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THESIS

DISABILITY EVALUATION SYSTEM AND TEMPORARY LIMITED DUTY ASSIGNMENT PROCESS: A QUALITATIVE REVIEW

by

M. Debra Keenan

and

Gail M. Wilkins

March 1998

Principal Advisor: Stephen L. Mehay

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DISABILITY EVALUATION SYSTEM AND TEMPORARY LIMITED DUTY ASSIGNMENT PROCESS: A QUALITATIVE REVIEW

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MASTER OF SCIENCE IN MANAGEMENT

from the

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March 1998

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ABSTRACT

The screening and management of services members with medical situations that render them non-deployable and unavailable for world-wide assignability is a key manpower and readiness issue. The Navy manages service members unable to perform their duties due to medical reasons utilizing both the Temporary Limited Duty Assignment process (TLD) and the Disability Evaluation System (DES). The objective of this thesis is to analyze the Temporary Limited Duty Assignment process and the Disability Evaluation System, identify process inefficiencies, compile a reference document and assess the impact on Force Structure and the Individuals Account. An in-depth review of the steps in each process is provided with timeline flow charts. This thesis analyzes the factors that contribute to the amount of time a service member spends in a transient and limited duty status. The thesis also identifies the primary claimants and their roles and responsibilities in each process and analyze the inter-relationship of TLD and DES. An extensive summary of findings is provided with recommendations for streamlining the processes to improve efficiency.

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I. INTRODUCTION

The end of the Cold War Era has resulted in a smaller U.S. Naval Force. The requirement for a fully capable operational force is critical for today's 21st century Navy. Contingency planning for regional threats such as Desert Shield/Desert Storm requires short notice response coupled with a higher state of fleet readiness. One of the key manpower and readiness issues is the screening of sailors for worldwide assignments and deployability. Personnel who are nondeployable produce manning shortages in the fleet and corresponding manning surpluses in shore billets. Nondeployability also imposes significant administrative and other costs on the government, and forces the services to take compensating actions to meet requirements. [Ref. 1]

One important resource management issue in the military services, and the subject of this study, is the process for dealing with service members with injuries or health problems that interfere with their duties and render them nondeployable. The Navy manages service members unable to perform their normal military duties due to medical reasons utilizing both the Temporary Limited Duty (TLD) assignment process and the Disability Evaluation System (DES) process. These complex processes involve assessing the extent, nature, and treatment of health problems, rehabilitating and, assigning individuals to limited duty (LIMDU), or referring them to Physical Evaluation Boards, and tracking the medical status of service members. The somewhat lengthy process involves a web of different policies; more over, execution, and procedural responsibilities rest with numerous organizations. Different organizations within each service branch,

and decision-makers at different levels attempt to manage the process. The status of the individual who is processed through this system affects a number of important components of the military personnel system. The "present state of health" of members in the military directly impacts force structure, end strength funding of the Navy's Individual Account, and personnel decision making.

It is widely thought throughout the Navy that the Temporary Limited Duty and Disability Evaluation processes are often inefficient and ineffective, and can interfere with Commanders' efforts to fill their billets. It has been stated that by eliminating steps within the two processes and primarily focusing on the DES, the Navy could save approximately one - third of the end strength (funded billets) required to account for individuals who are physically unable to fully execute their duties. [Ref. 2] However, little formal research exists to validate these propositions.

The primary objective of this thesis is to analyze the strengths and weaknesses of the TLD assignment and DES processes, and to determine how well the processes are meeting their objectives. This thesis will also attempt to identify factors that contribute to the amount of time service members spend in a transient and limited duty status for medical reasons. This should allow for further evaluation of current policies and programming decisions that drive these processes and the management of transient and LIMDU populations.

The assignment of a member to Temporary Limited Duty (TLD) and referral into the Disability Evaluation System (DES) are administrative processes in the U.S. Navy that often generate confusion during decision-making and programming. The Temporary

Limited Duty assignment process begins with convening a medical board at a Medical Treatment Facility where a determination is made to return the member to full duty, place the person in a temporary limited duty status, or refer the case into the DES. Directing a person to temporary limited duty is intended to provide the member and commands with the medical treatment and the time that will be needed to eventually return the member to full duty. The DES process begins when a member is referred from a medical board. The process is intended to determine fitness for duty by a Physical Evaluation Board (PEB). If found unfit for duty by the PEB, a determination is made to retain in a permanent limited duty status, or to medically separate or retire the individual with an assigned disability rating.

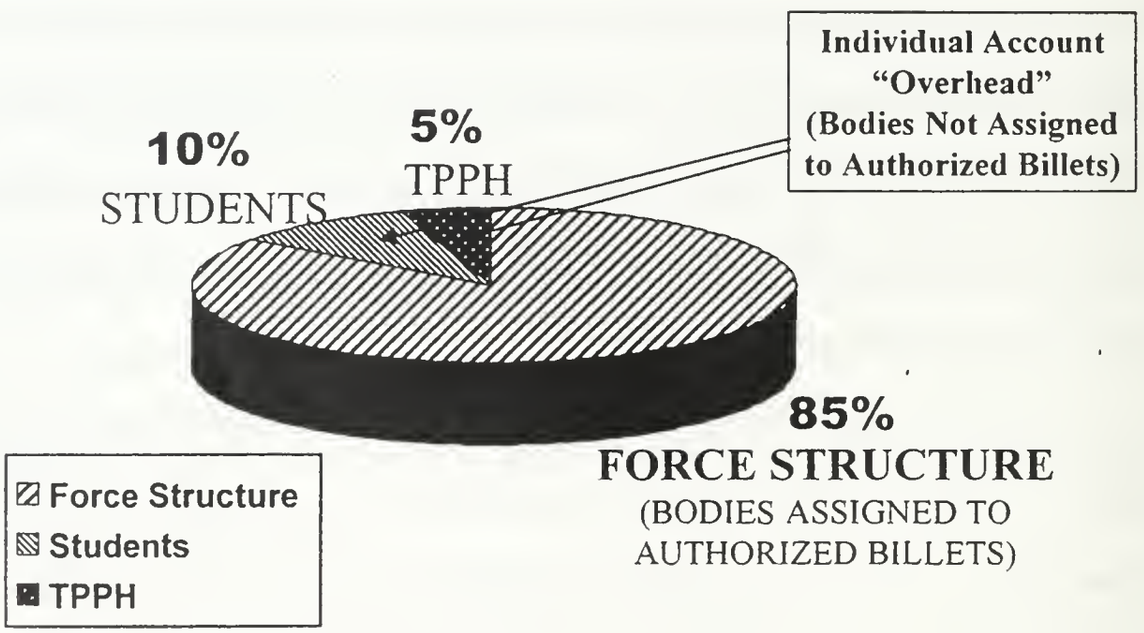
Assigning a member to Temporary Limited Duty is a process supervised by the Chief of Naval Operations, monitored and managed by the Bureau of Naval Personnel, but executed by healthcare providers under the auspices of the Bureau of Medicine and Surgery. The DES is supervised by the Under Secretary of Defense for Personnel and Readiness, monitored and managed by the Secretary of the Navy, and executed by the President and members of the Physical Evaluation Board (PEB) under the auspices of the Director, Naval Council of Personnel Boards.

The Temporary Limited Duty assignment and the Disability Evaluation System processes impact both the Force Structure and the Individual Account (IA). Consequently, inefficiencies in either of these two processes can affect several areas:

- Deployability requirements and timetables,
- Unit readiness,

- Manning of fleet billets,
- Military Personnel Navy (MPN) expenditures to provide an operationally ready Naval force, and to purchase the end strength required to account for members in the IA who are physically unable to perform their normal military duties,
- Management of the flow of personnel through the transient pipeline.

Force Structure is the aggregation of units and personnel associated with fleet and shore establishments required for sustained performance of the defense mission. The Force Structure does not include manpower associated with transients, patients, prisoners and holdees (TPP&H), students, Midshipmen, and Officer Candidates. The Individual Account (IA) is a Defense Planning and Programming category of manpower, which includes manpower other than Force Structure. The IA consists of TPP&H personnel, students and cadets. [Ref. 2] Figure 1 demonstrates the IA relative to the Force Structure.



Source: N120 TPPH Program Brief, 3 December 1997.

Figure 1. Individual Account – Force Structure Relationship

BUPERS (Total Force Programming and Manpower, Pers-5) sponsors the TPP&H program. Data for FY97 indicate that the TPPH program contained 18,975 individuals, which was five percent of total officer and enlisted strength. Personnel in the Transient category consist largely of active duty personnel who are enroute as a result of PCS moves, and to a lesser extent personnel anticipated to be in a TEMDU status six months or less. Transients made up 89 percent of the TPP&H program and 23 percent of these were TEMDU-Transients. The sub-category of TEMDU-Transients includes the specific Account Category Codes (ACC) of relevance to the TLD assignment and DES processes: (a) personnel pending results of a medical board/PEB (ACC 355); (b) personnel pending special duty physical evaluations (ACC 356); and (c) personnel pending further assignment (ACC 320), of which an unknown number are going to or from a limited duty status. Among the 23 percent of TEMDU-Transients, 16.4 percent (690) were in ACC 355, only 3.7 percent of the total TPP&H program; 8.5percent (356) were in ACC 356, 2.1 percent of the total TPP&H program; and 34 percent (1447) were in ACC 320. [Ref. 2] Figures 2 and 3 show the breakdown of the TPPH Program and the TEMDU-Transients, respectively. Since personnel who are awaiting the results of a medical board or, if referred directly into the DES and are awaiting findings of a PEB, are classified in ACC 355 it follows that this category will be our primary focus for an analysis concerning the expeditious processing of transient personnel in the TLD assignment and DES processes. Identifying members classified in ACC 320 as a result of these two processes is beyond the scope of this thesis. However, factors contributing to the length of time spent in this category will be an important element examined in this

study. Figures 4 through 6 show the trends in the ACC 355 and ACC 320 accounts from 1992 through 1997.

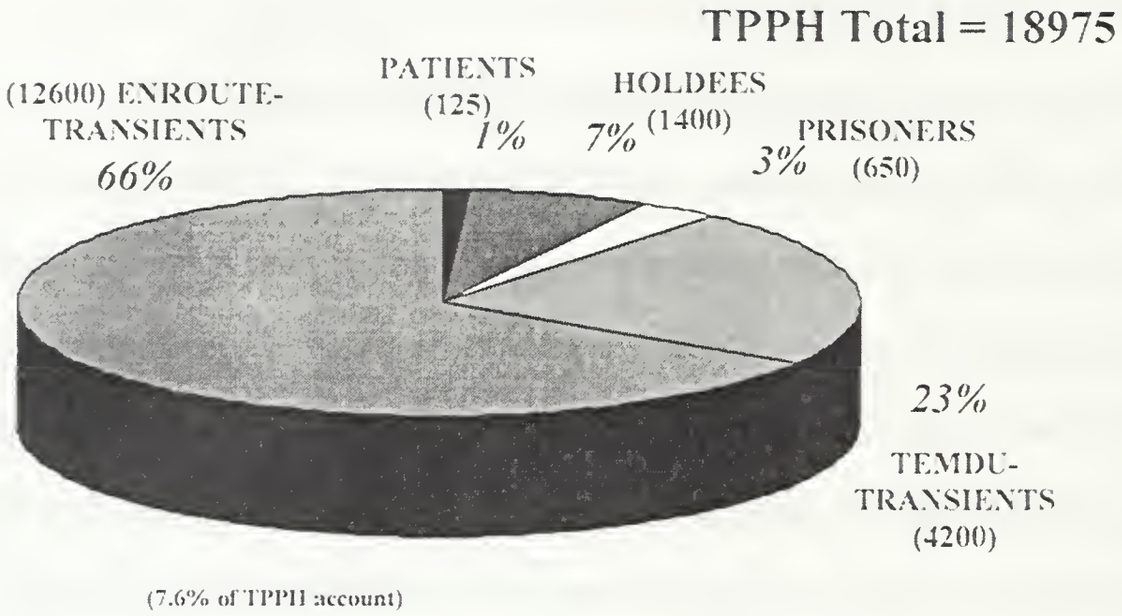
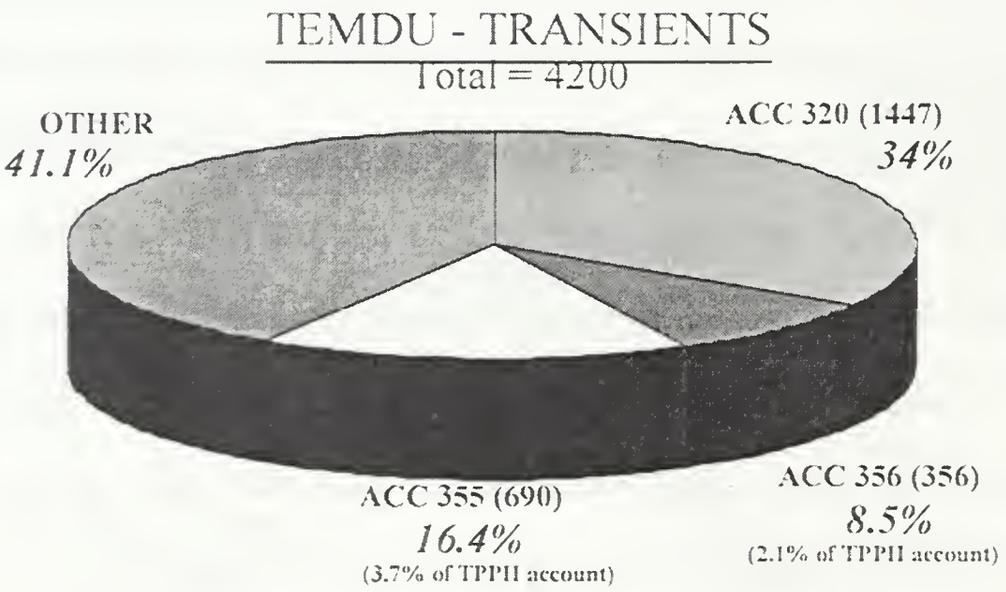


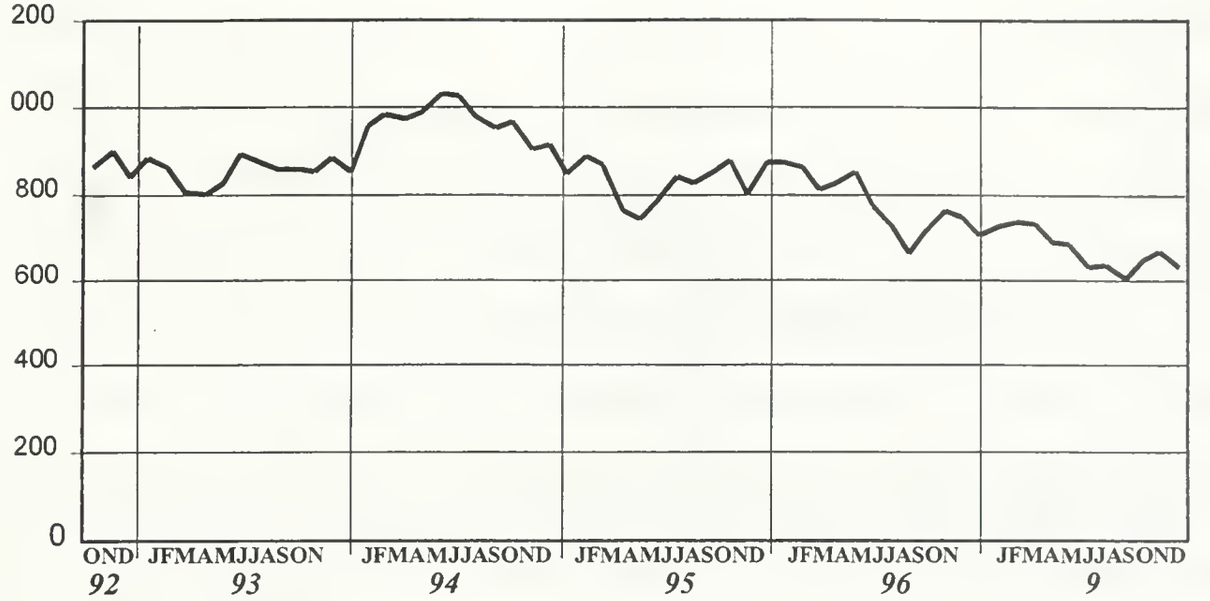
Figure 2. TPPH Program Relative Sizing



ACC 320: For Further Assignment
ACC 355: Pending Medical Board/PEB Results
ACC 356: Pending Special Duty Evaluation
OTHER: ACC's 330, 350, 351, 354, 358, 400

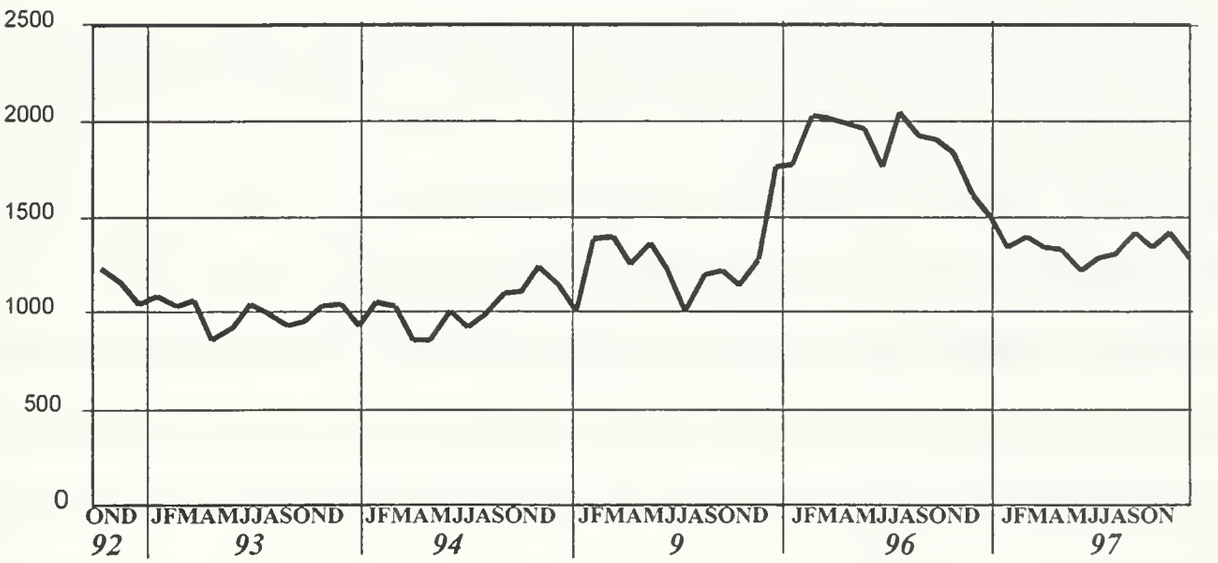
Source: N120 TPPH Program Brief, 3 December 1997.

