RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXXXXXXXXXX BRANCH OF SERVICE: Army

CASE NUMBER: PD1100785 SEPARATION DATE: 20041228

BOARD DATE: 20120904

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SPC/E-4 (91W10, Health Care Specialist), medically separated for a low back condition and a left hip condition. The CI did not respond adequately to conservative treatment for his low back or operative treatment for his left hip to meet the physical requirements of his Military Occupational Specialty (MOS), worldwide deployment standards or satisfy physical fitness standards. He was issued a permanent L3 profile and referred for a Medical Evaluation Board (MEB). Eight other conditions, as identified in the rating chart below, were forwarded on the MEB submission as medically acceptable conditions. The Physical Evaluation Board (PEB) adjudicated the low back and left hip conditions as unfitting, rated 10% and 10%, respectively, with likely application of the US Army Physical Disability Agency (USAPDA) pain policy as the PEB cited “regulatory guidance contained in AR 635-40, paragraph B-24f, restricts the maximum rating for pain-regardless of how many separate anatomical sites to 20%.” The remaining conditions were determined to be not unfitting and were not rated. The CI made no appeals, and was medically separated with a 20% disability rating.

CI CONTENTION: “To review the fairness of the medical disability rating awarded at the time of separation of the US Army.”

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 service ratings for unfitting conditions will be reviewed in all cases. The conditions right ankle talar osteochondral defect, Fuchs’ dystrophy, intermittent left shoulder pain, positive TB test, gastroesophageal reflux disease (GERD), stable adrenal adenoma, headache and hypertension as requested for consideration meet the criteria prescribed in DoDI 6040.44 for Board purview; and, are addressed below, in addition to a review of the service ratings for the unfitting conditions. The remaining conditions rated by the VA at separation and listed on the DA Form 294 application are not within the Board’s purview. Any conditions or contention not requested in this application, or otherwise outside the Board’s defined scope of review, remain eligible for future consideration by the Army Board for Correction of Military Records (BCMR).

RATING COMPARISON:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Service PEB – Dated 20041101** | | | **VA (6 Mos. Post-Separation) – All Effective Date 20041229** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Chronic Low Back Pain | 5299-5237 | 10% | Degenerative lumbar disc syndrome, claimed as thoracic and lumbar spine, back condition; left thigh  pinched nerve | 5243 | 20% | 20050602 |
| Chronic Lt Hip Pain | 5099-5003 | 10% | S/P Surgery Lt Trochanteric Bursitis | 5255 | 10% | 20050602 |
| Rt Ankle Talar Osteochondral Defect | Not unfitting | | Residuals of right ankle fracture, soft tissue calcification (claimed as right ankle condition) | 5271 | 10%\* | 20051207 |
| Fuchs’ Dystrophy | Not unfitting | | Fuchs’ Dystrophy | 6099-6000 | NSC | 20050523 |
| Intermittent Lt Shoulder Pain | Not unfitting | | Lt Shoulder Condition | 5201 | NSC | 20050602 |
| Positive TB Test | Not unfitting | | NO VA ENTRY | | | |
| GERD | Not unfitting | | Gastroesophageal reflux disease | 7399-7346 | 10%\* | 20051207 |
| Headaches | Not unfitting | | Chronic Headaches | 8199-8100 | NSC | 20050523 |
| Stable Adrenal Adenoma | Not unfitting | | Adrenal Adenoma | 7915 | 0% | 20050523 |
| Hypertension | Not unfitting | | Hypertension w/ Proteinuria | 7101 | 10% | 20050523 |
| ↓No Additional MEB/PEB Entries↓ | | | Duodenal Ulcer | 7305 | 0% | 20050523 |
| Sleep Apnea | 6847 | 50% | 20050523 |
| Depression w/ Cognitive Impairment | 9434 | 50% | 20050518 |
| Degenerative Cervical Disc Syndrome | 5242 | 10% | 20050602 |
| Degenerative Joint Disease Bilateral Feet | 5010 | 10% | 20050602 |
| Tinnitus | 6260 | 10% | 20050523 |
| Not Service-Connected x 3 | | |  |
| **Combined: 20%** | | | **Combined: 90%** | | | |

