RECORD OF PROCEEDINGS

IN THE MATTER OF: XXXXXXXXXXXX

DOCKET NUMBER: BC-2021-00236

COUNSEL: NONE

HEARING REQUESTED: NO

APPLICANT'S REQUEST

Her medical disability retirement rated at 30 percent be changed to 100 percent.

APPLICANT'S CONTENTIONS

Her medical condition of Venous Thromboembolic disease on indefinite anticoagulation and cervicalgia with C-7 radiculopathy should have been found compensable and unfitting by the Informal Physical Evaluation Board (IPEB). She did not suffer from any conditions that existed prior to service (EPTS) and submits medical evidence that shows these conditions did not exist prior to service and were incurred while entitled to basic pay.

The applicant's complete submission is at Exhibit A.

STATEMENT OF FACTS

The applicant is a medically retired Air National Guard colonel (O-6).

On 30 Jun 16, AF IMT 618, *Medical Board Report*, indicates the applicant was referred to the IPEB for venous thromboembolic disease on indefinite anticoagulation, obstructive sleep apnea, and cervicalgia with left C7 radiculopathy.

On 13 Sep 16, the Department of Veterans Affairs (DVA) proposed a disability rating for her service-connected medical conditions of Major Depressive Disorder at 30 percent, chronic anticoagulation due to unspecified chronic Thromboembolic disease at 60 percent, cervical degenerative joint disease at 30 percent, and left arm radiculopathy at 20 percent.

On 14 Sep 16, AF Form 356, *Informal Findings and Recommended Disposition of USAF Physical Evaluation Board*, indicates the applicant was found unfit due to her medical condition of Depressive Disorder with a disability compensation rating of 30 percent with a recommendation of "Permanent Retirement." Her other condition of chronic anticoagulation due to unspecified chronic Thromboembolic disease was found to have EPTS and not service aggravated. Her medical condition of cervicalgia was found as a category II condition that can be unfitting but is not currently unfitting.

On 22 Sep 16, AF Form 1180, *Action on Physical Evaluation Board Findings and Recommended Disposition*, indicates the applicant agreed with the findings and recommended disposition of the IPEB and waived her rights to a formal hearing. She also indicates she did not request a one-time reconsideration of the disability rating for the conditions found unfitting.

Dated 4 Oct 16, Special Order XXXXX, indicates the applicant was permanently disability retired in the grade of colonel with a compensable percentage for physical disability of 30 percent, effective 27 Nov 16.

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

AIR FORCE EVALUATION

AFPC/DPFDD recommends partially granting the applicant's request for her medical conditions of Venous Thromboembolic disease (VTED) on indefinite anticoagulation and Cervicalgia with C-7 radiculopathy unfitting for continued military service, finding there is indication an error or injustice occurred at the time the PEB processed her disability case. The medical reviewers for this advisory noted they do not agree with the original IPEB decision to place the applicant's VTED condition in Category I, but recommend placement of this condition in Category II, conditions that can be unfitting but are not currently unfitting. The requirement for chronic anticoagulation therapy is not a contraindication for performance of duty for a physician. Per the Pulmonary Consultation, "the significant issue resulting from her pulmonary embolism episode is her continued anticoagulation. Warfarin therapy is a clear contraindication to worldwide deployment, though it would allow in-garrison duties as a physician." This condition would require an Assignment Limitation Code (ALC) for this applicant's Air Force Specialty Code (AFSC); however, the medical reviewers opine that treatment with chronic anticoagulation would not prevent her from reasonably performing the duties of her office, grade, rank or rating, aside from deploying to austere or hostile locations, and would NOT be considered unfitting for continued service for this experienced physician and senior officer. Additionally, the medical reviewers for this advisory noted they do not agree with the original IPEB decision to place the applicant's Cervicalgia with C7 Radiculopathy affecting the left upper extremity condition in Category II, but recommend placement of this condition in Category I but find that it EPTS without Permanent Service Aggravation and therefore is non-compensable under the DES. The AF Form 469, *Duty Limiting Condition Report*, dated 3 May 16, indicated the applicant had significant mobility, duty, and fitness restrictions due to cervicalgia and C7 radiculopathy including: no running/walking/sit-ups/push-ups on the Air Force Fitness Assessment (AFFA); no crawling, stooping, duties requiring kneeling more than 1 minute at a time; no lifting of objects weighing more than 2 lbs; no pushing or pulling of objects weighing more than 5 lbs; walking as tolerated; no running; no marching; no PCS/TDY/mobility. The lack of dexterity and sensation in the applicant's left hand would impede performance of even in-garrison tasks (such as typing, examining patients, etc.) and the requirement for opioid medication conveys a risk of cognitive impairment or safety miscues and is unfitting for continued military service for a physician. Although the medical reviewers suggest these changes to the original IPEB results, these revisions would not change the overall compensable disability rating of 30 percent as originally awarded.

