RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: marine corps

CASE NUMBER: PD0900410 BOARD DATE: 20091202

SEPARATION DATE: 20080115

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SUMMARY OF CASE: This covered individual (CI) was a Corporal Logistic Vehicle System Operator who was medically separated from the Marine Corps in 2008 after 3 years of service. The medical basis for the separation was Low Back Pain and PTSD. Appropriate therapy failed to alleviate his symptoms and he was referred to the Navy Physical Evaluation Board (PEB). The Informal PEB determined he was unfit for continued military service and he was then separated with a combined 20% disability for Low Back Pain and PTSD using the Veterans Affairs Schedule for Ratings Disabilities (VASRD) and applicable Navy and Department of Defense regulations.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CI CONTENTION: “It is my contentions that my low back and my PTSD conditions are more severe than the assigned 10 percent disabling that was awarded for each condition at the time I was separated from the USMC. The symthomatology of my medical conditions, which were incurred coincidental to my combat service in Iraq, supports that I was entitled to a higher disability rating at the time of my discharge from the USMC.”

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RATING COMPARISON:

|  |
| --- |
| **Previous Determinations**  |
| **Service** | **VA** (Exam 3 and 4 months pre-discharge) |
| **PEB Condition** | **Code** | **Rating** | **Date** | **Condition** | **Code** | **Rating** | **Exam Date** | **Effective date** |
| Back and Mild Right Leg Pain with an MRI Suggestive of Lumbosacral Disk Degeneration | 5243 | 10% | 20071107 | Lumbar Degenerative Arthritis | 5242 | 20%Then 40% | 20070928Then20080814 | 20080116Then20080728 |
| Radiculopathy, Right Lower Extremity Associated withLumbar Degenerative Arthritis | 8599-8520 | 10% | 20080814 | 20080814 |
| PTSD | 9411 | 10% |  | PTSD | 9400-9411 | 50%50% | 20071009 20081212 | 20080116 |
|  |  |  |  | Post Concussive Headaches | 8045-9304 | 10% | 20070928 | 20080116 |
|  |  |  |  | Degenerative Changes at C4-5, C5-6, and C6-7 | 5003-5242 | 10 | Treatment records | 20080116 |
| Patellar tendonitis | Fit; Cat III |  |  | Patellar Tendonitis |  | NSC |  |  |
| Hypertension |  |  | Hypertension | 7101 | 0% | 20070928 | 20080116 |
|  |  |  |  | Residuals of Right ankle Strain | 5299-5271 | 0% |  | 20080116 |
|  |  |  |  | Left Calcaneal Spur | 5284 | 0% | 20070928 | 20080116 |
|  |  |  |  | Erectile Dysfunction | 7599-7522 | 0% | 20070928 | 20080116 |
|  |  |  |  | Exogenous Obesity |  | NSC |  |  |
| TOTAL Combined: 20% | TOTAL Combined (*incl non-PEB Dxs)*: 60% from 20080116  70% from 20080728 80% from 20080814 |
|  | K-1 Entitled to special monthly compensation under 38 U.S,C. 1114, subsection (k) and 38 CFR 3.350(a) on account of loss of use of a creative organ from *01/16/2008,* |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ANALYSIS SUMMARY:**

**1. Back and Mild Right Leg Pain with an MRI Suggestive of Lumbosacral Disk Degeneration and Radiculopathy**

Back pain started after an incident in April 2006—CI was pulling himself onto a gun turret while in Iraq and he experienced a sharp pain. His pain gradually increased over time and he also began to have right leg pain and tingling. He received multiple treatment modalities without relief of his symptoms: conservative care, physical therapy, TENS, chiropractic care, traction, and epidural steroid injections. He had received treatment, including the epidural injections form a civilian Pain clinic. These brought little relief and he asked to be evaluated for surgery. The next step was further diagnostic studies to determine if surgery might help--last note dated 20070709. No further information available. MEB NARSUM was done 20070817 and it mentioned a history of decreased sensation in the right leg but did not include a sensory examination. Multiple progress notes documented complaints of deceased sensation to right leg and perineal area and decreased sensation to light touch on exam. Pt also complained of both bladder and bowel incontinence; bladder infrequent, bowel, one occasion. Multiple progress notes document diagnosis of radiculopathy, including those with MRI results.

Range of motion (ROM) exams done by both the Navy and the VA (initial) warrant a 20% rating for lumbosacral disc disease. Thoracolumbar flexion was limited to 60 degrees in the NARSUM and 55 degrees on the VA C&P exam. The VA exam also documented spasm causing an abnormal spinal contour which by itself would warrant a 20% rating. The later VA exam documents a thoracolumbar flexion of only 20 degrees. There are no progress notes documenting limitation of ROM at this level during service and this appears to be a worsening of the back conditions after the time of separation. This measurement occurred only 7 months after separation and no intervening injury was documented but this exam is inconsistent with every other examination in the record.

