ADDENDUM TO RECORD OF PROCEEDINGS

IN THE MATTER OF: XXXXXXXXXXX

DOCKET NUMBER: BC-2016-02604

COUNSEL: XXXXXXXXXX

HEARING REQUESTED: YES

APPLICANT'S REQUEST

The Board reconsider her request to remove the Assignment Limitation Code (ALC) from her electronic health record.

Additionally, the applicant:

a. Requests reconsideration of her request to remove the Bipolar diagnosis from her electronic health records, previously denied by the Air Force Board for Correction of Military Records (AFBCMR) under docket number BC-XXXX-XXXXX.

b. In a new request, asks the AFBCMR to award seven years active duty credit toward retirement.

RESUME OF THE CASE

The applicant is a currently serving Air Force Reserve senior master sergeant (E-8).

On 7 May 15, the Board considered and denied her request to remove her Bipolar II Disorder diagnosis from her military medical records, finding the applicant had provided insufficient evidence of an error or injustice to justify relief. The Board concurred with the AFMOA/SGH advisory opinion rationale that the diagnosis of Bipolar II Disorder, annotated in her medical records in 2004, reflected the history of her medical condition at that time, and as such, should remain because removing it would render the health information incomplete as it provided the history of the applicant's health status at the time of treatment.

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 L.

On 20 Mar 18 and 16 Aug 18, the Board considered and denied her request to remove the ALC C-3 from her military electronic health record, finding the applicant had provided insufficient evidence of an error or injustice to justify relief. The Board concurred with the rationales and recommendations detailed in the advisory opinions of the offices of primary responsibility (OPR), and upon consideration of the applicant's rebuttal, found she had not provided substantial evidence which successfully refuted the assessment of her case by the OPRs.

For an accounting of the applicant's original request and the rationale of the earlier decision, see the AFBCMR Letter and Record of Proceedings at Exhibit M.

On 13 Aug 23, the applicant requested reconsideration of her requests to remove her Bipolar II Disorder diagnosis and the ALC from her military medical record. Additionally, in a new petition, she requested award of seven years active duty credit toward retirement. Via counsel, the applicant again contends she was misdiagnosed by a civilian mental health provider with Bipolar II Disorder, a medically disqualifying condition for military service. After successfully fighting to continue her service, she was subsequently plagued by unnecessary and unwarranted

ALCs that directly impeded her career progression. The Air Force steadily retreated from these ALCs in recognition of the applicant's sustained outstanding performance throughout her career, which is blatantly inconsistent with her purported diagnosis. Multiple doctors, both civilian and military, have now concluded the applicant was misdiagnosed. As a result of her misdiagnosis, she missed irreplaceable career opportunities and lost substantial time toward retirement. Her misdiagnosis, coupled with the negative effects on her career, and her concerted effort to demonstrate an erroneous diagnosis, constitute a substantial injustice for which she is entitled to relief.

In 2004, while serving in the Regular Air Force, the applicant self-identified for treatment of alcohol abuse. She underwent a 28-day inpatient treatment program and successfully completed all rehabilitation treatment. During this time, she saw a mental health provider off-base to help with her addiction recovery. At some point during this treatment, after disclosing symptoms she suffered while heavily drinking alcohol, she was diagnosed with Bipolar II Disorder. The original records evidencing this diagnosis, and any purported basis for this diagnosis, have been lost by the Air Force.

In 2006, she transferred from active duty to the Air Force Reserve (AFR). Pursuant to her release from active duty, she was evaluated by the Veterans Administration (VA) for standard compensation and pension (C&P) exams. The applicant provided a hard copy of her medical records to the VA where they were available to the reviewing physician. Relevant to her Bipolar analysis, the VA records reflect the applicant's recollections regarding her symptoms, to include, but not limited to, depression, mood fluctuation, low energy, motivation and interest levels, cycles of increased energy consistent with hypomania, and periods of increased anxiety. Based upon this information, the VA provider concluded her symptoms were consistent with Bipolar II Disorder. Pursuant to this evaluation, the applicant was awarded a 30 percent disability rating and began receiving monthly disability payments. During this time, she continued to serve as a traditional reservist and used her disability payments to pay for educational expenses not covered by the GI Bill.

In 2011, the applicant applied and was selected for a commission; however, while completing her medical forms in anticipation of commissioning, she disclosed she had previously been diagnosed with Bipolar II Disorder. After completing treatment for alcohol abuse in 2004, she had not experienced any symptoms related to her alleged Bipolar II Disorder, nor was she taking any medication or undergoing any treatment related to the disorder. Nevertheless, she was informed the Bipolar II Disorder diagnosis would preclude her not just from commissioning, but from continuing her military service.

