

**DEPARTMENT OF HOMELAND SECURITY
BOARD FOR CORRECTION OF MILITARY RECORDS**

Application for Correction of
the Coast Guard Record of:

BCMR Docket No. 2005-024

XXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXX

FINAL DECISION

AUTHOR: Andrews, J.

This is a proceeding under the provisions of section 1552 of title 10 and section 425 of title 14 of the United States Code. It was docketed on November 15, 2004, upon receipt of the application and the applicant's military and medical records.

This final decision, dated August 31, 2005, is signed by the three duly appointed members who served as the Board in this case.

APPLICANT'S REQUEST AND ALLEGATIONS

The applicant asked the Board to correct his record to show that he was retired from the Coast Guard on July 11, 2003, with a physical disability rating of at least 30%, instead of being discharged with a 20% rating and severance pay. In addition, he asked that he be retired as a commander (O-5) because at the time of his separation, there was a commander selection board scheduled to convene three months later.

The applicant alleged that although at the time of his separation, he had several medical conditions that contributed to his unfitness for duty, the Coast Guard only rated one of his conditions—diabetes mellitus—and assigned him only a 20% rating, whereas upon separation, the Department of Veterans' Affairs (DVA) assigned him a 60% rating for diabetes and ratings for other conditions that combined for a 100% disability rating. He alleged that the DVA's ratings prove that the Coast Guard's rating was erroneous and unjust and that he should have received a retirement by reason of physical disability.

SUMMARY OF THE APPLICANT'S MEDICAL RECORDS

The applicant became an officer in the regular Coast Guard on May 24, 1989. In 1996, he resigned, but six months later received a commission in the Coast Guard Reserve. He served on active duty from September 24, 1996, to April 30, 1997, and from June 1, 1997, until his medical discharge on July 11, 2003.

Records Regarding Diabetes Mellitus and Associated Conditions

By 1995, the applicant had "demonstrated hyperlipidemia and hypercholesterolemia in several successive blood tests." On September 25, 1997, he was diagnosed with diabetes mellitus (DM). He was instructed about diet, exercise, and monitoring his blood sugar levels. He was prescribed glucophage tablets. On January 14, 1998, the doctor noted that the applicant was "doing well" but needed to exercise more. In spring of 1998, the applicant's blood sugar levels began to rise and he had "mild proteinuria." He was placed on glucose-lowering medications.

Because DM requiring glucose-lowering medications as well as dietary control is a disqualifying condition for retention on active duty under Article 3.F.10.e. of the Medical Manual, the applicant had to receive a waiver to remain on active duty. In December 1998, he received a waiver to remain on active duty upon the recommendation of his physician.

A doctor's report indicates that from September 1998 through June 1999, the applicant's glycemic level was controlled without medication. After the applicant reported blood sugar spikes on July 1, 1999, he was again placed on glucose-lowering medication. He occasionally complained of tingling or pain in his legs. However, based on the recommendation of his physician, the waiver was continued in 1999 and 2000. In February 2001, his DM was considered "marginally controlled" by medication, but by May 2001, his condition was noted as "well controlled on oral medications."

In January 2002, the applicant underwent more dietary counseling. The doctor noted that his DM was "well controlled" but that the medication, Metformin, made him feel nauseous. The doctor prescribed Avandia in lieu of the Metformin.

From April 30 to May 13, 2002, the applicant's glycemic levels tested consistently high. He was placed on insulin. After the applicant submitted a request for retirement or discharge due to his condition, his command initiated an Initial Medical Board (IMB).

Records Regarding Other Conditions

Headaches: In January 1998, during a diabetes check-up, the doctor noted that the applicant had a history of migraine headaches. On August 14, 2002, the applicant

sought treatment for a chronic headache. He reported that he had had headaches for about ten years and got them three or four times a week. He reported that he got very bad headaches three or four times a year. An MRI of the brain had "normal" results. On December 6, 2002, the applicant sought medical help for dizziness and nausea, but not for a headache. The doctor noted that the applicant's dizziness might be either benign positional vertigo or a migraine variant.

Depression: At a follow-up medical appointment for the applicant's dizziness and nausea on December 6, 2002, he informed the doctor that he was taking Celexa, an anti-depressant. In addition, a doctor who examined the applicant pursuant to a medical board noted that the applicant reported a history of depression.

