RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXX BRANCH OF SERVICE: NAVY

CASE NUMBER: PD1000909 SEPARATION DATE: 20011214

BOARD DATE: 20111212

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty Seaman/E3 medically separated from the Navy for a left ankle condition. The left ankle was fractured in a crush injury, which was complicated by lower leg and foot compartment syndromes and skin infections. He was managed with external fixation, open reduction and internal fixation, debridement, skin grafting, physical therapy and two periods of limited duty. He did not respond adequately to perform within his rating or participate in a physical fitness test and underwent a Medical Evaluation Board (MEB). “Left closed bimalleolar fracture complicated w/compartment syndrome status post open reduction and internal fixation and fasiotomies and left ankle pain most likely secondary to post-traumatic early arthritic” was forwarded to the Physical Evaluation Board (PEB) as medically unacceptable on NAVMED Form 6100/1. Additional conditions supported in the Disability Evaluation System (DES) file are discussed below, but were not forwarded for PEB adjudication. The Informal PEB (IPEB) adjudicated the left ankle pain condition as unfitting, rated 10% with likely application of SECNAVINST 1850.4E. The other diagnosis was adjudicated as Category II (conditions that are contributing to the unfitting condition). The CI made no appeals, and was then medically separated with a 10% combined disability rating.

CI CONTENTION: The CI states: “Injured ankle has deteriorated over time. Increased pain and swelling with decreased elasticity and movement”.

RATING COMPARISON:

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| --- | --- | --- | --- | --- | --- | --- |
| **Service IPEB – Dated 20010723** | | | **VA ( 6 Mo. Pre-Separation) – All Effective 20011215** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Left Ankle Pain | 5299-5003 | 10% | L. Ankle Sprain, DJD, Bimalleolar Fx | 5010-5271 | 20% | 20010625 |
| Ankle Fx / Compartment Syn. | | Cat II | L. Leg & Lateral Foot Fasciotomy Scars | 7800 | 10% | 20010625 |
| L. Leg & Foot Mixed … Neuropathy | 8522-8523 | 10% | 20010625 |
| L. Lower Ext. & Foot Circulatory … | 7121 | 40% | 20010625 |
| ↓No Additional MEB Entries↓ | | | Acne Rosacea | 7899-7806 | 10% | 20010625 |
| 0% x 1/Not Service Connected x 0 | | | 20010625 |
| **Combined: 10%** | | | **Combined: 70%** | | | |

ANALYSIS SUMMARY: The Board acknowledges the sentiment expressed in the CI’s application i.e., that the gravity of his condition and predictable consequences which merit consideration for a higher separation rating. It is a fact, however, that the DES has neither the role nor the authority to compensate service members for anticipated future severity or potential complications of conditions resulting in medical separation. This role and authority is granted by Congress to the Department of Veterans’ Affairs (DVA). The Board utilizes VA evidence proximal to separation in arriving at its recommendations; and, DoDI 6040.44 defines a 12-month interval for special consideration to post-separation evidence. The Board’s authority as defined in DoDI 6044.40, however, resides in evaluating the fairness of DES fitness determinations and rating decisions for disability at the time of separation. Post-separation evidence therefore is probative only to the extent that it reasonably reflects the disability and fitness implications at the time of separation.

Left Ankle Condition. The CI sustained a left ankle crush injury, with fractures of both sides of his left ankle (bimalleolar fractures). He was initially seen in the emergency room, splinted and referred to orthopedics. Overnight he suffered with excruciating leg and foot pain, swelling, and numbness of the lower leg and foot. He was urgently taken to the operating room to definitively care for compartment syndromes of his left leg and foot including opening the calf compartments. An external fixator was applied to reduce the bimalleolar fractures. The CI had several skin infections of the left lower leg and required several skin grafts. The malleolar fractures did not heal and he required ankle surgery (open reduction, internal fixation [ORIF]) to repair the fractures. Imaging and exams indicated there was likely nonunion of the medial malleolar fracture. The CI continued to have pain, numbness, infections and limited mobility of the left ankle and foot impairing his ability to perform his military duties.

There were two goniometric range-of-motion (ROM) evaluations in evidence for the left ankle condition, which the Board weighed in arriving at its rating recommendation. These exams are summarized in the chart below.

