RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: MARINE CORPS

CASE NUMBER: PD1100479 SEPARATION DATE: 20061231

BOARD DATE: 20120309

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty member, E-5/Sgt (6462/Aviation Electronics) medically separated for chronic left knee pain. He did not respond adequately to treatment and was unable to perform within his Military Occupational Specialty (MOS) or meet physical fitness standards. He was placed on light duty and underwent a Medical Evaluation Board (MEB). Chronic left knee pain was forwarded to the Physical Evaluation Board (PEB) as medically unacceptable IAW SECNAVINST 1850.4E. Four other conditions, as identified in the rating chart below, were forwarded on the MEB submission as medically acceptable conditions. The PEB adjudicated the chronic left knee pain condition as unfitting, rated 10%, with application of SECNAVINST 1850.4E. The CI made no appeals, and was medically separated with a 10% disability rating.

CI CONTENTION: “I believe that the initial disability rating should be changed from 10% because there were several disabilities noted of my left knee injury, lower back, right hip and altered gait, however, only one was rated at 10%, copy of finding of Physical Evaluation Board Proceedings is included.”

RATING COMPARISON:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Service IPEB – Dated 20061106** | | | **VA (3Mo. After Separation) – All Effective Date 20070101** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Chronic Left Knee Pain | 5299-5003 | 10% | Residuals of Lateral Canthal Ligament Repair, Left Knee | 5261 | 30% | 20070314 |
| S/P Surgical Treatment Left Knee | Cat II |  |
| Altered Gait | Cat II |  |
| Internal Coxa Saltans of the Right Hip | Cat II |  | Tendonitis, Right Hip | 5252-5024 | 10% | 20070314 |
| Mechanical Low Back Pain | Cat III |  | Strain, Lumbar Spine | 5237 | 20% | 20070314 |
| ↓No Additional MEB/PEB Entries↓ | | | Tendonitis, Right Shoulder | 5024-5201 | 20% | 20070314 |
| Limited Extension Right Knee Pain | 5261 | 10% | 20070314 |
| 0% x 2/Not Service Connected x 1 | | | 20070314 |
| **Combined: 10%** | | | **Combined: 70%** | | | |

ANALYSIS SUMMARY: The Disability Evaluation System (DES) is responsible for maintaining a fit and vital fighting force. While the DES considers all of the service member's medical conditions, compensation can only be offered for those medical conditions that cut short a service member’s career, and then only to the degree of severity present at the time of final disposition. However the Department of Veterans’ Affairs (DVA), operating under a different set of laws (Title 38, United States Code), is empowered to compensate all service-connected conditions and to periodically re-evaluate said conditions for the purpose of adjusting the Veteran’s disability rating should the degree of impairment vary 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. Furthermore, a “crystal ball” requirement is not imposed on the service PEB’s by the Board; and, the 12-month window specified in DoDI 6040.44 is appropriate for rating comparisons but not for new developments after separation.

Chronic Left Knee Pain. The CI incurred a sprain of the left knee fibular collateral ligament (also called the lateral collateral ligament) in March 2005 during martial arts training. Persisting pain prompted further evaluation by orthopedic surgery. On examination there was no instability of the knee; however, there was tenderness about the lateral aspect of the knee. Magnetic resonance imaging (MRI) of the left knee two months after the injury demonstrated evidence of a chronic sprain of the left fibular collateral ligament (intact ligament with abnormal signal, abnormal thickening, small effusion). There were no other associated injuries identified by the MRI which demonstrated normal, intact medial collateral ligament, anterior cruciate ligament, posterior cruciate ligament, medial and lateral menisci, articular cartilage, and peri-articular and subchondral bone. An incidentally noted popliteal cyst was present. The orthopedic surgeon diagnosed a grade one sprain (minor sprain) of the fibular collateral ligament. The CI’s knee pain did not improve with non-surgical treatment and he underwent arthroscopic surgery in January 2006 for debridement of scar tissue and plica excision. Post-operatively, the CI continued to experience pain preventing him from running and performing vigorous military duties. A repeat MRI, 11 September 2006, demonstrated that the fibular collateral ligament was normal (without the abnormalities shown in May 2005). There were surgical changes at the posterior aspect of the iliotibial band. There was no effusion and the remaining structures were normal (medial collateral ligament, anterior cruciate ligament, posterior cruciate ligament, medial and lateral menisci, articular cartilage, and periarticular and subchondral bone). There was a small popliteal cyst of no clinical significance. An orthopedic surgery examination on 15 September 2006 documented left knee range-of-motion (ROM) of extension to 0 degrees and flexion to 130 degrees. The left knee was tender to palpation on the lateral aspect. There was no instability. At the time of the MEB narrative summary (NARSUM), dated 25 September 2006, the knee extended to 0 degrees, and flexed to 130 degrees (the NARSUM states “right” knee, however it is assumed to refer to the left knee since it is consistent with contemporaneous examinations and the NARSUM otherwise refers to the left knee). There was no instability. There was tenderness of the fibular collateral ligament and iliotibial band insertion region of the lateral knee. The MEB history and physical examination 19 October 2006 also documented full extension to 0 degrees and flexion to 130 degrees. Physical therapy treatment records documented that the CI did not use assistive device such as a cane or crutch, including after the original injury and after surgery. The PEB concluded the left knee pain was unfitting rated 10%, coded 5299-5003. The initial VA Compensation and Pension (C&P) examination was performed 14 March 2007, three months after separation. The C&P examiner recorded the clinical history inaccurately, writing that the CI had a lateral collateral ligament tear status post open surgical repair (the CI had a sprain and arthroscopic debridement of scar tissue and a plica). On examination, the left knee was diffusely tender, limited in extension by 20 degrees and limited to 105 degrees in flexion. There was no instability. The CI walked with a cane. The VA assigned a 30% rating based solely on the C&P examination reporting 20 degrees of lost extension. Due to the significant differences between the ratings adjudicated by the PEB and VA, the Board carefully considered the whole record in order to develop a consistent picture of the CI’s left knee condition. The marked reduction in the left knee ROM at the time of the post separation C&P examination was not explained by re-injury, and was not consistent with prior examinations or the expected severity based on the known pathology. Following arthroscopic surgery in January 2006, there were twelve ROM examinations. Three examinations showed loss of extension including shortly after surgery (10 degrees loss of extension), and an examination 30 August 2006 that recorded extension at 30 degrees with tight hamstring muscles that was otherwise unexplained and bracketed by examinations showing full extension. The remaining nine examinations documented full extension (0 degrees) and flexion ranging from 110 to 140 degrees. The MEB history and physical examination 19 October 2006 also documented full extension to 0 degrees and flexion to 130 degrees. Upon deliberation the Board agreed in this case that the orthopedics NARSUM examination and outpatient notes were more reflective of the anticipated severity based on the clinical pathology. The Board therefore relied on the MEB and service treatment record (STR) evidence. The MEB NARSUM ROM was non-compensable under diagnostic codes for limitation of flexion (5260) or extension (5261) and the PEB likely applied §4.59 (painful motion) or §4.40 (functional loss) using code 5003 in arriving at a 10% rating for the left knee. There is no route to rating higher than 10% for the left knee or criterion for dual coding of the knee. There was no recurrent subluxation or instability for rating under code 5257. There was no evidence of torn or dislocated menisci to support a minimum rating under code 5258. All evidence considered, there is not reasonable doubt in the CI’s favor supporting a change from the PEB’s rating or coding decision for the knee condition.

