DEPARTMENT OF HOMELAND SECURITY
BOARD FOR CORRECTION OF MILITARY RECORDS

Application for the Correction of
the Coast Guard Record of:

BCMR Docket No. 2011-143

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FINAL DECISION

This is a proceeding under the provisions of section 1552 of title 10 and section 425 of title 14 of the United States Code. The Chair docketed the case after receiving the applicant's application form on January 28, 2011, which was completed upon receipt of her military and medical records on March 25, 2011. The Chair assigned the case to staff member J. Andrews to prepare the decision for the Board as required by 33 C.F.R. § 52.61(c).

This final decision, dated February 23, 2012, is approved and signed by the three duly appointed members who were designated to serve as the Board in this case.

APPLICANT'S REQUEST AND ALLEGATIONS

The applicant, a retired [redacted]/E-6), was processed under the Coast Guard's Physical Disability Evaluation System (PDES) and medically retired from the Coast Guard on June 1, 2007, with a 60% combined disability rating for a pain disorder; incomplete, mild paralysis of the sciatic nerve; and thoracolumbar strain. She asked the Board to correct her Coast Guard record to show that she was retired with a 100% disability rating.

The applicant alleged that her application is timely filed, even though she was retired in 2007, because her total disability was not made clear to her until she was evaluated by doctors for the Department of Veterans' Affairs (DVA) and received the DVA's rating decision awarding her a 100% disability rating on February 13, 2008. The DVA found her 100% disabled due to unemployability, and this rating was made retroactive to her date of retirement from active duty. The applicant alleged that this 100% rating from the DVA, her medical records, and a doctor's statement that her chronic widespread pain is unlikely to improve, which are summarized below, prove that the Coast Guard erred when it assigned her only a 60% permanent disability rating.

The applicant alleged, in particular, that the Coast Guard failed to properly assess her degree of "impairment secondary to mood/pain disorders," intervertebral disc syndrome (IDS) of the thoracolumbar spine, and IDS of the cervical spine. The applicant stated that whereas the

Coast Guard assigned her a 30% disability rating for pain disorder, a 20% rating for incomplete paralysis of the sciatic nerve, and 20% rating for thoracolumbar strain, the DVA assigned her a 50% disability rating for major depressive disorder, a 40% rating for degenerative disc disease (DDD) of the thoracolumbar spine, and a 30% rating for DDD of the cervical spine.

The applicant alleged that the DVA's ratings for her conditions are accurate and prove that the Coast Guard's ratings are erroneous. She alleged that her physical condition deteriorated after she was examined by military doctors pursuant to her PDES processing but before her retirement and that this deterioration was not reflected in the disability ratings she received from the Coast Guard. In particular, she alleged that the measurement of her forward flexion as 15 degrees during her DVA examination shows that she should have received a 40% rating for IDS of the thoracolumbar spine from the Coast Guard. She also alleged that the measurement of the forward flexion of her cervical spine as 10 degrees during her DVA examination shows that she met the requirements for a 30% rating for IDS in her cervical spine as well.

The applicant argued that if there is any doubt about which disability ratings should apply, she should be given the benefit of the doubt pursuant to 38 U.S.C. § 5107(b) and 38 C.F.R. § 4.3. She noted that this doctrine has been enforced by the Court of Veterans Appeals.[1]

The applicant argued that the Board should revise her Coast Guard disability ratings to those assigned by the DVA for these conditions, which would give her an 80% combined disability rating. Moreover, the Board should consider awarding her a 100% disability rating based upon individual unemployability.

SUMMARY OF THE RECORD

The applicant enlisted in [redacted]. On December 28, 2005, a Medical Board (MB) reported that the applicant had complained of chronic low back pain without radiculopathy since January 2004, after she participated in heavy weather surf training. On January 21, 2004, an x-ray revealed mild degenerative changes at L4-5 with a bone spur. On January 29, 2004, an MRI showed minimal disc bulge at T12-L1, which was unlikely to be the cause of her pain due to its location, which she described as a dull constant ache in her right lower back with no radiation or burning. Her gait was normal, and she had a normal range of motion and strength. Results of a bone scan were negative.

