



DEPARTMENT OF THE NAVY
OFFICE OF THE SECRETARY
1000 NAVY PENTAGON
WASHINGTON, DC 20350-1000

SECNAV INSTRUCTION 1850.4E

From: Secretary of the Navy

Subj: DEPARTMENT OF THE NAVY (DON) DISABILITY EVALUATION MANUAL

Ref: (a) Title 10, United States Code
(b) DOD Directive 1332.18 of 4 Nov 96 (NOTAL)
(c) DOD Instruction 1332.38 of 14 Nov 96 (NOTAL)
(d) DOD Instruction 1332.39 of 14 Nov 96 (NOTAL)
(e) SECNAVINST 5300.30C
(f) Manual of the Medical Department
(g) SECNAVINST 1770.3B
(h) Manual of the Judge Advocate General
(i) SECNAVINST 5212.5D

Encl: (1) Table of Contents and DON Disability Evaluation System (DES) Summary
(2) Abbreviations and Definitions
(3) Disability Evaluation Policies
(4) Physical Evaluation Board (PEB) Procedures
(5) Petitions for Relief (PFR)
(6) Permanent Limited Duty (PLD) Procedures
Attachment:
(a) Request for Permanent Limited Duty
(7) Officer Disability Review Board (ODRB) Procedures
(8) Medical Conditions and Physical Defects Which Normally are Cause Referral to the Physical Evaluation Board (PEB)
Attachments:
(a) Minimum Requirements for Medical Evaluation Board (MEB), Addenda and Narrative Summary with Annotations
(b) Conditions Not Constituting a Physical Disability
(c) Sample MEB report
(d) Plates
(9) Special Instructions and Explanatory Notes, VASRD
Attachments:
(a) Analogous Codes
(b) SWATO Undiagnosed Symptom Complex Coding
(c) Tables
(10) What You Need to Know about the Physical Evaluation Board
(11) Non-Medical Assessments (NMA)

Attachment:

(a) Sample Non-Medical Assessment Questionnaire/Narrative Summary

(12) Death Imminent Procedures

Attachment:

(a) Death Imminent Processing

(13) Waiver of Disability Processing

(14) Master Index

1. Purpose. To revise and simplify policies and procedures for evaluation of physical fitness for duty and disposition of physical disability in the Department of the Navy in compliance with Chapter 61 and Section 1554 of reference (a) and with references (b) through (e). This instruction is a complete revision and should be reviewed in its entirety.

2. Cancellation. SECNAVINST 1850.4D. All other regulations, Director Naval Council of Personnel Boards (DIRNCPB) and President, PEB (PPEB) policy letters, and memoranda providing guidance governing disability evaluation, medical processing for disability evaluation, disability separation, PLD status, and PEB organization, procedures and delegations inconsistent with this instruction are cancelled.

3. Authority. Elements of the Department of the Navy Disability Evaluation System listed below are designated and directed to act on behalf of the Secretary of the Navy (SECNAV) to make determinations as to fitness for active and reserve duty of Navy and Marine Corps members, entitlements to disability benefits, and disposition of members properly referred for physical disability evaluations:

a. Informal PEB (formerly the Record Review Panel)

b. Formal PEB (formerly the Hearing Panels)

c. President, PEB

Physical Evaluation Board
Naval Council of Personnel Boards
720 Kennon Street, S.E. Rm 309
Washington Navy Yard, D.C. 20374-5023

d. DIRNCPB

Director, Naval Council of Personnel Boards
720 Kennon Street, S. E. Rm 309
Washington Navy Yard, D. C. 20374-5023

Website: www.hq.navy.mil/ncpb/

Officers comprising these elements shall be governed by the enclosures to this instruction in performing their responsibilities.

4. Responsibility

a. Physical Evaluation Board. Subject to limitations contained in this instruction, acts on behalf of SECNAV to make determinations of Fitness to continue naval service, entitlement to benefits, disability ratings, and disposition of service members referred to it. Composition and procedures are contained in enclosure (4) to this instruction.

b. Assistant Secretary of the Navy for Manpower and Reserve Affairs (ASN (M&RA)). Responsible for management oversight of the DES and for resolution of disability cases referred to the SECNAV under this instruction.

c. Director, Naval Council of Personnel Boards (DIRNCPB)

(1) Assigned overall responsibility for the management, integrity and efficiency of the PEB. In that regard, DIRNCPB may issue internal instructions within the DES to further interpret, implement and govern the workings of the PEB, and coordinates closely with the Chief, Bureau of Medicine and Surgery (CHBUMED) on issues that impact non-PEB portions of the DES.

(2) As the Secretary's principal agent in overseeing the PEB, DIRNCPB may stop action on and refer any case to ASN (M&RA) for resolution should the Director disagree with the disposition proposed by the PEB.

(3) DIRNCPB directs disability separations and retirements. In cases where the service member also is undergoing disciplinary or administrative discharge proceedings which result in a punitive discharge or administrative discharge for misconduct, disability separation is superceded.

(4) Any opinion of the Office of the Judge Advocate General (OJAG) involving an issue of law shall be binding on the PEB and DIRNCPB. If the OJAG determines that there are insufficient facts to support a finding, DIRNCPB may accept the opinion and order appropriate action, return the case to a cognizant authority for more information, or appeal the decision to SECNAV for final resolution.

(5) DIRNCPB shall:

(a) assign, supervise, and direct activities of the President, PEB;

(b) provide budget, facilities, automated data processing, and personnel

support to the PEB;

(c) establish billet/position assignment criteria for all elements within the DES;

(d) provide training for Physical Evaluation Board Liaison Officer (PEBLO) and Collateral Duty Counselors;

(e) provide training for line and medical officers assigned to the PEB;

(f) provide for quality assurance review of the PEB;

(g) submit recommendations to ASN(M&RA) for legislative proposals, Department of Defense (DOD) matters, and changes to this instruction;

(h) maintain appropriate liaison with the Office of the Secretary of Defense, Department of Veterans Administration (VA), Chief, Naval Personal (CHNAVPERS), Commandant of the Marine Corp_for Manpower and Reserve Affairs CMC (M&RA), Commander, Naval Reserve Forces (COMNAVRESFOR), CHBUMED, and OJAG in matters associated with the DES;

(i) provide advisory opinions to the Board for Correction of Naval Records (BCNR) upon request;

(j) provide responses to Congressional interest letters (Congrints);

(k) inform ASN (M&RA) of matters of interest;

(l) protect the privacy of individuals evaluated by the PEB;

(m) maintain a system of records, including PEB records and correspondence files; and

(n) perform such other specific duties and exercise such other discretionary authority as elsewhere set forth in this instruction.

(o) DIRNCPB shall submit a management report of the PEB, within 30 days of the end of each Fiscal Year (FY), including evaluations in the following areas, to ASN (M&RA), with copies to the CNO and CMC:

1. Informal PEB Statistics. Category will report FY-data in the following four areas:

a. Cases carried from the previous FY (Active Duty/Inactive Duty Reservists; and Temporary Disability Retirement List (TDRL).

b. Cases received during current FY (Active Duty/Inactive Duty Reservists; and TDRL).

c. Cases reviewed/completed; and terminated.

d. Cases pending at end of FY (Active Duty/Inactive Duty Reservists; and TDRL).

2. Formal PEB Statistics. Category will report FY-data in the following two areas:

a. Active Duty/Inactive Duty Reservists cases scheduled at Bethesda, MD and San Diego, CA.

b. TDRL cases scheduled at Bethesda, MD and San Diego, CA.

3. Petitions for Relief (PFR) to DIRNCPB. Category will report FY-data in the following two areas:

a. Number of PFRs received.

b. Number of PFRs pending.

4. Additional Workload Statistics. Category will report FY-data in the following four areas:

a. Number of referrals from BCNR.

b. BCNR cases pending.

c. Congressional inquiries received.

d. Congressional inquiries pending.

5. Significant Issues Adversely Affecting PEB Processing. Issues adversely affecting cases processing and developing trends.

(6) DIRNCPB is responsible for the conduct, efficient resourcing, and personnel management of the PEB as prescribed in this instruction. DIRNCPB shall:

(a) Propose, in coordination with CNO, CMC, and the Surgeon General, changes to the DES as appropriate.

(b) Request ASN (M&RA) recommend to Assistant Secretary of Defense for Force Management Policy (ASD (FMP)) changes to references (c) and (d) which serve the needs of the Department of the Navy and naval personnel.

(c) Issue under signature, on behalf of SECNAV, the final Department of the Navy determination in special interest cases, and cases in which relief were granted on the basis of Petitions for Relief.

(d) Liaison with the Department of Defense, Navy, Marine Corps, OJAG, CHBUMED, and other governmental agencies in matters relating to the DES. Keep ASN (M&RA) apprised of actions and issues that might modify or impact the effectiveness of Department of the Navy policies and programs under this instruction.

d. Chief of Naval Operations (CNO) and Commandant of the Marine Corp (CMC). Are responsible for management of medical treatment facilities (MTFs), line of duty investigations, Reserve personnel Notice of Eligibility status, Permanent Limited Duty (PLD) members, and the TDRL in their respective service to meet the policy and procedural objectives in this instruction. CNO and CMC are required to provide alternate and reserve members for service on the PEB upon request of the President, PEB. CNO and CMC have delegated the following responsibilities to the following:

(1) CHNAVPERS and CMC (M&RA)

(a) CHNAVPERS and CMC (M&RA) are assigned certain personnel management actions in support of naval disability evaluation policy.

(b) CHNAVPERS and CMC (M&RA) may, after consultation with the President, PEB, withdraw or suspend any case from any stage of the PEB process for good and sufficient reason. In cases where the member is to be retired or separated, the member need not meet the ability to perform the full military duty standard during the separation physical in order to be separated or retired.

(c) CHNAVPERS and CMC (M&RA) shall:

1. provide statements of naval service and access to fitness reports and performance evaluations for review by the PEB;

2. take action on requests for continuance on active duty in a PLD status, authorize retention on PLD, and administer those personnel consistent with guidance in enclosure (6) of this instruction;

3. accomplish appropriate disposition of members whose disability evaluation has been completed (see paragraph 2022);

4. administer the TDRL as specified in part 6 of enclosure (3);

5. recommend to ASN (M&RA) via the DIRNCPB appropriate changes to this instruction; and

6. perform such other specific duties and exercise such other discretionary authority as elsewhere set forth in this instruction.

(2) CHBUMED. Under the CNO, is responsible for the Medical Treatment Facilities (MTF) compliance within the time standards specified in paragraphs 1008 and 1009 of enclosure (1), for professional medical support of the DES as required in this instruction, and for ensuring reference (f) conforms with this instruction.

(a) Responsible for the efficiency of processing and overall quality of Medical Board reports prepared within the Department of the Navy. In addition, CHBUMED shall provide medical and medical personnel support to the DES, and advice to SECNAV and ASN (M&RA) upon request.

(b) CHBUMED shall:

1. ensure MTF commanding officers provide Medical Board reports to the PEB and further medical support as required by the DIRNCPB, President, PEB, CHNAVPERS, CMC (M&RA), or COMNAVRESFOR in support of the DES;

2. ensure MTF commanding officers establish medical board membership and procedural rules in compliance with this instruction, and professional medical guidance in accordance with accepted medical standards;

3. develop and provide professional training to Medical Corps Officers in proper preparation of Medical Board reports to ensure clear, concise, complete, and timely reports;

4. ensure MTF commanding officers establish and maintain a review of Medical Board reports to ensure the completeness and competency of preparation.

5. provide additional information as requested by the PEB;
6. nominate Medical Corps officers of requisite education and experience to serve on the PEB;
7. recommend to ASN (M&RA) via DIRNCPB appropriate changes to this instruction; and
8. perform such other specific duties and exercise such other discretionary authority as elsewhere set forth in this instruction.

(3) COMNAVRESFOR and CMC (M&RA). COMNAVRESFOR and CMC (M&RA) under guidelines of reference (g), shall provide advisement attached to medical boards for Ready Reservists if a Notice of Eligibility has not been granted.

(4) Judge Advocate General (JAG). Is responsible for reviews for legal sufficiency in classes of cases specified in this instruction, for adjustments to procedural requirements for Line of Duty determinations in reference (h), for support of requirements within this instruction, and for assigning qualified judge advocates to act as legal counsels for members appearing before PEB Formal Boards.

(a) JAG shall provide legal resources to support the DES; take such other actions as directed by statute and this instruction.

(b) JAG shall:

1. review for legal sufficiency, in accordance with 10 U.S.C. 5148, PEB determinations in which an officer is to be retired for disability;
2. as a matter of Secretarial policy, review for legal sufficiency PEB final determinations in the following cases:
 - a. all flag cases
 - b. when requested by SECNAV, DIRNCPB, or President, PEB.
3. return cases determined to be legally insufficient to DIRNCPB for action in accordance with paragraph 4c (4);
4. recommend to ASN (M&RA) via DIRNCPB appropriate

changes to this instruction; and

5. perform such other specific duties and exercise such other discretionary authority as elsewhere set forth in this instruction.

e. Enclosures (1) through (13) comprise the Department of the Navy Disability Evaluation Manual (DEM).

5. **Entitlement Approval.** The entitlement portions of this instruction were approved by the Department of Defense Military Pay and Allowances Committee on 9 November 1989 in accordance with 37 U.S.C. 1001.

6. **Reports and Forms**

a. The management reports required by this directive are exempt from reports control per SECNAVINST 5214.2B.

b. DD 149 (2/86), "Application for Correction of Military Records Under the Provisions of Title 10, U.S. Code, Sec. 1552," is available from the Board for Correction of Naval Records, Department of the Navy, Washington, D.C. 20370.

c. The following forms may be ordered from the Navy supply system CD ROM NAVSUP Pub 600 (NLL):

NAVJAG 5800/15 (3-77), "Injury Report," S/N 0105-LF-105-8075

NAVPERS 1830/1 (2-77), "Application for transfer to Fleet Reserve," S/N 0106-LF-018-3006

NAVMED 6100/2 (5-81), "Statement of Patient concerning the findings of a Medical Board,"

William A. Navas, Jr.
Assistant Secretary of the Navy
(Manpower and Reserve Affairs)

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C4HH (Ambulatory Care Center)
C17 (Naval Council of Personnel Boards Detachments) (San Diego and Bethesda)
C28C (Personnel Support Activity Detachments, LANT)
C28G (Branch Dental Clinic, LANT)
C28H (Branch Medical Clinic, LANT)
C31D (Branch Dental Clinic, PAC)
C31E (Personnel Support Activity Detachments, PAC)
C31J (Branch Medical Clinic, PAC)
C31K (Medical Administrative Unit, PAC)
C34C (Support Activity Detachments, EUR)
C34F (Branch Medical Clinic, EUR)
C34G (Branch Dental Clinic, EUR)
C52A (Medical Command Detachment)
C52D (School of Health Sciences Detachments)
C52E (Operational Medicine Institute Detachment)
C52F (Medical Information Management Center Detachment)
C55A (Naval Personnel Command Detachments)
C55C (Recruiting District Detachments)
C55D (Enlisted Placement Management Center Detachment)
C58Q (Branch Dental Clinic, CNET)
C58R (Branch Medical Clinic, CNET)
C61B (Recruiting Command Detachments, Reserve)
C85A (Branch Medical Clinic, NAVDIS)
D1A (Naval Council of Personnel Boards)
D1B (Board for Correction of Naval Records)
FA4 (Ambulatory Care Center, LANTFLT)
FA5 (Construction Battalion Center)

FA6 (Air Station LANT)
FA7 (Station LANT)
FA8 (Fleet Technical Support Center, LANT)
FA10 (Submarine Base LANT)
FA13 (Submarine Support Facility)
FA18 (Amphibious Base LANT)
FA24 (Base LANT)
FA27 (Weapons Station, LANT)
FA28 (Security Force Company, Marine Corps, LANT)
FA29 (Security Force Battalion, and Anti-Terrorism Team)
FA37 (Personnel Support Activity LANT)
FA40 (Health Care)
FA47 (Hospital/Medical Center, LANT)
FA48 (Dental Center, LANT)
FB6 (Air Facility PAC)
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FB9 (Ambulatory Care Center, PACFLT)
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FC7 (Station EUR)
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FH13 (Hospital Corps School)
FH18 (Operational Medical Institute)

FH20 (Health Research Center)
FH24 (Medical Information Management Center)
FH26 (Environmental Health Center)
FH28 (Health Sciences, Naval School)
FH35 (Hospital Operations and Training Command)
FH36 (Healthcare Support Office)
FH38 (Medical Support Office)
FJA8 (Reserve Personnel Center)
FJA9 (Enlisted Personnel Management Center)
FJA10 (Manpower Analysis Center)
FM1 (Security Force Company, Marine Corps, Central)
FO1 (Legal Service Command)
FO2 (Legal Service Office)
FO4 (Justice School)
FR3 (Air Station, RESFOR)
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FR5 (Air Reserve)
FR9 (Reserve Readiness Command Region)
FR10 (Reserve Centers)
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FT1 (Chief of Education and Training)
FT2 (Air Training)
FT4 (Ambulatory Care Center)
FT6 (Air Station)
FT13 (Air Technical Training Center)
FT20 (Construction Training Center)
FT22 (Fleet Combat Training Center)
FT24 (Fleet Training Center)
FT27 (Nuclear Power Training Unit)
FT28 (Education and Training Center)
FT29 (Recruit Training Command)
FT30 (Service School Command)
FT31 (Training Center)
FT38 (Submarine Training Center)
FT39 (Technical Training Center)
FT44 (Diving and Salvage Training Center)
FT46 (Fleet Anti-Submarine Warfare Training Center)
FT51 (Mine Warfare Training Center)
FT65 (Fleet Intelligence Training Center)
FT78 (Education & Training Professional Development and Technology Center)
FT97 (Intelligence Training Center, Navy and Marine Corps)

FT108 (Hospital)
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ENCLOSURE 1: DON DISABILITY EVALUATION SYSTEM (DES) SUMMARY

1001 Summary of Major Changes

a. Permanent Limited Duty (PLD)

CHNAVPERS and CMC (M&RA) may retain on active duty in a PLD status members found Unfit to continue naval service, if it is determined that a need for the service member's skill or experience justifies the continuance of that service member on active duty or in an active status in a limited assignment. Authority to grant PLD is limited solely to service headquarters. The President, PEB will no longer grant up to 90 days of PLD for sailors and 60 days of PLD for Marines. The conditional acceptance offering members the option to select 60/90 days of PLD from the President, PEB or requesting longer time periods via the President, PEB is no longer an option. See enclosure (6) for a detailed discussion of PLD.

b. PLD Reevaluations

Members found Unfit to continue naval service and approved for PLD for a period in excess of 12 months shall be given a current examination and again be referred to the DES for reevaluation. Service Headquarters, in conjunction with the member's command, will ensure members are again referred for reevaluation. Reevaluations should be received by the PEB a minimum of 4 months before the completion of the PLD period or at such time as the PLD period is otherwise terminated. New conditions will be evaluated and addenda submitted with the final reevaluation. Reevaluations should include at a minimum, a new medical board report with medical board report cover sheet NAVMED (6100/1), associated medical board statement of patient NAVMED (6100/2), and health record entries since dictation of original medical board placing the member in a PLD status. In those cases where, upon reevaluation, the member's disability rating changes from their initial rating when placed on PLD, the member shall be afforded the opportunity to request a Formal PEB. The President, PEB shall determine whether a Formal PEB is appropriate on a case-by-case basis. See enclosure (6) for a detailed discussion of PLD and PLD reevaluations. When a member returns for reevaluation at the end of his/her PLD, any new and unrelated conditions listed and addressed will be subject to the "presumed fitness" rule and will have to overcome presumed fit in order to be rated.

c. Waiver of Disability Processing

With the approval of the PPEB, acting on behalf of the Secretary of the Navy, a service member may waive entrance into the Disability Evaluation System under certain circumstances. A member requesting a waiver must complete the waiver request form per enclosure (13). See paragraph 3209 for a detailed discussion on waiver of disability processing.

d. Existed Prior to Service(EPTS)

In the case of a member who is on active duty for more than 30 days whose disability is determined to have been incurred before the member became entitled to basic pay in the member's current period of active duty (EPTS), the disability shall be deemed to have been incurred while the member was entitled to basic pay and shall be so considered for purposes of determining whether the disability was incurred in the line of duty provided the member has over 8 years of active service. The 8 years of active service does not have to be continuous. Members found Unfit – EPTS, Not Ratable are not eligible for disability severance pay or retirement if the member has less than 8 years cumulative active service, but may be eligible for severance pay or retirement under other provisions of law.

e. Presumption of Fitness (PFit)

PFit means evidence establishes that the member's functional impairment has not caused a premature termination of a career. Members found PFit are afforded the same rights within the DES as those found Fit to continue naval service. Members found PFit are not eligible for disability retirement, but are eligible for retirement under other provisions of law, and for evaluation by the Department of Veterans Affairs for disability compensation. MEBs submitted on members meeting the definition of PFit must be received by the PEB 60 days prior to the originally approved retirement date to allow for adequate processing time. MEBs received within the 60-day window will be screened by a medical officer of the Informal PEB to ensure serious conditions overcoming PFit are not overlooked. Cases not accepted after medical review will be rejected, returned to the MTF, and service headquarters notified to continue processing the member for retirement. See paragraph 3305 for a detailed discussion of PFit.

f. Overcoming PFit

The PFit rule can be overcome when certain conditions exist. Previously, if within the presumptive period an acute, grave illness or injury occurred leading to an otherwise Unfitting medical condition and the natural progression of that condition would normally result in either a significant life-span reduction/death or deterioration to the point where it could warrant a permanent disability rating of 60 percent or higher the member would overcome the presumption. This revision eliminates the 60 percent threshold. See paragraph 3305.

g. Reconsideration

If found Fit to continue naval service, the service member may either accept the finding or submit a written request for reconsideration to the Informal PEB. The request for reconsideration will include new medical information or significant non-medical information not previously available. If found Unfit to continue naval service, the service member has the right to accept the findings or demand a formal hearing before a Formal PEB. In certain instances, members found Unfit may be reconsidered by the Informal PEB. See paragraph 4214.

h. Death Determinations

Death determinations shall be made in accordance with accepted medical standards and the laws of the state where the member is located at the time of his/her evaluation or military

medical standards in effect for the foreign area where the member is located at the time of his/her evaluation. In cases where Death Imminent Processing is desired, a signed statement from the attending physician stating that the local laws governing determination of death are understood, is required [refer to attachment (a) to enclosure (12)]. Do not forward to the PEB, death imminent medical board reports for members who, by the applicable standards, have died.

i. Medical Board Evaluations

A member may be removed from full military duty for up to 30 days of light duty for the purpose of evaluation or treatment of a medical condition. If the member is unable to return to full military duty at the end of these 30 days of light duty, the member will be referred to a Medical Board for evaluation for placement on Temporary Limited Duty (TLD) or referral to the PEB. Continuous periods of light duty are prohibited (except that members referred to a Medical Board may be recommended for another 30 days of light duty in order to prevent further aggravation of the condition necessitating the Medical Board referral.) Only enlisted members may be moved TEMDU to an MTF Medical Holding Company as clinically indicated.

j. Temporary Limited Duty (TLD)

(1) For members of the Navy and Marine Corps, the period of TLD shall not exceed 16 months per career, cumulative, before the member either is referred to the PEB for evaluation or is returned to military duty.

(2) If TLD originally is granted for 8 months, and extension or renewal is needed, the MTF shall submit the request to BUPERS (PERS-821) or CMC (MMSR-4), as appropriate, based on a medical evaluation that additional TLD months likely will be sufficient to restore the member to military duty.

k. Non-Medical Assessments (NMA)

A NMA is the commanding officer's assessment of the member's performance of duty. NMAs will be forwarded with the MEB report in all cases except in situations of critical illness or injury where the member has been declared "Death Imminent". This document is crucial in summarizing the member's limitations from the perspective of the commanding officer. The NMA is one document, comprised of a brief questionnaire along with a narrative summary. Given the disability evaluation system's emphasis on performance, the NMA's ability to highlight the sailor or Marine's ability/inability to execute duties as required of his/her rating/rank and the reality of their contribution is critical in portraying a service member's limitations. Capturing the command's observations as to how the service member's impairments have or have not impacted upon the member's ability to function within the command through concise and succinct statements greatly assists the voting members in determining the Fit/Unfit potential of the member. Commanders will ensure that NMAs are submitted to the requesting facility within 15 calendar days from the date of receipt of such request. See enclosure (11) for the format required of NMAs.

l. Medical Boards on Fibromyalgia

This diagnosis must be made by or with the consultation of a rheumatologist, who will either be a signatory of the MEB report (with recent consultation report included when sent to the Informal PEB) or the author of a recently typed addendum. A psychiatry addendum must also be included.

m. Rejection of Cases

Upon receipt, each case submitted to the PEB will undergo screening to ensure that the fundamental elements needed for a determination of Fitness are included, i.e. current physical exams, NMAs, appropriate signatures, etc. The President, PEB may reject any case that lacks necessary or required information needed to determine Fitness, mental competence, eligibility for disability benefits, or an appropriate disability rating. If, upon review, it is determined that the medical board package lacks an item required for submission, the case will be rejected and returned to sender. When rejecting a case, the President, PEB shall specifically identify case deficiencies to enable the submitting medical facility, general court-martial convening authority (GCMCA), or command having cognizance over the member, to provide the necessary information. See paragraph 3203 for detailed discussion of case rejection.

n. Medical Board Reports

Medical Board reports referring members to the PEB will be processed and received by the PEB within 30 days of dictation of the MEB rather than 30 days from the decision by the medical officer to submit a MEB. Rejection of a MEB by the PEB for completion of case documentation standards per paragraph 3202 is included in this 30-day standard.

1002 Applicability

a. This instruction is to be used in the adjudication of all cases entering the DES after the publication date of this instruction. [Cases entering the DES prior to 22 Dec 1998, but after May 14, 1997 are to be adjudicated under the provisions of SECNAVINST 1850.4C and references (b), (c), and (d) of the basic instruction. Cases entering the DES prior to May 15, 1997, will be adjudicated in accordance with SECNAVINST 1850.4C.]

b. This instruction applies to all members of the active force, the reserve component, members placed on the TDRL, and former officers retired or released from active duty without pay for physical disability. Processing for punitive discharge and processing for administrative discharge for misconduct takes precedence over processing for disability. For cases already being considered at the PEB, once the PEB is formally notified that punitive action has been initiated, disability case processing is immediately suspended pending the outcome of the punitive action. Do not submit a case to the PEB for a member who is being processed for a punitive discharge as the result of a captain's mast or court-martial or for a member who is pending an administrative discharge due to misconduct. When a punitive discharge or administrative discharge for misconduct does not result, disability processing shall be resumed and completed.

1003 Policy

a. Department of the Navy policy is to operate a system for disability evaluation which makes a single determination of physical fitness to continue naval service, provides for one nonautomatic appeal for members found Unfit to continue naval service, assures the rights of the member afforded by law, protects the interests of the government, and eases transition to civilian life for those found Unfit for continued naval service.

b. No active duty member of the naval service, including reservists on extended active duty or reservists issued a Notice of Eligibility (NOE), may be retired or separated for physical disability without a Formal PEB if demanded under section 1214 of reference (a).

c. No member of the reserve component shall be separated for being Not Physically Qualified for continued naval service without a Formal PEB unless he or she waives the right. In this case, the member will bear the associated travel cost.

d. Inactive-duty reservists found Not Physically Qualified for continued naval service by the CHBUMED shall be separated, unless the inactive duty reservist requests referral to the PEB.

e. A reservist on extended active duty for more than 30 days or more who has been released from active duty and is now in an inactive duty status and requests referral to the PEB for a condition which the member alleges was incurred or aggravated while on active duty shall be processed into the DES and the PEB shall determine and record whether the member is Fit or Unfit. In this instance the reservist comes under the provisions of 10 U.S.C. 1201 – 1203 and not 10 U.S.C. 1204 – 1206 (reference (a)). In such a situation, “in line of duty while entitled to basic pay” rather than “proximate result” is the applicable statutory requirement for entitlement to disability compensation. Paragraph c of part 4 of reference (c) pertains.

f. Officers Separated for Disability without Pay. An ad hoc Officer Disability Review Board (ODRB) is established as required by Section 1554 of reference (a). DIRNCPB will convene the ODRB when needed to review, at the request of an officer retired or released from active duty without pay for physical disability, the findings and decisions of the PEB, or of the predecessor board which made that determination. Procedures for its operation are set out in enclosure (7).

g. The TDRL will be managed to minimize the number of members awaiting final resolution of their duty status through timely reevaluation of their disabilities every 18 months, and prompt determinations of fitness for duty.

h. The number of members Unfit to continue naval service but retained in Permanent Limited Duty (PLD) status shall be maintained at the minimum level consistent with the guidance in this instruction.

1004 Procedure

Physical evaluation proceedings shall be conducted under procedures in enclosure (1) through (12) as follows:

a. The PEB is established to act on behalf of the Secretary of the Navy (SECNAV) in making determinations of Fitness to continue naval service, entitlement to benefits, and disposition of service members referred to the PEB. Excluding any case designated by the Secretary, the President, PEB, acting for the Secretary, shall issue the findings of the PEB.

b. The Informal PEB will perform record reviews in cases sent before it, and the President, PEB will notify the member by hand delivery or certified mail of the preliminary findings based on a preponderance of the evidence of the record. The preliminary findings become the PEB final determination upon a finding of Fit to continue naval service or upon waiver of the hearing right by the member.

c. The PEB will advise the member of its preliminary findings as to Fitness to continue naval service, degree of disability, and entitlement to disability pay, and will provide an opinion as to the combat-relatedness for federal income tax purposes of any disability found. Dependent upon the nature of the case, a member has the following options:

(1) Agree with a records-only finding of Fit to continue naval service (or Physically Qualified for continued service in the Naval/Marine Corps Reserves in the case of inactive-duty reservists). In this case, there is no right to a hearing; therefore, the member is referred to his or her service headquarters for appropriate assignment or disposition.

(2) Disagree with a records-only finding of Fit to continue naval service (or Physically Qualified for continued service in the Naval/Marine Corps Reserves in the case of inactive-duty reservists) and request reconsideration. For the case to be reconsidered, the member must provide medical or non-medical information not previously available or considered. The member also must state whether or not a hearing is desired if the finding of Fit or Physically Qualified for continued naval service is unchanged. If the finding of Fit or Physically Qualified for continued naval service is confirmed, there is no right to a hearing. Service members found Fit or Physically Qualified for continued naval service will be referred by the PEB to their service headquarters for appropriate assignment or disposition. TDRL personnel found Fit to continue naval service will be given the option either of returning to active duty, being discharged from the naval service, or demanding a Formal PEB. The DIRNCPB is authorized to grant a request for a hearing in the case of a member found of Fit or Physically Qualified for continued naval service in order to preclude an error or injustice.

(a) Within a finding of Fit to continue naval service is the understanding that the mere presence of a diagnosis is not synonymous with a disability. In order to find that a member is Unfit for continued naval service, it must be established that the medical disease or condition underlying the diagnosis actually interferes significantly with the member's ability to carry out the duties of his or her office, grade, rank or rating.

(b) The PEB does not determine a member's status for deployability or suitability; therefore, a PEB determination of Fit to continue naval service does not preclude subsequent non-PEB determinations of temporary unfitness for specific assignments, PRT/PFT participation, disqualification from special duties, or administrative action (including separation) resulting from such determinations.

(3) Agree with records-only findings of Unfit to continue naval service and waive the right to a hearing. Service members found Unfit who waive their right to a hearing are referred by the PEB to CHNAVPERS, CMC (M&RA), or COMNAVRESFOR for separation or retirement, as appropriate.

(4) Disagree with records-only findings, which include a finding of Unfit to continue naval service and exercise the right to a hearing. The Formal PEB then will conduct a hearing and recommend a final determination. The PEB merely expresses an opinion on the combat relatedness of injuries or conditions. Pursue disagreements with the PEB opinion by petitioning the Office of the Judge Advocate General. Disagreement with the PEB opinion on combat-relatedness is not a basis for demanding or requesting a Formal PEB.

(5) Disagree with records-only finding of Not Physically Qualified for continued service in the Naval/Marine Corps Reserves (in the case of inactive-duty reservists) and request a hearing. The Formal PEB then will conduct a hearing and make recommended findings to the President, PEB, who will issue a final determination.

d. The member must exercise his or her options in subparagraph 1004c within 15 calendar days of notification by the PEB of the preliminary findings. Acceptance will be presumed on the 16th calendar day following receipt of notification.

e. For members who have been found mentally incompetent, the assigned MTF PEBLO will advise (in the following precedence order) either the member's court appointed legal representative or the next-of-kin as defined in section 2049, of the findings and available options. To assist the PEBLO in the performance of these duties, the PEB and NCPB Legal Counsel are available for consultation.

f. When a member exercises the right to a hearing, or when SECNAV or DIRNCPB authorizes a hearing, the Formal PEB will conduct a full and fair hearing, subject to the review of President, PEB. The President, PEB, will issue the final determination.

g. President, PEB may defer acceptance of a case by the PEB when the accompanying medical records, Line of Duty Determination/Investigation, or non-medical documentation lack detailed information required for determination of Fitness, eligibility, combat-related injury, mental competence, or inactive reserve entitlement status, and task the medical facility, command, or general court-martial convening authority having cognizance over the submitting command or member to correct document deficiencies or supply the required information. Prompt responses to such requests shall be provided.

h. The findings of the PEB are final upon issuance by the President, PEB, or when the member has agreed with the findings of the PEB and waived the right to a hearing. The findings may not be changed, modified, set aside or reopened except for the correction of errors or upon submission of a Petition for Relief (PFR). A member may petition DIRNCPB for relief as provided in enclosure (5). Submit a PFR within 15 calendar days of notification of the final determination of the PEB. Acceptance will be presumed on the 16th calendar day following receipt of notification.

i. DIRNCPB will make a determination on each PFR filed based on the merits of the case, and advise the petitioner by certified letter, with copies to the President, PEB, CHNAVPERS and the CMC (M&RA), as applicable.

j. In the special interest cases of flag and general officers, and medical corps officers of any grade who are on active or reserve duty, and at the time of referral for physical disability evaluation, were scheduled for nondisability retirement under any provision of reference (a) for age or length of service, the PEB determination will be made as a recommendation to the Assistant Secretary of the Navy (Manpower and Reserve Affairs) (ASN (M&RA)), prepared for submission to the Assistant Secretary of Defense (Health Affairs) (ASD (HA)) for approval prior to final decision by SECNAV. Section 1216 of reference (a) and reference (c) applies.

k. Members who are Unfit to continue naval service may be retained on active duty in PLD status for a specified period of time to meet shortages against authorized strength in an enlisted skill, competitive category, designator or specialty, or a military occupational field or specialty, provided they can perform required duties in an authorized billet for that skill. Unfit members may be retained in PLD status to complete a current tour of duty or to provide continuity in key billets pending relief. Requests from Unfit members for continuation in PLD status may also be considered as provided in enclosure (6).

l. Members Unfit to continue naval service may be retained in a PLD status for a specified period of time, at the request of a commanding officer of a medical treatment facility (MTF), to meet the need for that specific type of condition in a graduate medical education program at a specific MTF that cannot be met at that MTF by other authorized means and is essential to maintaining program accreditation. Unfit members also may be retained for MTF-specific medical research protocols. In each case, retention requirements must be fully documented to demonstrate essentiality, and must be approved by CHBUMED and CHNAVPERS or CMC (M&RA), as applicable.

m. Members Unfit to continue naval service may be retained in a PLD status for a specified period of time, at the request of a commanding officer of a MTF, to complete a current episode of treatment at a specific MTF when the continuity of care is deemed essential for the following reasons:

(1) medical specialties or facilities are not available in the Department of Veterans Affairs (VA) or,

(2) transportation to another medical facility is medically contraindicated.

Transfer to the VA will take into consideration VA clinical resources. In each case, the request must be documented fully and approved by the CHBUMED and the CHNAVPERs, CMC (M&RA) or COMNAVRESFOR, as applicable.

n. Members Unfit to continue naval service may be retained on active duty in a PLD status for the period required to complete their active service obligation for:

(1) enlisted education and training, including Enlisted Education Advancement Program, initial and advanced skill training schools which require obligation beyond initial enlistment contract, nuclear power field, advanced electronic field, and advanced technical field programs and similar programs. CHNAVPERs, CMC (M&RA) or COMNAVRESFOR may waive this requirement on a case by case basis when, as the result of a disabling condition, there is no billet in which disabled members can perform the required duties adequately.

(2) funded education programs including Naval Academy, Naval Reserve Officer Training Corps (NROTC), Armed Forces Health Professions Scholarships, Uniformed Services University of Health Sciences and equivalent funded education programs; advanced education or technical training requiring additional obligated service, including postgraduate education, service school or college, law school, medical residency (including fellowships), flight training, naval flight officer training, and equivalent programs. ASN (M&RA) may waive the requirement in cases where CHNAVPERs, CMC (M&RA) or COMNAVRESFOR demonstrates that, as the result of the disabling condition, there is no billet in which the disabled officer can perform the required duties adequately.

1005 Prompt Identification of Disability

It is not within the mission of the Department of the Navy to retain members on active duty or in the Ready Reserve to provide prolonged, definitive medical care when it is unlikely the member will return to full military duty. Accordingly, line commanders, commanding officers of MTFs and individual medical and dental officers shall promptly identify for evaluation by Medical Boards and appropriate referral to the PEB under this instruction, those members presenting for medical care whose physical or mental fitness to continue naval service is questionable.

1006 Use of Earned Leave

a. Under current law, unused leave is reimbursed upon separation at less than full pay and allowances. Members whose Medical Board reports have been accepted by the PEB are encouraged to use their earned leave, especially leave that would be lost upon separation. Cognizant commands shall make every effort to accommodate leave requests of members physically able to do so.

b. Commands shall not charge annual leave to members required to report for examination, medical treatment, rehabilitation, therapy, etc.

c. Do not charge a member annual leave when official duty or convalescent leave is the proper category.

1007 Transition

Complete those Medical Board reports, which have been signed by the convening authority prior to the date of this instruction under the procedures in the preceding edition of this instruction, as modified by reference (b) through (d). All members on the TDRL on the date of this instruction will be managed under this edition of this instruction.

1008 Medical Board Evaluations and Temporary Limited Duty(TLD) Processing Time Standards

a. Medical Board Evaluations: A member may be removed from full military duty for up to 30 days of light duty for the purpose of evaluation or treatment of a medical condition. If the member is unable to return to full military duty at the end of the 30 days of light duty, the member will be referred to a Medical Board for evaluation for placement on Temporary Limited Duty (TLD) or referral to the PEB. Continuous periods of light duty are prohibited (except that members referred to a Medical Board may be recommended for another 30 days light duty to prevent further aggravation of the condition necessitating the Medical Board referral.) Enlisted members may be moved TEMDU to an MTF Medical Holding Company as clinically indicated.

b. Temporary Limited Duty (TLD): Members should be placed on TLD when the prognosis is that the member can be restored to full military duty within a reasonable period of time, usually 16 months or less. The period of TLD shall be the number of months needed to correct the incapacity, applying generally accepted medical standards of practice. All officer MEBs, enlisted MEBs recommending initial periods of LIMDU longer than 8 months, and enlisted MEBs recommending subsequent periods of LIMDU must be submitted to the member's service headquarters for departmental review.

(1) U. S. Navy

(a) Active Duty: TLD periods shall not exceed 16 months, per career, cumulative. Extensions may be authorized by CHNAVPERS (PERS-821) on a case-by-case basis. If TLD is originally granted for 8 months, and an extension or renewal is desired, the MTF shall submit the request to CHNAVPERS (PERS-821). Any extension or renewal of TLD greater than 8 months must be approved by CHNAVPERS (PERS-821) based on a medical evaluation that the additional months of TLD will be sufficient to restore the member to full duty. Upon completion of the authorized TLD, return the member to duty or refer to the PEB.

(b) Naval Reserve: There is no TLD for members in a Ready Reserve status.

(2) U. S. Marine Corps

(a) Active Duty

1. TLD may be approved for enlisted Marines at the local MTF for up to an initial 8 months without the approval of CMC (MMSR-4). A copy of the board must be forwarded to CMC (MMSR-4) for historical record.

2. A re-evaluation of the member must be made 2 months prior to the completion of any period of LIMDU, and the MTF will inform CMC (MMSR-4) of the member's new medical status prior to the completion of the LIMDU period.

3. After 16 months of LIMDU, CMC (MMSR-4) will forward MEBs to the PEB. However, CMC (MMSR-4) reserves the prerogative to authorize an additional period of LIMDU for severe and unusual cases.

(b) Marine Corps Reserve. There is no Temporary Limited Duty for members in a Ready Reserve status.

1009 Disability Evaluation System (DES) Processing Time Standards

a. Refer service members to the PEB for disability evaluation as soon as it has been ascertained that return to full duty is unlikely, and optimal medical treatment benefits have been attained. To minimize the amount of Navy and Marine Corps manpower awaiting determination of fitness for duty, and to provide prompt decisions to service members being evaluated for disability, the following time standards are established. These time standards may be exceeded only in unusual circumstances.

b. Medical Board Reports. Medical Board reports referring members to the PEB will be processed and received by the PEB within 30 days of the dictation of the MEB. Rejection of a MEB by the PEB for completion of case documentation standards per paragraph 3202 is included in this 30-day standard.

c. Physical Evaluation Board (PEB)

(1) Records-based Disability Determination. Upon acceptance of the Medical Board report and all necessary medical and non-medical documentation by the PEB, the processing time to the date of the determination of the final reviewing authority of preliminary findings normally should be no more than 40 days.

(2) Hearing-based Disability Determination. Upon PEB receipt of the member's decision to demand a Formal PEB hearing, the processing time to the date of the determination of the final reviewing authority normally should be no more than 90 days.

d. Petitions For Relief (PFR). Upon DIRNCPB receipt of the Petition for Relief, the processing time to the date of the determination of the final reviewing authority normally should be no more than 45 days

e. Officer Disability Review. The final reply to requests from officers retired or released from active duty without pay for physical disability for review of their case normally should be issued within 45 days of the date the request is received.

f. Separation/Retirement Date. The effective date of retirement/separation because of physical disability (either permanent or temporary) normally shall be within 4-6 weeks, on the average, after issuance of the "Notification of Decision". The 4-6 week average elapsed time standard, however, is a guideline, not an inflexible rule. It may be exceeded by CHNAVPERS and CMC (MMSR-4) in such circumstances as severe hardship on the member, taking earned leave when the member is unable to sell it, infeasibility, such as when there is longer lead-time for properly vacating government quarters or arranging movement of household effects, and adverse effect on the service such as when it would preclude contact relief of officers in command or other key billets.

1010 – 1099 Reserved

ENCLOSURE 2 ABBREVIATIONS AND DEFINITIONS

2001 Abbreviations

ASD (HA) - Assistant Secretary of Defense (Health Affairs)
ASN (M&RA) - Assistant Secretary of the Navy (Manpower & Reserve Affairs)
BAC - Blood Alcohol Concentration
BCNR - Board for Correction of Naval Records
BUMED – Bureau of Medicine and Surgery
CCEP - Comprehensive Clinical Evaluation Program
CHBUMED - Chief, Bureau of Medicine and Surgery
CHNAVPERS - Chief of Naval Personnel
CMC - Commandant of the Marine Corps
CNO - Chief of Naval Operations
COMNAVRESFOR - Commander, Naval Reserve Forces
DES - Disability Evaluation System
DFAS – Defense Finance and Accounting Service
DIRNCPB - Director, Naval Council of Personnel Boards
DNEPTS - Did not exist prior to service (enlistment)
DSM – Diagnostic and Statistical Manual of Mental Disorders
DOD - Department of Defense
En Bloc - Notification of Decision to service headquarters
EPTS - Existed Prior to service (enlistment)
GCM - General Court-Martial
IRR - Individual Ready Reserve
JAG - Judge Advocate General of the Navy
JAGMAN - Manual of the Judge Advocate General
JFTR - Joint Federal Travel Regulations
LODI - Line of Duty Investigation
LODD – Line of Duty Determination
MANMED - Manual of the Medical Department
MEB – Medical Evaluation Board
MOS - Military Occupational Specialty
MTF - Medical Treatment Facility
NCPB - Naval Council of Personnel Boards
NEC - Naval Enlisted Classification
NOE - Notice of Eligibility
NMA – Non-Medical Assessment
NROTC - Naval Reserve Officer Training Corps
ODRB - Officer Disability Review Board
PDRL – Permanent Disability Retired List
PEB - Physical Evaluation Board
PEBLO - Physical Evaluation Board Liaison Officer
PFR - Petition for Relief
PLD - Permanent Limited Duty

PPEB – President, Physical Evaluation Board
SECDEF - Secretary of Defense
SECNAV - Secretary of the Navy
SECNAVINST - Secretary of the Navy Instruction
SURGEN - Surgeon General
SWATO - Southwest Asia Theater Of Operations
TDRL - Temporary Disability Retired List
TLD - Temporary Limited Duty
UCMJ - Uniform Code of Military Justice
VA - Department of Veterans Affairs
VASRD - Department of Veterans Affairs Schedule for Rating Disabilities

Definitions 2002-2086

2002 Accepted Medical Principles

Fundamental deductions, consistent with medical facts, which are so reasonable and logical as to create a virtual certainty that they are correct.

2003 Accession Standards

Physical standards or guidelines that establish the minimum medical conditions and physical defects acceptable for an individual to be considered eligible for appointment, enlistment or induction into the military services under DoD Directive 6130.3 of 3 June 1994 (NOTAL).

2004 Active Duty

Full-time duty in the active military service of the United States. It includes:

- a. Full-time Active Reserve Duty.
- b. Annual training .
- c. Attendance while in active military service at a school designated as service school by law or by the Secretary of the Military Department concerned.
- d. Service by a member of a Reserve component ordered to active duty (with or without consent), or active duty for training (with consent), with or without pay under competent orders.

2005 Active Duty For A Period Of More Than 30 Days

Active duty under a call or order that does not specify a period of 30 days or less (10 U.S.C. 101(23)).

2006 Active Reserve Status

Status of all Reserves not on an active-duty list maintained under Section 574 or 620 of 10 U.S.C. (reference (a)), except those on an inactive status list or in the Retired Reserve. Reservists in an active status may train with or without pay, earn retirement points, and may earn credit for and be considered for promotion. In accordance with the Reserve Officer Personnel Management Act (ROPMA), a member in an Active Reserve status must be on the Reserve Active-Status List (RASL)(10 U.S.C. 14002 reference (a)).

2007 Active Service

Service on active duty or in the full-time Active Reserve program.

2008 Amputation

- a. Upper Extremities: Amputation of part or parts of an upper extremity, which results in impairment at least equivalent to the loss of use of a hand.

b. Lower Extremities:

(1) Loss of a toe or toes, which precludes the ability to run or walk without perceptible limp, or to engage in fairly strenuous jobs.

(2) Any loss greater than that specified above to include foot, leg, or thigh .

2009 Amputation Rule

The combined rating for disabilities of an extremity shall not exceed the rating for the amputation at the elective level, were amputation to be performed. For example, the combined evaluations for disabilities below the knee shall not exceed the 40 percent evaluation, diagnostic code 5165. This 40 percent rating may be further combined with evaluation for disabilities above the knee but not exceed the above the knee amputation elective level. Painful neuroma of a stump after amputation shall be assigned the evaluation for the elective site of reamputation.

2010 Analogous Ratings

An unlisted condition may be rated under a code for a closely related disease or injury in which not only the functions affected, but also the anatomical localization and symptomatology are closely analogous. Conjectural analogies will be avoided, as will the use of analogous ratings for conditions of doubtful diagnosis, or for those not fully supported by clinical and laboratory findings. Nor will ratings assigned by analogy to organic diseases and injuries be assigned by analogy to conditions of functional origin.

2011 Bilateral Factor

When a partial disability results from injury or disease of both arms, both legs, or of paired skeletal muscles , the ratings for the disabilities of the right and left paired sides are first combined in the standard manner. Add 10 percent of the result (called the Bilateral Factor) to the first combined rating before proceeding with further combinations, or converting to degree of disability . Bilateral Factor is applied to the bilateral disability combination before final combinations with unpaired disabilities are carried out. Treat rating for a "Bilateral" disability (combined rating plus the Bilateral Factor) as one disability rating when arranging multiple impairments in order of severity prior to calculating further combinations. For example, with disabilities evaluated at 60 percent, 20 percent, 10 percent and 10 percent (the two 10s representing bilateral disabilities), the order of severity would be 60, 21 and 20. The 60 and 21 combine to 68 percent and the 68 and 20 to 74 percent, converted to 70 percent as the final degree of disability. (See paragraph b, below, when there is more than one paired disability.)

a. The terms "arms" and "legs" refer to the whole upper and lower extremities respectively. Thus, when there is a compensable disability of the right thigh (for example, amputation), and of the left foot (for example, amputation of the great toe), the Bilateral Factor applies. Similarly, the Factor is applied whenever there are compensable disabilities affecting use of paired extremities regardless of location or specified type of impairment, except as noted in paragraph c., below.

b. The correct procedure when applying the Bilateral Factor to disabilities affecting both upper extremities and both lower extremities is to combine the ratings of the disabilities affecting the four extremities in order of their individual severity and apply the Bilateral Factor by adding 10 percent of the result to the total combined value thus attained.

c. Bilateral Factor is not applicable unless there is an unfitting disability in each of two paired extremities or paired skeletal muscles. Special instructions regarding the applicability of the Bilateral Factor are provided in various parts of the VASRD. For example, codes 7114 - 7117 and codes 8205 - 8412. Bilateral Factor is not applicable in skin disabilities rated under code 7806.

2012 Clear and Convincing Evidence

As a standard of proof, it is that quantum of evidence beyond a mere preponderance, but below that of "beyond a reasonable doubt," such that it will produce in the mind of the fact finder a firm belief as to the facts sought to be established.

2013 Combat-Related Injury Or Disease

This standard covers those injuries and diseases attributable to the special dangers associated with armed conflict or the preparation or training for armed conflict. Consider physical disability to be combat-related if the injury or disease, by itself, makes the member Unfit, and was incurred under any of the circumstances listed below.

a. As a direct result of armed conflict: Armed conflict (5 U.S.C. 3502, 5532, 6303) (part 5 of reference (c)). The physical disability is a disease or injury incurred in the line of duty as a direct result of armed conflict. The fact that a member may have incurred a disability during a period of war or in an area of armed conflict, or while participating in combat operations, is not sufficient to support this finding. There must be a definite causal relationship between the armed conflict and the resulting Unfitting disability.

(1) Armed conflict includes a war, expedition, occupation of an area or territory, battle, skirmish, raid, invasion, rebellion, insurrection, guerrilla action, riot, or any other action in which service members are engaged with a hostile or belligerent nation, faction, force, or terrorists.

(2) Armed conflict also may include such situations as incidents involving a member while interned as a prisoner of war or while detained against his or her will in custody of a hostile or belligerent force, or while escaping or attempting to escape from such confinement, prisoner of war, or detained status.

b. While engaged in extra hazardous service. Such service includes, but is not limited to, aerial flight duty, parachute duty, demolition duty, experimental stress duty, and diving duty.

c. Under conditions simulating war. In general, this covers disabilities resulting from military training, such as war games, practice alerts, tactical exercises, airborne

operations, leadership reaction courses; grenade and live fire weapons practice; bayonet training; hand-to-hand combat training; repelling, and negotiation of combat confidence and obstacle courses. It does not include physical training activities, such as calisthenics and jogging or formation running and supervised sports.

d. Caused by an instrumentality of war. Occurrence during a period of war is not required. A favorable determination is made if the disability was incurred during any period of service as a result of such diverse causes as wounds caused by a military weapon, accidents involving a military combat vehicle, injury, or sickness caused by fumes, gases, or explosion of military ordnance, vehicles, or material. However, there must be a direct causal relationship between the instrumentality of war and the disability. For example, an injury resulting from a service member falling on the deck of a ship while participating in a sports activity would not normally be considered an injury caused by an instrumentality of war (the ship) since the sports activity and not the ship caused the fall. The exception occurs if the operation of the ship caused the fall. See paragraphs 3506 and 3507.

2014 Compensable Disability

A medical condition determined to be Unfitting by reason of physical disability, which meets the statutory criteria under Chapter 61 of 10 U.S.C., reference (a) for entitlement to disability retired or severance pay.

2015 Competency Board

A board consisting of at least three medical officers or physicians (including one psychiatrist) convened to determine whether a member is competent (capable of making a rational decision regarding his or her financial affairs). See paragraph 2046 (Mental Incompetence).

2016 Conditions Not Constituting a Physical Disability

Certain conditions and defects of a developmental nature designated by the Secretary of Defense do not constitute a physical disability and are not ratable in the absence of an underlying ratable causative disorder. If there is a causative disorder, rate it in accordance with other provisions of this instruction. These conditions include, but are not limited to, those listed in the paragraph below. Such conditions should be referred for appropriate administrative action under other laws and regulations.

- a. Enuresis
- b. Sleepwalking and/or Somnambulism
- c. Dyslexia and Other Learning Disorders
- d. Attention Deficit Hyperactivity Disorder
- e. Stammering or Stuttering
- f. Incapacitating fear of flying confirmed by a psychiatric evaluation

- g. Airsickness, Motion, and/or Travel Sickness
- h. Phobic fear of Air, Sea and Submarine Modes of Transportation
- i. Certain Mental Disorders including:
 - (1) Uncomplicated Alcoholism or other Substance Use Disorder
 - (2) Personality Disorders
 - (3) Mental Retardation
 - (4) Adjustment Disorders
 - (5) Impulse Control Disorders
 - (6) Homosexuality
 - (7) Sexual Gender and Identity Disorders and Paraphilias
 - (8) Sexual Dysfunction
 - (9) Factitious Disorder
- j. Obesity
- k. Over height
- l. Psuedofolliculitis barbae of the face and/or neck
- m. Medical Contraindication to the Administration of Required Immunizations
- n. Significant allergic reaction to stinging insect venom
- o. Unsanitary habits
- p. Certain Anemia's (in the absence of unfitting sequelae) including G6PD Deficiency, other inherited Anemia Trait, and Von Willebrand's Disease
- q. Allergy to Uniformed Clothing or Wool
- r. Long sleeper syndrome
- s. Hyperlipidemia

2017 Convalescent Rating (see VASRD)

This principle does not apply to the ratings awarded by the DON since it is presumed the member has had an appropriate amount of time for convalescence prior to submission of the medical board.

2018 Death

Total and permanent cessation of all vital functions. A determination of death must be made in accordance with accepted medical standards and the laws of the State where the member is located or the military medical standards in effect at an overseas location. See paragraph 3904.

2019 Deployable

A determination that the member is free of a medical condition(s) that prevents positioning the member individually or as part of a unit, with or without prior notification, to a location outside the Continental United States for an unspecified period of time. Non-deployability does not necessarily equate to Unfitness.

2020 Disability Benefits

a. Active Duty. Disability retirement pay and severance pay, authorized by 10 U.S.C., Chapter 61, provided for members, who, if otherwise qualified, become Unfit to continue naval service because of physical disability acquired or aggravated while entitled to receive basic pay. Once released from active duty and no longer entitled to receive base pay, members or former members are not authorized benefits under 10 U.S.C., Chapter 61, even though their disabilities are service connected. Rather, such members or former members must file separate disability claims with the Department of Veterans Affairs (VA).

b. Reserve Component Members. A Reserve component member shall be adjudicated under the statutory provisions applicable to his or her duty status at the time of onset or aggravation of the condition for which the member is determined Unfit. This means a Ready Reserve member not on extended active duty at the time of his or her referral into the DES, but who is determined Unfit for a disability incurred or aggravated while the member was on a call to active duty of more than 30 days, comes under the provisions of 10 U.S.C. 1201 - 10 U.S.C. 1203 and not 10 U.S.C. 1204 - 1206 (reference (a)). In such a situation, "in line of duty while entitled to basic pay" rather than "proximate result" is the applicable statutory requirement for entitlement to disability compensation.

2021 Disability Retired Pay

Regular periodic compensation a member receives who is retired because of disability from active service.

2022 Disability Severance Pay

One-time compensation received by a member who is discharged because of disability resulting from active service. Also, see 10 U.S.C. 1212.

2023 Disposition

PEB directs service headquarters to effect a member's status within the naval service. As used in this instruction, "disposition" may mean one or a combination of the following:

<u>Disposition:</u>	<u>Directed Action</u>
Fit to continue naval service	Return to duty Discharge under other provisions of law Remove from TDRL
Unfit to continue naval service	Discharge with severance pay Discharge without severance pay Transfer to TDRL Continue on TDRL Transfer to Permanent Disability Retired List
Physically Qualified for continued naval service in the Reserves	Return to duty
Not Physically Qualified for continued naval service in the Reserves	Discharge from the Reserves Non-Disability Retirement (more than 15 years service-10 U.S.C. 12731b)

Administrative removal from the TDRL for failure to undergo 18-month periodic physical examinations, and discharge without severance pay and other benefits will be effected at the end of the service member's 5-year authorized TDRL period.

2024 Duty Related Impairments

Impairments which, in the case of a member on active duty for 30 days or less, are the proximate result of, or were incurred in the line of duty after September 23, 1996, as a result of:

- a. Performing active duty or inactive duty training ;
- b. Traveling directly to or from the place at which such duty is performed; or
- c. After September 23, 1996, an injury, illness, or disease incurred or aggravated while remaining overnight, between successive periods for purposes 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. Reasonable commuting distance is defined as a 100-mile radius.

2025 En Bloc

See paragraph 2054 Notification of Decision.

2026 Existed Prior To Entry (EPTE)

A finding formerly used by the PEB when evidence established that the member was Unfit due to a medical impairment that existed prior to entry in the military service which was not permanently aggravated by military service; therefore, was not rated. The term EPTE as used in previous versions of this instruction means the same as, and has been replaced by, the term Existed Prior to Service (EPTS).

2027 Existed Prior To Service (EPTS)

A finding by the PEB that evidence establishes that the member is Unfit to continue naval service due to a medical impairment that manifested or existed prior to entry in the military service which has not been permanently aggravated by military service. Members found Unfit – EPTS, Not Ratable are not eligible for disability severance pay or disability retirement if they have less than 8 years cumulative active service, but may be eligible for severance pay or retirement under other provisions of law (See “What is the 8 year rule” enclosure (10)). The term EPTS as used in references (b) through (d) and for the purposes of this instruction replaces the term EPTE .