The initial pre-separation VA exam did not document any evidence of radiculopathy but multiple progress notes document sensory radiculopathy and radiating pain both before and after the time of this exam. NARSUM and multiple progress notes also document decreased strength 4-4+/5 in right lower extremity but some of these appear to be related to pain in back with exertion, not a true motor weakness. Second VA exam done 7 months after separation clearly documents a sensory radiculopathy and abnormal nerve conduction studies were noted. Lumbar MRIs done 20061122 and 20080410 (3 months after separation) document a bulging disc at L5-S1 consistent with the radicular signs and symptoms documented. If VA had done a relook at STR they might have back dated the service connection for radiculopathy to the day after separation. The radicular symptoms noted at the second VA exam do not appear to be a worsening condition but merely the presence of intermittent symptoms that happened to have been absent on the day of the first VA exam. No EMG studies were done while the CI was in service but one was done 5 months after separation and the findings were suggestive of a right S1 radiculopathy.

Therefore, the right lower extremity sensory radiculopathy with abnormal sensory exam and occasional bladder and bowel incontinence should be rated as an objective neurologic abnormality associated with the CI’s unfitting lumbosacral degenerative disc disease. The objective findings and MRI results are consistent with radiculopathy. It should be rated as 5243-8520 Right Lower Extremity Radiculopathy at 10% for mild, incomplete paralysis of the sciatic nerve.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Movement****Thoracolumbar** | **Normal ROM** | **ROM Service****20070817** | **ROM VA****20070928** | **ROM VA** **20080814** |
| Flex | 0-**90** | 60 | 55 | 20 |
| Ext | 0-**30** | 20 | 20 |  |
| R Lat flex | 0-**30** | 30 | 25 |  |
| L lat flex | 0-**30** | 40 (30) | 25 |  |
| R rotation | 0-**30** |  | 30 |  |
| L rotation | 0-**30** |  | 30 |  |
| COMBINED |  **240** | 140-200 | 185 |  |
| notes |  | 4+/5 motor at hip on right; o/w 5/5; neg straight leg raise; h/o decreased sensation RLE but no sensory exam recorded**MEB H&P**: post SLR bilateral; pos localized tenderness | Increased lordosis with assoc muscle spasm; No evidence of radiculopathy; No sensory deficits; motor 5/5 bilat; DTRs 1+ bilat throughout | Decreased sensation in right L5-S1 dermatomes(10% Rating for radiculopathy added after this exam) |
| Rating and Basis |  | 20% ROM(Flex≤60) | 20% ROM (Flex≤60)**or** Spasm causing abnormal contour | 40% ROM(Flex≤30) |

**MRI 20061122:**

Vertebral bodies have normal height, signal and alignment. No fractures, spondylolysis or spondylolisthesis are identified. Intervertebral disc space decreased signal and height are focal at the L5-S1 level. Conus medullaris is normal in location, with appropriate signal and contours. Surrounding soft tissue and bony skeleton are unremarkable to include the sacroiliac joints.

The following levels were imaged in the axial plane:

L3-4 and L4-5: No facet or ligamentum flavum hypertrophy, neural foraminal or central canal stenosis, or disc herniation or protrusions are identified. L5-S1: Asymmetric right disc protrusion into the lateral recess creates moderate right neural foraminal narrowing, but no significant central canal stenosis. The exiting L5 nerve root has increased signal, but normal caliber. The disc protrusion contacts the right S1 nerve root, which has normal signal and caliber.

IMPRESSION: L5-S1 disc protrusion with abnormal signal seen within the exiting right L5 nerve root.

**MRI VA 20080410:**

At L1/L2, L2/L3 and L3/L4 there is no focal posterior disc abnormality. Patent central canal and neural foramina. At L4/L5, there is a very small diffuse posterior bulging disc. Mild narrowing of the canal and both neural foramina. Foraminal narrowing is slightly worse at the right side. At L5/S1, there is a moderate sized right paracentral bulge which abuts the right S1 dorsal root ganglion. The canal is ample. Mild bilateral neural foraminal narrowing is appreciated. There are very mild osteoarthritic changes of the facet joints. Normal paraspinal and retroperitoneum soft tissues.

Impression: Moderate size right paracentral bulging disc at L5/S1 accounting for mass effect upon S1 right-sided dorsal root ganglion.

**2. PTSD**

VA C&P exam and the Psychiatric Addendum to the NARSUM were completed within 10 days of each other and report similar histories, symptoms, and examinations. The CI has multiple symptoms in each of the symptom groupings of PTSD: re-experiencing, avoidance, and increased arousal. These symptoms cause distress and impairment in social and occupational functioning. However, the Navy psychiatrist reported a GAF of 55-60 and the VA psychiatrist reported a GAF of 40.

