DEPARTMENT OF HOMELAND SECURITY
BOARD FOR CORRECTION OF MILITARY RECORDS

Application for the Correction of
the Coast Guard Record of:

BCMR Docket No. 2013-177

[redacted]

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 completed application on September 18, 2013, and assigned it to staff member [redacted] to prepare the decision for the Board as required by 33 C.F.R. § 52.61(c).

This final decision, dated June 27, 2014, 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, who retired from the Coast Guard Reserve on July 31, 2013, after being found fit for duty, asked the Board to direct the Coast Guard to complete a medical board[1] to determine her fitness for duty and, if found unfit for duty, to void her Reserve retirement and award her a medical retirement. She also asked to receive back pay from the date of her medical retirement. The applicant alleged that although she was found not to have a disqualifying condition during her pre-separation physical examination on July 29, 2013, she did, in fact, have three disqualifying conditions and should have been referred to a medical board before she was retired:

- Right knee impairment—The applicant stated that she incurred her knee injury while on active duty in 2002 and that she continues to suffer from patellar instability and attendant pain. She alleged that under the Veterans' Affairs Schedule for Rating Disabilities (VASRD) code 5257, she does not physically qualify for duty as there is recurrent subluxation and lateral instability.

[1] A medical board is a clinical body comprised of two or more medical officers who evaluate an individual's condition in light of the requirements of military duty and provide a written professional opinion concerning the evaluee's physical and mental qualifications in relation to military service and makes certain recommendations regarding the evaluee. Physical Disability Evaluation System (PDES) Manual, Article 2.A.29.

- Carpal tunnel syndrome—The applicant stated that she has constant numbness and pain bilaterally in her hands and that she is not physically qualified for duty because she has limited use of her hands. She alleged that the provider who performed her retirement physical ignored these "clinical circumstances."

- Thoracolumbar spine impairment—The applicant stated that since 2006 she has had a physically disqualifying range of motion in flexion of the thoracolumbar spine and has had constant, significant leg and back pain. She stated that her range of motion on May 13, 2013, was well below physical qualification standards, and were as follows:

    A. Forward flexion - 15 degrees.
    B. Backward extension - 5 degrees.
    C. Left and right bend, and left and right rotation: - 5 degrees.

  The applicant stated that she was diagnosed with L5-S1 isthmic spondylolisthesis which had become so severe that it required surgery. She noted that she had anterior/posterior spinal fusion in February 2013 but continues to have severe range of motion issues. She alleged that the Coast Guard physician who performed her pre-retirement physical examination "did nothing to ascertain her range of motion" and that the failure to do so was "disgraceful."

The applicant stated that on July 17, 2013, the medical clinic at Coast Guard [redacted] recommended that she be placed in the Temporary Limited Duty (TLD) program[2] with the potential for a medical board. She also stated that on June 19, 2013, the Coast Guard found that she was not physically qualified for separation due to medical reasons, and on that same date a Coast Guard physician's assistant stated in an email that he had determined that the she was not fit for duty (NFFD). However, she noted that the physician's assistant who declared her NFFD on July 19, 2013, also performed her retirement physical examination on July 29, 2013, and found her qualified for service.

The applicant stated that prior to her retirement, her counsel demanded to the Coast Guard that she be evaluated by a medical board, but the Coast Guard Personnel Service Center (PSC) responded that the demand was premature because her pre-retirement physical examination had not been completed to determine if she had any disqualifying conditions.

Finally, the applicant stated that that the Coast Guard erroneously shifted the burden of her medical care to the Department of Veterans Affairs (DVA) rather than provide a medical evaluation board as she requested while serving on active duty. In support of these allegations, the applicant submitted copies of emails and her medical records, which are included in the Summary of the Record below.

