RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXXX BRANCH OF SERVICE: Army

CASE NUMBER: PD1100510 SEPARATION DATE: 20071207

BOARD DATE: 20120607

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SGT/E-5 (25U/Signal Support Specialist) medically separated for a cervical strain condition, with secondary shoulder pain and tension headaches. He suffered a forceful injury to his neck during combatives training in 2006. He experienced instant cervical and left shoulder pain and spasm; and, 2 weeks later developed occipital headaches which were attributed to the injury. All three complaints (cervical, left shoulder, and headaches) persisted and imposed significant duty limitations. They did not respond to a protracted trial of various treatment modalities; and, the CI could not meet the physical requirements of his Military Occupational Specialty (MOS) or satisfy physical fitness standards. He was consequently issued permanent P3 and U3 profiles, and was referred for a Medical Evaluation Board (MEB). All three conditions (characterized as “neck pain,” left shoulder pain,” and “prostrating headaches”) were forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501. A fourth condition, an ulnar neuropathy at the left elbow, was addressed by the MEB and forwarded as meeting retention standards. The PEB adjudicated the three primary MEB submissions as a single unfitting condition, rated 10%. Reconsideration PEB by the US Army Physical Disability Agency (USAPDA) adjudicated the cervical, left shoulder and headache conditions as separately unfitting. Cervical strain was rated 20%, citing criteria of the Veteran’s Affairs Schedule for Rating Disabilities (VASRD); “shoulder pain secondary to cervical strain” was rated 0%, referencing the USAPDA pain policy; and, “tension headaches secondary to cervical strain” was rated 0%, citing VASRD criteria. The left ulnar neuropathy was determined to be not unfitting. Although a congressional inquiry was fielded by the USAPDA after separation, the CI did not appeal the final PEB findings in service; and, he was medically separated with a combined 20% disability rating.

CI CONTENTION: “Unable to operate a motor vehicle for long periods of time. Difficulty bending to get dressed without pain. Suffer from frequent minor to severe headaches. Some days unable to even go to work due to headache pain. Unable to lift heavy objects due to shoulder pain. The inability to enjoy the daily activities playing with my children due to neck pain and headaches. Unable to perform any jumping, running or twisting without pain. … [Further elaborates current limitations from the cervical, shoulder, and headache conditions.] … Also my hearing seems to keep deteriorating, and I continually have to ask them to repeat what they have said. I feel that I should have received a higher rating for the headaches and the shoulder pain since they are ongoing symptoms.” The left elbow neuropathy was included in the entry for VA rated conditions, but it was not requested for Board consideration.

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 all three of the unfitting conditions are addressed below. The left elbow neuropathy, determined by the PEB to be not unfitting, was not requested for consideration by the Board. This condition, the hearing loss noted by the CI, 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:

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| **Service PEB – Dated 20070924** | | | **VA (14 Mo. Post-Separation) – All Effective 20071208** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Cervical Strain | 5257 | 20% | Chronic Cervical Strain | 5237 | 10% | 20090120 |
| Secondary Shoulder Pain | 5099-5003 | 0% | Tendonitis, L Shoulder | 5201-5024 | 10% | 20090120 |
| Secondary Tension Headaches | 5399-5323 | 0% | No VA Entry | | | 20090120 |
| Left Ulnar Neuropathy | Not Unfitting | | L Cubital Tunnel Syndrome | 8516 | 0% | 20090120 |
| No Additional MEB/PEB Entries. | | | Tinnitus | 6260 | 10% | 20090120 |
| 0% x 3 / Hearing Loss - Not Service-Connected | | | 20090120 |
| **Combined: 20%** | | | **Combined: 30%** | | | |

ANALYSIS SUMMARY: The Board acknowledges the sentiment expressed in the CI’s application regarding the significant impairment with which his service connected conditions continue to burden him. 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). The DVA, operating under a different set of laws (Title 38, United States Code), 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 the degree of impairment vary over time. The Board utilizes DVA evidence proximate to separation in arriving at its recommendations; but, its authority as defined in DoDI 6044.40 resides in evaluating the fairness of DES rating determinations for the disability existing at the time of separation. Post-separation evidence therefore is probative only to the extent that it reasonably reflects the disability at the time of separation. DoDI 6040.44 specifies a 12-month interval for special consideration to DVA findings.