The MB reported that on May 21, 2004, the applicant was evaluated by a pain management specialist, who gave her a steroid injection in her sacroiliac joint and prescribed non-steroidal anti-inflammatory drugs, ice, heat, and physical therapy. She was also referred for psychological and rheumatological evaluations. Rheumatoid arthritis was ruled out. Because the injection relieved her pain, from August 2004 through May 2005, a physician treated the applicant for sacroiliac joint disorder, with steroid injections, and with various oral and topical medications. During this time, she "had several episodes of acute exacerbations of back pain …. Coincidently, her exacerbations tend to occur following her failed drills or failed requalification for a small boat coxswain." In April 2005, the applicant's command sent her to a psychologist,

[1] *Caffrey v. Brown*, 6 Vet. App. 377, 383 (1994); *see also Gilbert v. Derwinski*, 1 Vet. App. 49, 57-58 (1990).

who diagnosed Somatization Disorder[2] and recommended administrative separation. The applicant disagreed and paid for a second opinion. Dr. R diagnosed her with mild depression and mild anxiety "with somatic expressions of numbness and tingling, wobbliness of legs, inability to relax, dizziness or light-headedness."

The MB reported that in July 2005, the applicant was transferred from the boat station "due to ongoing low back pain with restricted duties and her [redacted]" She consulted an orthopedic surgeon and told him that her pain increased with stress, cold weather, bending, driving, and lifting and improved with heat, rest, exercise, and swimming. The orthopedic surgeon found that she had normal posture and gait, normal lumbar lordosis (curvature), no paraspinous muscle tenderness, no trigger points, and a normal range of motion. An MRI conducted on August 4, 2005, showed no change since the MRI conducted in January 2004. The orthopedic surgeon recommended that she continue taking Prednisone and that she perform only desk work. He found that she was not a candidate for surgery.

The MB reported that the applicant continued to search for the etiology of her pain. An MRI of both hips on November 8, 2005, was "unremarkable." Also in November 2005, a psychologist diagnosed the applicant with "Pain Disorder associated with both psychological factor and a general medical condition" (DSM 307.89)[3] and chronic low back pain.

The MB concluded that the applicant might have to live with low back pain and that she was not expected to be fit for overseas or sea duty. The MB stated that she "will continue to seek medical attention relentlessly until she finds specialists who agree with her opinion regarding her diagnosis and treatment." The Board unanimously recommended that she be retired due to disability. Therefore, her records were referred to a Central Physical Evaluation Board (CPEB) for evaluation.

On January 9, 2006, the applicant's commanding officer endorsed the MB report, stating that the applicant could no longer perform as a [redacted] and had been reassigned to administrative work.

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[2] "Somatization Disorder" is a pattern of recurring, multiple physical symptoms, such as pain, numbness, and weakness, that suggest a general medical condition and are not fully explained by the person's apparent physical condition, by another mental disorder, or by a substance. The symptoms are not feigned and cause clinically significant distress or impairment in social or occupational functioning. Pain must be related to at least four sites or functions and there must be a history of at least two gastrointestinal complaints and one sexual or reproductive complaint. The complaints must begin before age 30. American Psychiatric Association, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, FOURTH EDITION, TEXT REVISION (2000) (DSM-IV-TR), p. 486 *et seq*. The Coast Guard relies on the DSM when diagnosing psychiatric conditions. *See* Coast Guard Medical Manual (COMDTINST M6000.1B), Chap. 5.B.1.

[3] "Pain Disorder associated with both psychological factors and a general medical condition" is pain that suggests the existence of a general medical condition but is not fully explained by the person's apparent medical condition, by another mental disorder, or by a substance. The pain "is the predominant focus of the clinical presentation and is of sufficient severity to warrant clinical attention … . The pain causes significant distress or impairment in social, occupational, or other important areas of functioning … . Psychological factors are judged to play a significant role in the onset, severity, exacerbation, or maintenance of the pain … . The pain is not intentionally produced or feigned as in Factitious Disorder or Malingering … . Pain Disorder is not diagnosed if the pain is better accounted for by a Mood, Anxiety, or Psychotic Disorder …" DSM-IV-TR, p. 498 *et seq*.

On February 16, 2006, the CPEB reviewed the applicant's records and recommended that she be permanently retired with a 40% combined disability rating based on the following two separate ratings:

- 30% for Pain Disorder (code 9422 in the Veterans' Affairs Schedule for Rating Disabilities (VASRD)) for "occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks (although generally functioning satisfactorily, with routine behavior, self-care, and conversation normal), due to such symptoms as depressed mood, anxiety, panic attacks, chronic sleep impairment, mild memory loss (such as forgetting names, recent events, directions)."

- 10% for IDS "rated as arthritis degenerative based on painful motion."

On May 6, 2006, after consulting counsel, the applicant rejected the CPEB's recommendation and demanded a formal hearing before the Formal Physical Evaluation Board (FPEB).

On June 20, 2006, the applicant's attorney submitted to the FPEB a response to the CPEB's recommendation. He argued that the applicant should receive a combined 60% disability rating based on the following individual ratings and conditions:

- 30% for Pain Disorder (9422) – The attorney stated that he would not argue with this rating, which was assigned by the CPEB. However, he noted that a doctor who evaluated the applicant on July 29, 2005, reported that her GAF was 49, which, he argued, would normally warrant a 50% rating under the criteria for mental disorders. The attorney admitted that the applicant's overall work and social situation had improved since that doctor had evaluated the applicant in July 2005.

