RECORD OF PROCEEDINGS
PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXXXXXXXXX
CASE NUMBER: PD1200343
BOARD DATE: 20130129

BRANCH OF SERVICE: ARMY
SEPARATION DATE: 20050505

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty (Reserve) CPT/O-3E (88A/Transportation Officer), medically separated for chronic radiating neck and shoulder pain. She did not respond adequately to conservative treatment was unable to perform within her Military Occupational Specialty, meet worldwide deployment standards or meet physical fitness standards. She was issued a U3 profile and referred for a Medical Evaluation Board (MEB). The MEB forwarded only one condition; "Cervical spondylosis and multilevel degenerative disk disease with previous radicular and myelopathic signs." The Physical Evaluation Board (PEB) adjudicated the chronic radiating neck and shoulder pain condition as unfitting, rated 0% with application of the Veterans Affairs Schedule for Rating Disabilities (VASRD). The CI appealed to the Army Board for Correction of Military Records (ABCMR) 2 years after separation with no change to her original PEB findings.

CI CONTENTION: "The rating issued by the PEB is inaccurate and did not include all of the medical conditions that I had since 1999. According to the DA Form 199 I was medically separated for Chronic radiating neck and shoulder pain with multilevel degenerative disc disease (DDD) with some compressed disc bulges at a 0% rating. However, the Department of Veterans Affairs rated my initial claim as an overall 40% combined evaluation. The MEB failed to document, assess, and rate all of my medical conditions per DODI 1332.38, furthermore the MEB did not use the proper VASRD rating criteria, or I would have been given a rating decision comparable to the decision of the Department of Veterans Affairs, which rated me at 40% for my initial claim. I understand my choice in terms of forum for review. I choose the PDBR to consider conditions documented as a matter of record, and in accordance with DoDI 6040.44."

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.

RATING COMPARISON:

Service PEB – Dated 20050419			**VA (20 Mos. Post-Separation) – All Effective Date 20061024**			
Condition	**Code**	**Rating**	**Condition**	**Code**	**Rating**	**Exam**
Chronic Radiating Neck and Shoulder Pain	5243	0%	Cervical Degenerative Disc Disease with Myelopathy and Bilateral Shoulder Pain	5242	20%	20070110
			Radiculopathy, Left Upper Extremity	8515	10%	20070110
			Radiculopathy, Right Upper Extremity	8515	10%	20070110
↓No Additional MEB/PEB Entries↓			Hypothyroidism	7903	10%	20070110
			Not Service-Connected x 4			20070110
Combined: 0%			**Combined: 40%**			

ANALYSIS SUMMARY: The Board acknowledges the CI's assertions that PEB rating was inaccurate and did not include all her medical conditions for which she received a combined 40% rating from the VA. It is noted for the record that the Board has neither the jurisdiction nor authority to scrutinize or render opinions in reference to asserted service improprieties in the disposition of a case. The Board wishes to clarify that it is subject to the same laws for service disability entitlements as those under which the Disability Evaluation System (DES) operates. 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. That role and authority is granted by Congress to the Department of Veterans 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 with the review of medical records, all evidence at hand and compared to VASRD standards.

Chronic Radiating Neck and Shoulder Pain Condition. This right hand dominant CI had a gradual onset of neck and bilateral shoulder pain that started in 1999 which she related to her military training especially with successful airborne status and an attempt for air assault status. These symptoms were treated conservatively with nonsteroidal and muscle relaxant medications with some relief. In May 2004 she continued to have severe neck and shoulder pain, 5 of 10 to a maximum of 10 of 10 in intensity with just sitting and driving. She developed new symptoms of bilateral finger paresthesias (numbness to the tips of fingers 2, 3 and 4) which caused her the inability to not use her hands very well. She also had a loss of balance with running or walking. These new symptoms lasted through July 2004, approximately 3 months. A chiropractic note corroborated the CI's pain intensity history and additionally documented she reported the pain was dull in nature with occasional sharp pains, a decreased energy level, feeling sluggish with difficulty walking and that she felt "clumsy." Magnetic Resonance Imaging (MRI) obtained and revealed straightening of cervical lordosis, significant disk herniation at C5-6 and C6-7 with moderate neural foraminal narrowing (spinal stenosis) and arthritic changes (osteophytes) at these levels. Orthopedic spine surgery next evaluated her, 7 months prior to separation, and their physical findings were consistent with C-spine cord compression which included; absent right triceps reflex, lower extremity hyperreflexia and significant positive neurologic signs (Hoffmann and inverted radial reflex bilaterally). X-rays revealed advanced degenerative disc disease (DDD) at the C5-6 and C6-7 levels with kyphosis. The CI's clinical diagnosis and status at this time is captured in the following excerpt.

