RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: MARINE CORPS

CASE NUMBER: PD0900655 SEPARATION DATE: 20090330

BOARD DATE: 20110114

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SUMMARY OF CASE: Data extracted from the available records reflects that this covered individual (CI) was a Private/ E-1 (from DD-294, DES shows PFC E-2), (0811, Artilleryman) medically separated from the Marine Corps in 2009 after five years of service. The medical basis for the separation was Chronic Pain Status Post Anterior Cruciate Ligament Reconstruction with Allograft Requiring Pain Management. The Physical Evaluation Board (PEB) also addressed the following additional diagnoses and determined each was a related, Category II condition: Patellofemoral Pain Status Post Anterior Cruciate Ligament Reconstruction and Anterior Cruciate Ligament Insufficiency Status Post Revision Reconstruction. An additional diagnosis of Anxiety Disorder—Not Otherwise Specified (NOS) was determined to be category III, not unfitting for Naval service. The CI was referred to the PEB, determined unfit for continued Naval service, and separated at 20% disability using the Veterans Affairs Schedule for Rating Disabilities (VASRD) and applicable Naval and Department of Defense regulations

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CI CONTENTION: The CI states: "Chronic Pain S/P Anterior Cruciate Ligament Reconstruction with Allograft Ligament Reconstruction Three Surgeries--Chronic Pain Management I have had three surgeries on my left knee. The dates of the surgeries are as follows: 8/5/07, 9/2/07 and 9/22/09. I am still undergoing Chronic Pain Management. The severity of my condition warrants medical retirement. Please review my records to aid in your decision."

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\*\* Rating Comparison Table is located on the next page.RATING COMPARISON:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Service PEB – Dated 20090114** | | | **VA (3-5 Months Prior to Separation)**  **All Effective 20090331** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Chronic Pain Status Post Anterior Cruciate Ligament Reconstruction With Allograft  Requiring Pain Management | 5262 | 20% | Post Operative ACL Repair, Left Knee, With Degenerative Joint Disease | 5259 | 10% | 20081209 |
| Left Anterior Cruciate Ligament Insufficiency Status Post Revision Reconstruction | CAT 2  Related diagnosis | | Scars, Left Knee | 7805 | 0% | 20081209 |
| Patellofemoral Pain Status Post Anterior Cruciate Ligament Reconstruction | CAT 2  Related diagnosis | |  |  |  |  |
| Anxiety Disorder (NOS) | CAT 3  Not Unfitting | | Post Traumatic Stress Disorder With Depression (Also Claimed As Sleep Disorder And Anxiety) | 9411 | 30% | 20081104 |
| Male Erectile Dysfunction | CAT 4  Not a disability | | Erectile Dysfunction | 7599-7522 | 0% | 20081209 |
| Low Back Pain | MEB H&P | | Thoracolumbar Spine Strain With Intervertebral Disc Syndrome At Bilateral Sciatic Nerve Dermatomes L4-L5 and SI-S2 | 5243-5237 | 10% | 20081209 |
| Tinnitus | MEB H&P | | Tinnitus | 6260 | 10% | 20081024 |
| Scar, Right Lower Leg | MEB H&P | | Scar, Right Leg | 7805 | 0% | 20081209 |
|  | Not in DES | | Patellofemoral Syndrome. Right Knee | 5260-5024 | 10**%** | 20081209 |
|  | Not in DES | | Plantar Fasciitis, Right Foot with Pes Planus | 5299-5276 | 0% | 20081209 |
|  | Not in DES | | Plantar Fasciitis, Left Foot with Pes Planus | 5299-5276 | 0% | 20081209 |
|  | Not in DES | | Bronchitis With Obstructive Pulmonary Disease | 6600-6604 | 0% | 20081209 |
|  | Not in DES | | Left Ulnar Nerve Entrapment | 8599-8516 | 0% | 20081209 |
| **TOTAL Combined: 20%** | | | **TOTAL Combined (*Includes Non-PEB Conditions*): 60%** | | | |

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ANALYSIS SUMMARY:

