RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: Army

CASE NUMBER: PD1100761 SEPARATION DATE: 20071115

BOARD DATE: 20120320

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SGT/E-5 (35P/98G, Cryptologic Linguist), medically separated for scoliosis, left ulnar neuropathy and left foot pain. The CI reported back pain with shortness of breath, left arm and left foot pain; all of which occurred without trauma. She did not respond adequately to treatment including physical therapy, and chiropractic and was unable to perform within her Military Occupational Specialty (MOS). She was issued a permanent U3 L2 profile and underwent a Medical Evaluation Board (MEB). Scoliosis, left ulnar neuropathy and left foot pain were forwarded to the Physical Evaluation Board (PEB) as medically unacceptable. Anemia and hirsutism, as identified in the rating chart below, were forwarded on the MEB submission as medically acceptable conditions. The PEB adjudicated the left foot condition as unfitting, but as existed prior to entry on active duty (EPTS) with no permanent service-aggravation, and therefore not ratable/compensable. The PEB adjudicated the scoliosis and left ulnar neuropathy conditions as unfitting, rated 10% and 10%; with likely application of the US Army Physical Disability Agency (USAPDA) pain policy and the VASRD respectively. The CI made no appeals, and was medically separated with a 20% combined disability rating.

CI CONTENTION: The CI states: “The ratings for the conditions that rendered the member unfit should be changed because the member has had increased difficulty in all and specifically the foot pain has lead to surgery. The member has an MBA implant in the left foot and has to have the same surgery on the right foot (once the left foot heals completely). Also, the member has been rated for other disabilities including fibromyalgia which was not originally rated while active duty.” She elaborates no specific contentions regarding rating or coding.

RATING COMPARISON:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Service PEB – Dated 20070806** | | | **VA (9 Days. After Separation) – All Effective Date 20071116** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Scoliosis … chest pain … and back pain … cervico/thoracic spine … (see text) | 5299-5237 | 10% | Cervical Strain w/ Torticollis … | 5237 | 20%\* | 20071126 |
| Lumbar Lordosis, … to Include Thoracic Kyphosis | 5299-5239 | 20% | 20071126 |
| Myalgia/Myositis of the … and Thoracolumbar Spine | 5003-5021 | 10% | 20071126 |
| Leg Length Discrepancy | 5275 | 0% | 20071126 |
| Left Ulnar Neuropathy | 8716 | 10% | L. Radiculopathy/CTS | 8516 | 10% | 20071126 |
| Scar, Left Elbow | 7804 | 10% | 20071126 |
| Left Foot Pain (EPTS) | 5299-5276 | --% | Pes Planus, … Flat Foot Deformity, Accessory Bone, Bunion and Hammertoes … | 5276 | 30% | 20071126 |
| Anemia | Not Unfitting | | Anemia | 7700 | NSC | 20071117 |
| Hirsutism | Not Unfitting | | Hirsutism | 7899-7831 | NSC | 20071117 |
| ↓No Additional MEB/PEB Entries↓ | | | Asthma | 6602 | 10% | 20071117 |
| L. Costrochondritis, … Chest Pains/Spasms | 5399-5321 | 10% | 20071126 |
| R. PFS w/ Chondromalacia | 5257 | 20% | 20071126 |
| L. PFS w/ Chondromalacia | 5257 | 20% | 20071126 |
| 0% x 1/Not Service Connected x 6 | | | 20071126 20071117 |
| **Combined: 20%** | | | **Combined: 90%** | | | |

\* VA rating based on exam most proximate to date of permanent separation.

ANALYSIS SUMMARY: The Board acknowledges the sentiment expressed in the CI’s application, i.e., that the gravity of her condition and predictable consequences which merit consideration for a higher separation rating. It is a fact; however, that 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. This role and authority is granted by Congress to the Department of Veterans’ Affairs (DVA). 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.