The complete advisory opinion is at Exhibit C.

NGB/SGP recommends denying the application finding no evidence of an error or injustice to the applicant's Medical Evaluation Board (MEB) regarding specific facts and circumstances in the IPEB final permanent retirement decision. It is not within NGB/SGP scope to weigh in on the IPEB decision and disability rating. The applicant received an in the line of duty (ILOD) for right leg Deep Vein Thrombosis and Intervertebral Disc Disorder with Myelopathy at Cervical Region C-7. The applicant was afforded the opportunity to have an impartial review of her MEB as well as provide a letter detailing concerns and she elected to do so by signing the Impartial Election Review Form on 11 Jul 16. An impartial provider completed the MEB review on 14 Jul 16 and concurred the narrative summary and MEB package adequately reflected the complete spectrum of injuries or illness of the applicant. The IPEB conducted the applicant's MEB accordingly and rendered their disposition. On 22 Sep 16 the applicant signed the AF Form 1180 agreeing with the findings and recommended disposition of the IPEB and waived her right to a FPEB hearing. The applicant also elected not to request a one-time reconsideration of the disability rating for the conditions found unfitting by the IPEB.

The complete advisory opinion is at Exhibit D.

The AFBCMR Medical Advisor recommends partially granting the applicant's request, concuring with the recommendation of AFPC/DPFDD, that the applicant's requirement for chronic anticoagulation, alone, status-post deep vein thrombosis (DVT) and pulmonary embolism, would not interfere with a physician leader's retainability, and would not have cut her career short, but not for her unfitting *Major Depressive Disorder* and *Cervicalgia*. The Medical Advisor also agrees that the applicant's *Cervicalgia* and *C7 radiculopathy* should have been found unfitting, but could *not* determine, through "clear and unmistakable evidence," while serving a period of 31 days or more, that the conditions were not *de novo* injuries or the result of permanent aggravation of her pre-existing, or EPTS, cervical degenerative disease. Thus, based upon the disability ratings assigned by the DVA to these two medical conditions, the Medical Advisor recommends inclusion of a 30 percent rating for *Cervical Degenerative Joint Disease* and a 20 percent rating for *Left Arm Radiculopathy* (Non-dominant) (claimed as *Left C7 radiculopathy*); thereby achieving permanent retirement with a *combined* [not added] disability rating of 60 percent.

The applicant's case involves two basic principles in the Disability Evaluation System (DES) adjudication; one involving whether or not a given medical condition is unfitting and the other determining whether or not the medical condition should be considered ILOD. In the military DES, in order for a traditional Reserve or Guard member to be eligible to receive disability compensation, the medical condition must be unfitting; that is, it must be shown to preclude the member's reasonable performance of the duties of his or her office, grade, rank, or rating. More importantly, the medical condition must be found ILOD. For the Air Reserve Component (ARC) member, serving a period of 30 days or less, the medical condition must be the proximate result of [caused by] the performance of military service, or occur during direct travel to and from the place of duty, or overnight when the distance between duty location and home warrants. While a given medical condition is presumed service-incurred if manifested during a period of 31 days or

