RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: NAVY

CASE NUMBER: PD1200920 SEPARATION DATE: 20020618

BOARD DATE: 20120919

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty AO3/E-4 (Aviation Ordnance man), medically separated for chronic back pain. Despite undergoing spinal disc surgery, spinal fusion, acupuncture, extensive physical therapy (PT), Pain Management, trigger point injections, narcotic medications (Vicodin), non-steroidal anti-inflammatory drugs (NSAIDS) (Vioxx), and a limited duty (LIMDU), the CI was unable to perform within her Rating and was referred to a Medical Evaluation Board (MEB). The MEB forwarded chronic back pain to the Physical Evaluation Board (PEB) on NAVMED 6100/1. The MEB forwarded no other conditions for PEB adjudication. The PEB adjudicated chronic back pain condition as unfitting, rated 20%, with likely application of SECNAVINST 1850.4E or DODI 1332.39. The CI filed a request for a formal hearing, but later rescinded this request, and was medically separated with a 20% disability rating.

CI CONTENTION: “Member had another corrective L4/L5 surgery in 2009, due to first fusion being done incorrectly. Member had tipped vertebrae for nearly 10 years until problem was corrected with surgery. Member continues to have extensive and debilitating sciatic and back pain causing continued trigger point and anesthetic injections. Member has mobility loss in right foot and diminished capability in toes. I have had severe continued pain for the better part of 10 years due to injury sustained while Active Duty. I have been told since my release, by civilian doctors, that the type of fusion performed on me was one that would be typically done in patients in the latter part of their life due to its failure rate. I have had to have another fusion because I had tipped vertebrae caused by initial fusion. I have been treated by pain clinics throughout my adult life due to this. I still have diminished capability in my legs and back and require injections and medications to keep the sciatica and neuropathy under control. I am in my early 30's and have been told by doctors that arthritis is now settling in my spine. Overall, my day to day activities are greatly hindered and I have pain almost all of the time.”

SCOPE OF REVIEW: The Board wishes to clarify that the scope of its review as defined in the Department of Defense Instruction (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 unfitting back condition meets the criteria prescribed in DoDI 6040.44 for Board purview, and is accordingly addressed below. 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 Board for Correction of Naval Records.

RATING COMPARISON:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Service IPEB – Dated 20020315** | | | VA (4 Mos. Pre-Separation) – All Effective Date 20020619 | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | Exam |
| Chronic Back Pain | 5293 | 20% | S/P Microdiscectomy & Lumbar Fusion w/Residual Surgical Scar | 5299-5293 | 40% | 20020215 |
| ↓No Additional MEB/PEB Entries↓ | | | Left Upper Extremity, Scalena Atticus Syndrome w/Cervical … | 8516 | 10% | 20020215 |
| Right Upper Extremity, Scalena Atticus Syndrome w/Cervical … | 8515 | 10% | 20020215 |
| Asthma | 6602 | 10% | 20030109 |
| 0% x 1 | | |  |
| **Combined: 20%** | | | **Combined: 60%** | | | |

ANALYSIS SUMMARY: The Board acknowledges the CI’s opinion that a medical error was responsible for her disability, with the implication that the disability rating should provide for remedy. It must be noted for the record that the Board has neither the jurisdiction nor authority to scrutinize or render opinions in reference to allegations regarding suspected improprieties or faulty medical care. The Board’s role is confined to the review of medical records and all evidence at hand to assess the fairness of PEB disability ratings and fitness determinations as elaborated above. Redress in excess of the Board’s scope of recommendations must be addressed by the Board for Correction of Naval Records and/or the United States judiciary system. The Board also acknowledges the sentiment expressed in the CI’s application regarding the significant impairment with which her service-incurred condition continues to burden her. It is a fact, however, that the Disability Evaluation System (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.

