UNITED STATES AIR FORCE
BOARD FOR CORRECTION OF MILITARY RECORDS

RECORD OF PROCEEDINGS

IN THE MATTER OF: [redacted]

DOCKET NUMBER: BC-2022-00665

COUNSEL: [redacted]

HEARING REQUESTED: YES

APPLICANT'S REQUEST

1. His Obstructive Sleep Apnea (OSA) be found in the line of duty (ILOD).

2. He be given a medical retirement.

APPLICANT'S CONTENTIONS

The Air Force incorrectly concluded his OSA was not found ILOD, therefore did not warrant a Physical Evaluation Board (PEB) and consideration for a medical retirement. He was discharged for service disqualifying sleep apnea and other medical conditions. His OSA was documented in his medical records as early as 1994. The Department of Veterans Affairs (DVA) initially denied his claim for a disability rating for his OSA based on the line of duty (LOD) determination; however, upon appeal, determined his OSA was service-connected, supported by medical documentation dating back to 1994 and awarded him 50 percent disability compensation. The LOD determination was incorrect, and he should have been processed through the Integrated Disability Evaluation System (IDES), instead of being separated for a medical disqualification. DODI 1332.18, *Disability Evaluation System*, indicates any reserve member in an inactive duty training (IDT) status that has a permanent injury, that was incurred in the LOD, including prior periods of service, are entitled to DES processing and will be retired if the Veterans Affairs Schedule for Rating Disabilities (VASRD) rating is above 30 percent.

The applicant's complete submission is at Exhibit A.

STATEMENT OF FACTS

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

On 8 Oct 10, according to AF Form 469, *Duty Limiting Condition Report,* provided by the applicant, he was found to have had a medical condition which did not meet the Air Force medical standards. As a result, he was placed on a Code 37 (Medical defect/condition requires Medical Evaluation Board (MEB) or PEB processing) profile and restricted from Reserve participation for pay and points.

On 3 Nov 12, according to AFRC IMT 348, *Informal Line of Duty Determination,* provided by the applicant, his medical condition of OSA was found to exist prior to service (EPTS) and had no correlation with his reserve service, which does not meet criteria for LOD. It was noted his OSA was controlled with continuous positive airway pressure (CPAP). The results of the investigation notes there was no data to link the incident to his active-duty service from 2008 and his personal statement and past treatment in 1994 would have revealed a candidate that was not suitable for Reserve duty. Sleep apnea, depression, etc. were not present or available when the applicant enlisted in the AFR.

On 3 Feb 13, according to LOD Determination memo, provided by the applicant, the Staff Judge Advocate found the LOD Determination to be legally sufficient.

On 10 Nov 14, according to AF IMT 131, *Application for Transfer to the Retired Reserve,* the applicant requested to be transferred to the Retired Reserve in lieu of an administrative discharge due to physical disqualification. The request was approved on 29 Nov 14 with an effective date of 12 Dec 14.

On 10 Dec 14, according to Reserve Order Work-Product the applicant was relieved from his current assignment and placed on the USAF Reserve Retired List, effective 12 Dec 14.

On 11 Oct 18, according to the DVA Rating Decision, provided by the applicant, the DVA granted the applicant a 50 percent disability rating for service-connected medical condition of OSA, effective 21 Jul 10.

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

AIR FORCE EVALUATION

AFRC/SGP recommends partially granting the application based on the documentation provided by the applicant and analysis of the facts, finding evidence of a potential error or injustice by not considering his OSA as a possible prior service impairment (PSI). After reviewing the attached clinical records, it seems the applicant's OSA diagnosis could be considered a PSI for the following reasons: the applicant complained of snoring and daytime sleepiness prior to separating from active duty in 1994; there is consistent reporting a throat exam via a scope saw an anatomic airway collapse when lying down; the applicant's weight was stable from 1994 through the time he started using a CPAP machine in 2009 (gaining weight over time is not an intervening event in this case); and sleep dysfunction symptoms reportedly improved with CPAP treatment.

OSA requiring the use of CPAP was disqualifying for military retention in 2014 when the medical disqualification case was processed. Likely, the applicant would have been returned to duty (potentially with a deployment limiting code) if this was his only disqualifying medical diagnosis as his Reserve Medical Unit reported his OSA symptoms were much improved with the use of CPAP therapy.