Since it goes to the probative value judgments which must be considered in the rating recommendations for each of the following conditions, the Board must note that significant concerns are in evidence regarding the possibility of malingering in this case. Such evidence, as elaborated below, is necessarily documented in these proceedings as it presented itself in the record. It is in no way intended to impugn the applicant, nor are expressed clinical opinions accepted as fact. It is rather presented as found, leaving the voting Board members and reviewers of this record to interpret and weigh it on an individual basis. In March of 2007 the CI was referred for evaluation of possible concussive syndrome, for which he underwent psychological testing. The overall results of that testing were interpreted as “high probability of malingering – exaggerated symptoms.” A subsequent clinical note by the same provider recorded “member is hoping for a medical board thus a high potential for secondary gain.” A primary care note in reference to the headache presentation stated, “He is already being seen by multiple specialty clinics for his complaint. Just started taking amitryptyline last night. Symptoms today seemed very exaggerated which is suspicious for malingering.” A subsequent note from a neurologist in April 2007 stated, “the misadventures with PO [oral] meds raises the issue of motivationally determined episodic events. Nevertheless we will pursue a source for the pain.” A treatment note by a different neurologist later that same month noted, “patient does not like taking meds and 3 or 4 weeks ago stopped all meds. After patient had left, I reviewed previous medical encounter, so the following was not discussed with patient. The issue of secondary gain has been raised. I did not realize he was seeing a German neurologist for ??.” A physiatrist following the cervical complaint, and laying out his treatment plan, documented, “however, question efficacy basing on psychological diagnosis of malingering all treatment modalities to date have failed which is consistent with that diagnosis overall prognosis with interventional cervical treatments in the face of this diagnosis with secondary gain issues is extremely poor.” The MEB’s narrative summary (NARSUM) addressed the issue as noted in the following excerpt.

There are several entries in the medical record concerning malingering. I have contacted the soldier's commander and she does not want to pursue chapter action for malingering. Also, it should be noted that none of the healthcare professionals discussed malingering with the soldier. On the day he took psychological tests he had a reaction to his medications and does not remember the activities of that day.

Although the clinical psychologist documented her plan to discuss this issue with the CI, no subsequent notes document the discussion. The CI also reported an over-medicated condition on the day of psychometric testing in his congressional letter, although no altered sensorium is documented throughout the service treatment record (STR). It is recognized by the Board, regardless, that such testing is never considered conclusively diagnostic.

The Board’s default posture regarding the severity of symptoms as reported by the applicant in the medical record and the validity of subjective exam findings is one of acceptance as factual evidence. The Board, however, must assign limitations to that principle in cases with well documented evidence that history and exam findings are reasonably subject to doubt. The evidence applicable to rating is always assigned probative value in arriving at recommendations, and no evidence is completely discounted. The Board treats factors which mitigate probative value only as variables, not as accepted conclusions; with the emphasis remaining on complying with VASRD §4.3 (reasonable doubt) and meeting the ‘fair and equitable’ standard of DoDI 6040.44.