Left Knee Instability: The CI initially injured his left knee in June 2007 while playing football for unit physical training. He had a hyperextension and a valgus stress, felt a pop, and noted immediate swelling and instability. Evaluation which included MRI (magnetic imaging) noted left knee anterior cruciate ligament (ACL) tear, medial meniscus tear, lateral meniscus tear, lateral femoral condyle bone bruise, and a second fracture over the lateral femoral tibial plateau. Despite conservative treatment with physical therapy, range of motion (ROM), strengthening, and an ACL brace, he continued to have generalized ligamentous laxity and genu recurvatum. Reconstructive surgery was performed 20070924 with allograft reconstruction of the ACL, medial meniscus repair, and lateral meniscus repair. However, he continued to have left knee instability and patellofemoral pain and he underwent a second surgery 20080513 with a bone tendon allograft reconstruction. After this surgery he did have some increased stability but was not able to return to a full active lifestyle or full duty. The CI was on Limited Duty (LIMDU) for his left knee injury from the time of injury in 2007 through his separation. The first LIMDU was at the time of initial injury and he had exceeded the twelve months allowed for LIMDU in August 2008. At that time he was three months post-op from his second surgery and was not able to return to full duty. A Medical Evaluation Board (MEB) Narrative Summary (NARSUM) was completed in November 2008.

At the time of the NARSUM the CI was undergoing treatment for his left knee at a Pain Clinic. He reported that he had constant pain when not taking medication. He was taking non-steroidal anti-inflammatory medications and narcotics (oxycodone 5 mg 2-3 tablets up to 6 daily), and despite medication he had constant pain while walking long distances. He reported that and he was unable to do the activities he could perform prior to the injury. His pain increased when walking without a leg brace and cane. He had pain at night, with cold weather, and regular walking. His baseline pain was 4-5/10 and his pain increased to 5-6/10 with strenuous exercise. This examination noted knee joint instability as documented in the chart below. A VA Compensation and Pension (C&P) examination was completed in December 2008, approximately three months prior to separation. At that time he was still wearing a knee brace and walking with a cane. This examination noted no left knee instability and findings are recorded in the chart below. The CI’s left knee instability was documented multiple times in his service treatment record (STR) and NARSUM and continued after he separated from service. Also he underwent a third surgery at the University of North Carolina (UNC), Chapel Hill on 20090922, less than six months after he separated. His left knee ACL was reconstructed a third time, this time with a bone-patellar tendon-bone autograft. He also had a partial medial meniscectomy, loose body removal/stitch removal, and hardware removal. Examination under anesthesia prior to this surgery documented motion of 0-130 degrees, no varus or valgus instability, obvious Lachman and grade II pivot shift, stable posterior drawer. Arthroscopic findings included obvious tearing of the ACL graft with no graft incorporation and a medial meniscal tear.

There were three goniometric ROM evaluations in evidence which the Board weighed in arriving at its rating recommendation, summarized in the chart below.

\*\* Range of Motion Chart located on the next page.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Knee ROM | MEB 20081120 | VA C&P  20081209 | UNC CH  20090828 | UNC CH Exam under anesthesia  20090922 |
| Flexion Left | 0-140⁰ | 120⁰  with pain at 120⁰ | 5-125⁰ | 0-130⁰ |
| Extension Left | 0⁰ | 0⁰ | 5⁰ | 0⁰ |
| Notes | Increased translation of ACL with a positive Pivot glide; Lachman 5mm with soft and slow end point; motor 4+/5; normal DTR, sensory exam; no joint line tenderness | Tender to palpation; No effusion or weakness; Normal motor and sensory; No instability; With repeated motion: increased pain, fatigue, lack of endurance; X-ray: Prior ACL repair and minor degenerative changes | Increase Lachman, positive pivot shift, stable posterior drawer, stable to varus and valgus stress | Obvious Lachman and pivot shift, stable to varus and valgus stresses |
| §4.71a Rating Left | 5257 20%  5259 10% | 5259 10% | 5257 20%  5259 10% | 5257 20%  5259 10% |
|  |  |  |  |  |
| Flexion Right | Not examined | 135⁰ | Not examined | Not examined |
| Extension Right |  | 0⁰ |  |  |
| Notes |  | Not tender to palpation; No effusion or weakness; Normal motor and sensory; No instability; With repeated motion: increased pain, fatigue, lack of endurance; X-ray: normal |  |  |
| §4.71a Rating Right |  | 5261 10% |  |  |

Despite two reconstructive surgeries prior to separation from service, the CI continued to have left knee pain and instability and well as decreased ability to walk or engage in any strenuous activity. He required a brace and cane. The instability was present on the NARSUM examination in November 2008 and the two UNC Chapel Hill (CH) examinations in August and September 2009. The VA C&P examination was after the NARSUM examination and before either UNC CH examination and did not show instability. However, there is no reason to doubt the accuracy of either the NARSUM or the UNC CH examinations. The instability was present both before and after separation from service and must be considered in the disability rating. The preponderance of evidence supports a determination that more likely than not, the CI’s left knee was unstable at the time of separation from service.