The complete advisory opinion is at Exhibit C.

AFRC/A1 recommends denying the application finding no error or injustice in the applicant's discharge. The applicant received a Not in Line of Duty (NILOD) determination based on the finding his medical condition EPTS and therefore was not applicable under AFI 36-2910, *Line of Duty (Misconduct) Determination,* dated 4 Oct 02.

The complete advisory opinion is at Exhibit D.

APPLICANT'S REVIEW OF AIR FORCE EVALUATION

The Board sent a copy of the advisory opinions to the applicant on 10 Nov 22 for comment (Exhibit E), and the applicant replied, through counsel, on 9 Dec 22. In response to the AFRC/SGP advisory opinion, the applicant concurs his OSA is a PSI and a PEB must review his case. In response to AFRC/A1 advisory opinion, the applicant disagrees with the advisory opinion. The AFRC LOD approval authority failed to consider the law and regulation of how to treat a PSI as it relates to a LOD finding. The advisory is devoid of reasoning or explanation and omits significant analysis of known controlling regulations.

The applicant's complete response is at Exhibit F.

ADDITIONAL AIR FORCE EVALUATION

The AFBCMR Medical Advisor recommends denying the application finding insufficient evidence to support the applicant's request for service-connection for OSA or to be medically retired for the same. There was no evidence of either a calculated error or rendered injustice occurred in the DoD's adjudication of his OSA condition being EPTS and a LOD determination was not applicable. The known pathophysiologic nature of OSA in reference to its chronic development coupled with the evidence of the applicant's ability to maintain duty requirements lent great credence an LOD was correctly identified as not applicable, and the condition would not be considered for IDES processing by not being unfit.

The applicant and counsel petition the Board requesting a DVA service-connected condition of OSA be found in the LOD and to receive a medical retirement for the same condition with all associated back pay. First, a few authored comments in counsels brief must be carefully questioned for accuracy of what was actually documented in medical terms. Counsel's brief stated the applicant's sleep apnea was documented in his medical records as early as 1994. This statement is not completely accurate as written. As written, its supposition appears a diagnosis of sleep apnea had already occurred or has been established. It was not established, but rather the applicant only voiced having a concern about possible sleep apnea. Second, counsel stated regarding the same Mar 94 encounter, the applicant received a consult secondary for snoring and there were concerns for sleep apnea, whereas the actual service treatment records (STR) for that date only note [redacted] – sleep disorder clinic" under plan. As written, one can only assume the plan was to have him go to that clinic; however, no written

consultation sheet was in evidence or available for review. Thirdly, within the same brief note in Mar 94, the word "concerned" was written twice, both noting the applicant was concerned about his voiced possibility of having sleep apnea… but there was no diagnosis of such a condition at the time.

Furthermore, counsel went on to say that on 2 May 94, the applicant was referred to a sleep clinic for sleep apnea. Again, the statement must be questioned in that the encounter simply stated per SF 93, *Report of Medical History*, has been referred to sleep clinic for work-up (w/u) of sleep apnea… again, not having been diagnosed with sleep apnea, but rather only snoring as verbally reported by the applicant. The key and accurate phrase in that sentence was for a w/u of sleep apnea. A medical w/u is simply to rule-out various medical/health conditions in hopes to rule-in on the proper/accurate diagnosis. An additional uncertainty in the STR was the SF 93 that was spoken about on the 2 May 94 encounter was not dated until 4 May 94 and specifically stated currently awaiting exam and possible treatment for sleep apnea. The possibility of treatment clearly meant a diagnosis has not yet been established and hence is currently waiting an examination to see if sleep apnea is a bonified diagnosis and if so, will treatment be necessary.