\*20060123 Rating Decision added right ankle and GERD

ANALYSIS SUMMARY:

Low Back Condition. The CI had an insidious onset of atraumatic low back pain since the year 2000. He was evaluated by multiple specialists to include rheumatology and orthopedics and treated with multiple medications (narcotics, neuropathic and nonsteroidal anti-inflammatory medications) and physical therapy for pain control without relief. The evidence reflects from November 2003 until August 2004 there was no service treatment record (STR) for acute low back pain visits although the pharmacy log reflects filling of his anti-inflammatory pain medications in April and June 2004. It was in August 2004 he presented with worsening back pain, 4 of 10 on a pain scale and aggravated by walking or sitting which occasionally caused a numbness of his left leg and the pharmacy log reflected a rise in the filling of his narcotic pain medication, monthly from August 2004. He had been passing an alternate Army Physical Fitness Test (APFT) with the bike as the aerobic event under a P2 profile for his right ankle as late as April of 2004. However, with his worsening back pain he was issued a new profile, P3, identifying the low back pain, hip pain and right ankle disorder with more physical and functional limitations thus prompting an MEB. He was pending an evaluation for pain management for his low back pain during the MEB period. The profile limitations included; unable to do any aerobic event of the, sit-ups, move with a fighting load at least two miles, construct an individual fighting position or do 3-5 second rushes under direct or indirect fire. His commander’s statement documented his non-deployable status, specifically citing the inability to wear a ruck or flak vest, and that he must be separated due to this fact. There were two range-of-motion (ROM) evaluations in evidence, with documentation of additional ratable criteria, which the Board weighed in arriving at its rating recommendation; as summarized in the chart below.

|  |  |  |
| --- | --- | --- |
| Thoracolumbar ROM | MEB ~3 Mo. Pre-Sep | VA C&P ~6 Mo. Post-Sep |
| Flexion (90⁰ Normal) | 90⁰ | 40⁰ |
| Ext (0-30) | 20⁰ | 20⁰ |
| R Lat Flex (0-30) | 30⁰ | 30⁰ |
| L Lat Flex 0-30) | 30⁰ | 10⁰ |
| R Rotation (0-30) | 30⁰ | 30⁰ |
| L Rotation (0-30) | 30⁰ | 15⁰ |
| Combined (240⁰) | 230⁰ | 145⁰ |
| Comment | + Tenderness | + Tenderness; painful motion, slow gait no limp, no spasm |
| §4.71a Rating | 10%\* | 20% |

\*Conceding §4.59 painful motion

At the MEB exam, the CI reported moderate to marked constant pain that interrupted his sleep, with a pain scale reflected in the STR of a minimum 4 of 10 intensity and a maximum 7 of 10 intensity for which he took Vicodin (narcotic based medication), Naproxen (an anti-inflammatory medication), Flexeril (muscle relaxant medication) and Neurontin (a neuropathic medication). The MEB physical exam noted tenderness in the left paraspinal, painful full flexion, 1 of 5 Waddell signs, Faber’s test negative for hip pathology and normal neuromuscular findings. There were no STR’s in evidence within 12 months prior to separation to corroborate the MEB exam. However, there was an exam 13 months prior to separation that corroborated the VA exam and another exam 17 months prior that corroborated the MEB exam. Magnetic resonance imaging (MRI) of the lumbar spine revealed mild degenerative changes of the discs and protrusions at multiple levels but otherwise no evidence of nerve root or cord compression. The STR had evidence of plain X-rays which revealed a Grade I spondylolisthesis of L5 on S1 with disc space narrowing and no evidence of spondylolysis. At the VA Compensation and Pension (C&P) exam performed after separation, the CI reported similar symptoms as the MEB and denied flare ups. The VA C&P exam documented tenderness of the central lumbar spine area, sciatic notch and S-I joint, mild straight leg raise on the left at 45 degrees, no spasm or Deluca observations and normal neuromuscular findings. X-rays revealed mild hypertrophic changes, narrowing of the disc spaces from L2 through S1 and spondylolisthesis grade I of L5.

