RECORD OF PROCEEDINGS
PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXXXXXXXX
CASE NUMBER: PD1200463
BOARD DATE: 20121219

BRANCH OF SERVICE: ARMY
SEPARATION DATE: 20060606

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an activated Reserve MSG/E-8 (92Y/Supply), medically separated for chronic neck and upper back pain. The CI suffered an injury to her neck while moving parachutes at a deployed location in March 2002. After non-operative treatment did not resolve her pain and magnetic resonance imaging (MRI) demonstrated a herniated disc, she underwent a C 6-7 fusion of her cervical spine. Her pain continued and a second cervical procedure, a C 6-7 foraminotomy, was performed a year later. Despite intensive physical therapy after the surgical procedures, the chronic neck and upper back pain condition could not be adequately rehabilitated to meet the physical requirements of her Military Occupational Specialty or satisfy physical fitness standards. She was issued a permanent U3 profile and referred for a Medical Evaluation Board (MEB). Chronic neck pain with radiculopathy, status post (s/p) neck surgery x2 and right cubital tunnel release; intermittent migraine and hypertension, as identified in the rating comparison chart below, were identified and forwarded by the MEB for adjudication. The Informal Physical Evaluation Board (IPEB) adjudicated the chronic neck and upper back pain with radiculopathy condition as unfitting, rated 10%, based on painful motion. The CI appealed to the Formal PEB (FPEB) who adjudicated that the CI be separated due to chronic neck and upper back pain with a 20% disability rating with application of the Veteran's Administration Schedule for Rating Disabilities (VASRD). The CI did not concur with the FPEB findings and her case was reviewed by the USAPDA who affirmed the FPEB's decision and she was medically separated due to chronic neck and upper back pain with a 20% disability rating.

CI CONTENTION: "I was only allowed to present and reviewed on one injury, which was the fusion and disk problem in my neck. I was not allowed to have them consider the injuries and illness that have come from the neck fusion. Such as, nerve damage and elbow surgery on both arms (2004 and 2006). The migraines and heartburn. Plus the changes needed in my life due to the damage, weakness and immobility. The immobility and lack of complete rotation in my neck has caused me to have a backup system installed in my car so that so that I may still safely operate my vehicle. The changes made to my life style and way of life since my neck injury have been numerous. They have impacted not only my way of life but my families."

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 migraine and cubital tunnel syndrome conditions, 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 ratings for the unfitting chronic neck and upper back pain condition. The other requested condition, heartburn, is 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.

RATING COMPARISON:

Service FPEB – Dated 20060302			VA (2.5 Mos. Post-Separation) – All Effective Date 20060605			
Condition	**Code**	**Rating**	**Condition**	**Code**	**Rating**	**Exam**
Chronic Neck and Upper Back Pain with Radiculopathy and status post Right Cubital Tunnel Release	5241	20%	DDD, Cervical Spine	5010-5242	20%*	20060821
			Ulnar Neuropathy, Rt Arm	8516	0%	20060821
Migraine Headaches	non disqualifying		Migraine Headaches	8100	0%*	20060821
Hypertension	non disqualifying		Hypertension	7101	0%	20060821
↓No Additional MEB/PEB Entries↓			Ulnar Neuropathy, Lt Arm	8516	0%*	20060821
			Synovitis, Right Hip	5020	10%	20060821
			Not Service-Connected x 1*			
Combined: 20%			**Combined: 30%***			

*added 5242, Chronic back strain, at 10% effective 20080714 and GERD service connected at 10% effective 20060605 (20081119 VARD); 5010-5242 increased to 30% effective 20081229 and 8100 increased to 10% effective 20060605 Combined overall rating increased to 60% effective 20081229. (20090126 VARD); 8516 increased to 10% effective 20060605 (20090625 VARD)

ANALYSIS SUMMARY: The Board 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 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 also acknowledges the CI's assertion that her "nerve damage and elbow surgery on both arms (2004 and 2006)" are related to her unfitting chronic neck and upper back pain condition and therefore should be subject to additional disability rating. The Board must note that a causality linkage of these contended conditions with the unfitting primary condition, even if conceded, is not a basis in itself for separation disability rating. A concomitant condition of this nature must itself be independently unfitting to merit additional rating. Finally, the Board acknowledges the CI's assertions that "I was only allowed to present and reviewed on one injury …." It is noted for the record that the Board has neither the jurisdiction nor authority to scrutinize or render opinions in reference to asserted improprieties in the disposition of a case. 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.

