UNITED STATES AIR FORCE
BOARD FOR CORRECTION OF MILITARY RECORDS

FOURTH ADDENDUM TO RECORD OF PROCEEDINGS

IN THE MATTER OF: Work-Product

DOCKET NUMBER: BC-2015-03944-5

COUNSEL: Work-Product

HEARING REQUESTED: YES

APPLICANT'S REQUEST

The Board reconsider his request for an increase in his medical retirement disability rating changing his 40 percent disability rating to 60 percent based upon his unfitting ankylosing spondylitis (AS) due to chronic residuals. In a later response, the applicant revised his request asking for a 90 percent disability rating due to chronic residuals of AS.

RESUME OF THE CASE

The applicant is a medically retired Air Force captain (O-3).

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 provided insufficient evidence of an error or injustice to justify relief. The Board noted the AFBCMR Medical Consultant recommended a permanent retirement with a 40 percent disability rating; however, the Board noted the applicant's earlier argument he was fit for retention and since being found unfit, the emphasis shifted to a medical retirement. Furthermore, 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. Additionally, the Board noted the Medical Consultant stated the decision of the Department of Veterans Affairs (DVA) Decision Review Officer (DRO) was, in large measure, prompted by evidence clearly obtained and considered well beyond the "snapshot" in 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 warrant a change to the current 20 percent disability rating. Therefore, the Board agreed with the opinions and recommendations of the AFPC Disability Office and the AFBCMR IMA Medical Consultant finding the applicant failed to sustain his burden of proof he had been the victim of an error or injustice.

On 16 Oct 19, the Board reconsidered 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 AS. As such, the Board agreed a higher disability rating would

be inconsistent with the preponderance of clinical evidence present at the "snapshot" in 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.

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 provided sufficient evidence to persuade the Board he should be entitled to a disability rating of 40 percent based on the chronic residuals of his AS**.** 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 AS, but was permanently retired on 28 Aug 12, with a 40 percent disability rating due to chronic residuals of AS with a separate unfit finding for his back, neck, and bilateral ankle pain, rated at 10 percent for each. However, the Board denied the applicant's request for a medical retirement with a 60 percent disability rating.

On 16 Nov 22, the Board reconsidered and denied his request to increase his disability retirement rating to 60 percent on his unfitting AS based on an active process; finding the applicant had provided insufficient evidence of an error or injustice to justify relief. The Board was ordered to explain what a "severely incapacitating exacerbation" is under the Veterans Affairs Schedule for Rating Disabilities (VASRD) diagnostic code 5002. The Board agreed with the AFBCMR 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 the 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 caregiver, under the direction or orders of a licensed healthcare provider.

The Board was also ordered to explain whether it had been presented with evidence 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 noted Dr. P------ provided a letter dated 22 Jun 12, 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 did 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 AFPC/DPFDI (Disability Office), 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 AS symptoms which 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 his symptoms were not incapacitating.

Although the DVA DRO granted a 60 percent rating for his AS 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. However, based on the lack of objective evidence to support a higher rating either as chronic residuals or active process, the Board concluded there was 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 agreed with the opinions and recommendations of the AFPC Disability Office and the AFBCMR Medical Advisor that the applicant failed to sustain his burden of proof he had been the victim of an error or injustice.

Counsel stated 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 requested the Board address the legal significance of the failure of the Medical Evaluation Board (MEB) and the Physical Evaluation Board (PEB) to address the rating criteria over the objections of the applicant and whether this error, by itself, warranted the grant of relief. The Board determined the applicant had not provided sufficient evidence to persuade them relief should have been granted on either basis. Regarding counsel's request to explain why approximately four years after the implementation of the Integrated Disability Evaluation System (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 the DES processing, it was still a pilot program and was not available to all members, to include the applicant. As such, the Board did not believe the applicant had been the victim of an error or injustice or that he was treated differently than others processed under the Legacy DES. Therefore, the Board recommended against correcting the applicant's records.

For an accounting of the applicant's original request and the rationale of the earlier decision, see the AFBCMR Letters and Records of Proceedings at Exhibits M, Q, Y, and CC.

On 15 Jun 23, the court remanded the applicant's case to the AFBCMR pursuant to Rule 52.2 of the Rules of the Court of Federal Claims in lieu of an answer to Plaintiff's Complaint, instructing the AFBCMR to evaluate all claims asserted by the plaintiff to include the following:

> a. The AFBCMR shall reconsider and explain whether plaintiff is or is not entitled to a 60 percent disability rating under VASRD diagnostic code 5002 (effective 28 Aug 12) for his AS based upon chronic residuals. Specifically, the AFBCMR shall explain, with specificity, whether the plaintiff is entitled to additional 10 percent ratings for each of his hips and additional 10 percent ratings for each of his feet as chronic residuals of his AS

under the VASRD. Thereafter, the AFBCMR shall determine if plaintiff is entitled to an increased disability rating due to chronic residuals of AS.

b. The AFBCMR shall consider whether the plaintiff was required to be or should have been processed under the IDES pursuant to the 29 Mar 10 Cross-Service (Personnel and Readiness) Memorandum.