Figure 3. TEMDU-TRANSIENTS



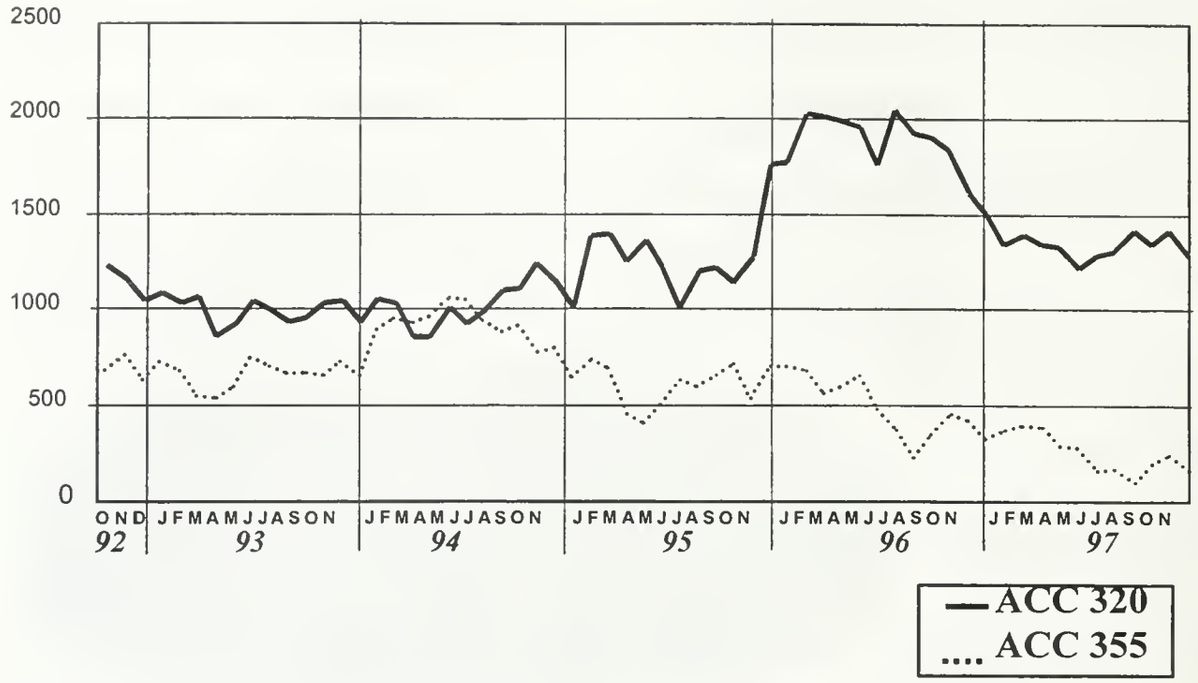
Source: J. Dooley, N120 brief.

Figure 4. Enlisted ACC 355 (TEMDU-Pending Results of a Medical Board/PEB) OCT 92 - DEC 97



Source: N120 TPPH Brief 3 December 1997.

Figure 5. Enlisted ACC 320 (TEMDU for Further Assignment) OCT 92 - DEC 97



Source: N120 TPPH Brief 3 December 1997.

Figure 6. Enlisted ACC 320 and 355
OCT 92 - DEC 97

Personnel in a limited duty status who are nondeployable are accounted for in the Force Structure as ACC 105. The ACC 105 category includes temporary and permanent limited duty.[1] Temporary limited duty personnel are temporarily assigned to valid non-operational shore assignments near a Medical Treatment Facility until they are re-evaluated and a determination is made to return to full duty, or to medically separate or retire from Naval service. Permanent limited duty (PLD) is a status authorized by CHNAVPERS if the member is found permanently unfit for worldwide assignment by the PEB yet the medical condition is manageable ashore. This assignment is generally limited to senior sailors in a critical job with the intention of allowing them to complete

[1] Permanent Limited Duty (PLD) comprises a small proportion of ACC 105, remaining less than 10 percent since May 1991, and in 1997 peaked at 2.5 percent. For the purposes of this thesis, unless otherwise specified, reference to the ACC 105 is intended to represent the TLD population (also referred to as the LIMDU population).

twenty years of active military service. Permanent Limited Duty personnel are classified as the L-4/L-5 limited duty category and are managed somewhat differently from TLD personnel. Temporary Limited Duty personnel comprise the "LIMDU" population. As of December 1997, LIMDU's were only 1.5 percent (4,833) of the active duty enlisted population. [Refs. 3 and 4] The LIMDU population is the focus of our study.

There are claims that the number of temporary limited duty incidences and the time that individuals stay in a temporary limited duty status reduces operational readiness. Of primary concern to fleet commanders is that they face increased training requirements and difficulties replacing personnel lost to a LIMDU status. Also, less flexibility is available due to force downsizing for replacing and substituting personnel to meet force requirements. [Ref. 5] Units are manned at lower rates in peacetime than is required in wartime. Thus, the extent to which units are significantly affected by nondeployable personnel may further degrade unit integrity, cohesiveness, and readiness. [Ref. 5]

Increasing the efficiency of the Temporary Limited Duty assignment process could improve readiness of the operational forces by expeditiously returning needed personnel to the fleet or accelerating referral into the DES. The same holds true for improving the efficiency of the DES. Members would receive a final disposition regarding fitness or separation from Naval service in a more timely manner. Costs can also be reduced in the IA if the length of time personnel remain in an ACC 355 or 320 status is reduced.

A qualitative analysis of the two processes is presented in this study. List I-A is included with this Chapter to identify numerous process-specific acronyms. Chapter II contains a synopsis of findings in the literature on Navy processes that deal with medical conditions and their impact on deployablity, unit readiness, and movement of personnel through the transient pipeline. The design and scope of the thesis is explained in Chapter III. Chapters IV and V provide a detailed review and findings of the TLD assignment and DES processes, respectively. The processes are dominated by unique concepts and terminology. To aid understanding of these chapters, at the end of each chapter a list with an extensive explanation of process-specific concepts is provided. Finally, an analysis of findings and recommendations for streamlining the processes to improve efficiency, and for policy changes and inclusion of quality measures to improve process effectiveness, are offered in Chapter VI.

LIST I-A

PROCESS SPECIFIC ACRONYMS

ACC	Accounting Category Code
ACC 100	Permanent assignment for duty
ACC 105	Limited duty where assignment restricted for medical reasons
ACC 320	Temporary duty for further assignment
ACC 350	Temporary duty not otherwise defined (security clearance, overseas screening, special screening, etc.)
ACC 355	Temporary duty awaiting formal medical board/physical evaluation board proceedings[2]
ACC 356	Temporary duty pending evaluation by local authorities for special duties (submarine, aircrew, diving, etc.)
ACC 370	Temporary duty under treatment (inpatient at Naval medical facility)
ACC 371	Temporary duty under treatment (medical holding company)
ACC 380	Temporary duty pending separation, discharge, release, retirement
ACC 381	Temporary duty pending separation, discharge, release, retirement (pay status, at home awaiting final disposition of Physical Evaluation Board)
APEBP	Awaiting Physical Evaluation Board Proceeding
ASD (HA)	Assistant Secretary of Defense (Health Affairs)

[2] ACC 355 does not include sailors assigned to shore commands (Type 1 duty).

ASN (M&RA)	Assistant Secretary of the Navy (Manpower & Reserve Affairs)
AVAILS	Availability's
BCNR	Board for Correction of Naval Records
BUMED	Bureau of Medicine and Surgery
BUPERS	Bureau of Naval Personnel
CA	Convening Authority
CHBUMED	Chief, Bureau of Medicine and Surgery
CHNAVPERS	Chief of Naval Personnel
CMC	Commander of the Marine Corps
DEP REVIEW	Department Review
DES	Disability Evaluation System
DESC	Disability Evaluation System Counselor
DNCPB	Director, Naval Council of Personnel Boards
DVA	Department of Veteran Affairs
EPMAC	Enlisted Personnel Management Center
EPTE	Existed Prior to Entry (enlistment)
ENLTRANSMAN	Enlisted Transfer Manual
FFA	For Further Assignment
FFFD	Fit for Full Duty
FFT	For Further Transfer
GCM	General Court-Martial
HAO	Home Awaiting Orders

ICD-9-CM	International Classification of Diseases, 9th Rev., Clinical Modification
JAG/OJAG	Judge Advocate General/Office of the Judge Advocate General
JDETS	Joint Disability Evaluation Tracking System
JFTR	Joint Federal Travel Regulations
LIMDU	Limited Duty[3]
LODD/LODI	Line of Duty Determination/Line of Duty Investigation
MANMED	Manual of the Medical Department
MAPMIS	Manpower Personnel and Management Information System
MBTS	Medical Board Tracking System
MEDBD	Medical Board
MEDHOLD	Medical Hold
MHC	Medical Holding Company
MTF	Medical Treatment Facility
NMIMC	Naval Medical Information Management Center
NCPB	Naval Council of Personnel Boards
ODRB	Officer Disability Review Board
PAD	Patient Administration Department
PEB	Physical Evaluation Board
PFR	Petition for Relief
PLD	Permanent Limited Duty

[3] For the purposes of this thesis "LIMDU" refers to temporary limited duty. The term "Total LIMDU" will be used when referring to both temporary and permanent limited duty.

PSD	Personnel Support Detachment
RRP	Record Review Panel
SECNAV	Secretary of the Navy
SEP AUTH	Separation Authority
SURGEN	Navy Surgeon General
TDRL	Temporary Disability Retirement List
TEMDU	Temporary Duty
TLD	Temporary Limited Duty
TMTR	Transient Monitoring Tracking Report
TPP&H	Transient, Patient, Prisoner & Holdee
TPU	Transient Personnel Unit
TMU	Transient Monitoring Unit
USDTF	Uniformed Services Dental Treatment Facility
USMTF	Uniformed Services Medical Treatment Facility
VASRD	Veterans Affairs Schedule for Rating Disabilities

[Refs. 6, 7, and Ref. 8]

II. LITERATURE REVIEW

There has been little prior research on the nondeployability of Navy uniformed personnel due to medical conditions resulting in a pending medical board (ACC 355) or LIMDU (ACC 105) status, and the impact of nondeployability on readiness, deployment requirements, and transient population management.

A General Accounting Office (GAO) report (August 1992) for the Congressional Subcommittee on Readiness, examined some of the problems of nondeployability during the Persian Gulf conflict. The report indicated that a number of active and reserve personnel were unable to deploy. The lack of complete, consistent, and comparable data bases made it impractical to develop reliable estimates of the total number of nondeployable personnel. [Ref. 5] The data that were available however, suggested a sizable number of nondeployables. Furthermore, GAO found that the nondeployability problems were exacerbated by systemic weaknesses in the peacetime screening of active and reserve personnel, and inadequate reporting of nodeployables in normal readiness reporting. Causes of nondeployability ranged from pending legal actions, lack of training, medical profiles, and pregnancy, to inadequate family care plans. The report did not attempt to quantify the various reasons for affecting nondeployability. The GAO report states that throughout the conflict, internal reports cited nondeployability problems as impairments to unit cohesiveness and personnel readiness.

Several of the problems were addressed in the Joint Universal Lessons Learned System (JULLS), a data base used to analyze lessons-learned to improve future

operations. While the DOD concurred with the findings of the GAO report, it also took the position that nondeployability was not a serious problem, and that it plans on nondeployables in its manpower calculations. Further, DOD asserted that it is not necessary or cost-effective to maintain every unit at the highest level of readiness. The DOD acknowledged that the active force does not maintain historical data on nondeployables. The number of deployables varies daily, so DOD's focus is on whether a unit is able to perform its assigned mission when called upon to do so. [Ref. 5]

Although the data in the GAO report indicate that Navy nondeployability problems were related primarily to reserve components, the report also recognizes that the majority of active Navy personnel are in some phase of a deployment cycle most of the time. Personnel deployability is a part of the Navy's routine business. Further, it is difficult to argue that there are significant monetary and readiness costs associated with retaining personnel who are not deployable. Thus, GAO asserts that a greater emphasis on a process for assessing and reporting on nondeployability issues during peacetime seems appropriate. An interesting outcome of the GAO report was a study by the Army of discrepancies in current deployability and retention criteria, and whether any change in DOD policy or public law are required. [Ref. 5]

A Center for Naval Analysis (CNA) annotated briefing (Garcia, Gasch, and Quester, July, 1996) introduced the incidence and magnitude of medical conditions on nondeployability. A second CNA report (Garcia and Gasch, September, 1996) examined nondeployability specifically as a result of a LIMDU status. The first CNA study was initiated to assist the Navy in satisfying reporting requirements in the area of

nondeployable personnel. Specifically, the Secretary of the Navy requires annual reports concerning the effect of pregnancy and other medical, administrative, and disciplinary factors on personnel deployability; and the 1995 Defense Authorization Act requires annual reports to Congress on all personnel either temporarily or permanently unavailable for worldwide assignment. The Congressional requirement was imposed on all services to measure the percentage of the force deployable at any one time. The Navy has historically evaluated readiness based on sea assigned sailors and the platforms they support with little emphasis placed on the readiness of its sailors on shore-based rotation assignments (these sailors deploy only for an emergency mobilization). [Ref. 1] Consequently, Garcia, Gasch, and Quester (July 1996) assert that record-keeping concerning deployability status is far more accurate when it is operationally relevant. They are not confident that a sailor who is early in a shore tour near an MTF, with a temporary medical condition, and who can perform the shore job, will have a record entry to indicate "limited duty, shore assignments only." It is not clear if the CNA report suggests that medical boards are less likely to be convened on such members, and if account category codes (ACC) entries are less likely to be accurate for them.

The second CNA report (Garcia and Gasch, September 1996) offers recommendations that may control the growth of LIMDU personnel by expediting the Temporary Limited Duty assignment and Disability Evaluation System processes. Garcia and Gasch (September, 1996) believed that deployability and readiness could be improved if these processes operated more efficiently. The following discussion of information provided by the literature pertains to the two CNA reports.

A. DATA SOURCES

The first CNA study utilized much of the same data set as the second and also collected information on trends in the LIMDU population and LIMDU status duration, and types of sailors with a high incidence of LIMDU or separation from the Navy. They analyzed the records of active-duty enlisted sailors with resolved LIMDU cases in 1985 through 1995 from the Enlisted Master Record. They claim the data files contained social security numbers (SSN's) and LIMDU start and end dates, as well as a field indicating whether the sailor remained on active duty or separated from the Navy (for medical, involuntary, retirement, or other reasons).[4] It is not clear at what point in the limited duty process the "LIMDU start and end dates" were entered into the file or whether these dates correspond with the ACC changes. CNA also matched the 1990-1995 SSN's in this file with the SSN's in a medical diagnosis data file from the Navy Medical Information Management Center (NMIMC). The NMIMC data file contains up to eight medical diagnosis codes and diagnosis dates for each SSN. The primary diagnosis code was used as it presumably described the more serious illness/injury.

