RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXXX BRANCH OF SERVICE: USMC

CASE NUMBER: PD0900154 BOARD DATE: 20100407

SEPARATION DATE: 20070123

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SUMMARY OF CASE: This covered individual (CI) was a Staff Sergeant/Air Support Operations Operator medically separated from the Marine Corps in 2007 after 15 years of service. The medical basis for the separation was residuals of a left elbow injury. The CI was referred to the Physical Evaluation Board (PEB), and found fit for duty. The CI appealed and a PEB reconsideration again found him fit for duty. The CI wrote numerous appeals to several different members of Congress, as well as an appeal to the Board for Correction of Naval Records (BCNR). The BCNR corrected the CI’s record to show that he was discharged by reason of physical disability on 23 January 2007, with entitlement to disability severance pay, for residuals of a left elbow injury rated at 10% under Department of Veterans Affairs code 5003 using the Veterans Affairs Schedule for Ratings Disabilities (VASRD) and applicable Naval and Department of Defense regulations.

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CI CONTENTION: The CI’s Lawyer wrote a lengthy supplemental statement excerpted as follows: “The informal medical board erroneously found that Applicant was fit to continue on active duty. Applicant's disability precludes him from passing the pull-ups portion of the Marine Corps physical fitness test or from performing his military duties. The Marine Corps then used this failure to bar his re-enlistment after 15-years of service. Four months after his separation, the Department of Veterans Affairs gave Applicant a disability rating of 90%.”

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RATING COMPARISON:

|  |  |
| --- | --- |
| Service PEB/BCNR | VA (3 Months after Separation) |
| Unfitting Conditions | Code | Rating | Date | Condition | Code | Rating | Exam | Effective |
| Residuals of a Left Elbow Injury  | 5003 | 10% | 20080610BCNR | Residual, Left Elbow Comminuted Avulsion Fracture of the Olecranon with Degenerative Arthritis (Claimed as Left Elbow and Left Arm Conditions) | 5003-5205 | 50% | 20070403 | 20070124 |
| Left elbow degenerative joint disease (PEB) | FIT | --- | 2006040320060508 | Ulnar Nerve Neuropathy With Chronic Reflex Sympathetic Dystrophy, Left Elbow (Claimed as Left Hand Condition, 4th and 5th Digits) Associated with Residual, Left Elbow Comminuted Avulsion Fracture of the Olecranon with De-generative Arthritis (Claimed as Left Elbow and Left Arm Conditions) | 8616 | 20% | 20070403 | 20070124 |
| Left Elbow Cubital Tunnel Syndrome | FIT | --- | 2006040320060508 |
| History of a Left Olecranon Avulsion Fracture Complicated by a Post Operative Mild Demyelinating Ulnar Neuropathy | FIT | --- | 2006040320060508 |
|  | MEB H&P | Multiple Scars, Left Elbow Region Associated withResidual, Left Elbow Comminuted Avulsion Fracture of the Olecranon with Degenerative Arthritis (Claimed as Left Elbow and Left Arm Conditions) | 7804 | 0%Then 10% | 20070403 | 2007012420070124 |
|  | Not addressed by DES | Tension-Type Headaches Associated with Ulnar Nerve Neuropathy with Chronic Reflex Sympathetic Dystrophy, Left Elbow (Claimed as Left Hand Condition, 4th and 5th Digits) | 8100 | 10% | 20070403 | 20070124 |
|  | Not addressed by DES | Chronic Lumbosacral Spine Strain And Degenerative DiscDisease At L5-S I | 5242-5237 | 10% | 20070403 | 20070124 |
|  | Not addressed by DES | Left Ankle Strain With Pain | 5299-5271 | 10% | 20070403 | 20070124 |
|  | Not addressed by DES | Residual, Left 8th Rib Fracture With Chest Wall Pain | 5299-5297 | 10% | 20070403 | 20070124 |
|  | Not addressed by DES | Tinnitus | 6260 | 10% | 20070403 | 20070124 |
|  | Not addressed by DES | Degenerative Arthritis with Carpal Tunnel Syndrome,Right Wrist (Claimed as Right Wrist Condition) | 8599-8515 | 10% | 20070403 | 20070124 |
|  | MEB H&P | Bilateral Hearing Loss | 6100 | 0% | 20070403 | 20070124 |
|  | Not addressed by DES | Chronic Allergic Rhinitis (Claimed as Sinus Condition) | 6522 | 0% | 20070403 | 20070124 |
|  |  | Other conditions NSCx5 |  |  |  |  |
| TOTAL Combined: 10% | TOTAL Combined (*Includes Non-PEB Conditions*): 80% from 20070124 |

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ANALYSIS SUMMARY:

Left Elbow Injury

The CI is right-hand dominant and sustained an injury to his left elbow secondary to a fall from a bicycle. Symptoms of severe left elbow pain and numbness of his left hand 4th and 5th digits began after a left olecranon avulsion fracture followed by a left elbow open reduction and fixation in 2000. He also underwent excision of olecranon osteophyte in September 2000 secondary to a block to extension. He continued to have persistent pain and decreased range of motion and was subsequently diagnosed with an ulnar neuropathy at the elbow and underwent an ulnar nerve transposition in 2001. At the time of this surgery he also underwent manipulation under anesthesia for his elbow range of motion stiffness. Following this procedure he continued to note activity-limiting focal elbow pain and paresthesias into the 4th and 5th digits as well as allodynia involving the medial elbow.