The applicant sought re-evaluation by a civilian provider. In Mar 12, she saw a clinical psychologist in Work-Product. He administered two different personality tests – the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) and the Million Clinical Multiaxial Inventory-Third Edition (MCMI III), which were the prevailing tests at the time to diagnose the presence of psychological disorders, concluding she did not appear to have a Bipolar II Disorder. The applicant also sought treatment at the Work-Product Air Force Base (AFB) mental health clinic to get the diagnosis re-evaluated and removed from her record. The Work-Product AFB provider immediately and unfairly accused the applicant of attempting to conceal the disorder because it did not appear in her medical records at the time of her disclosure on her commissioning paperwork. The applicant had previously provided her sole hard copy of her medical records to the medical group at Work-Product AFB when she transferred to the AFR, before medical records were digitized. She also provided a copy of her VA disability rating paperwork to her supervisor, which evidenced her Bipolar II Disorder diagnosis, and this paperwork was filed locally in her Personnel Information File. Nevertheless, the provider continued to accuse her of wrongdoing and intentional concealment. Specifically, he questioned whether the applicant was aware she was required to provide her medical records on an annual basis for her Periodic Health

Assessment. The applicant indicated she was not aware of this requirement, but regardless, she had no records to disclose because she was not seeking treatment or taking any prescriptions related to her previous Bipolar diagnosis. In addition to seeking civilian and military re-evaluation, the applicant sought re-evaluation from the original diagnosing VA physician; however, he no longer worked at the VA. The VA provider that did evaluate the applicant noted she had no symptoms of depression, hypomania, or anxiety that warranted a current diagnosis and declared the applicant in full sustained remission. As a result, the applicant's disability rating for Bipolar II Disorder was reduced to 0 percent.

As a result of her disclosure, the applicant met an Informal Physical Evaluation Board (IPEB) in 2013, and the IPEB found her unfit for duty. The applicant appealed to the Formal Physical Evaluation Board (FPEB) in 2014. The FPEB found she was fit for duty and recommended she be returned to duty. Despite this finding, the Air Force Reserve Command Surgeon (AFRC/SG) placed her on an indefinite ALC C-3 status, preventing her from performing any duty outside of unit training assemblies (UTA) and annual tours (AT) at her home station. AFRC/SG further noted the restrictions are permanent and may not be removed without prior approval from AFRC/SG. In effect, the applicant could not perform any duty away from home station, mobilize for any deployments, or attend any formal schools. During the time she was going through the IPEB and FPEB, the applicant was in a "no points, no pay" status, accruing no time toward retirement while she continued to fight for her ability to serve. After placement in ALC C-3 status, AFRC/SG repeatedly denied the applicant's requests to attend formal training. In fact, the Air Force nearly separated her on the basis of failing to fulfill training obligations for their own self-imposed limitation on her career. After two years, she was granted permission to attend the Paralegal Apprentice Course, where she finished as a top graduate, earning the distinguished graduate title.

Due to the restrictions the ALC C-3 status had on her career, the applicant petitioned the AFBCMR in May 15, requesting the Bipolar II Disorder be removed from her military records. The AFBCMR denied her first application, noting the advisory opinion recommendation to deny indicating there is no evidence of an error or injustice. Despite suggesting the diagnosis should remain, the advisory opinion did recommend her electronic health record reflect she be medically qualified for worldwide duty and deployable. Nevertheless, AFRC/SG kept her on ALC C-3, meaning she was not qualified for worldwide duty or deployable.

The applicant again applied to the AFBCMR in 2018, requesting the ALC be removed. The AFBCMR denied her second application for relief. The medical advisory recommended denial: however, acknowledged error or change in diagnosis may occur. The advisory stated diagnosis opinions may vary among providers given the same information during the same period of time, and a change in diagnosis may occur following a greater period of observation. Ultimately, the medical advisory opined the fact that a different diagnostic conclusion had been reached, while compelling, is insufficient to invalidate the initial evaluation and treatment.