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[2] Chapter 2.A.53. of the PDES Manual defines TLD as "[a] determination by a physician that a member is temporarily unable to perform the essential duties of the member's office, grade, rank or rate. A member placed on TLD will have duty limitations specified, such as: no lifting, climbing, swimming, running, prolonged standing, no sea or flying duty, etc. Before placing a member on TLD, the physician must find that an amelioration of the condition for which the member is being placed on TLD will allow for the member's return to full duty within 9 months. For members of the selected reserve who are temporarily physically disqualified or in an Available for Limited Duty status, see the Reserve Policy Manual, COMDTINST M1001.28 (series)."

SUMMARY OF THE RECORD

The applicant enlisted in the Coast Guard Reserve on January 30, 1980, and served on active duty in the regular Coast Guard from March 17, 1980, through January 28, 1983, when she was released into the Reserve. She reenlisted in the Reserve on January 24, 1987, and served in the Selected Reserve or the Individual Ready Reserve until she began serving on extended active duty in 2002. According to a Statement of Creditable Service in her record, the applicant began an extended period of active duty on this date and served almost continuously on active duty until she retired in 2013. At the time of her retirement, she was serving as [redacted]

The applicant submitted her own medical records, which show that she incurred some injuries as a civilian (she was hit by a car in 1974 and had a skydiving accident in which she was burned by a power line in 1993) but also incurred and/or was treated for several medical conditions while serving on extended active duty:

August 6, 2003: The applicant underwent x-rays of her lumbar spine. She stated that she had slipped and fallen in a parking lot at work in December 2002. Although she did not seek a medical evaluation at the time, she had suffered chronic lower back pain since her fall. The x-rays showed grade I-II spondylolisthesis at the lumbosacral junction with no vertebral compression fracture or bony destructive process.

April 15, 2005: During a physical examination to determine her fitness for duty, the applicant complained of chronic back pain, which she rated as 6 or 7 out of 10 and described as dull and achy. She also noted that she had dislocated her knee while skiing in 1999. The doctor found that she had no disqualifying defects and was fit for duty.

April 29, 2005: An MRI of the applicant's lumbar spine showed grade II anterior spondylolisthesis of about 8 millimeters of L5 on S1, bilateral neuroforaminal stenosis and an L paracentral disc herniation abutting the L nerve root.

September 19, 2005: At a follow-up examination, the applicant reported that her back pain had nearly resolved through massage, yoga, and exercises. The doctor reported that she had a normal range of motion at the waist and that her diagnoses were lumbar spondylosis with degenerative disc disease and localized shoulder pain.

March 30, 2006: The applicant sought treatment for a gradual onset of left lumbar pain. She was diagnosed with a lumbar strain. At a follow-up appointment on April 4, 2006, she reported that her back pain was much improved, and she was found fit for full duty. The doctor noted that she was in a training program and had passed all of the physical fitness tests.

August 15, 2006: The applicant sought and received a referral for physical therapy due to intermittent episodes of lower back pain. The doctor noted that she reported a history of lumbar degenerative disease and spondylolisthesis and diagnosed her with lumbago.

October 10, 2006: The applicant reported that her back pain had resolved through physical therapy.

October 23, 2007: The applicant called the [redacted] Primary Care clinic and requested an MRI of her lumbar spine because of her back pain, which radiated into her lower gluteal region. On October 29, 2007, an MRI found advanced degenerative disc disease at L5-S1 with grade I spondylolisthesis, moderate foraminal stenosis, and impingement on the exiting L5 nerve roots. She was referred to a neurology clinic.

November 27, 2007: A doctor noted that a neurologist had diagnosed the applicant with a back muscle spasm and prescribed medication.

April 29, 2008: The applicant was again referred to the neurology clinic for complaints of lower back pain.

August 19, 2009: The applicant underwent an annual periodic health assessment. No complaints of or prescriptions for back or knee pain were noted during the examination, and she was found fit for full duty.

June 21, 2010: The applicant underwent an annual preventive health assessment and was found fit for duty with no unresolved operational or deployment health issues.

