Sensitive Material

The Inspector General of the Department of the Air Force

Report of Inquiry (S9844)

Air Reserve Component Line of Duty (LOD) Determinations

December 2024

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EXECUTIVE SUMMARY

The Inspector General of the Department of the Air Force (SAF/IG) directed this inquiry in November 2023 due to concerns regarding the improper handling of Line of Duty (LOD) determinations[1] and associated benefits and entitlements in the Air Reserve Component (ARC). After reviewing historical LOD complaints, in general, service members alleged:

a) They were unlawfully denied In the Line of Duty (ILOD) determinations and subsequent benefits because:

   i) The ARC failed to process LODs in a timely manner.
   ii) Members were improperly required to provide statements regarding their injuries that were then used against them.
   iii) The ARC LOD Determination Board intervened and overturned wing commander ILOD decisions without authority.
   iv) Service members were improperly removed from Medical Continuation (MEDCON) orders with unresolved unfitting conditions while awaiting Disability Evaluation System (DES) processing.

b) Members were not provided the "clear and unmistakable evidence" used by the ARC LOD Determination Board to conclude the member's medical condition(s) were Not In the Line of Duty (NILOD) Existed Prior to Service – Not Service Aggravated (EPTS-NSA).

c) Medical personnel reviewing the LOD packages are unqualified to make medical diagnoses/decisions and make inaccurate statements in their decisions.

The Department of the Air Force Inspector General directed this inquiry to conduct a review of the ARC processes and procedures governing LOD cases. Specifically, SAF/IG directed:

A thorough review of:

a) DoD, Department of the Air Force (DAF), and ARC guidance related to LOD determinations;

b) How LOD determinations and subsequent actions are processed in the Air National Guard (ANG) and Air Force Reserve Command (AFRC);

[1] "LODs" and "LOD determinations" are used interchangeably throughout this ROI.

c) ARC guidance provided by the National Guard Bureau (NGB), ANG, AFRC, and the ARC Case Management Division (ARC CMD) to assess whether service members are educated on how to navigate the LOD, MEDCON, and Incapacitation Pay (INCAP) processes.

Scope and Methodology

The inquiry focused primarily on processes and policies and how they related to the administrative processing of 11 specific ARC service members' cases. The goal of this inquiry was to identify whether there were systemic issues in the way ARC LOD cases were processed and adjudicated. The SAF/IG team reviewed:

a) U.S. Code (USC), DoD, DAF, and ARC legal and instructional standards;

b) Internal records, reports, documentation of LOD cases, and filed IG complaints;

c) Wing and HHQ-level processes and procedures, including Guard Medical Units (GMUs) and Reserve Medical Units (RMUs) coordination, actions, and responses to the service members' reporting of medical conditions.

Additionally, the inquiry team conducted independent interviews with 24 wing LOD Program Managers (LOD PMs) (12 ANG and 12 AFRC). The team conducted interviews with LOD PMs to obtain experiences, perspectives, and recommendations from wing-level LOD administrators with no known affiliation with the 11 ARC cases reviewed as part of this inquiry. In addition, the inquiry team incorporated information from previous ARC LOD reform efforts, investigations, and documentary evidence to determine whether LOD processing procedures met applicable standards, conducting additional interviews in certain instances to clarify documentary evidence.

Of note, this report does not provide an assessment or judgment of the medical conditions and adjudications of the LOD submissions of the 11 ARC service members whose cases were reviewed during this inquiry.[2] Furthermore, as the medical conditions associated with the 11 service members' LOD submissions are assessed by clinically licensed medical professionals, this inquiry does not evaluate how the final LOD determinations are made by ARC LOD Determination Boards or the staffing and medical credentials of the board members. The report assesses whether systemic issues impacted the effectiveness of ARC processes and procedures to meet established standards and if these systemic issues also impacted wing-level agencies' ability to respond appropriately to support ARC service members. Finally, findings and

[2] The ARC cases involved in this inquiry are receiving an independent technical medical review by the Assistant Secretary of the Air Force (Manpower & Reserve Affairs (SAF/MRR) ARC LOD Quality Assurance Program (QAP) as part of a SAF/IG complaint resolution process.

recommendations in this report are based on the comprehensive review of the LOD processes and the 11 ARC service member cases reviewed in this inquiry.

Standards

Department of Defense Instruction (DoDI) 1241.01, *Reserve Component (RC) Line of Duty Determination for Medical and Dental Treatments and Incapacitation Pay Entitlements,* 19 Apr 2016.

DoDI 1332.18, *Disability Evaluation System,* 10 Nov 2022.

DAFI 36-2910, *Line of Duty (LOD) Determination, Medical Continuation (MEDCON), and Incapacitation (INCAP) Pay*, 8 Oct 2015, 3 Sep 2021, 23 May 2023, and DAF Guidance Memorandum 2023-02, 17 November 2023.[3]

Inquiry Summary

Without addressing the unique and specific circumstances of the 11 service member cases reviewed, this inquiry found the cases were generally processed in accordance with existing regulatory guidance. However, the overall LOD process, especially when viewed from the Airman's perspective, has significant shortcomings and requires immediate improvements. For example, one area identified as a procedural weakness requiring attention is the method of notifying members of their NILOD determinations. Specifically, there is no standardized procedure for what evidence or explanation should be provided to ARC service members and no standardized way to transmit and document this notification. Per DAFI 36-2910, paragraph 1.11.1.2, members shall be provided "clear and unmistakable evidence" for all NILOD determinations for any subsequent appeal efforts. [4] As unit commanders are not trained medical providers, their ability to communicate why a member's medical condition may not qualify for military entitlements relies primarily on the information provided by the LOD Approval Board.

Additionally, ARC service members at all levels lack a fundamental understanding of the LOD, MEDCON, and INCAP programs and processes. This knowledge deficit negatively impacts how these programs are administered and executed at the wing level, which ultimately affects the support ARC service members receive and results in a frustrating experience where the service members' expectations are not met. This inquiry found no standardized initial or reoccurring awareness training existed for ARC service members to reasonably educate them on

[3] For consistency and ease of reference, unless specifically noted otherwise, "DAFI 36-2910" will refer to DAFI 36-2910_DAFGM 2023-02, 17 Nov 2023.
[4] On 17 Oct 24, The Inspector General issued a Collateral Issue Memorandum to SAF/MR requesting they "issue updated language in a guidance memo to DAFI 36-2910 that clearly addresses the evidence required to support a NILOD determination." (Ex 232)

the purpose of the programs or how to navigate the processes to determine whether their medical condition qualifies for the associated benefits and entitlements. This inquiry also identified no standardized wing leadership-level training for these programs and processes. As these programs have the potential to significantly impact ARC service members' well-being, careers, and mission readiness, leadership plays a critical role in ensuring their members understand the parameters of the program.

Based on a review of applicable standards, the history and current state of the LOD program, and a review of the administrative processing of the 11 ARC service members' LOD cases, this inquiry determined the following cross-cutting factors contributed to an apparent failure to adequately support ARC service members, eroding their trust in the LOD, MEDCON, and INCAP programs:

- **The standard of "clear and unmistakable" evidence is not clearly defined.** When a member is on orders for more than 30 days, the standard of evidence outlined in DAFI 36-2910 to overcome the presumption of In the Line of Duty is "clear and unmistakable evidence," which is "undebatable" information upon which "reasonable minds could only conclude" the condition was Not In the Line of Duty. However, that standard of "clear and unmistakable" evidence can be established "by accepted medical principles meeting the reasonable certainty requirement." In some of the cases reviewed, service members were provided vague medical terms such as "authoritative medical literature" as evidence and explanations for their NILOD determinations.

- **ARC service members are not provided sufficient feedback or evidence explaining why their medical conditions were found NILOD.** There is no standardized method to ensure ARC service members receive a clear explanation as to why their medical condition was determined to be NILOD. Significantly, there is no direction on what specifically to provide members regarding their NILOD determinations. While the unit commander has the responsibility to brief members of their LOD determinations, there is no direction on what to brief or information to provide. ANG and AFRC representatives both described LODs as a commander's program. However, the representatives did not know what was being communicated to members or how, and they assumed members were being provided adequate information. The inquiry team found wings handled this process very differently. Some unit commanders handed or emailed forms without explanation, while others briefed members with representatives from the medical unit to explain any unclear medical determinations.

- **Training is not provided to those responsible for administering wing-level programs.** There is no comprehensive, mandatory training for members involved with the LOD process at the wings. As the face of the LOD program for members, wings are

critical to the program's success. LOD PMs report learning through on-the-job training, trial and error, and asking peers for advice. Of the 24 LOD PMs independently interviewed during this inquiry, none reported receiving any official training upon appointment to the position. Additionally, the assignment of the LOD PM varies at each wing between the Force Support Squadron (FSS) and Medical Group (MDG). The level of involvement and support to the service member varies widely based on where the LOD PM is assigned and their experience level.

- **A lack of standardized, mandatory training for ARC service members on the LOD/MEDCON program.** As a commander's program, wings have wide latitude to implement the program; while some wings had deliberate training efforts, others had none. Members not informed of the program may not be familiar with the requirements to report LOD conditions to begin the process. Many service members interviewed described learning about the program as they reported a medical condition or through word of mouth. Once members learned of the program, they generally described a process where they educated themselves by reading available guidance and connecting with other service members or advocacy groups. Even with attempts to self-educate, nuances of the program, particularly understanding specific terminology related to whether a service member's medical condition qualifies for LOD entitlements, have led to general confusion about what to expect regarding care and benefits.

- **Governing guidance is inconsistent when addressing how ARC service members access medical care related to LOD determinations, resulting in misperceptions.** Federal law authorizes medical care and treatment to service members whose conditions or injuries result from military service; however, how the medical care and treatment are provided is left to DoD, which then directs the Services to implement their own regulations to do so. This inquiry found ARC service members are not aware the DAF has the authority to impose DAF-specific provisions not enumerated in law or DoD publications for them to receive medical care and treatment.

- **The LOD program is not transparent**. Members cannot view their LODs or track their progress, relying instead on receiving updates from their LOD PMs, medical focal points, or unit commanders. This lack of transparency throughout the LOD process results in ARC service member not being provided with accurate and timely updates on the status of their individual case. Members generally reported having to request updates, leading to frustration of being uninformed. This inquiry noted the Electronic Case Tracking (ECT) system for processing LODs requires enhancements to increase transparency and efficiency. While the program accurately tracks information, it has significant limitations, to include an unreliable way to pull and sort data, inability to quickly re-route packages for minor errors, lack of visibility into the system above wing level, and users having different profiles in ECT that can lead to delays in LOD processing.

- **ARC wing, NGB, AFRC, and DAF are lacking LOD program oversight.** There is no current adequate oversight of the LOD program at any level. Wings choose how they manage and oversight their LOD programs, with some units reporting regular updates to the commanders and others with less engagement. For example, when a member reports an LOD condition, the wing has 60 days to process it. However, there is neither accountability nor oversight of meeting this timeline. If a member's wing does not process an LOD or process it in a timely manner, there is no recourse for the member outside their chain of command. Notably, if a wing refuses to or delays initiating an LOD, there is no record to reference. Additionally, there is no ARC wing-level self-inspection or mechanism to ensure compliance with DoDI 1241.01, or DAFI 36-2910. There is no requirement in DAFI 90-302, *The Commander's Inspection Program (CCIP)*, to assess the LOD process at ARC wings.

Key Observations

Since approximately 2021, DAFI 36-2910 has undergone multiple revisions to address the delays and length of time to process LOD cases, including a pilot program in 2022 involving 10 AFRC and 10 ANG wings that installed wing commanders as approval authorities. Although some positive trends in efficiency emerged from these LOD reform efforts, overall, the accuracy of LOD determinations saw a significant drop-off. Most recently, the Assistant Secretary of the Air Force Manpower and Reserve Affairs (SAF/MR) stood up the Air Reserve Component Line of Duty Determination Quality Assurance Program (ARC LOD QAP). The ARC LOD QAP will establish SAF/MR oversight by reviewing a minimum of 10% of completed LOD cases monthly, either selected randomly or in accordance with a specified request. The objective is to ensure ARC authorities accurately adjudicate LOD determinations in a timely manner in accordance with DAFI 36-2910. Also of note, SAF/MR is conducting a comprehensive rewrite of DAFI 36-2910 to address numerous issues identified as vague or causing confusion for service members. Throughout this inquiry, the SAF/IG team engaged with the ARC LOD QAP team to ensure findings and recommendations from this inquiry and the individual complaint resolution efforts are considered in future ARC LOD QAP lines of effort. The IG team also provided input to both the DAFI 36-2910 Interim Change (IC) guidance and the ensuing DAFI 36-2910 review and rewrite.

Additionally, the Office of the Under Secretary of Defense Personnel and Readiness (OUSD P&R) is currently reviewing DoDI 1241.01, which provides overarching guidance to all military reserve components' LOD programs. As part of this review, OUSD P&R has requested participation from all service components to provide representation for their review. The DAF has provided approximately 15 representatives to assist with the review, to include ANG and AFRC members.

Finally, in Apr 2023, the Air National Guard Readiness Center (ANGRC) completed an independent Commander Directed Inquiry (CDI) to review the processing operations involving

LOD determinations, the Disability Evaluation System (DES), pre-MEDCON, and MEDCON to determine whether these processes were conducted in accordance with applicable laws and regulations. The investigation found NGB processes and systems were generally consistent with the law, DoD policy, and Air Force regulatory guidance, but it also listed numerous processes it assessed as inadequate to execute and administer the LOD program. Among processes identified, NGB/A1 approved a waiver for itself to continue to utilize current LOD routing and approval authority through the ANG LOD Board in lieu of following a DAFI 36-2910 change that delegated the LOD approval authority to wing commanders. NGB/A1 coordinated the waiver through HAF/A1PPS and notified wings LOD PMs informally via email but never published the waiver to the repository in the ANGRC portal as required by policy.[5] This NGB policy change is highlighted as a point of contention in several IG complaints reviewed during this inquiry.[6] According to ANG service members familiar with the results of this CDI, no actions were taken to address findings presented in the final report.

Conclusions and Recommendations

The medical benefits and entitlements associated with the programs reviewed during this inquiry may significantly impact ARC service members' well-being, careers, and mission readiness. Overall, this inquiry found no evidence of a systemic effort to deny ARC service members' medical benefits and entitlements. Specifically, this inquiry did not uncover evidence of a deliberate effort to deny ARC service members medical entitlements by way of NILOD determinations due to monetary considerations; all witnesses interviewed with responsibilities to administer or execute the LOD program refuted this notion. The following chart provides a snapshot of ARC LOD cases adjudicated within the last two calendar years. The raw numbers and percentages indicate the majority of LODs in both Air Reserve Components are found to be In the Line of Duty.

[5] ANG Waivers (intelink.gov), see DAFI 33-360, *Publications and Forms Management*, paragraph 12.4. (superseded but the regulation in effect at the time); also see ANGMAN 33-360, paragraph 2.

[6] SAF/IG determined NGB/A1's Nov 2021 waiver to then-existing DAFI 36-2910 removed authority from wing commanders, and a waiver was not the appropriate mechanism to change the DAFI. (b) (5) [redacted] SAF/IG determined it was improper for a staff element to unilaterally remove a wing commander's specified approval authority.

Count and Proportion of ARC LOD Outcomes for Cases Completed from 1/1/23 to 3/31/24:

Counts	AFR	ANG
In Line of Duty (ILOD)	754	446
Not ILOD (NILOD)	306	191
Total	1060	637

Proportion	AFR	ANG
In Line of Duty (ILOD)	71%	70%
Not ILOD (NILOD)	29%	30%
Total	100%	100%

This inquiry revealed several significant issues in processing LOD cases:

- ARC service members are not adequately educated on the LOD process or expectations upon initiation, not provided with timely updates to the status of their LOD determinations, and not provided with a sufficient evidence or explanation upon receiving their final NILOD determinations. A lack of awareness or understanding by ARC service members of how the LOD process is intended to function impacted the members' expectations of potential outcomes upon reporting a potentially qualifying medical condition. Nearly every service member and subject matter expert the inquiry team interviewed believed Airmen are not familiar with the LOD process. This lack of understanding is exacerbated by an inadequate and, at times, non-existent methods of communication among service members, wing leadership, program managers, and the ARC LOD approval authorities. This inquiry found examples of wings not submitting LODs when conditions were reported and when specifically requested, highlighting problems with processes and procedures and confusion over DAFI 36-2910 guidance. Refusals or significant delays in initiating the LODs also shows the lack of training LOD PMs receive to administer the LOD program throughout the process.

- The LOD program is being executed inconsistently at the wing level by LOD PMs who receive no discernable training. As ARC subject matter experts described it, the LOD program is a commander's program, and the wings determine how to execute it. While providing commander discretion, this approach creates significant variance in the baseline interaction of LOD PMs and medical units with members as well as how NILOD determinations are explained to members, directly impacting ARC members' understanding of the program and the care and benefits to which they may be entitled. More concerning is the lack of any formal training for critical wing members involved in the execution of the programs (i.e., LOD PMs, CCs, and MDG personnel).

While this inquiry found the cases were generally processed in accordance with existing regulatory guidance, the aforementioned factors contributed to an apparent failure to adequately support ARC service members who were experiencing health challenges and eroded their trust in the LOD, and MEDCON programs. Based upon the cross-cutting contributing factors and

conclusions described in this inquiry, SAF/IG recommends the SecAF direct the following actions:

1. As part of the DAFI 36-2910 rewrite, establish a formal, standardized notification to ARC service members, including a baseline of information to constitute the required clear and unmistakable evidence or preponderance of the evidence for all NILOD findings. The ARC LOD QAP should standardize a thorough and comprehensible explanation to ensure service members understand how and why the board reached the NILOD determination as well as requirements and limitations associated with medical entitlements such as MEDCON orders. (OPR: SAF/MR)

2. As part of the DAFI 36-2910 rewrite, provide a comprehensive review of all terms and phrases used to define and characterize LOD determinations and related medical information to ensure these terms are clearly defined and ARC service members have a reasonable level of understanding about the processes associated with this program. (OPR: SAF/MR)

3. Establish a SAF/MR directed central patient support cell to answer questions and concerns from members who have received NILOD determinations to eliminate confusion and address questions members may have. (OPR: SAF/MR)

4. Develop ARC-wide awareness training for service members and leadership to ensure a clear understanding of the LOD process and subsequent actions/entitlements. (OPR: NGB/AFRC)

5. Standardize LOD PM responsibilities and training. Additionally, direct appointment of the LOD PM to personnel assigned to the wing-level GMU or RMU. (OPR: HAF/A1)

6. Ensure LOD processing is included as ARC-wide inspectable scheduled requirements as mandated by DAFI 36-2910, paragraph 3.1.5. (OPR: SAF/IG/AFIA)

7. Establish a myFSS application for ARC members to readily access resources and training related to LOD processes and subsequent entitlements unique to the reserve component. (OPR: HAF/A1)

8. ARC members should be provided the rights advisement any time they are requested to provide a statement relating to the origin, incurrence, or aggravation of a disease or injury in accordance with 10 USC § 1219. (OPR: SAF/MR)

9. Conduct an independent review of the following ARC LOD Determination Board aspects: medical adjudication processes, staffing and subject matter expertise of ARC LOD Board members. (OPR: SAF/MR)

10. Establish the requirement for the Surgeon General to designate medical specialists to sit on and advise the LOD Boards and appellate authorities. (OPR: SAF/MR)

11. Establish the requirement for an immediate DAF-level appellate review authority process for ANG LOD and AFRC LOD denials. (OPR: SAF/MR)

12. Coordinate with OUSD P&R to thoroughly review guidance to reduce confusion and ambiguity between the broader DoD regulations and the authority for the Air Force to execute service-specific functions. (OPR: SAF/MR)

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REPORT OF INQUIRY (Case S9844)

CONCERNING

AIR RESERVE COMPONENT (ARC) LINE OF DUTY (LOD)

PREPARED BY
SAF/IG ARC LOD INQUIRY TEAM
December 2024

I. INTRODUCTION

The Inspector General of the Department of the Air Force (SAF/IG) directed this inquiry in November 2023 due to concerns regarding the improper handling of Line of Duty (LOD) determinations and subsequent benefits and entitlements in the Air Reserve Component (ARC), comprising the Air Force Reserve Command (AFRC) and the Air National Guard (ANG).

SAF/IG directed this inquiry review ARC processes and procedures governing LOD cases, including: (Ex 11)

- DoD, DAF, and ARC guidance related to LOD determinations;
- How LOD determinations and subsequent actions are processed in the Air National Guard (ANG) and Air Force Reserve Command (AFRC);
- ARC guidance provided by the ANG, AFRC, and the ARC Case Management Division (CMD) to assess whether service members are educated on how to navigate the LOD, MEDCON, and Incapacitation Pay (INCAP) processes;
- Trends and statistics of ARC LOD determinations resolved from the initial appellate authority through final appeal to the Air Force Board for Correction of Military Records (AFBCMR).[7]

Scope and Methodology

This inquiry focused on LOD processes and subsequent entitlements provided specifically to 11 ARC service members. The inquiry team reviewed previous LOD reform efforts, investigations, testimony, and documentary evidence to determine whether procedures

[7] At the onset of this inquiry, SAF/IG planned to conduct a review of the appeal process as a follow-on effort and published those findings separately. Through the course of this inquiry, concerns with the appeal process were identified and recommendations to address these concerns are documented in this report.

met applicable standards. The team also reviewed DoD/DAF/ARC regulations and standards; internal records, reports, and documentation of LOD cases, and filed IG complaints; and wing and HHQ-level processes and procedures (including Guard Medical Units (GMU) and Reserve Medical Units (RMU) coordination, actions, and responses to the service members' reporting of medical conditions) to provide insights into whether the cases under review follow a wider pattern.

To examine ARC processing of LOD determinations as well as subsequent benefits and entitlements, SAF/IG also spoke with subject matter experts. Additionally, the inquiry team independently interviewed 24 wing LOD program managers (LOD PMs) (12 ANG, 12 AFRC). These interviews provided experiences, perspectives, and recommendations from the wing-level Airmen who administer the LOD program.

The inquiry team also interviewed the 11 ARC service members to obtain their personal experiences with the processing, adjudication, or appeal of their LODs and/or related issues involving MEDCON. Some of these members have submitted IG complaints; this inquiry does not draw conclusions or make recommendations specific to their IG complaints, which are being adjudicated in a separate process.[8]

Note: This report does not provide an assessment or judgment of the medical conditions associated with the LODs of the ARC service members interviewed during this inquiry.[9] Furthermore, as the medical conditions associated with the 11 service members' LODs are evaluated by clinically licensed medical professionals, this inquiry does not assess how the final LOD determinations are made by ARC LOD Determination Boards or the staffing and medical credentials of the board members. This report assesses whether systemic issues impacted the effectiveness of ARC processes and procedures to meet established standards and if these systemic issues also impacted wing-level agencies' ability to respond appropriately to support ARC service members.

