**AFI 10-203 Supplemental Guidance**

***Note: The waiver authority for the supplemental guide is AFMSA/SG3PF. Deviation from this guidance can be directed from AFMSA/SG3PF or through individual waivers, as long as the requirements within AFI 10-203 are met.***

## 1. PROVIDER GUIDANCE (INCLUDES ALL MILITARY CREDENTIALED PROVIDERS WHO HAVE MILITARY PATIENTS)

**1.1. CONSULTANT TIMELINESS METRIC:** Ideal metric for Airmen with mobility restricting conditions, examinations (including laboratory/radiology studies and specialty evaluations) should be completed within 30 days after initiation of the AF Form 469 for that condition, unless there reasons are adequately explained and documented in the medical record. (For ARC Airmen with Line of Duty (LOD) or other condition limiting their ability to perform their duties, the 30-day limit applies. For ARC Airmen with non-duty related conditions, examinations shall be completed within 90 days.)

## 1.2 PROVIDER COMPLETION OF AF FORM 469

1.2.1. All providers, including military consultants, will ensure patient encounters are appropriately documented in the medical record. This will include duty limitations, anticipated recovery time and further evaluation/ treatment plans. Providers will also ensure duty limitation data is entered into ASIMS (or equivalent program) and an AF Form 469 is initiated for transmission to the unit. Examples of documentation in the Assessment and Plan portion of the medical note for a patient with the diagnoses are noted below. Additional aids for determining restrictions are located at:
https://kx2.afms.mil/kj/kx4/FlightMedicine/Pages/AFI10203SupplementalGuidancesubpage.aspx

- Ankle sprain mild; WWQ, Duty restriction - limited walking/standing for one day, Fitness restriction - no run/walk/sit-ups for 30 days.

- Pulmonary embolus; Not WWQ, refer to DAWG. Duty restriction - walking/standing for as tolerated, Fitness restriction – no run/walk/push-ups/sit-ups for 90 days.

- Asthma controlled; Code C-1 (next RILO DEC 2016). No fitness restrictions. Duty limitations – SM to carry relief medications and identify triggers to supervisor.

1.2.2. Providers will evaluate/re-evaluate the Airman's AF Form 469 at every face-to-face clinical encounter. Additionally, all special purpose medical examinations and Preventive Health Assessments (PHA) must include a review of existing limitations. For ongoing conditions, a simple annotation in the medical record encounter note (e.g. "WWQ, no change to DLC" or "Code C, DLC remains appropriate") will suffice if there are no changes. See examples in 1.2.1. for new conditions identified.

1.2.3. Ensures Airmen under their care with mobility restrictions originally anticipated to expire within 30 days are converted to an Assignment Availability Code (AAC) 31 if the restrictions need to be extended beyond 30 days.

1.2.4. On initiation of an AF Form 469, providers must ensure Airmen understand the DLC process.

1.2.4.1. Local process can be developed to ensure that service members understand the meaning of the limitation and any requirements they may have.

1.2.5. If an Airman has a medical condition that does not meet retention standards or may result in mobility restrictions (trigger event), the provider (including specialty providers) is to refer the case to the DAWG for consideration of an initial RILO; ideally using the "Refer to DAWG" feature in ASIMS.

1.2.5.1. If a trigger event is identified and patient is referred to the DAWG, then place a brief statement within the assessment of the medical encounter describing the trigger event and referral.

1.2.5.2. Providers should refer cases to the DAWG if the continuous or cumulative time for the restriction or recovery from the condition exceeds 365 days, or is reasonably anticipated to exceed 365 days. Providers, in consultation with the SGP and/or SGH as appropriate, are encouraged to refer cases to the DAWG for Initial RILO consideration at the earliest time possible once it can be reasonably anticipated that the Airman will not be recovered to mobility status within 365 days.

1.2.6. Once an Airman has been identified by the DAWG as requiring an Initial RILO (or FFD/WWD evaluation for ARC Airmen with non-duty related conditions), the provider will work with the Physical Evaluation Board Liaison Officer (PEBLO) (or ARC equivalent) to ensure all Initial RILO (or FFD/WWD) requirements are met IAW AFI 41-210.

