RECORD OF PROCEEDINGS
PHYSICAL DISABILITY BOARD OF REVIEW

NAME: BRANCH OF SERVICE: NAVY
CASE NUMBER: PD1200294 SEPARATION DATE: 20090930
BOARD DATE: 20121101

SUMMARY OF CASE: Data extracted from the available evidence of record reflects that this covered individual (CI) was an active duty AZ4/E-4 (AZ/Aviation Maintenance Administration), medically separated for a left lower limb condition. She did not respond adequately to treatment and was unable to fulfill the physical demands within her Rating, meet worldwide deployment standards or meet physical fitness standards. She was placed on limited duty and underwent a Medical Evaluation Board (MEB). Reflex sympathetic dystrophy of the lower limb and nontraumatic rupture of other tendons of foot and ankle were forwarded to the Informal Physical Evaluation Board (PEB) IAW SECNAVINST 1850.4E. The IPEB adjudicated complex regional pain syndrome (CRPS), left foot and ankle as unfitting, rated 20% and symptomatic posterior tibial tendinitis, left as a Category II condition with application of the Veteran's Affairs Schedule for Rating Disabilities (VASRD), respectively. The Navy defines Category II conditions as 'contribute to the unfit.' The CI made no appeals, and was medically separated with a 20% combined disability rating.

CI CONTENTION: "More evidence, additional conditions."

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 symptomatic posterior tibial tendinitis, left foot condition requested for consideration and the unfitting CRPS, left foot and ankle conditions meet the criteria prescribed in DoDI 6040.44 for Board purview, and are accordingly addressed below. The remaining conditions rated by the VA at separation and listed on the DD 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.

RATING COMPARISON:

Service IPEB – Dated 20090609		
Condition	**Code**	**Rating**
Complex Regional Pain Syndrome, Left Foot and Ankle	8799-8724	20%
Symptomatic Posterior Tibial Tendinitis, Left Foot	Cat 2	
↓No Additional MEB/PEB Entries↓		
Combined: 20%		

VA (1 Mos. Pre-Separation) – All Effective Date 20091001			
Condition	**Code**	**Rating**	**Exam**
Left Ankle Strain and Degenerative Arthritis, Status Post Fracture	5010-5271	10%	20090826
Status Post Left Foot Fracture	5299-5284	0%	20090826
Lumbar Spine Scoliosis	5299-5239	10%	20090826
0% X 2 / Not Service-Connected x 1			
Combined: 20%			

ANALYSIS SUMMARY: The Board also acknowledges the CI's contention suggesting that ratings should have been conferred for other conditions documented at the time of separation and for conditions not diagnosed while in the service (but later determined to be service connected by the VA). While the Disability Evaluation System (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 Department of Veterans' Affairs (DVA), however, 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 the degree of impairment vary over time.

Left Lower Limb Condition. The Board deliberated the unfitting CRPS, left foot and ankle and the Category II condition, symptomatic posterior tibial tendinitis, left foot with the below discussion. The CI sustained a left ankle and foot injury in February 2008 falling down a set of stairs and immediately heard a popping sound and had pain of the medial left ankle and foot. She was casted for 9 weeks, and then placed in a Cam Walker and given a trial of physical therapy. The pain persisted and she was unable to bear weight, had decreased sensation of the foot with paresthesias and thus underwent further evaluation with orthopedics to include several X-rays, Magnetic Resonance Imaging (MRI) studies and a Dexa scan. With the totality of the reports and exams, the orthopedic examiner diagnosed posterior tibial tendonitis, stress fracture and reflex sympathetic dystrophy (RSD), recommended a referral to a pain specialist and started her on a trial of Lyrica as she had failed a trail of Neurontin due to side effects, both of these medications were anticonvulsants used for pain disorders. In October 2008 she was evaluated by pain clinic (anesthesia). The examiner documented she had been in a Cam Walker for 6 months, used crutches for ambulation and was still unable to bear full weight as the pain was made worse with any walking or ambulating more than a few steps. The examiner further documented the pain was completely relieved with rest and elevation. The exam demonstrated an antalgic gait, intact motor and neurologic findings, able to heel and toe stand, tenderness of the posterior tibial tendon behind the medial malleolus, abnormal cooler temperature measurements on the left lower shin, ankle and distal tibia, no allodynia and normal hair distribution. The examiner diagnosed posterior tibial tendinopathy with superimposed CRPS, type I, counseled her for lumbar sympathetic nerve blocks as she had failed medication treatment and recommended a bone scan and nerve conduction (NCV) tests. Follow-up evaluations by the same examiner included documentation of normal NCV and 3 lumbar nerve blocks, the last in February 2009, which provided very brief pain relief. The non-medical assessment (NMA) documented the CI was not working in her Rating and was missing 16 hours of work per week. 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; as summarized in the chart below.

DOS 20090930

Left Ankle ROM	PT ~12 Mo. Pre-Sep	MEB ~6 Mo. Pre-Sep	VA C&P ~1 Mo. Post-Sep
Dorsiflexion (0-20°)	10°(passive)	#° Pain at neutral	20°
Plantar Flexion (0-45°)	#°	30°	45°
Comment	Limited by pain	Painful Motion	Limited by pain
§4.71a Rating	10%	10%	10%*

*With consideration of §4.59 painful motion.

