RECORD OF PROCEEDINGS
PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXXXXXXX
CASE NUMBER: PD1200077
BOARD DATE: 20130205

BRANCH OF SERVICE: ARMY
SEPARATION DATE: 20071102

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(92A/Automated Logistics Specialist), medically separated for mechanical low back pain (LBP) and right hip pain. The CI did not improve adequately with treatment to meet the physical requirements of his Military Occupational Specialty or satisfy physical fitness standards. He was issued a permanent L3 profile and referred for a Medical Evaluation Board (MEB). The MEB forwarded chronic right hip pain secondary to sciatic radiculopathy and mechanical LBP as medically unacceptable IAW AR 40-501 to the Informal Physical Evaluation Board (IPEB). Five other conditions, identified in the rating chart below, were also identified and forwarded by the MEB as medically acceptable. The PEB adjudicated the mechanical LBP and right hip pain as unfitting, rating them at 10% and 10% respectively, with application of the Veterans Affairs Schedule for Rating Disabilities (VASRD). The IPEB adjudicated the five other conditions as not unfitting. The CI appealed to the Formal PEB (FPEB), which affirmed the IPEB findings; and was then medically separated with a 20% disability rating.

CI CONTENTION: The CI states: “I feel important pieces of information were not considered when the PEB evaluated my disabilities. The first disability I want to discuss is "Mechanical Lower Back Pain.” Dr.---, chief of orthopedic surgery at the time of my evaluations, stated that "MRI evaluation of his lumbar spine shows that he has some markedly irregular lumbar disk" and that the AMA Pain Rating Scale is "Moderate to severe and frequent to constant.” I also made my Army lawyer aware of muscle spasms I was having and to include that as evidence. The second disability, "Chronic Right Hip Pain secondary to Sciatic Radiculopathy", was diagnosed by Dr.---. The PEB proceedings states this disability as "what is being called Sciatic Radiculopathy.” Stating this condition in these terms makes it seem "non-serious" and "questionable" when in fact it is a very serious and disabling condition that has severely altered the quality of my life. I was issued a cane at Darnall Army Hospital's in physical therapy department in December 2006 by Dr. --- to assist me with ambulation, something I continue to rely on it today. All of these issues were brought to the attention of my Army lawyer and although he thought it could greatly benefit my case, he thought that it was still a risk and recommended that I take the settlement. I also was not allowed to finish treatment for "Sleep Apnea.” Diagnosis of this condition began when I brought it to the attention of Dr. --- during an appointment in October 2007 that I had trouble sleeping and that my wife said that I would stop breathing when I slept. I made PEB and MEB officials aware of this ongoing treatment and requested that it be evaluated also along with my other disabilities. They all declined to assist me. I was officially diagnosed with "Sleep Apnea" in April 2008 and it has been "service connected" through Veteran Affairs with a 50% rating. I feel that if the PEB approving officials had been made aware of these issues that I would have been assigned a higher disability rating.”

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; and, 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 conditions eustachian tube dysfunction, hearing loss, knee pain, esophageal reflux, and erectile dysfunction as requested for consideration meet the criteria prescribed in DoDI 6040.44 for Board purview; and, are addressed below. The sleep apnea did not meet the criteria prescribed in DoDI 6040.44 referenced above for Board 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.

RATING COMPARISON:

Service FPEB – Dated 20071001			**VA (1 Mos. Post-Separation) – All Effective Date 20071103**			
Condition	**Code**	**Rating**	**Condition**	**Code**	**Rating**	**Exam**
Mechanical Low Back Pain	5237	10%	Lumbar Strain w/L Sciatica	5237	10%	20071217
Right Hip Pain / Sciatica	8799-8720	10%	R Hip Bursitis / Hamstring Pain	5019	10%	20071217
Eustachian Tube Dysfunction	Not Unfitting		Eustachian Tube Dysfunction	6201	0%	20071217
Hearing Loss	Not Unfitting		Hearing Loss		NSC	
Joint Pain, Localized in Knee, Patellar Tendonitis	Not Unfitting		Left Knee Pain	5260	10%	20071217
			Right Knee Pain	5260	10%	20071217
Esophageal Reflux	Not Unfitting		Gastroesophageal Reflux	7399-7346	0%	20071217
Male Erectile Disorder	Not Unfitting		Erectile Dysfunction	7522	0%	20071217
			Sleep Apnea	6847	50%	20080626
↓No Additional MEB/PEB Entries↓			Bilateral Tinnitus*	6260	10%	20071217
			0% X 1/ Not Service-Connected x 7			20071217
Combined: 20%			**Combined: 70%**			