- 19% rounded to 20% for bilateral, mild incomplete paralysis of the sciatic nerve (8520) – The attorney argued that the recent nerve conduction studies revealed mild left L5 radiculopathy and mild left and right S1 radiculopathy with nerve responses consistent with L5 and S1 root innervations. He argued that the condition warranted a separate disability rating because it adversely affected the applicant's ability to kneel, squat, crawl, work in confined spaces, run, stand, or walk for extended periods. He argued that because the nerve conduction studies corroborated the applicant's symptoms of parathesias (numbness) in her lower extremities, she should receive a 20% rating for this bilateral condition.

- 10% for thoracolumbar strain (5237) – The attorney noted that radiographic studies and MRIs had shown mild degenerative changes at L4-5, DDD with desiccation and bulging at T12-L1, and disc bulging at T6-7 and T7-8, and that a range of motion study conducted on March 7, 2006, showed that the applicant's forward flexion was limited to 60 degrees. He stated that this limitation merits assignment of a 20% rating under VASRD code 5237 but admitted that the applicant's combined range of motion fell within the criteria for a 10% rating. He noted that the condition had not responded to treatment and argued that it warranted a separate rating because it adversely affected the applicant's ability to lift, carry, bend, reach, or pull without pain.

- 20% for thoracic outlet syndrome (analogous to 8599/8513) – The attorney noted that the applicant had complained of numbness, pain, and weakness in her upper left extremity for a couple of years and that testing on September 27, 2005, indicated possible diagnoses of Compression Thoracic Outlet Syndrome and Hyperabduction Thoracic Outlet Syndrome. The attorney stated that although he raised this issue in rebuttal to the IMB, no further action had been taken to rule out these diagnoses. He argued that the applicant's condition warranted at least a 20% rating under these codes because her ability to lift, carry, pull, fire a weapon, drive a vehicle, and perform repetitive hand motions was adversely affected.

In July 2006, the FPEB referred the applicant to a Disposition Medical Board (DMB) to undergo thoracolumbar range of motion testing, psychiatric examination, an MRI of the cervical spine, and evaluation for possible Thoracic Outlet Syndrome.[4]

On August 7, 2006, a Navy psychiatrist submitted a report for the DMB. He described her then-current condition as follows:

> She displays no problems with speech or behavior. She does get up from time to time to stand due to pain upon sitting for prolonged periods. Her mood is mildly irritable and depressed with decreased affect range. Her thought processes are linear, logical and goal directed. … Her judgment and insight are good as she shows good knowledge and decision making regarding her medical care. She does not display any cognitive problems although this is not tested formally.

The psychiatrist noted that the applicant was being treated for "Pain Disorder Associated with Psychological Factors and a General Medical Condition" and also an "Adjustment Disorder with Mixed Anxiety and Depressed Mood." He stated that the applicant told him that she had become withdrawn and depressed since a psychologist had diagnosed her with Somatization Disorder and her command and other doctors believed she was not really in pain. Zoloft had alleviated her mood and anxiety. The psychiatrist found that the applicant's symptoms of poor sleep, depressed mood, poor appetite, increased isolation, decreased energy and activity, and poor concentration had remained steady since March 2005. He also noted that she was anxious and depressed because of her uncertain future and ongoing pain. The psychiatrist diagnosed her with "Major Depression, Single Episode, Moderate" and stated that her social and occupational functioning were moderately affected by this condition. He also diagnosed her with "Pain Disorder Associated with Both Psychological Factors and a General Medical Condition, Chronic" and noted that this condition severely impaired her military service and industrial capacity.

On August 17, 2006, the applicant underwent range of motion testing of her thoracolumbar spine. Her flexion was measured three times at 42 degrees, 36 degrees, and 37 degrees.

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[4] Thoracic outlet syndrome (TOS) is caused by compression of the subclavian artery (arterial), vein (venous), or brachial plexus nerve (neurogenic or neurologic) in the shoulder. It can be treated with surgery. Arterial TOS reduces blood pressure in the arm and causes signs of emboli, such as blue or black spots, on the hand. Venous TOS causes swelling of the arm. Neurogenic TOS causes pain radiating down the arm, weakness in the arm and hand, and numbness in the fourth and fifth fingers. "Disputed" TOS is diagnosed in "a large number of patients with chronic arm and shoulder pain of unclear cause. The lack of sensitive and specific findings on physical examination or laboratory markers for this condition frequently results in diagnostic uncertainty." Eugene Braunwald *et al*., eds., HARRISON'S PRINCIPLES OF INTERNAL MEDICINE, 15TH EDITION (McGraw-Hill, 2001), p. 89.

