**BEFORE THE FOREIGN SERVICE GRIEVANCE BOARD**

In the Matter Between

[redacted]
Grievant

and

Department of State

Record of Proceedings
**FSGB Case No. 2014-007**

September 30, 2014

**DECISION**
EXCISION

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For the Foreign Service Grievance Board:

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| Presiding Member: | Warren R. King |
| Board Members: | Lois E. Hartman<br>J. Robert Manzanares |
| Special Assistant: | Lisa K. Bucher |
| Representative for the Grievant: | *Pro se* |
| Representative for the Agency: | Margaret E. McPartlin<br>Attorney<br>HR/G |
| Employee Exclusive Representative: | American Foreign Service Association |

## OVERVIEW

**HELD:** The Board found that under the agency's regulations grievant's spouse was entitled to medical evacuation per diem starting in the 10th week of her pregnancy but that grievant was not entitled to payment for his airline ticket as a non-medical attendant when he traveled with his wife.

**SUMMARY:** During grievant's tour in [redacted] his spouse became pregnant. She had had five previous pregnancies, none of which resulted in a viable birth. The post medical team (FSMP) and the State Department Office of Medical Services (MED) both agreed that this was a very high-risk pregnancy and that the preferred option was that the spouse return to the U.S. as soon as possible for a special procedure and stay under the care of a single obstetrician specializing in high-risk care for the remainder of her pregnancy. Although MED authorized a 14-day medical evacuation for the procedure, it advised grievant that, under its longstanding practice, it could not authorize further medical evacuation per diem under 16 FAM 317.1(c) prior to the 24th week of gestation. MED instead directed grievant to seek the much lower Separate Maintenance Allowance (SMA).

Grievant claimed that the regulation itself stated only that per diem for complicated obstetrical care could be provided for up to 180 days, and therefore permitted his spouse to receive such per diem beginning in approximately the 10th week of pregnancy, when she returned to the U.S. for treatment. He also claimed that he was entitled to have his airline ticket paid for by the agency as a non-medical attendant when he accompanied his wife back to the U.S., since her condition precluded her from carrying her own bags.

The Board concluded that the agency's regulation was not ambiguous, and that any clarification meant to be provided by the agency's longstanding practice was both plainly erroneous and inconsistent with the agency's own regulations, and arbitrary and capricious. We, therefore, did not accord any deference to the agency's interpretation of its regulations by virtue of this practice, and relied instead on the language of the regulation itself.

The Board found that, under the terms of the regulation, grievant's spouse was entitled to medical evacuation per diem from the time she returned to the U.S. through early April, as requested.

With regard to grievant's request for reimbursement for his airline ticket as a non-medical attendant we found that grievant has not proven by a preponderance of the evidence that his wife could not have traveled alone. While the Post's medical professionals (Medical Unit and local obstetrician) acknowledged it was a high risk pregnancy, there was nothing in the record that documented that grievant's spouse was incapacitated and unable to travel alone. The Board thus denied his request for reimbursement for travel as a non-medical attendant.

## DECISION

## I. THE GRIEVANCE

State/MED advised grievant that, under its longstanding practice, it could not authorize medical evacuation per diem under 16 FAM 317.1(c)[1] prior to the 24th week of gestation of his wife's high-risk pregnancy. It instead directed grievant to seek the much lower Separate Maintenance Allowance, which he did.

Grievant claims that MED's longstanding practice is inconsistent with the regulation itself, which states only that per diem for complicated obstetrical care may be provided for up to 180 days. Therefore, his spouse should have been permitted to receive per diem beginning in approximately the 10th week of pregnancy, when she returned to the U.S. for treatment.

Grievant also claims that he should have been permitted to be classified as a non-medical attendant when he accompanied his wife back to the U.S., since she could not carry her own bags.

As relief the grievant asked for the following:

1. Payment of $16,955 (71 days' per diem -- $19,305 less $2,350 received under a Separate Maintenance Allowance (SMA) for the period of January 19, 2013, through April 1, 2013);
2. Reimbursement for his airline ticket as a non-medical attendant;
3. Any other relief deemed just and proper.