> "It is my impression that this patient has severe myeloradiculopathy. Due to these symptoms, it is my opinion that this patient should consider a surgical decompressive procedure. The risks and benefits of surgery have been discussed with her. We have provided her with educational information regarding cervical surgery. As well, we have would ask that a cervical collar be obtained for this patient and that she wear a cervical collar "when she is not driving or sleeping. We would also obtain a CT myelogram of the cervical spine and ask that she return to see us within the next two to three weeks as she decides on the surgical options. In my opinion, surgery should be performed to prevent progression of her problem and that she, should have limited activity and decrease her risk of falls or trauma to the cervical spine as this could precipitate a catastrophic neurologic deficit."

In a follow-up evaluation, 4 months later and a month prior to separation, the same orthopedic spine surgeon documented the CI reported an episode of upper extremity dysfunction in which she was unable to use her arm, however this had resolved. The surgeon diagnosed cervical myelopathy and additionally recommended a CT myelogram and an electromyogram (EMG) of the upper and lower extremities prior to surgery. The CI reasonably declined surgery at that time and was entered into the DES. The permanent profile specified the medical condition as cervical spondylosis with the following limitations; no push-ups, sit-ups, running, heavy lifting

more than 10 pounds, ruckmarching or physical training testing. The commander statement is captured in the following excerpt.

> "…her profile will severely limit her ability to serve in the expeditionary Army we now support Her desire is not to stay in the Army, as a leader, if she cannot perform all the requisite physical tasks to include being fully deployable. If she cannot be fully deployable, I therefore support her desire to leave active duty."

There were four goniometric 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 (Degrees)	Ortho 5 Mo Pre-Sep	PT ~1 Mo. Pre-Sep	MEB	VA C&P ~20 Mo. Post-Sep
Flex (45^{o} Normal)	45(60)	45/45/45	Full	20
Ext (0-45)	30	40/43/43	Full	10
R Lat Flex (0-45)	30	40/42/42	Full	5
L Lat Flex (0-45)	30	42/42/42	Full	5
R Rotation (0-80)	70	50/50/50	Full	60
L Rotation (0-80)	70	50/50/50	Full	50
COMBINED (340^{o})	275	265	Full	150
Comment	NA	Painful motion, No tenderness, no spasm	No pain with motion	+ Tenderness; painful motion
§4.71a Rating	10%	10%	0%	20%

At the MEB exam the CI reported daily cervical and periscapular pain worse with activity, and left upper extremity paresthesias, specifically pain from the left shoulder to the left arm which worsened with dressing and undressing which had been ongoing for a couple of weeks. She reported that her right upper extremity paresthesias had resolved. The MEB physical exam demonstrated no tenderness, muscle atrophy or loss of light sensory touch and normal motor strength. The exam, however, demonstrated significant objective neurologic signs, also found in the orthopedic exam, consistent with severe cervical myeloradiculopathy/cord compression to include; a questionable Hoffman sign bilaterally, hyperreflexia of the patella and ankle reflexes bilaterally, equivocal Babinski on the right, questionable on the left with 1 beat of clonus bilaterally. X-rays revealed multilevel spondylosis and a reverse of the normal lordosis and the examiner cited the above referenced MRI. The examiner diagnosed cervical spondylosis and multilevel DDD with previous radicular and myelopathic signs. The examiner further opined her significant condition was not compatible with vigorous activity, that she be referred for a PEB and probable separation from the military.

At the VA Compensation and Pension (C&P) exam, 20 months after separation, the CI reported severe constant neck pain that radiated into both shoulders and down the right arm into the 3rd and 4th fingers. She reported taking muscle relaxant and narcotic pain medications with good relief, had no flare-ups yet was unemployed due to her neck condition. The C&P exam demonstrated no muscle weakness, atrophy, spasm, or Deluca observations, normal posture and no ankylosis of the spine. The exam, however, demonstrated diminished grip strength and decreased sensation to light touch over fingertips, bilaterally. The MRI of cervical spine revealed moderate to severe central canal stenosis with cord compression at C5-C6 and C6-C7 and moderate to severe right neural foraminal stenosis at C6-C7. The examiner diagnosed cervical myelopathy with radiculopathy and further documented mild impairment with activities of daily living to include bathing, dressing and grooming and severe impairment with independent activities of daily living to include shopping and chores.

The Board directs attention to its rating recommendation based on the above evidence. It is noted for the record that the Board recognizes the significant interval (20 months) between the date of separation and the VA evaluation. DoDI 6040.44, under which the Board operates,

specifies a 12-month interval for special consideration to VA findings. This does not mean that the VA information was disregarded, as it was a valuable source for clinical information and opinions relevant to the Board's evaluation. In matters germane to the severity and disability at the time of separation the information in the MEB exam and the service record thus were assigned proportionately more probative value as a basis for the Board's rating recommendations.