As the left knee instability was significant enough to warrant surgical repair and continued use of a brace and cane, it is considered moderate and warrants a rating of 20% for 5257 Left Knee Instability, status post two failed ACL reconstructive surgeries. The CI also had decreased ROM secondary to pain. This decreased ROM was below the minimal compensable level but does warrant a minimum 10% rating for painful motion IAW VASRD §4.59. This 10% rating could be applied to VASRD code 5260 Leg, limitation of flexion of or 5259 Cartilage, semilunar, removal of, symptomatic as the CI had undergone both lateral and medial meniscal repair. It is not possible to separate out pain symptoms due to patellofemoral pain syndrome and pain symptoms due to Cartilage, semilunar, removal of, symptomatic. Therefore separate ratings for these conditions cannot be applied without pyramiding and only one code will be chosen. Applying either code would result in a 10% rating and neither code offers the CI any advantage. Applying separate ratings for instability and persistent symptoms despite meniscal repair is consistent with VASRD DeLuca criteria and is not considered pyramiding. The left knee scar does not interfere with performance of duties required by the CI’s rank or rating and is not considered unfitting. Therefore no disability rating is applied for this condition.

Mental Health Condition: The CI deployed to Iraq twice, January to August 2005 and September 2006 to March 2007. He performed infantry work and received a Combat Action ribbon. He was diagnosed with Anxiety Disorder--NOS while on active duty and received individual and group psychotherapy with only minimal symptom relief. A Post-Deployment Health Assessment (PDHA) was completed 20070105, approximately two months before he redeployed. It noted significant symptoms of little interest or pleasure in things as well feeling down, depressed and hopeless in the previous two weeks. It also noted some thought that he might be better off dead or hurting himself in some way in the previous two weeks. It also noted that he had an experience that was so frightening, horrible, or upsetting that he had the following in the previous month: nightmare or thought about the experience when he did not want to; tried hard not to think about it or went out of his way to avoid situations that reminded him of it; was constantly on guard, watchful, or easily startled; and felt numb or detached from others, activities, or his surroundings. It also noted the CI had thought or concerns that he might have serious conflicts with his spouse, family members, or close friends and that he might hurt or lose control with someone. He was referred to combat stress when this PDHA was completed. No information about this referral is in the service treatment record (STR).

In March 2007 he was referred to psychiatry for acute depressed mood and post traumatic stress. At his initial psychiatric evaluation on 20070328, he was noted to have a flat affect, depressed mood, and poor eye contact. At that time his diagnoses were Adjustment disorder with mixed emotional features, panic disorder (provisional), and brief stress reaction (rule out combat stress). He was treated with Zoloft and Ativan. He was released to full duty and follow-up was scheduled in three to four weeks. At a follow-up visit 20070424 he reported he had felt better with the medications but had run out. His affect was blunted and his mood was worried. The Zoloft was continued but the Ativan was discontinued due to a history of alcohol abuse/dependence. He was married in 2004 and separated in 2007; there were no children. No other mental health visits are noted in the STR until 20080428 when the CI was seen by a clinical psychologist and symptoms of PTSD were noted. His mood was anxious and his affect was congruent. The diagnosis was Anxiety Disorder--NOS and a GAF (Global Assessment of Functioning) of 60 was assigned. There is no mention of medication but individual psychotherapy was initiated along with stress management and a follow-up with psychiatry was scheduled approximately four weeks later. A psychiatric treatment plan dated 20080428 states the CI was psychological fit for light duty and recommendation for excuse from the following duties was recommended: handling of weapons or ammunition, overnight watches, driving motor vehicles, deployment, and firing range.

A Psychiatric Addendum to the MEB NARSUM was completed 20081015. It noted a diagnosis of Anxiety disorder NOS and stated the CI did not meet the criteria for the diagnosis of Post-Traumatic Stress Disorder (PTSD). The mental status examination documented a mildly anxious mood and affect congruent with his mood. The examining psychologist noted the CI’s anxiety disorder occurred as a result of his exposure to combat in Iraq and opined the CI was not fit for full duty or world-wide deployment. He assigned a GAF of 60-65 and stated military prognosis was poor and civilian occupational and relationship prognosis was good.