Chronic neck and upper back condition. There were two goniometric 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	ROM from PT Consult 10 Mos. Pre-Sep Comments from MEB NARSUM	VA C&P 2.5 Mos. Post-Sep
Flex (45° Normal)	10	25°
Ext (0-45)	15°	30°
R Lat Flex (0-45)	25	20°
L Lat Flex (0-45)	25	20°
R Rotation (0-80)	45	50°
L Rotation (0-80)	50	50°
COMBINED (340°)	10	195°
Comment	No erythema or edema; Slight tenderness along cervical spine; Significant limitation of movements in all directions; Two 4 cm healed scars L anterior neck and base of posterior neck; Neurology addendum noted 5/5 strength and 2/4 reflexes throughout	Non-tender spine & surgical scar; No muscle spasm; Mild painful motion was present at the end point of all ROMs; No loss of motion due to pain, weakness or lack of endurance; Normal upper extremity strength; Normal upper extremity deep tendon reflexes; Normal sensory exam in upper and lower extremities
§4.71a Rating	30%	20%

At the MEB exam accomplished 9 months prior to separation, the CI reported a neck injury occurred in 1981 and neck fusion in May 2004 with an additional neck surgery in May 2005. The MEB physical exam noted the following entries: normal gait; neck and spine with no erythema or edema; slight tenderness along the cervical spine; significant loss of motion in all directions and healed scar along crease left side of anterior neck. The narrative summary (NARSUM) prepared 9 months prior to separation noted the chief complaint as "I have neck pains and headaches." Sometime in March 2002, while moving parachutes, she felt a sharp pain in her mid-back between the shoulder blades. She was treated conservatively with medication and was issued a temporary profile. She continued to have pain and a follow up MRI of the neck was performed in May 2002 which, reported a small left lateral disc protrusion at C5-7 with slight mass effect on the thecal sac, cervical cord, and left C6-7 neuroforamina. There was no significant improvement of her pain in spite of the medications, extensive physical therapy and 2 months of chiropractic treatments. She was referred to neurosurgery where she received one nerve root sleeve injection and felt well after the injection. However, about 2 months later, she experienced a recurrence of the pain and eventually underwent an anterior cervical decompression and fusion in May 2004. She did well for approximately 5 months and when her left sided radicular symptoms returned she underwent an electromyogram (EMG). She was referred back to neurosurgery and was treated conservatively. However, her radiculopathy persisted and she underwent a second neck surgery in May 2005 when a left C6-7 posterior foraminotomy with micro-dissection was performed. Postoperatively, she was again referred for intensive physical therapy but claimed that there was no significant improvement of the radicular pain. After an additional neurosurgical evaluation; she underwent a right cubital tunnel release in October 2005 and postoperatively claimed that her right radicular symptoms had improved. Her left arm still had some pain and numbness but to a lesser degree and was tolerable. She was last seen by neurosurgery in November 2005, when it was stated that there was no foreseeable surgical intervention contemplated and she had reached her maximum medical improvement. Pertinent physical exam findings are summarized in the cervical ROM chart above.

EMG/nerve conduction study (NCS) study performed in February 2005 revealed minimal evidence of an old left C7 or C8 radiculopathy. There was no evidence for a superimposed median or ulnar neuropathy. Repeat EMG/NCS 5 months later revealed evidence of a moderate demyelinating right ulnar motor neuropathy across the elbow and a demyelinating right ulnar sensory neuropathy. Although, the absolute values of the left ulnar NCS were within normal limits, when compared to the February 2005 study there had been an increase in the left ulnar sensory distal latency from 2.9ms to 3.5ms. This corresponded with the clinical increase in ulnar distribution paresthesias. There was no evidence of a left median neuropathy or left lower trunk plexopathy. The patients left sided symptoms were consistent with this study and, in conjunction with the February 2005 EMG report, are unlikely to be radicular in nature.

At the VA Compensation and Pension (C&P) exam performed 2 months after separation, the CI reported a similar history to the one noted above with the following additional entries noted. Both arms tingled and felt like they are going to sleep. The third through fifth fingers had decreased sensation, left greater than the right. Flares lasted one to two hours, were mild to moderate, occur weekly and had loss of motion during flares. She had additional loss of rotation to the left and right during the flares. There were 4 days of incapacitating episodes (requiring best rest and treatment by a physician) during the past 12 months due to neck pain. She experienced associated symptoms of radiation of dull aching pain in both arms with constant numbness or tingling into fingers three to five of each hand. Pertinent physical exam findings are summarized in the chart above.