Bronchitis: During his time on active duty, the applicant was periodically treated for upper respiratory tract infections or bronchitis.

Carpal Tunnel Syndrome: The applicant complained of pain and numbness in his right arm in July and August 2001. He was diagnosed with carpal tunnel syndrome. After he complained of numbness and tingling in his fingers in August 2002, he was referred for a nerve conduction test, which determined that his carpal tunnel syndrome was moderate to severe. The neurologist recommended surgery. Although documentation of the wrist surgeries is not in the record before the Board, they apparently occurred in February and May 2003, prior to the applicant's discharge.

Physical Disability Evaluation System (PDES) Processing

On December 3, 2002, the physician treating the applicant for DM issued a report pursuant to the IMB. He noted that the applicant's diagnoses, *inter alia*, included diabetes mellitus type II, which was under "very good control" with twice daily injections of 48 units of insulin; mild diabetic neuropathy; proteinuria secondary to the DM; hypertension, which was "well controlled" with medication; hyperlipidemia, though with medication his LDL (cholesterol level) had decreased to 134; and bilateral carpal tunnel syndrome, which might be fixed surgically. The doctor also noted that with prophylactic treatment of his migraines, the applicant "is actually noticing significant improvement." In addition, he noted that in November 2002, the applicant had complained of "a moderate amount of depression," had been prescribed 40 milligrams of Celexa per day, "and is doing well with that."

At a medical examination on February 3, 2003, pursuant to his IMB, the applicant completed a Report of Medical History, on which he noted having had, *inter alia*, chronic bronchitis since 1998; carpal tunnel syndrome since the summer of 2001; pain and tingling in his feet due to mild diabetic neuropathy; proteinuria since 1994; complex migraines since the mid 1990s; high blood pressure, and depression. After questioning the applicant about this report, the doctor noted that the applicant had a history of

bronchitis from 1998 to 2000 and had been "OK since," but had suffered from depression since 2002. The doctor also noted that the applicant would soon be undergoing surgery for his carpal tunnel syndrome. The doctor noted that the applicant's conditions other than his DM was "NCD," which means not considered disqualifying for retention on active duty.

On February 3, 2003, the IMB found that the applicant was not fit for duty because of his DM and referred him to the Central Physical Evaluation Board (CPEB) for further processing. The IMB noted that he was then taking 62 units of insulin twice daily. The IMB did not list any of the applicant's other diagnosed medical conditions as causing him to be unfit for duty. The applicant was advised of the finding and recommendation and indicated that he would not rebut them.

On February 21, 2003, the applicant's commanding officer (CO) forwarded the report to the CPEB. The CO noted that the applicant was currently assigned as the Executive Officer of xxxxxxxxxxxx at a busy port and was "able to fully perform" all of his assigned administrative and management duties. However, the CO noted "it has become necessary to make accommodations to his work schedule due to difficulties he has experienced with his medical condition. In addition, he has had to absent himself from work, at an increasing rate, on sick leave for not insignificant periods of time due to medical complications, ... [which has] had negative consequences on the effective management of the unit." The CO stated that during the previous three months, the applicant had been absent from work for ten workdays for reasons related to his DM.

On June 2, 2003, the CPEB recommended that the applicant be discharged with a 20% disability rating because of "diabetes mellitus: requiring insulin and restricted diet," under VASRD code 7913.

On June 4, 2003, after being informed of his right to counsel and his right to a formal hearing, the applicant signed the CPEB recommendation to indicate that he accepted it and waived his right to a formal hearing.

On June 13, 2003, following review by the Judge Advocate General, the CPEB's recommendation was approved by the Commander of the Coast Guard Personnel Command (CGPC), who directed that the applicant be discharged with a 20% disability rating and severance pay. The applicant was therefore discharged from active duty in the Reserve on July 11, 2003.

Decision of the DVA

A rating decision dated July 30, 2004, shows that effective as of the day after his discharge from the Coast Guard, the DVA has granted the applicant a 100% disability

rating based on the following separate disability ratings for service-connected conditions:

- 60% for diabetes mellitus with peripheral vascular disease, left leg, hypertension and hyperlipidemia and proteinuria;
- 70% for major depression;
- 30% for migraine headaches;
- 20% for peripheral vascular disease, right leg;
- 10% for bronchitis;
- 10% for left carpal tunnel syndrome; and
- 10% for right carpal tunnel syndrome.

