DEPARTMENT OF HOMELAND SECURITY
BOARD FOR CORRECTION OF MILITARY RECORDS

Application for the Correction of
the Coast Guard Record of:

BCMR Docket No. 2006-112

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FINAL DECISION

AUTHOR: Andrews, J.

This proceeding was conducted according to the provisions of section 1552 of title 10 and section 425 of title 14 of the United States Code. The Chair docketed the case on May 9, 2006, upon receipt of the completed application.

This final decision, dated January 31, 2007, is 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 asked the Board to correct his record to show that he was separated from the Coast Guard on August 4, 2006, with a 40% disability rating and disability retirement pay, instead of being discharged with a 20% disability rating and severance pay. He alleged that the Coast Guard's Formal Physical Evaluation Board (FPEB) erroneously rated his back condition as only 20% disabling. He alleged that his medical records show that the limited range of motion (ROM) in his back warranted a 40% rating under the Veterans Affairs Schedule for Rating Disabilities (VASRD).

The applicant alleged that in finding his back condition to be only 20% disabling, the FPEB relied upon a simple visual assessment by a physician's assistant, LT G, who had never before conducted an examination for an Initial Medical Board (IMB). The applicant alleged that other, more scientific examinations by more experienced medical professionals showed clearly that the range of forward flexion in his back was less than 30 degrees and thus met the VASRD criterion for a 40% rating. He argued that even if the FPEB had some doubt as to whether his range of motion merited a 40% rating, Coast

Guard regulations required that such doubt be resolved in his favor. The applicant also complained that the Coast Guard repeatedly changed its explanation of the 20% rating.

The applicant alleged that during his hearing before the FPEB, the board members primarily asked questions concerning his character, integrity, loyalty, and why he had recently signed a one-year extension contract instead of reenlisting for a longer period.

SUMMARY OF THE RECORD

On November 10, 1997, the applicant enlisted in the Coast Guard. He reported no history of back pain during his pre-enlistment physical examination. In 2000, the applicant hurt his back while moving a heavy piece of furniture. Thereafter, he occasionally sought treatment for back pain.

On October 21, 2002, the applicant underwent a physical examination for the purpose of separation. He did not report any back injury or recurrent back pain on his Report of Medical History. He was found fit for separation but decided to reenlist.

On December 7, 2004, the applicant sought treatment for lower back pain. He reported that he had suffered from lower back pain four or five time a year since his injury in 2000. On January 4, 2005, the applicant underwent an MRI, which showed disc herniation at L3-L4, a small disc protrusion at the L4-L5, and sacralization (congenital fusion) of the L5 and S1 vertebrae.

On March 11, 2005, the applicant sought treatment for lower back pain. He stated that his back had been hurting since December 2004 although previously his back pain had never lasted more than two or three weeks. The doctor referred him for neurology and physical therapy evaluations.

On March 21, 2005, the applicant underwent a physical examination for the purpose of separation as he had declined to reenlist. He reported that he suffered from "constant back pain due to herniated disks" but had not seen a doctor yet. The physician noted that he would await results from a neurological examination.

On March 25, 2005, a neurosurgeon examined the applicant and noted that he had no complaints of numbness, good strength, and a "full range of motion of the lumbosacral spine." The neurosurgeon prescribed physical therapy and Celebrex.

On March 28, 2005, the applicant reported that his back pain was much better. However, on April 22, 2005, he again sought treatment for lower back pain.

On April 30, 2005, the applicant's physical therapist measured his lumbar flexion at 27 degrees, his extension at 5 degrees, and his "side-bending" at 8 degrees to the right and 10 degrees to the left.

On May 2, 2005, the physician reported that the applicant did not have any disqualifying defects. Therefore, he was found fit for separation. The applicant objected to the finding and extended his enlistment for one year. In June 2005, the applicant was transferred to a new unit in Louisiana.

On July 21, 2005, the applicant sought treatment for lower back pain, which he stated was inhibiting his sleep. The doctor noted that the applicant had "no low back tenderness" and "no low back spasms" and that he could "touch his fingers to about 8 inches from the floor." The applicant was found fit for duty but referred for physical therapy and prescribed Celebrex.

Also on July 21, 2005, the results of a nerve conduction study were normal, except that a tibial nerve study indicated that there might be a right S1 radiculopathy or a right tibial or sciatic nerve lesion. On July 22, 2005, a radiologist, Dr. H, reported that the applicant had "a transitional last lumbar vertebra with a large pseudoarthrosis on the left. A smaller pseudoarthrosis is seen on the right. The transitional space is rudimentary. The spine is otherwise unremarkable."

On July 29, 2005, the applicant's physical therapist measured his forward lumbar flexion as 60 degrees, his extension as 13 degrees, and his side bending as 19 degrees to the left and 17 degrees to the right.

On August 9, 2005, the applicant again sought help for back pain. He stated that he had only been able to attend three of his physical therapy sessions because of work. He complained that he did not think the Celebrex was working and was having more pain when trying to sleep. The applicant was found fit for light duty and prescribed Combunox.

On October 5, 2005, the applicant sought help for back pain. He stated that he had been working 12-hour shifts due to Hurricane Katrina, which was hard on his back. The physician ordered another MRI and prescribed steroid injections.

On October 12, 2005, the applicant sought help for severe back pain. He stated that he had awoken in pain the day before and had received injections at a hospital emergency room. The physician prescribed Vicodin.

On October 13, 2005, the applicant underwent another MRI, which showed that he had a small posterior central disk herniation at L3-4 and a disc bulge at L4-L5.

On October 18, 2005, the applicant's command referred him for a physical examination to determine whether an Initial Medical Board (IMB) should assess his condition. The physician reported that the applicant stated "that he was moving furniture 5 yrs ago and slipped backwards, pain was immediate. [He] states that pain was constant after that and he was treated by several different methods." The applicant was referred to a pain specialist.

On November 8, 2005, Dr. D, a neurosurgeon, examined the applicant and reported that after the applicant's back injury in 2000

> his initial pain resolved but since then he has had gradually worsening frequency and severity of pain, and he has reached the point where now his pain is set off with almost any overexertion of the lower back. In addition, he describes wakening from sleep every morning with severe lower back pain which takes approximately one hour to subside to the point where he can function normally. … The patient describes his pain as occurring directly in the mid line and at approximately waist level. It tends not to radiate laterally. He also describes frequent crepitus of the lower back but states that when this occurs it tends to reduce his pain rather than worsen it.

Dr. D further stated that the applicant had "no active paraspinous spasm or tenderness" but might have discogenic pain. He stated that an MRI showed "some desiccation of the L3-L4 and L4-L5 discs" and "some minimal disc protrusions at each of these levels in the mid line which appear to be non-compressive." Dr. D stated that because the applicant was not interested in surgery, he would not order further testing.

On December 1, 2005, a physical therapist used an inclinometer to take the following series of measurements of the range of motion in the applicant's lower back.

LUMBAR ROM MEASUREMENTS BY INCLINOMETER ON 12/1/05

	Flexion			Extension			Rt. Lateral Extension			Lt. Lateral Extension		
T12*	40	40	45	15	13	15	22	24	23	18	19	20
[–] Sacrum	14	12	10	10	10	9	5	5	5	4	4	4
[=] Total Lumbar ROM	26	28	35	5	3	6	17	19	18	14	15	16

*T12 is the lowest thoracic vertebra—just above L1—while the sacrum is just below the lowest lumbar vertebra.

On December 15, 2005, Dr. D reported that the applicant stated that he did not feel that his back pain was severe enough to warrant undergoing lumbar fusion surgery. Dr. D wrote that the applicant's symptoms "do impact on many of his daily activities but he states that they really are not particularly severe. He has an achy pain in his back during the day and some difficulty with sleeping at night, but not what he would call unremitting, severe lower back pain. He stated definitively today that he is not interested in surgery to eradicate the level of pain that he is experiencing." Dr. D noted that the likely outcome of surgery would be unknown until a discogram and bone scan were conducted, but he would not refer the applicant for such studies "due to

the controllable nature of the patient's symptoms. … [U]ntil the patient feels that his symptoms are severe enough where he is desirous of an operation, I would not recommend [the tests]. With regard to outcomes, his likelihood of success is entirely contingent upon the diagnostic studies."

On December 21, 2005, an Initial Medical Board (IMB) evaluated the applicant's chronic lower back pain. The IMB noted that the applicant had injured his back while moving furniture in October 2000 and that when he went to the emergency room he reported that he had previously suffered from a decreased range of motion and pressure to his legs. The IMB reported that an

> MRI of the lumbar spine dated 13 OCT 2005 revealed disk degeneration at L3-L4 accompanied by small posterior central disk herniation of L3-L4. At L4-L5, disk bulging was demonstrated. No significant canal of foraminal encroachment noted. MRI dated 04 JAN 2005 denotes the same findings, in addition to finding no nerve root involvement at either level. … Treatment consisted of multiple trials of steroidal and non-steroidal anti-inflammatory drugs, none of which offered any long term pain relief. Most recently, evaluee was prescribed Vicodin ES, which offers some short term relief. Physical therapy offered no symptomatic relief, as well.
>
> The physical exam showed a young adult male in no acute distress. Upon inspection of the back, no lesions or scars were present. Palpation of the spine revealed a normal spine alignment. Palpation of the lumbar spine elicited tenderness approximately between L4-L5. Assessment of the ROM [of] the lumbar spine revealed decreased flexion with pain around 45 degrees. Extension of the lumbar spine was difficult to perform without the evaluee expressing extreme discomfort. … ROM of the back by goniometer measurements are as follows: lumbar extension: 5, 3, and 6 degrees. Right lateral flexion: 17, 19, and 18 degrees. Left lateral flexion: 14, 15, and 16 degrees. Right SLR: 55 degrees. Left SLR: 59 and 60 degrees.
>
> It is the opinion of the board that the diagnosis of chronic low back pain is correct, and that the patient is unable to perform work activities associated with lifting, prolonged standing, and frequent bending.
>
> The prognosis of his patient is poor from the standpoint of low back symptom relief. He has been treated with multiple medications and physical therapy, but still complains of constant low back pain. This functional impairment of the low back precludes the evaluee from performing satisfactory performance of duty.

The applicant agreed with the IMB's report. On January 11, 2006, the applicant's commanding officer forwarded the report of the IMB to the Coast Guard Personnel Command (CGPC) with a recommendation that he be found not fit for duty and separated from active duty. The commanding officer noted that the applicant was "presently limited in the performance of normal duties of his grade" and could not function fully in an afloat or overseas assignment.

On January 19, 2006, the CPEB reviewed the applicant's records and recommended that he be discharged with a 20% disability rating and severance pay for intervertebral disc syndrome under VASRD code 5243.

On January 27, 2006, a physical therapist used a goniometer to take the following series of measurements of the applicant's thoracolumbar spine before and after exercise.

THORACOLUMBAR ROM MEASUREMENTS BY GONIOMETER ON 1/27/06

	Before Exercise			After Exercise		
Flexion	20	19	20	25	25	28
Extension	10	11	8	10	11	12
Right Lateral Extension	10	11	13	12	15	14
Left Lateral Extension	15	13	15	17	20	17
Right Rotation	33	30	32	34	37	35
Left Rotation	40	42	40	42	45	46
Total ROM [handwritten]	128	126	128	135	153	152

On February 13, 2006, LT G responded to a query from the applicant's attorney by stating that when she examined the applicant, she asked him to bend down to touch his toes, but he was only able to go about half way down and therefore made a "clinical visual assessment" that his total range of motion was about 45 degrees rather than 90 degrees.

On February 13, 2006, the applicant rejected the findings and recommendation by the CPEB and demanded a hearing before the FPEB. He argued that an inclinometer is "not recognized by VA standards and does not measure forward flexion of the thoracolumbar spine, which is the requisite area of measurement for rating, nor does the measurement correlate with the VA scale." He noted that the VASRD states that measurement by goniometer is "indispensable" and submitted the report of the measurements dated January 27, 2006. He further argued that since the IMB's report erroneously attributed the December 1, 2005, measurements to a goniometer, rather than an inclinometer, the CPEB must have erroneously assumed that the measurements were taken by goniometer. In addition, he argued that the CPEB erroneously based its determination on his forward flexion at T12 and the sacrum.

On February 15, 2006, the president of the CPEB responded to the applicant's request that his case be reconsidered. He stated that the CPEB felt that the applicant had submitted insufficient evidence to change the findings already rendered by the CPEB. He further stated that

> although the VASRD does indeed note that the use of a goniometer is indispensable, it does not specifically preclude the use of an inclinometer nor does it indicate that such measurements are invalid. The use of an inclinometer is, in fact, commonly used for tho-

> racolumbar range of motion measurements. The measurements made by physical therapy … on 1 Dec 2005 were absolutely valid. The report indicated flexion at T12 was 40-45 degrees. These were an appropriate and accurate measure of functional thoracolumbar range of motion, and correlate well with the VASRD ratings under the General rating formula for diseases and injuries of the spine. These measurements were also more consistent with physical exam findings of full range of motion by neurosurgery on 25 Mar 2005, and physical therapy observations that the member was able to reach with his fingers to about 8 inches from the floor on 18 October 2005.

On February 17, 2006, the medical member of the CPEB wrote the following to the applicant's counsel:

> The board noted the MRI finding (4 JAN 2005) that the member was found to have sacralization of L5. This is a congenital anomaly in which L5 is fused to S1. As such, there is no true motion about L5-S1. Hence, the member's restricted lumbar range of motion as indicated by [on December 1, 2005, and January 27, 2006] cannot be attributed solely to the member's impairment. (See note (3) 4.71a-19 of the VASRD). Therefore, application of the VASRD rating of 40% based on ROM is not appropriate. However, the board recognizes that the member's impairment, specifically, the HNP at L3-4, is likely responsible for a portion of his restricted lumbar ROM. In order to resolve this in favor of the member, the board awarded the next lower relevant rating, which was 20%. Again, this rating is more consistent with the member's noted functional range of motion.

On March 24, 2006, in response to written questions from the applicant's attorney, Dr. S, a neuroradiologist, stated that on January 4, 2005, an MRI had shown that the applicant has "lower lumbar degenerative disc disease with L3-4 and L4-5 disc protrusions which are largely central. These may cause localized low back pain and doubtfully radicular or shooting type pain. No spinal canal stenosis is evident." The doctor further stated that he did not know if the applicant had sacralization of L5 but that "sacralization of L5 has no clinical import" as he had "never heard of sacralization of L5 preventing a full range of motion." The doctor further stated that "there is no indication for lumbar fusion surgery."

On March 24, 2006, in response to written questions from the applicant's attorney, LT G stated that the applicant himself had initiated is evaluation by an IMB. She stated that her belief that his range of motion was about 45 degrees was based on her "clinical, visual assessment" when she asked him to try to touch his toes. She stated that the applicant "was only able to bend approximately half of my imaginary 90 degree angle [perpendicular to his legs] before pain was elicited. I did not use any measuring tools to ensure that the flexion of his lumbar spine was actually 45 degrees." LT G noted that the applicant could expect to have "good days and bad days" depending upon his fitness and exercise. LT G stated that although she had inadvertently left her December 1, 2005, measurement of his forward flexion out of her report, the measurement was included in another medical record reviewed by the CPEB. LT G stated that the applicant had told a neurosurgeon that he would refuse surgery even if a discogram

and bone scan indicated it that surgery was appropriate and that, because of his refusal, the advanced testing was not done. LT G further stated that the applicant

> Has notable defects found on objective data gathered over the years since his injury. [He] had the opportunity to be released Fit for Discharge in March 2005, in which case he could have been assessed by the Veterans Administration. Instead, he took a calculated risk, on false information given to him by someone else undergoing a Medical Board, and reenlisted for an additional year. At the time of signing reenlistment documents, [he] had to be aware of the fact that he had limitations that would deem him unfit down the road. [He], in my opinion, is weighing his case on one clinical finding and a clerical error. When in reality, the percentage of disability awarded was based upon weighty evidence, i.e., MRI findings, neurosurgical consults, physical therapist findings, and his own comments in respect to surgery.

On March 27, 2006, in response to written questions from the applicant's attorney, Dr. H, a radiologist, stated that it was unlikely that pseudoarthrosis, sacralization, or lumbarization of the applicant's spine would affect his forward flexion or the range of motion in his thoracicolumabar spine, which is 90 degrees.

On March 28, 2006, the FPEB convened to hear the applicant's case. At the hearing, LT G, the physician's assistant, stated that when she asked the applicant to bend over as if to touch his toes, he was able to bend over about half way in comparison to a horizontal line, which would be a 90 degree bend. Therefore, she had reported her clinical observation that his flexion was about 45 degrees. Ms. P, the applicant's physical therapist, stated that on December 1, 2005, she measured the applicant's lumbar ROM to be 29 degrees and that on January 27, 2006, she measured his thoracolumbar ROM to be 26 degrees. However, when asked for her opinion as to whether the applicant's back condition had changed between the two measurements, she stated that his condition had remained the same. In response to a question, Ms. P stated that she was aware of the VASRD standards when she conducted the tests on January 27, 2006. She further stated that a person's forward flexion was a "pretty good" indicator of functional limitations and that a person's total ROM, including flexion, backward and sideways extension, and rotation, provided a "more global picture." The applicant's supervisor testified that the applicant's ability to perform his duties had deteriorated in fall 2005 as he could not sit for long periods and was often absent due to his back pain.

The FPEB recommended that the applicant be discharged with severance pay and a 20% disability rating for intervertebral disc syndrome under VASRD code 5243. The FPEB provided the following amplifying statement regarding their determination:

- Witness for the Evaluee, a licensed physical therapist, stated that the best way to determine [the applicant's] functionality in light of his condition is the use of total range of motion measurements of the thoracolumbar spine. Evaluee's 27 Jan 2006 examination, requested on his behalf following rejection of the findings of his Central Physical Evaluation Board (CPEB), indicated a total range of motion of 128 degrees.

Applying the VA formula for rating spines (VASRD Sec. 4.71a-18) would result in a disability rating of 10 percent.

- Evaluee's CPEB, however, determined that [he] should be rated at the 20 percent level. We believe this is the appropriate determination. Visual observation of his forward flexion range of motion, as record in the Initial Medical Board report, indicated a range of motion of 45 degrees. This forward flexion range of motion falls within the range (greater than 30 degrees, not greater than 60 degrees) prescribed for a 20 percent disability rating.

- When there is a reasonable doubt as to which of two percentage evaluations should be applied, Coast Guard policy requires that the Board assign the higher evaluation (Physical Disability Evaluation System Manual, COMDTINST M1850.2C, art. 9.A.3.b.).

On April 10, 2006, the applicant submitted a rebuttal to the FPEB's report. He complained that the FPEB had used the 26-degree measurement by his physical therapist in its determination that his total range of motion was 128 degrees but then discounted the same measurement as his total forward flexion. He stated that there was no justification for discounting the 26-degree measurement as the true measurement of the forward flexion of his thoracolumbar spine. He pointed out that on March 27, 2006, his neurosurgeon had noted that a current measurement by a physical therapist would be more accurate than the neurosurgeon's own measurement made one year earlier, on March 25, 2005. The applicant claimed that it was also wrong for the FPEB to base its decision a purely visual, inexact observation by a physician's assistant made a month before the 26-degree measurement was taken by goniometer. In addition, he argued that under the VASRD, his limited flexion of the thoracolumbar spine should have been the FPEB's primary consideration, but the FPEB instead relied on the oral testimony of an expert about the functionality of his spine. The applicant further claimed that the FPEB had not resolved any doubt about his range of motion in his favor, as required by Article 9.A.3. of the PDES Manual.

The applicant stated in his rebuttal to the FPEB that he extended his enlistment in 2005 for just one year simply because he has a "special needs" child and he was not certain that the climate of his new billet in Louisiana would work for his child's condition, although it was an "optimal area that was suitable and recommended for my child's condition." He stated that it was unjust for the physician's assistant to say that his one-year extension was a "calculated risk" he took in hopes of getting a disability separation. The applicant argued that if not permanently retired, he should at least be placed on the Temporary Disability Retired List (TDRL). The applicant included with his rebuttal a faxed note from the neurosurgeon who examined him on March 25, 2005, stating the following:

To whom it may concern: It is impossible to determine what [the applicant's] range of motion is at this time since his last office visit with me was on March 25, 2005. His range

> of motion at that time was full but that was over a year ago. A better/recent range of motion can be provided by physical therapists.

On April 20, 2006, the president of the FPEB responded to the applicant's rebuttal, stating that the FPEB had reviewed the rebuttal and affirmed its decision:

> The Board found the assessment of the Medical Board Evaluator as determinative of your range of motion. The Board notes that a licensed Physician Assistant, employing a medically valid method to gauge your range of motion, determined your forward flexion at 45 degrees.
>
> The Board considered the findings of your Physical Therapist, but did not find the evidence compelling. The Board balanced the Physical Therapist's measurement of forward flexion at 26 degrees against the same Physical Therapist's testimony that the truest estimate of your functionality is your total range of motion, which was 128 degrees.

On April 24, 2006, a captain serving as the Physical Review Counsel (PRC) concurred with the FPEB, stating that he had reviewed it for completeness, accuracy, consistency, and equitable application of policy and regulation. On June 14, 2006, the Chief Counsel found the proceedings correct and the findings and recommendation supported by the evidence of record. On June 29, 2006, Commander, CGPC, approved the FPEB's findings and recommendation.

On August 4, 2006, the applicant was discharged from the Coast Guard due to his physical disability with a 20% disability rating and lump sum disability severance pay.

VIEWS OF THE COAST GUARD

On September 27, 2006, the Judge Advocate General (JAG) of the Coast Guard submitted an advisory opinion in which he recommended that the Board deny the requested relief. In so doing, he adopted the facts and analysis of the case in a memorandum prepared by CGPC.

CGPC stated that there is "no evidence that the Coast Guard's decision in this matter is in error or unjust. The record indicates that the CPEB's findings and recommendations were reasonable and appropriate." CGPC stated that the applicant has based his claim on a single clinical finding, whereas the FPEB "determined the percentage of disability awarded based upon the overall evidence of record (i.e., MRI findings, neurosurgical consults, physical therapist findings, and expert testimony during the FPEB)."

CGPC pointed out that the applicant received and exercised his full due process rights under the PDES, as his case was reviewed by a CPEB, FPEB, PRC, the Chief Counsel, and Commander, CGPC. CGPC noted that under Article 1.D.6.9. of the PDES

Manual, when a member rebuts the findings and recommendation of the FPEB, the PRC reviews the entire record to ensure that the correct VASRD code was used, that there has been no pyramiding of impairments, that the correct disability percentage has been assigned under the VASRD descriptive diagnosis, and that the findings and disability rating are supported by a preponderance of the evidence in the record.

APPLICANT'S RESPONSE TO THE COAST GUARD'S VIEWS

On October 24, 2006, the BCMR received the applicant's response to the views of the Coast Guard. The applicant argued that CPEB erroneously relied on the measurements of his T12 vertebra and that the angle of that vertebra should not be used to estimate his ROM in his entire thoracolumbar spine. He argued that, since the average of the three measurements of just his lumbar spine on December 1, 2005, was 29.6 degrees, that average should be considered his total thoracolumbar ROM, which would correlate to a 40% disability rating under the VASRD. He argued that the FPEB should have relied entirely on the physical therapist's measurements of his ROM in determining his disability rating rather than considering all of the other medical evidence as well. He stated that the other medical evidence simply proves that he has a back injury and does not evince how disabled he is.

The applicant argued that because his thoracolumbar ROM was measured at 26 degrees, which would justify at 40% rating, and his total ROM was measured at 128 degrees, which would justify only a 10% rating, there was doubt and so the FPEB should have awarded him the higher rating. Moreover, he argued, it was not appropriate to consider the 128-degree measure since his physical therapist testified at his FPEB hearing that the "degree of flexion limitation gives you a pretty good picture of what his functional limitations would be." The applicant pointed out that his flexion was measured at under 30 degrees by both inclinometer and goniometer on December 1, 2005, and January 27, 2006.

The applicant argued that the FPEB relied too heavily on the opinion of LT G, a physician's assistant, that his ROM was 45 degrees given that her opinion was based on her observation rather than on a measurement with a goniometer or inclinometer.

The applicant further argued that the medical evidence regarding the effect of the congenital sacralization (fusion) of his L5 and S1 vertebrae is inconsistent. He pointed out that two doctors have denied that the sacralization would affect his ROM, but the medical member of his CPEB assumed that it would in stating that his rating should be 20% rather than 40%.

SUMMARY OF 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 disability 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 VASRD shall be discharged with severance pay.

Veterans Affairs Schedule for Rating Disabilities (38 C.F.R. part 4)

Under the VASRD in effect during the applicant's PDES processing (2005 edition), the possible disability ratings for intervertebral disc syndrome that might apply under VASRD code 5243—with or without symptoms such as pain, stiffness, or aching—were as follows:

- **100%** for "unfavorable ankylosis [immobility due to disease or surgical fusion] of the entire spine."
- **50%** for "unfavorable ankylosis of the entire thoracolumbar spine."
- **40%** for "forward flexion of the thoracolumbar spine 30 degrees or less; or, favorable ankylosis of the entire thoracolumbar spine."
- **20%** for "forward flexion of the thoracolumbar spine greater than 30 degrees but not greater than 60 degrees; … or, the combined range of motion of the thoracolumbar spine not greater than 120 degrees; … or, muscle spasm or guarding severe enough to result in an abnormal gait or abnormal spinal contour … ."
- **10%** for "forward flexion of the thoracolumbar spine greater than 60 degrees but not greater than 85 degrees; … or, combined range of motion of the thoracolumbar spine greater than 120 degrees but not greater than 235 degrees; or muscle spasm, guarding, or localized tenderness not resulting in abnormal gait or abnormal spinal contour … ."

VASRD Note (2) for this section states that "[f]or VA compensation purposes, … [n]ormal forward flexion of the thoracolumbar spine is zero to 90 degrees, extension is zero to 30 degrees, left and right lateral flexion are zero to 30 degrees, and left and right lateral rotation are zero to 30 degrees. The combined range of motion refers to the sum of the range of forward flexion, extension, left and right lateral flexion, and left and right rotation."

VASRD Note (5) for this section states that "[f]or VA compensation purposes, unfavorable ankylosis is a condition in which the … entire thoracolumbar spine, or the entire spine is fixed in flexion or extension … . Fixation of a spinal segment in a neutral position (zero degrees) always represents favorable ankylosis."

Section 4.46 of the VASRD states in part that the "use of a goniometer in the measurement of limitation of motion is indispensable in examinations conducted with the Department of Veterans Affairs."

Provisions of the PDES Manual (COMDTINST M1850.2C)

The PDES Manual governs the separation of members due to physical disability. Chapter 3 provides that 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. Chapter 3.I.7. provides that before forwarding an IMB report to the CPEB, the member's commanding officer (CO) shall endorse it "with a full recommendation based on knowledge and observation of the member's motivation and ability to perform."

Chapter 4 provides that a CPEB, composed of at least one senior commissioned officer and one medical officer (not members of the IMB), shall review the IMB report, the CO's endorsement, and the member's medical records before making findings about the member's condition, fitness for duty, and any recommended disability rating.

Chapter 2.C.10.a.(2) provides that the CPEB or FPEB will consider a medical condition to be "permanent" when "[a]ccepted medical principles indicate the defect has stabilized to the degree necessary to assess the permanent degree of severity or percentage rating" or if the "compensable percentage rating can reasonably be expected to remain unchanged for the statutory five year period that the evaluee can be compensated while on the TDRL." Under Chapter 8, if the CPEB (or the FPEB) determines that a member is unfit for duty and the condition may not be permanent but is at least temporarily greater than 30 percent, the member may be placed on the temporary disability retired list (TDRL) for a maximum of five years.

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 evaluee 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 evaluee 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 form military service for disability. In making this professional judgment, board members will only rate those disabilities which make an evaluee 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.

Chapters 4.A.13.a. and b. provide that the Commandant shall appoint legal counsel to inform each member of the recommendation of the CPEB and to assist each member in responding to the recommendation by advising him of his rights and the PDES. Chapter 4.A.14.c. provides that the member has the right to reject the CPEB's recommendation and demand a formal hearing by the FPEB in accordance with 10 U.S.C. § 1214. Chapter 5.A.4. provides that an FPEB convened under 10 U.S.C. § 1214 normally consists of three officers, one of whom is a medical officer and none of whom have served on the member's CPEB.

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. (see above). Under Chapter 1.D.9., the FPEB must base its decision on the preponderance of the evidence. Chapter 9.A.1. states that not all of the policy provisions under the VASRD are applicable to the Coast Guard as they were written for DVA rating boards, which apply different presumptions and consider different factors. Chapter 9.A.3. states the following:

> Where there is a reasonable doubt as to which of two percentage evaluations should be applied, the higher evaluation will be assigned if the disability picture more nearly approximates the criteria for that rating. Otherwise, the lower rating will be assigned. When, after careful consideration of all reasonably procurable and assembled data, there remains reasonable doubt as to which rating should be applied, such doubt shall be resolved in favor of the member, and the higher rating assigned.

The applicant has 15 working days in which to file a rebuttal. Chapter 5.D.2.c. provides that the FPEB will inform the member or his counsel whether the rebuttal supports a change in the FPEB's determinations.

Chapter 6.B.1. provides that whenever a member rebuts the recommended disposition of the FPEB, a Physical Review Counsel (PRC) who must be a commissioned officer in pay grade O-5 or above will review the entire case to "check for completeness and accuracy, and ensure consistency and equitable application of policy and regulation." Chapter 6.B.2. provides that the PRC will not normally modify the findings and recommended disposition of the FPEB unless they are clearly erroneous. Chapter 6.B.3. provides that the PRC must concur with the FPEB unless it has assigned the wrong VASRD codes, pyramided the impairments, applied an "[i]ncorrect percentage of disability to the VASRD descriptive diagnosis/code(s), or was arbitrary and capricious or abused its discretion in making its determinations. If the PRC finds such an error, he shall return the case to the FPEB for reconsideration." Chapter 6.B.6. allows a member to submit new evidence or any pertinent information in writing to the PRC officer.

Chapter 1.B.4. provides that the Chief Counsel will review the actions of the CPEB, FPEB, and PRC to ensure legal sufficiency. If no legal insufficiency is found, the

Chief Counsel forwards the case to CGPC for final action. CGPC may return a case to the appropriate board with an explanation if there are doubts about the case.

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 section 1552 of title 10 of the United States Code. The application was timely.

2. Under 33 C.F.R. § 52.24(b), the Board "begins its consideration of each case presuming administrative regularity on the part of the Coast Guard and other Government officials. The applicant has the burden of proving the existence of an error or injustice by a preponderance of the evidence." Under the PDES, the CPEB, FPEB, and PRC are also supposed to base their recommendations about a member's disability rating on the preponderance of the evidence. PDES Manual, Chap. 1.D.9. The applicant alleged that the fact that on January 27, 2006, his physical therapist measured the average forward flexion of his thoracolumbar spine to be 26 degrees proves that the FPEB erred in recommending a 20% disability rating because one of the possible criteria for a 40% rating under the VASRD is forward flexion of the thoracolumbar spine of less than 30 degrees.

3. A 40% rating under the VASRD requires either ankylosis (immobility) of the entire thoracolumbar spine in a neutral position or forward flexion of the thoracolumbar spine of less than 30 degrees. Although on January 27, 2006, a physical therapist measured the applicant's forward flexion at 26 degrees, the Board is not persuaded the FPEB erred in determining that the preponderance of the evidence in the record showed that the applicant's "disability picture more nearly approximate[d] the criteria" for a 20% disability rating, pursuant to Article 9.A.3. of the PDES Manual. As the record indicates that the applicant's back condition varied over time, a single day's measurements are not necessarily probative of his usual condition.

4. The FPEB noted in its amplifying statement that the 26-degree measurement of the applicant's forward flexion on January 27, 2006, was not compelling in light of the other evidence in the record. The applicant's medical records contain other evidence showing that his usual ROM was significantly greater than indicated by the January 27, 2006, measurements of his forward thoracolumbar flexion:

(a) One year earlier, a neurosurgeon reported that the applicant had a full range of motion in his back.

(b) On July 21, 2006, the applicant was able to bend down far enough that his fingertips were about 8 inches from the floor.

(c) While evaluating him for his IMB, a licensed physician's assistant asked him to bend over to try to touch his toes and observed that he got about half-way down (45 degrees) to an imaginary horizontal line, or 90-degree bend.

(d) On December 1, 2005, the physical therapist took three measurements of the forward flexion in the applicant's lumbar spine, which were 26 degrees, 28 degrees, and 35 degrees. With the applicant's average forward flexion in his lumbar spine alone measuring 29.67 degrees and with there being nothing wrong with his thoracic spine and its ability to flex forward, the forward flexion of his entire thoracolumbar spine of December 1, 2005, was likely significantly higher than 30 degrees.

(e) The applicant's total ROM on January 27, 2006, averaged 127.33 degrees before exercise and 146.67 degrees after exercise, which measurements, considered alone, would justify only a 10% disability rating under the VASRD.

Therefore, considering the preponderance of the evidence in the record, the Board finds that the FPEB did not err by concluding that the applicant's back condition merited a 20% rating rather than a 10% or 40% rating under the VASRD.

5. The applicant argued that because of the 26-degree measurement of his forward flexion, the FPEB should have had "reasonable doubt" about whether to assign him a 20% or 40% disability rating and so should have awarded him the 40% rating in accordance with Chapter 9.A.3. of the PDES Manual. The fact that the January 27, 2006, measurement of his forward flexion supported a 40% rating does not prove that the members of the FPEB should have doubted the appropriateness of the 20% rating. As medical conditions vary, medical measurements vary, and the FPEB was required to recommend the percentage rating supported by a preponderance of all the evidence—not to recommend the highest percentage rating that could possibly be justified by any part of the medical record. The record indicates that the FPEB members carefully considered all of the medical evidence, including the January 27, 2006, measurements, and resolved their doubt as to whether he should receive a 10% or 20% rating in his favor.

6. The applicant complained that Coast Guard repeatedly changed its explanation for his 20% rating. By regulation, the CPEB and FPEB are composed of different members. While the members of each medical board must agree among themselves on an assigned disability rating, they are not required to reach their conclusions for the same reasons. The record shows that some of the members of the applicant's medical boards weighed the evidence differently and so arrived at the same conclusion—a 20% disability rating—for different reasons. The president of the CPEB indicated on February 15, 2006, that the CPEB considered the December 1, 2005, 40- to 45-degree measurement of the applicant's T12 vertebra to be significant. The CPEB's medical member wrote separately on February 17, 2006, to say that he believed that some of the appli-

cant's ROM limitation was due not to a service-incurred injury but to the congenital sacralization (fusion) of his sacrum with his L5 vertebra. Since the applicant rejected the CPEB decision and demanded an FPEB, the former board's reasoning and conclusion, whether correct or not, are not significant because they were superseded by the reasoning and conclusion of the latter board.

7. The FPEB's amplifying statement showed that its members agreed on the 20% rating primarily because of the applicant's total ROM measurements on January 27, 2006, which would justify only a 10% rating, and the observation of the physician's assistant during an examination pursuant to his IMB that he was able to bend half-way, or 45 degrees, down to an imaginary horizontal line representing 90-degree forward flexion, which would justify a 20% rating. The applicant argued that the FPEB illogically ignored the January 27, 2006, measurement of his forward flexion yet relied on that day's measurement of his total ROM. There is nothing illogical about finding the aggregated results of tests of many types of motion more compelling or indicative of disability than the results of the testing of just one type of motion. The Board notes that while the applicant's physical therapist stated during the FPEB hearing that forward flexion was a "pretty good" indicator of functional limitations, she also stated that the sum total ROM provided a "more global picture" of his amount of motion.

8. The record shows that the applicant received all due process under the PDES as his case was considered by an IMB, CPEB, FPEB, PRC, the Chief Counsel, and CGPC. His requests for reconsideration by the CPEB and the FPEB were timely reviewed and addressed.

9. The applicant has not proved by a preponderance of the evidence that his 20% disability rating for intervertebral disc syndrome is erroneous or unjust. Accordingly, his request should be denied.

[ORDER AND SIGNATURES APPEAR ON NEXT PAGE]

ORDER

The application of former xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx, USCG, for correction of his military record is denied.

Bruce D. Burkley

Harold C. Davis, M.D.

George A. Weller