The Board directs attention to its rating recommendation based on the above evidence. The PEB and VA applied different Veterans Administration Schedule for Rating Disabilities (VASRD) codes, but were subject to the same rating criteria IAW §4.71a (schedule of ratings) musculoskeletal system under general rating formula for diseases and injuries of the spine. The PEB’s DA Form 199 reflected the likely application of the USAPDA pain policy for rating, and its 10% determination was consistent with §4.71a. The VA chose code 5243 (intervertebral disc syndrome) and rated at 20% based on limited forward flexion which was also consistent with §4.71a and the clinical pathology. It is a clear there is a disparity between the MEB and VA ROM examinations which had significant implications regarding the Board's rating recommendation. The Board thus carefully deliberated its probative value assignment to these conflicting evaluations, and carefully reviewed the service file for corroborating evidence in the 12-month period prior to separation. The Board carefully considered the whole record IAW VASRD §4.2 (interpretation of examination reports) in order to acquire a consistent picture of the CI’s back condition. The Board also utilizes VA 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. Two exams in the STR, 13 and 17 months prior to separation, corroborated the VA and MEB ROM exam findings, respectively and while both these exams are outside the 12-month interval these exams were not disregarded. There is no VA evidence 12 months post-separation or beyond for consideration. The Board considered the absence of muscle spasm and normal gaits in both exams and agreed these findings were more consistent with the 10% rating. The Board considered if the VA ROM rating evaluation which is based on subjective pain threshold was subject to loss of objectivity as it is an exam for a financial disability incentive. However, the Board agreed there is enough corroborating evidence and clinical pathology to account for the disparate ROM exams signifying some moderate functional impairment due to the moderate to marked level of pain document in the evidence. The Board majority agreed however the MEB exam is most proximate to the date of separation, consistent with the diagnostic and clinical pathology, and for this reason assigns the MEB exam more probative value. The pain component of a radiculopathy is subsumed under the general spine rating as specified in §4.71a. The subjective sensory component in this case has no functional implications, and no motor weakness was in evidence. Since no evidence of functional impairment exists in this case, the Board cannot support a recommendation for additional service rating based on peripheral nerve impairment. There was no evidence for incapacitating episodes to achieve a higher rating under that alternate formula. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board majority concluded that there was insufficient cause to recommend a change in the PEB adjudication for the low back condition.

Hip Condition. The CI had chronic left hip pain which ultimately led to an operative intervention for definitive care, a left snapping hip release, in 1998. This procedure resolved a lot of his symptoms, but for the last 3-4 years he had progressive pain in the left hip. He had multiple attempts at conservative treatment with multiple medications and therapy without relief. The left hip condition was implicated in the permanent profile and the Board agreed the limitations specifically for the hip could not be separated from the back and refers to the low back discussion for review of his limitations. 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 chart below.

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| --- | --- | --- |
| Left Hip (Thigh) ROM | MEB ~3 Mo. Pre-Sep | VA C&P ~5 Mo. Post-Sep |
| Flexion (0-125⁰) | 125⁰ | 125⁰ |
| Extension (0-20⁰) | 20⁰ | >20⁰ |
| External Rotation (0-45⁰) | 45⁰ | 45⁰ |
| Abduction (0-45⁰) | 45⁰ | 25⁰ |
| Adduction (0-45⁰) | 45⁰ | 10⁰ |
| Comment | Full ROM, Painful motion | Painful motion,  Slow gait, no limp |
| §4.71a Rating\* | 10% | 10% |

\*Conceding §4.59 painful motion

The MEB physical exam documented pain with internal rotation of the left hip that was centered over the greater trochanter and a subjective loss of sensation with previously positive Tinel's sign over the lateral femoral cutaneous nerve. Magnetic resonance imaging (MRI) arthrogram of the hip revealed a small labral tear of the left acetabulum but otherwise normal.

At the VA Compensation and Pension (C&P) exam the CI reported no additional history from the MEB exam. The VA C&P exam documented no Deluca observations and the X-rays were without any significant abnormalities.