Cervical Spine Condition. The mechanism of the 2006 injury during combatives training was forceful hyperflexion per the NARSUM, and falling backwards per the VA Compensation and Pension (C&P) examination after separation. In addition to severe neck and shoulder pain, there were transient paresthesias of the left hand. Magnetic resonance imaging (MRI) revealed “very small disc protrusions” at C3/4 and C4/5 without neural encroachment; no contour abnormality was mentioned in the report. The condition was followed by physical medicine (PM), and pain scale ratings varied from 8-10 of 10. The physical examinations recorded “diminished” and painful range-of-motion (ROM), more so with rotation. Neurologic examinations were normal, other than sensory findings of the left hand which were subsequently determined to be of distal ulnar nerve origin. The PM consultant stated, “his musculoskeletal exam is most consistent with myofascial pain. I found nothing from a neuromuscular standpoint suggestive of foraminal entrapment, or discogenic in etiology.” Multiple treatment modalities were pursued by PM; which included numerous medication regimens (encountering frequent side effects), physical therapy (PT), transcutaneous electrical nerve stimulator (TENS), and anesthetic/botox injections. The NARSUM reported pain rated 3-4/10 “on a good day,” with exacerbations to 8/10 by “certain movements of the neck.” There were two ROM evaluations in evidence, with documentation of additional ratable criteria, which the Board weighed in arriving at its rating recommendation; as summarized in the following chart.

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| Cervical ROM | MEB PT ~5 Mo. Pre-Sep | VA C&P ~14 Mo. Post-Sep |
| Flexion (45⁰ Normal) | 40⁰ | 40⁰ |
| Combined (340⁰) | 160⁰ | 245⁰ |
| Comments | + Tenderness/Spasm | + Tenderness; painful motion. |
| §4.71a Rating | 20%\* | 10% |

\*Based on combined ROM.

The Board directs attention to its rating recommendation based on the above evidence. The PEB’s 20% was based on abnormal contour referencing an x-ray report documented in the NARSUM. Although demonstration of abnormal contour by imaging, out of context and not corroborated by physical exam findings, is generally not applied to rating recommendations by the Board; the combined ROM measurements from the MEB evaluation meets the ≤170⁰ threshold for a 20% rating IAW VASRD §4.71a. It was also noted that the MEB measurements were made with an inclinometer, which is counter to the directives of VASRD §4.46 (accurate measurement); and, the VA measurements were made by a bubble goniometer IAW §4.46. The possibility of biased ROM measurements during the MEB period was considered; but, member consensus was that, considering the 14-month interval from separation to the VA evidence, that the MEB’s ROM evidence should be conceded for prevailing probative value assignment. 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 a change in the PEB adjudication for the cervical spine condition.

Left Shoulder Condition. The clinical course of the associated left shoulder condition was similar to that described above for the cervical problem. The STR abundantly documents a left trapezial myofascial etiology; and, imaging was normal. It was managed by the PM/Rehabilitation service along with the cervical condition, and similarly multiple treatment modalities were undertaken. The NARSUM did document that lidocaine and botox injections had “mildly improved the pain but moderately improved the range of motion of his left shoulder.” The NARSUM physical examination did not document spasm or tenderness of the shoulder, although left trapezial spasm was noted on multiple STR entries. The MEB ROM measurements were 150⁰ flexion and 125⁰ abduction; normal is 180⁰ for each, and the minimal compensable limitation is 90⁰ for each. The NARSUM; however, specifically documented “the soldier had moderate pain in the left shoulder during range of motion measurements. The left shoulder range of motion was reduced secondary to pain.” The 14-month VA, post-separation, measurements were 140⁰ flexion and 160⁰ abduction, although painful motion was documented. The PEB’s 0% rating was supported by the USAPDA pain policy, but was not compliant with VASRD §4.59 (painful motion) which would yield a minimally compensable joint rating of 10%. Although probative value concerns were raised regarding application of §4.59 as a subjective exam finding in this case, members agreed (as with the cervical ROMs) that reasonable doubt must be conceded. After due deliberation, the Board therefore recommends a service disability rating of 10% for the left shoulder condition. The action officer recommended, and the Board concurred with, the code 5099-5020 (synovitis) for its clinical compatibility.