II. BACKGROUND

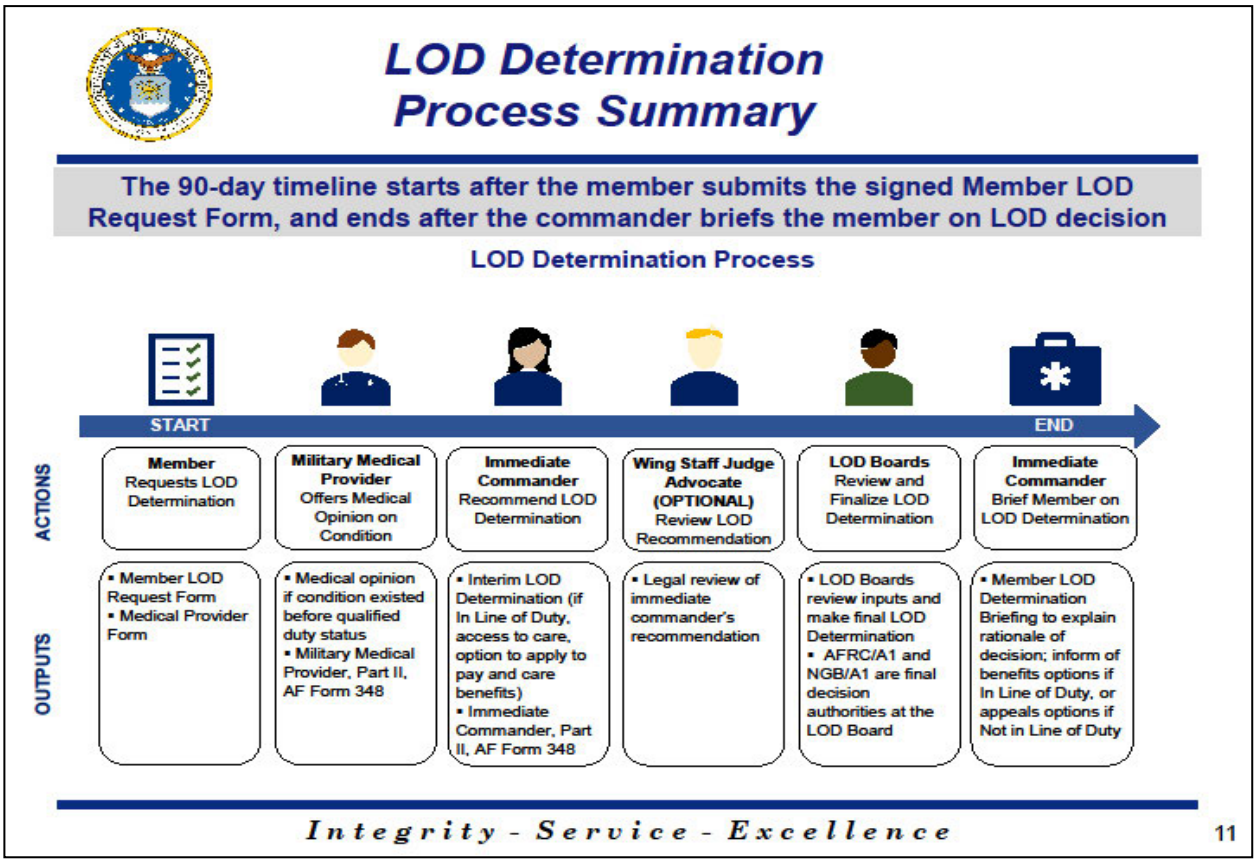
ARC service members who incur or aggravate an injury, illness, or disease while in a qualified duty status are entitled to medical and dental care, provided the condition was not the result of gross negligence or misconduct, which is determined through the LOD process.[10] (Ex 1:1)

[8] There were significant changes to DAF policy during the period reviewed. For specific cases, the policy in effect at the time the case was processed will be applied; otherwise, the most current policy will be referenced.
[9] The ARC cases involved in this inquiry are receiving an independent technical medical review by the SAF/MR ARC LOD Quality Assurance Program (QAP) as part of a SAF/IG complaint resolution process.
[10] DoDI 1241.01, *Reserve Component (RC) Line of Duty Determination for Medical and Dental Treatments and Incapacitation Pay Entitlements*, 19 April 2016, paragraph 3.a.

To begin the LOD process, military medical providers and commanders who learn of a member's illness, injury, disease, or death that occurred under circumstances that may warrant an LOD determination shall take an active role by advising the member on how to submit the required documentation within required timeframes and ensuring timely processing of the LOD determination.[11] (Ex 2:4-6) The member is responsible for providing medical documentation if seen by a civilian provider. To assist the member, each wing has an LOD PM, who receives the member's documentation and uploads information into the Electronic Case Tracker (ECT), a Health Insurance Portability and Accountability Act (HIPAA) compliant portal used between the wings and their respective Guard or Reserve LOD Determination Boards to adjudicate LOD applications. At the wing level, a medical provider transcribes medical diagnoses from ARC service members' civilian medical providers into their military medical records. Next, the commander verifies whether the member was in a qualified duty status and makes a recommendation on whether the condition was incurred or aggravated during the duty status. The commander has the option of having the legal office review the package prior to it being sent to the LOD Determination Board. The Guard and the Reserve each have their own board, which determines and approves whether the medical condition was In the Line of Duty (ILOD) or Not In the Line of Duty (NILOD). Finally, the commander has the responsibility to notify the member of the LOD Determination Board's decision.

[11] There are three types of LODs: administrative, formal, and informal, and each has different approvals. Administrative LODs are for minor medical ILOD issues that do not require continuing medical care. (Ex 2:34-35) Formal LODs are not common and are required in cases of misconduct or other circumstances that require investigation by command. (Ex 2:44) Unless otherwise specified, "LODs" used in this report refer to informal LODs. The current approval authority is the ARC LOD Determination Board, but during the timeframe of "LOD Reform," there was a period where approval authority was delegated to wing commanders; this distinction is relevant to some of the complaints about LOD processing and will be addressed later in the report.

The slide below from SAF/MR shows the LOD determination process as intended. (Ex 218:11)



Line of Duty

For a condition to be ILOD, a few key issues must be analyzed: Was the condition "incurred" in duty status?[12] If the condition existed prior to service, did the military service "aggravate" the condition while the member was in duty status? Finally, was the condition the result of gross negligence or misconduct?

[12] DAFI 36-2910 defines "duty status" as "during any period of Active-duty, funeral honors duty or IDT [Inactive-duty Training] while traveling directly to or from the place at which funeral honors duty or IDT is performed; while remaining overnight immediately before the commencement of IDT or between successive periods of IDT, at or in the vicinity of the site of the IDT, if the site is outside reasonable commuting distance of the member's residence; and while remaining overnight at or in the vicinity of the place the funeral honors duty is to be performed immediately before serving such duty, if the place is outside of a reasonable commuting distance from the member's residence." (Ex 2:90)

Condition was Incurred

DAFI 36-2910_DAFGM 2023-02, dated 17 Nov 2023, *Line of Duty (LOD) Determination, Medical Continuation (MEDCON), and Incapacitation (INCAP)Pay*, provides the following definition:[13]

> **Incurred** – To occur or come into being (develop), regardless of when discovered, diagnosed, and during a qualified duty status. (Ex 2:82)

It is important to highlight the distinction between an injury, illness, or disease being incurred versus discovered during a period of service. Subject matter experts noted this is a point of confusion, and the inquiry team observed this from some members who were interviewed. For example, experiencing symptoms of a previously existing condition while on orders or being diagnosed for the first time with a previously existing condition while on orders is not the same as incurring that condition while on orders.

An ANG doctor involved in the process explained the complexity:

> There's a variety of things we look at. First of all, was the member in a military status? We look at when it was incurred. And there's a lot of confusion, and I understand, there's a lot of confusion with the members and even the docs at the local level for something to be in the line of duty, it had to have been incurred while you were in a military status. And they confuse incurred with, "Well, I got ***diagnosed*** when I was in military status. The ***symptoms*** started when I was in military status." That's not incurred. (Ex 201:27) (emphasis added)

Existed Prior to Service – Service Aggravated

A member is entitled to medical care for a pre-existing condition if the military service aggravated the condition. Two concepts come into play: "prior to service" and "aggravated." For ARC service members who serve on discrete sets of orders, the term "Existed Prior to Service" means the condition existed prior to a specific set of orders. It does not mean that an injury, illness, or disease existed prior to the time a service member entered the service.[14] From interviews with subject matter experts involved in the process, the phrase "Existed Prior to Service" is often confused to mean a condition existed prior to the initial period the member

[13] For consistency and ease of reference, unless specifically noted otherwise, "DAFI 36-2910" will refer to DAFI 3602910_DAFGM 2023-02 dated 17 Nov 2023.

[14] If a member does not report a condition within 180 days of completion of a set of orders, absent special circumstances (such as latent onset of post-traumatic stress disorder and other mental, behavioral, and neurodevelopmental conditions), the avenue to address the condition is through the Department of Veterans Affairs. (Ex 2:11)

began serving in the military. The inquiry team encountered this confusion as well from some members.[15]

The Chief of Aerospace Medicine at the Air National Guard Readiness Center (ANGRC), who is involved with the ARC LOD Determination Board, testified:

> [F]or the National Guard, because we go on orders, come on and off orders so frequently, uh, it's, it's a little bit more -- it's kind of quite harder to capture, and for service members to understand, um, the difference, again, between acute against chronic. When we say something exists prior to service, not service aggravated, what we're saying is during that period, those -- that period of orders, not your entire career. (Ex 211:26)

Additionally, a member aggravating a pre-existing condition is different than a member exacerbating that condition. A member who exacerbates a condition is not entitled to medical care and benefits. DAFI 36-2910 provides the following definition:

> **1.8.2. Existed Prior to Service-Service Aggravation (EPTS-SA)**. A condition is aggravated in a qualified duty status when there is a ***worsening of the condition over and above natural progression, caused by trauma or the nature of military service***. Natural progression is the course an illness, injury or disease would take over time, regardless of military service. (Ex 2:22) (emphasis added)
>
> **Exacerbation** – ***A temporary flare or escalation of symptoms/pain*** that does not result from or result in a permanent change in condition. Often flares are expected in some medical conditions otherwise stated as an acute episode of a chronic condition. (Ex 2:91) (emphasis added)

An ANG doctor explained if a member has chronic knee pain and experiences a flare-up during the PT test, which is exacerbation and part of the condition's natural progression:

> [S]ay they got a bad knee, and you look at the x-rays, and they have, you know, stage 3, stage 4 osteoarthritis, and their cartilage is eroded away, that didn't just happen over drill week and when they're doing the PT test…But they might've felt really bad after the PT test, but that's not going to be, um, in line of duty. That would just be an exacerbation of their underlying osteoarthritis and lack of cartilage . . .. So there's a difference between service aggravation and exacerbation…[S]ervice aggravation is permanently[16] worsening beyond the natural progression due to military duty, right? An exacerbation is, you got this underlying problem, it flares, and then it goes back. You know, you rest it, you ice it, you

[15] As part of a current DAFI 36-2910 Interim Change and overall rewrite, commonly used terms such as EPTS-SA and exacerbation are being reviewed for clarifying definitions.

[16] The definition of Service Aggravation in the 8 Oct 2015 version of AFI 36-2910 included the language "permanent worsening" (Ex 3:10); as included in this report, the word "permanent" was removed in the current 3 Sep 2021 version.

elevate, you do ibuprofen, you maybe a little PT, and then it goes back. But, but service aggravation, that's a higher bar, and that's when that course is altered. (Ex 201:39-40)

Not In the Line of Duty (NILOD)

For a condition to be considered NILOD, the reported condition either resulted from member misconduct or Existed Prior to Service (EPTS) and was Not Service Aggravated (NSA), commonly abbreviated as NILOD-EPTS-NSA. From DAFI 36-2910:

> **1.8.3.2. Existed prior to service-not service aggravated (EPTS-NSA) . . .** A NILOD-EPTS-NSA finding can only be made after a thorough review of the evidence determined that the member's illness, injury, or disease existed prior to the member's entry into military service with any branch or component of the Armed Forces or current periods of such service and was not service aggravated. (Ex 2:22)

Burden of Proof

For members on orders greater than 30 days, their conditions are presumed to have been incurred ILOD for injuries, illnesses and/or diseases sustained while in a qualified duty status, and the burden of proof is on the government to prove NILOD. The burden of proof varies, depending on the length of the member's orders, per DAFI 36-2910:

Table 1.1. Standards of Proof.

Duration of Member's Orders	In Line of Duty	Not in Line of Duty– Not Due to Member's Misconduct-EPTS-Not Service Aggravated	Not in Line of Duty – Due to Member's Misconduct
30 days or less	Preponderance of the Evidence	Preponderance of the Evidence	Clear and Convincing Evidence
Greater than 30 days	Preponderance of the Evidence	Clear and Unmistakable Evidence	Clear and Convincing Evidence

Members may appeal NILOD findings through their respective appellate authority (ANGRC/CC for ANG and AFRC/CD for Reserves). (Ex 2:8) DAFI 36-2910 states for any NILOD finding, "This clear and unmistakable evidence shall be furnished to the member in

conjunction with the finding to be used in any appeal efforts."[17] (Ex 2:14) More discussion will follow below regarding the standard of proof.

Finally, as noted above, if a member has a pre-existing condition that is exacerbated by military service, then the decision will result in NILOD, and the member will not receive medical care for that condition. However, for members who have more than eight years of active service, if the pre-existing illness, injury, or disease occurred in a prior duty status, the member may qualify for disability separation or retirement by a Physical Evaluation Board (PEB).[18]

Medical Continuation (MEDCON)

If a member's injury, illness, or disease is found ILOD and requires medical care beyond the member's current set of orders, that member may be placed on Medical Continuation (MEDCON) orders for medical evaluation and/or treatment of their ILOD condition. (Ex 2:19) Under DAFI 36-2910, paragraph 6.1, the "primary purpose of MEDCON is to facilitate the authorization for access to medical care for members who incur or aggravate an injury, illness or disease while in a qualified duty status and to return members to duty as expeditiously as possible…" (Ex 2:58)

While on MEDCON, per DAFGM to DAFI 36-2910, the member is expected to have an "active treatment plan" or a "restorative care plan" that will return the member to duty. (Ex 2:58) Once on MEDCON, the member reports information to the Air Reserve Component Case Management Division (ARC CMD), which "serves as the central point of contact for all MEDCON related issues, medical and non-medical, to ensure standardization, efficiency and accountability." (Ex 2:62) The member has to provide current and sufficient medical documentation to ARC CMD or may be processed for "discretionary termination" from the program. (Ex 2:60)

[17] Clear and unmistakable evidence standard is rooted in federal law. 38 USC § 1111, *Presumption of sound condition*, states, "For the purposes of section 1110 of this title, every veteran shall be taken to have been in sound condition when examined, accepted, and enrolled for service, except as to defects, infirmities, or disorders noted at the time of the examination, acceptance, and enrollment, or where **clear and unmistakable evidence** demonstrates that the injury or disease existed before acceptance and enrollment and was not aggravated by such service." (emphasis added) Furthermore, 38 USC § 1110, *Basic entitlement*, states, "For disability resulting from personal injury suffered or disease contracted in line of duty, or for aggravation of a preexisting injury suffered or disease contracted in line of duty, in the active military, naval, air, or space service, during a period of war, the United States will pay to any veteran thus disabled and who was discharged or released under conditions other than dishonorable from the period of service in which said injury or disease was incurred, or preexisting injury or disease was aggravated, compensation as provided in this subchapter, but no compensation shall be paid if the disability is a result of the veteran's own willful misconduct or abuse of alcohol or drugs."

[18] See 10 USC §1027a.

Members may initially be placed on pre-MEDCON orders of up to 30 days to allow additional time to determine more about the condition and provide medical documentation to support a request for MEDCON orders. (Ex 2:63) Members can be placed on pre-MEDCON with a unit commander's recommendation once the unit commander has signed the LOD but before it is fully adjudicated.[19] (Ex 2:39) Members request MEDCON orders through ARC CMD. (Ex 2:65) If the member cannot be returned to duty within one year, the member will be processed through the Disability Evaluation System (DES) to determine fitness for duty or may be eligible for care through the VA. (Ex 2:59) MEDCON orders beyond 270 days require review by SAF/MR for potential termination. (Ex 2:59)

The Disability Evaluation System (DES)

If a member has an injury, illness, or disease and cannot be returned to duty even with treatment, the condition is considered unfitting per DAFI 36-3212, *Physical Evaluation for Retention, Retirement and Separation,* 22 Feb 24:

> **Unfitting Condition(s) –** A disability that prevents a service member from performing the duties of his or her office, grade, rank, or rating. These duties include those performed during a remaining period of Reserve obligation. This also includes condition wherein if the service member were to continue on active-duty or in an active Reserve status, the disability would represent a decided medical risk to the health of the service member or to the welfare or safety of other service members, or would impose unreasonable requirements on the military to maintain or protect the service member. (Ex 6:76-77)

The DES is the mechanism for determining fitness for duty, and members found unfit for duty due to disability will be separated or retired. (Ex 5:6) Members with ILOD conditions may go to a Medical Evaluation Board (MEB) and be processed through the DES for potential entitlements based on their disability rating. (Ex 6:26) Members discharged from service with NILOD-EPTS-NSA conditions are not entitled to disability compensation. (Ex 6:27) Members may appeal their DES findings through the Secretary of the Air Force Personnel Council (SAFPC) and the Air Force Board of Correction of Military Records (AFBCMR).

DAFI 36-2910 states:

> 1.6.8.6. To enter the DES for a duty-related determination, the member must have an ILOD determination for a referred condition, or meet the eight year rule (see paragraph 1.13), or have a Prior Service Condition (PSC) that meets the criteria set forth in paragraph 1.12 and DoDI 1332.18, Enclosure 3 to Appendix 3, paragraph 7.e. (T-0). (Ex 7:18)

DoDI 1332.18, *Disability Evaluation System,* 10 Nov 2022, states:

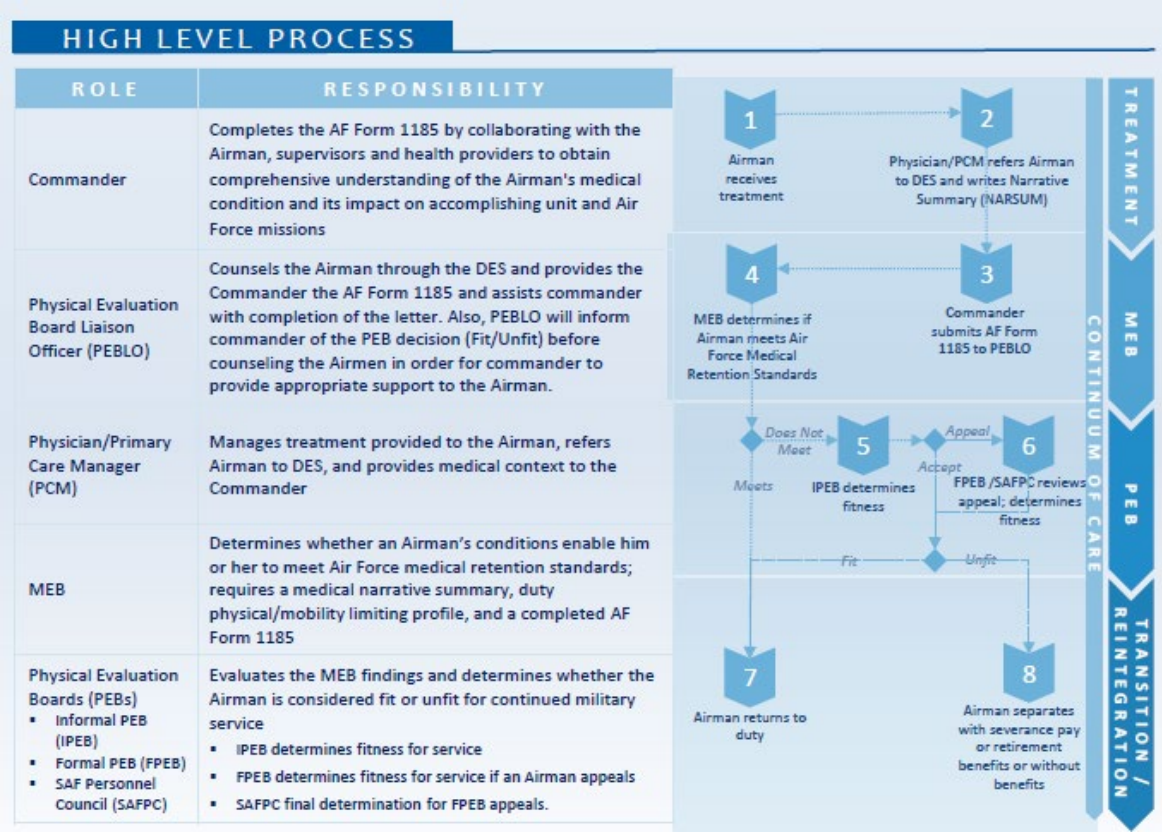
[19] An LOD (AF Form 348) signed by the military medical provider and unit commander is considered an interim LOD. (Ex 2:92)

a. Relationship of LOD Findings to DES Determinations.

(1) LOD determinations will be made in accordance with the regulations of the respective Military Department. When an LOD determination is required, the PEB may consider the finding made for those issues mutually applicable to LOD and DES determinations. These issues include whether a condition is pre-existing, is aggravated, is aggravated by military service, and whether there are any issues of misconduct or negligence.

(2) When the PEB has reasonable cause to believe an LOD finding appears to be contrary to the evidence, disability evaluation will be suspended for a review of the LOD determination in accordance with the regulations of the respective Military Department. The PEB will forward the case to the final LOD reviewing authority designated by the Secretary of the Military Department concerned with a memorandum documenting the reasons for questioning the LOD finding. (Ex 5:45)

The graphic below from a Feb 2019 myPers Fact Sheet on the Disability Evaluation System depicts the process. (Ex 219)



LOD Reform

Over the past five years, the Air Force LOD process has undergone significant changes. Starting in 2019, SAF/MR began "LOD Reform" based on findings from the Invisible Wounds Initiative that LODs for ARC members were taking too long to process. Especially concerning was the length of time taken to process complex LODs, such as for Post Traumatic Stress Disorder (PTSD). One SAF/MRR subject matter expert who was involved with the process explained:

> Adjudications of LODs were going a year, two years almost. And so, um, in order for members to move forward, either return to duty, get their care or be processed through the DES and be separated, they needed a line of duty. And we needed a line of duty adjudicated much more -- much more quickly than 480 days or, or 600 days, right? Because the line of duty is the key to everything. It's the key to get healthcare. It's the key to get into DES. (Ex 200:5-6)

The SAF/MRR representative stated the Guard and Reserve components were "busting timelines left and right," and "it was impacting Airmen . . . and so, we started an LOD reform." (Ex 200:5- 6) Significantly, SAF/MR directed the approval authority for ARC LODs from AFRC headquarters and ANGRC LOD Determination Boards to wing commanders in the revised DAFI 36-2910, published 3 Sep 2021, with a goal of completing LOD determinations within 60 days. (Ex 4:20) The SAF/MRR representative stated delegating the authority to wing commanders was meant to adjudicate LODs "more efficient and timely" and "thinking that would be quicker." (Ex 200:6) Notably, this initiative was contentious, with key voices expressing concerns about wing commanders having the expertise or time available to make accurate decisions. SAF/MRR described the results, stating, "what we found in '21, '22 is that it might've been quicker, but not accurate . . . so we sacrificed a little accuracy, not a little, we probably sacrificed a lot of accuracy for time." (Ex 200:7)

In May 2023, SAF/MR published DAFGM 2023-01 to DAFI 36-2910, reinstating ARC LOD determination boards as the approval authorities for LODs. The below chart shows the chronology of the DAFI 36-2910 rewrites.

