndrome, mixed” were forwarded to the Informal Physical Evaluation Board (IPEB) as medically unacceptable IAW AR 40-501. Acne condition, as identified in the rating chart below, was forwarded as medically acceptable conditions. The IPEB adjudicated “chronic low back pain and migraine headaches and mixed headaches” as unfitting, rated 10% and 10% respectively, with probable application of the US Army Physical Disability Agency (USAPDA) pain policy. The PEB administratively corrected this case IAW Para 4-22c. (1), AR 635-40, after a PDA review based on changes to disability guidance in the 2008 NDAA. The CI made no appeals, and was medically separated with a 20% combined disability rating.

CI CONTENTION: : The CI states: “The rating should be changed because I was found to be disabled by The Department of Social Security and received a 90% disability rating from The Department of Veterans Affairs. I am unable to work due to my conditions.” She elaborates no specific contentions regarding rating or coding and mentions no additionally contended conditions.

RATING COMPARISON:

|  |  |
| --- | --- |
| **Service IPEB – Dated 20080421** | **VA (6 Mo. After Separation) – All Effective Date 20080414** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Chronic Low Back Pain | 5236 | 10% | Lumbosacral Strain | 5237 | 10% | 20081004 |
| Migraine Headaches and Mixed Headaches | 8100 | 10% | Migraine Headaches | 8100 | 30%\* | 20081004  |
| Acne | Not Unfitting | Acne | 7828 | 10%\*\* | 20081004 |
| ↓No Additional MEB/PEB Entries↓ | Cervical Strain | 5237 | 10% | 20081004 |
| 0% x 1/Not Service Connected x 4 |
| **Combined: 20%** | **Combined: 50%\*\*\***  |

\*Increased to 50% effective 20090528; \*\*Increased to 30% effective 20090528 \*\*\* the combined rating was increased to 90% effective 20090528 after these and other increases were made and additional conditions were added.

ANALYSIS SUMMARY: The Board acknowledges the sentiment expressed in the CI’s application regarding the significant impact that her service-incurred condition has had on her current earning ability and quality of life. It is a fact, however, that the Disability Evaluation System (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. This role and authority is granted by Congress to the Department of Veterans’ Affairs (DVA). 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 separation from service. 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, however, 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 Condition: There was one goniometric range-of-motion (ROM) evaluation in evidence and four evaluations without ROM’s in evidence, with documentation of additional ratable criteria, which the Board weighed in arriving at its rating recommendation.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Goniometric ROM - Thoracolumbar | Physical Medicine~ 14 Mo. Pre-Sep | Neuro MEB ~ 12 Mo. Pre-Sep | Form 2808~8 Mo. Pre-Sep | MEB ~ 8 Mo. Pre-Sep | VA C&P ~ 4 Mo. After-Sep |
| Flex (0-90) |  |  |  | 65°, 66°, 67° (65°) |  90⁰, 80°\* |
| Ext (0-30) |  |  |  | 15°, 15°, 13° (15°) | 20⁰, 10°\* |
| R Lat Flex (0-30) |  |  |  | 18° (20°) | 30⁰, 25°\* |
| L Lat Flex 0-30) |  |  |  | 18°, 20°, 18° (20°) | 30⁰, 25°\* |
| R Rotation (0-30) |  |  |  | 20° | 30, ⁰25°\* |
| L Rotation (0-30) |  |  |  | 20° | 30⁰, 25°\* |
| COMBINED (240) |  |  |  | 160° | 230⁰ |
| Bone scan 20070413-bialteral sacroiiliitis; MRI 20070220-large broad based disc protrusion at L5 with probable impingement of S1 nerve roots | Decreased (normal) lumbar lordosis; motor/sensory intact; TTP(tenderness to palpation) L5,S1 bilaterally; pain left SI joint; L/S spine limited ROM; all ROM caused pain in end ranges; sacral spring test + on left; antalgic gait-mildly shortened stride length on ambulation *(antalgic gait not due to muscle spasm)* | Normal gait; motor/sensory intact; TTP Lumbar spine, sacrum; paraspinal muscle spasm Lumbar spine and upper thoracic regions;Used in MEB exam | \*TTP midline and SI joints; minimal TTP Right paralumbar muscles; DTR’s 2+motor/sensory intactUsed in MEB exam | All passive ROM; measurements from PT consult for MEB; MEB examiner noted ROM limitations were due to pain. Negative Waddell signs and straight leg raising. Normal motor, sensory, and reflex examinations. MEB neurology consult noted normal sensation to light touch, temperature, and vibration as well as normal reflexes, motor function, and gait. | \*pain occurs; joint function additionally limited after repetitive use by 5⁰; TTP entire Lumbar spine; motor/sensory intact |
| §4.71a Rating | 10% | 10% | 10% | 10% | 10% |

