RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: NAVY

CASE NUMBER: PD1100631 SEPARATION DATE: 20060106

BOARD DATE: 20120808

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty MM1/E-6 (3359, Nuclear Machinist’s Mate), medically separated for lumbar degenerative disc disease (DDD), status post (s/p) revision and symptomatic osteochondral defects, bilateral talar domes. He did not respond adequately to treatment and was unable to perform within his Rating or meet physical fitness standards. He met an abbreviated Medical Evaluation Board (MEB) on 31 July 2003 and was placed on limited duty (LIMDU) for 8 months. A second 8 months of LIMDU was recommended on 24 February 2004, but not approved. His case was referred to the central Physical Evaluation Board (PEB) on 17 June 2004 with an orthopedic addendum dated 10 November 2004. The PEB terminated this Board without finding and returned it for additional information. The CI underwent another MEB on 17 March 2005. “Degeneration of lumbar or lumbosacral intervertebral disc; acquired musculoskeletal deformity of other specified site; plantar fascial fibromatosis and depressive disorder, not elsewhere classified” were forwarded to the PEB as medically unacceptable IAW SECNAVINST 1850.4E. No other conditions appeared on the MEB’s submission. The PEB adjudicated the lumbar and ankle conditions as unfitting, each rated 10%, with application of the Veterans Administration Schedule for Rating Disabilities (VASRD); six additional conditions were identified in the chart below and rated as Category III, (not separately unfitting and do not contribute to the unfitting condition). The CI appealed to a Formal PEB (FPEB) which added overweight as a Category IV condition (does not constitute a physical disability), but otherwise upheld the decision. The CI made no further appeals and was then medically separated with a 20% combined disability rating.

CI CONTENTION: The CI elaborated no specific contentions in his application.

SCOPE OF REVIEW: The Board wishes to clarify that the scope of its review as defined in DoDI 6040.44, Enclosure 3, paragraph 5.e.(2) is limited to those conditions which were determined by the PEB to be specifically unfitting for continued military service; or, when requested by the CI, those condition(s) “identified but not determined to be unfitting by the PEB.” The ratings for unfitting conditions will be reviewed in all cases. Any conditions or contention not requested in this application, or otherwise outside the Board’s defined scope of review, remain eligible for future consideration by the Board for Correction of Naval Records (BCNR).

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RATING COMPARISON:

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| --- | --- |
| **Service FPEB – Dated 20050922** | **VA (3 Mos. After Separation) – All Effective Date 20060107** |
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Lumbar DDD, S/P Revision | 5242 | 10% | DDD L5-S1 | 5242 | 10% | 20060428 |
| Symptomatic Talar Domes | 5003 | 10% | Bilateral Talar…Defect | 5003 | 0% | 20060428 |
| Plantar Fasciitis S/P Bilateral Fasciectomies | Category III | S/P Left Plantar …Spurs | 5284 | 10% | 20060428 |
| S/P Right Plantar …Spurs | 5284 | 10% | 20060428 |
| Diarrhea…IBS | Irritable Bowel Syndrome | 7319 | NSC | 20060428 |
| GERD | HH, GERD w Schatzki’s Ring | 7399-7346 | 10% | 20060428 |
| Depressive Disorder NOS | Major Depressive Disorder | 9434 | 10% | 20060417 |
| Psychological Factors … | No VA Entry |
| Occult Positive Stool…  | Hemorrhoids | 7336 | 0% | 20060428 |
| Overweight | Category IV | No VA Entry |
|  | Obstructive Sleep Apnea… | 6847 | 50% | 20060428 |
| ↓No Additional MEB/PEB Entries↓ | Tinnitus | 6260 | 10% | 20060426 |
|  | 0% x 3/Not Service-Connected x 6 | 20060428 |
| **Combined: 20%** | **Combined: 80%** |

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. 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 nor for conditions determined to be service connected by the Department of Veteran Affairs (DVA), but not determined to be unfitting by the PEB. However, the 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. 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.

Lumbar Degenerative Disc Disease (DDD), Status Post Revision Condition. There were three goniometric range-of-motion (ROM) evaluations in evidence, with documentation of additional ratable criteria, which the Board weighed in arriving at its rating recommendation.

