RECORD OF PROCEEDINGS

IN THE MATTER OF: XXXXXXXXXXXXXX

DOCKET NUMBER: BC-2016-04417

COUNSEL: XXXXXXXXXXXXXXX

HEARING REQUESTED: YES

APPLICANT'S REQUEST

1. His Traumatic Servicemembers' Group Life Insurance (TSGLI) Protection appeal denied on 21 October 2016, be reversed and his claim be reinstated for 90 days (1 May 12 through 19 July 2012) loss of ability to independently perform two or more Activities of Daily Living (ADL), be approved.

2. He be awarded $50K under the TSGLI Schedule of Losses #17 for Coma from traumatic injury and/or Traumatic Brain Injury (TBI) due to 90 consecutive days of ADL loss (bathing, dressing, toileting, and transferring) and/or for suffering permanent loss of use of both testicles, which under Schedule of Losses #19, alternatively qualifies for a maximum of $50K.

APPLICANT'S CONTENTIONS

The applicant through counsel makes the following contentions:

The preponderance of the evidence establishes he has met the requirements for a payment of at least $50K for 90 days of ADL loss (bathing, dressing, toileting, and transferring), as a result of traumatic injury/TBI, and/or permanent loss of use of both testicles.

His injuries and ADL losses are well documented and validated by undisputed medical evidence. His denial was based on presumptions, which is an error and injustice, especially under the low burden of proof for the preponderance of the evidence standard. Furthermore, his genitourinary loss denial was improperly based on a direct injury argument. However, he meets the loss standard as nowhere in the Procedures Guide does it require a direct injury; therefore, secondary effects are covered.

For more information, see the excerpt of the applicant's record at Exhibit B and the advisory at Exhibits C, D and E.

STATEMENT OF FACTS

The applicant is a former Air National Guard (ANG) senior airman (E-4).

According to the documentation provided by the applicant and analysis of the facts, the following is provided:

According to the applicant's DD Form 214, *Certificate of Release or Discharge from Active Duty,* he was partially mobilized from 18 November 2011 to 28 September 2012, in support of Operation ENDURING FREEDOM in accordance with Title 10, United States Code (USC), sections 12301(H) and 12302.

Special Order Work-Product, dated 15 November 2011 reflects the applicant was on Military Personnel Appropriation (MPA) orders from 18 November 2011 through 5 June 2012 in support of Operation ENDURING FREEDOM.

AF IMT 348, *Line of Duty (LOD) Determination*, dated 16 March 2012, reflects that on or about 7 March 2012, the applicant was "stuck or trapped" by a Mine-Resistant Ambush Protected (MRAP) hydraulic door for approximately five minutes, resulting in significant mid-thoracic back pain from the pressure. On 17 March 2012, the injury was determined to be "in the line of duty (ILOD)."

On 8 March 2012, due to worsening pain in his back, headaches, and a new complaint of numbness/tingling down his left leg into his calf, the applicant was medically evacuated to Landsthul Regional Medical Center (LRMC), wherein he experiences a syncopal episode enroute.
Subsequently, while waiting for his Magnetic Resonance Imaging (MRI), he experiences another pre-syncopal episode.

On 26 March 2012, he was medically evacuated to Andrews Air Force Base (AFB), MD enroute to his next duty station of Travis AFB, CA, wherein again, he suffered another pre-syncopal event. On 27 March 2012, he was admitted to David Grant Medical Center (DGMC) for further observation and evaluation and on 30 March 2012, he was discharged to the care of his parents and fiancé.

According to SGLV 8600, *Application for TSGLI Benefits, part B, Medical Professional's Statement,* dated 1 June 2012, provided by the applicant, his medical provider certified that he required physical assistance (hands-on), stand-by assistance (within arms' reach), and verbal assistance (must be instructed), with bathing, drying and dressing lower body, food preparation, and toileting for the period 17 March 2012 through 19 July 2012.

The applicant was awarded $50K for 30 days of ADL loss due to TBI for the period 17 March 2012 through 30 April 212.

On 29 August 2012, a LOD was initiated for Neurological Hypotension – Syncope versus Seizure, TBI, Temporal Mandibular Joint (TMJ) – Left jaw pain history of Bruxism, Tinnitus, and Ulnar Neuropathy. On 9 September 2012, the injuries were determined to be Existed Prior to Service – Service Aggravated (EPTS-SA).

