RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: Army

CASE NUMBER: PD1100481 SEPARATION DATE: 20050310

BOARD DATE: 20120209

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was a mobilized National Guard member, SGT/E-5 (62E, Heavy Construction Equipment Operator), medically separated for low back pain with secondary depressive symptoms. The CI reported taking a “bad” step during an organizational physical training in April 2003, which resulted in his low back pain (LBP) condition.The CI 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 L3, S3 profile and underwent a Medical Evaluation Board (MEB). The MEB forwarded “LBP, moderate/constant and depressive disorder, not otherwise specified (NOS)” were forwarded to the Informal Physical Evaluation Board (PEB) on DA Form 3947 as medically unacceptable IAW AR 40-501. No other conditions appeared on the MEB’s submission. Other conditions included in the Disability Evaluation System (DES) packet will be discussed below. The IPEB of 10 November 2004adjudicated 5237 “low back pain with secondary depressive symptoms, no evidence of significant neurologic abnormality, thoracolumbar range-of-motion (ROM) limited by pain, tender to palpation, antalgic gait with cane,” rated 20%. The CI initially submitted a rebuttal to the IPEB findings to the US Army Physical Disability Agency (USAPDA). The USAPDA found no change in the IPEB findings were warranted and a Formal PEB (FPEB) was scheduled for January 2005. The FPEB was convened 24 Janaury 2005 and initially returned findings identical to the IPEB. The CI submitted a rebuttal to the FPEB findings but USAPDA affirmed the FPEB findings. However, the FPEB findings were administratively corrected and the final USAPDA document stated the CI was unfit due to 5243 “low back pain secondary to herniated nucleus pulposis” and a rating of 20% was again recommended. This document also stated the MEB diagnosis 2, depressive disorder, not otherwise specified, was not unfitting. In a memo dated 25 February 2005 USAPDA was notified that the US Army Human Resources Command had denied the CI’s request for continuance in the active National Guard. The CI was then medically separated with a 20% disability rating.

CI CONTENTION: The CI states: “Back and nervous disorder. I am requesting a re-consideration of disability rating used for retirement and award of severance pay (20%) when I should have received a higher rating and retired pay benefits.” He elaborates no specific contentions regarding rating or coding and mentions no additionally contended conditions.

RATING COMPARISON:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Service USAPDA – Dated 20050210** | | | **VA (2 Mo. After Separation) – All Effective Date 20050311** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Low Back Pain Secondary to Herniated Nucleus Pulposus | 5243 | 20% | Herniated Nucleus Pulposus L5-S1; Degenerative Disc Disease L4-L5, L3-L4 And T11-T12; Severe Lumbar Myositis | 5243-5237 | 50%\* | 20050524 |
| Right L5 And S1 Radiculopathy Associated With Herniated Nucleus Pulposus L5-S1; Degenerative Disc Disease L4-L5, L3-L4 And T11-T12; Severe Lumbar Myositis | 8699-8620 | 10%\* | 20050524 |
| Depressive Disorder, not otherwise specified | Not Unfitting | | Dysthymia | 9433 | 30%\* | 20050615 |
| ↓No Additional MEB/PEB Entries↓ | | | Not Service Connected x 7 | | | 20050531 |
| **Combined: 20%** | | | **Combined: 70%** | | | |

\*March 2009 (20090309), the VA severed the service connection for all conditions.

Analysis Summary: The Board acknowledges the sentiment expressed in the CI’s application, i.e., that the gravity of his condition merit consideration for a higher separation rating. The Board wishes to clarify that it is subject to the same laws for service disability entitlements as those under which the 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 all service-connected conditions and to periodically reevaluate 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 6040.44, 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.

Low Back Pain secondary to Herniated Nucleus Pulposus. There were two goniometric ROM evaluations in evidence which the Board weighed in arriving at its rating recommendation. Both of these exams are summarized in the chart below.

