RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: Army

CASE NUMBER: PD1100734 SEPARATION DATE: 20060406

BOARD DATE: 20120403

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SGT/E-5 (11B20/Mechanized Infantry), medically separated for chronic low back pain (LBP). He 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 profile and underwent a Medical Evaluation Board (MEB). Acquired spondylolisthesis was forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW AR 40-501. No other conditions appeared on the MEB submission. Other conditions included in the Disability Evaluation System (DES) packet will be discussed below. The PEB adjudicated the chronic LBP condition as unfitting, rated 10% with application of the Veterans Administration Schedule for Rating Disabilities (VASRD). The CI made no appeals, and was medically separated with a 10% combined disability rating.

CI CONTENTION: “At the time of my discharge I was a career soldier 1.5 years removed from what would have been my “indefinite” re-enlistment which would have kept me soldiering through the 20 year mark or longer. Since my discharge my medical issues stemming from my medical discharge have made it extremely difficult to get hired for work and sustain work.” He elaborates no specific contentions regarding rating or coding and mentions no additionally contended conditions.

RATING COMPARISON:

|  |  |
| --- | --- |
| **Service PEB (Admin Corrected)– Dated 20060103** | **VA (8 Mo. After Separation) – All Effective Date 20060406** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Chronic Low Back Pain | 5239-5241 | 10% | Lumbar Spine Fusion, L4-L5-S1 S/P Lumbar Spine Fracture | 5235 | 10% | 20061204 |
| Sciatic Nerve Injury L Lower Ext. Assoc. w/ Lumbar Spine Fusion | 5235-8521 | 10% | 20061204 |
| ↓No Additional MEB/PEB Entries↓ | Migraine Headaches | 8100 | 30% | 20061204 |
| S/P Rt Hand 5th Digit Injury w/ Distal Peripheral Neuropathy | 8515 | 10% | 20061204 |
| Anxiety Disorder | 9413 | 10% | 20061204 |
| 0% x 2/Not Service-Connected x 3 | 20061204 |
| **Combined: 10%** | **Combined: 50%\*\*\*** |

ANALYSIS SUMMARY: The Board acknowledges the sentiment expressed in the CI’s application regarding the significant impairment with which his service-incurred condition continues to burden him. The Board wishes to clarify that it is subject to the same laws for service disability entitlements as those under which the DES operates. The 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. That role and authority is granted by Congress to the Department of Veterans’ Affairs (DVA), operating under a different set of laws (Title 38, United States Code). The Board evaluates DVA evidence proximal to separation in arriving at its recommendations, but its authority resides in evaluating the fairness of DES fitness decisions and rating determinations for disability 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. 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 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 the degree of impairment vary over time.

Back Condition. The CI first presented for low back pain (LBP) in 1995, 1 year after enlistment. He was managed conservatively and able to meet duty requirements although seen periodically for flares in his pain. Imaging did show spondylolisthesis of L5 on S1. On or about 3 October 2003, he was struck from behind while driving a Bradley fighting vehicle by another Bradley. He suffered neck and back pain. The former resolved, but the latter persisted and prevented him from meeting full duty requirements or deploying. On MRI, he was noted to have right L5 nerve root impingement from foraminal stenosis. Conservative management of the LBP, including epidural steroid injections, was unsuccessful and he had lumbar fusion of L4-5 and L5-S1 in September 2004. His pain was reduced after surgery, but persisted and impaired full duty performance. The CI also noted left leg numbness and weakness after surgery. Post-surgical imaging showed good fusion, but anterolisthesis of L4 on L5 (grade I) with mild posterior displacement of the graft cage at L4-5. The MEB narrative was dictated 31 October 2005, 5 months prior to separation and over a year after surgery. The CI was unable to lift over 30 pounds, wear protective gear, perform in cold weather, or walk or stand for prolonged periods. He also noted difficulty sleeping secondary to the pain. Thoracolumbar range-of-motion (ROM) (inclinometer) was flexion of 85 degrees (normal 90 degrees), extension 25 degrees (normal 30 degrees), with normal lateral flexion and rotation and a combined range of motion of 230 degrees (normal 240 degrees). His examination was notable for mild pain with thoraco-lumbar extension and reduced sensation over the lateral aspect of the thigh, calf and foot over the left L2-3 distribution. Motor weakness on extension of the left knee was also noted, rated at 4+/5. The ankle jerk reflex was absent on the left. The VA Compensation and Pension (C&P) examination was on 4 December 2006, 8 months after separation. The CI noted persistent LBP and numbness of the left leg, the latter attributed to injury to the sciatic nerve during surgery. Bowel or bladder incontinence was denied. Gait and posture were normal and no assistive devices in use. Thoracolumbar ROM (goniometer) was normal, including flexion of 90 degrees, extension 30 degrees, as well as normal lateral flexion and rotation and a normal combined ROM of 240 degrees. Sensation was again noted to be diminished, but motor strength and deep tendon reflex exams were normal. The PEB coded the LBP as 5239-5241 (5239 spondylolisthesis or segmental instability; 5241 spinal fusion) and rated it at 10%. The VA also rated the back at 10%, coded 5235 (5235 vertebral fracture or dislocation), and awarded an additional 10% for sciatic nerve injury coded 5235-8521 (8521 paralysis of common peroneal nerve). The Board notes that the VA upheld its adjudication on review in 2008 and that no coding option would support higher than the 10% rating awarded by both the PEB and VA.

The Board next considered the 10% rating awarded by the VA for the sciatic nerve injury. This was awarded by the VA for a sensory deficit which was persistent on multiple exams after surgery and separation. 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. The motor impairment was relatively minor and cannot be linked to significant physical impairment separate from that due to the persistent pain. The Board notes that on subsequent VA exams, the motor strength examination was normal. 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 in consideration of the totality of the evidence, the Board concluded that there was insufficient cause to recommend a change from the PEB fitness adjudication for the LBP condition.

Remaining Conditions. Other conditions identified in the DES file were a neck injury, hyperlipidemia, hearing loss, asthma, bronchitis, shoulder pain, knee pain, wrist, ankle, toe, heart burn, mitral valve prolapse, trouble sleeping, knee pain, right fifth finger, and forearm injury. Several additional non-acute conditions or medical complaints were also documented. None of these conditions were clinically or occupationally significant during the MEB period, none carried attached profiles, 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, migraine headaches, gastroesophageal reflux disease and anxiety disorder were noted in the VA proximal to separation, but were not documented in the DES file. At the time of the MEB history and physical examination, the CI checked “no” to the question on DD Form 2807 regarding frequent or severe headaches. 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, the Board unanimously recommends no change from the PEB adjudication. In the matter of left radiculopathy, the Board unanimously agrees that it cannot recommend any findings of unfit for additional rating at separation. In the matter of the neck injury, hyperlipidemia, hearing loss, asthma, bronchitis, shoulder pain, knee pain, wrist, ankle, toe, heart burn, mitral valve prolapsed, trouble sleeping, knee pain, right fifth finger, and forearm injury or any other condition eligible for Board consideration, the Board unanimously agrees that it cannot recommend any findings of unfit for additional rating at separation.

RECOMMENDATION: The Board, therefore, recommends that there be no recharacterization of the CI’s disability and separation determination, as follows:

|  |  |  |
| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Chronic Low Back Pain | 5239-5241 | 10% |
| **COMBINED** | **10%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110830, 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 f

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)