Chronic Back Pain Condition. The Chronic back condition was rated IAW the 2002 VASRD standards which are no longer in effect. The 2002 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 23 September 2002 for code 5293 (intervertebral disc syndrome) criteria, and then changed to the current §4.71a rating standards in 20030926. The 2002 standards for rating based on range-of-motion (ROM) impairment were subject to the rater’s opinion regarding degree of severity, whereas the current standards specify rating thresholds in degrees of ROM impairment. The pertinent 5293 criteria also specifically included symptoms compatible with sciatica which were present in this case. (NOTE: The current VASRD general spine formula does not include similar 5293 criteria). For the reader’s convenience, the 2001 rating code under discussion in this case is excerpted below.

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

There were three evaluations in evidence [one with partial goniometric ROM] evaluation 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 | PT ~11 Mo. Pre-Sep | MEB~7 Mo. Pre-Sep | VA C&P ~4 Mo. Pre-Sep |
| Flexion (90⁰ Normal) | <75% ROM throughout | ROM decreased in all planes, flexion approx 50% of normal | 85⁰\* |
|  | Decreased ROM |
| Combined (240⁰) |
| Comment: Surgeries 24. and 17 Mo. Pre Sep | + Left Straight Leg Raise(SLR); + pain with lying prone | DTR’s wnl; strength 5/5; subjective decreased sensation left foot; minimal paravertebral midline tenderness to palpation (TTP); normal heel and toe walking | \*“She cannot repetitively bend”; Gait normal; tenderness bilaterally L>R paraspinals, gluteals, and iliotibial; pressure above greater trochanter creates pain running down leg L>R; SLR pain/tightness without radiation; Faber’s/Gaenlen’s/sacral compression maneuver neg for sacroiliac (SI) pain |
| §4.71a Rating | 20% | 20-40% (PEB 20%) | 40% |

The CI had a well documented history of chronic severe unrelenting pain with radiation unresponsive to numerous treatment modalities. The CI was initially diagnosed with severe low back pain (LBP) in March 2000. An MRI done in April 2000 demonstrated central disc osteophyte complex with effacement of the left L5 nerve root. The CI was referred to PT for a herniated disc and radiculitis and a L4-5 microdiscectomy was done 24 months prior to separation. The CI continued with LBP and left leg numbness following surgery and PT. A second surgery, L4-L5 fusion, was done in January 2001, 17 months prior to separation, without symptom relief. The CI had an emergency room visit for pain and urinary incontinence and was sent for a rehabilitation evaluation for radicular pain. There was another sick call visit for acute mid back sprain without complaints of leg pain. A repeat MRI indicated an L5-S1 disc bulge. Based on the poor results from PT, medication and surgeries, the CI was referred for Acupuncture which was ineffective. The MEB examination performed 7 months prior to separation, noted unchanged LBP and radiating pain (to left hip leg and foot) with baseline pain of 5/10 and “a bad day” as 7/10. The CI was referred to Pain Management for exacerbations. The examiner documented normal lower extremity strength and reflexes with “subjective decreased light touch to the left lateral foot.” A CT scan of the SI joint was negative for sacroiiliitis. The examiner stated the CI “continues to complain of chronic back pain that is grossly affecting her ability to function with both activities of daily living and … aboard a ship.” The non-medical assessment (NMA) indicated that the CI’s condition required an average of 2 to 3 hours weekly of time away from her duties, that she was performing well in an administrative position and recommended for retention. Treatment notes following the narrative summary (NARSUM) documented a pre-injection evaluation documenting a decreased left ankle reflex, and no use of narcotic medication “in at least one month.” Post-injection (ESI) the acupuncture physician assessment was “chronic debilitating pain 7-8/10 now 2-3/10” with pain relief following treatment. Pain recurred 2 weeks later with treatment of injections 5 months prior to separation. Follow-up indicated increased pain and narcotic use to “3-4/day with the pain clinic diagnosis of failed back syndrome.”

