RECORD OF PROCEEDINGS
PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: MARINE CORPS
CASE NUMBER: PD1200256 SEPARATION DATE: 20050715
BOARD DATE: 20121019

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SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty LCPL/E-3 (7051/Aircraft Fire Fighting and Rescue Specialist), medically separated for left tibia open IIIA fracture, status post (s/p) open reduction internal fixation (ORIF) with intramedullary nail. On 7 March 2004, the CI suffered a penetrating wound of the left lower leg with fractures of the tibia and fibula. He underwent numerous surgical procedures and rehabilitation, but did not improve sufficiently to meet the physical requirements of his Military Occupational Specialty (MOS) or satisfy physical fitness standards. He was placed on limited duty (LIMDU) twice and referred for a Medical Evaluation Board (MEB) which forwarded "other orthopedic aftercare" and "other symptoms involving nervous and musculoskeletal systems", "major depressive disorder, single episode, moderate severity" and chronic PTSD (posttraumatic stress disorder) to the Physical Evaluation Board (PEB) as medically unacceptable. The PEB adjudicated the left leg condition as unfitting, rated 10%, with application of the Veteran's Affairs Schedule for Rating Disabilities (VASRD) as outlined in SECNAVIST 1850.4E. The PEB determined "nerve deficit to the distribution of the superficial peroneal and deep peroneal continuous distributions" and "wound closure with the use of status post split-thickness skin graft" conditions were related Category II diagnoses. Major depressive disorder (MDD) and chronic PTSD were determined to be not separately unfitting and to be Category III conditions. The CI made no appeals and was medically separated with a 10% disability rating.

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CI CONTENTION: "Initial PEB filing regarded blast injury to lower left leg, with addendum concurrently filed for PTSD/Major Depressive Disorder. Both evaluating physicians were USN medical officers. On 25 May 2005, Board found Category I: Unfitting Condition: [injury to leg]. and assigned rating. Above additional psychiatric conditions concurrently found to be Category III: Not Unfitting. I was counseled by the PEBLO at NMCSD that the unfitting conditions did not likely constitute sufficient grounds to appeal the Board's decision at that time and accepted the findings. On 18 May 2005 initial application (VA form 21-526) made to Dept. of Veterans Affairs (VA) for disability/benefits. Information provided to VA was identical to that provided to PEB, with sole (*sic*) the addition of the Board's formal report dated 17 March 2005, prior to VA rating decision. On 25 July 2005, V A awarded combined rating of 100% effective 16 July 2005 citing: "PTSD, status post leg [injury], left knee and left ankle impairment, scars (and bilateral hearing loss)" (see VA addendum Pg. 2, dated 25 July 2005). The VA rating for these conditions has not changed negatively to date, has been separately affirmed multiple times upon additional review/evaluation and is permanent."

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SCOPE OF REVIEW: The Board wishes to clarify that the scope of its review as defined in the Department of Defense Instruction (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. The left leg, PTSD, and MDD conditions, as requested for consideration by the CI, meet the criteria prescribed in DoDI 6040.44 for Board purview. The remaining conditions rated by the VA at separation and listed on the DA Form 294 application are not within the Board's purview. 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.

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RATING COMPARISON:

| Service IPEB – Dated 20050526 | | | VA (1 Mos. Pre -Separation) – All Effective Date 20050716 | | | |
|---|---|---|---|---|---|---|
| **Condition** | **Code** | **Rating** | **Condition** | **Code** | **Rating** | **Exam** |
| Lt Tibia Open IIIA Fracture | 5299-5003 | 10% | Lt Tibia Fx S/P ORIF w/ Medullary Nail | 8523-5262 | 20%* | 20061025 |
| Nerve Deficit to the Distribution of Superficial Peroneal & Deep Peroneal Cont Distributions | Related Cat II | | | | | |
| Wound Closure S/P STSG | Related Cat II | | | | | |
| MDD | Cat III | | NO VA ENTRY (Subsumed under PTSD) | | | |
| PTSD | Cat III | | PTSD | 9411 | 100%* | 20050622 |
| ↓No Additional MEB/PEB Entries↓ | | | 0% X 0 / Not Service-Connected x 0 | | | 20050622 |
| **Combined: 10%** | | | **Combined: 100%** | | | |

*The initial VA rating was for 100% for stabilization and included PTSD, the left leg, knee and ankle as well as bilateral hearing loss. The left leg was separated out as 20%, w/ code 8523-5262, and the PTSD, coded 9411, at 100% on the 20061103 VARD. TBI was also added at 10% on this VARD. Back pain and right knee pain were granted on the 20060404 VARD and tinnitus on the 20060725 VARD, each at 10%. Scars were added at 0% on the 20091229 VARD.