DATE	EVENT
2019	Through SAF/MR, the Invisible Wounds Initiative analyzed and provided solutions to resolve issues with ARC Airmen receiving care; one of these initiatives focused on shortening the LOD approval process. (Ex 200:6; Ex 207:4)
July 2021	A pilot program was initiated, which included 10 AFRC and 10 NGB wings, so SAF/MR could have test cases for LOD processing with the wing commander as the approval authority for informal LODS to use to evaluate results. (Ex 223) For AFRC, the 10 wings participating in the pilot program submitted LODs in a separate track in ECT, which the LOD Determination Board could not view. (Ex 204:50)
3 Sep 2021	DAFI 36-2910 was revised, providing wing commanders the authority to approve informal LODs. (Ex 4:20)
3 Sep 2022 – 7 Apr 2023	For AFRC, wing commanders were the approval authority for informal LODs. (Ex 204:51)
4 Nov 2021	NGB/A1 approved an AF Form 679 waiver for the LOD Determination Board with the intent to continue to act as the reviewer and approving authority for ANG informal LOD determinations.[20] The waiver was "approved" for "up to one year or earlier, pending full analysis of audit results."[21] (Ex 206, Ex 211:7)
15 Mar 2022	NGB/A1 withdrew the waiver signed on 4 Nov 21. (Ex 213:19-20)
15 Mar 2022 – 22 May 2023	ANG directed units to stop using ECT, except for those 10 wings that were in the pilot program. (Ex 211:7-9)
23 May 2023	DAFGM 2023-01 Guidance Memorandum posted to DAFI 36-2910 returning final adjudicating authority to the ARC LOD Determination Board informal LOD. (Ex 2:8)

Ongoing ARC LOD Reform Efforts

Per HAF Mission Directive (HAFMD) 1-24, *Assistant Secretary of the Air Force (Manpower and Reserve Affairs)* paragraph A2.1., states the Assistant Secretary of the Air Force for Manpower and Reserve Affairs is responsible for the overall supervision of all matters pertaining to LOD determinations. (Ex 17:39) In May 2024, independent of this inquiry, SAF/MR stood up the ARC LOD Quality Assurance Program (QAP),[22] which is examining

[20] On 15 Nov 21, AF/A1PPS acknowledged receipt of the AF Form 673 and noted it was completed correctly. (Ex 222: 1-2)
[21] The AF Form 679 was submitted on 9 Sep 21, but was not signed/approved until 4 Nov 21, with an expiration date of 9 Sep 22. NGB/A1 was both the requestor and the Approval Authority for the waiver. (Ex 206)
[22] The QAP is led by an O-6 and presently consists of a line officer/LOD policy expert, a medical officer, and a Health Services Manager (subject matter expert in policy, process, data collection).

LOD cases from the ARC LOD Determination Boards to determine whether they are meeting timeliness and accuracy requirements. The ARC LOD QAP will fulfill SAF/MR's Mission Directive to provide formal oversight by conducting reviews of adjudicated ARC LOD cases and report observations to SAF/MRR. When fully implemented, the objective of the ARC LOD QAP is to ensure ARC approval authorities adjudicate LOD determinations in accordance with DAFI 36-2910. (Ex 72) Also of note, the ARC LOD QAP will conduct a comprehensive rewrite of DAFI 36-2910 to address numerous issues identified as vague or that cause confusion for service members. (Ex 200:7-9)

In addition to the efforts at the DAF level, The Office of the Under Secretary of Defense Personnel and Readiness (OUSD P&R) is currently reviewing DoDI 1241.01, which provides overarching guidance to all military reserve components LOD programs. As part of this review, OUSD P&R requested participation from all service components to provide representation for the review. According to the Office of Primary Responsibility (OPR) for DoDI 1241.01, the DAF has provided approximately 15 representatives to assist with the review to include ANG and AFRC members.

Voice of LOD Program Managers

This inquiry interviewed 24 LOD PMs from the ANG and AFRC to understand how, at the wing level, the LOD/MEDCON/INCAP programs are administered to support ARC service members. A standard list of questions and topics were presented to each of the PMs to understand their perspectives and experiences related to how they are trained, supported, and ultimately how they administer the LOD program at their wing. The interviews provided candid testimony that was consistent with a number of the themes and contributing factors identified during the inquiry. In general, all the LOD PMs interviewed indicated that wing-level LOD procedures align with DoD and DAFI guidance, although inconsistencies in the execution of procedures were noted throughout.

Additionally, all interviewed LOD PMs identified an overall lack of ARC service member awareness or understanding of the LOD/MEDCON/INCAP programs and what status and medical conditions qualify a member for associated medical benefits and entitlements. As one LOD PM put it, ARC service members do not have "the first clue" about the processes involved in these programs because there is a lack of emphasis and training provided to service members. (Ex 39:2) Overall, the sentiment about the LOD/MEDCON/INCAP programs provided by LOD PMs was negative.

More specifically, LOD PMs identified their lack of training as a key issue. Interviews revealed that none of the LOD PMs received training regarding their responsibilities or instructions on how to manage the program. Many reported feeling uncomfortable managing the program for many months to years before they could confidently fulfill their responsibilities. All

felt strongly a formal training program should be developed for newly assigned LOD PMs. Additionally, with regard to training, no LOD PMs interviewed reported any level of formal LOD training for wing service members or leadership.

Furthermore, of the LOD PMs who experienced a member receiving a NILOD determination, all said the information provided to ARC service members justifying the NILOD determination is insufficient, and the method of delivering this information varied from wing to wing. One senior enlisted LOD PM who has managed the program for approximately six years said ARC service members are not provided with a sufficient level of clear and unmistakable evidence. They said the member is usually provided with standard language out of medical literature that is very difficult to understand or explain to the member. Further, they said the last member they worked with who received a NILOD determination had no idea what evidence they needed to submit an appeal based on the explanation provided to them on their AF Form 348. (Ex 39:3) Another senior enlisted LOD PM summarized their experience of the explanations provided on NILOD determinations:

> [T]ypically, it's, it's having to do with, um, you know, the, the disease process of that disease not, um, occurring in, in the status or not sufficient evidence of, um, of what was presented in the documentation that was received….but yes, I don't think that it's, it's usually ever sufficient to give the member a full understanding of why. (Ex 226:92)

Lastly, LOD PMs said the LOD/MEDCON/INCAP programs and processes are difficult for ARC service members and leaders due to the requirements placed on the members to qualify and obtain medical benefits and entitlements. Specifically, the timeline requirements for each phase of the programs are difficult due to the part-time nature of the reserve component and should be extended to account for this factor. Additionally, the terms and processes associated with these programs are ambiguous for those without medical backgrounds. Words used by LOD PMs to describe various aspects of the LOD/MEDCON/INCAP programs and processes included cumbersome, complicated, confusing, difficult, frustrating, inconsistent, problematic, unrealistic, conflicting, and inefficient. (Ex 39:3; Ex 40:2-3; Ex 41:3; Ex 42:2; Ex 43:4; Ex 44:1,3; Ex 45:1-4; Ex 47:3)

Experiences and perspectives from the 24 ARC LOD PMs interviewed will also be included in the complaints section of this report.

III. COMPLAINTS, STANDARDS, ANALYSIS AND CONCLUSIONS

SAF/IG examined the cases of 11 ARC service members who had filed IG complaints regarding their experience with the LOD program, resulting in difficulties or inability to acquire medical benefits and entitlements. Their experience helped assess whether there are shortcomings in LOD processes and procedures. These 11 cases present a sampling of what

concerns a service member might experience when navigating the LOD program and related processes. This inquiry does not attempt to determine the frequency these issues are experienced across the ARC.

For privacy reasons, the individuals whose cases will be referenced in this report will be identified as ARC Members (AM) 1 through 11. The inquiry team identified common themes, which are grouped below as Complaints 1 through 7, followed by a discussion.

At the onset of the inquiry, the primary complainants alleged:

a) They were unlawfully denied In the Line of Duty (ILOD) determinations and subsequent benefits based on:

   i) The ARC failing to process LODs in a timely manner.
   ii) Members were improperly told to provide statements regarding their injuries that were then used against them.
   iii) The ARC LOD Determination Board allegedly intervened without authority to overturn wing commander ILOD decisions.
   iv) Service members were improperly removed from Medical Continuation (MEDCON) orders with unresolved unfitting conditions awaiting Disability Evaluation System (DES) processing.

b) The ARC LOD Determination Board does not meet the standard of "clear and unmistakable evidence" when finding conditions Not In the Line of Duty (NILOD) Existed Prior to Service – Not Service Aggravated (EPTS-NSA).

c) Medical personnel reviewing the LOD packages are not qualified to make medical diagnoses/decisions and make inaccurate statements in their decisions.

d) Members are not provided the "clear and unmistakable evidence" used, as required, when the ARC LOD Determination Board found conditions NILOD EPTS-NSA.

Though interviews with 11 service members, the following seven complaints were consistently highlighted by ARC service members. These seven complaints are addressed below:

	AM1	AM2	AM3	AM4	AM5	AM6	AM7	AM8	AM9	AM10	AM11
Wings failed to initiate LODs	X					X	X		X		
Wing improperly required a statement	X						X				
ARC LOD Board intervened without authority	X						X	X			
ARC/SG did not meet evidentiary standard		X		X						X	
ARC LOD Board did not provide evidence	X		X				X	X			
MEDCON requirements are arbitrary/unreasonable	X	X			X		X	X	X		X
MEDCON program is not transparent	X	X			X		X	X	X		X

COMPLAINT 1 – Wings failed to initiate LODs.

Four complainants, AM1, AM6, AM7, and AM9, reported their wings initially refused to submit LODs for their reported conditions.

AM1 was on orders from [redacted] Jun 2020 to [redacted] Sep 2020 when they injured (b) (6), (b) (7)(C) [redacted] Jun 2020 while (b) (6), (b) (7)(C) [redacted]. (Ex 22:1) AM1 sought medical care, (b) (6), (b) (7)(C) and diagnosed (b) (6), (b) (7)(C) [redacted]. (Ex 22:4) When AM1 reported the injury to their LOD PM, they stated they thought the injury may have initially occurred in Aug 2019 but did not realize the seriousness of the injury until the fitness test they had just taken. (Ex 24:14-15) AM1 stated that due to a reference of the initial injury occurring in 2019, their LOD PM refused to submit the LOD request because the injury was not reported within 180 days of the end of their orders. (Ex 24:15) DAFI 36-2910, 2015 version in effect at the time of AM1's injury, states after release from active duty or Inactive Duty Training (IDT), members have up to 180 days to report their medical conditions for LOD determination. According to AM1, the LOD PM said, "You didn't report this. This happened a year ago. Almost a year ago. You didn't report it. It's not a Line of Duty injury. Therefore, I'm not initiating an LOD. Good luck." (Ex 24:15)

The avenue for addressing previously unreported conditions is through the VA. (Ex 3:9) The 3 Sep 2021 version of DAFI 36-2910, in effect at the time AM1 reported their (b) (6), (b) (7)(C) injury, clarified failure to report a condition in a timely manner would not impact a member's ability to request and obtain an LOD. (Ex 4:26) Only after AM1 engaged their chain of command was the LOD initiated on 25 Sep 2020. (Ex 22:7; Ex 21:52)

During the timeframe of AM1 being seen for their (b) (6), (b) (7)(C) injury, they were diagnosed with (b) (6), (b) (7)(C), (b) (6), (b) (7)(C), (b) (6), (b) (7)(C), and [redacted]. (Ex 37:3; Ex 25:2; Ex 27:4; Ex 38:1) AM1 then attempted to submit LODs for these conditions; however, the medical group refused to initiate LODs. (Ex 24:49) It was only after AM1 filed IG complaints and engaged their Congressperson that AM1's wing submitted LODs in Feb and Mar 2022. (Ex 21:16-21; Ex 24:49-50; Ex 27:6; Ex 36; Ex 37; Ex 38)

AM7 was on orders from when they experienced a (b) (6), (b) (7)(C) injury [redacted] Oct 2021. AM7 reported this condition to medical health providers over the next several months during a (b) (6), (b) (7)(C) [redacted], but no providers initiated an LOD. When AM7 went to the wing LOD PM in Dec 2022, an LOD was initiated. (Ex 113:2- 3) The LOD was forwarded to the unit commander in Jan 2023, who had it for 209 days before it was submitted to the ARC LOD Determination Board in Aug 2023. (Ex 119:19-20)

AM9 was on orders from [redacted] Jan 2021 to [redacted] Apr 2021, when AM9 was diagnosed with (b) (6), (b) (7)(C) [redacted] Apr 2021. (Ex 154:1) An LOD was initiated for AM9 on 8 Apr 2021 and

completed on 14 Jun 2021. (Ex 154:5) This LOD allowed AM9 to be put on MEDCON and receive care as AM9 was (b) (6), (b) (7)(C) . AM9 testified as they were being discharged, they communicated with their wing about new LODs for other conditions. (Ex 150:51) However, it was not until 7 Apr 2023, 18 months after (b) (6), (b) (7)(C), that AM9's wing initiated an LOD for (b) (6), (b) (7)(C) and, on (b) (6), (b) May 2023, AM9's wing initiated an LOD for (b) (6), (b) (7)(C) . (Ex 151:6,7; Ex 152:1) AM9 testified they unsuccessfully tried to initiate LODs through their wing before they were terminated from MEDCON orders. A limitation in examining this complaint for AM9 and all cases in general, is before an LOD is initiated, there are no specific records for requests and subsequent communications regarding LOD packages except for documentation individual members may have created.

STANDARDS

During the pertinent timeframe of the three cases, DAFI 36-2910 was under revision, updated on 3 Sep 2021. (Ex 4) Applicable versions did not change the responsibility for the military medical provider to initiate LODs. Both 2015 and 2021 versions require LOD determinations be made when an ARC member incurs or aggravates an illness, injury, or disease while in a qualified duty status. (Ex 3:8; Ex 4:11)

Per DAFI 36-2910, dated 8 Oct 2015, medical military providers, commanders and Staff Judge Advocates (SJA) have a responsibility to take an active role in ensuring LODs are initiated while military medical providers initiate the actual processing:

> 2.1.2. Responsibilities. Military medical providers, commanders and Staff Judge Advocates (SJA) who learn of a member's illness, injury, disease or death that occurred under circumstances that ***may warrant an LOD determination*** shall take an active role in ensuring that an LOD determination is initiated. (T-1) (Ex 3:13) (emphasis added)

> 2.2.2 Military Medical Provider. The military medical provider shall initiate and process an LOD determination within 5 working days of seeing a member and receiving supporting medical documentation… (Ex 3:14)

DAFI 36-2910, dated 3 Sep 2021, has similar language but removed the SJA from responsibility for ensuring LODs are initiated:

> **2.25. Military Medical Provider (MMP).**
> 2.25.2 **(ARC Only)** Initiates Informal LOD cases ***at the request of the service member*** and completes the corresponding and appropriate information within the AF Form 348, if needed. (Ex 4:21) (emphasis added)

3.1. Administering the LOD Determination Process.
3.1.2. Responsibilities. Military medical providers and commanders who learn of a member's illness, injury, disease or death that occurred under circumstances that ***may warrant a LOD determination*** shall take an active role by advising the member on how to submit the required documentation within required timeframes and ensuring timely processing of the LOD determination….(Ex 4:24) (emphasis added)

DAFGM, dated 17 Nov 2023, updated language in Table 3.1, *Processing Timelines for LOD Determinations*, and identified the "LOD-Medical Focal Point" as responsible to "Initiate and route [LODs] to the medical officer within 5 calendar days of receiving necessary records and request from member." (Ex 2:4) This language is unchanged in the responsibilities section which identifies the military medical provider as responsible for initiating LODs. (Ex 2:3, 31)

DISCUSSION AND ANALYSIS

AM1, AM7, and AM9 all reported being unable to submit LODs through their wings for different reasons. In AM1's case, the wing refused to submit LODs because, at the time, the LOD PM responsible for processing LODs did not think the reported conditions warranted LODs. In AM7's case, AM7 did not know how to initiate the LOD process at their wing. Although they reported conditions to their medical providers, it was not the method AM7's wing used to initiate LODs, despite the guidance in DAFI 36-2910. Once AM7 contacted the wing LOD PM, the first of two LODs was initiated. However, at that point, the LOD remained with AM7's immediate commander for 209 days, even though DAFI 36-2910 (2021 version), Table 3.1., states the timeline is 10 days for ARC members. (Ex 226:56-57) After having lost trust in the process of filing the first LOD, AM7 took a different approach filing a second LOD. They explained, "So, I just, um, I had the, the forms from the (b) (6), (b) (7)(C) LOD. I had the, um, I had blank versions of them, so I just, I didn't even go to the medical, I didn't go to the LOD program manager for anyone at medical. I just sat in my office, and I filled it out, and I filled out a statement, um, and I just basically did everything that I knew to do, and I sent it to [LOD PM], the, the LOD program manager, and I think [they] responded, like, the same day, saying, "Yep, you know, I'll, I'll take a look at it, and, um, I'll, I'll get it going." (Ex 116:38-39)

AM9 testified they unsuccessfully tried to initiate LODs through their wing before they were terminated from MEDCON orders.[23]

[23] A Command Directed Inquiry (CDI) initiated by AM9's previous unit of assignment was completed in Apr 2024 and substantiated a finding stating, "The preponderance of the evidence indicates that by failing to initiate a new LOD for [AM9's] (b) (6), (b) (7)(C) the [MDG] more likely than not did cause [AM9] to be denied care at military medical facilities." (Ex 231:20)

Role of Wing LOD PMs

The wings are given wide latitude on how to implement the LOD program, and the verbiage in DAFI 36-2910 regarding when to initiate LODs, specifically "under circumstances that may warrant a LOD determination," could be interpreted as providing discretion to the wings whether to initiate an LOD when requested. (Ex 2:34) Although there are some administrative requirements for a member to initiate an LOD, such as providing the needed medical documentation and medical releases, NGB and AFRC officials involved with the LOD process believed the wings should initiate LODs when requested regardless of the circumstances. An AFRC personnel explained:

> The medical technician is only filtering based on the requirements to submit an LOD, if that makes sense. So, they're, they're not going to refuse an Airman who wants to submit an LOD. If an Airman wants to submit an LOD, the medical technician is going to tell them, "Okay, here's what you need to submit an LOD. I need these documents." Um, and if the Airman does not provide those documents, then that LOD sits in the medical technician queue and is not advanced into the process…And, and the medical community . . . are very, very careful to say, you know, "We make recommendations. We aren't" -- like, I'm going to tell you, no, you can't submit an LOD. They'll submit an LOD, and we've seen it, um, even though they might say, "Well, this might not rise to the level of an LOD." (Ex 204:44)

As previously discussed, no standardized formal training is provided to ARC LOD PMs. Therefore, those assigned to this role are forced to administer the program as they see fit. Based on the interviews conducted with the 24 ARC LOD PMs, there is no ARC-wide standard process used to initiate an LOD for a service member. Depending on which wing organization is assigned the LOD PM role, FSS or MDG, the initial contact with the service member to acquire the necessary information and complete the required LOD documentation varies widely. This disconnect in the LOD initiating process is further exacerbated by the general lack of knowledge by the ARC service members about the LOD program.

Responsibility to Initiate the LOD

While the current version of DAFI 36-2910 places responsibility on the military medical provider to initiate the LOD "at the request of the service member." In practice, that is not how the wings operate. (Ex 2:31) Initiating LODs in the ARC requires the use of the ECT system, and that process starts with the LOD Medical Focal point.[24] (Ex 226:84-86) The DAFI identifies commanders and military medical providers as having responsibility for "taking an active role" in assisting members to submit their LODs. Rather than reporting a medical condition and then being informed of LODs, members at some wings are required to specifically request LODs.

[24] The "Medical Technician" or "ANG Tech" is the label of the role in ECT for the person to initiate the LOD.

(Ex 226:85) Whether wings are knowledgeable enough to advise members as specified in DAFI 36-2910 is dependent on the training provided at the wing level by the LOD PMs or LOD Medical Focal Points.

CONCLUSION

The fact LODs were not submitted for the three service members when conditions were reported and when specifically requested highlights problems with processes and procedures and confusion over DAFI 36-2910 guidance. Refusals or significant delays in initiating the LODs also show the lack of training LOD PMs receive to administer the LOD program throughout the process. That LODs can remain at the wing level after the member has submitted the required records significantly beyond prescribed timelines shows the lack of training to effectively administer the process and a lack of accountability and oversight outside of the wings. Without a system of record for members to create requests, wings will continue to be challenged by maintaining visibility of members in the initial stages of initiating LODs or holding members accountable for actions taken or inaction in those stages. This inquiry found the lack of training for those responsible for administering the program, coupled with the fundamental lack of knowledge of ARC service members about the program, has eroded the trust some service members have in the process of receiving their entitled medical benefits. It also exacerbates some misperceptions by service members that they are being denied benefits for fiscal reasons.

Contributing Factors

- **A lack of standardized, mandatory training for ARC service members on the LOD/MEDCON program.** As a commander's program, wings have wide latitude to implement the program; while some wings had deliberate training efforts, others had none. Members not informed of the program may not be familiar with the requirements to report LOD conditions to begin the process. Many individuals interviewed described learning about the program as they reported a medical condition or through word of mouth.
- **Training is not provided to those responsible for administering the program at the wing level.** There is no comprehensive, mandatory training for members involved with the LOD process at the wings. The inquiry team found wings create their own checklists and processes to gather information from members who report potential LOD conditions. While the unit commander determines what information is required to describe the circumstances of each LOD submitted, each wing has its own checklist and/or process they typically follow.

- **ARC wing, NGB, AFRC, and DAF are lacking LOD program oversight.** There is no current adequate oversight of the LOD program at any level. Wings choose how they manage and oversight their LOD programs, with some units reporting regular

updates to the commanders and others with less engagement. If a member's wing does not process an LOD or process it in a timely manner, there is no recourse for the member outside their chain of command. Notably, if a wing refuses to or delays initiating an LOD, there is no record to reference. Additionally, there is no ARC wing-level self-inspection or mechanism to ensure compliance with the DoDI 1241.01 or DAFI 36-2910. There is no requirement in DAFI 90-302, *The Commander's Inspection Program (CCIP)*, to assess the LOD process at ARC wings.

COMPLAINT 2 – Wings improperly told members to provide statements as part of their LOD package.

Two complainants, AM1 and AM7, said their wings required them to provide statements as part of their LOD package, which they believed violated federal law. After review, the inquiry team determined requests to provide statements did not violate 10 USC § 1219, *Statement of origin of disease or injury,* provided service members were advised of the law.