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| Goniometric ROM –  Left Ankle | NARSUM 7 Mo Pre-Sep | VA C&P-6 Mo Pre-Sep |
| Dorsiflexion (0-20) | 10⁰ | 3⁰ |
| Plantar Flexion (0-45) | 40⁰ | 10⁰ |
| Comment | Pain; likely nonunion; -5/5 motor; normal sensory; normal pulses; good capillary refill | Pain; calf atrophy; normal gait; unable to squat or toe walk; spot hypoesthesia; cool toes; no arterial pulses; likely nonunion; neurovascular compromise of foot and skin(scar) of leg; stasis dermatitis |
| §4.71a Rating\* | 20% | 10-30% |
| §4.124a Rating\* | 10% | 20-30% |

\* Ratings may overlap and are not independent

The MEB narrative summary (NARSUM) seven months prior to separation indicated the CI had diffuse ankle pain worse with changes in weather and high impact activity. He had recuperated from all his surgeries with progressive increase in strength and ROM. The exam of the left ankle demonstrated well-healed wounds with no areas of erythema, drainage or cellulitic (skin infection) changes. There was point tenderness over the inner ankle (medial malleolus), but showed no tenderness over his heel bone (sinus tarsi) area. There was limited sub-talar motion and motor functioning tests showed slight (-5/5) decrease in strength in some muscle groups. There was no tenderness to palpation over his calf area or tendons. There was normal light touch over the deep and superficial peroneal sensory nerve distribution as well as his plantar sensory distribution. The patient showed brisk capillary refill and 2+ dorsalis pedis pulses. Radiographs completed three months prior to the MEB revealed mild, diffuse osteopenia (thinned bone), normal hardware, and medial malleolus abnormality that was consistent with nonunion of the medial malleolus (tibia) confirmed by bone scan.

The VA compensation & pension (C&P), one month after the NARSUM and six months pre-separation, indicated the CI complained of left ankle pain, cracking and popping. He could not run and had limitation of walking with resultant ankle swelling. The CI’s gait was normal, but he was unable to squat or walk on his toes. There was stasis dermatitis around the ankle and foot. There was left calf atrophy and the examiner opined that “this may be from disuse.” The foot exam demonstrated a mixed nerve hypoesthesia (decreased sensation). The temperature of the toes was decreased, and arterial exam was difficult and deemed nonpalpable (no pulse felt). The motor strength of the foot was normal. The examiner specifically stated the CI could not work in law enforcement, fire fighting, or construction work. Radiographs demonstrated normal hardware in place, soft tissue swelling; two avulsion bone fragments distal to the medial malleolus and avulsion fragment distal to the lateral malleolus. No ligamentous laxity was identified on inversion or eversion stress images.

The Board first deliberated on the disparate exams of the MEB and the VA C&P in regards to ROM, vascular, neurologic and skin findings. When comparing the findings of these exams with the service treatment records there were inconsistencies with both exams. The MEB’s slightly limited ROM and normal arterial vascular exam is more consistent with the STR. The C&P’s neurologic findings, venous vascular exam and skin findings are more consistent with the STR. The Board’s recommendation must incorporate a probative value judgment between the disparate evidence from the Service file and the VA’s C&P examination. The probative value judgment has to acknowledge a normal tendency to maximize symptoms in the context of VA rating evaluations with their attendant secondary gain pressure; but, the Board concedes the validity of all evidence unless contradicting evidence can be cited. Both exams were accomplished in the same timeframe, and the VA exam was the single exam indicating any abnormality to the lower extremity artery and limitation to ROM to more than a slight to moderate range. The Board adjudged that the MEB and VA exams had the equivalent probative value for separation rating.

The Board must also consider if the PEB Category II (ORIF and fasciotomy) condition is separately, or in combination, unfitting when combined with the primary unfitting condition to the extent that they are separately ratable. While ankle fracture was the initial event leading to chronic ankle pain, the compartment syndromes of the lower leg and foot with sequlae of surgeries, infections and grafting lead to some sensory deficits of the lower leg and foot. The Board specifically avoided pyramiding in considering pain with ROM of the ankle and foot and deliberated if the pain and cutaneous sensory loss secondary to a neurologic disorder were to the level of being unfitting. There was no indication that scars or skin conditions were to the level of impairing duty performance. Board precedent is that a functional impairment tied to fitness is required to support a recommendation for addition of a peripheral nerve rating at separation. The sensory component in this case has no functional implications. The motor impairment 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 separate rating based on peripheral nerve impairment; however, the entire disability picture of the ankle/foot/calf was considered in rating. All evidence considered, there is not reasonable doubt in the CI’s favor supporting recharacterization of the PEB fitness adjudication for the compartment syndrome S/P ORIF condition, or addition of any neurologic or skin unfitting condition.