On September 27, 2006, the applicant underwent evaluation for thoracic outlet syndrome at a vascular surgery clinic. Dr. S, the chief of thoracic surgery, reported that the applicant presented complaining of "left shoulder pain, left arm pain, and debilitating left upper extremity pain," which had not been "ameliorated with narcotics, muscle relaxants, physical therapy, or other modalities." The applicant stated that she did not have any blue or black spots on her hands or fingers or any swelling of her upper extremities. She reported that her pain was not increased by repetitive motions, writing, or similar use of her hands but that she could not do anything for long because the pain was so severe. The doctor reported that the applicant did not have arterial or venous thoracic outlet syndrome. However, she complained of pain, numbness, and weakness in her arm and hand. Therefore, he reported that

> [s]everal features of neurologic thoracic outlet syndrome exist in this patient and as this is typically a diagnosis of exclusion and she has no evidence of any significant cervical pathology or peripheral nerve traumatic injury to explain her symptoms, this remains a viable, potential diagnosis on this patient. … This patient would be best served by referral to an outside facility for definitive evaluation for neurologic thoracic outlet syndrome and potential management of this disease process.

The applicant also underwent more MRIs pursuant for the DMB, which showed the following:

- Lumbar spine MRI:

> Findings: There is no spondylolisthesis or evidence of spondylosis. The vertebral body heights are well maintained. There are no significant vertebral marrow signal abnormalities. The conus medullaris is normal in position, located at L1. The cauda equine is grossly unremarkable.
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> There is no significant desiccation or loss of height of the lumbar discs with incidental note made of what is likely a mildly hypoplastic L5-S1 disc. There are moderate posterior disc bulges throughout the lumbar spine. There is no evidence of focal disc protrusion, central canal stenosis or significant compressive neural foraminal stenosis. The broad-based disc protrusion at T12-L1 is described on the thoracic spine MRI report of the same day.
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> IMPRESSION: No evidence of focal disc protrusion, central canal stenosis or significant compressive neural foraminal stenosis at the L1-2 through L5-S1 levels.

- Thoracic spine MRI:

> Findings: There is no spondylosis. The vertebral body heights are well maintained. There are no significant vertebral marrow signal abnormalities. The thoracic cord is normal in contour, caliber and signal characteristics. There is very mild desiccation and mild loss of height of the T6-7 through T9-10 discs. Again noted are minor posterior disc bulges at T6-7 and T7-8. There is no evidence of focal disc protrusion, central canal stenosis or gross neural foraminal stenosis. There is mild desiccation and loss of height of the T12-L1 disc. There has been no significant change in the mild, broad-based central disc protrusion at this level without associated central canal stenosis or cord impingement. There is no gross neural foraminal stenosis.
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> IMPRESSION: No significant interval change with a stable, noncompressive, broad-based T12-L1 disc protrusion.

- Cervical spine MRI:

IMPRESSION:

1. Straightening of the usual cervical lordosis and mild multilevel disc desiccation.
2. At C3-4, there is left posterolateral disc bulge with mild to moderate left foraminal narrowing.
3. At C4-5 and C6-7, there is slight posterolateral disc bulge with mild proximal left foraminal narrowing.
4. At C5-6, there is approximately 2 mm broad-based central disc bulging, effacing the ventral thecal sac and resulting in slight proximal foraminal encroachment bilaterally.
5. Following the intravenous administration of gadolinium contrast, no abnormal intra- or extra-axial enhancement is appreciated.

On October 11, 2006, the DMB summarized and submitted these reports to the FPEB along with an email dated July 25, 2006, from the applicant describing how, on a scale of 1 to 10, her pain was at 8 but at 4 to 5 with medication and at 0 immediately following her physical therapy sessions. She explained that she had suffered shoulder pain since May 2006 when she took a misstep and "felt something pull in the upper left shoulder blade and back" although she did not fall. The applicant also described her constant back pain, which radiated to her feet and made it hard to sit for long, and pain, numbness, and weakness in her lower extremities, as well as vertigo, when walking.

On October 14, 2006, the applicant's commanding officer endorsed the DMB report, stating that the applicant continued to perform only administrative work.

On November 17, 2006, the applicant's attorney submitted to the FPEB her rebuttal to the DMB report. He stated that she should be awarded a 70% combined disability rating based on the following ratings:

- 50% for pain disorder (9422) – The attorney argued that the DMB ignored the fact that the applicant had been diagnosed with both *moderate* Major Depressive Disorder and *severe* Pain Disorder and that the Pain Disorder should therefore be "the primary unfitting diagnosis for psychiatric purposes, given the degree of severity of this condition vice the Major Depressive Disorder." He also noted that the psychiatrist found the applicant's GAF to be 55 and argued that she should receive at least a 30% rating for pain disorder and that the more appropriate rating would be 50%.