According to SGLV 8600, dated 21 September 2012, provided by the applicant, his medical provider certified he required physical assistance (hands-on), stand-by assistance (within arms' reach), and verbal assistance (must be instructed) with bathing, dressing lower body, food preparation, and toileting for the period 17 March 2012 through 19 July 2012, while hospitalized in LRMS, Saint Mary's Regional Medical Center and Martinez VA TBI Center.

On 7 February 2013, the Office of Servicemembers' Group Life Insurance (OSGLI) denied his claim for additional TSGLI benefits. The OSGLI noted the applicant's claim was not approved because the medical documentation provided does not indicate his loss met the TSGLI standard. To qualify, a claimant must have been unable to independently perform at least two ADLs for at least 15 consecutive days. Your inability to perform at least two or more ADLs for at least 15 days must also have been certified by a medical professional. The claimant is considered *unable* to perform any activity independently only if he/she *requires* at least one of the following, without which they would be incapable of performing the task:

Physical assistance (hands-on), stand-by assistance (within arms' reach), or verbal assistance (must be instructed).

His claim for the inability to perform ADLs due to TBI was not approved because the medical documentation provided does not indicate his inability to perform ADLs for 60 consecutive days. The claim for loss of hearing in both ears was not approved because loss of hearing is defined as an average hearing threshold sensitivity for air conduction of at least 80 decibels measured via pure tone audiometry by air conduction< without amplification device. In addition, loss of hearing must be clinically stable and unlikely to improve. His claim for hospitalization was not approved because under TSGLI, hospitalization is defined as an inpatient hospital stay, which lasts for 15 or more consecutive days in a hospital or series of hospitals, that is accredited as a hospital under Hospital Accreditation Program of the Joint Commission on Accreditation of Healthcare Organizations. The number of days includes transportation time from the site of the injury to the hospital, the day of admission, and the day of discharge.

DD Forms 261, *Report of Investigation, LOD and Misconduct Status*, dated 3 December 2013, reflects the applicant's diagnoses of Temporal Mandibular Joint (TMJ), Ulnar Neuropathy and mild TBI (mTBI), were determined to be "Not in Line of Duty – Not Due to Own Misconduct and his diagnosis of Neurologic Syncope/Conversion Disorder were determined to be "In Line of Duty.

On 22 January 2015, the OSGLI disapproved the applicant's claim request for additional TSGLI benefits. His claim for facial reconstruction of the jaw and left mandibular was not approved because the losses did not meet the TSGLI standard. Specifically, under TSGLI, facial reconstruction is defined as traumatic avulsions of the face or jaw that cause discontinuity defects. The loss must be certified by an oral maxillofacial surgeon, plastic surgeon or ear, nose and throat specialist.

A LOD Appeal Request dated 13 May 2016, reflects the applicant was diagnosed with three Formal LOD conditions: TMJ – Left jaw pain with a history of Bruxism, mTBI, and Tinnitus secondary to mTBI, were previously deemed EPTS LOD Not Applicable. Subsequently, the applicant appealed the LOD determinations. On this same date, NGB/SGPA did not recommend a change in determination of the Formal LOD determination for the diagnoses of TMJ – Left jaw pain with history of Bruxism; mTBI and Tinnitus secondary to mTBI. However, SGPA does recommend the diagnoses of "Tinnitus secondary to Non-Steroid Anti-Inflammatory Drugs (NSAIDS)," be considered ILOD. NGB/JA concurred with SGPA that the TMJ – Left jaw pain with history of Bruxism, mTBI and Tinnitus secondary to mTBI should remain EPTS LOD- Not Applicable. Also, JA concurred with SGPA recommendation that the Tinnitus condition change of diagnoses to "Tinnitus secondary to NSAIDs," be found ILOD. ANGRC/CC approved TMJ – Left jaw pain with history of Bruxism, mTBI and Tinnitus secondary to mTBI conditions to remain EPTS LOD Not Applicable and to change Tinnitus diagnosis to "Tinnitus secondary to NSAIDs" be found ILOD.

