RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXXXXX BRANCH OF SERVICE: Army

CASE NUMBER: PD1200010 SEPARATION DATE: 20020205

BOARD DATE: 20120821

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty Soldier, SSG/E-6(79R, Recruiter), medically separated for chronic right shoulder and arm pain. The CI had right upper extremity and neck pain including right arm numbness and tingling since 1991. He had surgery for decompression of thoracic outlet syndrome in 1996. Return of symptoms and a new magnetic resonance imaging (MRI) indicating a herniated cervical disc led to cervical discectomy fusion and plating in March 2001. The symptoms did not improve adequately with treatment to meet the physical requirements of his Military Occupational Specialty (MOS) or satisfy physical fitness standards. He was issued a permanent U3 profile and referred for a Medical Evaluation Board (MEB). The CI’s appeal to the MEB concerning thoracic outlet syndrome pain was considered by the MEB. The MEB forwarded “cervical herniated nucleus pulposus w/neck and right upper extremity pain. Pain is constant and slight” as medically unacceptable IAW AR 40-501. Thoracic outlet syndrome was also forwarded by the MEB without indication of not meeting standards. The Physical Evaluation Board (PEB) adjudicated “chronic pain, right shoulder and arm, without neurologic or electrodiagnostic abnormality, status post C6-7 anterior cervical discectomy, fusion, and plating. Rated as slight/constant” as unfitting, rated 10%, with specified application of the US Army Physical Disability Agency (USAPDA) pain policy. The PEB adjudicated the thoracic outlet syndrome as not unfitting. The CI appealed to the Formal PEB (FPEB); however, he withdrew his appeal, and was then medically separated with a 10% disability rating.

CI CONTENTION: “The result of my PEB was a 10% disability rating. Before and after my PEB I had seen several different doctors with varying opinions on thoracic outlet syndrome some understood and recognized it and treated it with OT and PT then the decompression surgery. After my decompression surgery where two muscles was taken out of the right side of my neck I had early success but it didn't cure the overall problem that I still live with today. My second neck surgery corrected a bulging disk I had between C-6 and C-7. After this surgery I had less shaking in my right and leg [*sic*] however I still have loss of strength and pain shooting down my arm. After months of PT OR OT [*sic*] the answer was to assign me to the pain clinic. Unfortunately the pain clinic only offered drugs and how to learn with the pain. I was also taught to stretch or build the chest and arm where I had the most pain. At the time this diagnoses I was assigned to the US Army Recruiting Command in Omaha, NE. My duties included visiting high schools, meeting with school officials, introducing the Army [*sic*] community leaders, parents and students. The duties also include reporting information to our recruiting company, Battalion and Brigade of recruiting efforts. I found this to be a challenge while on the different medications I was given. I finally had to make the decision to either take the meds or live with the pain or go through a PEB to seek other options. I chose the PEB. The board results came back that I was unfit for duty with a 10% rating. My current VA rating is 50%. Today I still suffer with the same problems however I am not under the physical standards or requirements that I had to maintain as a soldier. The rating for the conditions should be raised due to the impact it had on my ability to perform my duties as a soldier. My performance as a soldier was always near the top or excellent every category during evaluations except for physical standards this is why I changed careers to recruiting. [*sic*] The physical demands of recruiting were a lot less than those of a truck driver however with my explanation above it became very challenging to maintain the minimal day to day standards of recruiting duty. I do not have any further records to add to the past PEB however I have seen my VA doctor for continued treatment for thoracic outlet syndrome and neck and arm pain. Thank you for reviewing my PEB and I hope you find that living thoracic outlet is a life changing ailment that effects the way a person has to live day to day.”

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 unfitting conditions will be reviewed in all cases. The thoracic outlet syndrome condition as requested for consideration meets the criteria prescribed in DoDI 6040.44 for Board purview; and, is addressed below, in addition to a review of the ratings for the unfitting chronic right shoulder and arm pain following cervical surgery condition. The remaining conditions rated by the VA at separation and submitted with the DA Form 294 application are not within the Board’s purview [the VA-rated history of right elbow fracture had non-painful limited motion and was therefore not within the scope of the Board]. 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 the Correction of Military Records.

