RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXX BRANCH OF SERVICE: marine corps

CASE NUMBER: PD0900725 SEPARATION DATE: 20021115

BOARD DATE: 20110603

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SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty Sgt (6672, Aviation Supply Clerk) medically separated from the Marine Corps for low back pain (LBP), status post (s/p) fusion at L5-S1. He did not respond adequately to treatment and was unable to perform within his military occupational specialty (MOS) or to meet physical fitness standards. He was placed on limited duty (LIMDU) and underwent a Medical Evaluation Board (MEB). Herniated disc at L5-S1 was forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW NAVPERS 18068F. No other conditions appeared on the MEB’s submission. Other conditions included in the Disability Evaluation System (DES) file will be discussed below. The PEB adjudicated the persistent LBP, s/p L5-S1 fusion, as unfitting, rated 20%, with application of SECNAVINST 1850.4E, DoDI 1332.39 and the Veterans’ Administration Schedule for Rating Disabilities (VASRD), respectively. The CI made no appeals, and was separated with a 20% disability rating.

CI CONTENTION: ‘’All the complications from my back surgery were not considered. My first rating from the VA was 50%. I have very limited feeling in my lower left leg post surgery. I have constant back pain.”

RATING COMPARISON:

|  |  |
| --- | --- |
| **Service IPEB – Dated 20020904** | **VA ( 2 Mo. Post Separation) – All Effective 20021116** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Low Back Pain, s/p Fusion L5-S1 | 5299-5295 | 20% | Fusion L5-S1 | 5293-5292 | 10% | 20030122 |
| Radiculopathy (L) LE | 5293-8520 | 40% | 20030122 |
| ↓No Additional MEB Entries↓ | 0% x 2 / NSC x 1 |
| **TOTAL Combined: 20%** | **TOTAL Combined (*Includes Non-PEB Conditions*): 50%** |

ANALYSIS SUMMARY:

Low Back Condition. The CI injured his low back in April 2000 while playing basketball. The CI was seen by orthopedics in December 2000 due to persistent pain, and was put on LIMDU. Magnetic resonance imaging revealed dessication and narrowing of the disc space at L5-S1 along with a central and paracentral disc protrusion. The CI was referred to neurosurgery in June 2001 and a discogram was positive for concordant pain at L5-S1 with some dye leakage. Due to persistent pain and failed attempts at conservative therapy, the CI underwent L5-S1 spinal fusion on 20 December 2001. The back pain improved after surgery. The CI continued to have occasional left leg pain and began having left foot pain. In February 2002, the CI was referred to the pain management clinic at Bethesda for left foot pain described as, “burning dysthesia following lumbar fusion.” From a technical point, the neurosurgeon considered the operation to be successful, but due to the persistent symptoms, the CI’s inability to deploy, inability to maintain weight standards, and inability to take a physical fitness test, an MEB was initiated. During the MEB exam on 5 June 2002 five months prior to separation the CI still complained of occasional back pain, some pain in his left foot, occasional left leg pain, and left lower leg numbness. The exam revealed motor strength of lower extremities to be 5/5 throughout and “sensory was non-focal”. Deep tendon reflexes (DTRs) were 2/4 bilaterally for patella and ankle.

