RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: navy

CASE NUMBER: PD1100494 SEPARATION DATE: 20060421

BOARD DATE: 20120224

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty ABE1/E-6 (Aviation Boatswain’s Mate [Equipment] First Class), medically separated for left knee posttraumatic arthritis, status post left knee anterior cruciate ligament (ACL) reconstruction. The CI injured his left knee in 1998 while playing basketball. Two months later, he underwent an ACL repair and partial medial meniscectomy. He underwent a Medical Evaluation Board (MEB) and was subsequently returned to full duty in 1999. Several years later he noted increasing pain and swelling of the knee with activity. Radiographs revealed degenerative changes and a possible loose body. His treatment included medications, physical therapy, and intraarticular steroid injection. He did not respond adequately to treatment and was unable to perform within his Rating or meet physical fitness standards. He was placed on limited duty and underwent an MEB. “Posttraumatic arthritis, left knee” and “possible labral tear, left shoulder” were forwarded to the Physical Evaluation Board (PEB) IAW SECNAVINST 1850.4E. No other conditions appeared on the MEB’s submission. Other conditions included in the Disability Evaluation System (DES) file are discussed below. The Informal PEB (IPEB) adjudicated the left knee posttraumatic arthritis, status post left knee anterior cruciate ligament reconstruction condition as unfitting, rated 20% with application of the Veterans’ Administration Schedule for Rating Disabilities (VASRD). The CI did not appeal for a formal PEB, and was medically separated with a 20% disability rating.

CI CONTENTION: “I was discharged at 20% for severe left knee post-traumatic arthritis, status post left knee anterior cruciate ligament reconstruction. It was determined that my disability is permanent and this condition has not gotten any better. It has been documented by a VA doctor (Dr. M. Orthopedics) that a total knee replacement is necessary, however, I am too young and if performed at this age, a second knee replacement would be required at a later date. Furthermore, months after I was discharged from Active Duty service, I had surgery by Dr. K. of the Andrews lnstitute in Gulf Breeze, FL and it was discovered that I had much loose body in my knee. As you review my previous records, it is respectfully requested that you pay close attention to the remarks and interpretations of Dr. K., Dr. D. (Emerald Coast Orthopedics and Star Sports Medicine), and Dr. M. In addition to the left knee condition, Dr. M. has concurred that this same condition has now caused me to have trendelenburg gait which now I am requesting secondary condition to my left knee. As you review my records, I believe you will see much evidence is available to grant me a medical retirement.”

RATING COMPARISON:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Service IPEB – Dated 20060126** | | | **VA (2 Wks. Pre Separation) – All Effective 20060422** | | | |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| L Knee Posttraumatic Arthritis | 5299-5262 | 20% | L Knee S/P ACL Repair w/ Degenerative Changes | 5010 | 10%\* | 20060410 |
| L Shoulder, Possible Superior Labrum Anterior and Posterior Tear | Cat III | | DJD, L Shoulder | 5201 | NSC\* | 20060410 |
| ↓No Additional MEB/PEB Entries↓ | | | S/P Avulsion Fx R Distal Tibia | 5271 | 10% | 20060410 |
| S/P Open Reduction Internal Fixation R Wrist | 5215 | 10% | 20060410 |
| 0% x 0 / Not Service Connected x 6 | | | 20060410 |
| **Combined: 20%** | | | **Combined: 30%\*** | | | |

\*L knee 5010 temporary 100% from 20071003-20071201, then 10%; L shoulder 5010-5201 added at 10% effective 20071015 (exam 20080410) with temporary 100% from 20090707-20090901, then 10%; combined 40% effective 20090901

ANALYSIS SUMMARY: The Board acknowledges the sentiment expressed in the CI’s application regarding the significant impairment with which his service-aggravated condition continues to burden him. 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 Veteran Affairs (DVA). The DVA, operating under a different set of laws (Title 38, United States Code), is empowered to compensate service-connected conditions and to periodically re-evaluate said conditions for the purpose of adjusting the veteran’s disability rating should his degree of impairment vary over time. The Board utilizes VA evidence proximate 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 6040.44, 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 Knee Condition: There were three knee examinations proximate to separation, including goniometric range-of-motion (ROM) measurements and additional ratable criteria, in evidence which the Board weighed in arriving at its rating recommendation. These exams are summarized in the chart below.