On 24 May 2016, the applicant was issued an AF Form 469, *Duty Limiting Condition Report*, indicating he was undergoing a Medical Evaluation Board (MEB) Initial Review In Lieu Of (IRILO), to determine his medical fitness for continued worldwide duty and retention, with a projected release date of 24 May 2017. In addition, he had the following duty/mobility/fitness restrictions: no running/walking/sit-ups/push-ups on the Air Force Fitness Assessment (AFFA); administrative duties only; cannot wear gas mask; no duties where sudden incapacitation would injure self or others; no duties requiring climbing ropes, ladders or more than the following flights of stairs; no duties requiring work-around moving machinery; no lifting objects weighing more than the following 30 pounds; and no permanent change of station/temporary duty (TDY)/mobility until IRILO disposition.

DD Form 261 dated 7 June 2016 reflects the applicant's diagnosis of Tinnitus secondary to NSAIDs was determined to be ILOD.

On 21 October 2016, AFPC/DPFD notified the applicant that based on the medical evidence received his TSGLI claim appeal package was not approved. With respect to his claim for permanent loss of use of both testicles, the TSGLI Program criteria states the member is eligible for a TSGLI benefit, if the member suffers damage to both testicles resulting in the need for hormonal replacement that is medically required and reasonably certain to continue throughout the lifetime of the member. The medical documentation submitted does not support a contention there was damage to both testicles on 7 March 2012.

With respect to the claim for the inability to perform at least two ADLs, due to TBI at the 60 and 90-day thresholds, AFPC/DPFD, reexamined his claim and the additional documents provided with his appeals package. However, the medical documentation does not support he was unable to perform at least two ADLs, due to TBI, for at least 60 consecutive days. Medical information provided included a neuropsychological evaluation that was done on 6 June 2012. According to the psychologist notes the applicant states "he typically spends time working on the guard base, attending medical appointments, and hanging out with friends (i.e. shopping; golfing; playing pool)." Further, the psychologist noted, the applicant continued to find leisure activities enjoyable; however, he had become frustrated at times because his hand-eye coordination had declined.

AFPC/DPFD opines that if the applicant received a mTBI, as diagnosed well after the MRAP incident, he should have been able to institute appropriate behavioral, equipment, and safety measures within 60 days (before the 60-day ADL threshold) to compensate his intermittent syncopal episodes. Finally, while the applicant apparently continued to receive assistance with his ADLs after the 30-day ADL threshold, he returned to work (at least part-time) on 8 May 2012 and should have been able to institute appropriate adaptive behaviors and equipment before the 60-day threshold.

According to AF IMT 618, *Medical Board Report,* on 7 April 2017, a MEB convened to consider the applicant for continued active duty. The board recommended the applicant be referred to an Informal Physical Evaluation Board (IPEB) for Ulnar Neuropathy of Left Upper Limb; Neurologic Syncope; Conversion Disorder, and TMJ. On this same date, the applicant was informed of the findings and recommendation of the MEB, to include the contents of the Narrative Summary and did not elect an impartial review or to submit a rebuttal letter.

On 19 April 2017, the IPEB returned the applicant's case without action. The board noted they could not determine fitness based on information that is 24 months old. Specifically, the board noted none of the conditions submitted are static and all have a reasonable possibility of improvement to the point of return to duty. Also, the IPEB noted the applicant had been noncompliant with requests to provide up to date clinical information. In addition, the only LOD condition is Neurologic Syncope/Conversion Disorder. Conversion disorder requires a mental health evaluation and if still considered potentially unfitting a mental health Narrative Summary (NARSUM) will need to be submitted.

AIR FORCE EVALUATION

The AFBCMR Medical Advisor opines, although compelling evidence is provided by both the applicant's parents and at least two physicians regarding the applicant's level of functions, the fact he returned to some form of duty and participated in recreational activities (i.e. Golf), brings significant doubt to his actual inability to perform basic ADLs, without assistance or stand-by assistance. Nevertheless, the Medical Advisor recommends the following two options:

1. Deny requested relief due to the significant uncertainty of the applicant's actual ability

to function with or without assistance at a given time, by virtue of his documented return to work and participation in recreational activities. Additionally, there is no certainty of whether or not the applicant's clinical symptoms were significantly influenced by or the result of a psychiatric condition; notwithstanding the overlapping symptoms of one or more of these with TBI, as determined by the Department of Veterans Affairs.