Since Jun 19, the applicant has been under continuous care from a clinical psychologist at Hurlburt Field, Florida. In Jun 19, the provider concluded there is no evidence of any current or recent symptoms meeting Diagnostic and Statistical Manual of Mental Health Disorders – Fifth Edition (DSM 5) criteria for Bipolar II Disorder, opining the Bipolar II Disorder assigned in the mid-2000s was erroneous. The provider also opined the applicant's symptoms were incorrectly attributed to Bipolar II Disorder when they were more appropriately associated with alcohol withdrawal. The provider further noted, regarding the VA diagnosis of sustained remission, research has shown there is no known cure for Bipolar II Disorder, so there is no remission or resolution for this chronic lifelong disease. Additionally, the provider concluded a patient with Bipolar II Disorder would not have been able to maintain over a 12-year period such positive and stable career performance. In Aug 19, the provider again opined the applicant was misdiagnosed, stating diagnostically during recovery, vacillation between restless anxiety states

and dysphoric emotions is common and could have been misconstrued as Bipolar II Disorder. The provider repeated her position regarding misdiagnosis after a Mar 20 evaluation, noting if stability in a setting of Bipolar II Disorder was possible, a consistent regimen of psychotropic medications and/or psychotherapy would be expected, and the applicant had not been prescribed psychotropic medications since the mid-2000s. The provider repeated her finding in Oct 20 after conducting the MMPI-2 and MCMI-IV tests, noting the results were negative for any significant psychopathy, and no indication of the applicant's remote and likely misdiagnosis with Bipolar II Disorder. The provider recommended return to worldwide duty qualification and permanent removal of any ALC restrictions.

Less than two years after the AFBCMR denied her request to remove the ALC, AFRC/SG reduced her ALC from C-3 to C-2 status based on a sustained period of solid performance with no symptoms present for the diagnosis at issue. The ALC C-2 status still placed restrictions on her career progression. The applicant was not worldwide qualified and could not deploy or be assigned to any location without a fixed medical treatment facility (MTF). She also had to seek SG approval to perform any duty away from home station. Most significantly, the ALC prevented her from returning to active duty. Since 2012, the applicant attempted to return to active duty, but she was precluded from doing so because she did not have the ALC C-1 status. AFRC/SG further reduced her ALC status from C-2 to C-1; however, by this time, there were no available spots for the applicant to return to active duty. As a result of this erroneous diagnosis, in 2011, the applicant was denied commissioning. If she had commissioned, to date, she would have gained seven years toward her retirement as an active duty member.

Over the last 15 years, multiple providers indicated the applicant does not have Bipolar II Disorder and the symptoms she experienced during a period of heavy alcohol consumption and subsequent withdrawal, are better attributed to her alcohol use disorder. Her medical records evidence a complete lack of any Bipolar cycling after she completed treatment for alcohol withdrawal. She was repeatedly accused of downplaying her symptoms or concealing her disorder for her own benefit, but such beliefs are misguided and ill-informed. At the time of her 2018 AFBCMR application, she provided the evaluation of a single psychologist; however, she now presents nearly 11 years of medical records evidencing she does not have this disorder. The original diagnosing provider should never have evaluated her during her recovery period from alcohol abuse, and her symptoms are better attributed to alcohol withdrawal and/or adverse reactions to medications she should never have been prescribed in the first place.

In conclusion, the concerns voiced by the various medical and administrative personnel in processing her case over the last decade have been unwarranted and unfounded. The applicant has been the victim of a substantial error concerning a misdiagnosis that has had perceptible, life-changing implications on her career progression, evidencing a substantial injustice. As a service member who has challenged this diagnosis since its inception, the applicant has surpassed her burden in this application illustrating she is entitled to relief.

In support of her reconsideration request, the applicant submitted the following new evidence: (1) medical records for the period 2018-2021; (2) AFRC/SGPA Memorandum, Subject: Report of Medical Evaluation, dated 7 May 20; (3) AFRC/SG Memorandum, Subject: Report of Medical Evaluation, dated 27 Jan 21; (4) Letters of Support and Recommendation; (5) military monthly award and decorations; (6) Enlisted Performance Reports (EPR); and (7) National Institute of Mental Health website health topic, *Bipolar Disorder*.

The applicant's complete submission is at Exhibit N.

STATEMENT OF FACTS

On 19 Mar 06, according to DD Form 214, *Certificate of Release or Discharge from Active Duty*, the applicant was furnished an honorable discharge from the Regular Air Force, with Narrative Reason for Separation: Completion of Required Active Service, and was transferred to the United States Air Force Reserve (USAFR).

On 20 Mar 06, according to DD Form 4, *Enlistment/Reenlistment Document Armed Forces of the United States*, the applicant enlisted in the USAFR for a period of six years.

On 10 Feb 13, according to AF Form 469, *Duty Limiting Report*, the applicant was placed on duty and mobility restrictions and was referred for a Medical Evaluation Board upon completion of medical evaluations.

