RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXX BRANCH OF SERVICE: MARINE CORPS

CASE NUMBER: PD0900542 BOARD DATE: 20100825

SEPARATION DATE: 20080131

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

SUMMARY OF CASE: This covered individual (CI) was a LCpl/E-3 (Rifleman) medically separated from the Marine Corps Reserves in 2008 after six years of combined service. The medical basis for the separation was Vertigo and Left Acromioclavicular (AC) Shoulder Separation, Grade 3. The Vertigo and Left AC Shoulder Separation were determined to be medically unacceptable and the CI was referred to the Physical Evaluation Board (PEB), determined to be unfit for continued Naval service, and separated at 20% disability using the Veterans Affairs Schedule for Ratings Disabilities (VASRD) and applicable Navy and Department of Defense regulations.

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

CI CONTENTION: ‘The Military did not give me proper evaluation/full physical and mental health evaluation. Once evaluated by the VA it was decided that I am 90 percent disabled.’

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

RATING COMPARISON:

|  |  |
| --- | --- |
| **Service** | **VA (2, 5 Mo. after Separation)** |
| **Unfitting Conditions** | **Code** | **Rating** | **Date** | **Condition** | **Code** | **Rating** | **Exam** | **Effective** |
| Vertigo  | 6204 | 10% | 20071113 | Meniere’ s Disease/VertigoResiduals Eustachian Tube Dysfunction w/Vertigo | 62056204 | Deferred0% | 20080305 (Audio)20080321 (ENT)No show for ENG tests | 20080201 |
| Eustachian Tube Dysfunction | CAT II |  |  |
| Left AC Shoulder Separation |  5299-5003 | 10% | 20071113 | Left Shoulder Post Traumatic Residuals, Chronic Stable  | 5299- 5203 | 10% | 20080314 | 20080201 |
| Shoulder Impingement | CAT II |  |  |
| High Frequency Hearing Loss Bilaterally | CAT III |  |  | Bilateral Hearing Loss | 6100 | DeferredNSC | 2008030520080321 |  |
| Chronic Lumbar Spine Pain | CAT III |  |  | Degenerative Disc Disease w/Low Back Bain | 5242 | 10% | 20080314 | 20080201 |
|  |  | Not in DES | PTSD | 9411 | 70% | 20080310 | 20080201 |
|  |  | Not in DES | Residuals, Traumatic Brian Injury w/Cognitive Impairment | 8045 | 40% | 200806112008102120081215 | 20081023(Date of New Law) |
|  |  | Not in DES | Degenerative Disc Disease w/Neck Pain | 5237 | 10% | 20080314 | 20080201 |
|  |  | NARSUM | Tinnitus | 6260 | Deferred10% | 2008030520080321 | 20080201 |
|  |  | NARSUM | Headaches |  8199- 8045 | Deferred10% | 20080314 | 20080201 |
| **TOTAL Combined: 20%** | **TOTAL Combined (Includes Non-PEB Conditions):** **80% 20080201****90% 20081023** |

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

ANALYSIS SUMMARY:

Vertigo/Eustachian Tube Dysfunction

The service treatment record (STR) documents recurrent bilateral suppurative otitis media. CI had this as a child and had had several sets of pressure equalization (PE) tubes placed. However, he had no current problems when he enlisted and was evaluated by Ear, Nose & Throat (ENT) at that time. After he enlisted he had recurrent ear infections, eustachian tube dysfunction, and had PE tubes placed again in June 2006 while in Iraq. While deployed to Iraq he developed recurrent ear infections, headaches, and vertigo and was evacuated for this. He was followed by a civilian ENT and progress notes from August 2006 to June 2007 are in the STR. The last note documented non-functional PE tubes bilaterally with bilateral middle ear effusion and eustachian tube dysfunction. This note stated the CI was to follow-up in three to six weeks but no further notes are available. No electronystagmography (ENG) examinations are in the STR.

The Medical Evaluation Board (MEB) narrative summary (NARSUM) stated the CI had vertiginous symptoms two to three times a day despite Antivert and steroid tapers, had been seen followed by ENT and no further therapies were available. There was no mention of whether gait was altered or not.