- 20% for bilateral, mild incomplete paralysis of the sciatic nerve (8520) – The attorney repeated the arguments that he made to the FPEB in his brief dated June 20, 2006.

- 20% for thoracolumbar strain (5237) – The attorney noted that radiographic studies and MRIs had shown mild degenerative changes at L4-5, DDD with desiccation and bulging at T12-L1, and disc bulging at T6-7 and T7-8, and that a new range of motion study on August 17, 2006, had shown forward flexion of just 38 degrees. He argued that the evidence supported at least a 20% rating.

- 20% for thoracic outlet syndrome (analogous to 8599/8513) – The attorney noted that a September 2006 addendum to thoracic surgery report stated that a diagnosis of neuralgic thoracic outlet syndrome was "viable" for the applicant and that her ability to perform

certain duties was significantly limited by "pain that she experiences in her left upper extremity." He also noted that an MRI of the cervical spine in July 2006 had shown disc desiccation and bulging at C3-4, C4-5, C5-6, and C6-7. The attorney argued that a diagnosis of thoracic outlet syndrome best reflects the nature of the applicant's symptoms and degree of impairment and that her degree of impairment under this diagnosis would warrant a 20% rating. However, he suggested that a range of motion study should be conducted to determine whether the applicant's cervical condition would be more appropriately evaluated under VASRD code 5237 instead.

On January 9, 2007, the FPEB recommended that the applicant be permanently retired with a 60% combined disability rating based on a 30% disability rating for pain disorder (9422), a 20% rating for incomplete paralysis of the sciatic nerve (8520), and 20% rating for thoracolumbar strain (5237). In an amplifying statement, the FPEB explained its decision as follows:

> 1) Evaluee suffers from Pain Disorder with both psychological and general medical conditions (VA Code 9422). Even though the report dated 07 August 2006 from [the psychiatrist] found her military and social/occupational impairment [to be] severe, the symptoms reported only substantiate a disability rating of 30%. These symptoms included: depressed mood, poor energy, poor sleep, decreased activity level, poor appetite. Examination revealed no problems with speech or behavior, mood was mildly irritable, and depressed with decreased affect. Her thought processes were linear, logical and goal directed. Her judgment and insight were good and she had intact impulse control. No obvious cognitive problems were displayed.
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> 2) Evaluee suffers from Bilateral Sciatic Nerve-Paralysis-Incomplete-Mild (VA Code 8520). The nerve conduction studies done 29 March 2006 showed mild left L5 and S1 radiculopathy and mild right S1 radiculopathy. This medical documentation substantiates a total disability rating of 20% for these conditions after the bilateral factor was added.
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> 3) Evaluee suffers from Thoracolumbar Strain (VA Code 5237). Active range of motion measurements using a goniometer done 17 August 2006 showed an average forward flexion of 38 degrees. This equates to a disability rating of 20%.
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> 4) There is no substantial evidence for a diagnosis for Thoracic Outlet Syndrome (VA Code 8599/8513). An evaluation by [Dr. S], thoracic surgeon, showed there were no findings to make a diagnosis of either arterial or venous thoracic outlet syndrome. He felt there were several features of neurologic thoracic outlet syndrome. He further stated that there was no evidence of any significant cervical pathology or peripheral nerve traumatic injury to explain her symptoms and that a diagnosis of neurologic thoracic outlet syndrome would be a diagnosis of exclusion. The Board felt that there was not enough evidence to find this condition ratable and chose to have her upper extremity pain included in the diagnosis of Pain Disorder associated with both psychological and general medical conditions.

On February 22, 2007, the applicant acknowledged the FPEB's recommendation and opted not to submit a rebuttal. The recommendation was approved by the Commander of the Personnel Command on May 1, 2007, following a legal sufficiency review. On June 1, 2007, the applicant was medically retired from the Coast Guard after 16 years of service with a 60% combined disability rating for a pain disorder; incomplete, mild paralysis of the sciatic nerve; and thoracolumbar strain as recommended by the FPEB.