RATING COMPARISON:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Service PEB – Dated 20011115** | | | **VA (3 Mos. Pre-Separation) – All Effective Date 20020602** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Chronic Pain, R Shoulder & Arm, w/o Neurologic or Electrodiagnostic Abnormality, S/P C6-7 Anterior Cervical Discectomy, Fusion, & Plating | 5099-5003 | 10% | Degenerative Changes in the R Shoulder | 5003 | 10% | 20011222 |
| Thoracic Outlet Syndrome, ORIF of C6-C7 & Mild Neural Foraminal Narrowing at C6-C7 w/Limitation of Motion\* | 5290-8710\* | 20%\* | 20011222 |
| Thoracic Outlet Syndrome | Not Unfitting | |
| R (Wrist) Ulnar Styloid Process, Old Ununited Fracture | 5215 | 10% | 20011222 |
| ↓No Additional MEB/PEB Entries↓ | | | Tinnitus | 6260 | 10% | 20011222 |
| Schmorl’s Node L4, With Limitation of Motion | 5292 | 10% | 20011222 |
| 0% X 3 / Not Service-Connected x 1 | | | 20011222 |
| **Combined: 10%** | | | **Combined: 50%** | | | |

\*The 5290-8710 condition and 20% rating was replaced with: Thoracic Outlet Syndrome w/Radicular Symptoms, RUE, 8710-8513 at 20% plus Post ORIF of C6-C7, 5290 at 10%, based on exam of 20031118, effective 20030608 (combined 50% was unchanged)

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 disability entitlements as those under which the Disability Evaluation System (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 Veteran 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 further acknowledges the CI’s contention for ratings for other conditions documented at the time of separation, and notes that its recommendations in that regard must comply with the same governance. 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 his degree of impairment vary over time.

Also of note, the 2001 Veterans’ Administration Schedule for Rating Disabilities (VASRD) coding and rating standards for the spine, which were in effect at the time of separation, were changed in September 2002 regarding criteria for code 5293 (Intervertebral disc syndrome), and then to the current §4.71a rating standards in 2004. The 2001 standards for code 5293 included radicular pain rather than incapacitating episodes. The older spine rating were also based on range of motion (ROM) impairment which were subject to the rater’s opinion regarding degree of severity, whereas the current standards specify rating thresholds in degrees of ROM impairment. The older spine ratings did not have the general spine rating formula provision of including pain (whether or not it radiates). For the reader’s convenience, the 2001 rating codes under discussion in this case are excerpted below.

5290 Spine, limitation of motion of, cervical:

Severe........................................................ 30

Moderate...................................................20

Slight.......................................................... 10

5291 Spine, limitation of motion of, dorsal:

Severe......................................................... 10

Moderate.................................................... 10

Slight............................................................. 0

5293 Intervertebral disc syndrome:

Pronounced; with persistent symptoms compatible with sciatic neuropathy with characteristic pain and demonstrable muscle spasm, absent ankle jerk, or other neurological findings appropriate

to site of diseased disc, little intermittent relief ............. 60

Severe; recurring attacks, with intermittent relief.......... 40

Moderate; recurring attacks ........................................... 20

Mild ................................................................................. 10

Postoperative, cured ........................................................ 0

Chronic Pain, R Shoulder & Arm, w/o Neurologic or Electrodiagnostic Abnormality, S/P C6-7 Anterior Cervical Discectomy, Fusion, & Plating. The CI was right hand dominant. The PEB combined right shoulder pain, right arm pain and cervical fusion as the single unfitting and solely rated condition, coded analogously to 5003. Although this approach complies with the USAPDA pain policy and AR 635.40 (B.24); the Board must apply separate codes and ratings in its recommendations, if compensable ratings for each condition are achieved IAW VASRD-only rating. 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 was reasonably unfitting, by itself or in combination. Not uncommonly this approach by the PEB reflects its judgment that the constellation of conditions was unfitting; and, that there was no need for separate fitness adjudications, not a judgment that each condition was unfitting. Thus the Board must exercise the prerogative of separate fitness recommendations in this circumstance, with the caveat that its recommendations may not produce a lower combined rating than that of the PEB. The PEB disability description did not separately attribute the CI’s right arm (RUE) pain, right shoulder pain, or cervical fusion to specific joints, nerves, or diagnoses used in VASRD-only coding and rating. The PEB’s phrase of “without neurologic or electrodiagnostic abnormality” is interpreted from usual (historical) Army use, as excluding objective neurologic signs such as electrodiagnostic testing abnormalities or loss of reflexes, but does not exclude subjective symptoms of radiating pain or paresthesias. The CI had multiple diagnoses which potentially overlapped and caused the CI’s disability picture; therefore, the cervical spine condition, right shoulder condition, and right arm pain (to include wrist fracture) will be discussed below. Although the PEB adjudicated thoracic outlet syndrome as not unfitting, any RUE, shoulder, or neck residuals of thoracic outlet decompression surgery will be considered in rating considerations and will be discussed below. The VA-rated conditions aligning with the PEB symptoms included right shoulder, cervical fusion with thoracic outlet syndrome (later separated into cervical fusion and RUE radicular symptoms from thoracic outlet syndrome), and right wrist limitation.