The DVA noted that the 60% rating for the applicant's diabetes was based on the applicant's statements that he had to see his doctor for this condition every one or two weeks; that he required hospitalization at least twice a year; that he felt progressive loss of strength, easy fatigability, dizziness, and numbness and tingling in his feet; and that he took insulin and medication for hypertension, hyperlipidemia, and proteinuria.

The DVA noted that the applicant's Coast Guard medical records "are very brief regarding depression, but they do show you were taking Celexa for depression in December of 2002." The 70% rating for depression was based on the applicant's taking 80 milligrams of Celexa a day and complaints of poor sleep, desire for isolation, poor motivation and interest, low self esteem, and declining concentration.

The DVA awarded the applicant a 30% rating for migraine headaches because he complained of getting "headaches twice a week that prevent [him] from doing anything." The DVA awarded the applicant a 20% rating for peripheral vascular disease in his right leg because numbness, tingling, and +2/+4 bilateral ankle and knee jerks. The DVA awarded the applicant a 10% rating for bronchitis because he stated that he had suffered from bronchitis two or three times a year for the past five years and because tests showed slightly decreased pulmonary function. The DVA awarded the applicant 10% ratings for carpal tunnel syndrome in each wrist because following his surgeries in February and May of 2003, he had slightly decreased sensation in his hands but otherwise had a "full range of motion in [his] wrists with no fatigue, lack of endurance, pain, or weakness."

VIEWS OF THE COAST GUARD

On April 5, 2005, the Judge Advocate General (JAG) of the Coast Guard submitted an advisory opinion in which he recommended that the Board deny relief in this case.

The JAG argued that the evidence submitted by the applicant—his DVA rating—is “insufficient to overcome the presumption of regularity afforded the Coast Guard.” DVA disability ratings are “not determinative of the same issues involved in military disability cases.” *Lord v. United States*, 2 Ct. Cl. 749, 754 (1983). The JAG alleged that the DVA “determines to what extent a veteran’s earning capacity has been reduced as a result of specific injuries or combinations of injuries. The Armed Forces, on the other hand, determine to what extent a member has been rendered unfit to perform the duties of his office, grade, rank, or rating because of a physical disability.” The JAG also alleged that the “procedures and presumptions applicable to the DVA evaluation process are fundamentally different from and often more favorable to the veteran than those applied under the PDES. ... The DVA’s finding that the Applicant was 100% disabled is not relevant to the Coast Guard’s finding that he was 20% disabled *based solely on the condition that rendered him unfit for continued service at the time of his separation*. ... [A]ny long-term diminution in the Applicant’s earning capacity attributable to his military service is properly a matter for the DVA, not the Coast Guard or the BCMR.”

The JAG also alleged that the applicant received due process and, prior to his discharge, accepted the finding and recommendation of the CPEB that he receive a 20% disability rating and severance pay.

APPLICANT’S RESPONSE TO THE VIEWS OF THE COAST GUARD

On April 6, 2005, the Chair sent a copy of the views of the Coast Guard to the applicant and invited him to respond within 30 days. The applicant was granted an extension of twelve days and responded on May 18, 2005.

The applicant stated that prior to his discharge, Coast Guard medical and administrative personnel advised him that the only medical conditions for which he would receive a disability rating would be the conditions that prevented him from continuing on active duty. Mistrusting their advice, he hired a private attorney, who told him the same thing.

The applicant objected to the JAG’s statement that the DVA’s rating is not persuasive evidence of an error by the Coast Guard. He noted that the PDES Manual requires the Coast Guard to use the DVA’s VASRD schedule when assigning disability ratings.

APPLICABLE LAW

Disability Statutes

Title 10 U.S.C. § 1201 provides that a member who is found to be “unfit to perform the duties of the member’s office, grade, rank, or rating because of physical dis-

ability incurred while entitled to basic pay” may be retired if the disability is (1) permanent and stable, (2) not a result of misconduct, and (3) for members with less than 20 years of service, “at least 30 percent under the standard schedule of rating disabilities in use by the Department of Veterans Affairs at the time of the determination.” Title 10 U.S.C. § 1203 provides that such a member whose disability is rated at only 10 or 20 percent under the schedule shall be discharged with severance pay.

