RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXXX BRANCH OF SERVICE: Marine Corps

CASE NUMBER: PD0900731 SEPARATION DATE: 20080331

BOARD DATE: 20110317

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty Sgt/E-5 (3381, Food Service) medically separated from the Marine Corps in March 2008. The medical basis for separation was anxiety disorder and lower back pain/extremity pain. At his Medical Evaluation Board (MEB), posttraumatic stress disorder (PTSD) and lower back strain were determined to be medically unacceptable and were forwarded to the Physical Evaluation Board (PEB). Additional conditions listed in the Disability Evaluation System (DES) file are discussed below. The PEB changed his primary mental condition to anxiety disorder, determined it to be unfitting, and rated it at 10%. PTSD and sleep disorder were found to be Category II (contributing to the unfitting anxiety disorder). Chronic lower back and extremity pain was also found unfitting and rated at 10%. Three other lower back conditions were found to be Category II. Headaches and ganglion cysts (bilateral) were determined to be Category III (not separately unfitting and not related to the unfitting conditions). The CI accepted the PEB findings and was separated at 20% combined disability using the Veterans Administration Schedule for Rating Disabilities (VASRD) and applicable Navy and DoD regulations.

CI‘s CONTENTION: The CI states, “I was rated 70% by the VA. I feel I should be retired because I have a lot of ailments that hinder my work performance and I could also use base facilities to get extra help when I need it.”

RATING COMPARISON:

|  |  |
| --- | --- |
| **Navy IPEB – dated 20080110** | **VA (~8 mo. Post Separation) – All Effective 20080401** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Anxiety Disorder | 9413 | 10% | PTSD and MDD (also claimed as Sleep Disorder) | 9411 | 50%\* | 20081031 |
| PTSD | Not unfitting | 30% | 20081031 |
| Sleep Disorder |
| Chronic Lower Back and Extremity Pain | 5237 | 10% | Herniated Disc | 5242 | 20% | 20081120 |
| (R)LE Radiculopathy | 8520 | 10% | 20081120 |
| Lumbar Sprain | Not unfitting | No corresponding VA entry |
| L4-5 Disk Bulge |
| L5-S1 Disk Bulge |
| Tension/Migraine Headache | Not unfitting | Migraine Headache | 8100 | 30% | 20081120 |
| Ganglion Cyst (R) & (L) Wrist | Not unfitting  | (R) Wrist Ganglion Cyst | 7819-5215 | 0% | 20081120 |
| (L) Wrist Ganglion Cyst | 7819-5215 | 0% | 20081120 |
| ↓No Additional MEB Entries↓ | Tinnitus | 6260 | 10% | 20081120 |
| Hearing Loss | 6100 | 0% | 20081120 |
| Not Service Connected X 2 | 20081120 |
| **TOTAL Combined: 20%** | **TOTAL Combined (*Includes Non-PEB Conditions*): 70%** |

 \* PTSD Initial Rating 50% 20080401(combined 80%). PTSD decrease 30% effective 20081001 (combined 70%)

ANALYSIS SUMMARY:

Mental Health Condition. The CI entered the Marine Corps in May 2001, and almost immediately began receiving treatment for mental problems including attention deficit/hyperactivity disorder (ADHD), depression and anxiety. During his years of active duty, he was on various medications, but was kept at full duty status the entire time, including deployments. The CI was deployed to Iraq in 2003 and again in 2005. After his 2003 deployment, he denied any symptoms of PTSD. He denied any exposure to significant combat stressors, or difficulty in adjusting to the combat situation. While deployed in 2005, he was seen by the Combat Stress Control Team on several occasions for his ADHD and his anxiety disorder and to have his medication adjusted. During the 2005 deployment, he experienced indirect combat fire including indirect exposure to mortar rounds and improvised explosive devices. The CI stated that he had nightmares and flashbacks related to his combat exposure. Other symptoms included fatigue, insomnia, restlessness, irritability, and muscle tension. The symptoms continued after he returned to the U.S. in August 2005. During a mental health (MH) visit in November 2005, it was felt that his symptoms were consistent with PTSD and his medications were adjusted. By December 2006 his psychiatric symptoms had worsened, despite different medication trials and psychotherapy. By October 2007, the CI’s symptoms now consisted of anxiety, insomnia, irritability, decreased energy, decreased concentration, and fear of crowds. Due to his persistent symptoms, an MEB was initiated.

At the time of his MEB psychological exam in November 2007, the CI reported his medication “only takes the edge off,” but helps control his irritability and anxiety. The CI reported occasional panic-like attacks, described as periods of intense anger, shortness of breath, twitching of the right eye, and light-headedness. He also reported a decrease in frustration tolerance and that he angered quickly. The CI stated that he was concerned about acting on his anger, but he had been able to manage it thus far. The CI denied any hallucinations or significant paranoid ideation. He also denied symptoms of depression, aside from sleep onset insomnia. The CI denied symptoms consistent with mania and had never been suicidal. On mental status exam (MSE) there was no evidence of psychomotor disturbance. His behavior was cooperative, respectful and pleasant. Affect was congruent, appropriate, but anxious. His mood was “frustrated.” Thought processes and thought content were normal. Concentration and memory were intact, and he had good judgment/insight. His impulse control was intact and there were no suicidal or homicidal ideations. The global assessment of functioning (GAF) was 51-60, indicating moderate difficulty in social or occupational functioning. PTSD was found to be medically unacceptable by the MEB and was forwarded to the PEB. The PEB in January 2008 changed the primary MH diagnosis to anxiety disorder. PTSD and sleep disorder were listed as related Category II conditions. The anxiety disorder was found to be mild, and the CI was separated with a 10% disability rating.

