UNITED STATES AIR FORCE
BOARD FOR CORRECTION OF MILITARY RECORDS

RECORD OF PROCEEDINGS

IN THE MATTER OF: [redacted]

DOCKET NUMBER: BC-2022-02938

COUNSEL: [redacted]

HEARING REQUESTED: NO

APPLICANT'S REQUEST

1. His not in the line of duty (NILOD) decision be set aside, with a finding of in the line of duty (ILOD).

2. He be properly processed through the Disability Evaluation System (DES) and be medically retired.

APPLICANT'S CONTENTIONS

He was in the middle of disability processing channels when his command abruptly halted the line of duty (LOD) determination process, thus ending his disability processing. It is unclear why the unit halted the process once the Informal Physical Evaluation Board (IPEB) requested more information from the Medical Evaluation Board (MEB). He was not provided an opportunity to review the medical recommendation nor was he provided an opportunity to review the new LOD information and reply. His unit did not follow proper procedures, and he was denied the ability to exercise appeal rights as established in the Integrated Disability Evaluation System (IDES) process. He only received notification he was fit for duty and his disabling conditions were "chronic" instead of service-aggravated after filing a congressional. He has service disqualifying conditions warrant disability processing and a medical retirement. His ST-Segment Elevation Myocardial Infarction (STEMI), coronary artery disease (CAD), and Hyperlipidemia (HLD) are ILOD since he suffered an acute cardiac arrest 30 minutes after completing the 1.5 mile run of his fitness assessment during his drill weekend on 6 Aug 16. The MEB referred him to the IPEB for cardiac arrest, STEMI and Acute Coronary Syndrome (ACS) which returned his case without action requesting clarification on the congestive heart failure (CHF) and underlying conditions. The unit reevaluated his LOD determination and in Dec 21, the Air National Guard Surgeon General (ANG/SG) returned the LOD as invalid and returned him to duty with an assignment limitation code (ALC) of C-3 which denotes he is medically fit to serve but no longer deployable.

The Department of Veterans Affairs (DVA) found his CHF as service-connected. He has documented chronic CHF, which warrants a 100 percent disability rating as of 2017. His metabolic equivalent tests (MET) warrant a minimum 60 percent rating, and he continues to have these same symptoms to date. In addition, he has been required to take continuous medication since his heart

attack, which is, at a minimum, a 10 percent rating. By law, he is entitled to the presumptions of soundness and service aggravation for conditions unknown at the time of his entry to service. There was no evidence to rebut these presumptions, and the finding of the remaining conditions are chronic and do not interfere with his service is not supported in the evidence. Nothing was noted on his entrance examination related to a heart condition. He passed numerous physical training examinations without experiencing chest pain or shortness of breath. If he had a chronic disease, this would not be possible. There is no evidence his condition existed prior to service (EPTS).

The applicant's complete submission is at Exhibit A.

STATEMENT OF FACTS

The applicant is a former Air National Guard (ANG) senior master sergeant (E-8).

On 20 Jun 05, ARPC/DPTT sent the applicant the standard Notification of Eligibility for retired pay (20-year letter) informing him he has completed the required years under the provisions of Title 10 United States Code, Section 12731 (10 U.S.C § 12731), and is entitled to retired pay upon application prior to age 60.

Dated 7 Aug 16, AF Form 348, *Line of Duty Determination*, provided by the applicant, indicates his medical conditions of cardiac arrest STEMI, and ACS were found to have occurred ILOD by the appointing authority on 24 Aug 16.

On 23 Feb 21, AF IMT 618, *Medical Board Report*, provided by the applicant, indicates he was referred to the IPEB for acute coronary syndrome.