The Remand Order, Number Work-Product is at Exhibit DD.

AIR FORCE EVALUATION

The AFBCMR Medical Advisor recommends partially granting the application finding an assignment of a separate 10 percent disability rating for each of the applicant's feet, when combined with his previous rating equates to an overall 50 percent disability rating. However, the Medical Advisor denies granting a separate 10 percent disability rating for each of his hips. Additionally, the Medical Advisor determined the applicant was not required, nor should have been, processed under the IDES, pursuant to the 29 Mar 10, Cross-Service (Personnel and Readiness) Memorandum.

Addressing the contention for separate 10 percent disability ratings for both feet and both hips, the Medical Advisor proposes the following, based upon a preponderance of medical evidence. The Medical Advisor opines what has been claimed as an ankle condition, anatomically is presented on the feet (calcaneus) and results in foot (heel) pain. Indeed, the enthesitis experienced by the applicant, is located at the syndesmosis of the Achilles tendon onto the calcaneus (heel bone) of the foot. Because pain was precipitated by motion of the ankle/foot (dorsiflexion and plantar flexion), the condition was claimed as an ankle condition, while the offending pathology involved the calcaneus of the foot. Accordingly, the DVA also errantly characterized the disability as calcaneal spurring of the left and right ankle, when in fact the spurring is shown radiographically on the calcaneus (heel bone) of each foot. Additionally, the Medical Advisor noted the applicant was diagnosed with bilateral Hallux valgus, a potential source of foot pain, for which he was assigned a 0 percent rating for each foot. Considering all known causes of hallux valgus, the Medical Advisor determined this condition was not a chronic residual of AS. While at least one author noted that hallux valgus may be the consequence of certain arthritic conditions, e.g., gouty, psoriatic, and rheumatoid arthritis, he states the precise etiology is not fully understood, with multiple contributing factors, including genetics, short first metatarsal, dorsiflexed first metatarsal, flexible or rigid forefoot varus, or rigid or flexible pes planovalgus, abnormal foot mechanics, and joint hypermobility as ween in certain connective tissue disorders. Another group of physician researchers, Orthopedics and Traumatology, authored the *Relationship Between Hallux Valgus and Pes Planus*: *Real or Fiction*, also concluded their results showed a high correlation between Pes planus and Hallux valgus, but conceded a larger patient cohort is needed to support their results. If one considers Hallux valgus was a chronic residual of AS, then the DVA erred by assigning a 0 percent disability rating, instead of the 10 percent recommended under VASRD diagnostic code 5002.

The Medical Advisor searched for specific references to the applicant's hips, noting an X-ray report of both hips, demonstrated no significant osseous, articular, or soft tissue abnormality was

identified, albeit conducted on 8 Feb 10; whereas a computerized tomography (CT) scan of the pelvis, conducted on 19 Feb 10, identified symmetric sacroiliac (SI) joint erosions or subchondral cysts with reparative bone, which the radiologist opined may be a manifestation of several named inflammatory arthropathies. The radiologist also noted no active erosion was seen and given the bilateral nature; infection was considered less likely. Again, given the extensive clinical evidence, absent any reference to a hip ailment, the Medical Advisor opines there is an insufficient clinical basis to grant a separate disability rating for each of the applicant's hips.

Addressing the Cross-Service (Personnel & Readiness) Memorandum, the Medical Advisor determined, through consultation with HQ AFPC/Disability Division, the applicant was neither required to be, nor should have been processed under the IDES, implicitly at an alternate facility, pursuant to the 29 Mar 10, Cross-Service (Personnel & Readiness) Memorandum. However, should a service member require or receive treatment at a sister-Service medical facility, e.g., one participating in the IDES Pilot Project, and requires hospitalization or inpatient care for a condition which then becomes disqualifying and requires an MEB, the host Service medical treatment facility (MTF) will not transfer the member back to the member's parent Service merely for conducting the MEB. That is, had the applicant received his principal care at the sister-Service, which identified a disqualifying condition warranting MEB processing, the member would not be transferred to his servicing MTF merely to conduct the MEB. The Medical Advisor acknowledged, although the IDES Pilot Project had been implemented at some military installations within the Department of Defense (DoD) at the time of the applicant's MEB/PEB processing, e.g., Bayne Jones Army Community Hospital, it would not have been appropriate or mandated he be transferred to sister-Service MTF, merely to participate in the IDES Pilot Project. To the contrary, the W... Medical Group (MDG) at Work-Product Air Force Base (AFB) was not required, nor should have been, to refer the applicant's case to the sister-Service for DES processing. Specifically, although the IDES Pilot Project was implemented at the sister-Service at the time, B------ J----- [redacted] Work-Product), roughly 129 miles from Work-Product AFB, the applicant would not be transferred to the alternate facility, as an outpatient or inpatient, unless the care was not available at his home medical facility or he required transfer for medical treatment purposes or due to unavailability of appropriate specialty care at the member's own servicing medical facility, at Work-Product AFB. When the questions were posed to the HQ Air Force Personnel Center (AFPC)/Disability Operations Branch Chief, the official stated MEBs for Air Force members are processed by the local/closest servicing Air Force MTF. The applicant's records show he was a pilot assigned to the Work-... Bomb Squadron at Work-Product AFB at the time of DES processing; therefore, there would not have been a need to request assistance from another MTF in processing his MEB. The attached Cross- Service support memorandum further clarifies a service member who is hospitalized or receiving treatment at an MTF of another Service should not be transferred merely to complete DES processing. Furthermore, it states the member's Military Department, i.e., the Air Force in this case, will make MEB and PEB determinations and coordinate the notification of the member and the host Department. Military Department PEBs and/or MEBs are authorized to communicate directly with host MTF's to clarify or obtain additional DES case information. In layman's terms, if the applicant was geographically separated from an AF installation and assigned to another Service's installation and receiving medical care from that host Service MTF then the MEB/PEB could receive any substantiating medical documentation from the host MTF to complete the required board(s) and then inform the service-member's installation MTF of such outcomes, if