The NARSUM documented the CI felt anxious, depressed, and angry and experiences recurrent, passive suicidal thoughts. Upon return from deployment the CI complained of depressed and anxious feelings accompanied by increased irritability, severe insomnia, recurrent combat-related nightmares, anhedonia, social withdrawal, startle responses, occasional flashbacks (usually around helicopters that he saw in Iraq), avoiding news from the Middle East, and frequent crying spells. His mood was moderately anxious, depressed, and dysphoric. His insight was fair.

The initial C&P exam documented a history of a contemplating suicide while in Iraq. The CI put a rifle in his mouth but stopped after looking at the photo of his son. The patient states his symptoms started prior to his return. He has trouble sleeping, falling, and staying asleep. He also has had flashbacks, nightmares, as if the traumatic event was recurring, intense distress that exposure to similar events and physiological reactivity to cues that symbolized an aspect of the event including increased heart rate and sweats. He demonstrates avoidance of stimuli associated with the trauma in that he makes efforts to avoid thoughts, feelings, and conversations associated with the trauma. He makes effort to avoid activities, places, and people that arouse recollections of the event. He has an inability to recall an important aspect of the trauma. He has markedly diminished interest in participation in significant activities. He has feelings of detachment and estrangement from others, and restricted range of affect. The claimant experiences the following symptoms of increased arousal due to the traumatic event. He has difficulty falling and staying asleep, irritability and outburst of anger, exaggerated startle response, difficulty concentrating, and hypervigilance. Examination showed a very flat affect, depressed mood, some difficulty concentrating in general, some mild forgetting names, directions, recent events, and possibly some problems retaining highly learned material. In addition to PTSD, the CI was also diagnosed with major depressive disorder and generalized anxiety disorder. These were three distinct diagnoses all with their own separate symptoms but all coming from the same etiology. There was no alcohol or drug diagnosis. The traumatic event for him is persistently experienced in recurrent recollections of the event, recurrent distressing dreams of the event, feelings as if the traumatic event were recurring, and intense distress at exposure to similar events and physiological reactivity that symbolizes an aspect of the event. There is persistent avoidance of stimuli associated with the trauma in that he makes efforts to avoid association with the trauma, he makes efforts to avoid activities that arouse event. He has inability to recalling aspect of the trauma. He has a sense of a foreshortened future, markedly diminished participation in activities, feelings of detachment from others, restrictive range of affect. There are persistent symptoms of increased arousal are indicated by difficulty falling and staying asleep, irritability and outburst of anger, exaggerated startle response, difficulty concentrating, and hypervigilance. The duration of the disturbance is more than one month and it does cause distress and impairment in social, occupational, and other areas of functioning and in fact is now chronic because the duration of the symptoms is more than three months.

A minimum rating of 30% is warranted at the time of separation. A higher rating could possibly have been appropriate but information on occupational functioning was limited. However, IAW VASRD §4.129 a 50% rating will be applied for the initial six months after separation.

The CI separated 20080115 and his re-evaluation for permanent PTSD rating should have been done in July 2008. No evaluation was done at this time but the VA did complete a follow-up evaluation on 20081212, 5 months later than the date needed. This evaluation reported continuing recurrent PTSD symptoms and depression. The depression appears to be more severe than at the time of the previous examinations. At the time of this evaluation, the CI appears to be at a lower level of functioning than was documented in the Psychiatric addendum and the first VA C&P exam. He was tearful during this evaluation and displayed a constricted affect. His mood was anxious. Exam also documented multiple symptoms including the following: Sleep impairment; recurrent distressing dreams of the event. Persistent avoidance: efforts to avoid thoughts, feelings, or conversations associated with the trauma. Efforts to avoid activities, places, or people that arouse recollections of the trauma. Markedly diminished interest or participation in significant activities. Difficulty falling or staying asleep. Irritability or outbursts of anger. All symptoms are chronic. Also flashbacks, trouble sleeping with nightmares, irritability, socially withdrawn, hears voices of peers asking for help and children crying, hypervigilant. Currently unemployed.

A GAF of 55 was reported (The rating decision mistakenly said the GAF was 65.). He remained unemployed after he left active duty. He separated from his second wife and moved in with his parents before July 2008. He appeared very isolated socially but was able to enjoy fishing and spending time with his son.

CI was admitted to an intensive VA Day Hospital Program (partial hospitalization) 6 May-2 June 2008 for depression and suicidal ideation. Various group and individual therapies all day with nights and weekends at home. Stated suicide is a prerogative of his own and that he can take this decision based on the power of freedom for decision making. He was referred to the doctor for this statement. During treatment, medications were optimized, participated in group and recreational therapy as well as individual therapy. His symptoms persisted after participating in this treatment.