Other PEB Conditions. The other conditions forwarded by the MEB included were status post surgical treatment of left knee, altered gait, internal coxa saltans of the right hip, and lumbago (mechanical lower back pain). Status post-surgical treatment of left knee, altered gait, and internal coxa saltans of the right hip were determined to be related category II diagnoses, conditions that contribute to the primary unfitting condition, but are not separately unfitting or ratable. Mechanical low back pain without radicular symptoms was determined to be not unfitting. The altered gait and status post surgical treatment of the left knee were considered by the Board in the rating for the left knee condition. Right hip internal coxa saltans, snapping hip syndrome (iliopsoas tendon moving over the lesser trochanter) was forwarded to the PEB by the MEB. STR first documented complaint of right hip pain in July 2006. Orthopedic evaluation 15 September 2006 diagnosed snapping hip (ilio-tibial band snapping across the lateral hip) and recommended conservative treatment. Examination reproduced the snapping tendon but here was no tenderness or pain with movement. A 5 October 2006 primary care clinic encounter records CI report of increased right hip pain. On examination there was no tenderness on palpation and full ROM. The CI had a history of chronic mechanical low back pain since a strain while lifting in 2003. He presented for care of recurrent low back pain after lifting in December 2005 and received care in the chiropractic clinic. There were no associated signs or symptoms and radiculopathy and MRI showed mild disc dessication (mild degenerative change). The commander noted complaint of right hip and low back pain after his left knee condition but these conditions did not result in any limited duty or were noted as failing retention standards. All were reviewed by the action officer and considered by the Board. There was no indication from the record that any of these conditions significantly interfered with satisfactory performance of duty requirements. All evidence considered, there is not reasonable doubt in the CI’s favor supporting recharacterization of the PEB fitness adjudication for any of the stated conditions.

Remaining Conditions. Other conditions identified in the DES file were hay fever, hearing problems (audiogram normal and unchanged), right knee pain, right shoulder pain once in a while, history of left calf laceration, and palpitations. None of these conditions were clinically or occupationally significant during the MEB period, none were the basis for limited duty and none were implicated in the commander’s non-medical assessment (NMA). 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 hemorrhoids was noted in the VA rating decision proximal to separation, but was not documented 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 VASRD in effect at the time of the adjudication. In the matter of the left knee pain condition and IAW VASRD §4.71a, the Board unanimously recommends no change in the PEB adjudication at separation or permanently. In the matter of status post surgical treatment of left knee, altered gait, internal coxa saltans of the right hip, mechanical lower back pain, 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:

|  |  |  |
| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Chronic Left Knee Pain | 5299-5003 | 10% |
| **COMBINED** | **10%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110701, 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) RECOMMENDATIONS

Ref: (a) DoDI 6040.44

(b) CORB ltr dtd 16 Mar 12

In accordance with reference (a), I have reviewed the cases forwarded by reference (b), and, for the reasons provided in their forwarding memorandum, approve the recommendations of the PDBR the following individuals’ records not be corrected to reflect a change in either 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)