The Board directs attention to its rating recommendation based on the above evidence. The IPEB adjudicated this case as chronic neck and back pain coded as 5241, spinal fusion, and

awarded a 10% evaluation noting "Soldier with pain limiting the ranges of motion." This adjudication did not comply with VASRD standards. The FPEB, whose decision was affirmed by the USAPDA, adjudicated the case as chronic neck and back pain coded as 5241, spinal fusion, and awarded a 20% evaluation specifically noting "forward flexion limited to 19 degrees" which complied with VASRD standards. The 19 degree measurement was the third and largest measurement of passive flexion recorded by PT in August 2005. The measurements were 14 degrees, 13 degrees and 19 degrees. However, active ROM measurements are used to measure ROM for rating purposes and the measurements are rounded to the nearest 5 degrees. The active flexion measurements were 8 degrees, 10 degrees and 9 degrees with 10 degrees used for rating purposes and this warrants a 30% rating IAW the General Rating Formula for Diseases and Injuries of the Spine. The VA utilized the analogous code of 5010-5242 and rated it 20% based on the C&P exam of 25 degrees of forward flexion. The ROM evaluations and associated physical exam findings utilized by the PEB and the VA were each complete and adequate examinations for rating purposes. The PT examination used in the NARSUM was performed 10 months prior to separation and only 3.5 months after the CI's second surgical procedure to her neck. The C&P examination is deemed the most probative examination for two reasons. It was performed only 2 months post-separation and it reflected the CI's response to her post-operative PT treatment sessions. The C&P exam documented a forward flexion of 25 degrees, a combined cervical ROM of 195 degrees, no muscle spasms with normal upper extremity strength and deep tendon reflexes. The General Rating Formula for Diseases and Injuries of the Spine states "…forward flexion of the cervical spine greater than 15 degrees but not greater than 30 degrees; or the combined range of motion of the cervical spine not greater than 170 degrees…" warrants a 20% evaluation. The next higher, 30%, rating requires a forward flexion of 15 degrees or less which is not present in this case. There were only 4 days of incapacitating episodes which does not raise to the level required to consider rating the disability under VASRD code, 5243, intervertebral disc syndrome. She had resolution of her radicular symptoms after the initial cervical decompression and fusion procedure in May 2004. The abnormalities identified by the EMG study performed in July 2005 were attributable to the CI's right cubital tunnel syndrome and not a cervical radiculopathy. There was no evidence supporting a separate peripheral nerve rating as there was no upper extremity weakness, atrophy, changes in deep tendon reflexes or decreased sensation that could be attributed to a cervical radiculopathy. The CI's cubital tunnel syndrome, which is a completely separate clinical entity from a cervical radiculopathy, will be discussed below in the contended conditions section. 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 FPEB adjudication for the chronic neck and upper back pain condition.

Contended PEB Conditions. The contended conditions adjudicated as not unfitting by the FPEB were migraine headaches and right cubital tunnel syndrome conditions. The Board's first charge with respect to these conditions is an assessment of the appropriateness of the FPEB'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. Neither of these conditions was profiled; neither was implicated in the commander's statement; and, neither was 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 either of these conditions significantly interfered with satisfactory duty performance at the time of separation. The CI's right cubital tunnel syndrome condition did begin during her period of service and worsened over time, however, the FPEB adjudicated this condition as not unfitting at the time of separation. The intermittent migraine headaches were responsive the pharmacological therapy and was determined to be "…not severe enough to disqualify her according to AR 40-501, para 3-30g" by the specialist who prepared a specialty care consult for the MEB. 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 migraine headache or right cubital tunnel syndrome 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 chronic neck and upper back pain condition and IAW VASRD §4.71a, the Board unanimously recommends no change in the PEB adjudication. In the matter of the contended migraine headache and right cubital tunnel syndrome 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
Chronic Neck and Upper Back Pain Condition	5241	20%
	COMBINED	**20%**

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20120530, w/atchs
Exhibit B. Service Treatment Record
Exhibit C. Department of Veterans' Affairs Treatment Record

XXXXXXXXXXXXXXXX, DAF
President
Physical Disability Board of Review

SFMR-RB

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

SUBJECT: Department of Defense Physical Disability Board of Review Recommendation for XXXXXXXXXXXXXXXX, AR20130000646 (PD201200463)

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

XXXXXXXXXXXXXXX
Deputy Assistant Secretary
(Army Review Boards)

CF:
( ) DoD PDBR
( ) DVA