2028 Extended Active Duty

Active duty under orders specifying a period of more than 30 days.

2029 Final Reviewing Authority

That position with the power to make final decisions on cases before the PEB.

2030 Final Decision

A final decision shall be construed as having been issued when:

- a. the member accepts, either actually or constructively, the findings of the PEB following a record review, subject to review and approval, or
- b. the President, PEB, issues the Findings Letter following a formal hearing, or
- c. a PFR is acted upon by the DIRNCPB or higher authority.

2031 Findings

Decisions concerning a member's Fitness to continue naval service and disability eligibility and rating arrived at by the PEB.

2032 Findings Letter

A letter from the President, PEB, DIRNCPB, or SECNAV to the member being processed within the DES informing him or her of the findings of the PEB.

2033 Fit

A finding by the PEB meaning that the member is Fit to continue naval service based on evidence that establishes that the member is reasonably able to perform the duties of his or her office, grade, rank or rating, to include duties during a remaining period of

Reserve obligation. Within a finding of Fit to continue naval service is the understanding that the mere presence of a diagnosis is not synonymous with a disability. It must be established that the medical disease or condition underlying the diagnosis actually interferes significantly with the member's ability to carry out the duties of his or her office, grade, rank or rating. Members found Fit to continue naval service by the PEB are eligible for appropriate assignment. However, a finding of Fit by the PEB does not preclude subsequent temporary determinations of unsuitability for deployment or PRT/PFT participation, disqualification for special duties, Temporary Limited Duty or administrative action resulting from such determinations.

2034 Full And Fair Hearing

A hearing held by a board, before which the Service member has the right to make a personal appearance with the assistance of counsel, and to present evidence in his or her behalf.

2035 Guardian /Committee

Person or persons appointed by a court of competent jurisdiction to act for a mentally incompetent member under limitations, if any, established by the court. Their actions are legally binding on the member.

2036 Impairment Of Function

Any disease or residual of an injury that results in a lessening or weakening of the capacity of the body or its parts to perform normally, according to accepted medical principles.

2037 Inactive Duty Training (IDT)

Duty prescribed for Reservists, other than active duty or full-time National Guard Duty, under 37 U.S.C. 206 or other provision of law. It does not include work or study in connection with a correspondence course of a Uniformed Service .

2038 Incapacitation Board

See paragraphs 2015 Competency Board, 2046 Mental Incompetence.

2039 Incurred While Entitled To Receive Basic Pay

a. "Incurred " refers to the date or time when a disease or injury is contracted or suffered, as distinguished from a later date, when the PEB determines that a member has become Unfit to continue naval service as a result of such disease or injury. Physical disability due to natural progression of disease or injury is "incurred" at the time the disease or injury causing the disability is contracted. When the increase in physical impairment during service is in excess of that due to natural progression of the disease or injury, the increase is due to aggravation by service.

b. "While entitled to receive basic pay" encompasses all types of duty, which entitled the member concerned to receive active duty basic pay. It also includes any duty without pay, which may be counted the same as duty with pay, such as reserve personnel drilling in non-pay billets. For purposes of administering disability benefit under 10 U.S.C.,

Chapter 61, midshipmen are not entitled to receipt of basic pay. In addition, members in an appellate or excess leave status are not entitled to receive basic pay. This definition shall not be construed to entitle any member not on active duty, who, at the time of separation from active duty was considered Fit to continue naval service, to benefits under 10 U.S.C., Chapter 61, because of an increase in impairment occurring while the member was not entitled to basic pay.

2040 Injury

Damage or wound to the body, traumatic in origin.

2041 Instrumentality Of War

A vehicle, vessel, or device designed primarily for Military Service, and intended for use in such service at the time of the occurrence of the injury . It also may be a vehicle, vessel, or device not designed primarily for Military Service if use of or occurrence involving such a vehicle, vessel, or device subjects the individual to a hazard peculiar to Military Service. This use or occurrence differs from the use or occurrence under similar circumstances in civilian pursuits. There must be a direct causal relationship between the use of the instrumentality of war and the disability, and the disability must be incurred incident to a hazard or risk of the service.

2042 Line of Duty Investigation

An inquiry used to determine whether an injury or disease of a member performing military duty was incurred in a duty status; if not in a duty status, whether it was aggravated by military duty; and whether incurrence or aggravation was due to the member's intentional misconduct or willful negligence.

2043 Medical Evaluation Board (MEB)

A body of physicians (or others specifically designated by CHBUMED) convened in accordance with reference (f), Chapter 18, to identify members whose physical and/or mental qualification to continue on full duty is in doubt or whose physical and/or mental limitations preclude their return to full duty within a reasonable period of time. They are convened to evaluate and report on the diagnosis; prognosis for return to full duty; plan for further treatment, rehabilitation, or convalescence; estimate of the length of further disability; and medical recommendation for disposition of such members.

2044 Member

Unless otherwise defined, a "member" may be a commissioned officer, commissioned warrant officer, warrant officer, aviation candidate or enlisted person of the regular or reserve forces, including a retired person of the naval service. The term "retired person" includes members of the Fleet Reserve and Fleet Marine Corps Reserve who are in receipt of retainer pay. Midshipmen of the Navy are not "members" (10 U.S.C. 5001).

a. "Navy" means the U.S. Navy. It includes the Regular Navy, the Fleet Reserve and the Naval Reserve.

b. "Marine Corps" means the U.S. Marine Corps. It includes the Regular Marine Corps, the Fleet Marine Corps Reserve and the Marine Corps Reserve.

c. "Member of the Naval Service " means a person appointed or enlisted in, or inducted or conscripted into, the Navy or the Marine Corps.

2045 Member, Enlisted

A person serving in an enlisted grade or rating (10 U.S.C. 5001 (a)(4)).

2046 Mental Incompetence

Mental incompetence is the condition of a member who has been found by medical authority designated in paragraph 3414 to be mentally incapable of managing his or her own financial or personal affairs. For the purposes of this instruction, mental incompetency and mental incapacitation are synonymous.

2047 Misconduct

For purposes of disability entitlements, misconduct consists of Intentional Misconduct or Willful Neglect as described in paragraphs 2087 and 3410d.

2048 Natural Progression

The worsening of a pre-Service impairment that would have occurred as a result of similar activity regardless of Military Service .

2049 Next Of Kin

Next of kin in order of preference: spouse; if no spouse, eldest child over age of majority (including children of a prior marriage); if there is no spouse and no child is over the age of majority, then the father or mother (when parents are living together, or separate after the member has entered the service, the father is normally considered the next of kin. When parents separate or divorce before the member's entry into the service, the parent having legal custody of the member will be considered the next of kin. If neither or both parents had legal custody, give preference to the parent the member resided with prior to entry into the service); if none of the foregoing, then the eldest sibling or other blood relative in that order.

2050 Non-Compliance

The unreasonable failure or refusal to submit to prescribed therapy, which aggravates a member's degree of disability. This includes, but is not limited to, the refusal to submit to medical or surgical treatment or therapy, to take prescribed medications, or to observe prescribed restrictions on diet, alcohol, drugs, or tobacco. See paragraph 3805.

2051 Non-Deployable

A determination made by service personnel authorities or local medical authorities that the member has a medical condition (s) that temporarily or permanently prevents positioning the member individually or as a part of a unit with or without prior notification to a location outside the Continental United States for a specified period of time. The

inability to perform duties in every geographic location and under every conceivable circumstance is not the standard to be used as the basis for making this determination. Members who are determined to be non-deployable for a condition that is permanent in nature and significantly interferes with his or her ability to perform the duties of office, grade, rank or rating should be referred to the PEB for disability evaluation. While non-deployability shall be one of many factors considered by the PEB in determining Fitness for continued naval service, non-deployability alone will not normally constitute a basis for a finding of Unfit to continue naval service. See paragraphs 2033 (Fit), 2085 (Unfit).

2052 Non-Duty Related Impairments

Impairments of members of the Reserve components that were neither incurred nor aggravated while the member was performing duty, to include no incident of manifestation while performing duty which raises the question of aggravation. Members with nonduty related impairments are eligible to be referred to the PEB for solely a Fitness determination but not a determination of eligibility for disability benefits.

2053 Notice Of Eligibility (NOE)

A document that is issued when it is determined that an injury or disease was incurred or aggravated by reserve service and may authorize disability severance pay or disability retired pay to include medical care, travel to and from medical treatment, incapacitation pay and/or drill pay and processing through the DES. A member of the selected reserve with more than 15 years of service is eligible for a non-regular retirement.

2054 Notification Of Decision (En Bloc)

A document issued by the President, PEB or DIRNCPB informing the CHNAVPERs or CMC (M&RA), as appropriate, of the final decision and directing disposition in a member's case.

2055 Not Physically Qualified (NPQ) For Continued Naval Service

A PEB-directed disposition applied to a reservist when he or she is unable to continue service in the Naval or Marine Corps Reserves because of a non-duty related disease or injury which precludes the member from performing the duties of his or her office, grade, rank, or rating in such a manner as to reasonably fulfill the purpose of his or her reserve employment. An NPQ vice Unfit determination is made in those cases in which an NOE has not been granted by CHNAVRES or CMC (M&RA).

2056 Observation Ratings

The VASRD, in cases of malignancy, has ratings applicable for a 6-month to 2-year period of observation. Following this period of observation, residuals will be rated. Observation ratings do apply to the Military Departments if the member is found UNFIT.

2057 Office, Grade, Rank, Or Rating, Military Occupational Specialty (MOS)

- a. Office. A position of duty, trust, authority to which an individual is appointed.

b. Grade. A step or degree in a graduated scale of office or military rank that is established and designated as a grade by law or regulation (E-7, O-5, W-2).

c. Rank. The order of precedence among members of the Armed Forces.

d. Rating. The occupational fields prescribed for Sailors (BM, Boatswain's Mate; DT, Dental Technician; etc.) or Primary Military Occupational Specialties (PMOS) prescribed for Marines (0311, Rifleman; 3531, Motor Vehicle Operator; etc). Does not include secondary specialties (NEC or SMOS).

2058 Officer

"Officer " means a member of the naval service serving in a commissioned or warrant officer grade . It includes, unless otherwise specified, a member who holds a permanent enlisted grade and a temporary appointment in a commissioned or warrant officer grade (10 U.S.C. 5001(a)(5)).

2059 Officer, Commissioned

"Commissioned Officer " means a member of the naval service serving in a grade above warrant officer, W-1. It includes, unless otherwise specified, a member who holds a permanent enlisted grade or the permanent grade of warrant officer, W-1, and a temporary appointment in a grade above warrant officer, W-1 (10 U.S.C. 5001(a)(6)).

2060 Officer, Warrant

"Warrant Officer " means a member of the naval service serving in a warrant officer grade. It includes, unless otherwise specified, a member who holds a permanent enlisted grade and a temporary appointment in a warrant officer grade (10 U.S.C. 5001(a)(7)).

2061 Optimum Hospital And Medical Treatment Benefits

The point of hospitalization or treatment when a member's progress appears to be stabilized; or when, following administration of essential initial medical treatment, the patient's medical prognosis for being capable of performing further duty can be determined.

2062 Pending Retirement

Service members shall be considered to be pending retirement when the dictation of the member's MEB report occurs after any of the circumstances designated in subparagraphs a through e below. See paragraph 3305.

a. When a member's request for voluntary retirement has been approved. Revocation of voluntary retirement orders for purposes of referral into the DES does not negate application of the presumption .

b. An officer has been approved for Selective Early Retirement.

c. An officer is within 12 months of mandatory retirement due to age or length of service .

d. An enlisted member is within 12 months of his or her High Year Tenure (HYT) or expiration of active obligated service (EAOS) and will be eligible for retirement at his or her HYT or EAOS.

e. An enlisted member is within 12 months of retirement eligibility and the member's EAOS has or will expire prior to the member being retirement eligible.

2063 Percentage Of Disability

Percentage ratings of the VASRD, as modified by enclosure (9) of this instruction, represent, as far as can practicably be determined, the average impairment in earning capacity resulting from diseases and injuries and their residual conditions in civil occupations.

2064 Performing Military Duty Of 30 Days Or Less

Term used to inclusively cover the categories of duty pertaining to 10 U.S.C. 1204 - 1206 (reference (a)) (active duty, IDT, and travel directly to and from active duty or IDT).

2065 Permanent Limited Duty (PLD)

The continuation on active duty or in the Ready Reserve in a limited duty capacity of a service member determined Unfit as a result of physical disability evaluation or medical disqualification. Authority to grant PLD is limited to service headquarters.

2066 Permanent Nature Of A Disability

For the purpose of this instruction, this term means that a service member is not able to return to full military duties. It does not mean that the condition is stabilized nor does it mean that it will continually impact on the member's future earning capacity.

2067 Petition For Relief (PFR)

When the findings of the PEB become final, after a Formal PEB hearing, and the member has exhausted all available options with the PEB, members who have not been discharged or separated, and TDRL personnel, may Petition For Relief (PFR). Members who have been separated or permanently retired may still petition the Board for Correction of Naval Records (BCNR). The only bases for relief by means of PFR are:

- a. New or Newly Discovered Evidence.
- b. Fraud, Misrepresentation, or Other Misconduct .
- c. Mistake Of Law.

See enclosure (5) of this instruction.

2068 Physical Disability

Any impairment due to disease or injury, regardless of degree, that reduces or prevents an individual's actual or presumed ability to engage in gainful employment or normal activity. The term "physical disability" includes mental disease, but not such

inherent defects as behavioral disorders, adjustment disorders, personality disorders, and primary mental deficiencies. A medical impairment or physical defect standing alone does not constitute a physical disability. To constitute a physical disability, the medical impairment or physical defect must be of such a nature and degree of severity as to interfere with the member's ability to adequately perform his or her duties.

2069 Preliminary Findings Letter

Initial findings from the Informal PEB.

2070 Preponderance Of Evidence

Evidence that tends to prove one side of a disputed fact by outweighing the evidence on the other side (that is, more than 50 percent). Preponderance does not necessarily mean a greater number of witnesses or a greater mass of evidence; rather, preponderance means a superiority of evidence on one side or the other of a disputed fact. It is a term that refers to the quality, rather than the quantity of the evidence. "More likely than not." See paragraph 2012 (Clear and Convincing).

2071 Presumed Fit (Pfit)

PEB finding applied to service members pending retirement at the time they are referred to the PEB for disability evaluation and, therefore, are evaluated under a presumption of Fitness. A finding of PFit means evidence establishes that the member's functional impairment has not caused the premature termination of their career. Members found to be PFit are afforded the same rights within the DES as those found Fit to continue naval service. Members found PFit are not eligible for disability retirement, but are eligible for retirement under other provisions of law, and for evaluation by the VA for disability compensation. See paragraph 3305.

2072 Presumption

An inference of the truth of a proposition or fact, reached through a process of reasoning and based on the existence of other facts. Matters that are presumed need no proof to support them, but may be rebutted by evidence to the contrary.

2073 Prior Service Impairments

Any medical condition incurred or aggravated during one period of service or authorized training in any of the Armed Forces that recurs or is aggravated during later service or authorized training, regardless of the time between. Prior Service Impairments normally should be considered incurred in the line of duty provided the condition or subsequent aggravation was not the result of the member's misconduct or willful negligence. See paragraph 3409.

2074 Proximate Result

A permanent disability the result of, arising from, or connected with active duty, annual training, active duty for training, or inactive duty training (IDT), (etc.) to include travel to and from such duty or remaining overnight between successive periods of inactive duty training. Proximate result is a statutory criteria for entitlement to disability compensation under Chapter 61 of reference (a) applicable to Reserve component members

who incur or aggravate a disability while performing an ordered period of military duty of 30 days or less.

2075 Pyramiding

Term used to describe the application of more than one rating to any area or system of the body when the total functional impairment of that area or system is reflected adequately under a single appropriate code. Disability from injuries to the muscles, nerves, and joints of the extremity may overlap to a great extent. Special rules for their valuation are included in appropriate sections of the VASRD and in part (8) of enclosure (3) of this instruction. Related diagnoses should be merged for rating purposes when the VASRD provides a single code covering all manifestations. This prevents pyramiding and reduces the chance of over-rating. For example, disability from fracture of a tibia involving malunion, limitations of dorsiflexion, eversion, inversion, and subtalar motion, as well as traumatic arthritis of the ankle would be rated using one diagnostic code (5271) that reflects overall ankle function, rather than by adding separate ratings for the limitations of motion and the traumatic arthritis.

2076 Ready Reserve

Units and individual reservists liable for active duty as outlined in Sections 12301 (Full Mobilization) and 12302 (Partial Mobilization) of 10 U.S.C. (reference (a)). This includes members of units, members of the Active Reserve Program, Individual Mobilization Augmentees and the Individual Ready Reserve.

2077 Reserve Component

Either the United States Naval Reserve or the United States Marine Corps Reserve (10 U.S.C. 10101).

2078 Retention Standards

Physical standards or guidelines that establish those medical conditions or physical defects that may render a service member Unfit for further military service and are therefore cause for referral of the member into the DES.

2079 Secretary

Unless otherwise qualified, refers to the Secretary of the Navy.

2080 Service Aggravation

The permanent worsening of a pre-service medical condition over and above the natural progression of the condition caused by trauma or the nature of military service .

2081 Temporary Disability Retired List (TDRL)

A list maintained by the CNO or CMC of members Unfit to continue naval service because of physical disability, who meet the requirements of 10 U.S.C., Chapter 61 for disability retirement, and whose disabilities are not yet determined to be stabilized or permanent. Except for cases processed under imminent death procedures, members with

unstable conditions rated at a minimum of 80 percent and which are not expected to improve to less than an 80 percent rating, shall be permanently retired.

2082 Temporary Limited Duty (TLD)

Specified period of limited duty, normally not to exceed 16 months per career, cumulative, authorized initially at a medical treatment facility (except for officer MEBs or MEBs longer than 8 months) by a medical board for cases in which the prognosis is that the member can be restored to full duty within the specified period. See paragraph 1001j and 1008b.

2083 Trustee

a. 37 U.S.C. 602 authorizes the SECNAV to appoint any person to receive active duty or retired pay of an incompetent member for the benefit of the member. That authority has been delegated to the Defense Finance and Accounting Service (DFAS).

b. A trustee appointed by the DFAS for the purposes of 37 U.S.C. 602 is a person authorized to receive and distribute the active duty or retired pay of a member of the Navy or Marine Corps, for the benefit of the member, who has been found mentally incapable of managing his or her financial affairs. This person, or the primary next of kin, has authority to act for the member in electing the member's options following receipt of PEB findings .

2084 Unauthorized Absence

Any absence from duty without authority such as contemplated under Articles 85 and 86 of the UCMJ.

2085 Unfit

A finding by the PEB that the member is Unfit to continue naval service based on evidence which establishes that the member is unable to reasonably perform the duties of his or her office, grade, rank or rating, to include duties during a remaining period of Reserve obligation. The PEB requests service headquarters to separate or retire members found Unfit to continue naval service. See paragraph 2033 (Fit).

2086 Unreasonable Refusal of Treatment

Unreasonable failure to act in accordance with medical, surgical or dental treatment requirements. See paragraph 3413.

2087 Willful Neglect

Intentional, unjustifiable, and inexcusable failure of the individual to perform some act or duty:

a. required in the occupation in which the individual was engaged at the time of incurring a physical impairment, or

b. required of the individual as a legal obligation, or

c. which could be reasonably evident to the average individual as required to protect such an individual from foreseeable injury or harm. See paragraph 3410d.

2088 – 2099 Reserved

ENCLOSURE 3: DISABILITY EVALUATION POLICIES

PART 1 - INTRODUCTION AND ADMINISTRATIVE POLICIES

3101 Objectives

Evaluation of physical disability within the Navy DES has as its objectives:

- a. The maintenance of a physically fit and combat ready Navy and Marine Corps, including Reserve components; and
- b. Equitable consideration of the interests of the government and individual service members.

3102 Summary Overview

a. A case usually enters the Department of the Navy DES when a Medical Evaluation Board (MEB) is dictated for the purpose of evaluating the diagnosis and treatment of a member who is unable to return to military duty because the member's condition most likely is permanent, and/or any further period of temporary limited duty (TLD) is unlikely to return the member to full duty. A condition is considered permanent when the nature and degree of the condition render the member unable to continue naval service within a reasonable period of time (normally 8-12 months or less). Note: The term "permanent" does not necessarily mean the condition is unfitting.

b. Medical Officers should be aware of the 16-month cumulative limitation on TLD when considering any condition where surgical intervention might return a member to duty. In light of the time necessary for convalescent leave and post-operative therapies (e.g. physical therapy), Medical Officers should normally consider performing operative procedures by the end of the first TLD period if conservative therapy has failed.

c. Referral of a Medical Board report to the PEB can come from two sources; i.e. Limited Duty board reports referred for PEB evaluation by service headquarters, and Medical Board reports submitted directly to the PEB by a medical treatment facility (MTF). An individual case is accepted by the PEB when all medical and non-medical information necessary to evaluate the case appropriately has been received by the PEB. Once a case has been accepted by the PEB, the Informal PEB conducts a record review of the case. The individual concerned then is notified of the preliminary findings and given 15 calendar days in which to make a decision concerning the findings. If the member accepts the preliminary findings, the case is finalized and service headquarters is directed to make an appropriate disposition (i.e., separate, retire or return to duty). If the member does not agree with the preliminary findings, the member can request reconsideration of that decision by the same Informal PEB and/or demand/request a personal appearance before a Formal PEB. If the member does not act on the preliminary findings, acceptance is presumed on the 16th day after receipt of the findings. Dependent upon certain factors later described in this enclosure, the member may or may not proceed to a personal appearance before the Formal PEB. If the Formal PEB hears a case, it makes findings, and, subsequent to legal review

and/or quality assurance review, findings are sent to the member. If the member accepts the findings, the case is finalized and appropriate disposition by service headquarters is directed. If a member disagrees with the findings/results of the Formal PEB, the member is given 15 calendar days from the date of receipt of the findings letter to petition the DIRNCPB. The member has the right to petition the Board for Correction of Naval Records (BCNR) at any time subsequent to final action on his or her case. See enclosure (10) of this instruction for additional details.

3103 Guidance to Members

Cases are very individual and can be very complex. Accordingly, the paragraph 3102 summary is designed just to provide a general overview. Personnel with specific problems should review more detailed sections of this and other applicable instructions or consult with a Physical Evaluation Board Liaison Officer (PEBLO) counselor or an attorney.

3104 Medical Board Requirements

a. Purpose of Medical Boards: A medical board serves to report upon the present state of health of any member of the Armed Forces and as an administrative board by which the convening authority or higher authority obtains a considered clinical opinion regarding the physical status of service personnel.

b. Convening Medical Board

(1) Medical boards may be convened by commanding officers of naval hospitals and other MTFs designated by the Chief, Bureau of Medicine and Surgery (CHBUMED).

(2) Convening of a medical board may be ordered by the CNO, CMC, CHNAVPERS, and the CHBUMED.

3105 Special Interest Cases

a. Special interest cases are those designated by SECNAV for referral to ASN (M&RA) for final determination. As required by paragraph 1004j, all cases involving flag and general officers who are within 12 months of mandatory retirement due to age or service limitations and medical corps officers in any grade who are pending nondisability retirement for age or length of service at the time of referral into the DES, on active or reserve duty, who are determined by the PEB to be Unfit, are designated special interest cases due to statutory or regulatory handling requirements.

b. DIRNCPB may designate a case to be of special interest.

3106 Prompt Identification of Disability

There exists no authority to omit or postpone disability evaluation of physical impairment, which renders questionable the ability of service members to perform reasonably the duties of office, grade, rank, or rating. Commanding officers of MTFs and

individual medical and dental officers are to identify promptly for referral to the DES those members presenting for medical care whose Fitness for active duty is questionable.

3107 Counseling

a. General. A member or, in appropriate cases, legal guardian, trustee, or next-of-kin shall be carefully counseled in clearly understandable terms by a PEBLO or collateral duty counselor concerning the significance of action being taken in a case, its probable effect on his or her future, and options available. Counselors shall discuss such other matters as estimated retired or severance pay, probable retired grade, potential veteran benefits, post-retirement insurance programs, the Survivor Benefit Plan, and recourse to and preparation of Petitions For Relief. Counseling shall be provided before, during, and after PEB consideration, at each stage of processing, and as questions are raised by the member.

b. PEBLOs/Counselors

(1) DIRNCPB shall assign counselors to medical treatment facilities (MTFs), where the volume of cases entering the DES warrants a full-time counselor, to provide counseling for members at and near those activities. At those naval MTFs where regularly assigned PEBLO counselors are not available, the commanding officer shall designate a staff member, preferably the patient administration officer or an assistant, to provide disability counseling as a significant collateral duty. PEBLO counselors and collateral duty counselors will, in addition, provide disability counseling as necessary for members of the naval service in MTFs controlled by other services.

(2) PEBLO counselors shall be senior enlisted (E-7 or above) or equivalent civilian employees.

c. Counselor Training. The DIRNCPB, in order to ensure effective counseling prescribed under paragraph 3107a above, will provide initial training, a Counselor's Manual and annual conference training to both PEBLO and collateral duty counselors. Travel funding for collateral duty counselors shall be provided by the MTF to which assigned.

3108 Conflict Of Interest/Recusal

a. No officer may appear as the member being evaluated by a panel of the PEB, which was convened by him or her, by anyone temporarily succeeding to his or her office, or by any subordinate in the chain of command.

b. No member of an Informal PEB who is being processed by the PEB may be evaluated by that Informal PEB. In such cases, the President, PEB, will designate another Informal PEB to consider the case. The new Informal PEB may not include any members of the original Informal PEB.

c. No member of a Formal PEB who is being processed by the PEB may be evaluated by the Formal PEB of which he or she is a member.

d. No medical corps officer shall act as a member of a board of the PEB if he or she had either direct charge of the member's care immediately preceding evaluation by a board, prepared medical reports under consideration by a board, or was a member of a board of medical officers which reported on the member concerned.

e. There will be occasions when it becomes very difficult, if not impossible, for a member of the Informal PEB, Formal PEB, or other reviewing authority within the PEB process to render a decision which is not influenced in some manner by personal bias. When confronted with a situation of this nature, the individual PEB member must make the determination as to whether he/she can make a determination based solely on the facts of record, personal bias/interest aside. The individual's determination regarding his/her ability to render an unbiased decision in the case will govern his/her future participation. If in any doubt as to whether the appearance or reality of an ethical conflict of interest exists in a specific case, the board member must seek an advisory opinion from DIRNCPB legal counsel.

3109 Restriction on Communications with Members

Except during the course of a Formal PEB, board members shall not engage in discussion with members under evaluation regarding their cases. The creation of any inference of undue influence or partiality shall be scrupulously avoided.

3110 Reservist Participation

a. Reserve Representation Required. Each board of the PEB shall include at least one member who is a Navy or Marine Corps Reservist when evaluating the fitness for active duty of a member of the Naval or Marine Corps Reserve (10 U.S.C. 12643).

b. Failure To Have Reserve Representation During Records Review. If, after referral of a Reservist's case to a Formal PEB, it is discovered that no member of the Informal PEB was a Reservist, the case will be considered by a properly constituted Formal PEB without return of the case to an Informal PEB for reconsideration. Formal PEB consideration is tantamount to a "de novo" proceeding and meets the protective requirements of 10 U.S.C. 12643.

3111 Travel Expenses

a. Members On The Temporary Disability Retired List. A member on the TDRL is entitled to travel and transportation allowances authorized by Joint Federal Travel Regulations (JFTR) for members in his or her retired grade for travel in connection with temporary duty while on active duty for periodic physical examinations and appearances before the PEB. See paragraph 3621.

b. Active Duty Members Appearing Before a Board. Personal appearance before a board by active duty members is official business and shall be covered by orders providing for all of the appropriate travel expenses authorized by the JFTR.

c. Inactive-Duty Reservists With A Notice Of Eligibility (NOE). Same as b above.

d. Inactive-Duty Reservists Without A Notice Of Eligibility (NOE). Inactive-duty reservists without an NOE who desire to appear before a board must do so at no expense to the government. Reservists covered under the provisions of paragraph 3201 b (3) rate travel expenses.

e. Escorts/Attendants. Certain members discussed in a, b, and c above may be incapable of traveling alone as determined by the attending physician. An accompanying escort/attendant is entitled to travel and transportation allowances as authorized by the JFTR. An escort/attendant may be a member of the Uniformed Services, a civilian employee of the U.S. government, or any other person considered suitable by the member and by the appropriate authority ordering the physical examination or appearance. Requests for an escort/attendant shall be submitted through the PEBLO with accompanying physician justification to the PEB for final approval.

3112 Leave

a. Members whose cases are being evaluated within the DES, if otherwise physically able to do so, shall be permitted to take earned annual leave. The command authorizing leave will notify the cognizant PEBLO of the inclusive dates and the member's leave address and phone number. Commands shall recall the member if required by the President, PEB.

b. Commands shall not charge annual leave to a member who is required to report to an MTF for treatment, examination, rehabilitation, therapy, etc., or when convalescent leave is the proper category of absence.

c. Members who have earned leave which they are unable to sell upon disability separation or retirement shall be permitted to use the additional leave before their separation date.

3113 – 3199 Reserved

**PART 2 - POLICIES CONCERNING REFERRAL OF CASES TO THE
PHYSICAL EVALUATION BOARD**

3201 Criteria For Referral To The Physical Evaluation Board

a. Active Duty Members. As a general rule, an active duty member or a reservist on extended active duty will be referred for disability evaluation only by a medical board that has found the member's fitness for continued naval service questionable by reason of physical or mental impairment. A determination of questionable fitness must be supported by objective medical data displaying the nature and degree of the impairment. In those cases where it is not practicable to have a medical board consider the case; e.g., the member being hospitalized in a non-military hospital, the case may be referred by cognizant authority to the PEB when available medical records show that the member's fitness for continued naval service is questionable. In all cases, Navy and Marine Corps members MEBs must be processed through a Navy MTF with Convening Authority for further referral to the PEB.

b. Inactive-Duty Reservists

(1) Refer per reference (g) for disability evaluation those inactive-duty reservists issued an NOE for disability benefits due to a disability that occurred while serving on active duty or performing inactive duty training .

(2) An inactive duty reservist who has not been given an NOE and who has been determined by the CHBUMED to be "Not Physically Qualified" (NPQ) for active duty or retention will be referred, at the member's request, to the Informal PEB for final determination of physical condition. If the member is then found Unfit by the Informal PEB and assigned the PEB finding of NPQ, the member has the right to demand a Formal PEB. The member will bear all associated travel, lodging, meal, and incidental costs to the Formal PEB site.

(3) Cases of inactive duty reservists without an NOE may be processed into the DES for a FIT/ UNFIT determination by the PEB under the following circumstances:

(a) While serving as an inactive duty reservists, the member is ordered to active duty and serves a period of active duty greater than 30 days; and

(b) The member incurs or aggravates a condition during this period of active duty and his/her medical records contain documentation as to the nature of member's conditions including the approximate date of incurrence/aggravation. A FIT/UNFIT determination will not be made if the PEB cannot determine from the member's records that his/her condition(s) was incurred/aggravated during a period of active duty. In such cases, a Physically Qualified/Not Physically Qualified determination will be made.

Recourse for former inactive duty reservists who incurred or aggravated a condition during a previous period of active-duty, but do not meet the above requirements, is a petition to the Board for Correction of Naval Records.

c. Specified Physical Impairments. A list of physical impairments that are normally cause for referral to the PEB is contained in enclosure (8) to this instruction.

3202 Circumstances Not Justifying Referral To The Physical Evaluation Board

a. Lack Of Motivation. Lack of motivation alone for performance of duty does not justify referral to the PEB.

b. Request for referral to the PEB by the service member.

c. Mere Presence Of Physical Defect. The mere presence of disease or injury alone does not justify referral. Referral should take place only when, in the opinion of a medical board, the defect may materially interfere with the member's ability to perform reasonably the duties of his or her office, grade, rank, or rating/MOS on active duty. Also see enclosure (3), part 3.

d. Inability To Meet Initial Enlistment/Appointment Standards. Once enlisted or commissioned, the fact that a member may fall below initial entry or appointment standards, specified in the reference (f) (MANMED), does not require that the case be referred for disability evaluation.

e. Physical Disqualification For Special Duties. Physical disqualification from special duties, such as flying, serving on submarines or in a medical specialty, does not necessarily imply physical unfitness. Referral is appropriate only in cases where the member's ability to reasonably perform active military service is in doubt.

f. Inability to Meet Physical Standards for Specific Assignment or Administrative Requirement. The inability to meet screening criteria for a specific assignment or administrative requirement; i.e., deployment, overseas or sea duty assignment, or participation in PRT/PFT cycle, does not justify referral. Referral is appropriate only in cases where the condition appears to be permanent in nature or of such a degree as to render the member unable to return to naval service within a reasonable period.

g. Members Being Processed For Separation Or Retirement For Reasons Other Than Physical Disability. Do not refer a member for disability evaluation who is being processed for separation or retirement for reasons other than physical disability, unless the member previously was found Unfit but retained on active duty in a Permanent Limited Duty (PLD) status, or the member's physical condition reasonably prompts doubt that he or she is Fit to continue to perform the duties of office, grade, rank or rating/MOS.

3203 Rejection Of Cases

a. President, PEB may reject any case, which lacks necessary or required information needed to determine fitness, mental competence, eligibility for disability benefits, or an appropriate disability rating. However, in extraordinary cases, with the concurrence of the DIRNCPB, the President, PEB may accept a case and direct evaluation based upon evidence of record.

b. If the President, PEB rejects a case, the MEB will be returned, to include all supporting documents, to the originating facility. Specific deficiencies shall be identified to enable the submitting medical facility, general court-martial authority, or command having cognizance over the member, to provide the required information.

c. The President, PEB may reject any case (medical information submitted as a new Medical Board report, or addendum to a previous board) in which the date of the newly dictated medical information is within 6 months of the date of the PEB's Notification of Decision if, upon review by a medical officer assigned to the Informal PEB, the medical officer advises:

(1) The condition reported does not alter the subject member's previous findings ; or

(2) The condition reported is not a significant deterioration of the previously reported condition; or

(3) The service member's treatment has not significantly changed; or

(4) The service member has required no significant outpatient treatment other than that required for maintenance.

d. If the member is rehospitalized but has had no surgical procedures performed within 6 months of the PEB's issuance of its Notification of Decision of the member's previously evaluated case, the convening authority of the Medical Board, with the advice of the patient administration office, should assess whether the outcome of the rehospitalization as reported in the proposed Medical Board report would alter the previously determined findings of the PEB. The application of this criteria is particularly important when no diagnoses other than those previously reported to, reviewed by, and finally determined by the PEB are identified, or a chronic condition is involved and no objective medical evidence indicates that a significant change in the nature and the degree of severity of the condition has occurred.

e. In all above-noted circumstances, in order to ensure a reliable medical history is preserved, maintain entries in the member's health record to document all medical procedures undergone by the member.

f. The following general rules apply to all Medical Boards:

(1) Timeliness of submission of new medical information is critical to ensure PEB determinations are based on up-to-date, complete and accurate information. A service member's case before the PEB is final when Notification of Decision (en bloc) has been signed and issued to CMC (M&RA) or CHNAVPERs. Accordingly, the PEB normally will reject submission of information after Notification of Decision.

(2) The PEB normally will reject the case of a service member whose physical condition is the same, for which a final decision was issued within the last 6 months, unless after medical review, the condition appears to have substantially changed.

(3) Cases before the PEB normally will not be held in abeyance, continued, or a Notification of Decision canceled because the member alleges a treating physician is submitting a note, letter, or other document allegedly presenting additional information about the service member's condition.

(4) Cases before the PEB normally will not be held in abeyance, continued or a Notification of Decision canceled based on any information other than that officially submitted by or through the MTF (convening authority).

(5) The PEB will reject all cases in which the sole diagnoses involves conditions not constituting a physical disability as defined in paragraph 2016.

(6) The PEB will reject all cases in which the member is being processed for misconduct which could result in the member receiving either a punitive or administrative discharge due to that misconduct.

g. MEBs submitted on members with mandatory/voluntary retirement dates must be received by the PEB 60 days prior to the originally approved retirement date to allow for adequate processing time. Presently, PEB will verify dates with the appropriate service headquarters. Those MEBs received within the 60-day window will be screened by a Medical Officer of the Informal PEB to ensure serious conditions potentially overcoming PFit are not overlooked. Cases not accepted after medical review will be rejected and returned to the MTF. Service headquarters will be notified of case rejection and to continue processing the member for retirement. Acceptance of cases within this window does not necessarily mean that members will overcome the presumption of fitness rule.

3204 Suspension Or Termination Of Cases

a. When the PEB terminates a case for the reasons cited in paragraph 3203, return the MEB report, to include all supporting documents, to the originating MTF for corrective action and resubmission, if warranted. Process as new those cases resubmitted to the PEB after termination. In the case of inactive duty Reservists, the case should be returned to the NOE Issuing Authority.

b. When the PEB suspends a case for the reasons cited in paragraph 3203, hold the case in abeyance pending receipt of required documentation/information.

(1) A case will not be suspended for a period of time in excess of 60 days. After the 60-day period the case will be terminated and returned to the originating MTF.

(2) Cases suspended by the Informal PEB are usually the result of administrative deficiencies; i. e., missing LODI, missing Non-Medical Assessments (NMA), missing MEB physician signatures, etc. Upon receipt of required information, these cases will be inserted back into the process at the point at which the evaluation stopped. Cases will not be suspended for administrative errors or oversights for more than 30 days. Cases will not be suspended for additional medical information in excess of 60 days. Cases that exceed the limits above will be terminated.

(3) Cases suspended at the Formal PEB level are usually the result of substantial issues; i. e., new medical information pending, unplanned surgery or hospitalization, etc.. In those instances, cases will not be suspended for periods of more than 60 days.

c. Once a case has been terminated or rejected, resubmission, if necessary, is not allowed until all actions or information requested by the PEB are complete.

d. All parts of a MEB included as part of a previously terminated or rejected case, to include medical and non-medical information, must be less than 6 months old when received by the PEB. Ensure all interim SF-600 entries and other medical documentation not previously submitted are included in resubmission. A case not meeting these criteria will be rejected.

3205 Non-Medical Documentation Reports - Current Performance Of Duty

a. When a member is referred for physical disability evaluation, an assessment of the member's performance of duty by his or her chain of command may provide better evidence of the member's ability to perform his or her duties than a clinical estimate by a physician. Particularly in cases of chronic illness, non-medical documentation may be expected to reflect a member's capacity to perform accurately.

b. Provide non-medical documentation in all Medical Board reports to include:

(1) Except in situations of critical illness or injury or where the member has been declared "Death Imminent", a statement from the member's immediate commanding officer, executive officer, company commander, or command senior enlisted advisor addressing:

(a) Indicators of medical problems or absence of medical problems based on observations of the member while in-duty and off-duty situations;

(b) Description of current job assignment, including an assessment of how the medical problem has or has not affected the member's performance, ability to participate in the Physical Readiness Test (PRT)/Physical Fitness Test (PFT), and ability to deploy;

(c) Recent disciplinary history of the individual, including any disciplinary action pending;

(d) Description of the member's rating/Military Occupational Specialty (MOS), Navy Enlistment Classification Code (NEC), and/or specialty, including an estimation of how the member's condition will affect his or her ability to fulfill occupational requirements in the future; and,

(e) Commanders are also required to complete the non-medical documentation form and submit a narrative assessment on how the service member's medical condition impacts on his/her ability to perform military duties. Enclosure (11) contains the NMA form and an example of a narrative assessment.

(f) When the member has been reassigned for medical purposes, the MTF will obtain this statement from the member's former unit commander.

(2) A copy of the line of duty determination, when required by reference (h).

(3) Official documentation identifying the next-of-kin, court appointed guardian, or trustee in the case of members who are determined incompetent.

(4) Pertinent personnel records; e.g., copies of annual evaluation reports and promotion recommendations, awards, letters of appreciation, letters of commendation, etc., may also be included, but are not required unless specifically requested by the President, PEB.

c. Regardless of the presence of illness or injury, do not consider inadequate performance of duty, by itself, as evidence of Unfitness due to physical disability unless it is established that there is a cause and effect relationship between the two factors. Further, lack of motivation for performance of duty alone does not constitute a basis to award a disability .

3206 Hospitalization And/Or Surgery Performed After Medical Evaluation Board Report Referral To The PEB

a. Prior to submission to the PEB, member must complete elective surgical procedures that may affect a member's physical qualification for duty before initiation of a Medical Board. If a MEB or health record entry states that a surgical procedure is scheduled (or contemplated) the MEB should not be submitted until after the surgical procedure is done and an appropriate period of convalescence has occurred. An addendum addressing the results of surgery must be submitted with the MEB or the case will be terminated or rejected.

b. When hospitalization or non-elective, urgent surgery occurs or is contemplated for a service member who has a case before the PEB, the MTF shall notify the PPEB by written statement via FAX or message traffic, information copy to CHNAVPER/CMC

(M&RA) and CHBUMED, requesting PEB suspend or terminate the case. The statement will include the rationale for the requested action including the urgent nature of the hospitalization or surgery.

(1) When considering a medical procedure for a member whose case has been referred to the PEB for disability evaluation, the MTF should consider whether or not the member will have sufficient time remaining on active duty for appropriate follow-up care and should not assume that the Department of Veterans Affairs (DVA) will accept responsibility for such care unless the member has already been accepted as a DVA beneficiary.

(2) The timeliness and completeness of submission of any new medical information after a case has been referred to the PEB is critical to ensure PEB determinations are based on up-to-date, complete and accurate information.

(3) If PEB is notified before the Notification of Decision (En bloc) has been issued to the service headquarters, the case will be medically reviewed to determine if the case should be suspended, or terminated. If PEB action on the case is suspended, the MTF shall submit an addendum after hospitalization or surgery and an appropriate period of convalescence has been achieved following the procedures outlined in 3204 to ensure up to date documentation is provided to the PEB.

3207 Periodic Physical Examinations TDRL

See enclosure (3), part 6 to this instruction. Diagnoses centering on EPTS conditions still are not ratable.

3208 Member's Access To Medical Board Reports And Counseling

a. Unless the information contained in the MEB report may, in the judgment of the MEB convening authority, have an adverse effect on the member's mental or physical health, the member shall:

(1) be provided a copy of the MEB report;

(2) be counseled regarding the opinions and recommendations of the medical board;

(3) be afforded the opportunity to discuss opinions and recommendations with each member of the MEB; and

(4) be afforded an opportunity to submit a statement regarding any portion of the MEB report. No precise format is prescribed. The medical board shall attach written comments to the report addressing the statements considered adverse by the member.

b. When the information contained in the MEB report may, in the judgment of the medical board convening authority, have an adverse effect on the member's mental or physical health, or when the member has been determined to be incapable of managing his

or her financial affairs by a board of medical officers convened and constituted in accordance with reference (f) (MANMED), Chapter 18, the member's court appointed legal guardian or the next-of-kin as defined in section 2049 will be counseled (in the above precedence order), provided with a copy of the report, and afforded the opportunity to exercise the member's rights as discussed in paragraph 3208a.

3209 Waiver of Disability Evaluation Processing

a. With the approval of the PPEB, acting on behalf of the Secretary of the Navy, a service member may waive entrance into the Disability Evaluation System (DES) under the following circumstances:

(1) When the MEB reflects that the service member's medical condition existed prior to service and was not aggravated by service; or,

(2) Physical disability evaluation requires extension past the date of the member's service agreement, end of active obligated service or approved retirement date, the member does not consent to retention, and the member has no remaining reserve service obligation. Members of a Reserve component on active duty for more than 30 days may continue disability evaluation upon release from active duty provided they maintain a Ready Reserve status. They must, however, sign a waiver declining retention on active duty.

b. Members approved for separation under any program that incurs a Reserve obligation and who have conditions which are cause for referral into the DES are prohibited from waiving physical disability evaluation.

c. Members in Permanent Limited Duty (PLD) status may not waive requirement for DES reevaluation until such time as the PLD period is completed or terminated if the PLD period was in excess of 12 months. Paragraph 6011 applies.

d. A member requesting waiver of disability evaluation processing must complete the waiver memo per enclosure (13). A waiver is not granted until approved by the PPEB.

3210 - 3299 Reserved

PART 3 - POLICIES CONCERNING FITNESS VERSUS UNFITNESS

3301 Standard Used for Disability Determination

The sole standard to be used in making determinations of physical disability as a basis for retirement or separation is unfitness to perform the duties of office, grade, rank or rating because of disease or injury incurred or aggravated while entitled to basic pay. Each case is considered by relating the nature and degree of physical disability of the member to the requirements and duties that member may reasonably be expected to perform in his or her office, grade, rank or rating.

3302 General Criteria For Making Unfitness Determinations

a. A service member shall be considered Unfit when the evidence establishes that the member, due to physical disability, is unable to reasonably perform the duties of his/her office, grade, rank, or rating (hereafter called duties) to include duties during a remaining period of Reserve obligation.

b. In making a determination of a member's ability to perform his/her duties, the following criteria may be included in the assessment:

(1) Medical condition represents a decided medical risk to the health of the member or to the welfare of other members were the member to continue on active duty or in an Active Reserve status.

(2) Medical condition imposes unreasonable requirements on the military to maintain or protect the member.

(3) Nature of service member's established duties during any remaining period of reserve obligation.

3303 Relevant Evidence

Consider all relevant evidence in assessing service member fitness, including the circumstances of referral. To reach a finding of Unfit, the PEB must be satisfied that the information it has before it supports a finding of unfitness.

a. Referral Following Illness or Injury. When referral for physical disability evaluation immediately follows an acute, grave illness or injury, the medical evaluation may stand-alone, particularly if medical evidence establishes that continued service would be deleterious to the service member's health or is not in the best interests of the respective service.

b. Referral For Chronic Impairment. When a service member is referred for physical disability evaluation under circumstances other than as described in paragraph 3303 (a), evaluation of the member's performance of duty by supervisors as indicated, for example, by letters, efficiency reports, credential reports, status of physician medical

privileges, or personal testimony may provide better evidence than a clinical estimate by a physician of the service member's ability to perform his or her duties. Particularly in cases of chronic illness, these documents may be expected to reflect accurately a member's capacity to perform.

c. Adequate Performance Until Referral. If the evidence establishes that the service member adequately performed his or her duties until the time the service member was referred for physical evaluation, the member may be considered Fit even though medical evidence indicates questionable physical ability to continue to perform duty.

d. Cause and Effect Relationship. Regardless of the presence of illness or injury, inadequate performance of duty, by itself, shall not be considered as evidence of unfitness due to physical disability, unless it is established that there is a cause and effect relationship between the two factors.

3304 Reasonable Performance Of Duties

a. Considerations. Determining whether a member can reasonably perform his or her duties includes consideration of:

(1) Common Military Tasks. The member, due to physical disability, is unable to reasonably perform the duties of his or her office, grade, rank, or rating (hereafter called duties) to include during a remaining period of Reserve obligation. For example, whether the member is routinely required to fire his or her weapon, perform field duty, or to wear load bearing equipment or protective gear.

(2) Physical Readiness/Fitness Tests. The PEB will consider a member's case when the MTF determines that the medical condition prohibits the member from taking all or a portion of the PRT/PFT, and permanent increased bodily harm will result from taking all or a portion of the PRT/PFT. When a member has been found Fit to continue naval service by the PEB for a condition which subsequently is used by the member to obtain a waiver, from the local medical department representative, of all or a portion of the PRT/PFT, the waiver shall not be used as the basis for an adverse (punitive or administrative for misconduct) personnel action against the member. However, the waiver may be the basis for non-punitive administrative action according to service policies.

(3) Deployability. See definition in paragraph 2019. Inability to perform the duties of his or her office, grade, rank, or rating in every geographic location and under every conceivable circumstance will not be the sole basis for a finding of Unfit. When deployability is used by a service as a consideration to determine fitness, the standard must be applied uniformly to both the Active and Reserve components of that service.

(4) Special Qualifications. Members whose medical condition causes loss of qualification for specialized duties, whether the specialized duties comprise the member's current duty assignment; the member has an alternate branch or specialty; or whether reclassification or reassignment is feasible, will not be the sole basis for a finding of Unfit.

b. General, Flag, and Medical Officers. An officer in pay grade O-7 or higher or a medical officer in any grade shall not be determined Unfit because of physical disability if the member can be expected to perform satisfactorily in an assignment appropriate to his or her grade, qualifications, and experience. Thus, the inability to perform specialized duties or the fact the member has a condition that is cause for referral to a PEB is not justification for a finding of Unfit. Medical doctors will have a review of clinical privileges with peer review required.

c. Members on Permanent Limited Duty. A member previously determined Unfit and continued in a permanent limited duty status or otherwise continued on active duty, normally will be found Unfit at the expiration of his or her period of continuation. However, the member may be determined Fit when the member's condition has healed or improved so that the member would be capable of performing his or her duties in other than a limited duty status. The member will be evaluated using current standards of fitness and if the member remains ratable, current VASRD standards will be used.

d. Overall Effect. A member may be determined Unfit as a result of the overall effect of two or more impairments even though each of them, standing alone, would not cause the member to be referred into the DES or be found Unfit because of physical disability .

3305 Presumed Fit

a. Application. Except for service members previously determined Unfit and continued in a permanent limited duty status, service members who are pending retirement at the time they are referred for physical disability evaluation enter the DES under a rebuttable presumption that they are physically Fit. The DES compensates disabilities when they cause or contribute to career termination. Continued performance of duty until a service member is approved for length of service retirement creates a rebuttable presumption that a service member's medical condition has not caused career termination.

b. Presumptive Period. Service members shall be considered to be pending retirement when the dictation of the member's MEB report occurs after any of the circumstances designated below:

(1) When a member's request for voluntary retirement has been approved. Revocation of voluntary retirement orders for purposes of referral into the DES does not negate application of the presumption .

(2) An officer has been approved for Selective Early Retirement.

(3) An officer is within 12 months of mandatory retirement due to age or length of service .

(4) An enlisted member is within 12 months of High Year Tenure (HYT) or expiration of active obligated service (EAOS), and will be eligible for retirement at his/her HYT or EAOS.

(5) An enlisted member is within 12 months of retirement eligibility and the member's EAOS has or will expire prior to the member being retirement eligible.

c. Overcoming the Presumption

(1) The Presumed Fit (PFit) rule shall be overcome when:

(a) Within the presumptive period an acute, grave illness or injury occurs that would prevent the member from performing further duty if he or she were not retiring; or

(b) Within the presumptive period, a serious deterioration of a previously diagnosed condition, to include a chronic condition, occurs and the deterioration would preclude further duty if the member were not retiring; or

(c) The condition for which the member is referred is a chronic condition and a preponderance of evidence establishes that the member was not performing duties befitting either his or her experience in the office, grade, rank, or rating before entering the presumptive period. Evaluate cases of members in a TLD status on the merits of each case.

(2) The PFit rule is not overcome when there has been no serious deterioration within the presumptive period. The ability to perform duties in the future as a result of presumed normal progression shall not be a consideration in overcoming PFit.

d. Application for Prisoners of War (POWs). The presumption of fitness will not be applied, and a disability rating will be assigned, for conditions of POWs resulting from the POW experience.

3306 Evidentiary Standards For Determining Unfitness Because Of Physical Disability

a. Factual Finding. A factual finding that a service member is Unfit because of physical disability depends on the evidence that is available to support that finding. Quality of evidence usually is more important than quantity. All relevant evidence must be weighted in relation to all known facts and circumstances which prompted referral for disability evaluation. Findings will be made based on objective evidence in the record as distinguished from personal opinion, speculation, or conjecture. When the evidence is not clear concerning a service member's fitness, attempt to resolve doubt based on further objective investigation, observation, and evidence. Benefit of unresolved doubt shall be resolved in favor of the fitness of the service member under the rebuttable presumption that the member desires to be found Fit.

b. Preponderance of Evidence. Make findings about fitness or unfitness for naval service based on preponderance of the evidence. Thus, if a preponderance (that is, more than 50 percent) of the evidence indicates unfitness, make a finding to that effect. If, on the

other hand , a preponderance of the evidence indicates fitness, the service member may not be separated or retired due to physical disability. The sole standard to be used in making determinations of physical disability as a basis for retirement or separation is Unfitness to perform the duties of office , grade , rank or rating because of disease or injury incurred or aggravated while entitled to basic pay. Each case is considered by relating the nature and degree of physical disability of the member to the requirements and duties that member may reasonably be expected to perform in his or her office, grade, rank or rating.

3307 Standards And Criteria Not Normally To Be Used As The Sole Basis For Determining Fitness Or Unfitness

a. Deployability. Inability to perform the duties of his or her office, grade, rank, or rating in every geographic location and under every conceivable circumstance will not be the sole basis for a finding of Unfitness.

b. Physical Fitness Test. Inability to take/pass the PRT/PFT will not be the sole basis for a finding of Unfit to continue naval service.

c. Special Qualifications. The inability to perform specialized duties or loss of special qualification, i. e., aviation, parachuting or diving qualifications, etc. (see paragraph 3304) will not be the sole basis for a finding of Unfitness.

3308 Members Undergoing Initial Active Duty For Training

a. Members with Medical Waivers. Provided no aggravation has occurred, service members who enter the military with a medical waiver may be separated without physical disability evaluation when the responsible medical authority designated by service regulations determines within 180 days of the member's entry into active service that the waived condition represents a risk to the member or prejudices the best interests of the Government. Once 180 days have elapsed, or the condition is one that causes referral into the DES, refer the member for physical disability evaluation, if otherwise qualified.

b. Members without Medical Waivers. Members undergoing initial active duty for training who incur an injury or condition which was not waived for the purpose of entry into military service, who will not be returned to training in a reasonable period of time, will be referred to the PEB for disability evaluation.

3309 - 3399 Reserved

PART 4 - ELIGIBILITY FOR DISABILITY BENEFITS AND RELATED POLICIES

3401 Conditions Not Constituting Physical Disability

Only those conditions that constitute physical disabilities may be considered by the PEB. Enclosure (8) to this instruction lists conditions not constituting physical disability.

3402 Non-Military Medical Records

A member may be processed for discharge, but the PEB may not award disability benefits for an injury or disease treated by a non-military medical doctor or other health care provider, or facility, unless the member signs a release to allow the medical board or PEB to obtain all records relating to that treatment.

a. When a case is being processed by the PEB in which the member has refused to release all medical records, the PEB shall determine whether the member is Fit or Unfit. If the member is found Fit, see paragraph 3701. If the member is found Unfit, rate only those conditions not related to the non-military medical treatment, if any. Do not assign rating or disability benefits to conditions for which the member has refused to release non-military medical records.

b. Prior to the PEB issuance of a Notification of Decision in such a case, the President, PEB, must be satisfied that the member has been counseled that the refusal to release non-military medical records will result in the prohibition of disability rating and compensation for the injury (ies) or disease treated by the non-military medical facility.

3403 Disciplinary Or Misconduct Administrative Action

a. The disability statutes do not preclude disciplinary separation. Such separations as described herein normally supersede disability separation or retirement. Whenever a member is being processed through the PEB and, subsequently the member is processed for an administrative involuntary separation for misconduct, disciplinary proceedings which could result in a punitive discharge, or an unsuspended punitive discharge is pending, or is pending separation under provisions that authorize a characterization of service of Under Other Than Honorable conditions (UOTH), disability evaluation shall be suspended and monitored by the PEB. The MEB Convening Authority should forward to the PEB either a copy of the Statement of Awareness/Letter of Notification, the court-martial charges, or the Court Martial Order, as appropriate. The PEB case will remain in suspense pending the outcome of the nondisability proceedings. If the action taken does not include punitive or administrative discharge for misconduct, the PEB will continue to process the case. If the action includes either a punitive or administrative discharge for misconduct, file the medical board report in the member's terminated health record.

b. Do not submit a case to the PEB for a member who is currently being processed for misconduct which could result in a punitive discharge as the result of a captain's mast or courts-martial or for a member who is pending an administrative discharge due to

misconduct. Once all misconduct proceedings are complete, and if still necessary, submit the member's medical board package to the PEB for consideration.

c. Notwithstanding paragraph (a) and (b) above, disability evaluation in an individual case may proceed if directed by the DIRNCPB or ASN (M&RA). In such a case, ultimate disposition shall be decided by the ASN (M&RA).

d. Non-misconduct/Non-UOTH administrative separations do not supersede or preclude disability separation. Consequently, final closure must occur on all disability processing/appeals prior to finalization of Non-misconduct/Non-UOTH administrative separation by field commanders/service headquarters.

3404 Deserters

When a member who is being evaluated within the DES is administratively declared a deserter, end the evaluation. Take no further action until appropriate disciplinary or administrative action has been completed, the member has been reexamined, and a current medical board prepared.

3405 Statutory Determinations To Be Made

a. The existence of a physical defect or condition that is ratable under the VASRD does not of itself provide justification for, or entitlement to, separation or retirement from military service because of physical disability .

b. Once unfitness has been determined, the PEB shall determine if the member is statutorily eligible to receive disability benefits before rating an individual. There must be findings that the disability is: (a) of a permanent nature or such a degree to preclude return to military duty within a reasonable period of time, and (b) not the result of intentional misconduct or willful neglect and was not incurred during a period of unauthorized absence. To warrant retirement, the length of service and degree of disability requirements prescribed in clause (3) of 10 U.S.C. 1201, must be satisfied. To warrant separation, the degree of disability requirements prescribed in clause (4) of 10 U.S.C. 1203 must be satisfied, and the member must have less than 20 years of qualifying service under the criteria of 10 U.S.C. 1208.

3406 Ineligibility for Disability Benefits

A member is not eligible to receive benefits under 10 U.S.C., Chapter 61 for an unfitting physical disability if:

- a. the disease or injury was incurred while not entitled to receive basic pay (i.e., Existed Prior to Service and is not service aggravated),
- b. the disease or injury was incurred Not In Line Of Duty,
- c. the disease or injury was incurred during a period of unauthorized absence,
- d. the disease or injury resulted from Intentional Misconduct or Willful Neglect,

e. disease or injury was incurred as a result of unreasonable refusal of medical, dental, or surgical treatment,

f. the member has not been granted a Notice Of Eligibility (applies to inactive-duty reservists only), and the PEB determines that the service member does not have a prior service illness/injury (see 3201b(3)), or

g. the member refuses to release medical records (see paragraph 3402).