necessary, to assist in counseling the member. However, DES processing remained under the Air Force's jurisdiction.

The complete advisory opinion is at Exhibit EE.

APPLICANT'S REVIEW OF AIR FORCE EVALUATION

The Board sent a copy of the advisory opinion to the applicant on 9 Sep 23 for comment (Exhibit FF) and the applicant replied on 10 Oct 23. In his response, the applicant contends, through counsel, while he agrees with the additional rating for his feet, he contests the denial of a rating for his hips and toes as a residual of AS. Furthermore, he also disagrees with the methodology used in arriving at the advisory opinion's recommendation for rating his residuals of AS. Contrary to the Medical Advisor's analysis, a disability rating of at least 60 percent and potentially up to 90 percent should be granted based on statutes, DVA case law, and applicable regulations.

To arrive at the proper rating, the AFBCMR must address the combined ratings that are applicable to his case under the VASRD, which is binding on the Air Force per 10 U.S.C. Section 1216a. Included in the VASRD is the requirement each disability be viewed in relation to its history with any reasonable doubt resolved in favor of the claimant per 38 C.F.R. Section 4.1, 4.2, 4.3, and 4.7. Under longstanding DVA case law interpreting the VASRD, a rating board, like the AFBCMR in this case, errs when it does not comply with the provisions in the law and when it bases the rating decision on an inadequate exam.

Under VASRD diagnostic code 5002, the criteria for residuals such as limitation of motion or ankylosis, favorable or unfavorable, rate under the appropriate diagnostic codes for the specific joints involved. Where, however, the limitation of motion of the specific joint or joints involved is non-compensable under the codes, a rating of 10 percent is for application for each such major joint or group of minor joints affected by limitation of motion, to be combined, not added under VASRD diagnostic code 5002. Limitation of motion must be objectively confirmed by findings such as swelling, muscle spasm, or satisfactory evidence of painful motion. All of his disabilities arising from his AS disease are to be rated separately, then combined taking into account the bilateral factor. The bases for rating are, in specific order, any generally applicable joint rating under the appropriate VASRD diagnostic code, a rating based on limitation of range of motion or based on pain alone. This reading of the VASRD is part of the case law binding on the Air Force per 10 U.S.C. Section 1216a. His AS residuals extend beyond the conditions already recognized by the Secretary of the Air Force. In addition to his neck, back, and bilateral ankles, each rated at 10 percent disabling, his bilateral feet, hips, and toes should also be considered residuals. Each of his residuals are required to be rated under VASRD diagnostic code 5002 using the correct diagnostic code for the affected joints, following the guidelines of the VASRD.

Especially relevant to the Advisory Opinion is the use of "negative evidence." The advisory opinion cites negative evidence extensively. Negative evidence is a negative inference taken from the absence of evidence on a matter supporting the claimant's position. The U.S. Court of Appeals for the Federal Circuit has discussed this issue in *AZ v. Shinseki*. The Medical Advisor's extensive reliance on negative evidence has resulted in conclusions not supported by the evidence. This is particularly concerning when there is often no foundational basis to expect a record would address

a specific issue. Moreover, plausible reasons for the absence of records are neither considered nor addressed. The absence of evidence in many of the Medical Advisor's reliance on negative evidence could be attributed to either a lack of targeted medical examinations or to periods when his AS symptoms were dormant. The lack of any evidence about an issue in contention must be considered in the context of the failure of the MEB to conduct a detailed exam sufficient to properly rate him and the failure of later boards to address the issue. The proper way to analyze whether his claimed disabilities are residuals of his AS is to account for all the evidence, favorable or not, and then to weigh the evidence. So long as the evidence is in relative equipoise (that is, it is at least as likely as not that the condition is a residual), then the proper course is to rate the condition under VASRD diagnostic code 5002 as a chronic residual. Once found to be a residual, the degree of disability assigned is again to be analyzed by weighing the evidence and assigning the rating that is at least as likely as not to meet the rating criteria. Since his Formal PEB hearing in 2011, the MEB failed to conduct proper examinations as required by Public Law and DoD Regulations.