Provisions of the Medical Manual

Article 3.F. of the Medical Manual lists conditions that are considered normally disqualifying for retention and trigger a member’s processing under the PDES. Article 3.F.10.e. of the Medical Manual provides that diabetes mellitus may be disqualifying for retention on active duty when “requiring insulin or not controlled by oral medications.”

Article 3.F.8.c.(2) provides that hypertension may be disqualifying for retention when the member’s “[d]iastolic pressure consistently more than 90 mm Hg following an adequate period of therapy on an ambulatory status” or if there is “[a]ny documented history of hypertension regardless of the pressure values if associated with one or more of the following: cerebrovascular symptoms; arteriosclerotic heart disease if symptomatic and requiring treatment; kidney involvement, manifested by unequivocal impairment of renal function; or grade III changes in the fundi.”

Article 3.F.16.c. provides that bipolar disorders or recurrent major depression are disqualifying for retention, as well as “[a]ll other mood disorders associated with suicide attempt, untreated substance abuse, requiring hospitalization, or requiring treatment (including medication, counseling, psychological or psychiatric therapy) for more than 6 months. Prophylactic treatment requiring more than one drug, or associated with significant side effects (such as sedation, dizziness or cognitive changes) or frequent follow-up that limit duty options.”

Article 3.F.15.h. provides that migraine headaches are disqualifying for retention when “[m]anifested by frequent incapacitating attacks or attacks that last for several consecutive days and unrelieved by treatment.”

Article 3.F.8.b.(1) provides that arteriosclerosis obliterans (peripheral vascular disease) may be disqualifying when there is “(a) intermittent claudication of sufficient severity to produce pain and inability to complete a walk of 200 yards or less on level ground at 112 steps per minute without a rest; or (b) objective evidence of arterial disease with symptoms of claudication, ischemic chest pain at rest, or with gangrenous or permanent ulcerative skin changes in the distal extremity; or (c) involvement of more than one organ system or anatomic region (the lower extremities comprise one region for this purpose) with symptoms of arterial insufficiency.”

Article 3.F.7.b.(4) provides that chronic bronchitis may be disqualifying for retention if there is a “severe persistent cough, with considerable expectoration, or with moderate emphysema, or with dyspnea at rest or on slight exertion, or with residuals or complications that require repeated hospitalization.”

Article 3.F.15.n.(1) provides that neuralgia (pain) of the peripheral nerves may be disqualifying for retention when “symptoms are severe, persistent, and not responsive to treatment.” In addition, under Article 3.F.12.a.(2), a member may be disqualified for retention if he does not have the following: at least a 15-degree total range of motion in the wrist (flexion plus extension); an “active flexor value of combined joint motions of 135 degrees in each of two or more fingers of the same hand; an “active extensor value of combined joint motions of 75 degrees in each of the same two or more fingers”; and a “[l]imitation of motion of the thumb that precludes apposition to at least two finger tips.”

Provisions of the PDES Manual

Chapter 2.A.38. defines “physical disability” as “[a]ny manifest or latent physical impairment or impairments due to disease, injury, or aggravation by service of an existing condition, regardless of the degree, that separately makes or in combination make a member unfit for continued duty.”

Chapter 3 provides that if a member’s fitness for continued duty is in question, an IMB of two medical officers shall conduct a thorough medical examination, review all available records, and issue a report with a narrative description of the member’s impairments, an opinion as to the member’s fitness for duty and potential for further military service, and if the member is found unfit, a referral to a CPEB. The member is advised about the PDES and permitted to submit a response to the IMB report. The member’s CO forwards the IMB report and any rebuttal to the CPEB with an endorsement addressing the impact of the member’s disability on his performance of duty.

Chapter 4 provides that a CPEB shall review the IMB report, the CO’s endorsement, and the member’s medical records. Chapter 2.C.3.a.(3)(a) provides that, if a CPEB (or subsequently an FPEB) finds that the member is unfit for duty because of a permanent disability, it will

propose ratings for those disabilities which are themselves physically unfitting or which relate to or contribute to the condition(s) that cause the evaluatee to be unfit for continued duty. The board shall not rate an impairment that does not contribute to the condition of unfitness or cause the evaluatee to be unfit for duty along with another condition that is determined to be disqualifying in arriving at the rated degree of incapacity incident to retirement from military service for disability. In making this professional judgment, board members will only rate those disabilities which make an evaluatee unfit for military service or which contribute to his or her inability to perform military duty. In accordance with the current VASRD, the percentage of disability existing at the time of evaluation,

the code number and diagnostic nomenclature for each disability and the combined percentage of disability will be provided.