At the MEB exam, the CI reported medial pain of the ankle and foot, 7 of 10 in intensity, use of a crutch or cane for ambulation, but she was weight bearing as tolerated, which was less than 50 percent of her body weight and her current medication was Lyrica. The MEB physical exam demonstrated the left foot was slightly cooler to touch than the contralateral right leg, hypoesthetic upon palpation of the entire left foot and ankle region, mobilized her left lower

limb muscles slightly less relative to the contralateral side with a volitional component due to pain, exquisitely painful posterior tibial tendon with resisted inversion, unable to perform a heel raise, pulses were palpable and minimal soft tissue edema. In August 2009, a month prior to separation, the anesthesia examiner documented that bearing weight, standing and walking all seem to aggravate her discomfort and she continued to use a single crutch to aid her walk. The exam demonstrated normal neuromuscular and vascular findings, no evidence of significant hyperpathia or allodynia, no focal atrophy, normal ankle mobility, positive Tinel's sign noted across the tarsal tunnel on the left side and exquisite tenderness along the medial ankle. The bone scan revealed posttraumatic changes with a mild uptake around the ankle. The examiner diagnosised posttraumatic arthritis, left ankle and findings suspicious for tarsal tunnel syndrome of the left leg, this may appear as causalgia or CRPS, and recommended more specific nerve testing in order to consider a tarsal tunnel release.

At the post-separation VA Compensation and Pension (C&P) exam the CI reported ankle symptoms, as often as 2-3 times per day lasting for up to 3-4 hour of; weakness, stiffness, swelling, redness, pain, lack of endurance, fatigability, and tenderness. From 1 to 10 (10 being worst pain) the pain level was at an 8. The symptoms were precipitated by physical activity, sitting for long periods, came spontaneously and were alleviated by rest. Flare-ups resulted in functional impairment; can't walk, sleep, or sit, and limitation of motion of the joint; can't pull foot back (toes up in air) and no toe raises. She had relief of pain with Ultram 50 mg enough to help her mentally get through the day while sitting at a desk longer than 1 hour and the condition had not caused incapacitation over the past 12-months. The CI also reported foot symptoms which included; significant pain located at the arch of foot to the heel of foot, up to the shin and the big toe, intermittently as often as 3-4 times per week, the pain level was at 7, exacerbated by physical activity and standing in place for more than 10 minutes with no arch support, relieved by massage and use of arch support. At the time of pain she could function with medication. The VA Compensation and Pension (C&P) exam demonstrated no edema of the lower extremities, normal gait, no abnormal wearing of the feet, no requirement for assistive device for ambulation and further documented normal bilateral ankle and foot exams to included motor, neurologic, vascular and skeletal findings. X-rays of the left foot (non weight bearing and weight bearing) were within normal limits. X-rays of the left ankle were also within normal limits.

The Board directs attention to its rating recommendation based on the above evidence. This rating includes consideration of functional loss lAW VASRD §4.10 (functional impairment), §4.40 (functional loss), §4.45 (DeLuca), and §4.59 (painful motion). The Board first considered the orthopedic MEB exam and compared the ratable data with the anesthesia exam completed one month prior to separation and agreed the anesthesia exam reflects a more specialized exam as well as being more proximate to separation and therefore considers this exam more probative than the MEB exam. Furthermore, the Board notes that the VA exam was complete, well documented, and similar in terms of ratable data to the anesthesia exam completed, however, the VA exam was more compliant with VASRD §4.46 (accurate measurement) and therefore the Board assigns the VA more probative value. The PEB and VA chose different coding options for the condition which had some implications on the rating for the Board to consider. The PEB's 20% rating under 8724 (Internal popliteal nerve, paralysis, neuralgia) cited CRPS for the left ankle and foot for moderate pain. This is consistent with §4.124a criteria which specifies to rate according to the most affected peripheral nerve with the maximum equal to moderate incomplete paralysis. The Board considered 8725 (posterior tibial nerve [tarsal tunnel]) for more clinical specificity however the VASRD criteria are the same as for the 8724 code. The Board agreed the evidence did not support a higher rating of 30% under code 8624 (neuritis severe). The Board notes while the posterior tibial tendinitis was determined to be a Category II condition by the PEB, the chosen neurologic code subsumes the pain of both the ankle and the foot. The VA chose to rate the residuals of the ankle and foot for moderate painful motion with residual degenerative arthritis as their exam showed an improvement of her CRPS with

residual arthritis and pain. Often this approach results in a higher combined rating, however, in this case, the VA's combined disability is lower than the PEB's again likely consistent with the natural progression of improvement of the CRPS.

The Board considered separate ratings for each joint and agreed the evidence did not support the 20% criteria of marked limitation of motion for the ankle under the 5271 code. If the Board considered to separately rate the residual posterior tibial tendonitis of the foot, first the Board would be challenge with a fitness determination. If the Board agreed the foot was separately unfit, the Board agreed the evidence supports the moderate 10% rating with the 5284 code (Foot injuries, other) for a combined disability of 20% which was not higher than the PEB's combined. There was no evidence of documentation of incapacitating episodes which would provide for additional or higher rating. The Board, after due diligence, found no additional route to any higher disability rating. 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 left lower limb condition. Additionally, the Board supports no recharacterization of the PEB fitness adjudication for the symptomatic posterior tibial tendinitis, left foot, as related Category II diagnoses since the associated impairments overlapped with those attributed to the primary diagnosis and is subsumed under that 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 lower limb condition and IAW VASRD §4.71a, the Board unanimously recommends no change in the PEB adjudication. There were no other conditions within the Board's scope of review for consideration.

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
Complex Regional Pain Syndrome, Left Foot and Ankle	8799-8724	20%
	COMBINED	**20%**

The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20120227, 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 26 Nov 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 individual's 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 USN
- former USMC
- former USMC
- former USMC
- former USMC

Assistant General Counsel
(Manpower & Reserve Affairs)