2. Grant relief for a $50K payment for the additional 60 days of ADL loss, through 19 July

2012 on ADL grounds, requiring stand-by assistance due to fall risk secondary to syncopal episodes, left upper extremity weakness, and possible cognitive decline due to TBI. Both of the applicant's parents have written compelling statements regarding their fears of the applicant's risk for self-injury, due to his unpredictable episodes of passing out, while in the shower, in addition to his questionable ability to maintain proper personal hygiene following toileting. In addition, Doctor's L----- and H-----, on 21 September 2012 and 24 October 2012, respectively, certified ongoing ADL losses, including the inability to dress, bathe, and toilet independently, which were also present for at least four months previously, between 17 March 2012 and 19 July 2012.

The Medical Advisor aims not to deprive the applicant of a benefit for which he and his counsel believe he has met eligibility to receive. However, the question is whether or not any of the signs or symptoms reportedly resulting from an injury in Mar 12, interfered with the applicant's ability to perform at least two ADLs, requiring assistance or stand-by assistance, during the requested period; and whether or not he should be granted the TSGLI benefit due to testicular injury. The Medical Advisor opines the singular significant risk to the applicant has been his predisposition for experiencing falls due to syncope, noting its possible multifactorial cause; notwithstanding his left upper extremity weakness. However, establishing a relationship between the mTBI, the risk of syncope, and left upper extremity weakness and the actual performance of ADLs, as defined in the TSGLI guide, warrants review of definitions [attached].

The Medical Advisor reviewed the TSGLI Procedures Guide, Version 2.45, which lists multiple criteria for receiving the benefit; which includes sensory loss [sight, hearing, speech] burns, paralysis [must be *complete* quadriplegia, paraplegia, hemiplegia, or uniplegia], amputations [hands, fingers, foot, toes], limb salvage surgery [to avoid amputation], facial reconstruction [due to injury that would otherwise leave a gap, or discontinuity defect], **activities of daily loss [loss of at least two of six ADLs],** *coma* due to TBI, loss of ADL due to TBI, coma *combined* with ADL due to TBI, coma due to TBI combined with another injury, loss of ADL due to TBI combined with another injury, loss of ADL due to injury other than TBI, inpatient hospitalization [for 15 consecutive days, including transport from site of injury to hospital and continues through subsequent hospital transfers, through date of release], and genitourinary losses.

With respect to the applicant's limited ability to bathe due to *left arm weakness*, the ADL standard is "unable to bathe more than one part of the body via tub bath or sponge bath or get in or out of tub or shower." The Medical Advisor opines with a fully functional [likely dominant] right upper extremity and with use of supportive appliances (i.e. chair for seating, use of bath sponge on stick, skid preventative measures on bottom of tub or shower, direct assistance and stand-by assistance would likely be **required**.

The applicant's limited ability to dress independently due to left arm and hand weakness, the level of weakness, as objectively documented in the record, should not preclude getting dressed, with alternative availability of clothing choices not requiring buttoning or zippering. There are devices available to facilitate these actions if needed.

The applicant's inability to eat independently, due to "limited ability with food preparation when two hands are required," the ADL standard is to be able to "get food from plate to mouth or take liquid nourishment from a straw or cup." Food preparation is not considered an ADL.

With respect to the applicant's difficulty with personal hygiene due to left shoulder pain and being "prone to syncope after defecating," as this causes a drop in heart rate, the ADL standard is unable to toilet independently; that is, "to go to and from the toilet, get on and off the toilet, clean self after toileting, and get clothing off and on before and after toileting." The Medical Advisor concedes, after toileting [getting off] and upon attempted standing, poses an already demonstrated risk for a postural hypotensive or syncopal episode. Thus, this reviewer opines that stand-by assistance to avoid injury would be justified due to the predisposition for syncope; although the causation of the applicant's syncope has crossed many domains in the record, neurological [mTBI], psychiatric [Conversion, Somatization], and cardiovascular [postural hypotension].

Regarding the applicant's *incomplete* **upper and lower extremity weakness [hemiplegia]**, as prescribed in the medical record, the Medical Advisor opines does *not* constitute complete paralysis and, thus, **would not qualify for the benefit under the attached paralysis criteria**.

Additionally, although loss of consciousness (LOC) and **coma** have been discussed in the applicant's case, the duration of time [in consecutive days/hours] in such status **did not qualify for the TSGLI benefit** under the TBI criterion based upon objective records evidence.