September 9, 2011: During an annual preventive health examination, the doctor noted that the applicant had a history of lower back pain "which continues to give her trouble." The applicant told the doctor that the pain was intermittent, increased with activity, and decreased with rest. She was released without limitations (fit for duty).

January 3 – 19, 2012: The applicant sought treatment for multiple issues, including complaints of lower back pain and right knee pain. She stated that she had dislocated her right patella while skiing about 10 years earlier; that her knee had been unstable ever since; and that it had hurt since she slipped and fell a few weeks earlier. An x-ray of her knee revealed no acute fracture; mild medial joint compartment narrowing; small joint effusion; and calcific fragment medial to the patella. An MRI revealed a patellar tracking abnormality, with mild lateral patellar tilt, subluxation, and superior trochlear dysplasia. The applicant received a steroid shot in her right knee, and a doctor at the Rothman Institute referred her for physical therapy and advised her that the knee would probably need surgery.

January 9, 2012: The applicant underwent an MRI of her spine which revealed grade 1 spondylolisthesis of L5-S1 with bilateral foraminal stenosis and possible impingement of the nerve root. Medical notes dated January 13, 2012, state that the MRI showed that everything was essentially unchanged, but that more x-rays of her back were needed to determine whether the "spondys" were stable or unstable—i.e., whether her vertebrae moved when she bent forward or backward.

February 2, 2012: The applicant was evaluated by the anesthesiology department regarding pain management, evaluation, and treatment for her back and knee pain.

April 12, 2012: The applicant returned to the [redacted] Primary Care clinic with complaints of back pain. The notes state that she had bilateral spondylolisthesis with bilateral foraminal stenosis. She was referred to the anesthesiology clinic with a diagnosis of lumbar radiculopathy.

April 19 and 24, 2012: The applicant received Synvisc[3] injections in her right knee. The notes state that she had had an orthopedic evaluation several weeks earlier and that the specialist had recommended extensive surgery, which the applicant sought to avoid by trying Synvisc injections instead. She was released without limitations.

May 18, 2012: The applicant underwent a physical examination at the [redacted] Primary Care clinic, and the provider's notes state that the applicant reported a history of back pain since 2003 and stated that she had tried physical therapy and pain management with minimal success. She told the doctor that two orthopedists had recommended lumbar fusion and that she wanted to explore that option. On June 26, 2012, she had a lumbar epidural steroid injection instead.

June 11, 2012: The applicant was seen at an arthritis clinic with complaints of hand and wrist pain with decreased grip and trouble moving her hands. She was diagnosed with overuse-related osteoarthritis and DeQuervain's tenosynovitis with no suspicion of rheumatoid arthritis.

June 18, 2012: The applicant was referred to an orthopedic clinic for her localized knee pain.

August 7, 2012: The applicant visited a civilian orthopedist for another follow-up examination of her right knee. The notes state that the applicant had decided to proceed with surgery on the knee.

August 10, 2012: An orthopedic surgeon at the [redacted] recommended that the applicant undergo an anterior posterior lumbar decompression and fusion surgery to stabilize her condition, prevent progression, and reduce pain radiating in her right leg. He advised her that following the surgery, her back pain might increase. He measured her flexion at 60 degrees.

November 5, 2012: The applicant underwent arthroscopic surgery on her right knee due to patella instability; patellar chondrosis; medial meniscus tear; and loose body. The doctor performed a partial medial meniscectomy, chondroplasty patella, and loose body removal.

December 5, 2012: The applicant called the [redacted] Primary Care clinic requesting referrals to the orthopedic clinic for her lower back pain and knee pain. A doctor at the [redacted] diagnosed her knee condition as malalignment syndrome, patellar instability, and multiple chondral lesions of the patella and trochlea, and noted that she was on the waiting list for a fresh osteochondral allograft transplant.