Weighing the favorable and unfavorable evidence, the evidence shows it is at least as likely as not, his valgus is a residual of his AS. There is favorable evidence for Hallux valgus being a residual of his AS; however, unfavorable evidence of record is non-existent. The Medical Advisor stated Hallux valgus can also be a source of foot pain with certain activities, but may be totally unrelated to AS, in this former avid runner. This statement is not based on record evidence and is not relevant to the issue of whether or not his Hallux valgus is a residual of AS. That this condition may be a source of foot pain with activities does not relate to the etiology of the condition. That it may not be related to AS is an unsupported and reductive statement. That there are other causes of Hallux valgus that others may have does not impact, one way or the other, the facts of his disease. There is no evidence of record showing that running is a more likely cause of his Hallux valgus than his AS.

The favorable evidence for his bilateral hip disability being a residual of AS is evident in the documents he submitted; however, the unfavorable evidence for this issue is also non-existent. The Medical Advisor states the medical records did not consistently display a problem with the applicant's hips. Overall, the comments by the Medical Advisor are in the nature of citing negative evidence, which as previously shown, is of questionable validity without a proper foundation. That foundation is lacking, and the explanation of flares and the waxing and waning nature of AS is not discussed in the comments. Therefore, the lack of evidence cited is of minimal value in assessing this issue. The Medical Advisor states from the outset, in the applicant's appeal to the Formal PEB he neither claimed nor made any reference to a hip condition. The Medical Advisor interprets this as reasonable evidence there was no chronic hip complaint predating or at the time of his appearance before the Formal PEB, nor one that can be characterized as a chronic residual of his AS. This is inaccurate and faulty reasoning; the MEB failed to accurately assess his AS. He should have received at least a 40 percent rating knowing the exams were deficient and an even higher award was likely appropriate. It is also noteworthy the Formal PEB's findings of rating the AS at 20 percent have since been found to be in error by the AFBCMR. Another issue the opinion fails to address in the analysis is the length of time between the MEB and Formal PEB and his separation from the Air Force.

A previous remand directed the AFBCMR to consider the effect of the length of time between the actions and the potential worsening of the AS during that time. The Medical Advisor again inappropriately focuses on the wrong time frame of the Formal PEB hearing and prior when he argues that the "snapshot" in time is the date of separation. Taken together, the Medical Advisor's interpretation lacks evidentiary support and is not credible evidence of his hip condition. A balanced evaluation of the existing evidence indicates it is at least as likely as not, and indeed more probable than not, his hip pain is a chronic residual of his AS.

The Medical Advisor wrote, in an earlier advisory opinion in a rating decision issued on 28 May 13, the DVA also assigned an initial disability rating of 20 percent, utilizing VASRD code 5243. Because there is agreement by all parties his back disability is a chronic residual of his AS, the next step in an analysis is the proper rating for that disability, which the AFBCMR previously rated at 10 percent disabling; however, VASRD diagnostic code 5002 requires a residual be rated under the appropriate diagnostic codes for the specific joints involved. Based on the limitation of range of motion documented on the pre-exam discharge the DVA found, based on the limitation of forward flexion of this thoracolumbar spine, he should be rated at 20 percent for his back as a residual. The evidence, including the Disability Benefits Questionnaire (DBQ), is greater than equipoise and shows, by a preponderance of the evidence, his back should be rated at 20 percent based on his actual limitation of range of motion.

The Medical Advisor's opinion on the DES Pilot program site seems to amount to circular logic and conclusory reasoning. If one posits that because a member is going through an MEB that is not a DES Pilot program site, they do not need to be processed at a DES site, then the directives in the Cross-Service memorandum would never apply. The Medical Advisor's interpretation raises a critical question: if not in his case, when would the Cross-Service memorandum ever come into play? By narrowly focusing on specific provisions, the Advisor's reading effectively nullifies the memorandum's broader intent and creates a situation where the memorandum would never apply and cannot be a correct reading of the meaning of the Cross-Service Memorandum. It is precisely in his case, where more than three years after the inception of the DES Pilot Program and after wide-spread application of the program, including for the vast majority of Service Members, he was being processed in the Legacy system that the memorandum would apply. The Medical Advisor's assertion MEBs for its members are processed by the local or closest servicing Air Force MTF fails to address the memorandum's clear directive for Military Departments to establish inter-Department agreements for DES processing. Given a sister-Service MTF participating in the DES Pilot was located approximately 129 miles away, it stands to reason, the Air Force should have transferred his case to that facility for DES Pilot Program processing. This is in line with the memorandum's objective to ensure Service members have equal and timely access to the most comprehensive disability evaluation available. The main impact of a finding that his case should have been processed through the DES Pilot Program or IDES is that his post-discharge increase in rating by the DVA would have received the same favorable treatment as those who were actually processed through the IDES.

