ADDENDUM TO RECORD OF PROCEEDINGS

IN THE MATTER OF: XXXXXXXXXXX

DOCKET NUMBER: BC-2014-05241

COUNSEL: NONE

HEARING REQUESTED: NO

APPLICANT'S REQUEST

The Board reconsider his request to amend his in the line of duty (ILOD) determination to reflect his diagnosis of Post-Traumatic Stress Disorder (PTSD) was "line of duty" vice "existed prior to service (EPTS)/service-aggravated." In addition, he submits the new additional request:

- His diagnosis of Obstructive Sleep Apnea (OSA) be amended to reflect ILOD.

RESUME OF THE CASE

The applicant is an Air Force Reserve technical sergeant (E-6) assigned to the Non-Obligated Non-Participating Individual Ready Reserve (IRR).

On 29 Jan 16, the Board considered and denied his request to amend his diagnosis of PTSD from "EPTS/service-aggravated" to "ILOD" finding the applicant had provided insufficient evidence of an error or injustice to justify relief.

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 I.

On 7 Dec 22, the applicant requested reconsideration of his request to amend his diagnosis of PTSD from "EPTS/service-aggravated" to "ILOD." In addition, he submits the new additional request: amend his diagnosis of OSA to reflect ILOD. He again contended the Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB) erred in reviewing the evidence regarding his diagnosis of PTSD. He contended the MEB and PEB did not consider the rating decision from the Department of Veterans Affairs (DVA), dated 30 Jan 14, during their review and erroneously utilized the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), which was no longer being used in 2013, vice the more current fifth edition (DSM-V) when evaluating his mental health condition. He further contended the PEB used old information from the 2011 DVA Compensation & Pension (C&P) examiner and the WHASC [Wilford Hall Ambulatory Surgical Center] provider in 2013. This affected the outcome of his MEB which could have a very significant outcome on his retirement because the appropriate information was not used during the proceedings. Additionally, his not ILOD determination for OSA should be changed because the determination did not include the 59th Medical Wing Sleep Disorder Center findings in 2011. His OSA was finally approved as service-connected in Aug 21, and should have been looked at and could change the outcome of his MEB. Since the PACT [Promise to Address Comprehensive Toxics Act], he checked his DVA benefits, when he came across this while reviewing his MEB findings. He saw the determination was made on evidence that was left out. Finally, the applicant contended the Impartial Reviewer left out portions of the DVA C&P examiner's evaluation, which overall showed the DSM-V criteria for PTSD was met. The MEB should have noticed this, but instead, took the Impartial Review's word and decided they did not have to review the package. He feels the 59th Medical Wing, MEB, and PEB did not do their duty, and had they done it, they would have caught the mistakes or issues that he is asking the Air Force Board for Correction of Military Records (AFBCMR) to correct. The

applicant provided a list of discrepancies for the AFBCMR to consider regarding the processing of his MEB and PEB.

In support of his reconsideration request, the applicant submitted the following new evidence: (1) DVA Board of Appeals Letter, dated 26 Mar 21; (2) DVA Rating Decision, dated 27 May 21; (3) DVA Board of Veterans' Appeals Remand Letter, dated 28 May 21; (4) Information Report, Military History, dated 17 Dec 21; (5) DVA Toxic Exposure Risk Activity Memo w/Individual Longitudinal Exposure Record, dated 28 Mar 23; and (6) Multiple articles from medical journals regarding DSM-IV/DSM-V and PTSD.

The applicant's complete submission is at Exhibit J.

AIR FORCE EVALUATION

AFRBA Psychological Advisor finds the applicant's Veterans Affairs Schedule for Rating Disabilities (VASRD) rating was determined accurately at 10 percent and there is insufficient evidence to support the applicant's request for a change in his rating.

The applicant contends the PEB based their decision on old information and left out key findings to make the determination. He contends the AFBCMR should correct his record to show DSM-V, because DSM-IV was no longer being used in 2013. This contention implies that his mental health diagnosis would have been different at the time he was diagnosed. Finally, he contended the decision from the DVA on PTSD, dated 30 Jan 14, was not included in the package.