On 19 Feb 13, according to Department of Veterans Affairs (DVA) Rating Decision, the applicant's evaluation of Bipolar Disorder in full sustained remission (claimed as depressive disorder/manic disorder/anxiety disorder), which was at 30 percent disabling, was proposed to be decreased to 0 percent disabling.

On 22 Feb 13, according to DVA letter, the applicant's combined evaluation for all service-connected disabilities dropped from 40 percent to 20 percent, with a reduced rate of monthly compensation.

On 23 Oct 13, according to HQ AFRC/SGPA memorandum, Subject: Medical Disqualification, the applicant was determined to be medically disqualified for continued military service in accordance with Air Force Instruction (AFI) 48-123, *Medical Examinations and Standards*, Chapter 5, paragraph 5.3.12., by reason of Diagnosis: Bipolar Disorder.

On 26 Nov 13, according to HQ AFPC/DPFDI memorandum, Subject: Fitness Determination, the applicant was found to be unfit to perform the duties of her office, grade, rank, or rating for the following diagnosis and VA Code: VA Code: 9432, Diagnosis: Bipolar Disorder II; Combat Related: No.

On 9 Dec 13, according to applicant memorandum, Subject: Selection of Rights to Formal Physical Evaluation Board (FPEB), the applicant requested her case be referred to the FPEB solely for a fitness determination.

On 31 Jan 14, according to HQ AFPC/DPFDF memorandum, Subject: Fitness Determination, the FPEB recommended the applicant be found fit and returned to duty for: VA Code: 9432, Diagnosis: Bipolar Disorder II; Combat Related: No.

On 21 May 14, according to HQ AFRC/SGPA memorandum, Subject: Report of Medical Evaluation, provided by the applicant, she was placed on ALC C-3 status indefinitely at the direction of the Air Force Reserve Command Surgeon and may not be removed from this status without prior approval from AFRC Command Surgeon. The memorandum provided additional instructions for the completion of AF Form 422, *Notification of Air Force Member's Qualification Status*, and AF Form 469.

On 14 Aug 14, the applicant petitioned the AFBCMR under docket number BC-XXXX-XXXXX, requesting her diagnosis of Bipolar Disorder be removed from her military medical records. On 7 May 15, the AFBCMR adjudicated her case and denied her request.

On 22 Jun 16, the applicant petitioned the AFBCMR under docket number Work-Product, requesting her ALC C-3 be removed from her military medical records. The AFBCMR adjudicated her case on 20 Mar 18 and 16 Aug 18 and denied her request.

On 7 May 20, according to HQ AFRC/SG memorandum, Subject: Report of Medical Evaluation, provided by the applicant, she was found medically qualified for return to duty and placed on ALC C-2 status indefinitely at the direction of the Air Force Reserve Command Surgeon and may not be removed from this status without prior approval from AFRC Command Surgeon. The memorandum provided additional instructions for the completion of AF Form 422 and AF Form 469.

On 27 Jan 21, according to HQ AFRC/SG memorandum, Subject: Report of Medical Evaluation, provided by the applicant, she was found medically qualified for return to duty and placed on ALC C-1 status indefinitely at the direction of the Air Force Reserve Command Surgeon and may not be removed from this status without prior approval from AFRC Command Surgeon. The memorandum provided additional instructions for the completion of AF Form 422 and AF Form 469.

As of 24 May 24, according to a *Point Credit Accounting and Reporting Systems (PCARS)* summary, the applicant was credited with active duty points for the following active duty service performed:

- 23 Jul 16 – 22 Jul 17: 168 points
- 23 Jul 17 – 22 Jul 18: 102 points
- 23 Jul 18 – 22 Jul 19: 256 points
- 23 Jul 19 – 22 Jul 20: 347 points
- 23 Jul 20 – 22 Jul 21: 297 points
- 23 Jul 21 – 22 Jul 22: 312 points
- 23 Jul 22 – 22 Jul 23: 348 points

APPLICABLE AUTHORITY/GUIDANCE

Department of the Air Force Instruction (DAFI) 36-2110, *Total Force Assignments*, dated 15 Nov 21 (Certified Current 16 Nov 22), Chapter 3 – *General Guidance and Procedures*:

3.6. *Assignment Limitation Codes*. Assignment limitations alert personnel managers of long-term constraints on utilization of Airmen. These codes limit the selection of Airmen to or from certain duties or areas and may be permanent or semi-permanent. An Assignment Availability Code (2910) limits a service member's duty during an assignment or duty location, although an assignment limitation code may be used by exception. Table 3.2 lists the various types of assignment limitations and corresponding system update codes.