On 30 Mar 21, AF Form 356, *Informal Findings and Recommended Disposition of USAF Physical Evaluation Board*, provided by the applicant, indicates his case was returned without action for clarification of both LOD issues as well as the nature of the unfitting condition(s) for which he had been referred. The following was requested to be addressed:

> a. Provide clarification regarding LOD determinations for the referred conditions, with all pertinent determinations (AF Form 348, LOD appeals) completed by the appropriate authority. Recommend review by NGB/SGP personnel and NGB/A1. LOD clarification should also specifically address LOD status of any chronic underlying conditions that may be unfitting, such as CAD or CHF.
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> b. Clearly delineate the current condition(s) that are considered potentially unfitting, and their etiology.
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> c. Provide all pertinent civilian clinical documentation, both from primary care physician and any specialty care.

d. If no unfitting condition has a valid ILOD determination, then the case does not warrant processing as a full MEB but instead will require submission as a non-duty related fitness case.

On 6 Sep 21, DD Form 4, *Enlistment/Reenlistment Document – Armed Forces of the United States*, indicates the applicant reenlisted for one year in the ANG in the grade of senior master sergeant (E-8).

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

NGB/SGPS recommends denying the applicant's request finding no errors with the applicant's approved appeal by the Air National Guard Readiness Center (ANGRC) Commander, which found his medical conditions of cardiac arrest STEMI and acute coronary syndrome ILOD but found his condition of CAD NILOD. The applicant's acute cardiac arrest STEMI and acute coronary syndrome were treated and the applicant recovered. The applicant has a history of hypertension, hyperlipidemia, hypothyroidism, and tobacco use which predisposes him to heart disease. The applicant's coronary artery disease is an underlying chronic condition which underwent a Fitness for Duty Evaluation and was dispositioned to return the applicant to duty with an ALC.

The complete advisory opinion is at Exhibit C.

The AFBCMR Medical Advisor recommends denying the application. The CAD is considered an underlying condition for which a return to duty under an ALC was appropriate. No conditions were found to be unfitting and therefore, no conditions were destined for impairment ratings via the DES process. The approved appeal by the applicant and the decision by the ANGRC Commander is the correct action for this case.

The applicant's counsel provided a detailed medico-legal brief which included statements that were inconsistent with some of the reviewed medical records. Counsel repeatedly comments on the applicant's continued symptom of chest pain (CP) citing, "In late 2020, after over four years of continued chest pain and impairment in doing his duties…" however, the chronology of visits clearly revealed continued CP was not continually present. Counsel cited an electrocardiogram (EKG) performed in Jun 21 (not available or provided for this review) revealed an ejection fraction (EF) of 46 percent with an additional statement of there have been zero improvements since his prior EF measurement in early 2017. That statement, in and of itself, may be accurate, but what was not cited by counsel was the quoted measurement of an EF of 46 percent would equate to improvement if compared to his initial EF measurement at the time of the Myocardial infarction (MI) event which measured at 35-40 percent. Such results signify mild to moderate improvement in his cardiac condition.

Counsel cited, the applicant also had a stress test in Aug 21 but could not reach the target heart rate due to shortness of breath. Again, counsel's statement as written was accurate, but failed to

explain it was an exercise stress test where the applicant could not reach the target heartrate and therefore, he underwent a successful pharmacologic-induced stress test which resulted in an EF of 56 percent. This parameter clearly documented significant improvement and a normalization of the applicant's overall cardiac condition. Recent medical literature has stated in most patients with an inability to exercise, pharmacologic stress testing is an essential diagnostic modality and widely used for the evaluation of ischemia and CAD. It is also used to assess prognosis in individuals with known CAD. Additionally, exercise stress testing is not very helpful in patients with an insufficient hemodynamic response to exercise due to abnormalities involving the respiratory system, and having ongoing issues involving muscles, bones, and vessels in the peripheral system. These patients are suitable candidates for testing involving pharmacologic agents. The applicant's exercise stress test having been stopped due to shortness of breath equates to an abnormality in the respiratory system and therefore, the corrective procedure to be performed in this case was indeed a pharmacologic stress test. Another avenue to assess the applicant's level of cardiac improvement (or worsening) is through metabolic equivalent (MET) measurements. At each of the 36 cardiac rehabilitation (CR) sessions, the applicant's METs were calculated via treadmill exercise. At the start of CR, the applicant had a MET level of 3.3 and on his last session his MET level was calculated at 10.7 with his highest having been achieved on session number 35 on 18 Jan 17 at 11.5 METs. According to the *Department of Health and Human Services Physical Activity Guidelines for Americans, 2nd Edition; Physical Activity Intensity*: MET level of activities are categorized as 1) under 3 METs equals light intensity activities, i.e., walking, slow or leisurely pace, cooking activities, or light household chores; 2) 3 to 5.9 METs equals moderate intensity activities, i.e., walking briskly, playing doubles tennis, or raking the yard; and 3) 6 or more METs equals vigorous-intensity activities, i.e., jogging, running, carrying heavy groceries upstairs, shoveling snow, or participating in a strenuous fitness class.