3407 Not Entitled To Receive Basic Pay

a. A determination of Unfit while on active duty is not sufficient to entitle a member to disability retirement or severance pay. There also must be a determination that unfitness is due to a disability, which was incurred or aggravated while entitled to receive basic pay.

b. The fact that a member was accepted physically for active duty is not conclusive that the disability was incurred after such acceptance. It is one piece of evidence to be considered with all the medical evidence. In addition to, and in conjunction with, all other pertinent medical evidence, due consideration and weight must be given to accepted medical principles, authenticated by medical authorities, in arriving at a final determination. It is not proper to exclude such accepted medical principles in making the determination, even in cases where there is no other evidence that the disability existed prior to entrance upon active duty.

c. Guidance concerning EPTS and service aggravation is contained in the Rating Policies section of this enclosure.

d. Examples of Individuals Not Entitled To Basic Pay:

- (1) Naval Academy Midshipmen.
- (2) NROTC Midshipmen not under ACDUTRA orders.
- (3) Medical School Programs (except during clinical clerkships).
- (4) Individuals on Excess Leave.
- (5) Individuals on Appellate Leave.
- (6) Nursing Programs.
- (7) Engineering Programs.

3408 Inactive-Duty Reservist without A Notice of Eligibility

An inactive-duty reservist is normally not eligible to receive disability benefits unless he or she has been granted an NOE under SECNAVINST 1770.3B, (reference (g)). See paragraph 3201 b (3) for the exception to this policy.

3409 Prior Service Impairments

Any medical condition incurred or aggravated during one period of service or authorized training in any of the Armed Forces that recurs or is aggravated during later service or authorized training, regardless of the time between, normally should be considered incurred or aggravated in the line of duty, provided the condition or subsequent aggravation was not the result of the member's misconduct or willful negligence.

3410 Line of Duty

Disease or injury incurred by naval personnel while in active service (see paragraph 2007) will be considered to have been incurred "in the line of duty."

a. Injuries incurred under the following circumstances will not be considered to have been incurred "in the line of duty."

(1) as the result of the member's own misconduct,

(2) while avoiding duty by deserting the service,

(3) during a period of unauthorized absence,

(4) while confined under sentence of a courts-martial which included an unremitted dishonorable discharge,

(5) while confined under sentence of a civil court following conviction for an offense which is defined as a felony by the law of the jurisdiction where convicted, or

(6) while on appellate leave.

b. Presumption of "In the Line of Duty." Any disease or injury discovered after a member enters active military service, with the exception of congenital and hereditary (genetically transmitted from parent to offspring) conditions, is presumed to have been incurred "in the line of duty." Clear and convincing evidence is required to overcome this presumption. This presumption does not apply in the case of chronic disease identified soon after entry on military duty nor does it apply when the signs or symptoms of a communicable disease appear within less than the medically recognized minimum incubation period after entry on active service.

c. Intentional Misconduct or Willful Neglect. Misconduct is wrongful conduct. However, simple or ordinary negligence or carelessness, standing alone, does not constitute misconduct. To support an opinion of misconduct, it must be established by clear and convincing evidence that the injury or disease either was intentionally incurred or the

proximate result of such gross negligence as to demonstrate a reckless disregard of the consequences. If a resulting injury or disease is such that it could have been reasonably foreseen from the course of conduct, it is said to be a "proximate result." The fact that the conduct violates a law, regulation, or order, -- or the fact that the conduct is engaged in while the individual is intoxicated -- does not, of itself, constitute a basis for a determination of misconduct. Such circumstances should, however, be considered along with all other facts and circumstances by the PEB in determining whether the conduct of the individual was grossly negligent, and whether the incurrence of injury or disease was reasonably foreseeable as a probable result of such conduct. Willful neglect is defined in paragraph 2087.

d. **Presumption of Not Misconduct.** It is presumed that disease or injury suffered by a member of the naval service is not the result of misconduct. Clear and convincing evidence is required to overcome this presumption. The criminal evidentiary standard of beyond a reasonable doubt does not apply.

e. **Applicability of Misconduct Determination**

(1) An injury which was incurred as the result of misconduct may later become service aggravated.

(2) A misconduct determination disqualifies a member from disability benefits only for the particular disability to which it applies.

f. **Examples of Misconduct and Not Misconduct Situations.** An intentional self-inflicted injury, other than suicide attempt discussed in paragraph 3414e, is deemed to be incurred as the result of the member's own misconduct, unless lack of mental responsibility is otherwise shown.

(1) If an individual intentionally wounds himself or herself with a firearm, the injury is due to his or her own misconduct .

(2) If an individual handles a firearm in a grossly negligent manner and thereby wounds himself or herself, that injury is due to his or her own misconduct because a wound is a reasonably foreseeable result of the grossly negligent handling of firearms; e.g., Russian Roulette.

(3) If, on the other hand , an individual was standing on a sidewalk and, while handling a firearm in a grossly negligent manner, was struck by an automobile which had gone out of control, the injuries are not due to his or her own misconduct because they would not have been reasonably foreseeable or the proximate result of the wrongful conduct in which the individual was engaged. In this example, the injuries are the result of an independent intervening cause.

g. **Misconduct /Line of Duty Determinations**

(1) Under the laws and regulations governing the Navy DES, members entitled to basic pay who incur or aggravate medical conditions which make them Unfit to perform their military duties are eligible to receive disability retirement or separation benefits. Members are not entitled to these benefits, however, if the physical disability resulted from the member's own intentional misconduct or willful neglect or was incurred while the member was in an unauthorized absence status.

(2) Chapter II of JAGINST 5800.7C (hereinafter the JAGMAN) (reference (h)), outlines policies and procedures for making line of duty/misconduct (LOD/M) determinations. JAGMAN section 0221 details circumstances that require such determinations. JAGMAN sections 0230 and 0231 prescribe that commands record LOD/M determinations in the member's health or dental record. When a command investigation or written preliminary inquiry has been prepared per JAGMAN, chapter II, commands will provide a copy of the inquiry, or investigation with General Court-Martial Convening Authority (GCMCA) endorsement, to the Medical Evaluation Board (MEB) convening authority for inclusion in the official records of the case which are forwarded with the MEB report for PEB consideration.

(3) Normally, the PEB will accept as binding the command LOD/M determination approved by the GCMA.

(a) The command determination will be subject to further review if either the PEB Legal Advisor, Informal PEB, Formal PEB, or PPEB, finds the LOD/M determination to be contrary to the evidence contained in a JAGMAN investigation, contrary to additional evidence obtained during the PEB review and hearing process, or predicated upon an investigation that may be deficient. In these cases, the PEB Legal Advisor, Informal PEB or Formal PEB will submit a written request to the PPEB for DIRNCPB review and decision. The PPEB will forward his/her recommendation along with a written legal analysis of the LOD/M determination from the PEB Legal Advisor to the DIRNCPB. If the Informal PEB initiates review of a LOD/M determination, the documentary review may be completed pending DIRNCPB decision. If the Formal PEB initiates a review of a decision made by DIRNCPB at the Informal PEB level, the formal hearing may be completed pending DIRNCPB's final decision. However, the Informal PEB or Formal PEB will not sign or promulgate a Preliminary Findings or Findings letter until the DIRNCPB has completed review of the case and issued a LOD/M determination. In the case of the Formal PEB, the member will be advised that an initial or revised LOD/M determination is being sought from the DIRNCPB. Upon receipt of the DIRNCPB's determination, the Informal or Formal PEB's will sign the Preliminary Findings Letter or Findings Letter, as appropriate, consistent with the DIRNCPB's determination. The case will then be forwarded to the PPEB for review and issuance of findings.

(b) Upon receipt of a request to review a LOD/M determination, DIRNCPB shall secure a written analysis of the LOD/M determination from the NCPB legal advisor before reviewing the analyses and recommendations from the President, PEB and the PEB legal advisor. DIRNCPB shall make a final LOD/M decision and return the

case to the President, PEB who shall issue a Findings Letter consistent with DIRNCPB's decision.

(4) Under chapter 18 of the reference (f) (MANMED), the convening authority of the MEB has the responsibility to review all MEB reports for completeness. Before referring a case for PEB review, the MEB convening authority shall review case records to ensure they contain required LOD/M determinations from the responsible field commander. The MEB convening authority shall process a case that fails to contain a required LOD/M determination according to the following principles:

(a) If the date of the injury giving rise to the requirement for an LOD/M determination was more than 2 years prior to the date of the MEB, the MEB convening authority shall continue to process the member's case, including forwarding the case to the PEB, without further effort to obtain the LOD/M determination or information normally required for making the determination. Consistent with the JAGMAN reference (h), the MEB will presume a finding of "in the line of duty and not due to the member's own misconduct" in processing such cases.

(b) If the date of the injury giving rise to the requirement for an LOD/M determination is less than 2 years from the date of the MEB, the MEB convening authority will contact the responsible field commander and request that steps be taken to properly investigate the facts surrounding the injury and to document and record appropriate findings. The MEB convening authority only shall forward the MEB report to the PEB for processing if:

1. MEB convening authority obtains a copy of the LOD/M investigation and includes it as part of the MEB report;
2. MEB convening authority obtains a copy of the health/dental record entry recording the LOD/M determination, and includes it as part of the MEB report package; or
3. MEB convening authority obtains a statement from the cognizant GCMCA stating that an LOD/M determination was not required (JAGMAN section 0221) or was not able to be obtained (i.e., that diligent efforts to complete the investigation were not productive due to witness unavailability).

(5) If the PEB receives a MEB report from a MEB convening authority that fails to contain a required LOD/M determination, processing of the MEB report will be governed by the following principles:

(a) If the date of the injury giving rise to the requirement for an LOD/M determination was more than 2 years prior to the date of the MEB reporting the medical evaluation of the associated injury/disease, the PEB will continue to process the member's case without further effort to obtain the LOD/M determination or information normally required for making the determination. Consistent with the JAGMAN and this

instruction, the PEB will presume the injury or disease was incurred or aggravated "in the line of duty and not due to the member's own misconduct " in these cases.

(b) If the date of the injury giving rise to the requirement for an LOD/M determination is less than 2 years from the date of the MEB reporting the medical evaluation of the associated injury/disease, the PEB will forward the case to the PEB legal advisor. Upon review of the case, if it is the legal advisor's opinion that an LOD/M determination was not necessary, the PEB shall process the case presuming an LOD/M determination favorable to the member. If it is the legal advisor's opinion that the relevant facts and directives require an LOD/M determination, and President, PEB concurs, the PEB will return the MEB report to the MEB convening authority for action as noted in subparagraph (4) above. (If the President, PEB does not concur with the recommendation of the PEB legal advisor, the provisions of paragraph 4103 (a) and (b) apply.) The PEB will advise the medical board report convening authority that prior to the PEB's acceptance of the medical board report for consideration, one of the following actions must be completed:

1. Obtain (or complete) a copy of the LOD/M investigation and include it as part of the MEB report;

2. Obtain (or complete) a copy of the health/dental record entry recording the LOD/M determination and include it as part of the MEB report; or

3. Obtain a statement from the cognizant GCMCA stating that an LOD/M determination was not required (JAGMAN section 0221) or was not able to be obtained. (In this case processing shall be made presuming the injury or disease was incurred or aggravated in the line of duty and not due to the member's own misconduct.)

(6) In the event that the member has incurred or aggravated an injury or disease while in an unauthorized absence status, JAGMAN sections 0223c(2) and 0230d require that the member's command complete an LOD/M investigation. JAGMAN section 0223 establishes separate standards regarding injury or disease incurred during a period of unauthorized absence: one standard is for JAGMAN investigations purposes, and the second standard is for the purposes of physical disability payments (severance/retirement) under chapter 61 of Title 10, U.S.C. Procedures set forth in the latter standard govern PEB processing of cases involving LOD/M determinations, as outlined in paragraph 3410a.

h. Passenger Misconduct. In accordance with paragraph 3410d, injuries sustained by a passenger will be presumed not to have occurred as a result of his/her own misconduct. However, subject to the criteria set forth in paragraph 3412a(3), this presumption may be overcome where clear and convincing evidence establishes that the passenger knew or should have known that the driver was incapable of operating a motor vehicle safely due to the intemperate use of alcohol or illegal use of a drug.

3411 Unauthorized Absence

When a disability is incurred at any time during a period of unauthorized absence, regardless of whether the absence interfered with the member's military duties, the member is excluded from receiving disability benefits (10 U.S.C. 1207). Legally excusable mental or physical conditions may provide a bona fide defense to a charge of unauthorized absence and may be an issue addressed in the context of disability evaluation.

3412 Substance Abuse-Related Disabilities

a. Injury Incurred as Proximate Result of Voluntary Intoxication

(1) Subject to the discussion in paragraph 3410, an injury incurred as the proximate result of prior and specific voluntary intoxication may be incurred as the result of misconduct. However, a finding of misconduct may only be made when:

(a) it clearly can be shown that the member's physical or mental faculties were impaired;

(b) the extent of impairment clearly can be determined; and

(c) it is clear that such impairment was the proximate cause of injury.

(2) In the case of an operator of a motor vehicle, the presence in the blood stream of a BAC of 0.1 grams percent or higher, standing alone, is sufficient to establish items a (1) (a) and a (1) (b) above. The fact that the operator was intoxicated does not, however, establish a (1) (c) above. Rather, other independent evidence such as a police report or written statement must be presented to establish that the member's injuries were a direct result of intoxication.

(3) While the gross negligence of an intoxicated driver, which is the proximate cause of injury, may support a finding of misconduct with regard to the driver, injury sustained by a passenger is normally not considered the result of misconduct. Injury to a passenger is normally the result of the driver's gross negligence and not the passenger's. Accordingly, in the case of passengers in motor vehicles, this paragraph is not applicable unless:

(a) the passenger exercises control over the operation of the vehicle,

(b) the negligence of the driver, by operation of law, can be "imputed" to another person or entity, or

(c) the evidence establishes a failure as a passenger to exercise due care for one's own safety.

b. Alcohol and Drug-Induced Disease

(1) General. Inability to perform duty resulting from disease, which is

directly attributable to a specific, prior, proximate, and related intemperate use of alcoholic liquor, or illicit and habit-forming drugs, shall be categorized as the result of misconduct . Habituation may or may not be associated with a specific inability to perform duty that is directly due to the specific and proximate use of alcohol or drugs. Controlled substances are listed in 21 C.F.R. 1308.

(2) Alcohol-induced disease. An alcohol-induced disease is the result of misconduct , if:

(a) according to recognized medical knowledge, it is the direct and foreseeable result of the intemperate use of alcohol; and

(b) the service member had been referred to a treatment and rehabilitation program for alcoholism at a time when the disease was preventable or treatable.

(3) Drug-induced disease

(a) If a disease, such as hepatitis, cannot be directly attributed to a specific, prior, proximate, and related intemperate use of a drug, it must be considered not due to misconduct .

(b) An individual will not be held responsible for his or her acts or their consequences if they result from mental disease. It must be determined therefore whether the drug use was a consequence of mental illness or the drug use was voluntary and brought on the mental illness. If a result of voluntary use or abuse, the findings may be misconduct and not compensable depending on the other circumstances involved; if a consequence of mental illness, no misconduct is involved. However, a determination that drug use was a consequence of mental illness would, by the same rationale, tend to establish the existence of mental illness prior to service in those cases where the member admits intemperate use of drugs prior to service. Brief experimentation with marijuana would not, in itself, meet this criterion.

3413 Unreasonable Refusal Of Medical, Dental, Or Surgical Treatment

a. If a member unreasonably refuses to submit to medical, dental, or surgical treatment, any Unfitting disability that proximately results from such refusal is incurred as a result of the member's willful neglect. However, unreasonable refusal under this section only may equate to willful neglect when the member most likely would be Fit had he or she submitted to or complied (see paragraph 3802(c) failure to comply with prescribed treatment) with the treatment regimen. Additionally, a member who refuses medical treatment on a bona fide religious basis is eligible for disability benefits; refusal shall not be considered willful neglect.

b. The PEB must determine whether refusal of treatment was or was not, in fact, reasonable regardless of any opinion expressed in a medical board report. The medical board report also shall contain the following:

(1) written comments by the member regarding the member's refusal;

(2) written comments by the physician explaining why the refusal is unreasonable, supported by specific medical references. If the PEB finds that the refusal of treatment was unreasonable, the member shall, unless a MEDICAL BOARD CERTIFICATE RELATIVE TO COUNSELING ON REFUSAL OF SURGERY AND/OR TREATMENT (NAVMED 6100/4) already is contained in the record, be notified before a finding of willful neglect may be made, and advised that continued refusal will result in a finding of willful neglect and loss of disability benefits.

3414 Mental Competency And Responsibility

a. Presumption of Mental Competence. All persons are presumed to be mentally competent and thus responsible for their acts. Clear and convincing evidence is required to overcome this presumption.

b. Mental Responsibility Considerations. A member may not be held responsible for his or her acts and their foreseeable consequences if, at the time of commission of such acts, as a result of severe mental disease or defect, he or she was unable to appreciate the nature and quality or the wrongfulness of the acts. A member's conditions not amounting to a lack of mental responsibility as defined above does not preclude holding a member responsible for his or her acts and their foreseeable consequences. As used in this paragraph, the terms "mental disease" and "defect" do not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct. Thus, an injury which was the proximate result of acts performed while the member was mentally impaired as a result of voluntary ingestion of an hallucinogenic drug would be deemed to have been incurred as a result of the member's own misconduct since certain properties of such drugs are notorious and their use is prohibited by Article 1151, U.S. Navy Regulations.

c. Determining Mental Incompetence

(1) Where mental competency is an issue, disbursement of a member's pay and allowances to a trustee properly designated under chapter XIV, JAGMAN, can only be made after a determination of mental incapacity to manage financial affairs by a board of medical officers convened and constituted in accordance with reference (f) (MANMED), chapter 18 and 37 U.S.C. 602. Such a board must consist of three members, at least one of whom must be a psychiatrist. Additionally, the members of such a board must be physicians of the Navy, Army, Air Force, or physicians employed by one of these Services, the Department of Health and Human Services, or the VA.

(2) In the case where a member who is on the TDRL elected to receive compensation from the VA in lieu of all retired pay from the Department of the Navy, a determination of mental incompetence by a psychiatrist other than a medical officer or physician employed by one of the Services, Departments, or agencies may be accepted subject to the approval of the DFAS.

(3) Where the member's attending physician determines that the member is mentally unable to acknowledge; i.e., accept or decline, the findings of the PEB, and is not expected to live more than 72 hours, the member's guardian appointed by a court, or, if no one has been appointed, the primary next of kin, may act on his or her behalf. The member's attending physician shall annotate this determination, and the reasons therefore, in the member's medical record. Should the member survive, however, and require active duty or retired pay, then his/her mental incompetence must be determined in accordance with paragraph 3414c (1).

d. Restoration of Mental Competency. Once a determination of mental incompetence has been properly made, a finding of restoration of competency or capability to manage financial affairs may be accomplished by a minimum of one medical officer, who shall be a psychiatrist. See JAGMAN, Chapter XIV.

e Suicide Attempts. In view of the strong human instinct for self-preservation, a bona fide suicide attempt, as distinguished from other acts of intentional self-injury, shall be considered to create a strong inference of lack of mental responsibility.

3415 - 3499 Reserved

PART 5 - POLICIES CONCERNING COMBAT-RELATED INJURIES

3501 Provision Of Combat-Related Opinion

a. Once a member has been rated, the PEB shall provide a combat-related opinion for the member which shall be binding on the appropriate finance center in the absence of guidance to the contrary from the Internal Revenue Service or from the JAG. CHNAVPERS and CMC (M&RA), as appropriate, shall communicate this opinion to the separating activity and to the appropriate finance center.

b. No combat-related opinion need be made when it is clear from the record of proceedings that the member was on active duty or under binding contract with the Armed Forces on or before 24 September 1975.

c. The PEB will state affirmatively, for contingent use in civil service matters by the JAG, if the disability is a result of an instrumentality of war or incurred as a direct result of armed conflict.

3502 General

Retired and severance pay awarded to members who were not a member of an armed force or under a binding contract to become such a member on 24 September 1975 is considered taxable under Section 104 of the Internal Revenue Code, found as 26 U.S.C. 104. An exception to this provision exists in Section 104(b)(1)(c) for a member receiving separation or retired pay by reason of a combat-related injury .

3503 Combat-Related Injury

The term "combat-related injury" as defined in 26 U.S.C. 104(b)(3) includes four separate categories. It means personal injury or sickness:

- a. Incurred as a direct result of armed conflict,
- b. Incurred while engaged in extra hazardous service, or
- c. Incurred under conditions simulating war; or
- d. Caused by an instrumentality of war.

3504 Direct Result Of Armed Conflict

The physical disability is a disease or injury incurred in the line of duty as a direct result of armed conflict. The fact that a member may have incurred a disability during a period of war or in an area of armed conflict, or while participating in combat operations is not sufficient to support this finding. There must be a definite causal relationship between the armed conflict and the resulting unfitting disability.

a. Armed conflict includes a war, expedition, occupation of an area or territory, battle, skirmish, raid, invasion, rebellion, insurrection, guerrilla action, riot, or any other

action in which service members are engaged with a hostile or belligerent nation, faction, force, or terrorists.

b. Armed conflict also may include such situations as incidents involving a member while interned as a prisoner of war or while detained against his or her will in custody of a hostile or belligerent force or while escaping or attempting to escape from such confinement, prisoner of war, or detained status.

3505 Engaged In Extra Hazardous Service

Includes, but is not limited to, aerial flight duty, parachute duty, demolition duty, experimental stress duty, and diving duty.

3506 Conditions Simulating War

In general, this covers disabilities resulting from military training, such as war games, practice alerts, tactical exercises, airborne operations, leadership reaction courses; grenade and live fire weapons practice; bayonet training; hand-to-hand combat training; repelling, and negotiation of combat confidence and obstacle courses. It does not include physical training activities, such as calisthenics and jogging or formation running and supervised sports.

3507 Caused By An Instrumentality Of War

For income taxation purpose only, incurrence during a period of war is not required. A favorable determination is made if the disability was incurred during any period of service as a result of such diverse causes as wounds caused by a military weapon, accidents involving a military combat vehicle, injury, or sickness caused by fumes, gases, or explosion of military ordnance, vehicles, or material. However, there must be a direct causal relationship between the instrumentality of war and the disability. For example, an injury resulting from a service member falling on the deck of a ship while participating in a sports activity would not normally be considered an injury caused by an instrumentality of war (the ship) since the sports activity and not the ship caused the fall. The exception occurs if the operation of the ship caused the fall.

3508 Appeals Of Combat-Related Opinions

a. JAG shall act on behalf of the SECNAV in providing departmental appellate resolution of combat-related opinions.

b. DIRNCPB may request an opinion from the JAG as to the appropriateness of a PEB combat-related opinion. Such opinion shall be binding on and shall be issued by the PEB.

c. A determination by the PEB that a disability is not combat-related may be appealed by the member to the JAG. The appeal shall be by letter addressed to the Judge Advocate General of the Navy (Code 131), Washington Navy Yard, 1322 Patterson Ave SE, Suite 3000, Washington, DC 20374-5066 and shall set forth the reasons the member disagrees with the determination of the PEB. The member's disability evaluation proceedings will not be delayed or abated pending action on the appeal by the JAG.

d. JAG may provide a combat-related opinion upon request by a member who was not provided one during earlier DES processing.

3509 - 3599 Reserved

PART 6 - POLICY GOVERNING THE TEMPORARY DISABILITY RETIRED LIST (TDRL)

3601 Applicability

Place service members on the TDRL when they would be qualified for permanent disability retirement but for the fact that the member's disability is not determined to be of a permanent nature and stable.

a. A disability shall be considered unstable when the preponderance of medical evidence establishes that accepted medical principles indicates the severity of the condition will change within the next 5 years so as to result in an increase or decrease of the disability rating percentage or a finding of Fit.

b. Except for cases processed under imminent death procedures, permanently retire those members with unstable conditions rated at a minimum of 80 percent and which are not expected to improve to less than an 80 percent rating. When a member is placed on the TDRL in accordance with this instruction the provisions of this part apply.

3602 Administration

CHNAVPERs and CMC (M&RA) are responsible for administering the TDRL for their services, in keeping with the following guidelines:

- a. maintain an accurate account of authorized members;
- b. designate medical facilities and direct members to undergo periodic physical examinations in accordance with the requirements of this chapter;
- c. arrange and coordinate with the President, PEB, alternate means of examination when members are unable to undergo periodic physical examinations by reason of circumstances beyond their control;
- d. order additional medical information when requested by the PEB;
- e. monitor failures to report for periodic physical examinations and take appropriate action in such cases as specified in paragraphs 3609, 3610, 3611 and 3612;
- f. implement disposition of members whose cases are finalized by the PEB as appropriate.

3603 Administrative Finality

During TDRL reevaluation, previous determinations concerning application of any presumption established by this instruction, line of duty, misconduct, proximate result, and whether a medical impairment was service incurred or preexisting and aggravated shall be considered administratively final for those conditions for which the member was placed on

the TDRL unless there is evidence of fraud; a change of diagnosis that warrants the application of accepted medical principles for a preexisting condition; or correction of error in favor of the member.

3604 Member's Responsibility to Maintain Current Mailing Address With Service

All members on the TDRL shall keep CHNAVPERs, CMC (MMSR-4), and the Defense Finance and Accounting Service (DFAS) Cleveland Center apprised of their current address. Failure to respond to correspondence or orders issued to the address on file with the appropriate finance center either willfully, or through negligence in keeping that address current, may result in the suspension of disability retired pay and will be considered as showing intent on the member's part to abandon benefits. Additionally, all active duty members being placed on TDRL and those TDRL members going before a Formal PEB must fill out an Address Information Form. PEBLOs will submit this form with the members Election of Options (for active duty personnel) and the Formal PEB Administrator will ensure that all TDRL members reporting for a hearing complete the form and include it in the PEB case file.

3605 Time Limit For Pay Purposes

10 U.S.C. 1210 provides that the maximum time that a member's name can be carried on the TDRL in a pay status is 5 years.

3606 Orders For Periodic Physical Examination

a. General. The law requires that members on the TDRL shall be given physical examinations at least once every 18 months. This includes members who have waived retired pay, in order to receive compensation from the VA, as they are still members of the naval service .

b. Issuance. CHNAVPERs or CMC (M&RA) shall issue orders (copy to PEB) to members on the TDRL to proceed and report for periodic physical examinations normally via the commanding officer of the designated examining activity. The examining facility will endorse the orders and specify the date, place, and time (giving the member a minimum of 30 days) at which the member is to report. The examination shall be conducted during the month specified in the orders or during the preceding or following month. The commanding officer of the medical facility shall notify CHNAVPERs or CMC (M&RA), as appropriate, and CHBUMED of failure to complete the examination within this time frame and the reason therefore.

3607 Priority

TDRL examinations, including hospitalization in connection with the conduct of the examination, shall be furnished on the same priority as given to active duty members.

3608 Member Medical Records

The service member shall provide to the examining physician, for submission to the PEB, copies of all medical records (civilian, VA, and all military medical records) documenting treatment since the last TDRL reevaluation.

3609 Refusal Or Failure To Report For Periodic Physical

As provided under chapter 61 of reference (a), when a service member on the TDRL refuses or fails to report for a required periodic physical examination, or to provide medical records in accordance with his or her disability, retired pay may be suspended. If the member later reports for the physical examination, retired pay will be resumed retroactively, to the date the examination actually was performed. If the service member subsequently shows just cause for failure to report, disability retired pay may be paid retroactively for not more than 1 year. If the member does not undergo a periodic physical examination after disability retired pay has been terminated, he or she will be administratively removed from the TDRL on the fifth anniversary of placement on the list and separated without entitlement to any of the benefits under reference chapter 61 of 10 U.S.C. (reference (a)).

3610 Reports From Non-MTFs

MTF's designated to conduct TDRL periodic physical examinations may use reports of medical examinations from medical facilities of another service, the DVA, other government agencies, and authorized civilian medical facilities and physicians to complete the examination. The designated MTF remains responsible for the adequacy of the examination and the completeness of the report. The report must include the information specified in paragraph 3616, if applicable.

3611 Incarcerated Members

A report of medical examination shall be requested from the appropriate authorities in the case of a service member imprisoned by civil authorities. In the event no report or an inadequate report is received, make documented efforts to obtain an acceptable report. If an examination is not received, disposition of the case shall be in accordance with paragraph 3609 above. Advise the member of the disposition, and that remedy rests with the Board for Correction of Naval Records.

3612 Action Required By Examining Medical Facility When Member Fails To Report For Periodic Physical Examination

Send notice of appointments for periodic physical examinations by certified mail (or by an equivalent form of notice if such service by U.S. Mail is not available for delivery at an address outside the United States) to the member's address of record. If the member fails to appear for the scheduled appointment without contacting the medical facility for rescheduling, and the member either signed for or failed to claim the certified notice of appointment, the medical facility shall forward a copy of the certified mail receipt to the member's records, and a signed statement documenting the member's failure to appear for the periodic physical examination to CHNAVPERs or CMC (MMSR) and President, PEB. If the certified notice of appointment is returned due to the member not being at that address, contact CHNAVPERs or CMC (MMSR) for a new address. If none exists, return all records to CHNAVPERs/CMC (MMSR).

3613 Admission For Inpatient Observation

Whenever inpatient observation is desirable or necessary for a proper evaluation, admission and retention as an inpatient for a period of as much as 10 days are authorized. This length of inpatient observation may be extended upon authorization of CHNAVPERs

or CMC (MMSR), as appropriate. It is particularly important that admission as an inpatient be considered for proper evaluation of psychiatric (neuropsychiatry) cases.

3614 Report Of Periodic Physical Examination

a. Format. The report may be prepared in medical board report, letter or narrative format.

b. Content. The report shall contain:

(1) the current address and contact telephone number of the member;

(2) an interval history since the last examination with particular reference to the member's employment and time lost (there from) due to the disability for which retired;

(3) a comprehensive physical examination, reporting all physical impairments, degree of impairment, and the examiner's findings associated with each impairment. Included will be any impairment from which the member has recovered and new ones acquired while on the TDRL. Advice of consultants should be obtained if the examining physician(s) are in doubt as to an actual physical condition or diagnosis;

(4) all clinical evaluations and laboratory studies necessary to document the member's physical condition;

(5) information regarding the member's current condition and prognosis including current stability and the likelihood of significant change within the remaining statutory time the member might remain on the TDRL and a comparative estimate of changes relative to the member's previous condition;

(6) in the case of psychiatric disabilities, a statement(s) as to the current degree of impairment of industrial adaptability and social adaptability. Also see paragraph 3616 and 3619; and

(7) a statement as to whether disclosure to the member of information relative to his or her physical or mental condition, or a personal appearance before the PEB would be detrimental to the member's physical or mental health.

(8) All members who served in Southwest Asia Theater of Operations (SWATO) must have either a CCEP evaluation or a waiver if the medical diagnosis included in the MEB report are assessed to be related to illnesses that are directly or causally related to service in this theater. If this was not done before the original MEB, it must be included with the periodic examination.

3615 TDRL Periodic Examinations

In addition to the requirements specified above, TDRL periodic examinations shall address:

- a. An estimate of change since the previous examination.
- b. All medical impairments diagnosed since the member was placed on the TDRL , to include:
 - (1) Whether the new diagnosis was caused either by the condition for which the member was placed on the TDRL or the treatment received for such a condition.
 - (2) If not caused by the condition for which the member was placed on the TDRL, whether the member's medical records document incurrence or aggravation of the condition while the member was in a military duty status; and if so, whether the condition was cause for referral into the DES at the time the member was placed on the TDRL.
- c. The stability of the condition. If the condition remains unstable, the report of examination shall address the progress of the disability and a suggested period (not to exceed 18 months) for the next examination.
- d. A detailed occupational history and an indication of pertinent social and recreational activities, and activities of daily living.

3616 Competency

TDRL periodic examinations shall include the results of a competency board when the member has a functional or organic disorder that makes questionable the member's ability to handle personal affairs and to understand and cooperate in MEB and PEB proceedings.

3617 New Diagnoses

A fitness and compensable determination shall be made on all diagnoses present during the period of TDRL evaluation. When a member is determined Fit for the condition for which he or she was placed on the TDRL, but Unfit for a noncompensable condition incurred while on the TDRL, separate the member from the TDRL without entitlement to disability benefits.

3618 TDRL Reevaluation With Regard To Compensability Of New Diagnoses/Re-evaluation Of Category III Conditions

a. Conditions newly diagnosed during TDRL periodic physical examinations shall be compensable upon finalization when:

- (1) the condition is unfitting; and
- (2) the condition was caused by the condition for which the member was placed on the TDRL, or directly related to its treatment; or
- (3) the evidence of record establishes that the condition either was incurred while the member was entitled to basic pay, or as the proximate result of performing duty, whichever is applicable, and was an unfitting disability at the time the member was placed

on the TDRL . Otherwise, such conditions shall be deemed unfitting due to the natural progression of the condition and noncompensable under chapter 61 of 10 U.S.C. (reference (a)), although the member may be eligible for benefits for these conditions under the DVA.

b. During the review of individual TDRL cases, the Informal and Formal PEBs will not consider those diagnoses previously categorized as Condition III. A final determination regarding a member's fitness for duty or recommended placement on the PDRL will be made based upon review of evidence pertaining to previously designated Category I or II conditions, or for conditions meeting the criteria of "new" diagnosis.

3619 Periodic Physical Examination Reports In Cases In Which Mental Competency Was Or Is An Issue

a. In addition to the paragraph 3614 requirements above, whenever a member on the TDRL was earlier found mentally incompetent or incapable of managing his or her affairs, the report shall contain either a statement that the member continues to be incompetent, or a finding of restoration of competency .

b. If a member was not earlier declared incompetent and his or her mental condition has deteriorated such that mental competency is an issue, a competency board shall be convened in accordance with paragraph 3905 of enclosure (3) of this instruction.

3620 Disposition Of The Report Of Periodic Physical Examination By The Examining Facility

a. Copy of Report To Member. Unless disclosure of the information contained therein would adversely affect his or her physical or mental health, provide the member a copy of the report by mail with instructions to send any comments directly to the President, Physical Evaluation Board, 720 Kennon Street SE Suite 309, Washington Navy Yard, Washington DC 20374-5023. If the member is incompetent, provide the report to the guardian .

b. Forwarding To President, PEB. The commanding officer shall forward the report, together with the medical records within 30 days following completion of the examination to the President, Physical Evaluation Board (TDRL), 720 Kennon Street SE Suite 309, Washington Navy Yard, Washington DC 20374-5023.

c. Copy to CHNAVPERS/CMC (MMSR-4). The commanding officer shall forward a copy of the report to CHNAVPERS/CMC (MMSR-4) for historical record.

3621 Travel Expenses

a. General. A member on the TDRL is entitled to travel and transportation allowances authorized for members in his or her retired grade traveling in connection with temporary duty while on active duty, by the Joint Federal Travel Regulations (JFTR) for periodic physical, examinations and any appearances before the PEB. (10 U.S.C. 1210(g)).

b. Escorts/Attendants. The discussion in paragraph 3111e concerning an accompanying attendant is applicable to TDRL personnel.

c. Reimbursement. To obtain reimbursement, a travel claim and properly endorsed orders showing travel actually performed are required. Submit claims in accordance with the instructions/addresses included with the orders.

3622 Action On Cases By The Physical Evaluation Board Following Periodic Physical Examination

Upon acceptance of a report of a periodic physical examination or a report of other current medical examination, the PEB shall evaluate such report and take one of the following actions:

a. For Conditions Not Stabilized And Not Near 5 Years On The TDRL :

(1) Members on the TDRL for less than 5 years whose conditions have not stabilized will be retained on the TDRL.

(2) A member's disability rating will not be changed during the period a member is assigned to the TDRL.

(3) A member who is continued on the TDRL does not have the right to demand a formal hearing.

b. For Conditions Which Have Stabilized Or Are Near 5 Years On The TDRL :

(1) Members on the TDRL for 5 years or whose conditions have stabilized or become permanent at the time of the periodic physical evaluation will be processed as follows:

(a) Fit

(b) Unfit, separate with benefits

(c) Unfit, retired to the PDRL

(2) Rate members on the TDRL under the VASRD criteria in effect at the time of their final reevaluation. VASRD rating policies for military members are authorized/implemented pursuant to 10 U.S.C. Section 1210c.

3623 Removal From The TDRL

Remove a member's name from the TDRL when:

a. The PEB determines that:

(1) The member is Fit to continue naval service. TDRL members determined Fit to continue naval service shall be entitled to a Formal PEB since removal from the TDRL represents a change in military status; or

(2) The member is Unfit to continue naval service. TDRL members determined Unfit to continue naval service and who have achieved maximum improvement or whose disability is permanent should have their case finalized by the fifth anniversary of placement on the TDRL. In the event that a member desires to contest the Unfit finding or the disability rating, the member shall be entitled to a Formal PEB.

b. The member is administratively removed by CHNAVPERS/CMC (M&RA) on the fifth anniversary of placement on the TDRL for failure to report for periodic examination and separated without entitlement to any benefits under Chapter 61 of 10 U. S. C. (reference (a)). See paragraph 3609.

3624 Disposition After Processing By The Physical Evaluation Board

a. Retention On The TDRL . The member maintains the status on the TDRL until evaluation by the PEB following the next periodic physical examination, or until administratively removed.

b. Removal From The TDRL

(1) Administrative Removal. See paragraph 3609.

(2) Fit to continue naval service . See paragraphs 3623 and 3625.

(3) Separation. See paragraph 3627.

(4) Retirement. See paragraph 3628.

3625 Fit To Continue Naval Service Following Evaluation Of Periodic Physical Examination - Reenlistment Or Reappointment

Assignment to the TDRL and disability retirement payments will terminate upon a determination by the PEB that a member is Fit to perform military duties. The member will be afforded the opportunity to re-enter military service if the member seeks reentry:

a. Members Of Regular Components

(1) Enlisted Members. An enlisted member of a regular component may be allowed to reenlist in his or her regular component provided he or she otherwise is qualified for reenlistment. An enlisted member of a regular component shall have either his or her status on the TDRL and disability retired pay terminated on the date preceding reenlistment in the regular component of which he or she was a member before being placed on the TDRL. Any such reappointment or reenlistment shall be in a rank, grade, or rating not lower than the rank, grade, or rating permanently held by the member at the time his or her name was placed on the TDRL, and may be in the rank, grade, or rating immediately above the rank, grade or rating permanently held. For the purpose of being placed on a lineal list, promotion list, etc., the member will be given such seniority in rank, grade, or rating, or will be credited with such years of service as the SECNAV may authorize. In this connection,

consider the probable opportunities for advancement and promotion to which the member might reasonably have been entitled had it not been for the placement of his or her name on the TDRL.

(2) Officers. With his consent, an officer of a regular component shall be recalled to active duty and, as soon as practicable, be reappointed to the active list of a regular component, even if this means that there will be a temporary increase in the number of officers authorized for his grade. Any such reappointment shall be in a rank or grade not lower than the rank or grade permanently held by the member at the time his or her name was placed on the TDRL, and may be in the rank or grade immediately above the rank or grade permanently held. For the purpose of being placed on a lineal list, promotion list, etc., the member will be given such seniority in rank or grade, or will be credited with such years of service as SECNAV may authorize. In this connection, consideration will be given to the probable opportunities for advancement and promotion to which the member might reasonably have been entitled had it not been for the placement of his or her name on the TDRL. An officer in a regular component shall have disability retired pay terminated on the date preceding recall to active duty.

b. Members Of Reserve Components. A member of a reserve component may be reappointed or reenlisted as the case may be, in the reserve component. A member of a reserve component, whether officer or enlisted, shall have his or her status on the TDRL and disability retired pay terminated on the date preceding reappointment or reenlistment in a reserve component.

c. Members Of The Fleet Reserve Or Fleet Marine Corps Reserve. A member of the Fleet Reserve or Fleet Marine Corps Reserve, found Fit to continue naval service with less than 30 years in service, shall resume his or her status in the Fleet Reserve or Fleet Marine Corps Reserve in the grade held when placed on the TDRL, or the next higher grade if considered qualified therefore in view of 10 U.S.C. 1210. Members of the Fleet Reserve or the Fleet Marine Corps Reserve found Fit to continue naval service who have 30 or more years in service will be permanently retired.

3626 Current Periodic Examination

Service members on the TDRL shall not be entitled to permanent retirement or separation with disability severance pay without a current TDRL or DVA periodic examination acceptable to the service Secretary .

3627 Disability Less Than 30 Percent Following Evaluation Of Periodic Physical Examination

a. Separation. A member on the TDRL who has less than 20 years of active service computed under 10 U.S.C. 1208 and a physical disability ratable at less than 30 percent disability (but continues to render him or her Unfit to continue naval service) under the VASRD in use at the time of determination shall be removed from the TDRL and may be separated under 10 U.S.C. 1203 or 1206, whichever applies in accordance with 10 U.S.C. 1210(e).

b. Severance Pay. If the disability is ratable at less than 30 percent but continues to render the member Unfit to continue naval service, and if the member has served at least six months, but less than 20 years of active duty (and will not be entitled to retired pay or retainer pay by other provisions of law), he or she will be discharged with severance pay computed in accordance with 10 U.S.C. 1212.

c. Exceptions To Separation With Severance Pay

(1) Reversion To Former Status - Members Of The Fleet Reserve Or Fleet Marine Corps Reserve. A member of the Fleet Reserve or Fleet Marine Corps Reserve on the TDRL who has 20 years service computed under 10 U.S.C. 1208 and who, as a result of a periodic physical examination, will become entitled to severance pay under 10 U.S.C., Chapter 61, shall be given an opportunity to request that his or her name be removed from the TDRL and that his or her status in the Fleet Reserve or Fleet Marine Corps Reserve be resumed.

(2) Transfer To Fleet Reserve Or Fleet Marine Corps Reserve. Members having completed 20 years or more of active service under 10 U.S.C. 6330. A member on the TDRL who has 20 years service computed under 10 U.S.C. 1208 and who, as a result of a periodic physical examination, will become entitled to severance pay under 10 U.S.C., Chapter 61, shall be given the opportunity to request transfer to the Fleet Reserve or Fleet Marine Corps Reserve if the member is eligible for transfer under 10 U.S.C. 6330.

(3) Transfer To Inactive Status List. Officers and enlisted members of the Naval and Marine Corps Reserve on the TDRL who have at least 20 years of service computed under 10 U.S.C. 127321 and who, as a result of a periodic physical examination, are determined to be entitled to severance pay under 10 U.S.C., Chapter 61, shall be given an election, instead of being separated, to request transfer to the inactive status list under 10 U.S.C. 1209 and 1335, to receive retired pay at age 60.

3628 Permanent Retirement

a. Members With 20 Years Or More Of Service Computed Under 10 U.S.C. 1208. If, as a result of a periodic examination or upon final determination, it is determined that a member's physical disability is of a permanent nature, and if he or she has at least 20 years of service computed under 10 U.S.C. 1208, remove the member's name from the TDRL and retire him or her under 10 U.S.C. 1201 or 1204, whichever applies, with retired pay computed under 10 U.S.C. 1401.

b. Members With Less Than 20 Years Of Service Computed Under 10 U.S.C. 1208. If, as a result of a periodic examination, or upon final determination, it is determined that the member's physical disability is of a permanent nature, and is at least 30 percent under the VASRD (as modified by this instruction) in use at the time of the determination, remove the member's name from the TDRL and retire him or her under 10 U.S.C. 1201 or 1204 whichever applies.

3629 – 3699 Reserved

PART 7 - DISPOSITION POLICIES

3701 Fit (Or Physically Qualified) Following Disability Evaluation

If the PEB determines that an active duty member is Fit or an inactive duty reservist is Physically Qualified, return the member to his or her normal duty or reserve status unless separated or retired on a non-disability basis. However, for personnel on the TDRL, see paragraphs 3625 and 4213a.

3702 Unfit Following Disability Evaluation.

Except in the cases of Unfit members being retained on active duty in a PLD status, any member on active duty or in active status who is found to be physically disabled will be retired, if eligible for retirement, or, if not so eligible, separated.

3703 Not Physically Qualified.

An inactive-duty reservist who is found Not Physically Qualified, subject to paragraph 6005, shall be honorably discharged, retired if eligible, or offered non-regular retirement in accordance with chapter 1223 of title 10, U.S. Code.

3704 Flag And Medical Corps Officers

a. Officers in grade O-7 or higher who are within 12 months of mandatory retirement due to age or service limitations or medical officers in any grade who are pending non-disability retirement for age or length of service at the time of referral into the DES, who are on active or reserve duty, may not be retired for physical disability unless the initial Unfit determination is approved by the Secretary of Defense on the recommendation of the Assistant Secretary of Defense (Health Affairs) (ASD(HA)). ASN (M&RA) will be the final decision authority in cases involving flag and medical officers who are retirement eligible, but are not pending non-disability retirement. DIRNCPB will be the decision authority in those medical officer cases where the member is not eligible for non-disability retirement. In death imminent cases involving general, flag, or medical officers pending non-disability retirement see paragraph 12004.

b. CHNAVPERs and CMC (M&RA) shall submit to the ASD (HA) via the ASN (M&RA) one copy of all retirement orders issued in the case of each general/flag officer (grades O-7 through O-10) retired because of physical disability .

c. All medical boards involving medical officers as patients forwarded to the PEB for consideration will be accompanied by a separate command evaluation to include the medical officer's current overall level of function, and a Peer Review delineating clinical privileges (SECNAVINST 6320.23 applies).

d. Officers in grade O-7 or above or medical officers in any grade shall not be determined Unfit because of physical disability if the member can be expected to perform satisfactorily in an assignment appropriate to his or her grade, qualifications, and experience. Thus, the inability to perform specialized duties or the fact the member has a condition which is cause for referral to a PEB is not justification for a finding of Unfit.

3705 Permanent Disability Retirement

If otherwise eligible, a member who is to be retired because of physical disability shall be placed on the permanent disability retired list if within 5 years of the initial determination under 10 U.S.C. 1201 or 1204:

a. based upon accepted medical principles, the member cannot reasonably be expected to recover so as to be physically Fit to perform the duties of his or her office, grade, rank or rating; and

b. the disability rating, as established under the VASRD, in use at the time of the initial determination that the member is Unfit because of physical disability, cannot reasonably be expected to increase or decrease so as to change the amount of disability retired pay to which the member would be entitled.

3706 Temporary Disability Retirement

a. If a member's nature of disability does not meet the criteria for permanent retirement set forth in paragraph 3705 and 10 U.S.C 1202, place the member on the TDRL in accordance with 10 U.S.C. 1202 or 1205, as appropriate. Also, place members whose disabilities are unstable on the TDRL, if otherwise qualified.

b. Once a member's name has been placed on the TDRL, special rules and procedures become applicable. In addition, there are special disposition rules following later removal from the TDRL. Both sets of rules are set forth in part 6 of this enclosure.

3707 Effective Date of Retirement/Separation

The effective date of retirement/separation because of physical disability (either permanent or temporary) normally shall be within 4-6 weeks, on the average, after issuance of the "Notification of Decision." The 4-6 weeks average elapsed time standard, however, is a guideline, not an inflexible rule. It may be exceeded by CHNAVPERs and CMC (M&RA) in such circumstances as severe hardship on the member, taking earned leave when the member is unable to sell it, infeasibility, such as when there is longer lead-time for properly vacating government quarters or arranging movement of household effects, and adverse effect on the service such as when it would preclude contact relief of officers in command or other key billets. These guidelines do not supersede service-unique transition rights and the Uniform Retirement Date requirement of 5 U.S.C. 8301, but rather provide for reasonable exercise of the Secretary's authority in 10 U.S.C. 1221.

3708 Permanent Limited Duty Exception To Continue On Active Duty, Members Otherwise Unfit Because Of Physical Disability

See enclosure (6) to this instruction.

3709 Waiver Of Disability Retirement/Separation

a. Members Qualified For Retirement For Other Reasons May Request Non-Disability Retirement/Separation. A member who meets all prerequisites for retirement or separation because of physical disability, but who also is qualified for retirement for other

reasons, or transfer to the Fleet Reserve or Fleet Marine Corps Reserve, may request that he or she be separated for reasons other than disability .

(1) A member who wants non-disability retirement must submit a request to ASN (M&RA) in a timely manner prior to the effective date of his or her disability retirement, stating the reason for the request. Forward the request via CHNAVPERs or CMC (M&RA), who will make a specific recommendation with supporting rationale.

(2) A member who wants non-disability transfer to the Fleet Reserve or the Fleet Marine Corps Reserve, must submit a Request for Transfer to the Fleet Reserve (NAVPERs 1830/1) or Fleet Marine Corps Reserve Application (via Naval Message or AA Form). Along with the application, the member must forward a signed waiver of rights to a formal hearing and to disability pay under MILPERSMAN 3855180.9 or MARCORPSEPMAN (MCO P1900.16), Chapter 8, as appropriate, and request an effective date of not more than 60 days from date of application. A copy of the waiver is to be provided to the DIRNCPB for finalization of the member's case.

b. Authority To Waive Disability Retirement/Separation. At the request of the member, the DIRNCPB, is authorized to waive disability retirement/separation where consistent with the law and this enclosure.

3710 Deferment of Mandatory Retirement or Separation

If a member is pending mandatory separation or retirement, such retirement or separation may only be deferred if the member is hospitalized or a medical board report has been accepted by the President, PEB for disability evaluation processing. 10 U.S.C. 640 applies.

3711 - 3799 Reserved

PART 8 - RATING POLICIES

3801 Policy

a. Ratable Disabilities. Disabilities determined to be physically unfitting and compensable under reference (c) shall be assigned a percentage rating.

b. Standard. Chapter 61 of reference (a) establishes the Department of Veterans Affairs' (DVA) Veterans Administration Schedule for Rating Disabilities (VASRD) as the standard for assigning percentage ratings. The percentage ratings represent, as far as can practicably be determined, the average impairment in civilian occupational earning capacity resulting from certain diseases and injuries, and their residual conditions. However, not all the general policy provisions in Sections 4.1 - 4.31 of the VASRD are applicable to the military departments. Many of these policies were written primarily for DVA rating boards, and are intended to provide guidance under laws and policies applicable only to the DVA. This instruction replaces these sections of the VASRD. The remainder of the VASRD is applicable except those portions that pertain to DVA determinations of service connection, refer to internal DVA procedures or practices, or are otherwise specifically identified in enclosure (9) as being inapplicable.

3802 Essentials Of Rating Disabilities

a. The VASRD primarily is used as a guide for evaluating disabilities resulting from all types of diseases and injuries encountered as a result of, or incident to, military service. Because of differences between military department and DVA applications of rating policies for specific cases, differences in ratings may result. Unlike the DVA, the military departments must first determine whether a service member is Fit to reasonably perform the duties of the member's office, grade, rank, or rating. Once a service member is determined to be physically Unfit for further military service, VASRD percentage ratings as modified by this instruction are applied to the unfitting condition(s). Percentages are based on the severity of the condition(s).

b. Medical Treatment at the Time of Voluntary and/or Mandatory Separation and/or Retirement. Medical and surgical procedures are frequently performed near the end of a service member's military career. Those are intended to improve a service member's health. Corrective treatment and convalescence will not be considered as a valid contribution to disability unless unexpected adverse effects occur that are expected to persist after discharge from active duty and are ratable.

c. Failure to Comply with Prescribed Treatment. A service member's degree of disability may have been aggravated or increased by an unreasonable failure or refusal to submit to medical or surgical treatment or therapy, to take prescribed medications, or to observe prescribed restrictions on diet, activities, or the use of alcohol, drugs or tobacco. The compensable disability rating may be reduced to compensate for such aggravation when the existence and degree of aggravation are ascertainable by application of accepted medical principles, and where it is clearly demonstrated that:

(1) the service member was advised clearly and understandably (documented in medical record) of the medically proper course of treatment, therapy, medication or restriction; and

(2) the service member's failure or refusal was willful or negligent, and not the result of mental disease or of physical inability to comply.

d. Illegal and/or controlled substances. The following applies to unfitting medical disorders and/or conditions that result from the use of substance abuse and/or chemical dependency:

(1) Illegal and/or controlled substances or generally known toxins; e.g., THC, cocaine, PCP, LSD, & heroin: Treat as misconduct unless use was the product of an otherwise unfitting condition or the LODI determined that there was no misconduct.

(2) Other substances; e.g., alcohol and nicotine: Any physical disability resulting from substance post Level III or equivalent treatment will be considered as non-compliance.

e. Objective Medical Findings and Disability Ratings. Physical examination findings, laboratory tests, radiographs and other findings are not, in themselves, ratable. A rating for a disability must be based on demonstrable impairment of function to the degree that this impairment makes the member Unfit unless otherwise provided in this regulation.

f. Elective Surgery or Treatment

(1) Prior to any elective treatment by the Military Health System (MHS) a service member must consult with a competent military medical authority.

(2) A service member who elects to have such treatment done by other than the MHS at his or her own expense will not be eligible for compensation under the provisions of this instruction for any adverse residuals resulting from the elected treatment, unless it can be shown that such election was reasonable or resulted from a significant impairment of judgment that is the product of a ratable medical condition.

(3) A record of the counseling will be made by the health benefits advisor or other designated individual to document that the member was counseled about the elective treatment and his or her subsequent risk of ineligibility for disability compensation for any adverse residuals incurred secondary to the elective treatment.

(4) To allow the PEB to make an appropriate determination in a case where the member's eligibility is in question all medical records from non-MHS providers and all documentation and/or a statement explaining the member's position as to why his/her choice to seek outside treatment was reasonable.

g. Disabilities Not Unfitting for Military Service. Conditions that do not themselves render a service member Unfit for military service will not be considered for determining the compensable disability rating unless those conditions contribute to the finding of unfitness.

h. The relative contribution of Non-Compensable Medical Conditions Not Constituting Physical Disabilities To Current Industrial Impairment Of Ratable Neuropsychiatric Conditions. Personality disorder(s), impulse control disorders, or substance use and/or abuse disorder(s) are examples of conditions not constituting a physical disability that often significantly contribute to, or may be the chief cause of, any industrial and industrially related social impairment suffered by the service member who has a compensable neuropsychiatric condition. Unfitting disability resulting there from will not be rated. In such instances, the overall rating of psychiatric impairment will be reduced to the impairment rating that would be warranted in the absence of the influence of the non-compensable condition according to generally accepted medical principles. It is imperative that the MEB reports quantify the contribution of each medical condition to the overall industrial impairment manifested by the service member.

3803 Use Of VASRD Codes

The VASRD code number appearing opposite a listed disability indicates the basis of the assigned valuation. Code numbers also are used for statistical analysis upon which policy decisions may be made. Great care must be exercised in the selection of the applicable code and in its citation on the rating sheet.

a. Each rated disability is assigned a single code number unless a hyphenated code is expressly authorized. It is not proper to use additional codes as a means of further describing defects except as authorized by the VASRD (e.g., in Gulf War cases). The written diagnosis entered on the rating sheet should include any description considered necessary to indicate the extent, severity or etiology of the coded condition.

b. Injuries are generally assigned codes that reflect the residual condition on which the rating is based.

c. Diseases are generally coded directly by the number assigned to the disease itself. If the rating is determined because of residual conditions, the number appropriate to the residual condition will be added, preceded by a hyphen. Thus, atrophic (rheumatoid) arthritis rated as ankylosis of the lumbar spine would be "5002-5289." The percentage rating in such cases is reflected in the second number ("5289" in the example). In this way, the basis of each rating can be easily identified.

d. Hyphenated codes are used only:

(1) When the VASRD provides that a listed condition is to be rated as some other code; e.g., nephrolithiasis rated as hydronephrosis (7508-7509).

(2) When the VASRD provides for a "minimum rating" and the disability is

being rated on residuals; e.g., multiple sclerosis rated as incomplete paralysis of all unilateral upper extremity radicular groups (8018-8513) in which case the minimal rating will be 30 percent.

(3) When an unlisted condition is rated by analogy; e.g., spondylolisthesis rated as sacroiliac injury and weakness (5299-5294). If an unlisted disease, injury, or residual condition is encountered, requiring rating by analogy, the diagnostic code number will be "built-up" as follows: the first two digits will be selected from that part of the schedule most closely identifying the part, or system, of the body involved; the second two digits will be "99." The resulting four-digit number will be connected by hyphen to the code for the analogous condition. This procedure facilitates monitoring of new and unlisted conditions.

(4) The DVA has prepared special analogous ratings for "undiagnosed symptom complexes" associated with Gulf War service . See enclosure (9), attachment (a) (1).

e. In the narrative citation of disabilities on rating sheets, the diagnostic terminology may be any combination of the medical examiner's or VASRD terminology which accurately reflects the degree of disability . Residuals of diseases or therapeutic procedures will not be cited without reference to the basic disease.

3804 Rating Issues

a. Higher of Two Evaluations. When the circumstances of a case are such that two percentage evaluations could be applied, assign the higher percentage only if the service member's disability more nearly approximates the criteria for that rating. Otherwise, assign the lower rating. When, after careful consideration of all reasonably procurable and assembled data, there remains a reasonable doubt as to which rating should be applied, resolve the doubt in the member's favor.

b. Changes in Rating Criteria. In accordance with Title 10, Chapter 61, United States Code, the pertinent VASRD codes in effect at the time of final case determination will be used when making that decision regardless of when the member first entered the DES. Specific guidance follows:

(1) TDRL

(a) Final Reevaluation. Rate members on the TDRL under the VASRD criteria in effect at the time of their final case determination.

(b) New Conditions. Although reference (b) through (d) permit new diagnoses to be added during periodic updates, do not rate new diagnoses until the case is finalized. New diagnoses included: (1) new condition(s) caused by the medical condition for which the member was placed on the TDRL , or directly related to its treatment; or (2) new condition(s) either incurred while the member was entitled to basic pay or as a proximate result of performing duty, whichever is applicable, and was an unfitting disability

at the time the member was placed on the TDRL but was not included in the Medical Board report or not rated.

(2) PLD. Rate members placed on PLD under the VASRD criteria in effect at the time of final reevaluation.

(3) Cases Terminated or Suspended by the PEB. When the case returns for final determination, the following rule applies (provided PEB determines the member remains Unfit due to an eligible condition): if a case has been suspended or has been terminated pending medical treatment or an LODI, or if the medical board is incomplete, submit a new medical board and apply the rating standards in effect at the time of the new board's date.