[1] 16 FAM 317.1(c): **Complicated obstetrical care**: If the Medical Director or designee or the FSMP at post determines that there are medical complications necessitating early departure from post or delayed return to post, per diem at the rates described in 16 FAM 316.1, may be extended, as necessary, from 90 days for up to a total of 180 days.

## II. BACKGROUND

Grievant, an FS-04, was assigned to Embassy [redacted] His wife, who accompanied him, became pregnant in late 2012. Because she had suffered five prior failed pregnancies or neonatal deaths, her pregnancy was considered high risk. Grievant's wife consulted with a local obstetrician, recommended by Embassy [redacted]'s Medical Unit (FSMP), who confirmed grievant's spouse was a very high risk pregnancy patient, and recommended an early cerclage procedure, preferably performed in the institution where she would be delivering.

On December 16, 2012, in response to the local obstetrician, FSMP [redacted] contacted the Medical Office in Washington, DC (MED), and requested that grievant's wife be medically evacuated to either [redacted] or the United States prior to the 10th week of gestation in order for grievant's wife to undergo the cerclage procedure.

FSMP [redacted] also asked if grievant's wife could be medically evacuated to [redacted] (her relatives resided in [redacted] and then move her medevac site to Washington, DC, in April 2013, when grievant would arrive there for his onward assignment. MED responded that grievant and his wife would have to choose between [redacted] and Washington, DC, as the medevac location. MED would not medevac her from [redacted] to Washington, DC, after grievant changed assignments because the purpose of medevac is to bring the patient to a location of medical care. On December 21, 2012, MED gave grievant and his wife options regarding medical evacuation and subsistence benefits prior to 24 weeks of gestation. In a December 21, 2012, e-mail to the couple, MED advised them of the following regarding medical per diem:

> Considering your wife's history, it is advisable that she be in the U.S. under the care of a high risk OB. Medical per diem cannot be authorized

> until your wife is 24 weeks pregnant, this date is considered viability. If she travels now and if you would like to wait until she is 24 weeks to apply for per diem, then we will be able to authorize medical per diem based on medical reports of complications/high risk. You need to work out which would be more financially beneficial to you. Waiting to apply for medical per diem which is at a much higher rate than ISMA or applying for ISMA before your wife departs post so it will begin upon her arrival. ISMA is at a much lower rate and may work well for you and your wife if she can stay with someone.

In addition, MED gave grievant and his wife the following options on his wife's medical evacuation and subsistence benefits during her stay in Washington, DC:

1. Grievant's wife could travel on his PCS travel orders and then wait until her 24th week of gestation to apply for medical per diem.
2. Grievant's wife could travel on PCS travel and apply through Embassy [redacted]'s Human Resources Office for SMA, but SMA would not be retroactive and had to be requested prior to his wife's departure.
3. Grievant could consider a compassionate curtailment and return to the U.S. for a domestic assignment.

However, after consultation with grievant and his wife, on December 28, 2012, MED authorized grievant's wife to travel on medevac orders to Washington, DC, for a "diagnostic evaluation and/or treatment." In addition, MED authorized 14 days of per diem for the medical evaluation and/or treatment. On January 6, 2013, grievant's wife traveled to Washington, DC, on medical evacuation orders, with grievant accompanying her. He did not request, nor was he issued, orders as a non-medical attendant.

On January 10, 2013, grievant's wife, acting on the recommendation of MED, met with a high risk specialist obstetrician at George Washington Medical Center, who confirmed the need for the cerclage procedure and scheduled it for February 1. The

George Washington Medical Center OB also advised grievant and his spouse that it was best for grievant's wife to remain under her care for the duration of the pregnancy and not to travel back to post. On January 14, MED advised grievant's wife that her medevac per diem would expire on January 20, even though the procedure would not have been performed by that date. On February 1, 2013, grievant's wife underwent the procedure. From January 19, 2013, until grievant's return to Washington, DC, on April 1, 2013, she resided with a family friend and paid rent. Although that was not their preferred option, other short-term housing arrangements would have entailed much greater expense. During that period she received SMA in the amount of $2,350, which grievant had requested when advised medevac per diem was not available.

On February 21, 2014, the agency issued its decision denying grievant's request for relief. On March 25, 2014, he appealed the Department's decision. The ROP was closed on September 12, 2014.