*Bilateral hearing loss, NSC. Sleep Apnea added by VARD of 12/8/08, increasing combined to 70%.

ANALYSIS SUMMARY: The Disability Evaluation System (DES) is responsible for maintaining a fit and vital fighting force. While the DES considers all of the member's medical conditions, compensation can only be offered for those medical conditions that cut short a member's career, and then only to the degree of severity present at the time of final disposition. The DES has neither the role nor the authority to compensate members for anticipated future severity or potential complications of conditions resulting in medical separation nor for conditions determined to be service-connected by the Department of Veterans Affairs (DVA) but not determined to be unfitting by the PEB. However the DVA, operating under a different set of laws (Title 38, United States Code), is empowered to compensate all 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. 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. The Board has neither the jurisdiction nor authority to scrutinize or render opinions in reference to the CI's statements in the application regarding suspected DES improprieties in the processing of his case.

Mechanical Low Back Pain Condition. According the MEB narrative summary (NARSUM), the CI experienced onset of chronic LBP since a fall in December 2004, associated with radiating pain into the right posterior hip and leg addressed separately below. Magnetic resonance imaging (MRI) of the lumbosacral spine on 20 November 2006 was normal with normal alignment and

normal discs without bulging, protrusion or herniation. The orthopedic surgeon noted disc irregularity on the MRI that was not reported by the radiologist on the MRI report. At a 7 February 2007 clinic appointment there was spinal tenderness with muscle spasm but gait and stance were normal. A physical therapy examination 30 March 2007, 7 months before separation, recorded flexion of 40 degrees, extension 5 degrees, left lateral bending 30 degrees, right lateral bending 35 degrees, left rotation 50 degrees, right rotation 35 degrees. The physical therapist noted normal spine contour and use of a cane that was issued in November 2006 for the right leg pain condition addressed separately below. The orthopedic NARSUM, dictated 18 April 2007, recorded the history noted above. On examination there was tenderness of paraspinous muscles without spasm. Neurologic examination was intact. The diagnosis was mechanical low back pain for which analgesic medication including narcotic medication was prescribed. The CI was evaluated by the pain clinic in July 2007 and his medication treatment adjusted. The CI sought care on 21 September 2007, 2 months before separation, for back spasm of 2 to 3 weeks duration. On examination, the examiner recorded thoracolumbar range of motion as "full" and lumbosacral spine motion as "normal." There was muscle spasm but posture and gait were recorded as normal. At the VA Compensation and Pension (C&P) examination on 17 December 2007, a month after separation, the range-of-motion (ROM) was significantly improved from the March 2007 PT examination, 7 months before separation. Flexion was 80 degrees (normal 90), extension 20 degrees (normal 30), left lateral flexion 20 degrees (normal 30), right lateral flexion 20 degrees (normal 30), left rotation 20 degrees (normal 30), and right rotation 20 degrees (normal 30), with more pain at all extreme ROM. There was no muscle spasm and spinal contour was preserved. A limp was observed due to right hip and sciatic pain discussed below. The C&P examination ROM was consistent with the September 2007 clinic examination as well as C&P examinations in March 2009 and March 2010.

