RECORD OF PROCEEDINGS

PHYSICAL DISABILITY BOARD OF REVIEW

NAME: XXXXXX BRANCH OF SERVICE: marine corps

CASE NUMBER: PD0900480 BOARD DATE: 20091117

SEPARATION DATE: 20070615

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SUMMARY OF CASE: This covered individual (CI) was a corporal (nuclear, biological and chemical defense specialist) medically separated from the USMC in 2007 after 3 years of service. The medical basis for the separation was right shoulder capsular stiffness following surgery. The CI initially separated his right acromioclavicular joint (shoulder-AC) and had a surgical repair (20030225) prior to entering Service. He reinjured his right shoulder in 2006 after falling on an obstacle course. He was diagnosed with a right rotator cuff SLAP tear which was surgically repaired. The CI underwent physical therapy, steroid injections and other appropriate therapy that failed to alleviate his symptoms of pain and limited overhead motion. He was on two periods of limited duty for his right shoulder and he was then referred to the Navy Physical Evaluation Board (PEB). The Informal PEB determined he was unfit for continued military service and he was then separated with a 10% disability for right shoulder capsular stiffness post-operatively using the Veterans Affairs Schedule for Ratings Disabilities (VASRD) and applicable Navy and Department of Defense regulations.

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CI CONTENTION: "The rating should be changed because it does not list all my all of my service connected injuries which I still have. Since being out of the Marine Corps, I have had one additional shoulder surgery and in my opinion, has not helped my condition. I have also completed a Basic Law Enforcement Training course and I feel that I will not be able to perform the duties of a police officer."

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RATING COMPARISON:

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Previous Determinations** | | | | | | | | |
| **Service** | | | | **VA** (Exam 2 months post-separation) | | | | |
| **PEB Condition** | **Code** | **Rating** | **Date** | **Condition** | **Code** | **Rating** | **Exam Date** | **Effective date** |
| Right Shoulder Capsular Stiffness  Post-Operatively | 5099-5003 | 10% | 20070327 | Residuals, AC Separation and Slap Tear, Right Shoulder,  Post-Operative with Scarring | 5099-5019 | 10% | 20070827 | 20070616 |
| Status Post Right Shoulder Labral Repair | Related Category 2 Diagnosis | | 20070327 |
| No Additional PEB or MEB Entries | | | | Left Knee Strain | 5099-5019 | 10% | 20070827 | 20070616 |
| Right Knee Strain | 5099-5019 | 10% | 20070827 | 20070616 |
| Anxiety Disorder, NOS (Not otherwise specified) (Claimed as Anxiety) | 9413 | 10% | 20070925 | 20070616 |
| Right Wrist, Heart Condition | NSC | |  |  |
| **TOTAL Combined: 10%** | | | | **TOTAL Combined (*incl non-PEB Dxs)*: 40%** | | | | |

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**ANALYSIS SUMMARY:** The right-hand dominant CI had two periods of Limited Duty for right shoulder pain and limitations of motion. Although the CI had pre-Service right shoulder surgery, there is clear evidence of right shoulder traumatic re-injury and a different type and kind of right shoulder injury. No EPTS deduction was or should be made in this case. Other conditions rated by the VA (left knee, right knee and Anxiety Disorder) as well as heart condition and right wrist not rated by the VA appear to be what the CI is contending for in addition to re-rating his right shoulder. By review of the record, the CI did not appear limited due to lower extremities problems or any mental health diagnosis. The CI's Summary Problem List and AHLTA problem list do not indicate any knee diagnoses or mental health diagnoses. Limited Duty Periods were 20060203-20060816; 20060816-20070215: "No deployments, PFT, PT, formations, field duty, or lifting with right arm." There was no Commander’s Statement in the record; however, it was mentioned on the JDETS Finding and Recommendation Work Card.

RIGHT SHOULDER CAPSULAR STIFFNESS POST-OPERATIVELY.

& STATUS POST RIGHT SHOULDER LABRAL REPAIR. This was the primary PEB unfitting diagnosis and includes the PEB Cat II diagnosis of Status Post Right Shoulder Labral Repair. The Orthopedic Exam demonstrated tenderness to palpation and a full ROM, noting historical exams of pain-limited motion and a nerve dysfunction of the right upper extremity post-operatively that resolved. PT Examination on 20070511 measured pain-limited ROM of forward flexion 0-130˚ and abduction of 0-110˚. Imaging was abnormal. The PEB rated this condition as 5099-5003 Arthritis, degenerative.