Lastly, counsel argues as documented on the 4 May 94 SF 93, the patient states frequent trouble sleeping 1988 – present, no treatment. Additionally, in counsel's brief he writes the applicant's trouble with sleep apnea continued after he was discharged from the active component. In a Report of Medical Evaluation dated 3 May 97, the applicant noted his ongoing sleep issues and referenced his prior sleep study from 1994, which the results were never documented, or the actual test reports were not available for review. The applicant reported the original sleep study results from 1994 were lost but maintains he was told by his doctor that his airway was closing off completely and sent for a sleep study just three days prior to his separation. However, the Medical Advisor found nowhere in the reviewed records could a statement of such severity be medically or clinically verified; nor was there any evidentiary proof the applicant was ever seen in the sleep clinic and/or diagnosed with OSA within the 1994 timeframe. Counsel additionally states on 7 Dec 04, an STR again notes his history of snoring and provides a diagnosis of sleep apnea; the actual clinic encounter was for the complaint of a sore throat and only through the taking of a history did the applicant describe having a history of snoring loudly and stating he was told he did have confirmed sleep apnea and airway obstruction. The physical examination revealed a red throat and the provider listed pharyngitis as the primary diagnosis and sleep apnea as the secondary diagnosis. However, the Medical Advisor found the sleep apnea diagnosis in this encounter was based only upon an unverified verbal history from the applicant himself. Under "Plan", it contained a note regarding the taking of antibiotics for the pharyngitis and a second note that was partially unreadable, but did state, referred to sleep study clinic.

Counsel argues the applicant continued to serve and deploy during this time through 2010. On 17 Nov 10, the applicant was notified of a medically disqualifying condition. However, the Medical Advisor notes from 2004 through 2010, the applicant had no physical condition that kept him from adequately performing the duties of his office, grade, rank, or rating. It was not until 8 Oct 10 when the applicant received an AF Form 469, which noted mobility restrictions as well as physical limitations/restrictions. The AF Form 469 does not reveal an actual diagnosis, but rather it does provide a clear picture of the official physical restrictions that are related to a specific medical

condition. In this case, it is reasonable to assume that the mid-Oct 10 AF Form 469 was in relation to the mid-Nov 10 notification of a disqualifying condition. However, when one reviews the actual written physical limitations and restrictions on this form, they would not correlate with a diagnosis of OSA. The diagnosis of OSA would not preclude one from stooping, crawling, pushing, or pulling objects, or standing for more than 15 minutes. This brings into question of what health condition this form is in reference too. The applicant had other conditions beside the OSA in question. Such physical restrictions could have been for one of the applicant's other conditions.

Additionally, counsel argues the applicant was discharged for service disqualifying sleep apnea and other medical conditions on 12 Dec 14 and was denied a PEB and consideration for medical retirement. However, the Medical Advisor finds the evidence discovered in the record review does not directly correlate with counsel's above written statement; for no documents denoted the applicant was ever denied a PEB or denied a consideration for treatment. Additionally, stating the applicant was discharged for service disqualifying sleep apnea and other medical conditions is not equivalent to the actual reason for separation, Physically Disqualified for Active Duty, without specification of any health condition. What is not explained on his separation order, dated two days prior to his actual separation, was the important fact that in having a disqualifying physical condition, (presumably OSA), and thus pending a possible administrative discharge, the applicant requested and was approved to be transferred to the retired reserve. He was not simply released from service because of a physical condition, but rather per his request for transfer.

Sleep apnea is a chronic condition that has many types of risk factors in its development or in its severity. It is a single condition that can be caused by a variety of other conditions or factors that can block airflow through the upper airways during sleep. Although it is normal for the muscles and soft tissues in the throat to relax and collapse to some minor degree while sleeping, and for most individuals such a minor collapse does not cause breathing problems, however, in individuals with OSA, the airway has narrowed because of several factors to include being overweight, having a large neck, adult age, being a smoker, or using alcohol. Function and structure of the upper airway have been a focus of interest in various scientific reports investigating increasing age and upper airway pathophysiology. Aging is associated with increased upper airway resistance, increased parapharyngeal fat, decreased pharyngeal size, and impairment of pharyngeal muscle reflexes that are important to maintain upper airway patency. In time, various throat muscles can and will lose tone and eventually bring on OSA or worsen an already identified condition.