Addressing the applicant's contention that his requirement for testosterone replacement, albeit reportedly secondary to the pituitary injury, should be a qualifying testicular injury, attention is directed to the additional attached extract from the TSGLI Guide. The Medical Advisor opines the applicant **does not qualify for the TSGLI benefit due to amputation or damage of one or both testicles**, not only because there was *no direct anatomic loss* or "damage" to the testicles, but that the hormonal replacement therapy cannot be reasonably certain to be required throughout the lifetime of the applicant. While current medical literature has established a potential causal relationship between TBI and pituitary gland dysfunction, commonly presenting as deficits in growth hormone, hypogonadism, and diabetes insipidus,[1] the frequency of pituitary dysfunction varies according to the severity of trauma, type of trauma, time elapsed since trauma, study population, study design, endocrine testing, and criteria used to diagnose anterior pituitary hormone deficiency. Moreover, although such hormonal deficits were monitored up to five years in one study, there is no reasonable certainty that such deficits will require lifelong replacement therapy. [2] It has also not been determined what the applicant's baseline hormonal levels were prior to the accident of 2012 and whether or not there was dysfunction predating the accident of 2012.

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[1] Dysfunction of hypothalamic-hypophysial axis after traumatic brain injury in adults, *Journal of Neurosurgery*, Kruhulik, D, Zapletalova, J., Frysak, Z., and Vaverka, M.

[2] Pituitary dysfunction following traumatic brain injury: clinical perspectives, *Neuropsychiatric Disease and Treatment*, Tanriverdi, F., Kelestimur, F., Dept. Endocrinology, University Medical School, Kayseri, Turkey, published online 2014 July 27.

Finally, the risks of syncope and the effects of cognitive impairment or extremity weakness, appear not to have been an impediment to unassisted functioning, due to applicant's self-reported participation in work-related and recreational activities.

The complete advisory opinion, with attachment, is at Exhibit C.

AFPC/DPFC recommends denial of the applicant's request, indicating that based on the documentation provided by the applicant and analysis of the facts, there is no error or injustice.

At the time he was injured, medical records made no mention of a head injury and, in fact, it was documented the applicant denied having a head injury. Subsequently, during his evaluation at Landsthul Regional Medical Center (LRMC), the applicant's injury history begins to evolve. As he is being evaluated for the odd "spells" that occurred during aeromedical evacuation (AE) transport, the description of the MRAP injury begins to transform. There is an unsubstantiated comment about exposure to three blasts. A bruise on the cheek is noted and it is apparently assumed the finding is related to the MRAP door injury. There are later reports in the medical record of the applicant being dazed and confused after the episode although this was not documented at the time of the injury. Most importantly, in the initial weeks of treatment following the MRAP incident, there was no indication the applicant was struck in the back of the head (or any part of his head) with the MRAP door. At Landstuhl, the applicant underwent an MRI of the brain with and without contrast and cervical, thoracic, and lumbar spine with 3D reconstruction. All were normal; only small annular disc protrusions were noted at T7-8 and T8-9 effacing the thecal sac but with no central or foraminal stenosis. EMG of the left arm indicated only ulnar nerve abnormalities consistent with the cubital tunnel diagnosis given by neurology in the theater. Of particular note, the EEG was completely normal despite the applicant having a 45 second episode of "shaking" and a "fainting spell" at the end of the study. Psychiatry was consulted for the concern about possible conversion disorder; the applicant indicated to psychiatry he was concerned about loss of pay and benefits; psychiatry diagnosed anxiety but conversion disorder was not ruled out.

The history of the applicant's injuries have evolved with time. The applicant's counsel refers to "a crush injury/traumatic brain injury" and that the applicant was "struck in the back of his head." As time goes on, the medical records begin to refer to more serious mechanisms of injury. In a note from the Ear, Nose and Throat (ENT) surgeon evaluating the applicant for his TMJ on 17 June 2012, it was noted that after the MRAP door struck the applicant in the back of the head, he then struck his chin on the opposing door roughly two feet away and subsequently had his head/skull compressed against the opposing door for several minutes." In a note from 28 September 2012, Dr. T. L----- documented an even more serious sounding mechanism of injury when he noted "His second TBI occurred in March 2012 while serving in Afghanistan when an armored door fell on his head with a brief LOC noted." Ms. B---- cited Dr. L-----'s discussion of the applicant's two TBI events as substantiation the second TBI occurred. She did not address the fact Dr. L----- had totally misconstrued the actual facts of the event as documented in contemporaneous medical records and the LOD determination. As time goes on, the history of the alleged TBI sounds increasingly serious. This is despite the fact clinical notes made proximate to the time of the injury made no mention of a head injury. When he originally sought treatment for his injuries, the applicant denied LOC or neck pain and there was *no mention of any head injury*, mild (mTBI) or otherwise.