1.2.6.1. The SGH will ensure local protocol exists on assignment of physicians for the narrative summary; this could include medical subspecialists. For example, an Airman with sole seizure disorder and no additional diagnoses could have their Initial-RILO or Narrative Summary completed by the Staff Neurologist. If the service member also has Post-traumatic Stress Disorder, Low Back Pain, and Depression, then the primary care provider would most likely take the lead on the Initial RILO with the appropriately consultative notes.

1.2.6.2. The local protocol may be approved at ECOMS or Executive Staff whichever is deemed most appropriate.

## 1.3. PROVIDER RECOMMENDATIONS FOR ASSIGNMENT, RETRAINING OR DEPLOYMENT

1.3.1. When completing these reviews, the provider will consider the requirements of the assignment, new AFSC, or deployment as well as the medical care available at the proposed location(s). MSME, POs and, if necessary, the Airman's commander may be consulted if there are concerns about medical risk related to the Airman's condition and/or the assignment, training, or deployment.

1.3.2. In cases where the medical condition of an Airman appears to resolve or develop in close association with a new assignment, training opportunity, or deployment tasking; commanders will contact the SGP or SGH if there are concerns about the fidelity of past and/or present duty or mobility restrictions. In such cases, the SGP and/or SGH will coordinate with the PCM and MSME, in consultation with the commander, to ensure that the Airman's restrictions are accurately reflected. In all cases, MTF personnel shall consider unit commanders and first sergeants to be teammates in the accomplishment of appropriate restrictions.

## 2. MTF/SGP AND PROFILE OFFICERS

**2.1. Non-concur by Commander:** When an Airman's Commander does not concur with a mobility restriction on an AF Form 469, the SGP should review the medical case and discuss with the commander his/her concerns. If unable to resolve, then the case is to be presented to the next level commander in the chain. If both commanders non-concur and it results in an Airmen being placed at risk for medical complications due to deployment, the MTF/SGP will advise MAJCOM/SGP of the case.

2**.2 Profile Officer**:

2.2.1. Receives formal training on their duties and the appropriate AFI's during the AMP Course.

2.2.2. Ensures unit interested (mission) and the patient's interests (sustainment or restoration of health) are considered to maximize the benefit to both.

2.2.3. Reviews 469's and 422's IAW AFI 10-203 to ensure they meet the intent of the AFI. In addition, they ensure unit interests (mission) and the patient's interests (sustainment or restoration of health) are considered to maximize the benefit to both.

## 3. MSME GUIDANCE

3.1. Manages the profiling/duty limitation system following the guidance below.

3.1.1. Provides oversight regarding AF Forms 422 & 469 processing status on each Airman, and acts to ensure process effectiveness and compliance with established timelines.

3.1.1.2. Tracks and reports compliance with AF Forms 422 & 469 processing timelines to the DAWG. Notifies SGP/SPO regarding timeline compliance issues as soon as possible after issues are identified.

3.1.1.3. Actively engages POs when SGP/SPO is unavailable or timelines are not being met.

3.1.1.4. Upon request, provides updates regarding AF Forms 422 & 469 processing status to Airmen, Commanders, Unit Fitness Program Manager (UFPM), PCM, or PO. **Note:** UFPMs must be appointed in writing as a commander's designee IAW AFI 41-210 in order to receive PHI, to include information contained on AF Forms 422 & 469.

3.1.1.5. Ensures Airmen with mobility restrictions originally anticipated to expire within 30 days will be converted to an AAC 31 if the restrictions need to be extended beyond 30 days.

3.1.1.6. MSME is responsible for timely execution and follow-up once the provider has initiated the AF Form 469. Questions on applicability of standards versus restrictions, as well as provider non-compliance, may be addressed with either the provider, the PO or the SGP/SPO.

3.2. Ensures that DAWG decisions secondary to trigger events (see AFI 10-203, 4.1.3.3 for trigger events) are appropriately documented in ASIMS "Refer to DAWG" section per ASIMS Guidance. Additional information for Health Care team can also be noted in the notes section at the request of the SGP.

3.3. Oversees the quality control reviews on AF Forms 422 and 469.

3.3.1. Performs administrative quality control review on AF Forms 422 & 469 after Initial RILO, MEB or Physical Evaluation Board (PEB) processing as applicable. Particular attention will be paid to Airmen who have been given an Assignment Limitation Code C (ALC-C) by DPANM or ARC SGP.