The CI has a long history of back pain that is well documented in the service treatment record (STR). The CI’s low back pain was present since at least 2004 with an atraumatic, insidious onset. The wearing of body armor made the pain intolerable and the CI was seen for this back pain while deployed and then in physical medicine and rehabilitation after redeployment. The CI underwent several chiropractic treatments without pain resolution. The CI was referred to physical therapy and underwent extensive treatment along with being fitted for a thoracolumbosacral orthosis (TLSO) brace to protect against excessive spine extension. At the physical medicine examination fourteen months prior to separation, the CI complained of shooting pain down the left leg posteriorly and worsening low back pain causing difficulty getting out of bed or standing without change for greater than twenty minutes. The examiner noted that neither physical therapy nor chiropractic care provided pain relief and the pain was worsened by the wearing of military equipment along with pushups and sit-ups but was relieved by lying down and heat application. Physical exam findings revealed a decrease in the normal lordotic curve to show a flattening of the spine; antalgic gait; and limited ROM; however motor and sensory exams were normal. An MRI done in February 2007 demonstrated a moderately large broad based disc protrusion at L5 with probable impingement of the S1 nerve roots. In February 2007 a bone scan showed bilateral sacroiiliitis. The commander’s statement noted that the CI’s performance in her MOS was exceptional however, because her profile made her non-deployable, this was her greatest challenge.

The CI underwent a neurological consultation 12 months prior to separation which indicated dull, constant, pain that could escalate to quite sharp after exercising ending or lifting, along with occasional shooting pain down both legs in the sciatic distribution. On the MEB history and physical examination eight months prior to separation there was documentation of tenderness to palpation (TTP) to the midline spine and bilateral sacroiliac joints. The MEB narrative summary (NARSUM) examination eight months prior to separation noted that the ROM limitations were due to pain.

The VA Compensation & Pension (C&P) examination four months after separation documented spine numbness and stiffness with chronic shooting pain down the back of the legs. This chronic low back pain was burning and sharp and relieved by rest and a muscle relaxant. The CI had functional impairment in that she was unable to work more than five hours a day, perform any sports activities, or physically play and interact with her children. On physical exam, there was TTP of the entire lumbar spine; however motor and sensory functions were intact and reflexes were normal. The spine was additionally limited by pain after repetitive movement and the straight leg raise test was negative bilaterally.

Although the CI had a sensory radiculopathy with pain, there was no significant motor component to the radiculopathy. 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. Since no evidence of functional impairment exists in this case, the Board cannot support a recommendation for additional rating based on peripheral nerve impairment.

The PEB and the VA chose different coding options but this did not significantly impact the rating as noted above. 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.” The PEB coded the chronic low back 5236 (sacroiliac injury and weakness) rated at 10% and the VA coded 5237 (lumbosacral or cervical strain) at 10% for ROM “limited by pain, with localized tenderness. All of the exams proximate to separation documented TTP of the lumbar spine, and ROM limited by pain. All examinations with goniometric measurements document forward flexion of the thoracolumbar spine greater than 60° but not greater and 85° as well as combined range of motion of the thoracolumbar spine greater than 120° but not greater than 235°. All evidence considered, there is not reasonable doubt in the CI’s favor supporting a change from the PEB’s rating decision for the chronic low back pain condition.

Migraine Headaches and Mixed Headaches.

The CI has a long history of both migraineous and mixed headache symptoms that are well documented in the STR. The CI’s migraine headaches started at either age 16 or 17; however she had only one headache at the time of diagnosis and one the following year. The headaches reemerged in 2005 during her deployment to Iraq with a frequency of two per week without a precipitating event. The migraine headaches continued after redeployment in 2006 at a frequency of one per month. The CI felt that these headaches were unusual and that she routinely experienced other headaches that were accompanied by symptoms of nausea and vomiting along with numbness and tingling on one or both sides of her head. These headaches required medication (Midrin) and sleep in a quiet, dark room however even after medication and rest, the headaches would return the next day and would often last for two days. At the time of the Neurological consultation 12 months prior to separation, the CI was experiencing chronic daily bilateral frontal headaches not responding to medications, often present three times a week. The CI would also experience monthly, throbbing one sided headaches, usually on the left that were clearly migraineous type. Although these migraine headaches occurred monthly, they responded well to Midrin. Additionally, the CI complained of milder daily bifrontal headaches that readily resolved with Ibuprophen. The MEB examination eight months prior to separation documented the chronic headaches both migraineous and mixed type that were unchanged from the time of her neurological consultation. The CI did not lose many successive days from her work because her schedule accommodated her timing of headaches-as she was allowed to be off work in the afternoon when the headaches usually occurred. The CI’s work schedule was changed so she would only work from 9:00am to 2:00pm due to the number of headaches and the medication. The examiner further opined that she had “a strong propensity to lose a fair amount of work time in the future.” The record also includes an update from the neurologist who performed the initial evaluation of her headaches for the MEB. This was dated 11 December 2001 and it stated she continued to have migraine headaches with the same severity and frequency of one to two (and occasionally three) times per month. The neurologist also noted her chronic daily headaches due to muscle tension and analgesic overuse was no longer disqualifying. The VA C&P examination four months after separation did not separate out the migraine and other headaches as definitively as the military neurologist had done. However, this examination indicated that the migraine headaches were triggered by bright lights rendered the CI incapable of performing any usual activities and necessitated bed rest. Although the prescribed migraine medication (Zomig) relieved the headache, the CI still needed bed rest until the headache dissipated. The examiner also noted the CI was only able to work from 9AM to 2PM due to the number of headaches and the medication.