(4) The military standards and policies in effect on the date the medical board report is received at the PEB will be applied for the following:

- (a) Addenda.
- (b) Reconsideration by the Informal PEB.
- (c) Appearance before the Formal PEB.
- (d) PFR.

c. **Pyramiding.** Pyramiding is the term used to describe the application of more than one rating to any area or system of the body when the total functional impairment of that area or system adequately is reflected under a single appropriate code. Disability from injuries to the muscles, nerves, and joints of the extremity may overlap to a great extent. Special rules for their valuation are included in appropriate sections of the VASRD and in enclosure (9) of this instruction. Merge related diagnoses for rating purposes when the VASRD provides a single code covering all manifestations. This prevents pyramiding and reduces the chance of over-rating. For example, disability from fracture of a tibia involving malunion, limitations of dorsiflexion, eversion, inversion, and subtalar motion, as well as traumatic arthritis of the ankle would be rated using one diagnostic code (5271) that reflects overall ankle function, rather than by adding separate ratings for the limitations of motion and the traumatic arthritis.

d. **Amputation Rule.** The combined rating for disabilities of an extremity shall not exceed the rating for the amputation at the elective level, were amputation to be performed. For example, the combined evaluations for disabilities below the knee shall not exceed the 40 percent evaluation, diagnostic code 5165. This 40 percent rating may be further combined with evaluation for disabilities above the knee but not exceed the above the knee amputation elective level. Painful neuroma of a stump after amputation shall be assigned the evaluation for the elective site of reamputation.

e. **Bilateral Factor.** When partial disability results from injury or disease of both arms, or both legs, or of paired skeletal muscles, the ratings for the disabilities of the right and left paired sides are first combined in the standard manner. Ten percent of the result (called the Bilateral Factor) will be added to the first combined rating before proceeding with further combinations, or converting to degree of disability. The Bilateral Factor is applied to the bilateral disability combination before final combinations with unpaired disabilities are carried out. The rating for a "Bilateral" disability (combined rating plus the Bilateral Factor) is to be treated as one disability rating when arranging multiple impairments in order of severity prior to calculating further combinations. For example, with disabilities evaluated at 60 percent, 20 percent, 10 percent and 10 percent (the two 10s representing bilateral disabilities), the order of severity would be 60, 21 and 20. The 60 and 21 combine to 68 percent and the 68 and 20 to 74 percent converted to 70 percent as the final degree of disability.

(1) The terms "arms" and "legs" refer to the whole upper and lower extremities respectively. Thus, when there is a compensable disability of the right thigh (for example, amputation), and of the left foot (for example, amputation of the great toe), the Bilateral Factor applies. Similarly, the Bilateral Factor is applied whenever there are compensable disabilities affecting use of paired extremities regardless of location or specified type of impairment, except as noted in paragraph (3), below.

(2) The correct procedure when applying the Bilateral Factor to disabilities affecting both upper extremities and both lower extremities is to combine the ratings of the disabilities affecting the four extremities in order of their individual severity and apply the Bilateral Factor by adding 10 percent of the result to the total combined value thus attained.

(3) The Bilateral Factor is not applicable unless there is an unfitting disability in each of two paired extremities or paired skeletal muscles. Special instructions regarding the applicability of the Bilateral Factor are provided in various parts of the VASRD. For example, codes 7114 - 7117 and codes 8205 - 8412. The Bilateral Factor is not applicable in skin disabilities.

f. **Total Disability Rating (Unemployability).** Total disability will be considered to exist when the member's impairment is sufficient to render it impossible for the average person suffering the same medical condition to engage in substantially gainful employment. Accordingly, in cases in which the VASRD does not provide a 100 percent rating under the appropriate (or analogous) code, a member may be assigned a disability rating of 100 percent if the member's impairment is sufficient to render it impossible to engage in substantially gainful employment.

g. **Extra-Scheduling Ratings in Exceptional Cases.** The requirement to use the VASRD in rating disabilities does not prevent the Secretary of the military department concerned from assigning ratings in unusual cases not covered by the VASRD. In such cases, extra-schedule ratings commensurate with the average earning capacity impairment due exclusively to service-connected disability may be assigned. Such cases must be rated in accordance with procedures established by the Secretary of the military department

concerned. The basis of the conclusion that the case presents such an exceptional or unusual disability picture that the regular VASRD standards do not apply must be documented.

h. Convalescent Ratings. Under certain diagnostic codes, the VASRD provides for a convalescent rating to be awarded for specified periods without regard to the actual degree of impairment of function. SUCH RATINGS DO NOT APPLY TO THE MILITARY DEPARTMENTS. Convalescence ordinarily will have been completed by the time optimum medical improvement (for disposition purposes) has been attained. If not, rate according to the manifest impairment.

i. Observation Ratings of Malignancies. The VASRD, in cases of malignancy, has ratings applicable for a period of observation of 6 months or more. Following this period of observation residuals will be rated. Observation ratings do apply to the military departments. Note that members with malignancies are not automatically continued for the 5-year TDRL period. The member will be reevaluated after the observation period and if, at the time, continued treatment is deemed necessary the member will be continued on the TDRL. If there is not a recurrence of tumor, regardless of whether the member has reached a 5 years tumor free period or not, the member's case will be finalized and any rating will relate to residuals, if any.

j. Analogous Ratings. When an unlisted condition is encountered, it is permissible to rate it by analogy to a closely related disease or injury. The unlisted and analogous conditions should reflect adverse impact upon reasonably similar functions, anatomical structures, or be symptomatically similar. Conjectural analogies, analogous ratings for conditions of doubtful diagnosis, and diagnoses not fully supported by clinical/laboratory findings are not acceptable. Organic diseases or injuries will not be rated by analogy to disorders of psychiatric origin, except when directed by law; e.g., Gulf War cases.

k. Overall Effect. A member may be determined Unfit as a result of the overall effect of two or more impairments even though each of them, standing alone, would not cause the member to be referred into the DES or be found Unfit because of physical disability. There is no VA code assigned and the only disability percent awarded is 0%.

l. Zero Percent Ratings and Minimum Ratings

(1) Zero Percent Rating for Residuals. Occasionally, a medical condition that causes or contributes to unfitness for military service is of such mild degree that it does not meet the criteria for even the lowest rating provided in the VASRD under the applicable code. A zero percent rating may be applied in such cases even though the lowest rating listed is 10 percent or more, except when "minimum ratings" are specified. Apply the "Bilateral Factor" (see paragraph 3804e) when a disability is present in two paired extremities, even though one extremity is rated at zero percent.

(2) Minimum Rating. In some instances, the VASRD provides a "minimum rating", without qualifications as to residuals or impairment. Diagnosis alone is sufficient to justify the minimum rating. Syringomyelia, code 8024, is an example. Although higher

ratings may be awarded in consonance with degree of severity, do not use a rating lower than the "minimum" if the diagnosis is satisfactorily established.

(3) Minimum Rating for Residuals. The VASRD provides a minimum rating for "residuals" in certain medical conditions. A given instruction may state, "rate residuals, minimum ___ percent," or may specify what impairment to rate and give a minimum rating for that impairment. Examples are code 8011, anterior poliomyelitis, and 6015, benign new growth of eyeball and adnexa, other than superficial. To justify the minimum rating for residuals, a functional impairment or other residual caused by the condition must exist. Otherwise, a zero percent is appropriate if the primary condition is unfitting.

m. Rating of Medical Impairments Existing Prior to Service

(1) Permanent Service Aggravation. A medical condition manifesting itself or existing prior to entry into military service will be considered "permanently service aggravated" when military service lastingly worsens that medical condition beyond its natural progression. Use generally accepted medical principles to determine "natural progression."

(2) No Permanent Aggravation. For service members for whom no permanent service aggravation has occurred, and whom do not meet the conditions outlined in paragraph 3804m(7), no rating will be listed. However, the Formal PEB rationale and/or Informal PEB workcard will state the basis for the determination that the unfitting condition existed prior to service (EPTS) and was not permanently aggravated by service. When the condition is considered unfitting due to natural progression without permanent service aggravation, the accepted medical principle that supports the finding of "natural progression" will be addressed in the Formal PEB rationale and/or Informal PEB workcard.

(3) Aggravation and Present Degree of Disability Less than 100 Percent

(a) In cases involving service members with permanent service aggravation and a current degree of impairment less than total, the rating will reflect only the degree of disability over and above that existing at the time of entrance into active service. This requirement applies whether the particular condition was noted at the time of entrance into active service or later is determined, upon the evidence of record, to have existed at that time. It is necessary, therefore, to deduct from the present degree of disability the degree of disability, if ascertainable, that existed prior to entrance into active service. In assessing EPTS disability, the full EPTS clinical course of the impairing medical condition will be taken into consideration. Such deduction should be in terms of the rating schedule for the given condition. The deduction will be recorded on the rating sheet. If the degree of disability at the time of entrance into the military service is not ascertainable in terms of the schedule, there will be a zero percent deduction. The rating sheet will reflect that the EPTS factor is indeterminable, and a zero percent deduction will be made.

(b) It is not uncommon that the PEB disagrees with or

overrides the medical board's designation as to whether a condition is EPTS or not. The service member and the medical board members must understand that the PEB's determination of EPTS factors and how those factors do or do not contribute to other conditions and the resulting degree of impairment may be different from the views contained in the medical board report, and that the decision of the PEB is final, unless overturned by a PFR decision.

(4) Aggravation and Present Degree of Disability 100 percent. When permanent service aggravation has occurred and the current degree of disability is 100 percent, the rating sheet will reflect the EPTS factor and percent, but no actual deduction will be made. However, if upon TDRL finalization, the total rating drops below 100 percent, the original EPTS deduction percentage will be applied.

(5) Congenital and Hereditary Conditions. Congenital and hereditary conditions that do not manifest symptomatology until after a member enters active duty under orders specifying a period of more than 30 days shall not be considered service-incurred. These conditions will be presumed service aggravated unless a preponderance of evidence based on accepted medical principles clearly establishes that the condition is solely the time result of the natural progression of the congenital or hereditary condition.

(6) Paired Organs Involving EPTS and Service Aggravation. No deduction for EPTS factor will be made when the member is Unfit for any of the following situations involving paired organs. However, the rating sheet will reflect the EPTS factor, and that the EPTS deduction is zero (0) percent.

(a) Blindness in one eye as a result of service-connected disability and blindness in the other eye as a result of non-service connected disability.

(b) Loss or loss of use of one kidney as a result of service-connected disability and involvement of the other kidney as a result of non-service connected disability.

(c) Total deafness in one ear as result of service-connected disability and total deafness in the other ear as a result of non-service connected disability.

(d) Permanent service-connected disability of one lung, rated 50 percent or more disabling, in combination with a non-service connected disability of the other lung.

(7) Disability Compensation for Certain Members with Pre-existing Medical Conditions. In the case of a member who is on active duty for more than 30 days whose disability is determined to have been incurred before the member became entitled to basic pay in the member's current period of active duty, the disability shall be deemed to have been incurred while the member was entitled to basic pay and shall be so considered for purposes of determining whether the disability was incurred in the line of duty provided the member has over 8 years of active service. The 8 years of active service does not have to be

continuous. Each stage of the PEB review process (Informal Board, Formal Board, PPEB issuance of findings, PFR) that considers a particular case will make an independent determination as to whether the member has 8 years of active service at the time of its review. A member's injuries will be deemed to be service aggravated if he/she is found to meet the 8-year rule at any time during the PEB review process.

n. **Presumption of Service Aggravation.** Any injury or disease discovered after a service member enters active duty -- with the exception of congenital and hereditary conditions -- is presumed to have been incurred in the line of duty. Any hereditary and/or genetic disease shall be presumed to have been incurred prior to entry into active duty. However, any aggravation of that disease, incurred in the line of duty, beyond that determined to be due to natural progression shall be deemed service aggravated. The presumption that a disease is incurred or aggravated in the line of duty only may be overcome by competent medical evidence establishing by a preponderance of evidence that the disease was clearly neither incurred nor aggravated while serving on active duty or authorized training. Such medical evidence must be based upon well-established medical principles, as distinguished from personal medical opinion alone. Preponderance of evidence is defined as that degree of proof necessary to fully satisfy the board members that there is greater than a 50 percent probability that the disease was neither incurred during nor aggravated by military service.

o. **Presumption of Sound Physical and Mental Condition Upon Entry.** A service member is presumed to have been in sound physical and mental condition upon entering active duty except for medical defects and physical disabilities noted and recorded at the time of entrance.

p. **Conditions Presumed to be Pre-Existing.** Occurrence of disease as described in paragraphs (1) and (2), below, shall be presumed to have existed prior to entry into military service.

(1) Signs or symptoms of chronic disease identified so soon after the day of entry on military service (usually within 180 days) that the disease could not have originated in that short a period will be accepted as proof that the disease manifested prior to entrance into active military service.

(2) Signs or symptoms of communicable disease within less than the medically recognized minimum incubation period after entry on active service will be accepted as evidence that the disease existed prior to military service.

(3) Congenital and hereditary conditions, even though they do not manifest symptomatology until the member enters active duty, are considered EPTS. Service aggravation of these conditions is discussed in paragraph 3804 m (5).

q. **Treatment of Pre-Existing Conditions.** Generally, recognized risks associated with treating preexisting conditions shall not be considered service aggravation.

r. Combined Ratings Table. When a member has more than one compensable disability, the percentages are combined rather than added (except when the VASRD modified by enclosure (3) indicates otherwise). The combined rating is based on the "whole person concept." A person without a medical impairment is considered 100 percent Fit. An unfitting ratable medical impairment renders an individual less than 100 percent Fit. A revised fitness level results. Subsequent impairments are calculated as a percentage basis of the new fitness level that is always less than 100 percent. Thus, a person having a 60 percent disability is considered to have a remaining efficiency or fitness of 40 percent. If there is a second disability rated at 20 percent, then the person is considered to have lost 20 percent of that remaining 40 percent (20 percent x 40 percent = 8 percent). Hence, a 60 percent disability combined with a 20 percent disability results in a combined rating of 68 percent, which is rounded off to a 70 percent rating in accordance with the VASRD. The combined rating for any combination of disabilities is always determined by first arranging the disabilities in their exact order of severity and then referring to the Combined Ratings Table in the VASRD in accordance with the following Instructions:

(1) Combining Two Percentages. The higher impairment percentage is located in the left-hand column. The combined percentage is found where the row indicating the percentage of the first (higher) impairment intersects with the column headed by the percentage of the second impairment.

(2) Combining Three or More Percentages. The first two percentages are combined as indicated in subparagraph 3804r (1). The result is a new impairment percentage that can be combined with a third percentage following the same procedure as in subparagraph 3804r (1). (Example: 50 combined with 30 equals 65, 65 combined with 20 equals 72). If there are additional percentages, the procedure is repeated using the new combined value and the next percentage. Rounding off is not done until the final value has been calculated and converted as described below in paragraph 3804r (3).

(3) Converting a Combined Rating. After all percentages have been combined, the resulting combined value is converted to the nearest number divisible by 10. Combined values ending in 5 are adjusted upward. If the combined value includes a decimal fraction of 0.5 or more as a result of applying the bilateral factor (see paragraph 3804e), the fraction is converted to the next higher whole number; otherwise the decimal fraction is disregarded. (Example: If the combined value is 64.5, the fraction is rounded to a combined value of 65, which is adjusted upward to 70. If the combined value is 64.4, the decimal fraction is disregarded and the combined value of 64 is rounded off to 60.)

s. Organ Transplants

- (1) Joint prosthetic transplants are discussed under codes 5051 through 5056.
- (2) Vascular system prosthetics are addressed under the 7000 code.
- (3) Service members requiring transplant ordinarily will be Unfit, regardless

of their current ability to perform their duties, due to organ failure. This determination will be made based on the fact that the member's duties may seriously compromise his/her health or well-being and may also prejudice the best interests of the government if the member were to remain in the military service. The service member should be placed on the TDRL. In those cases in which a definite or imminent date has been set for transplantation, disposition shall be postponed and residuals rated after the transplantation.

(4) Rate cases that have not come before the PEB before transplantation on the following factors:

(a) Functional status of the transplanted organ.

(b) The need for sustained immunosuppression or its adverse effects. Adverse effects may be rated because of specific infections or by analogy (see enclosure (9), attachment (a), Table of Analogous Ratings).

(5) To encourage organ and tissue donations, NAVMEDCOMINST 6300.8 (NOTAL) authorizes military members to participate in organ donation. Loss of an organ as a result of donation of an organ will not become a basis for special duty assignment and such donation by the member may result in subsequent ineligibility for disability compensation for any adverse residuals incurred secondary to organ donation.

t. Rating Principles for Specific Disabilities. Enclosure (9) provides instructions and explanatory notes for rating certain disabilities. This guidance will be followed unless a subsequent change to the VASRD makes the guidance obsolete. The VASRD is a living document and is continuously being revised. Changes to the VASRD will supersede direction contained in this instruction. Where service specific variations are necessary, change transmittals or NCPB policy letters will be generated to cover any special interpretations for new VASRD ratings.

3805 Assignment Of Aggravation Factors When Prescribed Treatment Is Refused Or Omitted

Although a service member would not be Fit to continue naval service, a member's degree of disability may have been aggravated or increased by, among other things, an unreasonable failure or refusal to submit to medical or surgical treatment or therapy, to take prescribed medications, or to observe prescribed restrictions on diet, alcohol, drugs, or tobacco. The compensable disability rating may be reduced to compensate for such aggravation or increase when the existence and degree of aggravation are ascertainable by application of accepted medical principles, and where it is clearly demonstrated that:

a. the member was advised clearly (with appropriate documentation) and understandably of the medically proper course of treatment, therapy, medication or restriction; and

b. the member's failure or refusal was willful or negligent, and not the result of mental disease or of physical inability to comply.

3806-3899 Reserved

PART 9 DES-RELATED SUBMISSION REQUIREMENTS

3901 General Requirements For Boards Being Referred For Disability Evaluation

a. Medical Evaluation. The report of the medical board shall make a clear statement of the member's impairment and its impact on his/her current duties. This opinion must be supported by objective medical data displaying the nature and degree of the impairment, if any. Medical board reports must include the results of a complete physical examination and comprehensively describe the physical condition of a member, the nature and extent of the physical impairments and will also include any and all SF 88 and SF 93 forms. The report must include all available information, with adequate documentation of the origin, aggravation by service, and other significant medical facts pertaining to the impairments observed including information on refusal of treatment. The report must include a NMA, see enclosure (11).

b. Explanation Of Apparent Contradictions In The Records. Apparent contradictions in the records, such as the board's disagreement with a report or consultation, should be thoroughly explained. The condition of a patient following therapy, the response thereto, the degree of severity of the disease or injury, and when appropriate, their effect on the member's functional ability must be described in detail.

c. Prohibition Of Conclusion Of Unfitness. The presence of a disease or injury does not, of itself, justify a finding of Unfit. Therefore, medical board reports shall not reflect a conclusion of unfitness or utilize the term "Unfit" because it could be confused with the definition of Unfit or Not Physically Qualified for continued naval service used within the DES.

3902 Line Of Duty/Misconduct Determinations In Injury Cases

a. JAGMAN, chapter II requires line of duty/misconduct determinations for injuries which may result in permanent disability and identifies who is responsible to order and/or conduct them. A medical board convening authority that refers a member for disability evaluation shall include a copy of the line of duty/misconduct determination with the medical board report. Officers in command of MTFs and other convening authorities of medical boards shall request cognizant commands deliver needed line of duty/misconduct determinations with endorsements within 10 days of receipt of the request. Make requests as soon as practicable and not later than the date of convening the medical board.

b. When the command to which a member was attached at the time of his or her injury is unknown, is incapable of conducting a proper investigation, or if an investigation is unduly delayed or not being conducted, the medical board convening authority shall promptly request assistance from the area coordinator, or the subordinate commander authorized to convene general courts-martial (GCM) and designated by the area coordinator for this purpose. See JAGMAN 0205. The GCM authority shall provide prompt assistance to correct deficiencies.

3903 Inactive-Duty Reservists

A medical board or other authority referring an inactive-duty reservist for evaluation shall include with the medical board report a copy of the NOE for benefits or affirmatively state that the reservist is not entitled to a NOE under reference (g).

3904 Prognosis Of Death Imminent

a. When competent medical authority determines that a service member's death is expected within 72 hours and it is determined to be in the best interests of his or her estate, the member may be referred expeditiously into the DES. To protect the interests of the government and the service member, disposition shall be placement on the TDRL provided all requirements under statute, legal opinions, and regulation are met .

b. In no case shall a service member be retired after his or her death or before completion of a required Line of Duty determination.

c. Determinations of death shall be made in accordance with accepted medical standards and the laws of the state where the member is located at the time of his/her evaluation or the military medical standards in effect in a foreign area where the member is located at the time of his/her evaluation.

d. Death Imminent medical board reports shall reference applicable state standards. Moreover, Death Imminent medical board reports for those members who, according to state standards, have died shall not be forwarded to the PEB for evaluation.

e. See enclosure (12) for a complete discussion of Death Imminent procedures.

3905 Mental Competency Issues

a. Reporting Presence Or Absence Of A Determination Of Mental Incompetence. Each medical board report shall affirmatively state whether or not records reflect the member being evaluated is or has ever been declared mentally incompetent or shows medical evidence of mental incompetence.

b. Cases In Which A Statement Concerning Competency Is Required

(1) Any MEB report listing a psychiatric diagnosis must contain a thorough psychiatric evaluation and include the signature of at least one psychiatrist (identified as such) on the MEB report signatory face sheet.

c. Determination of Mental Competency Required. When the medical board finds under paragraph 3905 that the member is not capable of managing his/her affairs, the medical board convening authority shall cause a determination of mental incompetency to be made as described in paragraph 3414c. The medical board shall include a copy of this incapacitation evaluation or competency certification in its report.

d. JAG Reporting Requirement. The medical board convening authority shall forward one copy of the medical board report and "Incapacitation " (or competency certification) to the appropriate personnel office as provided in JAGMAN, chapter XIV.

3906 Attempted Suicide

In each instance of an attempted suicide, the member concerned shall undergo psychiatric examination, and the report of that examination shall be included in any medical board report submitted for disability evaluation.

3907 Mental Illness With The Abuse Of Drugs And/ Or Alcohol

When the abuse of drugs and/or alcohol are significant factors in describing a condition of mental illness, the medical board shall provide detailed information with regard to the type and amount of drugs and/or alcohol used by the member as well as the frequency and duration of such abuse. Moreover, the board shall provide an opinion as to whether the abuse was a consequence of the mental illness, or whether such abuse was voluntary and precipitated the condition of mental illness.

3908 – 3999 Reserved

ENCLOSURE 4: PHYSICAL EVALUATION BOARD PROCEDURES

PART 1 - PHYSICAL EVALUATION BOARD POLICY

4101 The President, Physical Evaluation Board

a. Reports to the DIRNCPB and performs duties assigned by the DIRNCPB and this instruction.

b. President, PEB shall:

(1) oversee the daily workings and administration of the Informal PEB, Formal PEB, counseling offices, and DES staff;

(2) refer to an appropriate board the cases of active duty personnel, personnel on the TDRL, inactive-duty reservists, and others referred for consideration as the result of:

(a) reports of medical boards;

(b) periodic physical examinations of TDRL members; and

(c) requests from SECNAV, CHNAVPERS, CMC (M&RA), COMNAVRESFOR, the DIRNCPB, and CHBUMED;

(3) establish and maintain for the DIRNCPB a record in each case;

(4) dispose of case files in accordance with SECNAVINST 5212.5D;

(5) protect the privacy of individuals whose records are reviewed by the PEB in accordance with SECNAVINST 5211.5D

(6) perform such other specific duties and exercise such other authority as set forth elsewhere in this instruction.

4102 Legal Review

Prior to issuing a Findings Letter, the President, PEB will ensure that the following cases are reviewed for legal sufficiency:

a. by NCPB legal counsel in cases designated in writing by the DIRNCPB;

b. by the OJAG for those cases specified in paragraph 4(d)(4) of the basic instruction.

c. all other cases will receive a quality assurance review and may be referred for NCPB legal counsel review when directed by President, PEB.

4103 Error On Legal Review

a. If the President, PEB concurs with the determination of the legal reviewer that there is an error, PPEB may direct or take corrective action, to include complete reconsideration (with recorded votes) by either an Informal or Formal PEB.

b. If the President, PEB does not concur with the legal reviewer, refer the case to the DIRNCPB for action consistent with paragraph 4c of the basic instruction.

4104 Cancellation And Correction Of Findings Letters And Notification Of Decision Letters

a. The President, PEB may modify or cancel Findings Letters and Notification of Decision Letters, and direct appropriate substitute disposition in those cases in which:

(1) there is determined to have occurred an administrative, clerical, legal, or mathematical error in the record of proceedings, and the correction does not affect the disposition of the individual or change the computation of disability compensation on the basis of percentage of disability;

(2) the member has been discharged under other provisions of law;

(3) the member has been rehospitalized or is pending surgery, provided retirement or separation has not occurred;

(4) a member has demanded a hearing after having previously accepted findings following an Informal PEB; or

(5) such action is directed by the SECNAV or the DIRNCPB.

b. If the correction of an error would affect the disposition or adversely change the computation of disability retirement pay, the President, PEB may modify or cancel Findings Letters and Notification of Decision Letters. The member shall be notified and given 15 days from receipt of such notice in which to submit a PFR before such correction is made.

4105 Processing Final PEB Findings from A Formal PEB

Following a Formal PEB and subject to legal and quality assurance review requirements discussed in this instruction, the President, PEB will issue the PEB findings as follows:

a. In cases where there are no legal, medical, or quality assurance errors, the President, PEB shall issue the findings of the Formal PEB as the PEB findings.

b. In cases where an error is identified on legal review, the President, PEB shall handle the case in accordance with paragraph 4103 of this instruction.

c. Formal PEB findings will undergo a quality assurance review by QA personnel and a medical review by the Medical Advisor to the President, PEB (as needed) prior to

issuance. If during this process the President, PEB determines that a change in findings from that recommended by the Formal PEB is warranted, and this change is adverse to the member (a finding of Fit to continue naval service is not adverse), the President, PEB shall request, after consultation with the PEB Legal Advisor, the DIRNCPB to invalidate the initial Formal proceedings and order a second Formal hearing. In those cases where, after the quality assurance review and after consultation with the Medical Advisor and PEB Legal Advisor, the President, PEB determines that a change in findings is warranted, and this change is not adverse to the member, the President, PEB without a second Formal hearing, may issue new findings.

4106 Processing Special Interest Cases

See paragraph 3105, Special Interest Cases, or paragraph 3704, Flag and Medical Corps Officers.

4107 Processing TDRL Cases

See enclosure (3), part 6 of this instruction.

4108 Processing Requests For Permanent Limited Duty (PLD) Status

See enclosure (6) of this instruction.

4109 Processing Fit To Continue Naval Service Cases When Member Requests A Formal Hearing

a. A member who has been found Fit to continue naval service or Physically Qualified for continued naval service from the review of the Informal PEB has no right to a Formal PEB hearing or a Petition for Relief by DIRNCPB.

b. The President, PEB, may grant a request for a hearing before a Formal PEB or recommend to the DIRNCPB, that the request be denied. The DIRNCPB, upon review of the case may grant the request for a hearing or deny it. The decision of the Director in any case will not be subject to appeal.

4110 Processing Cases Containing A Condition Not Constituting A Physical Disability (See paragraph 2016)

a. If a medical board reports only a condition or defect not constituting a disability, the case shall be rejected and referred by the President, PEB, back to the submitting MTF.

b. If a medical board reports conditions that include both physical disabilities and conditions not constituting physical disabilities, only the former shall be considered in determining the member's fitness to continue naval service. If the member is Fit to continue naval service, but may be unsuitable for continued military service due to a condition not constituting a physical disability, the case will be forwarded to the appropriate service headquarters for action as described in (a) above, unless the member is accorded a Formal PEB. If, still found Fit at the Formal PEB, the case will then be forwarded to the service headquarters.

4111 Categorization Of Findings

All PEB findings should be arranged into four categories for members found Unfit to continue naval service :

- a. Category I: All Unfitting Conditions
- b. Category II: Those Conditions That Are Contributing to the Unfitting Condition.
- c. Category III: Those Conditions That Are Not Separately Unfitting, And Do Not Contribute To The Unfitting Condition.
- d. Category IV: Conditions, Which Do Not Constitute A Physical Disability .

Note: Only Category I and Category II conditions will be rated by the PEB.

4112 – 4199 Reserved

PART 2 - INFORMAL PHYSICAL EVALUATION BOARD

4201 General Functions Of Informal PEB.

The Informal PEB shall screen incoming cases for acceptance and, if accepted, perform the initial disability evaluation on the basis of documentary review of case records . The board shall follow the policies and procedures set forth in this instruction.

4202 Board Composition

a. An Informal PEB shall be composed of three members: two line officers (normally a Navy line officer and a Marine Corps officer), and a Medical Corps officer. All members shall be senior military officers (O-6 preferred) selected on the basis of wide military experience, proven performance and education. All Medical Corps officers assigned shall possess a wide cross-section of clinical experience.

b. One of the two line officers shall be the Presiding Officer for each Informal PEB. While not mandatory, it is preferred that the Presiding Officer be the line officer of the same service as the member being considered.

c. All members of a board shall be assigned by the DIRNCPB and report to the President, PEB.

d. While not mandatory, it is strongly preferred that the Presiding Officer of a panel be a Navy line or Marine Corps officer in the grade of O-6 or above and that the Presiding Officer be of the same service as that of the member being considered. However, in every circumstance, the Presiding Officer shall be at least in the grade of O-5.

e. The composition of a board shall be consistent and shall not be altered by reason of the grade, status or organization of a member under disability evaluation, except as specified in paragraphs 3108 and 4204 or by specific direction of the DIRNCPB.

4203 Reserve Membership

See paragraph 3110a.

4204 Alternate Members

a. In the absence of a principal member, an alternate member may sit on a board.

b. Alternate members must be in the grade of O-5 or above. An alternate line member may be of the same service as the Presiding Officer . However, one of the line officers on a board will normally be of the same service as the member being evaluated.

c. CHNAVPERS, CMC (M&RA), and CHBUMED shall designate in advance and provide alternate board members including funding for Navy and Marine Corps reservists, as requested by the President, PEB.

4205 Administrator

A member of the PEB shall be assigned as Administrator of the Informal PEB, and is responsible to the President, PEB for the leadership and management of day-to-day board affairs.

4206 Recorders

The President, PEB shall assign to the Informal PEB at least one Recorder to assist with administrative processing. Recorders shall be Navy or Marine Corps officers. Recorders report to the Executive Secretary, PEB.

4207 Oaths

Each board member shall act under oath or affirmation.

4208 Preliminary Findings

- a. Preliminary findings shall be reached through a majority vote of board members.
- b. In arriving at preliminary findings, a board shall comply with this instruction.
- c. Each finding made, which is concurred in by a majority of a board, shall constitute the preliminary PEB findings or action of the board.
- d. Record votes of individual members in the board's records .
- e. Any dissenting member of a board shall make a minority report concerning those particulars in which he or she does not agree with the action of the board. The report will become part of the record. Reference will be made to its attachment in the space provided for minority findings.
- f. Preliminary findings as the result of record review shall be set forth in writing.
- g. The preliminary findings in each case shall be recorded in summary form and attached to the record. Detailed case analyses or rationales shall not normally be prepared, except in specific instances. In those specific cases, as defined by the President, PEB, justification will be recorded on the Informal PEB workcard.

4209 Documents To Be Reviewed

Base findings upon review of documents namely:

- a. Medical board reports and associated documents together with endorsements of convening authorities and statements of members referred for disability evaluation.
- b. Line of duty/misconduct determinations, when appropriate.
- c. Statements of service, when appropriate.
- d. Reports of periodic physical examination (TDRL), when appropriate.

- e. Reports of special consultations, when appropriate.
- f. Statements of non-medical information as to the observation by the reporting senior of performance of duty, see enclosure (11) (Non-Medical Assessment Form).
- g. Fitness reports and performance evaluations supplied by the CHNAVPERs or the CMC (M&RA), as they apply to disability evaluation, when appropriate.
- h. NOEs, when appropriate.
- i. Member's health record.
- j. Any other pertinent materials.

4210 Eligibility Determinations

Include certain eligibility determinations in the record, but they need not be published to the member in the findings. If the member is found to be Unfit to continue naval service, the determinations may be:

- a. The disability (was)(was not) (incurred)(aggravated) while entitled to receive basic pay.
- b. The disability (is)(is not) the result of intentional misconduct or willful neglect, and whether such disability (was)(was not) incurred during a period of unauthorized absence.
- c. Select appropriate finding:
 - (1) the disability (is)(is not) the proximate result of active duty or inactive-duty training (because of aggravation, when applicable), or
 - (2) the disability (was)(was not) incurred in line of duty in time of war or national emergency, or
 - (3) the disability (was)(was not) (incurred)(aggravated) after 24 September 1975;
- d. The disability (is)(may be) permanent; and
- e. The disability is ratable in accordance with the VASRD and this instruction.

4211 Format Of Findings

- a. Cases of Active Duty Members and Inactive-Duty Reservists who have been issued a Notice Of Eligibility, or are referred under the provisions of paragraph 3201b(3). A

board shall find that the member is Fit to continue naval service , or Unfit to continue naval service because of physical disability:

(1) If the member is Fit to continue naval service, board evaluation is complete.

(2) If the member is Unfit to continue naval service:

(a) the disability (was)(was not) (incurred) (aggravated) while entitled to receive basic pay;

(b) the disability (is)(is not) the result of intentional misconduct or willful neglect, and whether such disability (was)(was not) incurred during a period of unauthorized absence;

(c) the disability (is)(is not) stabilized at the present degree of impairment;
and

(d) the disability is ratable at (percentage)

(e) the disability (is)(is not) combat related as defined by section 104 of the Internal Revenue Code. See paragraphs 3501 through 3507.

b. Cases Of Inactive-Duty Reservists Not Eligible For Disability Benefits. When the member is an inactive-duty Reservist who has not been issued an NOE authorizing disability benefits and does not have an injury or illness incurred during a period of active duty of more than 30 days, the only findings to be made are:

(1) Physically Qualified, or

(2) Not Physically Qualified for active duty in the Naval or Marine Corps Reserve.

c. Cases Of Members On The TDRL Being Recommended For Administrative Removal From The TDRL (see enclosure (3), part 6).

d. Signatures. Preliminary findings following the Informal PEB shall be signed by the Executive Secretary (PEB), the Presiding Officer of the Informal PEB, or by officers designated by the President (PEB), "By direction of the President, PEB." A copy is sufficient for delivery to the member.

4212 Completion of Evaluation

Upon completion of review by a Informal Board:

a. The Informal PEB shall refer all cases to the President, PEB for further processing.

b. The President, PEB, upon written request of (1) the Medical Advisor PEB, (2) the Legal Advisor PEB, or (3) the Administrator PEB, may direct the Informal PEB to completely reconsider (with recorded votes) any case. The President, PEB may as a matter of discretion, direct reconsideration by an Informal PEB Board comprised of entirely new members.

c. President, PEB shall assign to a Formal PEB:

(1) all cases of members found Unfit to continue naval service in which the member demands a hearing;

(2) all cases in which a member having been found Fit to continue naval service, requests a hearing, and the request is granted by the President, PEB or DIRNCPB;

(3) TDRL members found Fit who demands a Formal PEB;

(4) such other cases as are deemed appropriate by the DIRNCPB.

d. President, PEB shall refer requests for PLD status in accordance with enclosure (6) of this instruction.

e. President, PEB shall process special interest cases in accordance with paragraph 4106.

f. President, PEB shall issue a Findings Letter in all other cases, which are not going to a Formal PEB.

4213 Notification To Member And Options

Findings following an Informal PEB will be transmitted to the member by certified mail, facsimile, hand delivery, or verbally, offering the following options, where applicable:

a. Fit To Continue Naval Service Findings:

(1) Accept the finding of Fit to continue naval service; or

(2) disagree with the finding of Fit to continue naval service and request reconsideration.

(a) The member shall provide new medical information or significant non-medical assessment not previously available or considered for reconsideration.

(b) If the member fails to submit new medical information or significant non-medical assessment that would alter the case, the Presiding Officer of the Informal PEB will deny reconsideration of the case.

(c) In those instances where new medical information or significant

non-medical assessment have been considered but results in no change to Informal PEB findings, then the Presiding Officer of the Informal PEB recommends to the DIRNCPB via the President, PEB whether a Formal PEB should be granted.

(d) The criteria the Presiding Officer is to use in determining whether to grant or deny reconsideration is whether the member has provided new or additional information and whether that new or additional information is beyond that previously considered by the Informal PEB; or is new medical information provided that would materially warrant a change to the previous findings. The member must also state whether or not a hearing is desired if the Fit to continue naval service finding remains unchanged.

(e) If the finding of Fit to continue naval service finding is confirmed upon reconsideration, there is no right to a hearing.

(f) Active duty and Reserve component members, see paragraph 3701.

(g) TDRL personnel will be given the option of either returning to active duty, being discharged from the naval service, or demanding a Formal PEB, see paragraphs 3625, 3627, and 4213a (2).

(h) The President, PEB, or DIRNCPB may grant a request for a hearing when deemed necessary to preclude an error or injustice, see paragraph 4109.

(i) If a member does not request a hearing or a hearing request is denied the Informal PEB findings become final.

(j) If upon reconsideration the finding is changed to Unfit to continue naval service then the member is entitled to receive a new notification and to be presented with his/her applicable options.

b. Unfit To Continue Naval Service Findings :

(1) Accept the findings and waive the right to a hearing. In this case, the Informal PEB findings then are referred to the President, PEB, who shall issue and promulgate them.

(2) Disagree with the findings and exercise the right to demand a full and fair hearing. In this case, the President, PEB, will refer the case to a Formal PEB. If the member disagrees only with the combat-related/taxability opinion, then the member may appeal that aspect of the case to the OJAG. The limited issue of combat-related/taxability does not affect the ultimate disposition of the case within the Department of the Navy and therefore does not prevent finality. Accordingly, such cases are treated as accepted and they shall be handled as described in subparagraph (1) above. In certain instances, members found Unfit may be reconsidered by the Informal PEB.

c. Physically Qualified For Continued Naval Service Findings:

(1) Accept the finding of Physically Qualified, or

(2) Disagree with the finding of Physically Qualified for continued naval service and request reconsideration. The member must provide new medical information not previously available or considered for reconsideration. The member also must state whether a hearing is desired if the Physically Qualified for continued naval service finding remains unchanged. If Physically Qualified for continued naval service finding is confirmed upon reconsideration there is no right to a hearing and case consideration is complete unless the President, PEB, or the DIRNCPB grants a request for a hearing when deemed necessary to preclude an error or injustice, see paragraphs 3701 and 4109. If upon reconsideration, the finding is changed to Not Physically Qualified for continued naval service, then the member is entitled to receive a new notification and to be presented with his or her applicable options. If a member does not request a Formal PEB or a Formal PEB request is denied, the Informal PEB findings become final.

d. Not Physically Qualified For Continued Naval Service Findings:

(1) Accept the findings and waive the right to a hearing. In this case, the Informal PEB findings are referred to the President, PEB, who shall issue and promulgate them.

(2) Disagree with the Informal PEB findings and demand a full and fair hearing. In this case, the President, PEB, will refer the case to a Formal PEB.

4214 Reconsideration by Informal PEB

a. If, subsequent to the dictation of the medical board and prior to issuance of preliminary findings, the member receives new medical diagnoses and/or undergoes relevant, new medical procedures which may have altered the severity of the condition (either positively or negatively), the member should forward this information to the President, PEB. Additional information submitted will be taken into consideration.

b. If, after issuance of the Informal PEB Preliminary Findings of Unfit or Not Physically Qualified and prior to the acceptance/non-acceptance of these findings the member has new and/or relevant medical information that may alter the findings, the member should forward this information along with his/her election of options. Upon review, if it is determined that the information submitted warrants a change in findings, reconsidered findings will be issued. If no change in the preliminary findings is warranted, the case will be forwarded to the Formal PEB or finalized per the member's election of options.

c. The President, PEB shall render final decision on reconsideration determinations. If after reconsideration the member has been found Unfit or Not Physically Qualified by the Informal PEB, the member still retains the right to demand a Formal PEB. If the member has been found Fit or Physically Qualified, the member may still request a Formal PEB.

d. If the Preliminary Findings have been issued, but further workup or procedures have been scheduled, this information must be forwarded to the President, PEB for review and determination of the proper course of action (e.g. suspension, termination, forwarding, finalization, etc).

4215 Acceptance/Non-Acceptance Of Findings

a. Following counseling as to available options, the member shall indicate acceptance or non-acceptance of the findings of the Informal PEB.

b. If, after the member receives the Preliminary Findings and prior to making an election of options, the member receives new medical diagnoses and/or undergoes relevant, new medical procedures, the member may submit this information to the President, PEB pursuant to the procedures referenced in paragraph 4214 of this instruction for possible reconsideration by the Informal PEB.

c. The President, PEB shall render final decision reconsideration determinations. If after reconsideration the member has been found Unfit or Not Physically Qualified by the Informal PEB, the member still retains the right to demand a Formal PEB. If the member has been found Fit or Physically Qualified, the member may still request a Formal PEB.

d. Incompetence. When the member has been determined to be incapable of managing his or her financial affairs by a board of medical officers convened and constituted in accordance with reference (f) (MANMED, Chapter 18), the member's court appointed guardian or next-of-kin will be counseled (in the above precedence order) and afforded the opportunity to exercise the member's options as discussed in paragraph 4213.

e. See paragraph 3414 for other special situations in which a member is mentally unable to comprehend and make elections concerning findings following records review.

f. Once a member elects to accept the findings, the PEB is authorized to issue a Notification of Decision to the appropriate service headquarters. When the Notification of Decision is issued the member's case is considered final. This finalization may occur prior to the end of those 15 calendar days depending on when the member signs the Election of Options form. If the member changes his/her mind after returning the signed Election of Options form, but before the 15 calendar days have run, action in accordance with the change of mind will be taken only if the PEB has not issued the En bloc. If the En bloc has not been issued, the most recent election of options made by the member shall be the decision upon which the PEB will proceed to process the member's case.

g. At any time prior to the convening on the record of the Formal PEB, members may withdraw their request for a Formal PEB and accept the Informal PEB findings.

4216 Presumed Acceptance

If no response to the Findings Letter is received by the PEB within 15 calendar days of hand delivery or receipt of certified mail by the member or legal representative concerned, acceptance of the Informal PEB findings is presumed. Receipt by a member's attorney of the written findings constitutes receipt by the member. In the case of personnel

on the TDRL only, acceptance also is presumed 15 calendar days after attempted unsuccessful delivery of certified mail to the last known address of the member. Once acceptance is presumed, the President, PEB, shall issue the findings.

4217 Assignment Of Legal Counsel

There is no right to legal counsel during the Informal PEB. However, a member may consult with legal counsel at no expense to the Government.

4218 – 4299 Reserved.

PART 3 - FORMAL PHYSICAL EVALUATION BOARD HEARINGS

4301 Purpose And Overview

a. No active duty or reserve member of the naval service found Unfit by the Informal PEB may be retired or separated for physical disability without the right to a Formal PEB hearing. Acceptance of the Informal PEB findings constitutes waiver of the right to a Formal PEB (10 U.S.C. 1214). As a matter of policy, although not required by statute, no member of the reserve component shall be separated for being Not Physically Qualified for continued naval service without a Formal PEB hearing unless he or she waives the right. TDRL members determined Fit shall be entitled to a Formal PEB hearing since removal from the TDRL represents a change in military status. The President, PEB shall provide such hearings when required.

b. Formal PEB hearings also may be conducted by the PEB as information gathering bodies for the development of cases when directed by the President, PEB or DIRNCPB under paragraph 4 of the basic instruction, see paragraphs 1004c (2), 4212b(2), or 4212b(4). The proceeding is non-adversarial and formal rules of evidence do not apply. Members of the board are charged with making findings concerning fitness and eligibility for disability benefits and must protect the interests of both the member and the government.

c. A Formal PEB hearing provides an opportunity for the member to present additional material to support his or her case. Once a hearing has convened, any preliminary findings of the Informal PEB are null and void and are of no precedential value to the Formal PEB or the member.

d. Service members requesting a Formal PEB should be encouraged to submit a rebuttal identifying the issues of disagreement with the Informal PEB's findings and recommendations.

4302 Functions Of Formal PEB

a. To conduct formal hearings pertaining to disability evaluation of members of the naval service as required by 10 U.S.C. 1214 and this instruction,

b. To evaluate on the basis of formal hearings attended by a member and/or counsel:

(1) physical fitness (or physical qualification in the case of an inactive-duty member of the Naval or Marine Corps Reserve) of a member for active duty; and

(2) if found Unfit to continue naval service, the entitlement of the member to benefits authorized by 10 U.S.C., Chapter 61;

c. To refer Formal PEB findings to the President, PEB for review, issuance and promulgation; and

d. To protect the privacy of individuals whose records are reviewed under SECNAVINST 5211.5D.

4303 Board Composition

a. A formal board normally shall be composed of three members, a Navy line officer, a Marine Corps officer, and a Medical Corps officer, all senior military officers selected on the basis of wide medical and/or military experience, proven performance and education. All Medical Corps officers assigned shall possess a wide cross-section of clinical experience.

b. Members of the Formal PEB shall be assigned by the DIRNCPB and report to the President, PEB.

c. The Presiding Officer for a formal board shall be a Navy line or Marine Corps officer in the grade of O-6 or above. While not mandatory, it is preferred that the Presiding Officer be of the same service as that of the member being considered.

d. The composition of boards shall be consistent and shall not be altered by reason of the grade, status or organization of a member under disability evaluation, except as specified in paragraphs 3108 and 4305, or by specific direction of the DIRNCPB.

4304 Reserve Membership

See paragraph 3110a.

4305 Alternate Members

a. In the absence of a principal member, an alternate member may sit on a board.

b. Alternate members must be in the grade of O-5 or above. An alternate line member may be of the same service as the Presiding Officer. However, one of the line officers on a board should be of the same service as the member being evaluated.

c. CHNAVPERS, CMC (M&RA), and CHBUMED shall designate in advance and provide alternate board members including funding for Navy and Marine Corps reservists, as requested by the President, PEB.

d. Changes in alternate member nominations shall be held to a minimum so as to retain as high a degree of expertise as practicable on the boards.

e. Alternates shall be carefully instructed in the provisions of this instruction by the Administrator. In addition, an alternate should observe at least one full hearing, including deliberations, before actually sitting as a board member. A prospective alternate may not discuss the case or vote while observing deliberations.

4306 Administrator

A board member at each Formal PEB site shall be assigned as Administrator. He or she shall be responsible for the leadership and management of day-to-day panel affairs.

4307 Counsel

Each Formal PEB shall be assigned the continuous services of no less than two judge advocates for a period of not less than 6 months. They shall act as counsel for members appearing before the boards. These counsel shall be provided from the staffs of appropriate Naval Legal Service Offices, or from such other sources as may be designated by the JAG. They shall be qualified under 10 U.S.C. 827b (Article 27(b), UCMJ). The principles attendant to the use of alternate members in paragraph 4305d, apply to military lawyers as well.

4308 Counsel For The Board

a. At the discretion of the Presiding Officer of a board, an attorney who is not involved in a particular case as counsel for the member may be assigned as counsel for the board.

b. A civilian employed by the government who is a member of the bar of a federal court or the highest court of a state may be appointed as counsel for a board.

4309 Duties Of Counsel For The Board

Counsel for the board shall:

a. ensure that the board has before it information to ascertain as accurately as possible:

- (1) the circumstances in which the physical impairment was incurred, and
- (2) the extent of the disability;

b. when requested by the Presiding Officer, present the evidence and represent the government during the hearing;

c. when requested by the Presiding Officer, question witnesses so as to impartially elicit all available evidence.

4310 Representation By Counsel

a. Military Counsel. In order to provide maximum pre-hearing preparation time, to minimize unnecessary travel and to avoid hearing delays, a military lawyer will be detailed as counsel for the member immediately subsequent to the receipt of a case by a Formal PEB. Members appearing before a Formal PEB hearing have the right to be represented by a designated military lawyer at no expense to the member. A military lawyer, other than those regularly assigned to the board, shall be provided upon request only if reasonably available and at no additional expense to the government.

b. Civilian Counsel. Members appearing before a Formal PEB have the right to be represented by counsel of their own choice provided by the member and at no expense to the government. This right includes the ability of the member to choose a non-lawyer to represent him or her.

c. Associate Counsel. When a member (or legal guardian or next-of-kin in incompetent cases) elects counsel of his or her choice, the military lawyer assigned shall act as associate counsel if requested to do so.

4311 Independence Of Military Counsel

Formal PEB members shall not limit or interfere with counsel's ability to fully represent their clients in any way. The scope of counsel's representation is a matter between the member and counsel only.

4312 Duties Of Counsel For The Member

a. The military lawyer assigned as counsel for a member shall represent the member being evaluated unless the member refuses counsel or elects other counsel of his or her choice. In the case of an incompetent, the military lawyer assigned shall act in that capacity in all cases except when a duly appointed guardian, spouse or next of kin obtains or requests other counsel.

b. A lawyer who acts as counsel for the member shall:

(1) confer with and fully advise the member of legal and other substantive considerations in his or her case;

(2) represent the member, presenting to the board information and arguments in support of the member's case and interests;

(3) arrange for the presence of desired witnesses and evidence in support of the member's case;

(4) interview witnesses prior to the hearing and question them during the hearing;

(5) counsel the member regarding Formal PEB findings and options open to the member, and recommend courses of action that are most favorable to the member which are consistent with the letter and intent of statutes, regulations and directives addressing disability evaluation and administration;

(6) advise the member of the procedural requirements involved in submitting a request for PLD, if the member has not already been denied this request by service headquarters;

(7) advise the member of the requirements of a PFR;

(8) prepare or assist in the preparation of a PFR at the request of the member;

(9) prepare or assist in the preparation of an appeal of the combat-related/taxability opinion of the PEB at the request of the member; and

(10) in the case of incompetents, fully inform the court-appointed guardian, or, if no guardian has been appointed by a court, the member's spouse or next of kin, of the legal and factual issues in the case and act following the wishes of the guardian, spouse or next of kin, as appropriate, if those wishes do not conflict with the proper exercise of the responsibilities of Counsel concerning the member's interests.

4313 Personal Appearance

A member shall have the right to appear personally at the Formal PEB, which may include video teleconferencing, unless such appearance proves impracticable because the member cannot travel (e.g., the member is incarcerated or incapacitated).

a. If the member's conduct or statements create a potential security risk to board members and/or other personnel, local security police shall be alerted and appropriate security precautions shall be taken.

b. Unless the Formal PEB hearing is directed by SECNAV, members of the Ready Reserve with nonduty-related impairments are responsible for their personal travel and other expenses.

4314 Waiver Of Personal Appearance

a. Actual Waiver. Members have the right to waive their personal appearance before a Formal PEB. In such cases, Counsel must represent the member during the hearing.

b. Constructive Waiver. After due notification of the time and place of a hearing, failure to appear before a Formal PEB on the part of the member, his or her counsel, and, in incompetent cases, the guardian, spouse or next of kin, shall be considered as a waiver by the member of his or her right to personally appear unless it is reasonably shown that the failure was through no fault of the party failing to appear. The hearing shall proceed "in absentia" and the Presiding Officer will include in the record a statement of the circumstances as well as evidence of notification.

4315 Late Appearances

Late appearances, while an "in absentia" hearing is in progress, shall be heard.

4316 Access To Records

Service members or, if incompetent, their legal representative, shall have the right of access to all records and information received by the PEB before, during, and after the formal hearing that may affect the findings of the PEB or appellate review authority.

4317 Scheduling Of Formal PEB Hearings

The Administrator of each Formal PEB shall establish the date and time of each hearing, subject to the following guidance:

a. Cases Involving Incompetent Members. If, after counseling by Counsel for the member, the guardian, spouse or next of kin, does not waive the right of the member to a hearing within 15 calendar days of counseling, schedule the case for a hearing.

b. Inadequate Information

(1) Hearings will not be scheduled unless all necessary records will be available and ready for review by the Formal PEB and the member, his or her counsel, guardian, spouse or next of kin for a reasonable period prior to the commencement of the hearing.

(2) Each board shall ensure that it has available the necessary information for competent decision.

c. Extensions

(1) An Administrator may authorize an extension of the above times upon presentation by the member or his or her counsel of substantial grounds for such extension. In such instances, the delay shall be the minimum reasonable on the basis of the grounds presented.

(2) Notwithstanding (1) above, except as specifically authorized by the President, PEB, conclude each requested hearing within 45 days following receipt of the case at the hearing site.

4318 Formal PEB Hearings - Presiding Officer

Presiding Officers shall preside over all sessions of a hearing and speak for the board in findings matters. The Presiding Officer is responsible for the accuracy and completeness of the records forwarded to the President, PEB.

4319 Formal PEB Hearings - Open Session And Conduct

a. Conduct hearings in open session unless, in the opinion of the Presiding Officer, such would be prejudicial to the objective of attaining a full and fair hearing, or unless the member requests a closed hearing. The adjudicatory function of board members is paramount. Members should avoid conduct, which is or could be construed to be investigatory or prosecutorial.

b. Conduct hearings with dignity and decorum and with the objective of eliciting all the facts bearing on a case. Encourage witnesses to contribute to this objective.

c. If the member's conduct or statements create a potential security risk to board members and/or other personnel, alert local security police and take appropriate security precautions.

4320 Formal PEB Hearings – Uniform

Active duty personnel and inactive-duty reservists shall appear in the site's uniform of the day for hearings unless specifically excused by the Presiding Officer from doing so.

4321 Formal PEB Hearings – Oaths

Each board member and Reporter shall act under oath or affirmation. Witnesses shall be sworn in by the Presiding Officer or by Counsel for the board if one is assigned.

4322 Formal PEB Hearings - Interlocutory Issues

Presiding Officers shall rule on all interlocutory questions except challenges. These rulings may be objected to by other board members, in which case, decide the matter by a majority vote of the members in closed session.

4323 Formal PEB Hearings - Challenges

a. Any Formal PEB member may be challenged by an individual undergoing physical disability evaluation at any time during the hearing for cause stated to the board. The Presiding Officer shall not receive a challenge to more than one member at a time. After disclosing grounds for a challenge, the challenging individual may examine the board member. This examination shall be recorded verbatim. Counsel for the board, if assigned, may cross-examine the member who has been challenged. After all questions have been put and answered, any other evidence bearing on the board member's fitness to serve shall be heard.

b. The burden of sustaining a challenge is on the individual who made the challenge. The challenged board member shall withdraw when the hearing is closed to vote upon the challenge. One vote of the remaining members is enough to sustain the challenge. The board shall decide the challenge according to the preponderance of the evidence. When a challenge is sustained, the Presiding Officer of the board or the remaining senior member will call alternate board members.

4324 Formal PEB Hearings - Recesses And Continuances

a. Presiding Officers may recess or adjourn a case where substantial reason is made apparent. However, a case may not be delayed for more than 30 days without the approval of the President, PEB.

b. Continuances of a hearing are not a matter of right; they are a matter of discretion. The decision to grant or deny a request for continuance shall be solely within the discretion of the President, PEB. Written request from the Administrator of the Formal PEB shall be submitted in writing documenting substantial reasons for the continuance and subsequent rescheduling of the case.

4325 Formal PEB Hearings - Procedural Guide

A procedural guide issued by the DIRNCPB shall be followed in all hearings.

4326 Formal PEB Hearings – Objections

Objections may be made to any action (other than a challenge) taken or proposed to be taken by a board, as well as to the admission of testimony. Objections, when made, are recorded as part of the proceedings. The Presiding Officer must note in the record the ruling on any objections that may be offered. The Presiding Officer rules upon objections.

However, if any other board member dissents from the Presiding Officer's ruling, the entire board rules upon the objection in closed session. The ruling is the decision of the majority of the board and is announced on the reopening of the hearing.

4327 Formal PEB Hearings - Admission Of Evidence And Testimony

a. Before taking testimony, the Presiding Officer shall, for the record, officially receive all papers pertaining to the case in open session. These papers may be inspected by the member and his or her counsel during the hearing.

b. The Formal PEB shall consider all documentary evidence transmitted to it by proper authority. A board, in addition, may require and examine records as may be in Department of the Navy files that relate to issues before the board. All evidence having probative value as to the determination of issues may be considered. In consideration of the weight and probative value to be accorded evidence, the members of a board are expected to utilize their background and experience, their common sense and their knowledge of human nature and behavior. In every case, the testimony of the member concerned shall be considered in connection with all the evidence adduced and given such weight, as the board may believe it merits. When the testimony presented at the hearing indicates that the member claims to have disabilities not disclosed by the official medical records or presents evidence sharply in conflict with official medical records, and the issue thus drawn is not one that can be readily resolved by the observation of the board, there shall be further development of the case by requesting further physical examination, special studies, or further investigation by appropriate agencies; and the hearing shall be adjourned until such development has been accomplished. Findings of a board shall be based upon evidence consistent with a reasonable probability of truth.

c. Members undergoing disability evaluation before a Formal PEB shall be permitted to introduce witnesses, depositions, documents, sworn (affidavits) or unsworn statements or other evidence in their behalf and to question all witnesses who testify at the hearing.

d. Members may make oral or written statements.

e. Members may elect not to offer evidence or testimony.

f. Members may not be required to sign any statement touching upon circumstances surrounding the origin, incurrence or aggravation of any disease or injury (10 U.S.C. 1219).

g. Members and witnesses introduced by them may be questioned by members of the board regarding evidence or testimony submitted by them.

h. Testimony of witnesses shall be taken under oath or affirmation unless otherwise requested by the member, his or her counsel, guardian, spouse, or next of kin.

i. Members have the right to remain silent. When the member exercises this right, the member may not selectively respond, but must remain silent throughout the hearing.

4328 Formal PEB Hearings – Witnesses

A board may obtain military witnesses whose presence is requested by the member or member's counsel, if witnesses are reasonably available and if, in the opinion of the board, their testimony is essential or contributes materially to the case. Article 49, UCMJ (10 U.S.C. 849), is used in determining reasonable availability of witnesses. The use of affidavits or depositions to obtain testimony of witnesses is encouraged. A board may obtain military witnesses considered necessary to complete its findings and to comply with the legal requirements of a full and fair hearing. To assure the attendance of a military witness, the Administrator of a board will request the proper commander make the necessary arrangements for the timely presence of the witness, provided the witness is reasonably available. If the commander considers that the witness is not reasonably available, he or she shall provide a statement giving the reasons therefore, and this statement shall be appended to the record.

