RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXX BRANCH OF SERVICE: Marine corpS

CASE NUMBER: PD1000109 SEPARATION DATE: 20060426

BOARD DATE: 20110407

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty SSgt. (0369, Platoon Sergeant) medically separated from the Marine Corps in 2006 after 13 years of service. The medical basis for the separation was degenerative lumbar intervertebral disc disease (DDD) and herniated nucleus pulposus (HNP) without myelopathy. The CI was diagnosed with the DDD since 1996. The CI had undergone and failed anti-inflammatory medication, extensive physical therapy (PT), activity modification and spinal injections. Despite being placed on limited duty (LIMDU) for six months, the CI was unable to perform within his military occupational specialty and was referred to a Medical Evaluation Board (MEB). The MEB forwarded lumbar DDD and HNP without myelopathy to the Physical Evaluation Board (PEB). The PEB adjudicated degenerative lumbar intervertebral disc as unfitting, rated 10%, with probable application of SECNAVINST 1850.4e and DoDI 13329.39 Section E2.A1.5. The PEB adjudicated the HNP without myelopathy as Category 2 (conditions that contribute to the unfitting condition). The CI did not appeal, and was medically separated with a 10% combined disability rating.

CI CONTENTION: The CI states “There have been changes in the rating system. I feel I should have been rated higher than I got.”

RATING COMPARISON:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Service IPEB – Dated 20060112** | | | | **VA (8 Mo. After Separation) – All Effective Date 20060429** | | | |
| **Condition** | | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Degenerative Lumbar Intervertebral Disc | | 5242 | 10% | DDD w/ HNP L5-S1, … | 5243 | 10% | 20061207 |
| - | HNP w/o Myelopathy | Category 2 | | Urinary Incontinence a/w DDD w/ HNP | 7599-7542 | 40% | 20061207 |
| Radiculopathy, LLE a/w DDD w/HNP L5-S1 … | 8620 | 10% | 20061207 |
| ↓No Additional MEB/PEB Entries↓ | | | | Tinnitus | 6260 | 10% | 20061206 |
| 0% x 5 / Not Service Connected x 3 | | | 20061207 |
| **Combined: 10%** | | | | **Combined: 60%** | | | |

ANALYSIS SUMMARY:

Lumbar DDD with HNP Condition. The CI had two goniometric range of motion (ROM) evaluations in evidence which the Board weighed in arriving at its rating recommendation. Both exams are summarized in the chart on the next page.

|  |  |  |
| --- | --- | --- |
| Goniometric ROM - Thoracolumbar | NARSUM w/ PT  ~ 5 Mo. Pre-Sep | VA C&P  ~ 8 Mo. After-Sep |
| Flex (0-90) | 80⁰ | 80⁰ |
| Ext (0-30) | 20⁰ | 20⁰ |
| R Lat Flex (0-30) | 25⁰ | 30⁰ |
| L Lat Flex 0-30) | 30⁰ | 30⁰ |
| R Rotation (0-30) | 30⁰ | 30⁰ |
| L Rotation (0-30) | 30⁰ | 20⁰ |
| COMBINED (240) | 215⁰ | 210⁰ |
| Comment | Mild TTP lower lumbar; -SLR; sensory/reflexes wnl; LLE motor 4+/5+ | Gait wnl; TTP; +L SLR; L5 & S1 sensory deficit of dorsal and lateral foot |
| §4.71a Rating | 10% | 10% |

The MEB exam four months prior to separation indicated that the CI had pain that radiated down the left side of his back to his left leg. The CI complained of sharp, throbbing pain usually 6/10 with 10 being the worst. The pain was aggravated by bending, carrying heavy objects, lying on his stomach, prolonged sitting, running, riding in a vehicle, wearing a backpack and kevlar. The examiner documented the CI had complaints of back pain, stiffness, weakness, giving way, locking, left buttock pain, left leg weakness, night sweats, and change in urinary function and loss of bladder control. The examiner documented that analgesics only provided temporary relief and the CI failed anti-inflammatory medication, PT, activity modification, and injection. The CI’s magnetic resonance imaging was not available at the time of the MEB exam; however, it was noted that previous radiology reports indicated a HNP and DDD at L5-S1. The examiner opined the CI’s condition interfered with his reasonable performance of his duties. In the VA compensation & pension (C&P) exam on 7 December 2006, eight months after separation, the examiner documented that the CI had constant, localized pain at 10 being the worst, elicited by physical activity and relieved by medication, muscle relaxers and steroid injections. The CI was noted to have a functional impairment as the inability to bend over with the joint function of the spine being additionally limited by pain, lack of endurance after repetitive use. Additionally, the CI was found to have thoracolumbar spine tenderness and positive straight leg raising on the left leg. The test is positive if pain in the sciatic distribution is reproduced between 30 and 70 degrees passive flexion of the straight leg. There was decreased sensory functioning in the left lower extremity. The Board noted the CI’s condition had significantly worsened by his later VA evaluations with increased VA rating at approximately 29 months post-separation.