A data file also used by CNA was provided by the Director, Naval Council of Personnel Boards (DNCPB) of the Physical Evaluation Board (PEB), which included cases acted on by the PEB for years 1994 through 1996. The file included the dates cases were received and resolved at the PEB, so the number of months from LIMDU start to

[4] The LIMDU Branch Navy Senior Chief at BUPERS (Pers-821/271) and the OIC of the Transient Monitoring Unit, EPMAC assert that LIMDU start and end dates are not available and obtaining a sailor's accurate ACC history from present data bases is not possible. Consequently, estimates of LIMDU duration may not be reliable.

action by PEB, and the number of months LIMDU cases spent in the PEB process was calculated.

B. THE LIMDU POPULATION

The LIMDU status identifies those active-duty personnel with treatable temporary medical conditions that prevent them from being worldwide assignable. The service member on LIMDU status is expected to be returned to full duty at the completion of the medical treatment regime. A more detailed discussion of the LIMDU population, and the medical and administrative process for determining assignment of a LIMDU status, will be presented in chapter IV. The CNA found from tabulations of the Navy personnel files that as of 30 September 1995, only 3 percent of active-duty sailors have an assignment limitation.[5]

CNA concluded that LIMDU is the most common reason for nondeployability, and that the incidence and average duration of LIMDU in the active-duty force has increased by 0.6 percent and 1.2 months during the years between 1985 and 1995.

CNA found the number of sailors temporarily nondeployable as of 30 September 1995 totaled 10,815, of which 6,548 were due to medical reasons.[6] Of the latter, 5,368 were in a LIMDU status (1.5 percent of the active-duty enlisted force) and 894 were

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[5] Assignment limitation includes medical permanent limited duty, HIV positive status, temporary medical limited duty (LIMDU), disciplinary, and administrative problems. Pregnancies are excluded. Weaker deployability restrictions, such as missing a Panorex dental X-ray, are considered not difficult to satisfy before deployment, and CNA found 13 percent had a weaker assignment consideration.

[6] Temporary medical reasons: LIMDU, pending medical board processing, medical holding company, hospitalization. Other categories for temporary nondeployability include: disciplinary, hardship, and administrative.

pending medical board action for a disposition regarding duty status. The number of sailors permanently nondeployable was 662, most of which (644) due to medical reasons. Of the 644, 173 were on permanent limited duty and the remaining 471 were nondeployable due to an HIV positive status. Table 1 shows medical reasons for members temporarily and permanently nondeployable.

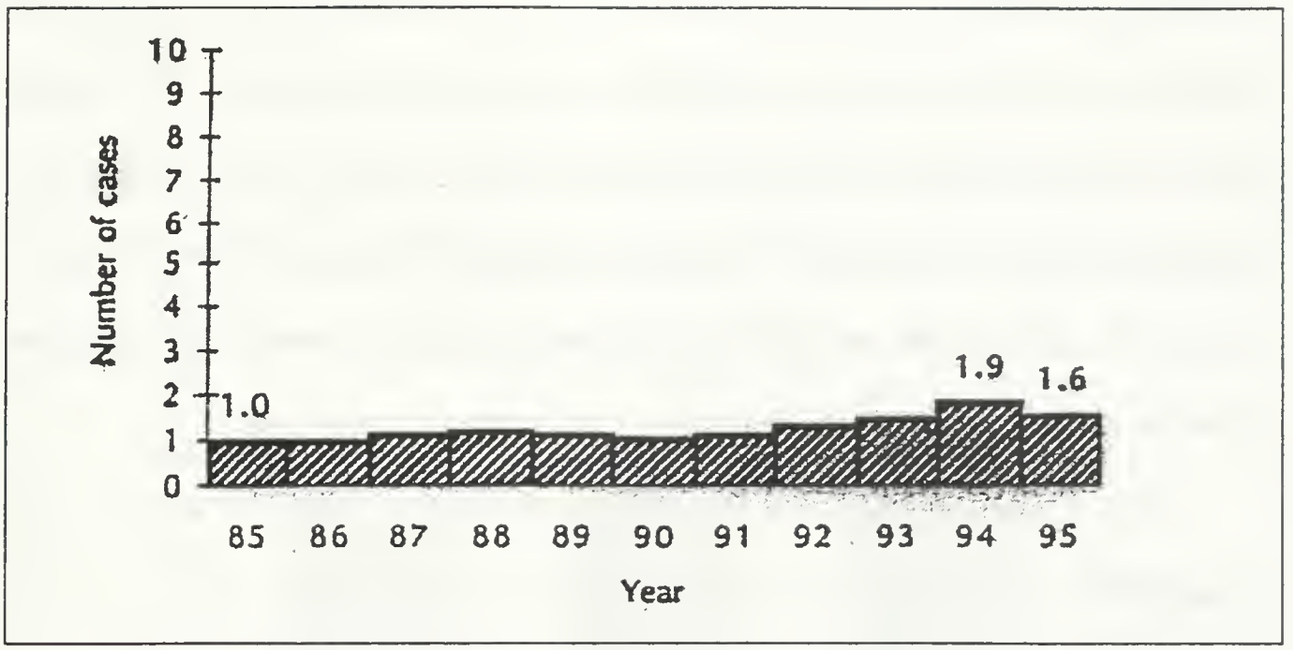
Table 1. Active Duty Enlisted Sailors with Assignment Limitations Due to Medical Reasons (as of 30 September 1995)

Category	Total	Male	Female	E1-E4	E5-E6	E7-E9
TEMPORARY						
Medical						
Assignment restricted for medical reasons (Temporary Limited Duty-LIMDU)	5,368	4,660	708	2,627	2,253	488
MEB or PEB proceedings pending	894	797	97	478	338	78
Medical holding company	198	163	35	129	61	8
Hospitalized	38	33	5	29	9	0
Other	50	50	0	26	14	10
PERMANENT						
Medical						
HIV Positive	471	452	19	22	333	116
Permanent Limited duty (PLD)						
Shore assignments CONUS only (L-S)	171	141	30	23	104	44
Shore assignments only (L-4)	2	1	1	0	1	1

Total with assignment limitations due to medical and non-medical reasons= 11,477

Source: CNA Study "Nondeployable and Assignment-Restricted Navy Personnel" (July 1996)

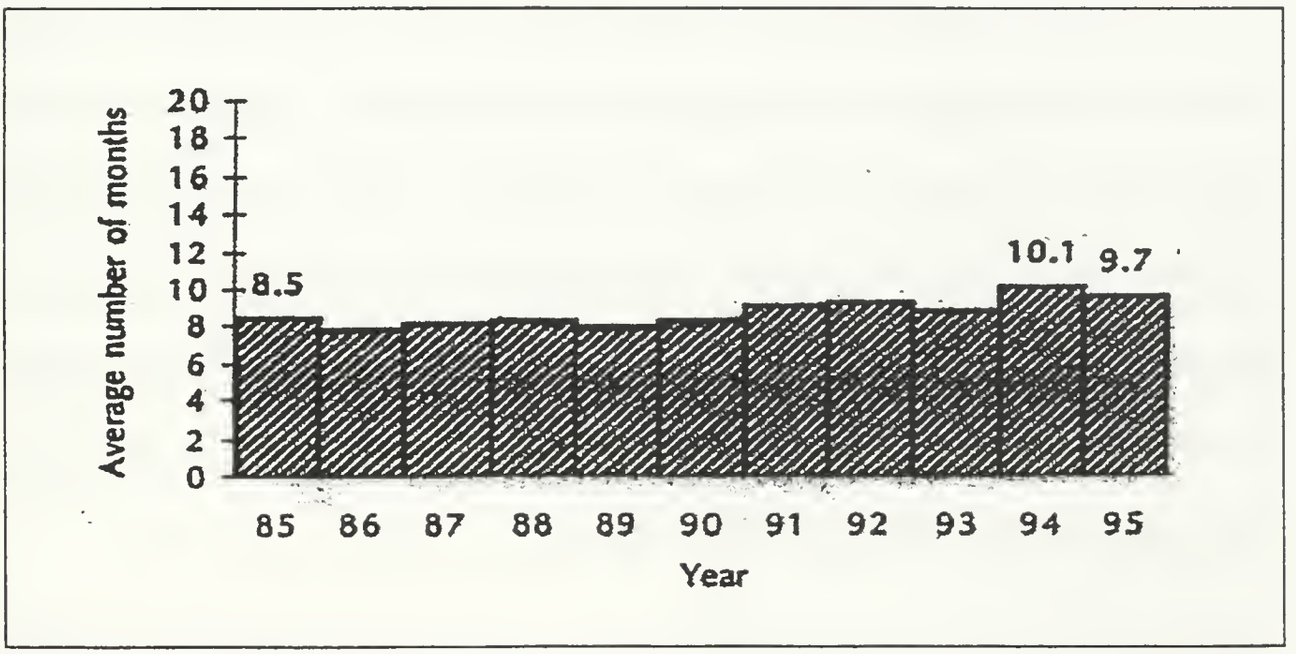
Looking at an 11-year trend the incidence of LIMDU in the active-duty enlisted force was 1percent of that population (5,037) in 1985, peaked to 1.9 percent in 1994 (7,664) and declined somewhat to 1.6 percent in 1995 (5,937). Figure 7 identifies this trend. During the 1990-1991 Desert Shield/Storm period the incidence was 1 percent in



Source: CNA Study, September 1996.

Figure 7. Panel A: Active-Duty Enlisted LIMDU Cases as a Percentage of Strength

1990 and only slightly above that level in 1991. The average duration of LIMDU cases resolved in 1985 was 8.5 months, peaking in 1994 at 10.1 months, decreasing to 9.7 months in 1995. Figure 8 shows the average LIMDU duration. Criticism that sailors are allowed to remain on LIMDU for too long found some support in the CNA study, which



Source: CNA Study, September 1996.

Figure 8. Panel B: Average Duration of Active-Duty Enlisted LIMDU Cases

found that in 1995, 37 percent remained on LIMDU longer than one year but less than two years, and 6 percent remained on LIMDU more than two years.[7] The CNA asserted that the decline in both incidences and duration in 1995 might be explained by the popularity of temporary Early Retirement Authorization (TERA) available as an incentive to retire for some sailors on LIMDU, additionally, BUPERS (Pers-821/271) probably reviewed sailors on LIMDU with more scrutiny due to force downsizing.

Both CNA studies claimed that Navy record-keeping regarding LIMDU status appeared more accurate when the medical condition was incompatible with sea duty and the sailors were in a sea assignment or in the "window" for sea duty. Their data indicated the highest proportion of LIMDU starts were upon rotation to sea duty and during the first 30 months of sea duty (12-17 percent). Higher accident rates probably account for a small portion of these higher rates of LIMDU starts. Only three percent of LIMDU cases started when the sailors were more than two years away from sea duty.

In 1991 the female rate for medical temporary limited duty surpassed the male rate, which had remained relatively constant since the mid-1980's. At the same time the rate of increase of both male and female rates sharpened. Then, in early 1995, the male rate stayed flat and the female rate declined, remaining slightly higher than the male rate through 1996. Since CNA asserted that medical temporary limited duty is underreported for sailors on shore duty, they relate some rise in the female rate during the period as a result of the increased number of women at sea.

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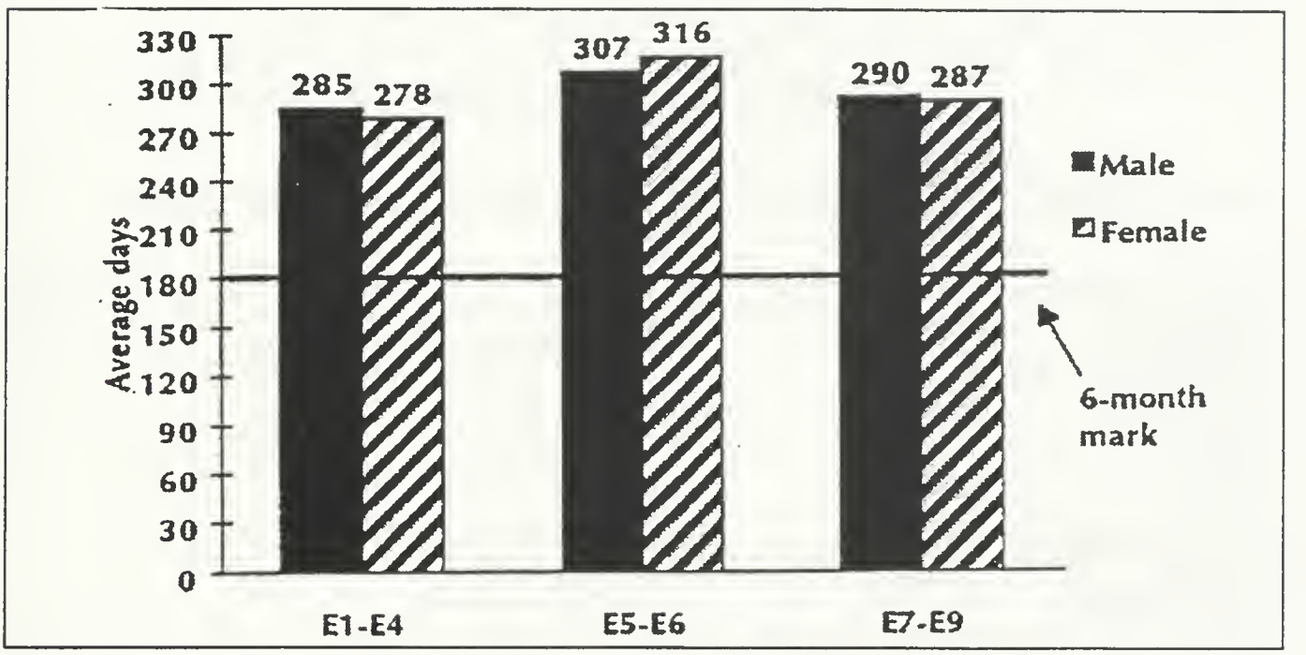
[7] Again, the estimates of LIMDU duration are questionable due to the inaccurate measure of ACC changes according to Pers-821/271 and TMU, EPMAC.

CNA reported that the incidence of LIMDU status was lower among E7-E9 personnel in FY 95. This is demonstrated in Table 1. Personnel at the E5-E6 level remain in LIMDU the longest and E1-E4 personnel the shortest. There was little difference, however, among the three paygrade categories in duration. The range is 278 days to 316 average days for personnel entering a LIMDU status in FY93 as shown in Figure 9.



Source: CNA, July 1996.

Figure 9. Time in Medical Temporary Limited Duty FY 93

Although the rates are quite small (approximately 1 in 1,000 sailors), the male rate in permanent limited duty has been stable during FY95 while the female rate has increased from nearly zero to equal that of males. Again, CNA suggests this merely reflects the increased number of women at sea.

CNA found virtually no difference in the male and female probabilities of awaiting the results of a medical board or PEB (as of 30 September 1995). Overall,

among the years between 1984 and 1996, the rates were very small (approximately 3 in 1000 sailors), but the rate has been increasing since 1984. CNA speculates the increase may be due to longer waits for boards, more sailors requiring board action, or a combination of the two.

The most common medical conditions affecting sailors in a LIMDU status for 1990 and 1995 were as follows (Garcia and Gasch, September, 1996):

Table 2. Medical Reasons for LIMDU

1990		1995	
Orthopedic -	58%	Orthopedic -	55%
Bad Knee -	12%	Bad Knee -	16%
Bad Back -	9%	Bad Back -	8%
Other -	37%	Other -	31%
Cardiopulmonary -	6%	Cardiopulmonary -	5%
Psychological -	7%	Psychological -	5%

Source: Garcia and Gasch September 1996.

Garcia and Gasch (September, 1996) also identified sailors at a higher risk of being on LIMDU, remaining in the LIMDU status longer, returning to a LIMDU status a second time, or separating from the Navy while in a LIMDU status:

- ***Bad Back:*** Although these sailors are eight percent of LIMDU cases in 1995, 15 percent remained on LIMDU greater than two years; and 44 percent were eventually medically separated, more than any other LIMDU medical condition.

- ***Overweight:*** Overweight E-5 - E-9 sailors were 2.5 times more likely to be affected by medical conditions resulting in a LIMDU status than peers on full duty.[8]

- ***Psychological Problems:*** 11 percent of sailors on LIMDU due to psychological conditions were involuntarily separated in 1990 through 1994. This is over twice the rate of other LIMDU sailors.

- ***Non-Diploma High School Graduates:*** Compared to high school graduates these sailors were 2.2 percent more likely to return to a LIMDU status one or more times. Also 12.7 percent of their LIMDU cases resolved between 1990 and 1995 (7.9 percent) had a duration longer than two years.[9]

An increased number of sailors on LIMDU have separated from the Navy for medical reasons.[10] In 1995, more than 3,000 separated for medical reasons, a large increase from 1,000 in 1987.