AM1

As discussed above, AM1 was asked to provide a statement when they requested an LOD for their (b) (6), (b) (7)(C) injury in Aug 2020, which the LOD PM allegedly used against AM1 to refuse to process the LOD:

> And then, so [they] had me write this statement. It said, you know, "In 2019, I (b) (6), (b) (7)(C) (b) (6), (b) (7)(C)." And then when I gave that to [them], [they] then said, You didn't report this. This happened a year ago. Almost a year ago. You didn't report it. It's not a Line of Duty injury. Therefore, I'm not initiating an LOD." And, um, so then I came back and it was a back and forth of, "Hey, that's -- I didn't -- ***that's not an actual sworn statement***. I'm not a doctor. I can't tell you when it was actually torn." (Ex 24:15) (emphasis added)

AM7

AM7 raised the issue as well.

> W: And then so when I left there, I said, "Okay, I'll go back to my office. I'll write the statement. And then I'll just email everything to you." And [they were] fine with that.
>
> So, [they were] actually helpful and very patient um, when explaining the – at least the paperwork to me.
>
> IO: Okay. But is it the statement [they] requested from you that you believe was unlawful?
>
> W: Well, the – according to 10 U.S. Code 1219, apparently, I'm not supposed to make a statement. Or I'm not supposed to write a statement. (Ex 113:2-3; Ex 116:18-19)

STANDARDS

10 USC § 1219, *Statement of origin of disease or injury*, states:

> A member of an armed force may not be required to sign a statement relating to the origin, incurrence, or aggravation of a disease or injury that he has. Any such statement against his interests, signed by a member, is invalid. (Ex 10:19)

The current DAFI 36-2910 states, "A LOD determination is a finding made after an informal or formal investigation into the circumstances of a member's illness, injury, disease or death." (Ex 2:17) In the DAFI, member responsibilities include reporting the injury and providing requested medical documentation "to reasonably identify the initial condition for which the LOD determination is being requested." (Ex 2:36) DAFI 36-2910, paragraph 3.1.2. further states members may consult with the Area Defense Counsel during any LOD determination for "advice on content, timelines, and submission documentation." (Ex 2:24)

Informal LODs: Informal LODs require the immediate commander to conduct some level of investigation by gathering "available information on the circumstances of the member's illness, injury, disease or death…" (Ex 2:38) The immediate commander determines whether the member's condition occurred during a period of unauthorized absence, due to member's conduct, or Existed Prior to Service (EPTS). (Ex 2:38) As part of the fact-gathering, the immediate commander may ask for statements from the member; however, DAFI 36-2910 provides no guidance regarding 10 USC § 1219 advisement during this informal stage.

Formal LODs: Formal LODs are initiated to conduct investigations where there are "strange or doubtful circumstances" or "circumstances the commander believes should be fully investigated." (Ex 2:54) Investigating officers are instructed to advise subjects before being interviewed of the 10 USC § 1219 advisement, in addition to Article 31, UCMJ rights. (Ex 2:90; Ex 3:69-70)

DISCUSSION AND ANALYSIS

Requirement to provide 10 USC § 1219 advisement

The governing regulation, DODI 1241.01, provides no guidance on, and makes no mention of, 10 USC § 1219. Neither does the Department of the Navy under SECNAVIST 1770.5, *Management and Disposition of Line of Duty Benefits for Members of the Navy and Marine Corps Reserve*, 23 Aug 2018. Unlike the DAF, the Department of the Army requires commanders to provide the 10 USC § 1219 rights advisement in informal as well as formal LOD investigations, including providing proof the soldier received the notice.

Finally, 10 USC § 1219 makes no distinction on whether the advisement should be given in informal or formal LOD proceedings, as DAFI 36-2910 does. As such, the law supports ARC members should be provided the rights advisement *any time* they are requested to provide a statement relating to the origin, incurrence, or aggravation of a disease or injury.

Cases involving AM1 and AM7

This inquiry found wings generally ask members to provide some kind of statement or explanation of the circumstances regarding their LOD submission. One LOD PM explained their role in gathering information:

> . . . if we determine that we do need to do an LOD . . . we do the full LOD briefing, and then there's an LOD checklist that we go through with them that lets them know every single piece of documentation that we're gonna need to initiate an LOD, starting with their certified orders, or if they're still on the orders, the partially certified orders, or UTAPS [Unit Training Assembly Participation System], or whatever the status they're in. That's the first step to make sure they're in the status. And then we need the medical documentation with the diagnosis, um, the full treatment notes. We need their member statement. We need, um, the -- a witness statement, if possible, and then the various things, depending on if it's a car accident, if it's a death, what, what we would need. (Ex 226:8)

As noted above, it appears LOD PMs, medical providers, and commanders should provide the 10 USC § 1219 advisement prior to requesting any statement regarding the origin of the condition under LOD consideration. To AM1's point, it does not appear advisement was given. In the cases reviewed as part of this inquiry, those involved in administering the process followed DAF guidance, in that DAFI 36-2910 specifically requires 10 USC § 1219 advisement only during the formal LOD investigation. If the advisement is not given, the remedy is the member's statement is "invalid" and cannot be used against them in the LOD determination.

CONCLUSION

DAFI 36-2910 requires commanders to gather available information on the circumstances of a member's illness, injury, disease, or death to initiate an informal LOD, and it is reasonable to request information from a member to assist in that process. However, the requirement to gather this information, when directly requested from a service member, beyond the medical records needed inherently puts those responsible for processing LODs at risk of asking members to make statements against their interests. As such, all service members should always be informed of the 10 USC § 1219 advisement prior to requesting a statement about the origin of their condition, not just during the formal LOD investigative process.

This inquiry identified the following contributing factors which led to this confusion:

Contributing Factors:

- **A lack of standardized, mandatory training for ARC service members on the LOD/MEDCON program.** The inquiry team found wings create their own checklists and processes to gather information from members who report potential LOD conditions. Without a standardized process, members can have different experiences from base to base regarding whether and when service members must submit a statement and whether 10 USC § 1219 rights advisement is given.

- **Training is not provided to those responsible for administering wing-level programs.** DAF members who administer LODs may not be aware of the requirement to tell members they are not required to provide or sign statements regarding the origin of their condition. DAFI 36-2910 requires 10 USC § 1219 rights advisement only in the formal LOD investigation, which appears to be an inadequate process.

COMPLAINT 3 – The ARC LOD Determination Board intervened without authority.

Three complainants, AM1, AM7, and AM8, alleged the ARC LOD Determination Board intervened when it did not have the authority, overturning wing commander decisions made during the period of LOD reform when the authority resided with wing commanders. Their complaints are described below.

AM1's wing submitted three informal LODs for AM1 between 22 Feb 2022 and 3 Mar 2022 with wing commander recommendations of ILOD. (Ex 23:1, 5; Ex 26:2, 6; Ex 25:2, 6) Upon review, the ARC LOD Determination Board determined the conditions to be NILOD. (Ex 23:1; Ex 26:4; Ex 25:1)

AM1 explained their understanding:

> [T]he AFI that was in effect at the time, the wing commander is the appointing and approval authority for informal LODs. And when they say that there's no negligence, no misconduct, then there was no reason for it to go to NGB 'cause NGB does formal LODs. So, the NGB overstepped their authority to take away, um, my commander's authority and overturn what was already done. (Ex 24:59)

AM7 is an AFRC member who had a formal LOD submitted in Dec 2022, and although the wing commander had approval authority for informal LODs, AM7 had a formal LOD, where the approval authority was at AFRC/A1. (Ex 4:38)

AM7 explained their understanding:

IO: So, at what point did you – were you made aware that there was a formal – this was going to be a formal LOD, and a formal investigation was going to take place to look into this LOD?

W: Okay…So, on October 10th of '23, last October . . . [the IO for the formal LOD] confirmed that the (b) (6), (b) (7)(C) LOD was now being processed as a formal. So – um, there was a formal investigation going on. So…on 3 October, the (b) (6), (b) (7)(C) LOD became a formal LOD. (Ex 116:21-22)

. . . so I filed my (b) (6), (b) (7)(C) LOD in December of '22, and so if that's the, the AFI 36-2910, that was in effect, that's fine, um, that, that reg states that two big things were, um, 60-day workday, uh, suspense date, and that the wing commander is the final authority for the LOD. It does not go to, um, what do they call it, the ARC LOD Determination Board? It does not leave the wing. It's just the wing commander to make the final decision. So that's what my (b) (6), (b) (7)(C) LOD should have been, um, processed as. It never should have left the wing. (Ex 116:36)

AM8's informal LOD was initiated on 31 Aug 2021 with a recommendation from the wing commander of ILOD and returned on 18 May 2022 with a determination of NILOD from the ARC LOD determination Board. (Ex 130:1-8)

STANDARDS

The applicable DAFI 36-2910 during the time period of the complaints analyzed is the 3 Sep 2021 version, which delegated informal LOD authority to wing commanders but had formal LODs approved by the ARC LOD Board (NGB/A1 and HQ AFRC/A1): (Ex 4:38)

Table 3.2. Authorities for LOD Processing.

Member is:	Immediate Commander	Appointing/ Reviewing Approving Authority	Formal LODs Reviewing Authority	Formal LOD Approving Authority	Appellate Authority
RegAF/USSF United States Air Force Academy cadets	Commander at lowest level unit in which member is assigned	Wing CC or equivalent	Next immediate commander in the chain of command over the appointing authority (see **Note 1**)	Officer who exercises general court-martial jurisdiction over the member (see **Note 1**)	GCMCA
ANG Title 10/32 AD and IDT	Commander at lowest level ANG unit in which member is assigned	Wing CC or equivalent	NGB LOD Determination Board (see **Note 3**)	NGB/A1	ANGRC/CC
AFRC assigned to or training with AFRC units (CAT A)	AFRC unit commander or senior AFRC commander present (see **Note 2**)	Wing CC or equivalent	AFRC LOD Determination Board (see **Note 3**)	HQ AFRC/A1	HQ AFRC/CD

The 3 Sep 2021 version of DAFI 36-2910 also provided discretion for the ARC LOD Board to determine informal LOD cases that would otherwise fall under the authority of the wing commander.

3.2.2. Informal LODs.

3.2.2.8. Approval/Appointing Authority.

> 3.2.2.8.1. Wing Commander or civilian equivalent commander director, (ANG, limited to Wing Commander). Reviews and approves informal LODs, and is the appointing authority for formal LOD determinations within his or her command. For authorities for superior and other Air Force units, see Table 3.2.
>
> 3.2.2.8.3. Is the final authority for informal LOD determination (for review authorities see Table 3.2). For ARC only, the wing commander may request input from the ARC LOD Determination Board before the final decision is made. If the member disagrees with the Wing Commander's determination, the member may appeal the determination to AFRC/CD, or ANGRC/CC or for Active-duty Members, the officer who exercises general court-martial jurisdiction over the AD member within 30 days (For appeal requirements, see Table 3.2). ***There may be cases that are determined by higher authorities (i.e.: Physical Evaluation Board (PEB), ARC LOD Board), during the DES or audit processing.*** . . . (T-1) (Ex 4:25-30) (emphasis added)

On 4 Nov 2021, NGB/A1 signed an AF Form 679, *Air Force Publication Compliance Item Waiver Request/Approval*, dated 9 Sep 2021, to continue to utilize the current routing and approval authority through the ANG LOD Board as a blanket policy.[25] The stated reason for the waiver was the need to "ascertain effectiveness of training to wings to accurately adjudicate complex LODs." (Ex 206) The current NGB/A1P Division Chief said the waiver was coordinated with and validated by HAF/A1P, the OPR for DAFI 36-2910, as well as SAF/MR.[26] (Ex 211:7) The NGB/A1P Division Chief further opined on the possible disconnect about the purpose of the waiver with ARC service members:

> And so, it was absolutely the responsibility of the ARC LOD Board to continue business as usual, right? Um, and, and that messaging was sent out to the wings. Um, you know, I guess you can go, you know, message not acknowledged is not a message received. Um, you could play that game. Um, but, yeah, there seemed to be some disconnects. And even -- I would say more so with the service members, right? They don't know that we have a 679 on file, you know, a waiver, uh, that makes all the LODs come up to the ARC LOD board. They just see what's in policy that's published on e-Pubs. Right? And that's saying -- and that is that the wing commander has the authority, and that we don't have the

[25] SAF/IG determined NGB/A1's Nov 2021 waiver to then-existing DAFI 36-2910 removed authority from wing commanders, and a waiver was not the appropriate mechanism to change the DAFI. (b) (5) [redacted] SAF/IG determined it was improper for a staff element to unilaterally remove a wing commander's specified approval authority.

[26] On 15 Nov 21, AF/A1PPS acknowledged receipt of the AF Form 673 and noted it was completed correctly. (Ex 222: 1-2)

> authority to overturn it. But they're missing that waiver piece. And I think that's what caused the consternation. (Ex 211:23)

According to SAF/MRR's Health Policy Analyst, the ANG LOD Board, as the higher-level authority, was permitted to review cases and make determinations at their discretion, as provided for in DAFI 36-2910 as referenced above. They stated:

> Um, and any questionable [case] could go to the ARC LOD board and any wing commander at any time could send their LOD or call the ARC LOD board for, for, you know, consultation or send it up to them and say, you know, "Hey, we don't think that we're reading this right, or you know, we need, we need your, we need your input." So, you're right. There probably, there was some being done at the ARC LOD Board, um, for, for all of those reasons. (Ex 212:5)

It is important to note, the waiver was withdrawn on 15 Mar 2022, the same time a previously initiated pilot program began to test LOD processing under the new system for SAF/MR to evaluate results. (Ex 213:19-20) The pilot program ended on 22 May 2023, and the DAFI was updated to remove the delegation to wing commanders the following day.

DISCUSSION AND ANALYSIS.

SAF/MR directed the approval authority for ARC LODs from AFRC headquarters and ANGRC LOD Determination Boards to wing commanders in the revised DAFI 36-2910, published 3 Sep 2021, with a goal of completing LOD determinations within 60 days. (Ex 4:20) On 4 Nov 21, NGB/A1 approved a waiver for itself to continue to utilize current LOD routing and approval authority through the ANG LOD Board in lieu of following a DAFI 36-2910 change that delegated the LOD approval authority to wing commanders. NGB/A1 coordinated the waiver through HAF/A1PPS and notified wings LOD PMs informally via email but never published the waiver to the repository in the ANGRC portal as required by policy. NGB/A1 withdrew the waiver on 15 Mar 2022.

AM1 – Informal LODs submitted between 22 Feb 2022 and 3 Mar 2022 were before NGB revoked their waiver on 15 Mar 2022 and the ARC LOD Board continued to review cases as part of their standard process. However, this inquiry found that the wing commander's three ILOD determinations for AM1 between 22 Feb 2022 and 3 Mar 2022 were, in fact, valid IAW DAFI 36-2910.

AM7 – AM7 did not distinguish the different approval authorities for informal versus formal LODs; the ARC LOD Board was the proper approval authority for their formal LOD.

AM8 – AM8's wing initiated an informal LOD on 31 Aug 2021 just before the 3 Sep 2021 version of DAFI 36-2910 was published. At the time the LOD was initiated, the

ARC LOD Board was the appropriate approval authority for informal LODs. However, AM8's ILOD determination was approved by the wing commander on 5 Mar 2022, at which time the NGB waiver to continue processing LODs at the ARC LOD Board was well in effect. However, this inquiry found that the wing commander's ILOD determination was valid IAW DAFI 36-2910 published at the time.

CONCLUSION

That members were confused about the appropriate approval authority for their LODs highlights the confusion and lack of transparency in the LOD program. The inquiry found the confusion associated with past LOD reform efforts eroded the ARC service members' trust in the system and created the appearance that their benefits and entitlements were withheld for fiscal reasons. In two cases the ARC LOD Board improperly reversed a valid ILOD determination. The inquiry team identified the following contributing factors to this specific complaint:

Contributing Factors:

- **Governing guidance is inconsistent when addressing how ARC service members access medical care related to LOD determinations, resulting in misperceptions.** Navigating the LOD process can be complicated and confusing. The significant policy changes to DAFI 36-2910 during the period of LOD reform from 2021 until the present added to that confusion.

- **The LOD program is not transparent.** Members did not understand what was happening with their LODs.

COMPLAINT 4 – The Air Force does not meet its burden of "clear and unmistakable evidence" to find conditions NILOD-EPTS-NSA, and ARC/SG does not have the expertise to render medical opinions.

At the heart of each complaint with the LOD process, whether it is an LOD or a Prior Service Condition (PSC) determination, is a disagreement between a member who believes they incurred or aggravated a condition in the line of duty and the ARC LOD Board or the ARC medical officers who determined it was not. Two themes emerged that capture the basis of most of the disagreement. The first is the assertion the Air Force's reliance on "authoritative medical literature" does not meet the standard of "clear and unmistakable evidence" required to overturn the ILOD presumption for members on orders for greater than 30 days. The second is the assertion that Air Force medical officers do not have the expertise to make determinations, particularly in specialized cases where the member has medical specialists supporting their position. To examine these issues, the case of AM2 is highlighted, who submitted LODs and took issue with the ARC LOD Board's reference to authoritative medical literature; and the case

of AM10, who submitted a PSC request and disputed the qualification of ARC/SG to render a decision in their [redacted] case.

AM2

AM2 submitted LODs for [redacted], all of which, except for [redacted], were determined to be NILOD. AM2 explained their belief the board did not meet its burden of proof:

> How can you tell me that this is absolutely, unequivocally, my [redacted] was not caused by, aggravated by military service? I just can't get there from here. Fine, for UpToDate [reference used for authoritative medical literature], everything -- I have no -- I have no basis of expertise to contend, or contest, excuse me, what UpToDate would say about [redacted] I'm sure all of that is very reasonable, but it does not -- you have to jump the Grand Canyon, in my mind, to say that it was not service aggravated. (Ex 56:55) The real clear and unmistakable evidence, it needs to be intensely personal. (Ex 56:72)

Because AM2 referenced their LOD for [redacted] in their testimony, their case was selected for further examination. While AM2 was on orders and [redacted], they were also having a series of medical appointments for other issues (Ex 56:13) and were diagnosed with [redacted] May 2023, submitting the condition for an LOD. (Ex 54:1)

The military medical provider diagnosed AM2 with [redacted] and the proximate cause of the condition was "unknown." (Ex 57:1-2) Regarding the details of the illness or history of disease, the provider stated:

> SM [service member] in further work up for [redacted] . . .. (Ex 57:1-2)

After reviewing the member's medical condition, discussing it with the military medical provider, and reviewing GI notes, AM2's commander recommended an ILOD determination based on AM2 being diagnosed with the condition while on full-time orders; member was serving in a military status when member began to experience [redacted]; and the member's PCM and care specialists concluded "patient with [redacted] (Ex 57:3)

Upon review, the ARC LOD Board recommended a finding of NILOD (not due to misconduct, existed prior to service, not service aggravated), reasoning:

SM with complicated past medical history including (b) (6), (b) (7)(C) [redacted] is not caused by, aggravated by or permanently worsened by military service. (Ex 57:3)

AM10

AM10 was diagnosed with (b) (6), (b) (7)(C) following a deployment in 2016, for which an LOD was submitted in 2017 and determined to be ILOD. (Ex 171) AM10 received treatment and was returned to duty. In 2021, AM10 was determined to be non-deployable, but due to a strong commander recommendation to retain, AM10 was returned to duty performing agreed-upon duties. (Ex 170) In late 2022, AM10 began to experience (b) (6), (b) (7)(C) [redacted] and was unable to perform their administrative duties, after which their commander recommended AM10 to not be retained. (Ex 170)

Because the condition for which the ILOD determination was made in 2017/2018 had now become unfitting and the LOD was well over a year old, AM10 requested a Prior Service Condition (PSC) determination from NGB/SG to go through the MEB process. NGB/SG found AM10's (b) (6), (b) (7)(C) [redacted] to be not service applicable because AM10 had been returned to duty and their condition had not been aggravated by military service but only became unfitting due to (b) (6), (b) (7)(C) [redacted]. (Ex 170)

NATIONAL GUARD BUREAU
3500 FETCHET AVENUE
JOINT BASE ANDREWS MD 20762-5157

[redacted] October 2023

MEMORANDUM FOR AIR FORCE PHYSICAL EVALUATION BOARD

FROM: NGB/SGP

SUBJECT: Prior Service Condition Determination – (b) (6), (b) (7)(C)

NGB/SGPS Prior Service Condition (PSC) reviews are accomplished IAW DoDI 1332.18, Disability Evaluation System (DES), Appendix 3 to Enclosure 3, Section 7.e., and consist of contracted and military Providers. NGB/SGPS has reviewed (b) (6), (b) (7)(C) PSC case for the diagnosis of (b) (6), (b) (7)(C) (b) (6), (b) (7)(C) and has found the conditions to be PSC not applicable

The Service Member (SM) presents with (b) (6), (b) (7)(C) (b) (6), (b) (7)(C) (b) (6), (b) (7)(C) SM has an In Line of Duty (ILOD) determination adjudicated by the ARC LOD Board from January 2018 for (b) (6), (b) (7)(C) [redacted] was able to manage (b) (6), (b) (7)(C) until 2021/2022. An Informal Review in Lieu Of (IRILO) was sent in 2021 and SM was Returned to Duty with an ALC-C3 due to strong recommendation by [redacted] Commander to retain, though SM was non-deployable. [redacted] was performing (b) (6), (b) (7)(C) duties as a Technician. In December 2022 SM (b) (6), (b) (7)(C) (b) (6), (b) (7)(C) (b) (6), (b) (7)(C) A subsequent review and updated Commander's Impact Statement with recommendation for SM to be non-retained due to inability to perform duties of primary AFSC was submitted for review. While [redacted] mental health conditions were determined previously to have been incurred in a duty status in 2016 [redacted] was returned to duty and that Line of duty is closed. [redacted] conditions did not become unfitting with inability to perform his duties until (b) (6), (b) (7)(C) occurred in 2022, while not on a duty status and unrelated to any previous condition or military service. Due to (b) (6), (b) (7)(C) recommend PSC not applicable for [redacted] (b) (6), (b) (7)(C)

Recommendation to refer SM to the Physical Evaluation Board for a Fitness for Duty determination.