Counsel cited the DVA 1 Nov 17 assessment of the applicant's MET level at greater than 3 to 5 METs to which the technique for this measurement was through an interview questionnaire and it was not accomplished via exercise testing, which is more accurate. Scientific literature denotes exercise cardiac stress test quantified METs were on average 3.3 METS higher than the METs estimated by the preoperative (questionnaire) evaluation history. The conclusion of the study stated the METs of an individual estimated by preoperative history often underestimates the METs measured by exercise stress testing. Based on the above cited literature, the MET interview questionnaire performed by the DVA in Nov 17 would really be, on average, an additional 3.3 METs greater than what was measured by the interview technique. Therefore, the MET level would approximately be greater than 6.3 to 8.3 METs; a bit lower than when measured in CR earlier in the year, but definitely an improved cardiac condition by the measured ability to perform vigorous-intensity activities.

Counsel accurately noted the DVA provider, as part of the Nov 17 compensation and pension **(**C&P) evaluation, stated the recorded MET level of greater than 3 to 5 (by interview questionnaire) was solely due to the heart conditions claimed in the diagnosis section of the Disability Benefits Questionnaire (DBQ), which included CHF. Although accurately stated, the additional average 3.3 METs (per cited literature above) was not considered. If such consideration was applied, the applicant continued to perform metabolically at a vigorous level of aerobic activity. Hyperlipidemia (HLD) and Atherosclerotic cardiovascular disease (ASCVD) involve lipids (fats)

that are carried in the vascular system and when present for years, may increase an individual's risk for an adverse cardiac event. The prolonged elevation of both the applicant's total cholesterol and low density lipoprotein (LDL) - bad cholesterol levels over many years reflect the presence of and the build-up and worsening condition of CAD. In other words, the condition has EPTS and there was no evidence his military service aggravated his CAD above the natural known progression of the condition. The applicant's family history was also significant for CAD in his mother and a sibling (age unknown) who underwent coronary bypass surgery; thus, his cardiovascular risk was elevated. Also, hypertension (HTN-high blood pressure) is known as a cardiac risk factor when present for a prolonged period. The electronic medical record revealed he was diagnosed with HTN which required ongoing medication since 2006; 10 years prior to his MI. Again, his cardiovascular risk was elevated.