C. THE LIMITED DUTY PROCESS

Garcia and Gasch (September, 1996) offer a brief discussion of the process of convening a medical board at the Medical Treatment Facility (MTF), and referral into the Disability Evaluation System (DES) for a physical evaluation board (PEB), and examine how those processes contribute to the length of the LIMDU status. They were unable to determine why the duration on LIMDU status increased between 1985 and 1995 because

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[8] The evaluation field on the Enlisted Master Record, the source for overweight information, is completed on E-5 sailors and above only.

[9] Garcia and Gasch (1996) suggest this effect may be because non-diploma high school graduates occupy many of the more accident-prone jobs.

[10] Medical separations involve the TDRL, PDRL, and disability separation with and without severance pay. These are dispositions determined by the PEB.

of a lack of long-term data. CNA data from the PEB and information from BUPERS briefings suggested factors contributing to the long duration. Those factors included:

- ***Time Before LIMDU Cases Referred to PEB:*** Members referred to PEB typically had been on LIMDU for about 8 months.
- ***Time in PEB:*** They found that the PEB takes more than a month to complete action on close to 33 percent of its cases.
- ***Medical Re-Evaluation Appointments:*** Clinics at MTF's do not schedule re-evaluation appointments for determining a return to full duty, LIMDU extension, or referral to the PEB, until 60 days prior to LIMDU PRD expiration, and patients may not keep the appointments.
- ***Command Involvement:*** Many sailors may have an incentive to continue their LIMDU status. Commands may not be enforcing the sailor's attendance at the reevaluation appointments and (Pers-821/271) rarely intervenes to enforce compliance.
- ***Medical Considerations:*** Medical treatment options have expanded over the past decade which may result in longer treatment/rehabilitation courses. Additionally, Garcia and Gasch (September, 1996) speculate that because some doctors are hesitant to "give up on patients," they may delay medical boards beyond the point where sailors should be discharged and continue their care at the Department of Veteran Affairs.

D. TIME SPENT IN THE DETAILING AND AVAILABILITY PROCESS

Delays were also noted in the process for detailing sailors to and from LIMDU status. As an example, Garcia and Gasch (1996) cite information according to the Enlisted Master Record for 20 May 1996: 411 sailors were pending availability reports to LIMDU and 292 were pending availability reports to full duty. The availability reports are required before orders can be issued. The median wait was 45 days for placement on

LIMDU and 53 days for returning to full duty. At the time of Garcia and Gasch's study (September, 1996), Pers - 40 was reviewing these detailing delays.

E. REDUCING DURATION OF LIMDU STATUS

Garcia and Gasch (1996) offer five recommendations to expedite return of LIMDU sailors to the fleet or their separation from the Navy, and reduce the size of the LIMDU population. These recommendations logically follow their findings of factors contributing to delays in the Temporary Limited Duty assignment and DES processes. The recommendations involve:

- ***Priority processing for LIMDU cases of bad backs and psychological problems.*** Many of these sailors are high-risk for separation while in a LIMDU status. Identification of these high-risk sailors in the early stages of the disability evaluation system for priority processing will facilitate a quicker determination to medically or involuntarily separate.[11]

- ***Arrange medical reevaluation appointments shortly after placement on LIMDU.*** MTF's are directed by BUMED to schedule reevaluation appointments 60 days prior to LIMDU PRD expiration, but current procedures for ensuring timely appointments do not appear to be effective.

- ***Monitor appointment compliance and discipline sailors who repeatedly miss scheduled appointments.*** Failure to keep these appointments slows down LIMDU processing. MTF's need to ensure commands and BUPERS are notified of sailors who miss reevaluation appointments to allow monitoring of LIMDU cases exceeding the LIMDU PRD.[12] Additionally, commands need to hold sailors accountable for missed appointments.

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[11] It is currently in violation of DES policy to offer priority processing except in the case of imminent death.

[12] Most LIMDU PRD's fall within the detailing "window" of 9 months, and delays result in double- fills against billets. (Garcia and Gasch, September, 1996)

Commands may not have an incentive to get sailors off LIMDU because they represent "free labor."[13]

- ***Assign a higher priority to detailing of LIMDU availabilities.*** As previously noted many sailors en route to LIMDU or returning to full duty wait several weeks to months before receiving orders assigning them to billets. Detailers should be required to act more promptly in cases of LIMDU availability reports.

- ***Trim down the disability evaluation process.*** BUPERS and BUMED should request that SECNAV shorten the DES without rushing medical boards or compromising fairness.

F. SUMMARY AND DISCUSSION

The literature review provides some helpful descriptive statistics of the LIMDU population that can strengthen a more detailed qualitative analysis of the TLD assignment and DES processes. The data limitation concerning inaccurate tracking of ACC histories is likely to result in an overestimation of the LIMDU status duration. This will be further discussed in Chapter III. The literature did not distinguish the duration of time in the TLD assignment process versus in the DES. Some sailors spend time in both processes, and some sailor's cases are referred to the PEB without first being assigned to a period of limited duty. This distinction is warranted for an accurate identification of process-specific problems and targeted resolutions in order to maximize efficiency and effectiveness. The reasons offered for case processing delays, and subsequent recommendations to eliminate unnecessary delays, provide a reasonable starting point for

[13] The claim that LIMDU sailors represent "free labor" is not supported by information provided by Pers-40 and the Transient Monitoring Unit of EPMAC. Non-operational shore activities can be assigned up to 15 percent LIMDU sailors. In some circumstances it may be a matter of getting a LIMDU sailor or no one, the LIMDU sailor does count against the activities strength.

further research. Many of the findings and recommendations noted in Garcia and Gasch (September, 1996) will be further discussed in later chapters.

The analysis attempted in the following chapters may provide improved insight into why sailors remain in a LIMDU, or awaiting medical board proceedings, status for "too long," and assist manpower planners and policy makers in decisions effecting the management of sailors classified as ACC 355 and ACC 105.

Chapter III, which follow discusses the design and scope of this thesis.

III. SCOPE AND METHODOLOGY

The goal of this thesis is to provide a comprehensive qualitative review of two separate and primarily sequential processes: Assignment to Temporary Limited Duty (TLD) and The Disability Evaluation System (DES). Extensive research on these processes will be required to make future policy and programming decisions affecting management of the TPP&H account, and the Force Structure's limited duty element. Both the TLD assignment and DES processes are complicated by many decision points, each with several options. Currently, clarity is lacking on the distinct objectives, requirements, and stakeholders for each process, and the interrelationship between the two. We have initiated the first step in conducting the necessary research by compiling an illustrative reference document, and preliminary analysis identifying process segments amenable to streamlining or improved effectiveness. This study involves an extensive review of applicable SECNAV, DOD, BUMED, BUPERS, and local command instructions, directives, and policies. It also incorporates the results of numerous semi-structured interviews with stakeholders involved in the processes. Finally, it utilizes descriptive statistics, obtained from various cognizant organizations, of the targeted transient and limited duty populations.

Active duty enlisted service members are the focus of the analysis. Active duty officer personnel are excluded from this study because they comprise a relatively small percentage of the ACC 105 and ACC 355 accounts. Transient population data provided by the TPP&H Sponsor, and Transient Monitoring Unit reports, reveal that in FY97 there

were only 165 officers in a limited duty status (ACC 105) and 2.4 officers awaiting results of a TLD medical board or PEB (ACC 355). [Refs. 2 and. 9]. This represents only 0.3 percent and .004 percent, respectively, of the December 1997 officer population. [Ref. 4] Results are quite similar for the ACC 320 (Temporary Duty for Further Assignment), and ACC 356 (Temporary Duty Pending Evaluation For Special Duties) accounts. [Refs. 2 and 9]

A. DATA SOURCE

The descriptive statistical data for this study were obtained from several sources. The majority of the primary source data on the active-duty enlisted transient and limited duty population is from the Navy's Active Readiness Information System (ARIS) and EAIS Enlisted Assignment Information System. Each of these data bases includes information from the Enlisted Master File. [Refs. 10 and 11] Data reports containing statistics on the transient and limited duty population were obtained from three sources: Medical/LIMDU Branch (Pers-821/271); the sponsor of the TPP&H account (N120); and the Transient Monitoring Unit, Enlisted Personnel Management Center. Statistics on medical boards were obtained for the Naval Medical Center, San Diego and Naval Medical Center, Portsmouth from internal Medical Board Tracking System (MBTS) reports. Additionally, information was obtained from annual Transient Monitoring Unit Assist Visit reports. Statistics on cases received by the PEB and case processing time were obtained from Joint Disability Tracking System reports (JDTS).

B. INTERVIEWS

The major stakeholders impacting the TLD assignment and DES processes were interviewed to gain a thorough understanding of potential problems. The following is a list of stakeholders interviewed regarding their governance, role, and application of the TLD or DES procedures. Participants were asked to assess problem areas from their perspective and to make recommendations.

1. BUPERS

- Sponsor, TPP&H Account (N120)
- Admin Ratings Assignment Officer (Pers-405C)
- Medical Board/LIMDU Branch Officer (Pers-821/271)
- Senior Chief, LIMDU Coordinator (Pers-27)
- DOD employee, Medical Board/LIMDU Branch (Pers-821/271)
- Petty Officer, Data Processing/Limited Duty Tracking Reports (Pers-452C3)
- Commander, Limited Duty Tracking Personnel (Pers-45)

2. BUMED

- Head, Patient Administration, Healthcare Operations (MED-03)

3. Medical Treatment Facility (MTF)

- Head, Patient Administration, Naval Medical Center, San Diego
- Head, Patient Administration, Naval Medical Center, Bethesda
- OIC, Medical Board Section, Naval Medical Center, Bethesda
- Supervisor, Medical Board Section, Naval Medical Center, Portsmouth

- Head, Orthopedic Surgery Department, Naval Medical Center, Portsmouth
- Convening Authority, Orthopedic Surgery Department, Naval Medical Center, Portsmouth

4. Transient Monitoring Unit (TMU), EPMAC, New Orleans

- OIC, TMU
- AOIC, TMU

5. Naval Council of Personnel Boards

- Administrative Officer, PEB
- OIC, Disability Evaluation System Counselors, PEB
- Recorder, PEB

C. DATA LIMITATIONS

Current estimates of LIMDU duration are not reliable. According to Limited Duty Coordinators at Pers-821/271 and the OIC, Transient Monitoring Unit, a field to precisely track changes in the ACC does not exist in the EAIS, ARIS, or the EMF data bases. The system is able to track changes in duty station, but not ACC's. If a member is on shore duty and is assigned to LIMDU, the ACC is changed but the member's report date is not. As a result, the data overstates the true period of time the member is in a LIMDU status. The only valid LIMDU start/end dates would be for a member assigned to a ship/deployable unit who is assigned to LIMDU and then returned to a ship/deployable unit upon being found fit for duty. Although detailers may enter a comment on LIMDU start and end dates, such information currently is not consistent. [Refs. 10, 11, and 12]

Another potentially limiting factor is the lack of precise data regarding the medical reasons causing a member to remain on LIMDU. Each individual clinical presentation is unique, as is each healthcare provider's judgment as to appropriate treatment. Although these medical decisions are based on accepted medical principles, it is reasonable to assume they are subjective and reflect conservative regimes.

We were unable to identify a source of data on the percentage of medical boards that are directly referred into the DES for a PEB without a recommendation for a period of TLD first. This group of sailors would remain coded in the ACC 355 category. If the sailor was in a LIMDU status prior to a referral for a PEB, he/she would be retained in the ACC 105 category pending the PEBs findings.[14] From the perspective of managing the ACC 355 category in the TPP&H account, this type of data is important; sailors in the ACC 355 category due to a pending PEB are likely to be the only 355 coded sailors remaining in that category for a significant period of time. Processing a case for a PEB is affected by more variables and delays than processing a TLD medical board. In terms of identifying cost-savings for TPP&H TEMDU-transients, accurate data on the number of sailors pending a PEB, as opposed to a TLD medical board, is needed.

It is also important to recognize that sailors assigned to a non-operational shore activity are not assigned to the ACC 355 category. They remain coded as ACC 100 until a determination is made by either a TLD medical board or an immediate PEB referral as to their duty status disposition. Consequently, the number of sailors in the ACC 355

[14] Once a sailor is coded as ACC 105 he or she cannot revert to ACC 355. Therefore, if a sailor is on a period of LIMDU and a subsequent medical board refers the case to Department Review or PEB, the sailor remains in ACC 105 pending findings.

category at any one time undercounts the true total number of sailors awaiting TLD medical board/PEB findings.

The Naval Medical Information Management Center (NMIMC) can provide data identifying a primary medical diagnosis with TLD medical boards or PEBs. However, such data are not readily available.

Substantial data in terms of framing complex processes were obtained based on document reviews and extensive interviews. Although some data were not obtained, the impact on this thesis is considered negligible. Although important, lack of data on the percentage of sailors in the ACC 355 category awaiting PEB findings does not preclude the assessment that the percentage is quite small relative to the TPPH Program and the total enlisted population. Data to allow correlation of notable trends or changes in the types of medical boards, by diagnosis, to changes in the size of the LIMDU population may prove useful, but are not critical to the goals of this thesis.

Chapter IV discusses the criteria for convening a medical board, the process of assigning a member to a LIMDU status by a TLD medical board, and the management of personnel in the Transient and LIMDU population solely as a result of requiring medical board action.

IV. THE TEMPORARY LIMITED DUTY ASSIGNMENT PROCESS

This Chapter discusses the process of convening a medical board and of assigning a member to Temporary Limited Duty (LIMDU). These processes include LIMDU reevaluations, Department Reviews at Pers-821/271, the management of personnel in the Transient and LIMDU population, ACC related actions, and assignment to the Medical Holding Company (MHC). The referral of members to Physical Evaluation Boards is introduced to clarify the relationships between convening medical boards, and LIMDU status and the DES. Definitions of process-specific terms are provided in List IV-A.

A. MEDICAL BOARDS

The assignment of a sailor to temporary limited duty (LIMDU)[15] begins with the convening of a medical board. The medical board process pertains to the method and procedures physicians use to evaluate sailors at a Medical Treatment Facility (MTF) for medical conditions that limit the sailor's ability to perform his or her normal military duties. The medical board is not a formal panel of physicians meeting as a team to review a sailor's health record. The evaluating physician assesses the service member's diagnosis, prognosis for return to full duty, plan for treatment and rehabilitation, and recommendation for a duty status. The evaluating physician dictates a medical board

[15] See the definition for Limited Duty, Temporary Limited Duty, and Permanent Limited Duty. "Limited Duty" and "Temporary Limited Duty" are often used interchangeably. Permanent limited duty (PLD) is a disposition option for members found unfit for duty by a PEB. Temporary limited duty (TLD) is a disposition recommended by a medical board - "TLD medical board." The LIMDU status refers to TLD. "Total LIMDU" would include TLD and PLD.

report summarizing findings and recommendations. At least one other physician reviews the report. Typically medical boards will be composed of two - three privileged physicians on staff at the MTF, and the senior member of the medical board should be the Department Head of the primary specialty for which the patient is being evaluated.[16] When no one on the medical board is trained in the specialty of the patient's primary impairment, appropriate consultations must be obtained before completing the medical board report. The final approval of the medical board report at the MTF level is the Convening Authority (CA). Depending on the recommended disposition approved by the CA, the medical board may be forwarded to Pers-821/271 for a Department Review, or referred into the Disability Evaluation System (DES) for a Physical Evaluation Board (PEB) The Department Review process is discussed in section 3(b) of this chapter, and the DES process is discussed in Chapter V.

According to the Manual of the Medical Department (Chapter 18), an MTF will convene a medical board when a physician, trained and certified to be a member of a medical board, determines a service member:

1. Is temporarily unable to perform full duty, but return to full duty is anticipated, and it is necessary to follow the patient for more than 30 days before an appropriate disposition can be made.[17]

2. Has condition that may permanently interfere with his/her ability to fulfill the requirements of active duty service.

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[16] If the Department Head is also the Convening Authority then another senior medical officer acts as senior member of the board.

[17] A service member can be placed on Light duty for up to 30 days without a requirement for a medical board.

3. Requires permanent assignment limitation such as a specific geographic assignment.

4. Requires extensive or prolonged medical therapy.

5. Who through continued military service would probably result in extended hospitalization, close medical supervision, or aggravation of an existing condition?

6. Has a condition that includes the presence of mental incompetency.

7. Refuses reasonable medical, dental, or surgical treatment and his/her ability to perform full duty is suspect.

The following guidelines present situations in which a medical board *may be considered*, regardless of whether the member is assigned to a shore command or deployable unit:[18]

1. Inpatient status will exceed 30 days.[19]

2. Total time away from parent command is expected to be greater than 60 days.

3. The member is unlikely to ever return to full duty.

4. The physician cannot estimate the prognosis or outcome for 45 days.

5. The member can return to duty but in a limited or restricted capacity

6. The member requires assignment near an MTF with specialty services.

7. The member requires multiple surgeries, or extensive, prolonged therapy. [Refs. 6 and 8)

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[18] A medical board is not appropriate in cases of pregnancy.