In Dec 2023, (b) (6), (b) (7)(C) examined AM10 virtually, rendering an opinion that AM10's (b) (6), (b) (7)(C) had persisted since deployment, and they should have not been returned to service since 2021 when they were deemed non-deployable, if not earlier. (Ex 172:8-9) Additionally, AM10's (b) (6), (b) (7)(C) took issue with NGB's PSC determination and the qualifications of the doctor who provided it, since the doctor was not a (b) (6), (b) (7)(C) and had a specialty in an unrelated field. (Ex 172:8) AM10's doctor further noted:

As laid out above, [AM10's] (b) (6), (b) (7)(C) continued during this period of time (see clinical VA records). As laid out by Shalev et al. in their New England Journal of Medicine review, "*Among those in whom the disorder does develop, the severity of symptoms fluctuates over time, with periods of greater severity* (b) (6), (b) (7)(C) The ongoing (b) (6), (b) (7)(C) are both co-occurring (b) (6), (b) (7)(C) . (Ex 172:8)

STANDARDS

Clear and Unmistakable Evidence

When ARC members on orders for greater than 30 days submit LODs, those conditions are presumed to be ILOD, and to overcome that presumption, the burden of proof is on the government to prove NILOD. (Ex 2:23) In the case of Airmen who are on orders for more than 30 days, the government must show, by "clear and unmistakable evidence," the condition was NILOD.[28] (Ex 2:23)

DAFI 36-2910 defines "clear and unmistakable evidence" as:[29]

> 1.11.1.1. Clear and unmistakable evidence means undebatable information that the condition existed prior to military service or if increased in service was not aggravated by military service. In other words, reasonable minds could only conclude that the condition existed prior to military service from a review of all of the evidence in the record. It is a standard of evidentiary proof that is higher than a preponderance of the evidence and clear and convincing evidence. (Ex 2:24)

> 1.11.1.2. Where clear and unmistakable evidence is required to establish a condition is NILOD, it may be provided by accepted medical principles meeting the reasonable certainty requirement. Accepted medical principles may be discerned through reference to medical literature. Medical determinations relating to the origination and onset of a disease or condition may constitute clear and unmistakable evidence when supported by the weight of medical literature. This clear and unmistakable evidence shall be furnished to the member in conjunction with the finding to be used in any appeal efforts. (Ex 2:24)

DAFI 36-2910 defines "clear and convincing evidence:"

[27] To clarify, the word "resolve" does not appear in the NGB/SG PSC determination memorandum.
[28] If a member is on orders for 30 days or less, the standard is "preponderance of the evidence." (Ex 2:23) Unless otherwise noted, the standard referenced in this report will be "clear and unmistakable evidence."
[29] The sections cited here are unchanged since the 3 September 2021 DAFI 36-2910 and were not changed in substance from the 8 October 2015 version of AFI 36-2910.

Evidence indicating that the thing to be proved is highly probable or reasonably certain. It is a burden of proof that is higher than a preponderance of the evidence but lower than clear and unmistakable evidence. (Ex 4:81)

DAFI 36-2910 defines "preponderance of the evidence:"

The greater weight of credible evidence. That evidence that, when fairly considered, produces the stronger impression and is more convincing as to its truth when weighed against the opposing evidence. (Ex 4:84)

DAFI 36-2910 explains "accepted medical principles:"

[B]ased on fundamental deductions, consistent with medical facts that are as reasonable and logical as to create a reasonable certainty that they are correct. (T-0). (Ex 2:24)

DoDI 1332.18, *Disability Evaluation System*, provides a different standard for "accepted medical principles." DoD uses "virtual certainty" instead of DAF's standard of "reasonable certainty." DoDI 1332.18 states:

[A]ccepted medical principles: Fundamental deductions, consistent with medical facts, that are so reasonable and logical as to create a virtual certainty that they are correct. . . . (Ex 5:65)

DAFI 36-2910 provides the following information on Prior Service Condition:

Prior Service Condition

1.12. Prior Service Condition (PSC).

1.12.1. For the purpose of DES processing, a prior service condition is any medical condition incurred or aggravated during one period of active service or authorized training in any of the Military Services that recurs, is aggravated, or otherwise causes the member to be unfit, should be considered incurred in the LOD, provided the origin of such condition or its current state is not due to the service member's misconduct or willful negligence, or progressed to unfitness as the result of intervening events when the service member was not in a duty status. (See DoDI 1332.18). Note: Intervening events can be a car accident that worsened the existing condition, a civilian job that aggravates the condition, member's willful neglect or misconduct. For example, if a member had an anterior cruciate ligament repair ten years during a period of active service or authorized training, and is now unfit because of the ACL failure, then that injury is considered PSC. If there was an anterior cruciate ligament repair ten years ago and the service member is now unfit because the meniscus is beyond repair that is not considered PSC. Note: Age is not an intervening event. (Ex 2:24-25)

DISCUSSION AND ANALYSIS

Confusion over what constitutes clear and unmistakable evidence

DAFI 36-2910 provides guidance that members' conditions are presumed ILOD unless there is undebatable, "clear and unmistakable evidence" to show NILOD, if members are on orders for more than 30 days. To establish "clear and unmistakable evidence," DAFI 36-2910 allows reliance on "accepted medical principles meeting the reasonable certainty requirement." However, as excerpted above, "reasonable certainty" is the standard for "clear and convincing" evidence. Thus, the ARC may use reasonably certain accepted medical principles as their "clear and unmistakable evidence" that a condition is NILOD. In contrast, DODI 1332.18 defines "accepted medical principles" as those that "create a ***virtual certainty*** that they are correct." (emphasis added) "Virtual certainty" more aligns with "undebatable."

To further compound the confusion, DAFI 36-2910 states, "medical determinations relating to the origination and onset of a disease or condition may constitute clear and unmistakable evidence when supported by the weight of medical literature." "Weight of" the medical literature encompasses "preponderance of the evidence," which DAFI 36-2910 defines as "the greater weight of credible evidence" and "evidence that . . . produces a stronger impression and is more convincing as to its truth when weighed against the opposing evidence." Therefore, it appears DAFI 36-2910 permits reliance on the preponderance of the evidence of medical literature to establish clear and unmistakable evidence to refute an ILOD determination.

To summarize, DAFI 36-2910 mixes and matches of different standards of proof as the basis to establish the highest standard of proof, clear and unmistakable evidence, in overturning a member's ILOD determination.

AM2

It is beyond the scope of this inquiry to determine whether medical information provided by the ANG in AM2's case constitutes "weight of," "reasonably certain," and "undebatable" evidence to comprise clear and unmistakable evidence to overcome an ILOD determination.[30] Further, as identified at the beginning of this complaint, there is considerable confusion regarding what is incurred or aggravated in the line of duty. For example, AM2's immediate commander wrote in block 20 of his AF Form 348: "[AM2] was diagnosed with [(b) (6), (b) (7)(C)] while serving on full-time orders" and "[AM2] was serving in a military status at [their assigned base] when [they] began to experience the [(b) (6), (b) (7)(C)] condition." (Ex 57:2) As mentioned earlier in this

[30] The ARC cases involved in this inquiry are receiving an independent technical medical review by the SAF/MRR ARC LOD QAP as part of a SAF/IG complaint resolution process.

report, being diagnosed with and first experiencing a condition are often confused with being incurred and being service aggravated as defined in DAFI 36-2910.

> **Incurred** – To occur or come into being (develop), ***regardless of when discovered, diagnosed***, and during a qualified duty status. (Ex 2:92) (emphasis added)
>
> **[Aggravation]** – A condition is aggravated in a qualified duty status when there is a worsening of the condition over and above natural progression***, caused by trauma or the nature of military service***. Natural progression is the course an illness, injury or disease would take over time, regardless of military service. (Ex 2:22) (emphasis added)
>
> **Exacerbation** – A temporary flare or escalation of symptoms/pain that does not result from or result in a permanent change in condition. Often flares are expected in some medical conditions otherwise stated as an acute episode of a chronic condition. (Ex 2:91)

ARC and ANG representatives state the ARC LOD Board has more experience dealing with complicated concepts specific to LODs than medical providers at the wings. One NGB doctor in the LOD review process explained:

> Um, having been involved intimately with the LOD reform at least since July of '21 and been the one who performed a lot of the audit work on the cases that were coming in during that timeframe, I can tell you that despite our best efforts . . . there is a vast array of, of expertise at the local level. Um, and, you know, A1 hosts training for LODs to, you know, wing commanders and LOD Program Managers. And they try to explain ***complicated, um, concepts like EPTS, Existed Prior To Service, Service Aggravation***.
>
> Um, but unless you are doing these cases regularly, those are difficult concepts to understand. And so, um, there's also a vast difference in, um, at, at the local level, the providers doing the cases, and their level of knowledge and experience. Um, and so that, that does happen. Um, and it's a big reason that SAF chose . . . the wing commanders would no longer be the approval authority, because there were all of these second and third order, um, effects from improperly adjudicated LODs by wing commanders. (Ex 214:16-17) (emphasis added)

As already noted, SAF/MR recounted the same experience:

> . . . we delegated the authority down to the wing commander to adjudicate the LODs thinking it would make it more efficient and timely. So, that was the big push in 2019, 2019 to 2021 . . . the authority went from the ARC LOD board to the wing commanders who could adjudicate these LODs thinking that would be quicker. Um, and so it was quicker. Uh, but what we found in '21, '22 is that it might've been quicker, but not accurate. Um, so we sacrificed . . . a lot of accuracy for time. (Ex 200:6-7)

AM10

AM10's (b) (6), (b) (7)(C) took issue with the qualifications of the author of NGB/SG's Prior Service Condition determination memorandum. Although no guidance or standard sets forth minimum qualifications for medical professionals on these boards, this inquiry will examine further the issue of non-specialists making determinations in complex cases. While doctors on the boards may not have expertise in each specialty they encounter, they said they will often reach out to experts and colleagues to discuss cases as needed. According to the Clinical Case Management Branch Chief, NGB/SGPS, at ANGRC:

> …[W]e often will utilize, um, subject matter experts as well, and we resort to the literature and accepted medical principles. So, you know, for example, if [a doctor at NGB] gets an appeal, and it's, you know, a neurologic case that is, um, the subject of the Line of Duty, [NGB doctor] will often reach to, um, a colleague if [the doctor] needs to discuss the case. Um, so [the NGB doctor has] got a list of consultants. Um, and I don't know if they're all officially -- like, the aeromedical, um, you know, like the Air Force consultant subject matter experts, . . . [the NGB doctor] does frequently consult with, um, you know, with the disease, whatever the disease process is that, that, you know, someone who's a subject matter expert. (Ex 214:18)

Secondly, similar to the officials at the wing level, other medical providers may not be familiar with concepts key to making LOD determinations. NGB/SGPS provided an example of this issue:

> [C]ivilian providers don't understand LOD processes . . . and they're not necessarily trained in occupational medicine . . . they may not -- and often I think don't based upon memos that I see, understand EPTS and service aggravation, and what that actually means. (Ex 214:18)

CONCLUSION

Without drawing conclusions regarding the cases of AM2 or AM10, both cases highlight the difficulty of determining whether conditions are ILOD, given the requirement to determine whether the condition was incurred, aggravated, or exacerbated by military service. Chronic conditions that first exhibit themselves when the members are on orders are especially difficult to assess. DAFI 36-2910 provides guidance that members' conditions are presumed in the line of duty unless there is undebatable, "clear and unmistakable evidence" the condition was NILOD. However, DAFI 36-2910 provides unclear definitions that appear to merge standards of proof. Additionally, members are frustrated when their wing commander determines their condition is ILOD, only to be overturned by ARC LOD Boards with unclear explanations. They are further frustrated when they believe they have not been provided the "clear and unmistakable evidence" of why their conditions are determined NILOD. This complaint is examined next.

Contributing Factors:

- **The standard of "clear and unmistakable" evidence is not clearly defined.** When a member is on orders for more than 30 days, the standard of evidence outlined in DAFI 36-2910 to overcome the presumption of In the Line of Duty is "clear and unmistakable evidence," which is "undebatable" information upon which "reasonable minds could only conclude" the condition was Not In the Line of Duty. However, that standard of "clear and unmistakable" evidence can be established "by accepted medical principles meeting the reasonable certainty requirement." Accepted medical principles may also be discerned through "the weight" of the medical literature and a lower standard of proof. (Ex 2:24) The differences in standards and how to apply them are confusing to members. Additionally, the average service member and even medical personnel may not be familiar with terms such as "existed prior to service" and others that are key to understanding why conditions are deemed NILOD.

COMPLAINT 5 – The Air Force does not provide "clear and unmistakable evidence" to members when it determines conditions are NILOD-EPTS-NSA.

As noted, each member interviewed believed their LOD or PSC determination was incurred or aggravated ILOD, while the adjudicating authority determined it was not. Of the four cases reviewed in which NILOD determinations for LODs formed the basis of complaints, all four testified they were not provided with clear and unmistakable evidence their conditions were NILOD. Testimony from all four members, AM1, AM3, AM7, and AM8, is included below, and the cases of AM1 and AM8 are examined further.

AM1

AM1 submitted LODs from 2020 through 2022 for (b) (6), (b) (7)(C) AM1 explained they were provided their finalized LODs (via AF Forms 348) through their wing's FSS without any further explanation from their medical unit (Ex 24:23). The member did not believe their determinations provided clear and unmistakable evidence. AM1 stated some of the forms listed as evidence "based on authoritative medical literature," or had statements such as "service member clearly has a history" and "the onset and progression of this is insidious and unknown." AM1 explained vague terms were used in their determinations, stating, "You can literally take out the (b) (6), (b) (7)(C) . You can plug in any, any disease you wanted to in there, and the narrative that they sent me would have made sense." (Ex 24:22) AM1 said when the FSS sent the LODs back, "I sent an email, and I said, . . . is there an evidence packet or an additional packet other than just these 348s . . . I was like, you know, 'They, they owe me the evidence, especially if they're going to classify these as existed prior to service, not service-aggravated, there's a specific evidentiary standard that they must satisfy and they have to give

me that evidence.' So, I was like, 'Did they -- is there any other additional documentation?' And, and I was basically told no." (Ex 24:22)

Below is the AF Form 348 from AM1's LOD for (b) (6), (b) (7)(C). The first image is what AM1's command submitted, which determined it was ILOD.[31] (Ex 36:2)

The below image is what the LOD Determination Board provided to AM1, showing the board found the condition NILOD: (Ex 36:3)

[31] In addition to redactions to protect members' identities, legal reviews have been redacted from the AF Form 348 when presented as they are considered attorney-client products.

20220303-003

Print Form Pages 1-3 | **LINE OF DUTY DETERMINATION** | Print Instructions

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 8013, Secretary of the Air Force and Executive Order 9397 (SSN), as amended.
PURPOSE: To provide medical condition information and the circumstances surrounding the medical condition for a military duty status determination. The determination may be used in assignment, evaluation, compensation, separation and retirement processes.
ROUTINE USES: The determination is kept permanently as part of your master personnel record. Disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act. In addition, pursuant to 5 U.S.C. 552a(b)(3), this record may be disclosed outside of DoD to the Department of Veteran Affairs and to dependents and survivors for benefit eligibility determinations.
DISCLOSURE: Mandatory. Positive identification is required for accountability and compensatory benefits.
SORN: F036 AF PC C, Military Personnel Records System.

PART I. MEMBER INFORMATION

1. TO: *(Immediate Commander)*	2. FROM: *(Military Medical Provider Office Symbol)*	3. REPORT DATE:
(b) (6), (b) (7)(C)	(b) (6), (b) (7)(C) a. ☐ MTF ☐ RMU ☒ GMU ☐ Deployed Location	03Mar2022

4. NAME: *(Last, First, Middle Initial)*	5. SSN:	6. RANK:	7. ORGANIZATION/UNIT:
(b) (6), (b) (7)(C)	(b) (6), (b) (7)(C)	(b) (6), (b) (7)	(b) (6), (b) (7)(C)

8. MEMBER'S STATUS: *(X as applicable)*
☐ a. RegAF ☐ b. AFR ☒ c. ANG ☐ d. USAFA Cadet ☐ e. AFROTC Cadet

f. DURATION OF ORDERS OR IDT DATE AND TIME: START *(DATE/TIME)* (b) (6), (b) (7)(C) / 0000 END *(DATE/TIME)* (b) (6), (b) (7)(C) / 0000

PART II. MILITARY MEDICAL PROVIDER

9. INVESTIGATION OF *(X one only)* ☐ DEATH ☐ INJURY ☐ ILLNESS ☒ DISEASE

10. NAME/LOCATION OF ☒ a. MILITARY ☐ b. CIVILIAN HOSPITAL OR TREATMENT FACILITY THAT FIRST PROVIDED TREATMENT
(b) (6), (b) (7)(C)
c. TREATMENT PROVIDED ON: DATE 28Aug2020 TIME 0000

11. DESCRIPTION OF SYMPTOMS AND DIAGNOSIS
Disease EPTS No I10 - Essential (primary) (b) (6), (b) (7)(C)

12. DETAILS OF DEATH, INJURY, ILLNESS OR HISTORY OF DISEASE:
While member was being examined for (b) (6), (b) (7)(C) . During a follow up visit, it was determined that this was not an isolated incident. He was diagnosed with (b) (6), (b) (7)(C)

(b) (6), (b) (7)(C)

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20220303-003

Print Form Pages 1-3 | Print Instructions

15. MILITARY MEDICAL PROVIDER

a. DATE: 03Mar2022 | b. NAME AND RANK: (b) (6), (b) (7)(C) | c. SIGNATURE: (b) (6), (b) (7)(C)

PART III. IMMEDIATE COMMANDER

16. TO: *(Appointing Authority)* (b) (6), (b) (7)(C)

17. FROM: *(Immediate Commander)* (b) (6), (b) (7)(C)

18. SOURCES OF INFORMATION:

☐ a. MEMBER ☐ b. CIVILIAN POLICE ☐ c. MILITARY POLICE ☐ d. OSI ☐ e. WITNESS ☒ f. OTHER *(Specify)* (b) (6), (b) (7)(C)

g. NAME(S), ADDRESS(ES), AND PHONE NUMBER(S) OF WITNESS(ES):
No witnesses presented

19. AT THE TIME OF THIS OCCURRENCE, THE MEMBER WAS:

☒ a. PRESENT FOR DUTY
☐ b. ABSENT WITH AUTHORITY
☐ c. ABSENT WITHOUT AUTHORITY FROM *(Date/Time)* / TO *(Date/Time)* /

~~ARC ONLY. IN ADDITION TO THE ABOVE, X MARK IF APPLICABLE~~

☐ d. MEMBER WAS TRAVELING TO OR FROM INACTIVE DUTY TRAINING OR BETWEEN SUCCESSIVE PERIODS OF IDT.
☐ e. MEMBER WAS TRAVELING TO OR FROM DUTY OR TRAINING, AND HAD MATERIALLY DEVIATED FROM AUTHORIZED TRAVEL ROUTE.

~~20. AS A RESULT OF MY INVESTIGATION, I HAVE DETERMINED THE CIRCUMSTANCES TO BE AS FOLLOWS: *(When, Who, Where, How, Why)*~~

While member was being examined for (b) (6), (b) (7)(C) it was discovered by his PCM that he had (b) (6), (b) (7)(C) . During a follow up visit, it was determined that this was not an isolated incident. He was diagnosed with (b) (6), (b) (7)(C)

21. THE PROXIMATE CAUSE OF THE MEMBER'S DEATH, INJURY, ILLNESS, OR DISEASE WAS:

☐ a. MISCONDUCT *(See AFI 36-2910, Attachment 1)*
☒ b. OTHER *(Specify)* Undetermined

22. LINE OF DUTY DETERMINATION RECOMMENDATION. AS A RESULT OF MY INVESTIGATION, I RECOMMEND:

☒ a. ILOD
☐ b. NILOD-NOT DUE TO MEMBER'S MISCONDUCT (only if EPTS-NSA with no indication of misconduct)
☐ c. FORMAL LOD DETERMINATION

23. IMMEDIATE COMMANDER

a. DATE: 03Mar2022 | a. NAME AND RANK: (b) (6), (b) (7)(C) | c. SIGNATURE: (b) (6), (b) (7)(C)

PART IV. WING STAFF JUDGE ADVOCATE

24. LEGAL REVIEW ☒ CONCUR ☐ NON-CONCUR

25. WING STAFF JUDGE ADVOCATE

a. DATE: 03Mar2022 | b. NAME AND RANK: (b) (6), (b) (7)(C) | c. SIGNATURE: (b) (6), (b) (7)(C)

PART V. APPOINTING AUTHORITY

26. AFTER REVIEWING THE FILE AS THE APPOINTING AUTHORITY, I FIND THE LOD DETERMINATION TO BE:

☒ a. ILOD
☐ b. NILOD-NOT DUE TO MEMBER'S MISCONDUCT (only if EPTS-NSA with no indication of misconduct)
☐ c. I HAVE APPOINTED AN INVESTIGATING OFFICER TO CONDUCT A FORMAL LOD INVESTIGATION

AF FORM 348, 20150914

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27. APPOINTING AUTHORITY

a. DATE	b. NAME AND RANK	c. SIGNATURE
03Mar2022	(b) (6), (b) (7)(C)	(b) (6), (b) (7)(C)

PART VI. ARC LOD DETERMINATION BOARD REVIEW

28. MEDICAL REVIEW/RECOMMENDATION

Based on current authoritative medical literature combined with review of the provided medical records, the following conclusion assessing the pertinent injury/disease, pre-existing conditions and contributory factors for their pathophysiology and prognosis, as related to causation, the

29. MEDICAL REVIEW REPRESENTATIVE

a. DATE	b. NAME AND RANK	c. SIGNATURE
02May2022	(b) (6), (b) (7)(C)	(b) (6), (b) (7)(C)

30. LEGAL REVIEW/RECOMMENDATION

(b) (6), (b) (7)(C)

31. LEGAL REVIEW REPRESENTATIVE

a. DATE	b. NAME AND RANK	c. SIGNATURE
25May2022	(b) (6), (b) (7)(C)	(b) (6), (b) (7)(C)

32. ARC LOD BOARD ACTION/RECOMMENDATION

- [ ] a. ILOD
- [x] b. NILOD-NOT DUE TO MEMBER'S MISCONDUCT (only if EPTS-NSA with no indication of misconduct)
- [ ] c. FORMAL LOD DETERMINATION
- [ ] d. REFER MEMBER TO DES FOR PROCESSING (10 U.S.C. § 1207a)

33. LOD BOARD ADMINISTRATOR

a. DATE	b. NAME AND RANK	c. SIGNATURE
03Jun2022	(b) (6), (b) (7)(C)	(b) (6), (b) (7)(C)

PART VII. APPROVING AUTHORITY (ARC ONLY)

34. APPROVING AUTHORITY FINAL LOD DETERMINATION:

- [ ] a. ILOD
- [x] b. NILOD-NOT DUE TO MEMBER'S MISCONDUCT (only if EPTS-NSA with no indication of misconduct)
- [ ] c. APPOINT AN INVESTIGATING OFFICER TO CONDUCT A FORMAL LOD INVESTIGATION
- [ ] d. REFER MEMBER TO DES FOR PROCESSING (10 U.S.C. § 1207a)

35. APPROVING AUTHORITY

a. DATE	b. NAME AND RANK	c. SIGNATURE
02Jun2022	(b) (6), (b) (7)(C)	(b) (6), (b) (7)(C)

PART VIII. REMARKS

Medical Review/Recommendation (cont'd): following determination was found in this case: Non Concur with Appointing Authority. Recommended new finding: Not ILOD-Not Due to Own Misconduct Recommend finding NILOD, not due to misconduct, EPTS-yes, NSA for (b) (6), (b) (7)(C) The pathogenesis (b) (6), (b) (7)(C) is poorly understood, but has an insidious onset, developing long before symptoms present and is most likely the result of numerous genetic and environmental factors combined. In fact, (b) (6), (b) (7)(C) because of the lack of symptoms prior to diagnosis. Although clinical diagnosis was made during this period of service, the condition itself clearly pre-existed this period of service and was not incurred as a result of or permanently worsened by military service.
Legal Review/Recommendation (cont'd): documentation indicates the member was diagnosed with (b) (6), (b) (7)(C). The SG explains on the AF Form 348 that the condition is NILOD:EPTS(NSA).