The Board directs attention to its rating recommendation based on the above evidence. The PEB and VA chose different coding approaches for the condition, but this did not bear on rating. The PEB permanent separation rating of 10%, under code 5299-5003 is consistent with VASRD rating criteria. VASRD §4.71a specifies for 5003 that “satisfactory evidence of painful motion” constitutes limitation of motion and specifies application of a 10% rating “for each such major joint or group of minor joints affected by limitation of motion.” The VA coding choice of 5255, (femur, impairment of) was not consistent with the clinical pathology. The Board considered 5253 (thigh, impairment of) for the non-compensable limitation of motion for adduction documented in the VA exam but agreed this did not yield a higher rating. The Board agreed there was no evidence of incapacitating episodes to support additional or a 20% rating under the 5003 code. 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 left hip condition.

Contended PEB Conditions. The contended conditions adjudicated as not unfitting by the PEB were right ankle talar osteochondral defect, Fuch’s dystrophy, intermittent left shoulder pain, positive TB test, GERD, stable adrenal adenoma, headache and hypertension. The Board’s first charge with respect to these conditions is an assessment of the appropriateness of the PEB’s fitness adjudications. The Board’s threshold for countering 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 CI had an inversion right ankle injury in May 1996 which was evaluated and a CT revealed a tiny osteochondritis dissecans (OCD) lesion. He continued to reinjure his right ankle which was treated repetitively with either a month of casting or splinting and ultimately led to an L3 profile in May 2000 with recommendation for either MOS Medical Review Board (MMRB) or MEB. There was no evidence of either proceeding in the case file and could not be located after the appropriate inquiries. Further attempts at obtaining the relevant documentation would likely be futile and introduce additional delay in processing the case. The speculative missing evidence is not suspected to significantly alter the Board’s recommendations. The CI continued to have pain and in October 2002 was diagnosed with a talar dome OCD lesion in which had been refractory to non-operative treatments and a referral was recommended for a foot/ankle specialist and a MRI. Both evaluations corroborated the OCD lesion, in addition, documented a disorder of the anterior talofibular ligament (ATFL) and the Achilles tendon. Surgery was performed in January 2003 for definitive care. The post-operative course was uneventful and the rehabilitation course reflected a downgrade of the profile in May 2003 to a permanent L2 with limitations to include run and road march at own pace up to four miles, and bike for the AFPT. The final profile referenced the right talar dome OCD lesion, but was not specific to which limitations applied to the ankle. The Board agreed this condition was bundled with his other lower body conditions for the final L3 permanent profile. If the condition had been isolated the Board reasonably speculates it would have continued to have been characterized on a L2 profile and not be unfitting as there had been no evidence of reinjury or further surgery leading up to the MEB. Furthermore, at the MEB exam the CI did not complain of right ankle pain and documented “feet demonstrates good range of motion.” None of the other conditions were profiled; implicated in the commander’s statement; and, judged to fail retention standards. All of the conditions 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. After due deliberation in consideration of the preponderance of the evidence, the Board concluded that there was insufficient cause to recommend a change in the PEB fitness determination for the any of the contended conditions and, therefore, no additional disability ratings can be recommended.

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. The Board did not surmise from the record or PEB ruling in this case that any prerogatives outside the VASRD were exercised. As discussed above, PEB likely reliance on the USAPDA pain policy for rating low back condition and left hip condition was operant in this case and the condition was adjudicated independently of that policy by the Board. In the matter of the low back 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 adopting the VA rating at 20 % with a more clinically specific code) submitted the appended minority opinion. In the matter of the left hip condition and IAW VASRD §4.71a, the Board unanimously recommends no change in the PEB adjudication. In the matter of the contended right ankle talar osteochondral defect, Fuchs’ dystrophy, intermittent left shoulder pain, positive TB Test, GERD, stable adrenal adenoma, headache and hypertension conditions, the Board unanimously recommends no change from the PEB determinations as not unfitting. There were no other conditions within the Board’s scope of review for consideration.