[19] An inpatient status refers to patients admitted to a hospital unit for 24-hour nursing care and medical treatment.

The medical board can recommend three dispositions concerning the member's duty status:

1. Continuation or return to full duty in a fit for duty status;
2. Assignment to a period of temporary limited duty (TLD);
3. Referral to the Disability Evaluation System (DES) for a Physical Evaluation Board (PEB).

While the findings of a medical board may affirm the physical condition of a sailor for assignment to full duty, the determination of "unfit for duty" or permanent limited duty (PLD) is not within the cognizance of a medical board. The PEB has sole authority to find a service member unfit. If the opinion of the medical board is that the medical condition will result in a permanent or prolonged disability that prevents the person from performing their regular military duties, then the case is referred to a PEB.

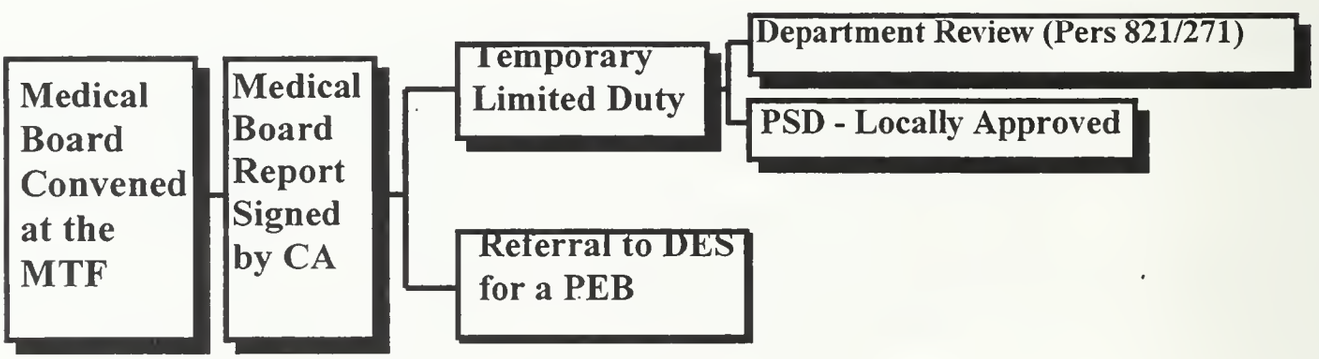

Figure 10. Convening a Medical Board (General Overview)

1. Convening Authority (CA)

Commanding officers of naval hospitals and clinics may convene a medical board for any member of the armed forces. The Chief of Naval Operations (CNO), fleet commanders in chief (FLTCINCs), Chief, Naval Personnel (CHNAVPERS), Commander, Naval Reserve Force, and the Chief, Bureau of Medicine and Surgery (BUMED) may order convening of a medical board.[20] Frequently the CA will delegate signatory responsibility for approving or disapproving the recommendations and findings of the physicians comprising the medical board. [Ref. 6]

The CA, who serves as an objective reviewer of the medical board report, should be a senior naval officer (0-5) with detailed knowledge of physical qualification standards for full duty, disposition options, and DES procedures. The CA can not be a member of the medical board. Approval of the medical board report by the CA signifies completeness, accuracy, and a disposition recommendation consistent with Navy policy. Additional responsibilities of the CA include ensuring training of physicians serving on a medical board with regard to policy and procedures of the DES, and ensuring that service members who are evaluated by a medical board are afforded counseling on the proceedings, findings, and recommendations. [Ref. 6]

When the CA concurs with the medical board report, he/she will endorse and forward the original report to the member's health record. If the CA does not concur, he/she will advise the physicians serving on the medical board and afford them an

[20] The Commandant of the Marine Corps (CMC) may order that a medical board be convened for a member in the Marine Corps.

opportunity to change the report. However, the CA cannot direct a change to the medical board. If the medical board report is not changed, the CA forwards the report with a full statement of the reasons for nonconcurrence to CHNAVPERS for a Department Review (Pers-821/271) or the Director, Naval Council of Personnel Boards, if the nonconcurrence involves a PEB referral. [Ref. 6]

The CA may approve the medical board report without forwarding it for approval by Department Review if the disposition of the board is to place the sailor on TLD for 6-12 months.[21] In this instance the CA should expect that the sailor will be able to return to "full unrestricted duty on a worldwide basis" in his/her rate or MOS by the end of that TLD period. [Ref. 6] Regardless of the board's recommended period of TLD, should the member submit a rebuttal and it is not withdrawn, the CA must forward the medical board report for approval by a Department Review.

Medical board reports that recommend a referral for a PEB rather than a period of TLD, are forwarded directly by the CA to the PEB. The CA also has the authority to approve the medical board's disposition for discharge by reason of erroneous enlistment, as in the case of existed prior to entry (EPTE) conditions.[22]

2. Incapacitation Medical Board

An incapacitation board will be convened when a member demonstrates impairment of judgment severe enough to raise a question of incapacitation, and such impairment is secondary to physical or mental disorders (excluding personality

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[21] All medical boards on officers must be forwarded for Department Review.

[22] See the definition for ETPE.

disorders). Mental incapacitation may result from temporary or permanent physical or mental instability as a result of injury, disease, or other mental condition. According to the JAG Manual, an incapacitation board will be convened immediately if the service member is determined mentally incapable of managing personal or financial affairs. The incapacitation board consists of three physicians, at least one of whom must be a psychiatrist. The physicians may be military, DVA, or civilian if licensed and privileged to practice in an MTF. The board report, endorsed by the commanding officer, is entitled "Report of Incapacitation ICO" and is sent directly to the Office of the Judge Advocate General. An Incapacitation Board cannot be held at the MTF waiting to convene a regular medical board or complete a line of duty investigation on the member. *The requirement for this type of board is in addition to, and separate from, medical board procedures discussed throughout this thesis.* [Refs. 6, 13, and 14]

3. Temporary Limited Duty Medical Board

A Temporary Limited Duty (TLD) medical board is convened when the recommended disposition is temporary limited duty, and the member is placed in a LIMDU status. The LIMDU status identifies members who are temporarily unfit for full duty, and who require a period of medical treatment and or rehabilitation. [Ref. 6]

LIMDU participants are assigned to valid non-operational shore commands near medical treatment facilities. Sailors are reassigned from sea/deploying units when assigned a LIMDU status. Sailors assigned to shore commands will also be assigned a LIMDU status if determined by a medical board, however, there is rarely a need to reassign them. [Ref. 1]

Data indicating the average number of sailors in the LIMDU population and ACC 355 find that TLD medical boards are more common than a direct referral to a PEB. [Refs. 10 and 15] The ACC 355 includes sailors awaiting the results of a TLD medical board and a PEB. If the case is directly referred to a PEB then the sailor remains coded as ACC 355 pending final action of the PEB. If the board recommends TLD, then the ACC is changed to 105 upon receipt of orders for a LIMDU assignment. A member who is subsequently referred for a PEB, remains classified in ACC 105. In December 1997, 4,830 sailors were on LIMDU and 563 were in ACC 355. [Refs. 3, 4, and 9] While data were not available to identify the proportion of sailors in an ACC 355 status who had medical boards referred to a PEB without first being assigned a period of LIMDU from a TLD board, it is reasonable to assume that proportion is small. The majority of medical boards assign a member to some time on LIMDU before their case goes to a PEB. Most cases that are referred immediately for a PEB are imminent death medical boards and cases with a catastrophic type of injury or illness. [Ref. 15]

The period of temporary limited duty (LIMDU) assigned is for a minimum of 6 months and a maximum of 24 months. However, the medical board may be written for a number of months between 6 and 24. The medical board can require a member to return for reevaluation at specified intervals during the LIMDU period or return the member to full duty before expiration of the LIMDU period. It is most common to assign a member to an initial period of 6 months and determine if an additional period of limited duty is required at the limited duty re-evaluation appointment.

If the examining physician believes that it is unlikely the member will be physically qualified for full duty, the case should be immediately referred for a PEB. A referral to the PEB can be made at anytime during the assigned TLD, and is required if a return to full duty is unlikely after 24 months of TLD.

The CA is the approving authority for all TLD medical boards where the recommended disposition is for a TLD period between six and twelve months. An exception occurs when the medical board report contains a surrebuttal. The rebuttal and surrebuttal procedures are discussed in section four of this chapter.

a. Reevaluations

No later than 60 days before the expiration of the TLD period (LIMDU PRD), the member is reevaluated by the physician to determine if the member will be physically qualified for full duty. If the physician concludes that the member is still physically unqualified for full duty, the next decision is whether to continue the member on another period of TLD or refer the case for a PEB. To avoid reevaluations to early to appropriately confirm a new disposition, the physician should factor in 60 days reevaluation and administrative processing time within the TLD period. [Ref. 6] When the determination is made that an additional TLD period, not to exceed 12 months, is necessary, all that is required is a health record entry with a progress note outlining the expected treatment plan and prognosis. The service member can hand-carry the health record to the MTF PSD/LIMDU Coordinator. If the additional TLD period results in total TLD greater than 12 months for a given condition, a new medical board report is

forwarded for a Department Review. If the reevaluation decision is to forward the member for a PEB then a new medical board is convened to ensure updated information is provided. [Refs. 6 and 16]

(1) **Administrative Responsibilities and Procedures.** The goal of the reevaluation process is to facilitate a determination of the member's duty status, expedite availability for a full duty assignment and return to the fleet, and minimize the risk of missed reevaluation appointments resulting in an expired LIMDU status. The PSD LIMDU Coordinator, the MTF, and the service member's command all play an important role in the effective coordination of LIMDU reevaluation appointments. The PSD LIMDU coordinator has the responsibility to:

1. Submit a request no later than 90 days prior to the LIMDU period expiration to the MTF, and info parent command, for a reevaluation appointment;

2. Submit tracer action to the MTF every 30 days until a message on reevaluation appointments is received;

3. Issue letter orders to member via member's parent command directing the member to report to the Medical Board Section of the MTF at least 30 minutes prior to the appointment time with all relevant medical records. This provides a basis for subsequent disciplinary action should the member fail to report;

4. Ensure member's PRD is adjusted correctly if an additional LIMDU period is assigned, submit message on updated status of LIMDU personnel to Pers-821/271, and info BUMED and TMU;

5. Submit the appropriate tracer action to Pers-821/271 if the reevaluation appointment resulted in an additional LIMDU period greater than 12

months, or to the MTF Disability Evaluation System Counselor if a referral for a PEB.[23]

The MTF LIMDU Coordinator's functions are to:

1. Respond to requests for reevaluation appointments within 10 days and submit a Reevaluation Appointment Notification message to parent commands. Info the servicing PSD LIMDU Coordinator with dates for LIMDU reevaluation appointments;

2. Submit weekly LIMDU Reevaluation Disposition messages to the servicing PSD LIMDU Coordinator and parent command. Info BUMED, TMU, and Pers-821/271 of the dispositions of LIMDU personnel reevaluated that week, including those members who failed to report for a scheduled reevaluation;

3. Comply with MANMED Chapter 18 regarding priority scheduling and completion of LIMDU reevaluation appointments.

Commands with LIMDU personnel assigned have the responsibility to:

1. Make LIMDU personnel available to the servicing PSD for processing and to the MTF for the reevaluation;

2. Notify LIMDU personnel of the time and date of the reevaluation appointment;

3. Take appropriate disciplinary action when personnel fail to comply with scheduled reevaluation appointments;

4. Ensure assigned duties are commensurate with the LIMDU physical limitations. [Ref. 8]

b. Department Review of TLD Medical Boards

Some major injuries or illnesses require more than 12 months of TLD in order to return the service member to full duty. The CA may concur with a

[23] See Section B (1) of this chapter. Criteria for LIMDU reevaluation tracer action are the same as pending results of a medical board.

recommendation for TLD requiring a rehabilitation or treatment regime greater than 12 months but not longer than 24 months, such as neoplasms and orthopedic problems. In such cases, all physicians involved in the medical board must concur that a finding of "physically qualified for duty" is likely at the conclusion of treatment.

Following the CA's signature, all TLD medical boards recommending a period of temporary limited duty greater than 12 months must be forwarded for a Department Review, conducted at Pers-821/271, for approval.[24] This criteria includes the recommendation for an initial period of TLD greater than 12 months, or a subsequent period of total limited duty that will exceed a total of 12 months for the same or similar condition.

The Department Review involves a review of the medical board's recommendation regarding the member's disposition. At the Department Review, the medical board can be approved, or the recommended limited duty period can be denied. The period of TLD should not be extended unless Department Review approves it based on a medical evaluation that the additional TLD period will be sufficient to restore the member to full duty. [Ref. 7] When the Department Review denies the recommendation to extend the TLD, the medical board is usually referred to the PEB for a final duty status disposition. [Refs. 6 and 8]

[24] All TLD medical boards on officers are forwarded for Department Review regardless of length of limited duty assigned. If the disposition is that a commission be revoked by reason of erroneous commission, a Department Review is not required.

Two other circumstances require that a medical board be forwarded for Department Review: (a) if the member submits a rebuttal and the responsible physician submits a surrebuttal indicating the findings and recommendations of the board still stand; and (b) if the CA does not approve the board's recommendation for temporary limited duty. [Ref. 6]

The length of time necessary for processing a medical board at Department Review is not provided as policy. However, the cognizant PSD does not initiate tracer action on boards forwarded for Department Review until after 30 days of the CA's signature. [Ref. 8]

Based on the recommendations of the medical board, the medical board report is forwarded to (a) the member's health record and PSD for submission of an availability report if the CA has final approval authority; (b) Pers-821/271 for Department Review; or (c) to a PEB. Table 3 provides a summary of the routing of medical board reports.

Table 3. Medical Board Dispositions

Medical Board Recommends	Rebuttal	Disposition
TLD 1st period; 6-12 months	NO	PSD
TLD 1st period; 6-12 months	YES	Pers-821/271
TLD 1st or subsequent period > 12 months	YES/NO	Pers-821/271
FFFD	YES/NO	PSD
Referral to PEB	YES/NO	President, PEB
Discharge, Erroneous Enlistment & did not waive rights to PEB	YES/NO	President, PEB
Discharge, Erroneous Enlistment & waived rights to PEB	N/A	Closed health record after endorsement by Separation authority
Any medical board with disciplinary action pending	YES/NO	Pers -821/271

Source: Manual of the Medical Department, Chapter 18.

Figure 11 "Medical Board Process" summarizes the decision points for a medical board.