The CI had a VA Compensation and Pension (C&P) exam done by an audiologist on 20080305 and this documented a similar clinical history. It also included a more detailed description of the dizziness and vertigo. The dizziness was random and made the CI feel like he was going to pass out. The episodes of vertigo were described as the room spinning and then he loses balance and falls down. He reported the symptoms occur three times a day and each time it lasts for one hour. On examination the CI had yellow purulent discharge from ears, both tympanic membranes were red and swollen, both showed negative pressure and there was no ipsilateral reflex in either ear with a 90dB stimulus. His gait was described as staggering and cerebellar. He was evaluated by ENT for the VA on 20080321 but failed to show for two scheduled ENG examinations so the examiner could not make any comments about his recurrent vertigo. VA rated condition at 0% because he failed to show for these exams which were necessary to objectively demonstrate or support disabling criteria.

A 10% rating is warranted under VASRD 6204 for occasional dizziness. He had dizziness two to three times a day for one hour at a time. This could be considered more than occasional but the CI does not meet the criteria for the 30% rating. This condition is between the 10% and the 30% rating criteria but is closer to the 10% rating. The 30% rating requires dizziness and occasional staggering. This implies the dizziness is constant and the CI did not have constant dizziness. He did complain of falling but only on the VA C&P Audiology exam; this complaint is not documented in the STR. The 30% rating also requires occasional staggering. Staggering was documented only on the VA C&P Audiology examination; there are no documented complaints or examination findings of this in the STR.

Left Shoulder Separation, Grade III/ Shoulder Impingement

The CI fell while walking on ice in February 2007 and suffered a left acromioclavicular (AC) joint separation. A magnetic resonance imaging (MRI) in April 2007 confirmed the AC separation and also noted a type 2-3 acromium and lateral down-sloping of the acromium. No rotator cuff injury was noted. He was treated by a civilian orthopedic surgeon and had physical therapy which had given him some relief. This surgeon thought shoulder surgery might be necessary in five to ten years. The NARSUM reported the CI had no shoulder pain at rest but he did have pain with active range of motion (ROM), lifting, and with changes in the weather.

The MED NARSUM stated the left shoulder had full range of motion (ROM) and slight tenderness to abduction but the Progress note from the visit for NARSUM exam on the same day (20071015) states: + pain with abduction and unable to lift elbow above level of clavicle. The NARSUM and the progress note were written by the same physician on the same day. Also, the CI saw this same physician on multiple other occasions where the pain with abduction was noted along with the inability to lift the elbow above the level of the clavicle: 20070416, 20070621, 20071015, and 20071023. It is possible the full range of motion referred to passive motion and the inability to lift the elbow above the clavicle referred to active motion but this is not specifically stated. The same progress notes listed above also all noted a visible deformity of the left AC joint with a 1.5 cm elevation of the clavicle.

A civilian physical therapy note 20070326 at an initial PT evaluation documented left shoulder active ROM limited to 90 degrees elevation, 80 degrees abduction. Motor was 4/5 for left shoulder IR, add, and bicep flexion. Point tenderness and tightness was present in the left upper trapezius and levator scapula muscle. They recommended avoid all lifting, carrying, pushing/pulling, and physical activity (i.e. running)

|  |
| --- |
| SEPARATION DATE: 20080131 |
| **Left****Shoulder** | Normal ROM | PT Exam 20070608 | NARSUM  | Progress note | C&P 20080314 |
| 20071015Same Provider |
| Forward Elevation (Flexion) | 0 - 180 | 150 active “tolerated” |  |  | 180 No pain |
| Abduction | 0 - 180 | 150 active“tolerated” |  | Positive pain, unable to lift elbow above clavicle | 120 pain |
| External Rotation | 0 - 90 | NA | No Pain |  | 90 no pain |
| Internal Rotation | 0 - 90 | NA | No Pain |  | 90 no pain  |
| Notes: |  | No mention of pain or at what degree it occurred.Demonstrated steady improved L shoulder ROM, but weakness present in internal/ external rotator and mid trap rhomboids with muscle spasm  | NARSUM states full ROM and slight tenderness to abduction **BUT** Progress note from visit for NARSUM exam (same day) states: + pain with abduction and unable to lift elbow above level of clavicle.  | Impingement signs to Hawkins and Neer tests were negative, no tenderness over the greater tuberosity, and negative for any DeLuca criteria.Motor 5/5 bilateral normal sensation and DTRs bilateral. |