## III. POSITIONS OF THE PARTIES

### A. THE GRIEVANT

Grievant claims that his wife, whose pregnancy was considered high risk, was not afforded the obstetrical care outlined in the Foreign Affairs Manual (FAM) at 16 FAM 300. Grievant argues that 16 FAM 311(a)[2] compels the Department to provide the best medical care possible at post, and, if there is no adequate care, then a medevac is authorized. Grievant also claims that 16 FAM 317.1(c) provided the agency's Medical

[2] 16 FAM 311(a): The general policy of the Department of State is to provide all medical program participants with the best medical care possible at post. In a situation where local medical facilities are inadequate to provide required services, travel to locations where such services can be obtained may be authorized.

Director the authority to approve medical per diem for up to 180 days for patients determined to have complicated, high-risk pregnancies.

When [redacted] FSMP contacted MED in Washington, DC, they were given the response that MED does not medevac for obstetrical care until after the 24th week of gestation. The 24th week of gestation is when the medical world deems a fetus viable outside of the womb. Grievant claims both [redacted] FSMP and the post's Human Resources (HR) reviewed the FAM and other MED documents to determine how MED handles high risk pregnancies at a hardship post and could not find any reference that limited a high risk pregnancy to the 24 weeks claimed by MED.

Grievant claims that since his wife's pregnancy had been defined as high-risk by [redacted] FSMP, the local OB and MED, grievant sought guidance on the applicability of 16 FAM 317(c), which states:

> Complicated obstetrical care: If the Medical Director or designee or the FSMP at post determines that there are medical complications necessitating early departure from post or delayed return to post, per diem at the rates described in 16 FAM.1 may be extended, as necessary, from 90 days to a total of 180 days.[3]

Grievant alleges that after [redacted] FSMP raised the above FAM section to the attention of MED the response it gave MED [redacted] was that it did not medevac for obstetrical care before the 24 weeks of gestation. Grievant claims he then wrote to MED for clarification, explaining that everything he and [redacted] FSMP were reading in the FAM and MED materials supported an obstetrical medevac for his spouse due to her high-risk pregnancy.

When grievant persisted in claiming per diem, grievant claims MED responded via e-mail again informing them that grievant's wife could travel to the U.S. but

[3] *Ibid*. 16 FAM 317.1(c).

reiterating that she would not be eligible for medical per diem until after 24 weeks. Grievant claims when he informed MED he did not have a house in Washington he was advised to apply for Involuntary Separate Maintenance Allowance (SMA). According to grievant he did apply for SMA but put the application on hold because HR [redacted] and [redacted] FSMP did not agree that MED's course of action complied with the FAM.

According to grievant, MED also advised him to send his wife to [redacted], where she had family to stay with. However, this proved to be difficult because all of the doctors in [redacted] and in Washington recommended that his wife stay with the same doctor for the cerclage and duration of the pregnancy.

Grievant alleges that when he and [redacted] FSMP persisted, his wife was given a two-week medevac to allow her to obtain the cerclage procedure and to be evaluated by a high risk obstetrician at Georgetown Medical Center, an OB whom MED recommended. The plan, according to the grievant, was for the OB to evaluate grievant's spouse's situation and then extend the per diem based on the OB's evaluation.

The George Washington Medical Center OB confirmed that grievant's spouse had a high-risk pregnancy and confirmed the need for the cerclage. In addition, grievant claims that the OB emphasized the need for grievant's wife to continue pre-natal care with her and not travel. She wrote:

> Ms. [redacted] is an obstetrical patient under my medical care. Her estimated date of delivery is 8/4/2013. Ms. [redacted] is scheduled for a cerclage on 2/1/2013. I recommend that she continues her prenatal care with me and she does not travel at this time.

However, grievant claims that before the cerclage procedure could be scheduled, MED informed him that the 14 days' per diem granted for the cerclage had expired. Grievant claims that due to the stressful situation he and his wife were placed in, he chose

to take the SMA to have some assistance to find a temporary place to stay, even though it was not enough and well below what he would have been eligible for under per diem.