In this case the DVA granting service connection for sleep apnea afforded the applicant eligibility for DVA compensation. However, the criteria for processing through the DoD IDES is having a disqualifying medical condition (occurring in a duty status) that has rendered the service member the inability to continue performing the duties of their office, grade, rank, or rating. In other words, a condition which caused the member to become unfit for continued military service. Although both the DoD and DVA work closely together in the IDES, they operate completely independent within Title 10 and Title 38 U.S.C., respectively. The DoD can only offer compensation or a rating for service incurred diseases or injuries which cause a service member to become unfit for continued active service and were the cause for career termination. The DVA is authorized to offer compensation for any medical condition determined service incurred service-connection,

without regard to and independent of its demonstrated or proven impact upon a service member's retainability, fitness to serve, or the length of time since date of discharge.

Counsel additionally cited regulatory guidance stating any reserve member in an IDT status that has a permanent injury/condition that was incurred in the line of duty, including prior periods of service, are entitled to IDES processing and will be retired if the VASRD rating is above 30 percent. The word permanent issue would indicate, due to the disqualifying permanent medical condition, the member was unable to adequately perform the duties of their office, grade, rank, or rating… thereby being considered as unfit. If found unfit, in those circumstances, the IDES process would have been applicable. These criteria of a condition being found unfit as per its definition includes the issue of a PSI condition. Bottomline, if a disqualifying medical condition is not found to be unfitting, then adjudicating under PSI condition or referral into the IDES is not applicable. As previously stated, OSA is a chronic condition whereby muscles in the throat or pharynx lose tone over time leading to a higher risk of airway collapse. Per AFI 36-2910, paragraphs 3.41 and 3.4.1.1, *Existed Prior to Service*, the military medical officer must determine whether the illness, injury, or disease or the underlying condition causing it, existed prior to the period of service in which the member exhibited symptoms. A clear distinction between the symptoms and the actual medical condition causing the symptoms is crucial in making an EPTS determination. A LOD determination is based upon the onset of the disease, illness, or injury process, not the mere existence of symptoms. EPTS conditions include chronic disease, illnesses, injuries and illnesses or disease with an incubation period that would rule out a finding that they were incurred during periods of active duty or active duty for training. In utilizing counsel's own words noting the applicant continued to serve and deploy during this time through 2010 only solidified his sleep apnea for which he described as occurring as early as 1994, did not at any time before or after 2010 caused him the inability to perform the functions of his military duties. The mere pathophysiology of OSA and its chronicity in development showed under regulatory guidance that despite granting service-connection by the DVA, the service's "EPTS-LOD not applicable" decision was the appropriate course in its final adjudication. The mid-November 2010 notification to the applicant clearly noted he elected to have his case reviewed by the PEB for strictly a fitness' determination as per regulatory guidance. Again, the record does not reveal as to what medical/health condition a fitness determination was necessary. For the sake of an example, if the AF Form 469 (Oct 10) was written strictly for OSA, and the notification of a disqualifying condition (Nov 10) was actually for OSA, then a question still remains of why did it take 3.5 years later to initiate a LOD determination for OSA when, according to his reserve point credit summary sheet, he successfully performed over 100 days of active duty during the delayed 3.5 year period? The Medical Advisor cannot deem an appropriate reason for such a prolonged delay for per AFI 36 2910 (Oct 02), paragraph 3.2. *Prompt and Accurate Processing*; an LOD determination must be completed promptly. Per AFI 48-123, *Medical Examinations and Standards*, (Sep 09), paragraph 5.3.2.1.4 which refers to OSA requiring the use of CPAP is disqualifying for service retention; however, a medical waiver is often approved for such condition, if requested. No evidence was submitted to show a waiver for a disqualifying condition (unknown as to what condition per his AF Form 469 from Oct 10) was ever requested in order to continue military service. Rather, the applicant requested a transfer to the Retired Reserve in lieu of administrative discharge due to physical disqualification. He submitted his transfer request on 10 Nov 14 and was approved by the recommending official on 29 Nov 14 for an effective date of

12 Dec 14. His point credit summary sheet revealed essentially no days of active duty from the date of his AF Form 469 thru to his placement on the retired reserve list. Even if the AF Form 469 was in reference to the condition of OSA and as per the applicant's choice to have his case reviewed by the PEB for strictly a fitness determination, the most likely outcome would have been that he was found fit thus resulting in obtaining an assignment limitation code (ALC) for permanent change of station (PCS) and deployments. Despite his Reserve Order for transfer to the retired reserves denoting a reason for separation as physical disqualification for active duty, it was the applicant's own choice to avoid an administrative discharge and request such a transfer.