Scoliosis (Including Thoracolumbar Spine; Cervical Spine and Chest Pain). The PEB disability description stated: “scoliosis which produces chest pain (non-cardiac) and back pain.” Scoliosis was not noted on the Soldier's entry physical. Spirometry, stress test and echocardiogram were normal. The Soldier could forward flex to 90 degrees. There is mild tenderness on palpation of the paraspinal area bilaterally. At the cervico/thoracic spine there is mild deviation. There is exaggerated lumbar lordosis and there is curvature of the lumbar spine convex to the left. The lower extremity neurogical exam is non focal. The Soldier cannot lift over fifteen pounds.” The “cervico/thoracic deviation” indicated that two spine segments (cervical and thoracic) were involved in the single rating. The PEB rated the entire spine under the single analogous code 5299-5237, lumbosacral or cervical strain. Chest pain (non-cardiac) was also included in this spine rating. This coding approach may have been countenanced by AR 635-40, but IAW DoDI 6040.44 the Board must apply only VASRD guidance to its recommendation. The Board must therefore apply separate codes and ratings in its recommendations if compensable ratings for each spine segment [cervical and thoracolumbar] and/or the chest pain conditions are achieved IAW VASRD-only rules. IAW Note (6) from the general rating formula for diseases and injuries of the spine the Board must separately evaluate disability of the thoracolumbar and cervical spine segments. If the Board judges that two or more separate ratings are warranted in such cases; however, it must satisfy the requirement that each “unbundled” condition (thoracolumbar spine; cervical spine and chest pain) was unfitting in and of itself. Since §4.71a criteria are met for separate spine segment ratings in this case, and §4.73 criteria for the chest pain condition, the Board is pursuing separate rating and fitness evaluations as follows. The Board precedence for “unbundling” conditions is the “reasonable doubt” standard, which is lower than the “preponderance of the evidence” standard for addition of a new unfitting condition.

Thoracolumbar Spine and Cervical Spine: There were two spine examinations in evidence proximate to separation which the Board weighed in arriving at its spine rating recommendations. Only the VA exam included a complete goniometric range-of-motion (ROM) evaluation and both exams are summarized in the chart below.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ROM – Thoracolumbar & Cervical | MEB ~ 4 Mo. Pre-Sep  (20070730) | | VA C&P ~ 9 Days After-Sep  (20071126) | |
| Lumbar | Cervical | Lumbar | Cervical |
| Flexion | 90⁰ | “Decreased ROM to 45 degrees to each side;” mild muscular tender; see text | 40⁰ | 40⁰ |
| Combined | decreased | 130⁰ | 240⁰ |
| Comment | Tenderness; see text | Thoracic kyphosis, inc lumbar lordosis; painful motion; add 5° loss on rep; antalgic gait | Paravertebral muscles tight on left; painful motion; add 5° loss on rep; torticollis |
| §4.71a Rating | 10%\* | 10%\* | 20% | 10%-20% (VA 20%) |

\* Conceding §4.59 (painful motion) and §4.40 (functional loss)

The commander’s statement indicated chronic pain and inability to stay in the office and work longer than several hours, as well as inability to perform the APFT (despite profile stating capable) principally due to profiled conditions of scoliosis/kyphosis of the spine, left elbow and flat feet conditions. The profile indicated U3L2 with “1) scoliosis/kyphosis of the spine causing chest pain. 2) lt elbow pain 3) flat feet.” The NARSUM indicated “problem #1, chest pain with shortness of breath” with an impression/recommendation of “problem #1, scoliosis producing chest (non-cardiac) and back pains” which was the MEB diagnosis #1.

The NARSUM exam indicated “neck: decreased range-of-motion (ROM) to 45 degrees to each side. There is mild muscular tenderness at palpation.” There was pain at palpation of the anterior chest wall and the spine exam was separated into two areas of 1) “cervical/thoracic spine: Mild deviation seen. Is tender to palpation at the thoracic spine.” And 2) “lumbar spine: There is tenderness in the palpation of the left flank. There is mild tenderness at palpation of the paraspinal area bilateral. Extension=30; Flexion=90; Lat Flexion= 30; Leg Elevation=60.” Radiographs of March 2006 documented cervical torticollis dextroscoliosis and kyphosis of the thoracic spine. The service treatment record (STR) indicated multiple treatment notes for neck and shoulder pain as well as profile restrictions for shoulder pain and torticollis. Many additional treatment notes did not separate evaluations for neck and thoracolumbar spine symptoms.

The C&P physical exam, 9 days after separation, revealed pain-limited cervical spine ROMs as charted above. The cervical paraspinal muscles were tight on the left side, and the examiner indicated additional limited ROM after repetition. The lumbar spine pain-limited ROM was also decreased by five degrees after repetition. The thoracic spine showed thoracic kyphosis with tenderness of the paravertebral muscles. Gait was antalgic with uneven leg length. Other VA C&P exams indicated normal gait and antalgic gait in one VA exam was attributed to left foot pain versus the spine condition. The Board considered the multiple evaluations and differential diagnoses in the record with potential overlap on the CI’s unfitting conditions. Any overlap from the left arm peripheral nerve condition was considered under the CI’s unfitting left ulnar neuropathy condition.

The Board first considered if the cervical spine torticollis/painful motion and tenderness, having been de-coupled from the single combined PEB spine adjudication, remained independently unfitting as established above. The Board majority agreed that the cervical spine, as an isolated condition, would have rendered the CI incapable of continued service within her MOS, and accordingly merits a separate service rating.