His symptoms gradually improved but in 2003 he had increasing left elbow pain associated with activity (including pull-ups) and increased left hand numbness. He also noted occasional swelling and cold sensations involving the left hand. He was subsequently diagnosed with reflex sympathetic dystrophy (RSD) and was managed with a number of medications in conjunction with additional physical therapy. Despite these interventions, he continued to experience activity limiting pain and was ultimately sent to a pain specialist in Hawaii in 2005. He underwent a stellate ganglion block as well as a continuous intrathecal infusion which provided some transient relief. He noted some initial improvement in overall pain level and was able to increase is activity accordingly. However, the effect was transient and he relapsed back to his previous pretreatment level of disability. There were also frequent paresthesias and dysesthesias in the ulnar nerve distribution as well as episodic autonomic changes consisting of color change and coldness involving the left hand.

Ongoing evaluations by orthopedics noted significant arthritis involving the left elbow joint. He noted continued chronic left elbow pain with any type of strenuous use. In April 2006 he presented to the Orthopedic Department for reevaluation of his left elbow after being found fit for full duty by the medical board. At that time he was unable to do pull-ups and reported significant difficulty with push-ups. He was able to do a few but experienced significant pain which prohibited him from continuing to do more. He felt that he could not carry a person and reported he was unable to participate in martial arts training as the physical contact to his left upper extremity caused him intolerable pain. He was unable to lift heavy weights in excess of 50 pounds and felt he was unable to perform the duties required of him as an active duty member of the United States Marine Corps. Furthermore, he felt that because of his physical limitations, he was unable to compete with his peer group for professional advancement.

The CI never regained full range of motion (ROM) of his left elbow but the limitations failed to meet the minimum compensable level. However, IAW Veterans Administration Schedule for Rating Disabilities (VASRD) §4.59, a rating of 10% is applied for ROM limited by pain, even if the minimum compensable level is not met. X-rays taken of the left elbow and forearm showed well corticated bony density along the proximal/superior most aspect of the olecranon portion of the ulna and its articular surface. No joint effusion was noted in elbow. The radial head was normally aligned. The distal humerus was unremarkable except for calcific density along the dorsal and inferior aspect just proximal to the elbow joint. There was specifically noted posttraumatic degenerative arthritis in the elbow.

Negative ROM measurements can be used to describe contractures or to describe hyperextension. When correlating the VA and Narrative Summary (NARSUM) ROM measurements with the verbal descriptions, it is clear the negative numbers in the chart below represent a contracture. The CI cannot fully extend or flex his left elbow.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Movement**LEFT ELBOW** | ROM Mil20051201 | AROM VA20070403 | ROM 20060412 | ROM 20050606 | ROM 20030620  |
| Flexion0-145 | -15 to 140 | -10 to 135 | Elbow ROM full pro/ sup/flex/ext, except mild extension block or approx 10 deg. Positive Ulnar tinel. | 15 to 150 | -20 to 135 |
| Supination0-85 | 90 | 0-85 |  | 90 | 90 |
| Pronation0-80 | 80 | 0-80 |  | 80 | 90 |
| Notes: | No crepitus or pain is noted with these ranges of motion. | Crepitus noted with movement in left elbow and active range of motion.The veteran was not able to fully extend left elbow and it remained flexed at about 10 degrees.Weakness in left hand mainly in the 4th and 5th digits.Reflexes essentially absent in left UE.Decreased light touch, pinprick, and monofilament sensation in left elbow area and hypersensitivity.Muscle atrophy on left compared to right UE. |  | No crepitus, no pain |  |

The Informal PEB and reconsideration PEB evaluated the three diagnoses in the Rating Comparison chart and determined the CI was fit for duty. The PEB appears to have placed a great deal of emphasis on the Commander’s letter. However, the NARSUM and its addenda as well as the first sergeant’s letter describe the CI’s functional limitations. He could not do pull-ups or push-ups or lift anything heavy. The second limited duty is not available so the specific limitations of his profile are unknown; but movement of the elbow joint without any weight at all caused pain. He was not able to perform any lifting that required the use of both arms. He was not worldwide assignable, would not have been able to perform all of his required duties while deployed, and his condition interfered with firing his rifle. The BCNR recognized the CI’s functional limitations and appropriately determined the CI was not fit for continued naval service secondary to residuals of a left elbow injury. The BCNR rated the condition at 10% under 5003. However, the rationale for this rating is not available and the BCNR did not specifically adjudicate the neuropathy or RSD.