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| --- | --- | --- | --- |
| Goniometric ROM – Thoracolumbar SpineDegrees | MEB ~ 10 Mos. Pre-Sep(20050317) | Ortho ~4 Mos. Pre-Sep (20050912) | VA C&P ~ 3 Mos. After Sep (20060428) |
| Flexion (0-90) | 70 | 60 | 65 |
| Combined (240) | 185 | 110 | 205 |
| Comment | ROM at onset of pain.+Muscle spasm at L5  Gait normal. |  | Normal gait and posture. Loss of lumbar lordosis. |
| §4.71a Rating | 10% | 20% | 10% |

The CI was treated for mechanical low back pain (LBP) without antecedent trauma for several years with progression of symptoms. On 17 April 2003, a magnetic resonance imaging (MRI) showed a small central and left paracentral L5 disc herniation. Treatment including epidural steroid injections was inadequate and he underwent disc replacement in December 2003. He did have a complication with polyethylene protrusion for which he underwent revision in June 2004. He enjoyed significant benefit from the surgery, but later had recurrent symptoms which prevented him from meeting his military duty requirements. At the time of the MEB narrative summary (NARSUM), performed on 17 March 2005, 10 months prior to separation, the CI endorsed occasional numbness, tingling and weakness without bowel or bladder disturbance. He reported he could not engage in significant activities including impact activities, had difficulty with prolonged sitting, standing or walking and could not lift more than 20 pounds. On examination, ROM was recorded as above to pain onset (“he can forward flex approximately 70 degrees before the onset of pain”). Tenderness and muscle spasm at L5 was noted, however no comment was made regarding spinal contour. Gait was normal and walking on heels and toes was normal. Strength, reflexes, and sensation were normal and straight leg raising was negative for radicular symptoms. A second orthopedic examination for ROM was performed on 12 September 2005 at the request of the attorney for the CI during the PEB appeal process. The CI was noted to have LBP radiating to the legs which was aggravated by sitting, standing, walking or carrying over 20 pounds. Sensory, motor strength and deep tendon reflex examinations were all normal. Gait and stance were normal. All motion of the back was painful; no comment was made regarding spasm or contour.

The VA Compensation and Pension (C&P) exam was performed on 28 April 2006, 3 1/2 months after separation. He stated that he had pain three times a week usually after twisting and improper body mechanics. The pain rarely radiated into his buttocks. He denied bowel or bladder complaints. He was unable to lift greater than 30-40 pounds and had given up golf. Gait was normal and unassisted; posture was normal. A slight loss of lumbar lordosis was noted. ROM is above. Pain was noted with flexion, but not on other movements. There was no atrophy and the neurologic exam was normal. The Board directs attention to its rating recommendation based on the above evidence. The FPEB and VA both coded the condition as 5242, degenerative arthritis of the spine, and rated it 10%. The Board notes that both the PEB exam and the C&P rate at 10% for flexion “less than 85 degrees but greater than 60.” The Board considered the second PEB orthopedic exam which was limited to 60 degrees of flexion. The Board notes that this examination was not consistent with the other two examinations. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board concluded that there was insufficient cause to recommend a change in the PEB adjudication for the back condition.

Symptomatic Osteochondral Defects, Bilateral Talar Domes. The PEB combined the left and right talar dome osteochondral defects as a single unfitting condition, coded analogously to 5003 and adjudicated a single 10% for ankles. The Board notes that “bundling,” the combining of conditions under a single code, is permissible under the VASRD 5003 rating requirements, and that this approach does not compromise the VASRD §4.7 directive to choose the higher of two valid ratings. Under code 5003, when the limitation of motion of the specific joint or joints involved is non-compensable under the appropriate diagnostic codes, a rating of 10% is applied for each such major joint or group of minor joints affected by limitation of motion. Limitation of motion must be objectively confirmed by findings such as swelling, muscle spasm, or satisfactory evidence of painful motion. The Board noted that PEBs often combine multiple conditions under a single rating when those conditions considered individually are not separately unfitting and would not cause the member to be referred into the DES or be found unfit because of physical disability (DoDI 1332.38, paragraph E3.P3.4.4.; “overall effect”). This approach by the PEB reflects its judgment that the constellation of conditions was unfitting, not a judgment that each condition was independently unfitting. When combining conditions in this manner, the PEBs concluded that there was no need for separate fitness adjudications.