On February 13, 2008, the DVA awarded the applicant a 100% disability rating retroactive to her date of retirement because the DVA found her "unable to work due to your service

connected disability/disabilities." The DVA's decision stated that she had an overall or combined rating of 90% based on the following separate ratings for service-connected disabilities:

- 50% for major depression with symptoms such as "occupational and social impairment with reduced reliability and productivity due to such symptoms as flattened affect; circumstantial, circumlocutory, or stereotyped speech; panic attacks more than once a week; difficulty in understanding complex commands; impairment of short- and long-term memory …; impaired judgment; impaired abstract thinking; disturbances of motivation and mood; difficulty in establishing and maintaining effective work and social relationships." The doctor noted that the applicant complained of sadness, depression, crying spells, sleep disturbance, and decreased appetite, motivation, and self-esteem.

- 40% for DDD of the thoracolumbar spine with symptoms such as pain, stiffness, aching, and forward flexion of 30 degrees or less. The doctor reported that the applicant had just 15 degrees of flexion with pain, an antalgic gait, spasms, and radiating pain.

- 30% for IDS of the cervical spine with symptoms such as pain, stiffness, aching, and forward flexion of 15 degrees or less. The doctor noted that the applicant complained of cervical pain with daily flares and radiation, which increased upon twisting and shifting, spasms, and tenderness and showed just 10 degrees of flexion with pain.

The DVA also awarded the applicant the following disability ratings for conditions that the Coast Guard did not rate because they did not make her unfit for military service: 10% for recurrent ovarian cysts, 10% for irritable bowel syndrome, 10% for chronic sprain of the right ankle, 10% for varicose veins, 10% for left shoulder strain, 10% for chronic right knee sprain with degenerative joint disease and chondromalacia, and 10% for a tender scar following a bunionectomy on her right big toe.

On August 12, 2010, a doctor who has been treating the applicant since December 2008 wrote a letter for the applicant, which she submitted with her application. The doctor stated that MRIs of the applicant's spine conducted in 2005 and 2006 revealed protrusion and disc desiccation at T12-L1; minimal annular disc bulges at T6-7 and T7-8; slight disc desiccation at C2-3; disc desiccation and bulging at C3-4, C4-5, C5-6; and disc bulging at C6-7. The doctor noted that the applicant had received physical therapy, chiropractic care, behavioral medicine therapy, gabapentin, and an epidural steroid injection; was "maintained on chronic opioid therapy"; and was also being treated for depression. The doctor stated that he does not believe that the applicant's "moderate severity pain" with inability to sit, stand, or walk for long periods will improve significantly in the future, which makes her uncompetitive for employment.

The applicant also submitted several medical reports regarding her condition since the DVA issued its decision in 2008.

VIEWS OF THE COAST GUARD

On August 16, 2011, the Judge Advocate General (JAG) submitted an advisory opinion in which he recommended that the Board deny relief in this case.

The JAG argued that the application was untimely, that the applicant did not submit anything to justify her delay, that no error or injustice was committed in this case, and that the application should therefore be denied based on its untimeliness. The JAG also noted that the applicant received all due process under the PDES and stated that her "only recourse regarding her disability rating rests with the VA."

In recommending denial, the JAG adopted the findings and analysis provided in a memorandum prepared by the Personnel Service Center (PSC). The PSC stated that the applicant argued that her 60% combined rating is erroneous and unjust because the DVA has awarded her an overall 100% rating based upon unemployability; she should have received a 50% rating for her mental health issues because the DVA rated her 50% for depression; she should have received a 40% rating for thoracolumbar spine impairment because the DVA gave her a 40% rating; she should have received a 30% rating for cervical spine impairment because the DVA gave her a 30% rating; and her Pain Disorder should be rated at 50% because the psychiatrist characterized her condition as severe.

Regarding these arguments, the PSC stated that the FPEB assigns ratings under the VASRD only for medical conditions that render the member unfit for duty and that a member's "employability is not a factor in his/her ability to perform his Coast Guard duties." The PSC stated that the DVA, however, "rates all service-connected disabilities for their impact on the veteran's ability to function under the ordinary conditions of daily life including employment. In other words, the DVA rates conditions for their impact on a veterans' daily life." The PSC alleged that because the Coast Guard and the DVA rate conditions for different purposes, "it is reasonable that the two agencies will achieve different rating results."

The PSC stated that under the VASRD, the FPEB cannot rate a member for multiple and similar mental health conditions, such as Major Depressive Disorder and Pain Disorder. However, if the two diagnoses, considered separately, would result in different ratings under the VASRD, the FPEB assigns the member the higher rating.

The PSC stated that the FPEB's findings were not rebutted by the applicant, sustained review, and are well supported by the evidence of record. The PSC argued that the later findings of the DVA "do not invalidate the accuracy, validity, and legality of the FPEB's findings." The PSC concluded that the application should be denied.

APPLICANT'S RESPONSE TO THE VIEWS OF THE COAST GUARD

The applicant repeated her claim that her application was timely filed because she discovered that the ratings she received from the Coast Guard were erroneous when she received the ratings from the DVA on February 13, 2008.