The complete advisory opinion is at Exhibit G.

APPLICANT'S REVIEW OF ADDITIONAL AIR FORCE EVALUATION

The Board sent a copy of the advisory opinion to the applicant on 25 Jan 24 for comment (Exhibit H); and the applicant replied on 11 Mar 24. In his response, the applicant contends, through counsel, the Medical Advisory opinion makes assumptions without looking at the evidence. The previous advisory from AFRC/SGP read the plain language of what has been asserted and compared it to the plain language of the supporting medical records to recommend a partial grant. An injustice occurred when the applicant was allowed to be discharged on 5 Aug 94 with an open medical issue with no overcome of examination and/or treatment. Secondly, the advisory opinion only focuses on two periods of service even though the applicant served over 30 years. He had a disqualifying condition under the AFR which had its onset during active duty which was established by the DVA ruling. It was a failure on the medical staff to properly review his records to include prior service notations to complete the LOD paperwork regarding the etiology onset of his OSA. His condition should have been characterized as a prior service condition not EPTS. He never asked to be transferred to the Retired Reserve and fought for his rights to be properly evaluated medically as he did not choose to have his case reviewed strictly for a fitness determination.

The applicant's complete response is at Exhibit I.

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 Board concludes the applicant is not the victim of an error or injustice. The Board concurs with the rationale and recommendation of the AFBCMR Medical Advisor and AFRC/A1 and finds a preponderance of the evidence does not substantiate the applicant's contentions. The applicant served over 30 years in the military and transferred to the Retired Reserve in lieu of being discharged for a physical disqualification; however, the Board finds the preponderance of evidence does not support his medical condition of OSA rendered him unfit for continued service. The applicant claims, he agrees with the finding from AFRC/SPG partially granting his request; however, the Board finds this advisory makes the same distinction

as the AFBCMR Medical Advisor that he would have most likely been approved for a medical waiver for his OSA and returned to duty if this was the disqualifying medical condition at the time of his separation from the AFR and the Board agrees. Despite the AFRC/SPG advisory opinion's recommendation of partial grant due to a possible PSI impairment which may have been overlooked, the Board does not find this a reason for granting the applicant's request. The Board finds the applicant's condition of OSA was correctly identified as EPTS and a LOD determination was not applicable in his case due to the known pathophysiologic nature regarding the chronic development of the applicant's OSA coupled with evidence of the applicant's successful ability to maintain his duty requirements. Additionally, the Board took note of the applicant's DVA ratings; however, a rating by the DVA for a service-connected disability does not warrant a change in a member's separation or warrant eligibility for a compensable medical retirement. The DVA (Title 38, U.S.C.) may evaluate a member over the years and their rating may be increased or decreased based on changes in the member's medical condition at the current time whereas the military's DES can by law (Title 10, U.S.C.) only offer compensation for those service incurred diseases or injuries, which specifically rendered a member unfit for continued active service and were the cause for career termination; and then only for the degree of impairment present at or near the time of separation and not based on post-service progression of disease or injury. 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 BC-2022-00665 in Executive Session on 21 Dec 22 and 22 Aug 24:

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

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

Exhibit A: Application, DD Form 149, w/atchs, dated 28 Feb 22.
Exhibit B: Documentary evidence, including relevant excerpts from official records.
Exhibit C: Advisory Opinion, AFRC/SPG, dated 26 Oct 22.

Exhibit D: Advisory Opinion, AFRC/A1, dated 8 Nov 22.
Exhibit E: Notification of Advisory, SAF/MRBC to Counsel, dated 10 Nov 22.
Exhibit F: Applicant's response, dated 9 Dec 22.
Exhibit G: Advisory Opinion, AFBCMR Medical Advisor, dated 8 Nov 22.
Exhibit H: Notification of Advisory, SAF/MRBC to Counsel, dated 16 Jan 24.
Exhibit I: Applicant's response, dated 11 Mar 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.

9/6/2024

X Work-Product

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