|  |  |  |
| --- | --- | --- |
| Goniometric ROM - Thoracolumbar | MEB ~ 8 Mo. Pre-Sep | VA C&P ~ 2 Mo. After-Sep |
| Flex (0-90) | 15⁰ | 29⁰ 29-90\* (30°) |
| Ext (0-30) | 10⁰ | 10⁰ 10-30\* |
| R Lat Flex (0-30) | 15⁰ | 10⁰ 10-30\* |
| L Lat Flex 0-30) | 10⁰ | 10⁰ 10-30\* |
| R Rotation (0-30) | 3⁰ (5°) | 15⁰ 15-30\* |
| L Rotation (0-30) | 10⁰ | 20⁰ 20-30\* |
| COMBINED (240) | 65⁰ | 95⁰ |
| MRI-desiccation of L3-4 disc asymmetric posterior bulging, L4-5 and desiccation and posterior disc herniation L5-S1; EMG right S1 radiculopathy | slight bilateral tenderness to palpation (TTP) over the lumbar area; positive straight leg raise test; motor/sensory intact; requires cane; pain radiates to right lower extremity | \*Additionally limited after repetitive use by pain, not additionally limited by fatigue, weakness, or lack of endurance; severe spasms lumbar paravertebral muscles at L4, L5 and S1; no guarding, or abnormal gait noted; flat lumbar lordosis; decreased pin prick plantar foot S1 distribution; hypersensitive pin prick L5 distribution; absent Achilles deep tendon reflexes on right; + straight leg raising Right; decreased muscle strength right dorsiflexors, plantar flexion and extensor hallicus longus 4/5; flat lumbar lordosis |
| §4.71a Rating | (MEB 20%) 40% | (VA 50%) 40% |
| §4.124a Rating | 10% | 10% |

The CI enlisted in the Army National Guard in 1990 and there was no mention of a back condition at that time. The CI has a long history of LBP that was well documented in the numerous notes starting in 1992. The CI initially started with LBP in 1992 with an MRI that indicated herniated discs L5-S1. In 1997 a note indicated that the CI was attending Physical Therapy for the HNP and radiculopathy. Repeated MRIs continued to indicate L5 radiculopathy and herniated discs at L3-4, L4-5 and L5-S1. In February 1999, the CI was approved for Social Security Administration (SSA) benefits, effective 30 January 1997. In October 2001, the CI’s enlistment was extended. In April 2003 the CI took a bad step that resulted in LBP during an organizational physical training event. At that time, he was evaluated and treated with non steroidal anti inflammatory drugs (NSAIDS) and muscle relaxants. In April 2004 a service treatment record (STR) note indicated that the CI received at least two nerve blocks and was placed on convalescent leave for six days due to his back pain. In May 2003 the CI was notified of a continuance of SSA benefits. A sworn statement given by the CI in July 2004 documented that although he had LBP, he was able to perform his duties; complete his Army physical fitness test (APFT) without complaining of pain; did not go to sick call or get treatment (until he was sent in April 2004) because he would take medication and the pain would resolve.

The MEB examination performed eight months prior to separation, noted that the CI continued with LBP and pain radiation to the lower extremity with numbness and paresthesias. An MRI completed at the time of the MEB exam revealed findings consistent with right S1 radiculopathy. The pain was aggravated by lifting anything over ten to fifteen pounds, made worse with prolonged walking, sitting or standing; interfered with sleep; and required the use of a cane; flare-ups occurred four to five times per week for which NSAIDS and muscle relaxants were required. The examiner opined that because of the CI’s significant symptoms that it was likely he would not be able to continue his soldiering duties. Although the limitation of motion documented on the MEB NARSUM examination would warrant a 40% rating IAW VASRD§4.71a, the initial IPEB rated this condition at 20%. After a series of appeals including a FPEB, the CI’s final rating at discharge was 20%. No rationale for the lowered rating is available and there is no indication the PEB deducted from the rating.

The VA Compensation & Pension (C&P) examination two months after separation stated that the CI had chronic sharp LBP that radiated to the right lower extremity, posterior thigh, kneecap, heel and large toe and with numbness in the right heel and large toe. The exam findings were decreased pin prick plantar foot S1 distribution; hypersensitive pin prick L5 distribution; absent Achilles deep tendon reflexes on right; positive straight leg raising on the right and decreased muscle strength right dorsiflexors, plantar flexion and extensor hallicus longus 4/5. The CI had an additional functional limitation of decreased ambulation. An MRI in 2006 noted spinal canal stenosis in L3-L4 and L5-S1 secondary to central disc protrusion; intervertebral disc desiccation from L3-L4 through L5-S and facet joint degenerative changes. The limitation of motion on this exam warrants a 40% disability rating. However, the VA elevated this rating to 50% because the CI’s motion was “additionally limited by pain after repetitive use.”