The applicant stated that the DVA found only 10 degrees of flexion in her cervical spine on July 31, 2007, just two months after her retirement and that the Coast Guard's advisory opinion did not take into consideration the possibility that the applicant's condition worsened

between the FPEB and the date of her retirement. The applicant stated that this range of motion limitation merits a 30% disability rating under DVA code 5237.

The applicant stated that the 20% rating she received under code 8520 for incomplete paralysis of the sciatic nerve and the 20% rating she received for thoracolumbar strain under code 5237 "adequately address the degree of disability secondary to this injury."

The applicant pointed out that the Navy psychiatrist diagnosed her with two separate mental health conditions—Pain Disorder and Major Depressive Disorder—and wrote that her impairment due to depression was moderate but that her impairment due to the Pain Disorder was severe. The applicant alleged that at her DVA mental health examination on July 11, 2007, her GAF was 55, as the Navy psychiatrist had found, and that her symptoms warranted a 50% rating for depression. The applicant acknowledged that ratings should not be assigned for both depression and Pain Disorder associated with both psychological factors and a general medical condition but argued that "the degree of impairment appears to be severe enough to justify the assignment of a 50% disability rating for this condition," instead of 30%.[5] Moreover, she argued, her condition could have declined after the FPEB but before her retirement date.

The applicant submitted with her rebuttal a decision of the Social Security Administration dated March 3, 2011, showing that she filed a disability claim on February 16, 2010. The Social Security Administration found that she had been disabled and unemployed since her retirement from the Coast Guard, that her mental condition caused moderate restrictions in daily living and moderate difficulties in maintaining concentration, etc., that she had residual functional capacity "to perform light work as defined in 20 CFR 404.1567(b)[[6]] except limited to simple, routine, repetitive work; and one to two absences a month," that her previously "acquired job skills do not transfer to other occupations within the residual functional capacity," and that "there are no jobs that exist in significant numbers in the national economy that the claimant can perform."

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[5] Under the Veterans' Affairs Schedule for Rating Disabilities (VASRD) at 38 C.F.R. § 4.130, the following descriptions are provided for 50% and 30% ratings for a mental disorder:

- 50%: "Occupational and social impairment with reduced reliability and productivity due to such symptoms as: flattened affect; circumstantial, circumlocutory, or stereotyped speech; panic attacks more than once a week; difficulty in understanding complex commands; impairment of short- and long-term memory (e.g., retention of only highly learned material, forgetting to complete tasks); impaired judgment; impaired abstract thinking; disturbances of motivation and mood; difficulty in establishing and maintaining effective work and social relationships."
- 30%: "Occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks (although generally functioning satisfactorily, with routine behavior, self-care, and conversation normal), due to such symptoms as: depressed mood, anxiety, suspiciousness, panic attacks (weekly or less often), chronic sleep impairment, mild memory loss (such as forgetting names, directions, recent events)."

[6] The Social Security Administration classifies working ability on the following increasing scale: sedentary, light, medium, heavy, and very heavy. "Light work" is defined as involving "lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. To be considered capable of performing a full or wide range of light work, you must have the ability to do substantially all of these activities. If someone can do light work, we determine that he or she can also do sedentary work, unless there are additional limiting factors such as loss of fine dexterity or inability to sit for long periods of time." 20 CFR 404.1567(b).

The applicant also submitted a DVA medical report dated December 5, 2007, showing that she sought treatment for eczema and back pain. She gave the doctor her MRIs of her "neck and lower back showing various disc bulging without spinal stenosis or nerve impingement (result in record), has tried physical therapy in the past, taking valium and vicodin for pain, was scheduled to see neurosurgeon in 2005 but never was called." The doctor diagnosed her with "discogenic syndrome" and "spondylosis: progressive since 2005," prescribed her vicodin and valium for pain and spasms, and referred her to a neurosurgeon.

FINDINGS AND CONCLUSIONS

The Board makes the following findings and conclusions on the basis of the applicant's military record and submissions, the Coast Guard's submissions, and applicable law:

1. The Board has jurisdiction concerning this matter pursuant to 10 U.S.C. § 1552.

2. The applicant requested an oral hearing before the Board. The Chair, acting pursuant to 33 C.F.R. § 52.51, denied the request and recommended disposition of the case without a hearing. The Board concurs in that recommendation.[7]

3. Under 10 U.S.C. § 1552(b), an application to the Board must be filed within three years after the applicant discovers the alleged error or injustice in her record. The applicant alleged that her application was timely filed because she received her DVA rating decision, which persuaded her that her Coast Guard disability rating was erroneous, in February 2008. However, the record shows that the applicant was well aware of her medical conditions, had received multiple medical opinions, and had the assistance of counsel in considering the FPEB's recommended disability ratings in 2006 and 2007. Moreover, the DVA's decision does not show that the Coast Guard misdiagnosed or otherwise failed to reveal the applicant's medical conditions to her even though the Coast Guard evaluated some of her medical conditions under different codes and at lower ratings than did the DVA and does not rate members for unemployability. Therefore, the Board finds that the applicant's date of discovery of the alleged error and injustice in her military record was June 1, 2007.[8] Her application was not timely filed.