3.3.2. Tracks, at the discretion of the SGP, Primary Care Team's trends on completion of 469 and 422's. Briefs these at the DAWG each month. For example; tracks by team the first 10 errors for each provider, reviews for trends, provides team training with approval of the SGP, and records these results/actions at the DAWG.

3.3.3. SGH directed Diagnostic and Medication Surveillance

3.3.3.1. At least ten times per year, MSME will present findings to the DAWG of selected diagnostic or medication utilization queries as directed by the SGH to ensure Airmen with certain medical conditions do not remain unidentified in the mobility reporting system. The steps for completing this review are described below.

3.3.3.2. The SGH will develop a list of the ten most frequently seen diagnoses that require mobility requiring Initial RILO, including ICD 9/10 Codes, at the MTF as well as medications

associated with treating these conditions. For each review a different diagnosis and/or medication from the list will be selected.

3.3.3.3. A Composite Health Care System (CHCS) and/or AHLTA query will be compared to existing AAC 31, 37 and 81 lists to provide increased visibility on conditions which may impact deployment availability. Personnel identified using this surveillance will be referred to their PCM for initiation of DLC action if indicated.

3.3.3.4. MSME will ensure the reviews are performed and will present findings, i.e., cases that may need DLC action or Initial RILO to the DAWG.

3.3.3.5. Findings will be presented to the professional staff by the SGH at least annually for education purposes. This paragraph does not apply to ARC units.

3.3.3.6. Example list: 1) Obstructive Sleep Apnea, sleep study referrals, 2) Diabetes, metformin, insulin, Januvia, 3) Asthma, Advair, Flovent, 4) Seizure, Epilepsy, Lithium, Seroquel, Abilify, Provigil, NuVigil 5) Low Back Pain and Narcotics > 3 months, 6) Crohn's, Celiac Disease, Ulcerative Colitis, 7) warfarin, pneumothorax, methotrexate, adalimumab (Humira), etanercept (Enbrel), infliximab (Remicade) 8) Review AD high utilizer list, 9) Epipen, 10) Locally determined list of personnel with chronic benzodiazepine and/or narcotic use

3.4. RETRAINING PERSONNEL; MSME will review retraining applications to ensure Airmen are qualified for entry into AFSC(s) specified for potential retraining. Review of each AFSC's physical requirements is found in the Air Force Enlisted Classification Directory (AFECD) and the Air Force Officer Classification Directory (AFOCD) located on the Air Force Personnel Center (AFPC) website. The AF Form 422 will indicate each of the selected AFSCs the Airman is and is not qualified to enter. When flying or special operational duty AFSCs are selected that require specific qualification examinations, AFI 48-123 will be reviewed for disqualification criteria and the certification examination process will be initiated IAW AFI 48-123. During the AFSC disqualification process, Airmen are considered for return to a prior AFSC for which they may remain qualified prior to considering possible AFSCs for retraining. MSME will then forward the edited AF Form 422 for appropriate signature by the provider, MSME technician, and PO. The signed/completed AF Form 422 will be transmitted to the unit Commander who will initiate AFSC disqualification.

3.4.1. Strength Aptitude Test (SAT) is used to determine if members applying for retraining or special duty meet minimum strength requirements.

3.4.1.1. The AFECD establishes a SAT standard for each AFSC.

3.4.1.2. When AFPC requests a SAT evaluation in writing, MSME reviews the accession MEPS physical and current medical records and completes the appropriate endorsement.

3.4.1.3. If the profile "X" factor equals or exceeds the SAT standard for the retraining AFSC, do not retest unless a medical condition is discovered changing the SAT. If a medical condition is

discovered, refer the individual to a health care provider for evaluation prior to SAT testing. See AFECD for detailed requirements.

3.4.1.4. If the profile "X" factor is blank, contains a numeric character 1, 2, or 3, or is an alpha character less than the SAT standard, the SAT results are unsatisfactory.

3.4.1.5. A provider's review of medical records must indicate no potential medical reason that member cannot perform safe successful lifting attempt.