Counsel cited one of the diagnoses listed on the initial MEB was CHF. This statement was false for the initial MEB listed the two diagnoses of cardiac arrest-STEMI, and ACS. There appeared to be some misunderstanding or confusion regarding the diagnosis of CHF. Although not found in the record review, counsel cited a reviewing physician recommended adding CHF to the MEB; hence the second and revised NARSUM to include CHF and the statement of with history significant for CAD, HLD, acute on (sic) chronic combined systolic (congestive) and diastolic (congestive) heart failure and essential hypertension was authored. However, the Medical Advisor did not see any evidence or symptoms related to any degree of heart failure. Although the DVA DBQ of 1 Nov 17 included CHF as a diagnosis, the listing date of the CHF diagnosis was 6 Aug 16, the date of his initial heart attack. The DVA's rationale regarding a diagnosis of CHF was, the applicant had no issues related to the claimed CHF before military service. The onset of the condition was during service, documented in the Service Medical Records. There is evidence of current, chronic, and continuous treatment and care. A nexus has been established. Additionally, counsel cited four days after his heart attack, the applicant was sent home with medications to treat and manage CHF. After reviewing the available records, the Medical Advisor is of the opinion the medications that were provided (angiotensin-converting enzyme (ACE) inhibitors and beta-blockers) were provided not to treat a present condition of CHF, but rather to reduce cardiovascular-related morbidity and or mortality. Atherosclerosis and its complications, stroke, coronary artery disease and peripheral arterial disease, remain the leading cause of mortality and morbidity and are increasing in incidence in the developing world. Scientific literature has shown that although our understanding of the renin–angiotensin system (RAS) and the development of atherosclerosis has grown increasingly complex, inhibition of the RAS with an ACE inhibitor has become a firmly established therapeutic approach for reducing morbidity and the risk of death across a broad spectrum of cardiovascular diseases based on multiple, well-conducted, randomized clinical outcome trials. In addition to the beneficial use of ACE-inhibitors post MI, a large scientific study involving thousands MI patients revealed that beta-blockers prescribed at discharge after an MI improved 3-year mortality regardless of baseline left ventricular ejection fraction. The way the applicant's discharge encounter was written, sent home with medications to treat and manage CHF, can easily be interpreted that the applicant was indeed in acute CHF; however, the clinical/medical evidence of such a condition was not apparent and therefore, based upon the scientific studies cited, the medications of an ACE-inhibitor and beta-blocker were provided as a preventive measure in reducing morbidity and mortality.

Counsel cited what was authored in the narrative summary (NARSUM) which stated the applicant's condition will not improve over the next 12 months for him to perform all the Air Force Specialty Code (AFSC) duties for his rank/position. This was written and documented in Jan 21. Still, in December of that same year, the applicant was suddenly found fit for duty despite any improvement in his condition. This final statement is false given the Aug 21 cardiac EF having been measured by exercise at 56 percent; a significant improvement in his condition. Lastly, counsel authored in Dec 21, the ANG/SG separately ruled the applicant was now fit for duty with the assigned limitation code of C-3. This means he is medically fit to serve but no longer deployable. Although the placement of an ALC of C-3 was accurate, the no longer deployable was not absolute. In accordance with AFI 41-210, *Tricare Operations and Patient Administration*, paragraph 4.76.2.1.3 defines an ALC-C-3 in designating service members who should not be deployed or assigned away from specialty medical capability required to manage their unique medical conditions. However, section 4.76.3 further describes the ALC-C status is not designed to limit deployment and/or overseas assignments. It is designed to ensure members with medical conditions are assigned and/or deployed to the appropriate location where care is available. This requires waiver coordination between the losing base and the medical waiver approval authority occur in a timely manner. In other words, an individual with an ALC C-3 does have the possibility to deploy when a waiver is approved. The waiver approval authority for members of the ANG is the Air Reserve Command, Chief of Aerospace Medicine (ARC/SGP). So, despite being labeled as non-deployable, deployment is/was possible.

The NGB/SGPS's advisory to NGB/A1 in Apr 23 was detailed and accurate in its review and the Medical Advisor, based on the above discussion, agrees the applicant's acute cardiac arrest-STEMI and ACS were treated, and the applicant recovered. The applicant recovered from an acute condition that by the nature of the incident was primarily caused by a CAD condition that is known to have developed over many years. Therefore, regarding an LOD determination, the recommendation from NGB/SGPS whereby both the cardiac arrest-STEMI and ACS be ILOD is appropriate. However, a simple ILOD determination of a medical condition in and of itself does not necessarily or automatically qualify for an impairment rating within the DES, but rather the ILOD condition must also be found as unfitting for continued military service. Although there was concern if the applicant could continue to perform the duties of his office, rank, rating, or grade as shown in the Mar 21 NARSUM whereby the provider documented, there is a concern regarding the applicant's ability to perform duties optimally in his AFSC with the exception of functionally performing administrative only duties. In the same NARSUM, the provider made a summary statement the applicant's condition will not improve over the next 12 months for him to perform all the AFSC duties for his rank/position. The Medical Advisor places minimal probative value or credibility on such a declarative summary statement given the fact that under the heading of prognosis within the same NARSUM, the provider documented the applicant undoubtedly requires routine follow-up with a cardiologist, unfortunately additional timeline and details of applicant's cardiac condition after Jan 17 is difficult to ascertain due to his limited follow-up with a cardiologist. Making such a declarative statement of no improvement for the future year while having limited knowledge of the prior four years is skeptical at best. Therefore, considering the normalization or recovery of the applicant's cardiac condition coupled with his ability to satisfactorily complete his active service requirement, earning an honorable discharge, simply provided more credence he was able to continue to function at work.