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| --- | --- | --- | --- |
| Goniometric ROM –  L Knee | MEB ~ 4 Mo. Pre-Sep | Ortho ~ 3 Mo. Pre-Sep | VA C&P ~ 11 Days Pre-Sep |
| Flexion (140⁰ normal) | “approximately 0 to 125⁰” | 100⁰ | 110⁰ |
| Extension (0⁰ normal) | 0⁰ | 0⁰ |
| Comment | Varus deformity, palpable femoral osteophytes, scar, crepitus, TTP, no instability (including Lachman’s), neg McMurray’s, mildly pos patellar grind | 3+ effusion, TTP (medial joint line & lat epicondyle), 30 ml normal joint fluid aspirated, steroid injected; Hx incr pain & effusion due to moving over last 2-3 wks, no locking | Painful motion, crepitus, scar nontender, no instability (including Lachman’s), neg McMurray’s, neg grind, no change with repetitive motion; 5° valgus deformity on weightbearing |
| §4.71a Rating | 20% | 20% | 10-20% (VA 10%) |

The Service treatment record contained multiple orthopedic entries within one year of separation (for brevity not included in above chart). ROMs were mildly reduced (non-compensable under specific knee ROM coding), but significant knee pathology was documented, including palpable osteophytes, crepitus, effusion, joint line tenderness, and a history of locking/catching. In an outpatient entry 10 months prior to separation, the CI’s MEB orthopedist stated “he will likely require an HTO [high tibial osteotomy] in the near future,” and he recommended an arthroscopy to assess for loose bodies (suggested on radiographs 11 months prior to separation). At a follow-up visit two months later, the examiner documented that the CI did not desire the surgery, “even though symptoms are getting worse.”

The narrative summary (NARSUM), dated four months prior to separation, documented mild ROM limitations with a varus deformity, palpable femoral osteophytes, patellofemoral crepitus, a mildly positive patellar grind, tenderness of the patella and medial joint line, and a well-healed surgical scar. There was no instability (including Lachman’s), and McMurray’s test was negative. The examiner reported a history of increasing knee pain with “occasional catching symptoms.” Knee radiographs revealed degenerative changes (femoral and patellar osteophytes and “significant narrowing of the medial compartment with osteophyte formation and subchondral sclerosis”) and a possible loose body. An orthopedic outpatient entry at three months prior to separation stated the CI experienced increased pain and effusion due to moving over the previous two to three weeks. Exam revealed reduced knee flexion (100°), “3+ effusion,” and tenderness over the medial joint line and lateral epicondyle. The examiner aspirated 30 ml of normal joint fluid and injected a local anesthetic and corticosteroid, which provided immediate pain relief.

The VA exam*,* eleven days prior to separation, revealed decreased knee flexion (non-compensable under specific knee ROM coding), with painful motion, crepitus, and a nontender surgical scar. There was no instability, and McMurray’s and patellar grind tests were negative. There was no change in ROM or pain with repetition, and gait was normal. There was a noted 5 degree valgus deformity with weight bearing. During this exam, the CI endorsed a history of locking and swelling without specified frequency and “he feels it is unstable, but he has never fallen.” Radiographs showed degenerative changes (cartilage loss, spurring) in the medial compartment and patellofemoral joint. The record indicated the CI underwent a second left knee surgery at 18 months after separation, which found a medial meniscal tear, a large (over one centimeter) loose body, an ACL tear, and extensive degenerative changes (grade IV chondromalacia). Post surgical recovery was good and the knee was re-assesed by the VA at 10% by later exams and rating determinations.