4329 Formal PEB Hearings - Findings

- a. Findings shall be reached through a majority vote of the board members.
- b. In arriving at findings, a board shall comply with this instruction.
- c. Each finding made, which is concurred in by a majority of a board, shall constitute the PEB findings subsequent to legal review.
- d. Record votes of individual members in the board's records of proceedings and findings .
- e. Any dissenting member of a board shall submit a minority rationale concerning those particulars in which he or she does not agree with the action of the board. The rationale will become part of the record.
- f. Set forth findings in writing, in summary form, and attached to the record. The Presiding Officer shall sign them. Also, see paragraph 4342.

4330 Formal PEB Hearings - Basis Of Findings

a. Each board shall make findings with regard to the physical fitness for active duty (or physical qualification for active duty in the case of an inactive-duty member of the Naval or Marine Corps Reserve) on the basis of a formal personal hearing conducted in the presence of the member being evaluated, unless such appearance is waived or would be injurious to health, and/or his or her counsel .

b. In connection with each formal hearing, a board shall consider the following information when applicable:

- (1) physical evidence presented;

- testimony;
- (2) statements of the member, his or her counsel, and/or witness's
 - (3) medical board reports and associated documents, together with endorsements of convening authorities and statements of members referred for disability evaluation;
 - (4) line of duty/misconduct determinations;
 - (5) statements of service ;
 - (6) reports of periodic physical examination (TDRL);
 - (7) reports of special consultations;
 - (8) statements of non-medical information as to the observation by the reporting senior on performance of duty of the member being evaluated;
 - (9) fitness reports and performance evaluations supplied by the CHNAVPERS or the CMC (M&RA), as they apply to disability evaluation;
 - (10) NOEs; and
 - (11) any other pertinent matters prior to conclusion of the hearing.

4331 Formal PEB Hearings - Eligibility Determinations

Each board shall determine a member's statutory eligibility for benefits as required by 10 U.S.C., Chapter 61 and enclosure (3) to this instruction. Include eligibility determinations in the record but; they need not be published to the member in the findings . These determinations are, if Unfit to continue naval service:

- a. the disability (was)(was not) (incurred)(aggravated) while entitled to receive basic pay,
- b. the disability (is)(is not) the result of intentional misconduct or willful neglect, and whether such disability (was)(was not) incurred during a period of unauthorized absence;
- c. (select appropriate finding)
 - (1) the disability (is)(is not) the proximate result of active duty or inactive duty training (because of aggravation , when applicable), or
 - (2) the disability (was)(was not) incurred in line of duty in time of war or national emergency, or

- d. the disability (is)(may be) permanent; and
- e. the disability is ratable in accordance with the VASRD and this instruction.

4332 Formal PEB Hearings - Inadequate Information

If a board is unable to make findings because of inadequate information, the Presiding Officer shall take appropriate action to obtain the necessary information before proceeding further.

4333 Formal PEB Hearings – Deliberations

Upon completion of the presentation of a case, a board shall be closed for deliberation. Except as provided in paragraph 4305 (e), no person, other than the voting members, shall be present during closed sessions. The voting members then arrive at the PEB findings as prescribed in this Part.

4334 Format Of Findings

a. Cases Of Active Duty Members And Inactive-Duty Reservists Who Have Been Issued An NOE. The Formal PEB shall determine that the member is Fit to continue naval service or Unfit to continue naval service; and

(1) If the member is Fit to continue naval service, Formal PEB evaluation is complete; or

(2) If the member is Unfit to continue naval service :

(a) the disability (was)(was not) (incurred) (aggravated) while entitled to receive basic pay;

(b) the disability (is)(is not) the result of intentional misconduct or willful neglect, and whether such disability (was)(was not) incurred during a period of unauthorized absence;

(c) the disability (is)(is not) stabilized at the present degree of impairment;

(d) the disability is ratable at (percentage); and, if applicable,

(e) the disability (is)(is not) combat related as defined by section 104 of the Internal Revenue Code. See paragraphs 3501 - 3507.

b. Cases Of Inactive-Duty Reservists Not Eligible For Disability Benefits. When the member is an inactive-duty reservist who is not eligible for disability benefits, under 10 U.S.C., Chapter 61; i.e., under SECNAVINST 1770.3B and reference (b), the member has not been issued an NOE, or the member is not referred under the provisions of paragraph 3201b(3), the only findings to be made are:

(1) Physically Qualified for continued naval service in the Naval or Marine Corps Reserve, or

(2) Not Physically Qualified for continued naval service in the Naval or Marine Corps Reserve.

4335 Categorization Of Findings

See paragraph 4111.

4336 Notification To Member

a. Every member appearing before a Formal PEB will be advised that:

(1) the Formal PEB's findings are subject to an automatic review for administrative and legal sufficiency before issuance by the President, PEB. PEB findings can only be challenged by means of a PFR or by Petition to the BCNR filed in accordance with enclosure (5) to this instruction.

(2) the member will receive the final PEB findings and rationale from the President, PEB after review, and

(3) the member has 15 calendar days from the date of receipt of the final PEB findings and rationale to submit a PFR, if desired, before the case is finalized and CHNAVPERS or CMC (M&RA) is notified of the disposition by means of a Notification of Decision Letter.

b. The Formal PEB will not, either orally or in writing, notify the member or the member's counsel of the Formal PEB's findings prior to issuance of the findings by the PPEB.

4337 Permanent Limited Duty (PLD) Requests

See paragraph 4312b(6) and enclosure (6) to this instruction.

4338 Disagreement With Formal PEB Findings

If a member disagrees with the findings after the Formal Board stage of disability processing, he or she may submit a PFR to the DIRNCPB or after discharge from active duty submit a petition to the BCNR. See enclosure (5) of this instruction. It is recommended that a member consult with Counsel.

4339 Final PEB Findings

See paragraph 4105.

4340 Rationale

Since it is essential that the record clearly reflects facts sufficient to form the basis for the findings, prepare a rationale which states the basis for the findings reached.

4341 Transcripts

a. A verbatim transcript of a hearing shall be prepared and forwarded to the President, PEB only when:

- (1) a finding of misconduct is to be issued;
- (2) there is not a unanimous decision by the board;
- (3) the case is a Special Interest case; or,
- (4) a transcript is specifically requested by the President, PEB or DIRNCPB.

b. A verbatim transcript is defined to include any oral mechanical recording, such as a cassette recording, of the proceedings from the time the proceedings are convened to the time they are adjourned. A typewritten transcript of the oral mechanical recording will be made only upon the approval and direction of the President, PEB. A duplicate copy of the oral mechanical recording will be made available upon the request of the member or designated counsel. It is the responsibility of the requester to provide a receptor, such as a blank cassette. PEB has the discretion to waive the requirement that the requester provide a duplication receptor.

4342 Disposition Of Records

a. Forward to President, PEB all records considered by a formal board, the board's findings, rationale, transcript when required, and a proposed final PEB findings letter with proposed rationale as an enclosure thereto.

b. A verbatim record on magnetic tape shall be kept of all hearings. This tape shall be forwarded to the Director, Naval Council of Personnel Boards. The Director will retain these tapes for 1 year and shall then forward them to the Washington National Personnel Records Center for retention per reference (i).

4343 – 4399 Reserved

ENCLOSURE 5: PETITIONS FOR RELIEF (PFR)

5001 Basis For PFR Within The Disability Evaluation System

a. Following a Formal PEB, when the findings of the PEB become final, and the member has exhausted all of the available options with the PEB, members who have not been discharged or separated, and TDRL personnel, may PFR to DIRNCPB. Members who have been separated or permanently retired may petition the Board for Correction of Naval Records (BCNR). The only basis for relief by means of PFR are:

(1) New Or Newly Discovered Evidence. Upon the presentation of new or newly discovered evidence which by due diligence could not have been presented prior to the effective date of disposition of the individual concerned, which related to a fact in existence at the time of such disposition, which is not merely cumulative or corroborative and not such as to merely affect the weight of evidence or credibility of witnesses or records; and which would have warranted a different finding or action had it been presented; new or newly discovered medical evidence to be accepted must be corroborated by competent medical authority.

(2) Fraud, Misrepresentation, Or Other Misconduct. Upon a showing that the directed disposition of an individual was based upon fraud, misrepresentation of material fact, or other misconduct of such nature that in the absence thereof a different finding would have been made or a different action taken.

(3) Mistake Of Law. Mistake of law is a basis for relief; e.g., failure to accord an individual found Unfit the opportunity for a formal hearing; a directed disposition which was without authority; a decision which is contrary to the great weight of evidence of record.

b. Appeals. Appeals concerning Notice of Eligibility (NOE) and combat-related determinations will not be addressed in the PFR.

(1) For appeals concerning NOEs, contact the appropriate service headquarters.

(2) Appeals concerning combat-related determinations should be directed to the Judge Advocate General of the Navy (Code 13), Washington Navy Yard, 1322 Patterson Ave SE, Suite 3000, Washington DC 20374-5066.

c. PFRs that cite to the basis for relief in a (1) through a (3) above, without justification or additional supporting evidence in the PFR, will not be considered to have met threshold requirements for consideration. Members are encouraged to consult with their Physical Evaluation Board Liaison Officer (PEBLO) or military counsel for assistance in filing a PFR.

d. When a PFR appeals a LOD/M determination, the DIRNCPB may make a final LOD/M decision in the matter, or, when appropriate, designate the matter as a special interest case, under paragraph 3105 for referral to ASN (M&RA).

5002 Who May Petition

Requests for relief on the grounds set forth in paragraph 5001 above may be made by the individual concerned or by legal representative or counsel.

5003 Format

No particular format is required. However, a petition must be in writing, set forth the grounds for requesting relief, and state the relief desired. If a petition is based upon evidence which is not on record in the Department of the Navy, forward the evidence upon which it is based as an enclosure.

5004 Where To File

a. For Members Who Have Not Been Discharged Or Separated. Make requests for relief by Petition For Relief to the Director, Naval Council of Personnel Boards, 720 Kennon Street SE, Suite 309, Washington Navy Yard, Washington, DC 20077-5513.

b. For Members Who Have Been Discharged Or Separated. Make requests for relief by Petition, using DD form 149, to the Board for Correction of Naval Records (BCNR), 2 Navy Annex Washington, DC 20370-5100.

5005 Time Constraints

a. File a Petition For Relief within 15 calendar days of the receipt of a Findings Letter. In that members are normally separated within 4 – 6 weeks of the date the President, PEB, issues the Notification of Decision, members should not delay in preparing and filing such a petition. Submit all requests for extensions for submitting PFRs in writing directly to the DIRNCPB. Include a statement detailing the reason an extension is necessary, the length of the extension, the date the Formal PEB hearing was held, and the date the member received the findings.

b. File Petitions to the BCNR in accordance with time limitations issued by that Board.

c. DIRNCPB will normally adjudicate a case within 45 days of PFR receipt.

5006 Principles Employed When Acting On A PFR

Action taken on PFRs by the DIRNCPB submitted in accordance with paragraph 5001 will not result in an adverse finding for the member and are subject to the following guidance:

a. The final physical disability percentage rating assigned by the PEB under the Informal PEB/Formal PEB process is final and cannot be reduced unless the member/former member is offered an additional appearance before a Formal PEB whose

members have not previously ruled on the case. PFRs whose content contains demonstrable fraud will be referred to the NCIS at DIRNCPB's option.

b. A determination that material error has occurred during the PEB process cannot be used to reduce the member's assigned physical disability percentage rating, but the error will be noted and can be used to offset any increase in the physical disability rating which might result from the presentation of new evidence, fraud, or mistake of law submitted by the member in the PFR.

c. The DIRNCPB may direct a realignment of a diagnosis, or a finding of Fit/Physically Qualified (not to include PRESUMPTION OF FITNESS). These findings/determinations are not adverse and do not require offering the member another formal board before they can be implemented.

5007 – 5099 Reserved

ENCLOSURE 6: PERMANENT LIMITED DUTY (PLD) PROCEDURES

6001 Continuance On Active Duty Of Physically Unfit

a. General policy is that any service member found to be Unfit to continue naval service by reason of physical disability to perform the duties of his or her office, grade, rank, or rating will be retired or separated. However, as an exception to this general policy, and consistent with the guidance in this enclosure, when CHNAVPERS or CMC (M&RA) determine that a need for a service member's skill or experience justifies the continuance of that service member on active duty or in active status in a limited assignment, the service member may be retained on active duty or in active status for a specified period of time. Such status is known as Permanent Limited Duty (PLD).

b. A service member who is continued on active duty or in active status in accordance with this enclosure, will be granted disability benefits upon final retirement or separation if eligible and if the disability is still present to a disabling degree.

6002 Limited Assignment

The term "limited assignment" means assignment with appropriate limitations based on the specific disabilities in each case. Specific limitations on duty assignments for members classified as PLD are contained in the Navy and Marine Corps personnel manuals.

6003 Authority To Retain

CHNAVPERS and CMC (M&RA) may retain on active duty in a PLD status, Unfit to continue naval service members who meet the following criteria. Each case shall be individually considered. The member's length of service is not controlling in PLD decisions.

a. Subject to the limitations in subparagraphs (e) and (f), the disabling physical condition must basically be stabilized or one in which accepted medical principles indicate a slow progression of the disabling impairment. The member also must be able to maintain himself or herself in a normal military environment, without adversely affecting his or her health or the health of other members.

b. Unfit to continue naval service members may be retained to complete service obligations for education or training. See paragraph 6006 of this instruction.

c. Unfit to continue naval service members may be retained to meet shortages against authorized strength in an enlisted skill, competitive category, designator or specialty, or a military occupational field or specialty, provided they can perform required duties in an authorized billet for that skill.

d. Unfit to continue naval service members may be retained to complete a current tour of duty or to provide continuity in key billets pending relief.

e. Unfit to continue naval service members may be retained in a PLD status for a specified period of time, at the request of a commanding officer of a medical treatment

facility (MTF), to meet the need for that specific type of condition in a graduate medical education program at a specific MTF that cannot be met at that MTF by other authorized means and is essential to maintaining program accreditation. Unfit to continue naval service members may also be retained for MTF-specific medical research protocols. In each case, the request for retention must be documented fully to demonstrate the essentiality and must be approved by the CHBUMED and the CHNAVPERS or CMC (M&RA), as applicable.

f. CHNAVPERS or CMC (M&RA) shall establish the termination date of the PLD period when authorizing PLD.

6004 Retirement Eligible Members

Members with over 20 years of active service shall not be continued on active duty solely to increase their monetary benefits, nor shall they be continued unless their employment is justified as being of value to the naval service under the criteria in paragraph 6003.

6005 Inactive-Duty Reservists

a. There is no PLD status for inactive-duty reservists.

b. Those inactive-duty reservists who have been found Not Physically Qualified for continued naval service and who have 18 but less than 20 satisfactory years for retirement may be retained in the Individual Ready Reserve (IRR). While in the IRR, the member may complete correspondence courses until attaining 20 qualifying years for retirement or reaching age 63, whichever occurs first.

6006 Retention In PLD Status To Complete Service Obligation

CHNAVPERS and CMC (M&RA) may retain Unfit to continue naval service members on active duty in a PLD status for the period required to complete their active service obligation for:

a. Enlisted education and training, including Enlisted Education Advancement Program, initial and advanced skill training schools which require obligation beyond initial enlistment contract, nuclear power field, advanced electronic field, and advanced technical field programs and similar programs. CHNAVPERS or CMC (M&RA) may waive this requirement on a case by case basis when, as the result of a disabling condition, there is no billet in which disabled members can adequately perform the required duties.

b. Funded education programs including Naval Academy, NROTC, Armed Forces Health Professions Scholarships, Uniformed Services University of Health Sciences and equivalent funded education programs; advanced education or technical training requiring additional obligated service, including postgraduate education, service school or college, law school, medical residency (including fellowships), flight training, naval flight officer training, and equivalent programs. ASN (M&RA), or CHNAVPERS or CMC (M&RA) as delegated by ASN (M&RA), may waive the requirement in cases in which, as a result of the disabling condition, there is no billet in which the disabled officer can adequately perform the required duties.

6007 Voluntary Retention

CHNAVPERS and CMC (M&RA) also may, upon a member's request, particularly from a member with over 18 years but less than 20 years of active service, retain Unfit to continue naval service members in a PLD status when such retention is consistent with the guidance in paragraph 6003 and is in the best interests of the service and the individual.

6008 Requesting PLD Status

a. Those members found Unfit by either the Informal or Formal Board who desire to continue on active duty may submit a request in writing, with command endorsement, via their PEBLO and the President, PEB, to either CHNAVPERS and CMC (M&RA), as appropriate, who will make the final determination on such request. Unfit members have one opportunity to submit this request. Requests will identify specific reasons for remaining on active duty and shall follow the format outlined in attachment (a) to this enclosure. The member has 15 calendar days from initial notification of informal findings or receipt of formal findings to make their election of options. PLD request with command endorsement must also be generated during this 15-day timeframe. Members must submit PLD requests, endorsements, along with the Election of Options form, via their PEBLO or Counsel, and the President, PEB, for final approval by CHNAVPERS or CMC (M&RA). Failure to do so within the prescribed period may result in finalization of the member's case by the PEB without appropriate consideration of the PLD request. Finalization of a member's case by the President, PEB does not preclude further action by the member's command with service headquarters.

b. For PLD requests where the member has been found Unfit, the endorsement provided by the President, PEB will state whether or not the requesting member's retention in a PLD status would jeopardize the member's health or safety, or that of others.

c. If a member's condition overcomes the PFIT rule, the only reason PLD would be considered for positive endorsement to service headquarters by the PEB would be for the member to continue treatment for the condition for which the member overcame PFIT.

6009 Action By President, PEB Following Decision Concerning PLD Status

a. PLD Authorized. When CHNAVPERS or CMC (M&RA) authorizes PLD for Unfit to continue naval service members, the President, PEB, shall take the following actions:

(1) For PLD of 12 months or less: the President, PEB, shall, in the Notification of Decision letter, direct the PLD authorized, and effective the day following the last day of the PLD, the appropriate separation and the percentage of disability from the Findings Letter.

(2) For PLD of more than 12 months: the President, PEB, shall, in the Notification of Decision letter, direct the authorized period of PLD, advise that disability separation and disability rating will be deferred until the end of the period of PLD, and require that the member be again referred to the DES for reevaluation as set forth in paragraph 6011.

b. PLD Not Authorized. If CHNAVPERS or CMC (M&RA) does not authorize PLD, the President, PEB shall complete normal processing of the case.

6010 Monitoring Members Retained On PLD

An Unfit to continue naval service member continued in a PLD status shall be closely observed to assure that further continuance, or conversely separation, is consistent with the best interests of the service and the member. When, in the opinion of a member's commanding officer, the member has become unable to perform his or her duties in the limited assignment, the member shall be referred to an MTF for observation, treatment, and appropriate disposition. Unless the disqualifying condition has progressed to a point at which the member is no longer able to perform duty with limitations, the member shall complete the PLD period.

6011 Expiration Of PLD Status

a. All members continued in PLD status for a period in excess of 12 months shall be currently examined and again referred to the DES for reevaluation. Reevaluations should be received by the PEB a minimum of 4 months before the completion of the PLD period or at such time as the PLD is otherwise terminated. New conditions will be evaluated and addenda submitted with the final reevaluation. Reevaluations should include at a minimum, a new medical board report with medical board report cover sheet NAVMED(6100/1), associated medical board statement of patient NAVMED(6100/2), and health record entries since dictation of original medical board placing member in a PLD status. Members will be rated under the VASRD criteria in effect at the time of their final reevaluation. Members may not request additional periods of active duty upon expiration of their originally approved PLD period.

b. In those cases where, upon reevaluation, the member's disability rating changes from their initial rating when placed on PLD, the member shall be afforded the opportunity to request reconsideration or a Formal PEB. The President, PEB shall determine whether reconsideration or a Formal PEB is appropriate on a case-by-case basis. If the member's rating doesn't change upon reevaluation there is no right to a Formal PEB. When a member returns for re-evaluation at the end of his/her PLD, any new and unrelated conditions listed and addressed will be subject to the "presumed fitness" rule and will have to overcome presumed fit in order to be rated.

6012 – 6099 Reserved

Attachment (a) to Enclosure (6)

SAMPLE REQUEST FOR PERMANENT LIMITED DUTY

Date _____

From: _____

To: Commander, Naval Personnel Command (PERS-821) or
Commandant of the Marine Corps (MMSR-4)

Via: (1) Commanding Officer/Medical Holding Company OIC
(2) President, Physical Evaluation Board

REQUEST FOR PERMANENT LIMITED DUTY

Ref: (a) SECNAVINST 1850.4E

Encl: (1) Preliminary/Reconsidered/Formal Findings of the PEB

1. Upon receipt and review of enclosure (1) and per reference (a), I hereby request Permanent Limited Duty for the reason(s) listed below. I understand that the final determination will be made by the appropriate service headquarters, and that the decision is made on a case-by-case basis.

- a) _____ To achieve 20 years of active service and be otherwise qualified for retirement.
- b) _____ To complete a service obligation (initial/advanced skill training school, funded education program, etc) until _____ (day/month/year).
- c) _____ Other valid personal/professional/medical reasons until _____ (day/month/year) (If for specific medical research protocol, endorsement must come via CO, MTF):

SIGNATURE

ENCLOSURE 7: OFFICER DISABILITY REVIEW BOARD (ODRB) PROCEDURES

PART 1 - DOCUMENTARY REVIEWS AND GENERAL BOARD REQUIREMENTS

7101 Introduction And Establishment

a. 10 U.S.C. 1554 empowers and directs the Secretary of the Navy (SECNAV) to establish a board to review a limited class of disability cases wherein officers were retired or released from active duty without pay for physical disability. The Officer Disability Review Board (ODRB) hereby is established by the SECNAV as that statutory board to render opinions in such cases in which an affected officer requests review of the findings and decisions of a retiring board, board of medical survey, or disposition board. Forward ODRB advisory opinions and recommendations to SECNAV for final decision.

b. In performing its responsibility, the ODRB shall be guided by the Navy disability evaluation instructions effective at the time of the contested action as well as by statutes and directives of higher authority.

7102 Oversight

The ODRB shall function as an element of the Naval Council of Personnel Boards. The DIRNCPB shall exercise oversight and administrative control of the ODRB.

7103 Functions

a. To meet on an ad hoc basis, under 10 U.S.C. 1554, to review the cases of officers who have been retired or released from active service without pay for physical disability and to provide recommended findings regarding their fitness and disposition;

b. To evaluate on the basis of documentary review, or formal hearing attended by a petitioner and/or his or her counsel:

(1) the physical fitness of an officer petitioner for active duty;

(2) if found Unfit, the percentage of disability of the petitioner at the time of the officer's separation from active duty, or at the time of removal from the Temporary Disability Retired List (TDRL); and

(3) the entitlement to disability severance or retired pay of a petitioner at the time of separation from active duty, or at the time of removal from the TDRL.

7104 Board Composition

The board constituted to act in a given case shall be composed of five career military officers, selected on the basis of wide medical and/or military experience, proven performance and education.

a. President, ODRB shall be a Navy or Marine Corps line officer in the grade of 0-6 or above.

b. Two of the remaining officers shall be of the Medical Corps in the grade of 0-5 or 0-6 with preference given to the latter.

c. Individual membership may vary within the limitations of the prescribed composition.

d. When the petitioner is or was a member of the Navy or Marine Corps Reserve, at least one member of the board shall be a member of the Navy or Marine Corps Reserve.

7105 Appointment of Officers

Officers to constitute the ODRB, if not available at the Naval Council of Personnel Boards, shall be made available by CHNAVPERs, CMC (M&RA), and CHBUMED.

7106 Convening

a. Upon petition to the DIRNCPB by an officer retired or released from active duty without pay for physical disability, DIRNCPB shall designate and appoint the membership of the ODRB.

b. The petition for review shall contain a request for a documentary or formal hearing; a statement identifying the board whose error is sought to be corrected; a statement identifying the error(s) in the finding or decision; and the relief requested.

7107 Recorder

A Recorder for a board shall be designated by the DIRNCPB in the convening order. The Recorder may be a commissioned officer or a civilian employee of the government.

7108 Conflict of Interest/Recusal

No member or counsel of the board may have a personal interest in or have been a member of another board that ever considered the case under consideration. See paragraph 3108 for further guidance.

7109 Adequate Information

The board shall ensure that it has before it, within a reasonable time frame, all information necessary for competent review and opinion. The CHBUMED shall provide medical assistance upon request of the board. The board shall afford a petitioner a reasonable amount of time to provide evidence outside Navy possession.

7110 Scheduling

Hold documentary reviews or hearings within 30 days, and issue a report within 45 days of receipt of the case for review. Issue notification of formal hearings by mail to all concerned at least 30 days in advance of the hearing.

7111 Types of Board Meetings

ODRB shall provide advisory opinions on the basis of formal, personal appearance hearings, unless waived by the petitioner, in which case a documentary review shall be conducted.

7112 Content Of Opinions

The Board shall render advisory opinions, in a letter report, as to whether:

- a. the petitioner was, at the time of separation or retirement from the naval service, Fit to continue naval service or Unfit to continue naval service because of physical disability;
- b. if the petitioner was Unfit, such disability (was) (was not) (incurred) (aggravated) while the petitioner was entitled to receive basic pay;
- c. such disability (was) (was not) the result of intentional misconduct or willful neglect, and whether such disability (was) (was not) incurred during a period of unauthorized absence;
- d. whether:
 - (1) such disability (was) (was not) the proximate result of active duty (because of aggravation, when applicable), or
 - (2) such disability (was) (was not) incurred in line of duty, in time of war or national emergency, or
- e. accepted medical principles indicate that such disability (is) (may be) permanent; and
- f. such disability was ratable at (percentage) in accordance with the Veterans Administration Schedule for Rating Disabilities (VASRD) in effect at the time of retirement or separation .
- g. If a prior Navy board (PEB, BCNR, etc...) is being reviewed as part of a case, a statement as to whether the decisions or recommendations of the board being reviewed are affirmed or reversed.

7113 Basis Of Opinions

In arriving at its opinions, the Board shall comply with:

- a. applicable statutes and directives in effect at the time of the contested separation or retirement without disability benefits; and
- b. the VASRD in effect at the time of the contested separation or retirement without disability benefits.

7114 Majority Vote.

Advisory opinions shall be formulated by vote of a simple majority of the five members.

7115 Signatures.

Advisory opinions of the Board shall be signed by the President, ODRB and the Recorder. See paragraph 7016.

7116 Minority Opinions.

If there is a minority vote, include a minority rationale in the record of proceedings. A minority rationale shall be signed by the member or members so voting.

7117 Documentary Reviews.

In connection with each review, the board shall consider:

- a. medical board reports and associated documents, together with endorsements of convening authorities and statements and medical evidence of petitioners;
- b. line of duty/misconduct investigations, when applicable;
- c. statements of service supplied by CHNAVPERs or CMC (M&RA);
- d. reports of physical examination;
- e. reports of special consultations, when applicable;
- f. fitness reports;
- g. statements of the petitioner, his or her counsel, guardian, or other witnesses (formal hearings); and
- h. any other pertinent matters.

7118 Oaths

- a. Members. Members of the Board shall be sworn as follows:

"Do you _____, _____, _____, _____, and _____ solemnly swear (or affirm) that you will honestly and impartially review and report upon the case(s) now before the Board and about to be reviewed. (So help you God)."

- b. Recorder. The Recorder shall be sworn as follows:

"Do you _____ solemnly swear (or affirm) that you will keep a true record of the proceedings of this Board in the case(s) before the Board and about to be reviewed."

- c. Reporter. The Reporter shall be sworn as follows:

"Do you _____ solemnly swear (or affirm) that you will faithfully perform the duties of reporter in aiding the recorder to take and record the proceedings of the Board."

d. Witnesses . A witness to be sworn appearing before the Board shall be sworn as follows:

"Do you _____ solemnly swear (or affirm) that you will make true answers to such questions as may be put to you in the case of _____ now before the Board."

e. Challenged Member. Any member of a board who is challenged shall be sworn by Counsel for the Board as follows:

"Do you _____ solemnly swear (or affirm) that you will answer truthfully to the questions touching upon your competency to serve as a member of the Board in this case. So help you God."

7119 Recording The Proceedings Of Documentary Reviews.

Record the proceedings in summary form.

7120 – 7199 Reserved

PART 2 - FORMAL ODRB HEARINGS

7201 Legal Counsel

a. An officer of the Judge Advocate's General Corps shall be assigned by the Commanding Officer, Naval Legal Service Office, North Central, Washington Navy Yard, when a formal hearing is conducted. The officer shall function as Counsel for the Board.

b. The petitioner may be represented by civilian counsel, provided by the petitioner, at no expense to the government.

7202 Conduct Of Formal ODRB Hearings

a. Open Sessions. Conduct formal hearings in open session unless, in the opinion of the President, ODRB, an open session would be prejudicial to the objective of attaining a full and fair hearing, or a closed hearing is requested by the petitioner.

b. Interlocutory Issues. The President of the Board shall rule on all interlocutory issues except challenges. His or her rulings may be objected to by other board members, in which case the matter will be decided by a majority vote of the members in closed session.

c. Recesses and Continuances. The President of the Board may recess or grant a continuance where good cause is shown.

d. Presiding Officer . The President of the Board shall preside over all sessions and shall speak for the Board in announcing recommended findings and the result of any interlocutory vote.

e. Decorum. Board sessions shall be conducted with dignity and decorum and with the objective of eliciting all facts bearing on a case.

7203 Administration Of Oaths

Once a formal hearing has been called to order by the President, the Legal Counsel for the board shall administer any required oaths.

7204 Evidence At Formal ODRB Hearings

a. Before taking testimony, Legal Counsel for the Board shall, for the record, present all papers pertaining to the case to the Board in open session. These documents may be inspected by the petitioner and Counsel. The petitioner or Counsel may cross-examine the author of a document, record, or statement by calling the author as a witness, if reasonably available, or by taking a deposition.

b. The ODRB shall consider all documentary evidence transmitted to it by proper authority. The Board, in addition, may require and examine such records as may be in the files of the Department of the Navy that relate to the issues before the Board. All evidence

tendered to the Board having probative value as to the determination of issues before the Board shall be considered. In consideration of the weight or probative value to be accorded evidence, the members of the Board are expected to utilize their background and experience, their common sense, and their knowledge of human nature and behavior. In every case, the testimony of the petitioner concerned shall be considered in connection with all evidence adduced and given such weight as the Board may believe it merits. When the testimony presented at the hearing indicated that the petitioner claims to have disabilities not disclosed by the official medical records or presents evidence sharply in conflict with official medical records, and the issue thus drawn is not one that can be readily resolved by the observation of the Board, there shall be further development of the case by requesting further physical examination, special studies, or further investigation by appropriate agencies; and the hearing shall be adjourned until such development has been accomplished. Recommended findings of the Board shall be based upon evidence consistent with a reasonable probability of truth.

c. A petitioner at a formal hearing before the ODRB shall be permitted to introduce witnesses, depositions, documents, sworn or unsworn statements, or other evidence in their behalf and to question all other witnesses who testify at the hearing.

d. A petitioner may make oral or written arguments personally and through Legal Counsel.

e. A petitioner may elect not to offer evidence or testimony.

f. A petitioner may not be required to make any statement touching upon circumstances surrounding the origin or aggravation of any disease or injury (10 U.S.C. 1219).

g. A petitioner, subject to (e) and (f) above, may be questioned by members of the Board regarding evidence or testimony submitted.

h. Testimony of witnesses will be taken under oath or affirmation unless otherwise requested by the petitioner, Legal Counsel, or trustee (guardian).

7205 Objections

Objections may be made to any action (other than a challenge) taken or proposed to be taken by the Board, as well as to the admission of evidence. Objections are recorded as part of the proceedings. The Board must note in the record its ruling on any objections that may be offered. Ordinarily, the objections are passed upon by the President of the Board. However, if any other member dissents from the President's ruling, the objection is ruled upon by the Board in closed session. The ruling is the decision of the majority of the Board and is announced on the reopening of the hearing.

7206 Challenges

a. Any member of the Board may be challenged for cause at any time during the hearing. The Board will not receive a challenge to more than one member at a time. After

disclosing grounds for challenge, the petitioner may examine the challenged member. Counsel for the Board may cross-examine the challenged member. After such examination and cross-examination, any other evidence bearing on the member's Fitness to serve shall be heard.

b. The burden of sustaining the challenge is on the person who made the challenge. The challenged member shall withdraw when the Board is closed to vote upon the challenge. A tie or majority vote is sufficient to sustain the challenge. The Board shall decide the challenge according to the preponderance of the evidence. When a challenge reduces the Board below the required number of members, alternate members will be called by the President of the Board, or the senior remaining member, if the President is removed as a result of a challenge.

7207 Recording Proceedings And Transcript Requirements

Record the entire hearing, and prepare a verbatim transcript

7208 Record Of Proceedings

- a. Record votes of individual members in the report of proceedings.
- b. The record of proceedings shall include copies of the appointing order and any other communications from the convening authority. Where a formal hearing was conducted, include a verbatim transcript. A transcript of the proceedings is not required in the case of a documentary review. Include the advisory opinions of the Board, together with documents, testimony and other information presented to the Board for its consideration.
- c. Assemble documents constituting the remainder of the record of proceedings, if applicable, as follows:
 - (1) ODRB letter of transmittal with record of proceedings (formal) or (documentary review);
 - (2) Notification to petitioner of formal hearing;
 - (3) Rights letter to petitioner;
 - (4) SECNAV action;
 - (5) Any PEB actions;
 - (6) Medical Board Report (with copy of Health Record and Clinical Record);
 - (7) NAVMED 6100/2 - Statement of Patient concerning findings of medical board;
 - (8) Line of Duty Investigation with endorsements;

(9) Statement of Service.

- d. The President of the Board and the Recorder shall sign the record of proceedings.
- e. The President of the Board shall initial any corrections to the proceedings and advisory opinions.
- f. Provide a copy of the record of proceedings to the petitioner and his or her Counsel.

7209 Transmittal of Proceedings

In both documentary reviews and formal hearings, transmit the record of proceedings to the Judge Advocate General for review and for further forwarding to the Secretary of the Navy (ASN (M&RA)) for resolution.

7210 – 7299 Reserved

ENCLOSURE 8: MEDICAL CONDITIONS AND PHYSICAL DEFECTS WHICH NORMALLY ARE
CAUSE FOR REFERRAL TO THE PHYSICAL EVALUATION BOARD (PEB)

8001 General

a. This enclosure provides a listing, mainly by body system, of medical conditions and physical defects which are cause for referral into the Disability Evaluation System (DES). The major objective of the list is to achieve uniform disposition under the law.

(1) This listing is not all-inclusive.

(2) A service member who has one or more of the listed conditions or physical defects is not automatically Unfit and therefore may not qualify for separation or retirement for disability .

b. In modifying these guidelines, SECNAV will consider conditions and defects not listed in this enclosure which justify referral of an individual to the PEB because the conditions or defects, individually or in combination:

(1) significantly interfere with the reasonable fulfillment of the purpose of the individual's employment in the military service ;

(2) may seriously compromise the health or well-being of the individual if he or she were to remain in the military service . This may involve dependence on certain medications, appliances, severe dietary restrictions, or frequent special treatments, or a requirement for frequent clinical monitoring;

(3) may prejudice the best interests of the Government if the individual were to remain in the military service .

c. Physicians who prepare MEB reports and TDRL periodic physical examinations for referral for physical disability evaluation are encouraged to use the DVA's Physician's Guide for Disability Evaluation Examinations to describe the nature and degree of severity of the functional impairment consequent to each of the member's conditions.

d. Any drug therapy which in and of itself presents significant medical hazards or potential significant complications and/or requires frequent monitoring may render a member Unfit even if the condition in and of itself does not. This treatment may preclude the full performance of duties.

e. Any condition that appears to significantly interfere with performance of duties appropriate to a service member's, office, grade, rank or rating will be considered for MEB evaluation. The MEB shall conform to the following general requirements:

(1) confirm the medical diagnosis(es).

- (2) document the service member's current medical condition to include treatment status and potential for medical recovery.
 - (3) review each case based on relevant facts.
 - (4) contain evaluation procedures and/or data of special importance to the assessment process.
 - (5) follow the suggested annotated format for the MEB report in attachment (a) of this enclosure.
 - (6) refer to the PEB if optimal medical treatment has been received in accordance with service specific guidelines.
 - (7) document how the member's condition impairs his/her ability to perform their duties.
- f. Whenever possible, members should be placed on LIMDU for an appropriate period of time before determining that a medical board report should be forwarded to the PEB for adjudication.
- g. Although not specifically mentioned after each of these illnesses/injuries, the physician should be aware that the presence of the condition alone is often not a criteria for submission of a MEB report - the member must have been tried on appropriate courses of medication (and proper use of LIMDU status), been unresponsive to them, and required untoward number of visits for medical care or hospitalizations. Just as importantly, the condition must have resulted in an impairment of the ability to perform the duties as a member of the DON. The physician writing the MEB report must document how a certain condition constitutes an impairment.

8002 Musculoskeletal System

a. Upper Extremity

- (1) The ability to pinch, grasp, or grip is prevented by disease, residuals of disease, acute injury, or chronic residuals of acute injury to the hand or fingers.
- (2) Amputation of a part or whole of the upper extremity. Amputation of part or parts of an upper extremity which results in impairment equivalent to the loss of use of a hand.
- (3) Recurrent dislocation (not subluxation) when not surgically correctable.
- (4) Ranges of Joint Motion (ROM): Motion that is less than the measurements listed below. Measurements should be validated by three measurements that agree at the 5 percent level. The measuring instrument should be noted. Both active and

passive ROM should be listed. When a normal paired extremity is present a comparison of the ROM of the normal to the impaired extremity should be included (See plate I).

(a) Shoulder: Flexion (forward elevation) or abduction to at least 90 degrees.

(b) Elbow and/or Forearm: Flexion to 100 degrees or extension to 60 degrees. Pronation and/or Supination arc to at least 80 degrees.

(c) Wrist: At least 15 degrees flexion plus extension total.

(d) Hand: The motion at each of the three finger joints, when added together, must reach 135 degrees of active flexion or 75 degrees of active extension, in two or more fingers of the same hand. The thumb must be able to be opposed to at least two fingertips.

b. Lower Extremity

(1) Disease, residual of disease, acute injury, or residual of injury that interferes with ambulation or the wearing of military shoes and/or boots for a period in excess of 180 days.

(2) Any documented condition that precludes the ability to run or walk without a perceptible limp.

(3) Shortening of an extremity that exceeds 2 inches (5 cms).

(4) Feet. Any condition that prevents walking, running, or normal weight bearing.

(a) Hallux valgus: When moderately severe, with exostosis or rigidity and pronounced symptoms; or severe with arthritic changes.

(b) Pes Planus, Symptomatic: When more than moderate, with pronation on weight bearing that prevents the wearing of a military shoe, or when associated with vascular changes.

(c) Talipes Cavus: When moderately severe, with moderate discomfort on prolonged standing and walking, metatarsalgia, that prevents the wearing of a military shoe.

(5) Knee. Internal derangement of the knee when there is residual instability following remedial measures such as surgery or physical therapy.

(6) Joint Ranges of Motion (ROM). Motion that is less than the

measurements listed below. Measurements should be validated by three (3) measurements that agree at the 5 percent level. The measuring instrument should be noted. Both active and passive ROM should be listed. When a normal paired extremity is present a comparison of the ROM of the normal to the impaired extremity should be included (See plate II).

(a) Hip: Flexion to 90 degrees, or extension to 0 degrees.

(b) Knee: Flexion to 90 degrees, or extension to 15 degrees.

(c) Ankle: Dorsiflexion to 10 degrees, or plantar flexion to 10 degrees.

(7) Amputations

(a) Loss of a toe or toes which precludes the ability to run or walk without a perceptible limp, or to engage in fairly strenuous jobs.

(b) Any loss greater than that specified above to include foot, leg, or thigh.

c. Inflammatory Conditions. Any inflammatory condition involving the bones , joints, or muscles of the extremities that, after accepted therapy, prevents the military member from performing the preponderance of duties assigned.

(1) Arthritis

(a) Arthritis due to infection associated with persistent pain and marked loss of function, with X-ray evidence, and documented history of recurrent incapacity.

(b) Arthritis due to trauma . When surgical treatment fails or is contraindicated and there is functional impairment of the involved joint which precludes the satisfactory performance of duty.

(c) Osteoarthritis. When severe symptoms are associated with impairment of function, supported by X-ray evidence and documented history of recurrent incapacity for prolonged periods.

(d) Rheumatoid arthritis or rheumatoid myositis. If the history of repeated incapacitating episodes is supported by objective and subjective findings .

(2) Chondromalacia or Osteochondritis Dessicans. Severe, manifested by frequent joint effusion, more than moderate interference with function or with severe residuals from surgery.

d. Prosthetic Replacement. Total or partial prosthetic replacement of a major joint; i.e., hip, knee, shoulder.

e. Muscles. Atrophy of, loss of substance of, direct injury to (or residuals thereof) one or more muscles or muscle groups that prevents satisfactory use of the upper or lower extremity. (Does not include muscular changes secondary to neurological disorders. Refer to section on the Nervous System.)

f. Tendon and/or Ligament Transplantation. If restoration of function is not sufficient to adequately perform the preponderance of duties required.

g. Fractures

(1) Malunion. When, after appropriate treatment, there is more than moderate malunion with marked deformity or there is more than moderate loss of function.

(2) Nonunion. When it persists after an appropriate healing period with more than moderate loss of function.

(3) Bone fusion defect. When manifested by more than moderate pain or loss of function.

(4) Callus, excessive, following fracture. When functional impairment precludes satisfactory performance of duty and the callus does not respond to adequate treatment.

h. Joints

(1) Arthroplasty with severe pain, limitation of motion and limitation of function, joint prosthesis or total joint replacement.

(2) Bony or fibrous ankylosis with severe pain involving major joints or spinal segments, or ankylosis in unfavorable position, or ankylosis with marked loss of function.

(3) Contracture of a joint with marked loss of function and the condition is not remediable by surgery.

(4) Loose bodies within a joint with marked functional impairment complicated by arthritis to such a degree as to preclude favorable results of treatment.

i. Miscellaneous

(1) Myotonia Congenita. Significantly symptomatic and precluding the satisfactory performance of duty.

(2) Osteitis Deformans. Involvement of single or multiple bones with resultant deformities, or symptoms severely interfering with function.

(3) Osteoarthropathy, Hypertrophic, Secondary. More than moderate pain present in one or multiple joints and with at least moderate loss of function.

(4) Osteomyelitis, Chronic. Recurrent episodes not responsive to treatment, and involving the bone to a degree which interferes with stability and function.

j. Spine

(1) Congenital Disorders. When more than mild symptoms cause a deterioration in performance of required duties or if fusion is required, resulting in loss of mobility. Examples are Spina Bifida, Coxa Vara, Spondylolysis, Spondylolisthesis, Kyphosis, Scoliosis.

(2) Acquired Disorders

(a) Fractures requiring spinal cord decompression with residual neurological deficit or loss of mobility due to fusion.

(b) Spondylolysis and/or Spondylolisthesis requiring fusion with loss of mobility.

(c) Herniated nucleus pulposus when more than mildly symptomatic with demonstrated neurological involvement; or subsequent surgical treatment does not provide symptomatic relief sufficient for performance of duties.

(d) When reporting on compression (or other) fractures that have "demonstrable deformity" the medical board must realize that this refers to a physical deformity, not a radiological one.

(e) Deviation or Curvature of Spine. More than moderate, or interfering with function, or causing unmilitary appearance.

k. Skull. Significant loss of substance without prosthetic replacement, or with prosthetic replacement in the presence of significant residuals.

l. Fibromyalgia. This condition must meet the criteria as put forth by the American College of Rheumatology (current edition). The diagnosis must be made by a rheumatologist and it is preferable that the MEB report be dictated by a rheumatologist when Fibromyalgia is the diagnosis. A psychiatry addendum must accompany any MEB submitted for fibromyalgia.

m. Tendon/Ligament Transplant. Unsatisfactory restoration of function, significantly interfering with the satisfactory performance of duty.

n. Muscles. Flaccid paralysis, spastic paralysis, or loss of substance of one or more muscles producing loss of function that precludes satisfactory performance of duty. Atrophy of, loss of substance of, direct injury to (or residuals) one or more muscles or muscle groups that prevents satisfactory use of the upper or lower extremity. Does not include muscular changes secondary to neurological disorders. Refer to section on the nervous system.

8003 Organs Of Special Senses

a. Eyes

(1) Eye Disease. Active eye disease or any progressive organic disease or degeneration, regardless of the stage of activity, that is resistant to treatment and affects the distant visual acuity or visual fields such that distant visual acuity is significantly affected or the field of vision of the better eye is less than 40 degrees. (See "Visual Acuity" below.)

(2) Visual Acuity

(a) Visual acuity that cannot be corrected with ORDINARY SPECTACLE LENSES, to at least 20/40 in one eye and 20/100 in the other eye, or 20/20 in one eye and 20/400 in the other eye, or

(b) Eye has been enucleated,

(c) When vision is correctable only by the use of contact lenses or other specified corrective devices (telescopic lenses, etc.).

(3) Aniseikonia. With subjective eye discomfort, neurologic symptoms, sensations of motion sickness, functional difficulties and difficulties in distinguishing forms, and not corrected by standard optical lenses.

(4) Binocular Diplopia. Which is severe, constant, and in zone less than 20 degrees from the primary position and not surgically or optically correctable.

(5) Bilateral Hemianopsia. Any type that is permanent, and based on an organic defect. Those due to functional neurosis and those due to transitory conditions, such as periodic migraine, are not normally considered to render an individual Unfit.

(6) Night Blindness. Of such a degree that precludes unassisted night travel.

(7) Visual Fields

(a) Visual fields with bilateral concentric constriction to less than 40 degrees.

(b) Visual field in better eye is less than 40 degrees.

(8) Aphakia, Bilateral

(9) Chronic Congestive (Closed Angle) Glaucoma or Chronic Non-congestive (Open Angle) Glaucoma. If well established with demonstrable changes in the optic disk or visual fields, or not amenable to treatment.

(10) Diseases and Infections of the Eye. When chronic, more than mildly symptomatic, progressive and resistant to treatment after a reasonable period.

(11) Ocular Manifestations of Endocrine or Metabolic Disorders. Not disqualifying per se; however, residuals or complications, or the underlying disease may render a service member Unfit.

(12) Residuals or Complications of Injury. When progressive, or when reduced visual acuity or fields do not meet the criteria of paragraphs a, b, or g, above.

(13) Retina, Detachment of

(a) Unilateral Detachment

1. When visual acuity does not meet the standard of paragraph a (2) of this section.

2. When the visual field in the better eye is constricted to less than 20 degrees.

3. When uncorrectable diplopia exists.

4. When detachment results from organic progressive disease or new growth, regardless of the condition of the better eye.

(b) Bilateral Detachment, regardless of etiology or results of corrective surgery.

b. Ears and Hearing

(1) Ears

(a) Otitis Externa, chronic, severe, requiring frequent and prolonged treatment.

(b) Mastoiditis requiring frequent and prolonged treatment; or, subsequent to mastoidectomy there is constant drainage from the mastoid cavity.

(c) Meniere's syndrome or labyrinthine disorders of sufficient severity to interfere with satisfactory performance of duties.

(d) Otitis Media, chronic, resistant to conventional therapy interfering with satisfactory performance of duties and necessitating frequent or prolonged medical care.

(2) Hearing

(a) Unaided hearing loss that adversely affects safe and effective performance of duty.

(b) In the assessment of hearing, when the unaided average loss in the better ear is 35 dB (ANSI) or more in the normal speech range (pure tone audiometric values at the 1000, 2000, 3000, 4000 hertz) the individual will be evaluated at an audiology and speech center. Audiology specialists at the center will recommend referral to a PEB when appropriate. This recommendation may be based on the results of either pure tone audiometry or speech reception threshold and discrimination, whichever in the judgment of the specialists most accurately reflects the degree of the hearing loss.

(c) The MEB report will indicate whether the member is capable of effective performance with a hearing aid.

(d) The MEB report must include:

1. current audiograms (not just the summary);
2. reference audiograms and especially entry audiogram;
3. speech discrimination test results.

8004 Systemic Diseases

a. Definition. Any acute or chronic condition that affects the body as a whole (systemic) and interferes with the successful performance of duty, or requires medication for control, or needs frequent monitoring by a physician, or that requires geographic assignment limitations or requires a temporary limitation of duty exceeding 180 days, or permanent limitation of duty that affects the whole body (systemic).

b. Infectious

- (1) Systemic Mycoses; e.g., Blastomycosis.
- (2) Tuberculosis. Pulmonary or generalized.
- (3) Leprosy.

(4) Systemic sexually transmitted diseases.

(a) Complications or residuals of venereal diseases.

(b) When chronicity or degree of severity is such that the individual is incapable of performing useful duty.

(5) AIDS /HIV Related Illness. Service members confirmed to be HIV antibody positive and who demonstrate immunologic deficiency, neurologic involvement, decreased capacity to respond to infection, or progressive clinical or laboratory abnormalities associated with HIV, which include Acquired Immune Deficiency Syndrome (AIDS). Uncomplicated HIV seropositivity should not result in referral to the PEB, but warrants the convening of a MEB for a public health monitoring purposes in accordance with appropriate regulations.

c. Arthritis

(1) Rheumatoid Arthritis.

(2) Spondyloarthropathy.

(a) Ankylosing spondylitis.

(b) Reiter's Syndrome.

(c) Psoriatic Arthritis.

(d) Arthritis associated with inflammatory bowel disease.

(e) Whipple's disease.

d. Other Systemic Diseases

(1) Amyloidosis.

(2) Sarcoidosis. Progressive, not responsive to therapy or with severe or multiple organ involvement.

(3) Panniculitis. Relapsing, febrile, nodular.

(4) Myasthenia Gravis.

(5) Porphyria cutanea tarda.

(6) Systemic Lupus Erythematosus.

- (7) Sjogren's Syndrome.
- (8) Chronic Fatigue Syndrome.
- (9) Myopathy. Inflammatory, metabolic, hereditary.
- (10) Progressive systemic sclerosis/Scleroderma .
- (11) Systemic vasculitis.
- (12) Hypersensitivity angiitis. Resistant to treatment and more than mildly symptomatic.
- (13) Behcet's Syndrome.
- (14) Adult-onset Still's Disease.
- (15) Mixed connective tissue disease (overlapping syndromes).
- (16) Dermatomyositis and polymyositis.

8005 Respiratory System

a. Upper Airway

(1) Sinusitis. Sinusitis or rhinitis (atrophic), with suppuration, unresponsive to conventional therapy.

(2) Rhinitis. Atrophic rhinitis characterized by bilateral atrophy of nasal mucous membrane with severe crusting, concomitant severe headaches, and foul, fetid odor.

(3) Larynx

(a) Obstructive edema of the glottis requiring tracheostomy.

(b) Vocal cord paralysis seriously interfering with speech or airway.

(c) Stenosis of such a degree as to cause respiratory embarrassment on moderate exertion.

(4) Trachea . Stenosis or narrowing of such a degree as to cause respiratory embarrassment on moderate exertion.

b. Lower Airway. Rating is usually based upon Pulmonary Function Tests (PFTs) measuring residual function. There must be a minimum of one set of PFTs.

(1) Studies should be performed both before and after medication:

(a) When the results of pre-bronchodilator PFTs are normal, post-bronchodilator studies are not required.

(b) In all other cases, post-bronchodilator studies should be done unless contraindicated (because of allergy to medication, etc.) or if a patient was on bronchodilators before the test and had taken his/her medication within a few hours of the study.

(c) A physician who determines that a post-bronchodilator study should not be done in a given case should provide an explanation.

(2) Where warranted, the member should have a methcholine challenge, especially when the original set of PFTs are "normal".

(3) In cases of exercise-induced asthma, PFTs after exercise should be performed.

(4) Infection

(a) Pulmonary Tuberculosis

1. If treatable but more than 15 months will be required before service member can be returned to full duty.

2. Cases unresponsive to therapy.

(b) Histoplasmosis, blastomycosis, toxoplasmosis, or other mycosis not responding to accepted therapy.

(5) Asthma. A clinical syndrome characterized by cough, wheeze, dyspnea and physiological evidence of reversible airflow obstruction or airway hyperreactivity that generally persists over 6 months. Reversible air flow obstruction is defined as more than 15 percent increase in FEV-1 following administration of an inhaled Bronchodilator. Airway hyperreactivity is defined as the exaggerated decrease in airflow induced by a standard methcholine challenge test. Chronic asthma requires the regular use of medication to allow the individual to perform the preponderance of military duties.

(6) Bronchiectasis or bronchiolectasis. Cylindrical or saccular with residuals requiring repeated medical care or moderately symptomatic, with productive cough at frequent intervals throughout the day, or with moderate other associated lung disease to include recurrent pneumonia, or with residuals or complications which require repeated hospitalization.

(7) Bronchitis. Chronic, severe, recurrent unresponsive to repeated medical care.

(8) Atelectasis. Unresponsive to conventional therapy requiring repeated medical care.

(9) Pulmonary Sarcoidosis. Progressive, unresponsive to conventional therapy or complicated by demonstrable moderate reduction in pulmonary function.

(10) Pneumoconiosis. Severe, with dyspnea on moderate exertion.

(11) Cystic disease of the lung.

(12) Pulmonary Emphysema. Resulting in dyspnea on mild exertion and supported by demonstrable moderate reduction in pulmonary function or when present, to at least a moderate degree, as a complication of any other respiratory condition.

(13) Pulmonary Fibrosis. Linear fibrosis or fibrocalcific residuals of such a degree as to cause dyspnea on mild exertion and demonstrable moderate reduction in pulmonary function.

(14) Residuals. Residuals of pneumothorax, hemothorax, empyema, or residuals of operative procedures on the lungs or chest wall.

(a) Hemopneumothorax, Hemothorax, Pyopneumothorax or Chronic Fibrotic Pleurisy . More than moderate restriction of respiratory excursions and chest deformity, or weakness and fatigability on slight exertion.

(b) Surgery of Lungs and Chest. If surgery results in impairment of pulmonary function to a moderate degree or more, as demonstrated by ventilatory tests.

(15) Bronchial Stenosis. Severe stenosis associated with repeated attacks of bronchopulmonary infections requiring frequent hospitalization.

(16) Diaphragmatic Dysfunction. Diaphragmatic dysfunction resulting in dyspnea on minimal exertion, not responsive to therapy.

(17) Lung Transplant

8006 Cardiovascular System

a. General. Evaluation and reporting of cardiovascular function should be in terms of metabolic equivalents (METs) of energy expended to produce a certain level of symptoms.

(1) Objective measurements of the level of physical activity, expressed as METs, at which cardiac symptoms develop is the main method of evaluating cardiovascular entities now.

(2) The exercise capacity of skeletal muscle depends on the ability of the cardiovascular system to deliver oxygen to the muscle, and measuring exercise capacity can, therefore, also measure cardiovascular function. The most accurate measure of exercise capacity is the maximal oxygen uptake, which is the amount of oxygen, in liters per minute, transported from the lungs and skeletal muscle at peak effort. Because measurement of the maximal oxygen uptake is impractical, multiples of resting oxygen consumption (or METs) are used to calculate the energy cost of physical activity. One MET is the energy cost of standing quietly at rest and represents an oxygen uptake of 3.5 milliliters per kilogram of body weight per minute. The calculation of work activities in multiples of METs is a useful measurement for assessing disability and standardizing the reporting of exercise workloads when different exercise protocols are used.

(3) Alternative methods of evaluating function are provided for situations where treadmill stress testing is medically contraindicated – the examiner’s estimation of the level of activity, expressed in METs and supported by examples of specific activities, such as slow stair climbing or shoveling snow that results in dyspnea, fatigue, angina, dizziness or syncope is acceptable.

b. Heart. In assessing the function of the heart, various functional therapeutic classifications (FTC) may be used as standards (New York Heart Association, Canadian Cardiovascular Society, etc.). Each of the cardiac conditions should be given an FTC. See enclosure (9), attachment (b), table (3).

(1) Arteriosclerotic Heart Disease. Associated with congestive heart failure, repeated anginal attacks or objective evidence of myocardial infarction.

(2) Inflammatory

(a) Endocarditis. Resulting in significant residuals (e.g., myocardial insufficiency).

(b) Pericarditis, chronic or repetitive.

(c) Rheumatic Heart Disease.

(d) Syphilitic Heart Disease.

(3) Cardiac Arrhythmias and/or Pacemakers

(a) Supraventricular Arrhythmias. When life threatening or symptomatic enough to interfere with duty performance.

1. Paroxysmal Supraventricular Tachycardia. If associated with organic heart disease or when life threatening or symptomatic enough to interfere with duty performance, if not adequately controlled by medication.

2. Atrial Fibrillation and Flutter. Associated with organic heart disease, or if not adequately controlled by medication.

(b) Heart Block (second or third degree AV block) and chronic symptomatic bradyarrhythmias with poor response to conventional therapy.

(c) Paroxysmal ventricular tachycardia /Ventricular Arrhythmias. When potentially life threatening or symptomatic enough to interfere with the performance of duty.

(d) Residuals of Sudden Cardiac Death Syndrome following successful resuscitation.

(e) Near or recurrent syncope of cardiac origin.

(f) Permanent indwelling pacemakers or defibrillators or other permanent anti-tachycardia devices.

(4) Hypertrophic Cardiomyopathy

(5) Dilated Cardiomyopathy

(6) Myocardial Disease. Myocarditis and Degeneration of the Myocardium. Myocardial damage producing symptoms such as fatigue, palpitation and dyspnea with ordinary physical activity.

(7) Valvular Heart Disease

(8) Hypertensive Cardiac Disease

(9) Reconstructive Surgery, Including Grafts and Prosthetic devices .

(10) Operative or other invasive procedures involving the heart, pericardium, or vascular system

(a) Permanent Prosthetic Valve Implantation.

(b) Coronary Artery Revascularization.

(c) Coronary or Valvular Angioplasty (including PTCA) or plaque removal.

(d) Cardiac Arrhythmia Ablation procedures, unless free of Unfitting symptoms and signs.

(e) Reconstructive Cardiovascular surgery.

(f) Cardiac Transplant.