The VA separately coded and rated the cervical and thoracolumbar spine conditions at 20% each based on the VA exam which indicated much decreased ROMs of the spine. In its assignment of probative value to such disparate cervical and thoracolumbar exams, the Board must acknowledge that VA goniometric examinations may predispose a lowered pain threshold since they are vulnerable to the compelling psychological influence of secondary gain. There were no treatment records to approach the level of VA limited ROM. The VA exam demonstrated antalgic gait and abnormal posture as well as an absence of any other significant findings to align with the disparate ROM goniometric measurements. There were other VA exams indicating normal gait and other diagnoses that the abnormal gait was potentially attributable to. The Board adjudged the MEB exam to have the highest probative value for rating on separation as it was supported by the remainder of the record, and was not in the context of a specified disability exam, more reflective of the anticipated severity suggested by the clinical pathology and less vulnerable to the undue influence just elaborated. The Board is therefore relying more heavily on the MEB measurements.

The 20% rating for abnormal contour is defined in §4.71a as “muscle spasm or guarding severe enough to result in an abnormal gait or abnormal spinal contour such as scoliosis” and the examination did not reflect that degree of spasm or guarding for either cervical or thoracolumbar spine segment. By precedent the Board does not base 20% recommendations under §4.71a for abnormal spinal contour evidenced only by radiographic findings without physical exam correlates. That position is consistent with the language and intent of the VASRD. The Board considered additional thoracolumbar rating for muscle pain in the back, thighs and lower legs as rated by the VA (myalgia/myositis of the … and thoracolumbar spine coded 5003-5021 at 10%); however, there was insufficient evidence to adjudge this condition additionally unfitting based on the record. In regards to the thoracolumbar and cervical spine conditions combined under a single 5299-5237 rating by the PEB, the Board majority recommends individual spine ratings as follows: scoliosis – thoracolumbar spine, 5299-5237 at 10% and cervical spine, 5299-5237 at 10%.

Chest Pain: The Board next considered if the chest pain (non-cardiac) was due to the unfitting spine conditions, or a separate entity; and if having been de-coupled from the combined PEB spine conditions, if it remained independently unfitting as established above. A principle complaint for the CI seeking treatment and for duty restrictions was episodic left-sided chest pain and shortness of breath (SOB). This symptom complex appeared more limiting than the back pain condition. The CI underwent extensive evaluation for chest pain and shortness of breath to include pulmonary function tests, exercise treadmill testing, and rheumatology evaluation which are well documented in the records. The MEB and PEB coded the CI’s chest pain as due to the CI’s spine condition. However, the atypical chest pain had been diagnosed as costrochondritis and the NARSUM indicated “SOB is most likely due to rib inflammation associated with the kyphosis.” The NARSUM exam, and multiple other treatment notes, indicated “pain at palpation of the anterior chest wall” or tenderness of the anterior chest wall. There was no indication that anterior chest wall tenderness was referred pain from the spine. The abnormal spine anatomy most likely made the CI more prone to rib inflammation; however, it is a separate diagnosis and separately ratable under the VASRD. The Board majority agreed that the chest pain with SOB, as an isolated condition, would have rendered the CI incapable of continued service within her MOS, and accordingly merits a separate service rating.

The Board adjudged that there was no unfitting cardiac component to the chest pain and the possible pulmonary component from the CI’s diagnosed asthma condition did not account for the evidence of record and asthma was not unfitting. The CI’s chest-pain (non-cardiac) was clearly musculoskeletal and the VA coding of 5399-5321, analogous to group XXI. Function: respiration. Muscles of respiration: thoracic muscle group was predominate and the “moderate” level (10%) was supported by the record. In regards to the thoracolumbar and cervical spine conditions combined with chest pain under a single 5299-5237 rating by the PEB, the Board majority recommends individual spine ratings as above and a separate rating for chest pain (non-cardiac) coded 5399-5321 at 10%.

Left Arm Pain (Left Ulnar Neuropathy). The CI’s left ulnar neuropathy was separately unfitting at 10% by the PEB and rated at 10% by the VA. The different disability descriptions used the same codes for the ulnar nerve. The CI had abnormal electrophysiological studies and underwent a surgical nerve release at the elbow level without symptom resolution. The military exam noted decreased grip strength and sensation in the last two fingers, while the VA exam documented normal grip strength. The unfit determination was considered administratively final despite apparent moderate improvement by the time of the VA exam. The Board examined all exams related to the left upper arm and additionally considered potential radicular pain from the CI’s cervical condition. There was no avenue to rating greater than 10%. All evidence considered, there is not reasonable doubt in the CI’s favor supporting a change from the PEB’s 10% rating decision for the left ulnar neuropathy condition.