4. Counseling and Rebuttals

Every service member receiving a medical board must be counseled by a member of the Medical Department specifically trained and knowledgeable regarding medical board proceedings, findings, recommendations, and member rights. Personnel assigned as counselors in the Medical Board Department of the MTF serve in this role as a collateral duty and provide counseling services to members undergoing a TLD medical board or a

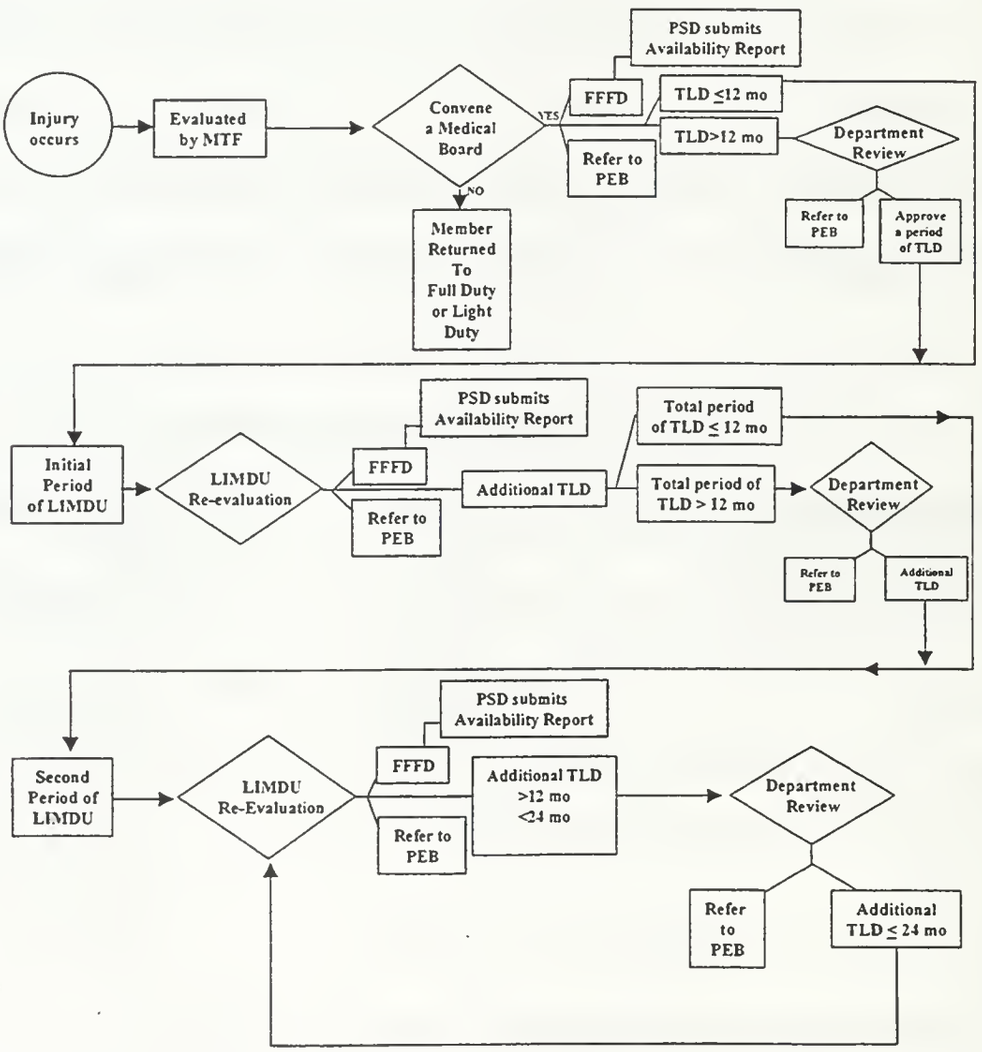

Figure 11. Medical Board Process (Timeline not to Exceed 24 months)

Medical board referring the member to a PEB. Some MTF's have a designated Disability Evaluation System Counselor (DESC), independent of the Medical Board Department, to counsel service members who are referred to the PEB. Specific functions of the DESC are discussed in Chapter V. The Medical Board Department counselor advises the member on the medical board's findings, recommendations, and potential for reclassification into another specialty, and affords them the opportunity to discuss the above with each physician member of the medical board. The counselor is responsible for obtaining the member's signature on the Medical Board Statement of Patient (NAVMED 6100/2).[25] In addition, the counselor provides the member an opportunity to submit a rebuttal to any part of the board's report and to present additional relevant information. Collecting additional information to support a rebuttal may require several more days, especially if it requires another physician appointment. Members are allowed five working days from the date he/she reads and signs the board report to complete a written rebuttal. However, they may request an extension if they demonstrate a justifiable need, providing the extension does not exceed 30 days from dictation of the report to the time the completed medical board package is mailed from the MTF. [Refs. 6, 13, and 14]

When a member submits a rebuttal, the medical board must review it and make any change to the medical board report considered appropriate. In these instances, the member may withdraw the rebuttal and the board report is forwarded without surrebuttal. If the medical board does not consider it appropriate to change the board's original findings or recommendations, the report is forwarded to the CA and then for Department

[25] See definition.

Review with a surrebuttal, which specifically addresses new information or issues raised by the member and the reasons why a change is not indicated. Rebuttal and surrebuttals become part of the medical board package.

5. Medical Board Processing

Normal processing time for each dictated medical board should not exceed 20 days. Processing time commences at the time the board is dictated and ends when the CA signs the medical board report. For boards forwarded to a PEB, the maximum time between the dictation of the board and the mailing of the completed package is 30 days. The MTF's Medical Board Department is responsible for obtaining copies of all relevant clinical records and requesting the following from the member's parent command when appropriate: a copy of the Line of Duty Determination (LODD) report endorsed by the General Court Martial CA (GCMCA) of the parent command, and Non-Medical Assessments (NMA).[26] This additional 10 days includes the time it may take to obtain the required accompanying documentation. [Refs. 6, 13, and 14] The completed medical board package includes the Medical Board Cover Sheet, the physician's narrative summary, signature page, copy of clinical records, and when indicated, the rebuttal, surrebuttal, LODD report, NMA, and addenda.

There are varying time allowances built into the processing procedures at each MTF that can make it difficult to meet the 20-day goal. The physician evaluation and dictation of medical board report, transcription of the dictated board into a draft, entering

[26] See the definition for LODD/LODI and Non-Medical Assessments.

information into the MBTS, completion of the medical board cover sheet and signature pages, and generation of messages to appropriate commands and, or departments, can take up to four days. The dictating physician and senior medical board member then have five days to review the draft and make any necessary corrections. However, two days is the norm.[27] Preparing the final medical board and obtaining all medical board member's signatures may take two days. The member is then counseled concerning his/her rights and responsibilities and the recommendations of the medical board. The member has one to five working days to review and sign the medical board once contacted by a Medical Boards Department clerk, at which time he/she must indicate the intention to rebut the board.[28] If the member cannot be located or does not sign the board within this timeframe the board can be canceled. If the member chooses to rebut the medical board, he/she has five working days to submit a written rebuttal and the physician who dictated the medical board is allowed five days to submit a surrebuttal. [Refs. 14, 17, and 18] Guidelines for a time allowance to obtain CA signature was not identified. Figure 12 identifies the numerous steps involved in processing a medical board at an MTF.

6. Abbreviated Temporary Limited Duty Medical Boards

Physicians convening a medical board recommending TLD are encouraged to use the Abbreviated Temporary Limited Duty Medical Board Report. Each MTF directs

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[27] If the MTF does not prepare a draft board then this time allowance is eliminated.

[28] This was the time allowance stated in the NNMC Bethesda Instruction on Medical Boards. Other MTFs may not allow up to 5 days.

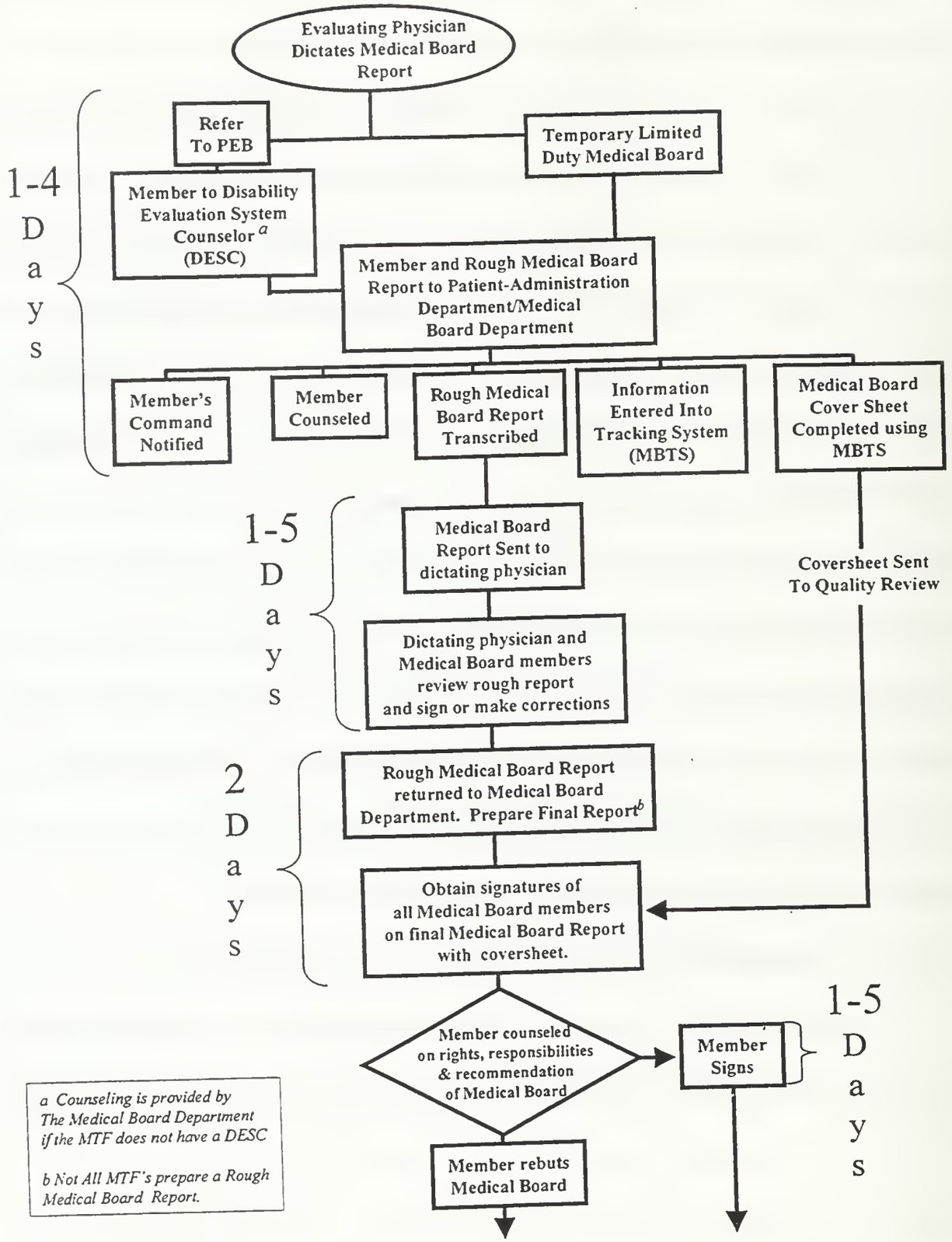
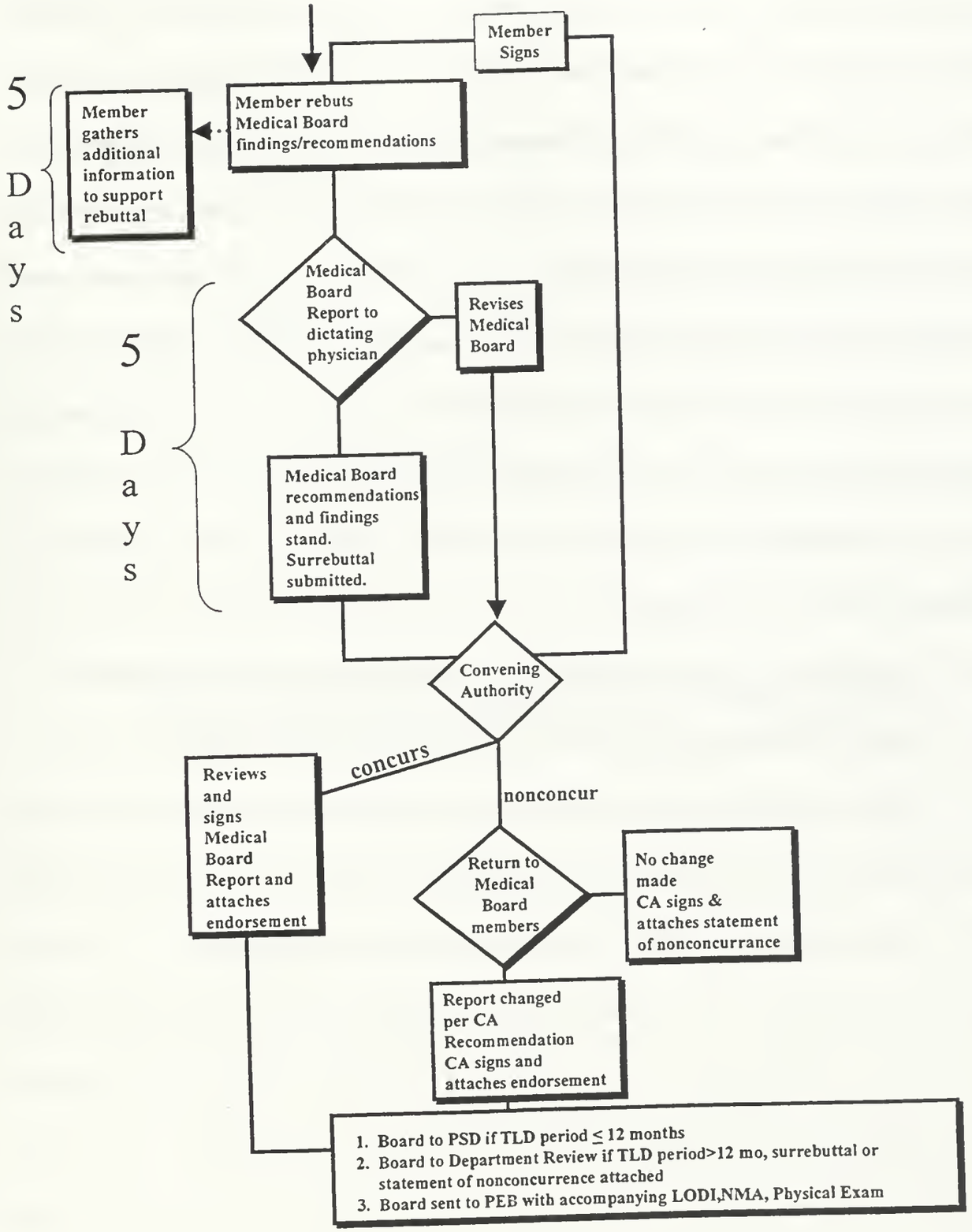


Figure 12. Steps in the Medical Board Process at the MTF (Part A)



Source: BUMED (MED-311) Medical Boards Brief and NNMC Bethesda Inst. 6110-2A.

Figure 12. Steps in the Medical Board Process at the MTF (Part B)

specific policy on the use of this report within the guidelines authorized by BUMED. The processing time for the abbreviated medical board is approximately one day and developed to decrease the workload for physicians and ensure a timely disposition for sailors with uncomplicated temporary disabling conditions.[29] It is a one-physician board convened to evaluate the medical condition of sailors if the physician expects the member to return to full duty following a TLD period not to exceed 12 months. A formal medical board report is not required and it is considered a local action that does not require Department Review. [Ref. 19] If a member's TLD is expected to be greater than 12 months, or if referral for a PEB is recommended, a regular medical board must be dictated. [Refs. 13, 14, 19, and 20]

B. ADMINISTRATIVE PROCESSING AND TRACKING OF PERSONNEL PENDING MEDICAL BOARD RESULTS (TRANSIENTS) AND PERSONNEL IN A LIMDU STATUS (FORCE STRUCTURE)

There are procedures for the proper reporting and administration of personnel pending results of a medical board and assignment to a LIMDU status. Various articles of the Enlisted Transfer Manual, Transient Personnel Administration User's Manual (EPMAC Instruction 5000.3A), and Manual of the Medical Department summarize the relevant policy and procedures. These directives consistently place the administrative responsibilities with the member's command, MTF, and servicing PSDs. This section identifies specific action related to changing the ACC as the member progresses through the transient pipeline and, changes to and from a LIMDU status. Specific attention is

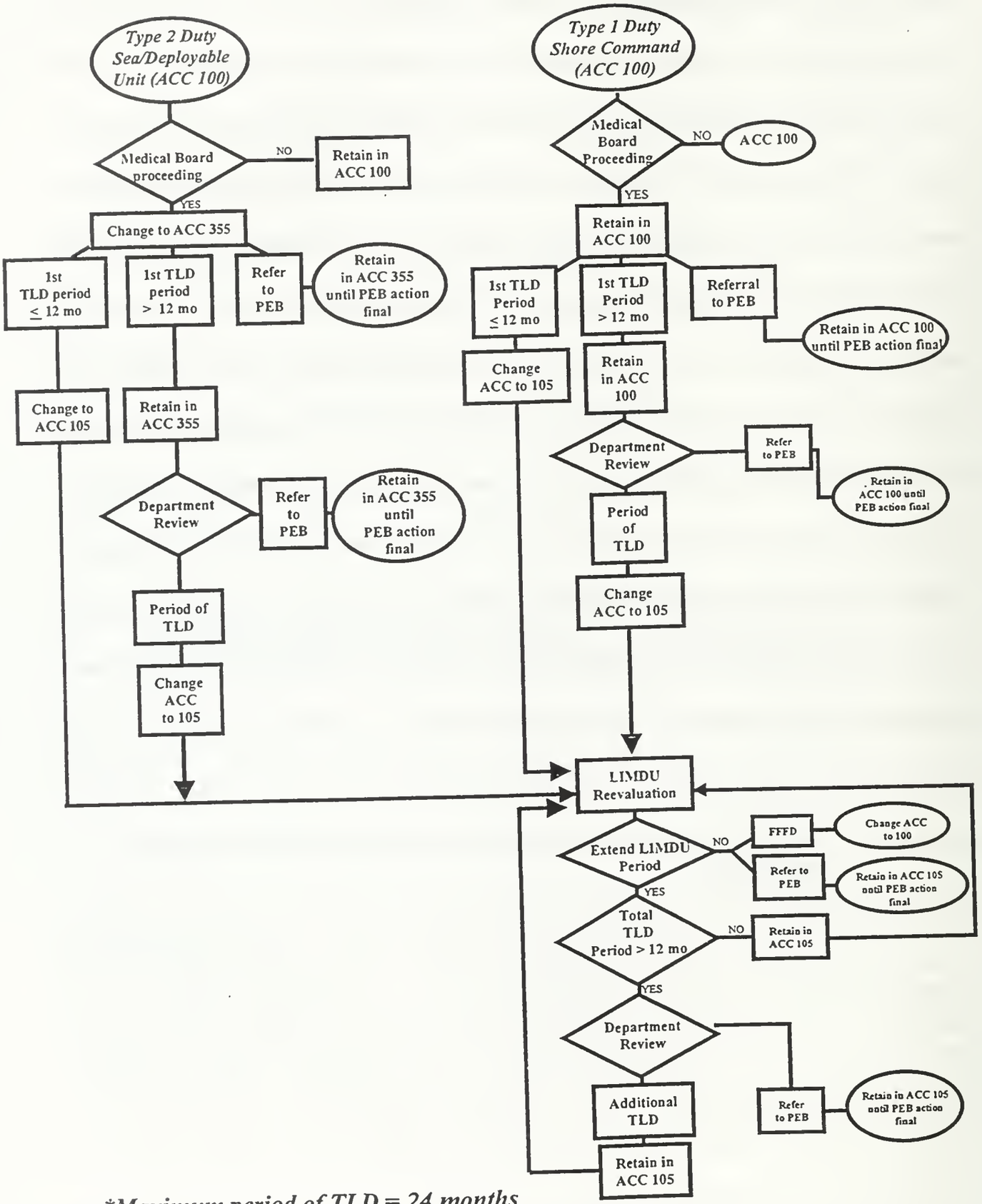
[29] Abbreviated Temporary Limited Duty Medical Board Reports are not authorized for Officers - any medical board that would require Department Review cannot be an abbreviated version.