more service, it can be *rebutted* based upon medical principles that indicate the condition could *not* have first begun during the specified period of 31 days or more service. Nevertheless, making a determination that a medical condition EPTS, while serving in a period of 31 days or more [as in the applicant's Title 32 orders], if disqualifying for continued service, there must be "clear and unmistakable" evidence that the condition EPTS. The Medical Advisor opines that the 60 to 70 percent stenosis of the applicant's left internal carotid artery was clearly and unmistakably not the proximate result of Reserve or Guard duty, nor was permanently aggravated by military service. Instead, the applicant's transient ischemic attacks (TIAs) were the expected manifestation of the release of fragments from an *ulcerated plaque* within the wall of the stenotic vessel that escaped into the cerebral circulation; thus, causing the warning central neurological signs and symptoms of thromboembolic stroke [not from the leg DVT and prior to undergoing endarterectomy]. The Medical Advisor agrees that a negative laboratory work-up for genetic markers of a predisposition for clotting, and the circumstances of the applicant's air travel and extended seating at a continuing medical education (CME) conference, would play heavily towards finding the applicant's DVT and any residual unfitting sequelae, specifically *post-phlebitic syndrome*, ILOD; but would like broader more complete evidence of negative testing results before a definitive recommendation. Therefore, before considering inclusion of the applicant's *post-phlebitic syndrome* as ILOD, the Medical Advisor recommends the applicant re-supply evidence of the negative work-up for a *broader spectrum* of known genetic factors, which would predispose her to future clotting events.

Addressing the applicant's *Obstructive Sleep Apnea*, *Migraine Headaches*, *Asthma*, and *Patellofemoral Syndrome,* the Medical Advisor found no objective *service* documentation, upon which to determine that either of these should have been an independent basis (pl.) for career termination of a physician; notwithstanding the history and examination findings disclosed during various Compensation & Pension Examinations and DBQs conducted in June 2016.

However, with respect to the *left C7 radiculopathy*, presumably caused by forcible intraoperative manipulation of the applicant's neck and shoulder, the Medical Advisor refers the reader to extracts from DoD Instruction 1332.38, *Physical Disability Evaluation*, paragraph E3.P4.5.6., and its contemporary, DoDI 1332.18, *Disability Evaluation System*, which respectively read, "Treatment of Pre-Existing Conditions. Generally recognized risks associated with treating pre-existing conditions shall not be considered service aggravation," and "Generally recognized risks associated with treating pre-existing conditions will not be considered service aggravation. **Unexpected adverse events**, over and above known hazards, directly attributable to treatment, anesthetic, or operation performed or administered for a medical condition existing before entry on active duty, **may be considered service aggravation**." The clinical record indicates that the applicant's *C7 left upper extremity radiculopathy*, resulted from the extreme manipulation of the applicant's shoulder and cervical spine, with possible further disc herniation, while under anesthesia, in the attempt to gain adequate surgical access to the left carotid artery. Therefore, the Medical Advisor finds it reasonable to consider this an "**unexpected adverse event**, over and above known hazards, directly attributable to treatment" of the applicant's carotid artery stenosis. Accordingly, the Medical Advisor opines the applicant's *C7 radiculopathy* should be considered service-incurred and ILOD. Likewise, the Medical Advisor could not determine, through "clear and unmistakable evidence," that the applicant *Cervicalgia* [neck pain and spasms] was not the result of permanent aggravation of the applicant's cervical degenerative disc disease, by the

manipulation of the neck and shoulder during surgery; and should also be included as a compensable unfitting medical condition. The Medical Advisor also acknowledges that chronic anticoagulation poses an unreasonable health risk to a service member, in an injury-prone deployed environment; but that it may also warrant retention with an ALC; in this case, with reclassification to performing nonflying, in-garrison, physician duties. As a final reminder, notwithstanding the lengthy discussion of LOD determinations, *if* the applicant had achieved the equivalent of at least 8 years of active service and was serving a period of 31 days or more when any of her medical conditions were determined unfitting/disqualifying, under Title 10, U.S.C., Section 1207a, the conditions would be considered service-incurred and the disability ratings assigned for these conditions by the DVA would be included in her final combined disability rating computation. It should also be noted, the DVA offers compensation for *any* medical condition determined service-incurred, without regard to its proven or demonstrated impact upon a former service member's retainability or fitness to serve.

The complete advisory opinion is at Exhibit E.