Information from the Dec 2008 VA exam warrants a 50% rating for PTSD. Basis for 50%: multiple, persistent, daily symptoms of PTSD; unemployed, living with parents, never goes out except to fish and spend time with son. Strained relationship with parents. Lives with parents. No friends. Ex-wife requested a protection order after arguing on telephone with CI. Constricted affect, tearful during interview. Reason for unemployment: medical appointments. Psychiatrist stated moderately severe impairment.

In July 2008, CI was at least half way between 30% and 50%. Using benefit of the doubt, 50% rating would be applied. While no comprehensive examination was done at this time, the STR reveals the requirement of an intensive five week long partial hospitalization, continued daily symptoms of PTSD at a moderate to moderately severe level, a failed second marriage, no employment, little motivation, social isolation, and poor psychological resources for coping with stress of everyday living. GAF did not exceed 55-60 from separation through December 2008.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 PDBR 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 concluded by simple majority that the CI’s condition is appropriately rated at a combined 60% with 50% for 9411 PTSD, 20% for 5243 Back and Mild Right Leg Pain with an MRI Suggestive of Lumbosacral Disk Degeneration using the VASRD General Rating Formula for Diseases and Injuries of the Spine, and 10% for 5243-8520 Radiculopathy, Right Lower Extremity.

Rationale for rating PTSD at 50% at six months after separation from service is based on occupational and social impairment with reduced reliability and productivity due to moderate persistent symptoms of PTSD and depression described above as well as difficulty establishing and maintaining effective work and social relationships.

A rating of 20% for 5243 Back and Mild Right Leg Pain with an MRI Suggestive of Lumbosacral Disk Degeneration is based on limitation of flexion of the thoracolumbar spine at less than 60 degrees. A radiculopathy secondary to the disk degeneration is rated at 10% for mild, incomplete paralysis IAW note 1 of the VASRD General Rating Formula for Diseases and Injuries of the Spine §4.71a-69 which directs the rater to evaluate any associated objective neurologic abnormalities, including, but not limited to, bowel or bladder impairment, separately, under an appropriate diagnostic code. Radicular pain is included in the rating for the spine as paragraph §4.71a-69 states rating will be determined with or without symptoms such as pain (whether or not it radiates), stiffness, or aching in the area of the spine affected by residuals of injury or disease.

The single voter for dissent (who recommended a permanent combined rating of 40% with 30% for 9411 PTSD and 20% for 5243 Back and Mild Right Leg Pain with an MRI Suggestive of Lumbosacral Disk Degeneration) elected not to submit a minority opinion.

The Board also examined Patellar Tendonitis, Hypertension, Erectile Dysfunction, Residuals Right Ankle Strain (Actually Left Ankle), and Post Concussive Headaches and did not find any of these conditions to be unfitting. The other diagnoses rated by the VA, Degenerative Changes C4-5, C5-6, and C6-7 and Calcaneal Spur, were not mentioned in any DES paperwork and are outside the scope of this Board.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RECOMMENDATION: The Board recommends that the CI’s prior determination be modified as follows; TDRL at 60% for 6 months following the CI’s prior medical separation (PTSD at minimum of 50% IAW §4.129 and DoD direction), and then a permanent combined 60% disability retirement as below.

|  |  |  |  |
| --- | --- | --- | --- |
| Unfitting Condition | VASRD Code | TDRL Rating | PermanentRating |
| Post-Traumatic stress disorder | 9411 | 50% | 50% |
| BACK AND MILD RIGHT LEG PAIN WITH AN MRI SUGGESTIVE OF LUMBOSACRAL DISK DEGENERATION | 5243 | 20% | 20% |
| Radiculopathy, right lower extremity | 5243-8520 | 10% | 10% |
| COMBINED | 60% | 60% |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090604, 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

Subj: PHYSICAL DISABILITY BOARD OF REVIEW (PDBR) RECOMMENDATION

Ref: (a) DoDI 6040.44

Encl: (1) PDBR ltr dtd 10 Dec 09

1. I have reviewed the subject case pursuant to reference (a) and accept the recommendation of the Physical Disability Board of Review (enclosure (1)).

2. The subject member’s official records are to be corrected to reflect the following disposition:

 a. Separation from the naval service due to physical disability rated at 60% with placement on the Temporary Disability Retired List effective 15 January 2008.

3. Please ensure all necessary actions are taken to implement this decision, including the recoupment of previously paid funds if appropriate, and notification to the subject member once those actions are completed.

 Principal Deputy

 Assistant Secretary of the Navy

 (Manpower & Reserve Affairs)