The applicant's complete response is at Exhibit GG.

ADDITIONAL AIR FORCE EVALUATION

The AFBCMR Medical Advisor recommends granting the applicant's request for a medical retirement with a combined disability rating of 90 percent[1]. This includes a 20 percent rating for the lumbosacral spine, and 10 percent ratings, respectively, for the cervical spine, each hip, each ankle, each foot, and great toe (Hallux valgus) of each foot. The Medical Advisor hesitantly accepts the applicant's bilateral "mild" Hallux valgus, an asymptomatic incidental finding identified on X-ray and during the DBQ of the foot, as a separately ratable chronic residual of AS; notwithstanding the absence of characteristic dactylitis of the toes, prior to discharge, and the longstanding history, since 2001 of Pes Planus, a recognized shared factor in the evolution of Hallux valgus.

The applicant's counsel has presented a multitude of legal arguments and court precedent, which causes this reviewer to reconsider the applicant's petition. While there are some statutory differences between the Military Department and the DVA, e.g., wherein a preponderance of objective evidence is the standard in the former and at least as likely as not is commonly used for support in the latter, there should otherwise be no difference in the interpretation of the VASRD, given the National Defense Authorization Act (NDAA) 2008 phrase in a paragraph to follow, "shall not deviate from." Additionally, the Military Department bases its diagnostic and fitness decisions upon objective evidence, without speculation or conjecture. Accordingly, this creates another statutory difference, with respect to negative evidence, cited in *AZ vs Shinseki*, using the example, the lack of service medical records of an assault is not relevant evidence of the lack of that assault or for service connection for PTSD. However, with respect to the applicant's painful motion of both hips, albeit "minimal to mild," the Medical Advisor cannot set aside, under *Lichtenfels vs. Derwinski,* where it has been established, VASRD diagnostic code 5003 (degenerative arthritis) and VASRD diagnostic code 5002, provide limitation of motion or painful motion which is non-compensable for the affected joint, may otherwise entitle a veteran to a 10 percent disability rating for each major joint or group of minor joints affected. The Court further determined, when VASRD diagnostic code 5002 is read in conjunction with Section 4.59, painful motion of a joint is deemed to be limited motion of that joint, and evidence of painful motion satisfies the requirement for limitation motion under VASRD diagnostic code 5002. The painful motion then entitles the applicant to the minimum disability rating for that joint under VASRD diagnostic code 5002 and Section 4.59, even though the claimant [may] not have actual limitation of motion. Therefore, in considering the history of painful hips, as in the rheumatologist's 1 Aug 11 medical letter, and the clinical evidence of painful motion of the hips, in the MEB Narrative Summary (NARSUM), the Medical Advisor recommends assigning the minimum 10 percent rating for each hip, under Section 4.59. In the absence of a more contemporaneous corroborating measurement of the applicant's hip range of motion demonstrating a painful motion or a significant decrement in the angular excursion, after repetitive motion prior to discharge, the Medical Advisor opines against separate ratings for each plane of the applicant's hip range of motion, as offered by the applicant's counsel.

The Medical Advisor acknowledges the relevance of the solicitude for the claimant in *Walters* v. *National Association of Radiation Survivors*, and the character of the veterans' benefits statutes

[1] In this advisory recommendation, the Medical Advisor errantly computed the bilateral factor; therefore, an additional advisory was needed. See Exhibit KK.