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AM7

AM7 (b) (6), (b) (7)(C) while performing the PT test in IDT status [redacted] Feb 2023 and submitted an LOD. (Ex 116:38) AM7 described receiving the report from their supervisor, who is not the unit commander, saying:

> . . . we had a wing staff meeting, and then right after the wing staff meeting, my supervisor, Lieutenant Colonel [REDACTED], handed me the MFR that . . . said it was not in the line of duty . . . I also want to emphasize, I only received this MFR. It's, if you see at the bottom, it says attachment, copy of case file. That was never, that was not handed to me, on October 14th, I had to ask for that. . . . I did not get a copy of my case file, like it says in the attachment . . . . (Ex 116:39-40)

AM7 received the below memo. Notably, the memo contains no explanation of why AM7's condition of was NILOD – simply that it was: (Ex 111)

DEPARTMENT OF THE AIR FORCE
AIR FORCE RESERVE COMMAND

14 October 2023

MEMORANDUM FOR (b) (6), (b) (7)(C)
IN TURN

FROM: (b) (6), (b) (7)(C)

SUBJECT: Notification of Determination of Not in Line of Duty under AFI 36-2910, Case# (b) (6), (b) (7)(C)

1. This letter serves to notify you that the (b) (6), (b) (7)(C) AFRC/A1 Approving Authority under AFI 36-2910, has determined that your (b) (6), (b) (7)(C) occurred Not in Line of Duty. This determination was reached after review of an Informal investigation of the circumstances of your injury or disease. This determination can be reconsidered only if you notify Col (b) (6), (b) (7)(C) in writing, of new and significant evidence that indicates the likelihood of error in the determination. Such a request for reconsideration must be made within 45 days of receipt of this notification.

2. Alternatively, you may appeal this determination to (b) (6), (b) (7)(C) Appellate Authority, in writing within 30 days of receipt of this notification. Any request for reconsideration or appeal must be sent to (b) (6), (b) (7)(C) (b) (6), (b) (7)(C)

Digitally signed by (b) (6), (b) (7)(C)
Date: 29 Sep 2023

Commander

Member's Acknowledgement

I acknowledge the outcome of Not in Line of Duty on September 14, 2023 and intend to:

_____ Submit new and significant evidence to the appointing authority within 45 days of receipt of this notification. (Formal LOD only)

_____ Submit an appeal to the AFRC/CD, Appellate Authority, within 30 days of receipt of this notification.

I understand any request for reconsideration or appeal must be sent to the Line of Duty Program Manager.

(b) (6), (b) (7)(C)

Attachments:

Copy of Case File

AM7's LOD PM testified there is confusion regarding the reference to the case file in the memo and what constitutes a case file:

> So the ECT case file should be the, the [AF Form] 348, um, and the pertinent documentation within, um, that case, but that would have to be manually, like pulled out and compiled, um, and provided to the member. That wasn't super clear, I think, in the previous AFI, but it did make it clear in this version of the AFI that it's the LOD Program Manager's role to provide that case file to the patient, um, but that's after the memo is given. So to me, that's kind of incongruent. I think it should be more clear when, when that case file, and, and is it only upon request or do we automatically do this? That hasn't been made clear to the LOD PMs either. (Ex 226:82-83)

When asked to clarify what pertinent documentation would be provided to members and if that would be anything from AFRC that would potentially explain the reason for the NILOD decision, AM7's LOD PM listed the member's "clinical documentation, orders, member's statement, LOD briefing, and release of information form – essentially, everything the member provided to adjudicate the LOD determination." (Ex 226:83-84) Asked whether the members receive anything from AFRC, AM7's LOD PM responded, "No." (Ex 226:83-84)

AM7's commander found AM7's condition to be ILOD because AM7's [redacted] were service aggravated by doing the [redacted] test during Annual PT Test." (Ex 110:2-3) The proximate cause was listed as performance of PT test. Upon review, AFRC did not concur with the ILOD determination, providing AM7's with the following explanation on the AF Form 348:

> Based on current ***authoritative medical literature*** combined with review of the provided medical records, the following conclusion assessing the pertinent injury/disease, pre-existing conditions and contributory factors for their pathophysiology and prognosis, as related to causation, the following determination was found in this case: Non-Concur with Appointing Authority. Recommend new finding: Not ILOD-Not Due to Own Misconduct. (Ex 110:2-3) (emphasis added)

PART VI. ARC LOD DETERMINATION BOARD REVIEW

28. MEDICAL REVIEW/RECOMMENDATION

Based on current authoritative medical literature combined with review of the provided medical records, the following conclusion assessing the pertinent injury/disease, pre-existing conditions and contributory factors for their pathophysiology and prognosis, as related to causation, the

29. MEDICAL REVIEW REPRESENTATIVE

a. DATE	b. NAME AND RANK	c. SIGNATURE
26Sep2023	(b) (6), (b) (7)(C) USAF	(b) (6), (b) (7)(C)

30. LEGAL REVIEW/RECOMMENDATION

(b) (6), (b) (7)(C)

31. LEGAL REVIEW REPRESENTATIVE

a. DATE	b. NAME AND RANK	c. SIGNATURE
28Sep2023	(b) (6), (b) (7)(C) USAF	(b) (6), (b) (7)(C)

32. ARC LOD BOARD ACTION/RECOMMENDATION

- [X] a. ILOD
- [ ] b. NILOD-NOT DUE TO MEMBER'S MISCONDUCT (only if EPTS-NSA with no indication of misconduct)
- [ ] c. FORMAL LOD DETERMINATION
- [ ] d. REFER MEMBER TO DES FOR PROCESSING (10 U.S.C. § 1207a)

33. LOD BOARD ADMINISTRATOR

a. DATE	b. NAME AND RANK	c. SIGNATURE
26Sep2023	(b) (6), (b) (7)(C)	(b) (6), (b) (7)(C)

PART VII. APPROVING AUTHORITY (ARC ONLY)

34. APPROVING AUTHORITY FINAL LOD DETERMINATION:

- [ ] a. ILOD
- [X] b. NILOD-NOT DUE TO MEMBER'S MISCONDUCT (only if EPTS-NSA with no indication of misconduct)
- [ ] c. APPOINT AN INVESTIGATING OFFICER TO CONDUCT A FORMAL LOD INVESTIGATION
- [ ] d. REFER MEMBER TO DES FOR PROCESSING (10 U.S.C. § 1207a)

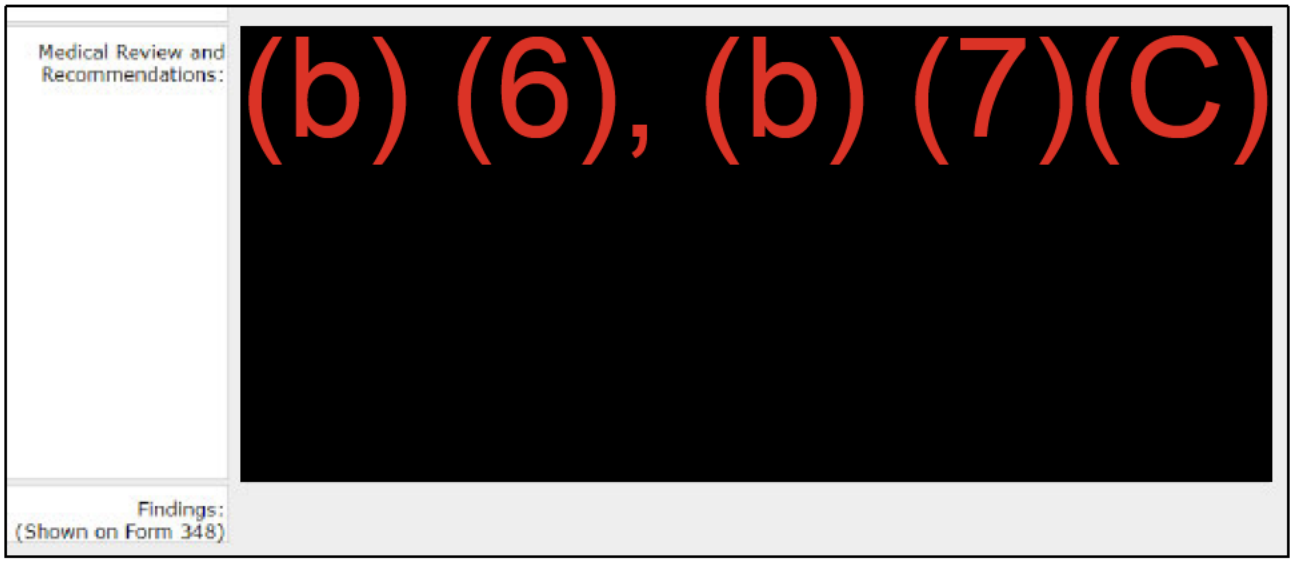
35. APPROVING AUTHORITY

a. DATE	b. NAME AND RANK	c. SIGNATURE
29Sep2023	(b) (6), (b) (7)(C)	(b) (6), (b) (7)(C)

PART VIII. REMARKS

Medical Review/Recommendation (cont'd): following determination was found in this case: Non Concur with Appointing Authority. Recommended new finding: Not ILOD-Not Due to Own Misconduct

Within ECT, internal AFRC notes show a discussion of AM7's medical history and discussion about the case, but it is not clear how or if these were intended to be communicated to the member or their unit. This again shows a difference in how ECT is used, as ANG uses the text blocks in ECT to generate the AF Form 348, but AFRC includes very little information in the blocks and keeps the discussion and comments internal by keeping them in other blocks. (Ex 117:9) The below image shows AM7's medical review notes as viewable in ECT:



AM7's LOD PM testified, those comments are not viewable at the wing level. (Ex 226:32)

> [I]f, if I could change it, um, right now, as it stands, the medical, uh, response from AFRC medical does not show up on the, um, 348 when it prints. Um, and unless you work at AFRC and you can read the internal comments, which I don't...
>
> Unless you can read the internal comments, you, me, nobody is gonna know why this was Not in the Line of Duty medically, because they put some, um, legal jargon at the beginning that basically says like, "According to most recent research, blah, blah, blah, blah, blah," and it takes up the entire block of what is able to print, so nobody actually gets that explanation.
>
> Um, when I have a case that I, I believe, "No. This, this is – this is in the Line of Duty, you know, and we do need to appeal this." I, I have to call up. I have to phone a friend in AFRC and say, "Hey, can you read me the internal comments so I can see why they're feeling this way?" Um, so that is, I think, a really broken process. . . . (Ex 226:32)

Additional Testimony

AM8 testified to a similar experience regarding their NILOD notification.

> I was never provided any clear and unmistakable evidence, uh, regarding this, uh, this LOD NILOD finding . . . nor did I have a case file, so I had no idea what they used as, as, you know, for their findings on this.

….

There [was] absolutely no case file that was, uh, attached to that email. (Ex 133:17,33)

AM3 testified what happened when they contacted ANG to ask for further information regarding their NILOD determination:

> IO: So did [they] give you any explanation whatsoever as far as the accepted medical principles used to deny you your line of duty?
>
> W: Absolutely not. Nothing. And the fact that I even asked the question appeared to irritate [them] more. It's just like, this is the law of the land. Like we say, accepted medical principles and you eat it. And that's all there is about it. Like, we do not have to give you anything. And our evidence that we're going to show you is a letter saying we reviewed it. That's their evidence.
>
> It -- not the evidence they used and they looked at to derive it, to show you like, "oh, hey, there was this medical case and this medical case, this is what we're using." It's "no. Hey, you just need to trust that we did the work. Good luck." And how you can't, you can't combat that. Like it's a, doing the Air Force, the BCMR, like how do you combat when they're just like, we did the research. Well, how do I combat the research you did if you don't tell me what you did? (Ex 70:15-16)

STANDARDS

DAFI 36-2910, paragraph 1.11.1.2, states when an ARC member has been on orders for more than 30 days and submits an LOD for a condition that is determined to be NILOD, that "clear and unmistakable evidence shall be furnished to the member in conjunction with the finding to be used in any appeal efforts." (Ex 2:24)

DAFI 36-2910, Attachment 5, illustrates a sample NILOD notification template. (Ex 2:97)

Attachment 5

SAMPLE FORMAT OF MEMBER NOTIFICATION OF NOT IN LINE OF DUTY DETERMINATION (NILOD)

Figure A5.1. Sample Format of Member Notification of NILOD Determination.

Date

MEMORANDUM FOR: (Member's Name)

FROM: (Immediate Commander)

SUBJECT: Notification of Determination of Not in Line of Duty (NILOD) under AFI 36-2910

This letter serves to notify you that (Name of Approving Authority), approving authority under AFI 36- 2910, has determined that your (describe illness, injury or disease at issue) occurred NILOD. This determination was reached after review of a formal investigation of the circumstances of your injury or disease. This determination can be reconsidered only if you notify (Name of Appointing Authority), in writing, of new and significant evidence that indicates a likelihood of error in the determination. Such a request for reconsideration must be made within 45 days of receipt of this notification.

Alternatively, you may appeal this determination to (name of appellate authority), appellate authority, in writing, within 30 days of receipt of this notification. Any request for reconsideration or appeal must be sent to (address of FSS/MPS).

(Commander's Signature Block)

Attachment:
Copy of Case File

Per DAFI 36-2910:

2.23. Immediate Commander.
2.23.4. Briefs members of their LOD determination outcome for ARC Informal LOD cases.

2.26. LOD Program Manager (PM).

2.26.10. Distributes LOD packages to members on behalf of the immediate commander after an LOD determination has been made. (Ex 2:30-31)

DISCUSSION AND ANALYSIS

DAFI 36-2910 specifies the immediate commander is responsible for briefing members on LOD determinations, which requires some medical explanation, and the LOD PM distributes LOD packages. However, there is no guidance directing the ANG or AFRC on what specifically needs to be provided to a member when notifying them of a NILOD determination, what needs to be briefed, or what constitutes an "LOD package." DAFI 36-2910, Attachment 5, above, is presented as the template to provide to service members who receive NILOD determinations. The template lacks direction to provide any reason or evidence as to why a NILOD determination was made, and the inquiry team found it insufficient to qualify as providing "clear and unmistakable evidence."

Although not all subject matter experts interviewed thought the AF Form 348 or the process to provide that information was insufficient, several thought there were weaknesses in the form and the process. For example, the AF Form 348 limits the number of characters in each block, which results in members receiving incomplete information – such as sentences cut mid-way. Both ANG and AFRC rely on wings to provide the required explanations needed to help members understand the reasons for NILOD-EPTS-NSA decisions. One NGB doctor involved with the LOD process explained, "right or wrong, we relied on the local GMU or RMU physician and the local, um, LOD program manager to sit down and say, okay, this is not in line of duty because it existed prior to service. There was no service aggravation." [32] (Ex 201:31)

Of the 24 LOD PMs interviewed during the course of this inquiry, none experienced or observed service members receiving what they viewed as adequate evidence or explanations from ARC LOD Determination Boards regarding their NILOD determinations. While some wing LOD PMs interviewed for this inquiry had notification processes that included the local medical unit, many did not and were not aware what the immediate commander provides or discusses with members during the notifications. According to one Lt Col appointed to the LOD PM position in an ARC wing, the unit commanders have "no clue" about their member's medical conditions and basically just read the information provided on the AF Form 348 with no further explanation to the member. (Ex 40:3) Witnesses explained sometimes that notification is nothing more than an email. For those wings with a notification process that includes the local medical unit, some believed they were provided enough information in ECT and the AF Form 348 to help explain the reason for NILOD determinations to the members.

[32] Again, the LOD PM may not be in the RMU or GMU but may be in the Force Support Squadron. (Ex 2:38)

As noted earlier in the testimony from AM7's LOD PM in AFRC, some involved in the process don't believe they get enough information and have to call to find out the rationale for NILOD decisions.

As one doctor at NGB involved in the process explained, they rely on the wings to provide further context because the AF Form 348 does not provide enough space for the information to be helpful.

> [O]n the Form 348, there's just a little tiny box for medical to put. And usually our explanations are this long, but there's just a little blurb…It was like a little standard generic explanation, which I know the members didn't understand it. (Ex 201:31)

Contributing to the sense members have that they are not being provided with clear and unmistakable evidence is, again, confusion over key, non-medical terms. For example, AM8 testified they believed "existed prior to service" meant before they joined the military rather than prior to the set of orders when they were injured. This basic misunderstanding would likely make any explanation seem insufficient:

> And then, uh, also it said there was a case file which no case file existed. So, I had no idea what information they were using to arrive at a NILOD, uh, EPTS. Uh, NILOD, not due to misconduct, EPTS, yes. NSA for (b) (6), (b) (7)(C) unspecified. Uh, EPTS, no existed prior to service. There, there was no existed prior to service. Um, ***prior to service, meaning prior to the day that I enlisted*** (b) (6), (b) (7)(C) , there was nothing, absolutely nothing to show that I have these conditions. (Ex 133:35) (emphasis added)

One AFRC member involved in the LOD process explained:

> . . . where we find the most challenge is members don't understand their not in the line of duty determination. And I think when you talk about the education piece, um, that probably is the one that stands out the most, which is educate the Airmen on their, their LOD determination so that they understand from why the LOD Board is doing what they're doing. And right now, that doesn't exist very well. We're trying. (Ex 204:40)

AM3 explained their frustration with not receiving evidence which could have been used in an appeal.

> [H]ey, can you provide me with the medical stuff that you reviewed? I would like it because I'm going to appeal this. . . . I'm going to appeal this because I don't agree. But I need the information that you used so I can do a proper rebuttal.
>
> Like, I, I'm not asking for the moon. I'm just saying, hey, as you guys are doing your little ARC Review Board and you're saying, hey, look at this medical thing that I found. This is why we're going to deny this guy, save that, send it to me with my letter saying, hey, "We

love you. We care about you. Thank you for your service. But we, we think this is NILOD and here's the information that I used to get to that point." If they would've done that to me, that would've been a game changer. (Ex 70:49)

CONCLUSION

When a member receives a NILOD determination for their condition, DAFI 36-2910 states, "clear and unmistakable evidence shall be furnished to the member in conjunction with the finding to be used in any appeal efforts." This inquiry found AFRC and ANG provided inconsistent explanations, from simply "based on current authoritative literature" to none at all, as illustrated above. Coupled with a non-descript "case file" attachment listed on the notification letter and lack of any medical explanation to constitute "clear and unmistakable evidence," this is undoubtedly a significant source of frustration for members that remain unanswered by policy or process. SAF/MRR noted this point will be addressed in an upcoming policy rewrite. (Ex 212:1-4) The inquiry team recommends the new policy provide clarity and direction to AFRC and ANG on what constitutes a case file and what is minimally necessary as "clear and unmistakable evidence."[33] Additionally, relying on the wings to provide medical explanations is problematic. The inquiry team recommends SAF/MR establish a central patient support cell that answers calls from members who have received NILOD determinations to eliminate confusion and address members' questions.

Contributing Factors

- **ARC service members are not provided sufficient feedback or evidence explaining why their medical conditions were found NILOD.** Service members are provided medical terms such as "authoritative medical literature" as explanations and in support of their NILOD determinations. Significantly, there is no direction on what specifically to provide members regarding their NILOD determinations. While the unit commander is responsible for briefing members on their LOD determinations, there is no direction on what to brief or information to provide. ANG and AFRC representatives both described LODs as a commander's program. However, the representatives did not know what was being communicated to members or how, and they assumed members were being provided adequate information.

- **Those responsible for the program are not trained on how to administer the program and communicate with the member.** AFRC/A1 and ANG/A1 typically do not communicate directly with service members and rely on the wings to convey information to the members and to request further information if required. However,

[33] On 17 Oct 24, The Inspector General issued a Collateral Issue Memorandum to SAF/MR requesting they "issue updated language in a guidance memo to DAFI 36-2910 that clearly addresses the evidence required to support a NILOD determination." (Ex 232)

AFRC/A1 and ANG/A1 do not direct how that communication happens; some wings communicate well and have deliberate discussions involving SMEs when LODs are returned NILOD, while others do not.

- **The LOD program is not transparent.** Members do not have access to ECT to review their case file or any notes. Instead they must rely on wings LOD PMs to relay information. Even so, those with ECT access are not able to retrieve all pertinent medical information to understand the rationale behind NILOD decisions.

- **Governing guidance is inconsistent when addressing how ARC service members access medical care related to LOD determinations, resulting in misperceptions.** ECT generates memos to notify members of their LOD determinations, referencing an attached "case file." However, no case file ever accompanies the memo. No guidance explains what might comprise a case file for informal LODs. When members receive this memo, they are understandably confused and led to believe they were not provided something to which they were entitled. Some members at the wings have taken the reference to a case file to mean the attachments within ECT. However, that would only provide the member with the documentation they submitted as part of their package, not any further reference, which would explain the NILOD determination. Further, there is no explanation or guidance as to what type of "clear and unmistakable evidence" is to be provided to the member in NILOD determinations.

- **ARC wing, NGB, AFRC, and DAF are lacking LOD program oversight.** Wings choose how they manage and oversee their LOD programs, with some units reporting regular updates to the commanders and others with less engagement. However, there was a lack of formalized ARC LOD program oversight at any higher level.

COMPLAINT 6 – Requirements to receive and maintain MEDCON Orders are arbitrary and unreasonable.

Of the eight complainants who were on MEDCON, all except one were dissatisfied with the process. Members allege the requirements the Air Force has put into place to be eligible for MEDCON are unreasonable and make receiving the entitlement unnecessarily difficult. AM1, AM5, AM8, AM9, and AM11 provided insight into their experiences. Members allege the requirements the Air Force has put into place to be eligible for MEDCON are not found in higher-level guidance, and these requirements impede members' ability to receive care as directed by federal law and DoD guidance. At issue is the DAF's discretionary ability to end MEDCON orders if the member's treatment plan requires less than two health care appointments per week. AM8 described their thoughts about the requirement for two appointments per week:

> . . . I talked to my (b) (6), (b) (7)(C) about this, and I was frantic. I was frantic. I was trying to get appointments at the VA. I was trying to get appointments at (b) (6), (b) (7)(C) and [they're] like, '[AM8], if, if you have a broken leg, you're not going to go in to the doctor twice a week. How can ARC CMD expect you to have two appointments per week to stay on MEDCON orders?' This doesn't make sense. In the (b) (6), (b) (7)(C) in 48 hours or 96 hours . . . . (Ex 133:49)

AM8 stated their (b) (6), (b) (7)(C) recommended two appointments a month "so that (b) (6), (b) (7)(C)." (Ex 133:49)

AM5 described their experience with MEDCON was straightforward initially, then becoming more difficult to navigate.

> I was in-briefed from MEDCON. And they told me the other rules and the, uh, parameters, and, and, uh, I understood everything and, and followed their guidelines to the letter. And didn't seem to, uh, see anything in particular there…And I made sure that I was, uh, on top of all the requirements and paperwork and things, so, for the ARC, uh, LOD system. And that's when things for -- uh, kind of started to change. It seemed like it wasn't as straightforward or as, um, as easy a process as it had been in the past. Um, we started getting a lot of questions about, um, how just -- how we were doing our plan of care, and what the (b) (6), (b) (7)(C) were saying, and, and stuff like that. (Ex 92:5-6)

AM8 described ARC CMD as not user friendly overall and was confused why they needed to coordinate leave through them.