The Board directs attention to its rating recommendation based on the above evidence. The FPEB cited the normal ROM at the time of the 21 September 2007 clinic examination in its 10% rating. The VA rated the back condition 10% based on the C&P examination. The Board noted that the ROM at the time of the physical therapy examination 7 months before separation supported a 20% rating; however a subsequent clinic examination 2 months before separation and the C&P examination a month after separation are consistent with the 10% rating under the VASRD general rating formula for diseases and injuries of the spine. These examinations are also consistent with the expected severity of the condition based on the known pathology as reflected by the normal MRI scan. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (Resolution of Resolution of reasonable doubt), the Board concluded that there was insufficient cause to recommend a change in the PEB adjudication for the mechanical LBP condition.

Right Hip Pain Secondary to Sciatic Radiculopathy. The NARSUM records report of right hip pain since a fall in December 2004. Service treatment record (STR) entry 1 December 2005 records report of right posterior thigh pain for 3 years that began while sprinting. On examination there was tenderness at the ischial tuberosity where the hamstring muscle attaches to the pelvis. A 31 July 2006 clinic evaluation recorded right posterior thigh (hamstring) pain for 3 years with re-injury since that time. An X-ray obtained of the right hip at that time was normal. An MRI scan of the right hip on 22 August 2006 was also normal. A 21 September 2006 clinic evaluation noted a history of pain in the right upper thigh hamstring for 2 years as a result of a pulled muscle while playing organized sports. Since that time, the pain was worse to the point that he was walking with a limp. The pain was increased by bending over. A physical therapy examination on 22 September 2006 noted right hip pain for 2 years that began with a cutting maneuver and feeling a pop. On examination, active hip ROM

was full and gait normal. A 2 November 2006 clinic evaluation noted predominant right posterior thigh pain aggravated by straight leg raising (SLR). Gait was observed to be normal. The physician thought the pain might be due to sciatica and ordered an MRI of the lumbar spine. A cane was issued on this date as well. The 20 November 2006 MRI was normal showing no abnormality that would cause sciatica. On follow up in the clinic 7 December 2006, the physician noted the results of the MRI and recorded "unlikely radiculopathy." An electromyogram (EMG), in January 2007 was normal (showing no evidence of radiculopathy or sciatica). A clinic follow up on 7 February 2007 recorded normal gait. The CI received an injection to the right ischeal bursa by physical medicine on 12 February 2007. An orthopedic examination on 18 April 2007 recorded normal hip motion with negative SLR, normal strength and reflexes. The 18 April 2007 NARSUM noted intermittent radicular symptoms that were not well localized. The NARSUM, dated 23 May 2007, noted a history of right hip pain since December 2004. At that time the right hip pain was described as a constant ache and pulling muscle sensation in the posterior hip with an occasional electric shock like sensation from the lower back and buttock down the right leg at which point he uses a cane. On examination, there was tenderness of the right posterior hip. There was hip pain with knee motion but with full strength. The right hip flexed to 85 degrees, extended to 6 degrees, and abducted to 57 degrees. For comparison, the unaffected left hip flexion was 106, extension 12 and abduction 52. Clinic examinations of the hip on 13 July 2007 and 6 August 2007 recorded "FROM" (full range of motion). A medical statement to the PEB 8 August 2007 cited the right hip pain secondary to sciatic radiculopathy as medically unacceptable. The 21 September 2007 clinic encounter for the back recorded the gait as normal. At the C&P examination on 17 December 2007, a month after separation, the right hip ROM was flexion 115 degrees (normal 125), extension 25 degrees (normal 20), adduction 20 degrees (normal 25), abduction 30 degrees (normal 45), external rotation 50 degrees (normal 45), and internal rotation 35 degrees (normal 40). The gait was observed to have a right limp. Laseague sign was "normal" indicating no nerve root irritation. On neurologic examination, strength, reflexes, and sensation were normal of both lower extremities.