Table 3.2. *Assignment Limitation Codes*.

LINE	A	B	C	D	E
	Code	**Title**	**Description (Applies to both officers and enlisted unless indicated otherwise)**	**Effective Date and Duration**	**Limitation on PCS Selection**
	X	Medical Assignment Limitation	C1 Stratification: assignable to global DoD fixed installations with intrinsic MTFs. Assignable to non-permanent installations or installations without intrinsic MTF with approval of gaining installation Chief of Aerospace Medicine (SGP) or Chief of Medical Staff (SGH) or MAJCOM equivalent if none at installation	Date authorized by MTF/SG, MAJCOM/SG, or AFPC/DP2NP. See paragraph 3.7 and Chapter 13.	Service member may not PCS outside the limits set by their stratification unless waived by the authority specified in AFMAN 41-210. See note 6.

AFI 41-210, *TRICARE Operations and Patient Administration Functions*, dated 6 Jun 12*:*

Chapter 4 – *Patient Administration Functions*:

4.76. *Assignment Limitation Code-C.*

4.76.1. *Definition*. When an active duty member has been returned to duty by the Air Force DES as fit, DPAMM will review the case to determine if an Assignment Limitation Code (ALC)-C needs to be placed in the Personnel Data System (PDS). This action is taken by the appropriate ARC/SGP when the member is an RCSM [Reserve Component Service Member]. This code restricts assignment and deployment availability to only CONUS, Alaska (Elmendorf), and Hawaii assignments, and will prevent reassignment anywhere else without prior approval by designated approval authorities described in detail further in this section. The intent of the ALC-C is to protect members from being placed in an environment where they may not receive adequate medical care for a possible life-threatening medical condition and to prevent the assignment of non-qualified personnel to overseas locations. This will further ensure the safe and effective accomplishment of the Air Force mission.

4.76.2. *Authority*. HQ AFPC/DPAMM retains sole authority to assign or remove the ALC-C on active duty members, while the ARC/SGP is the authority to assign or remove the ALC-C or DAC-42 for RCSMs.

Chapter 5 – *Health Records Management*:

5.3. *Correcting Health Records.*

5.3.1. Patients have the right, under HIPAA, to access their health records and request amendment if they think the documentation is in error. However, there is no MTF requirement to agree to the proposed amendment. Furthermore, at no time should any documentation be

removed from the record (including automated record documentation systems) unless it is determined that the documentation does not pertain to the patient in question or any one of the following two scenarios applies:

5.3.1.1. Records or PCM support staff may remove an outdated DD Form 2766C, Adult Preventive and Chronic Care Flowsheet as long as the most current version of this form documents the latest immunization history for the patient.

5.3.1.2. Outdated or expired recommendations for special operations and/or flying status in accordance with Attachment 11 for AF Form 1042 an AF Form 1418.

Department of the Air Force Manual (DAFMAN) 36-2136, *Reserve Personnel Participation*, dated 15 Dec 23, Chapter 2 – *Allowable Federal Service for Members of the AFR*:

2.2. *Crediting Points and Satisfactory Federal Service*. Award one point for each day of active duty. Award one point for each IDT period (reference paragraph 4.1.1), not to exceed two IDT periods per calendar day. Points may only be credited to the date a reservist actually performed the duty, except in those activities where the cumulative method is authorized (e.g., ALO, teleworking, etc.).

DAFMAN 36-2114, *Management of the Air Force Reserve Individual Reserve (IR) and Full-Time Support (FTS) Programs*, dated 24 May 21, Chapter 6 – *AFR Management of the Full-Time Support (FTS) Program – Active Guard Reserve (AGR) Program*:

6.3.8. Applicants selected for an initial AGR assignment must meet the medical standards as outlined in DAFMAN 48-123 prior to assignment.

6.3.8.1. The appropriate reserve medical unit (or HQ AFRC/SGO in the absence of a gaining reserve medical unit), will certify medical evaluations for active military or prior service applicants applying for initial AGR positions as long as no disqualifying medical conditions are present. (T-2).

6.3.8.2. The Chief of Aerospace Medicine of the supporting reserve medical unit or HQ AFRC/SGO will certify the appropriate medical documentation. If applicable, a memorandum from the gaining commander or equivalent is required stating their willingness to accept an individual's physical restrictions. (T-2).