The CI’s elbow injury caused functional impairment due to both the degenerative arthritis and the nerve conditions: neuropathy and RSD. It is not possible to determine that his functional limitation was due to one and not the other as both contribute to the overall impairment. However, both conditions are due to separate clinical entities and rating both would not constitute pyramiding.

Degenerative/Traumatic arthritis:

ROM limitations do not meet minimal rating criteria so a 10% rating for painful motion is assigned. The elbow joint has limitations at extremes, flexion and extension, but the joint is not held in one position with minimal movement as is required for the condition of ankylosis.

The healthcare provider who performed the VA Compensation and Pension (C&P) examination used the term ankylosis in describing the CI’s condition and a rating consistent with this condition was applied. However, no examination documented ankylosis and code 5205 cannot be accurately applied to the CI’s condition.

Neuropathy:

The CI had signs and symptoms of neuritis before and after the ulnar nerve transposition surgery. Electromyelogram nerve conduction (EMG/NCV) studies before and after the surgery showed ulnar neuropathy. The abnormal study done after the surgery was completed after the CI had increased symptoms following an increase in activity. A third study done five months later when symptoms had abated somewhat with decreased activity was normal.

It appears the elbow fracture did affect the ulnar nerve. More likely than not, there was some damage to the nerve with the initial injury. Also more likely than not, the post-traumatic changes also affected the nerve. This led to continued neuropathy, especially after exertion such as doing pull-ups two weeks prior to the 20030121 EMG/NCV testing. There is no history included with the normal June 2003 EMG/NCV testing. Most likely the CI had not been doing pull-ups or any other strenuous activity prior to this test. It appears the symptoms of neuropathy would increase with increased exertion but were not always present at rest. This is consistent with the history of intolerance to strenuous activity.

The CI did continue to have significant chronic neuropathic pain at rest (up to 8/10) as well as decreased sensation, paresthesias, and hyperesthesias. These symptoms occurred both with and without strenuous activity and the CI also had RSD. Symptoms persisted even after the ulnar nerve transposition surgery and he had both abnormal and normal EMGs after this surgery. The neurologist documented the symptoms continued after the surgery.

VASD §4.123 states neuritis, the 86XX codes, can be rated up to a maximum of severe, incomplete paralysis if loss of reflexes, muscle atrophy, sensory disturbances, and constant pain, at times excruciating are present. The CI had loss of reflexes and muscle atrophy on the VA exam in April 2007 but not on any service examinations. He did have direct damage to his nerve from the initial incident and increased affects with strenuous activity. These resulted in sensory changes and pain and can therefore be rated up to a maximum of severe, incomplete paralysis.

The persistent ulnar nerve injury is mild and when combined with the RSD, the CI has a moderate functional impairment. A determination of moderate is based on the mechanism of injury, EMG studies, constant pain, sensory deficits, positive Tinel’s, and left bicep, hand, and pronator weakness (weakness intermittently documented on various service exams) as noted by the neurologic examinations and the diagnosis of RSD. The VA exam also noted atrophy and loss of reflexes. All of these symptoms persisted after the left ulnar nerve transposition surgery in July 2001 and this suggests that most likely the nerve was permanently affected by the initial injury.

Other Conditions

Multiple Scars, Left Elbow Region Associated with Residual, Left Elbow Comminuted Avulsion Fracture of the Olecranon with Degenerative Arthritis and Bilateral Hearing Loss: No evidence these conditions interfered with performance of any required duty.

Other Conditions Not in Disability Evaluation System (DES)

Chronic Lumbosacral Spine Strain And Degenerative Disc Disease at L5-S1; Left Ankle Strain With Pain; Residual, Left 8th Rib Fracture With Chest Wall Pain; Tinnitus; Tension-Type Headaches Associated with Ulnar Nerve Neuropathy with Chronic Reflex Sympathetic Dystrophy, Left Elbow; Degenerative Arthritis with Carpal Tunnel Syndrome, Right Wrist; and Chronic Allergic Rhinitis are not mentioned in the DES.

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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. After careful consideration of all available information the Board determined by simple majority that the CI’s condition is most appropriately rated at a combined 30% with 20% for 8616 Post-Traumatic Ulnar Nerve Neuropathy With Chronic Reflex Sympathetic Dystrophy, Left (Non-Dominant) Elbow rated as Moderate Incomplete Paralysis and 10% for 5010 Residual, Left Elbow Comminuted Avulsion Fracture of the Olecranon with Degenerative Arthritis. The single voter for dissent (who recommended no recharacterization) submitted the addended minority opinion.