Left Foot Pain. The Board’s main charge regarding this condition is evaluation of the PEB’s EPTS determination. The Board’s authority for recommending a change in the service’s EPTS determination is not specified in DoDI 6040.44, but is considered adjunct to its DoD-specified obligation to review service fitness adjudications. As with its consideration of fitness adjudications, the Board’s threshold for countering service EPTS 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 CI entered the USMC and was separated during basic training for non-medical reasons. The CI was granted a waiver for asymptomatic severe flat feet with orthotic use for entry into the Army. By history, the CI was an avid runner and never had any feet pain until she went to Korea in September 2004. The onset of feet pain was attributed to “a lot of ruck marching.” Custom insoles were of some help for symptom relief, but the CI could not perform her APFT. Radiographs demonstrated an extra navicular bone with surgery recommended for symptom relief. The MEB found the condition did not meet standards and was exacerbated by service. The PEB found the condition unfitting with no permanent service-aggravation of her pre-existing (EPTS) severe flat feet. The VA adjudged the bilateral flat feet as pre-existing with service-aggravation and awarded a 30% disability rating.

The CI was granted a waiver for service entry for severe pes planus and use of orthotics with no evidence of foot pain. There was no in-service foot surgery, no specific left foot injury, and no additional diagnosis of plantar fasciitis or other additional foot condition not present on service entry. The Board adjudged that there was no preponderance of evidence to indicate permanent service-aggravation not attributable for normal progression of the EPTS condition. After due deliberation in consideration of the totality of the evidence, the Board concluded that there was insufficient cause to recommend a change in the PEB adjudication as unfit and EPTS without permanent service-aggravation, and therefore non-compensable for the left foot condition.

Other PEB Conditions. The other conditions forwarded by the MEB and adjudicated as not unfitting by the PEB were anemia and hirsutism. Neither of these conditions were profiled, implicated in the commander’s statement or noted as failing retention standards. Anemia is an abnormal lab value and not a physical disability. Both 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.

Other Contended Conditions. The CI’s application asserts that compensable ratings should be considered for fibromyalgia. The CI was evaluated by a rheumatologist and Fibromyalgia was not diagnosed in service. The VA exam proximate to separation indicated that the CI did not meet the diagnostic criteria for Fibromyalgia at that time. Fibromyalgia was not indicated 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. Other service connected conditions with a compensable rating by the VA within 12 months of separation were asthma (10%), and left chondromalacia patella (knee; 10%). These conditions were reviewed by the action officer and considered by the Board, especially as they had symptoms that overlapped with the CI’s primary unfitting condition of back and chest pain. It was determined that none could be argued as unfitting and subject to separation rating. The Board, therefore, has no reasonable basis for recommending any additional unfitting conditions for separation rating.

Remaining Conditions. Other conditions identified in the DES file were asthma, knee condition, tumor/fibroids removed, dizziness, severe headaches, irregular heart beat, sleep problems, hernia, abnormal pap smear, heavy menstrual bleeding, and chest pains. 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 (except the chest pains), 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. No other conditions were service connected with a compensable rating by the VA within 12 months of separation or contended by the CI. 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 scoliosis (including thoracolumbar spine; cervical spine and chest pain) condition, the Board, by a vote of 2:1, recommends that each spine segment and the chest pain be separately adjudicated as follows: an unfitting cervical spine condition coded 5299-5237 and rated 10%, an unfitting thoracolumbar spine condition, coded 5299-5237 and rated 10% (both IAW VASRD §4.71a.); and an unfitting chest pain condition, coded 5399-5321 and rated 10% (IAW VASRD §4.73). The single voter for dissent (who recommended no recharacterization) did not elect to submit a minority opinion. In the matter of the left ulnar neuropathy condition and IAW VASRD §4.124a, the Board unanimously recommends no change in the PEB adjudication at separation. In the matter of the anemia and hirsutism conditions, the Board unanimously recommends no change from the PEB adjudications as not unfitting. In the matter of the asthma and left knee 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 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** | **RATING** |
| Scoliosis – Thoracolumbar Spine | 5299-5237 | 10% |
| Cervical Spine | 5299-5237 | 10% |
| Left Ulnar Neuropathy | 8716 | 10% |
| Chest Pain (non-cardiac) | 5399-5321 | 10% |
| **COMBINED** | **30%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110906, 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

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 30% 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 30% 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:

Encl

Deputy Assistant Secretary

(Army Review Boards)