At the VA compensation and pension (C&P) exam on 22 January 2003 nine weeks after separation the CI complained that his pain was worse than before his surgery. He reported back pain all of the time, left sided numbness from knee down, occasional shooting pain into the left first toe and trouble lifting the left foot while walking. He reported that the back pain increased with walking, and he was unable to lift or bend. The examiner reported that the CI ambulated without difficulty and no limp was detected. Exam of his back revealed some tenderness in the lumbar region, but no tenderness with pressure over the sciatic notch. Straight leg raising on the right caused pain at 80 degrees and left straight leg raising was to 90 degrees with minimal pain. Knee DTRs were 2+ bilaterally and toe-walk was normal bilaterally. The CI was able to heel-walk on the right, but not the left, and his left toes extensor strength was rated at 3/5. There was decreased sense of light touch on the lateral aspect of the left leg into the foot. The examiner reported that flexion was good, but no range of motion (ROM) measurements were recorded. The diagnosis was residuals, lumbar disc s/p surgery and radiculopathy L5-S1 distribution. At the neurological C&P exam on 11 April 2003 five months after separation the CI stated that he had some slow improvement with his left foot drop and no longer had the shooting pain to his left first toe. He reported that he was still unable to work due to residual symptoms of back pain along with left leg numbness and weakness. On this exam it was noted that the CI had a mild left foot drop and had difficulty with heel walking on the left. On motor exam, he had normal muscle bulk/tone and his power was 5/5 in all muscle groups except for the left tibialis anterior which was 5-/5. DTRs were 1+ knee jerks and 2+ ankle jerks. Sensation was decreased to pinprick and temperature on the left in the L5-S1 distribution. An electromyography done during the evaluation was interpreted as a severe left lumbar radiculopathy. The examiner diagnosed a left L5 radiculopathy and determined that it caused a mild to moderate impairment. The VA rated his limitation of motion of the lumbar spine at 10 % (coded 5293-5292) and his left lower extremity radiculopathy at 40% (coded 5293-8520).

The PEB and VA used two different approaches to rating the CI. The PEB rated him under one analogous code 5299-5295 (lumbosacral strain, with muscle spasm on extreme forward bending, loss of lateral spine motion, unilateral, in standing position = 20%) while the VA used two separate codes. The VA rated him using 5293-5292 (intervertebral disc syndrome causing slight limitation of motion = 10%) and 5293-8520 (intervertebral disc syndrome causing a moderately severe paralysis of the sciatic nerve = 40%). There are no service treatment record (STR) entries in the Disability Evaluation System (DES) file after the MEB and prior to separation concerning the back condition or presence of a significant neuropathy. The only mention of a radiculopathy in the STRs is sensory (pain and numbness of the left lower extremity), and there was no evidence that these sensory complaints prevented the CI from performing the duties of his MOS. Although the C&P exam done two months after separation revealed some mild motor weakness of the left foot, the CI ambulated without difficulty and had no limp. The Board felt that there was not enough evidence to rate the radiculopathy separately unfitting at separation. With the presence of some radicular findings, the Board also considered using the 5293 code for intervertebral disc syndrome. Using this code the Board determined the CI met the criteria for a “moderate” rating of 20%. Since this did not affect the CI’s overall rating the Board by precedent did not change the coding. All evidence considered, there is not reasonable doubt in the CI’s favor supporting a change from the PEB’s rating decision for the low back pain condition.

Remaining Conditions. The other condition identified in the DES file was lumbar laminectomy scar. By firm precedent the Board does not recommend separation rating for scars unless their presence imposes a direct limitation on fitness. This condition was not clinically active during the MEB period, did not carry an attached profile, and was not implicated in the non-medical assessment. This condition was reviewed by the action officer and considered by the Board. It was determined that it could not be argued as unfitting and subject to separation rating.

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. In the matter of the LBP condition, the Board unanimously recommends a disability rating of 20%, coded 5299-5295, IAW VASRD 4.71a. In the matter of the scar and IAW VASRD §4.3, the Board unanimously recommends no change in the PEB adjudication. The Board unanimously agrees that there were no other conditions eligible for Board consideration which could be recommended as additionally unfitting for rating at separation.

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

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| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Low Back Pain | 5299-5295 | 20% |
| **COMBINED** | **20%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20091207, 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

Subj: PHYSICAL DISABILITY BOARD OF REVIEW (PDBR) RECOMMENDATION

 ICO XXXXX, FORMER USMC

Ref: (a) DoDI 6040.44

 (b) PDBR ltr dtd 13 Jun 11

 I have reviewed the subject case pursuant to reference (a) and, for the reasons set forth in reference (b), approve the recommendation of the Physical Disability Board of Review 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.

 Assistant General Counsel

 (Manpower & Reserve Affairs)