The medical record of initial treatment for the MRAP-related injury is clear. The applicant was treated and released for his complaints of mid back pain, left scapular pain, and numbness/tingling left arm. Additionally, a LOD determination dated 16 March 2012 indicated the applicant was "stuck" or "trapped" by a MRAP's hydraulic door for approximately five minutes which involved a few people having to lift a door off the applicant; resulting in significant mid-thoracic back pain from the pressure." This description is consistent with the initial description of the incident in the medical record. At the time he was being transported to LRMC, the Patient Movement Record (PRM) refers to "being trapped in high pressure MRAP door, applying intense pressure along left side of back." Again, there is absolutely no mention of a head injury and the reason the applicant was being transported to LRMC was for an MRI evaluation of his spine, not his head. Medical records clearly indicate the applicant was transferred to LRMC because of his persistent complaints of back pain, not due to concerns for a head injury. He did not even undergo an assessment for TBI in-theater.

While the applicant was previously approved for 30-days loss of ADLs due to TBI, this decision appears to have been made by a medical reviewer who was without the benefit of having all medical records documenting the initial care and follow-up for his injuries. Contrary to Ms. B---- argument, "there is no doubt applicant suffered a TBI," there has actually been considerable doubt in the minds of multiple Air Force medical reviewers the applicant actually sustained a head injury as a result of the MRAP incident and those three Air Force medical reviewers have come to the same conclusion the applicant did not suffer a TBI at the time he sustained torso injuries from the MRAP door. Contrary to the comments in Ms. B----'s review, there is nothing "unjust" about three physicians all agreeing a review of the medical record reveals was no definitive evidence of a TBI occurring as a result of the events of 7 March 2012. In addition, the applicant did have a documented history of TBI in the past. By his own admission, when he sought treatment for headaches in his first week of basic training, that injury occurred prior to the time he entered service.

In order to approve a claim for compensation under TSGLI, we need to be able to draw a direct connection between a known external force trauma and a specific physical injury sustained by the applicant. Based on multiple physician reviews performed since the applicant was originally compensated for loss of the ability to perform covered ADLs due to TBI, multiple Air Force medical reviewers have determined beyond their reasonable doubt, medical records from the initial period after the applicant's injury do not reflect the diagnosis of head injury or TBI. As a result, we cannot establish the direct cause of the symptoms later attributed to the MRAP incident in March 2012 by clinicians who did not initially care for the applicant. This is particularly problematic when the applicant has a documented history of a previous TBI. Even if the AFBCMR rejects our opinion the applicant did not sustain a TBI in March 2012, we believe four Air Force medical reviews have determined conclusively for reasons already stated, the applicant did not have a medical requirement for assistance with ADLs at the 60-day threshold or beyond.

With regard to the claim of loss of testicular function, the medical literature documents neuroendocrine function (NED) has been shown to occur as the result of TBI. As a result of NED, reduced production in testosterone does occur. As already noted, we do not believe there is sufficient evidence to establish the applicant actually sustained a TBI on 7 March 2012.

However, even if we accepted that assertion, there is no evidence in the medical record which would indicate the applicant sustained any direct force injuries to the testicles in the MRAP mishap. In fact, his argument for compensation is predicated on the assertion his testicular hypo-function was the result of his alleged TBI.

The applicant's claim for loss of the use of testicles was previously disapproved on multiple occasions because he did not sustain direct, external force injury to the testicle(s). Ms. B---- argues this was an error because, "Nowhere in the TSGLI guidelines does it state there must be a direct injury to the testicles." A more complete review of the TSGLI Procedures Guide and knowledge of the history of the program all support our contention Ms. B---- is in error. When the TSGLI Program was established, it was based on civilian Accidental Death and Dismemberment (AD&D) Insurance. While AD&D does not generally cover GU losses, the losses it does cover require:

1. Accident to occur (our traumatic event).
2. Accident to cause "physical" damage to a specific part of the body (say an eye or arm), and
3. That damage to result in the payable loss (loss of eye, amputation etc.) to that same part of the body.