The VA Compensation & Pension (C&P) examination performed 4 months prior to separation indicated chronic LBP with numbness radiating to the left hip and down the left leg and foot without motor dysfunction. There was poor sleep, use of narcotic pain medication, increasing pain and difficulty with forward bending and “She gets pain in her left abdominal quadrant, which at times, the pain will even aggravate and bring on some diarrhea type symptoms.” Limitations included difficulty standing or sitting for any prolonged period (1-2 hrs). As summarized above, there was decreased ROM with the examiner stating “Examination of her lumbosacral spine shows that she has slow and somewhat pain to forward flexion. She can get to 85 degrees. She comes up slowly using her hands on her knees, several times, as are quite tired with the movement.” Impression statement indicated “She cannot repetitively bend”, but did not specify a ROM value. Remote VA rating exams (>5 years post-separation) indicate worsening radicular back pain, abnormal electrophysiological study and back surgery over seven years post-separation.

The Board directs attention to its rating recommendation based on the above evidence. The predominate symptoms were back pain and radiating pain into the left leg/foot with decreased left foot light touch sensation and great toe weakness. Both the PEB and VA used the criteria from 5293. The PEB adjudged the disability as 20% (Moderate; recurring attacks), versus the VA determination of 40% (Severe; recurring attacks, with intermittent relief). Of note, the CI did not have objective neurologic deficits supported by lab findings to support a 40% rating IAW SECNAVINST 1550.4E (ENC 9). ROMs were adjudged to be moderately limited (20% rating criteria range) proximate to separation. Board deliberations focused on the level of severity and frequency of code 5293 intervertebral disc syndrome symptom severity, recurring attacks and relief frequency for the 40% versus 20% rating criteria detailed above.

The 2002 VASRD 5293 criteria included symptoms compatible with sciatic neuropathy with neurological findings appropriate to site of the back disease and the Board cannot support a recommendation for additional rating based on peripheral nerve impairment. The Board evaluated if there was ample evidence to justify the 5293 criteria for the 40% rating for “Severe; recurring attacks, with intermittent relief” as assigned by the VA. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board recommends a disability rating of 40% for the chronic back pain condition.

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 SECNAVINST 1850.4E (or DODI 1332.39) for rating chronic back pain was likely operant in this case and the condition was adjudicated independently of that instruction by the Board. In the matter of the chronic back pain condition, the Board unanimously recommends a disability rating of 40%, coded 5293 IAW VASRD §4.71a. 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** |
| Chronic Back pain | 5293 | 40% |
| **COMBINED** | **40%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20120322, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans’ Affairs Treatment Record

President

Physical Disability Board of Review

MEMORANDUM FOR DEPUTY COMMANDANT, MANPOWER & RESERVE AFFAIRS

COMMANDER, NAVY PERSONNEL COMMAND

Subj: PHYSICAL DISABILITY BOARD OF REVIEW (PDBR) RECOMMENDATIONS

Ref: (a) DoDI 6040.44

(b) PDBR ltr dtd 3 Oct 12 ICO

(c) PDBR ltr dtd 3 Oct 12 ICO

(d) PDBR ltr dtd 12 Oct 12 ICO

1. Pursuant to reference (a) I approve the recommendations of the Physical Disability Board of Review set forth in references (b) through (d).

2. The official records of the following individuals are to be corrected to reflect the stated disposition:

a former USN, XXX-XX: Disability retirement with a final disability rating of 40 percent effective 18 June 2002.

b. former USN, XXX-XX: Disability retirement with a final disability rating of 30 percent effective 17 November 2003.

c. XXX XX former USMC: Disability separation with a final disability rating of 10 percent (increased from 0 percent) effective 30 December 2004.

3. Please ensure all necessary actions are taken to implement these decisions, included the recoupment of disability severance pay if warranted, and subject members are notified once those actions are completed.

Assistant General Counsel

(Manpower & Reserve Affairs)