In March 2009 the VA severed the service-connection for the low back disorder, dysthymia and right radiculopathy. The VA based their decision on information received from the SSA. The CI was approved for SSA benefits on 27 January 1999 stemming from an accident in January 1997 when he suffered trauma to his low back after trying to control a mental patient in the hospital where he worked. He had a subsequent hospitalization; MRI’s revealed herniated discs at the lumbar spine levels and radiculopathy; and extensive PT. The CI was granted SSA disability benefits for severe impairments due to herniated disk with radiculopathy and depression. The SSA history of proceedings dated 27 January 1999 notes the CI had been unable to work since the injury that occurred while working at his civilian job in January 1997. The VA contended that based on the severity of the LBP injury that the CI was fraudulent in not reporting this previous history of degenerative disc disease with radiculopathy and the mental health problem at the time he began active duty in September 2002 or at his initial VA examinations in May and June 2005 after he had been separated from service. The VA further contended that the CI would not have been accepted into the service had this been disclosed. The VA stated “in your case, review of the evidence we now have shows the severity of your low back condition and related mental disorder were of such a degree that rendered you totally disabled and would have prevented enlistment to military service at the time you re-entered active duty service.” The VA also stated, “it is under omission of the facts concerning your prior treatrnent, your in-service examiners evaluated your low back and mental conditions based on subject complaints and unreliable reporting of symptoms and events. The provision for the presumption of soundness is thus considered rebut because there was a determination showing you were totally disabled due to your herniated nucleus pulposus at the time of entry to active duty service.”

At the time of enlistment in the Army National Guard in January 1990, the CI did not complain of back pain. The CI did not indicate he had any history of back pain, radiculopathy, or mental illness on the DD Form 2807-1 medical history form dated 9 September 2002 and completed as part of his activation to active duty. In fact he specifically marked no to the question “have you ever had or do you have now” for: recurrent back pain or any back problem, numbness or tingling, nervous trouble of any sort, frequent trouble sleeping, received counseling of any type, and depression or excessive worry. He also marked no to the question, “have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury?” The CI’s first complaint of back pain noted in the STR was in April 2003 when he complained of back pain during an organizational physical training and required a clinic evaluation and treatment with NSAID and muscle relaxant medications. VA visits for back pain did not arise in the file until September 2003 when the CI was referred for PT due to LBP.

The records available for the Board’s review clearly show that the CI had back pain, herniated disc, L5-S1 radiculopathy, and depression with severe impairments that prevented employment as early as January 1997. Records show these conditions resulted from an injury that occurred during civilian employment and not while the CI was on active duty. SSA disability benefits were granted from January 1997 forward and there is no evidence in the record that these benefits were ever discontinued. The records reflect that the SSA had determined the CI was not able to be employed in any type of job. There is also no evidence of any further injury or incident during military service when an aggravation occurred.

The SSA history of proceedings document from 27 January 1999 contains detailed information about the CI’s condition prior to his latest period of active Service. The CI was hospitalized after a work-related injury in January 1997. An MRI during this admission showed small disc herniations at both L4-L5 and L5-S1. The CI had low back pain with tenderness to palpation and muscle spasms and the straight leg raise was positive at 10° on the left. There was some weakness of the left leg but reflexes were normal. He was diagnosed with disc herniation and compression of the L5 nerve root. In April 1997 an exam by a neurologist document forward flexion of the thoracolumbar spine to 30° as well as tenderness to palpation on a positive Lasegue’s sign on the left. He had a slow gait and bilateral ankle reflexes were absent. A repeat MRI in June 1997 showed worsening disc herniation at L3-L4, L4-L5, and L5-S1 and an EMG revealed a sensorial neuropathy and left L5-S1 radiculopathy. In December 1997 the CI was observed ambulating without difficulty. He had a negative Lasegue’s sign on the left but had poor walk on the heels. In January 1998, the CI reported he had had a relapse of his condition the previous month. On exam by a neurologist on 9 January 1998, his forward flexion was limited to 20° and he had muscle spasms. He also had a positive Lasegue’s sign on the left, numbness and paresthesias in the left foot and knee, and weakness of the left leg. These findings would support a 40% disability rating for back condition.