Multiple examinations on multiple different days in the STR document an inability to abduct the arm above 90 degrees and this warrants a 20% rating under VASRD 5201 Arm, limitation of motion of. The NARSUM exam and the VA C&P do not document this degree of limitation. There is no specific VASRD code for acromioclavicular separation and an analogous code must be used. VASRD codes 5299-5003 used by the Navy PEB and 5299-5203 used by the VA both result in a 10% rating and neither offers any advantage to the CI. The CI had residual pain and disability as a result of his left shoulder AC separation. However there was no instability of the joint and no loose movement.

Other Conditions:

Chronic Lumbar Spine Pain

The Non-Medical Assessment stated back pain and vertigo interfere with performance of required duties. The CI was on limited duty for back pain from November 2006 until he separated from service. The PEB determined this condition was not unfitting and the Board must determine whether this condition should have been considered unfitting at the time of separation from service.

The CI did have a long history of back pain that began while preparing for his deployment to Iraq. He was put on light duty and his symptoms improved with physical therapy. He was then able to deploy. However his back pain gradually worsened and he was placed on limited duty for six months for back pain on 20061115. The limited duty was extended for another six months in May 2007 and he then underwent a MEB and was referred to the PEB. The CI had back pain since December 2005 and it started after heavy lifting. At first it was intermittent but it gradually worsened. He was on light duty for one to two months and received physical therapy. His symptoms improved and he was allowed to deploy. At the time of the NARSUM in October 2007 he reported daily constant pain with radiation down both legs laterally to just above his knees. He was unable to run or jump without significant pain. He had been receiving physical therapy again but had no improvement. An MRI in December 2006 documented slight disc space narrowing of L5-S1 with mild degenerative disc disease at that level. He had epidural steroid injections and also a trigger point injection in the right SI ligament but neither brought any significant improvement.

Multiple progress notes by military, civilian and VA providers documented an ability to flex to 90 degrees with pain at end of flexion.

|  |
| --- |
| SEPARATION DATE: 20080131 |
| **Thoraco-lumbar**Movement | Normal ROM | NARSUM 20071015 | C&P 20080314 |
| Flex | 0-90 | 90 | 90, pain at 90 |
| Ext | 0-30 | Full | 30, pain at 30 |
| R Lat flex | 0-30 | Without Difficulty | 30 no pain |
| L lat flex | 0-30 | Without Difficulty | 30 no pain |
| R rotation | 0-30 | NA | 45 (30) no pain |
| L rotation | 0-30 | NA | 45 (30) no pain |
| TOTAL | 240=VA normal | NA | 240 |
| Notes: |  | Reports daily constant pain w/radiation down both legs laterally to just above the knees; positive Schmorl nodes at L4-5 and disc space narrowing at L5-S1; received epidural steroid injection and DepoMedrol injection of R sacroiliac (S1) joint and trigger pt injections of S1 ligament Mar 07 w/no improvement in pain. Completed lumbar nerve ablation July 2007, not helped chronic pain. Reports having a dull ache, burning constant pain of the low back which radiates up his back to his shoulder blades. This has had no effect on the other aspects of his low back pain | No additional loss of motion on repetitive use of joint;Normal gait, no spasm, no tenderness to palpationMotor 5/5, sensory and DTRs normal bilaterallyPositive straight leg raise test while supine, negative when sitting5 of 7 Waddell’s positive |

Multiple exams show full ROM with pain only at the extreme. MRI did not show any impingement on nerve roots but CI persistently complained of pain radiating down both legs. He had normal motor and sensory exams. His pain did not respond to multiple treatment modalities. He had 5 out of 7 positive Waddell’s signs on the VA C&P exam. While the CI did have chronic low back pain there is insufficient evidence in the STR to determine this condition was unfitting at the time of separation from service. He injured his back prior to deployment but was able to deploy. The condition did not prevent performance of his required duties while deployed. He did complain of increased pain after he returned from deployment. However, there is no evidence this condition had worsened to the point of causing him to be unfit for continued service.

