RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXX BRANCH OF SERVICE: Army

CASE NUMBER: PD1100633 DATE OF PLACEMENT ON TDRL: 20000627

BOARD DATE: 20120313 Date of Permanent SEPARATION: 20050517

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SFC/E-7 (92R4P / Parachute Rigger and Jumpmaster), medically separated for migraine headaches, mechanical low back pain (LBP) and fibromyalgia. She did not respond adequately to perform within her Military Occupational Specialty (MOS) or meet physical fitness standards. She was issued a permanent P4, U3 and L3 profile and underwent a Medical Evaluation Board (MEB). The MEB forwarded “mechanical LBP and fibromyalgia syndrome; migraine headaches and bilateral cubital tunnel syndrome and bilateral vestibular hypofunction” on DA Form 3947 to the Physical Evaluation Board (PEB) 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 PEB adjudicated “fibromyalgia, migraine headaches and mechanical LBP” as unfitting with likely application of the Department of Defense Instruction (DoDI) 1332.39 and the CI was placed on Temporary Disability Retired List (TDRL) with ratings as reflected in the chart below. The conditions stabilized and in March 2005 the PEB adjudicated “fibromyalgia, migraine headaches and mechanical LBP” as unfitting rating each 0%. The CI appealed to the Formal PEB (FPEB), and was then medically separated with a 20% combined disability rating

CI CONTENTION: The CI contends: “I was on the TDRL from June 2000 until May 2005 when I was finally separated. The final separation rating and decision in May 2005 was based on my ability to perform a civilian job and not on continued performance of the military occupational speciality [sic] of 92R4P and continued mandatory participation in parachute jump operations.” She additionally lists all of her VA conditions and ratings as per the rating chart below. A contention for their inclusion in the separation rating is therefore implied.

RATING COMPARISON:

|  |  |
| --- | --- |
| **Final Service FPEB – Dated 20050510** | **VA\* – All Effective 20000628** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| **On TDRL – 20000306** |  | **TDRL** | **Sep.** |
| Fibromyalgia | 5025 | 20% | 10% | Fibromyalgia | 5025 | 10% | 20000605 |
| Migraine Headaches | 8100 | 10% | 10% | Migraine Headaches | 8100 | 30% | 20000605 |
| Mechanical LBP | \*5299-5295 | 10% | 0% | Degenerative Joint Disease | 5010 | 10% | 20000605 |
| Bilateral Vestibular Hypo function | Not Unfitting | Vestibular Hypo function Bilateral | 6299-6204 | 10% | 20000621 |
| Bilateral Cubital Tunnel Syndrome | Not Unfitting | Cubital Tunnel Syndrome Right | 8516 | 10% | 20000605 |
| Cubital Tunnel Syndrome Left | 8516 | 10% | 20000605 |
| ↓No Additional MEB/PEB Entries↓ | Tinnitus | 6260 | 10% | 20000509 |
|  | 0% x 7/Not Service Connected x 8 | 20000605 |
| Combined: 20% | Combined: 60% |

\*The Code was changed to 5237 with the IPEB 20050322

ANALYSIS SUMMARY: The Board acknowledges the CI’s assertions that the final separation rating and decision in May 2005 was based on her ability to perform a civilian job and not on her continued performance of the MOS. It is noted for the record that the Board has neither the jurisdiction nor authority to scrutinize or render opinions in reference to asserted Service improprieties in the disposition of a case. The Board’s role is confined to the review of medical records and all evidence at hand to assess the fairness of PEB rating determinations, compared to VASRD standards, based on severity at the time of separation. It must also judge the fairness of PEB fitness adjudications based on the fitness consequences of conditions as they existed at the time of separation. The Board also acknowledges the CI's contention suggesting that service ratings should have been conferred for other conditions documented at the time of separation and for conditions not diagnosed while in the service (but later determined to be service connected by the VA). 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. The Department of Veterans’ Affair (DVA), however, is empowered to compensate service connected conditions and to periodically re-evaluate said conditions for the purpose of adjusting the veteran’s disability rating should his degree of impairment vary over time.