The complete advisory opinion is at Exhibit D.

NGB/A1PS recommends denying the application. NGB/A1PS concurs with NGB/SG and finds no error or injustice in the applicant's approved LOD appeal. The applicant was treated for the acute cardiac arrest-STEMI and ACS, recovered, and was returned to duty with an ALC. In the original LOD package the applicant claimed he incurred the syncopal episode and turned purple 30 minutes after completing his Air Force Fitness Assessment. The LOD determination of NILOD, not due to member's misconduct, EPTS with no service aggravation (NSA) was finalized on 2 Aug 17. The NGB/SG Advisory states the initial LOD was completed for the cardiac arrest-STEMI and ACS and was found NILOD - not due to own misconduct by the ARC LOD Determination Board. The applicant appealed the NILOD decision he received on 16 Sep 17, and on 1 Apr 18 the appeal was disapproved by the ANGRC commander. On 14 Dec 18, the ANGRC commander overturned the initial disapproval to approve an ILOD for cardiac arrest-STEMI and ACS. The approved appeal determination only applied to the acute event and did not apply to the full spectrum of CAD beyond the cardiac arrest and interventions. Additionally, NGB/SG stated the applicant has a history of hypertension, hyperlipidemia, hypothyroidism and tobacco use which predisposes him to heart disease.

Per AFI 36-2910, *Line of Duty (LOD) Determination, Medical Continuation (MEDCON), and Incapacitation (INCAP) Pay*, paragraph 1.10.2.2, a determination of NILOD-Not Due to Member's Misconduct is also made when an investigation determined, by clear and unmistakable evidence, the member's illness, injury, disease or the underlying condition causing it, existed prior to the member's entry into military service with any branch or component of the Armed Forces or between periods of such service, and was not service aggravated. EPTS-NSA conditions include chronic conditions and conditions where the incubation period rules out a finding the condition started during any period of active duty, active duty for training (ADT) or IDT. Once the NILOD was overturned and approved as ILOD for the acute condition, the applicant was then placed in the DES and submitted to the Physical Evaluation Board (PEB). On 30 Mar 21, the PEB returned the case without action requesting clarification of both the LOD issue as well as the nature of the unfitting condition(s) for which the service member had been referred. The applicant has since been reviewed for his NILOD chronic artery disease as a Fitness for Duty Evaluation, non-duty related. Upon review, the applicant was dispositioned to return him to duty with an ALC of C-3 per the NGB/SG advisory.

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 31 May 23 for comment (Exhibit F), and the applicant replied on 22 Jun 23. In his response, the applicant's counsel contends the medical advisory is false when it states the applicant does not suffer from CHF. His medical records show he suffers from CHF and there is a consistent diagnosis of CHF noted in his medical records throughout, after his acute heart attack. The medical advisor insists the medications provided were to treat atherosclerosis, despite any notes in the medical records to support this

position. These medications were to treat and manage his CHF. The DVA rated his CHF as service-connected with no evidence of this condition EPTS. The applicant was never diagnosed with hypothyroidism. Furthermore, the medical advisory falsely states there were no complaints related to his heart conditions during his primary care visits in 2017 through 2019. Office notes from these visits do list chest pain which is related to his CHF.