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

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| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Chronic Low Back Pain | 5299-5237 | 10% |
| Chronic Left Hip Pain | 5099-5003 | 10% |
| **COMBINED** | **20%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110914, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans’ Affairs Treatment Record

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President

Physical Disability Board of Review

MINORITY OPINION:

The service rating in this case cited “Regulatory guidance contained in AR 635-40, paragraph B24f, restricts the maximum rating for pain--regardless of how many separate anatomical sites--to 20%”. The Board agreed this language could not be found in AR 635-40 and likely represented the application of the US Army Physical Disability Agency (USAPDA) pain policy and certainly did not reflect application of the Veterans Administration Schedule for Rating Disabilities (VASRD). IAW DoDI 6040.44, under which the Board operates, the Board must apply only VASRD guidance to its recommendation.

The Board deliberated at length the probative value of the MEB exam and the VA exam after reviewing the service file for corroborating evidence in the 12-month period prior to separation as well as the 12-month interval, specified by the DoDI 6040.44 for special consideration to VA findings. The Board majority agreed the MEB exam was most probative based on being most proximate to separation. The action officer disagrees that due to proximity alone the MEB exam should be assigned more probative value. While there was no service or VA evidence within the 12-month interval for consideration, per the DoDI 6040.44, there was pre-separation evidence at 13- and 17-months that reasonably reflects the disability and fitness implications of the back at the time of separation. This evidence reflects corroborating evidence for both the MEB and the VA exam. The Board unanimously agreed the evidence does not reflect a VA exam subject to pain thresholds for financial incentives, rather, when considering the totality of the evidence IAW VASRD §4.2 the exams reflect the functional impairment of the back based on the waxing and waning nature of his pain with coexisting pathology of multilevel disc disease and the bony disease of L5 (spondylolisthesis grade I). Therefore, based on all evidence and associated conclusions just elaborated, the action officer considers both the MEB and the VA exam equally probative and further considered the whole record IAW VASRD §4.2 for the permanent rating recommendation.

During deliberations it was noted there was no evidence of acute care visits for over 9 months for back pain from November 2003 till August 2004, however the evidence also reflects there was a lack of STR treatment during this time interval for the CI’s other medical conditions. As noted in the right ankle OCD discussion there was speculative missing evidence in the case file and the action officer opines that more than likely there is missing evidence for this time interval and further the pharmacy log documents the filling of anti-inflammatory pain medications in April and June of 2004. Therefore the action officer opines the lack of STR does not equate to the lack of back pain.

During deliberations it was noted the CI passed an AFPT in April 2004. To clarify, this AFPT test was an alternate aerobic test allowing push-ups, sit-ups and the bike. It was not until August 2004, when the CI sought acute care for back pain, that led to more narcotic pain prescriptions and the more physically and functionally limited P3 profile; eliminating sit-ups, an aerobic event and functionally limited the use of a rucksack or flak vest thus being non deployable.

Finally, the action officer considered VASRD §4.7 (higher of two evaluations) which directs the evaluator to assign the higher of two valid ratings if the disability picture more nearly approximates the criteria. With the emphasis remaining on meeting the ‘fair and equitable’ standard of DoDI 6040.44, the action officer agreed the back pain condition most nearly approximated the 20% standards for the general rating formula for diseases and injuries of the spine based. The action officer recommends coding 5239 (Spondylolisthesis or segmental instability) analogous to 5243 code for more clinically specificity to capture the clinical coexistent pathology in this case.

The action officer respectfully submits that the Secretary consider the minority recommendation 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 his prior medical separation:

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| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Chronic Low Back Pain | 5239-5243 | 20% |
| Chronic Left Hip Pain | 5099-5003 | 10% |
| **COMBINED** | **30%** |

SFMR-RB

MEMORANDUM FOR Commander, US Army Physical Disability Agency

(TAPD-ZB / Mr. Brower), 2900 Crystal Drive, Suite 300, Arlington, VA 22202

SUBJECT: Department of Defense Physical Disability Board of Review Recommendation for XXXXXXXXXXXXXXXXXXXXX, AR20120016856 (PD201100785)

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 XXXXXXXXXXXXXXXXXXX

Deputy Assistant Secretary

(Army Review Boards)

CF:

( ) DoD PDBR

( ) DVA