The Board directs attention to its rating recommendation based on the above evidence. The PEB rated the right hip pain 10% using the 8720 code for neuralgia of the sciatic nerve noting the pain had been attributed to sciatic radiculopathy despite the negative MRI and EMG evaluations. The VA subsumed sciatica with the rating for the back condition and adjudicated a 10% rating for right hip bursitis with right hamstring pain (coded 5019, bursitis). All Board members agreed the right hip/thigh pain condition most nearly approximated the 10% rating using the VASRD code 8720 chosen by the PEB. The Board also noted that the hip ROM was non-compensable under VASRD codes for limitation of motion (5251, 5252, and 5253). Based on the evidence of the record, the VA choice to rate the right hip pain condition under bursitis was also reasonable and supported the 10% rating. In accordance with §4.14 two ratings may not be assigned for the same symptomatology. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (Resolution of reasonable doubt), the Board concluded that there was insufficient cause to recommend a change in the PEB adjudication for the right hip pain condition.

Contended PEB Conditions. The contended conditions adjudicated as not unfitting by the PEB were Eustachian tube dysfunction, hearing loss, knee pain, esophageal reflux and erectile dysfunction. 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 (Resolution of reasonable doubt) standard used for its rating recommendations, but remains adherent to the DoDI 6040.44 "fair and equitable" standard. The CI had a history of Eustachian tube dysfunction for several years for which

episodic treatment was provided including placement of a PE tube. At the time of the 17 April 2007 NARSUM, the CI had stable hearing loss in the left ear since 2005 with normal hearing in the right ear. A non-disqualifying H2 profile was assigned. Esophageal reflux and erectile dysfunction were treated and had no impact on duties. The first STR for knee pain was 7 November 2005 when the CI presented for care of intermittent right knee pain for the preceding year that occurred "only after running," and resolved with Motrin and icing. The physical examination of both knees was normal (full painless ROM, no tenderness, swelling or crepitus, and no instability). An X-ray of the right knee was normal. After this clinic encounter, the STR fall silent regarding knee pain or knee problems until the MEB history and physical examination on 9 March 2007. At the time of the MEB history and physical examination, the CI reported a history of knee pain with swelling whenever he ran. The 18 April 2007 orthopedic clinic note and the orthopedic NARSUM of the same day make no mention of knee pain. The NARSUM 23 May 2007 makes no mention of knee problems. The 3 July 2007 pain clinic evaluation mentions only the back and hip pain. The 26 July 2007 warrior transition unit clinic evaluation recorded a history of longstanding bilateral knee pain markedly improved in the prior year since on a profile for the back condition. When he was participating in unit physical training he would get knee pain the following day; however, it never limited his runs or activities. At that time he noted occasional soreness with knee bending. The physical examination was normal except for patellar tendon tenderness. Knee pain, patellar tendonitis was referred by the MEB as medically acceptable. None of these conditions were profiled; none were implicated in the commander's statement; and, none were judged to fail 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. 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. In the matter of the mechanical LBP condition and IAW VASRD §4.71a, the Board unanimously recommends no change in the PEB adjudication. In the matter of the right hip pain due to sciatica condition and IAW VASRD §4.124a, the Board unanimously recommends no change in the PEB adjudication. In the matter of the contended Eustachian tube dysfunction, hearing loss, knee pain, esophageal reflux and erectile dysfunction 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, therefore, recommends that there be no recharacterization of the CI's disability and separation determination, as follows:

UNFITTING CONDITION	VASRD CODE	RATING
Mechanical Low Back Pain	5237	10%
Right Hip Pain Secondary to Sciatic Radiculopathy	8799-8720	10%
	COMBINED	**20%**

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20120122, w/atchs
Exhibit B. Service Treatment Record
Exhibit C. Department of Veterans' Affairs Treatment Record

XXXXXXXXXXXXXXX, DAF
Director
Physical Disability Board of Review

SFMR-RB

MEMORANDUM FOR Commander, US Army Physical Disability Agency (TAPD-ZB / XXXXXX), 2900 Crystal Drive, Suite 300, Arlington, VA 22202-3557

SUBJECT: Department of Defense Physical Disability Board of Review Recommendation for XXXXXXXXXXXXXXXXXXX, AR20130003097 (PD201200077)

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)