are strongly and uniquely pro-claimant. The Medical Advisor has also been schooled that negative evidence is not proof a given fact or condition does not or did not exist. This legally-driven concept is divergent from the principles of medicine, which relies upon the presence or absence of certain evidence, to decide whether a person is taken to an operating room, or to undergo cardiac catheterization, where there is no clinical evidence of impending myocardial infarction, or in the absence of electrocardiographic evidence of muscle ischemia, or in the absence of positive serum troponins, a recognized marker of myocardial injury. Nevertheless, setting the stage for the rationale for the Medical Advisor's recommendation to grant relief, under the NDAA 2008, certain old guidelines, such as DoDI 1332.39, *Application of the Veterans Administration Schedule for Rating Disabilities*, were discarded, with new ones targeting the seamless and timely transition to benefits, nearest time of separation, a single "one-stop" examination, and the elimination of previous disparities between disability ratings, as determined by DoD PEBs and the DVA for the same medical condition(s). Specifically, according to the *Policy Memorandum on Implementing Disability-Related Provisions of the NDAA 2008*, dated 14 Oct 08, Enclosure 7, *Application of the DVA VASRD*, states the Secretaries of the Military Departments may not deviate from the schedule or any interpretation of the schedule, including any applicable interpretation of the VASRD by the United States Court of Appeals for Veterans Claims. The Secretary concerned may utilize in lieu of the VASRD such criteria as the Secretary of Defense and the Secretary of Veterans Affairs may jointly prescribe if utilization of such criteria will result in a greater percentage of disability than would be otherwise determined through the utilization of the schedule. Accordingly, in meeting the above mandate, certain other specific guidelines were to be followed, under the following paragraph E.7.1, *General*, and subparagraphs E.7.1.1, E.7.1.2, E.7.1.3, and E.7.1.4, with emboldened features under paragraph E7.1.1, *Objective Medical Findings and Disability Ratings*, physical examination findings, laboratory tests, radiographs, and other findings do not, in and of themselves, constitute a basis for determining a member is to be rated for a condition. Prior to rating a condition, it is required the condition caused impairment of function to such extent the condition is unfitting and compensable. The Medical Advisor does not contend the applicant's Hallux valgus, a misaligned joint, was caused by his running activities, but its incidental finding on DVA examination, initially rated at 0 percent and its multifactorial causation, could not be clearly and unmistakably eliminated as a chronic residual of AS. In paragraph E7.1.2, the VASRD shall be used in making rating determinations for each of the medical conditions determined to be unfitting independently or due to combined effect, to include in combination with an independently unfitting condition. If more than one military unfitting condition exists, the VASRD will be used to determine a combined disability rating for each unfitting condition. For purposes of establishing a rating, the VASRD will be used in relation to the Service member's physical disability at the time of the evaluation. If use of convalescent ratings and/or other interim ratings (i.e., pre-stabilization ratings) applies, the Service member may be placed on the Temporary Disability Retired List (TDRL) for reevaluation purposes. Even though documented early in the applicant's career and years prior to his diagnosis of AS, the Medical Advisor determined the applicant's Pes Planus, standing alone, would not have been considered a basis for career termination as a former aviator, but through its combined effect, with the unfitting ankle pain, couched as causing painful ankle motion and morning stiffness, has a contributory impact upon overall foot function and unfitness, commonly manifested through bilateral Plantar Fasciitis. Hence, the Medical Advisor recommends a separate rating for bilateral foot pain secondary to Plantar Fasciitis, associated with Pes Planus, analogized under hyphenated VASRD codes 5284-5299-5003.

Paragraph E7.1.3 states, use of the VASRD is statutorily required, to the extent feasible. In applying the VASRD, any determination of infeasibility would have to be based on statutory differences between the DoD and DVA disability systems, compelling differences in mission grounded in statute, or some other major difference in the two systems. A policy disagreement or different medical opinion would not constitute infeasibility. A key difference includes the requirement, under DoDI 1332.18, for the presence of objective evidence, in determining whether or not a condition exists or previously existed, wherein, under 38 C.F.R., and prior Court actions, negative evidence or absence of evidence, does not mean the condition, incident, or event did not occur or does not exist. In paragraph E7.1.4, the DVA, specifically, the Veteran Benefits Administration (VBA) uses various internal issuances (Fast Letters, Training Letters, etc.) in its application and clarification of the VASRD. Although not legally binding on the DoD, these issuances may be used by DoD rating personnel to assist in making rating determinations. The Medical Advisor has utilized the VASRD to reach a clinically relevant, anatomic, and physiologic, rating decision for the applicant's claimed bilateral foot pain. Among arguments presented by the applicant's counsel, a reference is made to 38 C.F.R., Section 4.1, *Essentials of Evaluative Rating*, which states for the application of this schedule, accurate and fully descriptive medical examinations are required, with emphasis upon the limitation of activity imposed by the disabling condition. Over a period of many years, a veteran's disability claim may require re-ratings in accordance with changes in laws, medical knowledge and his or her physical or mental condition. It is thus essential, both in the examination and in the evaluation of disability, each disability be viewed in relation to its history. To the contrary, for the Military Department, operating under Title 10, U.S.C., post-service changes in a service member's medical condition, or progression of disease or injury, has no bearing upon the clinical decision-making at the time of release from military service.

Finally, the Medical Advisor cannot remedy the alleged failure of referral of the applicant's MEB to a sister service, so he could avail himself to the Pilot Program. However, noting the DVA issued a 20 percent disability rating for the applicant's AS, as did the Military Department, the Medical Advisor opines, had the applicant been adjudicated via the Pilot Program, it would have resulted in the same administrative outcome, discharge with severance pay for the unfitting AS, which at the time was limited to his neck and spine. The Medical Advisor also acknowledges the applicant would have been given the benefit of a one-time reconsideration of the rating decision, had his case been rated under the Pilot Program, but also noted the rating remained unchanged following an initial appeal to the DVA. The Medical Advisor acknowledges this does not absolve the Military Department's obligation to comply with the established policy, but the initial outcome would have been equivalent for the unfitting condition, had the case been processed by the Pilot Program.