In this case, no physical damage to the testicle(s) occurred. In order to clarify this issue, DPFC contacted the Department of Veterans Affairs and received the following clarification from Ms. K. H------, Insurance Specialist, Program Management Division, Veterans Benefits Administration: "The (TSGLI) program would be moving away from its intent of providing service members with comparable coverage to the private AD&D market if we were to eliminate the 2nd criteria above. In my view, this would lead to further complexity in claims adjudication by the branches – not just on a case like this, but similarly situated cases – where damage to one part of the body could be claimed to have impacted another part of the body… AD&D is designed to be clear cut in the sense that damage to (a specific) part of the body causes the loss to the same part of the body." In summary, we believe the prior denial of the claim of loss of function of the testicles by the Air Force on repeated reviews was justified and consistent with the intent of the TSGLI Program.

The applicant was found to have sustained physical injuries which were found to have resulted in a loss of the ability to perform two or more ADLs for a period of 30 days. While the initial Air Force medical reviewer found the losses were as a result of TBI, multiple medical reviewers for the Air Force subsequently determined there was no objective evidence a TBI actually occurred at the time of the MRAP injury. As a result of the recommendations of the initial medical reviewer, the applicant was approved for loss of ability to bathe, toilet and dress at the 15 and 30-day threshold due to TBI (as well as other traumatic injury (OTI)) and he has already received compensation in the amount of $50K. However, for the reasons cited in the review of the case, the applicant does not qualify for any further reimbursement for ADL loss as the result of TBI or OTI. In addition, the applicant did not sustain an external force injury to the testicle(s); therefore, he does not qualify for loss of testicular function under the TSGLI Program.

The complete AFPC/DPFC advisory opinion is at Exhibit D.

On 15 January 2020, due to complexity of the case, the Board staff requested an additional advisory opinion from the AFBCMR Medical Advisory and requested the AFRBA Psychological Advisor review for concurrence/non-concurrence.

The AFBCMR Medical Advisor and the AFRBA Psychological Advisor both recommend denial of the applicant's request, indicating the applicant has not met the burden of proof of an error or injustice that warrants the desired change to his record. Pivotal in reaching this conclusion, with respect to eligibility under the ADL rule, whether effected through a cognitive deficit, syncopal episodes, seizure disorder, or a mental disorder, there is evidence of record that the applicant participated in occupational and recreational activities, during the requested period, that are inconsistent with the requirement for assistance or stand-by assistance, with at last two activities of daily living for the claimed extended period, as defined in the TSGLI policy.

The AFBCMR Medical Advisor again thanks the applicant for his service and the care he has received from his parents; particularly as expressed in their letters of concern for his wellbeing. However, despite the letters of support previously submitted in evidence from reputable civilian medical authorities, in support of the applicant's petition, the Medical Advisor identified certain other facts of record, which raised significant doubt to his true requirement for assistance in **at least two activities of daily living** (ADL's), as defined in the TSGLI policy. These include documentation of the applicant's performance of military duties, albeit limited to administrative clerical tasks, and participation in certain physical activities [golfing and pool]; the latter that are inconsistent with the need for consistent or uninterrupted assistance, or stand-by assistance, in performing at least two ADL's; notwithstanding his plausible singular alleged need for assistance [dressing] to assure the selection of proper military attire. In the work environment, it is also assumed that the applicant did not require or seek assistance or stand-by assistance had toileting or other needs arose.

Thirdly, there has been significant doubt that the applicant actually experienced a second TBI, in addition to the professional disagreement as to the diagnostic source or cause of the applicant's symptoms, following the injury on 7 March 2012; first noting no objective reference to a head injury during the entire month of injury, followed by negative cardiovascular, neurological, and electro-diagnostic studies [EEG, EMG, and NCV]; leaving a psychological condition as a possible cause; while not discarding the possible association with *mild Traumatic Brain Injury (mTBI)*.

The Medical Advisor considered the plausibility that the applicant's symptoms were the result of a repeat *mTBI*, despite its possible causal relationship with a *conversion disorder*, *somatization*, or *somatoform disorder*. However, whether due to *mTBI*, *conversion disorder*, an Axis I mental disorder, such as *anxiety disorder* or *major depression*, *non-epileptic seizure disorde*r, or *somatization*, neither condition appears to have prevented the applicant from performing military duties at the Guard nor his self-admitted participation in certain recreational activities, inclusive of the requested extended period of benefits; which this reviewer opines would require a similar or greater level of intact sensory-motor and cognitive function necessary in performing the claimed deficient ADL's.