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[3] Synvisc is a gel-like mixture made from a substance called hyalurona. When injected into the knee it supplements the fluid in the knee to help lubricate and cushion the joint, and can provide up to six months of osteoarthritis knee pain relief.

December 20, 2012: The applicant was evaluated at the [redacted] with complaints of numbness in her right hand. The doctor reported that the applicant had evidence of carpal tunnel syndrome on the right with a mild to moderate degree with no evidence of axonal loss. She was referred to a surgery clinic.

January 14, 2013: The applicant was seen at the [redacted] regarding complaints of lower back pain. The doctor recommended surgical intervention for her LF-S1isthimic spondylolisthesis, and the applicant stated that she wanted to proceed with surgery.

January 29, 2013: The applicant underwent "part 1" of a pre-separation physical examination because she had decided to retire. The doctor noted that she was currently being seen by Dr. K, a certified physician's assistant (PAC), "for back surgery and right knee surgery post op." She was released without limitations.

February 20, 2013: The applicant underwent an anterior and posterior lumbar decompression and fusion. She was granted 30 days of convalescent leave and told to follow up on March 18, 2013, regarding an extension.

March 8, 2013: At a follow-up examination, the surgeon noted that the applicant was doing well and was not having any leg pain, but that she complained of post-operative back discomfort.

March 20, 2013: The applicant was granted another 30 days of convalescent leave. She told clinic personnel that she was going to retire "due to her many orthopedic issues."

April 8, 2013: At a follow-up visit six weeks after her back surgery, the surgeon noted that the applicant was doing well; that both her back pain and leg pain had improved; and that she walked with a normal gait. However, he renewed her prescriptions for pain medication and advised her to continue using her brace when walking and to not lift more than 10 pounds or to bend more than 90 degrees.

April 18, 2013: At the clinic, the applicant's doctor noted that she was recuperating well from her back surgery but needed another 30 days of SIQ (sick in quarters) status. He extended her SIQ status until May 21, 2013.

April 23, 2013: The applicant submitted a Reserve Retirement Transfer Request and it was approved by her supervisor on May 1, 2013.

May 2, 2013: The applicant returned to [redacted] complaining of bilateral base of the thumb pain. She was diagnosed with bilateral thumb CMC arthritis, recurrent, and given a second injection of Kenalog and lidocaine.

May 13, 2013: The applicant was evaluated by the DVA, and a physician assistant (PA) completed a Back (Thoracolumbar Spine) Conditions Disability Benefits Questionnaire. The applicant reported that she still had pain about 80% of the time, and that in accordance with her surgeon's post-operative instructions, she was still wearing a back brace when walking long dis-

tances. The PA wrote that the applicant "continues to heal from surgery and still has post-op restrictions and pain." In addition, the PA recorded the following range of motion measurements for the applicant's back:

A. Forward flexion – 15 degrees
B. Extension – 15 degrees
C. Right lateral flexion ends – 5 degrees
D. Left lateral flexion ends – 5 degrees

June 19, 2013: HSCM X, the Health Services Clinic Supervisor at [redacted] sent an email to the unit's Servicing Personnel Office (SPO) stating that Dr. K, the PAC, had indicated that the applicant was NFFD and that he was waiting on the results of a consultation and follow-up examinations. In turn, the SPO sent an email to Reserve Personnel Management at PSC stating that he had not previously handled the case of a reservist on extended active duty but because the applicant was not physically qualified for separation, [redacted] might have to retain her beyond her retirement date of July 31, 2013.

July 17, 2013: HSC Y sent an email stating that the [redacted] medical clinic had asked for the applicant to be entered into the TLD program and that the request was approved and would expire on February 28, 2014. However, on July 18, 2013, PSC advised the clinic that as a reservist serving on an extended active duty contract, the applicant could not be entered in the TLD program because her contract was ending and reservists can be released into the Reserve and still receive treatment as reservists. PSC stated that the head of Enlisted Personnel Management would consult with PSC's staff medical officer to determine whether the applicant's conditions warranted a delay of her retirement date or a release back to the Reserve for continued treatment.