The NARSUM indicated the CI had right upper extremity and neck pain including right arm numbness and tingling since 1991. Review of the records indicated that the CI had a right shoulder injury (1982) with recurrent dislocations and two shoulder surgeries (1983) prior to entry into service. Orthopedic consult for his entry physical (MEPS) indicated no post-surgical dislocations, full painless-ROM and a good prognosis. The CI had a right shoulder dislocation in June 1990 that was self-reduced. The CI had a right wrist (distal radius) fracture in 1992 (radiographs indicated no union of the styloid) with wrist and hand complaints. Following exacerbation of shoulder pain in 1995, radiographs showed degenerative changes of the shoulder (glenohumeral) joint. Multiple orthopedic, vascular and surgery clinic evaluations in 1995 for shoulder pain and arm paresthesias included electrodiagnostic studies (EMG/NCV—mild prolonged latencies on the right with stimulation) and the clinical picture was consistent with thoracic outlet syndrome. Cervical spine MRI demonstrated minimal spondylosis and the CI underwent thoracic outlet surgery (scalene muscle resection) in 1996 with good “symptom relief (with all but the most strenuous activity [running])” that lasted for 9 months. Post-surgical recurrence of symptoms (right hand and forearm paresthesias, increased subjective fatigue in the RUE, decreased grip strength, right-sided scapular pain with exam findings of decreased light touch in ulnar distribution of RUE and a positive Tinels at the right supraclavicular region with a diagnosis of ulnar nerve entrapment), increased neck pain and new MRI findings of a large disc herniation at C6-7 on the right, led to anterior cervical discectomy fusion and plating in March 2001. Only the neck burning pain was resolved and the CI continued to have right shoulder and arm pain complaints. There were 2 cervical 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.

|  |  |  |
| --- | --- | --- |
| Cervical ROM | MEB ~6 Mo. Pre-Sep | VA C&P ~3 Mo. Pre-Sep |
| Flex (45⁰ Normal) | 90⁰ | 20⁰ |
| Ext (0-45) | 15⁰ | 20⁰ |
| R Lat Flex (0-45) | - | 20⁰ |
| L Lat Flex (0-45) | - | 20⁰ |
| R Rotation (0-80) | - | 55⁰ |
| L Rotation (0-80) | - | 55⁰ |
| COMBINED (340⁰) | - | 190⁰ |
| Comment: Surgery 11 Mo. Pre-Sep (20010302) | Sensation decreased pin prick in C7 distribution; motor 5/5; reflexes 1+ symmetric; Spurling sign positive | Repetition increases pain and fatigability with no ROM changes |
| §4.71a Rating | 20% | 20% |

At the MEB exam, the CI reported RUE burning pain, numbness in the arm, and pain on the anterior chest and inner arm. “The numbness and pain wakes him from sleep at night” and high impact activity aggravates the pain. The MEB physical exam noted limited cervical ROM decreased sensation and positive Spurling sign (provocative cervical radiculopathy maneuver). Post-PEB and pre-separation trigger point injections appeared to provide symptom “relief and improved arm strength”, while a subsequent treatment note listed diagnoses of “chronic pain syndrome/fibromyalgia and osteoarthritis – generalized and mild to moderate at this time” (non-rheumatologist). The MEB exam of the neck is summarized above and other findings were good distal pulses. The PEB requested additional information provided to the PEB included a neurosurgeon update indicating the “neurogenic thoracic outlet syndrome is a controversial diagnosis,” reiteration of MEB exam findings of decreased sensation in (right) the C7 distribution, and a physical medicine and rehabilitation consult. The CI’s complaints were “persistent sharp and shooting pain intermittently involving the right anterior chest and radiating to the right shoulder, posterior aspect of the right arm, ulnar forearm, and into the small finger and ring finger with associated paraesthesias.” The CI was using narcotic pain medication and exam demonstrated normal strength, reflexes and sensory exam. Tinel test was positive at the right elbow over the ulnar nerve and Spurling test was negative. Electrodiagnostic testing was normal and the diagnosis included “No conclusive clinical evidence of a vascular or neurogenic thoracic outlet syndrome at this time.”

