

U.S. Department of
Homeland Security

United States
Coast Guard



Physical Disability Evaluation System

COMDTINST M1850.2D



Commandant
United States Coast Guard

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COMDTINST M1850.2D

COMMANDANT INSTRUCTION M1850.2D

MAY 19 2006

Subj: PHYSICAL DISABILITY EVALUATION SYSTEM

1. PURPOSE. This Manual promulgates policies, procedures, and standards for administering the Coast Guard Physical Disability Evaluation System for military personnel throughout the Coast Guard.
2. ACTION. Area, district, and sector commanders, commanders of maintenance and logistic commands, commanding officers of headquarters units, assistant commandants for directorates, Judge Advocate General, and special staff offices at Headquarters shall ensure that the provisions of this Manual are followed. Internet release is authorized.
3. DIRECTIVES AFFECTED. The Physical Disability Evaluation System, COMDTINST M1850.2C, is cancelled.
4. SIGNIFICANT CHANGES.
 - a. This is the first revision to the Physical Disability Evaluation System Manual since 1996. Since that time, the Veterans Administration disability rating policy has changed several times. The Coast Guard is required, by law, to follow their policy, and this Manual incorporates significant changes based on it. In addition, the Coast Guard is subject to the identical laws that govern the disability determinations and rights of active duty members of all the Armed Services. Accordingly, this revision endeavors to better align our terminology with that of our sister Services. Finally, this Manual introduces the new Temporary Limited Duty policy, a useful tool by which units can more effectively manage their workforce.

DISTRIBUTION – SDL No.145

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NON-STANDARD DISTRIBUTION:

- b. The following summary highlights the most significant changes reflected in this Manual.
- (1) ALCOAST 012/03. Interim policy as directed in paragraph 5 of this message has been incorporated, including the requirement for all Formal Physical Evaluation Boards to issue amplifying statements along with their findings, and the requirement to provide to this Formal Board prior Informal Physical Evaluation Board findings as background material to consider during deliberations.
 - (2) ALCOAST 121/04. Paragraph 3 of this message has been incorporated, which directs the elimination of the death imminent disability retirement process. All references to the prior policy of disability retirement via the urgent death imminent process have been removed.
 - (3) Chapter 1. Policy guidance concerning the dissemination of medical information on individuals within the Physical Disability Evaluation System, in accordance with the Health Insurance Portability and Accountability Act, which became law in 2003.
 - (4) Chapter 2. The following updated terminology is introduced:
 - (a) Medical Evaluation Board replaces Initial Medical Board, aligning our terminology with the other Armed Services.
 - (b) Informal Physical Evaluation Board replaces Central Physical Evaluation Board, aligning our terminology with the other Armed Services.
 - (c) Available For Full Duty is introduced as a term to be used exclusively by medical officers in the field when making duty status determinations. Use of this term replaces Fit For Duty, where applicable, to eliminate the confusion that exists from using Fit For Duty at both the clinic and Board levels.
 - (d) Available For Limited Duty is introduced as a term to be used exclusively by medical officers in the field when making duty status determinations. Use of this term replaces Not Fit For Duty, where applicable, to eliminate the confusion that exists from using Not Fit For Duty at both the clinic and Board levels.
 - (e) Fit For Duty and Not Fit For Duty are determinations that may be made by a Physical Disability Evaluation Board only. A finding of Not Fit For Retention, a conclusion drawn by a Medical Evaluation Board report, may or may not indicate an individual is Not Fit For Duty according to the Physical Disability Evaluation Board System.
 - (f) Temporary Limited Duty is introduced as a duty status to be used judiciously by medical officers in the field. It requires the medical officer to have an expectation of the individual's short-term (less than 6 – 9 months) recovery outlook. This status provides visibility at the Personnel Command level of those individuals who may eventually enter the Physical Disability Evaluation System.

- (5) Chapter 3. Medical officers preparing Medical Evaluation Board reports are required to do the following:
- (a) Use the Medical Board Report Cover Sheet, CG-5684, whenever possible.
 - (b) Use a military psychiatrist or the combination of a military psychologist and civilian psychiatrist for mental health evaluations regarding fitness for retention determinations by a Medical Evaluation Board.
 - (c) Use specific physical exam methodology for assessing impairments related to endocrine conditions, spinal impairments, and cardiac conditions.
- (6) Chapter 4.
- (a) A Disposition Medical Board is clearly differentiated from an addendum to a Medical Evaluation Board. A Disposition Medical Board or addendum are actions initiated by a Physical Disability Evaluation Board.
 - (b) Procedures are established and outlined for the reconsideration of findings made by an Informal Physical Evaluation Board.
 - (c) Retention policy is better aligned with existing policy in chapter 17 of the Personnel Manual, COMDTINST M1000.6 (series).
 - (d) Composition of Informal Physical Evaluation Boards is expanded to include civilians who work for the Coast Guard. Such civilians must have specific skills and experience to qualify for membership on a Board.
- (7) Enclosure (1). This enclosure contains the rating principles found in chapter 9 of the former Manual and introduces specific criteria for rating a disability involving the spine.
5. REQUESTS FOR CHANGES. Units and individuals may recommend changes by writing via the chain of command to:
- Commander (adm-1)
 - Coast Guard Personnel Command
 - 4200 Wilson Boulevard, Suite 950
 - Arlington, VA 22203
6. ENVIRONMENTAL ASPECT AND IMPACT CONSIDERATIONS. Environmental considerations were examined in the development of this Manual and have been determined not to be applicable.

7. **FORMS AVAILABILITY.** The following Coast Guard forms and Standard Forms referred to in this Manual are available in Adobe Acrobat Portable Document Format on the Coast Guard electronic forms website; intranet:
<http://cgweb2.comdt.uscg.mil/cgforms/welcome.htm>, or internet:
<http://www.uscg.mil/ccs/cit/cim/forms1/welcome.htm>.

CG-3822	Injury Report for Not Misconduct and In Line of Duty Determination
CG-4920	Evaluee's Statement Regarding the Findings of the Medical Board Report
CG-5684	Medical Board Report Cover Sheet
CGHQ-4808	Coast Guard Physical Disability Evaluation Board Findings and Recommended Disposition
SF-502	Medical Record Narrative Summary (Clinical Resume)

DA Form 3947 and AF Form 618 are not supported by the Coast Guard but will be accepted from other agencies as part of a Medical Evaluation Board.

Stephen W. Rochon /s/
Director of Personnel Management

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CHAPTER 1. OVERVIEW OF PHYSICAL DISABILITY EVALUATION SYSTEM (PDES)

- A. Purpose of the System. The PDES exists to ensure equitable application of the provisions of Title 10, United States Code, Chapter 61, which relates to the separation or retirement of military personnel by reason of physical disability. These laws were enacted primarily for the purpose of maintaining a vital and fit military organization with full consciousness of the necessity for maximum use of the available work force. These laws provide benefits for eligible members whose military service is terminated due to a service-connected disability, and they prevent the arbitrary separation from the service of those members who incur a disabling injury or disease, yet remain fit for duty.
- B. System Components. These components and levels of review represent a system of counterbalances, each playing an important role in protecting the rights and interests of both the evaluatee and the government.

[Note: Full and complete descriptions of these components, their roles, membership, convening authorities, and limitations are provided in the definition section of chapter 2 and in chapters 3 through 9.]

1. Medical Evaluation Board (MEB). This is the first step in the PDES. A MEB is convened to conduct a thorough and expeditious evaluation of a member whose fitness for duty is questionable. (chapter 3)
2. Informal Physical Evaluation Board (IPEB). The IPEB is a standing administrative board located at CGPC and convened by precept of the Commander, CGPC. The IPEB evaluates MEBs as well as periodic evaluations of members on the TDRL. (chapter 4)
3. Formal Physical Evaluation Board (FPEB). The FPEB is a standing board located at the CGPC and convened by precept of the Commander, CGPC. The FPEB meets to evaluate the case of an evaluatee who has exercised the right to demand a formal hearing subsequent to the evaluation of the case by the IPEB, or upon which the IPEB could not unanimously agree. The formal board is a fact-finding body which evaluates the evidence presented, hears witnesses, and records their testimony so as to provide a full and fair hearing. When authorized by Commander, CGPC, commanders of maintenance and logistics commands, district commanders, and commanding officers of certain headquarters units may convene a formal board. (chapter 5)
4. Physical Review Council (PRC). The PRC reviews IPEBs and FPEBs in which evaluatees rebut the findings or recommended disposition. (chapter 6)
5. Physical Disability Appeal Board (PDAB). The PDAB is established for the purpose of reviewing disability evaluation cases forwarded to it by the PRC. It is the final component in the system. (chapter 7)

C. General Responsibilities.

1. Commandant. The Commandant is responsible for prescribing regulations to carry out the provisions of Title 10, United States Code, as they apply to the PDES. Except with respect to the categories and circumstances specified in articles 1.E. and 1.F., the Commandant has authority to make all determinations regarding:
 - a. unfitness as a basis for retirement or separation by reason of physical disability;
 - b. the percentage of disability at the time of retirement or separation; and
 - c. the entitlement to disability severance pay.
2. Assistant Commandant for Human Resources. Commandant (CG-1) has overall responsibility for personnel management within the Coast Guard. Commandant (CG-1) has the following specific responsibilities relating to the PDES:
 - a. oversee the PDES and approve its policies; and
 - b. interpret and implement policies emanating from higher authority.
3. Commander, Coast Guard Personnel Command. Commander, Coast Guard Personnel Command (CGPC) is responsible for executing all aspects of the PDES, as follows:
 - a. develop and implement operating procedures for the PDES;
 - b. review IPEB and FPEB proceedings to ensure efficient, timely processing, and uniformly equitable consideration of individuals under applicable laws, policies, and directives;
 - c. promulgate the precepts for the IPEB, FPEB, PRC, and PDAB;
 - d. manage medical and complete administrative aspects of personnel on the Temporary Disability Retired List (TDRL);
 - e. finalize physical disability cases for the Commandant; and
 - f. implement personnel policy regarding the PDES.
4. The Judge Advocate General. Commandant (G-L) has responsibility for certifying the legal sufficiency of board actions in the PDES. Commandant (G-L) has specific responsibility, as follows:
 - a. review the actions of the IPEB, FPEB, PRC, and PDAB for legal sufficiency to ensure

- (1) the proceedings are in accepted form and technically correct, and
 - (2) the findings and recommended disposition are supported by the evidence of record;
- b. detail legal full time support of the PDES to counsel individuals who are being evaluated by the PDES, including legal counsel to brief the evaluatee on IPEB findings and recommended disposition, and, if applicable, to represent the evaluatee before FPEB and PDAB proceedings; and
 - c. provide legal advice to the IPEBs, FPEBs, PRCs, and PDABs on the laws and regulations which apply to the PDES.
5. Commanders of Districts, Sectors, and Maintenance and Logistics Commands (MLCs). Commanders of Districts, Sectors, and MLCs have specific responsibilities, as follows:
- a. convene medical evaluation boards when required; and
 - b. review medical evaluation boards forwarded to them for any indication of fraudulent enlistment. Any boards in which it appears there may have been fraudulent enlistment will be forwarded immediately to the command's servicing Staff Judge Advocate for action.
6. Commanding Officers. Commanding officers have the following responsibilities:
- a. become familiar with the purpose of and the policies and procedures governing the PDES, and comply with the detailed instructions in article 3.I.;
 - b. upon receipt of the medical evaluation board report, ensure the board includes all items required by article 3.G. 3. (if this is the case, coordinate further actions with CGPC-adm-1);
 - c. provide the evaluatee with a copy of the board, unless it has been determined by competent medical authority that disclosure of its contents might adversely affect the evaluatee's physical or mental health;
 - d. ensure the evaluatee is counseled about the contents of the board report subject to the restrictions of article 1.C.6.c.;
 - e. have the evaluatee sign the Evaluatee's Statement Regarding the Finding of the Medical Board Report, CG-4920;
 - f. endorse the medical evaluation board report with a full recommendation based on knowledge and observation of the evaluatee's motivation and ability to perform military duty;

- g. distribute the medical evaluation board report in accordance with article 3.J.;
 - h. establish an interim duty status for the evaluatee during PDES processing, following guidelines in article 3.M.; and
 - i. forward any case of suspected fraudulent enlistment to the command's servicing Staff Judge Advocate for action.
7. All Stakeholders. Health Information Portability and Accountability Act (HIPAA). The Coast Guard has published a notice at 68 FR 22407 indicating that an authorized disclosure of protected health information regarding Armed Forces personnel is to "determine the member's fitness for duty" or "to determine a member's fitness to perform any particular mission." For a commanding officer to assess an active duty or reserve member's fitness for duty, it is conceivable that he or she would consult with the command's subordinate personnel.
- a. A covered entity (as defined by applicable federal statutes and regulations, and as specifically delineated in the Coast Guard Medical Manual, COMDTINST M6000.1 (series), for Coast Guard administration), including a covered entity not part of or affiliated with the Department of Homeland Security, may use and disclose the protected health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission.
 - b. Purposes for which protected health information may be used or disclosed:
 - (1) to determine the member's fitness for duty, including but not limited to the member's compliance with standards and all other activities carried out under the authority of the Weight/Physical Fitness Standards for Coast Guard Military Personnel, COMDTINST M1020.8 (series), this Manual, and similar requirements pertaining to fitness for duty;
 - (2) to determine the member's fitness to perform any particular mission, assignment, order, or duty, including any actions required as a precondition to performance of such a mission, assignment, order, or duty;
 - (3) to carry out activities under the authority of the Medical Manual, COMDTINST M6000.1 (series), chapter 12;
 - (4) to report on casualties in any military operation or activity according to applicable Coast Guard regulations or procedures; or
 - (5) to carry out any other activity necessary to the proper execution of the mission of the military.

D. System Process.

[Note: The provisions of this section are presented for the purpose of giving, in one location, a general overview of the entire disability process from the MEB through final disposition. This section is not to be relied upon as authority for official action; each step in the process is covered in detail in subsequent chapters.]

1. Medical Evaluation Board (MEB). A member is introduced into the PDES when a commanding officer (or medical officer or higher authority as described in chapter 3) questions the member's fitness for continued duty due to apparent physical and/or mental impairment(s) and directs that an MEB be convened to conduct a thorough examination of the member's physical and/or mental impairment(s). The results of this examination, prepared in MEB format, should be as detailed as possible so as to provide a complete portrait of the member's physical and mental impairments for subsequent review.
2. Commanding Officer Endorsement. The MEB will then be sent to the evaluatee's unit for action set forth in articles 1.C.6 and 3.I. The unit commanding officer will prepare an endorsement. This endorsement shall reflect the commanding officer's observations of the evaluatee's working ability and any impact the injury or disease has on the evaluatee's ability to perform the military duties associated with his or her office, grade, rank, or rating. The commanding officer shall fully evaluate the more intangible aspects such as motivation and ability to adapt.
3. Evaluatee Response to MEB. A copy of the MEB shall also be provided to the evaluatee, who will be given an opportunity to comment on the report. To help the evaluatee in reviewing the report, the evaluatee's commanding officer will arrange assistance by a qualified individual capable of explaining the meaning of the report and the evaluatee's rights.
4. Convening Authority Review. The commanding officer then forwards the entire record, properly endorsed, including the evaluatee's statement, if any, to Commander (CGPC-adm-1).
5. Commander (CGPC-adm) Referral to IPEB. CGPC-adm will then review the record and, if it is sufficient, refer the MEB to the IPEB. If an MEB is insufficient, CGPC-adm will hold the case in abeyance pending receipt of the required information.
6. IPEB Action. The IPEB reviews the record of each case referred to it and evaluates the fitness and disability of the evaluatee. IPEB findings and recommended disposition must be unanimous (article 4.A.6.). The findings and recommended disposition are initially only sent to the evaluatee. If the evaluatee elects counsel, the decision will be provided to the assigned legal counsel as well.
7. Evaluatee Response to IPEB. Elected counsel, if chosen by the evaluatee, will examine the records and review the case, the findings, and recommended disposition with the evaluatee. Counsel shall explain to the evaluatee the full implications of the IPEB's findings and

recommended disposition, the evaluatee's rights, and alternative IPEB courses of action that should be considered. The evaluatee must then make a decision on the findings and recommended disposition based on the counseling provided (see articles 4.A.13 and 4.A.14 for available options). The time frame for responding is not later than 30 calendar days from the date of receipt of notification of findings from CGPC.

[Note: An evaluatee must request counsel if desired. Legal counsel is not automatically appointed. An evaluatee is not required to use counsel in the PDES process; however, use of counsel is in the evaluatee's best interest.]

8. FPEB Action and Evaluatee Response. Upon receiving a case, the FPEB arranges for the presence of the evaluatee and witnesses. This board provides the full and fair hearing which, if demanded by an evaluatee, is required by 10 USC §1214. An audio recording is made of the testimony and proceedings, witnesses are heard under oath or affirmation, and other evidence may be received to establish the evaluatee's fitness or unfitness for duty and the degree of disability, if applicable. The evaluatee is given a copy of the audio recording, if requested, and the findings, amplifying statement, and recommended disposition. The evaluatee is allowed not more than 21 calendar days from the date of receipt of the FPEB findings, recommended disposition, and amplifying statement, to review and, if desired, to submit a rebuttal to the President, FPEB. If no rebuttal is submitted within the 21 calendar day period, the case is forwarded to Commandant (G-LGL) for review.
9. PRC Action and Evaluatee Response. If an evaluatee has rebutted the findings and recommended disposition of an IPEB or FPEB, the entire record is reviewed by the PRC. The PRC, in reviewing the record, ensures that the correct Department of Veterans Affairs Schedule for Rating Disabilities (VASRD) diagnostic code(s) has been assigned, there is no pyramiding of impairments, a correct percentage of disability has been assigned to the VASRD descriptive diagnosis(es), and there is a preponderance of evidence of record to support the findings and, if found unfit, the disability rating. If the IPEB or FPEB findings and recommended disposition are approved by the PRC, or if only minor changes are made, the record is forwarded to Commandant (G-LGL) for a determination of legal sufficiency and for action by CGPC. If the PRC does not approve the findings and recommended disposition of the IPEB or FPEB, it will take action as provided in article 6.C. Substitute findings and disposition will be sent to the evaluatee, who has the opportunity to rebut or appeal the substitution within 21 calendar days from the date of receipt from CGPC. The PRC will consider the evaluatee's comments and will either modify the substitute findings and recommended disposition to accommodate the evaluatee, or adhere to substitute findings or disposition and so notify the evaluatee of the decision and the right to request a hearing before a PDAB. If a rebuttal statement is not received within the 21 calendar day period, the evaluatee will be deemed to have concurred with the substitute finding. (chapter 7)
10. PDAB. The PDAB is the final board in the disability system. It will review the record of a case presented to it and will hear statements, in person, of the evaluatee and counsel if they wish to make such statements. The PDAB will not normally call witnesses or hear

other testimonies which are not already contained in the record. The PDAB's decision is forwarded to Commandant (G-LGL) for legal sufficiency review. If legally sufficient, the record is forwarded to the final approving authority. If legally insufficient, the record is returned to the PDAB with recommended corrective action. Upon completion of Commandant (G-LGL)'s review, the record is returned to the PDAB for completion of necessary endorsements, then forwarded to the final approving authority.

11. Legal Review. When an evaluatee accepts the findings and recommended disposition of an IPEB, FPEB, or PRC, the record is forwarded to Commandant (G-LGL) for legal review. If legally sufficient, the record is forwarded to the final approving authority. If legally insufficient, the record is returned to the IPEB, FPEB, PRC, or PDAB with recommended corrective action. A case involving a flag officer is forwarded for review to the Director of Health and Safety (CG-11); then to Commandant (G-LGL) for legal review and transmittal to the final approving authority (articles 1.E. and 1.F).
12. Final Action. Policy and procedure regarding final action in physical disability evaluation cases is published in article 17.B. of the Personnel Manual, COMDTINST M1000.6 (series).

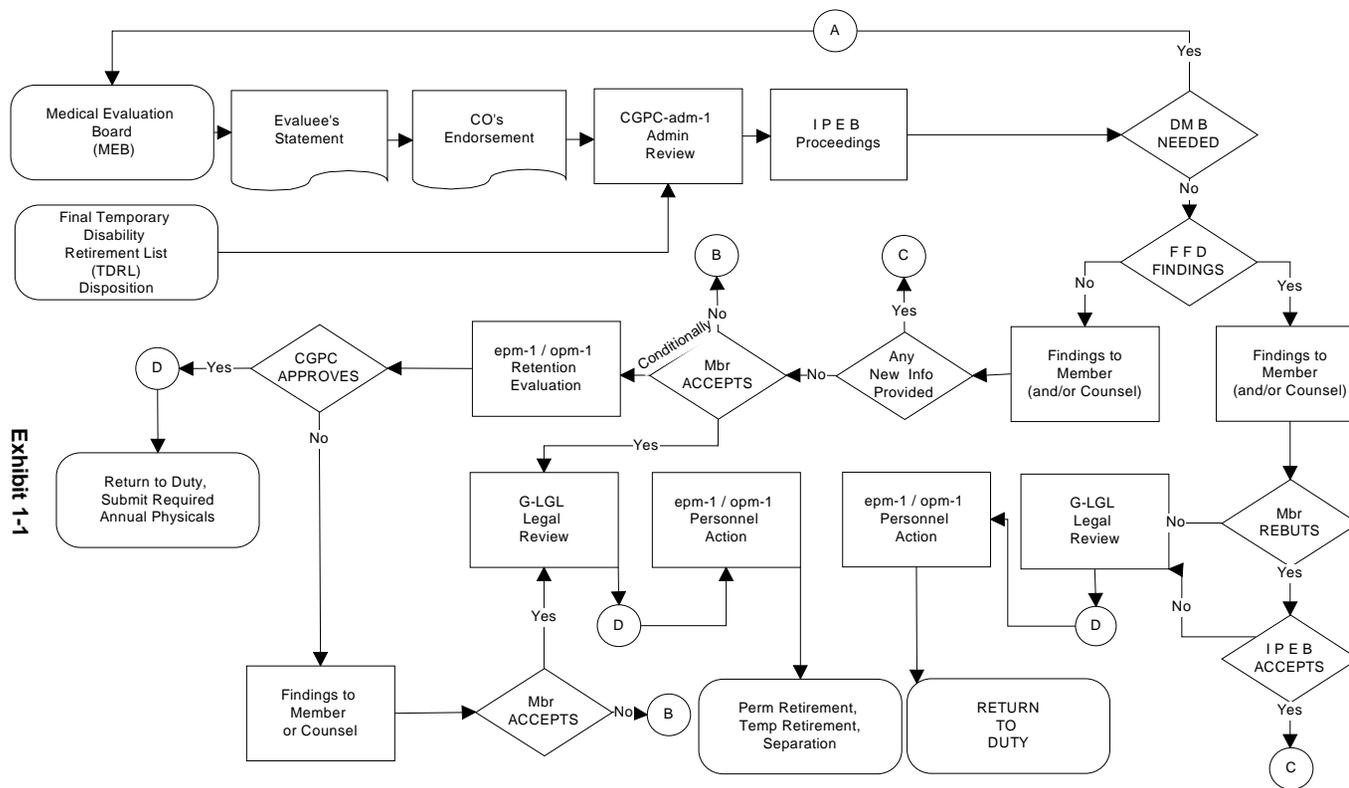
E. Final Approving Authorities.

1. The incumbents of the following positions will act for the Commandant as final approving authority in all cases except those involving O-9 and O-10 flag officers. The Secretary of Homeland Security will act on all disability cases involving O-9 and O-10 flag officers found not fit for duty in accordance with article 1.F. Commandant (CG-1) is final approving authority in cases where flag officers are found fit for duty.
 - a. CGPC-adm-1, providing the following conditions are met:
 - (1) the evaluatee is in pay grade 0-5 or below;
 - (2) the incumbent was not a member of a board or PRC for the case;
 - (3) the findings and recommended disposition were decided unanimously;
 - (4) the case did not involve either a "not in the line of duty" or "misconduct" determination; and
 - (5) the evaluatee is not concurrently being processed for an administrative discharge by reason of misconduct or a punitive discharge.
 - b. Commander, CGPC provided the incumbent has not been a member of a board or PRC for the case.
 - c. Commandant (CG-12) for O-6 officers, provided the incumbent has not been a member of a board for the case.

2. The findings and recommended disposition made during the physical disability evaluation process are not binding on a final approving authority. In the event a final approving authority has doubts or questions concerning a particular case to the point where that authority would consider other findings and recommended disposition, the case may be returned to the appropriate board, with appropriate comment. Having followed this procedure, when the final approving authority does not accept the findings and recommended disposition of the board, the final approving authority shall provide an explanation.

F. Flag Officers.

1. The Secretary, Department of Homeland Security is the final approving authority for physical disability retirements of officers in the grade of O-9 and above. The Director of Health and Safety shall provide the Secretary with an evaluation of the effects of the disease or injury that renders the officer physically unfit to perform the duties associated with the officer's grade.
2. Commandant (CG-1) is the final approving authority for physical disability retirements of officers in the grades of O-7 and O-8.
3. In the case of a flag officer, the next senior officer in the chain of command is the official responsible for preparing the commanding officer's endorsement pursuant to article 3.I.7.
4. When a flag officer is being processed by the PDES, a flag officer will be assigned as President of the IPEB and as President of the FPEB. Precepts for the IPEB, FPEB, PDAB, and PRC evaluating a flag officer will be prepared by CGPC and promulgated by Commandant (G-CCS).
5. In the event substitute findings and recommended disposition by the PRC are rejected by the evaluatee, and meet the requirements in article 6.C.2., the case will be referred to a PDAB convened by the Commandant to hear such cases (refer to chapter 6 for details).
6. The president of any IPEB, FPEB, PDAB, or PRC convened to consider a flag officer on active duty will be senior to the evaluatee, if practicable. Membership on these boards may consist of officers not on active duty.
7. In the event of an expedited review case for a flag officer, the provisions of this section are inoperative. The case will be referred to the IPEB convened by CGPC.



INFORMAL PHYSICAL EVALUATION BOARD FLOWCHART

Exhibit 1-1

- (A) - The board is referred back to the originator for a Disposition Medical Board (DMB) when member's impairment is not stable enough to render a finding.
- (B) - Forward to the Formal Physical Evaluation Board (FPEB) for adjudication
- (C) - Return board to IPEB admin proceedings for adjudication.
- (D) - Final Action Authority SEC DHS, COMDT, or CGPC, as appropriate

This exhibit is for the sole purpose of graphically understanding the flow of the PDES. This graphic representation will not be used to interpret policy determination nor the rights of the evaluatee in the PDES.

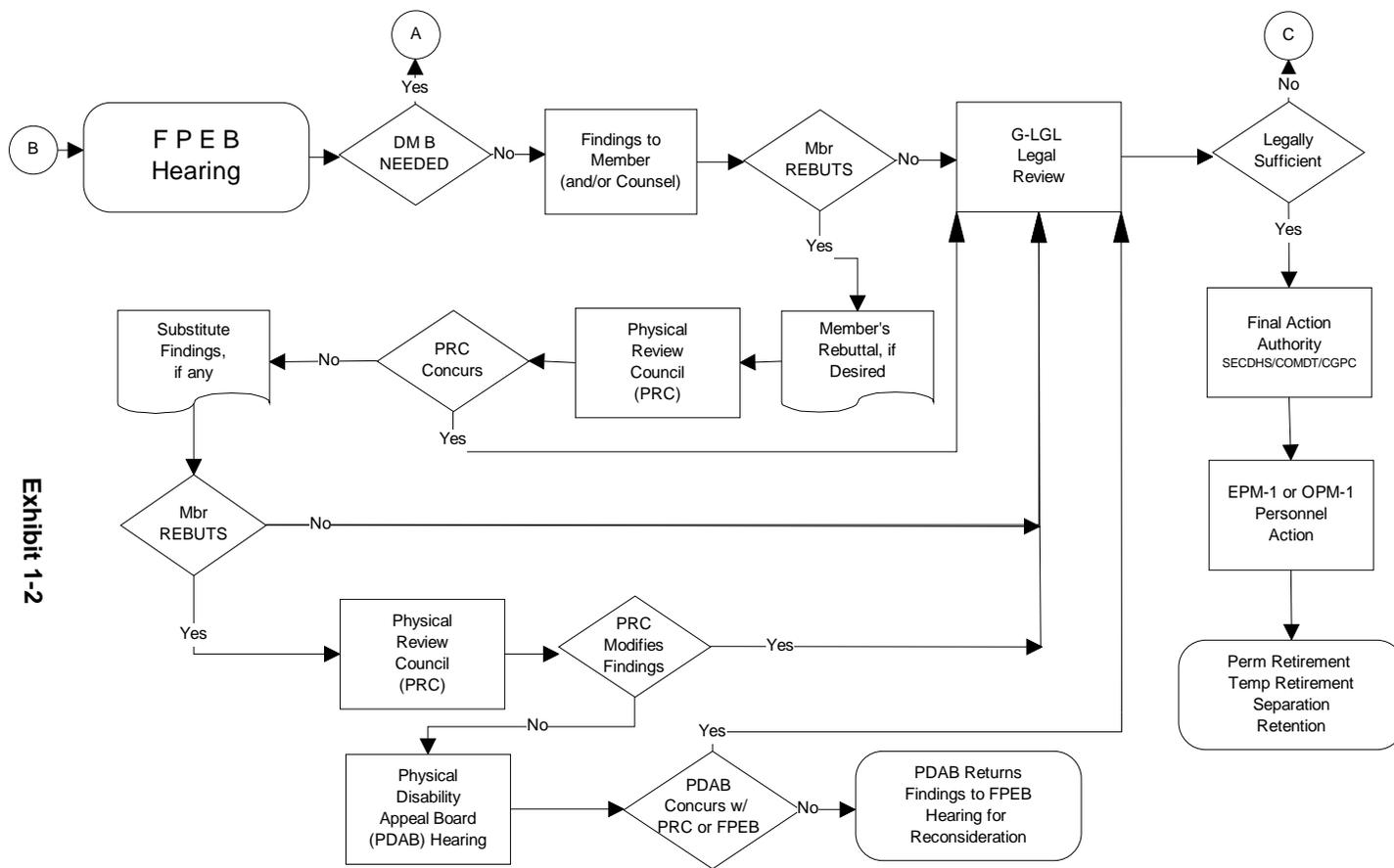


Exhibit 1-2

FORMAL PHYSICAL EVALUATION BOARD FLOWCHART

- (A) - Forwarded from the IPEB proceedings for adjudication
- (B) - The board is referred back to the originator for a Medical Evaluation Board (MEB) when member's impairment is not stable enough to render a finding. The DMB will be re-submitted to the IPEB for adjudication
- (C) - Return to FPEB Hearing to implement G-LGL's recommendations or return to the PRC, as appropriate

This exhibit is for the sole purpose of graphically understanding the flow of the PDES. This graphic representation will not be used to interpret policy determination nor the rights of the evaluatee in the PDES.