3.4.1.6. Refer member to the Fitness Center (gym) for administration of the SAT.

3.5. ASSIGNMENT ACTION REVIEWS: MSME will review assignment actions to ensure Airmen are qualified for PCS to gaining base IAW applicable Personnel Processing Codes (PPC). The PPC provides processing instructions for the Airman and Military Personnel System to ensure the Airman is qualified and prepared to proceed on assignment. PPCs are generally included in the Airman's notification of PCS, but are also located on the AFPC website. The AF Form 422 will contain a statement as indicated by PPC listing.

**4. DAWG GUIDANCE FOR REVIEWING TRIGGER EVENTS**

**4.1.** The DAWG will review each case using the criteria listed below. (Previously listed in AFI 41-210).

**4.1.1.** Is timing appropriate for Initial RILO Referral? Verify the Member‘s hospitalization or treatment progress appears to have medically stabilized (and the course of further recovery is relatively predictable). This wording replaced the term ―Optimal Medical and Hospital Benefit‖ under E3.P1.6.1 DoDI 1332.38 [see Personnel and Readiness Policy Memorandum on Implementing Disability-Related Provisions of the National Defense Authorization Act of 2008, 14 Oct 08]. There is no minimum medical evaluation time period and no need to wait for complete or near-complete recovery. There should be no delay in referral of a member‘s case as long as the course of recovery is relatively predictable, and a reasonable determination can be made that the limiting condition is not likely to resolve or improve within 12 months to an extent which renders the SM capable of fully performing the duties of his/her office, grade, rank or rating, to include the ability to deploy to field conditions.

4.1.1.1. In cases where there is no definitive diagnosis, but the preponderance of clinical evidence suggests a probable underlying cause in which the treatment progress, and/or progression of the condition, appears to be reasonably predictable, Initial RILO processing may proceed without a definitive diagnosis.

4.1.1.2. Neoplastic Diseases. A diagnosis of cancer or neoplastic disease may require additional time (beyond 90 days) to establish a clear prognosis. However, if it is clear the SM will require lengthy treatment, or will be unable to perform his/her job for a protracted period of time, referral of Initial RILO to DPAMM should expeditiously occur regardless of prognosis.

4.1.1.3. Solid Organ Transplants. When it is determined that a patient requires a solid organ transplant, an Initial RILO shall be submitted within 90 days of the initial organ transplant determination date.

4.1.2. Is the case appropriate for Initial RILO Referral? Only unfitting conditions are eligible for referral. Unsuiting conditions must be distinguished from unfitting conditions because they are handled using administrative action. Unsuiting conditions are listed in Enclosure 5 of DoDI 1332.38 and AFI 36-3208, Administrative Separation of Airmen, and do not qualify for disability processing. (EXCEPTION: History of anaphylaxis and/or severe reactions requiring venom immunotherapy, although unsuiting conditions, require an Initial RILO for ALC-C consideration.)

4.1.3. Is the member unable to reasonably perform the duties of his or her office, grade, rank, or rating due to a physical or mental condition which is not likely to resolve or improve such that he/she can perform the duties of his/her office, grade, rank or rating within 12 months?

4.1.4. Is this a chronic condition which imposes unreasonable requirements on the military to either maintain or protect the member?

4.1.5. Is this a chronic condition which may preclude or limit the member‘s ability to safely and effectively deploy to field conditions?

4.1.6. Has an Initial RILO package been directed by DPAMM?

4.1.7. Is this a condition with 12 months of cumulative AAC 31 status for the same or related issue(s)?

4.1.8. Is the Member refusing required professional, medical or dental care which would be necessary to achieve fitness for continued military service?

4.2. Upon preliminary review of a case referred due to a trigger event, if it is determined that above criteria (4.1.1) and (4.1.2), plus any of one of criteria (4.1.3), (4.1.4), or (4.1.5) are met, OR if any one of criteria (4.1.6), (4.1.7), or (4.1.8) are affirmed, the Initial RILO package will be completed. If additional review of the Initial RILO package is required, this will be accomplished at the next scheduled DAWG meeting. However, the Initial RILO case may be referred to DPAMM without another DAWG review if the SGP and SGH concur the entire RILO package meets all requirements. All decisions should be tracked in the ASIMS “Refer to DAWG” Tool.