Fibromyalgia Condition: The CI had a well documented history of joint pains in the service treatment record (STR) dating back to 1980’s. She started with shoulder girdle pain and then progressed on to low back pain. She had onset of alopecia in 1998 with other skin lesions of her face and nodules on her body that were biopsied revealing dermal fibrosis. She had sleep disturbances that also started in 1998. With these constellations of symptoms, the CI was seen in the medical clinic and where it was noted she had pain in the hands, wrists, elbows, shoulders, neck, back and hips. The pain occurred all day but worse with prolong sitting or standing. The rheumatologist consult at the time of the narrative summary (NARSUM)/MEB, 7 months pre TDRL entry, documented a normal joint, laboratory and radiograph exams and further opined her physical exam met the diagnostic criteria for fibromyalgia (history of pain above and below the waist and left and right, must include the axial skeleton), having 11/18 tender point sites. The rheumatologist also opined while she had some signs and symptoms which may indicate a low level nondiagnosed mixed connective tissue disorder, she did not meet the diagnostic criteria for a specific collagen vascular disease (CTD) at that time. The CI medicated her fibromyalgia pain with nonsteroidal anti inflammatory (NSAIDS) medications. In October 1999 the CI was issued a permanent P4U3L3 profile with limitations of no running, jumping, marching, sit-ups, push-ups or use of LCE, Kevlar, backpack or performing any airborne operations. The commander’s statement noted she was unable to participate in airborne operations and in addition she was unable to do basic physical activities therefore it was difficult to find any MOS that would support her condition.

The Department of Veterans’ Affairs (DVA) Compensation and Pension (C&P) examination at TDRL entry and 58 months prior to TDRL exit documented that the CI was easily fatigued; had interrupted sleep; and trigger points on the chest wall and shoulder areas. On examination there were findings of pain to palpation in the lower lumbosacral area; crepitus and shoulder tenderness over the right AC joint; pain on percussion of the elbows with radicular pain to the fingers, little finger in both hands, pain on palpation over the carpal bones of both wrists; and finally no motor abnormalities were noted. The examiner opined that there was insufficient evidence to make the diagnosis of fibromyalgia yet the VA rated fibromyalgia claimed as bilateral hip condition. A re-evaluation TDRL exam completed 12 March 2002 documented the CI having better days than previous. She was continuing care with a Rheumatologist who opined the patient did not meet the diagnostic criteria for fibromyalgia because she had mild improvement in her pain with less trigger points (seven) than she did previously. Her condition had not impacted her social or occupational functioning as she was able to take 21 credit hours of college courses in a semester. The final TDRL evaluation was completed 7 months prior to TDRL exit. The examiner documented the CI taking NSAIDS, Tylenol and Fioricet (an opiod analgesic) daily to control the effects of fibromyalgia. Her pain was described as a constant, 9/10 on a pain scale, which was completely alleviated by sleep. While she was able to work as a civilian speech pathologist with school children, her fibromyalgia prevented her from doing rigorous or strenuous activity and she had become overweight and deconditioned. The examiner noted that the CI had multiple tender trigger points concentrated around her trapezius and neck area; and some tenderness on palpation along the lower back. He opined she was unfit for active service and that she would not spontaneously improve with an overall lack of improvement in the past 5 years.

The Board directs its attention to its rating recommendations based on the evidence just described. The PEB (TDRL entry) coded the fibromyalgia condition 5025 and rated at 20% (That are episodic, with exacerbations often precipitated by environmental or emotional stress or by overexertion, but that are present more than one-third of the time). The VA after rating all her other symptoms, subsequently rated the fibromyalgia condition coded 5025 (claimed as bilateral hip condition later claimed as bilateral leg numbness) at 10%. The Board carefully looked for evidence to meet the 40% rating criteria (symptoms that are constant, or nearly so, and refractory to therapy) but did not find any. The reevaluation TDRL exam in 2002 noted an improvement in her fibromyalgia with better days and less trigger points and in fact no longer met the diagnostic criteria for fibromyalgia. The TDRL exit exam, on which the FPEB based its recommendation, noted that the fibromyalgia condition appeared to be controlled with medications noting her ability to function as a speech pathologist, intermittent medication use and lack of exercise and adjudicated a permanent rating of 10%. The Board carefully looked for evidence of episodic exacerbations to meet the higher rating at 20% and noted instead an overall improvement in her condition with less trigger points than at entry on TDRL. All evidence considered, there is not reasonable doubt in the CI’s favor supporting recharacterization of the TDRL and permanent PEB fitness adjudication for the Fibromyalgia condition.