(11) Any consequences of chronic cardiovascular drug therapy which would interfere with the performance of duty and is required to prevent a potentially fatal outcome or severely symptomatic events.

c. Vascular System

(1) Arteriosclerosis Obliterans. Evidence of arterial disease such as intermittent, ischemic rest pain, or gangrenous/ulcerative skin changes of a permanent nature. Involvement of one or more organs or systems, or anatomic region with symptoms of arterial insufficiency. When any of the following pertain:

(a) intermittent claudication of sufficient severity to produce pain and inability to complete a walk of 200 yards or less on level ground at 112 steps per minute without a rest; or

(b) objective evidence of arterial disease with symptoms of claudication, ischemic rest pain or with gangrenous or ulcerative skin changes of a permanent degree in the distal extremity; or

(c) involvement of more than one organ system or anatomic region (the lower extremities are considered one region for this purpose) with symptoms of arterial insufficiency.

(2) Major Cardiovascular Anomalies

(a) Coarctation of the Aorta.

(b) Aneurysm of any major vessel, including those corrected by surgery.

(3) Periarteritis Nodosa

(4) Chronic Venous Insufficiency. When symptomatic despite elastic support, significantly interfering with the satisfactory performance of duty.

(5) Raynaud's Phenomenon/Syndrome. Manifested by trophic changes of the involved parts characterized by scarring of the skin, or ulceration.

(6) Thromboangiitis Obliterans. With claudication. Intermittent claudication of sufficient severity to produce pain and inability to complete a walk of 200 yards or less on level ground at 112 steps per minute without rest, or other equally significant complications.

- (7) Recurrent Thrombophlebitis
- (8) Varicose Veins. Severe and symptomatic despite conventional therapy.
- (9) Any vascular reconstruction

d. Miscellaneous Conditions

(1) Cold Injury

- (a) Frostbite, if significant or with residuals.
- (b) Trench foot.
- (c) Hypothermia.

(2) Erythromelalgia

(3) Hypertensive Cardiovascular and/or Vascular disease

- (a) Diastolic pressure consistently greater than 100mm Hg following adequate therapy; and/or,
- (b) associated changes in the brain, heart, kidney, or optic fundi.
- (c) blood pressure readings must have 5 readings, each reading taken after the member has been sitting for at least 15 minutes.

(4) Neurocirculatory Syncope

e. Anticoagulant Therapy. When chronically required.

8007 Gastrointestinal System

a. General. Any organic condition of the Gastrointestinal System that prevents adequate maintenance of the service member's nutritional status, or requires significant dietary restrictions.

b. Inflammatory and/or Infectious Conditions

- (1) Esophagitis. Persistent and not responsive to therapy.
 - (a) Infectious (e.g., Candidiasis).
 - (b) Reflux. When not responsive to therapy.

(c) Hiatal hernia. With severe symptoms not relieved by dietary or medical therapy, or bleeding is recurrent in spite of prescribed treatment.

(2) Gastritis. When not responsive to therapy. Severe, chronic gastritis with repeated symptoms requiring hospitalization and confirmed by gastroscopic examination.

(3) Hepatitis

(a) Persistent symptoms or persistent evidence of impaired liver function.

(b) Persistence of biochemical markers indicating chronicity.

(4) Pancreatitis, chronic, with residuals (such as malabsorption/glucose abnormality due to enzyme deficiency), or recurrent.

(5) Regional Enteritis

(6) Ulcerative Colitis /Crohn's disease

(7) Proctitis. Moderate to severe symptoms of bleeding, or painful defecation, or tenesmus and diarrhea, with repeated admissions to the hospital.

(8) Intra-abdominal abscess. When unresponsive to therapy.

(9) Hepatic abscess. When unresponsive to therapy.

c. Obstructive Conditions

(1) Congenital

(a) Diverticula

(b) Webs

(c) Strictures. Stricture of the esophagus of such a degree as to require an essentially liquid diet, frequent dilatation, and hospitalization, and/or which causes difficulty in maintaining weight and nutrition.

(2) Acquired

(a) Diverticula

(b) Webs

(c) Strictures. Same as above.

(d) Peritoneal Adhesive Bands. Recurring episodes of intestinal obstruction characterized by abdominal colicky pain and vomiting, and requiring frequent admissions to the hospital.

d. Dysfunctional Conditions

(1) Achalasia of the Esophagus. Manifested by dysphagia not controlled by dilatation with frequent discomfort, or inability to maintain normal vigor and nutrition.

(2) Biliary Dyskinesia.

(3) Cirrhosis. Moderate with evidence of portal hypertension, esophageal varices, distended abdominal veins and/or impaired liver function and/or significant impairment of health.

(4) Ulcers (Duodenal, Gastric, Intestinal) when there are complications or residuals. Repeated incapacitation or absences from duty because of recurrence of symptoms (pain, vomiting, or bleeding) in spite of good medical management, and supported by laboratory and x-ray evidence of activity or severe deformity.

(5) Gastrectomy

(a) Total

(b) Subtotal, with or without vagotomy, or gastrojejunostomy or pyloroplasty with or without vagotomy, when in spite of good medical management, the individual experiences any of the following:

1. Develops incapacitating dumping syndrome.

Postoperative symptoms such as a moderate feeling of fullness after eating, or the need to avoid or restrict the ingestion of high carbohydrate foods, or the need for a daily schedule for a number of small meals should not be confused with dumping syndrome.

2. Develops frequent episodes of incapacitating epigastric distress with characteristic circulatory symptoms or diarrhea.

3. Continues to demonstrate significant weight loss.

(Preoperative weight representative of obesity should not be taken as a reference point in making this assessment.)

(6) Permanent Gastrostomy, Enterostomy, Ileostomy, Colostomy, Pancreoenterostomy

(7) Total Pancreatectomy

(8) Fecal Incontinence

(9) Pancreaticoduodenostomy, Pancreaticogastrostomy
Pancreaticojejunostomy

(10) Proctopexy, Proctoplasty, Proctorrhaphy, or Proctotomy. If fecal incontinence remains after appropriate treatment.

e. Abdominal Wall Defects. Hernia, recurrent, when repair is contraindicated and the defect interferes with duty performance. This includes removal; e.g., post mastectomy reconstructive surgery.

8008 Genitourinary System

a. Urinary System. There are three general dysfunctions of the urinary system: Renal Dysfunction, Voiding Dysfunction, Urinary Tract Infection. Some conditions involve a combination.

(1) Renal Dysfunction. Medical workup will include creatinine clearance to quantitate the degree of dysfunction (see table 5 of attachment (b) to enclosure (9)). In addition, the report should contain current BUN, creatinine values and creatinine clearance.

(a) Retained Renal Calculus. When resulting in recurrent symptoms, abnormal renal function, or recurrent infection and is not correctable by therapy.

(b) Cystic Kidney, when renal function is impaired or the focus of recurrent infection. Congenital renal anomaly, resulting in frequent or recurring infections, or when there is evidence of obstructive uropathy not responding to medical or surgical treatment.

(c) Glomerulonephritis

(d) Hydronephrosis. When not correctable and with continuous or frequent symptoms.

(e) Hypoplasia of the kidney. When complicated (e.g., high blood pressure, frequent infections).

(f) Chronic Nephritis. With renal function impairment.

(g) Nephrosis. With renal function impairment.

(h) Stricture of the Ureter, if clinically significant and not correctable.

(i) Residuals of Ureteral Operations, including:

1. Ureterocolostomy and/or Ureterosigmoidostomy .

2. Ureterocystostomy. When both ureters are markedly dilated with irreversible changes.

3. Ureteroileostomy.

4. Ureteroplasty. When unilateral procedure is unsuccessful and nephrectomy is necessary, consider on the basis of the standard for a nephrectomy.

5. When bilateral, evaluate residual obstruction or hydronephrosis and consider Unfitness based on residuals.

6. Ureterosigmoidostomy.

(j) Pyeloplasty, with significant residuals.

(k) Nephrectomy. When there are complications with the remaining kidney.

(l) Nephrostomy, Pyelostomy, Ureterostomy . When there is persistent drainage.

(m) Renal Transplant

1. Recipient

2. Donor. If there is malfunction of the remaining kidney .

(n) Pyelonephritis, if chronic and has not responded to medical or surgical treatment, with evidence of persistent hypertension or reduction in renal function.

(2) Voiding Dysfunction

(a) Cystitis, when complications or residuals preclude satisfactory performance of duty.

(b) Urinary Incontinence, if unresponsive to treatment.

(c) Neurogenic Bladder

(d) Epispadias. When there is an inability to perform required duty due to soilage or recurrent infection.

(e) Stricture of the Urethra, not amenable to treatment.

(f) Cystectomy

(g) Cystoplasty. When residual urines are greater than 50 cc and/or refractory infection.

(h) Urethrostomy

(i) Penis, Amputation of. When urine is voided in such a manner as to soil clothing or surroundings, or result in severe mental symptoms.

(3) Urinary Tract Infection

(a) Chronic Urethritis

(b) Chronic Pyonephrosis/Pyelonephritis which has not responded to medical or surgical treatment, with evidence of persistent hypertension or reduction in renal function.

(c) Perirenal Abscess

(d) Cystoplasty. When there is refractory infection.

b. Female Genitourinary Conditions

(1) Dysmenorrhea. When severity is such that duty performance is affected.

(2) Endometriosis. When the severity is such that duty performance is affected.

(3) Menopausal Syndrome. When constitutional symptoms prevent duty performance.

(4) Chronic Pelvic Pain. When the severity is such that duty performance is affected.

(5) Hysterectomy. When residual complications preclude satisfactory performance of duty.

(6) Oophorectomy. When residual symptoms preclude satisfactory duty performance.

8009 Hemic And Lymphatic Systems

a. Anemia. When symptomatic and not responsive to therapy.

b. Hemolytic Crises. When complicated, chronic, and symptomatic.

- c. Leukopenia. When not responsive to therapy or when therapy is prolonged, or when complicated by recurrent infections.
- d. Polycythemia. When unresponsive to therapy.
- e. Purpura or Bleeding disorders
- f. Chronic Anticoagulation Therapy
- g. Hypercoagulable states with thromboembolic disease.
- h. Indwelling Filter to prevent embolic phenomena.
- i. Leukemia, or history thereof.
- j. Lymphomas, or history thereof.
 - (1) Hodgkin's
 - (2) Non-Hodgkin's
- k. Splenomegaly, Chronic.

8010 Skin And Cellular Tissues

a. General: Regardless of whether specifically stated under each diagnosis, the following encompassing statement applies to all: a MEB report shall be submitted when conditions are severe, unresponsive to therapy, and interfere with the satisfactory performance of duty, wearing of the uniform, or using military equipment.

- b. Systemic Conditions including:
 - (1) Amyloidosis
 - (2) Dermatomyositis /polymyositis
 - (3) Eczema
 - (4) Chronic Lymphedema
 - (5) Erythema Multiforme. More than moderate and chronic or recurrent.
 - (6) Hyperhidrosis
 - (7) Leukemia Cutis or Mycosis Fungoides
 - (8) Neurofibromatosis

(9) Psoriasis

(10) Parapsoriasis

(11) Scleroderma

(12) Pemphigus. Not responsive to treatment and with moderate constitutional or systemic symptoms.

(13) Exfoliative Dermatitis

(14) Epidermolysis Bullosa

(15) Urticaria

(16) Lichen Planus

(17) Cutaneous Lupus Erythematosus

c. Localized Conditions

(1) Radiodermatitis. Particularly if there is malignant degeneration not amenable to therapy.

(2) Intractable Plantar Keratosis

(3) Scars and Keloids. Locally extensive and adherent, interfering with the function of a body part or preventing the wearing of the uniform.

(4) Xanthoma

(5) Cysts and Tumors. When not amenable to accepted therapy.

(6) Atopic Dermatitis. More than moderate or requiring frequent hospitalization.

(7) Ulcers of the skin. When not responsive to therapy; e.g., Fungus Infections, Superficial - if not responsive to therapy and resulting in frequent absences from duty.

(8) Hidradenitis, Suppurative, and Folliculitis Decalvans.

d. Infectious Conditions

(1) Acne, Cystic, Severe. When unresponsive to therapy.

(2) Dermatitis Herpetiformis

(3) Panniculitis

(4) Cutaneous Tuberculosis

(5) Elephantiasis

e. Other Chronic Skin Disorders

8011 Endocrine System And Metabolic Conditions

a. General. Any abnormality that does not respond to therapy satisfactorily or where replacement therapy presents significant management problems.

b. Diabetes

(1) All cases requiring oral hypoglycemics where control is not adequate, excluding the "honeymoon" period.

(2) All cases requiring insulin and/or restrictive diet for control.

(3) When individuals requiring insulin for maintenance are under poor control ("brittle diabetics").

c. Acromegaly

d. Adrenal Hyper or Hypofunction

e. Diabetes Insipidus

f. Hyper- or Hypothyroidism. Severe symptoms not controlled by accepted therapy.

g. Hyper- or Hypoparathyroidism. Especially when residuals or complications of surgical treatment (renal, skeletal or mental alterations) prevent performance of duty.

h. Hyperinsulinism. When caused by malignancy or not readily controlled.

i. Gout. In advanced cases with frequent (>3/yr) acute exacerbations or severe bone, joint, or renal damage.

j. Osteomalacia. Residuals preventing performance of duties.

k. Hypogammaglobulinemia

l. Hypercoaguable States

m. Heat Injury

(1) Recurrent Heat Exhaustion. Manifested by collapse, including syncope, occurring during or immediately following exercise or in an environment of increased heat. Must occur at least three or more times in 24 months. No complicating factor can be identified.

(2) Heat Stroke. Hyperpyrexia (core temperature >106 degrees Fahrenheit), collapse, encephalopathy and organ damage and/or systemic inflammatory activation during the episode. In the absence of encephalopathy, exertional rhabdomyolysis and myoglobinuria are sufficient. A trial of duty may be recommended if complicating factors have been identified and there are no residuals.

n. Malignant Hyperthermia

8012 Nervous System

a. General. To better measure conditions involving the nervous system, it is mandatory that certain yardsticks be employed:

(1) Dementia And Head Trauma. Neuropsychologic or neuropsychiatric measurements should be performed as early as possible. There should also be a set of current neuropsychologic or neuropsychiatric measurements submitted with the MEB report. Current here means within 6 weeks of submission of the board.

(2) Migraine Headaches. The number of incapacitating episodes (those that require the individual to stop the activity in which engaged and seek medical treatment) per week, month or year should be noted and verified by a physician.

(3) Seizure Disorders. The evaluation will be done by a neurologist. An EEG, MRI/CT will be included in the initial examination. When subsequent seizure episodes occur while on medical therapy, blood levels of prescribed medication(s) will be determined. The date of the most recent seizure and seizure frequency must be recorded.

(4) Neuropathies. EMG and nerve conduction studies will be performed.

(5) Multiple Sclerosis. All cases will have an MRI of the head or spinal cord.

(6) Impairment Estimate. Estimation of the degree of industrial and (industrially related) social impairment incurred by the service member due to migraine and seizure disorder should be included.

b. Neurogenic Muscular Atrophy

- (1) Amyotrophic Lateral Sclerosis
- (2) All Primary Muscle Disorders
 - (a) Facioscapulohumeral Dystrophy
 - (b) Limb Girdle Dystrophy
 - (c) Myotonia Dystrophy
 - (d) Myelopathic Muscular Atrophy
- (3) Myasthenia Gravis. Other than solely ocular.
- (4) Polio
- (5) Progressive Muscular Atrophy
- c. Progressive Degenerative Disorders
 - (1) Parkinson's Disease. Paralysis Agitans.
 - (2) Huntington's Chorea
 - (3) Hepatolenticular Degeneration
 - (4) Friedreich's Ataxia
- d. Demyelinating Disorders
 - (1) Multiple Sclerosis
 - (2) Optic Neuritis. Recurrent or with residuals.
 - (3) Transverse Myelitis/Myelopathy
- e. Cerebrovascular Accidents, Residuals
- f. Traumatic Brain Injuries, Residuals
- g. Headaches. Headaches, Migraine , Tension, Vascular, Cluster Types When manifested by documented frequent incapacitating (e.g., lasting for several consecutive days, and unrelieved by treatment) attacks.
- h. Seizure disorders

- i. Narcolepsy. Documented with sleep clinic workup
- j. Sleep Apnea Syndrome, when complicated by requirement for an appliance such as CPAP for control.
- k. Peripheral Nerve Dysfunctions
 - (1) Neuralgia. When severe, persistent, and not responsive to therapy.
 - (2) Neuritis. When manifested by more than moderate, permanent functional impairment.
 - (3) Paralysis due to Peripheral Nerve Injury. When manifested by more than moderate, permanent functional impairment.
- l. Syringomyelia
- m. General Neurological Disorders. Any other neurological condition, regardless of etiology, when, after adequate treatment, residual symptoms prevent the satisfactory performance of duty.

8013 Psychiatric Disorders

- a. General
 - (1) The terminology and diagnostic concepts used in this section are in consonance with the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV). As the DSM is updated, appropriate revisions in the disability system will be made in conjunction with VA approval of use of any new editions.
 - (2) The Multiaxial System of Diagnosis will be used for all psychiatric conditions that are the subject of an MEB:
 - AXIS I. Clinical Psychiatric Disorders and Other Psychiatric conditions that may be a focus of clinical attention.
 - AXIS II. Personality Disorders; Mental Retardation.
 - AXIS III. General Medical Disorders.
 - AXIS IV. Psychosocial and Environmental problems.
 - AXIS V. Global Assessment of Function (GAF).
 - (3) All AXIS I and II diagnoses will be assessed as to the impairment for

military duty as well as the impairment for social and industrial functioning. This applies even though conditions normally placed on Axis II do not render a service member medically unable to perform assigned duties.

(4) Personality, Sexual, or Factitious Disorders, Disorders of impulse control not elsewhere classified, Adjustment Disorders, Substance-related Disorders, Mental Retardation (primary), or Learning Disabilities are conditions that may render an individual administratively unable to perform duties rather than medically unable, and may become the basis for administrative separation. These conditions do not constitute a physical disability despite the fact they may render a member unable to perform his or her duties.

(5) Any MEB report listing a psychiatric diagnosis must contain a thorough psychiatric evaluation and include the signature of at least one psychiatrist (identified as such) on the MEB report signatory face sheet. If competency is questionable, an incapacitation board must be conducted. This board must consist of three physicians, one of whom must be a psychiatrist.

b. Disorders with Psychotic Features (Delusions or prominent Hallucinations). One or more psychotic episodes, existing symptoms or residuals thereof, or a recent history of a psychotic disorder.

c. Affective Disorders (Mood Disorders). When the persistence or recurrence of symptoms requires extended or recurrent hospitalization, or the need for continuing psychiatric support.

d. Anxiety, Somatoform, Dissociative Disorders (Neurotic Disorders). When symptoms are persistent, recurrent, unresponsive to treatment, require continuing psychiatric support, and/or are severe enough to interfere with satisfactory duty performance.

e. Organic Mental Disorders. Dementia or organic personality disorders that significantly impair duty performance.

f. Eating Disorders. When unresponsive to a reasonable trial of therapy or interferes with the satisfactory performance of duty.

8014 Venereal Diseases

Complications or Residuals of Venereal Diseases. When chronicity or degree of severity is such that the individual is incapable of performing useful duty.

8015 Neoplasms

a. Malignant Neoplasms

(1) Malignancies which are unresponsive to therapy or whose residuals prevent satisfactory performance of duty.

(2) When the service member with a malignant neoplasm refuses accepted

therapy.

(3) When, for a variety of reasons, a service member, who has been treated for a malignant neoplasm, will leave active duty before having had an adequate period of observation to determine whether a cure has been effected. These do not include basal cell carcinomas or small squamous cell carcinomas without metastases.

b. Benign Neoplasms . Usually benign tumors do not prevent satisfactory performance of duty.

(1) However, there may be residuals of treatment, which do make the individual Unfit and thus require a medical board.

(2) There are instances in which a benign tumor behaves like a malignant tumor or has the potential to be aggressive and damaging as a malignant tumor. These tumors may be rated by analogy to the VA rating for malignancies.

(3) Examples of benign tumors which might interfere with the performance of duties (and might be considered analogous to malignant tumors) are:

(a) Ganglioneuroma

(b) Meningeal Fibroblastoma

(c) Pigmented Villonodular Synovitis

8016 Southwest Asia Theater Of Operations (SWATO) Cases

a. General. All service members who are referred to the PEB, who have served in SWATO during the period 2 August 1990 to present will be afforded the opportunity to undergo a Comprehensive Clinical Evaluation Program (CCEP) examination if the medical diagnoses included in the MEB report are assessed by the physician to be related to illnesses that are directly and causally related to service in this theater. The results of the CCEP evaluation (submitted as an official addendum in narrative form) will be forwarded to the PEB along with the MEB report. If the member waives this right, the member's waiver must accompany the MEB report. Also, NAVMED Form 6100/1 must indicate whether or not the service member has served in SWATO during the period 2 August 1990 to present.

b. CCEP participants who are diagnosed with conditions referred to as "undiagnosed symptom complex attributed to service in SWATO " that are cause for referral into the DES shall receive a MEB to determine if the case is to be referred to the PEB. Referral of a CCEP participant can occur at any point during the CCEP process once a condition which is cause for referral into the DES is identified. However, CCEP participants who have undiagnosed medical conditions should not be referred until they have completed Phase II and III of the CCEP protocol.

c. Anyone for whom SWATO time of service is an issue in the production of symptoms for which an MEB is contemplated must have been evaluated by CCEP , with an addendum dictated by CCEP prior to referral to the Informal Board.

d. All disability cases that involve service members who have undergone any part of the CCEP shall include copies of all CCEP documentation (e.g., test results, consultation report, et al). An addendum will be dictated by the CCEP physician.

e. Failure to include the foregoing information in any case referred to the PEB for adjudication shall result in its return to the convening authority.

f. Members reporting for TDRL periodic examinations are subject to these same guidelines unless previously evaluated or waived.

g. Enclosure (9), attachment (a) (1) SWATO Undiagnosed Symptom Complex Coding applies.

8017 Dental.

Diseases and abnormalities of the jaws or associated tissues when, following restorative surgery, there remain residuals which are incapacitating, or deformities which are severely disfiguring.

Attachment (a) to Enclosure (8): MINIMUM REQUIREMENTS FOR MEDICAL EVALUATION BOARD (MEB), ADDENDA AND NARRATIVE SUMMARY WITH ANNOTATIONS

1. Purpose.

This attachment details the minimum medical information requirements to be annotated in any Medical Evaluation Board or addendum. This information must be documented and approved prior to forwarding the case to the Physical Evaluation Board (PEB).

a. Fulfillment of these requirements is a joint responsibility. The physicians must work closely with the Medical Boards Section of the Medical Treatment Facility to ensure compliance with these guidelines.

b. Attachment (c) is an example of a comprehensive MEB report.

2. Medical Evaluation Board (MEB) Documentation

a. Required Information:

(1) Member's name, rank, grade, and social security number.

(2) The name and specialty of the signatory physicians. The name of the physician dictating the report must be marked with an asterisk on the 6100/1.

(3) The Clinical Department and/or service authoring or sponsoring the document.

(4) The Medical Treatment Facility and its location.

(5) Date Medical Evaluation Board (MEB) report was conducted.

(6) A copy of the member's health record should accompany the MEB report. Although helpful, "shadow files" should NOT be submitted in place of the health record. Any supplemental records should be submitted. Any pertinent records of encounters with civilian physicians should be submitted.

(7) Copies of all narrative summaries of hospitalizations and all procedure reports are to be submitted with the medical board. Copies of labs, x-rays, special study reports also should be submitted.

(8) Signatures of the medical board members on the 6100/1, cover sheet. Electronic signatures will not be accepted.

b. On Each Page:

(1) Member's last name, social security number, and date of the MEB on the bottom margin.

(2) Page number will be annotated at the bottom center of the page.

Document is marked "For Official Use Only – Privacy Act Protected".

c. Reason For Doing The MEB

(1) The mere presence of a diagnosis is not synonymous with disability. It must be established that the medical disease or condition underlying the diagnosis actually interferes significantly with the member's ability to carry out the duties of his/her rank and rate.

(2) When assessing the severity of symptoms, evaluate the subjective symptoms in light of objective findings; report discrepancies in addition to positive findings.

d. Eligibility for MEB.

See Enclosure (1), Article 1002, and Enclosure (3), Articles 3405-3408.

e. Military Information

(1) Date of first and most recent entry into service.

(2) Estimated termination of service.

(3) Administrative actions ongoing, pending, or completed (e.g., line of duty investigations, courts-martial, selective early retirement, retirement or separation dates).

f. Chief Complaint. Preferably stated in service member's own words.

g. History Of Present Illness.

Exact details, including pertinent dates regarding illnesses/injuries, how injuries were incurred. Enclose and summarize any pertinent previous MEB reports. The oft used terms "interval history" are inappropriate and assume that the PEB has access to the previous boards which is not always the case. The author of the MEB report must give a complete history chronologically as well as simply event-based.

h. Past Medical History

(1) Past injuries and illnesses.

(2) Prior disability ratings (e.g., given by the DES or Department of Veterans Affairs).

(3) Past hospitalizations and relevant outpatient treatment, including documentation of diagnosis and therapy, pertinent dates, and location should be listed.

(4) Social information pertinent to the member's condition (e.g., activity level and sports activities engaged in would be pertinent to orthopaedic evaluation; alcohol and drug

usage rates must also be included) should be provided. There is an inclusive list under the specialty specific section for psychiatric disorders.

(5) Illnesses, conditions, and prodromal symptoms, existing prior to service (referred to as EPTS or EPTE conditions).

i. Laboratory And X-Ray Studies.

All studies that support and quantify the diagnosis (es) should be included as should any studies that conflict with the diagnosis (es).

j. Present Condition/Review Of Systems And Current Functional Status

(1) Current clinical condition(s) should be noted including all current complaints and review of systems; required medications and any non-medication treatment regimens (e.g., physical therapy) in progress.

(2) Functional status

(a) The service member's functional status as to the ability to perform his or her required duty should be indicated.

(b) If possible, a summation of the member's ability to perform the civilian equivalent of their assigned duties should be indicated.

(3) A statement should be given regarding the prognosis for functional status after completion of treatment if chronic treatment is not necessary.

(4) A statement should be given regarding the prognosis for functional status in cases requiring chronic treatment.

(5) The stability of the current clinical condition and functional status should be addressed.

(6) Statement of compliance with treatment recommendations and reasonableness of any refusal of recommended treatment procedures, including surgery. NAVMED Form 6100/4 must be submitted when refusal of surgery or treatment is considered unreasonable.

(7) Requirement for monitoring including frequency of indicated treatment and/or therapy visits and associated operational assignment limitations.

k. Conclusions

(1) Treatment recommendations including medications, procedures, and behavior and/or lifestyle modifications. Include a statement concerning the member's compliance. If non-compliant, indicate whether the non-compliance is reasonable.

(2) Under no circumstances is the narrative to indicate that the member is Unfit, nor recommend a disability percentage rating. It is the PEB's responsibility to determine fitness

and disability percentage ratings. The MEB report may state something to the effect, "the member is referred to the PEB because we are of the opinion that the member's condition may interfere with the performance of his or her duties because the member does not meet medical retention standards as described in..." [indicate location as appropriate].

l. Drug Therapy.

There may be certain instances where a specific drug therapy may in and of itself preclude the full performance of duties. This must be stated specifically if it is the reason for the board.

m. Limited Duty.

The authoring physician should not only address previous periods of limited duty (and what they were for) but also consider whether a member might obtain greater benefit by being referred to a LIMDU Board for placement on LIMDU vice direct submission to the Informal PEB.

n. Surrebuttal.

When the member submits a rebuttal to a medical board or an addendum, the authoring physician **MUST** address the member's specific issues. If necessary, this will include referral through the medical board section of all necessary departments.

o. Referral of hospitalized patients.

Referral to PEB while a member is still hospitalized. The MEB report will cite the reasons for continued retention in the hospital:

(1) When it is necessary that a member be transferred to a VA hospital for continued, extended treatment and he/she is not ready to be released on his/her own recognizance, the evidence presented in the MEB report will support taking these actions and the rating will most likely be between 50 and 100 percent.

(2) If a member is retained in the hospital for transfer to a VA facility as a convenience for transition to civilian care and life without anticipated problems, the rating will generally be a minimum of 30 percent and not more than 50 percent.

(3) For members who are hospitalized for an acute psychiatric emergency, the MEB report should include a mental status exam and statement of functional status within 30 days of submission of the medical board.

p. Competency Statements.

Where a member's competency is in question, an incapacitation board must be held and reports submitted to the PEB. This board must consist of three physicians including a psychiatrist.

q. Trauma.

Severe trauma and acute clinical, fulminant presentations. In clinical situations where the level of impairment could possibly to change significantly within or over the

following 2 to 4 months, submission of the MEB report should be delayed until this period of time has elapsed.

(1) It is important that the MEB report be dictated at the latest possible time prior to submission. This is particularly important when the MEB report is done and then months pass while waiting for completion of the LODI. If the MEB report has previously been dictated, an addendum should be included stating current condition. Statements such as "There has been no change since the previous medical board was dictated" are generally insufficient, especially since they are not usually correct.

(2) Ensure that all of the member's complaints/conditions are addressed by the appropriate specialty in attached addenda. The authoring service in conjunction with the Medical Boards Department of the MTF is responsible for ensuring that all required addenda and non-medical information are included in the original package.

r. Submission Of Photographs.

Current photographs are essential in burn cases and very useful in cases with significantly disfiguring scars. Photographs submitted should be certified, by the medical photography department, to have been taken within 1 month of the date of dictation of the MEB report. Each photo must be dated with the date the photo was taken.

s. Organ Transplants.

When the MTF has opted to retain the member to receive his/her transplant, the MTF will place the member on a Limited Duty Status pending the transplant. MEB report referral to the PEB should be delayed until the procedure has been done and the maximum benefit of treatment has been achieved.

t. "Death Imminent" Cases.

When it is anticipated that a member will die within 72 hours, the case may be submitted as a "death imminent" case for rapid processing. The physicians must explain why the member is deteriorating so rapidly (see enclosure (12) for full details). The need for an LODI in these cases is addressed in other sections of this document. A competency statement is required for complete processing of the case when a member is deemed incompetent to manage their personal and financial affairs. The MEB report in these cases will be signed by three physicians, one of whom will be a psychiatrist. Death imminent cases will be placed on the TDRL, not PDRL in accordance with policies in this instruction. "Death Imminent" should not be used to simply expedite a case.

u. TDRL Evaluations.

Physicians performing TDRL evaluations are responsible for knowing the information contained in enclosure (3), part 6 that addresses TDRL.

3. References.

Physicians and medical board personnel should be familiar with the pertinent instructions, some of which are:

(1) The Manual of the Medical Department

(2) Secretary of the Navy Instructions. Those governing TDRLs and the Disability System.

(3) DVA's physician's guide for Disability Evaluation Examinations

4. Physical Examination (PE).

A complete physical examination must be recorded in the MEB report and have been conducted within 6 months of the date of the MEB report. For all conditions, hand dominance must be stated. Height and weight must be documented in all MEBs (in the narrative).

5. Selected Specialty-Related Considerations And Guidelines

a. Cardiology

(1) Results of special studies to support and quantify the cardiac impairment should be noted e.g., treadmill and thallium stress tests, angiography, and other special studies.

(2) General Information. Evaluation and reporting of cardiovascular function should be in terms of METs of energy expended to produce a certain level of symptoms.

(3) The Functional Therapeutic Classification of the cardiac condition must be included. Either the New York or Canadian classification system may be used (see enclosure (9) attachment (b), table (3))

(a) Objective measurements of the level of physical activity, expressed as METs (metabolic equivalents), at which cardiac symptoms develop is the main method of evaluating cardiovascular entities now.

(b) Exercise capacity of skeletal muscle depends on the ability of the cardiovascular system to deliver oxygen to the muscle, and measuring exercise capacity can, therefore, also measure cardiovascular function. The most accurate measure of exercise capacity is the maximal oxygen uptake, which is the amount of oxygen, in liters per minute, transported from the lungs and skeletal muscle at peak effort. Because measurement of the maximal oxygen uptake is impractical, multiples of resting oxygen consumption (or METs) are used to calculate the energy cost of physical activity. One MET is the energy cost of standing quietly at rest and represents an oxygen uptake of 3.5 milliliters per kilogram of body weight per minute. The calculation of work activities in multiples of METs is a useful measurement for assessing disability and standardizing the reporting of exercise workloads when different exercise protocols are used.

(c) Alternative methods of evaluating function are provided for situations where treadmill stress testing is medically contraindicated – the examiner's estimation of the level of activity, expressed in METs and supported by examples of specific activities, such

as slow stair climbing or shoveling snow that results in dyspnea, fatigue, angina, dizziness or syncope is acceptable.

b. Gastroenterology

Service members with fecal incontinence should have recorded findings of rectal examination e.g., digital exam, manometric studies as indicated, and radiographic studies. The degree and frequency of the incontinence should be noted as well as the incapacitation caused by the condition.

c. Neurosurgery / Neurology

(1) For Vertebral Disc problems, radicular findings on PE should be supported by laboratory studies such as CAT scan, MRI, EMG, NCV. In cases where surgery has been performed, both pre- and postoperative deep tendon reflexes should be documented.

(2) General

(a) DEMENTIA AND HEAD TRAUMA. Neuropsychiatric or neuropsychological assessment should be accomplished in all head injury cases. Results should be included. Neuropsychiatric or neuropsychological measurements should be performed as early as possible. Current tests (performed within 6 weeks of submission of the board) are also required.

(b) MIGRAINE HEADACHES. The number of incapacitating episodes (those that require the individual to stop the activity in which engaged and seek medical treatment) per week, month or year should be noted and verified by a physician. Other pertinent information: 1. Types and names of medications tried (i.e. prophylactic or abortive), response, reason why changed, etc.) 2. Effect has on performance of duties.

(c) SEIZURE DISORDER. The evaluation will be done by a neurologist. An EEG, MRI/CT will be included in the initial examination. When subsequent seizure episodes occur while on medical therapy, blood levels of prescribed medication(s) will be determined.

(d) NEUROPATHIES. EMG and nerve conduction studies will be performed.

(e) MULTIPLE SCLEROSIS. Appropriate MRI(s) will be performed.

(f) INDUSTRIAL AND (INDUSTRIALLY RELATED) SOCIAL IMPAIRMENT. Estimate the degree of impairment that will be incurred by the service member.

(g) IMAGING STUDIES. For all neurological and neurosurgical conditions appropriate imaging studies should be obtained in concert with current standards of practice. Copies of all studies must be submitted.

d. Ophthalmology

(1) If standards are not met for reasons related to vision, visual fields must be included in the PE and verified by an ophthalmologist. Specialist examination should include uncorrected and corrected central visual acuity. Snellen's test or its equivalent will be used and if indicated, measurements of the Goldmann Perimeter chart will be included.

(2) Visual Field Deficits must be documented on a Goldmann Field chart using the III-4-e objective. Cases of diplopia must be documented using a Goldmann Perimeter Chart plotting the fields of diplopia.

e. Orthopaedics

(1) Range of Motion (ROM) measurements must be documented for injuries to the extremities. The results of the measurement should be validated and the method of measurement and validation should be stated. Attachment (d) to enclosure (8) gives appropriate reference points for reporting the ROM measurements.

(2) In cases involving back pain, the use of Waddell's signs should be included in assessing the severity and character of the pain. (Waddell G, McCulloch JA, Kummel E, Venner RM. Non-organic physical signs in low back pain. *Spine*. 1980;5:1171-25. Waddell G, Somerville D, Henderson I, Newton M. Objective clinical evaluation of physical impairment in chronic low back pain. *Spine*. 1992;17:617-628.)

(3) For Vertebral Disc problems, radicular findings on PE should be supported by laboratory studies such as CAT scan, MRI, EMG, NCV. In cases where surgery has been performed, both pre- and postoperative deep tendon reflexes should be documented.

f. Otolaryngology

Audiograms must include speech discrimination scores. Current and entry level audiograms must also be included.

g. Psychiatry

(1) Particular attention should be paid to documenting all prior psychiatric care. Supportive data should be obtained for verification of the patient's verbal history.

(2) Psychiatric hospitalization is not prima facie evidence of an unfitting psychiatric disorder. It may, however, be evidence that the condition is administratively unsuiting.

(3) Psychometric assessment should be carried out if such assessment will help quantify the severity of certain conditions and allow a reference point for future evaluation.

(4) The Diagnostic and Statistical Manual of Mental Disorders (most recent edition) will be used for diagnostic terminology. The Multiaxial System of Assessment will be used to include Axes I-V. The degree of industrial and industrially related social impairment must be individually determined and documented, for each Axis I and Axis II diagnosis, and correlated to the service member's clinical manifestations. Increased severity of symptoms due to transient stressors associated with the PEB and prospect of separation, retirement,

relocation or re-employment will not be considered in determining the degree of impairment. The service member's total impairment for civilian industrial adaptability from all sources (Axes I, II, III) should be determined and documented. The contribution of each condition to the total adaptability impairment should then be individually noted and correlated with the service member's clinical manifestations.

(5) Every effort must be made to distinguish symptoms and impairment resulting from personality disorder or maladaptive traits from impairments based on other psychiatric conditions. The MEB report must specifically address the issues of relative contribution of not compensable conditions (e.g., personality disorders, adjustment disorder, impulse control disorder, substance abuse etc.).

(6) Documentation shall be submitted addressing the following:

(a) Living arrangements (e.g., by oneself, with spouse and children, with parents and siblings).

(b) Marital status. Single, married, separated, divorced, and the type of relationship (harmony or strife).

(c) Leisure activity. Sports, hobbies, TV, reading.

(d) Acquaintances. Male, female, both sexes, many, few.

(e) Substance use or abuse. Alcohol, drugs.

(f) Police encounters/record.

h. Pulmonary

When the MEB is held for restrictive or obstructive pulmonary disease, rating is usually based upon Pulmonary Function Tests (PFTs) measuring residual function. There must be a minimum of one set of PFTs.

(1) Studies should be performed both before and after medication.

(a) Pre-bronchodilator PFTs. When the results are normal, post-bronchodilator studies are not required.

(b) In all other cases, post-bronchodilator studies should be done unless contraindicated (because of allergy to medication, etc.) or if a patient was on bronchodilators before the test and had taken his/her medication within a few hours of the study.

1. A physician who determines that a post-bronchodilator study should not be done in a given case should provide an explanation.

2. The members of the Informal PEB shall request either the

explanation when not provided or a repeat of the studies.

3. The post-bronchodilator results will be used in applying the evaluation criteria in the rating schedule. There is a small group of patients (5 percent or less) in whom there may be a paradoxical reaction to bronchodilators; i.e., the post-bronchodilator results will be poorer than the pre-bronchodilator results. When there is a paradoxical response, the better (pre-bronchodilator) values will be used in the rating.

4. When there is disparity between the results of different tests (FEV-1, FVC, etc.) so that the level of evaluation would differ depending on which test result is used, the test with the better (higher) values (i.e., that would give the lower evaluation) will be used. This is because such tests are effort-dependent, and such a difference is ordinarily due to a difference in effort from test to test. However, if there is a substantial disparity in the results, the MEB physician may be asked for an explanation and/or request that the test be repeated if there is no clear reason.

5. When the FEV-1 is greater than 100 percent, an FEV-1/FVC ratio that is below normal should be considered a physiological variant rather than an abnormal value.

(2) Where warranted, the member should have a methcholine challenge, especially when the original set of PFTs are “normal”.

(3) In cases of exercise-induced asthma, PFTs after exercise should be performed.

i. Urology

(1) Cases involving neurogenic bladder must include studies that document the condition.

(2) All cases involving incontinence must include studies that document the condition.

(3) Cases involving incontinence and/or neurogenic bladder should have documentation regarding severity as indicated by the number of times self catheterization is required, the number and type of pads required in a day, or the soilage frequency.

Attachment (b) to Enclosure (8): CONDITIONS NOT CONSTITUTING A PHYSICAL DISABILITY

1. Purpose.

To detail conditions which do not constitute a physical disability .

2. General Considerations

a. Certain conditions and defects of a developmental nature designated by the Secretary of Defense do not constitute a physical disability and are not ratable in the absence of an underlying ratable causative disorder. If there is a causative disorder it will be rated in accordance with other provisions of this Instruction.

b. These conditions include but are not limited to those listed in paragraph 3 below.

c. Such conditions should be referred for appropriate administrative action under other laws and regulations.

3. Developmental Defects And Other Specific Conditions

a. Enuresis.

b. Sleepwalking and/or Somnambulism.

c. Dyslexia and Other Learning Disorders.

d. Attention Deficit Hyperactivity Disorder.

e. Stammering or Stuttering.

f. Incapacitating fear of flying confirmed by a psychiatric evaluation.

g. Airsickness, Motion, and/or Travel Sickness.

h. Phobic fear of Air, Sea and Submarine Modes of Transportation.

i. Certain Mental Disorders including:

(1) Uncomplicated Alcoholism or other Substance Use Disorder.

(2) Personality Disorders

(3) Mental Retardation

(4) Adjustment Disorders

- (5) Impulse Control Disorders
- (6) Homosexuality
- (7) Sexual Gender and Identity Disorders and Paraphilias
- (8) Sexual Dysfunction
- (9) Factitious Disorder

- j. Obesity
- k. Overheight
- l. Psuedofolliculitis barbae of the face and/or neck.
- m. Medical Contraindication to the Administration of Required Immunizations.
- n. Significant allergic reaction to stinging insect venom.
- o. Unsanitary habits.
- p. Certain Anemias (in the absence of Unfitting sequelae) including G6PD Deficiency, other inherited Anemia Trait, and Von Willebrand's Disease.
- q. Allergy to uniformed clothing or wool.
- r. Long sleeper syndrome.
- s. Hyperlipidemia.

Attachment (c) to Enclosure (8): SAMPLE MEB REPORT

FOR OFFICIAL USE ONLY

SSN:

RANK: Petty Officer First Class

MOS:

UNIT:

DATE: 18 June 97

MILITARY HISTORY:

Petty Officer _____ entered into active duty on

She attended Recruit Training Command in Orlando, Florida. She then attended Yeoman A School in Meridian, Mississippi. She has been stationed at various locations and received awards for her exemplary service. She was twice named sailor of the quarter and once sailor of the year for the _____ area. She has received 3 consecutive good conduct medals and two Navy and Marine Corps achievement medals.

CHIEF COMPLAINT: Back and Foot Pain

HISTORY OF PRESENT ILLNESS:

Petty Officer _____ back pain began in 19 _____ after a motor vehicle accident. She developed worsening of her symptoms in _____ after a second motor vehicle accident. The back pain is constantly present with varying intensity. Exacerbating factors include walking or standing for greater than 2 minutes. Some palliation is noted with non-weight bearing rest. The symptoms have progressed insidiously to include plantar foot pain and arthralgias involving the hips, knees, and ankles. The plantar foot pain occurs daily and is exacerbated by any weight bearing activity. She has received a variety of health care evaluations with subsequent therapeutic recommendations. Unsuccessful treatments employed have included NSAIDS, muscle relaxants, tricyclic antidepressants to modify the pain threshold, orthotics, physical therapy, plantar and sacroiliac anesthetic injections, nighttime ankle splints, and local ultrasound treatment. A lumbosacral series revealed sacralization of the 5th lumbar vertebrae. She was evaluated by Physical Medicine and Rehabilitation at which time a bone scan was obtained that showed mild increased tracer uptake in both sacroiliac joints consistent with sacroiliitis. She was then referred to Rheumatology where she was initially evaluated in March 1997. Sacroiliac radiographs were suspicious for sacroiliac disease. An MRI subsequently revealed no evidence of

sacroiliitis. Her symptoms have persisted despite maximal therapy and negatively impacted on her ability to perform her naval duties. She is therefore being referred to the Physical Evaluation Board for further review and disposition.

ALL: None

MEDICATIONS: Indomethacin SR 75mg bid, Norplant

PAST MEDICAL HISTORY: Spina bifida occulta, childhood asthma, duplicated left renal collecting system without reflux or obstruction (urology evaluation completed in 1997), perivaginal cyst, tinea versicolor

PAST SURGICAL HISTORY: None

SOCIAL HISTORY: No tobacco or alcohol

REVIEW OF SYSTEMS:

Musculoskeletal: Arthralgias involving hips, knees, and ankles, occurs with resting or ambulation, occasionally resolves with rest or spontaneously, chronicity 11 years, episodes last days to weeks; Back pain of 11 years duration with symptoms worsening since 1992, pain is worse with activity, palliation with resting and laying supine, prevents restorative sleep; Plantar foot pain with radiation into achilles tendon and gastrocnemius, pain is constantly present and worse with weight bearing and ambulation, refractory to shoe inserts and nighttime splints. Neurologic: midline occipital headaches, occurs in the AM upon awakening, resolves with aspirin, chronicity 11 years; dizziness and fainting spells, episode duration approximately 2 minutes, chronicity 7 years, associated with gastrointestinal symptoms, no known loss of consciousness. Gastrointestinal: "knot-like" sensation with pain in the epigastrium, associated nausea and increased bowel motility, associated salivary regurgitation without acid brash, no diarrhea or bloating, onset is spontaneous and without identifiable provocative factors, chronicity 7 years.

PHYSICAL EXAMINATION:

BP 123/77 P 75 T 98.9F Wt 123lbs

HEENT- extraocular movements intact, Fundi normal, no oral ulcers, tympanic membranes clear

NECK- normal range of motion, nontender, no lymphadenopathy, no thyroid enlargement or nodules

LUNGS- clear

HEART- regular rhythm, no murmurs or gallops

ABDOMEN- no hepatosplenomegaly, nontender, bowel sounds present

PELVIC- (Ob-Gyn) normal

MUSCULOSKELETAL-, Feet : plantar pain bilaterally at the calcaneus and metatarsal heads, callus formation overlying #1, 2, 5 bilaterally at the metatarsal heads. Back: focal area of palpable low pain overlying sacrum and lumbosacral junction, presacral fat pad, Schober's test reveals 2.5 cm lumbar distraction with back flexion, straight leg raise

test negative, hyperextension hips without pain provocation, flattening appearance to lumbar spine , FABERE negative, no leg length discrepancy. Joints : no synovitis
NEUROLOGIC- strength normal, deep tendon reflexes present and equal bilaterally, babinski absent, no sensory deficits elicited, muscle tone normal
DERMATOLOGIC - scar at dorsum of left wrist, acneiform lesions on back

LABORATORY:

urinalysis- SG 1.026, trace protein, 1-2 RBC/HPF, 5-9 EPI/HPF
chemistries- normal
complete blood count- normal
erythrocyte sedimentation rate- 9
C-reactive protein- <0.1
HLA-B27 negative

ELECTROCARDIOGRAM: sinus bradycardia

RADIOLOGY:

(23 May 97) chest x-ray- normal
(4 April 97) MRI pelvis - normal
(21 Mar 97) ferguson pelvis- normal
(6 Mar 97) bone scan- increased uptake in the spinous processes of L4, 5; mild increased uptake in both sacroiliac joints
(27 Feb 97) lumbar spine series- sacralization of L5 vertebrae

FINAL DIAGNOSES:

- (1) Plantar Fasciitis
- (2) Mechanical low back pain
- (3) Duplicated collecting system of left kidney without evidence of reflux or obstruction

PHYSICAL PROFILE:	P	U	L	H	E	S
(Plantar Fasciitis)	3	1	2	1	1	1

PRESENT CONDITION:

Petty Officer _____ is currently unable to successfully perform her military duties as reflected by the member and her direct supervisors. Her condition has placed an undue burden on coworkers in her office attempting to support those duties which Petty Officer _____ is unable to perform. Her current medical problems have also significantly impacted her personal life by limiting her hobbies, interrupting normal sleep patterns, and making activities of daily living difficult.

PROGNOSIS:

Petty Officer _____ is likely to require ongoing therapy and medical follow-up by clinicians interested in musculoskeletal ailments.

30 APRIL 2002

RECOMMENDATIONS:

1. Petty Officer _____ medical condition at this time precludes her from continuation on active duty. She is therefore being referred to the Physical Evaluation Board for further evaluation and disposition .
2. Continued use of proper shoe inserts and nighttime splints on a regular basis.
3. Daily stretching exercises targeting the plantar fascia and low back.
4. Daily strengthening exercises targeting the abdominal muscles and intrinsic muscles of the feet .
5. Regular use of NSAIDS at analgesic doses.
6. Periodic formal physical therapy evaluations to document proper self-directed rehabilitation routines and to monitor progress.
7. Evaluation every 3-4 months by a physician interested in the diagnosis and treatment of musculoskeletal problems.

Rheumatology Fellow
National Naval Medical Center

Rheumatology Staff
National Naval Medical Center

Walter Reed Army Medical Center
National Naval Medical Center
Last Name/ Last Four SSN/ Date Typed

Attachment (d) to Enclosure (8) :Plate Description

**MEASUREMENT OF ANKYLOSIS AND JOINT MOTION
Upper Extremities**

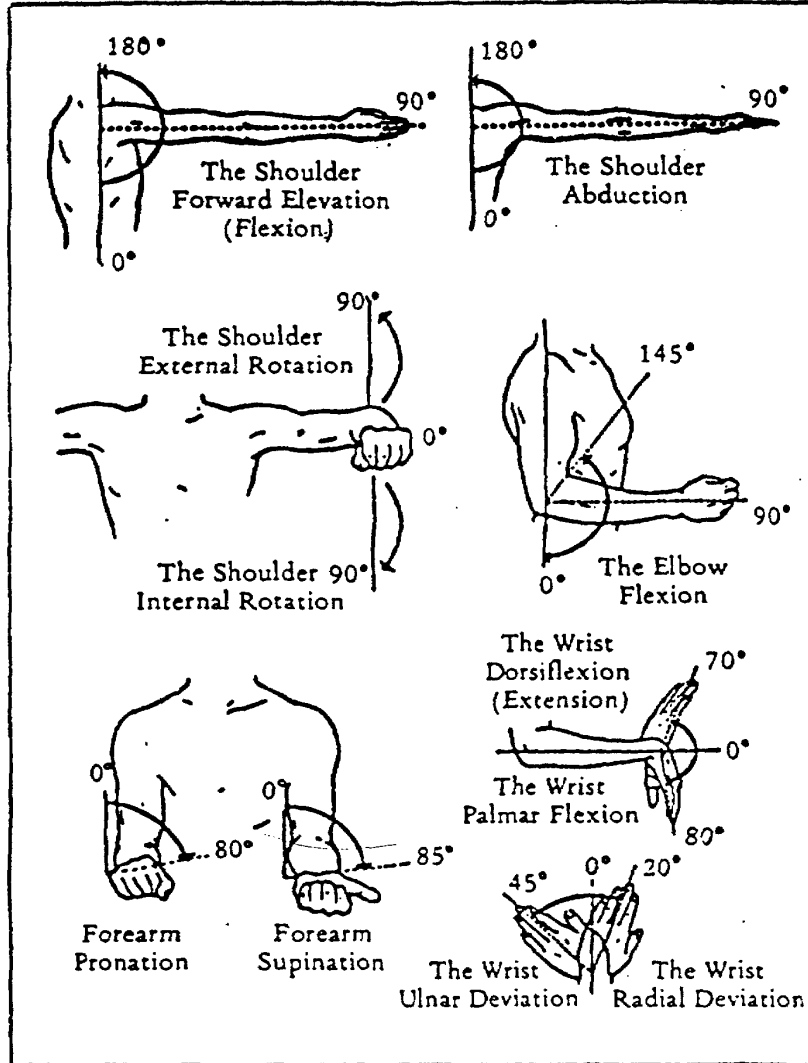


PLATE I

This plate provides a standardized description of ankylosis and joint motion measurement of the upper extremities. The anatomical position is considered as 0° with two major exceptions: (1) in measuring shoulder rotation, the arm is abducted to 90° and the elbow is flexed to 90° so that the forearm reflects the midpoint (0°) between internal and external rotation of the shoulder; and (2) in measuring pronation and supination, with the arm next to the body and the elbow flexed to 90°, the forearm is in mid-position (0°) between pronation and supination when the thumb is uppermost.

PLATES

Attachment (d) to Enclosure (8)

MEASUREMENT OF ANKYLOSIS AND JOINT MOTION

Lower Extremities

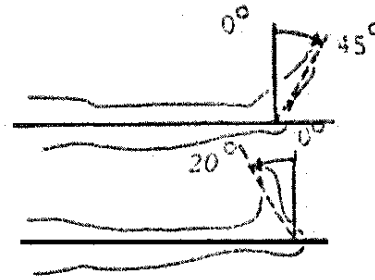
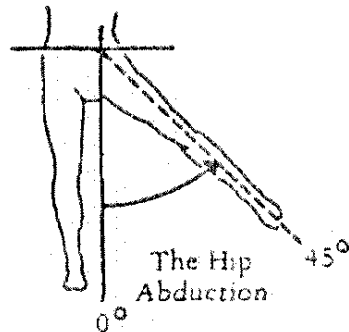
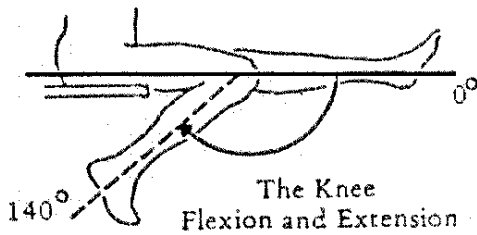
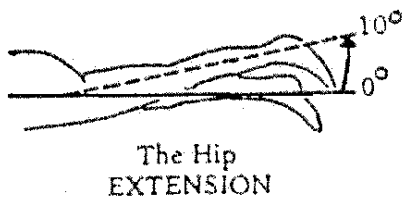
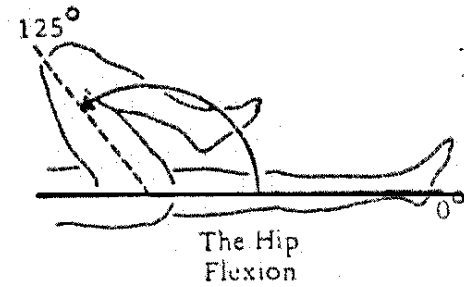


PLATE II

This plate provides a standardized description of ankylosis and joint motion measurement of the lower extremities. The anatomical position is considered as 0°.

Attachment (d) to Enclosure (8)

RATING OF MULTIPLE FINGER DISABILITIES

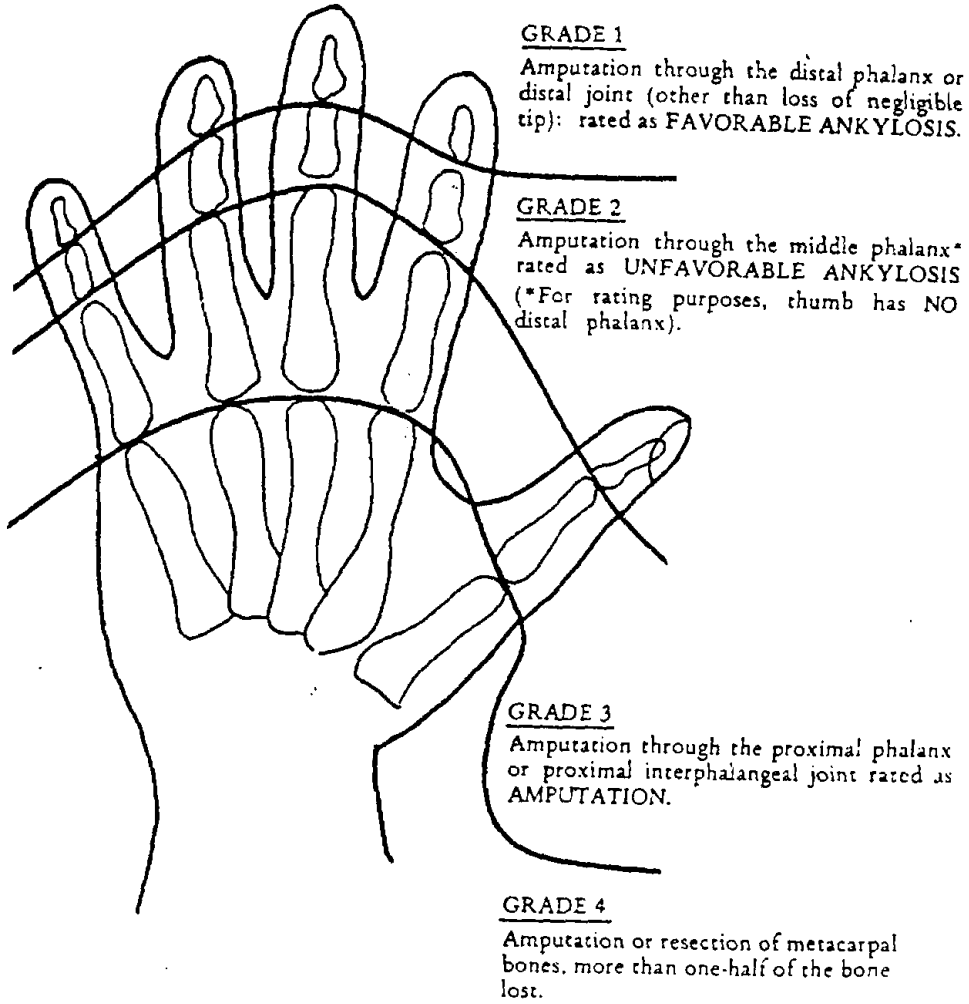
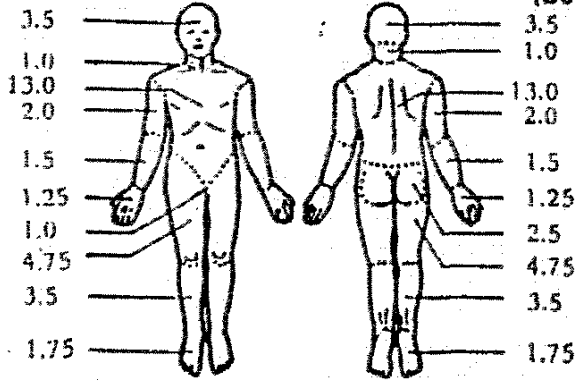


PLATE III

Attachment (d) to Enclosure (8)

*** ESTIMATION OF BODY SURFACE AREA
(Barkow)**



The diagram at the left provides the basic scheme for estimation of body surface area. The table below is for convenient conversion to actual surface area measurement, based upon application to the average 70 kgm. man with a body surface area of 2,636 sq. in. (18.3 sq. ft.).