When a condition is known to have existed prior to service, either by the documentation of a condition at the time of entrance or where clear and unmistakable evidence demonstrates the condition existed prior to service, the Board must consider whether the condition was permanently aggravated by service. This involves comparing the clinical symptoms that pre-existed to those observed during the period of active service. The CI’s back pain and radiculopathy did result in significant symptoms and impairment while on active duty. However, the level observed while on active duty, while significant enough to render the CI unfit for continued service and warrant a 40% disability rating, was not more than what was present prior to active duty which would also warrant a 40% rating. When, IAW VASRD §4.22, the Board deducts the degree of disability present prior to the period of active service that began in September 2002 from the degree present at the time of separation from service in 2005, a 0% disability rating would result. After due deliberation the Board determined that this condition existed prior to service and was not permanently aggravated by service and therefore the CI was not entitled to severance pay. However, IAW DoDI 6040.44, no reduction of the previously issued combined disability rating will result as a product of a PDBR review. Therefore, the Board has no recourse but to recommend no recharacterization of the CI’s disability and separation determination.

Although neither PEB nor USAPDA specifically adjudicated the L5-S1 radiculopathy condition, it was presented in the MEB evidence sent forward for review. The Board must thus approach this issue as a de facto service determination that the radiculopathy was not a separately unfitting condition. 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.

An EMG done at the time of the MEB exam, eight months prior separation demonstrated findings consistent with radiculopathy. The CI had pain that radiated to right lower extremity and a positive straight leg raise. At the VA exam two months after separation, the CI had decreased pin prick in the right plantar foot S1 distribution and hypersensitive pin prick in the right L5 distribution. The examination also noted an absent Achilles deep tendon reflex on right and positive straight leg raising on the right. However, the evidence available for review does not support any functional impairment that can be attributed solely to a radiculopathy. After due deliberation, the Board agreed that evidence does not support a conclusion that radiculopathy, as an isolated condition, would have rendered the CI incapable of continued service within his MOS, and accordingly cannot recommend a separate service rating for it.

Depression. The IPEB included secondary depression symptoms under the rating for 5237 lumbosacral or cervical strain. However, the final determination by the USAPDA was that this condition was not unfitting. The VA coded the dysthymia condition as 9433 dysthymic disorder rated at 30%.

There are records in the CI’s file indicating that he attributed the depression to his chronic LBP. A note from December 2004 noted that the CI felt overwhelmed about the financial consequences of unemployment if he was discharged from the Army. The psychiatrist directly attributed the CI’s depression to the constant chronic LBP. The CI attended outpatient therapy and was prescribed antidepressant medications. The MEB examination eight months prior to separation indicated an Axis I diagnosis caused by the lack of functionality. The CI was given a L3, S3 Profile. The commander's statement emphasized the CI’s lack of physical ability to perform his MOS; there was no reference to his mental health as interfering with his MOS. The VA C&P examination three months after separation, noted complaints of irritability and verbal aggressive reactions relating to his functional limitations from the chronic LBP. The CI’s Global Assessment of Functioning (GAF) was 65 - some difficulty in social, occupational, or school functioning, but generally functioning pretty well, has some meaningful interpersonal relationships.

The USAPDA, as noted in its administrative correction dated 10 February 2005, determined that depressive disorder, not otherwise specified was not unfitting. In analyzing the intrinsic impairment for appropriately coding and rating the secondary depression symptoms condition, the Board is left with a questionable basis for arguing that secondary depression symptoms was indeed independently unfitting. Although the CI required an S3 profile, the condition was not mentioned in the commander’s statement, he required no inpatient hospitalizations, and no functional impairments can be attributed solely to this condition. After due deliberation, the Board agreed that evidence does not support a conclusion that depressive disorder, as an isolated condition, would have rendered the CI incapable of continued service within his MOS, and accordingly the Board cannot recommend a separate service rating for it.

Remaining Conditions. Other conditions identified in the DES file were chest pain, umbilical hernia, and severe abdominal pain. 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.

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 low back pain secondary to herniated nucleus pulposis condition, the Board unanimously determined this condition existed prior to service and was not permanently aggravated by service and therefore the CI was not entitled to severance pay. However, DoDI 6040.44 prohibits any reduction of the previously issued disability rating. Therefore, the Board has no recourse but to recommend no recharacterization of the CI’s disability and separation determination. In the matter of the radiculopathy, depressive disorder, chest pain, umbilical hernia and severe abdominal pain 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 therefore recommends that there be no recharacterization of the CI’s disability and separation determination:

|  |  |  |
| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Low Back Pain secondary to Herniated Nucleus Pulposis | 5243 | 20% |
| **COMBINED** | **20%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110615, 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

SUBJECT: Department of Defense Physical Disability Board of Review Recommendation

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 and hereby deny the individual’s application.

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

Deputy Assistant Secretary

(Army Review Boards)