July 19, 2013: The applicant's attorney submitted a letter to the Commandant of the Coast Guard demanding that the applicant be retained on extended active duty and evaluated by a medical board because she had three recognized disqualifying conditions. He argued that she should not be passed off to the DVA.

July 25, 2013: The Personnel Service Center (PSC) responded to the attorney's request. PSC cited Article 1.C.3. of the Military Separations Manual and Chapter 2.C. of the PDES[4] Manual and stated that it was premature to grant the applicant's request because she was scheduled to complete her pre-retirement physical examination on Monday, July 29, 2013. PSC stated that once these results were received, the Coast Guard would determine if a delay was appropriate.

July 29, 2013: The applicant returned to the clinic for part 2 of her pre-retirement physical examination. On the Report of Medical History she reported the numerous medical conditions she had incurred or aggravated on active duty, including the spondylolisthesis, carpal tunnel syndrome, and a pending allograft knee surgery. The applicant also wrote that she had lower

[4] The structure within the Coast Guard composed of administrative boards and reviewing and approving authorities for evaluating a member's physical ability to perform the duties associated with the member's office, rank, grade, or rating, and the equitable application of the laws and regulations relating to separation or retirement of members because of physical disability. Article 2.A.42. of the PDES Manual (2006).

back problems with a greatly decreased range of motion, right knee problems, and carpal tunnel syndrome. Dr. K, who performed the examination, noted her many medical conditions but indicated that she was qualified for service and separation, and he did not indicate that any of her conditions were permanently disabling. A senior medical officer concurred in this finding.

July 31, 2013: The applicant was retired from the Coast Guard Reserve.

In August 2013, the applicant sought physical therapy through the DVA. She advised the doctor that since her back surgery, her back and leg pain had decreased, but still suffered "6-8/10 back pain/spasm which shoots down both buttocks with bending and moving around." She could walk four or five blocks, but her range of motion was "markedly limited in all planes due to non-radiating back pain. SLR with severe back pain at 30-40 degrees." Her right knee was tender and painful when flexed beyond 90 degrees.

VIEWS OF THE COAST GUARD

On March 11, 2013, the Judge Advocate General (JAG) of the Coast Guard submitted an advisory opinion recommending that the Board deny relief in accordance with the findings and analysis in a memorandum submitted by Commander, Personnel Service Center (PSC).

PSC stated that while it agrees that the applicant has several medical conditions that were incurred during her Coast Guard career, she was never referred to a Medical Evaluation Board (MEB) for PDES processing by her command or her treating physician because according to the Coast Guard PDES Manual, "The sole standard in making any determination of physical disability as a basis for retirement or separation shall be unfitness to perform the duties of office, grade, rank, or rating because of disease or injury incurred or aggravated through military service." In this regard, PSC noted that while the applicant had several periods of convalescence following her surgeries and treatment, she returned to work after every treatment and continued to work a regular schedule and perform her duties up until her retirement. PSC alleged that because she did not appear incapable of completing her duties, her command did not initiate a medical board by requesting a fitness for duty assessment from a medical officer. PSC stated that an MEB can only be initiated after a medical officer determines that the member has a condition that prevents her from completing her duties, and that although the applicant was persistent in seeking treatment for her medical conditions, she was unable to convince a medical officer to find that any of her impairments were permanent, stable, and preventing her from completing her duties. PSC noted that under Chapter 2.C.2.c. of the PDES Manual, if a member being processed for retirement adequately performs the duties of her office, grade, rank or rating, then the member is deemed fit for duty even though medical evidence indicates that she has impairments.

PSC stated that the applicant requested retirement and that she was properly processed for a voluntary retirement in accordance with Coast Guard policy and that her argument that she should have been evaluated by an MEB prior to her retirement is without merit. PSC stated that the applicant was never referred for an MEB and PDES processing because she was fit to perform the duties of her office, grade, rank, or rating.