Grievant claims he contacted the head of MED and asked for an explanation as to why MED was not following 16 FAM 317.1(c), which allowed for medevac for high risk pregnancies. M/MED/FP responded with the following in an e-mail dated August 27, 2013:

> This issue of how early a woman can be medevac'd for delivery comes up regularly. So does the situation of cervical cerclage – up to 80,000 procedures are done in the U.S. per year. While not in the FAM, MED has a long standing internal SOP that the earliest we will medevac a mother for obstetrical delivery is at 24 weeks gestation.

Grievant claims that his spouse's pregnancy was high-risk enough to qualify for medical evacuation prior to the 24 weeks' gestation. Grievant also argues that every medical professional in [redacted] and in Washington, including MED staff, agreed. Grievant argues that MED's justification for how they choose which pregnancy to deem OB-medevac-worthy for high risk is ambiguous. Grievant takes issue with MED imposing internal rules that are not published in the FAM. Grievant claims that the alternatives offered by MED were not in accordance with 16 FAM 317.1(c).

Grievant also claims he is entitled to reimbursement for his own airline ticket, which he bought to accompany his spouse. Grievant claims his spouse was advised not to carry anything, so he needed to accompany her to care for her and her suitcases.

### B. THE AGENCY

The agency bases its denial of medical evacuation per diem for grievant's wife on two somewhat distinct arguments:

1) The agency acknowledges that 16 FAM 317.1(c) provides that per diem may be extended if there are medical complications that necessitate the mother's early departure from post or delayed return to post. However, the agency claims this was not the purpose of the medevac in the instant case. The agency asserts that grievant's wife was medevac'd to Washington, DC, to receive obstetrical care. MED did not believe there were medical complications necessitating early departure from post or delayed return to post. Thus, the agency claims, 16 FAM 317.1(c) does not apply to her situation.

2) The agency further argues that, in any event, although not compelled by law, the Department's Office of Medical Services (MED) has a longstanding internal Standard Operating Procedure (SOP) that the earliest MED will authorize a medevac of a pregnant woman for delivery, even in the case of complicated pregnancies, is 24 weeks' gestational age. This SOP, MED asserts, is based on the medical community's widely accepted recognition that the gestational age for fetal viability is 24 weeks. The agency claims that grievant and his wife, after consulting with MED and receiving much information from them, made an informed decision that grievant's wife would remain in Washington, DC, after the evaluation procedure.

Grievant's claim for reimbursement of travel to accompany his wife for obstetric travel to Washington is dismissed by the agency because he has not sustained his burden to prove by a preponderance of evidence[4] that reimbursement is justified. The agency claims he did not request Embassy [redacted] to place him on his wife's medevac orders as a non-medical attendant. However, the agency states that had he requested such, the request would have been denied. While the pregnancy was high-risk, his spouse could

[4] 22 CFR § 905.1(a)

have traveled alone. MED/FP's view was that her condition did not qualify her as an incapacitated medical evacuee.

In addition, the agency claims that MED's guidance on obstetrical travel states that there are no provisions in the regulations that even allow MED to authorize travel to allow for a husband to attend the birth of a child. The agency claims the decision to accompany his wife was his personal choice and therefore he cannot be reimbursed for his airfare.

## IV. DISCUSSION AND FINDINGS

Except in disciplinary cases the grievant has the burden of proving by a preponderance of the evidence that the grievance is meritorious.[5] In the instant case the Board finds that grievant's claim with regard to medical evacuation per diem has merit, but that his second claim requesting reimbursement for his airfare as a non-medical attendant does not have merit.

The core of this grievance is based on the decision of the Office of Medical Services, Foreign Programs (MED) to deny grievant's request for per diem, to include both lodging and meals and incidental expenses (M&IE), for travel costs necessitated by grievant's wife's high-risk pregnancy. Grievant also challenges the fact that he accompanied his wife to Washington, DC, for her obstetrical evaluation but was not listed on his wife's medical evacuation orders as a non-medical attendant and, therefore, had to absorb the cost of the airfare expenses.

[5] *Ibid*.