Chapter 2.C.2.a. provides that the “sole standard” that a CPEB may use 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.” Chapter 2.C.2.i. states that the “existence of a physical defect or condition that is ratable under the standard schedule for rating disabilities in use by the [DVA] does not of itself provide justification for, or entitlement to, separation or retirement from military service because of physical disability. Although a member may have physical impairments ratable in accordance with the VASRD, such impairments do not necessarily render him or her unfit for military duty. ... Such a member should apply to the [DVA] for disability compensation after release from active duty.”

Chapter 4.A.14.c. provides that if the member objects to a CPEB finding, he may demand a hearing by the Formal Physical Evaluation Board (FPEB), where he may be represented by assigned or private counsel. Chapter 5.C.11.a. provides that the FPEB shall issue findings and a recommended disposition of each case in accordance with the provisions of Chapter 2.C.3.a. The applicant may submit a rebuttal within 15 working days, and the FPEB must respond and, if indicated, prepare a new report. The FPEB’s final report is reviewed for sufficiency by an officer at CGPC and by the Judge Advocate General, and forwarded to CGPC for final action.

VASRD

Under the VASRD at 38 C.F.R. § 4.119, diabetes mellitus is rated as follows:

RATING	REQUIRED LEVEL OF ILLNESS
100	Requiring more than one daily injection of insulin, restricted diet, and regulation of activities (avoidance of strenuous occupational and recreational activities) with episodes of ketoacidosis or hypoglycemic reactions requiring at least three hospitalizations per year or weekly visits to a diabetic care provider, plus either progressive loss of weight and strength or complications that would be compensable if separately evaluated
60	Requiring insulin, restricted diet, and regulation of activities with episodes of ketoacidosis or hypoglycemic reactions requiring one or two hospitalizations per year or twice a month visits to a diabetic care provider, plus complications that would not be compensable if separately evaluated
40	Requiring insulin, restricted diet, and regulation of activities
20	Requiring restricted diet and either insulin or oral hypoglycemic agent

10

Manageable by restricted diet only

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 submission, and applicable law:

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

2. The Board begins each case presuming that the applicant's military records are correct and that Coast Guard officials, including his doctors and medical evaluation boards, have acted correctly and in good faith in assigning his disability rating.¹ Although prior to his discharge, the applicant accepted the CPEB's recommendation that he be discharged with a 20% disability rating and severance pay, he now alleges that the 20% disability rating he received from the Coast Guard was erroneous and pointed to his 100% combined disability rating from the DVA as evidence of the alleged error. The record indicates that the applicant's 100% combined disability rating from the DVA includes 70% for major depression; 60% for diabetes mellitus (DM) with peripheral vascular disease in his left leg, hypertension, hyperlipidemia, and proteinuria; 30% for migraine headaches; 20% for peripheral vascular disease in his right leg; 10% for bronchitis; 10% for carpal tunnel syndrome in his left wrist; and 10% for carpal tunnel syndrome in his right wrist.

3. Under Chapter 2.C.3.a.(3)(a) of the PDES Manual, the CPEB may assign a disability rating for only "those disabilities which are themselves physically unfitting or which relate to or contribute to the condition(s) that cause the evaluatee to be unfit for continued duty. The board shall not rate an impairment that does not contribute to the condition of unfitness or cause the evaluatee to be unfit for duty along with another condition that is determined to be disqualifying in arriving at the rated degree of incapacity incident to retirement from military service for disability. In making this professional judgment, board members will only rate those disabilities which make an evaluatee unfit for military service or which contribute to his or her inability to perform military duty." Although the applicant's military medical records contain diagnoses of depression, migraine headaches, bronchitis, and bilateral carpal tunnel syndrome, there is insufficient evidence in the record for the Board to conclude that these conditions were disqualifying for retention at the time of his discharge or that they actually interfered with his performance of duty or contributed to his unfitness for duty at the time of his discharge. Specifically, the Board notes the following with respect to these conditions:

¹ 33 C.F.R. § 52.24(b). See *Arens v. United States*, 969 F.2d 1034, 1037 (Fed. Cir. 1992); *Sanders v. United States*, 594 F.2d 804, 813 (Ct. Cl. 1979) (holding that "absent strong evidence to the contrary," government officials are presumed to have acted "lawfully, correctly, and in good faith").

a. As the DVA stated, the applicant's military medical records contain very little information or evidence of his depression. There is a notation in the records that in November 2002, he complained of feeling depressed and was prescribed Celexa. However, there is no evidence in the record that he was ever diagnosed with the potentially disqualifying condition "recurrent major depression" while on active duty, pursuant to Article 3.F.16.c. of the Medical Manual. Nor is there any evidence that his depression interfered with his performance of duty or contributed to his unfitness for duty as is required for a condition to be assigned a disability rating under Chapter 2.C.3.a.(3)(a) of the PDES Manual.

b. The applicant's medical records indicate that he complained of getting severe migraine headaches three or four times per year. Article 3.F.15.h. provides that migraine headaches are only disqualifying for retention when "[m]anifested by frequent incapacitating attacks or attacks that last for several consecutive days and unrelieved by treatment." The records do not indicate that the applicant's migraines met this standard. Moreover, the Board notes that the applicant apparently performed active duty for more than ten years despite his headaches. Therefore, the evidence is insufficient to prove that the applicant's migraines rendered him unfit for continued service or contributed to his unfitness for duty as is required for a condition to be assigned a disability rating under Chapter 2.C.3.a.(3)(a).

c. The applicant's medical records indicate that he occasionally complained of tingling or pain in his legs and that this condition was deemed secondary to his DM. However, there is no evidence in his military medical records that the applicant's peripheral vascular disease ever met the standards set under Article 3.F.8.b.(1) of the Medical Manual for a disqualifying condition while he was on active duty. There is no evidence that the tingling and pain in his legs ever rendered him unfit for continued service or contributed to his unfitness for duty as is required for a condition to be assigned a disability rating under Chapter 2.C.3.a.(3)(a).

d. The applicant's medical records indicate that he was periodically diagnosed with bronchitis or an upper respiratory tract infection during his years of service. However, although bronchitis may have caused him to take occasional days of sick leave, there is no evidence that it rendered him unfit for continued service or contributed to his unfitness for duty as is required for a condition to be assigned a disability rating under Chapter 2.C.3.a.(3)(a) of the PDES Manual. Furthermore, the Board notes that during the applicant's medical examination for the IMB, he apparently told the doctor that he had suffered from bronchitis frequently from 1998 to 2000 but had been "OK since."

e. The record indicates that in 2002, the applicant's carpal tunnel syndrome was deemed moderate to severe and that he underwent surgery on both wrists prior to his discharge in 2003. The DVA report indicates that following surgery, testing

revealed that the applicant had slightly decreased sensation in his hands but a “full range of motion in [his] wrists with no fatigue, lack of endurance, pain, or weakness.” There is no evidence in the record that at the time of his discharge the applicant suffered disqualifying pain in his wrists or hands pursuant to Article 3.F.15.n.(1) of the Medical Manual or any of the limitations of motion described in Article 3.F.12.a.(2). He has not proved that at the time of his discharge carpal tunnel syndrome rendered him unfit for continued service or contributed to his unfitness for duty as is required for a condition to be assigned a disability rating under Chapter 2.C.3.a.(3)(a).

f. The record also indicates that the applicant was being treated for hypertension, hyperlipidemia, and proteinuria at the time of his discharge. Of these, only hypertension is a potentially disqualifying condition, and the medical records do not indicate that the applicant’s hypertension met the requirements for a disqualifying condition under Article 3.F.8.c.(2) of the Medical Manual. Moreover, his medical records indicate that the applicant was diagnosed with each of these conditions at least seven years before his discharge, was treated for them, and continued to perform active duty. There is no evidence that these conditions rendered him unfit for continued service or contributed to his unfitness for duty as is required for a condition to be assigned a disability rating under Chapter 2.C.3.a.(3)(a) of the PDES Manual.

Therefore, the Board finds that the applicant has not proved that the CPEB committed error or injustice in failing to assign disability ratings for the applicant’s medical conditions other than diabetes mellitus.