The PEB and the VA chose the same disability code 8100 migraine. However the PEB rated 10% and the VA rated 30% with a later increase to 50% based on worsening symptoms over time. The PEB determined this condition did exist prior to service (EPTS) but was permanently aggravated by service and the EPTS factor could not be determined. Therefore no deduction was made. The VASRD § 4.124a rating schedule for 8100 migraine is excerpted below for convenience:

With very frequent completely prostrating and prolonged attacks

productive of severe economic inadaptability------------------------------------ 50

With characteristic prostrating attacks occurring on an average once

a month over last several months--------------------------------------------------- 30

With characteristic prostrating attacks averaging one in 2 months over

last several months--------------------------------------------------------------------- 10

With less frequent attacks--------------------------------------------------------------0

The DoDI 1332.39 (E2.A1.4.1.4) which defined prostrating as quotes “the Service member must stop what he or she is doing and seek medical attention” was in effect during the MEB period, but is not applicable to the Board’s recommendations. VA guidance uses the clear english definition of prostrating and significantly differs in that seeking medical attention is not required (NOTE: This differs from the VA definition of “incapacitation” for spine conditions which requires physician prescribed bed rest). The Board evaluated the CI’s history for prostrating attacks and adjudged that the requirement of a change in work schedule to accommodate migraine headaches along with the presence of severe headaches lasting two days causing functional impairment and requiring bed rest constituted sufficient severity to meet the threshold as prostrating. The severe migraine headache lasting two days and occurring once or twice (and occasionally three times) a month for over one year meets the 30% criteria as stated above. Although migraine headaches did exist prior to military service, the CI had no migraines in service until 2005 and the assumption of service aggravation is not overcome. As the CI was asymptomatic prior to military service, the preservice percentage is zero and therefore no deduction from the disability rating percentage at separation is required. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a separation rating of 30% for the migraine headaches and mixed headaches condition.

Other PEB Conditions. The other condition forwarded by the MEB and adjudicated as not unfitting by the PEB was acne. This condition was not profiled, implicated in the commander’s statement or noted as failing retention standards. This condition was reviewed by the action officer and considered by the Board. There was no indication from the record that this condition 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 this stated condition.

Remaining Conditions. Other conditions identified in the DES file were cervical strain; bilateral bunions; herpes simplex virus; motion sickness; scars on chin, left lateral thigh, right thigh and knee; frequent urination; scars, bilateral mammoplasty; and upper respiratory infection. 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 sleep apnea; hyperhidrosis; and tuberculosis exposure and several other non-acute conditions were noted by the VA proximal to separation, but none of these conditions were documented in the DES file. The VA also later granted service connection for posttraumatic stress disorder (PTSD) and traumatic brain injury (TBI) effective 28 May 2009 based on an examination completed 4 August 2009. The CI was also subsequently granted social security disability for depressive disorder and PTSD in addition to other previously discussed conditions effective 4 August 2009. However, PTSD, TBI, and depression 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 condition and IAW VASRD §4.71a, the Board unanimously recommends no change in the PEB adjudication. In the matter of the migraine headaches and mixed headaches condition, the Board recommends a rating of 30% IAW VASRD §4.124a. In the matter of the acne condition, the Board unanimously recommends no change from the PEB adjudications as not unfitting. In the matter of the cervical strain; bilateral bunions; herpes simplex Virus; motion sickness; scars on chin, left lateral thigh, right thigh and knee; frequent urination; scars, bilateral mammoplasty; and upper respiratory infection condition 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:

|  |  |  |
| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Chronic Low Back Pain | 5236 | 10% |
| Migraine Headaches and Mixed Headaches | 8100 | 30% |
| **COMBINED** | **40%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110617, 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 xxxxxxxxxxxxxxxxxxxx (PD201100467)

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