Medical Evacuation of Grievant's Spouse

The agency's first argument, that grievant's claim does not fall under 16 FAM 317.1(c) since it would have authorized grievant's wife's return to post after the required procedure, constitutes a *post hoc* rationale. The record clearly shows that the Department's medical personnel involved at the time acknowledged that this was a high-risk pregnancy and that it was "advisable" that grievant's wife be in the U.S. under the care of a high-risk OB for the duration of her pregnancy. The OB in [redacted] wrote:

> Options on first trimester screening were explained. Emphasis was placed on diagnosis of cervical incompetence and placement of early cerclage preferably in institution she will be delivering in to place importance on continuity of care especially since she is a very high risk pregnancy."

MED in multiple communications advised grievant's wife she should be in the U.S. for the duration of the pregnancy. MED's RN wrote, "Considering your wife's history, it is advisable that she be in the U.S. under the care of a high risk OB."

One of MED's reviewing physicians also wrote:

> . . . sounds like a very, very high risk patient. I would recommend doing the whole thing in the U.S. if possible. It is better to stick with one OB to manage the whole thing. No specialist likes to come in and take care of a problem that another specialist started, so it is better to go the whole route with one OB doc. It would also help to diminish the amount of air travel she had to do which cannot be easy on a pregnancy.

Although grievant and his wife were left to make the final decision, the issue was not what the best, and safest, medical approach was, it was simply what funding the Department would provide. MED personnel communicating with both grievant and the post FSMP repeatedly relied on the SOP that no medevac would be provided prior to the 24th week of pregnancy as the basis for their guidance. They did not cite grievant's

wife's particular medical circumstances as the rationale for denying an earlier continuous medevac.

The Department cannot now say it would have taken a different approach, or provided different advice, from that which it provided at the time. Nor do we find support in the record for the Department to have reached this conclusion. Both the medical personnel at post and the OB in Washington, DC, to which the Department referred grievant's wife recommended that she stay in the U.S., under the care of one qualified high-risk pregnancy physician for the rest of her pregnancy. Given grievant's wife's history, and the evaluations of the medical personnel who personally evaluated her, it would have seemed like an extremely high-risk approach for the Department to have authorized her return to post. The fact remains, however, that the Department did not do so at the time.

In denying grievant's request for medevac-related per diem, the agency also argues, notwithstanding the provision of 16 FAM 317.1(c), that both the agency and grievant are bound by the agency's long established practice of providing medevac per diem in high risk or complicated pregnancies only at the 24th week of pregnancy.

16 FAM 317.1(c) sets forth the agency's regulation for providing per diem for medical evacuations in the case of employees or dependents in his wife's situation, in need of complicated obstetrical care:

> **Complicated obstetrical care**: If the Medical Director or designee or the FSMP at post determines that there are medical complications necessitating early departure from post or delayed return to post, per diem at the rates described in 16 FAM 316.1, may be extended, as necessary, from 90 days for up to a total of 180 days.

Grievant argues that the decision process MED used in the instant case is inconsistent with the FAM and that relying on standard operating procedure without documentation to support this assertion is contrary to the regulations.

With respect to the agency's second argument, it is not entirely clear whether the agency is arguing that 16 FAM 317.1(c) is ambiguous and that the SOP elaborates the agency's interpretation of the regulation, or whether it believes that the SOP applies as a free-standing provision. In any case, our conclusions are the same.

We agree with the agency that to the extent that the FAM provision cited above is ambiguous and thus subject to interpretation, it may be clarified by the agency's interpretation, as demonstrated by its established practice, and such interpretation will be accorded substantial deference by the Board.[6] However, the agency's interpretation may not be "plainly erroneous or inconsistent with the regulation" or "arbitrary and capricious or an abuse of discretion." An agency's interpretation of its regulations should "reflect the agency's fair and considered judgment of the matter in question.[7]

It is the Board's view that 16 FAM 317.1(c) is not ambiguous. It provides for the Medical Director or designee or the FSMP at post to determine if there is a complication requiring early departure or a delayed return, and authorizes up to 180 days' per diem when such a determination is made. The entire context of the provision is to define what benefits are provided when based upon **medical** needs, and the provision appears to reflect the individualized medical decision making required in the case of complicated

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[6] FSGB-2012-048 (February 26, 2013); *Chevron vs. NRDC*, 467 U.S. 837, 842-43 (1948).