The PEB and VA chose different coding options for the condition which had significant implications on the rating for the Board to consider and is the pivotal discussion in this case. The Board notes the PEB rated the condition with only a musculoskeletal code, IAW 4.71a, yet the VA rated the condition with a musculoskeletal code, IAW 4.71a, and two neurologic codes, IAW 4.124a. The Board acknowledges that the chronic radiating neck and shoulder pain, identified by the PEB as the unfitting condition, was consistently diagnosed as cervical myeloradiculopathy in the service treatment record and later in the VA exam. Furthermore the MEB forwarded "Cervical spondylosis and multilevel degenerative disk disease with previous radicular and myelopathic signs." The action officer offers the following summary of this disorder for the Board members as they consider the permanent rating recommendation. Degenerative spondylotic myeloradiculopathy is thought to be the result of chronic, repetitive compressive damage to the cervical spinal cord and roots. When the myelopathic spinal cord is examined, changes are found that suggest chronic demyelination, vascular compromise, and inflammation of the nerve roots. In this case the myeloradiculopathy was due to several C-Spine pathologies to include; cervical spondylosis, DDD and herniated nucleus pulposus (HNP) at C5-6 and C6-7 which led to spinal stenosis and ultimately to symptoms and signs consistent with C-spine cord compression. Cervical myeloradiculopathy occurs in 5 to 10% of patients with symptomatic cervical spondylosis. There is no well-defined pattern of neurologic deficits yet the varying symptoms and signs presented in this case are consistent for this diagnosis to include the early gait/balance disturbance noted by the CI. This disability is not specifically listed in the VASRD rating schedule; therefore, it must be rated analogous to a disability in which not only the functions affected, but anatomical localization and symptoms, are closely related. The challenge before the Board is to consider how best to capture the radiating pain of the neck and shoulders with consideration of all the C-spine pathologies that led to the severe myeloradiculopathy. The Board agreed to consider any closely related musculoskeletal codes, neurologic codes or coding with a combination of both similar to the VA's rating decision.

The Board first considered ratings assigned by the PEB and the VA IAW 4.71a. The PEB assigned 0% with diagnostic code (DC) 5243 (Intervertebral disc syndrome) for neck pain with full ROM, no paraspinous tenderness and no unfitting clinical signs of radiculopathy. The Board notes the MEB exam is without goniometric detail. The Board carefully reviewed the file for corroborating evidence in the 12-month period prior to separation and agreed there is corroborating evidence for limited combined cervical ROM to warrant the minimum of 10% under the PEB's chosen code. The Board next considered the VA chosen 5242 code (degenerative arthritis of the spine) which defaults to the 5003 criteria and 5238 (spinal stenosis) and agreed the combined limitation of motion evidenced supports the 10% rating under both these codes and does not support the 20% higher rating under 5003 for incapacitating episodes. Finally, with regards to the musculoskeletal codes, the Board considered the evidence for the PEB chosen code 5243 under the formula for rating intervertebral disc syndrome for incapacitating episodes in which there are periods of acute signs and symptoms due to intervertebral disc syndrome that requires bed rest prescribed by a physician and treatment by a physician. The evidence documents significant disk herniation at C5-6 and C6-7 with moderate neural foraminal narrowing (spinal stenosis). The Board agreed the evidence supports two significant episodes of increasing neck and shoulder pain with additional neurologic deficits (of the upper and lower extremities) prior to separation, one which lasted for 3 months and the other which lasted for over a couple weeks (2 weeks). These episodes were consistent with the MRI documented C5-6 and C6-7 disc disease. These disc

levels could manifest as radicular neck pain and radicular shoulder pain, respectively, along with other associated sensory and motor deficits consistent at each of these levels. While the neck collar prescribed by a physician was to prevent any trauma to the C-spine, the Board considered the limited activity recommendation by the treating orthopedic surgeon, the significant limitations noted on the permanent profile and the commanders statement "the profile will severely limit her ability" and agreed this represented physician prescribed limited activity to consider the 60% higher rating under this diagnostic code for "incapacitating episodes having a total duration of at least 6 weeks during the past 12 months."