Additionally, the Medical Advisor cannot remedy the alleged inadequate examination(s) conducted by the Military Department, and thus, relied upon the findings of the NARSUM, rheumatologist's progress notes, and applicable DBQs, e.g., ankles and feet. The Medical Advisor considered the clinical evidence, in the MEB NARSUM, noting mild painful range of motion of both hips, and could not eliminate AS, as the inciting origin of this findings. In light of the total history of the applicant's medical condition, findings in *Petitti v. McDonald*, and *Southall-Norman v. McDonald*, the Medical Advisor finds it reasonable and appropriate to assign separate disability ratings for each of the applicant's hips. The Medical Advisor digresses and is not in position to

refute or challenge laws and rulings governing compensation by the DVA but finds the notion of negative evidence or the absence of evidence does not rule out the presence of a disease entity, to be totally inconsistent with recognized principles of medical practice. Nevertheless, the alleged inadequate examinations, partly remedied by Disability Benefits Questionnaires, could be a reason for such absence of evidence. The Medical Advisor will not use this forum to further discuss quality of care matters.

In view of NDAA 2008 and the mandate for strict adherence to the VASRD and actions by the Board of Veterans Appeals, the Medical Advisor has also been enlightened on the solicitude of the claimant in *Walters* v. *National Association of Radiation Survivors* and *Hodge* v. *West*, and the Supreme Court's long recognition the character of the veterans' benefits statutes is strongly and uniquely pro-claimant. The Medical Advisor, after counsel's successful argument claiming negative or absence of evidence does not rule out the presence of a given entity, is free to use the term adopted standard under 38 C.F.R., at least as likely as not, but under Title 10, U.S.C., and DoD policies, decisions are based upon a preponderance of objective evidence. The Medical Advisor takes favorable consideration of including the applicant's hips in the disability rating computation, to include bilateral factors for each applicable hip motion. This decision is based in part upon the inclusion of hips in the discussion by the treating rheumatologist, but not due it[sic] alleged causation due to referred pain from the SI joints. The Medical Advisor did not and does not believe TDRL placement was an option by the Formal PEB, as the condition did not meet the minimum 30 percent rating to warrant such placement. The Medical Advisor further makes it clear the 40 percent ultimately offered, but now declined by the applicant, was based solely upon the errant inclusion of the applicant's calcaneal spurs, as a foot ailment, initially believed to be unrelated to the applicant's AS. The notion the applicant's condition was unstable at the time of discharge cannot be based upon the fact an increase in disability rating was made, after a second DRO appeal granted in 2017, five years after the applicant's discharge. For unknown reasons, the counsel has elected not to supply the DVA evidence utilized in the rating decision of May 17.

The complete advisory opinion is at Exhibit HH.

APPLICANT'S REVIEW OF ADDITIONAL AIR FORCE EVALUATION

The Board sent a copy of the advisory opinion to the applicant on 20 Nov 23 for comment (Exhibit II), and the applicant replied on the same day. In his response, through counsel, the applicant contends, he agrees with the advisory opinion recommending his records be corrected to reflect a permanent retirement with a 90 percent disability rating. Even though he does not agree with every point made by the Medical Advisor, he does agree with the recommended outcome and does not intend to submit any additional matters to the Board at this time.

The applicant's complete response is at Exhibit JJ.

ADDITIONAL AIR FORCE EVALUATION

In the previous advisory recommendation, the Medical Advisor errantly computed the bilateral factor; therefore, an additional advisory was needed. The Medical Advisor recommends granting the applicant permanent retirement with a 70 percent disability rating. In addition to the ratings

for the applicant's back, neck, and ankles, it is recommended he receives a 10 percent rating for each foot, each of his hips, and toes of each foot. After properly including the 10 percent rating plus bilateral factor for each of the applicant's affected joints, a combined disability rating of 70 percent was achieved.

The additional advisory opinion is at Exhibit KK.

APPLICANT'S REVIEW OF ADDITIONAL AIR FORCE EVALUATION

The Board sent a copy of the advisory opinion to the applicant on 18 Dec 23 for comment (Exhibit LL), and the applicant replied on 21 Dec 23. In his response, through counsel, the applicant contends, he agrees with the advisory opinion recommending his records be corrected to reflect a permanent retirement with a 70 percent disability rating. Even though he does not agree with every point made by the Medical Advisor, he does agree with the recommended outcome.

The applicant's complete response is at Exhibit MM.