> . . . we're trying to get the, the ARC CMD to get the MEDCON orders going. Uh, there's, there's some -- there's some things in there where they, uh, they were -- they're, they're not real, uh, user friendly. For instance, to take leave, um, I needed a [AF Form] 988, [*Leave Request/Authorization*], signed by my commander, which I completely complied with. Uh, there were other arbitrary things like the ARC CMD required their, their chief to also approve it, which I'm like, wait a minute. It's a commander, uh, directed commander approved. I don't understand why this needs to go through another layer. (Ex 133:48)

AM9's attorney testified because AM9's wing did not update necessary paperwork such as their profile or updating their LOD, AM9 was not able to stay on MEDCON orders:

> [F]rom what I was able to find out through working with ARC CMD, the unit was notified that there was this disconnect between [AM9's] [AF Form] 469 and the line of duty, whether it be the diagnoses or the due date, the expiration date on the 469, some combination of both, the unit had been notified that they needed to fix it to keep [AM9] on MEDCON, and they didn't. And that's really where everything fell apart, um, was the unit could have done a new LOD. They could have adjusted the diagnoses in ASIMS. I mean, they, they clearly were messing around in ASIMS all over the place with [their] profiles.

Um, so it would have been a relatively easy administrative fix to keep [AM9] on MEDCON orders. (Ex 155:42)

STANDARDS

10 USC § 1074a, *Medical and dental care; members on duty other than active duty for a period of more than 30 days,* states:

a) Under joint regulations prescribed by the administering Secretaries, the following persons are entitled to the benefits described in subsection (b):
(1) Each member of a uniformed service who incurs or aggravates an injury, illness, or disease in the line of duty while performing-
(A) active duty for a period of 30 days or less;
(B) inactive-duty training; or
(C) service on funeral honors duty . . . .
. . .

(b) A person described in subsection (a) is entitled to-
(1) the medical and dental care appropriate for the treatment of the injury, illness, or disease of that person until the resulting disability cannot be materially improved by further hospitalization or treatment; and
(2) subsistence during hospitalization.
. . .

10 USC § 12322, *Active duty for health care*, states:

A member of a uniformed service described in paragraph (1)(B) or (2)(B) of section1074a(a) of this title ***may*** be ordered to active duty, and a member of a uniformed service described in paragraph (1)(A) or (2)(A) of such section ***may*** be continued on active duty, for a period of more than 30 days while the member is being treated for (or recovering from) an injury, illness, or disease incurred or aggravated in the line of duty as described in any of such paragraphs. (Ex 13:1) (emphasis added)

Per DoDI 1241.01, *Reserve Component (RC) Line of Duty Determination for Medical and Dental Treatments and Incapacitation Pay Entitlements,* 19 Apr 2016, RC Service Members on orders for more than 30 days with unresolved In the Line of Duty conditions that are potentially unfitting ***will*** be kept on orders until their condition resolves or they are separated. Paragraph 3, *Policy*, states:

a. An RC Service member is entitled to medical and dental treatment for an injury, illness, or disease that was incurred or aggravated while in a qualified duty status and that is not the result of gross negligence or misconduct (referred to in this instruction as a "covered

condition"). A determination that establishes a covered condition will be referred to in this instruction as an "in-LOD determination."

(1) In the case of a qualified duty status other than active duty for a period of more than 30 days, the in-LOD determination for a covered condition will establish eligibility for appropriate medical and dental treatment in accordance with section 1074a of Title 10, United States Code (U.S.C.) (Reference (e)).

(2) When an RC Service member is on active duty (AD) or full-time National Guard duty (FTNGD) for a period of more than 30 days and, at the scheduled end of that period, has an unresolved in-LOD condition that may render the member unfit for duty under the Disability Evaluation System (DES), but this has not yet been determined by the DES, the member:

(a) ***Will,*** with his or her consent, ***be retained on AD or FTNGD*** until:
1. Outstanding in-LOD conditions are resolved; or
2. He or she is either found fit for duty, separated, or retired as a result of a DES finding. (Ex 1:1-2) (emphasis added)

Under DoDI 1241.01, ILOD determinations authorize care for up to one year before a member goes through the Disability Evaluation System (DES):

c. The in-LOD determination will be used to authorize appropriate medical and dental treatment for the covered condition for not longer than 1 year from diagnosis without being identified for referral to the DES. An RC Service member will be referred to the DES when the criteria for referral are met in accordance with DoDI 1332.18 (Reference (g)). (Ex 1:2)

Secretaries of the military departments have the authority to put reserve component members on orders with their consent for the purpose of receiving medical care or to be separated if the condition is unfitting. 10 USC § 12301(h) states in its entirety:

(1) When authorized by the Secretary of Defense, the Secretary of a military department ***may***, with the consent of the member, order a member of a reserve component to active duty –

(A) to receive authorized medical care;

(B) to be medically evaluated for disability or other purposes; or

(C) to complete a required Department of Defense health care study, which may include an associated medical evaluation of the member.

(2) A member ordered to active duty under this subsection may, with the member's consent, be retained on active duty, if the Secretary concerned considers it appropriate, for medical

treatment for a condition associated with the study or evaluation, if that treatment of the member is otherwise authorized by law.

(3) A member of the Army National Guard of the United States or the Air National Guard of the United States may be ordered to active duty under this subsection only with the consent of the Governor or other appropriate authority of the State concerned. (Ex 15:3) (emphasis added)

DoDI 1241.01 then directs:

5. AUTHORITY TO ORDER TO AD FOR MEDICAL AND DENTAL TREATMENT

a. Medical Evaluation and Other Purposes

(1) With his or her consent, an RC Service member ***may*** be ordered to AD in accordance with section 12301(h) of Reference (e) when authorized by the Secretary of the Military Department concerned and, in the case of a member of the National Guard, with the consent of the Governor or other appropriate authority of the State concerned:

(a) To receive authorized medical care;

(b) To be medically evaluated for a disability or other medical purposes as determined by the Secretary of the Military Department concerned; or

(c) To complete a required DoD health study, which may include an associated medical evaluation of the RC Service member. (Ex 1:12) (emphasis added)

DAFI 36-2910 requires an active and restorative treatment plan for ARC members to be put on MEDCON orders.

6.1. Purpose. The primary purpose of MEDCON is to facilitate the authorization for access to medical and dental care for members who incur or aggravate an injury, illness or disease while in a qualified duty status and to return members to duty as expeditiously as possible[.] Members who are referred into DES while on AD ***may*** be retained on AD while processing through the DES IAW DoDI 1332.18. However, ***members without an active treatment plan will not be maintained on MEDCON solely for the purpose of entry in DES.*** If the member requires further treatment and has a restorative care plan, they may reapply for MEDCON while processing through the DES. (Ex 2:58) (emphasis added)

Further, DAFI 36-2910 allows for discretionary termination of MEDCON orders if the member does not have a treatment plan that requires at least two care appointments per week:

6.10.2. Discretionary Termination. MEDCON orders may be terminated at the discretion of the ARC CMD Division Chief, or SAF/MR on extension, for the following:

…

6.10.2.4. If the member's treatment plan requires less than two health care appointments per week.

DAFI 36-2910 states:

6.4. Program Responsibilities.

6.4.1. Member.

6.4.1.1. Will provide current and sufficient medical documentation, at minimum every 30 days, while on MEDCON and respond to official correspondence from the servicing medical unit and/or ARC Case Management Division regarding the member's medical status within two duty days of the request. (T-2). If the member is not responding to correspondence or supporting documentation is not provided, the service member may be processed for discretionary termination (see paragraph 6.6.2). Requested medical documentation should be limited to relevant information to reasonably identify the initial condition for which the LOD determination is being requested; this can include an initial diagnosis, treatment plan, or note from provider describing the condition. Note: if the diagnosis evolves, another LOD may be warranted for subsequent care.

6.4.1.2. Members on MEDCON orders will report to their unit of assignment or alternate duty location to perform assigned duties consistent with their diagnosis or physical limitations unless approved for leave in accordance with AFI 36-3003 *Military Leave Program.* (T-2). Members not compliant with reporting duty at the unit or an alternate duty location may have their MEDCON terminated and may apply for INCAP Pay. (Ex 2:60-61)

6.4.1.2.1. (ADD) Although leave is a unit commander's program, all out of local area leave requests require concurrence from the ARC CMD Division Chief and must be coordinated through ARC CMD. These requests additionally require a memorandum from the treating physician stating that it is safe to travel and that the travel will not interrupt treatment or aggravate the LOD condition. Local area leave should be coordinated with Case Management Team. [34] (Ex 2:10)

6.4.1.3. Fully participate with medical provider prescribed treatment plans. (T-2).

6.4.1.4. Members who require convalescent leave must have an AF Form 988, *Leave Request/Authorization* completed for duration of convalescent leave and copy submitted to Air Reserve Component Case Management Division (ARC CMD). (T-1).

6.4.1.4.1. (NGB only). Members who require greater than 90 days of convalescent leave must have their convalescent leave approved by NGB/SG. (T-2).

[34] This requirement first appeared in DAFI 36-2910 in the 23 May 2023 DAFGM2023-01.

6.4.1.4.2. (AFRC only). Members requiring convalescent leave for greater than 90 days will need medical re-evaluation as well as approval from AFRC/SG and a copy of the completed AF Form 988 will be submitted to the ARC CMD. (T-1). (Ex 2:61)

DISCUSSION AND ANALYSIS

There are three basic requirements for MEDCON: 1) ILOD determination; 2) active and restorative plan; and 3) mobility and duty restrictions on the AF Form 469.

In Line of Duty Condition

MEDCON is only authorized to treat conditions that are determined to have been incurred or aggravated ILOD. ARC CMD will validate a member has a valid LOD. MEDCON can be initiated for a member based on an interim LOD (an LOD that has been signed by the immediate commander but has not yet been adjudicated) for up to 90 days. The ARC CMD Division Chief explained:

> . . . what we look for is, uh, do they have a valid LOD? They could potentially have an interim LOD, um, which has not been finalized, uh, and we will accept that up until 90 days . . . to get it finalized, to bring somebody into MEDCON. (Ex 217:6)

> Additionally, the medical care teams . . . do reach out to the service member, uh, for periodic updates, uh, for, um, provider notes, uh, to make sure that the service member is getting regular care. Um, to make sure that they are, uh, still eligible for MEDCON, meaning their LOD hasn't been overturned, um, or maybe their, their interim LOD was found, uh, In the Line of Duty. However, it got to the Guard Bureau or AFRC and they are told, nope, sorry, we found this NILOD no longer or Not in the Line of Duty. And then all of a sudden, now they're, they're no longer eligible for MEDCON. And then we have to go through the administrative process to remove them from, uh, medical continuation. (Ex 217:7-8)

Active and Restorative Treatment Plan

The purpose of MEDCON is to bring a member onto full-time orders to receive care for their ILOD condition to either be returned to duty or to receive care while being out-processed through the DES. (Ex 2:58) The ARC CMD Division Chief described the process to ensure there is an active treatment plan:

> [A]nd then it gets turned over to the medical branch, at which point they review now for medical sufficiency . . . they're looking to make sure that the LOD condition is something that, that can be, uh, remedied by some measure of, um, medical treatment. (Ex 217:6)

> Uh, once we bring somebody on to a MEDCON order, uh, we continue the observation process to make sure that they have, um, sufficient, uh, medical care. Uh, and that can -- that can be sort of a nebulous term, um, but generally we look for anything that is -- because most of our injuries in most of our MEDCON cases are orthopedic in nature, we're looking for at least two appointments per week. And again, most of those are gonna be, um, uh, physical therapy. Uh, it could be observations. It could be, um, orthopedic surgery, uh, follow-ups, uh, things like that.
>
> Um, and within a moderate reason of, of those expectations, we look for . . . [do] the members have enough appointments, uh, to justify being on a longer-term order. It could be 45 days. It could be, um, six months. It could be, you know, upwards of nine months or a year. Uh, so we look for those elements. (Ex 217:7-8)
>
> [ARC CMD reviews for medical sufficiency]…the treatment plans that are there, uh, meaning they've got plenty of appointments scheduled during that, that order or the extension, um, to justify keeping them on to MEDCON because there are some people who get sent home for home exercise programs, um, uh, post-physical therapy. And because they're not actually seeing a provider at that point on a regular basis, uh, they're no longer eligible for MEDCON. (Ex 217:10)

However, requiring an active and restorative treatment plan to enter MEDCON presumes a member has enough time to schedule the necessary doctor and other required visits to be diagnosed and develop those active and restorative treatment plans in the 30 days authorized for pre-MEDCON. Several wing-level LOD PMs expressed their opinion this was not enough time, given the current state of delays with medical appointments, to get all of that accomplished. When asked if ARC CMD's ability to terminate MEDCON orders due to the lack of two scheduled medical appointments per week was reasonable, this LOD PM responded:

> W: No, I definitely do not. Uh, and our provider here does not -- doesn't understand it either because, um -- and part of it is, what bothers me too. And we tried to fight this fight was that, it's not actually like a standard. It's a, um, like a "may", right? It says, may or it may be curtailed. It doesn't say shall. So, um, that's been a -- that's been, uh, something we've tried to say, hey, like, it doesn't have -- we don't have to take them off of this if we're trying to figure out what's going on. But, um, yeah, that's -- **we've had many cases cut off because of that two appointments.** (emphasis added)
>
> IO: Did -- does ARC CMD ever work with you on those or is it pretty much, uh, a no -- a no go?
>
> W: They have, you know, to a degree, right? Like if, if a member is trying, um, or if, you know, it's a holiday, they don't -- they're not going to hold them to that standard, um, uh, things like that. And let me -- let me think. There's -- there was something with, if somebody was totally incapacitated, then it was possible as well. But, um, but generally, yeah, that, that, that two appointments is like I said, the problem that I have with it, is that

> we're working the system, right? When we do that. Like we're telling them -- we're telling the member, whatever, hey, they're going to curtail your -- you won't even get MEDCON if you don't get two appointments a week. So what does the member do? They go and get two appointments a week. Right? And so, that's not always, uh, um, efficient or it's not good for the taxpayer -- taxpayers. Right? If the member doesn't actually need that, uh, two appointments, I don't -- I don't know. I'm not a medical provider. Um, I just -- I know my provider doesn't 100% agree with it. And, um, [they've] had to explain to the active duty providers, this is why they need two appointments, so. (Ex 228:33-34)

AM5 testified ARC CMD's requirements for information were not always realistic given the limitations of being able to schedule appointments.

> [W]e had requested an extension of orders based off of, you know, everything that they [ARC CMD] were asking for, and they just -- they just denied it. Um, I would say if I got any -- if my, my, my mind -- my, my memory's a little fuzzy on it, but I think it was a few days, uh, I think it might have been just a handful of days. And part of that was, uh, they were demanding a follow-up with my (b) (6), (b) (7)(C), and [they were] -- I was unable to get a -- an appointment with [them] quick enough for, for their -- you know, for their liking.
>
> Um, it's not easy to just go in and be seen by the (b) (6), (b) (7)(C). Everybody's kind of overwhelmed and overworked, and I also had been through, uh, I want to say three different primary care providers here on base, just because the other, the previous two, [providers] were PCS'd… (Ex 92:22-23)

A lawyer who formerly served on the Office of Disability Counsel (ODC) provided their thoughts on how realistic the requirement was for an active treatment plan:

> Other things that we, um, to look at are, uh, well, they have to have a treatment plan. Again, I, I have no issues with a treatment plan per se, but you're not gonna get a treatment plan until you can get in to see the provider that you need to see for whatever specialty care that you need.
>
> So let's say you blow out your knee. We know that you've got a torn ACL . . . and you need to get into ortho. Well, being realistic in today's day and age in, you know, post-COVID medical care, how soon can you get in to see an ortho? It's gonna take weeks, maybe months to get in, depending on where you're located and what the availability is and everything else. So you can go to the ER, they can diagnose you with that tear, um, but. . . how soon are you gonna be able to get in to see a provider who's gonna be able to give you a treatment plan so you can check that box for MEDCON criteria? (Ex 209:68)

Members allege the Air Force is violating USC and/or DoD guidance by placing requirements for members to obtain MEDCON orders when they have an ILOD condition. The inquiry team determined the DAFI 36-2910 requirement that members have a twice-a-week

treatment plan did not violate USC or DoD policy. Generally, ARC members with ILOD conditions are entitled to treatment, but they are not necessarily entitled to active-duty orders (MEDCON). Members may receive treatment without being on MEDCON orders. With an approved LOD, members may receive care at a Military Treatment Facility (MTF) or reimbursement for medical care received through civilian medical providers.

With the exception of one specific circumstance, the USC and DoD guidance does not direct but authorizes the Air Force to put ARC members on active-duty orders to receive care. It is appropriate the DAF-level instruction implementing this broader guidance has specific processes and requirements that are not necessarily found in that higher-level guidance. According to the OPR for DoDI 1241.01:

> IO: Right. So what, what would you say to service members that, that argue that the DoDI -- the DoDI doesn't levy such requirements, so how can the services regulations levy this -- a more restrictive requirement than what the DoDI, uh, prescribes?
>
> W: And, and -- because the, the DoDI, I'd say that the DoDI provides the right and left limits, and each service is different, um, and their, their requirement is to develop, um, policies and procedures for, um, the Line of Duty. Um, and an example would be, um, the DoDI, excuse me, requires the -- In, uh, Line of Duty to be initiated within 180 days, um, um, barring, um, um, special circumstances that, you know, may, you know, late in onset, I guess, if something were, you know, doesn't -- not, you know, it occurred while in duty status, but didn't manifest until, um, later in the 180-day period. Um, the, the service could, could require, you know, we want service members to, um, initiate the Line of Duty in 140 days. As long as it meets the requirement from the DoDI, um, each service is given, you know, uh, you know, authorities to, to identify, you know, policy -- procedures and policies that the specific service is gonna, uh, go by. (Ex 96:9)

The ARC CMD Division Chief explained the rationale for the requirement for two appointments per week:

> [S]omebody is going to physical therapy twice, at least twice a week. Um, I think that is sufficient. I think that is, um -- I think that's just -- that, that is a way to justifiably keep them in the MEDCON process.
>
> Um, anything less than that, um, it, it kind of -- I, I begin to question from a -- from experience. I, I begin to question really, why does that person need to be on MEDCON if they're only going to an appointment once a week or one appointment every three weeks? Because at that point, you can just get put on an RMP [Readiness Management Periods] or you know, bring them -- put them on an RPA [Reserve Personnel Appropriation] a day or rescheduled UTA [Unit Training Assembly] or whatever.

> And bring them in for something, have them get seen at the MTF and or by a provider there, uh, at your unit, and, uh, it just -- I don't -- I don't see the goodness in keeping them on a long-term order from a fiscal standpoint. How does that? How does anything less than two appointments a week, uh, justify, from a fiscal standpoint, keeping them on? (Ex 217:32)

Requirement for Profile

Because the purpose of MEDCON is to bring a member onto full-time orders to receive care for their potentially unfitting condition, that member should have a medical profile for that condition. If a member is no longer on profile for that condition, there is no basis to continue to receive treatment for that condition. The ARC CMD Division Chief explained the rationale for the profile to align with the LOD:

> . . . the [AF Form] 469 is also important because we want to make sure that they're profiled for the condition that they have an LOD for. Because if you get profiled for a knee, but your real issue is your -- is your ankle -- well, something is not like the other. So, we need those things to agree. Um, so again, that, that is kind of one of those things where we have found that, you know, they send us a profile that doesn't support the LOD. (Ex 217:22)

Requirement to Coordinate Leave

The 23 May 2023 DAFGM to DAFI 36-2901 provides the rationale for the requirement for leave:

> 6.4.1.2.1. (ADD) Although leave is a unit commander's program, all out of local area leave requests require concurrence from the ARC CMD Division Chief and must be coordinated through ARC CMD. These requests additionally require a ***memorandum from the treating physician stating that it is safe to travel and that the travel will not interrupt treatment or aggravate the LOD condition.*** Local area leave should be coordinated with Case Management Team. (Ex 2:10) (emphasis added)

CONCLUSION

The Air Force requirements for MEDCON, such as an active treatment plan, are not arbitrary and are based on what is required to effectively oversee and manage the program. To effectively manage the program requires coordination and documentation from the member, the member's provider, the member's commander and the member's medical unit.

Additionally, the Air Force has the authority, not the indiscriminate obligation, to bring members on active duty and therefore has latitude on how to implement its program to either restore RC members to duty or separate them when they incur or aggravate an injury, illness or disease in the line of duty. The requirements established by SAF/MR and managed by ARC

CMD are reasonable, good faith efforts to ensure members on full-time orders have active and restorative care plans for their ILOD conditions. If members need continued care for conditions with less demanding care plans, they can be brought onto orders and receive care as needed. Like other aspects of the LOD program, the MEDCON program also depends in part on members' wings to ensure input and update information. Of note, members can now view and input their information directly into myFSS to communicate with ARC CMD, which helps ensure the flow of information without depending on wings to coordinate.

Contributing Factors

- **Governing guidance is inconsistent when addressing how ARC service members access medical care related to LOD, resulting in misperceptions.** Members are not informed of the LOD program and related entitlements, to include MEDCON and pre-MEDCON. Investigating officers found members' understanding of MEDCON came from a variety of sources, and information was not always consistent with USC or DoDIs referenced. For MEDCON specifically, USC and DoD guidance requires the services to provide care for RC members with ILOD conditions. DAFI 36-2910 implements the law and DoD guidance, providing conditions for members to have active treatment plans and to provide those plans to ARC CMD on a regular basis and other documentation as required. Members report believing the Air Force has developed these requirements with no basis in USC or DoDI, and these requirements serve as arbitrary barriers to prevent people from receiving their entitlements. Members who are customers of the process but do not understand the reasons for changes may experience unexplained changes to how their cases are handled.

COMPLAINT 7 – The MEDCON program is not managed in a transparent manner.

Complaint 7 focuses on the processing and members' awareness of what is happening with their MEDCON applications and why. AM2 and AM5 testified regarding their experiences. Testimony from AM7, who was not on MEDCON but believed they should have been, was also included because it relates to the overall transparency of the process.

AM2 provided their experience of how the LODs being returned NILOD impacted MEDCON.

> And so, um, ARC CMD calls and says, hey, where are your records? Okay. Well, let me give you all my records. (b) (6), (b) (7)(C) [redacted] And they said, okay, well, that's all well and good. Where are your LODs for these things? "Uh, hey Guard Medical Unit, I need those LODs. Where are they?" "Um, yell, you know, so and so hasn't signed them yet. They're all in a draft format." "Okay. Well, give me what you got. Let's upload them to ARC CMD."

"ARC CMD, here's a -- here's a volume of medical records. Here's all these pending LODs." Uh, and ARC CMD says, "hey, good for you. None of these LODs count. Oh, by the way, your -- all these medical records are really invalid because they're not -- they don't have to deal with your [redacted] . . you're not really supposed to be seen for these other conditions when you're on MEDCON for [redacted]." I said, "well, okay. Well, I'm active duty right now. So like help me square the corner and understand how you're prohibiting me from getting ongoing care, uh, when I'm in an active status."[35] "Well, okay. We're going to let that one slide. You know, so you are off of orders effectively July 13th because these LODs are not interim LODs. They do not count for MEDCON. If and when your immediate commander and your medical provider sign these, they become in which -- in which time they become interim LODs. You may then reapply for MEDCON." Okay?