4. The record indicates that the disability that caused the applicant to be unfit for continued service at the time of his discharge was DM. The DVA assigned the applicant a 60% rating for this condition. Under the VASRD, a 60% rating should be assigned when a person requires “insulin, restricted diet, and regulation of activities with episodes of ketoacidosis or hypoglycemic reactions requiring one or two hospitalizations per year or twice a month visits to a diabetic care provider, plus complications that would not be compensable if separately evaluated.”² The DVA’s rating decision indicates that the applicant was awarded the 60% rating based primarily upon his own statement of his condition.

5. Although the DVA assigned the applicant’s DM a 60% rating, as the JAG argued, DVA ratings are “not determinative of the same issues involved in military disability cases.”³ In assigning ratings pursuant to 10 U.S.C. §§ 1201 and 1203 and Chapter 2.C.2.a. of the PDES Manual, the CPEB considers to what extent a member is permanently disabled by a condition that renders him unfit for continued service, whereas the DVA considers the extent to which a veteran’s current earning capacity is diminished

² 38 C.F.R. § 4.119.

³ *Lord v. United States*, 2 Ct. Cl. 749, 754 (1983).

by all of his medical conditions. Therefore, the Board finds that the 60% rating assigned by the DVA is not dispositive of whether the 20% rating assigned by the Coast Guard is erroneous or unjust.

6. The CPEB assessed the applicant's DM as meeting the standard for a 20% disability rating under the VASRD. As stated in finding 2 above, the Board must presume that this rating is correct unless the applicant proves otherwise by a preponderance of the evidence. The medical records before the Board indicate that at the time of the applicant's physical examination for the IMB, his DM was under "very good control" with twice daily injections of insulin, appropriate exercise, and dietary precautions. Although his CO stated that the applicant was able to perform all the duties of his job, the CO also stated that the applicant was increasingly absent from work for medical reasons. While there is no evidence in the military or medical records to indicate that, prior to the applicant's discharge, he was required or should have been told to "regulate his activities," as is required for a 40% rating under the VASRD, that may very well have been the case. Nor does the record before the Board show that, prior to his discharge, he was hospitalized once or twice each year for episodes of ketoacidosis or hypoglycemic reactions, as he told the DVA. While it is possible that the applicant was required to "regulate his activities" and did periodically require hospitalization prior to his discharge, the applicant has not submitted evidence on these matters.

Moreover, the record indicates that with the advice of counsel, the applicant accepted the 20% rating prior to discharge. The applicant did not explain why, if he thought the 20% rating was too low, he accepted it and waived his right to formal hearing.

Although the applicant has not proven that the Coast Guard erred or acted unjustly in assigning him a 20% rating, the Board finds that it would be in the interest of justice to grant further consideration to this matter if within 180 days of the date of this decision, the applicant is able to submit new, substantial evidence that his DM met the criteria for a 40% or 60% disability rating under the VASRD prior to his discharge. To receive further consideration, the applicant needs to provide substantial evidence that his activities were "regulated" by his DM in ways that affected his ability to perform his Coast Guard duties, either based upon medically indicated advice from his physician at the time, or possibly, based upon a subsequent expert opinion from a physician that his activities were or should have been so regulated. The applicant also must explain why if the 20% rating was too low, he failed to object to it and even waived his right to a formal hearing.

7. The applicant also asked that he be retired as a commander (O-5) because at the time of his separation, there was a commander selection board scheduled to convene three months later. The applicant cited no law that would or could have entitled him to be retired or separated at the higher rank, and the Board knows of none. The

Board finds that the applicant has not proved by a preponderance of the evidence that his discharge as a lieutenant commander, the highest grade in which he served, was erroneous or unjust.

8. Accordingly, the applicant's request that he be retired as a commander (O-5) should be denied. With respect to the applicant's request for a higher disability rating, the Board denies it based upon the current record but will grant further consideration if within 180 days of the date of this decision, the applicant submits to the Board new, substantial evidence that his DM met the criteria for a 40% or 60% disability rating under the VASRD prior to his discharge.

[ORDER AND SIGNATURES APPEAR ON NEXT PAGE]

ORDER

The application of former xxxxxxxxxxxxxxxxxxxxxxxxx, USCGR, for the correction of his military record is denied.

Toby Bishop

Philip B. Busch

Nancy L. Friedman