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ANALYSIS SUMMARY: The Disability Evaluation System (DES) is responsible for maintaining a fit and vital fighting force. While the DES considers all of the member's medical conditions, compensation can only be offered for those medical conditions that cut short a 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 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 his 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 DVA 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 is probative only to the extent that it reasonably reflects the disability and fitness implications at the time of separation. The Board noted the post-separation, elective left below the knee amputation, but emphasizes that its adjudication is limited to the disability present at separation. The Board has neither the jurisdiction nor authority to scrutinize or render opinions in reference to the CI's statements in the application regarding suspected DES improprieties in the processing of his case.

Left Leg Condition. On 7 March 2004, the CI suffered a penetrating injury to his left lower leg with open fractures of the tibia and fibula while deployed to Iraq. He was evacuated to his home station via Landstuhl, receiving stabilization treatment en route including external fixation of the tibial fracture. On 19 March 2004, he had an intramedullary nail placed in the left tibia with removal of the external fixator. Later, some of the hardware was removed on 1 October 2004 as it was symptomatic. He was initially placed on LIMDU status 18 August 2004 and underwent extensive rehabilitation. Despite improvement, he was not able to meet retention standards at the end of the LIMDU period and was

then referred to MEB. The narrative summary (NARSUM) was dictated by the orthopedics staff on 17 March 2005, 4 months prior to separation. The CI was still limited to 10 minutes on the exercise (bike) and 20-25 minutes of walking secondary to left knee, leg and ankle pain. Walking also resulted in tingling in his leg and foot; the gait was antalgic. Range-of-motion (ROM) of his hip was full. His left knee flexion was 120 degrees with 140 degrees (VA normal) on the unaffected right knee. Extension was zero degrees on the left (VA normal), but showed hyperextension of ten degrees on the right. The ankle ROM was also reduced for the affected left side with 5 degrees dorsi flexion and 50 degrees of plantar flexion while the right side was ten and 60 degrees, respectively, with VA normal values of 20 and 45 degrees. The surgical scars and skin graft were well healed. Sensation was decreased in the distribution of the superficial and deep peroneal nerves. Peroneal strength was reduced to 4/5, but the extensor hallucis longus (EHL), posterior tibialis and anterior tibialis strength was normal indicating good motor function of the deep and superficial peroneal nerves. His X-rays showed a healed tibial shaft fracture with a well-positioned intramedullary nail. He was thought to have plateaued in his level of function. The commander noted on 23 March 2005 that the CI was limited to administrative duties as he could not perform any of the more physically demanding tasks.

The VA Compensation and Pension (C&P) examination was performed on 22 June 2005, 3 weeks prior to separation. The CI reported left knee pain, weakness, sensory changes and restricted ankle motion. He was riding a stationary bicycle for 15-20 minutes 3 to 4 times a week and could walk for 15-20 minutes. The ROM of the left knee was normal and the ligaments were stable without signs of meniscal injury. The ankle showed reduced dorsiflexion at 5 degrees with normal plantar flexion. The examiner noted 3+/5 strength for dorsiflexion, inversion and eversion consistent with "functional group XII left leg muscle deficit is moderately severe functional loss." Diminished sensation was also documented over the anterolateral wound, dorsum of the foot and into the second, third and fourth toes. The X-rays of the knee and ankle were normal other than evidence of the intramedullary nail and a proximal fibular fracture. The reduced ROM of the ankle was thought to be secondary to contracture of the Achilles tendon due to the prolonged immobilization. Moderate to severe impairment from the muscle deficit and nerve involvement was diagnosed, but relative loss of function from each was not assigned. On the general C&P examination that same day, the scars were noted to be "not dysfunctional". Significant loss of soft tissues was also documented. Two months after separation the CI was working as a courier. At an orthopedic pre-operative exam performed on 28 December 2005, a little over 5 months after separation, the CI reported continued pain and desired hardware removal. He had a slightly antalgic gait with persistent weakness and sensory loss. The examiner wrote "Associated with this injury, he had near complete loss of his peroneals as well as most likely superficial peroneal nerve..." The CI was able to stand on both heels, but was weaker on the left side. He had 3/5 strength of his EHL and tibialis anterior muscles, contributing to the foot drop, a change from the prior to separation NARSUM, and 5/5 strength in plantar flexions.