APPLICANT'S REVIEW OF AIR FORCE EVALUATION

The Board sent a copy of the advisory opinion to the applicant on 20 Sep 21 for comment (Exhibit F), and the applicant replied on 15 Oct 21. In her response, the applicant agrees with the AFBCMR Medical Advisor's recommendation of a 30 percent rating for Cervical Degenerative Joint Disease and a 20 percent rating for left arm Radiculopathy (Non-dominant) (claimed as left C7 radiculopathy) stating Cervicalgia and C7 radiculopathy should be considered as two separate conditions. Cervicalgia and C7 radiculopathy should have been found unfitting because neither condition was de-novo nor EPTS, and both conditions merged while on military orders. These two conditions presented themselves while serving on military orders for a period of 31 days or more. She disagrees with the advisory opinions concerning her medical condition of Chronic Anticoagulation due to Thromboembolic disease. She provides evidence that Chronic Anticoagulation due to unspecified chronic thromboembolic disease did not EPTS and was service aggravated. All genetic factors were confirmed as testing negative; her DVT was provoked by prolonged sitting and was ILOD. Neither the Medical Advisor, nor MEB or IPEB took into consideration her clinical picture in its entirety (e.g., hypertension, prone to falls due to her Lumbar Discogenic Disease, inability to move head up and down or side-to-side with increased risk of falls and injuries, and further severe complications on anticoagulation including death). She has multiple medical and mental conditions that limits her activities as a physician and her activities daily. Due to the severity of the entire spectrum of medical/mental conditions and countless medications that prevented her from performing her physician duties, she was retired.

The applicant's complete response is at Exhibit G.

FINDINGS AND CONCLUSION

1. The application was not timely filed, but it is in the interest of justice to excuse the delay.

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

3. After reviewing all Exhibits, the Board concludes the applicant is the victim of an error or injustice. The Board concurs with the rationale and recommendation of the AFBCMR Medical Advisor and finds a preponderance of the evidence substantiates the applicant's contentions in part. Specifically, the applicant has provided medical evidence, which is sufficient to justify granting the applicant's request to increase her medical disability retirement to 60 percent. However, for the remainder of the applicant's request, the evidence presented did not demonstrate an error or injustice, and the Board therefore finds no basis to recommend granting that portion of the applicant's request. Therefore, the Board recommends correcting the applicant's records as indicated below.

RECOMMENDATION

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

a. On 14 September 2016, she was found unfit to perform the duties of her office, rank, grade, or rating by reason of physical disability, incurred while she was entitled to receive basic pay. The inclusion of a diagnosis for Cervical Degenerative Joint Disease, under VASRD code 5242, rated at 30 percent and left arm radiculopathy (non-dominant), claimed as left C7 radiculopathy, under VASRD code 8710, rated at 20 percent, when combined with her initial disability rating of 30 percent due to Depressive Disorder, results in a combined [not added] disability rating of 60 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 27 November 2016, she was discharged from active duty and on 28 November 2016, she was permanently retired with a compensable percentage for physical disability of 60 percent.

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

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

CERTIFICATION

The following quorum of the Board, as defined in Air Force Instruction (AFI) 36-2603, *Air Force Board for Correction of Military Records (AFBCMR)*, paragraph 1.5, considered Docket Number BC-2021-00236 in Executive Session on 23 Nov 21:

, Panel Chair
, Panel Member
, Panel Member

All members voted to correct the record. The panel considered the following:

Exhibit A: Application, DD Form 149, w/atchs, dated 14 Nov 20.
Exhibit B: Documentary evidence, including relevant excerpts from official records.
Exhibit C: Advisory opinion, AFPC/DPFDD, w/ atchs, dated 29 Mar 21.
Exhibit D: Advisory opinion, NGB/SGP, w/ atchs, dated 17 Jun 21.
Exhibit E: Advisory opinion, AFBCMR Medical Advisor, w/ atch, dated 17 Sep 21.
Exhibit F: Notification of advisory, SAF/MRBC to applicant, dated 20 Sep 21.
Exhibit G: Applicant's response, dated 15 Oct 21.

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

X

Board Operations Manager, AFBCMR