Neuropathy and traumatic arthritis both contribute to the CI’s functional impairment of inability to perform heavy lifting or any strenuous or sustained activity with his left arm. It is not possible to attribute the functional limitations which caused the CI to be unfit to one condition at the exclusion of the other.

VASRD §4.123states that peripheral neuritis 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 CI’s ulnar neuritis is considered moderate based on the cumulative effects of direct injury to the nerve as well as RSD.

Traumatic arthritis is rated at 10% based on pain-limited range of motion that does not meet the minimal compensable level IAW VASRD §4.59.

The Board also considered Multiple Scars, Left Elbow Region Associated with Residual, Left Elbow Comminuted Avulsion Fracture of the Olecranon with Degenerative Arthritis and Bilateral Hearing Loss but did not find any evidence that either of these conditions interfered with performance of any required duty. The Board unanimously determined that neither condition was unfitting at the time of separation from service and therefore no rating is applied.

The other diagnoses rated by the VA (Chronic Lumbosacral Spine Strain And Degenerative Disc Disease at L5-S1; Left Ankle Strain With Pain; Residual, Left 8th Rib Fracture With Chest Wall Pain; Tinnitus; Tension-Type Headaches Associated with Ulnar Nerve Neuropathy with Chronic Reflex Sympathetic Dystrophy, Left Elbow; Degenerative Arthritis with Carpal Tunnel Syndrome, Right Wrist; and Chronic Allergic Rhinitis) were not mentioned in the Disability Evaluation System (DES) package and are therefore outside the scope of the Board. The CI retains the right to request his service Board of Correction for Naval Records (BNCR) to consider adding these conditions as unfitting.

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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 |
| Post-Traumatic Ulnar Nerve Neuropathy With Chronic Reflex Sympathetic Dystrophy, Left (Non-Dominant) Elbow rated as Moderate Incomplete Paralysis | 8616 | 20% |
| Residual, Left Elbow Comminuted Avulsion Fracture of the Olecranon with Degenerative Arthritis | 5010 | 10% |
| COMBINED | 30% |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090209, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

 President

 Physical Disability Board of Review

Minority Opinion:

The facts as stated in the Record of Proceedings are accurate, but I do not share my fellow Board members’ opinion that this Board’s threshold has been met for adding the neuropathy as a separately unfitting condition. I believe the PEB and the BCNR were correct in not finding the neuropathy unfitting, and that this case was adjudicated fairly and accurately. There were no discrepancies and errors that need to be corrected, and it is not a case that the PDBR should recommend overturning.

A nerve conduction study done on 20030605 (the last one performed prior to separation) was normal, stating ‘There is currently no evidence of ulnar neuropathy at the elbow.’ There is no medical information that the CI’s arm strength or sensory impairment was the impediment to his ability to perform PFT requirements. It is conceded that the neuropathy was an additional source of pain interfering with performance, but the only compensable element of the joint rating was painful motion.

It is undisputed, even taken from the CI’s own words, that his significant impairment was the inability to complete the pull-up requirement for the PFT. I do not believe that the Board should take the position that the inability to perform pull-ups because of a single (non-dominant) joint condition constitutes a rational basis for 30% disability and medical retirement.

However, this member agrees with the CI that his ‘catch 22’ administrative separation was unfair. The BCNR appropriately provided relief in that regard. Neither the PEB nor the BCNR felt that the neuropathy was additionally unfitting and the PEB specifically addressed the same issue and found it to be not unfitting. I believe that the disability is accurately represented by the BCNR decision, for the elbow joint code at 10%. I do not believe that this Board has sufficient evidence to outweigh the several considered opinions which preceded the CI’s application. Lending due consideration to the principle of reasonable doubt favoring the CI, I nevertheless believe that this case was accurately and fairly adjudicated by BCNR and should not be recharacterized. The applicant should be assured that his service is gratefully acknowledged by the Board and it recognizes that his acquired disabilities were no small price to pay.

MEMORANDUM FOR DIRECTOR, SECRETARY OF THE NAVY COUNCIL OF REVIEW

 BOARDS

Subj: PHYSICAL DISABILITY BOARD OF REVIEW (PDBR) RECOMMENDATION ICO

XXXXXX

Ref: (a) DoDI 6040.44

 (b) PDBR ltr dtd 19 Apr 10

 I have reviewed the subject case pursuant to reference (a) and do not concur with the recommendation of the Physical Disability Board of Review (reference (b). Accordingly, Mr. XXXXX’s records will not be corrected to reflect a change in the disability rating previously assigned by the Department of the Navy’s Board for Correction of Naval Records.

 Principal Deputy

 Assistant Secretary of the Navy

 (Manpower & Reserve Affairs)