This psychological advisor agrees with the past findings of the PEBs on 24 Feb 15 and 22 Jan 16 determining a mental health diagnosis of anxiety disorder NOS [not otherwise specified] with a rating of 10 percent. While a previous PEB decision on 23 Jun 14 rated him at 100 percent (for anxiety disorder NOS), they noted that his condition was not stable and, therefore, placed him on the Temporary Disability Retired List (TDRL). He was later re-evaluated and the PEB (24 Feb 15) determined that his symptoms most closely matched a VASRD rating of 10 percent. This decision was based on the level and degree of his symptomology. The board noted that he was employed full-time, he was promoted at work, his depressed mood passes fairly quickly, his nightmares have reduced with the use of medication, and he has had several positive things occur in his life. They noted that he no longer requires medication (Depakote) for mood stabilization. Finally, they noted that there is no evidence in available records that he continues to seek mental health treatment. The PEB assessed his degree of mental health symptoms and determined it matched a VASRD rating of 10 percent ("The SM's status can best be described as occupational and social impairment due to mild or transient symptoms which decrease work efficiency and ability to perform occupational tasks only during periods of significant stress, or symptoms controlled by continuous medication."). The PEB on 22 Jan 16 determined the same rating but added "combat related." The board recommended a disposition of Discharge with Severance Pay at 10 percent.

The applicant contended that this decision was based on old information and left out key findings. There is insufficient evidence to support this claim. The decision of the PEB was based on a current evaluation of the applicant's symptoms at the time of the examination in determining its findings/ratings. The applicant contended that his diagnosis was based on an older version of the DSM (DSM-IV vs DSM-V) and that these versions are fairly different and could change the outcome of his MEB. From his records, the criteria he did not meet at the time was avoidance of stimuli associated with the trauma/traumatic event (criteria C), as he appeared to meet all the other criteria in both versions. Criteria C, in both DSM editions, are fairly similar, with minor changes, and in this psychological advisor's opinion, would not have changed his diagnosis at the time. For clarity, here is criteria C from both manuals:

- DSM-IV
    - Criteria C
        - Persistent avoidance of stimuli associated with the trauma and the numbing of general responsiveness (not present before trauma), as indicated by three or more of the following:
            - Efforts to avoid thoughts, feelings, or conversations associated with the trauma.
            - Efforts to avoid the activities, places, or people that arouse recollections of the trauma.
            - Inability to recall important aspect of the trauma.
            - Markedly diminished interest or participation in significant activities.
            - Feelings of detachment or estrangement from others.
            - Restricted range of affect (e.g., unable to have loving feelings).
            - Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span).

- DSM-V
    - Criteria C
        - Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:
            - Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
            - Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

The basic description in both versions is essentially the same. The DSM-V has moved the numbing symptoms from Criteria C and created a new Criteria D (negative alterations in cognition and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred). After reviewing all pertinent records at the time of the evaluations, the applicant would not meet either criterion C in DSM-IV or -V. The C&P evaluation from 1 Feb 11 noted he did not report sufficient avoidance symptoms at this time to meet full criteria for a PTSD diagnosis. His narrative summary dated 12 Dec 13 noted that at the time he was assessed, after patient interview and thorough psychological testing, the patient did not meet criteria for PTSD as the patient did not endorse sufficient avoidance symptoms to meet criteria for PTSD. It is interesting to note that even though he did not meet sufficient criteria to be diagnosed with PTSD because of avoidance symptoms, a mental health encounter dated 22 Dec 10 noted that the applicant reported some of these symptoms (avoidance) started prior to deployment as he is "controlling." Both versions of the DSM indicate the onset of avoidant symptoms should occur after the traumatic event and not before.

Even if the applicant were diagnosed with PTSD, this would not change his VASRD rating. The VASRD is a guide for evaluating the severity of a disability, which is then expressed as a percentage. In the applicant's case, the level of severity during his evaluation most closely matches a 10 percent rating. A 10 percent rating is defined as:

- Occupational and social impairment due to mild or transient symptoms which decrease work efficiency and ability to perform occupational tasks only during periods of significant stress, or; symptoms controlled by continuous medication.