High Frequency Hearing Loss

No evidence this condition was unfitting at the time of separation from service. This condition did not interfere with performance of any required duties and no duty restrictions can be attributed to this condition.

Headaches

No evidence this condition was unfitting at the time of separation from service. This condition did not interfere with performance of any required duties and no duty restrictions can be attributed to this condition.

Tinnitus

No evidence this condition was unfitting at the time of separation from service. This condition did not interfere with performance of any required duties and no duty restrictions can be attributed to this condition.

Other Conditions Not in the Disability Evaluation System (DES) package

Post Traumatic Stress Disorder (PTSD); Residuals, Traumatic Brian Injury with Cognitive Impairment; Degenerative Disc Disease w/Neck Pain. The service treatment record (STR) does contain evidence that the CI was in treatment for PTSD with a civilian provider prior to his separation from service. However, this diagnosis is not mentioned in any Disability Evaluation System documents.

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

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 Vertigo and Shoulder condition are most appropriately rated at a combined 20% with 10% for Vertigo and 10% for Left AC Shoulder Separation, Grade 3. A 10% rating is warranted under VASRD 6204 for occasional dizziness. The CI had dizziness two to three times a day for one hour at a time. This could be considered more than occasional but the CI does not meet the criteria for the 30% rating. This condition is between the 10% and the 30% rating criteria but is closer to the 10% rating. The 30% rating requires dizziness and occasional staggering. This implies the dizziness is constant and the CI did not have constant dizziness. He did complain of falling and staggering but only on the VA C&P Audiology exam; neither is documented at any other outpatient visit, the NARSUM examination or the C&P examination done by the VA ENT surgeon.

There is no specific VASRD code for acromioclavicular separation and an analogous code must be used. VASRD codes 5299-5003 used by the Navy PEB and 5299-5203 used by the VA both result in a 10% rating and neither offers any advantage to the CI. The CI had residual pain and disability as a result of his left shoulder AC separation. However there was no instability of the joint and no loose movement.

The Board also considered Chronic Lumbar Spine Pain. While the CI did have chronic low back pain there is insufficient evidence in the STR to determine this condition was unfitting at the time of separation from service. He injured his back prior to deployment but was able to deploy. The condition did not prevent performance of his required duties while deployed. He did complain of increased pain after he returned from deployment. However, there is no evidence this condition had worsened to the point of causing him to be unfit for continued service.

The Board also considered the following conditions and unanimously determined that none of these conditions were unfitting at the time of separation from service and therefore no disability rating is applied: Eustachian Tube Dysfunction, Shoulder Impingement, High Frequency Hearing Loss Bilaterally, Headaches, and Tinnitus.

The other diagnoses rated by the VA (Post Traumatic Stress Disorder (PTSD); Residuals, Traumatic Brian Injury with Cognitive Impairment; and Degenerative Disc Disease w/Neck Pain) were not mentioned in the Disability Evaluation System 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 (BCNR) to consider adding these conditions as unfitting.

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

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

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

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090901, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

 Deputy Director

 Physical Disability Board of Review

MEMORANDUM FOR DIRECTOR, SECRETARY OF THE NAVY COUNCIL

 OF REVIEW BOARDS

SUBJECT: Physical Disability Board of Review (PDBR) Recommendation ICO XXXXX

Ref: (a) DoDI 6040.44

 (b) PDBR ltr dtd 8 Sep 10

 I have reviewed subject case pursuant to reference (a) and approve the recommendation of the Physical Disability Board of Review (reference (b)) that Mr. XXXX’s records not be corrected to reflect a change in either his 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)