Well, that kind of stinks because I'm in the middle of all of this. I [redacted] scheduled literally the next day. [redacted] scheduled, you know, [redacted] scheduled and on and on and on. I'm sure you've heard, but, but I mean, just a full docket of medical appointments to try to ultimately get to the bottom of whatever this [redacted] is, as well as now the [redacted]. And so, um, what -- I, I, I reentered MEDCON or reapplied for MEDCON . . . . (Ex 56:16-17)

Okay. So fast forward here. Uh, this is now November of -- this is just a month ago . . . my [redacted], texts me or calls me and says, ARC CMD just called again or emailed us, and you're off of orders. And what had happened was, a spate of LODs that were under review, they had all left [REDACTED] Air Force Base . . . they had all kind of been backed up. And then finally the dam breaks, and they all go up to Guard Bureau. And they're now under review at the ARC LOD Review Board.

And basically, over the course of two weeks . . . five of these LODs have now come back NILOD. Four of them went up in the line of duty. Five of them came back NILOD. The fifth one, of course, went up NILOD. (Ex 56:25-26)

Um, I'm, of course, um, removed because of the NILOD. The trickle-down effect here is, if you -- if your interim LOD is ultimately then deemed to be not in the line of duty, well, guess what that also, you know, impacts? Eligibility for MEDCON, right?

And so here I am on -- [redacted]
Uh, and all of a sudden, just at the whim of the ARC LOD Review Board -- and so -- I mean, this is quite literally October -- or excuse me. November 28th. I'm in a uniform. I'm on base. I'm doing [position at the unit], uh, at my computer. An email comes in saying, "oh, effective yesterday, retroactively, your orders are over." So, I'm like, "hey, that's --

[35] AM2 signed a Letter of Acknowledgement upon entering MEDCON and initialed by the requirement that any "non-Line of Duty/elective surgery/procedures must have PRIOR coordination/approval through AFRC/SGP or ANG/SGP." (Ex 20)

for one thing, what gives? Secondly, not cool at all because I'm sitting here working. Like I would be in a T-shirt in my civilian job, but you, ARC LOD Board -- or excuse me, ARC CMD in this case have pretty capriciously just cut my, my order effective yesterday." And it is kind of like, "well, sorry, them is the rules. Good luck to you. Uh, you can always reapply to MEDCON." (Ex 56:27)

AM5 testified requests for extension to their MEDCON orders were being returned without action and it seemed like the requirements were changing.

. . . I noticed is that all of a sudden . . . the goal posts were kind of -- were being moved. The targets were being moved. So, every -- we were getting return without action. And then we would get denial, uh, from MEDCON for extension. (Ex 92:7)

. . .

Um, probably the, the biggest example I know of was the, the new set that I've been on since November. Uh, they called, uh, the MEDCON folks at [REDACTED], called my, my POC, my MEDCON POC here, [REDACTED], uh, and said, "Okay. We need proof that the member is going to (b) (6), (b) (7)(C) twice a week. We need to see appointment dates. Uh, we need to see a plan of care from [their] physician, and we need to see the (b) (6), (b) (7)(C) concur in [their] plan, and we need that by close of business today."

. . . luckily, I was at (b) (6), (b) (7)(C) . . . and I provided them with everything they asked for, and I did it within about an hour and a half. My (b) (6), (b) (7) doc, uh, did something really great for me. [They were] so frustrated with the MEDCON system and, and the process. [They] gave me [their] personal cell number, and [they] said, "You know, call me anytime and, and with anything that you need me to help you," because [they see] me, and [they see] what, you know, what I'm dealing with, and, uh, [they] said, "I'm, I'm here to help." (Ex 92:21-22)

AM7 testified they believed they should have immediately been offered pre-MEDCON once their unit commander signed their LOD, but they were not.

[W]hat I do know in June, but it didn't really register until two or three months ago. Is that when, on 22 August, when, um, the [REDACTED] the Nurse Practitioner, and [REDACTED], the Wing Commander, when they signed that [AF] Form 348, that constituted an interim LOD, and I should have been offered MEDCON orders that day…an interim LOD…entitles you to MEDCON orders. (Ex 116:47)

STANDARDS

DAFI 36-2910 states:

2.2.3. Immediate Commander

2.23.5. Recommends approval or disapproval of pre-MEDCON orders for all EPTS, PSC or other duty status and misconduct cases for ARC.

3.2.2.6.3. Interim LOD (ARC Only). The immediate commander ***may*** issue an Interim LOD determination to establish initial care and treatment pending a final LOD determination. (Ex 2:39) (emphasis added)

The following of DAFI 36-2910 provides requirements for a member's medical unit to update profiles and LODs as part of members' MEDCON applications:

6.4.3. Medical Unit.

6.4.3.1. The servicing GMU or RMU medical unit will initiate LOD determinations, track the related treatment, update the AF Form 469 as necessary (see AFI 48-133, *Duty Limiting Conditions*), send all current and related LOD clinical documentation along with MEDCON request to the ARC CMD (see paragraph 6.8.1). (T-2). (Ex 2:61)

The 2021 version of DAFI 36-2910 addresses termination of Pre-MEDCON and MEDCON orders:

6.6. Termination of Pre-MEDCON Orders.

6.6.1. Mandatory Termination. The member's Pre-MEDCON orders shall be terminated on the earliest date when one of the following actions occurs:

6.6.1.1. The member declines to continue on Pre-MEDCON orders or; **(T-1)**.

6.6.1.2. The member is able to perform military duties, as determined by ARC/SG; **(T-1)**.

6.6.2. Discretionary Termination. Pre-MEDCON orders may be terminated at the discretion of the MAJCOM Functional Area Manager, for the following reasons:

6.6.2.1. The member's failure to fully participate in their prescribed treatment or provide current and sufficient information.

6.6.2.2. The member's refusal, when not on approved convalescent or ordinary leave, to report for and perform duty consistent with the member's diagnosis and/or physical limitations.

6.10. Termination of MEDCON Orders.

6.10.1. Mandatory Termination. The member's MEDCON orders shall be terminated on the earliest date when one of the following actions occurs: **(T-1)**.

6.10.1.1. The member declines to continue on MEDCON orders;

6.10.1.2. The member is able to perform military duties, as determined by the ARC CMD Division Chief (or delegated authority, see paragraph 6.9.2.1); or

6.10.1.3. The member is separated or retired as a result of a DES determination.

6.10.2. Discretionary Termination. MEDCON orders may be terminated at the discretion of the ARC CMD Division Chief, or SAF/MR on extension, for the following:

6.10.2.1. The member's failure to engage in their prescribed treatment plan in accordance with their providers care plan or to provide current and sufficient information as required by the MEDCON validation process.

6.10.2.2. The member's refusal to reply to official requests or correspondence regarding the member's medical status from either the ARC CMD or their GMU/RMU within 30 days; or

6.10.2.3. The member's refusal, when not on approved convalescent or ordinary leave, to report for and perform duty consistent with the member's diagnosis and/or physical limitations.

6.10.2.4. If the member's treatment plan requires less than two health care appointments per week.

6.10.2.5. 365 days has passed from the initial diagnosis and an IRILO has not been completed.

6.10.2.6. The condition has become chronic, and the member may continue their care through the DVA [Department of Veteran's Affairs].

6.10.2.7. If the member requires intermittent treatment (ex: infusion every eight weeks for one day or occupational therapy one day every other week) they may be brought on orders for the duration of the single intermittent treatment.

DISCUSSION AND ANALYSIS.

To address AM7's complaint, MEDCON is not appropriate for every LOD, and there is no requirement for a commander to indiscriminately put a member on pre-MEDCON with an interim LOD. DAFI 36-2910 states a commander ***may*** recommend a member for pre-MEDCON. (Ex 2:39) While there is a requirement for the pre-MEDCON PM to brief members about

entitlements and responsibilities while on MEDCON orders, there is no requirement to inform members of the program. (Ex 2:64)

Part of the initial package members fill out when they first receive MEDCON orders is the Letter of Acknowledgement form, which is a four-page document the member, their medical unit, and commander sign and initial to indicate their acknowledgment of their responsibilities and expectations to be in the program. (Ex 220) Members may disagree with the requirements themselves or the manner in which information is communicated may be unclear, but by signing the Letter of Acknowledgement, all requirements for the MEDCON program are communicated to the member and their unit.

Even though members can now communicate directly with ARC CMD via myFSS regarding their MEDCON applications, the wings are still responsible for ensuring other requirements are met. As with the LOD program, overall, there is a lack of consistent training for those involved in the process, and the wings are left to their own to determine how to manage the program. The ARC CMD Division Chief said the ARC CMD interacts with members' medical POCs for information, and often these POCs have other jobs to do:

> I've got case managers who call, um, and it's usually just to get updates on service members. Um, but I have people -- I have my case managers they usually call probably -- uh, usually about once a month, um, sometimes more frequently depending on, on the case. Um, it certainly has become more -- it becomes more frequent if they're missing something in their -- in their application or if they're filing for an extension.
>
> Um, if they're trying to get an extension to their, their MEDCON, uh, orders, then sometimes we have to ask for, for more information. And the good thing is, the majority of those MED POCs do a really good job of responding to our -- to my case managers. So, um, again, it's that kind of 10 to 15, maybe 20 percent of the -- of the RMUs and GMUs who either they just don't really understand ….
>
> Um, a lot of times, those, those MED POCs are double, and triple hatted with many, many other, uh, additional duties and details. Um, you know, uh, they don't have the bandwidth, especially when you're going into a drill weekend or a unit who's getting ready to deploy. Um, they don't have the bandwidth to go, oh, let me call [a member] over here and get [their] treatment plan because I've got 75 cops getting, getting ready to go out the door, to go kick in doors down range.
>
> … I think MED POCs as a whole, um, they, they, they manage, and they balance as best they can. But I think there's a number of them that are probably overworked and underpaid. (Ex 217:23-24)

CONCLUSION

While it is possible for members to have MEDCON orders terminated due to administrative oversights, from interviews of those involved in the process, members may not understand the reasons for certain MEDCON requirements and therefore the termination of their orders seemed arbitrary.

There is no Air Force-level policy regarding the education of ARC members on the LOD program and associated benefits and entitlements, including MEDCON. Leaving how to educate wing members to the discretion of each wing results in inconsistent processing and potentially different outcomes for members depending on where they are assigned. Members may not even be aware of the different programs and entitlements potentially available. This is a shortfall in DAFI 36-2910 and should be addressed.

Contributing Factors:

- **The LOD program is not transparent.** Until recently, service members relied on wings to communicate with ARC CMD and update MEDCON requests or extensions. Now, members can update their own information directly through myFSS, improving transparency of the MEDCON process.

- **A lack of standardized, mandatory training for ARC service members on the LOD/MEDCON program.** There is no standardized, mandatory training for ARC members on the LOD/MEDCON programs. As a commander's program, wings have wide latitude to implement the program; while some wings had deliberate training efforts, others had none.

IV. SUMMARY

Without addressing the unique and specific circumstances of the 11 service member cases reviewed, this inquiry found the cases were generally processed in accordance with existing regulatory guidance. However, the overall LOD process, especially when viewed from the Airman's perspective, has significant shortcomings and requires immediate improvements. For example, one area identified as a procedural weakness requiring attention is the method of notifying members of their NILOD determinations. Specifically, there is no standardized procedure for what evidence or explanation should be provided to ARC service members and no standardized way to transmit and document this notification. Per DAFI 36-2910, paragraph 1.11.1.2, members shall be provided "clear and unmistakable evidence" for all NILOD determinations and any subsequent appeal efforts. However, there is no standardized procedure for what evidence or explanation should be provided to ARC service members and no standardized way to transmit and document this notification. As unit commanders are not trained

medical providers, their ability to communicate why a member's medical condition may not qualify for military entitlements relies primarily on the information provided by the LOD Approval Board.

Additionally, ARC service members at all levels lack a fundamental understanding of the LOD, MEDCON, and INCAP programs and processes. This lack of understanding can negatively impact how these programs are administered and executed at the wing level, which ultimately affects the support ARC service members receive in acquiring medical benefits and results in a frustrating experience where the service members' expectations are not met. This inquiry found no standardized initial or reoccurring awareness training for ARC service members that could reasonably educate the member on the purpose of the programs or how to navigate the processes required to acquire the associate benefits and entitlements. This inquiry also identified no standardized leadership-level training for these programs and processes. As these programs have the potential to significantly impact ARC service members' well-being, careers, and mission readiness, leadership plays a critical role in ensuring their members receive these entitlements.

Through the course of reviewing the history and current state of the LOD processes and associated entitlements and applying the applicable standards to the ARC service members' LOD cases reviewed during this inquiry, the following cross-cutting contributing factors impacting ARC service member's awareness and comprehension of the LOD processes emerged:

- **The standard of "clear and unmistakable" evidence is not clearly defined.** Service members are provided medical terms such as "authoritative medical literature" as explanations and in support of their NILOD determinations. The ARC service members included in this inquiry were provided with insufficient feedback or evidence addressing why their medical conditions were found NILOD.

- **ARC service members are not provided sufficient feedback or evidence explaining why their medical conditions were found NILOD.** Significantly, there is no direction of what specifically to provide members regarding their NILOD determinations. While the unit commander has the responsibility to brief members of their LOD determinations, there is no direction on what to brief or information to provide.

- **Training is not provided to those responsible for administering the program at the wing level.** There is no comprehensive, mandatory training for members involved with the LOD process at the wings. The level of involvement and support to the service member varies widely based on where the LOD PM is assigned and their experience level.

- **A lack of standardized, mandatory training for ARC service members on the LOD/MEDCON program.** There is no standardized, mandatory training for ARC members on the LOD/MEDCON program.

- **Governing guidance is inconsistent when addressing how ARC service members access medical care related to LOD, resulting in misperceptions.** USC, DoD, and DAF guidance do not use consistent language when addressing how ARC service members receive medical care related to LOD determinations. This inquiry found ARC service members are not aware the DAF has the authority to impose DAF-specific provisions not enumerated in DoD or USC for them to receive medical care and treatment.

- **The LOD program is not transparent**. Members do not have access to view their LODs or track their progress, relying instead on receiving updates from their LOD PMs, medical focal points, or unit commanders. This lack of transparency throughout the LOD process results in a failure to ensure the ARC service member is provided with accurate and timely updates to the status of their individual case.

- **ARC wing, NGB, AFRC, and DAF are lacking LOD program oversight.** There is no current adequate oversight of the LOD program at any level. Additionally, there is no ARC wing-level self-inspection or mechanism to ensure compliance with the DoDI 1241.01 or DAFI 36-2910. There is no requirement in DAFI 90-302, *The Commander's Inspection Program (CCIP)*, to assess the LOD process at ARC wings.

KEY OBSERVATIONS

Since approximately 2021, DAFI 36-2910 has undergone multiple revisions intended to address the LOD determination procedures and deficiencies associated with latency concerns in processing times, including a pilot program in 2022 involving 10 AFRC and 10 ANG wings. Although some positive trends in efficiency emerged from these LOD reform efforts, overall, the accuracy of LOD determinations saw a significant drop-off. Most recently, the Assistant Secretary of the Air Force Manpower and Reserve Affairs (SAF/MR) stood up the Air Reserve Component Line of Duty Determination Quality Assurance Program (QAP). The ARC LOD QAP will establish SAF/MR oversight by reviewing a minimum of 10% of completed LOD cases monthly, either selected randomly or in accordance with a specified request. The objective of the ARC LOD QAP is to ensure ARC authorities accurately adjudicate LOD determinations in a timely manner in accordance with DAFI 36-2910. Also of note, SAF/MR is conducting a comprehensive rewrite of DAFI 36-2910 to address numerous issues identified as vague or that cause confusion for service members. Throughout this inquiry, the SAF/IG team engaged with the ARC LOD QAP team to ensure findings and recommendations from this inquiry and the

individual complaint resolution efforts are considered in future ARC LOD QAP lines of effort. The SAF/IG team also provided input to both the DAFI 36-2910 Interim Change (IC) guidance and the complete DAFI review and rewrite.

Additionally, The Office of the Under Secretary of Defense Personnel and Readiness (OUSD P&R) is currently reviewing DoDI 1241.01, which provides overarching guidance to all military reserve components LOD programs. As part of this review, OUSD P&R has requested participation from all service components to provide representation for their review. The DAF has provided approximately 15 representatives to assist with the review, to include ANG and AFRC members.

Finally, in Apr 2023, the Air National Guard Readiness Center (ANGRC) completed an independent Commander Directed Inquiry (CDI) to review the processing operations involving LOD determinations, the Disability Evaluation System (DES), pre-MEDCON, and MEDCON to determine whether these processes were conducted in accordance with applicable laws and regulations. The investigation found NGB processes and systems were generally consistent with the law, DoD policy, and Air Force regulatory guidance, but it also listed numerous processes it assessed as inadequate to execute and administer the LOD program. Among processes identified, NGB/A1 approved a waiver for itself to continue to utilize current LOD routing and approval authority through the ANG LOD Board in lieu of following a DAFI 36-2910 change that delegated the LOD approval authority to wing commanders. NGB/A1 coordinated the waiver through HAF/A1PPS and notified wings LOD PMs informally via email but never published the waiver to the repository in the ANGRC portal as required by policy.[36] This NGB policy change is highlighted as a point of contention in several IG complaints reviewed during this inquiry. According to NGB service members familiar with the results of this CDI, no actions were taken to address findings presented in the final report.

V. OVERALL CONCLUSIONS AND RECOMMENDATIONS

The medical benefits and entitlements associated with the programs reviewed during this inquiry significantly impact ARC service members' well-being, careers, and mission readiness. Overall, this inquiry found significant shortcomings and inconsistencies in existing ARC LOD policies and processing, however, there was no evidence of a systemic effort to deny ARC service members' medical benefits and entitlements. Specifically, this inquiry did not uncover evidence of a deliberate effort to deny ARC service members medical entitlements by way of NILOD determinations due to monetary considerations; all witnesses interviewed with responsibilities to administer or execute the LOD program refuted this notion. The following chart provides a snapshot of ARC LOD cases adjudicated within the last two calendar years. The

[36] ANG Waivers (intelink.gov). See DAFI 33-360, *Publications and Forms Management*, paragraph 12.4. (superseded but the regulation in effect at the time); also see ANGMAN 33-360, paragraph 2.

raw numbers and percentages indicate the majority of LODs in both Air Reserve Components are found to be In the Line of Duty.

Count and Proportion of ARC LOD Outcomes for Cases Completed from 1/1/23 to 3/31/24:

Counts	AFR	ANG
In Line of Duty (ILOD)	754	446
Not ILOD (NILOD)	306	191
Total	1060	637

Proportion	AFR	ANG
In Line of Duty (ILOD)	71%	70%
Not ILOD (NILOD)	29%	30%
Total	100%	100%

This inquiry did reveal two significant issues in processing LOD cases:

- ARC service members are not adequately educated on the LOD process or expectations upon initiation, not provided with timely updates to the status of their LOD determinations, and not provided with a sufficient level of evidence or explanation upon receiving their final NILOD determinations. A lack of awareness or understanding by ARC service members of how the LOD process is intended to function impacted the members' expectations of potential outcomes upon reporting a potentially qualifying medical condition. Nearly every service member and subject matter expert the inquiry team interviewed believed Airmen are not familiar with the LOD process. This lack of understanding is exacerbated by an inadequate and, at times, non-existent methods of communication among service members, wing leadership, program managers, and the ARC LOD approval authorities. This inquiry found examples of wings not submitting LODs when conditions were reported and when specifically requested, highlighting problems with processes and procedures and confusion over DAFI 36-2910 guidance. Refusals or significant delays in initiating the LODs also shows the lack of training LOD PMs receive to administer the LOD program throughout the process.

- The LOD program is being executed inconsistently at the wing level by LOD PMs who receive no notable training. As ARC subject matter experts described it, the LOD program is a commander's program, and the wings determine how to execute it. While providing commander discretion, this approach creates significant variance in the baseline interaction of LOD PMs and medical units with members as well as how NILOD determinations are explained to members, directly impacting ARC members' understanding of the program and the care and benefits to which they may be entitled. More concerning is the lack of any standardized formal training for critical wing members involved in the execution of the programs (i.e., LOD PMs, CCs, and MDG personnel).

While this inquiry found the cases were generally processed in accordance with existing regulatory guidance, the aforementioned factors contributed to an apparent failure to adequately support ARC service members who were experiencing health challenges and eroded their trust in the LOD, and MEDCON programs. Based upon the cross-cutting contributing factors and conclusions described in this inquiry, the following recommendations are provided for consideration:

1. As part of the DAFI 36-2910 rewrite, establish a formal, standardized notification to ARC service members, including a baseline of information to constitute the required clear and unmistakable evidence or preponderance of the evidence for all NILOD findings. The ARC LOD QAP should standardize a thorough and comprehensible explanation to ensure service members understand how and why the board reached the NILOD determination as well as requirements and limitations associated with medical entitlements such as MEDCON orders. (OPR: SAF/MR)

2. As part of the DAFI 36-2910 rewrite, provide a comprehensive review of all terms and phrases used to define and characterize LOD determinations and related medical information to ensure these terms are clearly defined and ARC service members have a reasonable level of understanding about the processes associated with this program. (OPR: SAF/MR)

3. Establish a SAF/MR directed central patient support cell to answer questions and concerns from members who have received NILOD determinations to eliminate confusion and address questions members may have. (OPR: SAF/MR)

4. Develop ARC-wide awareness training for service members and leadership to ensure a clear understanding of the LOD process and subsequent actions/entitlements. (OPR: NGB/AFRC)

5. Standardize LOD PM responsibilities and training. Additionally, direct appointment of the LOD PM to personnel assigned to the wing-level GMU or RMU. (OPR: HAF/A1)

6. Ensure LOD processing is included as ARC-wide inspectable scheduled requirements as mandated by DAFI 36-2910, paragraph 3.1.5. (OPR: SAF/IG/AFIA)

7. Establish a myFSS application for ARC members to readily access resources and training related to LOD processes and subsequent entitlements unique to the reserve component. (OPR: HAF/A1)

8. ARC members should be provided the rights advisement any time they are requested to provide a statement relating to the origin, incurrence, or aggravation of a disease or injury in accordance with 10 USC § 1219. (OPR: SAF/MR)

9. Conduct an independent review of the following ARC LOD Determination Board aspects: medical adjudication processes, staffing and subject matter expertise of ARC LOD Board members. (OPR: SAF/MR)

10. Establish the requirement for the Surgeon General to designate medical specialists to sit on and advise the LOD Boards and appellate authorities. (OPR: SAF/MR)

11. Establish the requirement for an immediate DAF-level appellate review authority process for ANG LOD and AFRC LOD denials. (OPR: SAF/MR)

12. Coordinate with OUSD P&R to thoroughly review guidance to reduce confusion and ambiguity between the broader DoD regulations and the authority for the Air Force to execute service-specific functions. (OPR: SAF/MR)

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The Inspector General

LIST OF EXHIBITS

Exhibits