As described in his evaluation documents, his symptoms most closely match this rating.

A 100% rating is defined as:

- Total occupational and social impairment, due to such symptoms as:
    - gross impairment in thought processes or communication;
    - persistent delusions or hallucinations;
    - grossly inappropriate behavior;
    - persistent danger of hurting self or others;
    - intermittent inability to perform activities of daily living (including maintenance of minimal personal hygiene);
    - disorientation to time or place;
    - memory loss for names of close relatives, own occupation, or own name

In reviewing the applicant's military and mental health record, his symptoms have never approached this level of severity, and as opined above are most consistent with the definition of a 10 percent rating.

This psychological advisor reviewed the decision from the DVA on 30 Jan 14 that granted the applicant a service connection for PTSD at 100 percent. With all due respect to the DVA evaluator, this psychological advisor acknowledges different providers have different diagnostic impressions and opinions and sometimes may not be in agreement with one another. There are many reasons for disparities in variances in diagnostic impressions among different providers and evaluators - some based upon variances in clinical presentation at a given time, different disclosures during a subsequent interview, clinical bias between equally competent providers, or legitimate differences due to new or different observations made throughout care. The differences in impressions and opinions do not sufficiently invalidate a provider's opinion as each provider is entitled to formulate an independent opinion based on available information but also from the provider's education, training, knowledge, expertise, and experience. In the applicant's case, there is insufficient evidence in his record that his impairment reached the VARSD rating definition of 100 percent, which much more closely fits the definition of a 10 percent rating.

The complete advisory opinion is at Exhibit L.

BCMR Medical Advisor addressed the applicant's stated medical condition only and recommends denying the applicant's request for a favorable ILOD finding for his diagnosed OSA condition. The burden of proof is placed on the applicant to submit evidence to support his contention/request. The evidence he did submit was assessed to show the known medical knowledge that OSA indeed is categorized as a gradual and chronic condition that takes time to develop and, when present, is not service-aggravated. Therefore, case documents do not support his request for an ILOD finding.

The applicant is requesting to favorably find his OSA condition as ILOD. In accordance with Air Force Instruction (AFI) 36-2910, *Line of Duty (LOD) Determination, Medical Continuation (MEDCON), and Incapacitation (INCAP) Pay*, the applicant's reason for change is due to not having the Department of Defense (DoD)-obtained sleep study prior to the ILOD determination amounts to a mere change in where the study took place, for the diagnosis (which is of paramount concern) remained unchanged and thus was the focus of the resultant LOD recommendation.

The applicant claimed his first sleep study with the diagnosis of OSA occurred on 7 Jul 09. One year and seven months later (Feb 11), he was seen for a Continuous Positive Airway Pressure (CPAP) evaluation to obtain a proper and comfortable pressure level of the machine as well as to document a valid sleep study performed within the military health care system, and not just one within the civilian system. After the DoD confirmed optimal CPAP titration, an encounter occurred to download data from the CPAP device to validate use compliance. The applicant's disposition was unchanged as he was released without limitations on 8 Mar 11 by the DoD sleep

disorder center. It was more than two years later when an administrative LOD documented the applicant was not on active duty orders when the non-DoD sleep study was performed in Jul 09. Additionally, this delayed administrative LOD clearly documented/explained that the onset of an OSA condition is a condition of chronic/gradual development. Therefore, the OSA condition is not an acute or sudden entity but rather it is a slow development which would have existed prior to any active duty orders while in the Air Force Reserve, as stated on the administrative LOD document. It further noted the OSA condition is not an injury or illness that results from any service-related circumstance. It was a six-year period of no medical record evidence such as OSA being a duty limiting condition in such severity whereby the applicant was unable to fulfill his military duties of his office, grade, rank, or rating. The applicant himself acknowledged his ability to "participate in Drills and TDYs" during 2009; when he claims the sleep study revealed severe OSA.