The complete advisory opinion is at Exhibit E.

APPLICANT'S REVIEW OF AIR FORCE EVALUATION

The Board sent a copy of the additional advisory opinion to counsel on 31 October 2022, as it was never sent to the counsel/applicant for comment. On 3 January 2023, counsel replied and provides an AF IMT 348, *Line of Duty Determination* dated 9 September 2012 and TSGLI Claim – Request for Reconsideration dated 24 September 2015.

The applicant's complete response is at Exhibit G.

FINDINGS AND CONCLUSION

1. The application was timely filed.

2. The applicant exhausted all available non-judicial relief before applying to the Board.

3. After reviewing all Exhibits to include the AF IMT 348, Line of Duty Determination, dated 9 September 2012, the prior TSGLI claim and decision letter, statements from the applicant, his fiancée an independent registered nurse, as well as the updated TSGLI application, the timeline and outline of medical records and, claimed, new and material medical records regarding the genitourinary loss, the Board concludes the applicant is not the victim of an error or injustice. The Board concurs with the rationale and recommendations of AFPC/DPFC and the AFBCMR Medical Advisor and finds a preponderance of the evidence does not substantiate the applicant's contentions. Specifically, the Board took notice of the applicant's complete submission, to include counsel's assertions in judging the merits of the case and do not find that it supports the applicant's TSGLI protection appeal denied on 21 October 2016, be reversed and his claim be reinstated for 90 days (1 May 2012 through 19 July 2012) loss of ability to independently perform two or more Activities of Daily Activities (ADLs) be approved and that he be awarded $50K under the TSGLI Schedule of Losses #17 for Coma from traumatic injury and/or Traumatic Brain Injury (TBI) due to 90 consecutive days of ADL loss (bathing, dressing, toileting, and transferring) and/or for suffering permanent loss of use of both testicles, which under Schedule of Losses #19, alternatively qualifies for a maximum of $50K. Based on the available evidence, it appears the applicant's TSGLI protection appeal denial was properly adjudicated and found no evidence which would lead us to believe that the denial decision was in error or contrary to the governing Air Force instructions. In this respect, we note there is evidence of record the applicant participated in occupational and recreational activities, during the requested period, that are inconsistent with the requirements for assistance or stand-by assistance, with at least two ADLs for the claimed extended period, as defined in the TSGLI policy. While the Board notes, the applicant's parents may have provided assistance for over 30 days; however, a neuropsychological evaluation dated 6 June 2012, states the applicant "typically spends time working on the guard base, attending medical appointments, and hanging out with friends (i.e. shopping, golfing and playing pool)." Further the psychologist noted, the applicant continued to find leisure activities enjoyable; however, he become frustrated at times because his hand-eye coordination had declined. Based on a review of the case, the applicant does not qualify for any further reimbursement for ADL loss as the result of TBI or OTI. In addition, we note the applicant did not sustain an external force injury to his testicle(s); therefore, he does not qualify for loss of testicular function under the TSGLI Program. Therefore, under strict application of the TSGLI policy and the definitions of ADLs involved, the Board notes the burden of proof of an error or injustice has not been met. Therefore, the Board recommends against correcting the applicant's records.

RECOMMENDATION

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

CERTIFICATION

The following quorum of the Board, as defined in the Air Force Instruction (AFI) 36-2603, *Air Force Board for Correction of Military Records (AFBCMR)*, paragraph 1.5, considered Docket Number BC-2016-04417 in Executive Session on 27 September 2019 and 20 April 2023:

, Panel Chair
, Panel Member
, Panel Member

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

Exhibit A: Application, DD Form 149, w/atchs, dated 28 October 2016.
Exhibit B: Documentary evidence, including relevant excerpts from official records.
Exhibit C: Advisory Opinion, AFPC/DPFC, dated 22 August 2019.
Exhibit D: Advisory Opinion, AFBCMR Medical Advisory, w/atch, dated 23 September 2019.
Exhibit E: Advisory Opinion, AFBCMR Medical Advisory, dated 6 February 2020.
Exhibit F: Notification of Advisory Opinion, SAF/MRBC to Applicant w/atch, dated 31 October 2022.
Exhibit G: Rebuttal Documents from Counsel.

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.