The Board next considered ratings assigned by the VA IAW §4.124. The VA assigned 10% each for the right and left upper extremity coded 8515 (paralysis of the median nerve (carpal tunnel) for mild incomplete paralysis of the hands demonstrated by diminished grip strength and decreased sensation of the fingertips to light touch and pain. The Board notes the condition included pain of the bilateral shoulders, arms and hands, paresthesias of the bilateral fingers, and an episodic impairment of balance. The Board agreed the 8515 code does not reflect the injury of the nerves involved in this case. The Board considered the diagnostic code 8513 which allows ratings for nerve damage to the upper nerve radicular group and the middle radicular group which covers the fifth, sixth and seventh cervicals and agreed the evidence supports C-spine pathology at all these cervical levels. Therefore Board agreed to consider ratings for diagnostic codes under 8513 (all radicular groups). The VASRD IAW §4.124a does not specifically delineate criteria for "mild," "moderate," or "severe" and therefore requires the evaluator to be reasonable and just when considering the evidence. However, the Board notes the VASRD §4.123 and §4.124 gives further guidance with respect to severity of nerve impairment when considering a neuritis or neuralgia diagnostic codes, respectively. "Neuritis, cranial or peripheral, characterized by loss of reflexes, muscle atrophy, sensory disturbances, and constant pain, at times excruciating, is to be rated on the scale provided for injury of the nerve involved, with a maximum equal to severe, incomplete, paralysis. The maximum rating which may be assigned for neuritis not characterized by organic changes referred to in this section will be that for moderate, or with sciatic nerve involvement, for moderately severe, incomplete paralysis." The Board agreed at the time of separation the evidence did support constant pain that could be excruciating, and while the evidence did support significant neurologic signs which resulted in intermittent organic changes, these organic changes were intermittent, not permanent. Therefore the Board agreed at the time of separation the evidence supports constant pain that could be excruciating and achieves the mild neuritis threshold however does not meet the moderate threshold absent permanent organic changes. When considering this diagnostic code, Major is defined as the dominant hand and therefore a major rating is assigned for the right upper extremity and minor for the left upper extremity. These ratings are combined with application of the bilateral factor IAW §4.124a, diseases of the peripheral nerves.

A lengthy deliberation ensued with which VASRD rating approach best would capture the chronic radiating neck and shoulder pain. First, the Board agreed IAW §4.14 (Avoidance of pyramiding) that the pain disability could only be coded with either a musculoskeletal and neurological code not both. Next the Board notes the VASRD specifies if two disability evaluations are potentially applicable, the higher evaluation will be assigned if the disability picture more nearly approximates the criteria required for that evaluation, §4.7. Otherwise, the lower rating will be assigned. The Board agreed the 10% rating achieved with the §4.71a limitation of motion with the DC 5238, 5242, and 5243 under the general formula for diseases and injuries does not represent the pain disability picture in this case. The Board agreed the pain disability is not manifested by limited cervical ROM but rather more closely manifests as a neurologic radicular radiating neck and shoulder pain due to the demyelinating disease of C-spine cord compression or due to C5-6, C6-7 HNP disc disease or both. Furthermore, the Board finds the evidence supports ongoing radicular symptoms with radiating neck and shoulder pain, left upper extremity dysfunction due to pain and persistent myelopathic signs on exam at the

time of the MEB, contrary to the MEB characterization's of "previous previous radicular and myelopathic signs." The Board agreed the VASRD code 5243 for incapacitating episodes, while it does capture the disc disease in this case, does not capture the remaining pathology of the C-spine. Furthermore, while the evidence supports physician prescribed limited activity, there is no evidence of physician prescribed bed rest. Therefore based on all evidence and associated conclusions, the Board agreed the VASRD code 8613 best captures the chronic radicular radiating neck and shoulder pain disability. The action officer prefers an analogous code to the 8613 code as the pathology originates in the cervical spine as cord compression and HNP disc disease at the level of the C5-6 and C6-7 with pain at times excruciating and with intermittent organic neurologic sensory disturbances. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (Resolution of reasonable doubt), the Board recommends a combined disability rating of 40% for the chronic radiating neck and shoulder pain condition IAW §4.124 and IAW §4.25. The Board notes this recommendation is consistent with application by the VA based on a review of VA Board of Appeals decisions for adjudicating radiating neck pain due to C-spine pathology which was not manifested as a limitation of motion of the C-spine.

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 chronic radiating neck and shoulder pain condition, the Board unanimously recommends a disability rating of 20% and 20% for myeloradiculopathy of the right and left upper extremity manifested as chronic radiating neck and shoulder pain coded 8613 for a combined disability rating of 40%. 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 her prior medical separation:

UNFITTING CONDITION	VASRD CODE	RATING
Myeloradiculopathy, Right Upper Extremity	8699-8613	20%
Myeloradiculopathy, Left Upper Extremity	8699-8613	20%
	COMBINED (w/ BLF)	**40%**

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20120417, w/atchs
Exhibit B. Service Treatment Record
Exhibit C. Department of Veterans' Affairs Treatment Record

XXXXXXXXXXXXXXXXXX, DAF
Acting Director
Physical Disability Board of Review

SFMR-RB

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

SUBJECT: Department of Defense Physical Disability Board of Review Recommendation for XXXXXXXXXXXXXXXXX, AR20130003821 (PD201200343)

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 40% 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 40% 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

XXXXXXXXXXXXXXXXX
Deputy Assistant Secretary
(Army Review Boards)