6.3.8.3. HQ AFRC/SG is the certifying and waiver authority for all applicants with no service affiliation, disqualifying medical conditions, or assignment limitation code "C" status. (T-1). Note: All requests for waivers shall be included with the submitted package. (T-1).

AIR FORCE EVALUATION

AFRBA Psychological Advisor recommends partially granting the applicant's request, removing the applicant's ALC, but not removing the Bipolar II Disorder from her military medical record. The applicant's request for award of active duty service credit was outside the advisor's practice; therefore, was not discussed or opined in this advisory.

The Psychological Advisor provided a detailed chronology of excerpts from the applicant's medical records used in formulating this advisory opinion, as well as highlights from her official military personnel record. In May 18, a psychiatric advisor from the AFBCMR recommended denying the applicant's request to have her ALC code of C-3 removed, citing the applicant did not meet the burden of proof. At that time, few encounters attested to her ability to function well in the military. A C&P exam, dated 7 Jan 13, noted although she was diagnosed with Bipolar II Disorder, her symptoms were not severe enough to interfere with her occupational functioning, and she received an excellent performance evaluation. An evaluation completed on 21 Mar 12 concluded the applicant should be able to function well in the military. In an encounter dated 9 Mar 18, the applicant reported her treatment was beneficial in that medication and therapy helped her learn how to manage distressing emotions.

Since then, numerous providers have continued to comment on her stability over the years. An encounter on 4 Jan 21 recommended permanently removing her ALC C-2 with no further ALC restrictions. A termination summary (23 Mar 21) continued to recommend the removal of her ALC, citing there has been no negative impact on her functioning in the military.

Additionally, the applicant's 12 EPRs demonstrate a consistent ability to be successful in her duties in a military setting. She earned 11 overall ratings of 5 out of a possible 5, and one 3 out of a possible 5. She earned achievement and commendation medals throughout her career and has been promoted to the grade of senior master sergeant.

Based on ongoing evidence that supports the applicant's ALC being permanently removed, this psychological advisor concludes and recommends her ALC be permanently removed. It is noted her most recent Mental Health Assessment/Periodic Health Assessment (4 Mar 24) stated she is overdue for her Review in Lieu of (RILO) exam.

The applicant's counsel is also petitioning the board to remove her Bipolar II diagnosis. While there is some evidence to suggest her Bipolar II diagnosis was in error, there is a fair amount of evidence to indicate she met the DSM 5 criteria for Bipolar II Disorder. A C&P examination on 27 May 06 diagnosed her with Bipolar II Disorder. She was initially service-connected for Bipolar II Disorder at 30 percent, which was later reduced to 0 percent (with the Bipolar II diagnosis remaining). An encounter dated 31 Jan 12 noted she admitted to having a history of Bipolar Disorder. An encounter from 14 Jan 16 stated, "it is conceivable that she met criteria for a Bipolar II Disorder diagnosis during 2004-2006. There is insufficient evidence to the contrary to invalidate the Bipolar diagnosis." An encounter from 8 Dec 16 noted she was "evaluated and treated for approximately 6 months for Bipolar II Disorder" in 2004. This encounter also stated since the applicant has failed to disclose anything about the history of her disease, her claims of not having Bipolar Disorder should be interpreted with caution. Finally, a Narrative Summary dated 4 Jan 21 noted, "even if the 2006 Bipolar II Diagnosis is considered valid, in 2012 a VA psychiatrist opined that it was in full remission so that a diagnosis of Bipolar II Disorder was no longer warranted." It should be noted a Bipolar II diagnosis that is determined to be in remission does not indicate the diagnosis is invalid/erroneous or that the condition does not exist. Rather, it indicates a period of few or minimal symptoms.

This psychological advisor concludes, based on all the evidence, the applicant likely met the DSM 5 criteria for Bipolar II Disorder at the time she was diagnosed. The provider at the time detailed the criteria that demonstrated criteria were met for a diagnosis of Bipolar II Disorder. Additionally, future encounters confirmed her Bipolar II diagnosis.

This psychological advisor acknowledges different providers have different diagnostic impressions and opinions and they sometimes may not agree 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. Based on all the pertinent materials, this advisor does not recommend removing the Bipolar II Disorder from her record.

The complete advisory opinion is at Exhibit P.

APPLICANT'S REVIEW OF AIR FORCE EVALUATION

The Board sent a copy of the advisory opinion to the applicant on 28 May 24 for comment (Exhibit Q), and the applicant replied on 20 Jun 24. In her response, applicant's counsel contended the Psychological Advisory stated there is some evidence to suggest the applicant's Bipolar Disorder diagnosis was in error; however, there is a fair amount of evidence to indicate she met the DSM 5 criteria for Bipolar II Disorder, and therefore, is not entitled to relief. The statement and recommendation are problematic for several reasons, most notably, its inconsistency and failure to address the actual DSM criteria.