The Board carefully reviewed all evidentiary information available. Based upon the CI’s psychological condition at the time of separation, the Board recommends by majority decision (2:1 vote) an initial 50% rating in retroactive compliance with VASRD §4.129. The permanent rating should be based on the CI’s level of functioning six months following separation. A full, comprehensive psychological evaluation was not performed right at the six-month point (1 October 2008), so the Board must use the best evidence available. The CI was seen by VA mental health providers in September 2008. However, the exam with the greatest probative value was the psychological Compensation and Pension (C&P) exam completed on 31 October 2008 (one month after the six-month point).

At that exam, the CI reported persistent problems with anxiety and insomnia despite medications. He was separated from his wife and daughter, lived alone, and was working as a roofer. He stated that his back pain makes the job a struggle and he was trying to find other employment. The CI described intrusive thoughts of his experiences in Iraq occurring on a daily basis. He stated that his memories of Iraq brought on feelings of sadness and fear. His mood appeared to be quite anxious and he demonstrated an increase in physiologic arousal and psychomotor agitation when the discussion turned toward Iraq. The CI indicated that he had been bothered by frequent nightmares, multiple times per week, related to events that occurred in Iraq. He described problems with exaggerated startle response, and, for example, stated that his roofing job had forced him to work near Fort Lee and he had experienced trouble coping with sounds of munitions going off. The CI reported that he had been quite withdrawn socially, and that he described feeling hypervigilant in a variety of social settings. He stated that he found it difficult to discuss his experiences in Iraq in great detail but had been trying to reach out for assistance in recent months. On MSE, it was noted that his affect was sad, and he was tearful during the interview. Mood was reported as anxious and depressed. Thought content was rational. He denied hallucinations or delusions. The CI's insight and judgment were reported as fair and adequate for current safety. The CI reported that he struggled with motivation, in part due to inadequate sleep. The CI reported experiencing fleeting suicidal thoughts but denied intent or plan to hurt himself. The CI was judged to be largely anhedonic and reported that he had difficulty feeling enjoyment from any experiences. The CI was pessimistic regarding his future and stated that he felt “worthless” since leaving the Marine Corps. The CI was diagnosed with PTSD, major depressive disorder, moderate, and his GAF was 55. In conclusion, the examiner felt the CI could tolerate workplace stressors and that his mental health problems could lead to periods of inefficiency, but would not preclude him from working on a consistent basis. The Board determined that, although the CI was generally functioning satisfactorily (with routine behavior, self-care, and conversation normal), his symptoms caused a moderate degree of occupational and social impairment, with occasional decreases in work efficiency and intermittent periods of inability to perform certain tasks. After considerable discussion and due deliberation, the Board determined by majority decision (2:1 vote) that the mental condition (PTSD, with anxiety disorder) should be given a permanent separation rating of 30% IAW VASRD §4.130.

Low Back Pain and Extremity Pain. The CI injured his back in May 2006 while playing basketball. He landed on his buttocks and complained of pain radiating down his right leg. X-rays of the lumbar spine were normal. He was treated with medication, and was referred to physical therapy (PT) in October 2006. Pain medication and PT produced minimal improvement. A magnetic resonance imaging (MRI) in November 2006 showed bulging discs at L4-L5 and L5-S1, but the spinal canal and neural foramina were patent. The impression was lumbar spondylosis. The neurologist felt his problem was mechanical rather than radicular. Computerized tomography (CT) was negative for lumbar disease but did show some asymmetric degeneration in the right sacroiliac (SI) joint. The CI was evaluated by neurosurgery in January 2007 due to the persistent back and right leg pain. During this exam, the CI said that his back pain and leg symptoms were worse with bending, prolonged standing, walking, running, and prolonged sitting. The CI also reported intermittent pain in the right foot. A second lumbar MRI in March 2007 again showed a mild bulge between L4-5 and L5-S1, and some degenerative changes at L5-S1. Plain X-rays of his lumbar spine showed no instability and the CI denied any bowel or bladder dysfunction. The CI underwent another trial of PT for eight weeks, was referred to the pain management clinic, and had epidural steroid injections, a caudal coccyx steroid injection and a right SI joint injection. None of these improved his symptoms. Bone scan and MRI of the pelvis in October 2007 were both normal. In October 2007, the CI underwent a pulse radiofrequency nerve block procedure at L4-L5, which was also unsuccessful in relieving his pain. By November 2007 it was felt that the CI had exhausted all treatment regimens and MEB was initiated. At the time of the MEB on 9 November 2007, the CI required several medications including morphine to help control his pain. The MEB exam revealed that the CI had a slight decrease in muscle strength of his right hamstring and quadriceps. It was also noted that he had a slight decrease in pinprick sensation along the lateral aspect of his right thigh. There was some mild to moderate tenderness in the region of his intragluteal folds but no mention of paravertebral muscle spasm or tenderness. The CI had a negative straight leg raise (SLR) test bilaterally and a normal gait. His deep tendon reflexes were normal for both lower extremities. The examiner reported that the CI was able to flex and extend at the waist without difficulty but no goniometric measurements were documented. His condition was determined to be medically unacceptable and he was diagnosed with lower back strain and bulging discs at L4-L5, L5-S1. The PEB in January 2008 found him unfit for military service. His chronic lower back and extremity pain were rated at 10%. His VA general medical C&P exam was completed on 21 November 2008, almost eight months after separation. The examiner reported no strength or neurological deficits of the extremities or spine. The thoracolumbar range of motion (ROM) is summarized in this table:

|  |  |
| --- | --- |
| Thoracolumbar | Separation Date: 20080331 |
| Goniometric ROM | VA C&P - 20081120 |
| Flexion (90⁰normal) | 90⁰ |
| Combined (240⁰ normal) | 230⁰ |
| Comments | pain began at ROM endpoints |
| VASRD §4.71a Rating  | 10%, based on painful motion |

There was no reported additional loss of motion on repetition. A MRI on 13 June 2008 showed mild degenerative disc disease at L5-S1 with mild disc bulging, mild facet arthropathy at L4-L5 and L5-S1, but no spinal stenosis or neural foraminal narrowing throughout the lumbar spine. The diagnosis was herniated disc, degenerative disc disease and degenerative joint disease of the lumbosacral spine.

Although the CI had subjective right foot complaints and some slight decrease in sensation in the right leg, there was no evidence that these radicular symptoms prevented the CI from performing his duties at the time of separation. All evidence considered, the Board cannot find sufficient evidence to support recommending lumbar radiculopathy as additionally unfitting for separation. There is not reasonable doubt in the CI’s favor therefore to justify a Board recommendation for other than the 10% rating assigned by the PEB for the chronic lower back and extremity pain condition.

Other PEB Conditions. The Navy PEB had determined that PTSD was Category II (related to one of the unfitting conditions). The Navy PEB also determined that sleep disorder, lumbar sprain, L4-L5 disc bulge, and L5-S1 disc bulge were all Category II (related to one of the unfitting conditions). The PEB also found that headaches and ganglion cysts (of both wrists) were Category III (not separately unfitting, and not contributing to either of the unfitting conditions). All evidence considered, the Board cannot find sufficient evidence to support recommending any of these other six PEB conditions as additionally unfitting for separation.

Remaining Conditions. Pes planus and knee pain were also mentioned in the Disability Evaluation System (DES) file. Several additional conditions were also documented. None of these other conditions were implicated in the commander’s statement. These conditions were reviewed by the action officer and considered by the Board. It was determined that none could 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 mental condition (PTSD, with anxiety disorder), the Board by majority decision (2:1 vote) recommends an initial Temporary Disability Retired List (TDRL) rating of 50% in retroactive compliance with VASRD §4.129, as directed by DoD. The Board by majority decision (2:1 vote) recommends a permanent rating of 30% at six months following separation IAW VASRD §4.130. The single voter for dissent (who recommended no re-characterization of the PEB adjudication) has elected not to submit a minority opinion. In the matter of the lower back condition (back pain and leg pain), the Board unanimously recommends a rating of 10% (coded 5237) IAW VASRD §4.71a. In the matter of the headaches, ganglion cysts, pes planus, knee pain, and any other medical conditions eligible for Board consideration, the Board unanimously agrees that it cannot recommend any findings of unfit for additional rating at separation.

RECOMMENDATION: The Board recommends that the CI’s prior separation be re-characterized to reflect that, rather than discharge with severance pay, the CI was placed on the TDRL at 60% for a period of six months (IAW §4.129 and DoD direction) and then permanently retired by reason of physical disability with a final 40% rating as indicated below.

|  |  |  |  |
| --- | --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **TDRL RATING** | **PERMANENT****RATING** |
| PTSD with Anxiety Disorder | 9411-9413 | 50% | 30**%** |
| Low Back Pain with radiation to Right Leg | 5237 | 10% | 10% |
| **COMBINED** | **60%** | **40%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294 dated 20091216, 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

 ICO XXXXXX, FORMER USMC, XXX XX XXXXX

Ref: (a) DoDI 6040.44

1. I have reviewed the subject case pursuant to reference (a). The subject member’s official records are to be corrected to reflect the following retroactive disposition:

 a. Separation from the naval service due to physical disability with placement on the Temporary Disability Retired List with a disability rating of 60% for the period 31 March 2008 thru 30 September 2008.

 b. Final separation from naval service due to physical disability effective 1 October 2008 with a disability rating of 40% and placement on the Permanent Disability Retired List.

2. 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)