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, the report provided by the Court remand order, the applicant's new evidence, and the AFBCMR Medical Advisory, the Board concludes the applicant is the victim of an error or injustice finding a preponderance of the evidence substantiates the applicant's contentions. Specially, the Board majority finds evidence to support granting a medical retirement with an overall disability rating of 70 percent, (chronic residuals of AS for his lumbosacral spine rated at 20 percent and cervical spine rated at 10 percent and chronic residuals of AS for his bilateral foot, hip, toe and ankle pain rated at 10 each). The applicant's unfitting bilateral foot pain and greater toe pain, separate from his ankle pain, as a chronic residual of AS warrants a 10 percent disability rating for each foot and each greater toe. The applicant submitted x-ray evidence he had calcaneal spurring on the heel bone of each foot and was diagnosed with bilateral Hallux valgus which the Board majority determined to be a chronic residual of AS. Furthermore, the Board considered counsel's argument regarding the applicant's bilateral hip pain finding his history of painful hips as documented in the rheumatologist's 1 Aug 11 medical letter and the MEB NARSUM as sufficient evidence to grant the applicant a separate 10 percent rating for each hip. However, without evidence showing a more contemporaneous measurement of the applicant's pain level regarding his hip range of motion prior to discharge, the Board could not reasonably assign a disability rating for each of his hip range of motion as suggested by counsel. Therefore, the Board majority recommends correcting the applicant's records as indicated below.

Additionally, the Board noted the applicant's contention he should have been processed under the IDES, pursuant to the 29 Mar 10, Cross-Service (Personnel and Readiness) Memorandum; however, the Board finds no basis for this assumption. Under the pilot program he was not required to be processed under the IDES at an alternate facility, nor should he have been. The

Board acknowledges the pilot program was implemented at B----- J----- [redacted] Work-Product); however, he would not have been transferred to the alternate facility, as an outpatient or inpatient, unless the care was not available at his home MTF. He was assigned to Work-Product AFB at the time of his DES processing; therefore, his DES processing correctly remained under the jurisdiction of the Air Force.

4. 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 pertinent military records of the Department of the Air Force relating to APPLICANT be corrected to show the following:

a. On 1 May 2012, he was found unfit to perform the duties of his office, rank, grade, or rating by reason of physical disability, incurred while he was entitled to receive basic pay; the diagnosis in his case was for chronic residuals of ankylosing spondylitis for his lumbosacral spine, rated at 20 percent (VASRD code 5243-5002) and his cervical spine rated at 10 percent (VASRD code 5237-5002) combined with his bilateral ankle (VASRD code 5271), foot (VASRD code 5284), hip (VASRD code 5251-5252), and great toe (Hallux valgus) (VASRD code 5280), rated at 10 percent each; when combined results in an overall disability rating of 70 percent. It is noted the degree of impairment was permanent; the disability was not due to intentional misconduct or willful neglect; the disability was not incurred during a period of unauthorized absence; and the disability was not as a direct result of armed conflict or caused by an instrumentality of war and was not combat-related.

b. On 28 August 2012, he was discharged from the Air Force and on 29 August 2012, he was permanently retired with a compensable percentage for physical disability of 70 percent.

c. His election of the Survivor Benefit Plan option will be corrected in accordance with his expressed preferences and/or as otherwise provided for by law or the Code of Federal Regulations.

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-2015-03944-5 in Executive Session on 28 Sep 23, 4 Dec 23, and 2 Jan 24:

Work-Product, Panel Chair
Work-Product, Panel Member
Work-Product, Panel Member
Work-Product, Panel Member

A majority of the panel voted to correct the record granting the applicant a 70 percent disability rating; however, Work-Product voted to correct the record to show a disability rating of 60 percent but did not provide a minority opinion. The panel considered the following:

Exhibit M: Original Record of Proceedings, w/ Exhibits A-L, dated 17 May 18.
Exhibit Q: Addendum Record of Proceedings, w/ Exhibits N-P, dated 16 Oct 19.
Exhibit Y: Second Addendum Record of Proceedings, w/ Exhibits R-X, dated 14 Jul 21.
Exhibit CC: Third Addendum Record of Proceedings, w/ Exhibits Z-BB, dated 16 Nov 22.
Exhibit DD: Remand Order Number Work-Product dated 15 Jun 23.
Exhibit EE: Advisory Opinion, AFBCMR Medical Advisory, w/ atchs, dated 8 Sep 23.
Exhibit FF: Notification of Advisory, SAF/MRBC to Applicant, dated 9 Sep 23.
Exhibit GG: Applicant's Response, w/ atchs, dated 10 Oct 23.
Exhibit HH: Advisory Opinion, AFBCMR Medical Advisory, w/ atchs, dated 19 Nov 23.
Exhibit II: Notification of Advisory, SAF/MRBC to Applicant, dated 20 Nov 23.
Exhibit JJ: Applicant's Response, dated 20 Nov 23.
Exhibit KK: Advisory Opinion, AFBCMR Medical Advisory, dated 14 Dec 23.
Exhibit LL: Notification of Advisory, SAF/MRBC to Applicant, dated 18 Dec 23.
Exhibit MM: Applicant's Response, dated 21 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.

1/25/2024

Work-Product

Work-Product
Board Operations Manager, AFBCMR
Signed by: Work-Product Work-Product