PSC stated that the applicant will be duly compensated for her military service because she qualified for and will receive retirement pay for her Coast Guard service. PSC alleged that the DVA is the correct venue for the applicant to pursue medical treatment and compensation for the medical problems that she sustained or that were aggravated by her Coast Guard duty if they become disabling after her retirement.

APPLICANT'S RESPONSE TO THE VIEWS OF THE COAST GUARD

On March 27, 2013, the BCMR sent the applicant a copy of the Coast Guard's views and invited her to respond within 30 days. No response was received.

APPLICABLE REGULATIONS

Chapter 3.F.1.c. of the Medical Manual states the following:

> Members are ordinarily considered fit for duty unless they have a physical impairment (or impairments) that interferes with the performance of the duties of their grade or rating. A determination of fitness or unfitness depends upon the individual's ability to reasonably perform those duties. Active duty or selected reserves on extended active duty considered permanently unfit for duty shall be referred to a Medical Evaluation Board for appropriate disposition.

Chapter 3.F.12.a. states that a wrist that limits the total range of motion of the wrist to less than 15 degrees is normally considered disqualifying for retention and grounds for convening an MEB. Carpal tunnel syndrome is a condition that is disqualifying for enlistment or induction into military service, pursuant to Chapter 3.D.22.b.(6), but it is not a disqualifying condition for retention under Chapter 3.F.

Chapter 3.F.12.b. states that an "internal derangement of the knee" may be disqualifying for retention on active duty if there is "[r]esidual instability following remedial measures, if more than moderate; or with recurring episodes of effusion or locking, resulting in frequent incapacitation." In addition, the knee should flex to at least 90 degrees.

Chapter 3.F.13. addresses conditions of the spine but does not specifically address the applicant's condition. However, congenital spondylolisthesis may be disqualifying if there are "more than mild symptoms resulting in repeated hospitalization or significant assignment limitation." Enclosure (1) to the Physical Disability Evaluation System (PDES) Manual provides that if a member is found to be permanently disabled due to spinal fusion (VASRD code 5241), the disability is to be rated as follows:

Unfavorable ankylosis of the entire spine …….……	100%
Unfavorable ankylosis of the entire thoracolumbar spine……..…….	50%
Forward flexion of the thoracolumbar spine 30 degrees or less; or favorable ankylosis of the entire thoracolumbar spine ……...…….	40%
Forward flexion of the thoracolumbar spine greater than 30 degrees but not greater than 60 degrees …….	20%
Forward flexion of the thoracolumbar spine greater than 60 degrees but not greater than 85 degrees ……	10%

Chapter 2.C.2. of the PDES Manual states the following:

Fit For Duty/Unfit for Continued Duty. The following policies relate to fitness for duty:

a. The sole standard in making determinations of physical disability as a basis for retirement or separation shall be unfitness to perform the duties of office, grade, rank or rating because of disease or injury incurred or aggravated through military service. Each case is to be considered by relating the nature and degree of physical disability of the evaluee concerned to the requirements and duties that a member may reasonably be expected to perform in his or her office, grade, rank or rating. In addition, before separation or permanent retirement may be ordered:

(1) There must be findings that the disability:

(a) is of a permanent nature and stable, and

(b) was not the result of intentional misconduct or willful neglect and was not incurred during a period of unauthorized absence.