As an initial matter, the records evidencing the original diagnosis are no longer available for review because the Air Force failed to maintain the applicant's medical records. Nevertheless, subsequent medical records reveal the original diagnosis occurred during a time when the applicant was voluntarily seeking treatment for alcoholism, and by medical standards today, an individual should not be diagnosed with a mental health disorder for the first time while undergoing alcohol withdrawal. The DSM 5 outlines the prevailing medical standards for the diagnostic criteria of Bipolar II Disorder. Importantly, the DSM 5 lists substance use disorder as a differing diagnosis of Bipolar II. The original diagnosis of Bipolar II must confirm the episode is not attributable to the physiological effects of a substance (e.g., drug abuse, a medication, or other treatment). According to the DSM 5 criteria, a diagnosis for Bipolar II Disorder requires both a hypomanic and a major depressive episode. For these episodes, the DSM emphasizes substance-induced psychotic disorders can (and should) be distinguished from brief psychotic episodes caused by the ingestion of a certain intoxicating substance, including alcohol. Specifically, the DSM states, "a careful history of substance use with attention to temporal relationships between substance intake and onset of the symptoms" is important from a diagnostic standpoint. Researchers who have studied the specific interplay between alcohol and Bipolar II Disorder have concluded unequivocally that Bipolar II Disorder should not be diagnosed during a time in which an individual is under the influence of alcohol or undergoing treatment for alcohol withdrawal.

Consistent with this research, the applicant's mental health provider and clinical psychologist stated the symptoms of her alcohol withdrawal, including restless anxiety and dysphoric emotions, mimicked the hypomanic diagnostic criteria for Bipolar II Disorder. Thus, the original diagnosis, which was given without any due regard to the interplay between her experienced symptoms during excessive alcohol intake and alcohol withdrawal is flawed and mistaken. The DSM 5 plainly requires the diagnosing psychiatrist to evaluate whether the patient's reported symptoms could be mistaken for alcohol use or withdrawal as a "differing diagnosis." To this end, the DSM 5 also requires the psychiatrist to consider the temporal and causal relationship between the patient's reported symptoms and the consumption or withdrawal of alcohol. The advisory opinion problematically ignores and refuses to address this clear language in the DSM 5, which is the prevailing medical standard for mental health disorders.

A careful review of the applicant's subsequent medical records demonstrates not a single mental health provider, clinical psychologist, or clinician ever confirmed her Bipolar II diagnosis based upon present and existing symptoms. They merely confirmed Bipolar II Disorder based upon her historically reported symptoms, despite a lack of present symptoms at every subsequent visit. Presented in support of this contention are notes from the applicant's original diagnosis, outpatient mental health care (2005), DVA C&P exam (2006), clinical psychologist visit (2012), DVA C&P exam (2013), mental health clinic (2016), mental health clinic (2018), and MEB narrative summary (2019, 2020, 2021). In sum, the advisory opinion that future encounters confirmed her Bipolar II diagnosis is unsupported by the record.

Bipolar II is a recurrent mental health disorder characterized by alternating hypomanic and depressive episodes. Thus, the bulk of the medical research available today focuses on the

effectiveness of various treatments, which are often defined by decreasing the time of the manic episode and increasing the remission time until the next episode. It is entirely inconsistent with Bipolar II Disorder to have a period of sustained remission for over 20 years. The only conclusion that can be drawn from the applicant's complete lack of symptoms for over 20 years, coupled with her lack of treatment and lack of psychiatric medication, is that she never had Bipolar II Disorder and she was misdiagnosed.

The advisory opinion erroneously suggests after the applicant's initial diagnosis, which occurred at an unknown time between 2004-2006, doctors have continuously diagnosed her with Bipolar II Disorder. This conclusion misunderstands the nature of each diagnosis. All examinations after her original diagnosis were based upon her reported history of symptoms, and were never once confirmed with current, ongoing symptoms. The 2006 DVA C&P exam did not diagnose her with Bipolar II Disorder. Instead, the examiner reviewed her historical record and simply concluded based upon past symptoms that she was diagnosed with Bipolar II Disorder in service. To support the original diagnosis, the advisory opinion emphasizes the applicant admitted to a medical provider in 2012 that she had a history of Bipolar Disorder. This is not an admission of having Bipolar Disorder, rather the applicant stated factually her medical history included a bipolar diagnosis. She was simply indicating her medical history, which was not available for review due to lost records, may have included a Bipolar II diagnosis. At that time, her records had been lost for several years, thus her statement was against her own interest and undercuts any notion she was intentionally withholding adverse medical information.