The NARSUM, initial VA C&P and December 2005 pre-operative examinations were all performed by orthopedic surgeons. Another VA C&P examination performed on 22 March 2006, 8 months after separation showed continued signs of muscle weakness and sensory loss with some loss of muscle bulk with abnormal gait. He walked without assistive devices. The Board directs attention to its rating recommendation based on the above evidence. The PEB rated the left leg condition at 10% and coded it 5299-5003, analogous to degenerative arthritis. The deficit to the deep and superficial peroneal nerves and the skin graft were both determined to be Category II conditions, conditions which contribute to the unfitting condition but are not separately unfitting themselves. As noted above, the VA initially awarded a 100% disability rating for the leg, PTSD and hearing loss, during a stabilization period, but also determined that the left leg condition met the 20% or greater disability requirement for vocational rehabilitation purposes. Subsequently, the VA rated the left leg condition separately from the combined rating in the 3 November 2006 VA rating decision and rated it 20%, coded 8523-5262, (incomplete) paralysis of the deep peroneal nerve and impairment of the tibia and fibula. The VA rated the scars separately, but at 0%; the neuropathy was subsumed under the left leg condition using the combined code 8523-5262. In its adjudication of the left leg condition, the Board considered VASRD §4.3, reasonable doubt, VASRD §4.14, avoidance of pyramiding, which prohibits the use of the same signs and

symptoms for multiple coding options and VASRD §4.56, evaluation of muscle disabilities. The latter notes "an open comminuted fracture with muscle or tendon damage will be rated as a severe injury of the muscle group involved unless, for locations such as in the wrist or over the tibia, evidence establishes that the muscle damage is minimal." No examiner noted that the scars interfered with function and one specifically wrote "not dysfunctional." Sensory deficits were observed, but not linked to an impairment in the wear of military foot wear or noted to be separately causal in functional impairment by any examiner. All examiners observed a loss of strength in some, but not all, of the muscles innervated by the peroneal nerves in addition to the muscle loss and damage from the injury itself. The relative contributions of the nerve and muscle conditions were not separated by any examiner. However, the strength of the tibialis anterior and EHL were noted to be normal by the NARSUM examiner, consistent with an intact deep peroneal nerve motor function. Soft tissue loss was documented by several examiners, including one note that the peroneal muscles, supplied by the superficial peroneal nerve, were lost. The VA C&P orthopedic examiner for the 22 June 2005 examination specifically wrote "functional group XII left leg muscle deficit is moderately severe functional loss."

The Board considered different rating options for the ankle, knee, leg, deep and superficial peroneal nerves and the muscle groups. No combination of coding options provided a better description or higher rating advantage to the CI than 5312, impairment of muscle group XII. The sensory impairment was not separately unfitting. While the motor loss could be attributed to direct trauma to the muscles of the lower leg and/or possibly to damage to the peroneal nerve branches, the functional loss is the ratable disability. This was not apportioned by any examiner and muscle loss is clearly documented. The limitations in ROM in the ankle and knee are not compensable and the X-rays for both were normal. The description for moderately severe disability of muscles, which merits a 20% disability rating, includes a description as "Through and through or deep penetrating wound…with debridement…or intermuscular scarring," a history of "hospitalization for a prolonged period for treatment of wound," cardinal signs such as weakness and fatigability with evidence of inability to keep up with work requirements. Objective findings include entrance and exit scars, indications on palpation of loss of deep fascia, muscle substance, or normal firm resistance of muscles compared with sound side, and tests of strength and endurance compared with sound side demonstrate positive evidence of impairment. For severe disability, consistent with a 30% disability rating, the CI had the additional history of open comminuted fracture with extensive debridement and sloughing of soft parts. The CI also showed evidence of inability to keep up with work requirements. Objective findings included loss of muscle substance. Of the other listed possible seven signs of severe disability, only visible or measurable atrophy was present. After due deliberation, considering all of the evidence and mindful of VASRD §4.3 (reasonable doubt), the Board determined that the description of severe disability best fit history of the injury and the functionality of the CI at separation. It recommends a disability rating of 30% for the left leg condition, coded 5312 for severe dysfunction of muscle group XII.