[7] *Ibid*.

obstetrical care. Although the preceding provision, 16 FAM 317.1(b),[8] places a set 45-day limit for per diem both before and after an uncomplicated pregnancy and birth, that limit is also, by all appearances, based on medical analysis of normal pregnancies and deliveries, which lend themselves to such generalizations. Airlines do not allow pregnant women to travel less than 45 days before birth, because of the risks involved. 16 FAM 317.1(b) recognizes and incorporates that medical evaluation under the circumstances of a normal pregnancy. Although not stated explicitly in the record, we assume that the 45 days of per diem permitted after delivery also reflects a medical assessment of recovery times under normal circumstances, which, because they are normal, can be generalized.

16 FAM 317.1(c), on the other hand, allows individual determinations to be made by informed medical personnel, on its face recognizing the impossibility of determining specific needs in advance when a pregnancy or delivery is complicated. It does not appear to be ambiguous and in need of clarification. Moreover, the hard and fast generalized rule that State has imposed through its long-established practice, permitting medevac and per diem only after the 24th week of pregnancy, appears to be clearly inconsistent with the individualized medical evaluation and decision-making set forth in the regulation.

In the Board's view, the longstanding practice is also arbitrary and capricious and an abuse of discretion. As stated by MED, the rationale for the 24-week practice is that a fetus is generally not considered viable before the 24th week of pregnancy. It is not

[8] 16 FAM 317.1(b) **Uncomplicated obstetrical care**: Per diem may be authorized for a period of up to 90 days for an evacuation for obstetrical care. The per diem rate within the United States is the rate of the elected location within the United States. The per diem rate for an approved location away from post, but outside the United States, is the rate of that location or Washington, DC, whichever is lower. The patient may depart from post approximately 45 days prior to the expected date of delivery and is expected to return to post 45 days after delivery.

based on, and does not take into consideration, whether the mother's need for medical care can be provided safely at post prior to the 24th week, or whether the medical care needed by any fetus of less than 24 weeks to come to full term as a healthy baby can safely be provided at post. It is difficult to see any link at all between the rationale offered by State/MED with the recognition of medical needs established in the regulations.

It is the Board's conclusion that 16 FAM 317.1(c) is not ambiguous, and that any clarification meant to be provided by the Department's longstanding practice of requiring the 24-week waiting period in cases of complicated pregnancies is both plainly erroneous and inconsistent with the Department's own regulations, and arbitrary and capricious. We, therefore, do not accord any deference to the Department's interpretation of its regulations by virtue of this practice, and rely instead on the regulation itself.

To the extent that the agency is arguing that the SOP is freestanding and applies by its own terms, apart from 16 FAM 317.1(c), again, we conclude that the agency is in error. By the same analysis as outlined above, the SOP conflicts with the provision of the published regulations of the agency. An SOP may not take precedence over a regulation with which it is in conflict.

The Board's conclusion, based on the record, is that this was a high-risk pregnancy, with risks to both the mother and the fetus, and that the necessary obstetrical care was in the U.S. Under these circumstances, medical evacuation per diem should have been authorized beginning upon the return of grievant's wife to the U.S., and continuing for 180 days.

Travel of Non-medical Attendants on Medical Evacuations

With regard to grievant's request for reimbursement for his airline ticket as a non-medical attendant, we find that grievant has not proven by a preponderance of evidence that his wife could not have traveled alone. While the FSMP acknowledged it was a high-risk pregnancy, there is nothing in the record that documents grievant's spouse was incapacitated and unable to travel alone. The Board thus denies his request for reimbursement for travel as a non-medical attendant.

## V. DECISION

The Board finds that pursuant to 16 FAM 317.1(c) grievant is entitled to payment of $16,955 (71 days' per diem - $19,305 less $2,350 received under a Separate Maintenance Allowance (SMA)) for the period of January 19, 2013, through April 1, 2013. The Board denies the grievant's claim for reimbursement of non-medical attendant travel.

**For the Foreign Service Grievance Board:**

[redacted]

Warren R. King
Presiding Member

[redacted]

Lois E. Hartman
Member

[redacted]

J. Robert Manzanares
Member