A VA C&P examination completed by a psychiatrist 20081104 diagnosed both PTSD and Depression. This examination documented symptoms sufficient to meet criteria for diagnosis of PTSD. These included difficulty sleeping four nights a week; nightmares a couple times per week; feeling anxious and tense with occasional panic attacks; constant general anxiety; startle and hypervigilance; he was more isolated, withdrawn, and distant; he stayed in his room all the time and did not do things with his friends; depression; loss of energy; loss of interest; increased irritability; and avoidance, he avoided news about Iraq, talking about Iraq and things that remind him of Iraq. The psychiatrist noted social impairment and stated the CI had become very isolated and withdrawn. His interests were video games, watching rented movies on his TV, and surfing the internet. He did not go out with friends. He reported being on good terms with his parents and sister. Mental status examination documents an abnormal affect with depression, psychomotor retardation and anxiety, and mild irritability. His insight was fair. The examiner noted the CI’s prognosis as fair to good and thought counseling would help. The current GAF was 65 and the psychiatrist wrote that while it seemed most of the CI problems were due to depression from his medical problems, it was difficult to be exact.

The PEB determined the CI’s mental illness was not unfitting and the Commander’s letter does not specifically mention mental illness. It simple states the CI did not have good potential for continued service in his present physical and mental condition. However, the Navy psychologist stated the CI was not psychologically fit for full duty as a result of his mental illness and recommended he be excused from handling weapons and ammunition as well as other duties as described above. The CI was noted to have combat stress while in theater and was treated by psychiatry with medication and by clinical psychology with individual and group counseling. The NARSUM noted the CI got little relief of symptoms from therapy but no mention of any affect of medication was present. It is not clear when the CI stopped taking Zoloft but he was not taking it at the time of the NARSUM in October 2008 or the VA C&P exam in November 2008. There is no information in the STR about the CI’s mental health condition after these two examinations were completed.

The Board thoroughly discussed adding Anxiety disorder as an unfitting condition. It ultimately determined this condition did not interfere with performance of the CI’s required duties and therefore should not be rated as an unfitting condition.

Other Conditions: Male erectile dysfunction (ED), Low Back Pain; Tinnitus; and Scar, Right Lower Leg. The Board determined the ED was not a disability was not unfitting for military service. For the low back pain, tinnitus, and scar, right lower leg; the Board determined none of the conditions interfered with performance of duties required by the CI’s rank or rating and none are mentioned in the commander’s letter. Therefore none are considered unfitting at the time of separation from service and no disability rating is applied.

Other Conditions Not in the DES: Patellofemoral Syndrome, Right Knee; Plantar Fasciitis, Right Foot with Pes Planus; Plantar Fasciitis, Left Foot with Pes Planus; Bronchitis With Obstructive Pulmonary Disease; and Left Ulnar Nerve Entrapment

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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 2 to 1 vote that the CI’s left knee condition is most appropriately rated at a combined 30% with 20% for 5257 Left Knee Instability, Status Post Two Failed ACL Reconstructive Surgeries and 10% for 5259. The left knee instability at the time of separation was significant enough to warrant further surgical repair and continued use of a brace and cane and is therefore considered moderate. In accordance with DeLuca criteria applying separate ratings for multiple conditions within the same knee is appropriate and is not considered pyramiding. The single voter for dissent (who recommended no recharacterization) did not elect to submit a minority opinion.

The Board considered the condition of Anxiety Disorder--NOS and unanimously determined that this condition was not unfitting at the time of separation from service and therefore no disability rating is applied. The Board also considered Erectile Dysfunction; Low Back Pain; Tinnitus; and Scar, Right Lower Leg and unanimously determined that none of these conditions interfered with performance of required duties. Therefore none were considered unfitting at the time of separation from service and no disability ratings are applied.

The other diagnoses rated by the VA (Patellofemoral Syndrome, Right Knee; Plantar Fasciitis, Right Foot with Pes Planus; Plantar Fasciitis, Left Foot with Pes Planus; Bronchitis With Obstructive Pulmonary Disease; and Left Ulnar Nerve Entrapment) 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 for Correction of Naval Records (BCNR) 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** |
| Left Knee Instability, Status Post Two Failed ACL Reconstructive Surgeries | 5257 | 20% |
| Left Knee Cartilage, Semilunar, Removal of, Symptomatic | 5259 | 10% |
| **COMBINED** | **30%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20091116, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

Deputy Director Physical Disability Board of Review

MEMORANDUM FOR DEPUTY COMMANDANT, MANPOWER & RESERVE AFFAIRS

Subj: PHYSICAL DISABILITY BOARD OF REVIEW (PDBR) RECOMMENDATION

Ref: (a) PDBR ltr of 31 Jan 11

(b) DoDI 6040.44

1. I have reviewed reference (a) pursuant to reference (b).

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 30 percent (increased from 20 percent) with placement on the Permanent Disability Retired List effective 30 March 2009.

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)