AFI 36-2910, Chapter 1, Section 1.10.2, Paragraph 1.10.2.2. states, "A determination of NILOD (Not in Line of Duty)-Not Due to Member's Misconduct is also made when an investigation determined, by clear and unmistakable evidence, the member's illness, injury, disease or the underlying condition causing it, existed prior to the member's entry into military service with any branch or component of the Armed Forces or between periods of such service, and was not service aggravated. EPTS-NSA conditions include chronic conditions and conditions where the incubation period rules out a finding that the condition started during any period of AD, AD for training or Inactive Duty Training (IDT)." Therefore, the chronicity in its development dictates this physical condition of OSA cannot favorably be found as occurring ILOD.

Lastly, in the applicant's memorandum, he cited his OSA diagnosis has been service-connected by the DVA and thus an assumed belief that the same should have been cited and adjudicated by the DoD. It remains paramount to note that the DoD and the DVA operate under different titles of the United States Code and therefore, under different sets of laws. In summary, between the two, service-connection by the DVA is not synonymous with nor does it equate to an automatic DoD disability impairment rating. The DoD deals with only conditions which are unfitting for continued military service and shortens a military career, whereas the DVA can authorize compensation for any medical condition determined service-incurred, without regard to, and independent of, its demonstrated or proven impact upon a service member's retainability, fitness to serve, or the length of time since date of discharge.

The complete advisory opinion is at Exhibit M.

APPLICANT'S REVIEW OF AIR FORCE EVALUATION

The Board sent a copy of the advisory opinion to the applicant on 27 Dec 23 for comment (Exhibit N), and the applicant replied on 28 Dec 23. In his response, the applicant contended the Integrated Disability Evaluation System allows DVA and DoD to share information and to complete each agency's respective process simultaneously, without need for duplicative exams and ratings systems. Per the advisor's written recommendation, his diagnosis matched a VASRD rating of 10 percent. So why did they have him as 100 percent disabled for anxiety disorder NOS for the MEB and DVA as 100 percent PTSD? He did not see any mention of the discrepancy of two different diagnoses. The advisor also tried to say DSM-IV and DSM-V are similar, which they are not. DSM-IV symptoms can be used to approximate DSM-V diagnosis, but there is nothing about using it vice versa. The American Psychiatric Association (APA) stated the change to DSM-V made numerous changes to the diagnostic criteria of nearly every DSM-IV order. In DSM-V, Anxiety Disorder does not include PTSD, but it states there is a close relationship among them. It also states panic attacks function as a marker and prognostic factor for severity of diagnosis and comorbidity across an array of disorders, including but not limited to anxiety disorders. Hence, panic attack can be listed as a specifier that is applicable to all DSM-V disorders.

The advisor failed to mention a new category was included for PTSD in DSM-V, Trauma and Stressor Related Disorders, and how that would affect both diagnoses. The advisor failed to mention in the 2014 DVA examination, the provider did state there was evidence of avoidance, even though vague, stated in the 2011 examination. The advisor and others did not review the DVA provider diagnosis of PTSD. They only used negative excerpts instead of using the whole documented diagnosis. The applicant provided an excerpt of his C&P evaluation in support. The advisor talked about disparities but questioned the diagnosis using the different DSMs and is basing the information in the outdated DSM being used. Using the inappropriate DSM could create human consequences, high rates of psychiatric misdiagnosis, incorrect treatment plans, and negative patient health. He does not see why the Air Force was not using the DSM-V during his MEB since it was established in 2013. There should not have been two different DSMs, and it should have been questioned. Additionally, the advisor stated he had stopped being treated. When he reviewed his case file from the DVA, he found he was a no-show for a C&P exam in 2006. He never received notification from DVA. A DVA audit found most veterans were not notified of scheduled appointments which led to drastic changes in 2010. He is currently seeing his DVA psychiatrist since 2010.

The OSA for being obese was at the time he was not participating in drills. He has been having sleep issues since he came back from deployment. In 2009, he was drilling that year and on temporary duty (TDY) when he was tested by his private doctor. Additionally, the DVA service-connected the OSA back to 2010, but when the LOD was submitted for OSA, did they check with DVA to find it had been on appeal for years?