4. Pursuant to 10 U.S.C. § 1552(b), the Board may excuse the untimeliness of an application if it is in the interest of justice to do so. To determine whether the interest of justice supports a waiver of the statute of limitations, the Board should "analyze both [a] the reasons for the delay and [b] the potential merits of the claim based on a cursory review.[9]

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[7] *See Steen v. United States*, No. 436-74, 1977 U.S. Ct. Cl. LEXIS 585, at *21 (Dec. 7, 1977) (holding that "whether to grant such a hearing is a decision entirely within the discretion of the Board"); *Armstrong v. United States*, 205 Ct. Cl. 754, 764 (1974) (stating that a hearing is not required because BCMR proceedings are non-adversarial and 10 U.S.C. § 1552 does not require them).

[8] *Detweiler v. Pena*, 38 F.3d 591, 598 (D.C. Cir. 1994) (holding that, under § 205 of the Soldiers' and Sailors' Civil Relief Act of 1940, the BCMR's three-year limitations period under 10 U.S.C. § 1552(b) is tolled during a member's active duty service).

[9] *Allen v. Card*, 799 F. Supp. 158, 164 (D.D.C. 1992); *see also Dickson v. Secretary of Defense*, 68 F.3d 1396 (D.C. Cir. 1995).

5. The applicant did not explain or justify her delay in applying to the Board. Her record shows that she suffers from depression, which in theory could have delayed her application. However, the record also shows that while suffering this depression and within three years of her retirement, she was able to file and pursue disability claims with both the DVA and the Social Security Administration. Therefore, the Board finds that her delay is not justified because she could have applied for correction of her military record more promptly.

6. A cursory review of the merits of this case indicates that the applicant received all due process under the PDES and was ably represented by counsel. She opted not to rebut the recommendation of the FPEB that she receive a 60% combined disability rating based on a 30% disability rating for a pain disorder, a 20% rating for incomplete paralysis of the sciatic nerve, and 20% rating for thoracolumbar strain. Although the applicant alleged that the higher DVA ratings show that her medical conditions and particularly her range of motion worsened between the date of the FPEB and her retirement on June 1, 2007, there is no evidence of such deterioration in her Coast Guard medical records. The Board is convinced that if the applicant's forward flexion of her cervical spine (neck) had been reduced to 10 degrees before she retired or if the forward flexion in her back had significantly decreased in the six months before her retirement, she would have complained about it while still on active duty and her complaints would appear in her Coast Guard medical records. Moreover, the fact that the DVA awarded her higher ratings does not prove that the Coast Guard's ratings were inaccurate.[10] In particular, the Board notes the applicant's claim that she should have received a 50% rating for her mental disability because, although the Navy psychiatrist reported her depression to be moderate, he reported that her pain disorder severely impaired her military service, and the DVA gave her a 50% rating for her mental disability. However, the FPEB's amplifying statement shows that the FPEB noticed the Navy psychiatrist's assessment that her occupational impairment was severe but compared her actual reported symptoms to the VASRD rating descriptions and found that her mental condition warranted a 30% rating. The applicant did not appeal the FPEB's decision, which is supported in the record and is not inconsistent with the VASRD. The Board also notes that although the DVA found the applicant to be unemployable, she was performing administrative work for the Coast Guard throughout her PDES processing. The Board's cursory review of the merits of the applicant's claim shows that it cannot prevail.

7. Accordingly, the Board will not excuse the application's untimeliness or waive the statute of limitations. The applicant's request should be denied.

[ORDER AND SIGNATURES APPEAR ON NEXT PAGE]

[10] DVA ratings are "not determinative of the same issues involved in military disability cases." *Lord v. United States*, 2 Cl. Ct. 749, 754 (1983); *see Dzialo v. United States*, 5 Cl. Ct. 554, 565 (1984) (holding that a VA disability rating "is in no way determinative on the issue of plaintiff's eligibility for disability retirement pay. A long line of decisions have so held in similar circumstances, because the ratings of the VA and armed forces are made for different purposes.").

ORDER

The application of xxxxxxxxxxxxxxxxxxxxxxxx, USCG (retired), for correction of her military record is denied.