made to distinguishing members going before a medical board who are assigned to a shore command or to sea duty. Generally, members assigned to shore commands are not assigned TEMDU Pending Results of a Medical Board/PEB (ACC 355) and consequently will remain accounted for in the force structure as ACC 100 until a determination has been made by a TLD medical board (or the PEB when immediately referred into the DES).[30] Figure 13 shows ACC changes for personnel assigned to shore and sea duty undergoing medical board proceedings. The following policies and procedures are applicable to members awaiting results of a TLD medical board or results of a PEB when the medical board referred them directly into the DES, and also to members in a LIMDU status while awaiting the final actions of a PEB. Since the majority of sailors entering the DES are not immediate referrals, and consequently enter the DES in a LIMDU status resulting from a previous TLD medical board, it seems appropriate to introduce these policy and procedures that also affect personnel undergoing a PEB in this chapter. [Ref. 15]

1. Personnel Pending Results of a Medical Board - The Transient Population

The MTF has the responsibility of notifying the member's parent command when a medical board is convened and immediately upon completion of medical board processing, to provide a copy of the board report to the servicing PSD. Upon notification of medical board proceedings, the parent command submits the diary loss entry and

[30] Enlisted personnel on shore duty who are hospitalized at an MTF more than 91 days are assigned to the MTF/MHC in a TEMDU status, and are retained in ACC 370 pending results of the medical board. [Ref. 8]



**Maximum period of TLD = 24 months*

Figure 13. ACC Changes

complies with policy for the Enlisted Manning Inquiry Report. The servicing PSD has the responsibility for transferring personnel assigned to sea duty to the MTF/MHC as TEMDU waiting Results of Medical Board (ACC 355), or when if berthing is not available at the MHC to the nearest TPU/Other activity.[31] Personnel assigned to shore commands are not routinely transferred to the MTF/MHC in a TEMDU (ACC 355) status. They remain on board their command assigned FOR DUTY (ACC 100) pending completion of medical board processing, including the final disposition of a PEB if not previously assigned to a LIMDU period. [Ref. 21] Careful attention is necessary to ensure those personnel are tracked in the same manner as those assigned to ACC 355.

Personnel in a TEMDU (ACC 355) status are accounted for by the member's servicing PSD and their movement through the transient system is monitored by way of several tracer action procedures:

1. Awaiting Results of Medical Board Action. The MTF is advised if the medical board is not received within 25 days from the effective date of ACC 355 status and every 10 days thereafter. Message information copies are sent to Pers-821/271, BUMED, and TMU.

2. Awaiting Results of Department Review. Pers-821/271 is notified that actions have not yet been received after 30 days of CA signature.

3. Awaiting Results of PEB Proceedings. The DESC at the MTF where the medical board originated is notified that results of the PEB have not yet been received after 60 days of CA signature. If there is no response from the DESC within 30 days of the request, the DNCP is notified.

4. Awaiting Final Action on PEB Proceedings. Pers-821/271 is notified after 30 days from the date of unconditional acceptance of the preliminary findings, if retirement/separation authority has not been received.

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[31] Further discussion of service members TEMDU to the MTF in the Medical Holding Company or to a TPU/Other activity is provided in Section C of this chapter.

a. ACC Related Actions

Personnel in a TEMDU status must be assigned the appropriate ACC which accurately reflects the primary reason for assignment or retention in the Transient pipeline. [Ref. 8] The following scenarios provide decision points for ACC changes affecting personnel TEMDU pending the results of a medical board or PEB proceedings (ACC 355). Personnel previously assigned TEMDU to the MTF/MHC are usually transferred to the nearest TPU/Other activity immediately after the medical board is completed.[32]

Assuming the member is TEMDU (ACC 355) to the MHC while the medical board is in progress and:

- The board indicates assignment to LIMDU or FFFD, the servicing PSD will transfer the member to the nearest TPU/Others activity no later than the next working day. The PSD servicing the TPU activity will receive the member in ACC 320 and submit an availability report to effect change to ACC 105 or 100.

- The medical board refers the case for Department Review, the servicing PSD effects transfer to nearest TPU/Other activity. The TPU activity receives the member in ACC 355 and retains in ACC 355, pending response from Pers-821/271.

- If Department Review approves the LIMDU period or FFFD, then the ACC is changed to 320 and an availability report is submitted to effect change to ACC 105 or 100.

[32] Section C of this chapter outlines the criteria for assignment of TEMDU to a TPU activity or remaining TEMDU to the MHC *after* completion of the medical board.

- The medical board indicates a referral for a PEB, then the servicing PSD transfers member to the nearest TPU/Others activity. The member is received in ACC 355 and retained in ACC 355 pending final PEB action.[33]

- The member unconditionally accepts the findings of the PEB and the request for Home Awaiting Orders is approved, then the PSD servicing the TPU activity changes the ACC to 381.

- The final actions of the PEB to separate or retire the service member are completed by Pers-821/271, then the PSD servicing the TPU activity changes the ACC to 380.

- The PEB recommendation of FFFD is processed by Pers-821/271, then the PSD servicing the TPU activity changes the ACC to 320 and submits an availability report to effect change to ACC 100.

- The medical board authorized a discharge of the member due to an EPTE physical disability, then the servicing PSD changes the status to ACC 380 and effects the discharge within 7 days. [Refs. 8 and 21]

2. LIMDU Personnel

Accurately monitoring personnel in a temporary limited duty status involves availability and assignment procedures, tracking ACC changes, and coordinating the reevaluation process. The methods involved in expeditiously processing a member for a LIMDU reevaluations were discussed in Section A 3(a)(i). Tracer action procedures for LIMDU reevaluations resulting in a medical board report forwarded for Department Review or a PEB are the same as those presented in section B(1) for personnel pending results of a medical board/PEB. This section focuses on the responsibilities and procedures for submission of availability reports on LIMDU personnel available for

[33] The member is retained in ACC 355 if immediately referred for a PEB. If the member had previously been assigned to a period of LIMDU and then subsequently referred for a PEB, the member is retained in ACC 105, and usually remains in the current LIMDU assignment, pending PEB findings. Changes from ACC 105 to ACC 355 are not authorized. [Ref. 8]

assignment to limited duty or return to full duty, and monitoring personnel retained in a LIMDU status.

An Availability Report communicates to the Assignment Convening Authority (ACA) that an individual requires assignment/reassignment and the reports should be submitted as soon as the member's final status has been determined. The member's date of availability for transfer to a new duty station is the date the full duty medical board was dictated. [Ref. 21] Personnel assigned to sea duty will always have an immediate availability report submitted.

If the sailor is assigned to a shore command, then an availability report is not submitted when going to or from a TLD status (ACC 105), unless the required medical care is not available in close proximity to the current duty station, or the condition prevents effective use on board the command during the period of TLD [Ref. 21]. Another notable exception is when the member assigned to a shore command is found fit for duty and is within 90 days of their PRD, in which case an availability report is submitted.

If the medical board is forwarded for Department Review or is referred to a PEB, then the final disposition from BUPERS (Pers-821/271) is required before an availability report can be submitted. [Ref. 21] EPMAC is the central coordinator for placement and assignment of LIMDU personnel. They ensure an equitable spread of LIMDU personnel to valid non-operational shore billets based on the following considerations:

1. The number in a specific rating assigned to an activity;
2. The readiness and mission capability impact on the activity;

3. Close proximity to an MTF capable of providing the required care and reevaluation;

4. Physical restrictions imposed by the medical board;

5. Factors to satisfy PCS cost constraints such as location of dependents. [Ref. 21]

LIMDU personnel are to be transferred immediately upon receipt of orders for their LIMDU assignment. The orders should be held only if factors, such as those stated above, preclude the assignment specified in the transfer directive. [Ref. 21] Upon receiving LIMDU personnel at the activity, or upon changing the ACC from 100 to 105, the PSD enters the member into its tracking system.[34] The tracking system contains information relative to the member's LIMDU status and provides PSD with the following: (a) a method of tracking required actions, (b) an account of the reevaluation process, (c) a source of information to be used in submission of required reports such as the monthly "Status of LIMDU Personnel" message sent to Pers-821/271, and (d) a reduction in the number of expired LIMDU periods which assists in returning personnel to the fleet. The member's LIMDU file is retained for one year at the PSD after the member has transferred from that activity or the status was changed to ACC 100. [Refs. 8 and 21]

Personnel who were on shore duty (Type 1 Duty) and then released from a LIMDU status will have the period of LIMDU applied to their Normal Shore Tour, and any time remaining after applying the LIMDU period will be completed at the current

[34] PSD activities either use Source Data System (SDS) ADHOC reports or a tickler card system to track LIMDU and L-4/L-5 personnel.

duty station. If there is no time remaining, then the member is assigned to sea. However, since the time spent in a LIMDU status is considered "idle time," that time will not be used in the computation of cumulative sea time for those sailors assigned overseas or to a sea/deployable unit when placed in a LIMDU status. [Refs. 8 and 21]

a. ACC Related Action

PSD will take action to change the status of LIMDU personnel based on the determination of LIMDU reevaluations and the previous duty type (shore or sea/deployable unit). The member will either be changed to ACC 100 or to ACC 320 and made immediately available for reassignment, or retained in ACC 105. The following scenarios provide decision points for the appropriate account changes from ACC 105:

- If found FFFD and member wants to incur obligated service/reenlist, then submit availability report and change ACC to 320. Member will report to new duty station in ACC 100.
- If found FFFD and within 90 days of EAOS, or EAOS is > 90 days but < one year, and member does not want to incur obligated service, then retain in ACC 105.
- If found FFFD and member previously assigned to a shore activity:
    * If PRD > 90 days beyond their TLD period, change ACC to 100 effective date found FFFD;
    * If PRD, < 90 days beyond their TLD period, change ACC to 100 effective date found FFFD and submit report to ACA indicating member's availability for reassignment at PRD;
    * If the PRD was adjusted to complete the period of TLD, change ACC to 320 and submit an availability report.
- For personnel awaiting subsequent medial board/PEB action, continue to account for in ACC 105.

- For members ordered to a new duty station for their LIMDU assignment, change ACC to 320 and submit an availability report. Member will report to new duty station in ACC 105.

- Personnel referred for a PEB at a LIMDU reevaluation, retain in ACC 105 until PEB findings are finalized.

- Personnel whose status changes to pending an administrative separation, retain in ACC 105.

- Personnel authorized to proceed home awaiting orders to await PEB proceedings will be accounted for in ACC 381. [Refs. 8 and 21]

C. MEDICAL HOLDING COMPANY

Medical Holding Companies (MHCs) are extended minimum-care facilities where enlisted patients, whose condition is such that they cannot return to full duty, are employed on light duty commensurate with their physical condition while completing medical treatment on an outpatient basis or awaiting action of a medical board. The sailor must be ambulatory and able to provide for self-care. A sailor may be assigned to the MHC without being previously admitted to the MTF as an inpatient. A MHC is under the cognizance of an MTF, and Commanding Officers of an MTF may establish the MHC at their MTF and operate it as part of their command. To reduce costly inpatient care, the Chief, BUMED has directed that patients not be admitted as inpatients when they can be treated as outpatients within the criteria of good medical practice. Sailors assigned to MHCs are usually from sea/deployable units or shore commands outside of the geographical area of the MTF.

1. Procedures

Sailors are not to remain in the MHC for longer than 60 days, including any convalescent leave granted, without having a medical board dictated. A medical board to assign a sailor to temporary limited duty or referral to the PEB must be initiated when the total time in MHC is anticipated to be 60 days or greater.[35] When a sailor exceeds 60 days in the MHC and a medical board has not been dictated, the MHC has the responsibility of sending a message to the Transient Monitoring Unit (TMU), and an info message to BUMED.

Sailors in the MHC awaiting results of a medical board remain in the MHC until the medical board determines a disposition. Upon results of a medical board, the sailor is transferred to the nearest TPU/Other activity to await further assignment or if the case was referred to the PEB, to await findings of the PEB. Any MHC patient subsequently transferred to a TPU/Others activity must be in an ambulatory status and not in need of nursing procedures, dietary care, or special treatment available only at the MTF. A sailor may also remain in the MHC after the medical board has been completed if the sailor requires extensive outpatient treatment for which commuting from the TPU activity would create undue hardship. [Refs. 21 and 22]

When berthing is not available in the MHC, sailors can be transferred to the nearest TPU/Other activity to await results of a medical board, providing they meet the

[35] Exceptions to the 60-day rule are sailors undergoing oral surgery procedures which normally require a 60-day recovery period and a TLD medical board is not necessary. [Ref. 22]

preceding ambulatory and treatment criteria, and Convalescent Leave is not warranted. [Refs. 21 and 22]

Sailors assigned to shore duty in the geographical area of the MTF will ordinarily be returned to their parent activity while receiving outpatient treatment instead of being assigned to the MHC. Exceptions are sailors ordered Temporary Additional Duty (TEMADD) for psychiatric evaluation or to treatment where return to the parent command would likely aggravate their condition. These sailors will be transferred in a TEMDU status, to the MHC, regardless of the parent command location. Other exceptions include sailors who require extensive outpatient treatment and commuting to and from their parent command would cause undue hardship.

Sailors may be assigned to the MHC in a TEMADD - Under Treatment status, if the sailor was originally ordered for treatment on TEMADD orders and the combined length of hospitalization and outpatient care is not anticipated to exceed 60 days. Sailors are originally issued TEMADD under treatment orders to the MTF when:

- Serving on sea duty and the period of hospitalization is expected to be less than 60 days, and the ship or unit is not scheduled to deploy for more than 60 days, while the member is assigned to the MHC;
- Serving on shore duty or neutral duty and the period of hospitalization is expected to be less than 91 days. [Ref. 21]

The MTF has the responsibility to notify the parent command when the sailor's status has changed. Within five days of receipt of notification by the MTF, the Commanding Officer of the parent command, or the supporting PSD, prepares TEMDU

(Temporary Duty) Under Treatment orders to effect the change from a TEMADD status. Conditions prompting a change to a TEMDU status to the MTF/MHC include:

- The member's Commanding Officer has the option to change the sailor's status from TEMADD to if serving on sea duty and the period of hospitalization exceeds 30 days.
- The expected period of hospitalization (including outpatient treatment in the MHC) will exceed 60 days or the ship/unit is expected to depart the area for a deployment of more than 60 days.
- Sailors on shore duty or neutral duty whose period of hospitalization is expected to be more than 91 days.
- Regardless of the location of the parent command, a sailor serving on shore duty ordered to TEMADD for psychiatric evaluation or treatment with the determination by the treating psychiatrist that return to the parent command would aggravate their condition.
- Sailors serving on shore duty who require extensive outpatient treatment, for which commuting from the parent command would create undue hardship [Ref. 8] and berthing in the MHC is more appropriate.
- For sailors assigned to a ship/deployable unit, or assigned to a command outside the geographical area of the MTF and the physician determines that a medical board is anticipated. [Ref. 21]

2. ACC Related Actions

MHCs have the responsibility of providing a copy of the medical board report or cover sheet to the servicing PSD upon CA signature. Upon receipt of the report, PSD will initiate transfer of the sailor to the nearest TPU/Other activity, no later than the next working day when appropriate. Sailors are admitted as outpatients to the MHC and are accounted for as ACC 371. Once a medical board has been dictated, ACC 355 is assigned. [Ref. 8] The following scenarios provide decision points for ACC changes.