Migraine Headaches Condition: The CI had a well documented history of migraine headaches in the STR dating back to 1985. At the time of the NARSUM, her migraines were noted to be tolerable until approximately May 1999 when she had headaches that caused her to miss 10-15 days of work. The headaches were left retro-orbital with associated nausea, vomiting, and photo/phonophobia. The abortive medications Midrin, Compazine and Fiorinal helped but she would still average one headache per week that would last 8-10 hours. The neurologist documented subjective headaches of seven per week lasting 8-10 hours, an inability to wear Kevlar, and headaches that caused her to stop what she was doing “in the plane.” The physical exam, CAT scans and brain MRI were normal. The neurologist diagnosed migraine and analgesic rebound headaches. In addition to taking her abortive medications, she was tried on multiple preventive medications from 1996 without success until she was introduced to Topamax and even then she noted to have “one severe headache per month that she would likely miss work and could not perform her normal activities of daily living. The VA C&P examination 3 months after TDRL entry documented headaches that occurred approximately 9 out of 30 days and could last between fifteen and twenty two hours which were associated with nausea and photosensitivity and relieved with fairly strong narcotics or muscle relaxants. The examiner noted a normal neurologic exam and diagnosed migraine headache, severe. The TDRL reevaluation exam on 8 March 2002 documented daily headaches with unchanged characteristics from her TDRL entry. She was attending college and had missed 7 days in 8 months nearly consistent with one incapacitating headache a month. The TDRL exit examination completed 7 months prior to TDRL exit noted no change in her headache history noting that the CI had a severe headache, “which would be considered prostrating,” approximately once per month “that she would likely miss work and cannot perform her normal activities of daily living” and opined her migraine headaches were unchanged over the last 4 years and considered her mildly impaired for disability determination.

The Board directs its attention to its rating recommendations based on the evidence just described. The PEB (TDRL entry) coded the migraine headaches as 8100 (migraine) rated at 10%, (with characteristic prostrating attacks averaging one in two months over last several months ). The VA used the same code and rated at 30% (with characteristic prostrating attacks occurring on an average once a month over last several months). The FPEB (TDRL exit exam) noted her headaches generally occurred once per week. The FPEB requested absentee work notes from the CI’s work to help define if these headaches were incapacitating yet these were not submitted The FPEB therefore concluded that her headaches were accommodated at work with non-narcotic medication and that she had rarely missed work for incapacitating episodes. The Board considered the history of the CI’s headache condition, and determined the number of prostrating the headaches averaged once a month at the time of separation from service as the evidence historically recorded she missed 7 days in 8 months of school while on TDRL and . which was consistent with 30% rating criteria. By precedence the Board requires evidence that an attack requires abandonment of work or activity at hand to seek treatment (which includes self-medication and/or sleep), or to escape noxious stimuli in the immediate environment, in order for it to be characterized as prostrating. The Board agreed absentee work notes would have reinforced this rating criteria but after due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a change in the TDRL entry rating decision to 30% and a permanent separation rating of 30% for the migraine headache condition.

Low Back Condition: There was one goniometric range-of-motion (ROM) evaluation and one non goniometric range of motion (ROM) evaluation in evidence, with documentation of additional ratable criteria, which the Board weighed in arriving at its rating recommendation.