Lastly, the advisory opinion stated 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. Yet the only providers who have conducted an independent medical examination after reviewing the applicant's history, have concluded she does not have Bipolar II Disorder and opined she was misdiagnosed. Not a single medical or mental health professional has diagnosed the applicant with Bipolar Disorder based upon any currently presenting symptoms from 2006 to present. The only diagnosis was from her originally reported symptoms documented in her DVA C&P exam in 2006. Subsequent doctors validated this diagnosis based upon medical history. Doctors who conducted formal psychological testing, which had occurred on four different occasions, have definitively concluded she does not have Bipolar II Disorder.

The applicant has taken all possible actions to remove this erroneous diagnosis from her record. She has sought continued and sustained mental health evaluations on a voluntary basis to demonstrate the absence of her symptoms. She has lived asymptomatically without the use of any psychoactive medications or ongoing mental health treatment. Meanwhile, she has excelled in her personal and professional life. Her Air Force job requires immense attention to detail, has fast deadlines, and requires the management of several ongoing and competing tasks. It is impossible for someone with Bipolar II Disorder to function in such a fast-paced and often dysregulated environment without any indication or relapse for 20 years without sustained and consistent treatment. The only possible conclusion, supported by clear and convincing medical evidence, is the applicant did not, and does not currently, have Bipolar II Disorder. She was misdiagnosed and has spent over a decade of her life continuing to fight this unjust diagnosis and the negative effects it has had on her career progression. Accordingly, the applicant requests relief as set forth in her initial application.

The applicant's complete response is at Exhibit R.

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 and recommendation of the AFRBA Psychological Advisor regarding the applicant's request to remove her Bipolar II Disorder diagnosis; however, does not concur with the Psychological Advisor's recommendation to remove the ALC from the applicant's record. In accordance with DAFI 36-2110, AFRC/SG is the authority for determining appropriate ALC status for AFR members returned to duty after a fitness determination. It is obvious from the evidence provided by the applicant, AFRC/SG has been performing periodic re-evaluations of the applicant's mental health diagnosis/condition, and adjusting the ALC status accordingly, with another RILO evaluation due this year.

Regarding the applicant's request for removal of the Bipolar II Disorder diagnosis, the Board concurs with the AFRBA Psychological Advisor, and finds the applicant likely met the DSM 5 criteria for Bipolar II Disorder at the time she was diagnosed, and the subsequent differences in impressions and opinions do not invalidate the original diagnosing provider's opinion, as each provider is entitled to formulate an independent opinion based on available information.

Finally, the Board finds insufficient evidence of error or injustice regarding applicant's contention she was unfairly denied active duty service due to her Bipolar II Disorder diagnosis and resulting ALC status. The applicant was afforded due process via the IPEB and FPEB, and her ALC status was determined in accordance with established guidance. While her ALC status restricted performance of active duty, it did not eliminate it, as evidenced by the applicant's PCARS summary which reflects active duty service performed during the period 2016-2023. Additionally, AFRC/SG is the waiver authority for AFR AGR active duty positions, yet there was no evidence presented by the applicant that shows she applied for an AGR position, or pursued a waiver, and was denied. The applicant has since been promoted and permitted to cross-train to her requested career field, hence, no career impediment. Therefore, the Board recommends against correcting the applicant's records.

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 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 DAFI 36-2603, *Air Force Board for Correction of Military Records (AFBCMR)*, paragraph 2.1, considered Docket Number [redacted] Work-Product in Executive Session on 18 Jun 24 and 17 Jul 24:

, Panel Chair
, Panel Member
, Panel Member

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

Exhibit L: Record of Proceedings, w/ Exhibits A-D, dated 7 May 15.

Exhibit M: Record of Proceedings, w/ Exhibits A-K, dated 16 Aug 18.
Exhibit N: Application, DD Form 149, w/atchs, dated 13 Aug 23.
Exhibit O: Documentary evidence, including relevant excerpts from official records.
Exhibit P: Advisory Opinion, AFRBA Psychological Advisor, dated 28 May 24.
Exhibit Q: Notification of Advisory, SAF/MRBC to Counsel, dated 28 May 24.
Exhibit R: Counsel's Response, dated 20 Jun 24.

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