The PEB and VA chose different coding options but this did not significantly impact the rating as noted above. The general rating formula for diseases and injuries of the spine considers the CI’s pain symptoms, “With or without symptoms such as pain (whether or not it radiates), stiffness, or aching in the area of the spine affected by residuals of injury or disease.” All exams proximate to separation met the 10% rating criteria for either forward flexion of the thoracolumbar spine greater than 60 degrees but not greater than 85 degrees or combined ROM of the thoracolumbar spine greater than 120 degrees but not greater than 235 degrees. Although the CI had localized tenderness, there is no documentation of abnormal gait, muscle spasms or guarding for the higher rating. After due deliberation and all evidence considered, 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 lumbar DDD with HNP.

Left Leg Radiculopathy Condition. The narrative summary (NARSUM) and Disability Evaluation System (DES) package indicate that the CI had radiation of pain into his left leg with paresthesias. The pain component of a radiculopathy is subsumed under the general spine rating as specified in §4.71a, as discussed above. There was no fixed motor impairment. The VA noted L5 sensory deficit of left dorsal foot and S1 sensory deficit of left lateral foot; the sensory component in this case was either intermittent or relatively minor and cannot be linked to significant physical impairment. Since no evidence of functional impairment exists in this case, the Board cannot support a recommendation for additional rating based on peripheral nerve impairment.

Urinary Incontinence Associated with DDD w/HNP Condition. The NARSUM examiner noted that the CI had symptoms of a change in urinary function and loss of bladder control. This complaint was also noted on the MEB history and physical exam with “at times (*unkn*) has no control of urine leakage. Started 4-5 mos ago. Not a dribble, enough to dampen underwear.” However, there was no expanding on the CI’s symptoms, no genitourinary or rectal exam performed, and no follow-up objective testing. There were no clinic visits for this condition and no medical treatments had been considered. This condition had never led to a LIMDU or light duty period, and was not commented upon in the commander’s statement. The Board considered the VA C&P examination eight months post-separation. The VA examiner noted that the history from the CI of “urinated two times during the day at intervals of four hours and during the night he urinated two times at intervals of four hours, with urinary incontinence which required a pad as often as four times per day.” The examiner stated, “There is no functional impairment resulting from the above condition.” The VA rated this condition 7599-7542 (neurogenic bladder-rate as voiding dysfunction) at 40%. There was no evidence for concluding that any urinary symptom or condition interfered with duty performance to a degree that could be argued as unfitting at the time of separation. All evidence considered, there is not reasonable doubt in the CI’s favor supporting addition of urinary incontinence associated with his back condition as an unfitting condition for additional separation rating.

Remaining Conditions. No other conditions were noted in the NARSUM, identified by the CI on the MEB physical or found elsewhere in the DES file. The Board does not have the authority under DoDI 6040.44 to render fitness or rating recommendations for any conditions not considered by the DES. The Board therefore has no reasonable basis for recommending any additional unfitting conditions for 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 VA Schedule for Rating Disabilities (VASRD) in effect at the time of the adjudication. In the matter of Lumbar DDD condition, the Board unanimously agrees that it recommends no change in the PEB adjudication of unfitting at 10%. In the matter of the left leg radiculopathy, urinary incontinence conditions or 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 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** |
| Degenerative Lumbar Intervertebral Disc w/Herniated Nucleus Pulposus | 5242 | 10% |
| **COMBINED** | **10%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20100101, 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, XXX XX XXXX

Ref: (a) DoDI 6040.44

(b) PDBR ltr dtd 19 Apr 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)