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| Goniometric ROM - Thoracolumbar | VA C&P ~ 58 Mo. Pre-TDRL Exit(20000605) | MEB ~7 Mo. Pre-TDRL Exit(20041109) |
| Flex (0-90) | 90⁰ | No gonio |
| Ext (0-30) | 30⁰ | No gonio |
| R Lat Flex (0-30) | 30⁰ | No gonio |
| L Lat Flex 0-30) | 30⁰ | No gonio |
| R Rotation (0-30) | 30⁰ | No gonio |
| L Rotation (0-30) | 30⁰ | No gonio |
| COMBINED (240) | 240⁰ |  |
|  | Full ROM; pain to palpation; motor/sensory intact | Numbness radiating down Left side/pain |
| Old Spine §4.71a Rating | 10% | 10% |
| Current Spine §4.71a Rating | 10% | 10% |

In 1990 the CI presented with low back pain for 4 days after completing a confidence course. She was treated with NSAIDS and physical therapy with apparent resolution. She did not represent for low back pain until 1992 when she also complained of bilateral hip pain. This insidious pain intermittently continued with new radiation to her left lower extremity in 1997 when she was further evaluated by neurosurgery. An MRI revealed degenerative disc disease (DDD) at L3-4 through L5-S1 levels with very minimal central canal stenosis and mild bilateral neural foraminal canal stenosis, left greater than right at L4-5 and L5-S1. The neurologist opined mild L5-S1 disc protrusion but no nerve root encroachment. In February 1999 she continued to complain of pain of her low back with activity, especially with running noting numbness and tingling of legs and feet and was evaluated by orthopedics in 1999 who documented an exam consistent with tenderness of the L5/S1 region, pain with hyperextension, normal straight leg raise, motor exam and with a decrease in pinprick of her left L4, L5 and S1 sensory exam. The examiner opined low back pain with unknown etiology of the left lower extremity sensory deficits and deemed her not a surgical candidate. The MEB NARSUM noted low back pain with extension and mild degenerative disc disease. The VA C&P examination 58 Mo. Pre-TDRL Exit indicated full ROM with pain on palpation. In March of 2004 the CI was by rheumatology who documented insidious low back pain and myalgias and opined the low back pain was likely related to degenerative changes rather than fibromyalgia. The TDRL exit examination noted her lower back pain had remained the same, her MRI’s had remained unchanged and documented an exam that had full ROM with a negative straight leg raise and opined severe DDD of the lumbar spine with radiculopathy down the left side.

The 2000 VASRD coding and rating standards for the spine, which were in effect at the time of separation, were modified on 23 September 2002 to add incapacitating episodes (5293 Intervertebral disc syndrome), and then changed to the current §4.71a rating standards on 26 September 2003. The 2000 standards for rating based on 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, the Board reconciles (to the extent possible) its opinion regarding degree of severity for the older spine codes and ratings with the objective thresholds specified in the current VASRD §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. For the reader’s convenience, the 2000 rating codes under discussion in this case are excerpted below. Furthermore, the Board policy (discussed above) of reconciling recommendations under the older 5295 rating schedule with current §4.71a based recommendations (when reasonable to do so) was considered.

5295 Lumbosacral strain:

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

Goldthwaite's sign, marked limitation of forward bending in

standing position, loss of lateral motion with osteoarthritic

changes, or narrowing or irregularity of joint

space, or some of the above with abnormal mobility on forced

motion....................................................... 40

With muscle spasm on extreme forward bending, loss of lateral

spine motion, unilateral, in standing position............... 20

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

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

The Board directs its attention to its rating recommendations based on the evidence just described. The PEB (TDRL entry) coded the Mechanical LBP as 5295 (Lumbosacral strain) rated 10% (With characteristic pain on motion). The VA rated cervical, thoracic, and lumbar spine degenerative disc disease with full ROM’s with an evaluation of 10% coded 5010. The FPEB (TDRL exit) permanently rated the low back condition at 0%, changed the coding from 5299-5295 to 5237(Lumbosacral or cervical strain) to reflect the new spine rules which were in existence at the time of the permanent separation, noted full ROM’s and subsumed the tenderness of the back in the fibromyalgia rating. The Board agreed there was evidence of a back injury, pain with motion, radiographic evidence of multilevel DDD and a rheumatologist opinion that the low back pain was related to her DDD not fibromyalgia. The Board therefore agreed the low back condition remained an unfitting as initially adjudicated on TDRL entry and recommended a permanent separate rating for the painful motion rather than subsuming the pain under the fibromyalgia condition. The Board precedent with regards to the addition of a peripheral nerve rating at separation is that a functional impairment be tied to fitness is required to support a recommendation. The pain component of a radiculopathy is subsumed under the general spine or fibromyalgia rating as specified in §4.71a. The sensory component in this case has no functional implications. The motor impairment was relatively minor and cannot be linked to significant physical impairment. Since no evidence of functional impairment exists in this case, the Board cannot support a recommendation for additional rating based on peripheral nerve impairment. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a permanent separation rating of 10% for the low back condition coded 5010 based on painful motion.