The Board considered several different options for analogous coding to include 5003 (arthritis, degenerative), 5271 (ankle, limited motion of), 5284 (foot injuries, other), and 5262 (tibia and fibula, impairment of, ankle). After due deliberation, the Board concluded that the preponderance of the evidence with regard to the functional impairment of the left ankle and lower extremity conditions should be combined into a single analogous code of 5010-5262 with consideration of VASRD §4.40 (functional loss) and combining all disability aspects of the CI’s left ankle and lower extremity with medial malleolus (tibial) likely nonunion. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board majority adjudged that the CI’s overall left ankle/leg disability picture was closest to the 30% (marked) criteria of 5010-5262.

Remaining Conditions. Other conditions identified in the DES file were venous insufficiency of the lower legs. Several additional non-acute conditions or medical complaints were also documented. None of these conditions were significantly clinically or occupationally active during the MEB period, none carried attached profiles, and none were specifically implicated in the non-medical assessment 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 additional separation rating. Additionally arterial insufficiency, left medial calf scar, acne rosacea and several other non-acute conditions were noted in the VA rating decision proximal to separation, but were not documented in the DES file. Also, by precedent, the Board does not recommend separation rating for scars unless their presence imposes a direct limitation on fitness. 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. The Board did not surmise from the record or PEB ruling in this case that any prerogatives outside the VASRD were exercised. In the matter of the left ankle condition and compartment syndrome and all left lower extremity disability, the Board recommended coding of 5010-5262 and by a vote of 2:1 recommends a rating of 30% IAW VASRD §4.71a. The single voter for dissent (who recommended a 20% rating) submitted the addended minority opinion. In the matter of the compartment syndrome condition, the Board unanimously recommends no recharacterization of the PEB adjudication as no separate rating. In the matter of the left lower leg neurologic deficits, scars, and venous insufficiency conditions or any other medical conditions eligible for Board consideration; the Board unanimously agrees that it cannot recommend any findings of unfit for separate additional rating at separation.

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.

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| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Lt Ankle Sprain, DJD, Bimalleolar Fracture/Nonunion | 5010-5262 | 30% |
| **COMBINED** | **30%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294 dated 20100722, w/atchs

Exhibit B. Service Treatment Record

Exhibit C. Department of Veterans' Affairs Treatment Record

President Physical Disability Board of Review

MINORITY OPINION:

I agree with the majority that the preponderance of the evidence with regard to the functional impairment of the left ankle and foot conditions should be combined into a single analogous code. But it is a subjective judgment whether the disability should be characterized as moderate (20%) or marked (30%). Based on the evidence and my past experience at rating similar conditions, keeping in mind the 40% amputation rule as the maximum rating available for total amputation below the knee, I would submit that the CI’s overall disability picture is accurately and appropriately coded analogously to 5010-5262, and characterized as moderate ankle disability rated at 20%. The CI’s gait was normal, the ankle ROMs were in the slight to moderate range, and there were no indications of instability. This rating is also more in line with the VA ankle rating of 20%. As previously addressed above, I agree with the majority that there is not reasonable doubt in the CI’s favor supporting recharacterization of the PEB fitness adjudication for the compartment syndrome S/P ORIF condition, or addition of any neurologic or skin unfitting condition.

RECOMMENDATION: The minority voter respectfully recommends that the CI’s prior determination be modified as follows, effective as of the date of his prior medical separation:

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| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Lt Ankle Sprain, DJD, Bimalleolar Fracture/Nonunion | 5010-5262 | 20% |
| **COMBINED** | **20%** |

MEMORANDUM FOR COMMANDER, NAVY PERSONNEL COMMAND

Subj: PHYSICAL DISABILITY BOARD OF REVIEW (PDBR) RECOMMENDATIONS

Ref: (a) DoDI 6040.44

(b) PDBR ltr dtd 3 Jan 12 ICO XXXXX

1. Pursuant to reference (a) I have reviewed the recommendation of the PDBR set forth in reference (b). For the reasons provided therein, I concur with the opinion of the minority voting member.

2. The official record of the following individual is to be corrected to reflect the stated disposition:

XXXXX, former USN, XXX-XX-XXXX: Separation from the Naval service due to physical disability rated at 20 percent (increased from 10 percent) effective 14 December 2001.

3. Please ensure all necessary actions are taken to implement this decision including notification to the subject member once those actions are completed.

Principal Deputy

Assistant Secretary of the Navy

(Manpower & Reserve Affairs)