Contended PEB Conditions. The contended conditions adjudicated as not unfitting by the PEB were MDD and PTSD. The two Category II conditions were discussed above with the left leg condition. The Board's first charge with respect to these conditions is an assessment of the appropriateness of the PEB's fitness adjudications. The Board's threshold for countering 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. The CI was first evaluated in mental health in April 2004 during his treatment for the left leg condition. He was diagnosed with both PTSD and MDD, not otherwise specified. He improved with medications and therapy, but some symptoms of both conditions persisted. Both conditions were listed by the MEB, but neither was listed on either LIMDU or implicated in the commander's statement. The CI was able to do administrative duties and only the physical limitations were cited by the commander. Both conditions were reviewed by the action officer and considered by the Board. There was no indication from the record that either significantly interfered with satisfactory duty performance after he had been treated. He was thought to have moderate military impairment and mild social impairment from the PTSD as well as partial remission of the MDD. Shortly after separation, the CI was able to find part-time work as a courier and planned to

attend college. After due deliberation in consideration of the preponderance of the evidence, the Board concluded that there was insufficient cause to recommend a change in the PEB fitness determination for the any of the contended conditions and, therefore, no additional disability ratings can be recommended.

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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 leg condition, the Board unanimously recommends a disability rating of 30%, coded 5312 IAW VASRD §4.73. In the matter of the deep and superficial peroneal neuropathy condition and IAW VASRD §4.124a, the Board unanimously recommends no change in the PEB adjudication. In the matter of the wound closure with split thickness skin graft and scars condition, the Board unanimously recommends no change in the PEB adjudication. In the matter of the contended MDD and PTSD conditions and IAW VASRD §4.130, the Board unanimously recommends no change from the PEB determinations as not unfitting. There were no other conditions within the Board's scope of review for consideration.

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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:

| UNFITTING CONDITION | VASRD CODE | RATING |
|---|---|---|
| Lt Tibia Open IIIA Fracture | 5312 | 30% |
| Nerve Deficit to the Distribution of the Superficial and Deep Peroneal Cutaneous Distributions | Cat II | |
| Wound Closure with use of S/P STSG | Cat II | |
| Major Depressive Disorder | Cat III | |
| Post-Traumatic Stress Disorder Chronic | Cat III | |
| | **COMBINED** | **30%** |

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20120130, w/atchs
Exhibit B. Service Treatment Record
Exhibit C. Department of Veterans' Affairs Treatment Record

President
Physical Disability Board of Review

MEMORANDUM FOR DEPUTY COMMANDANT, MANPOWER & RESERVE AFFAIRS
COMMANDER, NAVY PERSONNEL COMMAND

Subj: PHYSICAL DISABILITY BOARD OF REVIEW (PDBR) RECOMMENDATIONS

Ref: (a) DoDI 6040.44
(b) PDBR ltr dtd 2 Nov 12
(c) PDBR ltr dtd 6 Nov 12
(d) PDBR ltr dtd 14 Nov 12

1. Pursuant to reference (a) I approve the recommendations of the Physical Disability Board of Review set forth in references (b) through (d).

2. The official records of the following individuals are to be corrected to reflect the stated disposition:

a. former USMC: Retroactive increase in disability rating from 30 percent to 50 percent for the period member was on the Temporary Disability Retired List with a final disability rating of 10 percent effective 1 October 2001.

b. former USMC: Disability retirement with a final disability rating of 30 percent and assignment to the Permanent Disability Retired List effective 15 July 2005.

c. former USMC: Disability retirement with a final disability rating of 30 percent and assignment to the Permanent Disability Retired List effective 30 April 2007.

3. Please ensure all necessary actions are taken, included the recoupment of disability severance pay if warranted, to implement these decisions and that subject members are notified once those actions are completed.

Assistant General Counsel
(Manpower & Reserve Affairs)