RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXX BRANCH OF SERVICE: NAVY

CASE NUMBER: PD0900448 BOARD DATE: 20100609

SEPARATION DATE: 20050605

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SUMMARY OF CASE: This covered individual (CI) was SN/E3 medically separated from the Navy in 2006 after 3 years of service. The medical basis for the separation was Failed Back Syndrome with Low Back and Radicular Pain. The CI was referred to the Physical Evaluation Board (PEB), determined unfit for the Low Back and Radicular Pain condition, and separated at 20% disability using the Veterans Affairs Schedule for Ratings Disabilities (VASRD) and applicable Navy and Department of Defense regulations.

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CI CONTENTION: The CI states: “The DOD should have used VASRD which would have resulted in higher ratings and a sufficient Disability rating for retirement. The MEB/PEB misinterpreted my medical conditions and improperly rated me. I respectfully request a review of discharge and request consideration for medical retirement and all benefits associated with it, if it's in my best. Thanks for your consideration.”

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RATING COMPARISON:

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Service PEB 20050504 | | | | | VA (10 Months After Separation) | | | | |
| Condition | Code | Rating | | Date | Condition | Code | Rating | Exam | Effective |
| Failed Back Syndrome with Lower Back and Radicular Pain | 8520 | 20% | | 20050504 | Residuals, Status Post Partial Disckectomy L5-S1 | 5243 | 10%  20% | 20060406  20080401 | 20050607  20080226 |
| Herniated Nucleus Pulposus, Status Post Laminectomy | CAT II |  | |  |  |  |  |  |  |
| Post-Traumatic Stress Disorder | CAT III |  | |  | Post Traumatic Stress Disorder | 9411 | 30%  30% | 20060406  20081211 (scheduled, failed to show) | 20050607 |
|  |  | MEB H&P | | | Bunion, S/P Bunionectomy Right Foot | 5280 | 0%  100%  10% | 20080129-20090206  (Treatment Reports) | 20050607  20080505  20080701 |
|  |  | MEB H&P | | | Bunion, S/P Bunionectomy Left Foot | 5280 | 0%  100%  10% | 20080129-20090206  (Treatment Reports) | 20050607  20090105  20090301 |
|  |  |  |  | | Residuals, Human Papilloma Virus (HPV) | NSC |  |  |  |
| TOTAL Combined: 20% | | | | | TOTAL Combined (*Includes Non-PEB Conditions*):  40% from 20050607  100% from 20080505  50% from 20080701  100% from 20090105  60% from 20090301 with Bilateral Factor 1.9 for 5280, 5280 | | | | |

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ANALYSIS SUMMARY:

Back Pain

The CI first noticed back pain after heavy lifting in October 2003. She developed paresthesias of the right anterolateral thigh and lower back, as well as occasionally in the left lower back. She had no weakness or changes in bowel or bladder function. She underwent conservative treatment without relief of her symptoms. While she was receiving a course of epidural steroid injections, a Magnetic Resonance Imaging (MRI) was done in January 2004. It revealed a herniated L5-S1 disc with a mild mass effect on the left S1 nerve root sleeve. She had EMG (electromyogram)/NCV (nerve conduction velocity) studies performed on her lower extremities and in March 2004 (prior to surgery) and these were reported as normal. She completed the course of steroid injections but her pain persisted and she underwent an L5-S1 diskectomy in July 2004. She initially did well after surgery but then continued to have back pain and paresthesias in the upper and lower extremities. A repeat MRI on 20041124 documented the presence of post-surgical changes and no evidence of recurrent or residual disc herniations.

She continued to have back pain and complain of paresthesias in her upper and lower extremities. Cervical and lumbar MRIs did not show any herniations or encroachment on any neurologic structures and the sensory examination by neurosurgery was normal. She continued to be followed by neurology and after approximately one year on limited duty (LIMDU) she was referred to the PEB.