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b. The law that provides for disability retirement or separation (10 U.S.C., chapter 61) is designed to compensate a member whose military service is terminated due to a physical disability that has rendered him or her unfit for continued duty. That law and this disability evaluation system are not to be misused to bestow compensation benefits on those who are voluntarily or mandatorily retiring or separating and have theretofore drawn pay and allowances, received promotions, and continued on unlimited active duty status while tolerating physical impairments that have not actually precluded Coast Guard service. The following policies apply:

(1) Continued performance of duty until a member is scheduled for separation or retirement for reasons other than physical disability creates a presumption of fitness for duty. This presumption may be overcome if it is established by a preponderance of the evidence that:

(a) the member, because of disability, was physically unable to perform adequately in his or her assigned duties; or

(b) acute, grave illness or injury, or other deterioration of the member's physical condition occurred immediately prior to or coincident with processing for separation or retirement for reasons other than physical disability which rendered him or her unfit for further duty. …

(2) A member being processed for separation or retirement for reasons other than physical disability shall not be referred for disability evaluation unless the conditions in paragraphs 2.C.2.b.(1)(a) or (b) are met.

c. If a member being processed for separation or retirement for reasons other than physical disability adequately performed the duties of his or her office, grade, rank or rating, the member is presumed fit for duty even though medical evidence indicates he or she has impairments.

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e. … Conversely, an evaluee convalescing from a disease or injury that reasonably may be expected to improve so that he or she will be able to perform the duties of his or her office, grade, rank, or rating in the near future may be found fit for duty….

f. The following standards and criteria will not be used as the sole basis for making determinations that an evaluee is not fit for duty by reason of physical disability:

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(6) pending voluntary or involuntary separation, retirement, or release to inactive status (see article 2.C.2.b.(1)).

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. The application was timely filed within three years of the applicant's retirement.

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.[5]

3. The applicant argued that she was not physically qualified for duty or separation when she retired because she had three disqualifying conditions: her right knee impairment, carpal tunnel syndrome, and thoracolumbar spine impairment. She alleged that she should have been retained on active duty and given a medical board. The Board begins its analysis in every case by presuming that the disputed information in the applicant's military record is correct as it appears in her record, and the applicant bears the burden of proving by a preponderance of the evidence that the disputed information is erroneous or unjust.[6] Absent evidence to the contrary, the Board presumes that Coast Guard officials and other Government employees have carried out their duties "correctly, lawfully, and in good faith."[7]

4. The applicant alleged that she should not have been retired or released from active duty, but on April 23, 2013, while she was convalescing from surgery, she voluntarily submitted a request to retire from the Reserve as of July 31, 2013, when her extended active duty contract terminated. She told the clinic that she was requesting retirement from the Reserve because of her medical conditions, but neither her doctors nor her command had initiated an MEB. The June 19, 2013, emails show that Dr. K considered her not fit for duty on that date because he was still awaiting the results of consultations and follow-up examinations. The July 17, 2013, email shows that by that date, the medical staff at the clinic, presumably including Dr. K, thought she should be placed in the Temporary Limited Duty (TLD) program, which indicates that they expected her to be fit for duty within nine months. The record shows that the request to place her in the TLD program was initially approved but then denied because the applicant's active duty contract was ending. This denial based on the termination date of her contract does not cast doubt on the assessment of the medical staff that she would recover from her back surgery and be fit for duty. According to the Coast Guard, although the applicant had impairments and was convalescing from surgery, she had not been deemed permanently disabled and was capable of performing her assigned duties at the [redacted]

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[5] *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"); *Flute v. United States*, 210 Ct. Cl. 34, 40 (1976) ("The denial of a hearing before the BCMR does not *per se* deprive plaintiff of due process."); *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).

[6] 33 C.F.R. § 52.24(b).

[7] *Arens v. United States*, 969 F.2d 1034, 1037 (Fed. Cir. 1992); *Sanders v. United States*, 594 F.2d 804, 813 (Ct. Cl. 1979).