VARD 20071115, Diagnosis as Residuals, AC Separation and SLAP Tear, Right Shoulder, Post-Operative with Scarring, was rated at 10% for pain-limited motion (based on exam of 20070827): The available service medical records show you sustained a separation of your acromioclavicular (AC) joint in 2003. This injury was surgically repaired on February 25, 2003. Later records show continued reports of pain. In 2006, you sustained an additional injury to your right shoulder after falling on an obstacle course. You were assessed as having a SLAP tear. This injury was surgically repaired. Despite surgery, your symptoms persisted. You were eventually found unfit for continued military service, medically discharged and awarded disability severance pay. During the course of the VA-sponsored Examination of August 27, 2007, you reported you currently experience weakness, stiffness, locking, fatigue and pain. You described your pain as, "aching" and "sharp." You denied any current treatment regimen. The physical examination revealed three, 1.0cm x 0.5cm scars over your right shoulder. No associated tenderness, disfigurement, ulceration, adherence, instability, underlying tissue loss, inflammation, edema, or keloids were noted. You were also noted to have weakness, tenderness and a guarding of movement. You could flex your right shoulder to only 110 degrees as a result of pain (normal is to 180 degrees). Abduction was accomplished to only 110 degrees as a result of pain (normal is to 180 degrees). External and internal rotation was accomplished to 60 degrees with pain noted at 60 degrees (normal is to 90 degrees). No changes were noted with repeated movements. The X-ray Examination did not reveal any abnormalities. The diagnosis was status post SLAP tear right shoulder with residual pain, weakness, lack of endurance and fatigue with scar. The evidence shows this disability developed while you were on active duty. Service-connection is warranted and has been granted. We have assigned an initial evaluation of 10 percent for this disability because the evidence shows you have painful motion and a limitation of motion as a result of pain. An evaluation of 10 percent is assigned when the evidence shows painful motion, a limitation of motion as a result of pain, or a malunion of the clavicle or scapula without loose movement. We did not assign a higher evaluation of 20 percent because the evidence does not show arm motion limited to shoulder level (approximately 90 degrees), recurrent dislocation, a malunion of the humerus, or a nonunion of the clavicle or scapula with loose movement. Consideration was also given to an increased evaluation due to an additional disability manifested by a limitation of motion, a restriction of activity, or functional impairment caused by pain during periods of flare-up, or when the body part is used repeatedly over a period of time. No change in the assigned evaluation is warranted.

C&P Exam 20070827: Diagnosis: S/P Slap Tear repair Right Shoulder with residual pain, weakness, lack of endurance and fatigue with scar. The subjective factors are constant pain, stiffness, lack of endurance, fatigability. The objective factors are 3 arthroscopic scars, decreased ROM, pain with ROM, fatigue, weakness, lack of endurance, incoordination.

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| --- | --- | --- | --- | --- | --- |
| Movement Shoulder Joint | Normal ROM | Military Exam 20070511 | VA Exam  20070827 | | Military Ortho Exam 20070207  "TTP" and "+FROM" |
| **Flexion** | 180 | 0-130 | AROM / Pain | |
| 110 | 110 |
| **Abduction** | 180 | 0-110 | 110 | 110 |

The CI had painful motion of his right shoulder with the ability to move it above the shoulder without pain using either the military or VA Exams (most limited ROM was 110˚). This condition would not rise to the 20% rating criteria under 5003-5019 unless evidence showed arm motion limited to shoulder level (approximately 90˚). The VA coding of 10% for Residuals, AC Separation and SLAP Tear, Right Shoulder, Post-Operative with Scarring using code 5099-5019 Bursitis provided the same disability percentage and is not predominate to the PEB rating of 10% as 5099-5003 Arthritis, degenerative. Both VASRD codes are analogous and are rated using the same criteria under 5003.