The narrative summary (NARSUM) completed in December 2004 did not include any spine range-of-motion (ROM) measurements and none were available in the service treatment record (STR). On multiple visits after her surgery in July 2004, neurosurgery documented full lumbar flexion and extension with no mention of presence or absence of pain on motion. The VA Compensation and Pension (C&P) exam of 20060406 was completed ten months after the CI separated from service and it documented full ROM of the thoracolumbar spine and no sensory or motor abnormalities.

Although the CI had radiating pain as well as subjective symptoms of radiculopathy, there is no objective evidence of either sensory or motor abnormalities. Even prior to the diskectomy surgery, there was no evidence of nerve damage on the EMG/NCV. This condition could also be rated with 10% for 5243 based on painful motion of the spine and 10% for 8520 radiculopathy based on the motor and sensory changes documented in the NARSUM examination. This would yield a combined total of 20% and offers no advantage or disadvantage to the CI.

Her symptoms did later increase and her thoracolumbar ROM did decrease by the time of the VA C&P exam in April 2008, 22 months after separation. This is more likely than not due to a worsening of her condition over time, not an error in the previous rating.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Movement  Thoracolumbar | Normal ROM | ROM Mil  20041207  (6 months prior to separation) | ROM VA  20060406  (10 months after separation) | ROM VA  20080401 |
| Flex | 0-90 |  | 90 | 30 |
| Ext | 0-30 |  | 30 | 10 |
| R Lat flex | 0-30 |  | 30 | 0 |
| L lat flex | 0-30 |  | 30 | 0 |
| R rotation | 0-30 |  | 30 | 0 |
| L rotation | 0-30 |  | 30 | 0 |
| COMBINED | 240 |  | 240 | 40 |
| Notes: |  | Motor is 5/5; may have had a slight weakness in the right-lower extremity; some pain in the back and right and lower extremities; subjective changes to light touch and pin prick in the lower extremity, particularly on the right side. | No pain with ROM, normal sensory, motor, and DTRs, No paresthesias reported with exam; normal gait and spinal curvature | Motor 5/5, no sensory or motor deficits, DTRs 2 bilaterally (should have been rated 40% for flexion of 30) |

PTSD

The CI reported she was sexually assaulted in February 2001 prior to entering the Navy. She also reported she was sexually harassed in June 2003 while serving on USS George Washington (NARSUM and VA C&P). This incident of sexual harassment brought up memories of the sexual assault and the CI experienced symptoms of PTSD. In July 2003 she was authorized leave and visited her family but did not return to duty as required. Instead she went to ship, picked up her clothes, and then went back home.

According to the VA C&P examination she had symptoms immediately after the sexual harassment occurred but did not seek care until Dec 2003, after going to Captain’s Mast in July 2003 for unauthorized absence alleged due to symptoms related to harassment/PTSD. The Seaman who harassed her also went to Captain’s Mast and was restricted to the ship for 45 days starting in August 2003. He eventually apologized to her in September 2003.

The CI also witnessed a mass casualty event on the ship in September 2003 and this was very distressing to her. However, she reported her symptoms had decreased significantly by August 2003 and abated by October 2003. Also in October 2003 she performed some heavy lifting and the back pain described above began at that time.

She self-referred and was evaluated by the ship psychologist on 20031211. His assessment was: Occupational Problem, fit for full duty.

The CI reported she lived off ship with her boyfriend from October 2003 to Jan 2004. In Jan 2004 she was reassigned because of her back issues. She was assigned to the Information and Technology Department in Norfolk, VA and appears to have had a desk type job.

She continued to have symptoms of PTSD and underwent psychotherapy with a Licensed Clinical Social Worker (LCSW) for PTSD from March 2004 to May 2005. She was not taking any medication and was not referred to a higher level of care. She was evaluated a psychiatrist in March 2005 because she was going through the PEB process.

