RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXXX BRANCH OF SERVICE: NAVY

CASE NUMBER: PD1000665 SEPARATION DATE: 20050531

BOARD DATE: 20100713

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SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active Petty Officer, Second Class/E-5 (ET2, Electronic Technician Second Class) medically separated from the Navy in 2005 for chondromalacia talus (left ankle). He did not respond adequately to treatment and was unable to perform within his military occupational specialty or meet physical fitness standards. Chondromalacia talus (left), and lumbago (musculoskeletal low back pain – exacerbated by altered gait from chronic ankle pain), were forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW SECNAVINST 1850.4E. Other conditions included in the Disability Evaluation System (DES) packet will be discussed below. The PEB adjudicated the chondromalacia talus condition as unfitting, rated 10%, with application of SECNAVINST 1850.4E, and Veterans’ Administration Schedule for Rating Disabilities (VASRD). The chronic back pain condition was determined to be category III (conditions that are not separately unfitting and do not contribute to the unfitting conditions). The CI made no appeals, and was then medically separated with a 10% combined disability rating.

CI CONTENTION: “I am continually having problems with both my back and feet. It is difficult for me to take part in daily activities in which I once enjoyed (running, hiking, etc). I also have difficulties standing/walking for prolong periods of time, with lifting items, which makes working conditions difficult for me. I am in constant pain. I have to take medication now to be able to sleep through the night without being awaked from back pain. I am now also having problems with chronic sinusitis, which is being caused by a deviated septum caused by an incident dating July 2003. Furthermore, the sinusitis is also affecting my sleep apnea. I also have headaches on a almost daily basis. I also have been recently seeing a mental health specialist lately an in an effort to better my physical health many time, only to see what little progress that I make go away with the onset of back and ankle pain lead me back into depression. I have also had to take several weeks off of work to rest as the pain the level of pain that I was experiencing was making working nearly impossible. During that time I was taking ibuprofen up to 2400mg at a time to be able to make it through a workday.”

RATING COMPARISON:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Service IPEB – Dated 20050321** | | | **VA (18 Mo. After Separation) – All Effective Date 20050601** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Chondromalacia Talus (Left) | 5299-5003 | 10% | (L) Ankle Degenerative Arthritis Talonavicular and Talotibial Joint | 5003-5271 | 20% | 20061117 |
| Low Back Pain | Cat III | | Chronic Low Back Pain with Degenerative Disk at L4-5-S1 | 5242 | 10% | 20061117 |
| ↓No Additional MEB/PEB Entries↓ | | | Headaches | 8199-8100 | 10% | 20061117 |
| Depression | 9434 | 10% | 20061106 |
| 0% x 1/Not Service Connected x 3 | | | 20061118 |
| **Combined: 10%** | | | **Combined: 40%** | | | |

ANALYSIS SUMMARY: The Board acknowledges the sentiment expressed in the CI’s application regarding the significant impact that his service-incurred conditions have had on his quality of life. However, the military services, by law, can only rate and compensate for those conditions that were found unfitting for continued military service based on the severity of the condition at the time of separation and not based on possible future changes. The VA, however, can rate and compensate all service connected conditions without regard to their impact on performance of military duties, including conditions developing after separation that are direct complications of a service connected condition. The VA can also increase or decrease ratings based on the changing severity of each condition over time. The Board’s role is confined to the review of medical records and all evidence at hand to assess the fairness of PEB rating determinations, compared to VASRD standards, based on severity at the time of separation. It must also judge the fairness of PEB fitness adjudications based on the fitness consequences of conditions as they existed at the time of separation. The Board’s threshold for countering DES fitness determinations is higher than the VASRD §4.3 reasonable doubt standard used for its rating recommendations; but, remains adherent to the DoDI 6040.44 “fair and equitable” standard.

Chondromalacia Talus (Left). The CI sustained left ankle sprains in November 2003. Left ankle pain persisted despite standard treatment. Further evaluation by imaging (x-ray, bone scan, magnetic resonance imaging[MRI]) disclosed mild degenerative changes of the talus (ankle bone) at the articulations with the navicular bone (just in front of the talus; talo-navicular joint) and tibia (the long leg bone on the inside of the ankle, the talo-tibial joint). At the time of the narrative summary (NARSUM) on December 23, 2004, the CI reported pain with extended walking, running, and jumping. There was none-to-minimal pain at rest, and no swelling. On examination of the left ankle, there was tenderness along the joint line at the affected areas shown on imaging. The CI stopped after two attempts at hopping on the left leg. There was no swelling or joint instability, and gait was normal. Range of motion (ROM) testing showed left ankle dorsiflexion of 10° (normal 20°) and plantar flexion of 35° (normal 45°). Inversion (left 30°; right 25°) and eversion (left 30°; right 25°) of both ankles was normal. While dorsiflexion of the left ankle appeared to be moderately decreased, dorsiflexion of the uninjured right ankle was less at 5° (right ankle plantar flexion was fully normal at 45°). The apparent symmetric decrease in dorsiflexion of both ankles discordant for injury is likely the result of relatively tight Achilles tendons. However, the normal gait indicates there is fully functional ankle dorsiflexion with ambulation. At the time of VA compensation and pension (C&P) examination of the ankles, 18 months after separation, the CI complained of similar pain with use. ROM was similar showing symmetric restriction of dorsiflexion of both ankles (left 7°; right 8°) with full plantar flexion (left 55°; right 60°). Gait was also recorded as normal, also reflective of functional dorsiflexion with ambulation. VASRD rating guidance for ankle conditions bases ratings on limitation of motion as moderate or marked. Board members agreed the preponderance of evidence indicated that the CI’s ankle condition and ROM findings were no worse than moderate warranting a 10% rating (5271). Consideration for rating under 5284 (other foot injuries), or 5003 (degenerative arthritis) similarly would not result in a rating higher than 10% (moderate). All evidence considered, there is not reasonable doubt in the CI’s favor supporting a change from the PEB’s rating decision for the left ankle condition.