**OTHER VA CONDITIONS.**

LEFT KNEE STRAIN & RIGHT KNEE STRAIN. Bilateral knee pain was mentioned in the MEB History and Physical. DD 2807 Med History 20070207 item #12i-Knees was positive with comment of "Painful knees when cold or walking long distances". DD 2808 Med Exam 20070207 item #34-Lower Extremities was checked Normal. Provider's comments were: "Painful bilateral knee pain. No falling, no injuries, never sought Medical help. Pt states knee pain started "Over 10 years ago." There was no indication in the record of any knee diagnosis on his Summary Problem List or AHLTA problem list. There were no significant notes in the record documenting any chronic knee disability or limitations due to the knees.

The VA rating determination of 20071115 for 10% each knee was based on painful motion and exam 20070827. CI noted stiffness and pain; denied any current functional impairment; there was pain limited ROM for each knee and left knee crepitus (grinding) and locking pain; imaging was normal. C&P Exam 20070827 noted: Specific History: Bilateral Knee Condition: The condition has existed since May 2007. The condition is due to injury; it occurred during combat training. He reports the following symptom(s) from the joint condition: stiffness (painful). He does not have weakness, swelling, heat, redness, giving way, lack of endurance, locking, fatigability and dislocation. Due to the joints condition he has pain located in the knees for 3 months. The pain occurs 3 time(s) per day. The pain is localized. The characteristic of the pain is aching in nature. From 1 to 10 (10 being the worst pain) the pain level is at 5. The pain comes by itself. It is relieved by itself. He states his condition does not cause incapacitation. The claimant is not receiving any treatment for his condition. He has not had any prosthetic implants of the joint. The claimant reports no limitation due to this condition. Exam of (both knees) shows no signs of edema, effusion, weakness, tenderness, redness, heat, subluxation or guarding of movement; non-traumatic weakness and insecurity on weight bearing; non-traumatic 'locking' pain and crepitus. (Both knees) the joint function is additionally limited by the following after repetitive use: pain and pain has the major functional impact. Exams for instability were all negative.

As the Service Treatment Record did not provide detailed examinations for the knees, the VA Examination of 20070827 was considered to be of high probative value to describe the CI's knee conditions at the time of his separation. Even considering these post-discharge exams, neither knee would reach the threshold for being found to be unfitting. As both right and left knee strains are not unfitting, they are therefore not ratable by the Board.

ANXIETY DISORDER, NOS (CLAIMED AS ANXIETY). There was no mention of any nervous trouble or mental health problem in the PEB, MEB, or MEB History and Physical. Specifically DD 2807 Med History 20070207 indicated #17 Nervous Trouble of any sort (a. thru i.) were noted as "Normal" with no other comments. DD 2808 Med Exam 20070207 indicated #39 Neurologic & #40-Psychatric both as "Normal" with no other comments. As the VA noted, the service medical records do not contain a specific record of treatment for any psychiatric symptoms or a continued, clinical diagnosis of a chronic psychiatric disorder.

The VA rated Service connected this condition and rated it at 10% on a rating determination of 20071115. The RD noted, in part; the available service medical records do not contain a specific record of treatment for any psychiatric symptomatology or a continued, clinical diagnosis of a chronic psychiatric disorder. During the course of the VA-sponsored Examination of September 20, 2007 (20070920), you reported you began to experience anxiety while in basic training. You stated you will, "worry" on a daily basis and constantly feel, "on edge." You stated you also have difficulties sleeping and increased irritability. As a result of your symptoms, you stated you tend to isolate yourself. You stated you never sought treatment while on active duty, for fear of repercussion. Despite your symptoms, you are married with children. The examiner stated your appearance and hygiene were appropriate. Your affect and mood was described as, "anxious." No difficulties with speech or communication were noted. No delusions, hallucinations, panic attacks, or feelings of suspiciousness were observed or reported. Judgment, abstract thinking and memory were considered, "intact." The diagnosis was anxiety disorder NOS.A GAF of 70 was assigned.\* (\*deleted explanation of GAF) The examiner stated this condition began while you were on active duty. She also stated the following: His psychiatric symptoms are mild or transient but cause occupational and social impairment with decrease in work efficiency and occupational tasks during periods of significant stress.The evidence shows this disability developed while you were on active duty. Service-connection is warranted and has been granted. We have assigned an initial evaluation of 10 percent for this disability because the evidence shows your symptoms decrease work efficiency and occupational tasks only during periods of significant stress.

No mental health condition was mentioned in the disability evaluation file and Anxiety Disorder, NOS is therefore not within the scope of the Board to adjudicate.