Table of Physical Disability Retirement and Severance Pay Benefits

Benefit	Action	Less Than 20 Years Active Service	20 or More Years Active Service
Severance Pay (see note 2)	If a regular active duty member, reservist ordered to active duty, or reservist on inactive duty for training . . .	incurred physical disabilities in line of duty or proximate result of performing active duty and rated under 30 % by a medical board (see note 1), then severance pay is authorized.	severance pay not authorized (see retirement).
Retirement (see note 3)	If a regular active duty member, reservist ordered to active duty, or reservist on inactive duty for training . . .	incurred physical disabilities in line of duty or proximate result of performing active duty and rated 30 % or more by a medical board, then retirement is authorized (see note 1).	no minimum percentage is necessary for retirement eligibility.

Notes

1. 10 U.S.C. §1209 and §1332. Member can elect Inactive Status List (ISL) if qualified for retirement.
2. There is no payment of severance pay when the evaluatee has less than 6 months service at time of separation (see 39 CompGen 291).
3. See chapter 2.C for instructions on determination as to temporary or permanent retirement.

CHAPTER 2
DEFINITIONS, PRESUMPTIONS, AND POLICIES

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Article No.

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Exhibit 2-1 Summary of Action Under the TLD Designation

CHAPTER 2. DEFINITIONS, PRESUMPTIONS, AND POLICIES

A. Definitions.

1. Accepted Medical Principles. Certain medical principles based upon the observation of a large number of cases and now so universally recognized and consistent with medical facts as to compel unquestionable conclusions and to create a virtual certainty that they are correct. For example, infectious diseases have incubation periods, which can define the time of incurrence, and certain chronic diseases have well defined clinical courses with remissions and relapses.
2. Active Duty. Full-time duty in the active military service of the United States includes full-time training duty, annual training duty, and attendance, while in the active military service, at a school designated as a service school.
3. Active Duty for a Period of More Than 30 Days. Active duty under a call or order that does not specify a period of 30 days or less.
4. Aggravated by Service. A measurable or demonstrated increase in the level of a member's impairment in excess of that due to the natural progress of a disease or injury which occurs after a member enters active duty in the Coast Guard or during inactive duty training.
5. Armed Conflict. An armed conflict may include a war, expedition, occupation, battle, skirmish, raid, invasion, rebellion, insurrection, guerrilla action or insurgency, etc., in which American military personnel are engaged with a hostile or belligerent nation, faction, or force.
6. Available for Full Duty (AFFD). The final status of a member who is able to perform all of the duties of the member's office, grade, rank or rate. A member placed in this status will have been determined to be fully ready for those duties expected of the member, given their current office, grade, rank, or rating. It pertains to a duty status that may result in an MEB or TLD report.
7. Available for Limited Duty (AFLD). The interim status of a member who is temporarily unable to perform all of the duties of the member's office, grade, rank, or rating. A member placed in this temporary status will have duty limitations specified, such as: no prolonged standing, lifting, climbing; or unfit for sea or flying duty. It pertains to a duty status that may result in an MEB or TLD report.
8. Clear and Convincing Evidence. This term means such evidence as would convince an ordinarily prudent-minded person beyond a well-founded doubt. It is a higher degree than preponderance of the evidence, but it does not require proof beyond a reasonable doubt as in criminal cases.

9. Conditions or Defects not Physical Disabilities. Certain conditions and defects may cause a member to be unfit for continued duty and yet not have physical disabilities within the meaning of the law, thereby subjecting the member to administrative separation. These conditions include, but are not limited to, alcoholism; allergy to uniform clothing; character disorders; enuresis; heat intolerance with disturbances of thermal regulation; inability to be fitted in uniform clothing; motion/travel sickness; obesity; primary mental deficiency; pseudofolliculitisbarbae of the face and/or neck; somnambulism; stuttering or stammering; systemic or marked allergic reactions following stings by red ants, bees, wasps or other stinging insects; unsanitary habits including repeated venereal disease infections. A full listing of personality and intelligence disorders is contained in chapter 5 of the Medical Manual, COMDTINST M6000.1 (series).
10. Counsel. Legal counsel assigned by the Commandant (G-L-6), a civilian employed by the evaluatee at no expense to the government, or a disability counselor provided by a veterans' service organization.
11. Deleterious to Health Type Case. Situations, medical boards, or disability cases in which disclosure of information on a member's physical condition would be harmful or detrimental to the individual's physical or mental health.
12. Disease. A definite morbid condition that is not caused by trauma and has a characteristic group of symptoms. A disease may affect the whole body or any of its parts, and its cause, pathology, and prognosis may be known or unknown.
13. Disposition Medical Board (DMB). The report of a medical board ordered by the senior member of a physical evaluation board or the final approving authority to update an MEB. DMBs are usually ordered when the president of the IPEB or the convened FPEB feels that the evaluatee's disease or injury was not sufficiently manifested at the time of the MEB to determine the cause or degree of the evaluatee's impairments. Additionally, DMBs will also evaluate any new conditions which were not present or considered at the time of the MEB. The time frame of the DMB is specified in the convening order.
14. Evaluatee. The member whose case is being considered (see also legal guardian).
15. Existed Prior to Entry (EPTE). An impairment that existed prior to an evaluatee's entry onto active or inactive duty.
16. Fit for Duty (FFD). The status of a member who is determined by the final approving authority within the PDES to be able to perform the essential duties of the member's office, grade, rank, or rating. This includes the physical ability to perform specialized duty, such as duty involving flying or diving, if the performance of the specialized duty is a requirement of the member's enlisted rating. Only a final approving authority within the PDES can determine a

member's fitness for duty. Physicians can determine whether a member is AFFD or AFLD, based upon the physician's assessment of a member's medical condition.

17. Formal Physical Evaluation Board (FPEB). A fact-finding body that holds an administrative hearing to evaluate an individual's fitness for duty and to make recommendations consistent with its findings. (chapter 5)
18. Grade, Rank and Rating. The terms grade, rank, and rating are defined by statute (10 U.S.C. §101(b)), as follows.
 - a. Grade. A step or degree, in a graduated scale of office or military rank, which is established and designated as a grade by law or regulation.
 - b. Rank. The order of precedence among members of the Armed Forces.
 - c. Rating. The name (such as boatswain's mate) prescribed for members of an Armed Force in an occupational field. The term rate means the name (such as chief boatswain's mate) prescribed for members in the same rating or other category who are in the same grade (such as chief petty officer or seaman apprentice).
19. Impairment of Function. Any lessening or weakening of the capacity of the body or any of its parts, to perform that which is considered by accepted medical principles to be the normal functional activity in the bodily economy.
20. Impairment, Latent. An impairment which is not currently manifested by current signs and/or symptoms, but which is of such a nature that there is reasonable probability, according to accepted medical principles, that signs and/or symptoms that demonstrate impairment of function will definitely appear within a period of time.
21. Impairment, Manifest. An impairment of function that currently exists that can be diagnosed by signs and/or symptoms.
22. Impairment, Physical. Any anatomical, functional or physiological abnormality of the body. Synonymous with "physical defect." Included is an alteration of mental capacity due to disease or injury.
23. Inactive Duty Training (IDT). Duty prescribed by competent authority for members of Reserve components under provision of 37 U.S.C. §206, 37 U.S.C. §1002, 10 U.S.C. §12315, and 10 U.S.C. §101(d)(7). It does not include work or study in connection with a correspondence course.
24. Incurrence of Disability. A disability is incurred (as in "incurred while entitled to receive basic pay") when the disease or injury is contracted or suffered as

- distinguished from a later date when the member's physical impairment is diagnosed or the physical defect renders the member unfit for continued duty. After the member is found unfit for continued duty, incurrence of disability is synonymous with the incurrence of an impairment. A physical disability that is due to the natural progress of disease or injury is incurred when the disease or injury causing the disability is contracted.
25. Informal Physical Evaluation Board (IPEB). A standing administrative board located at CGPC that evaluates MEB reports and the fitness for duty of individuals on the TDRL. (chapter 4)
 26. Injury. A term describing damage done to the body by kinetic (trauma), thermal (burn or frostbite), or chemical (poisoning) means.
 27. Legal Guardian. An individual designated as legally empowered to act on behalf of a member whom a court, having jurisdiction in the matter, or the Commandant has declared as incompetent to act on his or her own behalf. In this Manual, whenever the term evaluatee is used it shall be interpreted to include the legal guardian, when one has been appointed. The legal guardian may exercise, on behalf of the evaluatee, all rights afforded by this Manual.
 28. Legal Sufficiency. A review of the PDES proceedings and recommended disposition by an attorney assigned by Commandant (G-LGL) in order to ascertain whether the proceedings substantially complied with the procedures set forth in this Manual, that the rights of the evaluatee, including the right to a full and fair hearing were not substantially prejudiced, and that the recommended disposition is supported by the evidence of record.
 29. Maximum Hospital Benefits. That point in time during hospitalization when it is determined that additional hospitalization will not contribute to any further substantial recovery. A member who can be expected to continue to improve over a long period of time without specific therapy or medical supervision or with only a moderate amount of treatment on an outpatient basis, may be considered as having attained maximum hospital benefits. It is not necessary to attain maximum hospital benefits, when those benefits will not lead to a FFD status, in order to begin the physical disability evaluation process.
 30. Medical Board. A medical board is a clinical body normally comprised of one or more medical officers who describe an individual's disease or injury, the physical impairment, and the impairment of function, including any latent impairment. It includes a written professional opinion on whether the member's physical and mental qualifications satisfy the medical standards for retention set forth in the Medical Manual.

31. Medical Evaluation Board (MEB). The initial medical report prepared by a medical facility, and submitted to CGPC for evaluating a member's fitness for duty. (chapter 3)
32. Member. Unless otherwise specified, a commissioned officer, warrant officer, cadet, officer candidate, or enlisted person of the Coast Guard or Coast Guard Reserve, including temporary retired and retired persons.
33. National Emergency. A period of time during which the President is granted statutory authority to suspend the provisions of specific federal laws.
34. Natural Progress of the Disease. The exacerbations and remissions and increase in severity or disabling effect of a disease or injury that normally occurs over a period of time by reason of the inherent character of the disease.
35. Not Fit for Duty (NFFD). The status of a member who is determined by the final approving authority within the PDES to be unable to perform the essential duties of the member's office, grade, rank, or rating. The status of NFFD applies to a member unable to perform specialized duty, such as duty involving flying or diving only if the performance of the specialized duty is a requirement of the member's enlisted rating.
36. Office. A duty assigned to or assumed by someone. For the purposes of the PDES, office is defined as the member's assigned duties.
37. Periodic Physical Examination. This refers to any physical examination required by the Medical Manual, COMDTINST M6000.1 (series), Personnel Manual, COMDTINST M1000.6 (series), or chapter 8 of this Manual.
38. Permanent Disability Retirement. A PDES final action that retires an evaluatee who is unfit for continued duty by reason of a physical disability which is permanent and stable.
39. Permanent Disability Separation with Severance Pay. A PDES final action that separates an evaluatee who is unfit for continued duty by reason of a physical disability.
40. Physical Disability. Any 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. The term "physical disability" includes mental disease, but not such inherent defects as behavior disorders, personality disorders, and primary mental deficiency.

41. Physical Disability Appeal Board (PDAB). Reviews the disability evaluation cases referred to it by the PRC. It is the final step in the review process. (chapter 7)
42. Physical Disability Evaluation System. 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.
43. Physical Review Council (PRC). The PRC reviews every IPEB and FPEB case in which the evaluatee rebuts the findings and recommended disposition. (chapter 6)
44. Predisposition. A special tendency toward developing a particular disease or condition due to heredity or environment.
45. Preponderance of the Evidence. A degree of proof based on superior quality of evidence rather than quantity. Preponderance does not necessarily mean a greater number of witnesses or greater mass of evidence; rather, preponderance means a superiority of evidence on one side or the other of a disputed fact. A fact will be proved by a preponderance of the evidence when the evidence tending to prove the fact qualitatively supports the establishment of the fact, no matter how slightly, more than the evidence tending to disprove the fact.
46. Presumption. A presumption is a proposition of fact. Matters which are presumed need no proof to support them. Usually a presumption is rebutted by clear and convincing evidence (see article 2.B.).
47. Proximate Result of Military Service. A disease or injury or aggravation thereof, resulting in physical disability which, after consideration of all facts and circumstances of a particular case, may reasonably be regarded as an incident of military service or may reasonably be assumed to be the effect of military service. The disease or injury did not result from an intervening cause unusual to active or inactive duty (see article 2.C.9.).
48. Reasonable Doubt. A reasonable doubt exists when the evidence is insufficient to either prove or disprove a fact.
49. Separation. A termination of military status.
50. Separation for Disability. See articles 2.A.38 and 2.A.39.
51. Service-Connected. This means, with respect to disability or death, that such disability was incurred or aggravated, or that the death resulted from a disability incurred or aggravated in line of duty in the military, naval, or air service.

52. Temporary Disability Retirement. A PDES final action, which, if the disability were of a stable nature, would qualify an evaluatee from a Permanent Disability Retirement. An evaluatee who is being temporarily retired will be placed on the Temporary Disability Retired List (TDRL).
53. Temporary Limited Duty (TLD). 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).
54. Unauthorized Absence. Any absence from military duty without authority (such as contemplated under Article 86 of the Uniform Code of Military Justice).
55. Veterans Affairs Schedule for Rating Disabilities (VASRD). The VASRD (38 CFR, Part 4) is used by PDES boards to assign codes and percentages of disability for evaluatees found unfit for duty.
56. While Entitled to Receive Basic Pay. A member entitled to pay under 37 U.S.C. §204.

B. Presumptions. The following presumptions are applicable to all cases before all physical evaluation boards:

1. An evaluatee is presumed to have been fit for duty at the time he or she entered the Coast Guard. The presumption stands unless rebutted by clear and convincing evidence (see article 2.C.5.).
2. An evaluatee is presumed fit to perform the duties of his or her office, grade, rank or rating. The presumption stands unless rebutted by a preponderance of evidence.
3. Any increase in the degree of a pre-service impairment, which occurs during active service is presumed to be due to aggravation unless it is shown to be due to the natural progression of the disease or injury, which existed prior to entry on active duty. The presumption stands unless rebutted by clear and convincing evidence.
4. Injury or disease is presumed to be incurred in the line of duty. The presumption stands unless rebutted by clear and convincing evidence.

5. Injury or disease is presumed not to be due to intentional misconduct or willful neglect. The presumption stands unless rebutted by clear and convincing evidence.
6. An evaluatee is presumed to be mentally competent. The presumption stands unless rebutted by clear and convincing evidence.

C. Policies.

1. General Administration. The following policies relate to general administration and guidelines for the PDES.
 - a. A physical evaluation board should not construe a physical standard in a way that a member with a minor impairment is considered unfit for duty, nor construe a physical standard in a way that a member with a physical impairment is required to be retained to the detriment of normal operational efficiency and normal planned rotation of personnel.
 - b. Laws pertaining to a disability retirement or separation shall be administered equitably and in good conscience. Although these laws shall be administered in a manner which protects the government from assuming unwarranted responsibility for payment of disability and retirement benefits, reasonable doubt as to the entitlement of an evaluatee shall be resolved in the evaluatee's favor. The reasonable doubt doctrine should not be applied if the issue can be resolved by additional evidence.
 - c. The decisions of disability evaluation boards should reflect a consistent application of the standards.
2. Fit For Duty (FFD) and Not Fit for Duty (NFFD). 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 evaluatee 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.
 - (2) to warrant retirement, the length of service and degree of disability requirements prescribed in clause 3 of 10 U.S.C. §1201 must be satisfied.
 - (3) to warrant separation, the degree of disability requirements prescribed in clause 4 of 10 U.S.C. §1203 must be satisfied, and the evaluatee must have less than 20 years of qualifying service under the criteria of 10 U.S.C. §1208.
 - (4) the member must be in a status whereby entitled to basic pay at the time that the determination of unfitness for duty is made; on excess leave under 37 U.S.C. §502(b) for an emergency purpose or to pursue an educational goal; or must satisfy the conditions set forth in 10 U.S.C. §1204(b) for members on active duty for 30 days or less, or on inactive duty training; or must satisfy the conditions of 10 U.S.C. §1204(b) or (c).
- b. The law that provides for disability retirement or separation (10 U.S.C. 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 significant 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 articles 2.C.2.b.(1)(a) or (b) are met.

- (3) The determination of a grave or serious condition or significant deterioration must be made by a competent Coast Guard medical officer. Such medical authority will consult with the CGPC senior medical officer, as necessary, to ensure proper execution of this policy in light of the member's condition. The member's command may concurrently submit comment to the CGPC senior medical officer.
- 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 deemed fit for duty even though medical evidence indicates he or she has impairments.
 - d. Inadequate performance of duty, by itself, does not constitute physical unfitness. The evidence must establish a cause and effect relationship between the inadequate performance and the evaluatee's physical impairments.
 - e. An evaluatee whose manifest or latent impairment may be expected to interfere with the performance of duty in the near future may be found not fit for duty even though the member is currently physically capable of performing all assigned duties. Conversely, an evaluatee 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. In this instance, the evaluatee will continue in an interim duty status until convalescence is complete, at which time he or she will be returned to a full duty status.
 - f. The following standards and criteria will not be used as the sole basis for making determinations that an evaluatee is not fit for duty by reason of physical disability:
 - (1) inability to perform all duties of the office, grade, rank ,or rating in every geographic location and under every conceivable circumstance. Where feasible, and if requested by the evaluatee, consideration should be given to providing the member an opportunity for a change in rating to one in which the disability is no longer a disqualifying factor;
 - (2) inability to satisfy the standards for initial entry into military service, except as specified in article 2.C.2.g.;
 - (3) lack of a special skill in demand by the service;
 - (4) inability to qualify for specialized duties requiring a high degree of physical fitness, such as flying, unless it is a specific requirement of the enlisted rating;

- (5) the presence of one or more physical defects that are sufficient to require referral for evaluation or that may be unfitting for a member in a different office, grade, rank, or rating; or
 - (6) pending voluntary or involuntary separation, retirement, or release to inactive status (see article 2.C.2.b.(1)).
- g. A member who entered military service with a waiver for a medical condition or physical defect that usually is cause for referral to a physical evaluation board shall normally not be considered unfit because of that physical disability, provided the condition has remained essentially unchanged and has not interfered with the performance of duty. If, however, based on accepted medical principles, the condition presents a risk were the member to remain in military service, separation may be appropriate.
 - h. An evaluatee found unfit to perform assigned duties because of a physical disability normally will be retired or separated. Under special circumstances, disability separation or retirement may be delayed in the best interest of the government.
 - i. The existence of a physical defect or condition that is ratable under the standard schedule for rating disabilities in use by the Department of Veterans Affairs (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. A member may have physical impairments that are not unfitting at the time of separation but which could affect potential civilian employment. The effect on some civilian pursuits may be significant. Such a member should apply to the DVA for disability compensation after release from active duty.

3. Required Findings by the IPEB, FPEB, and PRC.

- a. Evaluatee on Active Duty for More than 30 Days (other than a ready reservist on active duty under an involuntary recall due to delinquency in drill). In these cases, the board shall make one of the following findings:
 - (1) Fit for Duty. If the board finds the active duty evaluatee “Fit for Duty,” it shall make no other findings.
 - (2) Not Fit for Duty by Reason of Condition or Defect Not a Physical Disability. If the board finds the evaluatee unfit for continued duty solely due to a condition or defect not a physical disability within the meaning of the law, it will recommend a finding of Not Fit for Duty. The condition or

defect shall be specified, and the following statement added: “Not a disability within the meaning of the law.”

(3) Not Fit for Duty by Reason of a Physical Disability. If the board finds the evaluatee not fit for duty by reason of physical disability, the board shall make the finding Not Fit for Duty. The board shall then

(a) 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. This policy applies to those evaluatees whose initial entry into the PDES occurs subsequent to 9 July 1987. 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.

(1) When rating a condition that does not appear in the VASRD, the board shall rate by analogy (see article 9.A.). The board shall state its diagnosis, followed by the following statement: “Rated by analogy to _____” (or words to that effect).

(2) In cases involving aggravation, the board shall compute the final combined total rating in accordance with article 2.C.6.

(b) determine whether each disability was the result of intentional misconduct, willful neglect, or incurred during unauthorized absence (see articles 2.C.7. and 2.C.8.).

(c) determine whether each disability was incurred while entitled to receive basic pay (see article 2.A.56).

(d) determine whether the evaluatee

(1) has at least 8 years of service, or

(2) has less than 8 years of service; and

(a) whether each disability is the proximate result of performance of active duty (see article 2.C.9.),

- (b) whether each disability was incurred in line of duty in time of war or national emergency, or
 - (c) whether such disability was incurred in the line of duty after 14 September 1978.
 - (e) whether each disability “is permanent” or, on the basis of accepted medical principles, “may be permanent.”
 - (f) whether the disability resulted from an injury or disease which was caused by direct armed conflict or an instrumentality of war.
 - (g) whether the disability occurred during either combat, extra hazardous service, under conditions simulating war, or by an instrumentality of war (see Public Law 94-455, Section 505, Tax Reform Act of 1976).
 - (h) whether the evaluatee is mentally competent.
 - (i) in the case of an evaluatee who has greater than 18 years active duty but less than 20 years, who has not requested retention as provided in article 3.H.4., the board will make a finding as to whether the evaluatee meets the medical requirements for retention as established by the Personnel Manual, COMDTINST M1000.6 (series).
- b. Evaluatee on Active Duty for 30 Days or less, Ready Reservists on Active Duty for Training Under an Involuntary Recall Due to Delinquency in Drill, or on Inactive Training Duty. When considering the case of evaluatees in this category, the board shall make findings as indicated in article 2.C.3.a. except that, in lieu of a finding of entitlement to basic pay, the board must find whether or not each disability is the proximate result of performing active duty or inactive duty training (see articles 2.A.47 and 2.C.9).
- c. Evaluatee on the TDRL. When the case of an evaluatee on the TDRL appears before the board, the board shall make independent findings and recommended disposition, based on the evaluatee’s current status and level of disability. The following policies apply to members on the TDRL.
- (1) An evaluatee will be continued on the TDRL when an intermediate (not final) periodic examination indicates that his or her condition has not stabilized and that he or she remains not fit for duty.
 - (2) In all other TDRL cases, the provisions of article 2.C.3.a. shall apply, except that the findings required by articles 2.C.3.a.(3)(b),(c), and (d) shall not be made for any disability rated at the time of temporary retirement. In such cases, the initial findings approved by the Commandant are

binding on all subsequent boards. These findings are, however, required for any impairment not previously rated. Impairments not previously rated shall be considered as incurred while entitled to receive basic pay only when the evidence shows that the condition was unfitting and that it existed at the time of temporary retirement.

(3) An impairment incurred after temporary retirement shall be found “Not incurred while entitled to receive basic pay.”

(4) Any impairment which still exists on a periodic physical evaluation held immediately prior to the end of the 5-year period during which the evaluatee’s name may be carried on the TDRL, shall be rated as permanent.

- d. Amplifying Statements. All FPEB and PRC findings will include an amplifying statement, setting forth the basis for the findings and recommended disposition. An IPEB will provide an amplifying statement when the board president determines that the basis for the board findings and recommended disposition are not readily apparent. The amplifying statement shall be entered in item 10 of CGHQ-4808, Coast Guard PDEB Findings and Recommended Disposition, or on a separate sheet of paper attached thereto.
4. Inception of Impairment. Determinations concerning the time of inception of injury or disease may be based on:
- a. material evidence relating to the incurrence, symptoms, and history;
 - b. accepted medical principles;
 - c. official and other records made prior to and during service; and
 - d. other pertinent lay and medical evidence.
5. Existed Prior to Entry (EPTE). An impairment rated as EPTE is one that existed prior to a member’s entry onto active duty (entitled to receive basic pay) or inactive duty.
- a. Clear and convincing evidence is required to establish the existence of an injury or disease before a member’s entrance into the Coast Guard. If preexistence is established, but the level of impairment at entry cannot be established, EPTE shall be rated at zero (0) percent. Those physical impairments recorded by an examining physician at the time of entry into the Coast Guard are considered not to have been incurred while entitled to receive basic pay unless the record establishes their inception in the line of duty during prior military service or upon an application of 10 U.S.C. §1207(a).

- b. When accepted medical principles establish the existence of an impairment prior to entrance into service, or a reservist's date of entry on active duty or inactive duty, no other corroborating evidence is necessary. For example:
 - (1) When residual conditions establish that an injury or disease did not occur during service (e.g., scars; fibrosis of the lungs; atrophy following disease of the central or peripheral nervous system; healed fractures; absent, displaced, or resected parts of organs; supernumerary parts; congenital malformations); or when manifestations of lesions, or symptoms of chronic disease develop so close to the date of entry into the Coast Guard that it is impossible for the disease to have originated after entry into the Service. (Infectious conditions shall be considered with regard to the circumstances of infection and the incubation period.)
 - (2) When manifestations of a disease develop within less than the minimum incubation period after entry on active or inactive duty.
 - (3) When psychiatric conditions are shown by clear and convincing evidence to have existed prior to service, with manifestations during service,
 - (a) it is essential that the medical history be reliable and that the evaluatee's recall and narration of facts to the attending physician establish a psychiatric finding by a physician prior to the member's entry into the Coast Guard. The attending physician shall not make a retroactive diagnosis, but obtain the medical records and diagnosis that occurred prior to the member's entry into the Coast Guard.
 - (b) there must be clear and convincing corroborative evidence when the evaluatee's ability to recall and narrate is in doubt.
- 6. Aggravation by Service. The following policies apply to aggravation by service of an injury or disease.
 - a. Aggravation during Coast Guard service may not be found when the medical evidence confirms the increase in disability to be due solely to the natural progression of a disease or injury that is confirmed to have existed prior to entry.
 - b. Aggravation may not be found where the impairment underwent no increase in severity during service based on the evidence of record.
 - c. The usual effects of service-provided medical and surgical treatment to ameliorate disease or other conditions incurred before entry into service (including postoperative scars, absent or poorly functioning parts or organs) do not constitute aggravation.

d. Aggravation by service of a preexisting impairment is determined by finding the combined total percentage of disability existing at the time of evaluation and subtracting this from the combined total percentage of disability:

(1) existing at the time of entry into active service.

(2) incurred during a period of unauthorized absence.

(3) otherwise not incurred in line of duty, provided the percentage of disability subtracted can be ascertained in terms of the VASRD. No deduction will be made from a total (100 %) rating; however, the percentage of disability existing upon entry into the service will be set forth in the record. If the condition(s) which existed upon entry cannot be ascertained in terms of the VASRD, insert 0 %.

[Note: If the current level of disability and the EPTE level are the same, the level of aggravation is to be listed as "NONE," not as zero.]

7. Line of Duty and Misconduct. The IPEB, FPEB, and PRC must make line of duty and misconduct findings and recommended disposition on each case, based on the information of record. The Board members should refer to chapter 5, Administrative Investigations Manual, COMDTINST M5830.1 (series), for specific guidance. In making their determinations, physical evaluation boards should review any board of investigation, or administrative report which is available, even if final reviewing authority action on the line of duty investigation has not been taken. Physical evaluation boards are bound by final line of duty determinations which are available at the time the physical evaluation board considers the evaluatee's case and which, if adverse to the evaluatee, were made after the right to a hearing and representation by counsel were provided. However, the IPEB, FPEB, or PRC may include an explanatory statement and recommendations for consideration by the final approving authority in cases where board members feel, based on the facts presented, the final line of duty determination was inappropriate.

8. Refusal to Submit to Surgical and Medical Treatment.

a. Article 8.2.1, United States Coast Guard Regulations (1992), COMDTINST M5000.3 (series), states that:

(1) persons in the Coast Guard shall not refuse to submit to necessary and proper medical or dental treatment to render themselves fit for duty, nor refuse to submit to a necessary and proper operation not endangering life; and

(2) persons in the Coast Guard shall permit such action to be taken as to immunize them against disease as is prescribed by competent authority.

- b. It is the policy of the Commandant that forced medical treatment is not permissible at any time. A member who refuses to submit to those measures considered by competent medical or dental officers to be necessary to restore him or her to a fit for duty status may be processed for administrative separation from the Coast Guard in accordance with applicable regulations. The member may be subjected to disciplinary action for refusal of necessary treatment or surgery if the refusal is determined to be unreasonable. Surgery shall not be performed on a person over his or her protest if the individual is mentally competent.
- c. Refusal of recommended emergency or lifesaving treatment or emergency diagnostic procedures required to prevent increased disability or threat to life is ordinarily determined to be unreasonable. The adequacy of facilities or the existence of more adequate facilities available within a reasonable distance shall be taken into consideration. A medical board shall be convened, comprised of two medical officers or two appropriate specialists, if the medical situation warrants, to establish that the treatment was or is of an emergent nature, and required to counter a threat to life or to decrease subsequent disability.
- d. If a member of the Coast Guard refuses elective medical, surgical, dental, or diagnostic procedures, a medical board must be convened to determine whether there is reasonable basis for refusal. This board, comprised of two medical officers or two appropriate specialists (when the determination requires specialized training), shall establish facts and make recommendations concerning the case.
- e. The following questions must be answered, by the medical board convened in articles c and d above, in making a determination as to reasonable or unreasonable refusal.

(1) What is the probability of the member's ultimate fitness for duty within a reasonable length of time if the procedure is undertaken?

[Note: If the conditions are such that a future status of fitness for duty is impossible, despite successful outcome of the procedure under consideration, it shall be held that the member is reasonable in refusing the treatment. In this case, the below listed questions need not be considered.]

(2) What is the probability of success of the procedure in view of current accepted medical principles?

[Note: While it is recognized that no one procedure has an absolute guarantee of success, certain procedures have a higher degree of expectation of success than others. The consideration at this point is the relationship of the individual case at hand to some accepted, and if known, quantifiable standard of success.]

- (3) What is the possible medical hazard to the health of the member and what is the possibility that omission of such procedure would constitute a potential and greater hazard to the member at some future time?
 - (4) Does age, existing physical or mental condition, or history of prior unsuccessful procedure sufficiently justify refusal of the procedure to overcome the indication for it?
 - (5) Based on the answers to the above questions, is refusal of the procedure in the judgment of the board reasonable or unreasonable?
- f. If the convened medical board determines the member's refusal to be unreasonable, the case will be processed through the PDES, but the disability, if found, will be determined to have resulted from misconduct and not in the line of duty (see chapter 5, Administrative Investigations Manual, COMDTINST M5830.1 (series)).
- g. Notification to member of medical board findings.
- (1) If a board decides that diagnostic, medical, dental, or surgical procedures are indicated, these findings must be made known to the evaluatee. The board's report shall show that the evaluatee was afforded an opportunity to submit a written statement explaining the grounds for refusal. Any statement submitted shall be forwarded with the board's report.
 - (2) The evaluatee shall be advised that
 - (a) the refusal to accept medical treatment and any statement submitted by the evaluatee shall be forwarded with the medical board report,
 - (b) refusal may lead to separation from the Service without disability benefits, and
 - (c) an unreasonable refusal may lead to disciplinary action after review of the medical board by the court martial convening authority.
9. Proximate Result of Performing Active Duty. A disability is the proximate result of performing active duty, active duty for training or inactive duty for training when the disability occurs while the member is performing acts consistent with such status, and the disease or injury does not result from an intervening cause

unusual to a member performing active or inactive duty, for example, injury while in the employ of a private employer.

10. Is Permanent or May be Permanent. These rules will be applied to the question of permanency of disability.

- a. A disability will be categorized “permanent” when it can be reasonably determined that the disability will not improve to the extent that the evaluatee will ever return to duty, and:
 - (1) accepted medical principles indicate the defect has stabilized to the degree necessary to assess the permanent degree of severity or percentage rating.
 - (2) the compensable percentage rating can reasonably be expected to remain unchanged for the statutory five year period that the evaluatee can be compensated while on the TDRL.
 - (3) the compensable percentage rating is 80 % or more with reasonable expectation that it will not fall below 80 % during the 5-year period.
- b. Those disabilities that, due to the natural progress of the disease or defect, will increase in severity over the next 5-year period, but not to an additional compensable degree (e.g., degenerative arthritis) will be categorized as permanent. A member eligible for normal longevity retirement who by reason of his or her disability will never be expected to return to duty will be considered for permanent disability retirement under the above criteria, provided any impairment can be appropriately rated.
- c. A disability will be characterized “may be permanent” if, based upon accepted medical principles, the defect has not stabilized to the degree necessary to assess the permanent degree of severity (percentage rating). This disposition is used only when permanent retirement is inappropriate under the criteria of article 2.C.10.a.
- d. Informal or Formal Physical Evaluation Boards evaluating TDRL cases for final disposition at the expiration of the five year period during which an evaluatee’s name may be carried on the TDRL, shall rate any disability which still exists as “permanent,” and recommend a disability rating based on the degree of the evaluatee’s impairment at the time of the evaluation (see 10 U.S.C. §1210(b)).

11. Cases Involving Disability Evaluation and Disciplinary Action Concurrently.

- a. Disability statutes do not preclude disciplinary or administrative separation under applicable portions of the Personnel Manual, COMDTINST M1000.6 (series). If a member is being processed for a disability retirement or

separation, and proceedings to administratively separate the member for misconduct, disciplinary proceedings which could result in a punitive discharge of the member, or an unsuspended punitive discharge of the member is pending, final action on the disability evaluation proceedings will be suspended, and the non-disability action monitored by Commander, Coast Guard Personnel Command.

- b. If the court martial or administrative process does not result in the execution of a punitive or an administrative discharge, the disability evaluation process will resume. If a punitive or administrative discharge is executed, the disability evaluation case will be closed and the proceedings filed in the member's official medical record.
12. Temporary Limited Duty (TLD). General guidelines for using this policy: In some cases, a member who becomes available for limited duty due to an incapacitation may eventually recover and become available for full duty. A member such as this would not be appropriate for the PDES per se, in that there is a reasonable expectation the member will fully recover – in a reasonable time period. The PDES is designed to be a thorough system for all stakeholders, to ensure every member subject to the system is afforded a full and fair hearing to determine fitness for duty. In that members who are expected to recover do not warrant this level of administrative oversight and processing, another mechanism is necessary to provide the Coast Guard with visibility of their condition, while not burdening the organization with undue administrative action. For members who fall into this category, TLD should be used to administratively identify the member during their recovery. TLD policy is in place to provide higher visibility to the Coast Guard of the member and their condition (and in some cases, triggering a replacement for the member) while allowing for eventual recovery of the member. Once a member is designated TLD, they will progress through a monitoring timeline as they move toward full recovery. At any point along this continuum, depending on the member's recovery process, they could be formally entered into the PDES via an MEB. While in a TLD status, the member's condition will be evaluated as outlined in Exhibit 2-1, which contains a concise summary of the triggering milestones and requisite actions. Note: the outline includes all potential actions by stakeholders under this policy (potential actions are identified as one of two probable outcomes: an expectation that the member will recover and become AFFD and an expectation that the member will not recover and thus will require an MEB). In addition, assignment decisions will always be made based on the needs of the Command and the Coast Guard as balanced by available resources. Designating a member as TLD may trigger an assigned replacement, just as entering someone into the PDES may trigger this replacement, however, these decisions will be made on a case-by-case basis. The maximum amount of time a member can be placed on TLD is 9 months. Given an evaluation period of up to 3 months, the maximum amount of time from the onset of the illness or injury to recovery normally cannot exceed 12 months. For

additional guidelines governing incapacitated reserve members, see the Reserve Policy Manual, COMDTINST M1001.28 (series).

- a. Medical Officer Action. A member who is being treated by a medical officer, who has exceeded three months of AFLD status, may be designated TLD. Only a Coast Guard medical officer can make the designation to initiate, continue, or terminate a member on TLD status. The medical officer shall:
 - (1) state in writing for the record, and to the member's command that it is his or her judgment that the member will become FFD within the next six months (total projected AFLD status would be less than or equal to nine months). If unable to so state, an MEB must be convened no later than nine months from the time the member was originally designated as AFLD by the field level medical officer.
 - (2) specify a date as to when he or she believes the member will be FFD. This must be recorded on an SF-502, Narrative Summary (Clinical Resume) as part of a narrative summary of the member's condition. The SF-502 becomes a part of the member's medical record.
 - (3) direct the clinic administrator to send copies of the TLD designation to CGPC-adm-1, CGPC-epm (enlisted members serving in active duty billets), CGPC-opm (officers serving in active duty billets), or the servicing ISC (pf) for reservists serving in any status other than Extended Active Duty (EAD), and the member's command. No command endorsement is required. A memorandum cover sheet must be included to identify who is submitting the SF-502 as well as who is receiving copies of it.
 - (4) perform a re-evaluation of the member two months prior to the completion of any TLD period. Results of this re-evaluation will be recorded on an SF-502 and will be made part of the member's medical record. Copies of this re-evaluation will be forwarded to CGPC-adm-1, CGPC-epm (enlisted members serving in active duty billets), CGPC-opm (officers serving in active duty billets), or the servicing ISC (pf) for reservists serving in any status other than EAD, and the member's current command. The medical officer will also notify the member's clinic administrator of the re-evaluation results.
 - (5) terminate the member's TLD designation by initiation of an MEB or return to AFFD.
 - (6) record such TLD termination via SF-502 when it appears the member will exceed 9 months of AFLD status or when the member becomes AFFD and can return to full military duty status. This will become part of the member's medical record and will also be forwarded to the member's

command, CGPC adm-1, and CGPC-epm (enlisted members serving in active duty billets), CGPC-opm (officers serving in active duty billets), or the servicing ISC (pf) for reservists serving in any status other than EAD.

(7) consult with CGPC Senior Medical Officer to obtain an extension to start an MEB beyond 9 months from initial TLD status of a member. Extending TLD designation beyond 9 months is only appropriate for severe and unusual cases. In addition, conditions that normally require slightly more time to complete a finite course of treatment with good prognosis (e.g., 12-month treatment of seizure disorder following initial treatment or 12 month treatment of hepatitis B) as well as conditions that would be considered sequential (and overlapping) yet unrelated (e.g., member recovering from a compound fracture of the lower right leg accidentally suffers compound fracture of the lower left leg toward the end of successful treatment for the lower right leg) are appropriate for consideration of extending TLD designation beyond 9 months.

- b. Clinic Administrator Action. Once a medical officer makes a TLD designation of a member, the medical officer will inform the clinic administrator to which the member is assigned. The clinic administrator will then inform the CGPC-adm-1 ombudsman and CGPC-epm/opm or the appropriate servicing ISC (pf), via email, of the member's TLD status, along with other amplifying information about the member, essential to the assignment process (employee ID number; expiration of enlistment; projected rotation date). In addition, the clinic administrator will forward to the CGPC-adm-1 ombudsman any updated information as a result of any re-evaluation of the member during the period of TLD or termination of the TLD status. E-mail notification to CGPC-adm-1 is acceptable for this process. Finally, the clinic administrator will ensure all documentation becomes part of the member's permanent medical record as well as any future MEB package that may be forwarded to CGPC-adm-1.
- c. Command Action. Once the TLD designation is made, the member's command is responsible for ensuring the TLD designation of the member is visible and is tracked among actionable administrative entities within the Coast Guard. The member's command will facilitate coordination between the initial examining medical officer (and clinic), the follow-on medical officer managing the member (if a different medical officer) and CGPC. The emphasis of the TLD designation is on recovery and future wellness. During this process, TLD members should be afforded all the consideration and rights given to members who are available for full duty.
- d. CGPC Action. Once TLD designation is made and CGPC-adm-1 begins tracking the member in this status, CGPC-epm/opm or the appropriate servicing ISC (pf) will consider re-assigning the member (PCS or administrative assignment) to an appropriate position to allow for continued

recovery. This new position must meet the following criteria (in priority order).

- (1) Allow for sufficient medical oversight and coordination between medical officer who originally placed member on TLD and new medical provider (if applicable).
- (2) Allow for proper physical recovery from illness or injury.
- (3) Minimize disruption to the member and member's family (if applicable).
- (4) Maximize the member's competencies and skills in a position of value.
- (5) The CGPC assignment branches will normally order a PCS replacement for the TLD designated member if that member occupies a critical active duty position. A critical active duty position is defined by service need and, in all cases, must be appropriately designated as such by CGPC-epm/opm. Replacements will be coordinated between the assignment branch and the affected commands in accordance with current policy and the criticality of the position. PCS replacement for all other positions shall normally occur at 9 months from the outset of the member's AFLD status, 6 months from the outset of the TLD status, or at such time coordinated between the assignment branch and the affected commands, in accordance with current policy. This assumes the member will not be AFFD and an MEB is forthcoming. Should TLD status be continued beyond 9 months, PCS replacement decisions will be coordinated between the member's command and CGPC. Throughout the TLD period, CGPC-epm/opm will periodically monitor the member's progress with the managing medical officer or clinic, commanding officer, and CGPC-adm-1.
- (6) The CGPC-adm-1 ombudsman will establish an in-house TLD tracking system whereby initial information regarding a member's TLD designation is recorded. The ombudsman will ensure all assignment branches are provided access to this tracking system, as well as updated versions of the same, as a result of new information from the clinic administrators. Once a member is removed from the TLD designation, CGPC-adm-1 will ensure the tracking system is updated regarding the member's changed status.

Summary of Actions Under the TLD Designation

Milestone	Action
Member becomes incapacitated and is on AFLD status.	Member is treated at local Military Treatment Facility (MTF).
<p style="text-align: center;">3-Month Point</p> Member is incapacitated on AFLD status.	<p>Medical Officer: Place member on TLD and inform the member's command of this action. Specify a day when the member will be AFFD (member's prognosis must be AFFD within the next 6 months). Command endorsement is not required.</p> <p>Command Clinic Administrator: Make TLD designation visible by informing CGPC-adm-1, and CGPC-epm/opm or servicing ISC (pf), and establishing a tracking system for the member.</p> <p>Member's Command: Coordinate follow-on medical evaluation or treatment for member with losing and receiving MTF (if applicable).</p> <p>CGPC: Issue PCS orders to fill critical position. Re-assign TLD member. Coordinate between (epm/opm) and the affected commands in accordance with the current policy and the criticality of the position.</p> <p>Note: 3 months is a guideline for the medical officer.</p>
<p style="text-align: center;">3 to 6 Month Point</p> Member is on TLD – time is cumulative from outset of initial AFLD status.	<p>Medical Officer/Command Clinic Administrator/CGPC: If required, initiate an MEB (Medical officer cannot state in writing that member's prognosis will be AFFD within the next 6 months).</p>
<p style="text-align: center;">7 to 8 Month Point</p> Member is on TLD – time is cumulative from outset of initial AFLD status.	<p>Medical Officer/Clinic Administrator: Re-evaluate member's TLD condition.</p>
<p style="text-align: center;">9 to 12 Month Point</p> Member is on TLD – time is cumulative from outset of initial AFLD status.	<p>Medical Officer: Terminate TLD status of member (either member becomes AFFD or an MEB is initiated on member).</p> <p>Command Clinic Administrator: Take appropriate action if member is terminated from TLD and has an MEB.</p> <p>CGPC: Issue PCS replacement orders for other than critical position if warranted (process begins once MEB received at CGPC). CGPC assignment officers (epm/opm) will coordinate with the affected commands in accordance with the current policy.</p> <p>Note: 9 to 12 months is a guideline for the medical officer.</p>
<p style="text-align: center;">More Than 12 Months</p> Member on TLD – time is cumulative from outset of initial AFLD status.	<p>Medical Officer/CGPC Senior Medical Officer: If an MEB is not warranted, request for extension of TLD status – status continued.</p> <p>CGPC: Issue PCS replacement orders for member's position if warranted (coordinate with command). Assignment officers (epm/opm) will coordinate with the affected commands in accordance with the current policy.</p> <p>Note: 12 months is a guideline for the medical officer.</p>

Exhibit 2-1

CHAPTER 3
MEDICAL EVALUATION BOARD
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Exhibit 3-1 Medical Evaluation Board Narrative Summary Format

Exhibit 3-2 Medical Evaluation Board Checklist

CHAPTER 3. MEDICAL EVALUATION BOARD

A. Purpose. The purpose of a Medical Evaluation Board (MEB) is to evaluate and report upon the present state of health of any member who may be referred to the MEB by an authorized convening authority and provide a recommendation as to whether the member is medically fit for the duties of his or her office, grade, rank, or rating.

B. Convening of Medical Evaluation Board.

1. An MEB may be convened by the following:
 - a. Commandant.
 - b. Area Commanders.
 - c. District Commanders.
 - d. Maintenance and Logistics Commanders.
 - e. Sector Commanders.
 - f. Commanding officers.
 - g. Medical officers of the Uniformed Services.
2. Supervisors or reporting officers of medical officers may not have Medical Evaluation Boards convened on themselves at their own facility.
3. When an MEB is convened for a flag officer, Commander (CGPC-c) and Commandant (G-C) shall be advised by For Official Use Only (FOUO) message.

C. Composition.

1. An MEB normally consists of two medical officers. The MEB may consist of one medical officer in exceptional circumstances, e.g., units with only one medical officer assigned or when another medical officer is not reasonably available. A military psychiatrist (or alternatively, a military psychologist along with an evaluation consult from a civilian psychiatrist) must be an MEB member when considering an evaluatee with psychological impairments. A Coast Guard Physician's Assistant (PYA) may be a member, though not the senior member, of an MEB.
2. When an aviator or another member in an aviation rating is before the board, at least one board member shall be a flight surgeon. Any medical evaluation board prepared in the case of an aviator will be reviewed by a Coast Guard flight surgeon.

3. Whenever the record presents a medical condition or mental disorder in which mental competency is in question, a determination of mental competency shall be made. This mental competency assessment will be conducted by 3 medical officers, one of whom shall be a board-certified psychiatrist.

D. Requirement for Medical Evaluation Board. Refer to the Medical Manual, COMDTINST M6000.1 (series), for guidance and policy on waiverable conditions, prior to convening an MEB. Existence of one or more of the following situations requires convening an MEB.

1. Detection of a physical impairment preexisting enlistment or appointment in the Coast Guard.
2. Refusal of medical or dental treatment or diagnostic procedure (see article 2.C.8.).
3. After 60 continuous days of hospitalization (Saturdays, Sundays, and holidays included), or intermittent admission to an inpatient facility for the same diagnosis for 60 out of any 90 consecutive days. This consecutive period is computed exclusive of convalescent or sick leave, when such leave leads to a fit for retention status at the end of the leave period. If, at the end of the sick or convalescent leave, a readmission for evaluation of the same condition is required, the entire period of hospitalization and sick leave will be counted in computing the 90 days.
4. Failure to meet physical standards at the following times:
 - a. required periodic physical examination (except for those conditions set forth in chapter 12, Personnel Manual, COMDTINST 1000.6 (series); e.g., obesity, motion sickness); or
 - b. aviation physical examination when the disqualification may lead to permanent removal from aviation.
5. After maximum hospital benefits have been attained and the member remains in a NFFD status; after outpatient treatment in a hospital or a clinic when the total of all visits in a 1-year period exceeds 30 visits for other than treatment for traumatic conditions. The 30-visit limitation applies to those visits where the member sees medical personnel (medical officers, physician assistants, health service technicians, etc.) or is referred to a civilian hospital or outpatient clinic.
6. For members retained on active duty under the authority of chapter 17, Personnel Manual, COMDTINST M1000.6 (series), at least 6 months prior to expiration of the period of retention. There is no requirement for a reevaluation of the disability when a member is retained for less than 6 months.
7. A member who is being processed for separation or for retirement by reason of age or length of service shall not normally be referred for physical disability evaluation. Unless previously retained on active duty under the provisions of chapter 17, Personnel Manual,

COMDTINST M1000.6 (series), absence of a significant decrease in the level of a member's continued performance up to the time of separation or retirement satisfies the presumption that the member is fit to perform the duties of his or her office, grade, rank or rating (see article 2.C.2.).

8. In any situation where fitness for continuation of active duty is in question.

9. Expiration of TLD designation and a prognosis of AFLD (see article 2.C.12.).

E. Requirement For Disposition Medical Board. DMBs are convened as provided for under chapters 4 and 5 of this Manual and adhere to the format prescribed for MEBs.

F. General Procedure for Medical Evaluation Board.

1. An MEB reviews and reports upon any evaluatee whose case has been referred for consideration. It conducts a thorough physical examination to evaluate the member's general health. Additionally, all impairments noted shall be separately evaluated in accordance with the VA Physician's Guide for Disability Evaluation Examinations, including psychiatric examination when indicated. It shall obtain and examine available records to formulate a conclusion regarding the member's present state of health and the recommendations for future action.

2. An MEB is not a forum for conducting a formal hearing, taking other than medical evidence, or making determinations required of physical evaluation boards by chapters 4, 5, 6, and 7 of this Manual. It presents a clear medical picture of the case in question making all pertinent diagnoses or prognoses and giving a medical opinion as to the evaluatee's fitness for retention and recommendations for future action. A checklist is provided as exhibit 3-2 to aid in preparing the MEB.

G. Medical Evaluation Board Report.

1. Organization of the Board Report. An original and five copies of an MEB report shall be prepared, consisting of the following:

a. Medical Board Report Cover Sheet, CG-5684, prepared by a Coast Guard or other Uniformed Services medical officer with all items completed, including International Classification of Diseases, 9th Revision (ICD-9) codes for diagnoses listed.

b. typed Narrative Summary, SF-502.

c. additional statements and documents as may be required under articles 3.H. and 3.I.

d. legible copies of all health record information pertaining to each diagnosed impairment or impairment listed in the evaluatee's rebuttal, including current and enlistment or commissioning SF-88s and SF-93s, and reports of x-rays.

- e. if the MEB is for
 - (1) a cardiac case, append EKG and American Heart Association Diagnostic Standards. A METS assessment and ejection fraction measurement should be made, if warranted or appropriate.
 - (2) an impairment of hearing, append audiometric examination and state the testing standard used (ASA, ISO, or ANSI) to include pure tone audiometry and speech discrimination without hearing aids.
 - (3) high blood pressure or hypertension, append the results of a 3-day serial blood pressure check taken twice a day while on medication.
 - (4) diabetes mellitus, state the types and dosage of prescribed medications; also, determine the level of restriction on physical activity and/or diet, as appropriate.
 - (5) all range of motion measurements, a goniometer, inclinometer, or other such device must be used to establish objective measures.
- 2. Quality of the Board Report. The importance of a legible, complete report cannot be emphasized too strongly, since this report is the basis for all further action in the case. Pertinent consultations, in particular, shall be presented in typewritten form.
- 3. Preparing the Narrative Summary, SF-502.
 - a. The Narrative Summary shall present a summary of the pertinent data concerning each complaint, symptom, disease, injury or disability presented by the evaluatee, which causes or is believed by the MEB to cause impairment of the evaluatee's physical condition. In presenting its summary, the board shall:
 - (1) set forth accurate and fully descriptive information, in the format of exhibit 3-1.
 - (2) whenever practicable, indicate impairment of functions in terms of objective tests or findings rather than as opinions, conjecture, or speculation. The discussion of any impairment shall show the limitation of activity imposed by physical impairments; disease; injury to any organ, system, or part; and the significance of symptoms causing impairment. In a case of ankylosis or limitation of motion, the angle of the affected joint and motion limitation shall be stated in quantitative terms consistent with the VASRD.
 - (3) set forth data to permit a reviewer to conclude whether the evaluatee suffers impairment of health in any respect, and the degree thereof. Such evidence is needed for use in rating disabilities in the event the evaluatee is later found to be unfit to perform the duties of grade or rating. All evidence bearing upon the permanent or temporary character of impairment of any organ, system, or part shall be completely set forth.

- (4) state if no limitation of physical activity exists.
 - (5) in all cases where mental disorders are diagnosed or other appropriate circumstances exist, the Medical Evaluation Board shall
 - (a) give an opinion as to whether disclosure to the evaluatee of information relative to the evaluatee's physical or mental condition would or would not be deleterious to the evaluatee's physical or mental health.
 - (b) indicate whether, if discharged into his or her own custody, the evaluatee will or will not constitute a danger to him or her self or to others.
 - (c) indicate whether the evaluatee is or is not likely to become a public charge.
 - (d) indicate whether the evaluatee is or is not mentally competent to conduct his or her personal affairs (see article 3.C.3.).
 - b. The MEB report shall neither assign a percentage rating nor make reference to the VASRD rating codes.
 - c. Every narrative summary shall be reviewed and commented upon by a Coast Guard medical officer.
4. Recommendation of an MEB.
- a. Based on the physical condition found, the MEB shall recommend one of the following dispositions.
 - (1) Disposition not requiring follow-up action, meets physical retention standards, and is either
 - (a) medically fit for duty, or
 - (b) medically fit for duty (aviation or diving).
 - (2) Dispositions which may lead to separation from the Service, where the member is
 - (a) not fit for duty because of possible physical impairment (referral to the IPEB),
 - (b) not fit for duty for reasons other than physical impairment, or
 - (c) not fit for duty because of physical impairment that existed prior to entry but was not aggravated by service.

- b. Findings of not fit for duty may be accompanied by one of the following recommendations.
 - (1) Available for limited duty. Indicate time limitation, not to exceed 6 months, and recommended limitations.
 - (2) Outpatient or inpatient treatment. Indicate time limitation, normally not to exceed 6 months.
 - (3) Outpatient treatment or available for limited duty not to exceed 6 months during which either control of aircraft, participation in flight, or diving is prohibited.
 - c. If the MEB's recommendation is that of article 3.G.4.b.(3) above, a 6-month composite time limit is placed on the MEB's recommendations of continued inpatient and outpatient treatment, available for limited duty, or any combination thereof. This time limit will commence when the MEB report is dated. Recommendations may be for periods less than 6 months.
5. Recommendation of a DMB. The DMB shall make a recommendation as prescribed for an MEB in article 3.G.4.
6. Preparing the Medical Board Report Cover Sheet (CG-5684). This cover sheet is the preferred MEB cover sheet to use. Coast Guard medical officers should utilize the CG-5684 whenever possible. Items on the CG-5684 shall be prepared as follows.
- a. (1) From: Enter originating command's address.
 - (2) Via: Enter evaluatee's commanding officer and superior command, if necessary.
 - b. Item 2. Enter evaluatee's last name, first name, and middle initial.
 - c. Item 3. Enter the official name and address of the duty station to which the member is permanently attached. For second and subsequent boards, note present duty station but also indicate, under remarks, the member's duty station when the initial board was held. Include phone numbers where member can be reached.
 - d. Item 4. Self-explanatory.
 - e. Item 5. Enter evaluatee's grade, rate, and rank as appropriate.
 - f. Item 6. Check appropriate box.
 - g. Item 7. Check appropriate box.

- h. Item 8. Enter length of service in years and months. Prior active service in other U.S. Uniformed Services and broken Coast Guard service shall be included.
- i. Item 9. Cause of injury. If the condition entered as item 16A (primary diagnosis) is not the result of an accident, violence, etc., enter N/A.
- j. Item 10. Check appropriate box.
- k. Item 11. Check appropriate box and add date using DD/MM/YYYY
- l. Item 12. Check appropriate box.
- m. Item 13. Add date using DD/MM/YYYY
- n. Item 14. Check appropriate box.
- o. Item 15. Enter full name, rank, service affiliation, and signature of the member convening the board.
- p. Item 16. Enter date using DD/MM/YYYY.
- q. Items 16a – f.

(1) General. Information on diagnoses related to the MEB is needed, not only for legal reasons, but also for planning and evaluation purposes by the Commandant (CG-11). The diagnostic nomenclature to be used in recording these diagnoses will be based on consistent and current medical terminology. ICD codes and Diagnostic and Statistical Manual of Mental Disorders (DSM), current editions, shall be used for establishing diagnoses. When recording the diagnoses, care should be taken to make them complete and definite. Vague and general expressions are to be avoided.

(2) Order of Diagnoses. Space has been reserved for recording six diagnoses. The first diagnosis listed, primary diagnosis, should be the major diagnosis or condition for which the MEB was convened. Where there is more than one diagnosis or condition recorded, the following rules apply:

(a) If the diagnoses are unrelated, the primary diagnosis should be the most significant.

(b) If there is a combination of related causes, the primary diagnosis should be the one which was determined to be the precipitating factor for the other diagnosis or diagnoses. For example, in the diagnosis of “schizophrenic reaction acute, undifferentiated type due to drug ingestion, LSD, and mescaline”, the diagnosis “drug ingestion” will be considered the primary diagnosis.

(c) The second through sixth diagnoses should be recorded in order of importance.

(3) Existed Prior to Entry (EPTE) Origin. From item 16 enter the appropriate number in the box provided for the origin of each diagnosis listed.

- r. Item 17. Enter the date the limited duty expires MM/DD/YYYY. Indicate the limitations imposed by the member's condition and the length of time the member will be retained in a limited duty status, e.g., "No heavy lifting or bending – 6 months."
- s. Item 18. Check appropriate boxes.
- t. Item 19. Type the name, grade, and service of each member of the board. Signatures of each member shall appear in the space provided. Indicate a psychiatrist by placing a (P) after the typed name. Indicate a clinical psychologist by placing a (CP) after the typed name. Facsimile signature stamps shall not be used. Copies of MEB reports submitted for review or action must include one signed copy.

H. Evaluee Notification.

1. Unless it is considered that the information contained in the board's report might have an adverse effect on the evaluee's physical or mental health:
 - a. the evaluee shall be furnished a copy of the board's report.
 - b. significant findings, opinions, and recommended disposition shall be brought to the evaluee's attention.
 - c. the PDES shall be explained and the evaluee shall be counseled by a qualified (knowledgeable) person with a working knowledge of the system.
2. Complete the Evaluee's Statement Regarding the Findings of the Medical Board Report, CG-4920, and refer it to the evaluee's command for the evaluee's signature. This form shall accompany the board's report. If the Medical Evaluation Board has been prepared in an Army or Air Force facility, completion of CG-4920 is not required – DA Form 3947 and AF Form 618 are considered suitable substitutes.
3. The evaluee shall be afforded an opportunity to submit a statement in rebuttal to any portion of the board's report. If the evaluee submits a rebuttal, the board shall, if practicable, review the rebuttal and make changes to the report or prepare additional comments, as deemed appropriate. A copy of any changes or comments will be provided to the member. If the evaluee has not acted within 21 calendar days of receipt of the board's findings and recommended disposition, the action indicated in article 3.I shall proceed without further delay.

4. Pursuant to chapter 17 of the Personnel Manual, COMDTINST M1000.6 (series), if an evaluatee anticipates that the physical evaluation board at CGPC may find them unfit for duty based on the MEB findings, the evaluatee may submit a letter to CGPC-epm/opm requesting retention on active duty. A copy of this letter request shall be forwarded together with the MEB or DMB to CGPC-adm-1.
5. An evaluatee who is in receipt of normal service retirement orders must elect, in writing, whether to be processed for a physical disability retirement or to comply with the normal service retirement orders. Article 12.C.3., Personnel Manual, COMDTINST M1000.6 (series) provides further guidance in this regard.

I. Action by Evaluatee's Commanding Officer.

1. Convene, or request the convening of an MEB, in accordance with article 3.D., when there is doubt concerning a member's physical ability to perform his or her duties of office, grade, rank, or rating. If a retirement physical has disclosed the impairment for which an MEB is convened, notify CGPC-epm/opm, the servicing ISC (pf) if a reservist, and CGPC-adm-1 immediately, in accordance with article 12.C.3., Personnel Manual, COMDTINST M1000.6 (series).
2. Upon receipt of the MEB report from a Military Treatment Facility (MTF), ensure the board includes all items required by article 3.G.
3. Provide the evaluatee a copy of the board, unless it has been determined by competent medical authority that disclosure of the contents of the MEB might adversely affect the evaluatee's physical or mental health (if this is the case, coordinate further actions with CGPC-adm-1).
4. Ensure the evaluatee is counseled about the contents of the board report, and a physician has provided the evaluatee a thorough explanation of his or her medical condition, subject to the restrictions of article 3.I.3. above.
5. Have the evaluatee sign the CG-4920. If the evaluatee refuses to sign the CG-4920, indicate with a statement to this effect.
6. Attach the CG-4920 to the MEB.
7. Endorse the report of an MEB with a full recommendation based on knowledge and observation of the member's motivation and ability to perform. The endorsement shall be a summary of the duties normally associated with the office, grade, rank, or rating of the evaluatee and the evaluatee's currently assigned duties, and it shall include a statement as to the evaluatee's ability to perform these duties. It is imperative that all factors affecting the health of the evaluatee be properly documented and included in the MEB or the endorsement so that the IPEB may make the proper disposition of the case. Include a current telephone number as well as a personal email address and home mailing address where evaluatee may be reached. The commanding officer's endorsement along with the

MEB report will be forwarded to CGPC-adm-1 within 30 calendar days from when the MEB report was submitted to the command for endorsement.

8. Establish an interim duty status for members during PDES processing in accordance with article 3.J, and include that status in the endorsement.
9. Distribute the MEB report in accordance with article 3.K.
10. Carefully screen MEBs, disclosing conditions existing prior to entry. Should it appear there may have been a fraudulent enlistment, the record shall be forwarded to CGPC-adm-1 via the chain of command.
11. In cases involving injury, append one of the following documents to the record. The evaluatee's present commanding officer is responsible for obtaining this documentation and including it with the MEB report, even though the injury may have been sustained elsewhere.
 - a. A copy of the investigative report if available, including action of the final reviewing authority (see Administrative Investigations Manual, COMDTINST M5830.1 (series)).
 - b. A copy of the Injury Report, CG-3822, if line of duty and misconduct findings are favorable (e.g., in line of duty, not due to misconduct).
 - c. A concise statement executed by the evaluatee's commanding officer, setting forth the time, place, and other circumstances surrounding the injury, accompanied by an opinion as to line of duty/misconduct.
12. In cases involving a member of the Coast Guard Reserve, append a copy of orders or other evidence that the evaluatee's illness or injury was incurred while entitled to receive basic pay.
13. When the MEB finds an evaluatee to be afflicted solely by a personality or intelligence disorder, or other impairment not a disability within the meaning of the law (see listings in article 2.A.7. of this Manual and in chapter 5 of the Medical Manual, COMDTINST M6000.1 (series)), the following applies:
 - a. if the evaluatee's commanding officer concurs with the MEB report, the case will be processed in accordance with the administrative discharge procedures set forth in chapter 12 of the Personnel Manual, COMDTINST M1000.6 (series).
 - b. if the evaluatee's commanding officer does not concur with the MEB report, or has any doubt concerning their findings and recommendations, the commanding officer will forward the original and two copies, with appropriate endorsement, to CGPC-adm-1.

14. When the evaluatee has requested retention as provided in article 3.H.4., the evaluatee's commanding officer will endorse the letter request in accordance with the Personnel Manual, COMDTINST M1000.6 (series), and forward the request and all endorsements, together with the MEB report, to CGPC-adm-1.

J. Distribution of Medical Evaluation Board Report. MEB reports shall be distributed as follows:

1. original and two copies to Commander (CGPC-adm-1).
2. copy to member's health record.
3. copy to evaluatee.
4. copy to convening authority's files. If convening authority is not the CO, then copy to CO.

Commander (CGPC-adm-1) will acknowledge receipt of the MEB report.

K. CGPC Action on MEB Report. On receipt of a correct (contains all required enclosures, properly completed and signed) MEB report, CGPC-adm-1 will refer the report to the IPEB for action in accordance with chapter 4.

L. Change in Evaluatee's Status or Physical Condition Prior to Final Action. When there is any significant change in the evaluatee's status or physical condition prior to final action, the evaluatee's CO shall notify CGPC-adm-1, and CGPC-epm/opm or the servicing ISC (pf) for reservists. The CO may make recommendations with respect to holding a case in abeyance.

M. Assignment of Personnel Awaiting Final Action in PDES. The commanding officer establishes the interim duty status of members being processed within the PDES, taking into consideration medical recommendations when available. A message report showing the assigned status shall be sent to CGPC-epm/opm or the servicing ISC (pf) if a reservist. One of the following actions shall be taken:

1. Full Duty or Available for Limited Duty. When full duty or available for limited duty pending disposition of the case is appropriate, the evaluatee shall be assigned to such duty if the evaluatee's services can be used effectively without detriment to physical or mental health, or to unit operations.
2. Continued Medical Treatment or Sick Leave. When continued medical treatment is recommended, an evaluatee, who at the time is hospitalized, will be retained under treatment. When hospitalization is no longer necessary, either sick leave (see the Personnel Manual, COMDTINST M1000.6 (series), chapter 7) or AFLD apply, and the evaluatee shall receive necessary follow-up care. Care from civilian sources shall be obtained in accordance with the Medical Manual, COMDTINST M6000.1 (series).

MEDICAL EVALUATION BOARD NARRATIVE SUMMARY FORMAT

1. If, in the board's opinion, the evaluatee is Not Physically Qualified, use the following format:

This _____ (a) _____ year old, _____ (b) _____ handed,
_____ (c) _____ (d) _____ approximately _____ (e) _____ and
_____ (f) _____ of active military service, was evaluated on an _____ (g) _____ basis at
this facility for the purpose of and Initial/Disposition Medical Evaluation Board, with the
diagnosis(es) of _____ (h) _____.

According to a review of health record, systems, and social and family histories, the
evaluatee was well until an _____ (i) _____ when an _____ (j) _____. Physical examination
revealed _____ (k) _____ were within normal limits except for _____ (l) _____.

Indicated laboratory studies, including _____ (m) _____ were within normal limits
except _____ (n) _____.

Treatment consisted of _____ (o) _____ and _____ (p) _____.

The physical examination shows _____ (q) _____.

It is the opinion of the board that the diagnosis(es) of _____ (r) _____ is/are correct and that the
patient is _____ (s) _____.

The prognosis for this patient is _____ (t) _____.

The patient is expected _____ (u) _____.

The additional treatment recommended is _____ (v) _____.

There is/are no disciplinary action(s) pending _____ (w) _____.

Personal appearance of the evaluatee before an FPEB would/would not be deleterious to the
patient's physical or mental health.

Disclosure to the evaluatee of information relative to his/her physical or mental condition
would/would not be deleterious to that condition. If discharged into one's own custody, the
evaluatee will/will not constitute a danger to self or the public safety

The evaluatee is/is not likely to become a public charge.

MEDICAL EVALUATION BOARD NARRATIVE SUMMARY FORMAT (cont'd)

KEY:

- a. Age
 - b. Major hand
 - c. Race
 - d. Sex
 - e. Years service
 - f.. Months service
 - g. Outpatient or Inpatient
 - h. Original diagnosis(es)
 - i. Date of onset of problem
 - j. Symptoms and complaints of present illness or circumstances of injury
 - k. Specify physical findings within normal limits
 - l. Significant physical findings
 - m. List laboratory studies conducted that were within normal limits
 - n. List positive laboratory studies
 - o. Outline treatment provided
 - p. Present subjective findings
 - q. Present objective findings
 - r. Diagnosis(es)
 - s. Specific manner in which evaluatee is unable to perform duties or normal activities
 - t. State prognosis of the evaluatee's impairment according to accepted medical principles
 - u. "To be fit for full duty in (state time frame)" or "To never be fit for full duty,"
 - v. State recommended further treatment or therapy
 - w. Inpatient only enter: "Maximum benefits of hospitalization have been achieved,"
or "Maximum benefits of hospitalization have not been achieved. Further treatment
and care is required and the evaluatee is to be transferred to the Veterans Administration
Hospital nearest his or her home."
2. If, in the board's opinion, the evaluatee is "fit for duty," the format will be the same as that of "not fit for duty," with the exception that the statement of opinion shall read as follows:

It is the opinion of this board that the diagnosis(es) or present objective findings are correct. The evaluatee does not have a physical impairment that precludes performing his or her duties.

Exhibit 3-1 (cont.)

MEDICAL EVALUATION BOARD CHECKLIST

Refer to Chapter 3, PDES Manual, COMDTINST M1850.2 (series), for details.

MEDICAL EVALUATION BOARD REPORT Include the following:

1. Cover Sheet (CG-5684).

Note: A Coast Guard physician, if one is available, shall prepare the cover sheet. If a DoD cover sheet has been prepared, it may also be included in the report package.

2. Typed Narrative Summary (SF-502).
3. Copies of all health record information pertaining to each diagnosed impairment, including SF-88 and SF-93 (current and enlistment or commissioning physical exams), consultations, reports of X-rays, photographs, and video tapes, when appropriate. All reports, including consultations, must be typewritten or printed legibly.
4. In cardiac cases:
 - EKG
 - American Heart Association Diagnostic Standards
 - METS test
 - Ejection fraction measurement
5. In impairment of hearing cases:
 - Audiometric Examination,
 - Statement as to testing standard used (ASA, ISO, or ANSI), and
 - Voice discrimination test results: pure tone audiometry and speech discrimination without hearing aids
6. In high blood pressure (hypertension) cases:
 - Results of 3-day serial blood pressure check taken twice a day while on medication
7. In diabetes mellitus cases:
 - Type and frequency of medications administered and observed results.
 - Degree and frequency of any limitation of activities
8. In brain surgery cases:
 - Size of hole in skull
9. In spinal impairment cases:
 - Range of motion (active) where indicated
 - Radicular symptoms, if indicated, objectively validated

COMMAND ACTION

1. Advise member of all the following:
 - Significant findings, opinions, and recommendations
 - Opportunity to comment on report
 - Opportunity to submit a letter requesting retention
 - Requirement to sign CG-4920, DA Form 3947, or AF form 618 within 21 calendar days
 - Entitlement to pre-separation counseling IAW 10 U.S.C. §1142

MEDICAL EVALUATION BOARD CHECKLIST (cont.)

2. Establish interim duty status for member.
3. Send message reporting assigned status to CGPC-epm/opm, or servicing ISC (pf) if reservist.
4. For injury cases, provide one of the following:
 - Copy of the investigative report, or, preferably
 - Copy of the Injury Report (CG-3822), or
 - CO's statement setting time, place, and other circumstances surrounding the injury, accompanied by an opinion as to line of duty and misconduct

Note: The member's current command is responsible for providing an opinion as to misconduct or line of duty, even if the injury occurred elsewhere.

5. Attach the following to the Board package (where applicable):
 - Member's comments regarding the board's report
 - Member's request for retention with CO's endorsement
 - If member is a reservist, a copy of the orders or other evidence that the impairment was incurred while entitled to receive basic pay
 - If member is in receipt of normal service retirement orders, the member's election in accordance with article 12.C.3. of Personnel Manual, COMDTINST M1000.6 (series)
6. Endorse board

Note: If the board recommends "fit for retention" and the command concurs, the statement - "I concur with the board," - will suffice. However, if the board recommends "not fit for retention," comply with article 3.I.7 of the Physical Disability Evaluation System, COMDTINST M1850.2 (series).

7. Distribute the board package as follows:
 - Original and two copies to CGPC-adm-1
 - Copy to the member
 - Copy retained by convening authority

MEMBER ACTION

1. Required - complete one of the following:
 - CG-4920, or
 - Bottom portion of DA form 3947, or
 - Bottom portion of AF form 618
2. Optional
 - Comment, in writing, on board report
 - Submit a letter requesting retention

CHAPTER 4
INFORMAL PHYSICAL EVALUATION BOARD
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CHAPTER 4. INFORMAL PHYSICAL EVALUATION BOARD

A. Policy Governing the IPEB.

1. Purpose. The IPEB is a permanently established administrative body convened to evaluate the following on the basis of records only:
 - a. the fitness for duty of active duty and reserve members.
 - b. the fitness for duty of members currently on the TDRL.
2. Convening Authority. Commander (CGPC-c) assigns members to serve on the IPEB by precept. Commandant (G-CCS) assigns members to serve on the IPEB by precept when the evaluatee is a flag officer.
3. Authority. The IPEB evaluates the fitness for duty of all evaluatees whose cases are referred to it for consideration by CGPC-adm-1.
4. Membership of the IPEB. An IPEB shall normally consist of a panel of at least two commissioned officers, one of whom serves as president and the other as medical member. Alternatively, the IPEB may consist of a panel of one commissioned officer and one civilian member of the Coast Guard, with the commissioned officer capable of serving as the medical member. The civilian employee of the Coast Guard must have former active duty or reserve Coast Guard and/or military experience and a full working knowledge of 10 U.S.C. 61 entitlements as well as the Coast Guard PDES.
 - a. A commissioned officer on active duty in the Coast Guard or Coast Guard Reserve, serving in pay grade O-4 or above, shall be designated by the IPEB precept as permanent president.
 - b. When the evaluatee is a reservist, one of the IPEB members shall be a reservist, senior to the evaluatee when practical.
 - c. The medical member shall normally be a medical officer (physician) assigned to the Coast Guard. The medical member shall not have participated in the medical board or treated the evaluatee for the matter under consideration.
5. Duties of the Members. It is the duty of each member of an IPEB to weigh and to impartially examine all relevant evidence in a case, and make findings and recommendations in conformity with applicable laws, regulations, and established policy. Each member has an equal voice and vote with other members in deliberating upon and deciding all questions submitted to vote. Members of the board may discuss the case freely in closed session. No disclosure shall be made of the opinions expressed by any member.

6. Unanimity of Members. The findings and recommended disposition of an IPEB panel shall be unanimous. If the members cannot agree, the case will be forwarded to the FPEB for consideration.
7. Disposition Medical Board or Addendum.
 - a. After reviewing the medical board record, if the IPEB determines the evidence is insufficient for the IPEB panel to make a judgment as to fitness for duty or to rate impairments, the IPEB may order a DMB or addendum. DMB and addendum actions will normally be completed in such time as specified by the IPEB. DMBs shall be prepared in the format prescribed for MEBs.
 - b. A DMB differs from an addendum in that a DMB is usually required for a long period of observation and treatment and thus requires another command endorsement. An addendum is less involved, as it may only require one or two additional tests or observations, usually over a relatively shorter time period. In addition, addenda do not usually require endorsements from the evaluatee's command.
8. IPEB Evaluation or Reevaluation of Members on the Temporary Disability Retired List (TDRL). The IPEB shall consider each periodic physical evaluation report following examination of an evaluatee on the TDRL. The IPEB will continue on the TDRL an evaluatee whose intermediate (not final) periodic evaluation indicates that the evaluatee's disability is not permanent, is rated at 30 % or greater, and the evaluatee remains not fit for duty. In a case where the periodic physical evaluation report indicates the evaluatee is fit for duty or that the evaluatee's condition is permanent or the degree of disability is less than 30 %, the IPEB will make findings and recommend a disposition.
9. Required Findings and Recommended Disposition of IPEB.
 - a. When the IPEB considers an active duty member's case, it shall make findings and recommend a disposition in accordance with articles 2.C.3.a. and 2.C.3.b.
 - b. When the IPEB considers the case of a member on the TDRL, it shall make findings and recommend a disposition in accordance with article 2.C.3.c.
10. Mental Competency. When reasonable doubt exists or arises during the course of consideration as to the mental competency of the evaluatee, and this matter was not covered in the report of the medical board or other medical documentation accompanying the medical board record, an IPEB shall act as follows:
 - a. suspend its proceedings.

- b. request that a mental competency assessment be conducted in accordance with article 3.C.3.
 - c. resume consideration of the case only upon receipt of the additional findings by the mental competency assessment relative to the competency of the evaluatee. The findings of the mental competency assessment shall be made a part of the record.
11. Occasions for Suspension of IPEB Proceedings. IPEB proceedings may be suspended under the following circumstances:
- a. if the evaluatee's mental competence is in doubt.
 - b. if, between the time a medical board report has been submitted to the IPEB and the time of final action on the case the evaluatee's condition changes markedly, or the evaluatee incurs additional impairments that may be disabling under article 2.C.2.. In such case, the evaluatee's commanding officer shall immediately notify CGPC-adm-1 by appropriate means, IAW article 3.L.
 - c. if the information received is inadequate.
 - d. disciplinary or administrative actions per article 2.C.11.
12. Policy Concerning Legal Counsel for the Evaluatee.
- a. Appointment of Legal Counsel for the Evaluatee. Legal counsel for the evaluatee will be assigned by Commandant (G-L).
 - b. Counseling Procedures. Upon designation by an evaluatee and receipt of a copy of the IPEB findings and recommended disposition, legal counsel shall normally contact the evaluatee within 5 working days. Legal counsel shall advise the evaluatee of the disability process and of the evaluatee's rights in light of the IPEB's findings and recommended disposition.
 - c. Action in a Case of Incompetent Evaluatee or a Case Where Disclosure of Findings Would be Deleterious to the Evaluatee's Health. An evaluatee in one of these categories imposes upon field personnel certain special constraints before action can be taken on IPEB findings and recommended disposition. The most critical situation is an evaluatee who is incapacitated to an extent precluding his or her own consideration of findings and recommended disposition, e.g., the case in which the evaluatee may not be conscious or lucid, or the case of an evaluatee who has been declared legally incompetent by a court having jurisdiction. Other situations are cases in which disclosure of the board's findings and recommended disposition (or other material in the record) would be deleterious to an evaluatee's health, or in which the evaluatee

has been found mentally incompetent by the IPEB. Upon receipt of IPEB findings and recommended disposition, the following pertains.

- (1) Mentally Incompetent Evaluator. In the case where an evaluator has been found mentally incompetent, legal counsel shall, in the absence of a court-appointed legal guardian, act on behalf of the evaluator. In this case, legal counsel shall sign the form CGHQ-4808 on behalf of the evaluator.
- (2) Deleterious to Evaluator's Health Case. In the case where the IPEB has found that disclosure of the recommended medical findings (i.e., identification and narrative description of the disability) would be deleterious to the evaluator's health, even though that evaluator has not been determined to be mentally incompetent, legal counsel is not authorized to accept or reject on behalf of the evaluator. In such a case, counsel will consult with CGPC-adm-1, who will then prepare a letter for the evaluator's signature. The letter will include a description of the IPEB's recommended disposition. If, however, an evaluator is unwilling to accept or reject the findings and recommended disposition, the legal counsel shall enter a rejection on the evaluator's behalf.

13. Policy Concerning Action Following IPEB Findings and Recommended Disposition.

- a. CGPC-adm-1 will notify the evaluator's command of the date on which the IPEB considered the evaluator's case. Command action shall be as follows.
 - (1) The evaluator must be readily accessible to designated legal counsel. Should the evaluator's location be other than that indicated in the medical board record, the command shall immediately notify CGPC-adm-1 with the evaluator's updated information.
 - (2) When an evaluator is contacted by legal counsel, the command shall make every effort to facilitate contact between the evaluator and counsel. Ideally, this location should be a quiet room or private office to permit the evaluator to weigh the counseling being offered in the absence of excessive background noise or distractions.
 - (3) The time limits imposed on an evaluator for action on IPEB findings and recommended disposition require expeditious consideration of a major career decision. While the burden of meeting the time requirements rests with the evaluator, the command shall make every effort to assist the evaluator in so doing.
- b. When an evaluator is found Fit for Duty or Not Fit for Duty by Reason of Condition or Defect Not a Physical Disability, the evaluator may not accept or reject, but may submit a written rebuttal within 30 calendar days of

notification, with a copy forwarded directly to CGPC-adm-1 (see article 1.D.7.). The IPEB will review the rebuttal and reconsider the case if the evaluatee's rebuttal raises issues that might change the original findings and recommended disposition.

- c. After being counseled on the IPEB's Not Fit for Duty findings and recommended disposition, it is the evaluatee's responsibility to take one of the following actions to continue PDES processing:
 - (1) Request reconsideration and submit, if available, information not previously presented to the IPEB.
 - (a) An IPEB has jurisdiction over a case until the FPEB hearing in that case is called to order.
 - (b) An IPEB has the discretion to reconsider any IPEB case within its jurisdiction, up until an FPEB is convened or the member accepts the findings. Reconsideration may be
 - (1) at the request of the evaluatee,
 - (2) at the request of the permanent FPEB president, or
 - (3) on the IPEB's own initiative.
 - (c) If an IPEB renders a new finding, the evaluatee may request an amplifying statement. The IPEB shall grant the request unless the basis for the finding is readily apparent from the record.
 - (d) In the event the IPEB makes new findings in response to the reconsideration request, the IPEB shall transmit the new findings to the evaluatee or counsel, if the evaluatee is represented, via CGHQ-4808. The evaluatee has 7 calendar days from receipt of findings in which to respond to the new findings. Exceptions to this 7 calendar day response requirement may be made on a case by case basis. No FPEB shall convene to hear the case prior to the expiration of this 7-day period, unless the member consents.
 - (e) In the event the IPEB denies the reconsideration request or the IPEB reconsiders the case but its original findings remain intact, the IPEB will notify the evaluatee of this action, by memo or email. The evaluatee has 7 calendar days from receipt of findings in which to respond to the IPEB's notification. Exceptions to this 7 calendar day response requirement may be made on a case by case basis. No FPEB shall convene to hear the case prior to the expiration of this 7-day period, unless the member consents.
 - (f) FPEB members reviewing a specific case in preparation for a hearing can request additional medical information through the permanent FPEB president. If the request is approved, CGPC-adm-1 will obtain

the information. Once the information is received, the permanent FPEB president shall, if practical, request that the IPEB reconsider their finding based on this new information.

(g) The evaluatee may only submit a request for reconsideration in writing to the IPEB via CGPC-adm-1, up until 7 calendar days before any scheduled FPEB. If the evaluatee's case is reconsidered, the IPEB shall inform the evaluatee of their decision in writing, via CGPC-adm-1 and counsel. If the IPEB denies a request for reconsideration, the IPEB shall explain the reason for their denial via email or memo to the evaluatee.

(2) Accept the findings.

(3) Conditionally accept, pending approval of a retention request (see article 4.A.14. for procedures).

(4) Reject and demand a formal hearing at the FPEB.

(5) Simply waive continued disability processing and request administrative separation or retirement processing.

d. Should the evaluatee fail to take one of the actions in article 4.A.13.c. within 30 calendar days from the date of receipt of written notification of the IPEB's offer by legal counsel, the conclusive presumption is that the evaluatee is accepting the IPEB findings and recommended disposition, and the case will be forwarded to Commandant (G-LGL) for legal review.

14. Policy Concerning IPEB Findings and Recommended Disposition of Not Fit for Duty. In order to improve the efficiency of the PDES, the following procedures are implemented.

a. An evaluatee who is found Not Fit for Duty by the IPEB will be permitted to make an acceptance of the IPEB findings and recommended disposition conditional upon approval of a retention request.

b. Upon receipt of the conditional acceptance from the evaluatee, the IPEB coordinator will forward the case, with the IPEB findings and recommended disposition, conditional acceptance, and retention request directly to CGPC-epm/opm/rpm, as appropriate, for a decision on the retention request.

c. If the retention request is approved, the evaluatee will be notified, and the case forwarded through the normal review chain for signature by the final approving authority.

- (1) Refer to the Personnel Manual, COMDTINST M1000.6 (series), chapter 17. A member (and the sponsoring command) retained on active duty after being found unfit by board action, must comply with specific procedures throughout the remainder of their active duty time. Such procedures include, but are not limited to, periodic physical evaluations to validate level of fitness for duty.
 - (2) CGPC-epm/opm/rpm will notify CGPC-adm-1 if a member is within 6 months of retirement and has been previously retained under these provisions. The member's command will submit a final physical evaluation to CGPC-adm-1 per the Personnel Manual, COMDTINST M1000.6 (series), chapter 17. CGPC-adm-1 will confirm a previous final disability determination if there has been no change in condition prior to the member's retirement. If there is a disability determination that differs from the previous determination, this constitutes a new finding and, as such, the member may invoke the full due process of the PDES.
- d. If the retention request is denied, a new CGHQ-4808 will be prepared. The evaluatee will be notified, but does not have the right to conditionally accept again. In addition, the evaluatee must respond to the IPEB's findings within 7 calendar days of notification following a denied retention request.

B. Policy Governing Action Following Evaluatee's Action on IPEB Findings and Recommended Disposition. (per article 4.A.13.c.(2), (3), and (4))

1. Action by Commanding Officer. Establish interim duty status as described in article 3.M. The commanding officer may request home-awaiting-orders status upon action by the final approving authority.
2. Action by Evaluatee's Legal Counsel. (or evaluatee if legal counsel is not assigned)
 - a. If article 4.A.13.c.(2) applies, the evaluatee will complete and sign the CG-4808 indicating acceptance of the IPEB findings.
 - b. If article 4.A.13.c.(3) applies, the evaluatee will complete and sign the CG-4808 indicating conditional acceptance of the IPEB findings and recommended disposition, and, if applicable, shall forward a letter requesting retention to CGPC-epm/opm/rpm, as appropriate.
 - c. If article 4.A.13.c.(4) applies, the evaluatee will complete and sign CG-4808, indicating rejection of the IPEB findings and recommended disposition. CGPC-adm-1 shall notify the commanding officer that an FPEB is required and will provide appropriate details.

- C. Final Action Following Evaluatee's Acceptance. The case will be forwarded to Commandant (G-LGL) for review for legal sufficiency. If legally insufficient, the record will be returned to the IPEB President with recommended corrective action. If legally sufficient, the record will be transmitted to the final approving authority, who may take one of the following actions:
1. Approve and forward the record to CGPC-epm/opm/rpm, as appropriate, for implementation.
 2. Disapprove and refer the record back to the IPEB for reconsideration, stating the reasons therefore.
 3. Disapprove and forward to CGPC-adm-1 for hearing by an FPEB.

CHAPTER 5

FORMAL PHYSICAL EVALUATION BOARD

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CHAPTER 5. FORMAL PHYSICAL EVALUATION BOARD

A. Policy Governing the FPEB.

1. Description and Purpose. A FPEB is a fact-finding body which holds an administrative hearing to evaluate a member's fitness for duty and to make recommendations consistent with the findings. This hearing is not an adversarial proceeding, and the implication of litigation must be avoided.
2. Convening Authority. Commander (CGPC-c) assigns members to serve on the FPEB by precept, which lists all permanent and alternate members. Commandant (G-CCS) will assign members to serve on an FPEB by precept when the evaluatee is a flag officer. The designation of members to serve on individual boards will be made by CGPC-adm-1.
3. Authority. The FPEB evaluates the fitness for duty of all evaluatees who have exercised their right to demand a full and fair hearing in accordance with 10 U.S.C. §1214. The FPEB also makes final recommendations concerning certain members on the TDRL in accordance with chapter 8 of this Manual, and in cases referred pursuant to article 4.A.6.
4. Membership of the FPEB. The FPEB normally consists of three commissioned officers, two of whom are normally line officers (or one line officer and one warrant officer) and the third a medical officer. In addition, there shall be assigned a counsel for the evaluatee and a nonvoting recorder. A member of the IPEB may not serve as a member of the FPEB convened to hear the same case.
 - a. A commissioned officer on active duty in the Coast Guard or Coast Guard Reserve, serving in pay grade O-6 or above shall be designated by the FPEB precept as permanent president. The precept may also designate alternate Presidents who are commissioned officers on active duty in the Coast Guard or Coast Guard Reserve, normally serving in pay grade O-5 or above, who shall act as president whenever designated by CGPC-adm-1. The designated president shall be senior to the evaluatee when practicable. In order to maintain independence in the oversight of the FPEB process, provide guidance to FPEB presidents, and to avoid the appearance of partiality, the CGPC-adm-1 Branch Chief shall avoid serving as an FPEB president as much as practicable.
 - b. When a flag officer is the evaluatee, a flag officer senior to the evaluatee, if practicable, shall be designated as president of the FPEB.
 - c. The medical member will be a member of the Public Health Service. A medical officer who has served as a member of the MEB or IPEB shall not serve as a member of the FPEB convened to hear the same case.

- d. When evaluating a member of the Coast Guard Reserve, one of the members of the board shall be a Coast Guard Reserve officer (see 10 U.S.C. §12643).
- e. If the board lacks a minority or female member, a minority or female evaluatee may request the convening authority add or substitute a minority or female member, if reasonably available. A senior petty officer of at least pay grade E-7 may be substituted for the junior officer member upon request of an enlisted evaluatee. If practicable, the enlisted member so assigned shall be senior to the evaluatee and in a rating in the specialty or related specialty of the evaluatee.
- f. When necessary to meet all membership requirements, there may be four or more voting board members.
- g. Legal counsel for the evaluatee shall be a commissioned officer on active duty in the Coast Guard or Coast Guard Reserve, designated by the Commandant (G-L), or counsel selected by the evaluatee. If the evaluatee elects to be represented by a disability counselor supplied by one of the veterans service organizations (e.g., Disabled American Veterans) or other counsel, such representation shall be at the personal expense of the evaluatee or the organization providing counsel.
 - (1) Normally, legal counsel for the evaluatee is assigned in accordance with article 4.A.13.a.
 - (2) When the evaluatee selects counsel other than Coast Guard legal counsel, Coast Guard co-counsel will not be provided, and the previously assigned Coast Guard legal counsel will, after conferring with the selected counsel and delivering relevant papers and documents, be discharged, at counsel's request, from further participation in the case by the president of the FPEB.
- h. If an evaluatee fails to appear at the time specified before an FPEB convened to hear the case, the evaluatee's legal counsel, or selected counsel if available, shall represent the evaluatee before the board. When the FPEB members decide that a personal appearance before an FPEB or disclosure of information relative to the physical or mental condition would adversely affect the evaluatee's health, the assigned legal counsel or selected counsel shall represent the evaluatee before the board, and the evaluatee shall not be present during the proceedings, except to testify (see article 5.A.6.a.(1)).

5. Duties of the Board Members.

a. Duties of All Members.

- (1) It is the duty of each voting member to weigh the evidence impartially and to make recommended findings in conformity with applicable laws, regulations, and established policies. Whenever the issue is raised, voting members must decide whether the appearance of the evaluatee before the board or disclosure to the evaluatee of information concerning his or her physical or mental condition would adversely affect the evaluatee's health. Each voting member has an equal voice with other members in deliberating upon and deciding each question submitted for consideration. Voting members shall discuss cases freely in closed sessions. The opinions expressed by members in closed sessions shall not be disclosed to anyone.
- (2) Voting members, legal counsel, and the recorder may question witnesses in an order prescribed by the president of the board.
- (3) No board member may testify or be called as an expert witness.

b. Duties of the President. The president of the board is responsible for accomplishing various administrative aspects of a case and for presiding over the hearing as chief hearing officer for that case. The following duties apply:

- (1) ensure CGPC-adm sets the time and place for the hearing, and ensuring appropriate notification to all persons involved;
- (2) ensure that Statement of Rights and Election of Counsel form are prepared and signed by the evaluatee;
- (3) ensure that the composition of the board meets the criteria set forth in article 5.A.4.;
- (4) meet with the recorder and legal counsel before the hearing to review the evidence of record, identify any witnesses to be called, and identify any anticipated stipulations, depositions or telephone testimony;
- (5) resolve any conflicts encountered in accomplishing the functions required in article 5.A.5.b.(3).;
- (6) preside over the hearing as chief administrative hearing officer, administering the oath to the recorder, and preserve order, decorum, and a courteous environment;

- (7) adjourn or recess the board, whichever best serves the proper transaction of the business before it, including conference of board members in closed session at any time; and
 - (8) rule on such procedural matters pertaining to the hearing as may be raised.
- c. Duties of the Recorder. The recorder is responsible for carrying out the following duties:
- (1) adhere to the ethical standards of conduct for counsel before any formal fact finding body;
 - (2) prior to the board, ensure members are familiar with their duties as described in this Manual;
 - (3) present to the board all relevant available evidence. Evidence may include, but is not limited to: medical records; investigation reports; depositions; affidavits; statements; telephonic conference calls; and video and tape recordings. All evidence should be introduced directly or by way of incorporation by reference into the record. Unless made a part of the board record, such evidence, even though it may be found elsewhere in Coast Guard files, cannot be used. Evidence includes information relating to:
 - (a) the nature and extent of the evaluatee's impairment,
 - (b) the extent of impairment that existed at the time of entrance into active service, should it appear that the impairment existed prior to that date,
 - (c) the line of duty status of the evaluatee which bears on the circumstances in which the impairment was incurred,
 - (d) other circumstances relating to the evaluatee's impairment,
 - (e) any other issues to be decided;
 - (4) administer the oath to the president and other members of the board, legal counsel, and all witnesses;
 - (5) examine and cross-examine witnesses appearing before the board;
 - (6) prepare a complete and accurate record of the proceedings of the board;
 - (7) prepare a list of witnesses who testify before the board.

d. Duties of Legal or Selected Counsel. Along with representing, generally, the interests of the evaluatee, legal counsel shall coordinate with the recorder for the availability of witnesses, including telephonic witnesses. The president will rule on the need for witnesses to personally appear before the board. The board will rule on whether evidence is material, relevant or cumulative.

6. Rights and Appearance of the Evaluatee.

a. Rights of Evaluatee. The FPEB shall afford the evaluatee a full and fair hearing, including:

- (1) the right to a hearing before a board and to be in attendance, unless the members of the FPEB, after consulting with the evaluatee's legal counsel, determine it is in the evaluatee's best interest not to be present;
- (2) not less than 3 working days notice of the time and place of the hearing, reasonable access to the record and any other evidence which the board is provided prior to the hearing;
- (3) the right to legal or selected counsel;
- (4) the right to present documentary evidence, including photographs, video tapes, x-rays, witnesses, and oral testimony on one's behalf;
- (5) where evidence is presented which calls into question the reliability of the medical reports, the right to cross-examine the authors of reports who are present or can be readily contacted by telephone; and
- (6) the right to challenge, for cause, any member of the FPEB. If a challenge for cause is raised, the convened board will recess and consider the challenge. The challenged member will not participate in the consideration or the decision. If the challenged member is the FPEB president, the remaining two FPEB members will consult with CGPC-adm-1 and will include this person in their deliberations regarding the merits of the challenge. When the board reconvenes, the FPEB will continue or adjourn to obtain a new member.

b. Order for Appearance. Except as provided in article 5.A.5.a.(1), each evaluatee is required to appear before the FPEB. If the evaluatee requests to be excused, stating reasons in writing, CGPC-adm-1 may waive appearance. Both the written request and a copy of the reply shall be attached to the record of the proceedings.

c. Failure to Appear.

- (1) An evaluatee who fails to appear before an FPEB convened to hear the case waives the right to be present at the hearing. The hearing may proceed, but the duty of legal or selected counsel to represent the evaluatee as though the evaluatee were present continues (see article 2.D.2.e., Administrative Investigations Manual, COMDTINST M5830.1 (series)).
- (2) An evaluatee who fails to appear after receiving orders which specify the time and place to appear may be subject to disciplinary action.

B. Procedure Prior to Formal Hearing.

1. Action by Commander (CGPC-adm-1). CGPC-adm-1 will act as follows:
 - a. order the evaluatee to appear before the FPEB.
 - b. designate the time and place of hearing. The board need not meet from day-to-day, but may recess for reasonable periods, as necessary, without requesting permission of the convening authority.
 - c. publish a schedule of FPEB hearings, listing the convening date and board membership.
2. Preparation of Case by Evaluatee and Legal Counsel.
 - a. The evaluatee and legal counsel for the evaluatee will be notified of the date of the convening of a formal board for preparation of the case. Legal counsel for the evaluatee may examine all records and papers pertaining to the case, under such supervision as may be necessary to properly protect the records.
 - b. Should the legal counsel recognize a need for a delay in the presentation, a written request will be submitted to CGPC-adm-1, whose response, as well as the request, will be appended to the record.
3. Preparation of Case by Members of the Board. The MEB record, official health record, personal data record, IPEB findings, recommended disposition, any amplifying statements, and any other documents having any bearing on the physical or mental condition of the evaluatee, will be provided to the board members for review prior to the hearing.

C. Procedure During Formal Hearing.

1. Evidence.

- a. The board shall consider documentary evidence transmitted to it by proper authority, and such other evidence as may be adduced at the hearing. The board may also require and examine such records as may be in Coast Guard files that relate to the issues before the board.
 - b. All oral evidence shall be taken under oath or affirmation and recorded.
 - c. The board may take notice of any generally accepted medical fact or principle. In consideration of the weight to be accorded evidence, the members of the board are expected to use their background, experience, common sense, and knowledge of human nature and behavior.
 - d. When the testimony presented at the hearing reveals that the evaluatee claims to have impairments not disclosed by the medical records or presents credible evidence in conflict with the medical records and the issue thus drawn is not one that can be readily resolved by the observation of the board, the case should be continued and further developed by additional physical examination, special studies, or investigation by appropriate agencies. The FPEB has authority to order a disposition medical board or addenda to satisfy this requirement.
 - e. Findings and recommended disposition of the board may be based only upon evidence of record.
2. Precept Read. When the board is called to order and after details of procedure have been decided, the precept convening the board and the appointment of the board members shall be read, unless waived by consent of the evaluatee.
3. Oaths. All participants in the FPEB shall be sworn or affirmed. Once a participant has been sworn, repeat of the oath is not required for subsequent participation. The board recorder shall inform each witness, immediately after the witness has been sworn, of the subject matter before the board.
4. Medical Testimony.
- a. A medical witness, if called, shall be questioned solely regarding the physical impairment(s) of the evaluatee and how they affect bodily functions. Testimony should be based upon the MEB record, other medical records, and the medical witness's personal examination of the evaluatee. Any conflict between a medical witness's testimony and other medical evidence shall be clarified. The medical evidence of record shall be clear and complete to permit the

board to accurately and fairly evaluate and rate each impairment under the current VASRD.

- b. In appropriate cases, upon determination by the board or at the request of the evaluatee, legal counsel or the recorder, the testimony of a medical witness may be obtained by sworn statement or deposition. A request for such statement or deposition shall be forwarded by the president of the FPEB, to the medical witness or witnesses setting forth specific questions, including any requests for clarification and amplification made by the evaluatee, legal counsel, recorder, or the board. When testimony of a medical witness is to be obtained by deposition in lieu of a sworn statement, such testimony may be a written or oral deposition.
5. Testimony by the Evaluatee. The evaluatee may testify on any matter pertinent to his or her condition. However, the evaluatee is not required to make any statement relating to the origin, incurrence, or aggravation of any disease or injury. (10 U.S.C. §1219)
6. Testimony by Other Witnesses. The recorder on behalf of the board, or the evaluatee, may call other witnesses if those witnesses are reasonably available. If a witness is called, no part of the expense shall be borne by the government with the exception of toll charges when testimony is by telephone.
7. Additional Statement by Witness. The board shall inform each witness immediately after being examined of the right to make any further statement on the record if the subject has not been fully brought out by the previous questioning. If the witness makes a statement, the board, the recorder, and the evaluatee have the right to further examine the witness.
8. Conference Call. The board may take sworn testimony by telephone with the participation of the evaluatee, legal counsel, voting board members, and the recorder.
9. Video Teleconference (VTC). Upon the evaluatee's request or concurrence with a recommendation by the FPEB president, the entire FPEB proceedings may be conducted via VTC. VTC use is subject to availability. Unless otherwise agreed upon, the government will bear the expense of VTC use.
10. Statements. Opening statements will be confined to the theory of the case. A discussion of controversial issues is inappropriate. After all evidence has been introduced, the recorder and legal counsel are afforded the opportunity to make any argument based upon the evidence of record.
11. Continuance. A continuance may, for good and sufficient reason, be granted by the president of the board upon motion of a member of the board, the evaluatee, legal counsel, or the recorder.

12. Required Findings and Recommended Disposition of the FPEB.

- a. When an active duty member appears before the FPEB, the FPEB's required findings and recommended disposition are to be in accordance with articles 2.C.3.a. and 2.C.3.b.
- b. When a member on the TDRL appears before the FPEB, the FPEB's required findings and recommended disposition are to be in accordance with article 2.C.3.c.
- c. When an inactive duty reserve member appears before the FPEB, the FPEB's required findings and recommended disposition are to be in accordance with article 2.C.3.b.

13. Minority Report. The FPEB's findings and recommended disposition shall be signed by the members concurring therein. Any member who does not concur may submit a minority report. The report shall be in memorandum format, addressed to the final approving authority, via the board president (or via the senior military member if the president is submitting the minority report). The president shall ensure that the members concurring in the majority report are afforded the opportunity to respond to the minority report if they so desire.

D. Procedure After Hearing.

1. Evaluee Furnished a Record of Board Findings and Recommended Disposition. Upon completion of board proceedings in the case, the recorder will provide the evaluee and legal counsel if appointed (or legal counsel when disclosure of the findings would be deleterious to the health of the evaluee) a letter setting forth the board's findings and recommended disposition. Receipt of this letter shall be acknowledged.
2. Rebuttal.
 - a. The president of the FPEB shall advise the evaluee and legal counsel that the board findings are not the final determination of the Coast Guard and that the evaluee has the right to file a rebuttal to the FPEB findings and recommended disposition. The evaluee must decide whether or not to file a rebuttal within 3 working days from the date of the final adjournment of the board, or upon receipt of the findings, whichever occurs later, and notify the FPEB in writing of the decision. If the evaluee does not notify the FPEB in writing of the decision within this period, the evaluee's right to file a rebuttal is forfeited.
 - b. The rebuttal must be submitted within 21 calendar days of the final adjournment of the board, or upon receipt of the findings of the board, whichever occurs later. A postmark or dated receipt by a mailing or shipping

entity shall establish the submission date. Facsimile may be used to file a rebuttal by an evaluatee having access to a facsimile machine. The evaluatee must state in the rebuttal the reasons for rebutting the decision of the FPEB, state the nature of the objection(s), and provide or cite evidence to support the position. A rebuttal may include substantial existing evidence, which by due diligence, could not have been presented before disposition of the case by the FPEB. A rebuttal that does not satisfy these requirements will not be acted upon, and the FPEB president shall so inform the evaluatee.

- c. If a letter of rebuttal is received within the required time frame, the FPEB will respond to the evaluatee or legal counsel (normally within 21 calendar days) confirming that the rebuttal has been received and considered.
 - (1) If, after consideration of the rebuttal, the FPEB is of the opinion that the elements contained in the rebuttal do not provide grounds for amendment of any portion of the FPEB's decision, the FPEB's response to the evaluatee will state that the rebuttal does not support a change to the findings and recommended disposition. The evaluatee and legal counsel will be informed that the entire record, including the rebuttal and the FPEB's response will be forwarded for further review and processing.
 - (2) If the FPEB concurs with all or part of the evaluatee's rebuttal, a new Coast Guard PDEB Findings and Recommended Disposition, CGHQ-4808, shall be prepared and forwarded to the evaluatee, with a copy to legal counsel, reflecting the revised determination(s). The record shall then be forwarded for review and final action.
 - d. When the evaluatee declines in writing to file a rebuttal, the record will be forwarded for review immediately. If a rebuttal is not submitted within 21 calendar days from the date of final adjournment of the FPEB hearing, and the evaluatee has not signed a declination of rebuttal, the record shall be forwarded and treated as if the evaluatee declined to file a rebuttal.
3. Request for Retention on Active Duty. A request for retention on active duty, if applicable, shall be submitted in accordance with the Personnel Manual, COMDTINST M1000.6 (series).
 4. Submission of the Records.
 - a. Assemble the record of proceedings of the FPEB in the following top to bottom order:
 - (1) copy of letter requesting retention, if submitted.
 - (2) Coast Guard PDEB Findings and Recommended Disposition, CGHQ-4808.

- (3) copy of board findings letter to evaluatee, along with evaluatee's receipt and statement, if any, concerning rebuttal. A certified mail receipt may serve in cases where the letter was sent by mail.
 - (4) rebuttal, if any (original only).
 - (5) copy of FPEB's letter response to the rebuttal, if any.
 - (6) Statement of Rights of evaluatee.
 - (7) recorded verbatim transcript, as required (see article 5.D.5.).
 - (8) Election of Counsel form.
 - (9) amplifying statement.
- b. Forward the record of proceedings promptly to Commandant (G-LGL) for review for legal sufficiency, unless transmittal to the Physical Review Council (PRC) is in order (see article 6.B.1.).
5. Transcripts. All FPEB hearings will be recorded verbatim and retained for 5 years. Unless the permanent president of the FPEB determines that a verbatim written transcript is required, an audiotape of the FPEB proceedings will be provided to the evaluatee:
- a. When the evaluatee or legal counsel has indicated that a rebuttal will be filed. The case will not be forwarded for review without a recorded verbatim transcript if the evaluatee has indicated within the required 3 working days that a rebuttal is forthcoming, and the rebuttal is submitted within the required 21 calendar days. Copies of the recorded verbatim transcript will be provided to the evaluatee and legal counsel.
 - b. When the case involves a determination of misconduct or not incurred in the line of duty.
 - c. When the findings and recommended disposition of the FPEB are not unanimous and the evaluatee has indicated that a rebuttal will be filed. If the evaluatee has accepted the board's findings and recommended disposition, the transcript may be reproduced either in part or in its entirety upon request of the board members, the PRC, or the final approving authority in their respective reviews of the minority report.
 - d. When subsequent PRC action results in substitute findings, which are appealed to the Physical Disability Appeal Board (PDAB).

6. Disciplinary Action. If an evaluatee becomes subject to disciplinary action after appearing before the FPEB, the evaluatee's commanding officer shall notify CGPC-adm-1 by e-mail or message traffic stating the action taken or contemplated. Further action in the case will be governed by article 12.B.1.e., Personnel Manual, COMDTINST M1000.6 (series). Subsequent developments in the case shall be promptly reported (also see article 2.C.11. in this Manual).

7. Change in Evaluatee's Status or Physical Condition Before Final Action. Whenever there is any significant change in the evaluatee's status or physical condition before final action is taken, the evaluatee's commanding officer shall promptly notify CGPC-adm-1. Subsequent developments in the case shall be reported as well.

CHAPTER 6
PHYSICAL REVIEW COUNCIL
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CHAPTER 6. PHYSICAL REVIEW COUNCIL

A. Policy Governing the PRC.

1. Description and Purpose. The PRC is a review body.
2. Convening Authority. Commander (CGPC-c) convenes the PRC by precept, which lists all permanent and alternate members. Assignment of council members will be made by CGPC-adm-1. (see articles 1.E. and F. for details regarding flag officer evaluatees)
3. Membership of the PRC.
 - a. In a case other than one in which a transcript is required by articles 5.D.5.b. and c., PRC membership shall normally consist of one commissioned officer on active duty in the Coast Guard or Coast Guard Reserve, serving in pay grade O-5 or above, who is designated by the PRC precept as president. The precept may designate other members who are commissioned officers on active duty in the Coast Guard or Coast Guard Reserve, serving in pay grade O-3 or above, who shall act for the president whenever directed.
 - b. For a case listed in articles 5.D.5.b. and c., or when specifically directed by the PRC president, the PRC membership shall consist of two additional members who have not previously served as a member of the IPEB or FPEB that evaluated the evaluatee.
 - (1) The military member will be a commissioned officer on active duty in the Coast Guard or Coast Guard Reserve, serving in pay grade O-3 or above.
 - (2) The medical member will normally be a member of the U.S. Public Health Service assigned to the Coast Guard.

B. Functions of the PRC.

1. The PRC shall review every Informal Physical Evaluation Board (IPEB) or Formal Physical Evaluation Board (FPEB) case in which the evaluatee rebuts the findings and recommended disposition, where the IPEB or FPEB has previously reviewed the rebuttal and has made no further change to its findings. In conducting this review, the PRC will check for completeness and accuracy, and ensure consistency and equitable application of policy and regulation.
2. The findings and recommended disposition of an FPEB will not normally be modified on review unless they were clearly erroneous. Due regard shall be given to the opportunity of the board members to observe the evaluatee and judge the credibility of witnesses.

3. In its review, the PRC shall not substitute its judgment for that of the IPEB or FPEB. The PRC must concur with the findings and recommended disposition of the IPEB or FPEB unless one or more of the following clearly identified errors or omissions is noted in the record:
 - a. incorrect assignment of VASRD code(s);
 - b. pyramiding of impairments;
 - c. incorrect percentage of disability assigned to the VASRD descriptive diagnosis(ses) or code(s); or
 - d. insufficient evidence to support the findings and recommended disposition; i.e., the IPEB's or FPEB's decision was arbitrary, capricious, not in compliance with law or regulation, or an abuse of discretion.
4. If the PRC identifies one or more of the errors described above, one of the following actions shall be taken:
 - a. return the case to the IPEB or FPEB president for reconsideration or remedial action, as appropriate;
 - b. if an IPEB case, refer to the FPEB for consideration; or
 - c. if an FPEB case, refer to a three-member PRC for consideration and disposition. Only a three-member council may make substitute findings and recommendations.
5. The evaluatee shall not appear before the PRC. However, the evaluatee or counsel may submit to the PRC in writing new or heretofore unconsidered evidence, or any otherwise pertinent information, with appropriate comment. A three-person PRC, as derived per article 6.B.4.c, may only consider evidence as presented to those adjudicating bodies which came before it.
6. The PRC shall recommend to Commander (CGPC-c) that a member's name be removed from the TDRL at the 5-year expiration date without benefits when the member, by failing to report for a physical examination, renders impracticable a final determination of fitness to perform the duties of grade or rating, or the degree of disability.

C. Actions of the PRC.

1. Action when No Error is Identified. After reviewing a case, the PRC shall, in the absence of error, concur with the findings and recommended disposition of the IPEB or FPEB.

2. When Substitute Findings and Recommended Disposition are Made (only applicable to a three-person PRC).
 - a. Whenever the PRC substitutes findings and recommended disposition, it shall cite specific elements in the record to support its action(s), and/or cite grounds for identifying the findings or recommended disposition in which it finds error or omissions and, as appropriate, provide recommended corrections. The evaluatee will be given an opportunity to file a rebuttal and/or to appeal modified findings and recommended disposition by the PRC if one or more of the following findings and/or recommended dispositions is made:
 - (1) Not Fit for Duty, instead of the rebutted FPEB finding of Fit for Duty.
 - (2) Fit for Duty, instead of the rebutted FPEB finding of Not Fit for Duty.
 - (3) Separation, instead of the rebutted FPEB recommended disposition of permanent retirement or placement on the TDRL.
 - (4) Permanent retirement, instead of the rebutted FPEB recommended disposition of placement on the TDRL.
 - (5) A change to “not in line of duty,” “not the proximate result of the performance of active duty,” or “not entitled to basic pay.”
 - (6) Decreased combined percentages of disability.
 - (7) Change in a finding that the injury or disease resulted from a disability caused by an instrumentality of war, occurred in line of duty during a period of war, or was incurred in combat with an enemy of the United States, to a disability not so caused.
 - b. The evaluatee shall be furnished a copy of the substitute findings and recommended disposition together with a summary of the PRC’s reasons for the modification(s). If the PRC makes the substitute findings and recommended disposition listed in article 6.C.2.a., the evaluatee shall execute the first endorsement to the PRC letter (see exhibit 6-1) and forward the endorsement to CGPC-adm-1, which shall be postmarked within 21 calendar days from the date the evaluatee receives the substitute findings and recommended disposition from CGPC. In the endorsement, the evaluatee may either concur with or rebut the substitute findings and disposition. If the evaluatee concurs with the substitute findings and disposition, the case will be forwarded to Commandant (G-LGL) for legal review and to the CGPC final approving authority. If the evaluatee rebuts the substituted findings and disposition, such rebuttal shall specify the findings and recommended disposition not concurred with, and set forth the basis for disagreement.

- c. If a rebuttal is not received within the prescribed period and the evaluatee has not signed a declination of rebuttal, the evaluatee will be deemed to have concurred with the findings and recommended disposition of the PRC.
 - d. If a rebuttal is submitted by the evaluatee or counsel, the PRC shall give due consideration to the arguments in the rebuttal. The PRC shall either:
 - (1) adhere to the initial substitute findings and recommended disposition, whereupon the evaluatee shall be so notified and advised of the right to request a hearing before the PDAB, or
 - (2) modify the substitute findings and recommended disposition. If the modification is in agreement with the rebuttal, the case will be forwarded to Commandant (G-L) for review for legal sufficiency. If the modification is not in agreement with the rebuttal, the evaluatee shall be advised of the right to request a hearing before the PDAB.
3. Minority Report. Findings and recommended disposition shall be signed by those concurring. Any member not concurring with the findings and recommended disposition of the majority shall submit a minority report to be appended to the record.

1850
Date _____

FIRST ENDORSEMENT on President, Physical Review Council (PRC) memo 1850
of _____, Case No. _____

From:
To: Commander (CGPC-adm-1)

Subj: PHYSICAL EVALUATION BOARD

___ 1. I have reviewed the substitute findings and recommended disposition of the PRC and I CONCUR with such findings and recommended disposition.

IF YOU CHECKED NUMBER 1 ABOVE, NO FURTHER ACTION IS NECESSARY OTHER THAN YOUR SIGNATURE.

___ 2. I have reviewed the substitute findings and recommended disposition of the PRC and I DO NOT CONCUR with same. My written rebuttal is attached hereto for further consideration by the Council. If the members of the PRC still fail to resolve the matter favorably in my behalf, I understand that my case will be submitted to the Physical Disability Appeal Board (PDAB) for consideration. I have checked the appropriate block(s) below expressing my desires:

a. **IF YOU CHECKED NUMBER 2 ABOVE, ONE OF THE FOLLOWING MUST BE CHECKED:**

___ I request to appear before the PDAB (at my own expense).

___ I will not appear before the PDAB.

b. **IN ADDITION, IF YOU CHECKED NUMBER 2 ABOVE, ONE OF THE FOLLOWING MUST ALSO BE CHECKED:**

___ I request previously assigned legal counsel continue to represent me.

___ I will furnish civilian counsel of my choice at my own expense.

___ I will be represented by other counsel (e.g., DAV, VA).

___ I will not be represented by counsel.

(Signature)

Exhibit 6-1

CHAPTER 7
PHYSICAL DISABILITY APPEAL BOARD
CONTENTS

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CHAPTER 7. PHYSICAL DISABILITY APPEAL BOARD

A. Policy Governing the PDAB.

1. Description and Purpose. A PDAB's role is to review the complete records of those disability evaluation cases referred to it. This review shall be consistent with accepted medical principles and applicable laws, regulations, and directives.
2. Convening Authority. Commander (CGPC-c) establishes the PDAB by precept, which lists all permanent and alternate members. Commandant (G-CCS) will establish a separate PDAB by precept to review cases of flag officers. CGPC-adm assigns the members to serve on individual boards.
3. Functions. The PDAB shall consider cases referred to it in accordance with chapter 6. In considering a disability evaluation case referred to it, the PDAB shall determine whether:
 - a. the member received a full and fair hearing;
 - b. the evaluation proceedings conformed to applicable laws, regulations, published directives and policies, and followed accepted medical principles; and
 - c. the findings and recommended disposition of the FPEB, as modified by the PRC, are supported by a preponderance of the evidence.
4. Membership of the PDAB. The PDAB shall consist of at least three commissioned officers: a president, a medical member, and a military member. In addition, counsel for the evaluatee and a non-voting recorder shall be assigned.
 - a. The president shall be a commissioned officer on active duty in the Coast Guard or Coast Guard Reserve, serving in pay grade O-6 or above. When the case of a flag officer is being considered by the PDAB, the president will be a flag officer. When practical, the president shall be senior to the evaluatee.
 - b. The military member shall be a Coast Guard officer and, if practical, senior to the evaluatee.
 - c. The medical member shall normally be a medical officer (physician) of the U.S. Public Health Service assigned to the Coast Guard.
 - d. When evaluating a member of the Coast Guard Reserve, one member of the board shall be a Coast Guard Reserve officer senior to the evaluatee as required by 10 U.S.C. §12643. Failure to meet this requirement will negate the proceedings.

- e. Upon request of the evaluatee, the convening authority may include a minority, female, or enlisted board member, if reasonably available. A senior petty officer of at least pay grade E-7 may be substituted for the junior officer member upon request of an enlisted member. The enlisted member so assigned shall be senior to the evaluatee when evaluating an enlisted person, if practical, and in a rating in the specialty or related specialty of the evaluatee.
 - f. When necessary to meet all membership requirements, there may be four or more voting board members.
 - g. Anyone who served as a member of the MEB, DMB, IPEB, FPEB, or PRC upon which the referral to the PDAB is based, or had been a witness at an FPEB, may not serve as a member of the PDAB with regard to that case.
 - h. Legal counsel for the evaluatee shall be a commissioned officer on active duty in the Coast Guard or Coast Guard Reserve, designated by Commandant (G-L), or a civilian attorney employed by the evaluatee. The evaluatee, however, may elect to be represented by a disability counselor supplied by one of the veterans service organizations (see article 7.A.4.i.).
 - i. Normally, legal counsel for the evaluatee is assigned in accordance with article 4.A.13. of this Manual. When the evaluatee has selected other legal counsel, he or she will normally not have a Coast Guard co-counsel, and the previously assigned Coast Guard legal counsel will, after an opportunity has been provided to confer with civilian counsel and deliver relevant papers and documents, be discharged from further obligations in the case.
 - j. If an evaluatee fails to appear at the time specified before a PDAB convened to hear the case, the evaluatee's counsel shall represent the evaluatee before the board. When the PDAB members decide that personal appearance before a PDAB or disclosure of information relative to the physical or mental condition would adversely affect the evaluatee's health, the assigned counsel shall represent the evaluatee before the board, and the evaluatee shall not be present during the proceedings.
- B. Procedures. The PDAB will meet in open session for presentation of the deliberations and determinations. The evaluatee may appear in person before the PDAB during open sessions of the board except that no expense for either the evaluatee's or civilian counsel's appearance will be borne by the government. An evaluatee who, after due notification of the time and place of hearing, fails to appear at the appointed time, is deemed to have waived the right to appear. An evaluatee may also expressly waive the right of appearance by notifying CGPC-adm.
1. Oaths. All participants in the PDAB shall be sworn or affirmed. Once a participant has been sworn, repeat of the oath is not required for subsequent appearances before the PDAB evaluating the same evaluatee. The board recorder

shall inform each witness, immediately after the witness has been sworn, of the subject matter before the board.

2. Challenges. A member of the PDAB may be challenged for cause by the evaluatee or legal counsel, if appointed. If a challenge for cause is raised, the convened board will recess and consider the challenge. The challenged member will not participate in the consideration or the decision. When the board reconvenes, the PDAB will continue or adjourn to obtain a new member.
3. Evidence.
 - a. Not less than 10 working days prior to the date set for the hearing, a copy of the available records and papers to be considered by the PDAB shall be furnished to the evaluatee's counsel, board members, and the recorder.
 - b. Not less than 3 working days prior to the date set for the hearing, the evaluatee or counsel and the PDAB recorder may submit a brief to the president of the PDAB with copies to all board members, the recorder, evaluatee and/or counsel (as appropriate) regarding the issues in the case, the names of any witnesses and any new or additional evidence that is considered relevant.
 - c. The PDAB shall consider the entire record transmitted to it by proper authority. The board may examine any other Coast Guard records which relate to the issues at hand. Any evidence having probative value as to the determination of issues before the board may be presented. The board shall assure that the evaluatee or counsel is aware of the evidence it is considering.
 - d. The presence of witnesses is neither required nor encouraged. The counsel for the evaluatee and the recorder are encouraged to use telephonic depositions and stipulations and other expeditious means to bring relevant evidence before the board. However, the board may call military personnel and physicians under Coast Guard or Department of Defense jurisdiction as witnesses whose presence is requested by the recorder, the evaluatee, or the evaluatee's counsel, only when the witnesses are reasonably available and only if, in the opinion of the president of the board, there is no other reasonable way to obtain the evidence they would present. It is the responsibility of the evaluatee and counsel to make arrangements for the attendance of a civilian witness to appear on behalf of the evaluatee. No cost incurred in obtaining civilian witnesses will be borne by the government.
 - e. All witnesses before the board shall be subject to questioning by the evaluatee, counsel, recorder for the board, and the board members. All oral testimony shall be taken under oath or affirmation administered by the recorder. All PDAB hearings will be recorded on magnetic tape which shall be retained for five years. Unless the permanent president of the FPEB determines that a

verbatim transcript is required, an audiotape of the PDAB proceedings will be provided when:

- (1) the case involves a determination of misconduct or not-in-line of duty; or
- (2) the decision of the PDAB is not unanimous.

4. Continuances. The PDAB may continue a hearing on its own motion or at the request of the evaluatee, counsel, or recorder.

C. Actions. The PDAB will take one of the following actions and forward the case to Commandant (G-LGL) for review for legal sufficiency:

1. concur with the FPEB;
2. concur with the PRC; or
3. return the record to the appropriate board for reconsideration of any matter deemed pertinent.

D. Minority Report. Any member of the PDAB may submit a minority report on any issue on which he or she disagrees. This report shall be included in the record of proceedings of the board.

E. Proceedings of the Board. The president of the PDAB shall take appropriate action to ensure that all sessions of the board are conducted with proper decorum but in a relaxed, courteous, and orderly manner. Interlocutory questions will be ruled on by the president. Objections to these rulings may be made by any other member of the board. These objections shall be decided by a majority vote of the board members in closed session. The president shall announce the board's decision and the result of any vote upon interlocutory questions.

F. Forwarding of Record of Proceedings. The record of proceedings of the PDAB shall be authenticated by the president or, in the president's absence, the next senior member of the board. Once authenticated, it shall then be forwarded to Commandant (G-LGL) for review for legal sufficiency. Upon completion of legal review, the record will be forwarded to the final approving authority.

CHAPTER 8
TEMPORARY DISABILITY RETIRED LIST
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CHAPTER 8. TEMPORARY DISABILITY RETIRED LIST (TDRL)

A. Overview.

1. A member who is qualified for disability retirement under 10 U.S.C. §1201 or §1204 will be placed on the TDRL in accordance with 10 U.S.C. §1202 or 10 U.S.C. §1205 when the disability is not permanent.
2. Placement on the TDRL does not guarantee a member permanent disability retirement. The TDRL is similar to a pending list. It provides a safeguard for the government against permanently retiring members who may later fully or partially recover from the disabling condition. Conversely, the TDRL safeguards members from being permanently retired with a condition that is not stable and could result in a higher disability rating.
3. Requirements for placement on the TDRL are the same as for permanent disability retirement, except that the disability is not stable. The disability must render the member unfit to perform the duties of his or her office, grade and rank or rating, and the disability must be rated at a minimum of 30 % or higher, unless the member has 20 years of active service for retirement purposes.
4. Temporary retirement status implies no inherent right for retention on the TDRL for the entire 5-year period provided by 10 U.S.C. §1210. Upon review of a periodic physical examination and a determination that the member's condition is of a permanent nature and stable, an IPEB or FPEB may recommend removal of the member's name from the TDRL by separation with severance pay, permanent disability retirement, or a finding of Fit for Duty, as appropriate.
5. Upon review of a periodic physical examination and a subsequent determination that the member's condition is not stable and that the member continues to be unfit for duty, an IPEB or FPEB may continue the member's name on the TDRL. Such cases will be continued with the same determination that was approved when the member's name was originally placed on the TDRL. The continuation shall become a part of the total case record. At the end of 5 years, the member is either permanently retired or FFD and returned to the Service.
6. If a member's name is not sooner removed from the TDRL, disability retired pay terminates at the end of 5 years on the list.

- B. Assignment to the TDRL. When an evaluatee's temporary retirement is finally approved, CGPC-adm shall place the member's name on the TDRL and shall be responsible for managing the case until final determination is made.

C. Periodic Physical Examination and IPEB Review. A member on the TDRL must undergo periodic physical examinations and IPEB review to determine if the medical condition has stabilized sufficiently to adjudicate the case. An examination and review is required:

1. at least once every 18-month period;
2. Not less than 12 months prior to the termination of 5 years from the date the member was first placed on the TDRL; and
3. at any other time as specified by appropriate authority.

D. Preparing a TDRL Case for IPEB Review.

1. Orders to Member for Periodic Physical Examination. CGPC-adm-1 will determine the schedule and initiate orders directing a member on the TDRL to undergo a required physical examination. The orders shall inform the member:

- a. that a physical examination is required during a prescribed month;
- b. that a specified medical treatment facility will schedule the examination and will advise the member when and where to report; and
- c. of authorized travel information.

2. Request to Medical Treatment Facility. Concurrent with the issuance of orders to the member, CGPC-adm-1 will forward a copy of the case to the medical treatment facility, requesting an examination be scheduled. The medical treatment facility will make the appropriate appointments and advise the member when and where to report for examination.

3. Completion of Physical Examination. The examining physician will develop a narrative summary (as described in chapter 3) that presents an objective and complete evaluation of the member's current condition. The medical treatment facility will return the copy of the case with the narrative summary to CGPC-adm-1 for IPEB action.

E. IPEB Periodic Review. The IPEB shall evaluate each case and recommend removal of the member's name from the TDRL if the member's condition is of a permanent nature and stable. In this regard, the IPEB shall adhere to the policies prescribed in article 2.C.3.c.

1. If the IPEB retains a member on the TDRL, CGPC-adm-1 will notify the member in writing of the board's decision.

2. In all other instances, including the final periodic review, the member's name must be removed from the TDRL. The IPEB shall consider each case in accordance with the provisions of article 2.C.3. CGPC-adm-1 shall then process the case for final determination as outlined in chapter 4.
- F. TDRL Members Residing in Foreign Countries. TDRL members who reside in foreign countries will report for their periodic physical examinations when ordered. Travel within the United States from and to debarkation and embarkation points and the medical treatment facility will be authorized and reimbursed. Upon request, CGPC-adm-1 may attempt to arrange for a uniformed services medical treatment facility in the area where the member is located to conduct a periodic physical examination. However, if such arrangements are not made, the member is still obligated to comply as ordered. If the member fails to report for the periodic examination, CGPC-adm-1 may initiate action to stop disability retired pay in accordance with 10 U.S.C. §1210(a).
- G. Periodic Physical Examination Not Performed.
1. Failure To Report. If a member fails to report, or fails or refuses to complete a physical examination, CGPC-adm-1 shall make an effort to discover the reason. If the reason for the member's failure to report cannot be discovered or is found unjustified, and the TDRL expiration date has not been reached, CGPC-adm-1 may initiate action to stop the member's disability retirement pay. Unless removed sooner by other action, the member's name shall remain on the TDRL until the 5-year expiration date, at which time the evaluatee's name shall be removed from the TDRL in accordance with article 6.B.6.
 2. Unable To Locate Member. When reasonable efforts to locate the member are unsuccessful, CGPC-adm-1 shall send a certified letter, return receipt requested, to the member at the last known address. This letter will state the obligation to comply with orders and advise the member to contact CGPC-adm-1 within a fixed period of time. If this effort is unsuccessful, CGPC-adm-1 will take the action prescribed in article 8.G.1.
 3. Restoring Disability Retirement Pay. The member's disability retirement pay may be reinstated and, if warranted, may be retroactive for a period not in excess of one year if, in the opinion of the final approving authority, failure to respond was justified.
- H. Removal Upon TDRL Expiration Date. 10 U.S.C. §1210(b) requires a final determination of the case of a member whose name is on the TDRL upon expiration of 5 years after the date when the member's name was placed on that list. When a case cannot be considered due to the member's failure to undergo a final physical examination, the case shall be forwarded to the PRC (see article 6.B.6.).

CHAPTER 9

APPLICATION OF THE DEPARTMENT OF VETERANS AFFAIRS
SCHEDULE FOR RATING DISABILITIES (VASRD)

CONTENTS

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CHAPTER 9. APPLICATION OF THE DEPARTMENT OF VETERANS AFFAIRS
SCHEDULE FOR RATING DISABILITIES (VASRD)

A. General Rating Policies.

1. Use of the VASRD.

- a. Congress established the VASRD, published in 38 CFR, Part 4, as the standard under which percentage determinations are to be made pursuant to Title IV of the Career Compensation Act of 1949 (now principally codified in Chapter 61 of 10 USC). However, not all of the general policy provisions set forth in Subpart A (4.1 through 4.31) of 38 CFR, Part 4, are applicable to the Coast Guard. Many of these policies were written primarily for DVA rating boards and are intended to provide guidance under laws and policies applicable only to the DVA.
- b. Section A of this chapter replaces Subpart A of the VASRD, 38 CFR, Part 4, with the exception of Table I, which is referenced in article 9.A.12. The remainder of the VASRD (4.40 et seq.) is applicable to the Coast Guard, except those portions that:
 - (1) pertain to DVA determinations of service connection,
 - (2) refer to internal DVA procedures or practices, or
 - (3) are otherwise specifically identified in section B of this chapter as being inapplicable.
- c. The following policy applies to an evaluatee whose initial entry into the PDES occurs subsequent to 9 July 1987:
 - (1) There is no legal requirement, in making disability retirement determinations, to rate a physical condition, not in itself considered to be disqualifying for military service, along with arriving at the rated degree of incapacity incident to retirement from military service for disability. Except as discussed in paragraph (2) below, in making this professional judgment board members will not rate those disabilities neither unfitting for military service nor contributing to the inability to perform military duty.
 - (2) In applying this policy, board members should take into consideration the residuals of the original impairment that has now led to the member being found unfit for continued duty. An example of this would be a member with a brain tumor who, after surgery to remove the tumor, is left with partial paralysis and an artificial plate replacing the surgically removed portion of skull. In this instance, it would be proper to rate both the

paralysis and the missing portion of skull. Another example is the member who, as the result of an accident, has a splenectomy as well as an amputated major arm. Even though the loss of the arm is the disability, it would be proper to rate the splenectomy since it is an immediate result of the original accident.

2. Essentials of Evaluative Rating.

- a. The VASRD is used in the evaluation of disability resulting from all types of diseases and injuries encountered as a result of or incident to military service. The percentage ratings represent, as far as can practicably be determined, the average impairment in earning capacity resulting from such diseases and injuries, and their residual conditions in civilian occupations.
- b. Conditions which do not render the member unfit for continued service will not be considered for determining the compensable disability rating unless they contribute to the finding of unfitness.

3. Higher of Two Evaluations.

- a. It is not expected that every case will show the exact symptomatology specified in the VASRD, especially with the more fully described grades. Findings that are sufficiently characteristic of the symptoms described in the VASRD and the rating with impairment of function are required in all instances. There is no rigid requirement for the presence of all enumerated manifestations of a given disability. Those manifestations which are sufficiently and significantly representative of the entity and the severity of limitations imposed on the member are the only requirements.
- b. Where there is a reasonable doubt as to which of two percentage evaluations should be applied, the higher evaluation will be criteria for that rating. Otherwise, the lower rating will be assigned. When, after careful consideration of all reasonably procurable and assembled data, there remains a reasonable doubt as to which rating should be applied, such doubt shall be resolved in favor of the member and the higher rating assigned.

4. Pyramiding.

- a. Pyramiding is the term used to describe the application of more than one VASRD rating to any area or system of the body when the total functional impairment of that area or system is more appropriately reflected under a single diagnostic code. Pyramiding is not permitted since it results in overrating the disability.
- b. Disability from injuries to the muscles, nerves, and joints of an extremity may overlap to a great extent, and special rules for their evaluation are included in

appropriate sections of the VASRD and in article 9.B. of this chapter. Related diagnoses should be merged for rating purposes when the VASRD provides a single diagnostic code covering all their manifestations. This prevents pyramiding and reduces the chance of overrating. For example, disability from fracture of a tibia with malunion, limitation of dorsiflexion, eversion, inversion, and traumatic arthritis of the ankle would be evaluated as 5262 in accordance with the effect upon ankle function, with no separate evaluation for the limitation of motion or traumatic arthritis.

5. Total Disability Ratings. Total disability will be considered to exist when the evaluatee's disability is sufficient to render it impossible for the average person to follow a substantially gainful occupation. Accordingly, in cases in which the VASRD does not provide a 100 % rating under the appropriate (or analogous) diagnostic code, an evaluatee may be assigned a disability rating of 100 % if the disability is sufficient to render it impossible for an evaluatee to follow a substantially gainful occupation. However, if the VASRD provides a 100 % rating, the evaluatee must be rated in accordance with the specified criteria. Total disability may not be found in conjunction with temporary retirement unless the impairment can reasonably be expected to continue for the five-year maximum TDRL period. Total disability may not be found in conjunction with permanent retirement unless the impairment can reasonably be expected to continue throughout the life of the evaluatee.
6. Convalescent Ratings. Under certain diagnostic codes, the VASRD provides for convalescent ratings to be awarded for specified periods of time without regard to the actual degree of impairment of function. Such ratings do not apply to the Coast Guard since the purpose of convalescent ratings is accomplished by other means under disability laws. Convalescence will ordinarily have been completed by the time maximum hospital benefit (for disposition purposes) has been attained. The ratings for observation periods as distinguished from convalescence, such as those for one year following treatment for a malignant neoplasm, are not affected by this policy.
7. Analogous Rating. When an unlisted condition is encountered, rate the disability under a closely related disease or injury in which not only the functions, but the anatomical localization and symptomatology are closely analogous. Conjectural analogies will be avoided, as will the use of analogous ratings for conditions of doubtful diagnoses or those not fully supported by clinical and laboratory findings. Ratings assigned to organic diseases and injuries will not be assigned by analogy to conditions of functional origin. The diagnostic code number will be built-up by taking the first two digits from that part of the VASRD most closely identifying the system of the body involved. The last two digits will be 99, which will denote an unlisted condition, followed by a slant bar and the diagnostic code

number that is most closely related to the actual impairment. For example, aortic valvular heart disease is rated by analogy to rheumatic heart disease as 7099/7000.

8. Zero Percent Ratings and Minimum Ratings.
 - a. Occasionally, a medical condition which causes or contributes to unfitness for military service is of such mild degree that it does not meet the criteria even for the lowest rating provided in the VASRD under the applicable diagnostic code. A zero percent rating may be applied in such cases even though the lowest rating listed is 10 % or more, except when minimum ratings are specified (see article 9.A.8.b.). It should be noted that the zero percent rating is a valid disability rating and receives the same compensation as prescribed by law for ratings of less than 30 %. It does not mean that a disability does not exist. The bilateral factor will be applied when a disability is present in two paired extremities, even though one is rated at zero percent.
 - b. In some instances the VASRD provides a minimum rating without qualification as to residuals or impairment. Syringomyelia, diagnostic code 8024, is an example. The diagnosis alone is sufficient to justify the minimum rating. Higher ratings may be awarded in consonance with degree of severity, but no rating lower than the minimum may be used if the diagnosis is satisfactorily established.
 - c. The VASRD provides for minimum rating for residuals in certain conditions. The instructions may be “rate residuals, minimum _____(%)_,” or may specify what impairment to rate and give a minimum rating for that impairment. Examples are 8011, anterior poliomyelitis, and 6015, benign new growth of eyeball and adnexa, other than superficial. To justify the minimum rating for residuals, a functional impairment or other residual must exist. Otherwise, a zero percent is appropriate.
9. Extra Scheduling Ratings in Exceptional Cases. In exceptional cases where schedular evaluations are found to be inadequate to properly rate the disability, extra schedular ratings, commensurate with the average earning capacity impairment due exclusively to the service connected record and in the findings of the board, clearly demonstrate the basis of the conclusion that the case presents such an exceptional or unusual disability picture as to render impracticable the application of the regular schedular standards. Such related factors as marked interference with employment, frequent periods of hospitalization, or extreme physical problems associated with the treatment and its side effects will justify the assignment of extra schedular ratings.
10. Rating Disabilities Aggravated by Active Service. It is necessary in all cases of this type to deduct from the present degree of disability the degree, if ascertainable, of the disability’s Existence Prior to Entry (EPT) into active

service. The difference between the current disability and the EPTE portion is considered to be the result of aggravation by active service. However, if the disability is total (100 %), the portion existing prior to entry will be recorded but no deduction in the compensable rating will be made. Determination of EPTE disability can be made whether or not the disability was noted upon entry, if the evidence of record is sufficient to establish its pre-existence (see article 2.C.5.). If the degree of disability at the time of entry into the service is not ascertainable in terms of the VASRD schedule, the EPTE factor will be rated as zero percent and the current disability will be considered totally the result of aggravation. If the percentage of disability at the time of entry on active service is the same as the current disability, the percentage attributable to aggravation is none, not zero percent.

11. Prescribed Treatment is Refused or Omitted. An evaluatee's degree of disability may have been aggravated or increased by an unreasonable failure or refusal to submit to medical or surgical treatment or therapy, to take prescribed medications, or to observe prescribed restrictions on diet, activities, or the use of alcohol, drugs, or tobacco. The compensable disability rating may be reduced to compensate for such aggravation or increase when the existence and degree of aggravation are ascertainable by application of accepted medical principles, and where it is clearly demonstrated that:
 - a. the evaluatee was advised clearly and understandably of the medically proper course of treatment, therapy, medication, or restriction; and
 - b. the evaluatee's failure or refusal was willful or negligent, and not the result of mental disease or of physical inability to comply.

12. Combined Ratings Table. When an evaluatee has more than one compensable disability, the percentages are combined rather than added (except when a note in the VASRD indicates otherwise). This results from the consideration of the evaluatee's efficiency as affected first by the most disabling conditions in the order of their severity. Thus, an evaluatee having a 60 % disability is considered to have a remaining efficiency of 40 %. If an evaluatee has a second disability rating at 20 %, the evaluatee is considered to have lost 20 % of that remaining 40 %, thus reducing the remaining efficiency to 32 %. Hence, a 60% disability combined with a 20 % disability results in a combined value of 68 %, which is rounded up to a rating of 70 %. The combined rating for any combination of disabilities can be determined by first arranging the disabilities in their exact order of severity and then referring to the combined ratings table I in 4.25 of the VASRD, in accordance with the following instructions:

- a. Combining Two Percentages. Enter the ratings table by locating the highest percentage in the left-hand column and reading across to where that horizontal line intersects with the vertical column headed by the next highest percentage.

EXAMPLE: 40 combined with 20 equals 52.

- b. Combining Three or More Percentages. First, combine the first two percentages as above. Second, reenter the table by locating that combined value in the left-hand column headed by the third percentage.

EXAMPLE: 50 combined with 30 equals 65; then 65 combined with 20 equals 72.

If there are additional percentages, the second step is repeated using the new combined value and the next percentage.

- c. Converting Combined Ratings. After all percentages have been combined, the resulting value is converted to the nearest number divisible by 10. Combined values ending in 5 will be adjusted upward. If the combined value included a decimal fraction of .5 or more as a result of applying the bilateral factor, the fraction is converted to the next higher whole number; otherwise, the decimal fraction is disregarded.

EXAMPLE: If the combined value is 64.5, first round off the fraction to make the combined value 65, which, in turn, is rounded off to 70. If the combined value is 64.4, the decimal fraction is disregarded and the combined value of 64 is rounded off to 60.

13. Bilateral Factor. When a partial disability results from injury or disease of both arms or both legs, or of paired skeletal muscles, the rating for the disabilities of the right and left sides will be combined as usual, and 10 % of this value will be added (not combined) before proceeding with further combinations converting to degree of disability. The bilateral factor will be applied to such bilateral disabilities before other combinations are carried out, and the rating for such disabilities, including the bilateral factor as above, will be treated as a disability for the purpose of arranging in order of severity and for all further combinations.

- a. The use of the terms arms and legs is not intended to distinguish between the arm, forearm, and hand, or the thigh, leg, and foot, but to describe the upper extremities and lower extremities as a whole. Thus, with a compensable disability of the right thigh (for example, amputation of leg at thigh level), and one of the left foot (for example, pes planus), the bilateral factor applies, and, similarly, whenever there are compensable disabilities affecting use of paired extremities, regardless of location or specified type of impairment (except as noted in 9.A.13.c.).

- b. The correct procedure when applying the bilateral factor to disabilities affecting both upper extremities and both lower extremities is to combine the ratings of the disabilities affecting the four extremities in order of individual severity, then apply the bilateral factor by adding, not combining, 10 % of the combined value thus attained.
- c. The bilateral factor is not applicable unless there is partial disability of compensable degree in the VASRD in each of two paired extremities or paired skeletal muscles. Special instructions regarding the applicability of the bilateral factor are provided in various parts of the VASRD (e.g., diagnostic code 7114 - 7117, diagnostic code 8205 - 8412, etc.). The bilateral factor is not applicable in skin disabilities rated under diagnostic code 7806.

B. Use of VASRD Diagnostic Code Numbers.

1. The VASRD diagnostic code numbers appearing opposite the listed ratable disabilities are arbitrary numbers for the purpose of showing the basis of the evaluation assigned and for statistical analysis.
2. Great care will be exercised in selecting the applicable diagnostic code number and in its citation on the rating sheet. Each rated disability is assigned the VASRD diagnostic code number unless a hyphenated code is expressly authorized. It is not proper to use additional diagnostic codes as a means of further describing the defects. The written diagnosis entered on the rating form should include any description considered necessary to indicate the extent, severity, or etiology of the condition.
3. In selecting diagnostic code numbers, injuries will generally be represented by the number assigned to the residual condition on the basis of which the rating is determined.
4. With diseases, the rating level of the disability is usually determined by decreased functional capacity, taking into account the level of medication for the disease. Preference is to be given to the number assigned to the disease itself. If the rating is determined on the basis of residual conditions, the number appropriate to the residual condition will be added, preceded by a hyphen. Thus, atrophic (rheumatoid) arthritis with the residual of ankylosis of the lumbar spine would be coded 5002-5289. In this way, the exact source of each rating can be easily identified. If there are several residuals, the major functional impairment should be the manifestation used to rate the individual; e.g., 7325-7301 (regional enteritis after a small bowel resection with obstruction due to adhesion).

5. In citing disabilities on rating sheets, any combination of diagnostic terminology from the medical board or VASRD that accurately reflects the degree of disability may be used. Residuals of diseases or therapeutic procedures will not be cited without reference to the basic disease. Hyphenated or slant bar diagnostic codes are used only in the following circumstances:
- a. When the VASRD provides that a listed condition is to be rated by residual; e.g., myocardial infarction rated as arteriosclerotic heart disease (7005-7006) or nephrolithiasis rated as hydronephrosis (7508-7509).
 - b. When the VASRD provides a minimum rating and the disability is being rated on residuals; e.g., multiple sclerosis rated as incomplete paralysis of all radicular groups (8018-8513).
 - c. When an unlisted disease, injury, or residual condition is encountered, the diagnostic code number will be built-up. The first two digits will be selected from the schedule of the involved body part and the last two digits will be 99. For example, spondylolithesis would be rated analogous to sacroiliac injury and weakness (5299/5294).

Rating Principles. Disabilities are listed in VASRD diagnostic code number sequence. Instructions and explanatory notes are listed according to the diagnostic code number in the VASRD. Only those conditions which require special comment or those that have been the cause of misunderstanding in the past are included:

5000, Osteomyelitis, Acute, Subacute, or Chronic
5002, Rheumatoid Arthritis
5003, Arthritis, Degenerative (Hypertrophic or Osteoarthritis)
5010, Arthritis, Due to Direct Trauma
5054, Total Hip Replacement
5055, Total Knee Replacement
5126-5151, Multiple Finger Disabilities
5171, Amputation of Great Toe
5200-5295, Ratings Involving Joint Motion (including the spine)
5205-5208, Absence or Limitation of Motion of Elbow and Forearm
5209-5212, Other Impairments of Elbow, Radius, and Ulna
5213, Impairment of Pronation and Supination
5214, Wrist, Ankylosis of
5235, Vertebral Fracture or Dislocation
5237, Lumbrosacral or Cervical Strain
5238, Spinal Stenosis
5239, Spondylolisthesis or Segmental Instability
5240, Ankylosing Spondylitis
5241, Spinal Fusion
5242, Degenerative Arthritis of the Spine
5243, Intervertebral Disc Syndrome
5251-5253, Limitation of Extension and Flexion of the Thigh
5255-5262, Defects of Long Bones of the Lower Extremity
5270, Ankle Ankylosis
5272, Subastragalar or Tarsal Joint Ankylosis
5296, The Skull
5297, Removal of Ribs
5299/5255, Hip Arthroplasty and Prostheses
5299/52xx, Dupuytren's Contracture
5301-5326, Muscle Injuries
6000-6092, Diseases of the Eye
6000-6009, Conditions Involving Structures of the Globe
6013, Glaucoma, Simple, Primary, Noncongestive
6029, Aphakia
6080, Field Vision, Impairment of
6081, Scotoma, Pathological
6090-6092, Diplopia
6100-6110, Impairment of Auditory Acuity
6200-6260, Diseases of the Ear
6200, Otitis Media, Suppurative, Chronic
6207, Deformity of Auricle

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6300-6354, Systemic Conditions
6309, Rheumatic Fever
6350, Lupus Erythematosus, Systemic
6351, Acquired Immunodeficiency Syndrome (AIDS)
6354, Chronic Fatigue Syndrome
6519, Aphonia, Organic
6600-6603, Diseases of the Trachea and Bronchi, and Pulmonary Emphysema
6721-6724 and 6731, Inactive Pulmonary Tuberculosis
6800-6802, 6811, 6812, and 6818, Non-Tuberculous Diseases
6814, Pneumothorax
6815, Pneumonectomy
6816, Lobectomy
6899, Sarcoidosis
7000 Rheumatic Heart Disease
7005-7006, Arteriosclerotic Heart Disease, Myocardial Infarction
7007-7101, Hypertensive Heart Disease and Hypertensive Vascular Disease
7007, Hypertensive Heart Disease
7015-7017, 7110, Surgical Procedures Associated with AV Block, Heart Valve
7099/7005, Aortic Grafts
7100, Arteriosclerosis, General
7114-7117, Peripheral Vascular Disease
7307, Gastritis, Hypertrophic
7308, Postgastrectomy Syndrome
7328-7329, Intestinal Resections
7332-7336, Ano-Rectal Conditions
7338, Hernia, Inguinal
7345, Hepatitis, Infectious
7347, Pancreatitis
7500-7531, The Genitourinary System
7703, Leukemia
7709, Lymphogranulomatosis (Hodgkin's Disease)
7714, Hemoglobinopathies
7801, Scars, Burns, Third Degree
7802, Scars, Burns, Second Degree
7804, Scars, Superficial, Tender and Painful
7806, Eczema
7809, Lupus Erythematosus
7913, Diabetes Mellitus
8000-8046, Organic Diseases of the Central Nervous System
8017, 8018, 8023-8025, Progressive Muscular Atrophy and Myasthenia Gravis
8205-8412, Diseases of the Cranial Nerves
8510-8730, Diseases of the Peripheral Nerves
8599, Scalenus Anticus Syndrome
8910-8914, The Epilepsies
9201-9210, Psychotic Disorders

5000, Osteomyelitis, Acute, Subacute, or Chronic

Note (1) following diagnostic code 5000 in the VASRD may appear to be ambiguous in its instructions concerning applying the amputation rule. It means that in rating active osteomyelitis of any part, the amputation of which would be ratable at less than 30 % (ordinarily the minimum) rating for active osteomyelitis, a rating of 10 % may be assigned. This constitutes disregard of the amputation rule in those instances where the rating for amputation at that level is ratable at 0 %.

Example: A case of active osteomyelitis of the little finger distal to the proximal interphalangeal joint may be rated at 10 % even though amputation at that level is ratable at 0 %. However, a ratable disability exists only so long as the distal phalanx with its active osteomyelitis remains.

Osteomyelitis should not be considered cured simply because saucerization or sequestrectomy has been performed. Cures sometimes may be effected, however, by removal or radical resection of the bone.

Under note (2), a rating may be assigned only when the disease is active clinically, by x-ray, or other laboratory studies.

Osteomyelitis extending into a major peripheral joint will not be rated higher than the elective amputation level that would remove the involved joint.

5002, Rheumatoid Arthritis

A distinction is made between active disease and chronic residuals. Diagnostic codes 5002, 5004-5009, and 5017 are ratable on the same criteria using the guidance provided under diagnostic code 5002.

As an active process, ratings assigned under these diagnostic codes will be based primarily on clinical and laboratory evidence. X-ray changes are not required.

For chronic residuals, ratings will be based on limitation of motion in accordance with the diagnostic code 5200 series. X-ray evidence alone will not support a rating in any of these conditions.

The bilateral factor will apply as appropriate.

The ratings under diagnostic code 5200 series will not be combined with ratings for active process.

5003, Arthritis, Degenerative (Hypertrophic or Osteoarthritis)

This is one of the more frequently encountered conditions in the field of disability evaluation, and one of the more difficult to adjudicate. The difficulty stems from the fact that it occurs in some degree in all individuals beyond age 40, and from its wide variability in rate of progression and severity of manifestations. Symptomatology is frequently disproportionate to demonstrable pathology, and in this area the effect of such intangibles as motivation and other psychogenic components must be considered.

Ratings under this diagnostic code can be assigned in either of the following situations. In the absence of limitation of motion with only x-ray evidence of involvement of two or more major joints or two or more minor joint groups; or, when there is objective evidence of some limitations of motion combined with x-ray findings of arthritis of one or more major joints or minor joint groups.

When the limitation of motion of the involved specific joint or joints is of sufficient degree, the rating assigned will be under one of the appropriate limitation of motion diagnostic codes (the 5200 or 9900 series of codes).

When a rating is assigned under a limitation of motion diagnostic code (5200 series), it will not be combined with a rating under diagnostic code 5003 for other joint involvement on the basis of x-ray findings.

It should be emphasized that separate ratings of specific joints or joint groups are not intended for application to the fluctuating types of impairments which tend to improve or disappear.

5010, Arthritis, Due to Direct Trauma

When an affected joint merits a rating higher than 10 %, the analogy appropriate to the impairment must be used. Diagnosis alone is insufficient for a 10 % rating. With an affected joint, the assignment of a 10 % rating requires the presence of objective evidence of limitations of motion in addition to x-ray findings.

5054, Total Hip Replacement

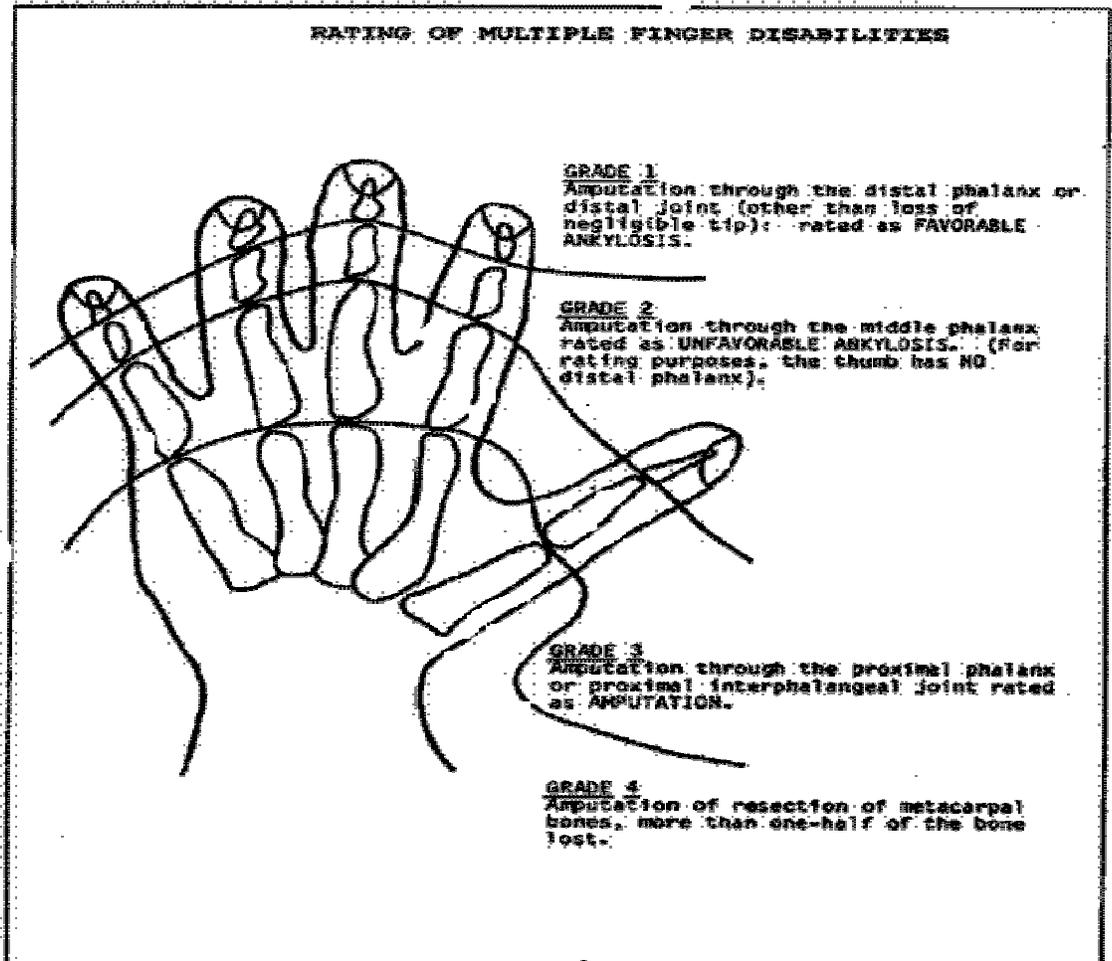
Amputation rule applies at middle or lower third of thigh. In uncomplicated cases, the member is usually ambulatory and disposition is possible approximately one month after the procedure has been performed. Place on TDRL, if appropriate, and rate for residuals after stabilization. Convalescent rating and ratings for a specified period of time do not apply.

5055, Total Knee Replacement

Convalescent ratings will not be used. The minimum rating of 30 % may be disregarded if full function is restored and the member may be found FFD. If, after maximum hospital benefit has been achieved, a member remains unfit, rate for residual impairment. TDRL, with an appropriate rating, is usually required prior to permanent disposition.

5126-5151, Multiple Finger Disabilities

The difficulty frequently encountered in rating multiple finger disabilities has been simplified by a convenient method of computation. By assigning graded values for each finger according to the level at which it was amputated, or for the severity of its ankylosis, it is possible to calculate an average amputation level for the fingers involved.



The disability may then be rated in accordance with the notes of instruction in the VASRD. The method is as follows:

Step One. Determine the grade value for each of the affected fingers from the chart below.

Finger Amputation Grade Level Chart

Defect of Individual Finger	Rated As	Grade Value
Amputation through distal phalanx or distal joint (other than negligible tip losses).	Favorable ankylosis.	Grade 1.
Amputation through middle phalanx.	Unfavorable ankylosis.	Grade 2.
Amputation through proximal phalanx or proximal I-P joint.	Amputation.	Grade 3.
Amputation of entire digit, with amputation or resection of more than one-half of the metacarpal.	Single finger amputation with metacarpal resection (codes 5152-5156).	Grade 4.

[Note: For rating purposes the thumb will be regarded as having no distal phalanx. Amputation of the thumb at the interphalangeal joint or distal thereto will be graded as unfavorable ankylosis (grade 2). The VASRD is ambiguous in this regard; no such distinction being made in the notes following diagnostic code 5151, yet diagnostic code 5152 shows 20 % for application at the distal joint or distal thereto, and diagnostic code 5224 also shows 20 % for application to unfavorable ankylosis of the thumb.]

Step Two. Find the average grade value by dividing the total of values for the individual fingers by the number of fingers involved. Round off fractions to the nearest whole number.

Step Three. From the second and third columns of the chart above, determine the appropriate category of the defects (favorable ankylosis, unfavorable ankylosis, amputation, etc.) for the average grade of the disabled hand. The proper diagnostic code number and rating can be determined within that category according to the number of fingers involved.

Example: An evaluatee has amputated a thumb through the distal phalanx, the index and little finger through the middle phalanges, and the entire ring finger, including more than one-half of the metacarpal.

Grade value for the thumb ----- 2
 Grade value for the index finger ----- 2
 Grade value for the little finger ----- 2

Grade value for the ring and metacarpal -----	$\frac{4}{10}$
Total value -----	10

Number of fingers involved = Ratable Value $4 = 2 \frac{1}{2} = 3$

Referring again to the previous chart, grade 3 is ratable as amputation. Amputation of four fingers – thumb, index, ring, and little – is ratable under diagnostic code 5130 at 70 % (for major hand) or 60 % (for minor hand). Unfavorable ankylosis of four fingers – thumb, index, ring, and little – is ratable under diagnostic code 5217 at 60 % (for major hand) or 50 % (for minor hand).

5171, Amputation of Great Toe. Must be through the proximal phalanx to warrant a 10 % rating.

5200-5295, Ratings Involving Joint Motion (including the spine).

General.

In the measurement and assessment of joint motion, it is incumbent upon the medical examiner to use the standardized description portrayed in plates I and II (pages 4.71-2 and 4.71-3) of the VASRD.

When the reported limited range of motion falls between two points specified in the VASRD, the higher percentage of disability will apply.

Ankylosis is the absence of motion of a joint. In application it is complete fixation, or a limitation of motion so severe in degree that the amount of movement is negligible.

The inclination (usually encountered when an analogous rating of an extremity is necessary) to use an analogy such as “other impairment of” elbow or knee (diagnostic code 5209 or 5257) is to be avoided when the actual impairment is a limitation of motion of the joint, which is properly ratable as limitation of flexion or extension of the part distal to the joint.

In some cases of limitation or of other abnormal joint motion, the basic cause is injury to muscle or tendon rather than to bone or joint; thus, 5300 series is applicable.

5205-5208, Absence or Limitation of Motion of Elbow and Forearm.

5205. Where a rating for unfavorable ankylosis is not based upon the additional finding of complete loss of supination or pronation, it may be combined with 5213 subject to the amputation rule. If there is less than complete loss of supination or pronation, 5205 may be combined with 5213, not to exceed the rating for unfavorable ankylosis under 5205.

5206-5208. These will combine with 5213, not to exceed the rate for unfavorable ankylosis under 5205.

5209-5212, Other Impairments of Elbow, Radius, and Ulna. These diagnostic codes are not to be combined with diagnostic code 5213.

5213, Impairment of Pronation and Supination.

Limitation of either pronation or supination may be rated, but never both in the same area. Full pronation is the position of the hand flat on a table. Full supination is the position of the hand palm up. In rating limitation of pronation, the arc is from full supination to full pronation. The middle of the arc is the position of the hand, palm vertical to the table.

There is an inconsistency in the VASRD for the major arm ratings: “hand fixed near the middle of the arc or moderate pronation” is rated 20 %; however, limitation of pronation with “motion lost beyond middle of arc” is rated 30 %. Cases in which this conflict arises shall be resolved in the member’s favor.

“Motion lost beyond last quarter of arc” means that the forearm can be pronated from 0° through 45°, but no further (see 4.71 of the VASRD).

5214, Wrist, Ankylosis of. Ankylosis of the wrist in 10° to 30° of dorsiflexion will be considered favorable and rated accordingly. Rate wrist replacement prosthesis according to functional impairment.

General Rating Formula for Diseases and Injuries of the Spine.

For diagnostic codes 5235 to 5243, unless 5243 is evaluated under the Formula for Rating Intervertebral Disc Syndrome Based on Incapacitating Episodes:

With or without symptoms such as pain (whether or not it radiates), stiffness, or aching in the area of the spine affected by residuals of injury or disease.

Unfavorable ankylosis of the entire spine_____100

Unfavorable ankylosis of the entire thoracolumbar spine_____50

Unfavorable ankylosis of the entire cervical spine, or forward flexion of the thoracolumbar spine 30 degrees or less, or favorable ankylosis of the entire thoracolumbar spine_____40

Forward flexion of the cervical spine 15 degrees or less; or favorable ankylosis of the entire cervical spine_____30

Forward flexion of the thoracolumbar spine greater than 30 degrees but not greater than 60 degrees; or forward flexion of the cervical spine greater than 15 degrees but not greater

than 30 degrees; or the combined range of motion of the thoracolumbar spine not greater than 120 degrees; or the combined range of motion of the cervical spine not greater than 170 degrees; or muscle spasm or guarding severe enough to result in an abnormal gait or abnormal spinal contour such as scoliosis, reversed lordosis, or abnormal kyphosis_____20

Forward flexion of the thoracolumbar spine greater than 60 degrees but not greater than 85 degrees; or forward flexion of the cervical spine greater than 30 degrees but not greater than 40 degrees; or combined range of motion of the thoracolumbar spine greater than 120 degrees but not greater than 235 degrees; or combined range of motion of the cervical spine greater than 170 degrees but not greater than 335 degrees; or muscle spasm, guarding, or localized tenderness not resulting in abnormal gait or abnormal spinal contour; or vertebral body fracture with loss of 50 % or more of the height _____10

Note (1): Evaluate any associated objective neurologic abnormalities including, but not limited to, bowel or bladder impairment separately under an appropriate diagnostic code.

Note (2): (See also Plate V.) For VA compensation purposes, normal forward flexion of the cervical spine is zero to 45 degrees, extension is zero to 45 degrees, left and right lateral flexion are zero to 45 degrees, and left and right lateral rotation are zero to 80 degrees. Normal 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. The normal combined range of motion of the cervical spine is 340 degrees and of the thoracolumbar spine is 240 degrees. The normal ranges of motion for each component of spinal motion provided in this note are the maximum that can be used for calculation of the combined range of motion.

Note (3): In exceptional cases, an examiner may state that, because of age, body habitus, neurologic disease, or other factors not the result of disease or injury of the spine, the range of motion of the spine in a particular individual should be considered normal for that individual, even though it does not conform to the normal range of motion stated in note (2). Provided that the examiner supplies an explanation, the examiner's assessment that the range of motion is normal for that individual will be accepted.

Note (4): Round each range of motion measurement to the nearest five degrees.

Note (5): For VA compensation purposes, unfavorable ankylosis is a condition in which the entire cervical spine, the entire thoracolumbar spine, or the entire spine is fixed in flexion or extension, and the ankylosis results in one or more of the following: difficulty

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walking because of a limited line of vision, restricted opening of the mouth and chewing, breathing limited to diaphragmatic respiration, gastrointestinal symptoms due to pressure of the costal margin on the abdomen, dyspnea or dysphagia, atlantoaxial or cervical subluxation or dislocation, or neurologic symptoms due to nerve root stretching. Fixation of a spinal segment in neutral position (zero degrees) always represents favorable ankylosis.

Note (6): Separately evaluate disability of the thoracolumbar and cervical spine segments, except when there is unfavorable ankylosis of both segments, which will be rated as a single disability.

5235, Vertebral Fracture or Dislocation.

5236, Sacroiliac Injury and Weakness.

5237, Lumbosacral or Cervical Strain.

5238, Spinal Stenosis.

5239, Spondylolisthesis or Segmental Instability.

5240, Ankylosing Spondylitis.

5241, Spinal Fusion.

5242, Degenerative Arthritis of the Spine. (see also diagnostic code 5003)

5243, Intervertebral Disc Syndrome.

Evaluate intervertebral disc syndrome (preoperatively or postoperatively) either under the General Rating Formula for Diseases and Injuries of the Spine or under the Formula for Rating Intervertebral Disc Syndrome Based on Incapacitating Episodes, whichever method results in the higher evaluation when all disabilities are combined.

Formula for Rating Intervertebral Disc Syndrome Based on Incapacitating Episodes:

With incapacitating episodes having a total duration of
at least 6 weeks during the past 12 months _____ 60

With incapacitating episodes having a total duration of
at least 4 weeks, but less than 6 weeks during the past 12 months _____ 40

With incapacitating episodes having a total duration of
at least 2 weeks, but less than 4 weeks during the past 12 months _____ 20

With incapacitating episodes having a total duration of at least one week, but less than 2 weeks during the past 12 months _____ 10

Note (1): For purposes of evaluations under diagnostic code 5243, an incapacitating episode is a period of acute signs and symptoms due to intervertebral disc syndrome that requires bed rest prescribed by a physician and treatment by a physician.

Note (2): If intervertebral disc syndrome is present in more than one spinal segment, provided that the effects in each spinal segment are clearly distinct, evaluate each segment on the basis of incapacitating episodes or under the General Rating Formula for Diseases and Injuries of the Spine, whichever method results in a higher evaluation for that segment.

Range of Motion of Cervical and Thoracolumbar Spine.

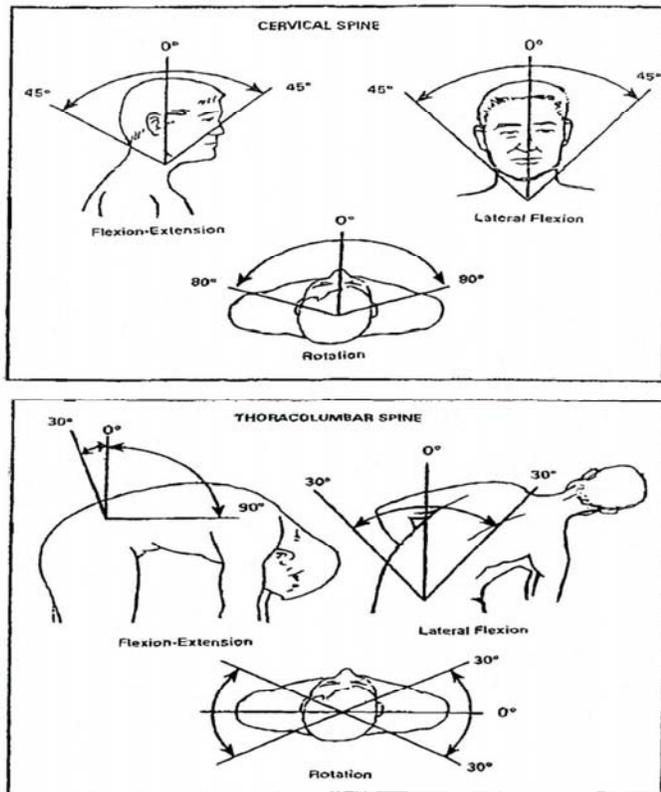


PLATE V
RANGE OF MOTION OF CERVICAL AND THORACOLUMBAR SPINE

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BILLING CODE 5320-01-C

5251-5253, Limitation of Extension and Flexion of the Thigh. Ratings allowable under these diagnostic codes may not realistically reflect the degree of disability because of basic or related disability of the sacroiliac region, pelvis, acetabulum, or head of femur. More appropriate ratings may be selected from diagnostic code 5250 (hip, ankylosis of), diagnostic code 5255 (femur, impairment of), or diagnostic code 5294 (sacroiliac injury and weakness). (See 4.67 of the VASRD for comments on pelvic skeletal fractures.)

5255-5262, Defects of Long Bones of the Lower Extremity. Apply these diagnostic codes (malunion, with adjacent joint disability) when appropriate to avoid multiple diagnostic codes and ratings. However, when both a proximal and distal major joint are affected, an additional rating may be indicated for the less disabled joint. These diagnostic codes are often appropriate when joint surfaces are included in the fracture lines.

5270, Ankle Ankylosis. Ankle prosthesis may be rated under this diagnostic code. The maximum disability is 40 % in keeping with the amputation rule. Place on TDRL if appropriate and rate on residual disability after stabilization.

5272, Subastragalar or Tarsal Joint Ankylosis. The assignment of a rating under this diagnostic code is only proper in the absence of motion of the subtalar joint, which is manifested by the lack of inversion or eversion of the foot.

5296, The Skull.

Diagnostic burr holes and other bony defects are ratable only when there is loss of both inner and outer tables of bone. Where there are more than one, the areas of each should be added, and the total rated. The following chart may be helpful as a reference in determining appropriate ratings.

Conversion Chart

Diameter of Circle*	Square Centimeter	Square Inch
1 centimeter	0.7854	0.1216
2 centimeters	3.1416	0.4869
3 centimeters	7.0686	1.0956
4 centimeters	12.5664	1.9478
½ inch		0.19635
1 inch		0.7854
1 ½ inches		1.76715
2 inches		3.1416

* Size of the average diagnostic burr hole

1 centimeter = 0.3937 inches
1 inch = 2.54 centimeters

1 square centimeter = 0.1550 square inch
2 square centimeters = 0.3100 square inch
3 square centimeters = 0.4650 square inch

Considering total bone loss for multiple areas such as in trephining, the rating should not be assigned based upon coin measurement, but on the basis of the aggregate area loss in terms of square inches. Attention is directed to the fact that approximately 50 % of diagnostic burr holes heal within 5 years.

Loss of part of the skull is ratable whether or not the defect has been repaired with a prosthetic plate. Residual neurological deficit or cosmetic deformity will be rated separately if appropriate. Burr holes, to be ratable, must be contiguous.

Areas of loss where bone regeneration has taken place are not ratable. If regeneration has partially closed the defect, only the remaining area of loss is to be rated.

The rating problem created by the disparity in the criteria for area measurement (50-cent piece = 1.140 square inches; 25-cent piece = 0.716 square inch) shall be resolved in favor of the member.

5297, Removal of Ribs.

The VASRD, for removal of ribs, requires the complete removal from the vertebral angle to the costo-cartilaginous junction. Removals to a lesser degree are rated as rib resections.

The presence of certain conditions precludes the assignment of an additional rating under diagnostic code 5297; however, exceptions are allowed in specific situations. Notes (1) and (2) under this diagnostic code in the VASRD provide pertinent guidance.

5299/5255, Hip Arthroplasty and Prostheses. The disability resulting from defects requiring hip prostheses shall be rated under diagnostic code 5054.

5299/52xx, Dupuytren's Contracture. Rate on the basis of limitation of motion of finger(s).

5301-5326, Muscle Injuries. When a joint is ankylosed, the muscles acting on that joint shall not be additionally rated.

6000-6092, Diseases of the Eye.

General.

Rating of eye diseases should be based on central visual acuity, field of vision, and muscle function.

The combined rating for disabilities of the same eye is not to exceed the amount for total loss of vision of that eye unless there is an enucleation or a serious cosmetic defect. When there is a cosmetic defect, even though limited to the eye with the visual loss,

representing a separate and distinct entity, namely, facial disfigurement, a separate rating is permitted under diagnostic code 7800, to be combined with the rating for the visual loss or rating for enucleation.

The Goldman Perimetry Test must be used to determine visual, field, and diplopia. Do not follow instructions given in 4.76 of the VASRD.

6000-6009, Conditions Involving Structures of the Globe. Disabilities resulting from these conditions shall be rated as follows:

Step One.

- (a) Rate impairment of visual acuity and field of vision.
- (b) Rate active pathology, if present, at 10 %.
- (c) Combine the ratings in (a) above, whichever is higher, with (b).

Step Two. Rate pain, rest requirements and/or episodic incapacity from 10-100 %. This rating, when only one eye is involved, is not necessarily limited to the 30 % rating for total loss of vision of one eye, since pain or rest requirements may be incapacitating in any degree including total. Assign this rating under whichever one of the diagnostic codes covers the basic condition, i.e., diagnostic code 6000 through 6009. Analogy to another diagnostic code number is not required. It is an estimate based as nearly as possible upon the actual impairment of social and industrial function that is imposed by the pain experienced, the time lost because of the requirement for rest, the frequency of incapacitating episodes, or any combination thereof. Do not combine an additional rating of 10 % during continuance of active pathology with this rating.

Step Three. Award the higher of the two ratings resulting from steps one and two above.

Step Four. Retained Foreign Body. Rate as active pathology under step one if in critical area or not stabilized, or rate for residuals under step two.

6013, Glaucoma, Simple, Primary, Noncongestive. The minimum rating is applicable if the diagnosis is satisfactorily established, whether or not visual acuity or field of vision has been affected. The rating is for the disease rather than for functional impairment of an individual organ and applies whether the disease process involves one or both eyes.

6029, Aphakia. The expression "one step less" used in the note under this diagnostic code in the VASRD refers to less vision, not to percentage evaluation.

6080, Field vision, Impairment of. The results of the Goldman Perimetry Test are utilized in determining the rating for concentric contraction of field of vision. If the resulting field of vision is proportionally decreased and is basically the same shape as the normal field of vision, the temporal degree reading is utilized in entering this diagnostic

code for the appropriate rating. If the resulting field of vision is skewed to a large extent, the individual's impairment is normally rated more accurately under another diagnostic code that describes the underlying problem or visual acuity. If no diagnostic code accurately describes the cause of the skewing, an analogous rating to a diagnostic code that best describes the impairment in terms of total person will be utilized.

6081, Scotoma, Pathological. The rating is 10 % for the unilateral condition. It may be combined with other ratings, with the reservation that the rating for one eye may not exceed 30 % unless there is an enucleation or a serious cosmetic defect. Central scotoma cannot, however, be combined with central visual loss.

6090-6092, Diplopia. To determine rating, substitute the 6090 reading for the visual acuity of the poorer eye and read percentage in the 6070- 6079 series. If vision is the same in both eyes, pick one as an arbitrary choice. For example, if an individual has 20/50 vision bilaterally with central diplopia, rate as 5/200 one eye and 20/50 other eye under 6073 at 40 %.

6100-6110, Impairment of Auditory Acuity.

The evaluations for deafness derived from the VASRD are intended to make proper allowance for improvement by hearing aid. Examination to determine this improvement is therefore unnecessary.

Evaluation of this impairment will be through the use of either Table VI (Numeric Designation of Hearing Impairment) or, when necessary, Table VIa (Average Puretone Decible Loss) and Table VII (Percentage Evaluations for Hearing Impairment) of the VASRD. Puretone averaging for purposes of the VASRD will be accomplished by adding the decibel losses at frequencies of 1000, 2000, 3000, and 4000 Hz, then dividing the answer by 4.

Most audiometric examinations now being performed use as reference-zero level that one recommended by The American Standards Institute (ANSI), which is essentially identical, for rating purposes, to the International Standards Organization (ISO) levels. The American Standards Association (ASA) reference standards are numerically less than, and may be converted to, the ISO and ANSI levels, by adding the difference in decibels at each frequency in the normal range of hearing, as follows:

At Frequency (CPS) -----	500	1000	2000
Convert ASA to ISO by adding -----	15	10	10

Uniformity in analyzing data obtained in audiometric examination for adjudication and review is essential. Reference standards must be clearly indicated as ANSI, ISO, or ASA. No individual shall be considered for rating unless member has been evaluated by an audiologist.

6200-6260, Diseases of the Ear.

6200, Otitis Media, Suppurative, Chronic. The 10 % rating during the continuance of the suppurative process is intended as compensation for the existence of active pathology rather than for additional impairment of the individual sense organ. This rating is therefore limited to 10 % whether the pathological process is unilateral or bilateral.

6207, Deformity of Auricle. If associated with disfiguring scars of face or head, diagnostic code 7800 may be appropriate. The rule against pyramiding shall be applied.

6300-6354, Systemic Conditions.

6309, Rheumatic Fever. Residual impairments will be rated under the appropriate diagnostic code. When a member is determined to be unfit due to recurrence of disease, and there is no residual functional impairment, consider using the 0 % rating.

6350, Lupus Erythematosus, Systemic. Collagen diseases will be rated under this diagnostic code. Sarcoidosis is a variable disease that in analogous to lupus, and this analogy allows residuals or the active disease to be rated, whichever is higher.

6351, Acquired Immunodeficiency Syndrome (AIDS). Policy under determination.

6354, Chronic Fatigue Syndrome. Rate fibromyalgia, myofascial pain syndrome, and myofasciitis analogous to this diagnostic code.

6519, Aphonia, Organic. Impairment of ability to speak may be ratable under more than one diagnostic code, depending upon the cause and severity of the impairment. In such instances, the highest applicable rating will be awarded. This instruction does not apply to speech impairment due to loss of whole or part of the tongue, which is to be rated under diagnostic code 7202.

6600-6603, Diseases of the Trachea and Bronchi, and Pulmonary Emphysema.

Appropriate ventilatory function studies must be included in clinical records to support the diagnosis and degree of severity in these pulmonary diseases.

6721-6724 and 6731, Inactive Pulmonary Tuberculosis. After tuberculosis (pulmonary or non-pulmonary) has been inactive for at least six months as defined below, the history thereof does not present a manifest or latent impairment of function and is, therefore, not considered to be a physical disability.

Pulmonary tuberculosis is considered to be inactive:

- (1) When the following criteria are met (these conditions shall have existed no less than six months):

No symptoms of tuberculosis origin.

Serial roentgenograms must be stable or show very slow shrinkage of the tuberculous lesion.

No evidence of cavity.

Sputum or gastric washings negative on culture or guinea pig inoculation.

- (2) On a date of inactivity established by evaluation. This is usually, but not always, at the time the patient is declared to have received the maximum benefits of hospitalization.
- (3) Six months after surgical excision of an active lesion, during which time there shall have been no evidence of tuberculous activity in any body system, or upon discharge from the medical treatment facility, whichever is later.

Treatment by medication is frequently continued beyond the date when the disease becomes inactive according to the c. above criteria. The ending date of such treatment schedule should not be confused with that of the beginning of the inactive status.

Residuals of Inactive Non-Pulmonary Tuberculosis. Graduated ratings for inactive non-pulmonary tuberculosis shall not be applied. After the condition has become inactive, residuals (e.g., ankylosis, surgical removal of a part, etc.) are rated under the appropriate diagnostic code for the specific residual, preceded by the diagnostic code for the tuberculosis of the body part affected; e.g., tuberculosis of the hip joint with residual ankylosis, coded as 5001-5250.

6800-6802, 6811, 6812, 6818, Non-Tuberculous Diseases. Appropriate pulmonary function studies must be included in clinical records to support the diagnosis and degree of severity of any of these pulmonary diseases.

6814, Pneumothorax. Do not apply 100 % for six months rating. Rate the underlying condition, if known, or consider rating by analogy to emphysema (diagnostic code 6603) or pneumoconiosis (diagnostic code 6802).

6815, Pneumonectomy. The 60 % rating is applied for pneumonectomy, regardless of the number of ribs removed at the time of the operation. If at a later date thoracoplasty becomes necessary for obliteration of space within the thorax, the rating for pneumonectomy will be combined with a rating for removal of ribs. Note (2) which follows diagnostic code 5297 in the VASRD provides guidance in a case of this type.

6816, Lobectomy. An entire lobe, other than the right middle lobe, must be removed for the defect to be ratable. Excision of the right middle lobe, segmental resection, or lingulectomies are not ratable.

6899, Sarcoidosis. This disease is difficult to rate because of its unpredictable course and the number of body systems that may be involved. It is usually rated by analogy to coccidiomycosis (diagnostic code 6821) or pneumoconiosis (diagnostic code 6802) when the predominant manifestation is in the lungs. With other organ or more generalized involvement and manifestations such as lymphadenopathy, transient joint pains, and occasional febrile episodes, assignment of diagnostic code 6399 and rating under diagnostic code 6316 may be appropriate.

7000 Series, Cardiovascular Disease.

General. To avoid pyramiding, only one rating should be given for all manifestations of cardiovascular-renal disease when, according to accepted medical principles, the conditions are etiologically related. For example, hypertension, arteriosclerosis, and nephritis involving vascular abnormalities are so closely associated that they may be regarded as one clinical entity. The disability should be rated under the diagnostic code representing the predominant signs and symptoms. Occasionally, the related manifestations in another body system will be so severe as to increase the individual's overall impairment to the point that the next higher percentage under the selected diagnostic code will be justified. The note in the VASRD under diagnostic code 7505 is pertinent in this respect.

Valvular Heart Disease. Valvular heart disease not of arteriosclerotic or hypertensive origin should be rated as rheumatic heart disease, diagnostic code 7000.

7000, Rheumatic Heart Disease.

Assumption of the existence prior to service of a ratable degree of rheumatic heart disease is sometimes justified, even though its presence was not previously recorded. Such an assumption, of course, would depend upon its compatibility with the interpretation of medical history and findings in the light of accepted medical principles. A stenotic valvular lesion discovered early in military service is an example of such a condition.

A definitely enlarged heart is one in which there is positive evidence of enlargement beyond the doubtful or borderline enlargement that is sometimes reported when the presence of enlargement is uncertain. Voltage criteria (abnormalities) alone are not acceptable as electrocardiographic evidence of definite enlargement.

The 100 % rating for active rheumatic heart disease for six months is not applicable.

Following valvulotomy or other corrective cardiovascular procedure, rate as discussed in 7005-7006.

7005-7006, Arteriosclerotic Heart Disease, Myocardial Infarction.

A rating for arteriosclerotic heart disease is not to be combined with one for hypertensive heart or hypertensive vascular disease (diagnostic codes 7007 or 7101).

A rating of 100 % under this diagnostic code solely on the basis of the acute attack occurring within a six month period will not be applied.

In assigning percentages under these diagnostic codes, the following criteria applies:

- (1) The 100 % rating: Following a myocardial infarction in which complications are so severe (e.g., intractable angina or intractable congestive heart failure) as to generally confine the individual at home or comparable environment, or following a myocardial infarction complicated by persistent or frequent episodes of congestive heart failure or other significant complication requiring continued active therapy, such as use of digitalis, diuretics, and/or similar supportive measures. More than strictly sedentary employment precluded.
- (2) The 60 % rating: Following a myocardial infarction with substantiated repeated attacks of angina pectoris at rest or with normal activity, or substantiated repeated attacks of angina pectoris without antecedent myocardial infarction. More than light manual labor is precluded. The term substantiated as used here means the existence of a clinical and/or medical history, or other documentation, which tends to support the diagnosis.
- (3) The 30 % rating: Following a myocardial infarction manifested by a definite clinical history and expected laboratory evidence and/or characteristic electrocardiographic changes, or electrocardiographic evidence which is diagnostic of a previous myocardial infarction without continuing symptoms indicative of complications of arteriosclerotic heart disease. Also, angina pectoris where ordinary activity does not cause frequent pain, but where strenuous activity is precluded.

When an infarction or other acute conditions evaluated under these diagnostic codes has occurred within approximately six months preceding evaluation, or when the member's condition does not appear to have stabilized sufficiently to permit evaluation, place on the TDRL and remove as soon as clinically stabilized.

Injuries, surgical procedures, pacemakers:

- (a) Wounds, retained fragments, or surgical procedures that disrupt the integrity of the myocardium or the conduction system are rated for residual impairments raised to the next higher level.
- (b) Ratings for heart injuries may be assigned in conjunction with disabilities rated as residuals of pleural injuries under diagnostic code 6818. Since these ratings are

for separate injuries, ratings under both diagnostic codes will not be considered pyramiding.

- (c) Coronary bypass procedures, valve reconstruction or prosthesis, pacemakers, and other significant procedures must be individually evaluated as the case merits. Members found unfit for continued duty will be placed on the TDRL with a minimum rating of 60 % if within six months of surgery. Upon removal from the TDRL, if still considered unfit because of physical disability, rate for residuals based upon underlying pathology raised to the next higher level with the exception of coronary bypass procedures, which ordinarily will be rated on residuals alone. The 30 % rating based solely on the performance of surgery will not apply to an evaluatee previously found fit for duty, unless the evaluatee is subsequently found unfit for continued duty by reason of some other impairment.

Definition of Terms as used in VASRD:

- (a) "Ordinary manual labor" includes work not involving sustained heavy energy expenditure and includes most skilled laborers, mechanics, and drivers.
- (b) "Strictly sedentary employment" involves low energy expenditures and minimal body movement.

7007-7101, Hypertensive Heart Disease and Hypertensive Vascular Disease. Blood pressure readings to be used in determining disability rating percentages should be obtained under normal circumstances and during usual activities. When antihypertensive medication is required for control, the rating is based on the pressures obtained during usual activities while under medication. It should be emphasized that hypertension brought under control through optimum conditions, that is, during hospitalization under a regimen of medication and enforced rest, will not be used as a basis for evaluation unless it is established that such control continues upon resumption of normal activity. Similarly, readings obtained during periods when indicated medication is withheld for purposes of medical observation, diagnostic study, etc. are not to be used as the basis for evaluation. A minimum of ten readings taken on at least five days, on treatment and under conditions as close as possible to normal duty performance, will be necessary. Blood pressure levels should also be correlated with other evidence of end organ change, such as eyeground, neurologic, etc. It should be appreciated that the member, while in a hospital status, may be engaged in activities which, for adjudicative purposes, are considered as unrestricted and comparable to outside of the hospital environment. For example, the member is ambulatory to the mess hall, receives weekend passes, and engages in ward housekeeping duties. The level of hypertension is not to be determined by an average of all readings, but rather, the predominant readings will be the basis for determining the level of hypertension.

7007, Hypertensive Heart Disease.

Diagnostic code 7007 is not to be combined with diagnostic codes 7005 or 7101. When a combination of 7007 or 7101 exists with 7005, rate the individual under the diagnostic code that most accurately reflects the disability. The presence of stigmata of hypertensive disease does not warrant rating at a higher level unless there is clinically significant secondary organ involvement, such as renal impairment. When significant changes are present, consider raising the rating one step.

Careful evaluation is necessary in making the frequently tenuous distinction between hypertensive heart disease and hypertensive vascular disease, especially for the minor degrees of severity. Generally, to justify the 30 % rating for hypertensive heart disease, all of the criteria mentioned in the VASRD for that rating shall be met. "Definite enlargement of the heart" means certain left ventricular hypertrophy by ECG criteria, other than voltage alone, with allowance for T-wave changes that may reflect medication more than pressure. The x-ray appearance of the heart is deceptive in concentric hypertrophy, but must be at least consistent with that diagnosis. Echo cardiography evidence should usually be included as proof of enlargement.

7015-7017, 7110, Surgical Procedures Associated with AV Block, Heart Valve Replacement, Aneurysms. Convalescent ratings and ratings for specified periods of time following surgery will not be applied. Rate on the basis of functional impairment. However, maximum ratings do apply. Although relatively few symptoms may exist following the insertion of a graft in treatment of this condition, the residual of such graft insertion usually warrants a 20 % rating under diagnostic code 7110.

7099/7005, Aortic Grafts. The possible grave prognosis for a member who has an aortic graft should be kept in mind when evaluating this condition. Although relatively few symptoms may exist following the graft, this procedure usually warrants a 30 % rating under diagnostic codes 7099/7005 on the basis of latent impairment. If symptomatology still exists following the grafting procedure, it should be rated according to the VASRD for the underlying condition.

7100, Arteriosclerosis, General. The 20 % rating under this diagnostic code is rarely appropriate. Manifestations of the disease should be rated for impairment of the body system involved to the greatest condition.

7114-7117, Peripheral Vascular Disease.

The symptoms and signs of each of these conditions are to be considered as manifestations of a systemic disease entity wherein bilateral involvement of extremities is natural and expected. They are distinct from local mechanisms affecting peripheral circulation, for example, varicose veins or phlebitis, in which bilateral involvement is more nearly equivalent to coincidental duplication of the disease rather than its direct extension.

When manifestations are limited to the extremities, the percentage of disability is to be based upon the most severely affected extremity. The rating of that extremity is to be used as the total percentage, unless each of the two or more extremities separately meets the requirements for evaluation in excess of 20 %. In the latter case, 10 % only will be added to (not combined with) the evaluation for the more severely affected extremity, except where the disease has resulted in amputation. When both upper and lower extremities are involved, the above procedure will be applied to the upper extremities, then to the lower extremities. These ratings will be combined if each group has a total rating in excess of 20 %.

The bilateral factor should be applied in all cases of an amputation of one extremity with any compensable degree of disability of the other extremity.

A peripheral vascular disease rating of 20 % or less will not be combined with any other peripheral vascular disease rating.

Use the following chart in rating peripheral vascular disease for diagnostic codes 7114 – 7117.

Peripheral Vascular Disease Rating Chart

One Extremity Involved	Combined Rating
20	20
40	40
60	60

Two Extremities, Not Paired (one arm and one leg)	Combined Rating
20 and 20	20
40 and 20	40
40 and 40	60
60 and 20	60
60 and 40	80
60 and 60	80

Peripheral Vascular Disease Rating Chart (cont.)

Two Paired Extremities (two arms or two legs)	Combined Rating
20 and 20	20
40 and 20	40
40 and 40 (40 + 10)	50
60 and 20	60
60 and 40 (60 + 10)	70
60 and 60 (60 + 10)	70

Three Extremities Involved, Paired Extremities	Other	Combined Rating
20 and 20	20	20
20 and 20	40	40
20 and 20	60	60
40 and 20	20	40
40 and 20	40	60
40 and 20	60	80
40 and 40	20	50
40 and 40	40	70
40 and 40	60	80
60 and 40	20	70
60 and 40	40	80
60 and 40	60	90
60 and 60	20	70
60 and 60	40	80
60 and 60	60	90

All Extremities Involved, Paired Extremities	Paired Extremities	Combined Rating
20 and 20	20 and 20	20
40 and 20	20 and 20	40
60 and 20	20 and 20	60
40 and 40	20 and 20	50
40 and 20	40 and 20	60
40 and 40	40 and 20	70
40 and 40	40 and 40	80
60 and 40	40 and 40	90
60 and 40	60 and 40	90
60 and 60	40 and 40	90
60 and 60	60 and 40	90
60 and 60	60 and 60	90

7307, Gastritis, Hypertrophic. Identification by gastroscopic examination is required to establish diagnosis.

7308, Postgastrectomy Syndrome. In evaluating and rating, take care to differentiate between nondisabling symptoms or minor discomfort which sometimes result from overindulgence, such as that experienced from overeating by a person without a gastrectomy, and discomfort symptomatic of a true postgastrectomy syndrome. Circulatory symptoms, even though mild or intermittent, or comparable symptoms such as a need for rest regularly after meals are indicative of disability which may be a basis for rating.

7328-7329, Intestinal Resections. Where portions of both intestines have been removed, rating should be made under the diagnostic code which is most representative of the clinical manifestations.

7332-7336, Ano-Rectal Conditions. Pilonidal cyst or sinus is primarily a disorder of ectoderm and should be rated as a skin condition, except when an active process is present it should be rated by analogy to diagnostic code 5000.

7338, Hernia, Inguinal. If correctable, hernia is not ratable even though operation is refused, unless complicated by circumstances contraindicating surgery, such as poor muscular or fascial structure, senility, psychosis, or serious disease that would interfere with healing or be aggravated by surgery, and the presence of other disabilities so serious or advanced that herniography would serve no useful purpose.

7345, Hepatitis, Infectious.

Acute infectious hepatitis may be associated with "A", "B", or variant antigens and will usually resolve without residual impairment at the time liver function tests return to normal.

Chronic persistent hepatitis is a condition exhibiting minimally disturbed histology and liver function tests. It causes no, or minimal, persistent disability or progression and rating for residuals is seldom justified. However, placement on the TDRL may be appropriate when the clinical and laboratory course, particularly in the presence of persistent antigenemia, indicate a need for continued observation to rule out chronic active hepatitis. This problem is not always resolved by liver biopsy and both time and supporting evidence may be needed.

Chronic active hepatitis is a serious, frequently progressive condition that may or may not be readily associated with a demonstrable antigen. Since the outcome is difficult to predict, placement on the TDRL may be appropriate prior to permanent disposition.

Rate other forms of inflammatory or infectious liver disease by analogy to infectious hepatitis or to other specific diagnostic codes, if applicable.

7347, Pancreatitis. Rate diabetes mellitus, if present, separately.

7500-7531, The Genitourinary System. Sterility and impotence are not ratable entities.

7703, Leukemia. If the use of chemotherapeutic agents is required, rate as leukemia requiring irradiation or transfusion.

7709, Lymphogranulomatosis (Hodgkin’s Disease).

Cases in remission with minimal residuals may not be unfitting. Staging is the basis for clinical management of Hodgkin’s Disease under treatment. Rating and disposition may be carried out according to the following guide.

Hodgkin’s Disease Rating and Disposition Chart

Stage	Stage A Rating	Stage B Rating	Disposition (if unfit)
I	30	60	TDRL
II	30	60	TDRL
III	60	--	TDRL
III	--	100	TDRL
IV	100	100	TDRL

Upon removal from the TDRL, if found unfit, the condition will be rated for residuals only. Splenectomy, if performed in the course of diagnosis, staging, or treatment, will not be rated separately, since it is generally performed incident to the direct management of the condition and a separate rating constitutes pyramiding. However, if the residuals are rated less than 30 %, then the policy of the higher of the two evaluations applies, and the 30 % splenectomy rating would be assigned.

7714, Hemoglobinopathies. The VASRD rates all the manifestations of sickle cell disease and its variants. Individuals with the more severe hemoglobinopathies are not acceptable for entry into the military services and appropriate policies concerning line of duty and service aggravation apply.

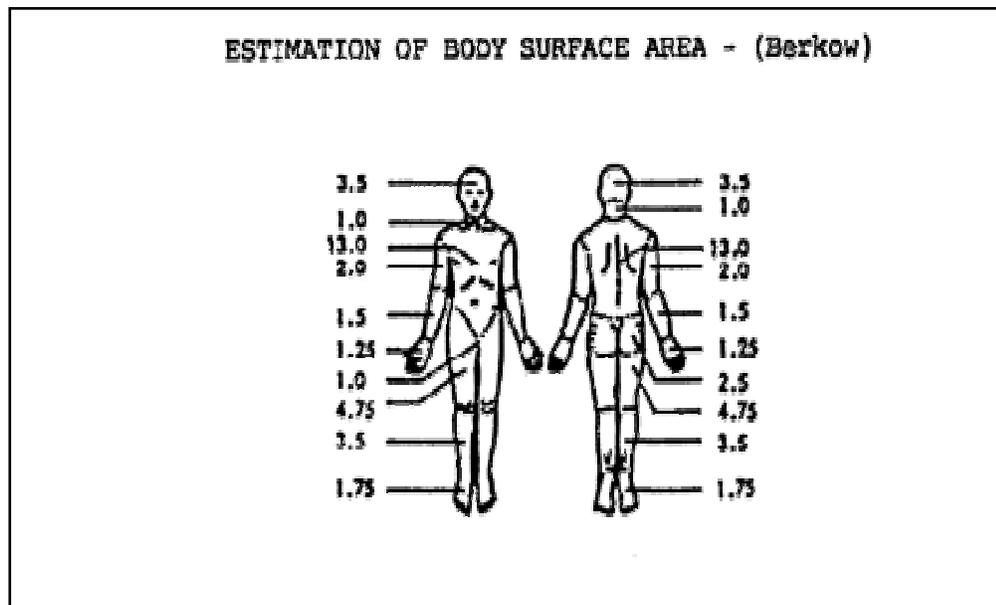
7801, Scars, Burns, Third Degree. The following instruction will supplement the criteria under diagnostic code 7801 in the VASRD to permit a realistic rating of actual impairment of function:

- (a) Third degree burn scars that cause limitation of function of underlying structures should be rated by analogy to other diagnostic codes which reflect the functional impairment.
- (b) Rate unsuccessfully healed or grafted areas according to diagnostic code 7801. Footnotes in the VASRD apply.
- (c) Rate successfully grafted third degree burn areas as second degree burns under diagnostic code 7802. The footnote in the VASRD applies.
- (d) The following may help in calculating burn area:

Average 70 kg. (150 lb.) male body surface = 1.7 sq. meters
 2636 sq. in. = 18.3 sq. ft.
 1 meter = 39.37 inches 1 sq. meter = 1550.6 sq. in.

7802, Scars, Burns, Second Degree. Diagnostic code 7802 limits rating to 10 % for second degree burns affecting an area or areas approximately 1 square foot. When there are widely separated areas and each is approximately 1 square foot or more, 10 % may be assigned for each scar.

7804, Scars, Superficial, Tender and Painful. This rating of 10 % may be assigned whenever the requirements are met for the area of involvement, even though the rating may exceed the amputation rating, but only if the amputation rating is 0 %. Do not combine a rating assigned for a scar under these circumstances, with any other rating for disability which involves the same area or digit. The figure below provides the basic scheme for estimating percentage of body



surface area. The following table is provided for convenient conversion from percentage of body surface area to actual surface area measurement in square inches and square feet. It is based upon application to the average 70 kg. man (approximately 154 lbs.) with a body surface area of 2,636 sq. in. (18.3 sq. ft.).

Body Surface Area Chart

Body Surface	Body Surface Percentage	Square Inches	Square Feet
Anterior or posterior head	3.5	92	0.64
Anterior or posterior neck	1.0	26	0.18
Anterior or posterior trunk	13.0	343	2.38
Anterior or posterior arm	2.0	53	0.37
Anterior or posterior forearm	1.5	40	0.27
Dorsal or palmar hand and fingers	1.25	33	0.23
Buttock	2.5	66	0.46
Genitalia	1.0	26	0.18
Anterior or posterior thigh	4.75	125	0.87
Anterior or posterior calf	3.5	92	0.64
Dorsal foot or sole, including toes	1.75	46	0.32

7806, Eczema. Eczema is a disease of the skin, which is a body system in and of itself. As such, the bilateral factor does not apply even if the eczema affects opposite limbs.

7809, Lupus Erythematosus. This applies to the localized (discoid) type involving only the skin. Systemic lupus erythematosus and collagen diseases should be rated under diagnostic code 6350.

7913, Diabetes Mellitus.

The severity of each case is to be individualized, taking into consideration complications, age of the member, and ease or difficulty in the control of blood sugar levels. However, under normal circumstances, members whose diabetes mellitus requires insulin for control will be found unfit for continued duty and not retained.

Rating should be determined primarily on complications, frequent hospitalization, ease or difficulty of control of blood need for sugar, and not on insulin dosage.

According to accepted medical principles, a large daily (24-hour) insulin dosage must be greater than 1.2 units per kilogram body weight.

An evaluatee whose diabetes is controlled by diet and/or oral medications and who is without impairment of health, vigor, and limitation of activity may be found fit for duty.

8000-8046, Organic Diseases of the Central Nervous System.

General. Careful correlation of the note under diagnostic code 8046 in the VASRD, with the italicized introduction to diagnostic codes 8000-8046, should enable boards to select

the proper rating approach. In some of these conditions, the minimum rating may be awarded on the basis of the diagnosis alone, whether or not there are residuals. If the latter have neither residuals capable of objective verification nor subjective residuals that are credible and consistent with the disease, and are not more likely attributable to other diseases, the condition should be ratable at 0 % percent.

8017, 8018, 8023-8025, Progressive Muscular Atrophy and Myasthenia Gravis.

Combined rating may be assigned under these diagnostic codes with the bilateral factor added.

8205-8412, Diseases of the Cranial Nerves. Notice the provision for combined ratings under these diagnostic codes where there is bilateral involvement, but without addition of a bilateral factor.

8510-8730, Diseases of the Peripheral Nerves. In cases where the rating is made on residuals, observe the general principle of adjudicating on the basis of impairment of function rather than on anatomical diagnosis. For example, a complete paralysis of the circumflex nerve of the major extremity carries a 50 % rating under diagnostic code 8518. In many cases, however, abduction of the arm where the circumflex nerve is paralyzed, occurs by virtue of other muscles taking over the function of the paralyzed muscles. To warrant the 50 % rating, the member's residual loss of function must actually include all the defects listed under diagnostic code 8518. When other muscles have, in fact, taken over the function of the circumflex-innervated deltoid, the residual loss of function is properly ratable under diagnostic code 5201, Limitation of Arm Motion, or 5303, muscle injury, group III, whichever best reflects that predominant impairment. Cases of paralysis of the common peroneal nerve with foot drop, diagnostic code 8521, will be rated in terms of loss of function rather than topographically. Amputation below the knee, diagnostic code 5165, is ratable at 40 %. In order to warrant a similar rating for peroneal palsies, there must be sufficiently severe symptoms, such as trophic and circulatory changes, and other concomitants to make the functional impairment reasonably equivalent to actual loss of the foot.

8599, Scalenus Anticus Syndrome. This syndrome should be rated by analogy with the lower radicular group (diagnostic code 8512), or, less commonly, with either erythromelalgia (diagnostic code 7119) or Raynaud's disease (diagnostic code 7117), depending upon predominant symptoms and overall functional impairment.

8910-8914, The Epilepsies.

Attacks following omission of prescribed medication or the ingestion of alcoholic beverages or other drugs to affect seizure frequency are not indicative of the controllability of the disease; they should not be included in the determination of the disability percentage. If there is evidence of the conditions described above, then it must be presumed that the evaluatee would be seizure-free if the prescribed medication therapy were followed and/or ingestion of alcohol or drugs were avoided.

Ultimately, members who remain seizure-free while on medication therapy will be rated as having confirmed diagnosis of epilepsy with a history of seizure, except as determined in accordance with the subparagraph below.

On a case-by-case basis, members who remain seizure-free while on medication therapy may be considered fit for duty based on their ability to adhere to the medical regimen, the controllability of the disease, the normalcy of their EEG tracings, and their motivation.

Seizure activity deriving from organic or pathological causes are generally more appropriately rated under the 8000 or 9300 diagnostic code series in the VASRD.

9201-9210, Psychotic Disorders. Loss of function, reflected in impaired social and industrial adaptability, is the principal criterion for establishing the level of impairment resulting from mental illness. Specifically included are those disorders manifesting disturbances of perception, thinking, emotional control, and behavior sufficiently severe to limit capacity to perform military duties or otherwise earn a living. Reference should be made to the member's social and industrial adjustment prior to diagnosed psychiatric illness as a baseline for assessing loss of function. All pertinent data provided by the medical board, TDRL examining physicians, and other competent medical authorities must be carefully reviewed before arriving at a final determination. When this material is conflicting, the problem issues should be resolved before a rating decision is made, and the action taken to resolve them clearly shown in the record of proceedings. It is often difficult to properly assess the degree of permanent impairment resulting from a psychotic process during the weeks immediately following an acute episode. On occasion, a member's period of intensive in-hospital treatment has not been completed at the time of the initial medical board action. With the passage of time, the clinical picture tends to stabilize, and the degree of permanent impairment may then be more accurately estimated. For purposes of assessing impairment resulting from most types of schizophrenia and the major affective psychoses, placement on the TDRL is warranted. Ratings should be based on actual industrial inadaptability. Social inadaptability and symptomatology (such as autism, affect-disturbance, and loosening of associations) are to be evaluated only as they affect industrial adaptability. See 4.125 through 4.131 of the VASRD.

Complete. Members receiving this rating on either a temporary or permanent basis will most often be declared incompetent and, if not transferred to a Department of Veterans Affairs hospital, be discharged to the care of a relative or guardian. Infrequently a member, though not declared incompetent, may still be entitled to this rating.

Severe. The severely impaired category includes members discharged to their own care or the care of relatives when manifesting marked degrees of mental deterioration, emotional impairment, permanent disintegration, and poor judgment that does not completely impair social and industrial adaptability. Evaluatees determined to have this degree of severity may or may not be found mentally incompetent.

Considerable. This category should be reserved for members who require frequent outpatient treatment and medication to maintain employment and avoid re-hospitalization and who, despite treatment, exhibit extensive job instability and experience periodic relapses requiring hospitalization.

Definite. The member requires occasional outpatient treatment and medication to maintain employment and avoid re-hospitalization, and may do well on this treatment program, although possibly experiencing some job instability. Often the illness may interfere with advancement.

Considerable and Definite. These degrees of severity are considered appropriate when the member has potential employability. A member's overall life adjustment and degree of potential employability will be considered in a choice of the degree of severity. Members determined to have these degrees of severity will generally not be found mentally incompetent and outpatient therapy and/or anti-psychotic medication may or may not be required. Members involved in sheltered employment, such as working for family members, will most often fit in one of these categories.

Mild. This degree of severity will be appropriately applicable subsequent to psychotic episodes, with or without residuals, when none of the foregoing is applicable. Outpatient therapy may or may not be required, but, generally, anti-psychotic medication is not required.

Full Remission. This category will be used when a psychosis is in full remission and has had little permanent effect on the member's personality. The member will not be in need of medication, follow-up, or medical supervision. Rate as 0 %.