Other PEB Conditions. Musculoskeletal low back pain, exacerbated by altered gait from chronic ankle pain was forwarded by the MEB and adjudicated as not unfitting by the PEB. The CI had a history of intermittent low back pain since prior to entry into active military service. Service treatment records reflected intermittent medical care for acute low back pain, often without specific injury (in 2001 had low back pain after a mountain bike fall). In December 2003 he was seen a few times for low back pain. On December 23, 2003, he presented for complaint of increased symptoms the night before that interfered with sleep. There was no report of injury or strain. On examination, his gait was antalgic (not specified whether due to back pain or the recent ankle injury), and forward flexion was decreased to 45°. An MRI scan in February 2004 documented degenerative disc disease with bulging discs at L4-5 and L5-S1, without nerve root impingement. Physical examinations documented no findings of radiculopathy. The limited duty dated April 5, 2004 lists chronic low back pain as well as chronic left ankle pain recommending restrictions including no lifting more than 30 pounds while the CI underwent physical therapy. A physical therapy clinic record entry on May 21, 2004 recorded the CI’s complaint that he couldn’t lift weights, and experienced pain with bending over to pick things up. The pain was not constant with infrequent sharp pain. The physical therapist indicated the CI was non-compliant with the therapeutic exercise program. On examination, the physical therapist recorded absence of tenderness and full flexion and extension without pain, indicating improvement since the December 23, 2003 encounter. There was mild pain with lateral shifting of the spine in both directions. Straight leg raise test for nerve root irritation was negative. An appointment log shows various recurring appointments with physical therapy, orthopedics, and sports medicine in 2004 approximately once per month into January 2005. These records were not in case file; however, a December 15, 2004 physical therapy encounter addresses only the ankle condition and makes no reference to back pain. The physical therapist opined the ankle was unlikely to improve and recommended separation on the basis of ankle. The NARSUM, December 23, 2004, discusses limitations due to the ankle condition but provides no discussion regarding limitations due to back pain. On examination the gait was normal, reflexes intact and straight leg tension testing for nerve root irritation negative. Thoracolumbar flexion was 90°, extension 35° with mild pain, left and right rotation 70° each side, and, left and right lateral bending 35° each side. The absence of clinical attention to the back by December 2004 accompanied by improved range of motion indicates improvement in symptoms. The commander’s assessment on January 31, 2005 makes no specific remarks with regard to the back or the ankle. The MEB history and physical examination documented a history of episodic low back pain with radiation into the right leg. The examiner indicated “NCD” for not considered disqualifying. At the time of a VA primary care clinic appointment, five months after separation (October 28, 2005), the clinician wrote, “Uses Motrin for chronic low back pain and foot pain L>R. Motrin couple of times weekly relieves pain…Back pain occ wakes him up from sleep. Taking Motrin before bed prevents this.” On examination, strength and reflexes were intact, and “walking ok today.” At the time of VA spine C&P examination, 18 months after separation, the CI complained of daily intermittent low back pain. He was able to walk several miles non-stop but wore a brace when at work (employed as field service technician; repair and install equipment). Physical examination was similar to the NARSUM examination showing normal thoracolumbar ROM (flexion 90°, extension 30°, rotation 30° each side, lateral bending 30° each side, with no additional functional impairment with repetition), no tenderness, muscle spasm, or abnormal contour. The low back condition was reviewed by the action officer and considered by the Board; there was no indication that this condition significantly interfered with the performance of MOS duty requirements. After due deliberation and in consideration of the totality of the evidence, there is not reasonable doubt in the CI’s favor supporting re-characterization of the PEB fitness adjudication for the back condition.

Remaining Conditions. Other conditions identified in the DES file were decreased internal rotation of the right hip, occasional left shoulder / arm pain / numbness, head injury at age 14 with amnesia and memory loss. Several additional non-acute conditions or medical complaints were also documented. 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. Additionally muscle contraction headaches claimed as post-concussion headaches/migraines, depression also claimed as anxiety, anger and memory loss due to head trauma concussion, and several other non-acute conditions were noted in the VA rating decision proximal to separation, but were not documented in the DES file. At the time of the MEB history and physical examination, the CI checked “no” to frequent or severe headaches, dizziness, depression or excessive worry. Obstructive sleep apnea was diagnosed after separation. 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 VASRD in effect at the time of the adjudication. In the matter of the chondromalacia talus (left ankle) condition and IAW VASRD §4.71a, the Board unanimously recommends no change in the PEB adjudication at separation. In the matter of low back pain condition 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 re-characterization of the CI’s disability and separation determination, as follows:

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| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Chondromalacia Talus (left) | 5299-5003 | 10% |
| **COMBINED** | **10%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20100602 w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

President

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 XXXXXXX, FORMER USN, XXX-XX-XXXX

Ref: (a) DoDI 6040.44

(b) PDBR ltr dtd 23 Aug 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)