Body Surface	Percent of body surface	Area	
		Square Inches	Square Feet
Anterior or posterior head	3.5	92	0.64
Anterior or posterior neck	1.0	26	.18
Anterior or posterior trunk.....	13.0	343	2.38
Anterior or posterior arm	2.0	53	.37
Anterior or posterior forearm	1.5	40	.27
Dorsal or palmar hand & fingers	1.25	33	.23
Buttock.....	2.5	66	.46
Genitalis.....	1.0	26	.18
Anterior or posterior thigh.....	4.75	125	.87
Anterior or posterior calf.....	3.5	92	.64
Dorsal foot or sole, incl toes	1.75	46	.32

PLATE IV

ENCLOSURE 9: SPECIAL INSTRUCTIONS AND EXPLANATORY NOTES

9001 General

a. This enclosure is a supplement to the VASRD and contains principles for rating disabilities where additional guidance or clarification is needed for processing active duty and Reserve military disability cases. Portions requiring special comment, or that have been the cause of misunderstanding in the past, are included. Comments and rating instructions also supplement the VASRD in those instances in which recent medical advances are inadequately covered. Supplements to the VASRD published by the DVA following the effective date of this Instruction shall take precedence unless the changes included in the supplement are identified by the Assistant Secretary of Defense for Health Affairs through a published interim change to this Instruction to be inappropriate to military requirements.

b. In adjudicating cases, the VASRD is the starting point and initial guidance for an impairment rating. Because this enclosure modifies selected VASRD ratings, it is the final reference for impairment adjudication.

c. Unless otherwise directed, separate disability ratings are combined rather than mathematically summed.

9002 New Growths, Malignant

a. The policies contained in this paragraph apply to malignant new growths except as modified by notes for specific tumors. Special consideration must be given to determination of fitness or unfitness, since these diseases, their treatment, or the outcome do not disable all service members.

b. A service member with a diagnosed malignant tumor that has metastasized, and has NOT FAVORABLY responded to therapy, if Unfit, SHALL be permanently retired, at 100 percent if such rating is not expected to change within the next 5 years. In such cases, metastasis may be defined as distant spread of the tumor or as local invasion that renders treatment non-curative.

c. A service member with a diagnosed malignant tumor that has not metastasized and has responded favorably to therapy to the extent that no current evidence of the disease exists, NEED NOT BE FOUND UNFIT. A service member who is functionally Unfit because of residual conditions secondary to treatment of a malignancy (e.g., chemotherapy, radiation therapy, or surgery) may be rated using the Alphabetical Listing of Analogous Ratings (enclosure (9), attachment (a)). The code for the relevant malignancy should be listed first, followed by the analogous code(s). For example, the code for leukemia in remission associated with fatigue secondary to chemotherapy would be "7703-6399-6354." Residuals shall be rated according to the applicable VASRD code and not necessarily according to the code for malignancy. The minimal rating for the malignancy does not apply.

d. A service member who is undergoing chemotherapy that constitutes the whole or part of definitive treatment may be retained on active duty, placed on TDRL, or permanently retired or separated, as indicated by individual circumstances.

e. When chemotherapy is used as an adjunctive treatment and no evidence of an unfitting residual malignant tumor exists, the use of chemotherapy will not necessarily influence the disposition of the case unless adverse unfitting effects of the chemotherapy have ensued.

f. Malignancies, including the leukemias, that require bone marrow transplantation usually result in a service member being Unfit and placed on the Temporary Disability Retired List (TDRL) to be reevaluated at 18 months, or sooner if required. A disability rating awarded after a TDRL interim evaluation shall be based on residual conditions. If recurrent tumor is found, permanent retirement at the appropriate disability rating disability is indicated.

g. An individual with minor new malignant skin growth, if found Unfit, will be rated as 'scars-disfiguring' or on the extent of constitutional symptoms, physical impairment and/or other contributing causes.

9003 Organ Transplants

a. Joint prosthetic transplants are discussed under codes 5051 through 5056.

b. Vascular system prosthetics are addressed under the 7000 code.

c. Service members requiring transplant will ordinarily be Unfit due to organ failure. The service member should be placed on the TDRL. In those cases in which a definite date has been set for transplantation, disposition shall be postponed and residuals rated after the transplantation.

d. Those cases that come to the PEB after transplantation shall be rated based on the following factors:

(1) The functional status of the transplanted organ.

(2) The need for sustained immunosuppression or its adverse effects.

Adverse effects may be rated on the basis of specific infections or by analogy (see Alphabetical Listing of Analogous Ratings (enclosure (9), attachment (a))

9004 Anticoagulant Prophylaxis Or Treatment

a. The long-term use of anticoagulants will not be cause to increase the rating of a given medical impairment.

b. Complications arising from the use of anticoagulants should be given separate ratings.

c. Hypercoagulable states requiring chronic use of anticoagulants shall be rated either at:

(1) Zero percent if there has been no thrombophlebitis or embolus in the past year; or,

(2) At least 10 percent if there has been thrombophlebitis or embolus in the past year. However, strong consideration should be given to placement on the TDRL .

(3) A rating greater than 10 percent shall be based on unfitting residuals due to thrombophlebitis or embolus.

9005 Human Immunodeficiency Virus Infection (HIV) And/Or Acquired Immune Deficiency Syndrome (AIDS).

Members found Unfit for HIV and/or AIDS will be rated according to the 6351 code and the rating scheme in the VASRD. The minimum rating of 30 percent, which existed prior to the establishment of the VASRD Code 6351, is no longer in effect. However, the VA has issued guidelines for rating HIV positive conditions and these guidelines should be followed.

9006 SWATO Cases

a. Military personnel who served in the Southwest Asia theater of operations (from August 2, 1990, through a date to be determined) and who are Unfit with a diagnosis of "undiagnosed illness" determined by the physician to be related to service in SWATO shall be rated in accordance with the VA guidance for "undiagnosed illnesses." See paragraph 8016 of enclosure (8) and attachment (a) (1) of enclosure 9.

b. A two-part hyphenated code is used to describe the unfitting condition. The FIRST PART is composed of a prefix of "88" combined with the first two numbers of the body system to which the unfitting symptoms most closely relate. The SECOND PART of the code is the medical condition, in the code series indicated by the second two numbers of the first part of the code, that most closely resembles the service member's circumstances. For example, the first part of the code to describe a case in which the predominant symptom is fatigue could be 8863. The second part is the medical condition in the 6300 series that most closely resembles that of the service member. In that example, the code "6354" is used. Thus, the case is rated by analogy to "Chronic Fatigue Syndrome." The resulting code is "8863-6354".

c. Two requirements must be met to justify using the coding system described in paragraph b above:

(1) The service member is suffering a symptom complex that is not

reasonably definable using currently acceptable diagnostic nomenclature (an "undiagnosed symptom complex"); and,

(2) The service member is Unfit because of the "undiagnosed symptom complex."

9007 Necrotizing Fasciitis

a. Those cases in which the condition has a systemic effect should be rated according to the Alphabetical Listing of Analogous Ratings (attachment (a) of enclosure (9)).

b. If the systemic component has overwhelmed the service member's endogenous immune system, the disability should be rated at 100 percent and the service member placed on the TDRL. Ratings at final disposition shall be based on residuals.

9008 Indwelling Foreign Bodies

Service members with cardiac, vascular or neurosurgical conditions that require indwelling foreign bodies (e.g., pacemakers, defibrillators, venous umbrellas, and ventriculoperitoneal shunts) who are Unfit will be ratable at a minimum of 30 percent for an 18-month observation period following placement of the device.

9009 Fibromyalgia [see VASRD code 5025, enclosure (8), and paragraph 9011a(5)]

a. This condition shall be evaluated by a rheumatologist and meet the requirements of paragraph A5 (b), under paragraph 9011.

b. The diagnostic criteria put forth by the American College of Rheumatology must be met. Current standards shall be used for making the diagnosis.

c. If the MEB report contains fibromyalgia as a diagnosis and is not written by a rheumatologist, there must be a report of recent consultation by rheumatology.

d. Any case with a diagnosis of fibromyalgia must have a psychiatry addendum submitted with the MEB.

9010 Future Changes

As medicine advances, new diagnoses will emerge. Those diagnoses generally accepted by the medical profession (or by a respectable minority of the profession) shall be rated by analogy until the diagnoses become incorporated in the VASRD.

9011 Instructions For Specific VASRD Codes

a. 5000 SERIES CODES

(1) 5000 - Osteomyelitis

(a) Saucerization or sequestrectomy does not necessarily equate with stabilization or cure.

(b) Osteomyelitis extending into a major joint is rated in accordance with the amputation rule.

(c) Note (1) following Code 5000 in the VASRD may appear to be ambiguous in its instructions concerning application of the amputation rule. The minimum rating for active osteomyelitis is 10 percent regardless of the amputation rule.

(d) Under Note (2), a rating may be assigned only when the disease is active clinically or by X-ray.

(2) 5002 - Rheumatoid Arthritis

(a) A distinction is made between active disease and chronic residuals. VASRD Codes 5002, 5004 through 5009 and 5017 will be rated by the same criteria and the VASRD guidance.

(b) Active process: The rating is based on clinical and laboratory features and coded under 5002.

(c) Chronic residuals are rated under appropriate limitation of motion codes (5200 series). Chronic residuals shall be based on clinical features plus radiographic evidence.

(d) The bilateral factor is applied when appropriate.

(e) Ratings for active disease process (5002) should not be combined with ratings for residuals (5200 series).

(f) Pulmonary involvement is rated separately under 6802.

(g) Enteropathies are rated separately under the 7300 series.

(3) 5003 - Arthritis , Degenerative, Hypertrophic, and Pain Conditions Rated by Analogy to Degenerative Arthritis

(a) Each major joint (or grouping of minor joints) with objective limitation of motion plus radiographic evidence is rated at 10 percent. (The bilateral factor applies.)

(b) Radiographic evidence of two or more major joints or groups of minor joints, when accompanied by occasional exacerbations of incapacitating symptoms, is given a total rating of 20 percent. Radiographic evidence alone without symptoms is rated at 10 percent. (No bilateral factor applies).

(c) Limitation of motion of affected joints may warrant rating under 5200 series (the bilateral factor applies) or 9905.

(d) In cases in which there is a limitation of motion not of sufficient degree to rate under the 5200 series or 9905, the rating shall be done under 5003.

(e) Arthritis Due to Direct Trauma, 5010. When an affected joint merits a rating higher than 10 percent, the analogy appropriate to the impairment must be used. Diagnosis alone is insufficient for the 10 percent rating. With an affected joint, the assignment of a 10 percent rating requires the presence of objective evidence of limitation of motion in addition to X-ray findings .

(f) For rating purposes, combinations of interphalangeal, metacarpal-phalangeal, and metatarsal-phalangeal joints are groups of minor joints equivalent to a major joint.

(g) Separate rating of specific joints or joint groups are not intended for application to the fluctuating types of impairments which tend to improve or disappear.

(h) The spine (5285-5295): each segment of the spine (cervical, dorsal, and lumbar) segments is regarded as a group of minor joints . Combination of sacroiliac and lumbosacral joints is regarded as a major joint. Each group of minor joints is ratable as 1 major joint only when separate ratings are justified by radiographic evidence of pathology besides limitation of motion or other evidence of painful motion of the individual segments involved.

(4) 5004 through 5024 - Arthritis , Miscellaneous

5004 through 5009 are rated as code 5002 (Rheumatoid Arthritis). Examples are Reiter's Syndrome, Ankylosing Spondylitis, Transplantation Antigen-related Arthritis or Arthritis secondary to bowel disease. Codes 5010, 5011, 5012 have specific instructions in the VASRD regarding rating. Codes 5013 through 5024 are rated according to Arthritis, Degenerative, 5003 except the code for Gout (5017), which is rated according to code 5002.

(5) 5025 - Fibromyalgia

(a) Fibromyalgia (also called fibrositis, myofascial pain syndrome, or primary fibromyalgia syndrome), is a syndrome of chronic, and widespread musculoskeletal pain associated with multiple tender or "trigger" points, and is often accompanied by multiple somatic complaints. It is a condition for which diagnostic criteria were formally established in 1990 (and have subsequently been revised - see the VASRD for specific guidance as it describes the specific criteria).

(b) Diagnostic criteria include the following:

1. A history of widespread pain that has been present for at least 3 months. There must be both axial skeletal pain and peripheral pain.
2. The presence of pain on digital palpation at 11 of 18 tender point sites.
3. The presence of a second clinical disorder does not exclude the diagnosis.
4. That diagnosis should have been made by or with the consultation of a rheumatologist, who will either be a signatory of the MEB report (with recent consultation report included when sent to the Informal PEB) or the author of a typed addendum.

(c) A psychiatry addendum will be included.

(6) 5051-5056 - Prosthetic Implants

(a) 5054. Total Hip / Total Joint Replacement. Convalescent ratings and ratings for specified periods of time will not be used. In uncomplicated cases the member is usually ambulatory and disposition is possible approximately 1- 3 month after the procedure has been performed. Assignment to the TDRL , with an appropriate rating, is usually required prior to permanent disposition. The provision that a member will be rated at 100 percent for 1 year following implantation of the prosthesis does not apply.

(b) Prosthetic implants do not necessarily render a service member Unfit.

(c) If a service member is considered to be Unfit at the time of a PEB, placement on TDRL should be considered.

(d) If the service member is still found to be Unfit at TDRL reevaluation, a permanent rating should be considered based on residual impairment. In such cases the amputation rule and minimum ratings apply, but convalescent ratings do not apply.

(e) 5055. Knee Replacement (Prosthesis).

1. The provision that a member will be rated at 100 percent for 1 year following implantation of the prosthesis does not apply.
2. If, after maximum hospital benefit has been achieved, a member remains Unfit, rate for residual impairment. If the member's condition has not stabilized for rating purposes, placing on the TDRL should be considered.
3. The VASRD footnote to Code 5055 does not apply.

(7) 5126-5151 - Multiple Finger Disabilities.

A convenient method of computation has made the difficulty often encountered in rating multiple finger disabilities simpler. An "average amputation level" for fingers involved may be calculated by assigning graded values for each finger according to the level at which it was amputated (See enclosure (8), attachment (d), plate III). Graded values may also be assigned for the severity of a finger's ankylosis. The disability may then be rated according to the notes of instruction in the VASRD. The method is as follows:

(a) Step One. The appropriate grade value for each of the individual finger defects is selected by referring to enclosure (8), attachment (d), plate III. Match the appropriate description in enclosure (9) attachment (b), table 1, column A with the corresponding value in column C. These values are ADDED together (totaled).

(b) Step Two. The average grade value is found by dividing the totaled values for the individual fingers by the number of fingers involved. Fractions are rounded to the nearest whole number.

(c) Step Three. The category of defects (favorable ankylosis, unfavorable ankylosis, and amputation) applicable to the multiple finger disabilities taken as a whole is found in column B by matching with the previously calculated average grade value in column C.

(d) Step Four. The correct disability percentage rating is arrived at by referring to the VASRD code that addresses the category of defects found in step three and calculating for the number of fingers involved.

(e) Example: A service member has had the following amputations: thumb amputated through the middle phalanx; long and little fingers through the middle phalanges; and the entire ring finger, including more than one-half of the metacarpal.

Grade value for the thumb	2
Grade value for the long finger	2
Grade value for the ring finger	2
Grade value for the little finger, including more than half of metacarpal	4
Total value	10

Total value/Number of fingers involved = ratable value
 $10/4 = 2 \frac{1}{2} = 3$

Referring to table 1, grade 3 is ratable as amputation. Amputation of four fingers (thumb, long, ring, and little) is ratable under VA code 5127 at 70 percent for major hand, or 60 percent for minor hand.

(f) For rating purposes, the thumb is regarded as having no distal phalanx. Amputation of the thumb at or distal to the interphalangeal joint shall be graded as unfavorable ankylosis (grade value 2).

(8) 5171 - Amputation of Great Toe

Must be through the proximal phalanx to warrant a 10 percent rating.

(9) 5200-5295 - Rating Involving Joint Motion

(a) In measuring joint motion the medical examiner should use the standardized description portrayed in plates I and II, enclosure (8) attachment (d), of this instruction.

(b) When the reported limited range of motion falls between two points specified in the VASRD, the higher percentage of disability is applied.

(c) Ankylosis is the absence of motion of a joint. For disability rating purposes, it is complete fixation, or a limitation of motion so severe in degree that the amount of movement is negligible.

(d) Use of analogies such as "other impairment of" elbow or knee (code 5209 or 5257), is to be avoided when the actual impairment is a limitation of motion of the joint, properly ratable as limitation of flexion or extension of the part distal to the joint.

(e) In some cases of limitation, or of other abnormal joint motion, the basic cause is injury to muscle or tendon rather than to bone or joint. A careful distinction must be made for appropriate rating.

(10) 5205-5208 - Ankylosis or Limitation of Motion of Elbow and Forearm

(a) 5205. When a rating for unfavorable ankylosis is not based on the additional finding of complete loss of supination or pronation, the rating may be combined with 5213, subject to the amputation rule. If less than complete loss of supination or pronation occurs, 5205 may be combined with 5213, but the percentage must not exceed the rating for unfavorable ankylosis under 5205.

(b) 5206-5208. These codes may be combined with 5213, but the percentage

must not exceed the rate for unfavorable ankylosis under 5205. If residuals exceed the maximum rating allowable under 5205 or 5209, the rating for amputation below insertion of the deltoid (5122) may be used.

(11) 5209-5212 - Other Impairments of Elbow , Radius and Ulna

These codes are not to be combined with Code 5213.

(12) 5213 - Impairment of Pronation and Supination

(a) Limitation of either pronation or supination may be rated. However, both should never be rated in the same arm. The higher rating applies.

(b) There is an inconsistency in the schedule for the ratings for the major arm, where "hand fixed near the middle of the arc or moderate pronation" is rated 20 percent, while limitation of pronation with "motion lost beyond middle of arc" is rated 30 percent. Cases in which this conflict arises shall be resolved in the member's favor.

(c) The following terminology for describing measurements of pronation and supination must be used, when assessing impairment, to facilitate uniformity of disability ratings.

1. The STARTING POINT for all motions of pronation and supination shall be zero degrees (thumb on the upper side of the hand with the hand held perpendicular to a flat surface). Supination is that motion between the starting point and palm up position. Pronation is that motion from the starting point to palm down.

2. Full supination is 80 degrees of motion from the starting point. Full pronation is 80 degrees of motion from the starting point.

3. Position of function is 20 degrees pronation (AMA guide).

4. The hand is fixed in full supination with the palm up.

5. Hyperpronation continues beyond the 80 degrees of full pronation with the thumb down.

6. The hand fixed in full pronation is fixed with palm down.

7. The VASRD term "middle of arc" is equivalent to zero degrees.

8. The VASRD term "beyond the last quarter of the arc" is equivalent to the inability to pronate beyond 40 degrees from the starting point.

(d) In some cases of limitation or other abnormal joint motion, the basic cause is injury to muscle or tendon rather than to bone or joint. A careful distinction must be made for appropriate rating.

(13) 5214 - Wrist , Ankylosis of

(a) Ankylosis of the wrist in 10 degrees to 30 degrees of dorsiflexion shall be considered favorable and rated accordingly.

(b) Wrist replacement prostheses are rated according to functional impairment.

(14) 5251-5253 - Limitation of Extension and Flexion of the Thigh

Ratings allowable under these codes may not accurately reflect the degree of disability in circumstances where limitation of motion may reflect a more serious underlying disability of the sacroiliac region, pelvis, acetabulum, or head of the femur. The variability of residuals following injuries to these structures necessitates rating specific residuals; e.g., faulty posture, limitation of motion, muscle injury , painful motion of the lumbar spine , mild to moderate sciatic neuritis , peripheral nerve injury, or limitation of hip motion. More suitable ratings may be selected from VA code 5250 (hip, ankylosis of), VA code 5255 (femur, impairment of, with hip disability), or VA code 5294 (sacroiliac injury).

(15) 5255-5262 - Defects of Long Bones of the Lower Extremity

These codes (malunion with adjacent joint disability) should be applied when appropriate, to avoid multiple codes and ratings. When both a proximal and a distal major joint are affected, however, an additional rating may be indicated for the less disabled joint. Those codes are often appropriate when joint surfaces are included in fracture lines.

(16) 5257 - Knee, Other Impairments

(a) Patellectomy, chondromalacia , osteochondritis dissecans should be rated under 5003. Exceptions are cases in which objective findings warrant rating under code 5257.

(b) Recurrent subluxation or external instability

1. A rating of 30 percent for severe knee instability is awarded in those cases where a Lachman's test of ligament instability-to-stress test reveals a reading in excess of 3+ and where a knee brace, usually a derotation brace, is prescribed for a functional as opposed to a protective purpose. Specifically, a functional knee brace supplements or replaces the function of a major ligament or ligaments required for stability. Laxity in an affected knee must be compared to that of the unaffected knee to determine deviation caused exclusively by the medical condition.

2. A rating of 20 percent for moderate instability is awarded in those cases where the Lachman's test measures an instability reading of 2+ and physical therapy results in no improvement of the knee's lateral instability.

3. A rating of 10 percent for slight knee instability is appropriate in

cases where the Lachman's test measures an instability reading between 1+ and 2+ and physical therapy does not improve the knee's lateral instability.

4. Knee joint replacement shall be rated according to code 5055.

(17) 5270 - Ankle prosthesis may be rated under this number

Maximum disability is 40 percent in keeping with amputation rule. Place on TDRL if appropriate and rate on residual disability after stabilization.

(18) 5272 - Subastragalar or Tarsal Joint Ankylosis

The assignment of a rating under this code is proper only in the absence of motion of the subtalar joint which is manifested by the lack of inversion or eversion of the foot.

(19) 5003-52xx - Stress Fractures

(a) Since the VASRD has no specific rating schedule for these conditions, rating shall be done, as follows:

1. If there is radiographic evidence of fracture of the femur or tibia, it should be rated as any other fracture. The Bilateral Factor would apply, if appropriate.

2. Fracture of the pubic rami confirmed by radiographic findings should be rated under 5003. That is a membranous bone that can be expected to heal quickly. Muscle action of the large thigh adductors is the main aggravating force, not weight bearing.

3. Fracture of tibial and fibular malleoli are seldom displaced, may not require surgery, and except for offering some comfort, casts are not required. The most appropriate rating would be analogous to 5262, slight.

4. Stress fracture of the tarsals or metatarsals should be rated under 5279, metatarsalgia.

5. Tibial plateau and femoral condyle stress fractures are stable unicortical defects which should be rated as analogous to 5259 because of some impairment of knee function. The use of the 5257 would be inappropriate because the lesion is extra-articular and produces pain, not knee instability.

6. Stress reaction without radiographic evidence of fracture should be rated as periostitis under 5022. When listing this VA code on a member's findings, it should be noted as 5022-5003.

7. Service members with stress fractures which are or become completed should probably be placed on the TDRL since the healing process is longer and may actually impact on the member's ability to obtain employment immediately after discharge.

(b) Radiographic Evidence. At the time of the original MEB, a service member may have pain not explained by routine radiographic examination. A bone scan, however, may reveal increased vascularity consistent with stress fracture or stress reaction. After a year, only routine radiographs are necessary to demonstrate that there is or is not evidence of a healed fracture. There is no need for a bone scan. If the service member originally had a fracture, it will be evident on the radiograph. If the current radiographic is normal, then a fracture did not exist at the time of the MEB. The most likely diagnosis was stress reaction.

(c) Service members who develop stress fractures, especially of the femoral neck, during basic training which prevents them from completing basic should be separated with appropriate rating as the injury most likely will recur when the service member is recycled.

(20) 5285-5295 - The Spine

(a) Each segment of the spine (cervical, dorsal, and lumbar) segments is regarded as a group of minor joints. Combination of sacroiliac and lumbosacral joints is regarded as a major joint. Each group of minor joints is ratable as one major joint only when separate ratings are justified by radiographic evidence of pathology besides limitation of motion or other evidence of painful motion of the individual segments involved. Otherwise, rate as for osteoarthritis.

(b) Arthritic impingement on nerve roots produces degeneration of the nerve function or frequent, prolonged attacks of neuralgia. These attacks are to be distinguished from brief episodes of radicular pain. The arthritic impingement should be rated as one entity under codes for neurologic conditions. The exception is a case in which limitation of spinal motion justifies an additional rating.

(21) 5285 - Residuals of Fracture of Vertebra

(a) The need for a service member to wear some type of brace to restrict lumbar or dorsolumbar movement is not similar to the requirement for a jury mast type of neck brace for abnormal mobility after cervical fracture. When no cord involvement is evident, the disability should be rated according to the degree of limited motion with brace in place.

(b) The 10 percent addition to the rating is made only for demonstrable, substantial deformity of a vertebral body (i.e., **VISIBLE TO THE NAKED EYE** and greater than 50 percent compression on a X-ray). It should not be added in those instances of insignificant deformity such as slight shortening of the anterior vertical dimension of the vertebral body. When a successful spinal fusion has been performed because of the deformity, the degree of instability has usually been removed, or so far reduced that the addition of 10 percent is not justified. An extensive spinal fusion may result in a ratable limitation of motion.

Example: If, as residuals of vertebral fractures, a member were to have moderate limitation of motion in cervical and lumbar segments, and substantial deformities of the bodies of C5, T12, and L1, the rating would be:

Line:	1. Code 5285-5290	20 percent
	2. Demonstrable deformity of C5	10
	3. (Subtotal)	30
	4. Code 5285-5292	20 percent
	5. Demonstrable deformity of L1	10
	6. (Subtotal)	30
	7. Combining lines 3 and 6	51 percent

(Since there is no associated finding, there can be no addition because of deformity in T12)

(22) 5286-5289 - Ankylosis of a Spinal Segment

(a) A rating for ankylosis is given only when the range of motion of the whole spinal segment is absent or negligible. Ankylosis of a part of a segment may leave some degree of useful motion for the segment as a whole. In such cases the appropriate rating would be for limitation of motion.

(b) The combination of separate ratings for ankylosis of a spinal segment shall not exceed 60 percent of the rating for complete ankylosis of the spine at a favorable angle.

(23) 5293 - Intervertebral Disc Syndrome

The intervertebral disc syndrome involves a herniation of the nucleus pulposus with impingement on the nerve root resulting in irritation and a radicular distribution of pain.

(a) Because 40 - 50 percent of the population have herniated discs which are asymptomatic, finding a herniated disk on MRI in a service member with back pain does not necessarily imply the herniated disk is the primary cause of the pain.

(b) Ratings of 40 percent - 60 percent will be predicated upon objective neurological findings supported by laboratory data, such as EMG, nerve conductive studies, flow and manometric studies for bowel and bladder involvement.

(c) The weight attached to each finding shall vary according to the co-presence of other findings. Preoperative neurological findings (e. g. absence of knee jerk) may be of less clinical and disability evaluation significance if they persist post-operatively because they may not reflect the actual severity of the current situation.

(d) Surgical excision of a disc without evidence of recurrent disc herniation at the same level or a different level precludes the application of the 5293 code.

(e) Residual cervical pain with radiculopathy, status post excision of a herniated disc should be rated for the pain (5003) or limitation of motion (5290) and for the radiculopathy under the appropriate 8500 series code.

(f) Residual lumbar pain with radiculopathy should be rated as 5295 and the relevant code for neurological impairment.

(24) 5295 - Lumbosacral Strain

(a) Zero percent rating shall be awarded for chronic low back pain of unknown etiology (mechanical low back pain).

(b) Demonstrable pain on spinal motion associated with positive radiographic findings shall warrant a 10 percent rating.

(c) If paravertebral muscle spasms are also present, a 20 percent rating may be awarded. Such paravertebral muscle spasms, however, must be chronic and evident on repeated examinations.

(25) 5296 - The Skull

(a) Area of bone loss where bone regeneration has taken place is not ratable. If regeneration has partially closed the defect, only the remaining area of loss is to be rated.

(b) Areas of total bone loss:

1. Total bone loss from a single area of the skull is not ratable if the defect has been successfully repaired with a prosthetic plate. Residual neurological deficit or cosmetic deformity shall be rated separately if appropriate.

2. When there is total bone loss from multiple areas, such as in trephining, the rating should not be assigned based upon "coin measurement" but on the basis of the aggregate area of loss in terms of square centimeters.

(c) The following conversion measurements shall be used in applying VASRD ratings:

1. Defect of a diagnostic burr hole approximates 1 square centimeter.

2. A 25 cent piece (quarter) = 4.6 square centimeters.

3. A 50 cent piece (half dollar) = 7.35 square centimeter.

4. ADDITIONAL MEASUREMENTS AND GUIDELINES

- 1 centimeter - 0.3937 inch
- 1 inch - 2.54 centimeters
- 1 square centimeter-----0.1550 square inch
- 2 square centimeters-----0.3100 square inch
- 3 square centimeters-----0.4650 square inch

	Diameter of Circle Square Centimeters	Area of Circle Square inches
1 centimeter	0.7854	0.1216
2 centimeters	3.1416	0.4869
3 centimeters	7.0686	1.0956
4 centimeters	12.5664	1.9478
½ inch		0.19635
1 inch		0.7854
1 ½ inches		1.76715
2 inches		3.1416

(d) Diagnostic burr holes and other bony defects are ratable only when contiguous and when there is loss of both inner and outer tables of bone. The areas are added and the total is rated. Approximately 50 percent of diagnostic burr holes heal within 5 years.

(e) Suboccipital skull defects shall not be rated.

(26) 5297 - Removal of Ribs

(a) For removal of ribs , the VASRD requires the complete removal from the vertebral angle to the costo-cartilaginous junction. Removals of a lesser degree are rated as rib resections.

(b) The presence of certain conditions precludes the assignment of an additional rating under Code 5297; exceptions are allowed in specific situations. "Notes (1)" and "(2)" under this code in VASRD provide pertinent guidance.

(27) 5299-52xx - Dupuytren's Contracture

Rate on the basis of limitation of motion of finger movement.

(28) 5301-5326 - Muscle Injuries

(a) Pyramiding must be avoided. There are specific limits to the permissible combination of ratings of muscle injuries in the same anatomical segment, and of muscle injuries in which the movements of a single joint are affected. For example, separate ratings should not be given for an ankylosed joint and an injured muscle rating on that joint.

(b) Ratings for bone and joint impairment should not be combined with ratings for muscle and nerve impairments affecting the same joint

b. 6000 SERIES CODES

(1) 6000-6092 - Diseases of the Eye

(a) The adjudication of disabilities of the visual apparatus is difficult. In some cases involving a combination of defects, arriving at an equitable percentage rating through literal application of the terms of the VASRD may not be possible. The complexity of those conditions does not permit the construction of a simple schedule that is adequate for the variety of defects and resulting types and degrees of impairment that may occur. Here, the concept of "visual efficiency" may be helpful. Visual efficiency is the product of the interdependent relationship of all the functions of the ocular apparatus, of which the three principal ones are central visual acuity, field of vision, and muscle function. Since the estimation of visual efficiency, as such, is not provided by the VASRD as a means of determining a degree of disability, it is useful only to determine the service member's real functional handicap so that an equitable rating in terms of the schedule can be recommended.

(b) The VASRD provides that the combined disabilities of the same eye are not to exceed the rating for total loss of vision of that eye, unless there is an enucleation or a serious cosmetic defect added to the total loss of vision. Accordingly, where there is a cosmetic defect, even though limited to the eye with the visual loss, representing a separate and distinct entity, namely, facial disfigurement, a separate rating of 10, 30, or 50 percent is permitted under 7800 to be combined with the rating for visual loss or rating for enucleation.

(c) Visual field defects must be reported according to the method prescribed in the VASRD, paragraphs 4.76 and 4.76a. Results of muscle function examinations should be reported in accordance with VASRD, paragraph 4.77. Reference to the AMA Guides to the Evaluation of Permanent Impairment (current edition) may assist in computing the extent of impairment.

(d) When computerized techniques are used to determine the extent of diplopia, visual fields, or scotomata, the results must be interpreted in relation to the standard VASRD charts to render a rating.

(e) Visual fields must be submitted using the Goldmann visual field chart plotted using the III-4-e target objective.

(2) 6000-6009 - Conditions Involving Structures of the Globe

(a) Disabilities resulting from these conditions are rated as follows:

1. STEP ONE:

- a. Impairment of visual acuity is rated.
- b. Impairment of field of vision is rated.
- c. Active pathology, if-present, is rated at 10 percent.
- d. The higher of the first two ratings is combined with the 10% active pathology.

2. STEP TWO: Pain, rest requirements and/or episodic incapacity are rated from 10 to 100 percent. This rating, when only one eye is involved, is not necessarily limited to the 30 percent rating for total loss of vision of one eye, since pain or rest requirements may be incapacitating to any degree, including total. This rating is assigned the code which covers the basic condition (i.e., Code 6000 through 6009). Analogy to another code is not required. It is an estimate based as nearly as possible upon the actual impairment of social and industrial function which is imposed by the pain experienced, the time lost because of the requirement for rest, the frequency of incapacitating episodes, or any combination thereof. The additional rating of 10 percent for continuance of active pathology should not be combined with this rating.

3. STEP THREE: The higher of the ratings resulting from Steps One and Two, is awarded.

(b) Retained foreign body is rated as active pathology as in Step One, above, if in a critical area or not stabilized. Otherwise, the rating is for residuals under Step Two.

(3) 6013 - Glaucoma , Simple, Primary, Noncongestive

The minimum rating is applicable if the diagnosis is satisfactorily established, whether or not visual acuity or field of vision has been affected. The rating is for the disease, rather than for functional impairment of an individual organ, and applied whether the disease progresses or not.

(4) 6029 - Aphakia . Process Involves One or Both Eyes

This condition is usually not Unfitting. However, requirements of a particular military occupational skill must be considered in making a Fitness determination. If the member is determined Unfit, the appropriate rating shall be applied. The condition, if corrected by successful prosthetic implants (pseudophakia), is not considered Unfitting or ratable unless the prosthetics are specified as too unstable to withstand duty stress.

(5) 6081 - Scotoma , Pathological

The rating is 10 percent whether unilateral or bilateral. Other ratings may be combined with the reservation that the rating for one eye may not exceed 30 percent, unless

there is enucleation or a serious cosmetic defect. Central scotoma cannot, however, be combined with central visual loss.

(6) 6090-6092 - Diplopia

The VASRD uses the Goldmann Perimeter Chart (plotted using the III-4-e target objective) to describe the location in the field of vision where diplopia occurs. The VASRD, under 6090-6092, converts the location in the field of vision where diplopia occurs to an equivalent visual acuity that then can be used in the final rating. The final rating is achieved by referring to VASRD Table V "Ratings for Central Visual Acuity Impairment". The equivalent visual acuity is substituted for the actual visual acuity of the worse eye (if visual acuity is the same in both eyes, one eye will arbitrarily be considered worse), and plotted against the actual visual acuity of the better eye. The intersecting box provides the percentage rating and the VASRD code.

(7) 6200 - Otitis Media, Suppurative, Chronic

The 10 percent rating during the continuance of the suppurative process is intended as compensation for the existence of active pathology rather than for additional impairment of the individual sense organ. This rating is therefore limited to 10 percent, whether the pathological process is unilateral or bilateral.

(8) 6207 - Deformity of Auricle

If associated with disfiguring scars of face or head, Code 7800 may be appropriate. Avoid pyramiding.

(9) 6300-6354 - Systemic Conditions

Convalescent ratings of 6 or 12 months provided under certain of these codes are not applied by the Military Departments.

(10) 6309 - Rheumatic Fever

When a member is determined to be Unfit because of recurrence of disease, the member may be rated at zero percent (see VASRD paragraph 4.31) if there is no residual functional impairment. If residual functional impairment is diagnosed, the member shall be rated accordingly under the proper code.

(11) 6350 - Lupus Erythematosus, Systemic

Some Connective-tissue diseases, such as vasculitis, collagen disease, immune complex disease, and other disseminated diseases, not elsewhere covered, are to be rated under this code. Refer to Alphabetical Listing of Analogous Ratings (enclosure (9), attachment (a))

(12) 6351 - Human Immunodeficiency Virus Infection (HIV) and Acquired Immune Deficiency Syndrome

(a) This is the only code used in rating HIV or AIDS.

(b) The rating criteria shall be according to the VASRD and VA guidelines

for rating HIV cases. The service member must be determined to be Unfit because of that condition before rating. Seropositivity alone is not Unfitting.

(13) 6354 - Chronic Fatigue Syndrome (CFS)

(a) These cases must meet the definition put forth by the National Institutes of Health (current standards). The VASRD also lists criteria to meet the definition.

(b) The VASRD requires that six or more of the characteristics listed in paragraph 4.88a-3 (of the VASRD) must be met .

(c) Both major criteria and eight or more of the minor criteria must be met .

(d) "Incapacitation " means that the service member requires COMPLETE bed rest and FREQUENT treatment by a RHEUMATOLOGIST.

(e) In accordance with the VASRD , the diagnosis of CFS requires new onset of debilitating fatigue severe enough to reduce daily activity to less than 50 percent of the usual level for at least 6 months.

(f) An active duty service member referred to the PEB for Chronic Fatigue Syndrome must have been thoroughly evaluated. The referring MEB report shall include a psychiatric evaluation, unit commander assessment, report of observation in a hospital setting, other observer (peers, et. al.) accounts, and interpretation of the results of (at least) the following laboratory tests: CBC (differential, WBC), ESR, liver function tests, albumin, globulin, calcium, phosphate, electrolytes, glucose, BUN, creatinine, thyroid studies, and urinalysis.

(g) The fatigue symptoms may be part of an underlying psychiatric disorder. In such cases, the psychiatric disorder rather than Chronic Fatigue Syndrome should be assessed as the potentially Unfitting condition. If the service member is rated separately for Chronic Fatigue Syndrome and the psychiatric disorder, pyramiding would result. However, if the service member has a psychiatric disorder that is clearly separate from a coexisting Chronic Fatigue Syndrome that is validly based on NIH diagnostic criteria, both conditions should be assessed and rated as to impact on Fitness.

(14) 6519 - Aphonia , Organic

Impairment of ability to speak may be ratable under more than one code, depending on the cause and severity of the impairment. In such instances, the highest applicable rating is awarded. This section does not apply to speech impairment due to loss of whole or part of tongue that is rated under Code 7202.

(15) 6600-6604 - Disease of the Trachea and Bronchi

Unless contraindicated, pulmonary function tests, performed both with and without medication, must confirm the clinical diagnosis and severity (see enclosure (9), attachment (b), table 2). If the service member's condition is subject to significant variation over time,

a single clinical and pulmonary function evaluation may not be adequate. Response to therapy is to be considered in all cases. Pulmonary Function Tests:

(a) The pulmonary function test values listed in enclosure (9), attachment (b), table 2 should serve as guidelines in determining ratings.

(b) When an MEB is held for restrictive or obstructive pulmonary disease, rating is usually based upon pulmonary function tests (PFTs) measuring residual function. There must be a minimum of one set of PFTs. Studies should be performed both before and after medication:

1. When the results of pre-bronchodilator PFTs are normal, post-bronchodilator studies are not required.

2. In all other cases, post-bronchodilator studies should be done unless contraindicated (because of allergy to medication, etc.) or if a patient was on bronchodilators before the test and had taken his/her medication within a few hours of the study.

a. A physician who determines that a post-bronchodilator study should not be done in a given case should provide an explanation.

b. The members of the Informal PEB shall request either the explanation when not provided or a repeat of the studies.

c. The post-bronchodilator results will be used in applying the evaluation criteria in the rating schedule. There is a small group of patients (5 percent or less) in whom there may be a paradoxical reaction to bronchodilators; i.e., the post-bronchodilator results will be poorer than the pre-bronchodilator results. When there is a paradoxical response, the better (pre-bronchodilator) values will be used in the rating.

d. When there is disparity between the results of different tests (FEV-1, FVC, etc.) so that the level of evaluation would differ depending on which test result is used, the test with the better (higher) values (i.e. that would give the lower evaluation) will be used. The reason is that these tests are effort-dependent, and the difference is usually due to the effort applied in each test. However, if there is a substantial disparity in the results, the MEB physician may be asked for an explanation and/or request that the test be repeated if there is no clear reason.

e. When the FEV-1 is greater than 100 percent, an FEV-1/FVC ratio that is below normal should be considered a physiological variant rather than an abnormal value.

3. Where warranted, the member should have a methcholine challenge, especially when the original set of PFTs are "normal".

4. In cases of exercise-induced asthma , PFTs after exercise should be performed.

5. Specific rating considerations under VASRD code 6602 are as follows:

a. 30 percent rating: VASRD provides that this rating will be assigned in the presence of “daily inhalational or oral bronchodilator therapy, or; [sic] daily inhalational anti-inflammatory medication”. For the proper interpretation and application of the forgoing, it is important to delineate the medical requirement for the type of medication specified. Thus, in order to qualify for the 30 percent rating, it must be shown that, by accepted medical principles, medication is required to permit normal day-to-day duty activities. The 30 percent rating is appropriate when the clinical situation is sufficiently tenuous as to not permit a day off of qualifying medication without running a significant risk that disabling symptoms would emerge. However, the 30 percent rating is not solely dependent on medication use. The PFTs must also be considered.

b. 60 percent rating: VASRD criteria include a reference to “at least monthly visits to a physician for required care of exacerbations”. For disability rating purposes, interpret the term “exacerbation ” as an episode requiring emergency department attention.

(16) 6701-6704: 6730 and 6732 - Active Tuberculosis

Active tuberculosis shall be rated under code 6730. All periods of time specified in the VASRD for the management of tuberculosis, active or inactive, apply only to the VA and do not apply to the military. Treatment and clinical response shall serve as the criteria for disposition . Rating for residuals shall be based on functional impairment.

(17) 6721-6724: 6731 - Inactive Pulmonary Tuberculosis

(a) Determining Inactivity. Pulmonary tuberculosis is considered to be inactive when:

1. There are no symptoms of tuberculosis origin. Serial roentgenograms show stability or very slow shrinkage of the tuberculosis lesion. There is no evidence of cavitation. Sputum or gastric washings show negative on culture or guinea pig inoculation. Those conditions shall have existed for at least 6 months.

2. Established by evaluation. That is usually, but not always, at the time the patient is declared to have received the maximum benefits of hospitalization.

3. Six months have passed since surgical excision of an active lesion during which time there shall have been no evidence of tuberculosis activity in any body system.

(b) Chemotherapy. Treatment by medication is frequently continued beyond

the date when the disease becomes inactive according to the above criteria. The ending date of such treatment does not define the beginning of the inactive status.

(c) Rating Residuals. A rating of 100 percent for 1 year after the date of attaining inactivity shall not be used. After the condition becomes inactive, residuals (e.g., impairment of pulmonary function, surgical removal or resection of a part) should be rated under the appropriate VA Code, subject to the limitations contained in paragraphs 4.96a and b of the VASRD .

(18) 6834-6839 - Mycotic Pulmonary Infections

These diseases are rated using the criteria set forth in DC (disability code) 6839.

(19) 6838 - Aspergilloses of Lung

This code refers only to invasive aspergillosis or to aspergilloma. Active or recurrent allergic aspergillosis is rated using the criteria listed under 6839.

(20) 6810 - Pleurisy . Serofibrinous

If significant ventilatory impairment is present, use the criteria listed under Code 6845.

(21) 6843 - Pneumothorax

The "100 percent 6 months" rating should not be applied. A known underlying condition may be rated. If there is none, rating accordance with criteria listed under 6845.

(22) 6844 - Pneumonectomy

Rate in accordance with disability code 6845. If, at a later date, thoracoplasty becomes necessary for obliteration of space within the thorax, the rating for pneumonectomy shall be combined with a rating removal of the ribs .

(23) 6844 - Lobectomy

An entire lobe other than the right middle lobe must be removed for the defect to be ratable. Excision of the right middle lobe, segment resection, or lingulectomies are not ratable. Ratings are based on total body impairment and pulmonary function tests.

(24) 6846 - Sarcoidosis

This disease is difficult to rate because of its unpredictable course and the number of body systems that may be involved. Rate by the criteria listed under code number 6846 when the predominant manifestations are pulmonary. With other organ or more generalized involvement and manifestations such as lymphadenopathy, transient joint pains and occasional febrile episodes, rate under specific body system involved.

(25) 6847 - Sleep Apnea Syndromes

The VASRD lists four percentage rating options: 0 percent, 30 percent, 50 percent, and 100 percent under this code, corresponding to assessed levels of disability relative to civilian earning capacity due to Sleep Apnea. The following interpretation will apply:

Total industrial impairment	100 percent
Considerable industrial impairment	50 percent
Definite industrial impairment	30 percent
Mild industrial impairment	0 percent

(26) Pulmonary function tests requirement

In general, the conditions listed under the following ratings must have pulmonary tests submitted with the board. Ensure that PFT testing is performed in accordance with the PEB's requirements prior to submission of the board.

- (a) 6520. Stenosis of the Larynx .
- (b) 6600-6604. Diseases of the Trachea and Bronchi.
- (c) 6825-6833. Interstitial Lung Disease.
- (d) 6840-6845. Restrictive Lung Disease.

c. 7000 SERIES CODES

(1) General

(a) Evaluation and reporting of cardiovascular function should be in accordance with current VASRD standards (to be upgraded as the VASRD is). These standards refer to evaluations in terms of METs of energy expended to produce a certain level of symptoms.

1. Objective measurements of the level of physical activity, expressed as METs (metabolic equivalents), at which cardiac symptoms develop is the main method of evaluating cardiovascular entities now.

2. The exercise capacity of skeletal muscle depends on the ability of the cardiovascular system to deliver oxygen to the muscle, and measuring exercise capacity can, therefore, also measure cardiovascular function. The most accurate measure of exercise capacity is the maximal oxygen uptake, which is the amount of oxygen, in liters per minute, transported from the lungs and skeletal muscle at peak effort. Because measurement of the maximal oxygen uptake is impractical, multiples of resting oxygen consumption (or METs) are used to calculate the energy cost of physical activity. One MET is the energy cost of standing quietly at rest and represents an oxygen uptake of 3.5 milliliters per kilogram of body weight per minute. The calculation of work activities in multiples of METs is a useful measurement for assessing disability and standardizing the reporting of exercise workloads when different exercise protocols are used.

3. Alternative methods of evaluating function are provided for

situations where treadmill stress testing is medically contraindicated – the examiner’s estimation of the level of activity, expressed in METs and supported by examples of specific activities, such as slow stair climbing or shoveling snow that results in dyspnea, fatigue, angina, dizziness or syncope is acceptable.

a. Other objective criteria which can be used as alternatives to the METs-based criteria for valvular heart disease include whether there is heart failure; the extent of any Left ventricular dysfunction; the presence of cardiac hypertrophy or dilatation; and the need for continuous medication.

b. Left ventricular ejection fraction of less than 30 percent or chronic congestive heart failure for a 100 percent evaluation

c. Left ventricular ejection fraction of 30 to 50 percent or more than one episode of acute congestive heart failure in the past year for a 60 percent evaluation.

d. Evidence of cardiac hypertrophy or dilatation on electrocardiogram, echocardiogram, or X-ray for 30 percent evaluation

e. Requirement for continuous medication for 10 percent evaluation.

(b) General guidance for various percentage ratings using METs for valvular heart disease (7000) as well as most of the cardiovascular disorders:

1. 100 percent. If a workload of three METs or less produces dyspnea, fatigue, angina, dizziness or syncope. A workload of three METs represents such activities as level walking, driving and very light calisthenics.

2. 60 percent. If a workload of greater than three METs but not greater than five METs results in cardiac symptoms. Activities that fall into this range include walking 2 ½ miles per hour, social dancing, light carpentry, etc.

3. 30 percent. If a workload of greater than five METs but not greater than seven METs produces symptoms. Activities that fall into this range include slow stair climbing, gardening, shoveling light earth, skating, bicycling at a speed of 9 to 10 miles per hour, carpentry, and swimming.

4. 10 percent. If a workload of greater than 7 METs but not greater than 10 METs produces symptoms. Activities that fall into this range include jogging, playing basketball, digging ditches, and sawing hardwood. When symptoms develop only during such activities, there may be some impairment of earning capacity, but it is likely to be slight. The alternative criterion for 10 percent evaluation is the need for consistent medication.

(c) Other specific Items:

1. The 30 percent minimum evaluation for arteriosclerotic heart disease and myocardial infarction (7005 and 7006) is NO longer warranted.

2. Placement of a cardiac pacemaker no longer warrants a 30 percent minimum rating in the VASRD but in accordance with paragraph 9008 the member generally will be put on the TDRL for at least one period of evaluation.

3. Placement of an AICD (Automatic Implantable Cardioverter-Defibrillator) warrants the unique application of a 100 percent observation rating and placement on the TDRL.

(2) 7000 Series - Cardiovascular Disease. (Tables 3 and 3a provide guidance for rating cardiac functional status.)

(a) Pyramiding Must be Avoided. Only one rating should be given for all manifestations of cardiovascular or renal disease when, according to accepted medical principles, the conditions have the same origin or cause. For example, hypertension and end organ nephropathy due to arteriosclerosis are related etiologically and may be regarded as one clinical entity. The disability should be rated under the code representing the predominant signs and symptoms. In some cases, the related manifestations in another body system will be so severe as to increase the service member's overall impairment to the point that the next higher percentage under the selected code shall be justified. The note in the VASRD under code 7507 is pertinent.

(b) A specific determination correlating energy/effort expended (METs) with clinical symptoms is required.

(c) Do not award convalescent ratings.

(3) Valvular Heart Disease

Valvular heart disease not of arteriosclerotic or hypertensive origin should be rated as rheumatic heart disease, code 7000 if the predominant symptoms are due to valvular pathology.

(4) Rheumatic Heart Disease

(a) A determination of existed prior to service for rheumatic heart disease may be justified even though its presence was not previously recorded. Such a determination shall depend upon the medical history and findings in the light of accepted medical principles. A stenotic valvular lesion, discovered early in military service, is an example.

(b) A "definitely" enlarged heart is one in which there is positive evidence of

enlargement beyond the "doubtful" or "borderline" enlargement that is sometimes reported when the presence of enlargement is uncertain. Voltage criteria alone are not acceptable as electrocardiographic evidence of definite enlargement. Enlargement of the heart shall be determined by objective evidence using appropriate measures other the electrocardiogram.

(c) The 100 percent rating for active rheumatic heart disease for 6 months is not applicable.

(5) 7005-7006 - Arteriosclerotic Heart Disease, Myocardial Infarction

(a) Do not combine a rating for arteriosclerotic heart disease with one for hypertensive heart or hypertensive vascular disease (Code 7007 or 7101).

(b) Rating of 100 percent under this code solely on the basis of the acute attack occurring within a three month period will not be applied.

(c) When an infarction or other acute conditions evaluated under these codes has occurred within approximately 6 months preceding evaluation or when the member's condition does not appear to have stabilized sufficiently to permit evaluation, place on the Temporary Disability Retired List (TDRL) and remove as soon as clinically stabilized.

(6) 7005-7017 - Disease of the Coronary Arteries. Surgical Procedures, and Trauma

(a) For service members on active duty, to include those active duty for less than 31 days, myocardial infarction incurred during such periods shall be presumed "aggravated" by performing such duty. This presumption may be overcome when it can be shown by a preponderance of evidence that the condition was not aggravated by military service.

(b) Coronary bypass surgery, valve prosthesis, or other cardiac surgery shall be rated on the extent of residual functional impairment when the condition is stable. If stability cannot be established, a period of TDRL should be considered.

(7) 7007-7101 - Hypertensive Heart Disease and Hypertensive Vascular Disease

(a) Obtain blood pressure reading, to be used in determining disability rating percentages, under normal circumstances and during usual activities. When antihypertensive medication is required for control, base the rating on the pressures obtained during usual activities, while under medication. Hypertension brought under control through optimum conditions (that is, during hospitalization under a regimen of medication and enforced rest) will not be used as a basis for evaluation, unless it is established that such control continues upon resumption of normal activity. Similarly, readings obtained during periods when indicated medication is withheld for purposes of medical observation, diagnostic study, etc., are not used as the basis for evaluation. A minimum of 10 readings taken on at least 5 days, on treatment, and under conditions as close as possible to normal

duty performance, will be necessary. Also, correlate blood pressure levels with other evidence of end organ change; e.g., eyegrounds, neurologic exam, etc. The member, while in a hospital status, may be engaged in activities which for adjudicative purposes, are considered as unrestricted and comparable to "outside of the hospital environment." For example, he/she is ambulatory to the mess hall, receives weekend passes, engages in ward housekeeping duties. The level of hypertension is not to be determined by an average of all readings, but rather the predominant readings are to be the basis for determination of the level of hypertension.

(b) When a combination of 7007 or 7101 exists with 7005, rate the individual under the code that most accurately reflects the disability. The presence of stigmata of hypertensive disease does not warrant rating at a higher level, unless there is clinically significant secondary organ involvement, such as renal impairment. When significant changes are present, consider raising the rating one step.

(c) Careful evaluation is necessary in making the frequently tenuous distinction between hypertensive heart disease and hypertensive vascular disease, especially for the minor degrees of severity. Generally, to justify the 30 percent rating for hypertensive heart disease, all of the criteria mentioned in the VASRD for that rating shall be met. "Definite enlargement of the heart" means certain left ventricular hypertrophy by EKG criteria, other than voltage alone, with allowance for T-wave changes which may reflect medication more than pressure. The X ray appearance of the heart is deceptive in concentric hypertrophy, but must be at least consistent with that diagnosis.

(8) 7015-7017; 7110 - Surgical Procedures Associated with AV Block, Heart Valve Replacement, Aneurysms

Convalescent ratings and ratings for specified periods of time following surgery do not apply. Ratings are based on the degree of functional impairment. However, maximum ratings do apply.

(9) 7100 - Arteriosclerosis, general

The 20 percent rating under that code is rarely appropriate. It is preferable to rate impairment of the body system most involved by the disease.

(10) 7120 (7199-7120) - Hypercoagulable states requiring chronic anticoagulation (see paragraph 9004)

(a) At least 10 percent (but with strong consideration of placement on the TDRL) is given if there have been episodes of thrombophlebitis or emboli in the past year.

(b) A zero percent rating is given if there have been no episodes of thrombophlebitis or embolus in the past year.

(c) Higher ratings are based on residuals to emboli or thrombophlebitis.

d. 7300 SERIES CODES

(1) 7305 - Ulcer, Duodenal

Medical and surgical management have been increasingly effective. Cases refractory to accepted medical therapy may be determined Unfit for continued active duty.

(2) 7307 - Gastritis , Hypertrophic

That diagnosis must be made by endoscopy. It should not be rated separately, however, if other conditions are present that produce a common impairment. A single valuation shall be assigned under the diagnostic code that reflects the predominant disability with elevation to the next higher rating if the severity of the overall disability warrants.

(3) 7308 - Postgastrectomy Syndrome

In evaluating and rating, care must be taken to differentiate between nondisabling symptoms or minor discomfort which sometimes result from overindulgence, such as that experienced from overeating by a person without a gastrectomy, and discomfort symptomatic of a true postgastrectomy syndrome. Circulatory or comparable symptoms, even though mild or intermittent, such as a need for rest after meals, are indicative of impairment that may be a basis for rating.

(4) 7328-7329 - Intestinal Resections

When portions of both large and small intestines have been removed, the rating should be done using the code that is most representative of the clinical manifestations.

(5) 7332-7336 - Ano-Rectal Conditions

Pilonidal cyst or sinus is primarily a disorder of ectoderm and shall be rated as a skin condition. However, when an active process is present the rating is by analogy to Code 5000.

(6) 7338 - Hernia , Inguinal

If correctable and there are no contraindications to surgery, hernia is not ratable if surgery is refused.

(7) 7345 - Hepatitis

(a) Acute infectious hepatitis will usually resolve without residual impairment. Liver function tests should return to normal. Although not generally considered Unfitting, there may be instances where the member should be placed on the TDRL to see what course their disease takes.

(b) Chronic persistent hepatitis is a condition with minimally disturbed histology and liver function tests. There is no persistent disability or progression, and both time and supporting evidence confirm that. Rating for residuals is seldom justified. Placement on the TDRL may be proper when the clinical and laboratory course (particularly in the presence of persistent antigenemia) indicates a need for continued observation to rule out chronic active hepatitis.

(c) Chronic active hepatitis is a frequently progressive condition that may or may not be associated with a demonstrable antigen. Since the course of the disease is often difficult to predict, placement on the TDRL may be proper before permanent disposition is made.

(d) Other forms of inflammatory liver disease will be rated by analogy to infectious hepatitis or to other specific VASRD codes if applicable.

(e) There are now specific sections in the VASRD for Chronic liver disease without cirrhosis (including hepatitis B, chronic active hepatitis, autoimmune hepatitis, hemochromatosis, drug-induced hepatitis, etc., but excluding bile duct disorder and hepatitis C). Hepatitis C (or non-A, non-B hepatitis).

Ratings are based on the severity, frequency and debilitating nature of signs/symptoms as they pertain to the member's performance. The VASRD has specific guidelines.

(f) Weight loss. For purposes of evaluating conditions in the GI/Digestive System section, the term "substantial weight loss" means a loss of greater than 20 percent of the individual's baseline weight, sustained for three months or longer; and the term "minor weight loss" means a weight loss of 10 to 20 percent of the individual's baseline weight, sustained for 3 months or longer. The term "inability to gain weight" means that there has been substantial weight loss with inability to regain it despite appropriate therapy. "Baseline weight" means the average weight for the 2-year period preceding onset of the disease.

(8) 7347 - Pancreatitis

If diabetes is present, the predominant disease should be rated, with consideration given to the other, under a single code, to avoid pyramiding .

e. 7500 SERIES CODES

(1) 7500-7542 - The Genitourinary System

The VASRD rating scheme for disabilities related to the genitourinary system is based on renal or voiding dysfunctions, infections, or a combination of these. The major areas of rating are as follows:

(a) Renal dysfunction

(b) Voiding dysfunction

1. Urinary frequency

2. Obstructed voiding

(c) Urinary tract infection

(2) 7500-7542 - The Genitourinary System

Sterility and impotence are NOT ratable entities. Anatomical loss of procreative organs shall not be rated.

(3) 7500-7509; 7531-7541 - Upper urinary tract

In assessing impairment of the upper urinary tract, the endogenous creatinine clearance tests serve as guidelines for evaluating renal function. Normal creatinine clearance is 80-139 milliliters (ml)/minute in men and 80-125 ml/minute in women. (See table 4). The criteria under renal function lists further numerical laboratory guidelines to be used in conjunction with table 4.