Headache Condition. The headaches appeared 2 weeks after the neck/shoulder injury and persisted. The CI underwent a comprehensive evaluation and a protracted trial of multiple pharmacologic regimens by the neurology service. Accompanying photophobia, vomiting and visual symptoms were also reported; and, the treating neurologist concluded that it was “a mixed headache disorder;” with components of migraine and “muscle contraction head pain” (tension headache) “most likely related to the recent neck injury.” Inadequate relief or intolerable side effects were reported for every medication trial. The NARSUM reported “very severe pains once a week,” and that the only treatment option was to “stop what he is doing and find a quiet and dark room. Upon awakening the headache has usually resolved.” A memorandum for the record from the CI’s NCOIC (non-commissioned officer in charge) documented that the headaches occurred “approximately once in every 7 to 14 days,” and that “I, [name of NCOIC], allow him to leave work to go rest.” There are no physician releases or orders for bedrest in the file. There is only one clinical encounter for rescue treatment of headache in the STR; and, this was associated with the neurology treatment note quoted in the introductory probative value discussion (9 months prior to separation). Headache was not mentioned at the time of the VA C&P evaluation after separation; and, although noted as a current and occupationally significant complaint in the contention, there is no VA rating for headache in evidence.

The Board directs attention to its rating recommendation based on the above evidence. The VASRD §4.124a rating schedule for 8100 (migraine) rests heavily on the frequency of “prostrating” attacks “over last several months.” The PEB’s 0% rating was premised on the DoDI 1332.39 definition of “prostrating,” which requires evidence that medical treatment is sought for each rated episode. Under DoDI 6040.44, the Board is directed to: “Use the VASRD in arriving at its recommendations, along with all applicable statutes, and any directives in effect at the time of the contested separation (to the extent they do not conflict with the VASRD in effect at the time of the contested separation).” Since the VASRD does not provide a definition of “prostrating,” it can be argued that the Board is directed to apply the DoDI 1332.39 definition. The Board, by precedence, has not required rigid proof of medical attention for each and every episode to characterize it as prostrating; but, does require objective evidence that an attack forces the abandonment of work or activity at hand to treat the migraine; which may include episodes of self management employing migraine-directed treatment under close outpatient supervision. The issue arising in this case is that it is clear that the episodes of self-treatment were managed at the command level, not under medical direction. The Board’s judgment regarding whether or not to characterize these episodes as “prostrating” must also accommodate a reasonable concern regarding the significant possibility of a secondary gain influence on the frequency and clinical necessity of these episodes. All members were in agreement that the §4.124a criteria for the highest 50% rating, i.e., “very frequent completely prostrating and prolonged attacks productive of severe economic inadaptability,” were not met. If weekly or semi-weekly “prostrating” episodes are conceded, the 30% criteria are met (“prostrating attacks occurring on an average once a month over last several months”). If the Board judges that a reasonable threshold for satisfying the “prostrating” criterion was not met, then it must recommend a 0% rating IAW VASRD §4.124a. After due deliberation, considering all of the evidence and mindful of the probative value principles set forth above, the Board concluded that there was insufficient reasonable doubt to recommend a change in the PEB adjudication for the headache 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. As discussed above, PEB reliance on the USAPDA pain policy for rating the left shoulder condition was operant in this case and the condition was adjudicated independently of that policy by the Board. In the matter of the cervical spine condition and IAW VASRD §4.71a, the Board by a vote of 2:1 recommends no change in the PEB adjudication. The single voter for dissent (who recommended a rating of 10%) submitted the addended minority opinion. In the matter of the left shoulder condition, the Board unanimously recommends a disability rating of 10%, coded 5099-5020 IAW VASRD §4.71a. In the matter of the headache condition, the Board unanimously recommends a disability rating of 10% 30%, coded 8100 IAW VASRD §4.124a. In the matter of the headache condition and IAW VASRD §4.124a, the Board unanimously recommends no change in the PEB adjudication. 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:

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| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Cervical Strain | 5237 | 20% |
| Myofascial Strain, Left Shoulder | 5099-5020 | 10% |
| Chronic Headaches | 8100 | 0% |
| **COMBINED** | **30%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110705, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans’ Affairs Treatment Record

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Director of Operations

Physical Disability Board of Review

MINORITY OPINION:

In this case, there is compelling evidence of secondary gain corruption of the VASRD rating criteria derived during the MEB evaluation period. This was noted independently by five separate physicians, most of them specialists; and, it was addressed head on in the NARSUM. It is conceded that the CI may have been blindsided by the psychologist’s opinion and may not have been in a mental state valid for his psychological testing, as he contended in Service; and, if so, it is agreed that he should have had the benefit of counseling and/or re-testing. Accepting the validity of the psychological testing; however, is not necessary to sustain a reasonable conclusion that legitimate concerns are raised in this case regarding the probative weight of subjective clinical evidence. Only two of the providers cited in the evidence made reference to the results of the psychometric testing. As stated in these proceedings, this factor must be weighed; it need not be accepted or rejected on an all-or-nothing basis. Although the VA evidence falls outside the DoDI 6040.44 directed interval of 12 months for special consideration of post-separation evidence, it provides good insight in this case of the clinical severity divested of the psychological factors in play during the MEB period. The orthopedic conditions were at a baseline that would be clinically expected for the nature of the injury and pathology, and the headache was not a medical issue for the CI at that time.

These probative value concerns were shared by all of the voting members, and relevant to the Board’s recommendation for all three of the Service rated conditions. They were of particular consequence, however, in probative weight assignment to the disparate ROM evidence in support of a fair and §4.71a-based recommendation for the cervical spine condition. I cannot agree with the PEB’s rationale for assigning a 20% rating based on abnormal contour, as supported by a single x-ray finding. This issue arises frequently, and the dominant Board posture is that abnormal contour should be supported by physical examination findings concurrent with the evaluation from which all rating criteria are derived. Imaging studies assess only the anatomic alignment of vertebrae, not whether there is “muscle spasm or guarding severe enough to result in abnormal contour” as per §4.71a. The majority recommendation in this case rested, in fact, on the MEB’s combined ROM measurements; not, on the PEB’s rating rationale. My position is that it would take very little psychological adulteration accumulated over six planes of motion to account for the 10⁰ difference between 10% and 20% ratings. Add to this the §4.46 compliance factor and the elimination of the probative value doubt intrinsic to the VA evaluation; and, I think it is convincingly concluded that the probative value weight should rest with the VA evidence in this set of circumstances. The doubt necessary to conclude otherwise, in my opinion, does not rise to the level of reasonable. I therefore respectfully request that the Secretary consider the following minority recommendation in this case:

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| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Cervical Strain | 5237 | 10% |
| Myofascial Strain, Left Shoulder | 5099-5020 | 10% |
| Chronic Headaches | 8100 | 0% |
| **COMBINED** | **20%** |

It is noted for the record that, although this recommendation encompasses a lower rating for the cervical condition as adjudicated by the PEB; it does not lower the service’s combined rating, and therefore remains compliant with DoDI 6040.44.

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 XXXXXXXXXXXXXXXXXX, AR20120011975 (PD201100510)

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 hereby deny the individual’s application. There is insufficient justification to support the Board’s recommendation in accordance with Army and Department of Defense regulations.

2. The record does not support a change in the individual’s combined rating. His conditions listed as cervical strain, shoulder pain, and headaches were assigned as a combined rating of 20% by the Physical Evaluation Board (PEB). These conditions were also rated by the Veterans Administration at 20%. Although the minority member recommends changes to the individual ratings, the recommendation for the combined rating is also 20%. Considering the complete record, there is insufficient documentation to conclude that the individual’s disability rating by the PEB was inaccurate or otherwise improper.

3. 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 XXXXXXXXXXXXXXXXXX

Deputy Assistant Secretary

(Army Review Boards)

CF:

( ) DoD PDBR

( ) DVA