RIGHT WRIST. The right wrist condition was not mentioned in the disability evaluation file and is not within the scope of the Board to adjudicate.

HEART CONDITION. MEB History & Physical noted comment: "Patient had T wave inversion in Aug 06. Angiogram on 10/03/06 was normal with no obstructions and EF of 55-60%. False Positive Cardiolite Scan Sep 06. Cleared by Cardiology."

During evaluation and treatment of his right shoulder the CI was noted to have an abnormal EKG and cardiac scan. Subsequent cardiac catheterization was normal and the prior abnormal studies were considered false positives. The CI did not have any underlying cardiac abnormality. The CI did mention inverted T-waves and his ICU admission in his MEB History.

The VA noted this condition as Not Service Connected (NSC) based on exam of 20070827 and the rating decision of 20071115 noted: The examiner stated there was no pathology to render a diagnosis. The claimant reports being diagnosed with Inverted T-waves. The condition has existed since 2006. As a result of his heart condition, he has experienced asymptomatic. He has no angina, shortness of breath, dizziness, syncope attacks and fatigue. The symptoms described occur constantly. He reports no congestive heart failure. He has no history of rheumatic heart disease. He said he did not have any surgery for his heart condition. The claimant is not receiving any treatment for his condition. All the symptoms are responsive to therapy or treatment. The side effects to treatment include: followed by doctor. The claimant reports no limitation due to this condition. No heaves or thrills. Regular sinus rhythm. No murmurs or gallops. Examination of the heart does not reveal any evidence of congestive heart failure, cardiomegaly or cor pulmonale. For the claimant's claimed condition of HEART CONDITION. No Pathology to render a diagnosis, Subjective: history of abnormal T wave inversion during surgical procedure. Objective: Normal EKG.

The CI's cardiac catheterization was normal and there was no indication of a cardiac diagnosis or chronic disability in the records. The "Heart Condition" has no diagnosis or underlying pathology or limitations and is not unfitting and therefore not ratable.

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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 PDBR 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. After careful consideration of all available information, the Board unanimously concluded the CI’s condition is appropriately rated at 10% for Right Shoulder Capsular Stiffness Post-operatively using the VASRD general rating formula for 5099-5003.

The Board also examined the CI's left knee, right knee and heart conditions. There was no documented adverse impact on performance or significant medical treatment due to any of these conditions. There was no cardiac related diagnosis or pathology. The Board determined the CI's left knee, right knee and heart conditions were not unfitting.

The CI's Anxiety Disorder rated at 10% by the VA and his VA claimed right wrist condition (VA NSC) were not mentioned in the PEB file and could therefore not be considered by the Board. The CI retains the right to request his service Board of Correction for Naval Records (BCNR) to consider adding these conditions as unfitting.

The CI's right shoulder had painful motion with the retained ability to move it above the shoulder without pain using either the military or VA Exams. His most limited ROM near the time of separation was 110˚. This condition did not rise to the 20% rating criteria under 5003-5019 since there was no evidence of arm motion limited to shoulder level (approximately 90˚). The VA coding of 10% for Residuals, AC Separation and SLAP Tear, Right Shoulder, Post-Operative with Scarring using code 5099-5019 Bursitis provided the same disability level of 10% and is not predominate to the PEB rating of 10% as 5099-5003 Arthritis, degenerative. Both VASRD codes are analogous and are rated using the same criteria under 5003. The Board voted unanimously for no re-characterization.

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RECOMMENDATION: The PDBR therefore recommends there be no re-characterization of the CI’s disability and separation determination.

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The following documentary evidence was considered:

Exhibit A. DD Form 294, dated 20090811, w/atchs.

Exhibit B. Service Treatment Record.

Exhibit C. Department of Veterans' Affairs Treatment Record.

MEMORANDUM FOR DIRECTOR, SECRETARY OF THE NAVY COUNCIL

OF REVIEW BOARDS

Subj: PHYSICAL DISABILITY BOARD OF REVIEW (PDBR) RECOMMENDATION

ICO XXXX

Ref: (a) DoDI 6040.44

(b) PDBR ltr dtd 4 Dec 09

I have reviewed the subject case pursuant to reference (a) and approve the recommendation contained in reference (b) that Mr. XXXX’s records not be corrected to reflect a change in either his characterization of separation or in the disability rating previously assigned by the Department of the Navy’s Physical Evaluation Board.