(4) 7512, 7516, 7542 - Total Incontinence

Incontinence may be rated as bladder fistula, 100 percent, when use of an appliance is unsatisfactory or not feasible.

(5) 7527 - Prostate Resection.

In order to be ratable, if the member is Unfit, there must be symptoms and objective evidence of impairment.

(6) 7528 - New growths, Malignant

Any specified part of genitourinary system. Some malignant tumors of the genitourinary tract are subject to cure, even if widespread metastases have taken place. Completion of treatment and follow-up on active duty are desirable. If adverse reaction to treatment or persistent evidence of tumor activity interfere with duty, TDRL may be considered. In those instances when specific tumors are refractory to all treatment, final disposition should be made.

(7) 7542 - Neurogenic Bladder

The number of required catheterizations or number of changes of absorbent pads per day should be listed to ascertain the functional impairment.

f. 7600 SERIES CODES

(1) 7600-7627 - Gynecological Conditions

The VASRD has rating criteria for unfitting gynecological conditions that include endometriosis .

(2) 7617, 7618, 7619 - Procreative Organs

Loss of procreative organs is not ratable. Only significant disqualifying and Unfitting residuals should be rated.

(3) 7626-7627 - Mammary Gland Removal

Not all service members who have had mastectomies for malignancy are Unfit. After the observation period has expired, unfitness is based on residual impairment of the arm or chest wall or effects of radiation or other treatment.

g. 7700 SERIES CODES

(1) 7703 - Leukemia

Leukemia requiring the use of chemotherapeutic agents is rated analogous to leukemia requiring irradiation or transfusion. Although some prolonged remissions and "cures" are being achieved with acute leukemia, temporary retirement should be considered in most cases at a maximum rating. Service members with chronic leukemia who require treatment are often Fit for prolonged periods of time with few performance restrictions. Such cases must be individually judged on their merits. The principles noted below under 7709 should be considered in leukemia cases.

(2) 7705-7706 - Purpura Hemorrhagica: Splenectomy

Only residuals, if any, of the basic condition leading to the splenectomy should be rated.

(3) 7709 - Lymphogranulomatosis (Hodgkin's Disease)

Staging is the basis for clinical management of Hodgkin's Disease under treatment.

(a) Clinical staging serves as a general guide for treatment, rating, and disposition of Hodgkin's Disease. Table 5 can be used with the understanding that many advances in treatment that may permit exceptions are taking place. Hodgkin's Disease ratings and disposition may be carried out according to the following guide:

	<u>(Stage A)</u> <u>Stage</u>	<u>(Stage B)</u> <u>Rating</u>	<u>Disposition</u> <u>Rating(if Unfit)</u>
I	30	60	TDRL
II	30	60	TDRL
III	60	--	TDRL
III	--	100	TDRL
IV	100	100	TDRL

Note: Fitness or Unfitness is not determined, as a rule, until response to initial treatment has been assessed.

(b) Prolonged remissions and cures, even with salvage treatment, are becoming more commonplace. Regardless of the pretreatment stage of the disease, retention on active duty during treatment, or return to active duty after treatment on the TDRL may be possible. Intensive treatment, however, may be extremely traumatic. Degradation of both physical and mental functions may be disabling for varying periods of time. Final disposition must be individualized according to both subjective and objective residuals.

(4) 7714 - Sickle Cell Anemia

The VASRD rates all the manifestations of sickle cell disease and its variants. Individuals with the more severe hemoglobinopathies are not acceptable for entry into the military services. Policies concerning line of duty and service aggravation apply.

(5) 7716 - Aplastic Anemia

(a) A service member scheduled for transplantation shall be rated after the transplant.

(b) When the MTF has opted to retain the member for a transplant, the MTF will place the member on a LIMDU status pending transplant. MEB referral to the PEB should be delayed until the procedure and maximum benefit of treatment has been achieved.

h. 7800 SERIES CODES

(1) 7801-7802 - Scars , Burns.

When calculating burn areas, enclosure (8), attachment (d) (1), plate IV, enclosure (9), attachment (b), table 6 and the following measurements may be of assistance:

Avg 70 kg (150 lbs.) male body surface = 1.7m^2

$2636\text{ in}^2 = 18.3\text{ ft}^2$

1 meter = 39.375 inches

$1\text{ meter}^2 = 1550.4\text{ in}^2$

(a) These instructions supplement the criteria in the VASRD to permit a realistic rating of actual impairment of function:

1. Rate third degree burn scars , which cause limitation of function of underlying structure, by analogy to other codes which reflect the functional impairment.
2. Rate unsuccessful healed or grafted areas according to Code 7801. Footnotes to code 7901 in the VASRD apply.
3. Rate successfully grafted third degree burn areas as second degree burns under Code 7802. The footnote to code 7802 in the VASRD applies.

(b) Use of photographs submitted by the MTF's medical photo department should be standard practice to assist with estimation of percentages. All photos should be labeled and contain the date taken.

(2) 7802 - Scars , Burns , Second Degree

VA Code 7802 limits rating to 10 percent of second degree burns affecting an area or areas approximately 1 square foot. When there are widely separated areas and each area is approximately 1 square foot or more, 10 percent may be assigned for each scar.

(3) 7804 - Scars , Superficial, Tender and Painful

This rating of 10 percent may be assigned whenever the requirements are met for the area of involvement even though the rating may exceed the amputation rating, but only if the amputation rating is 0 percent. Do not combine a rating assigned for a scar under these circumstances, with any other rating for disability which involves the same area or digit.

i. 7900 SERIES CODES

7913 - Diabetes Mellitus

(1) The format published by the National Diabetes Group shall serve as the basis for classifying diabetes mellitus (DM). The severity of each case should be individualized taking into consideration the expected natural course of the disease variants. Insulin dosage is not a good indicator of severity and is only one factor to consider in the overall evaluation of the disease. Response to specific therapy, diet, activity, compliance, and time are all important. With adequate compliance, many diabetics are Fit with minimum restrictions. Young adults with type I DM (insulin dependent) are not a good risk for retention.

(2) If Unfitness derives, in part, from documented noncompliance with prescribed treatment, including diet and weight control, the assigned rating should not be higher than the disease would warrant if the member followed prescribed treatment.

(3) DM controlled by diet and oral medication, without a need for daily insulin, and that does not impair health or vigor, or cause significant limitation of activity, is considered to be mild, if unfitting.

(4) Ratings must reflect the severity of the DM, as such. Undue importance should not be given to early or questionable complications. That is particularly true in considering ratings of 60 percent or above. In most instances, a lower rating should be given. Complications such as vascular insufficiency, visual defects, pruritis, and neuropathies should be rated separately. The presence of early or questionable complications in otherwise less than severe DM does not automatically warrant a higher rating.

j. 8000 SERIES CODES

(1) 8000-8412 - Organic Disease of the Central Nervous System

Careful correlation of the footnote under 8046 with the italicized introduction to 8000-8046 should enable Boards to select the proper rating approach. In some of those conditions, the minimum rating may be awarded on the basis of the diagnosis alone, whether or not there are residuals. In others, the minimum rating may be awarded only if there are residuals. If such cases have neither residuals capable of objective verification nor subjective residuals which are credible, consistent with the disease, and are not more likely

attributable to other disease, the condition should be ratable at zero percent, if the service member is Unfit.

(2) 8007-8009 - Brain Vessels

The 6-month convalescent rating does not apply. In many of these cases, the danger of disastrous recurrences justifies a rating (of residuals) sufficiently liberal to provide temporary retirement and subsequent reevaluation.

(3) 8017-8018, 8023-8025 - Degenerative Disorders of the Central Nervous System

Combined ratings may be assigned under those codes with the bilateral factor added.

(4) 8100 - Migraine

"Prostrating" means that the service member must stop what he or she is doing and seek medical attention and is incapacitated.

(a) The number of prostrating attacks per time period (day, week, month) should be recorded by a neurologist for diagnostic confirmation.

(b) Documentation of these visits to the medical department representatives must be available in the medical record. Estimation of the social and industrial impairment due to migrainous attacks should be made.

(c) The Medical Board report must contain the types of medications that the member has tried, both prophylactically and abortive and the results of each medicine.

(5) 8108 - Narcolepsy

The VASRD defers the determination of disability ratings to code 8911 (epilepsy, petit mal). The latter code lists five percentage rating options for minor seizures: 10 percent, 20 percent, 40 percent, 60 percent, and 80 percent corresponding to assessed levels of disability relative to civilian earning capacity due to subject condition. The following interpretation will apply:

Profound industrial impairment	80 percent
Severe industrial impairment	60 percent
Considerable industrial impairment	40 percent
Definite industrial impairment	20 percent
Mild industrial impairment	10 percent

(6) 8205-8412 - Diseases of the Cranial Nerves

There is provision for combined ratings under these codes when there is bilateral involvement, but without the addition of the bilateral factor.

(7) 8510-8730 - Disease of the Peripheral Nerves

(a) Cases that are rated based on residuals should be adjudicated on the basis

of impairment of function rather than on anatomical diagnosis. For example, a complete paralysis of the circumflex nerve of the major extremity carries a 50 percent rating under 8518. In many cases, however, abduction of the arm when the circumflex nerve is paralyzed is possible because other muscles take over the function of the paralyzed muscles. To warrant the 50 percent rating, the service member's residual loss of function must actually include all the defects listed under 8518. When other muscles have taken over the function of the circumflex-innervated deltoid, the residual loss of function is properly ratable under 5201, "limitation of arm motion," or 5303, "muscle injury, Group III," whichever better reflects the predominant impairment. Careful documentation of evaluations are required before assigning a rating for paralysis that would equal that for amputation of the innervated area. For example, cases of "paralysis of the common peroneal nerve with foot drop," 8521, should be rated in terms of loss of function. "Amputation below the knee," 5165, is ratable at 40 percent. In order to warrant a similar rating for peroneal palsies, there must be sufficiently severe symptoms, such as trophic and circulatory changes and other concomitants, to make the functional impairment reasonably equivalent to loss of foot.

(b) Service members with paralysis of an extremity or hemiparesis shall be rated according to the Table of Analogous Ratings. Codes are as follows:

1. 8599 - 8513 - Paralysis of upper extremity
2. 8599 - 8520 - 8526 - Paralysis of lower extremity

(c) 8599 - Scalenus Anticus Syndrome. That syndrome is rated by analogy with the lower radicular group (8512), or less commonly, with either erythromelalgia (7119) or Raynaud's Disease (7117), depending upon predominant symptoms and overall functional impairment

(8) 8910-8914 - Epilepsies

(a) Service member must be evaluated and the diagnosis made by a neurologist.

(b) The number of seizures each time frame (day, week, and month) must be recorded.

(c) Attacks following omission of prescribed medication or the ingestion of alcoholic beverages are not indicative of the controllability of the disease and are not relevant to the determination of seizure frequency for rating purposes.

(d) Estimation of the social and industrial impairment due to the seizure activity should be made.

(e) Seizures that occur during sleep ("nocturnal seizure") are not relevant to

the determination of seizure frequency and shall not be included in the determination of the disability rating unless they can be shown to significantly impair industrial adaptability.

k. 9000 SERIES CODES

(1) 9200-9521 - Mental Disorders

General factors to be considered in evaluating the degree of a member's disability are listed below. These are descriptive, not all inclusive, and are meant to be amplifications, not substitutions for the VASRD criteria.

(a) Functional Impairment. Loss of function is the principal criterion for establishing the level of impairment resulting from mental illness. Loss of function is reflected in impaired social and industrial adaptability. Psychoses specifically include disorders manifesting disturbances of perception, thinking, emotional control, and behavior, severe enough to hinder economic adjustment, that is, hinder the service member's capacity to perform military duties or to earn a living. Even psychosis, however, may resolve such that the impact on economic adjustment is minimal to none.

1. In rating impairment of social and industrial capability, if any, a comparison must be made between pre- and post-illness adjustment.

2. Assessing the degree of permanent impairment resulting from a psychotic process is often difficult during the weeks immediately following an acute episode. Sometimes a service member's period of intensive in-hospital treatment has not been completed at the time of the initial MEB. With the passage of time, the clinical picture often becomes stable. The degree of permanent impairment may then be estimated more accurately.

(b) Vocational functional impairment. Since the 30% rating in the VASRD requires "...intermittent periods of inability to perform occupational tasks," the following definition of vocational functional impairment is provided: Symptoms of a psychiatric condition causing a period or periods of "inability to perform occupational tasks" should be of such severity as to result in a pattern of job loss, demotion, disqualification from obtaining employment, or inability to engage in or maintain reasonable employment. "Reasonable employment" is determined, in part, by considering the service member's premorbid vocational adjustment, education, and accomplishments.

(c) Social impairment. The degree of social impairment should be considered in regard to industrial impairment, not just social interactions. Information that relates to social impairment includes, but is not limited to, the following:

1. Living arrangements (by oneself, with parents and siblings, or with wife and children).

2. Marital status (single, married, separated, or divorced, and the

type of relationship (harmony or strife)).

3. Leisure activity (sports, hobbies, TV, reading, sleeping).
4. Acquaintances (male, female, both sexes, many, few).
5. Substance use or abuse (alcohol and/or illicit drugs).
6. Police record.

(d) Industrial Impairment. Information that relates to industrial impairment includes, but is not limited to, the following:

1. Job stability (unemployed, part-time work, full-time job, quit, fired, or promoted).
2. Type of job (menial, responsible, OJT, technical, for a relative, or for a private employer).
3. Schooling (grade , technical, academic, high school, college, or postgraduate).

(e) Additional Factors. Other factors that bear on social and industrial adaptability include, but are not limited to, the following:

1. Mental Competency . If the member's competence is in question, an incapacitation board must be held and submitted.
2. Level of Supervision. There are several levels of supervision. The most disabling is constant hospitalization. Constant supervision at home or intermittent and repeated hospitalizations are disabling factors to be considered. Being placed in one's own custody suggests that a lower level of supervision, if any, is required.
3. Contact with Reality. Certain service members have lost all contact with reality and cannot tell fact from fantasy. Dreams, imaginations, delusions, and hallucinations are just as real to certain service member as actual events. The quality of loss of contact with reality as well as quantity of time that the service member is not in contact with reality are factors to be considered.
4. Potential for Harm. At times, individuals suffering from mental disorders may be dangerous to themselves or to others. They may be homicidal, suicidal, or violently destructive to property. Their judgment may be so impaired that they could jeopardize or destroy a family, business, or themselves, financially, socially, and legally.
5. The degree of industrial and industrially related social impairment

is influenced by the number and intensity of signs or symptoms of mental disorders. Those signs or symptoms may be overtly apparent or they may be subtle and apparent only to skilled examiners. Their significance must be carefully evaluated. A partial list of the more common signs or symptoms include autism, ambivalence, inappropriate affect, dissociative thinking, bizarre behavior, delusions, hallucinations, pronounced anxiety, hyperactivity, depression, disorientation, emotional lability, memory defects, unfounded somatic complaints, phobias, compulsions, lack of insight, and poor judgment.

6. Medication or Psychotherapy. The type (potent or mild), amount (large or small doses) and the route of administrations of medication as well as the frequency (daily, weekly, or as needed) should be considered. The frequency of psychotherapy and by whom administered (psychiatrist, psychologist, social worker, nurse) also should be considered. Because a service member is receiving medication and/or psychotherapy, this does not automatically equate with a certain level of "Unfitness" or disability. As discussed previously in enclosure (8), there may be a few select medications that in and of themselves may predicate performance of full duties.

(f) VASRD Classification. The VASRD uses specific terms to classify the level of industrial and (industrially related) social impairment. Those are further characterized below for ratings under 9201 through 9521. As stated above, this is not a substitute for but simply an elaboration of additional characteristics commonly associated with rating levels. In situations where the disability evaluation appears not to be resolved by the VASRD per se, the following additional guidance is provided. The intent is not to require that ALL of these characteristics be present in order to warrant a given rating.

1. 100 percent. Total occupational and social impairment, due to such symptoms as:
- a. Gross impairment in thought processes or communication.
 - b. Persistent delusions or hallucinations.
 - c. Grossly inappropriate behavior.
 - d. Persistent danger of hurting self or others.
 - e. Intermittent ability to perform activities of daily living (including maintenance of minimal personal hygiene).
 - f. Disorientation to time or place.
 - g. Memory loss for names of close relatives, own occupation, or own name.
 - h. Commonly mentally incompetent to handle financial affairs and to participate in PEB proceedings.

2. 70 percent. Occupational and social impairment, with deficiencies in most areas, such as work, school, family relations, judgment, thinking, or mood, due to such symptoms as:

- a. Suicidal ideation.
- b. Obsessional rituals which interfere with routine activities.
- c. Speech intermittently illogical, obscure, or irrelevant.
- d. Near-continuous panic or depression affecting the ability to function independently, appropriately and effectively.
- e. Impaired impulse control (such as unprovoked irritability with periods of violence).
- f. Spatial disorientation.
- g. Neglect of personal appearance and hygiene.
- h. Difficulty in adapting to stressful circumstances (including work or a work like setting).
- i. Inability to establish and maintain effective relationships.
- j. Usually financially mentally competent and capable of cooperating in PEB proceedings but occasionally may be incompetent.

3. 50 percent. Occupational and social impairment, with reduced reliability and productivity due to such symptoms as:

- a. Flattened affect.
- b. Circumstantial, circumlocutory, or stereotyped speech.
- c. Panic attacks more than once a week.
- d. Difficulty in understanding complex commands.
- e. Impairment of short- and long-term memory (e.g. retention of only highly learned material, forgetting to complete tasks).
- f. Impaired judgment.
- g. Impaired abstract thinking.

- h. Disturbances of motivation and mood.
- i. Difficulty in establishing and maintaining effective work and social relationships.
- j. Nearly always mentally competent to handle financial affairs and participate in PEB proceedings.

4. 30 percent. Occupational and social impairment with occasional decrease in work efficiency and intermittent period of inability to perform occupational tasks (although generally functioning satisfactorily, with routine behavior, self-care, and conversation normal), due to such symptoms as:

- a. Depressed mood.
- b. Anxiety .
- c. Suspiciousness.
- d. Panic attacks (weekly or less often).
- e. Chronic sleep impairment.
- f. Mild memory loss (such as forgetting names, directions, recent events).

5. 10 percent. Occupational and social impairment due to mild or transient symptoms which decrease work efficiency and ability to perform occupational tasks only during periods of significant stress; or symptoms controlled by continuous medication.

6. 0 percent. A mental condition has been formally diagnosed, but symptoms are not severe enough either to interfere with occupational and social functioning or to require continuous medication.

(g) Table (7) has been compiled to assist in the determination of functional impairment. Terminology is consistent with the "Diagnostic and Statistical Manual of Mental Disorders IV. It is viewed as an aid rather than a prescription.

(2) 9520-9521 - Eating Disorders.

Now ratable. Many are associated with depression. Avoid pyramiding .

(a) The member must be Unfit in order to be rated.

(b) Rating Formulas for Eating Disorders (from the VASRD issue effective 7 November 1996):

1. 100 percent. Self-induced weight loss to less than 80 percent of expected minimum weight, with incapacitating episodes of at least 6 weeks total duration per year, and requiring hospitalization more than twice a year for parenteral nutrition or tube feeding.

2. 60 percent. Self-induced weight loss to less than 85 percent of expected minimum weight with incapacitating episodes of 6 or more weeks total duration per year.

3. 30 percent. Self-induced weight loss to less than 85 percent of expected minimum weight with incapacitating episodes of more than two but less than 6 weeks total duration per year.

4. 10 percent. Binge eating followed by self-induced vomiting or other measures to prevent weight gain, or resistance to weight gain even when below expected minimum weight, with diagnosis of an eating disorder and incapacitating episodes of up to 2 weeks total duration per year.

5. 0 percent. Binge eating followed by self-induced vomiting or other measures to prevent weight gain, or resistance to weight gain even when below expected minimum weight, with diagnosis of an eating disorder but without incapacitating episodes.

Attachment (a) to Enclosure (9): ANALOGOUS CODES

(Also see attachment (a) (1) SWATO Undiagnosed Symptom Complex Coding)

ALPHABETICAL LISTING OF ANALOGOUS CODES

(Analogous codes will be eliminated as the VASRD is updated to include code numbers for specific diagnoses that were previously rated by analogy)

DIAGNOSIS	CODE 1	CODE 2	CODE 3
A-C SEPARATION/SUBLUXATION	5299	5003	
ACHALASIA	7299	7203	
ACNE	7899	7806	
ANAPHYLAXIS	7199	7118	
ANKLE INSTABILITY	5299	5271	
ANKYLOSING SPONDYLITIS	5099	5002	
ANTERIOR COMPARTMENT SYN	5299	5312	8723
APHASIA, ORGANIC	8099	9305	
APHONIA, FUNCTIONAL	9499	9424	
ATOPIC DERMATITIS	7899	7806	
ATYPICAL DEPRESSION	9499	9435	
AVASCULAR NECROSIS	5299	5003	
FEMORAL HEAD (when not adequately covered by 5299-5003; if consequences are beyond those of simple arthritis)	5299	5255	
BEHCET'S SYNDROME	5099	5002	
BLEPHAROSPASM	8199	8103	
BONE MARROW TRANSPLANT	RESIDUALS		
BRIEF REACTIVE PSYCHOSIS	9299	9210	
CARPAL BONE INJURY	5299	5212	
CARPAL TUNNEL SYN	5299	8515	
CEREBELLAR DEGENERATION	8199	8105	
CHARCOT-MARIE-TOOTH	8099	8023	
CHONDROMALACIA PATELLAE	5299	5003	
CHRONIC RENAL INSUFFICIENCY	7599	7502	
COLOSTOMY/ILEOSTOMY	7399	7330	
CONNECTIVE TISSUE DISEASE NOS	6399	5002	
CORONARY ARTERY STENT	7099	7017	
CROHN'S DISEASE/ COLITIS	7399	7323	
CUBITAL TUNNEL SYNDROME (ULNAR NERVE)	5299	8516	
DUPUYTREN'S CONTRACTURE (HAND)	5299	52XX	
DYSARTHRIA	8299	8212	
DYSMENORRHEA	7699	7613	
ERYTHEMA MULTIFORME	7899	7806	
ESSENTIAL TREMOR	8199	8105	

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FABRY'S DISEASE	6399	5002	
FEVER of UNKNOWN ORIGIN	6399	6316	
GASTROESOPHAGEAL REFLUX	7399	7536	
GOODPASTURE'S SYN	7599	7502	
GRANULOMATOUS COLITIS	7399	7323	
GUILLAIN-BARRE SYN	8199	8011	
HIDRADENITIS	7899	7806	
HISTOPLASMOSIS EYE (unless clinical diagnosis warrants otherwise)	6099	6000	
HOST-GRAFT REACTION (XX is the number of the organ system involved)	XX99 or primary manifestation	5002	
HYPERHIDROSIS	7899	7806	
HYPERSOMNIA	8199	8108	
HYPOKALEMIC PERIODIC PARALYSIS	7999	7903	
JOINT PAIN, NOS	5299	5003	
LEGG-PERTHES DISEASE	5299	5255	
LEISHMANIASIS	7899	6316	
VISCEROTROPIC, UNPROVEN			
LYMPHEEMA	7199	7121	
MALIGNANT HYPERTHERMIA	7999	7900	RESIDUALS
MALIGNANT MELANOMA	7899	7709	RESIDUALS
MITRAL VALVE PROLAPSE (ARRHYTHMIA) rate the appropriate arrhythmia	7099		
MULTIPLE MYELOMA	7799	7703	
MYOFASCIAL PAIN SYN	5099	5021	5003
MYOTONIC DYSTROPHY	8099	8023	
NEAR SYNCOPAL EPISODES	8199	8911	
NEPHROTIC SYNDROME	7599	7502	
NYCTALOPIA (NIGHT BLINDNESS)	6099	6011	
OSGOOD-SCHLATTER	5299	5003	
OSTEOCHONDRITIS DISSECANS	5299	5003	
PARALYSIS LOWER EXTREMITY	8599	8520	8526
PARALYSIS UPPER EXTREMITY	8599	8513	
PATELLOFEMORAL SYN	5299	5003	
PELVIC FRACTURE	5299	5294	
PELVIC PAIN (FEMALE)	7699	7629	
PES PLANUS, CONGENITAL	5299	5276	
PEYRONIE'S DISEASE	7599	7522	
PILONIDAL CYST (include the 5000 for active disease)	7899	7806	5000
PLANTAR FASCIITIS	5399	5310	(or 5021- 5003)
REFLEX SYMPATHETIC DYSTROPHY (ARM) (if localized, use a more appropriate	8799	8713	

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code)			
REFLEX SYMPATHETIC DYSTROPHY (LEG)	8799	8720	
REGIONAL ENTERITIS (CROHN'S)	7399	7323	
REITER'S SYN	5099	5002	
RETROPATELLAR PAIN	5299	5003	
RHABDOMYOLYSIS			
	RATE		
	RESIDUALS		
RUPTURED TENDON ACHILLES	5399	5311	
S/P Ca CHEMO/RAD (TUMOR REMISSION)			
	RESIDUALS		
SARCOIDOSIS (SYSTEMIC)	6846	6399	5002
SCALENUS ANTICUS SYN	8599	8513	
SCAPHOID FRACTURES (NON-UNION)	5299	5212	
SCHEUERMANN'S DISEASE	5299	5295	
SCHIZOPHRENIFORM DISORDER, PARANOID (Provisional)	9299	9203	
SCHIZOPHRENIFORM DISORDER, OTHER (Provisional)	9299	9204	
SCHIZOPHRENIFORM DISORDER (Established)	9299	9210	Maximum 0-10 %
SCLERODERMA	6399	5002	
SCOLIOSIS	5299	5295	
SHIN SPLINTS	5022	5003	
SHOULDER IMPINGEMENT SYN	5299	5003	
SHOULDER SUBLUXATION (PAIN)	5299	5003	
SJOGREN'S SYN	6399	5002	
SPONDYLOLYSIS/SPONDYLOLISTHESIS	5299	5295	
STARGARDT'S DISEASE	6099	6006	
STILL'S DISEASE	5099	5002	
STREP FASCIITIS LOCAL			
	RESIDUALS		
STREP FASCIITIS SYSTEMIC			
	RESIDUALS	5002	
STRESS FRACTURE, FULL THICKNESS BONE (BONE INVOLVED)	5299	52XX	
STRESS FRACTURE, UNCOMPLICATED	5022	5003	
SUBLUXATION PATELLAE	5299	5257	
SUPERIOR VENA CAVA SYN	7199	7121	
SYNCOPE/SEIZURE ASSOC	8199	8911	
SYNCOPE NOS	8299	8911	
SYNCOPE, VASO-VAGAL	7199	8210	
SYNCOPE, CARDIOGENIC	7099	8911	
TARSAL TUNNEL SYN	5299	8525	
TENSION HEADACHES	5399	5323	
TENSION HEADACHES (PSYCHOGENIC)	9499	9422	
TESTALGIA	8799	7525	
THORACIC OUTLET SYN	8599	8513	

TORTICOLLIS	8199	8103	
TOURETTE'S SYN	8199	8104	
TRACHEOSTOMY	6599	6520	
TROPICAL SPRUE	7399	7323	
URTICARIA/COLD ALLERGY/ACUTE ALLERGY	7199	7118	
VASCULAR HEADACHES	8199	8100	
VASOVAGAL SYNCOPE	7188	8210	
VESTIBULOPATHY	6299	6204	
VON WILLEBRAND DISEASE	7799	7705	RESIDUALS
V-P SHUNT	8099	9326	
WOLFF-PARKINSON-WHITE SYN	7099	7010	
WRIST PAIN/CARPALS ANALOGY TO TARSALS/METATARSALS	5299	5283	

Attachment (b) to Enclosure (9): SWATO UNDIAGNOSED SYMPTOM COMPLEX
CODING

UNDIAGNOSED CONDITION

DIAGNOSTIC CODE	DESCRIPTION	SYSTEM
8850-50()()	UNDIAGNOSED CONDITION	MUSCULOSKELETAL
8851-51()()	UNDIAGNOSED CONDITION	AMPUTATIONS
8852-52()()	UNDIAGNOSED CONDITION	JOINT, SKULL, RIBS
8853-53()()	UNDIAGNOSED CONDITIONS	MUSCLE INJ
8860-60()()	UNDIAGNOSED CONDITION	DISEASES OF THE EYE
8861-61()()	UNDIAGNOSED CONDITION	HEARING LOSS
8862-62()()	UNDIAGNOSED CONDITION	EAR/OTHER SENSE ORGAN
8863-63()()	UNDIAGNOSED CONDITION	SYSTEMIC DISEASE
8865-65()()	UNDIAGNOSED CONDITION	NOSE/THROAT
8866-66()()	UNDIAGNOSED CONDITION	TRACHEA/BRONCHI
8867-67()()	UNDIAGNOSED CONDITION	TUBERCULOSIS
8868-68()()	UNDIAGNOSED CONDITION	LUNGS/PLEURA
8870-70()()	UNDIAGNOSED CONDITION	HEART
8871-71()()	UNDIAGNOSED CONDITION	ARTERIES/VEINS
8872-72()()	UNDIAGNOSED CONDITION	UPPER DIGESTIVE
8873-73()()	UNDIAGNOSED CONDITION	LOWER DIGESTIVE
8875-74()()	UNDIAGNOSED CONDITION	GENITOURINARY
8876-76()()	UNDIAGNOSED CONDITION	GYNECOLOGY
8877-77()()	UNDIAGNOSED CONDITION	HEMIC/LYMPHATIC
8878-78()()	UNDIAGNOSED CONDITION	SKIN
8879-79()()	UNDIAGNOSED CONDITION	ENDOCRINE
8880-80()()	UNDIAGNOSED CONDITION	CENTRAL NERVOUS
8081-81()()	UNDIAGNOSED CONDITION	MISC NERVOUS
8882-82()()	UNDIAGNOSED CONDITION	CRANIAL NERVE PARALYSIS
8883-83()()	UNDIAGNOSED CONDITION	CRANIAL NERVE NEURITIS
8884-84()()	UNDIAGNOSED CONDITION	CRANIAL NERVE NEURALGIA
8885-85()()	UNDIAGNOSED CONDITION	PERIPHERAL NERVE PARALYSIS
8886-86()()	UNDIAGNOSED CONDITION	PERIPHERAL NERVE NEURITIS
8887-87()()	UNDIAGNOSED CONDITION	PERIPHERAL NERVE NEURALGIA
8889-89()()	UNDIAGNOSED CONDITION	EPILEPSIES
8892-92()()	UNDIAGNOSED CONDITION	PSYCHOTIC
8893-93()()	UNDIAGNOSED CONDITION	ORGANIC MENTAL
8894-94()()	UNDIAGNOSED CONDITION	PSYCHONEUROTIC
8895-95()()	UNDIAGNOSED CONDITION	PSYCHOPHYSIOLOGIC
8899-99()()	UNDIAGNOSED CONDITION	DENTAL/ORAL

Attachment (c) to Enclosure (9): Tables

TABLE 1

Grade Value Table

A Individual Finger Defect	B Rated As	C Grade Value
Amputation through distal Phalanx or distal joint (except the thumb) other than negligible tip loss.	Favorable ankylosis (See VASRD, note c following code 5151)	1
Amputation through middle phalanx or distal phalanx of thumb.	Unfavorable ankylosis (See VASRD, note b following code 5151)	2
Amputation through proximal phalanx or proximal interphalangeal joint.	Amputation (See VASRD, note a following code 5151)	3
Amputation of entire digit, with amputation or resection of more than one-half of the metacarpal.	Single finger amputation with metacarpal resection (See VASRD, codes 5152-5156)	4

Attachment (c) to Enclosure (9)

TABLE 2

Pulmonary function test values ¹

Forced Expiratory Volume (FEV-1)

<u>Percentage of predicted</u>	<u>Rating</u>
<hr/>	
Chronic Obstructive Pulmonary Disease (Before Bronchodilators)	
50 or less	Severe
55-65	Moderate, moderately severe
65-70	Mild
70 or better	Normal

Vital Capacity (VC)

<u>Percentage of predicted</u>	<u>Rating</u>
<hr/>	
Chronic Restrictive Pulmonary Disease	
50 or less	Severe
55-65	Moderate, moderately severe
65-80	Mild
80 or better	Normal

¹ The AMA "Guides to the Evaluation of Permanent Impairment," while differing slightly from the above values, is otherwise helpful in interpreting clinical and functional values. There are no FEV-1 Percentage or VC Percentage between 51 and 54.

Attachment (c) to Enclosure (9)

TABLE 3
Methods of Assessing Cardiovascular Disability

New York Heart Association Functional Class Classification	Canadian Cardiovascular Society Functional Classification	Specific activity Scale (Goldstein et al: Circulation 64:1227;1981 and Science of American Medicine I:15-16)	New York Association Functional Class classification (Rev)
I Patient with cardiac disease, but without Resulting limitations of physical activity. Ordinary physical activity does not cause undue fatigue, palpitations, dyspnea, or anginal pain.	Ordinary physical activity, such as walking or climbing, does not cause angina. Angina with rapid or strenuous or prolonged exertion at work or recreation.	Patients can perform to completion any activity requiring 7 metabolic equivalents, e.g., can carry 24 lbs. up eight steps, carry objects that weigh 80 lbs., do outdoor work (shovel snow or spade soil), do recreational activities (skiing, basketball, squash, handball, jog and walk 5 MPH). (See table 3A, Approximate Metabolic Cost of Activities)	Cardiac status uncompromised.
II. Patients with cardiac disease resulting in slight limitation of physical activity. They are Are comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea, and anginal pain.	Slight limitation of ordinary activity. Walking or climbing stairs rapidly, walking uphill, walking or stair climbing after meals, in cold, in wind, or under emotional stress, or during the few hours after awakening. Walking more than two blocks and climbing more than one flight of stairs at normal pace under normal conditions.	Patient can perform completion of any activity requiring > 5 metabolic equivalents, but cannot and does not perform to completion activities requiring metabolic equivalents: e.g., have sexual intercourse without stopping, garden, rake, weed, roller skate, dance, fox trot, walk at 4 MPH on level ground. (See table 3A, Approximate Metabolic Cost of Activities).	Cardiac status slightly compromised.
New York Heart Association Functional Class Classification	Canadian Cardiovascular Society Functional Classification	Specific activity Scale (Goldstein et al: Circulation 64:1227;1981 and Science of American Medicine I:15-16)	New York Association Functional Class classification (Revised)
III. Patient with cardiac disease resulting in marked	Marked limitation of ordinary physical activity. Walking one	Patients can perform to completion any activity requiring > 2 metabolic	Cardiac status moderately compromised.

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<p>limitation of physical activity. They are comfortable at rest. Less than ordinary physical activity causes fatigue, palpitation, dyspnea or anginal pain.</p>	<p>to two blocks on the level and climbing more than one flight in normal conditions.</p>	<p>equivalents but cannot and does not perform to completion any activities requiring > 5 metabolic equivalents: e.g., shower without stopping, strip and make bed, clean windows, walk 2.5 MPH, bowl, golf, dress without stopping. (See table 3A, Approximate Metabolic Cost of Activities)</p>	
<p>IV. Patients with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of cardiac insufficiency or of the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.</p>	<p>Inability to carry on any physical activity without discomfort -- anginal syndrome may be present.</p>	<p>Patient cannot and does not perform to completion activities requiring < 2 metabolic equivalents. Cannot carry out activities listed above (specific activity scale, Class III). (See table 3A, Approximate Metabolic Cost of Activities)</p>	<p>Severely compromised.</p>

New York Heart Association Therapeutic Classification

<u>Class A</u> -- Patients with cardiac disease whose physical activity need not be restricted.	<u>Class I</u> - Good
<u>Class B</u> -- Patients with cardiac disease whose ordinary physical activity need not be restricted, but who should be advised against severe or competitive physical efforts	<u>Class II</u> - Good with therapy.
<u>Class C</u> -- Patients with cardiac disease whose ordinary physical activity should be moderately restricted, and whose strenuous efforts should be discontinued.	<u>Class III</u> - Fair with therapy.
<u>Class D</u> -- Patients with cardiac disease whose ordinary physical activity should be markedly restricted.	<u>Class IV</u> - Guarded despite therapy.
<u>Class E</u> -- Patients with cardiac disease who should be at complete rest, confined to bed or chair.	<u>Not Applicable</u>

Attachment (c) to Enclosure (9)

TABLE 3A

Approximate Metabolic Cost Of Activities (Source: American Heart Association)

1.5 - 2 METs ¹ 4-7 ml O ₂ /kg/min 2-2.5 kcal/min (70 kg person)	Desk work Driving an automobile ² Typing (electric) Electric calculating machine operation.	Standing Walking (strolling 2.6 km or 1 mph) Piloting a plane ² , motorcycling ² , Playing cards ² , Sewing, knitting
2-3 METs 7-11 ml O ₂ /kg/min; 2.5-4 kcal/min (70 kg person)	Auto Repair Radio/TV work Janitorial work Typing (manual) Bartending	Level Walking (3.25 km or 2 mph) Level bicycling (8 km or 5 mph) Riding lawn mowers Billiards, bowling Skeet ² , shuffleboard Woodworking (light) Driving a powerboat ² Golf (using power cart) Canoeing (4 km or 2.5 mph) Horseback (walk) Playing various musical instruments
3-4 METs 11-14 ml O ₂ /kg/min; 4-5 kcal/min (70 kg person)	Bricklaying, plastering Pushing a wheelbarrow (45 kg or 100 lb. load) Machine assembly Driving a tractor Welding (moderate load) Cleaning windows	Walking (5 km or 3 mph) Cycling (10 km or 6 mph) Horseshoe pitching Volleyball (6 man, competitive) Golf (pulling bag cart) Archery Sailing (handling small boat) Fly fishing (standing in waders) Horseback (sitting while trotting) Badminton (social doubles) Pushing light power mower Energetically playing various music instruments

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<p>4-5 METs 14-18 ml O₂/kg/min; 5-6 kcal/min (70 kg person)</p>	<p>Painting Masonry Paperhanging Light carpentry</p>	<p>Walking (5.5 km or 3.5 mph) Cycling (13 km or 8 mph) Table tennis Golf (carrying bag) Dancing (fox-trot) Badminton (singles) Tennis (doubles) Raking leaves, hoeing Various calisthenics</p>
<p>5-6 METs 18-21 ml O₂/kg/min; 6-7 kcal/min (70 kg person)</p>	<p>Digging in the garden Shoveling light earth</p>	<p>Walking (6.5 km or 4 mph) Cycling (16 km or 10 mph) Canoeing(6.5 km or 4 mph) Horseback (posting while trotting) Stream fishing (walking in light current in waders) Ice or roller skating (15 km or 9 mph)</p>
<p>6-7 METs 21-25 ml O₂/kg/min; 7-8 kcal/min (70 kg person)</p>	<p>Shoveling 10/min (4.5 kg or 10 lb.)</p>	<p>Walking (8 km or 5 mph) Cycling (17.5 km or 11 mph) Badminton (competitive) Tennis (singles) Splitting wood Shoveling snow Hand lawn mowing Square dancing Downhill skiing (light) Ski Touring (4 km or 2.5 mph) (light snow) Water-skiing</p>
<p>7-8 METs 25-28 ml O₂/kg/min; 8-10 kcal/min (70 kg person)</p>	<p>Digging ditches Carrying 36.3 kg or 80 lb. Sawing hardwood</p>	<p>Jogging (8 km or 5 mph) Cycling (19 km or 12 mph) Horseback riding (gallop) Downhill skiing (vigorous) Basketball Mountain climbing Ice hockey Canoeing (8 km or 5 mph) Touch football Paddleball</p>
<p>8-9 METs 28-32 ml O₂/kg/min; 10-11 kcal/min (70 kg person)</p>	<p>Shoveling 10/min (6.4 kg or 14 lb.)</p>	<p>Running (9 km or 5.5 mph) Cycling (21 km or 13 mph) Ski Touring (6.5 km or 4 mph) (loose snow) Squash (social)</p>

		Handball (social) Fencing Basketball (vigorous)
> 10 METs > 32 ml O ₂ /kg/min; > 11 kcal/min (70 kg person)	Shoveling 10/min (7.3 kg or 16 lb.)	Running: 6 mph = 10 METs 7 mph = 11.5 METs 8 mph = 13.5 METs 9 mph = 15 METs 10 mph = 17 METs Ski Touring (8 km or 5+ mph) Handball (competitive) Squash (competitive)

¹ One MET = energy expenditure at rest equivalent to approximately 3.5 ml O₂/kg body weight / minute.

² A major excess metabolic increase may occur owing to excitement, anxiety, or impatience in some of these activities. A physician must assess the patient's physiologic reactivity.

Attachment (c) to Enclosure (9)

TABLE 4

Creatinine Clearance and Renal Impairment

<u>Creatinine Clearance</u>	<u>Impairment</u>
Less than 28 ml/minute	Severe (pronounced nephritis)
28-52 ml/minute	Moderate (moderate nephritis)
52-80 ml/minute	Mild (mild nephritis)

Attachment (c) to Enclosure (9)

TABLE 5

Hodgkin's Disease

<u>(Stage A)</u> <u>Stage</u>	<u>(Stage B)</u> <u>Rating</u>	<u>Disposition</u> <u>Rating</u>	<u>(if Unfit)</u> ¹
I	30	60	TDRL
II	30	60	TDRL
III	60	--	TDRL
III	--	100	TDRL
IV	100	100	TDRL

NOTE:

¹ Fitness or Unfitness is not determined, as a rule, until response to initial treatment has been assessed.

Attachment (c) to Enclosure (9)

TABLE 6

Body Surface Area Measurements

<u>Body Surface</u>	<u>Percentof Body Surface</u>	<u>Area Sq Inches</u>	<u>Area SqFeet</u>
Anterior or posterior head	3.5	92	0.64
Anterior or posterior neck	1	26	0.18
Anterior or posterior trunk	13	343	2.28
Anterior or posterior arm	2	53	0.37
Anterior or posterior forearm	1.5	40	0.27
Volar or palmar hand and fingers	1.25	33	0.23
Buttocks	2.5	66	0.46
Genitalia	1	26	0.18
Anterior or posterior thigh	4.75	125	0.87
Anterior or posterior calf	3.5	92	0.64
Dorsal foot or sole, including toes	1.75	46	0.32

Attachment (c) to Enclosure (9)

TABLE 7

Psychiatric Functional Impairment - Guideline summary

	100 Total	70 Severe	50 Considerable	30 Definite	10 Mild	0 Remission
<u>Competence</u>	Usually incompetent	Usually competent Frequently incompetent	Nearly always Competent	Competent	Competent	Competent
<u>Signs</u>	Actively psychotic; totally out of contact with reality	Actively psychotic; intermittent contact with reality	Overt display of symptoms listed	Displays signs or symptoms on exam	Usually some evidence on exam	None
<u>Hospitalization</u>	Usually hospitalized	Usually hospitalized	Intermittent hospitalization	Possible	Not required	Not required
<u>Supervision</u>	Constant supervision/ care	Required > 50 percent of the time	Limited to none	Not required	Not required	Not required
<u>Job Stability</u>	Unemployable	Employable Sheltered workshop	Extreme instability	Unstable	Adequate job adjustment potential	Stable
<u>Social Adjustment</u>	Incapable of social adjustment	Minimal social adjustment	Significant social mal-adjustment	Moderately unstable	Some instability	Satisfactory
<u>Medication</u>	Assume constant	Assume constant	Requires constant medication	Usually required	May require	No medication
<u>Psychotherapy</u>	Assume constant	Assume constant	Requires frequent psychotherapy	Periodic or Frequent Requirement	Possible including Rx monitoring	Not required
<u>Harm to self/others</u>	Significant potential	Some potential	Low potential	Potential	Potential	None

ENCLOSURE 11: NON-MEDICAL ASSESSMENT (NMA)

11001 Requirements for Submission of a NMA

a. DOD Instruction 1332.38 of 14 November 1996 requires commanding officers submit a statement describing the impact of the service member's medical condition upon the member's ability to perform his/her normal military duties and to deploy or mobilize as applicable.

b. A Non-Medical Assessment (NMA) will be forwarded with the MEB report in all cases except in situations of critical illness or injury or when the member has been declared "Death Imminent". Commanding officers will ensure that NMAs are submitted to the requesting facility within 15 calendar days from the date of receipt of such request. Naval message traffic is acceptable as long as the format outlined in this enclosure is followed.

c. The sample NMA may also be obtained by accessing the PEB web page at www.hq.navy.mil/ncpb/. Click on the link for the PEB.

d. NMA Requirements. There are two sections to the NMA:

(1) The first half is basic empirical data about the member including the member's current position, responsibilities, results of the most recent PRT/PFT, height/weight measurements, etc.

(2) The second half of the NMA contains the commanding officer's comments and is the most critical and influential information in the NMA. The CO's comments capture his/her observations and those of other senior command personnel as to how the service member's medical impairments have or have not impacted the member's ability to function within the command. These comments are vital in assisting the PEB to make the proper determination of medically Fit or Unfit. It is therefore imperative that the comments be those of the CO or some other senior command personnel versus a first line supervisor who may have a limited perspective on the needs of the service.

e. For service members assigned to Temporary Holding Units (TPUs), or Medical Treatment Facilities (MTFs), commanding officers will answer those questions pertaining to those questions that pertain to the period of observation. If the TPU/MTF CO has had sufficient opportunity to observe the member, then the TPU/MTF CO will complete the questionnaire. If not, coordination with the previous command will be required to assist in answering questions covering the member's period of assignment to that command.

f. Inactive Duty Reservists. In the case of inactive duty reservists assigned to the Voluntary Training Unit while awaiting the decision of the PEB, a statement from the member's former reserve unit/activity commanding officer is also helpful. This statement should address the member's ability to perform reserve duties as well as his/her potential for performing mobilization duties in the event he/she were activated or recalled to active duty.

g. Attachment (a) to this enclosure provides the format and description of the NMA for commanding officers' use.

Attachment (a) to Enclosure 11: Format for Non-Medical Assessments

FOR OFFICIAL USE ONLY
COMMAND LETTERHEAD

Date:

From: Commanding Officer
To: Medical Treatment Facility

NON-MEDICAL ASSESSMENT (NMA) IN THE CASE OF
_____ (member's full name, rank/rate, SSN,
service/component-regular, reserve, AR, TAR)

1. Purpose: The NMA describes how well the member performs his/her military duties, e.g., MOS/rating duties, field duties or exercises, participation in the PRT/PFT, etc. The first half of this document, "Questionnaire", details basic data on the service member. The purpose of the second half, "Commanding Officer's Comments", is for the CO to comment on what the member can and cannot do. Be as specific as possible about what duties and responsibilities the member can and cannot perform. Explain how the member's medical condition has affected the member's ability to perform the duties of his/her rate or MOS, and the reality of the service member's contribution to the unit. The CO's insights are crucial in assisting the PEB in making a determination of Fit or Unfit. Prior to writing the NMA, the CO should first review the member's Medical Board (MEB) or medical record to gain a better understanding of the member's medical condition.

2. Questionnaire. The following assessment is submitted to assist the PEB in their determination of Fitness/Unfitness of SNM:

- a. Service member's rating/NEC/MOS/Primary Specialty: _____
(Examples: 0311/Rifleman; AO3/Aviation Ordnancemen; 1100/Surface Warfare Officer, etc.).
- b. Member's current position: _____
- c. Is the member currently working out of his/her specialty because of the medical condition? (Yes/No)
- d. Date member last passed the PRT/PFT: _____ (MM/YY)
- e. Can member presently take the PRT/PFT? (Yes/No/Partial)
- f. Member's height and weight: _____ (inches/lbs.)

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g. Is the member within weight and body fat standards? (Yes/No). If not, is the member on weight control (Yes / No / N/A).

h. To your knowledge, is the member fully complying with the prescribed appointments and treatment for the therapy? (Yes/No). Has the member complied in the past? (Yes/No)

i. What is the average number of work hours per week that the member's condition has required the member to be away from current duties for treatment, evaluation, and/or recuperation? _____

j. Is member pending disciplinary action or involuntary administrative separation for misconduct? (Yes/No) If so, for what?

k. What is the member's current length of service and date of entry into service?

LOS: _____ (years/months) ADSD/ADBBD: _____ (mo/yr)

l. Considering the member's current physical condition, is he/she worldwide assignable? (Yes/No)

m. Does the member have good potential for continued service in his/her present physical and mental condition? (Yes/No)

n. Does the member desire to continue his/her military service? (Yes/No)

o. For active duty members: Based on member's performance of duties, would you recommend that Naval Personnel Command / Headquarters Marine Corps authorize the member's retention on active duty in a Permanent Limited Duty status, if found Unfit? (Yes/No)

Commanding Officer's Comments: (use additional pages as necessary)

POC at this command is _____ (name/rank/position) at (Comm) _____/(DSN) _____ or (email) _____.

Commanding Officer Signature
(per Para 11001)

ENCLOSURE 12: DEATH IMMINENT PROCEDURES

12001 General

The Physical Evaluation Board (PEB) processes Death Imminent (DI) cases on a 24 hour a day, 7-day-a-week basis.

12002 Normal Working Hours Notification

During normal working hours (M-F 0600-1530 EST), notification of a DI case to the PEB shall be made via the telephone. This call should be made as soon as a possible DI case becomes known to either the Physical Evaluation Board Liaison Officer (PEBLO), patient administration or medical boards section personnel.

12003 After Normal Working Hours Notification

a. After normal working hours, to include all weekends and holidays, notify the PEB by placing a telephone call to an electronic pager voice messaging system (numbers listed at the end of this enclosure). This will alert the PEB duty officer who will return the phone call as soon as possible. The duty officer will record all pertinent information concerning the case and then give the Medical Treatment Facility (MTF) instructions and a telephone number to be used to send all information via facsimile machine. The information required would be the Medical Board (MEB) and all applicable supporting documents.

b. In some situations, the duty officer may instruct the MTF representative to forward, via facsimile, the needed information directly to the PEB. This option would be elected if the time of the notification were close to the normal working hours for the PEB. In such a case, the duty officer would immediately proceed to the PEB to begin processing the case.

12004 Procedures

a. Current PEB manning levels directly impact the ability to process DI cases after normal working hours. MTFS must provide advance notification and sufficient lead-time to allow the PEB to do the following:

- (1) Constitute and convene the Informal Board
- (2) Vote the case
- (3) Ensure proper Legal Review
- (4) Issue a preliminary findings letter
- (5) Direct the appropriate service headquarters to retire the service member

b. Accordingly, MTFS can expect that from receipt of the MEB report at the PEB, a minimum of 4 hours is required to finalize a DI case.

c. DI cases will be processed in exactly the same sequence as all other cases before the PEB, except that they will be given first priority. All necessary steps will be followed and at no time will steps be compromised or eliminated to expedite processing. All DI cases

will be processed in accordance with statute and DOD and SECNAV instructions. In no case will a service member be retired after death.

d. Determination of death shall be under the laws of the State where the service member is located at the time of his/her evaluation or under military medical standards in effect for the foreign area where the member is located at the time of his/her evaluation when the member is outside the United States. The member's attending physician must submit a signed copy of Attachment A to the PEB. The physician dictating the medical board, after consultation with the member's attending physician, may also sign a copy of Attachment A for the attending physician.

e. All DI Medical Board Reports submitted to the PEB must state specifically that the service member is expected to die within the next 72 hours, and include medical evidence supporting this statement. Commanding officers or MTFS will ensure that this statement and supporting medical information required are included in DI MEB reports. Cases that do not state this will not be given DI status.

f. DI cases must include all necessary addenda and statements. Members determined to be incompetent must have a competency statement included in the medical board signed by three medical doctors, one of whom must be a psychiatrist.

g. A clear and legible copy of the Page 2 from the USN Service Record, or in the case of a Marine, the Record of Emergency Data (RED) from the Service Record Book, must accompany the competency board or statement.

h. If a Line Of Duty Determination (LODD) or Line Of Duty Investigation (LODI) is necessary, include it with all necessary endorsements. PEB will begin adjudicating the case, however, the PEB Preliminary Findings Letter will not be issued until receipt of the LODD or LODI.

i. Death Imminent cases involving general, flag, or medical officers will be processed in accordance with the procedures outlined in paragraph 3904. In order to meet strict timelines for such cases, the PPEB will retain the authority to medically retire all general, flag, and medical officers. In the event the general, flag, or medical officer who is being processed under Death Imminent procedures is also pending non-disability retirement, the PPEB will forward the case to the ASN(MR&A) for review the next working day. ASN(MR&A) will either reverse the PPEB decision or forward the case to ASD(HA) for review if the member has not since died.

12005 Death Imminent boards on members previously finalized by the PEB

When a service member becomes death imminent after having already been found Unfit to continue naval service with a disability rating of 100 percent, accepting those findings, and notification sent to service headquarters by the PEB, dictation of a new medical board is not required. Instead MTFs should notify the PEB during working hours, or the DI watch stander for the PEB after working hours, of the member's death imminent

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status so service headquarters can be officially notified and the member expeditiously processed by service headquarters for retirement.

12006 Telephone Numbers

a. Telephone numbers and the PIN number (1155191) to activate the electronic pager carried by the PEB duty officers are listed below by individual country. Follow all instructions given to leave a voice message. Identify the MTF from which you are calling. Give your name and leave a complete commercial and DSN telephone number with complete dialing instructions as appropriate.

FOR CONUS/HAWAII/PUERTO RICO:	1-800-759-8888
FOR GUAM:	1-800-671-0150
FOR ITALY (TO INCLUDE SIGONELA):	1678-77100
FOR JAPAN (TO INLCUDE OKINAWA):	0031-12-3373
FOR UNITED KINGDOM:	0800-89-3648
FOR SPAIN:	900-981-464

FOR GUANTANAMO BAY, CUBA: Call the BUMED OOD (24 Hour Watch) at (202) 762-3211, DSN 762-3211. Identify yourself to the OOD and instruct the OOD to call 1-800-759-8888 and use the PIN 1155191. Instruct him/her to leave a voice message informing the PEB Duty Officer of a DI case from Guantanamo Bay, Cuba. Provide the OOD with the commercial and DSN telephone numbers to be called along with a point of contact.

b. In the event of a vendor change, telephone number, or PIN change to the electronic pager for the PEB Duty Officer, the change will be published via a naval message as soon as possible for widest possible dissemination and incorporation into this instruction.

Attachment (a) to Enclosure (12): Sample Letter for DI Processing

FOR OFFICIAL USE ONLY

From: Medical Officer
To: President, Physical Evaluation Board

DEATH IMMINENT PROCESSING OF (member's full name,
rank/rate, SSN, service/component-regular, reserve, AR, TAR)

Ref: (a) SECNAVINST 1850.4E
(b) BUMEDINST 5360.24

1. Pursuant to reference (a), the following information is provided to expedite the death imminent processing in the case of (Service Member):

a. I am the attending physician at (Medical Facility) for the subject named patient.

b. The service member is expected to die within the next 72 hours.

c. I am familiar with the definition of death under the laws of (insert State where medical facility is located) or under reference (b) and I certify this service member is currently alive.

2. I am available for consultation at (Phone Number).

3. This information is current as of (Time) on (Date).

Physician signature

SAMPLE

ENCLOSURE 13: WAIVER OF DISABILITY PROCESSING

With the approval of the PPEB, acting on behalf of the Secretary of the Navy, a service member may waive entrance into the Disability Evaluation System if the criteria outlined in paragraph 3209 is met. Members requesting waiver of disability processing must complete a waiver request per Attachment (a) to this enclosure.

Attachment (a) to Enclosure (13): Format for Waiver Letter

MEMORANDUM

From: (Name, Rank, SSN, Service)
To: President, Physical Evaluation Board
Via: (Service Member's Commanding Officer)

WAIVER OF NAVAL DISABILITY EVALUATION
PROCESSING ICO (NAME, RANK, SSN, SERVICE)

Ref: (a) Title 10 U.S.C., Chapter 61
(b) DoD Inst 1332.38
(c) SECNAVINST 1850.4E

1. I hereby certify that I qualify to submit a waiver because:
2. The Medical Board indicates that my condition existed prior to entry on active service, and I acknowledge that it was not aggravated by military service. (Member's Initials) or,
3. I am currently retirement eligible, have submitted a retirement request, have an approved retirement date, and do not consent to retention to complete disability evaluation (Member's Initials) or,
4. I am currently within 6 months of my Expiration of Obligated Active Service (EAOS), do not intend to extend and/or reenlist, have no remaining Reserve obligation, and do not consent to retention to complete disability evaluation (Member's Initials) or,
5. I am currently within 6 months of mandatory separation/retirement due to:
 - Length of Service, or
 - High Year Tenure (HYT), or
 - Continuation Board Results/Failure to Select to Next Senior Rank, or
 - SERB Board Results, or
 - Reduction in Force (RIF) Requirements; and
 - Do not consent to retention to complete disability evaluation, and have no remaining Reserve obligation (Member's Initials)
6. After consultation with a military medical doctor (Medical Corps) who discussed both my current diagnosis/future prognosis, and after consultation with legal counsel and the PEB liaison officer, I hereby voluntarily waive any and all legal rights under the Department of the Navy Disability Evaluation System.

7. More specifically, I acknowledge that by submitting this waiver I relinquish any and all statutory/regulatory rights granted by references (a), (b), and (c) to military disability processing and possible severance pay or possible military disability retirement (Temporary Disability Retirement List or Permanent Disability Retirement List).
8. Furthermore, I also realize that, by signing this waiver, I am relinquishing any and all rights to be granted limited duty extensions for medical reasons and/or Permanent Limited Duty on active service.
9. By submitting this waiver, I intend to expedite my separation from the military service to ensure that my transition to the civilian sector is efficient and timely.
10. Nothing in this waiver, however, forecloses my ability to be evaluated by the Department of Veterans Affairs for injuries incurred incident to military service. I am aware that any disability compensation awarded by the Department of Veterans Affairs will be tax free, whereas, within the Department of the Navy only combat-related injuries or injuries occasioned by an instrumentality of war are tax free.
11. Notwithstanding the above facts, I hereby affirm my intent to waive any and all rights under the Department of the Navy Disability Evaluation System.

Respectfully submitted,

(Member's name)
(Rank, SSN, Service)

Rank, Name, Service, and Telephone
Number of MEB Medical Doctor (Medical Corps)

Rank, Name, Service, and Telephone number of
Legal Counsel (Judge Advocate and/or Civilian Counsel)

Rank, Name, Service of PEBLO
Copies to:
Service Member, Legal Counsel, Medical Doctor

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