The Board considered rating options and the possibility of dual coding for the left knee condition. Both exams proximate to separation noted an absence of ligament laxity or mechanical instability, so coding under 5257, for recurrent subluxation or lateral instability, was not warranted. Occacional locking or “catching” of the left knee history was noted by both examiners proximate to separation, and in multiple (at least four) Service treatment record entries within a year of separation. Effusions were not noted in the NARSUM or VA exams, but were reported in three clinical entries in the Service medical record during the third month pre-separation. Several entries noted medial joint line tenderness, and one noted positive McMurray’s test (indications of meniscal tear). Coding under 5258, dislocated meniscus, which requires “frequent episodes of ‘locking,’ pain, and effusion into the joint,” (20%), was not supported by the evidence. The history of partial meniscectomy, coupled with the documented meniscal symptoms (locking or “catching,” popping, effusions), supported the 5259 post-menisectomy code (10%) coding option. This could be coupled with a separate 10% rating under 5003, degenerative arthritis, given the pain-limited ROM and clinical and radiographic evidence. The PEB’s analogous coding to 5262 (impairment of tibia and fibula) considered both degenerative changes and meniscal symptoms and was appropriate; the Board considered wheter the CI’s knee disability would most closely be considered “moderate” (20%) or “marked” (30%). The Board determined that the preponderance of evidence favored a “moderate” (20%) rating. Although a combined coding of 5259 at 10% and 5003 at 10% was an option, there was no route to higher than a 20% rating under any other applicable codes. All evidence considered, there is not sufficient reasonable doubt in the CI’s favor supporting a change from the PEB’s rating decision for the left knee condition.

Other PEB Conditions. The other condition forwarded by the MEB and adjudicated as not unfitting by the PEB was possible superior labrum anterior and posterior tear of the left shoulder. The NARSUM stated the CI had had symptoms for five years with no recent treatment for the shoulder. The exam indicated that the CI had full ROM, normal muscle strength, a mildly positive Speed’s and O’Brien’s test, and deep tenderness anteriorly. Negative tests included Neer’s, Hawkins’, cross-arm abduction, lift-off, and Jobe’s. Radiographs of the shoulder showed a type II acromion, but otherwise normal. An MRI revealed “findings suspicious for tear of the posterior glenoid labrum.” The VA exam reported mildly reduced ROMs (noncompensible absent painful motion), pain with internal and external rotation, and negative Hawkins’ and empty can tests (for rotator cuff pathology). The VA denied service connection for the shoulder condition at separation, but later granted a 10% rating effective 18 months after separation. Although remote from separation, the CI underwent left shoulder surgery (SLAP repair and debridement of glenohumeral and subacromial spaces) at 27 months after separation (July 2008), and the VA temporarly increased the shoulder rating to 100% for the convalescent period, resuming their 10% evaluation thereafter. This condition was not a basis for duty restrictions, implicated in the non-medical assessment (NMA) or noted as failing retention standards. It was reviewed by the action officer and considered by the Board. There was no indication from the record that the condition significantly interfered with satisfactory duty performance. All evidence considered, there is not a preponderance of evidence in the CI’s favor supporting recharacterization of the PEB fitness adjudication for the shoulder condition.

Remaining Conditions. Other conditions identified in the DES file were right ankle sprain (VA 10% for status post avulsion fracture of the right distal tibia), right forearm injury requiring surgery (Galeazzi fracture in 2000 with MEB and return to full duty; VA 10% for status post open reduction internal fixation of the right wrist), constant headaches, head injury (2003), anger management counseling, eczema, low back pain, and herpes simplex virus infection. Several additional non-acute conditions or medical complaints were also documented. None of these conditions were occupationally significant during the MEB period, none carried attached duty limitations, and none were implicated in the non-medical assessment. 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. No other conditions were service connected with a compensable rating by the VA within twelve months of separation or contended by the CI. 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 knee condition and IAW VASRD §4.71a, the Board unanimously recommends no change in the PEB adjudication. In the matter of the left shoulder condition, the Board unanimously recommends no change from the PEB adjudication as Category III, not unfitting. In the matter of the right ankle condition, right forearm/wrist 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 recharacterization of the CI’s disability and separation determination, as follows:

|  |  |  |
| --- | --- | --- |
| **UNFITTING CONDITION** | **VASRD CODE** | **RATING** |
| Left Knee Posttraumatic Arthritis | 5299-5262 | 20% |
| **COMBINED** | **20%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110605, 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 letter dtd 6 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)