If the advisor's recommendation is based upon what they have at the time, that means there is reasonable doubt that inappropriate findings were made based on what they have and no knowing if there are circumstances that were left out. Being a reservist at the time, he did not have the luxury of getting medical care through the Air Force, while not on active duty.

The MEB should have used DSM-V and questioned why the Air Force did not use it. He feels they deceived him by not using DSM-V to make their decision. He is still being seen for PTSD at the DVA, not anxiety disorder NOS as the Air Force and advisor state.

He has submitted articles from the APA, National Institute of Health, and DVA to the AFBCMR that show there are major differences in DSM-IV and DSM-V. The advisor is basing the information on the recommendation and opinion without showing they are similar. This leaves doubt since the DSM-IV was used on medical retirement, and the Air Force used a manual which can be deemed outdated. He feels this is an injustice that needs to be corrected.

The applicant submitted supplemental rebuttal documents reiterating his position regarding DSM-IV vs DSM-V accompanied by articles from various medical agencies, journals, and sites in support.

The applicant's complete response is at Exhibit O.

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 applicant's rebuttal, the Board remains unconvinced the evidence presented demonstrates an error or injustice. The Board concurs with the rationale of the AFRBA Psychological Advisor and recommendation of the BCMR Medical

Advisor and finds a preponderance of the evidence does not substantiate the applicant's contentions. The basic description of criteria C (avoidance) definitions outlined in both DSM-IV and DSM-V are essentially the same. However, whether the applicant was diagnosed with Anxiety Disorder NOS, as identified during the MEB and PEB, or PTSD, as identified by the DVA, the VASRD is used as a guide to determine the severity of the disability, and the corresponding rating of 10 percent most closely matches the level of severity found during the applicant's evaluation. The temporary assignment of a 100 percent VASRD rating which resulted in the applicant's placement on the TDRL was because his mental health condition had not yet stabilized. Upon re-examination, he was found to be employed full-time, with depressed mood passing quickly, and other symptoms improved with medication management; therefore, his rating was appropriately reduced to 10 percent prior to discharge.

Additionally, insufficient evidence has been presented to warrant a change in the EPTS determination for the applicant's diagnosis of OSA. The Board concurs with the BCMR medical advisor's finding that OSA is a condition of chronic/gradual development, not an acute or sudden entity, and is not an injury or illness that results from any service-related circumstance. Further, there is no evidence the OSA diagnosis impacted the applicant's ability to reasonably perform the duties of his office, grade, rank, or rating. While the OSA condition was found to be service-connected by the DVA, it is important to note the DVA and DoD operate under different titles of the United States Code. A service-connection by the DVA is not synonymous with, nor does it equate to, and automatic DoD disability impairment rating. The DoD deals only with conditions which are unfitting for continued military service and shortens a military career, whereas the DVA can authorize compensation for any medical condition determined service-incurred, without regard to, and independent of, its demonstrated or proven impact upon a service member's retainability, fitness to serve, or the length of time since date of discharge. 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 Department of the Air Force Instruction (DAFI) 36-2603, *Air Force Board for Correction of Military Records (AFBCMR)*, paragraph 2.1, considered Docket Number BC-2014-05241 in Executive Session on 21 Feb 24:

, Panel Chair
, Panel Member
, Panel Member

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

Exhibit I: Record of Proceedings, w/ Exhibits A-H, dated 8 Mar 16.
Exhibit J: Application, DD Form 149, w/aches, dated 7 Dec 22.
Exhibit K: Documentary evidence, including relevant excerpts from official records.
Exhibit L: Advisory Opinion, AFRBA Psychological Advisor, dated 21 Sep 23.
Exhibit M: Advisory Opinion, BCMR Medical Advisor, dated 20 Dec 23.
Exhibit N: Notification of Advisory, SAF/MRBC to Applicant, dated 27 Dec 23.
Exhibit O: Applicant's Response, w/atchs, dated 28 Dec 23.

Taken together with all Exhibits, this document constitutes the true and complete Record of Proceedings, as required by DAFI 36-2603, paragraph 4.12.9.

X

Board Operations Manager, AFBCMR