5. Under Chapter 2.C.2.b. of the PDES Manual, if a member is voluntarily retiring and has been serving on unlimited active duty while tolerating physical impairments, the member is not entitled to an MEB and processing under the PDES unless the member is unable to perform her assigned duties or suffers an "acute, grave illness or injury, or other deterioration of the member's physical condition occurred immediately prior to or coincident with processing for separation." According to the Coast Guard, neither of these conditions applied because the applicant was able to perform her assigned duties and was convalescing from surgery but did not suffer an acute injury coincident with her processing for retirement. The applicant claimed that she had disqualifying conditions but did not explain how or whether her disabilities would prevent her from returning to her assigned duties conducting classes for new military recruiters at the training center. Nor did she respond to or rebut the arguments in the Coast Guard's advisory opinion.

6. The preponderance of the evidence shows that the applicant was still recovering from her back surgery when she requested retirement and when she was retired on July 31, 2013: (a) On April 18, 2013, she was granted SIQ status to convalesce through May 21, 2013, (b) on July 17, 2013, the clinic's medical staff asked that she be placed in the TLD program, indicating that they expected her to become fit for duty within nine months, and (c) in August 2013, the applicant sought physical therapy to help her recover from her back surgery and improve her range of motion. Under Chapter 2.C.2.e. of the PDES Manual, a member who is convalescing from surgery may be found fit for duty and separation if her condition is expected to improve enough to allow her to return to duty. The medical staff's request that she be placed in the TLD program indicates that they expected her to improve enough to return to duty. Because the preponderance of the evidence shows that she was convalescing but expected to improve enough to return to duty, the finding of Dr. K and the senior medical officer that she was medically qualified for separation on July 29, 2013, is not clearly erroneous or unjust.

7. Although the applicant alleged that the doctor or her command should have convened an MEB because she had three disqualifying conditions, the Board finds that the applicant has not proven by a preponderance of the evidence that her doctor or her command erred in this regard for the following reasons:

- The applicant was still recovering from back surgery, and she was apparently expected to improve enough to be fit for duty because the medical staff at the clinic asked to place her in the TLD program on July 17, 2013.[8] As noted above, the fact that a member is convalescing from surgery does not entitle the member to an MEB.[9]
- Carpal tunnel syndrome is not a disqualifying condition for retention or separation under Chapter 3.F. of the Medical Manual.
- Although the applicant still had some instability in her knee after her surgery in November 2012 and was a candidate for an allograft transplant, her medical records show that

[8] According to Article 2.A.53. of the PDES Manual, TLD means that a physician has determined that a member is temporarily unable to perform her duties but expects an amelioration of the condition that will allow the member to return to full duty within 9 months.

[9] PDES Manual, Chap. 2.C.2.e.

she was able to bend her knee up to 90 degrees without pain in August 2013, and they do not show that in July 2013 the residual instability was more than moderate or frequently incapacitated her, as required under Chapter 3.F.12.b. of the Medical Manual.

8. It is not clear to the Board why the applicant requested retirement from the Reserve on April 23, 2013, when she was still convalescing from back surgery in SIQ status. Had she not requested retirement, she would have been released from active duty when her contract ended on July 31, 2013, and as a reservist on inactive duty, she would have been entitled to incapacitation benefits, including medical care and full active duty pay and allowances, as long as she remained unable to perform her military duties.[10] And if she did not recover, she would have been evaluated by an MEB and processed under the PDES for a medical separation. As a senior chief yeoman in the Reserve with 28 years of experience, the applicant must have known these longstanding rules in the Reserve Policy Manual. Because she voluntarily requested retirement from the Reserve, however, the rules in Chapter 2.C.2. of the PDES Manual applied, and under those rules, she was not entitled to an MEB or processing under the PDES.

9. The applicant has not proved by a preponderance of the evidence that her voluntary retirement on July 31, 2013, without prior PDES processing was erroneous or unjust. Therefore, her request should be denied.

(ORDER AND SIGNATURES APPEAR ON NEXT PAGE)

[10] 37 U.S.C. § 204(g); Reserve Policy Manual, Chap. 6.A.4.b.

ORDER

The application of [redacted] USCGR (retired), for correction of her military record is denied.

June 27, 2014

[redacted]