There is a presumption of soundness regarding medical conditions that were not known prior to entering service. All evidence supports the finding the CHF is directly related to the heart attack in Aug 16. The benefit of the doubt should go to the applicant when finding whether there was a preexisting condition or not. In addition, it is clear the events of performing military-related tasks aggravated his heart, which supports the ILOD status for his CHF.

The applicant was not fully able to continue to function at work, and his condition did interfere with his service. He was on administrative duties only, and could not fully perform his AFSC heating, ventilation, and air conditioning (HVAC) duties. He was ordered to attend monthly drill meetings to meet medical obligations and appointments for his ongoing medical issues. He had service disqualifying conditions, was on limited duty as a result, and was unable to deploy.

The applicant's complete response is at Exhibit G.

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 recommendations of the AFBCMR Medical Advisor and NGB/SG and finds a preponderance of the evidence does not substantiate the applicant's contentions. Specifically, the Board finds the applicant did not suffer from acute or chronic CHF. The evidence supports the applicant has a history of hypertension, hyperlipidemia, hypothyroidism, and tobacco use, all of which can independently be precursors of heart disease. Furthermore, he has a family history of CAD. Although the medication of Beta Blockers and ACE-inhibitors are appropriate medications to treat various forms of CHF, in this case however; they were prescribed as a preventive measure in reducing morbidity and mortality after a STEMI and not for CHF. His underlying chronic condition of CAD underwent a Fitness for Duty Evaluation and he was returned to duty with limitations. The Board finds no error or injustice occurred with the processing of his LODD. The approved appeal by the applicant and the decision by the ANGRC Commander to find his cardiac arrest-STEMI and ACS ILOD was correct; however, an ILOD determination does not automatically qualify for an impairment rating within the DES. The ILOD condition must also be found as unfitting for continued military service. In the applicant's case, his acute cardiac arrest STEMI and acute coronary syndrome were treated and he recovered and was deemed fit for duty. Additionally, the Board finds his condition of CAD EPTS and was not aggravated beyond the nature progression of the disease. A Service member shall be considered unfit when the evidence establishes the member, due to physical disability, is unable to reasonably perform the duties of his or her office, grade, rank, or rating. The mere

existence of a medical diagnosis does not automatically determine unfitness and eligibility for a medical separation or retirement. The applicant's military duties were not degraded due to his medical condition, although it periodically impacted his deployability. The applicant was limited but could still deploy with a waiver. Furthermore, a higher rating by the DVA, based on new and/or current exams conducted after discharge from service, does not warrant a change in the total compensable rating awarded at the time of the member's separation. The military's DES established to maintain a fit and vital fighting force, can by law, under 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 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.

RECOMMENDATION

The Board recommends informing the applicant the evidence did not demonstrate material error or injustice, and the Board will reconsider the application only upon receipt of relevant evidence not already presented.

CERTIFICATION

The following quorum of the Board, as defined in Department of the Air Force Instruction (DAFI) 36-2603, *Air Force Board for Correction of Military Records (AFBCMR)*, paragraph 2.1, considered Docket Number BC-2022-02938 in Executive Session on 25 Aug 23:

[redacted] Panel Chair
[redacted], Panel Member
[redacted] Panel Member

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

Exhibit A: Application, DD Form 149, w/atchs, dated 2 Nov 22.
Exhibit B: Documentary evidence, including relevant excerpts from official records.
Exhibit C: Advisory Opinion, NGB/SGPS, dated 3 Apr 23.
Exhibit D: Advisory Opinion, AFBCMR Medical Advisor, w/atchs, dated 8 May 23.
Exhibit E: Advisory Opinion, NGB/A1PS, atch, dated 22 May 23.
Exhibit F: Notification of Advisory, SAF/MRBC to Applicant, dated 31 May 23.
Exhibit G: Applicant's Response, w/atchs, dated 22 Jun 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.

2/17/2024

Work-Product

Board Operations Manager, AFBCMR

Signed by: Work-Product