Neither of the two LIMDU Boards or the NARSUM completed for her back pain mentioned any mental illness diagnosis or symptoms. All stated her medical history was unremarkable or non-contributory.

A Psychiatric Addendum was completed 20050322 and this was the first time she was seen by psychiatrist. He started her on Effexor for PTSD and Ambien for insomnia at this visit. She had previously been on Pamelor for insomnia/pain.

The CI had been in therapy for PTSD by the LCSW since March 2004. There was no LIMDU, no referral to psychiatrist or to MEB or PEB for mental illness. She was on no medications until March 2005 when saw psychiatrist for the first time. Only after she was referred for MEB for persistent back pain, then a psychiatric addendum was done. The psychiatrist (who had not been treating her) stated she was unfit for military service secondary to PTSD. He did not provide any evidence that she had any problems at her job. She had been in therapy for PTSD with the LCSW for over a year and no work-related difficulties were reported. There is no evidence this condition interfered with satisfactory performance of her required duties.

The record does not contain any evidence of occupational problems related to mental illness after the incident on the ship in June 2003. In fact the VA C&P documented she was sexually harassed in her new job in January 2004 but did not have any psychological problems related to that incident. She was not in treatment at that time and was not on any medication. She appears to have dealt with the situation appropriately by telling her co-worker his actions were inappropriate. She reported the actions of her co-worker to a superior, did not request a change of duty, and did not experience any adverse psychological reactions to the event.

It is not clear when the diagnosis of PTSD was made but the evaluation by the psychiatrist confirms this condition was present. However, while she did have PTSD it appears to have caused no significant interference with her ability to perform her assigned duties, even before she was in therapy or on medications. She was able to effectively cope with unwanted sexual advances in January 2004 as well as perform her required duties. This is not the description of someone unfit for duty secondary to mental illness. If she did not have back pain, she would not have been unfit for duty.

**Bilateral bunions**

No evidence these were unfitting at the time of separation. No duty restrictions directly attributable to bunions.

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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 unanimously determined that the CI’s condition of Failed Back Syndrome with Lower Back and Radicular Pain does not warrant a rating higher than the 20% assigned by the Navy.

There is no evidence of limited range-of-motion of the spine but back pain was present along with radiating pain. If the condition was rated under VASRD 5243, a rating of 10% could be applied for painful motion IAW VASRD §4.59 but this offers no advantage to the CI. No VASRD code would effect a rating greater than 20%.

The Board also considered Post Traumatic Stress Disorder and unanimously determined that this condition was not unfitting at the time of separation from service in June 2005. The CI was under treatment for this condition from March 2004 through May 2005 (with LCSW, therapy but no medications) and during this time was able to perform all of her required duties except those limited by back pain. She was not referred to the PEB for mental illness but it was appropriately evaluated during her MEB process. The psychiatrist who provided the NARSUM addendum opined she was unfit for service secondary to PTSD and prescribed Effexor in March 2005 but there is no evidence of any actual effect on performance of any required duties. There is evidence that she was able to appropriately deal with an incidence of sexual harassment in January 2004 without any adverse psychological affect or any adverse effect on her duty performance.

The Board also considered Bilateral Bunions and unanimously determined that this condition was not unfitting at the time of separation from service in June 2005. This condition did not prevent the CI from performing her required duties and no physical limitations can be attributed to this condition.

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RECOMMENDATION: The Board therefore recommends that there be no recharacterization of the CI’s disability and separation determination.

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090716, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

Deputy Directory

Physical Disability Board of Review

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 16 Jun 10

I have reviewed the subject case pursuant to reference (a) and approve the recommendation of the Physical Disability Board of Review (reference (b)) that Ms. XXXXX’s records not be corrected to reflect a change in either her characterization of separation, or in the disability rating previously assigned by the Department of the Navy’s Physical Evaluation Board.

Principal Deputy

Assistant Secretary of the Navy

(Manpower & Reserve Affairs)