## 5. DAWG GUIDANCE FOR FITNESS EXEMPTIONS

### 5.1. Abdominal Circumference Waivers

See (https://kx2.afms.mil/kj/kx4/FlightMedicine/Pages/discussions.aspx?forumID=1) on the Flight Medicine Standards page of the Knowledge Exchange for updated guidance on abdominal circumference waivers. If you have any questions, post on the discussion thread or contact your MAJCOM/SGP or AFMOA/SGP.

**5.2. Cases Referred Secondary to Prolonged Fitness Exemptions or Cancelled Deployment, TDY, or PCS.** These cases are reviewed with the 8 questions listed above. These cases do not automatically require an initial RILO. However require a DAWG review using the guidance

above. Consider using the "Refer to DAWG" Tool to send response to commander or document DAWG review on a AF Form 422 when referred for prolonged fitness exemption to inform the Commander; "Member has been reviewed by the XXth MDG/DAWG with PULHES as indicated. No require for MEB at this time." This will also indicate that member was reviewed and physical condition at the time of that review.

**6. SGH GUIDANCE**

**6.1. Process for profiling deployment limiting conditions without duty limitations.** The SGH with assistance from the SGP should have a local policy on how to support appropriately profiling these conditions and also how to also ensure the privacy of the patients.

6.1.1 Identify and teach the providers on how to profile for these conditions.
6.1.2. Identify which provider will sign for Mental Health personnel in order to mask the Mental Health diagnosis. If none assigned, the PCM is the default provider.
6.1.3. Identify a standard statement for all these conditions. Recommend, "service member undergoing medical evaluation and/or treatment for a condition that precludes deployment at this time. A deployment waiver may be considered if tasked to deploy prior to expiration date. Contact (SGP/MSME/PCM) if tasked for deployment"
6.1.4. Recommend to not include the statement "A deployment waiver may be considered if tasked to deploy prior to expiration date." if the provide does not recommend a waiver.

**6.2. Duty Limiting conditions and peer reviews**

**6.2.1. Provider Peer Review:** May be used to monitor the quality of the Duty Limiting Condition (DLC) determinations, Fitness Assessment Exemptions (FAE), and application of medical standards. The SGP's role is to monitor and SGH's role is to ensure this is accomplished with data reported in the appropriate forum (ex. DAWG).

**6.2.2. DLC Quality Reviews.** The DAWG will determine the method the DLC Quality Reviews will be performed. Often these will be accomplished via the Provider Peer Review process. They will include the following at a minimum:

6.2.2.1. Are functional limitations appropriate for the diagnosis and written appropriately?

6.2.2.2. Is the estimated duration of medical recommendations (duty, mobility, and/or fitness) appropriate?

6.2.2.3. Was mobility qualification appropriately addressed?

6.2.2.4. Was potential medical disqualification (e.g. diagnosis rendering an Airman unfit for duty), with concomitant need for Initial RILO referral to the DAWG, appropriately identified?

6.2.2.5. Were FAE appropriate?

6.3. **SGH directed Diagnostic and Medication Surveillance.** At least ten times per year, MSME will present findings to the DAWG of selected diagnostic or medication utilization

queries as directed by the SGH to ensure Airmen with certain medical conditions do not remain unidentified in the mobility reporting system. The steps for completing this review are described below. It is the responsibility of the SGH (with the input from the SGP) to assign a provider/s to complete each of the reviews. See 3.3.3. on specifics for execution with the MSME.

## 7. PROVIDER AND PRIMARY CARE TEAM TRAINING

7.1. Responsibility shared by the MTF SGP and SGH. A regular training program when provider arrives at MTF and at a minimum annual concerning appropriate application of medical standards and completion of profiles and duty limitations; Fitness Restrictions (FR), and Fitness Assessment Exemptions (FAE); and the Initial Review-In-Lieu-Of (RILO) and Medical Evaluation Board (MEB) process.

7.2. The SGP will ensure that all Primary Care Management (PCM) providers understand the purpose of the DAWG and the processes utilized by the DAWG to meet its mission.

7.3. Training can include members of the Primary Care Team and can be completed by any member of the DAWG as directed by the SGP.