Other PEB Conditions. The other conditions forwarded by the MEB and adjudicated as not unfitting by the PEB were bilateral cubital tunnel syndrome, which CI lists as “paralysis of ulnar (R) nerve; paralysis of ulnar nerve (L)”, and bilateral vestibular hypofunction. The Boards’ main charge in respect to this condition is an assessment of the appropriateness of the PEB’s fitness adjudication. 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. The bilateral cubital tunnel syndrome was first diagnosed in 1999 with complaints of pain at the elbows and numbness and tingling of her ring and fifth fingers bilaterally. Two electromyleogram EMG’s completed pre TDRL entry, last one 1 month after the MEB/Narsum were positive for ulnar neuropathy on both the right and left. Her MEB/Narsum revealed normal bilateral motor function of the elbow, wrist, and hand with a normal grips strength bilaterally. She medicated with NSAIDS much like her fibromyalgia symptoms. For her bilateral vestibular hypofunction, she was seen by ENT who documented episodic imbalance with rapid movements and noted no head injury, loss of consciousness, no use of caustic medication and noted her work up for an unspecified CTD for which has eluded a diagnosis. After extensive studies to evaluate complaints of dizziness and tinnitus she was diagnosed with vestibular hypofunction based on a positive electronystagmogram (ENG). Both of these conditions were profiled, but not specifically implicated in the commander’s statement nor noted as failing retention standards. All were reviewed by the action officer and considered by the Board. There was no indication from the record that any of these conditions 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 any of the stated conditions.

Remaining Conditions. Other conditions identified in the DES file were; carpal tunnel syndrome, chronic degenerative joint disease (R Greater Than L) shoulder; glaucoma suspect; leg instability; extra heart beats DDD of the cervical spine left salpingectomy with residual left lower quadrant pain and gastro esophageal reflux (GERD). 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 was/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 tinnitus, traumatic arthritis 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 fibromyalgia condition and IAW VASRD §4.71a, the Board unanimously recommends no change in the PEB adjudication at time of TDRL entry and permanent separation. In the matter of the migraine headaches condition, the Board unanimously recommends a change in the TDRL entry rating to 30% and a 30% permanent rating, coded 8100 IAW VASRD §4.124a. In the matter of the low back condition, the Board unanimously recommends an initial TDRL rating of 10% and a 10% permanent rating, coded 5010 IAW VASRD §4.71a.

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 her prior medical separation:

|  |  |  |  |
| --- | --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **TDRL RATING** | **PERMANENT****RATING** |
| Fibromyalgia | 5025 | 20% | 10% |
| Migraine Headaches | 8100 | 30% | 30% |
| Mechanical LBP | 5010 | 10% | 10% |
| **COMBINED** | **50%** | **40%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110815, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans Affairs Treatment Record.

 XXXXXXXXXX

 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 XXXXXXXXXX, AR20120006626 (PD201100633)

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 constructively place the individual on the Temporary Disability Retired List (TDRL) at 50% disability rather than 40% disability for the period June 27, 2000 to May 16, 2005 and then following this period recharacterize the individual’s separation as a permanent disability retirement with the combined disability rating of 40%.

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 temporary disability 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 day following the TDRL period.

 c. Adjusting pay and allowances accordingly. Pay and allowance adjustment will account for recoupment of severance pay, provide 50% retired pay for the constructive temporary disability retired period effective the date of the individual’s original medical separation and then payment of permanent disability retired pay at 40% effective the day following the constructive TDRL period.

 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:

Encl XXXXXXXXX

 Deputy Assistant Secretary

 (Army Review Boards)

CF: