UNITED STATES AIR FORCE
BOARD FOR CORRECTION OF MILITARY RECORDS

THIRD ADDENDUM TO RECORD OF PROCEEDINGS

IN THE MATTER OF: XXXXXXXXXX

DOCKET NUMBER: BC-2015-03944-4

COUNSEL: XXXXXXXXXX

HEARING REQUESTED: YES

APPLICANT'S REQUEST

His medical retirement with a 40 percent disability rating be changed to 60 percent based on his unfitting Ankylosing Spondylitis (AS) as an active process.

RESUME OF THE CASE

On 31 May 06, the applicant entered the Regular Air Force.

On 1 May 12, the Secretary of the Air Force (SECAF) directed the applicant be discharged with a 20 percent disability rating.

In a letter dated 22 Jun 12, Dr. P------ stated the applicant was "presenting with symptoms including incapacitating episodes of 11-12 a year before treatment. With treatment, the condition has stabilized and now he presents with 4-5 incapacitating episodes a year."

On 28 Aug 12, the applicant received an honorable discharge with a narrative reason for separation of "Disability, Severance Pay, Non-Combat." He was credited with 6 years, 2 months, and 28 days of active service.

On 28 May 13, a Department of Veterans Affairs (DVA) Rating Decision granted service-connection for ankylosing spondylitis with thoracic spine strain (claimed as lumbar spine condition, thoracic spine condition and ankylosing spondylitis) with an evaluation of 20 percent effective 29 Aug 12.

On 25 May 17, a DVA Decision Review Officer (DRO) stated in part that the evaluation of ankylosing spondylitis in the cervical spine, thoracolumbar spine, sacroiliac joint, bilateral ankle and foot/toes which was 20 percent disabling, was increased to 60 percent effective 29 Aug 12. The effective date is the day following his release from active duty as he continuously prosecuted his claim since that time. The DRO assigned a 60 percent evaluation based on severely incapacitating exacerbations occurring four or more times a year. The decision represented a full grant of benefits sought on appeal for this issue.

On 28 Mar 18, the Board considered and denied the applicant's request for a medical retirement with a 40 percent disability rating finding the applicant had provided insufficient evidence of an error or injustice to justify relief. The Board noted the Medical Consultant recommended a permanent retirement with a 40 percent disability rating. The Board also noted the applicant earlier argued he was fit for retention and since being found unfit, the emphasis shifted to a medical retirement. The applicant's treating rheumatologist consistently referred to his condition as "mild" in handwritten progress notes although a worse clinical picture was painted in his 22 Jun 12 letter. The Medical Consultant stated the decision of the DRO was, in large measure, prompted by evidence clearly obtained and considered well beyond the "snapshot" time of the applicant's discharge date. After carefully considering all the evidence, the Board opined the applicant's disability rating(s) were properly adjudicated and indicated the applicant had not provided sufficient evidence to persuade them that a change in the current 20 percent disability rating [previously assigned by the Military Department and the DVA at a time when the applicant voiced his improvement and desire for retention], was warranted. Therefore, the Board agreed with the opinions and recommendations of the AFPC Disability Office and the BCMR IMA Medical Consultant that the applicant had failed to sustain his burden of proof that he had been the victim of an error or injustice. For an accounting of the applicant's original request and the rationale of the earlier decision, see the AFBCMR Letter and Record of Proceedings at Exhibit M.

On 20 Feb 19, the U.S. Court of Federal Claims, issued Order Number Work-Product, directing the AFBCMR to address, among other issues, whether the applicant was entitled to a disability rating higher than 20 percent based upon "chronic residuals" of his ankylosing spondylitis, and, if so, determine and explain what that disability rating should be; and determine and explain whether the applicant was entitled to any relief, including correction of records and retirement pay, based upon any errors or injustices found. The order also directed the AFBCMR to address any other pertinent issues raised by the parties in writing to the AFBCMR within 45 days of the order.

A complete copy of the Remand Order is at Exhibit N.

On 16 Oct 19, the Board considered and denied the applicant's request for a medical retirement with a 40 percent disability rating. After reviewing all Exhibits, the Board remained unconvinced the evidence presented demonstrated an error or injustice to warrant a medical retirement. The Board did not believe the applicant should be entitled to a disability rating higher than 20 percent based upon "chronic residuals" of his ankylosing spondylitis. As such, the Board agreed that a higher disability rating would be inconsistent with the preponderance of clinical evidence present at the "snapshot" time upon entering the Disability Evaluation System (DES) and at the time of final military disposition. Therefore, the Board found a preponderance of the evidence did not substantiate the applicant's contentions. Accordingly, the Board recommended against correcting the applicant's records. For an accounting of the applicant's request and the rationale of the earlier decision, see the AFBCMR Letter and Record of Proceedings at Exhibit Q.

On 16 Nov 20, the U.S. Court of Federal Claims issued Order Number Work-Product, directing the AFBCMR to address all issues within its authority, including but not limited to the issues listed

below, and any other pertinent issues raised by the parties in writing to the AFBCMR within 45 days of the order. The order states the AFBCMR shall consider all the medical evidence in the record regarding the applicant's medical conditions up to the date of the applicant's discharge and whether a 20 percent, 40 percent, or other rating is the correct retirement disability rating for the applicant. The AFBCMR shall also fully explain what that disability rating for the applicant should be; and determine and explain whether the applicant is entitled to any relief, including correction of records and retirement pay, based upon any errors or injustices found. The foregoing was not meant to limit the scope of the AFBCMR's authority or issues the parties may raise on the remand.

A complete copy of the Remand Order is at Exhibit R.

On 14 Jul 21, the Board granted the applicant's request for a medical retirement with a 40 percent disability rating. After carefully considering all the evidence it was the Board's opinion the applicant's disability rating(s) were improperly adjudicated and that he had provided sufficient evidence to persuade the Board that he should be entitled to a disability rating of 40 percent based on the "chronic residuals" of his ankylosing spondylitis**.** The Board recommended the applicant's record be corrected to show on 28 Aug 12, he was not discharged with entitlement to severance pay with a 20 percent disability rating due to ankylosing spondylitis, but was permanently retired on 28 Aug 12, with a 40 percent disability rating due to chronic residuals of ankylosing spondylitis, rated at 10 percent for each major joint or group of minor joints affected by limitation of motion. However, the Board denied the applicant's request for a medical retirement with a 60 percent disability rating based on his unfitting ankylosing spondylitis as the evidence presented did not demonstrate an error or injustice. For an accounting of the applicant's request and the rationale of the earlier decision, see the AFBCMR Letter and Record of Proceedings at Exhibit Y.

On 26 Oct 21, the U.S. Court of Federal Claims, issued Order Number *Work-Product*, directing the AFBCMR to address all issues within its authority, including but not limited to the issues listed below, and any other pertinent issues raised by the parties in writing to the AFBCMR within 45 days of this order. The AFBCMR shall consider all the information available to the AFBCMR during the prior remands including plaintiff's 18 Mar 21 and 25 Jun 21 responses to the AFBCMR Medical Advisor's advisory opinions. The Board shall reconsider and explain whether the applicant is entitled to a 60 percent or other combined disability rating under the Veteran Affairs Schedule for Rating Disabilities (VASRD) diagnostic code 5002 (effective 28 Aug 12) for his ankylosing spondylitis as an active process. Specifically, the AFBCMR shall explain what a "severely incapacitating exacerbation" is under diagnostic code 5002 and explain whether the AFBCMR has been presented with evidence that the applicant had, at the time of his discharge, suffered from four or more severely incapacitating exacerbations in a year or a lesser number over prolonged periods. Consistent with the court's 2020 Opinion, the AFBCMR shall not consider a 60 percent "active process" disability rating to be foreclosed based upon the AFBCMR's earlier determination that the applicant suffered from "chronic residuals" of his ankylosing spondylitis at the time of his discharge.

A complete copy of the Remand Order is at Exhibit Z.

APPLICABLE AUTHORITY/GUIDANCE

Per DoDM 1332.18-V2*, Disability Evaluation System (DES) Manual,* Enclosure 2, para 3(a.) 17, dated 5 Aug 14, the Secretaries of the Military Departments, for their respective Departments establish procedures to: Correct the records, upon application by former Service members who successfully appeal disability ratings received in the Integrated Disability Evaluation System (IDES) to DVA and the respective Military Department Board for Correction of Military Records (BCMR). This includes the records of Service members who are veterans temporarily retired through the IDES who appeal ratings that affect unfitting conditions for which the retiree was placed on Temporary Disability Retired List (TDRL).

AIR FORCE EVALUATION

The AFBCMR Medical Advisor recommends denial of the applicant's request for a permanent retirement with a 60 percent disability rating, due to ankylosing spondylitis as an active process. During the applicant's final year of service, or for the year preceding and ending at his date of discharge, there is *no* objective service or private medical evidence, prior to discharge, that he suffered weight loss and anemia productive of severe impairment of health or severely incapacitating exacerbations occurring four or more times a year or a lesser number over prolonged periods. There is also no objective evidence the applicant experienced a lesser number of exacerbations that lasted or persisted over prolonged periods.

In response to the Court's request to define a *severely incapacitating exacerbation*, there is no official DVA definition for an incapacitating exacerbation other than the one utilized, when rating a condition as i*ntervertebral disc syndrome based on incapacitating episodes,* for which an incapacitating episode is defined, under Note (1) in the following: "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."

The Medical Advisor defines a "*severely incapacitating exacerbation*" as one acutely manifested by either one or a combination of acute extreme pain, of a subjective level of 8 to 10, with 10 being worst possible pain, profound weakness or fatigue, most notable during voluntary manual muscle strength testing of 3+/5 or less in hand grip, shoulder shrug, elbow extension and flexion, knee extension and flexion, hip flexion and extension, and ankle dorsiflexion and plantar flexion, causing postural instability and profound inability to stand from seated position, due to severe [8-10/10] pain and stiffness, requiring assistance [not just stand-by assistance]. Accompanying the severely incapacitating exacerbation there will be significant impairment of all voluntary axial musculoskeletal functioning, due to pain, stiffness, or weakness, necessitating prostration [must lay down with or without a physician's directive]; and possibly requiring transport for urgent medical intervention in an emergency or urgent care setting, or the immediate use of a pre-established treatment protocol by a care giver, under the direction or orders of a licensed healthcare provider.

Further, confounding the recommendation to grant a 60 percent disability rating emanates from significant differences between actions and authorities by the Military Department, operating

under Title 10, United States Code (U.S.C.), and the laws and policies governing DVA, under Title 38, C.F.R. The Military Department bases its decisions upon the evidence present at the "snapshot" end date of military service, and not based upon post-service progression of disease or re-characterization of disease, particularly when there has been a clinical change in the medical condition or new evidence [via interviews and examinations] procured after discharge justifies the increased disability rating. The Medical Advisor holds firmly that the DRO's decision was clearly supplemented by medical evidence, disclosures, and examinations conducted well *after* the applicant's period of service, which, if accepted to determine the severity of his condition at the time of separation, would set a precedent for the Military Department, operating under Title 10, United States Code (U.S.C.), which to date, bases its final personnel actions upon the preponderance of evidence present *during* military service and at the "*snapshot*" end of military service; the point at which the Military Department hands-off accountability for the service member's future post-service disability benefits to the DVA,

In summary, the two fundamental reasons for recommending denial of the applicant's request for a 60 percent disability rating, are: (1) There is no service evidence nor private treatment records, to indicate that the applicant *suffered less than criteria for 100 percent but with weight loss and anemia productive of severe impairment of health* or *severely incapacitating exacerbations* occurring *4 or more times a year* or a *lesser number over prolonged periods*. While it has been proposed that the applicant may have experienced an exacerbation at or about the time, to justify the contents of Dr. P------'s letter, the required medical evidence covering the previous *year* does not objectively indicate there was (or were) an exacerbation(s) of such magnitude or duration to support the 60 percent disability rating at the time of discharge. (2) The Military Department makes its assessments of fitness and unfitness, and in this case, the disability rating, based upon the objective evidence present at the time of discharge.

The complete advisory opinion, with attachments, is at Exhibit AA.

APPLICANT'S REVIEW OF AIR FORCE EVALUATION

The Board sent a copy of the advisory opinion to the applicant on 29 Mar 22, for comment (Exhibit BB), and the applicant replied on 8 Jun 22. In response, counsel disagreed with the definition offered as overly restrictive and not in accordance with federal law. In deciding this case, the AFBCMR must resolve reasonable doubt in favor of the applicant. Based on the Medical Advisor's definition, the applicant meets the criteria for a 60 percent rating based on an "active process" for his ankylosing spondylitis because he had "severely incapacitating exacerbations," defined as one acutely manifested by either one or a combination of acute extreme pain, of a subjective level of 8 to 10, with 10 being worst possible pain…" and these occurred at least 4 times per year. On this basis, the AFBCMR should find that the applicant meets the criteria for a 60 percent rating for his ankylosing spondylitis based on an active process, whether it adopts the Medical Advisor's definition of "severely incapacitating exacerbations."

The issue before the AFBCMR is what is a "seriously incapacitating exacerbation" for ankylosing spondylitis, not for a global definition that covers all possible disabilities. The Medical Advisory's definition of a "seriously incapacitating exacerbation" appears to describe an

extreme level of disability, but it also seems to provide that definition as it applies to all potential disabilities. The clearest evidence the applicant met the criteria for a 60 percent rating is the DVA rating decision, dated 25 May 17, which granted a 60 percent rating for his ankylosing spondylitis based on an active process with an effective date the day after his separation (the first date that under the law the DVA could grant him compensation). The Air Force is required to give at least some deference to the DVA's decision in interpreting its own regulations. Absent a grant of relief, the AFBCMR should discuss what deference, if any, it applied to the decision of the Secretary of Veterans Affairs granting the applicant a 60 percent rating for ankylosing spondylitis based on an active process. At the very least, contrary to the Medical Advisor's opinion, there is some evidence the applicant had "four or more severely incapacitating exacerbations in a year or a lesser number over a prolonged period," as evidenced by the decision of the DVA finding the same.

The AFBCMR should also address whether the previously admitted errors and the time to resolution of the same, and the ongoing time for the consideration of the present matters before the Board, should constitute an injustice that merits additional relief. A direct order for travel pay and entitlements, payment for health costs, or other relief may be options that the AFBCMR should address.

Had the applicant been processed under the IDES process, he would have the right to direct correction of his records based on his DVA appeals under the DoD Memorandum, "Policy and Procedural Update for the Disability Evaluation System (DES) Pilot Program Pilot Program Disability Manual," dated 11 Dec 08. Under that regulation, the Secretary of the Air Force would have been required to "Correct the records of those Veterans who successfully appeal their ratings to the DVA, using the appropriate Military Department Board for Correction of Military Records (BCMR). This same process will apply to TDRL retirees who appeal ratings that affect unfitting conditions for which the retiree was placed on the TDRL." The applicant successfully appealed his DES rating for ankylosing spondylitis to the DVA, was awarded a 60 percent rating based on an active process and applied to the AFBCMR for correction of his records using that appeal as a basis for the correction of his records. The AFBCMR should accord the applicant the same rights after a successful appeal as a member who was processed at the same time under the IDES program or, should it deny relief on this basis, it should explain why approximately four years after the implementation of the IDES pilot program, his case was processed under the Legacy DES case, and why he should be treated differently from members who were processed under the IDES program at the same time.

In further support of his request, the applicant provides an affidavit dated 7 Jun 22, stating in part that he had episodes of severe pain in his joints at a level of 9 out of 10, 1-2 times per month in the year before his separation. The applicant also provides a copy of a DVA Rating Decision dated 25 May 17 and articles discussing ankylosing spondylitis.

The applicant's complete response, with attachments is at Exhibit CC.

ADDITIONAL AIR FORCE EVALUATION

AFPC/DPFDI recommends denial of the applicant's request for a higher rating of 60 percent. Based on the documentation provided by the applicant and analysis of the facts, there is no indication the AFBCMR erred in its decision to assign a 40 percent disability rating for chronic residuals of ankylosing spondylitis based on the severity of his condition(s) at the time of DES processing and prior to discharge. The documentation contained in his available medical records do not indicate that, prior to discharge, he suffered from four or more severely incapacitating exacerbations in a year or a lesser number over a prolonged period to support an increase to this rating. Severely incapacitating exacerbations as referenced in the VASRD are not specifically defined by the DVA, but medically this could only be interpreted as essentially complete inability to function independently due to such factors as extreme pain/weakness/fatigue, immobility, profound cardiovascular or pulmonary dysfunction, and/or marked neurologic impairment. In general, such severe incapacitation could arise from many potential causes and would also be expected to require higher level care on an urgent or emergent basis. There is no evidence within healthcare encounter documentation of any severely incapacitating exacerbation from initial presentation on 1 Feb 10 until the time of discharge, or even an incapacitating exacerbation. Furthermore, the presence of any incapacitating exacerbations since being placed on Humira would not be expected to result in any rheumatologist characterizing the disease as being "remarkably well controlled." The evidence in the actual medical record indicates the absence of any incapacitating or severely incapacitating exacerbations of ankylosing spondylitis. The extensive records reviewed do not suggest that any pertinent healthcare encounters occurred outside those documented in the DoD Electronic Medical Record (EMR) or the rheumatology clinical notes. There does not appear to be any significant history of back pain or other ankylosing spondylitis symptoms prior to 1 Feb 10. The applicant reported pain resulting from ankylosing spondylitis as no more than mild (rated 0-3/10), while reporting moderate 4/10 pain at seven encounters. At two encounters in May 10, he reported moderate 5/10 pain. He was seen in the flight medicine clinic on 20 May 10 and reported 5/10 neck and back pain but specifically stated that the pain was not incapacitating, and this was noted to have no Personnel Reliability Program (PRP) impact. At a physical therapy appointment on 24 May 10, he reported 5/10 pain but also stated that he remained able to safely perform his job duties. The symptoms of ankylosing spondylitis were consistently noted as not distracting or impairing, as not affecting his ability to safely perform his job duties, and as having no associated PRP impairment. PRP decertification was not a result of any incapacitating episodes related to ankylosing spondylitis, but rather due to the potential for side effects from Humira and not from any actual side effects that materialized.

Starting in May 11, Dr. P------ consistently records the primary diagnosis as "Ankylosing Spondylitis, Mild Symptoms" and his clinical notes also do not appear to document any significant impairment arising from his symptoms. In addition, the DoD EMR contains a clinical note from a rheumatology encounter with Dr. K on 31 Oct 12 (two months after discharge), resulting from a DoD referral for care. Dr. K------ recorded that the applicant was "ultimately placed on Humira about two years ago and has had at least 70 to 90 percent improvement" and further noted that "on his activities of daily living (ADL) he is functioning in the well range," with a final impression that the applicant was a "very pleasant 30 year old gentleman with an apparent two to three years history of probable ankylosing spondylitis, remarkably well controlled on Humira and doing extremely well." The medical record does not contain evidence of incapacitating episodes/symptoms or significant functional impairment due to ankylosing

spondylitis. The only reference to incapacitating episodes related to ankylosing spondylitis is contained within a memorandum written by Dr. P------ the treating rheumatologist, on 22 Jun 12 (approximately 1.5 months after DES processing and 2 months prior to discharge). That memorandum states the applicant had experienced 11-12 incapacitating episodes per year prior to treatment and 4-5 incapacitating episodes per year with treatment. Although Dr. P------ does not define incapacitating, nor is incapacitating specifically defined by the DVA, the word typically means being made incapable of performing some function(s) or act(s). Accepted synonyms for incapacitation include crippling, immobilizing, paralyzing, disabling and prostrating, among others. Regardless, incapacitating can only be construed as indicating the presence of significant functional impairment. The basis for Dr. P------'s opinion expressed solely in the 22 Jun 12 memorandum is unclear and appears to be contradicted by his own clinical notes. From neither a lay nor professional medical perspective can mild symptoms plausibly be expected to be incapacitating. The actual medical record contains no evidence of any ankylosing spondylitis symptoms that can be construed as incapacitating, and the only time the word "incapacitating" is used in actual clinical notes is in the negative, with specific statements that his symptoms were not incapacitating, as noted above on 20 May 10 and also on 1 and 8 Feb 10, while at other encounters his ankylosing spondylitis symptoms were noted to not be impairing or distracting and thus would not have been incapacitating.

DPFDI discussed the difference between the DoD and DVA disability systems. To be unfitting, the condition must be such that it alone precludes the member from fulfilling their military duties. The PEB then applies the rating best associated with the level of disability at the time of disability processing (a snapshot in time). That rating determines the final disposition and is not subject to change after the service member has separated. A higher rating by the DVA "based on new and/or current exams conducted after discharge from service" does not warrant a change in the total DoD compensable rating awarded at the time of the member's separation. Based on Title 10, the PEB and the AFBCMR must assign the rating that most appropriately corresponded with the applicant's medical condition(s) level of impairment at the time of DES processing prior to his discharge. Under Title 38, the DVA may reassess his service-connected disabilities throughout the years and if a change in rating is warranted, they will make the appropriate change at that time.

The complete advisory opinion, with attachments, is at Exhibit DD.

APPLICANT'S REVIEW OF ADDITIONAL AIR FORCE EVALUATION

The Board sent a copy of the advisory opinion to the applicant on 22 Aug 22, for comment (Exhibit EE), and the applicant replied on 17 Oct 22. In response, the applicant, contends the advisory opinion is an administratively impermissible review by the Air Force Physical Evaluation Board (PEB) and it fails to address the relevant issues or the full contents of the case before the AFBCMR. The Air Force has failed to state what definition it is applying to "severely incapacitating exacerbations." The previous advisory opinion, dated 24 Mar 22, finally offered a definition. Based on our earlier response and the evidence in the case, the applicant meets the definition of having the requisite frequency of "severely incapacitating exacerbations." The advisor's statement discounting Dr. P------'s opinion contains logical fallacies, does not properly apply the benefit of the doubt doctrine, and places the blame for a lack of discussion of the

relevant criteria on the applicant without addressing that counsel argued this point both at the PEB Formal hearing and in his written rebuttal back in 2011. The criticism that the "only reference to incapacitating episodes related to ankylosing spondylitis is contained within a memorandum written by Dr. P------," seems to suggest that as basis to discount Dr. P------'s evaluation. However, Dr. P------ was best poised to address this issue as the applicant's treating physician. The corollary to the criticism is that there is no clear statement or evaluation refuting Dr. P------'s letter. Viewed through that prism, the lack of contradicting contemporaneous evaluation refuting that the applicant's 4-5 incapacitating episodes per year with treatment shows that this letter should be accorded deference. Air Force and DoD regulations required the Air Force to address the rating criteria and both the applicant and counsel repeatedly raised this issue at the earliest opportunity. Request the AFBCMR address the legal significance of the failure of the MEB and the PEB to address the rating criteria over the objections of the applicant and whether this error, by itself, warrants the grant of relief. Included in this issue is the impact of this, if any, on the lack of additional evidence requested by the applicant regarding his ankylosing spondylitis exacerbations in the record. The advisory opinion does not address any of the arguments or evidence previously submitted in response to the previous advisory opinion. Especially relevant and probative is the applicant's affidavit, dated 7 Jun 22.

An argument raised in a preceding response was whether it was an error or injustice for the applicant's case not to have been processed under the IDES. Had his case been so processed, then under DoD Instruction 1332.18 v.2, Enclosure 3, paragraph 3 a.(17), the Secretary of the Air Force would have been required to increase the applicant's rating to 60 percent under the active process because of the DVA's grant of this rating on appeal. Correct the records, upon application by former Service members who successfully appeal disability ratings received in the IDES to DVA and the respective Military Department Board for Correction of Military Records (BCMR). If not an error, is it not an injustice that the presumed processing, under the IDES, was not done in the applicant's case, especially when such a result would have mandated the award of a 60 percent rating under an active process for ankylosing spondylitis. There are several issues that the DVA award by itself should be accorded deference. It is based on full medical exams that comply with regulation, including the resolution of reasonable doubt under 38 C.F.R § 4.3. Counsel ask the AFBCMR to consider whether there is a valid reason for a result wherein if the only fact that changed was the applicant's case being processed in 2011 under IDES, which first came into being via the DES Pilot Program memorandum, dated 11 Dec 08, he would be entitled to a 60 percent rating under DoD Instruction 1332.18 v.2, Enclosure 3, paragraph 3 a.(17). Counsel challenges the arbitrary decision to not treat the applicant the same as an airman assigned to the IDES and argues that it is an injustice to treat him differently. Counsel requests this issue be considered and discussed by the AFBCMR, including the basis for not adjudicating his case via the IDES.

The applicant's complete response is at Exhibit FF.

FINDINGS AND CONCLUSION

After reviewing all Exhibits, the Board remains unconvinced the evidence presented demonstrates an error or injustice to warrant a 60 percent disability rating based on his unfitting ankylosing spondylitis as an active process. The Board was ordered to explain what a "severely

incapacitating exacerbation" is under VASRD diagnostic code 5002. The Board agrees with the Medical Advisor's definition of a "*severely incapacitating exacerbation*" as one "acutely manifested by either one or a combination of acute extreme pain, of a subjective level of 8 to 10, with 10 being worst possible pain, profound weakness or fatigue, most notable during voluntary manual muscle strength testing of 3+/5 or less in hand grip, shoulder shrug, elbow extension and flexion, knee extension and flexion, hip flexion and extension, and ankle dorsiflexion and plantar flexion, causing postural instability and profound inability to stand from seated position, due to severe [8-10/10] pain and stiffness, requiring assistance [not just stand-by assistance]. Accompanying the severely incapacitating exacerbation there will be significant impairment of all voluntary axial musculoskeletal functioning, due to pain, stiffness, or weakness, necessitating prostration [must lay down with or without a physician's directive]; and possibly requiring transport for urgent medical intervention in an emergency or urgent care setting, or the immediate use of a pre-established treatment protocol by a care giver, under the direction or orders of a licensed healthcare provider."

The Board was also ordered to explain whether it had been presented with evidence that the applicant had, at the time of his discharge, suffered from four or more severely incapacitating exacerbations in a year or a lesser number over prolonged periods. The Board notes Dr. P------ provided a letter dated 22 Jun 22, stating the applicant was presenting with symptoms including incapacitating episodes of 11-12 a year before treatment and with treatment, the condition had stabilized, and he presented with 4-5 incapacitating episodes a year. The Board also noted the applicant's affidavit dated 7 Jun 22, stating he had episodes of severe pain in his joints at a level of 9 out of 10, 1-2 times per month in the year before his separation. However, the Board does not find this evidence sufficient to correct the applicant's record to show at the time of his separation, he met the 60 percent level of disability reflected in the Medical Advisor's definition of "Seriously incapacitating exacerbation." As noted by DPFDI, the basis for Dr. P------'s opinion expressed solely in the 22 Jun 12 memorandum is unclear and appears to be contradicted by his own clinical notes. The medical record contains no evidence of any ankylosing spondylitis symptoms that can be construed as incapacitating, and the only time the word "incapacitating" is used in actual clinical notes is in the negative, with specific statements that his symptoms were not incapacitating. Although the DRO granted a 60 percent rating for his ankylosing spondylitis based on an active process effective 29 Aug 12, as noted by the Medical Advisory, his decision was clearly supplemented by medical evidence, disclosures, and examinations conducted well *after* the applicant's period of service. The Board considered all the prior remands, including the applicant's 8 Mar 21 and 25 Jun 21 responses to the Medical Advisor's advisory opinions. Based on the lack of objective evidence to support a higher rating either as chronic residuals or active process, there is insufficient evidence the applicant suffered from four or more severely incapacitating exacerbations in a year or a lesser number over prolonged periods. Therefore, the Board agrees with the opinions and recommendations of the AFPC Disability Office and the AFBCMR Medical Advisor that the applicant has failed to sustain his burden of proof that he had been the victim of an error or injustice.

Counsel states the AFBCMR should address whether the previously admitted errors and the time to resolution of the same should constitute an injustice that merits additional relief. Counsel also request the Board address the legal significance of the failure of the MEB and the PEB to address the rating criteria over the objections of the applicant and whether this error, by itself, warrants

the grant of relief. The Board determined the applicant had not provided sufficient evidence to persuade them that relief should be granted on either basis. Regarding counsel's request to explain why approximately four years after the implementation of the IDES pilot program, the applicant's case was processed under the Legacy DES, and why he should be treated differently from members who were processed under the IDES program at the same time. Although there was an IDES program when the applicant started DES processing, it was still a pilot program and was not available to all members, to include the applicant. As such, the Board does not believe the applicant has been the victim of an error or injustice or that he was treated differently than others processed under the Legacy DES. Therefore, the Board recommends against correcting the applicant's records.

The applicant has not shown a personal appearance, with or without counsel, would materially add to the Board's understanding of the issues involved.

RECOMMENDATION

The Board recommends informing the applicant the evidence did not demonstrate material error or injustice, and the application will only be reconsidered upon receipt of relevant evidence not already considered by the Board.

CERTIFICATION

The following quorum of the Board, as defined in Air Force Instruction (AFI) 36-2603, *Air Force Board for Correction of Military Records (AFBCMR)*, paragraph 1.5, considered Docket Number BC-2015-03944-3 in Executive Session on 16 Nov 2022:

, Panel Chair
, Panel Member
, Panel Member

All members voted against correcting the record. The panel considered the following:

Exhibit Y: Record of Proceedings, dated 21 Jul 21, w/Exhibits A-X.
Exhibit Z: Remand Order, dated 26 Oct 21.
Exhibit AA: Advisory Opinion, AFBCMR Medical Consultant dated 25 Mar 22.
Exhibit BB: Notification of Advisory, SAF/MRBC to Counsel, dated 29 Mar 22.
Exhibit CC: Letter, Counsel, dated 8 Jun 22, with atchs.
Exhibit DD: Advisory Opinion, AFPC/DPFDI dated 22 Aug 22, w/atchs.
Exhibit EE: Notification of Advisory, SAF/MRBC to Counsel, dated 22 Aug 22.
Exhibit FF: Letter, Counsel, dated 17 Oct 22.

Taken together with all Exhibits, this document constitutes the true and complete Record of Proceedings, as required by AFI 36-2603, paragraph 4.11.9.

X

Board Operations Manager, AFBCMR