However, the Board must apply separate codes and ratings in its recommendations if compensable ratings for each condition are achieved IAW VASRD §4.71a. If the Board judges that two or more separate ratings are warranted in such cases, however, it must satisfy the requirement that each unbundled condition was unfitting in and of itself. Thus the Board must exercise the prerogative of separate fitness recommendations in this circumstance, with the caveat that its recommendations may not produce a lower combined rating than that of the PEB. The Board therefore considered whether the right ankle (talar dome osteochondral defect) and the left ankle (talar dome osteochondral defect) considered alone was unfitting for continued military service. On 6 March 2002, the CI was incidentally discovered to have bilateral osteochondral defects of the medial talar dome during an MRI done for chronic heel pain secondary to bilateral plantar fasciitis (the plantar fasciitis was successfully treated with bilateral fasciectomies). The talar dome osteochondral defects were initially asymptomatic and the ankles had full range of motion, but became symptomatic with impact sports over the next year. Treatment for the ankles, including activity modification, non-steroidal anti-inflammatory drugs (NSAIDs) and physical therapy (PT), was inadequate, although he was primarily symptomatic on the right. Surgery was discussed, but declined due to the low likelihood of a long-term benefit to his problem; considered a reasonable decision by his surgeon. The MEB NARSUM, performed on 17 March 2005, noted that his symptoms waxed and waned, but were particularly aggravated by impact sports. There were no symptoms of instability. On examination, there was no swelling, but he was tender over the talar domes bilaterally. ROM was five degrees of dorsiflexion and 25 degrees plantar flexion in both ankles. Motor strength and gait were normal. A second orthopedic examination was performed on 12 September 2005 at the request of the CI’s counsel. It was noted that his symptoms increased with activity and improved with rest. Popping was noted, but the ankles did not give way. There was no swelling, erythema, warmth or laxity and the anterior drawer’s test was negative. Motion about the anteromedial aspect of the talar dome was painful. Range of motion was unchanged from the MEB NARSUM (five degrees of dorsiflexion and 25 degrees plantar flexion in both ankles). Gait and stance were normal as were heel and toe walking. The C&P Exam was 3 months after separation. The osteochondral conditions were addressed indirectly in the history. Gait and stance were normal. No ambulatory aids were in use although the CI did have orthotics for the bilateral plantar fasciitis. On imaging the ankle mortises were normally outlined bilaterally, but degenerative changes were noted posteriorly on the right ankle along with bilateral heel spurs. The impression of the examiner was “b/l talar dome osteochondral defect, symptomatic, mild functional impact right greater than left symptom.” The Board first considered if the right and left talar dome osteochondral defects were separately unfitting. The Board notes that the clinical record consistently records the right ankle as more symptomatic than the left and that many entries were solely for the right ankle. The service treatment record consistently showed medical appointments for the right ankle, but not the left except in conjunction with the right. Imaging of the ankles was significant for posterior degenerative changes on the right. While ROM was reduced symmetrically, the gait and stance were consistently normal, indicating that the limited ROM had no functional impact on the CI’s gait. The Board reviewed all the evidence. It noted the 28 April 2006 C&P exam referenced a March 2006 rheumatology note which documented left knee pain, but no problems with other joints. The same C&P examiner noted the CI thought the foot condition for which he was being evaluated most likely referred to “residual of the plantar fasciectomy and occasional cramping of his toes” without mention of ankle pain. The Board concluded that the left ankle would not have been separately unfitting in the absence of the right ankle pathology. The Board then considered the appropriate rating for the unfitting right ankle.

The Board considered rating under the diagnostic code for ankle limitation or motion (5271). The VASRD does not define the limitation for either marked or moderate limitation under code 5271. Although there was limitation of motion, the normal gait on multiple examinations was not consistent with a moderate limitation of motion for the minimum rating under this code. The Board also noted minimum rating was not attained under other ankle codes (such as 5272 for ankylosis of the tarsus or 5273 malunion of the talus). Foot injuries, other (5284) indicates a moderate level of impairment for 10%. The Board also considered the application of VASRD §4.59, painful motion and §4.40 (functional loss) to the ankle condition. It noted that the VASRD states that the intent is that the painful joint is “entitled to at least the minimum compensable rating for the joint.” After due deliberation, considering all of the evidence and mindful of VASRD §4.59 (painful motion) and VASRD §4.3 (reasonable doubt), the Board recommends a disability rating of 10% for the right ankle condition coded 5299-5271.

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 back condition and IAW VASRD §4.71a, the Board unanimously recommends no change in the PEB adjudication. In the matter of the bilateral talar dome osteochondral defect condition the Board unanimously recommends that each the right and left talar dome condition be separately adjudicated. The Board unanimously recommends that the right ankle be adjudicated as unfitting and the left ankle as not unfitting. In the matter of the unfitting right talar dome osteochondral defect condition, the Board unanimously recommends a disability rating of 10%, coded 5299-5271 IAW VASRD §4.71a. There were no other conditions within the Board’s scope of review for consideration.

RECOMMENDATION: The Board 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** |
| Lumbar degenerative disc disease s/p revision | 5242 | 10% |
| R ankle osteochondral defect talar dome | 5299-5271 | 10% |
| L ankle osteochondral defect talar dome | Not unfitting |
| **COMBINED** | **20%** |

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20110816, 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 24 Aug 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 that 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:

 - former USMC

 - former USN

 - former USN

 - former USN

 - former USMC

 - former USMC

 Assistant General Counsel

 (Manpower & Reserve Affairs)