At the VA Compensation and Pension (C&P) exam performed prior to separation, the CI reported a similar history with symptoms including loss of strength in the right arm, frequent arm and the hand ‘going to sleep’, frequent episodes of pain in the right arm, decreased right wrist strength with “frequently drops items”; as well as pain, weakness, and stiffness in the neck with flare-ups. Exam demonstrated painful motion of the right shoulder to VA normal limits, painful motion of wrist of the VA normal limits with radiographs showing an old un-united fracture of the right ulnar styloid process and degenerative and postoperative changes of the right shoulder and pain-limited cervical ROM as summarized above. Cervical spine imaging showed in-place fixation of C6 to C7 with narrowed, ill-defined disc space bilaterally.

The Board directs attention to its rating recommendation based on the above evidence. The multiple VA ratings of the same symptom complex as the PEB disability description was discussed in detail. The Board considered the CI’s multiple conditions, underlying pathology of the neck, shoulder and scalene area, ulnar nerve and wrist; and determined that the bulk of the CI’s symptoms aligned with analogous coding to VASRD 5293, Intervertebral Disc Syndrome with symptoms compatible with neuropathy. The CI’s disability picture was worse than that envisioned by the “Moderate, recurring attacks” (20%) rating level, and multiple shoulder and arm symptoms preceded the onset of cervical pathology and did not align with cervical radicular symptoms. The Board considered that additional analogous rating of the shoulder at 10% as 5099-5003 fairly encompassed the non-cervical pathology of degenerative changes with muscle surgery. The wrist condition and ulnar nerve findings were better attributed to the radicular symptoms of the cervical condition given the mixed picture of peripheral (shoulder/elbow/wrist-level) radiculopathy that is encompassed under coding of either 5293 (cervical level) or the VA applied upper radicular group peripheral nerve (8710) coding. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), §4.7 (higher of two evaluations), §4.40 (functional loss) and §4.14 (avoidance of pyramiding) the Board recommends disability ratings of 20% coded 5299-5293 for the cervical spine fusion and arm pain (radicular) condition and a separate 10% rating for the shoulder pain condition coded 5099-5003, and no other unfitting or ratable conditions.

Contended PEB Conditions. The contended condition adjudicated as not unfitting by the PEB was thoracic outlet syndrome. The Board’s first charge with respect to this condition is an assessment of the appropriateness of the PEB’s fitness adjudication. 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. There was significant potential symptom overlap from any disability attributable to the CI’s primary unfitting chronic right shoulder and arm pain condition as discussed above and any residuals of decompression surgery for thoracic outlet syndrome. Specialty consult proximate to the PEB indicated “No conclusive clinical evidence of a vascular or neurogenic thoracic outlet syndrome at this time.” 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 thoracic outlet syndrome condition; 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. As discussed above, PEB reliance on the USAPDA pain policy for rating chronic pain, right shoulder and arm status post C6-7 discectomy, fusion, and plating condition was operant in this case and the condition was adjudicated independently of that policy by the Board. In the matter of the chronic pain, right shoulder and arm status post C6-7 discectomy, fusion, and plating condition, the Board unanimously recommends that it be rated for two separate unfitting conditions as follows: cervical spine fusion and (radicular) right arm pain coded 5299-5293 and rated 20%, and right shoulder pain coded 5099-5003 and rated 10%; both IAW VASRD §4.71a. In the matter of the contended thoracic outlet syndrome condition, the Board unanimously recommends no change from the PEB determination as not unfitting. 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; and, that the discharge with severance pay be recharacterized to reflect permanent disability retirement, effective as of the date of his prior medical separation:

|  |  |  |
| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Status Post C6-7 Anterior Cervical Discectomy, Fusion, and Plating with Chronic Right Arm Pain | 5299-5293 | 20% |
| Right Shoulder Pain | 5099-5003 | 10% |
| **COMBINED** | **30%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20111231, 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

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 XXXXXXXXXXXXXXXXXXXXXXXXXXXX, AR20120016152 (PD201200010)

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 XXXXXXXXXXXXXXXXXXXXXX

Deputy Assistant Secretary

(Army Review Boards)

CF:

( ) DoD PDBR

( ) DVA