If an individual is assigned to an activity in ACC 370 (inpatient at an MTF) and:

1. Released from treatment and transferred to MHC for continued outpatient care, then gain to the MHC in ACC 371.

2. Released from treatment and transferred to MHC awaiting completion of a local medical board, then gain to MHC in ACC 355.

3. Retained in an inpatient status and a medical board will be dictated for assignment to LIMDU, then retain in ACC 370 until receipt of medical board, and upon release and receipt of medical board, transfer to nearest TPU/Other activity in ACC 320.

4. Retained in an inpatient status and a medical board will be dictated for referral to a PEB, then retain in ACC 370 until receipt of a medical board, and upon the release from the hospital, transfer to nearest TPU/Others activity in ACC 355.

5. Released from treatment and found FFFD, then transfer to nearest TPU/Others activity in ACC 320.

If a sailor is assigned to an MHC in ACC 371 and:

1. A medical board found member FFFD, then transfer to nearest TPU/Other activity in ACC 320 to await further assignment and transfer.

2. A medical board recommends assignment to LIMDU, transfer to nearest TPU/Other activity in ACC 320, then submit availability report to prompt assignment to ACC 105.

3. A medical board recommends referral to either Department Review or PEB, then transfer to nearest TPU/Other activity in ACC 355. If the member was not TEMDU to the MHC and is assigned to other than a sea/deployable unit, they will be returned to their parent command to await PEB findings. [Refs. 8 and 22]

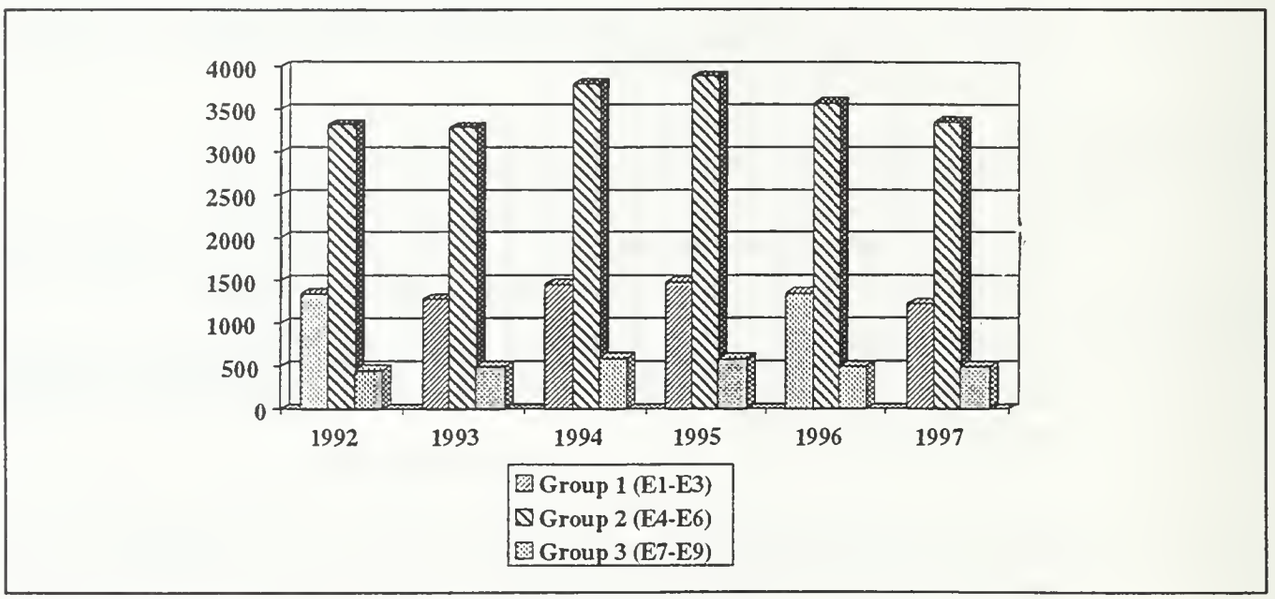
D. FINDINGS

1. LIMDU Population

(i) There was nothing conclusive identified to explain why the percentage of LIMDU and ACC 355 personnel has not decreased relative to the enlisted population as a result of force downsizing. January 1998 Limited Duty Tracking Reports reveal that the absolute number of sailors on LIMDU increased from May 1991

through May 1994 but has decreased since that time. The January 1998 total of 4,804 is the lowest number since July 1992. Figure 14 shows the LIMDU population trend from May 1991 through January 1998. [Ref. 3] The CNA studies discussed in Chapter II found that the incidence of LIMDU as a percentage of the active duty enlisted force increased by 0.6 percent between 1985 and 1995. Also, according to the same CNA studies and December 1997 Limited Duty Tracking Reports, the percentage of active duty sailors on LIMDU was 1.5 percent in both September 1995 and December 1997. The assertion made by the CNA study that the decline in members on LIMDU in 1995 might be explained by the availability of TERA, would seem appropriate. However, we did not find evidence to support their claim that the decline might be explained by increased BUPERS (Pers-821/271) scrutiny. The average number of enlisted members by paygrade for the period of 1992 to 1997 is shown in Table 4. The trend has remained

Table 4. LIMDU Duty Members by Paygrade Annual Averages 1992-1997

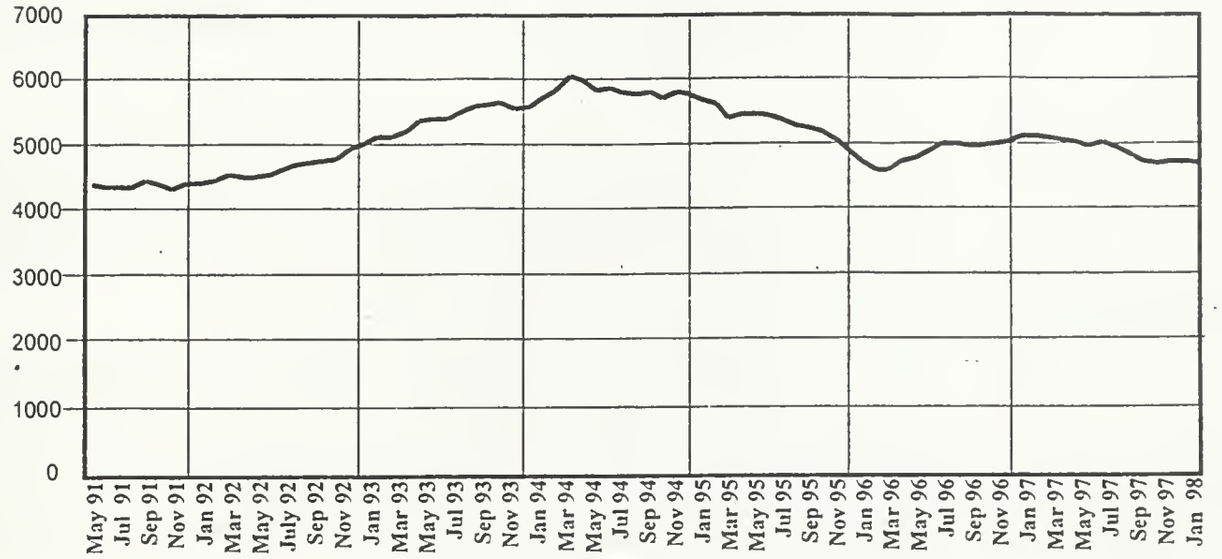


Source: Limited Duty Tracking Reports January 1998.

consistent. Members in paygrades E4-E6 represent the largest group on LIMDU and E7-E9 the smallest.

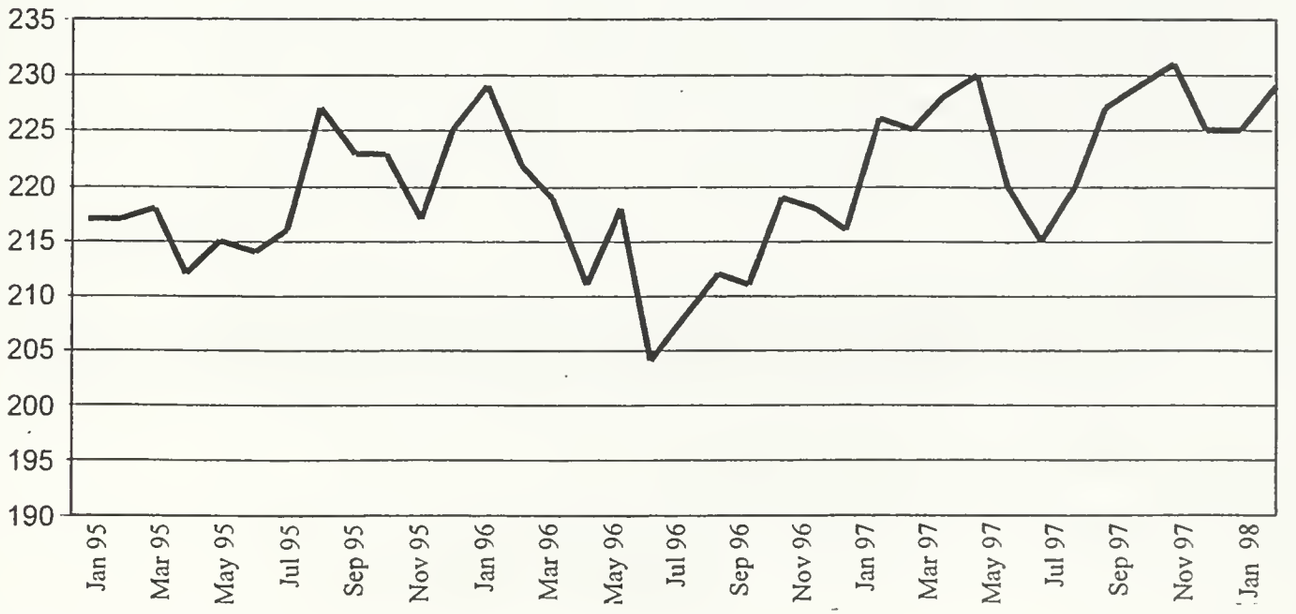
(ii) The LIMDU computerized tracking system at Pers-271/821 cannot access the effective date of an ACC change entered by the PSDs into their SDS computer system. The current Pers-821/271 report takes the date the member was received at the current UIC and reports the member as being on LIMDU for the entire period at that command. Consequently, the reported LIMDU durations will be

overstated for any member on LIMDU while assigned to a shore command. [Ref. 11] The stated average in a TLD status was approximately 217 days in January 1995 and 229 days in January 1998. Figure 15 shows the trend in the average TLD duration from January 1995 through January 1998. This data suggests that the majority of TLD periods are less than 12 months.



Source: Limited Duty Tracking Reports, January 1998.

Figure 14. LIMDU Statistics TLD May 1991-1998
May 1991 – January 1998



Source: Limited Duty Tracking Reports, January 1998.

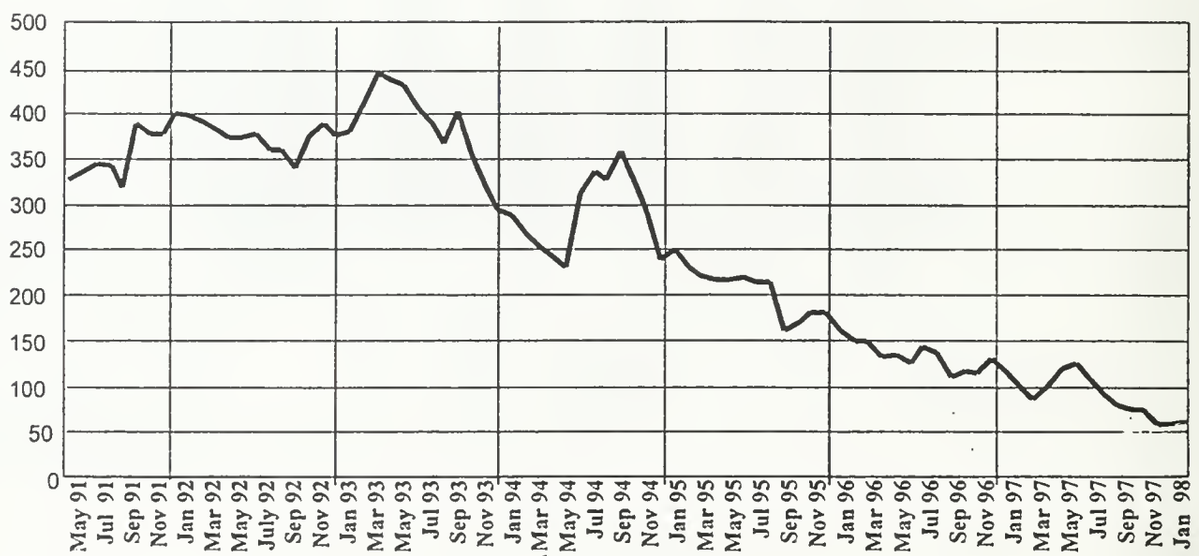
Figure 15. Average Days In TLD Status
Period January 1995 – January 1998

(iii) The OIC, TMU suggests a high number of personnel are retirement eligible and placed on TLD rather than referred for a PEB for disability retirement. The Limited Duty Tracking Report (dated 05 January 1998) reveals 88 personnel assigned to TLD with over 20 years of active service, and 61 with 20 years of active duty service.

(iv) The PLD population has been decreasing since December 1994. Figure 16 reveals the total number in the PLD population between May 1991 and January 1998.

(v) San Diego and Portsmouth have the largest LIMDU population because of their large fleet concentrations. According to the TMU the TPUs in those areas are excellent in tracking and coordinating the LIMDU personnel assigned to them.

(vi) LIMDU Coordinators from the MTF, PSD, and commands with LIMDU personnel assigned shall meet a minimum of once a month to resolve problems and analyze the process. Suggestions for improvement in the LIMDU management process should be submitted to BUPERS (Pers-821/271, attention LIMDU QMB). [Ref. 8] Few of the stakeholders interviewed were aware of a



Source: Limited Duty Tracking Reports, January 1998.

Figure 16. Limited Duty Statistics – PLD May 1991 – January 1998

LIMDU QMB. According to OIC, TMU and TMU reports these meetings do not occur often, but those MTFs that ensure this

collaborative effort have the best medical board and LIMDU processes.

- Delays exist in issuing orders for a LIMDU assignment. According to OIC, TMU it can take 30 days after submitting the availability report to receive orders for a LIMDU assignment. The member will remain in ACC 320 until LIMDU orders are received, at which time the ACC can be changed to 105.

2. Medical Boards

a. Processing Time

- The OIC of the TMU claims that overall processing time is good at the MTF level. This includes the 20 days from dictation to CA signature and the 10 days to mail the completed package.

- The number of medical boards completed does not include the number received and processed in the medical board department each month. The workload requirements to complete a medical board is not captured by the numbers in the MBTS reports. For instance, requests for addenda to a medical board by the PEB are very time consuming, taking almost as much time as a new dictated medical board. Similarly, the number of LIMDU reevaluations involves sending messages specifying the LIMDU extension or forwarding a new medical board report if Department Review or PEB is indicated. A Naval Medical Center (NMC) Portsmouth MBTS report for January 1998 showed that 319 dictated medical boards, and 134 Abbreviated TLD medical boards were completed. However, the medical board department was working on approximately 800 initial TLD medical boards, LIMDU reevaluations, and addenda requests. [Ref. 18]

- The annual TMU audits review MTF MBTS reports and Medical Department records. Reports from the TMU audits reveal the following regarding medical board processing time.[36] [Ref. 23]

1. ***NMC Portsmouth (May 1996 Report)***

   * Approximately 4, 957 Navy medical boards were processed in the past year.

[36] TMU only reviews and reports on Navy medical boards, therefore medical boards processed on members of any other service will not be included.

* The average processing time from date of dictation to signature by CA for 669 dictated medical boards was 23.6 days, a decrease from 26.67 days noted in the last audit.

* The average processing time for 538 abbreviated medical boards reviewed was one day.

2. ***NMC San Diego (February 1996 Report)***

* Approximately 2,198 Navy medical boards were processes in the past year.

* Average processing time from date of dictation to signature by the CA for 650 dictated medical boards was 29.39 days, an increase from 25.55 days in the last audit.

* The average processing time for 480 abbreviated medical boards reviewed was 0.9 days.

3. ***NNMC Bethesda (September 1997 Report)***

* Approximately 908 Navy medical boards were processes in the past year.

* Average processing time from date of dictation to signature by the CA for 338 dictated medical boards was 19.7 days, a decrease from 37.22 days noted in last audit.

* The average processing time for 142 abbreviated medical boards reviewed was 2.18 days, an increase from 0.56 days in the last audit.

4. ***NNMC Bethesda (May 1996 Report)***

* Approximately 700 Navy medical boards were processes in the past year.

* Average processing time from date of dictation to signature by the CA for 293 dictated medical boards was 37.22 days, an increase from 13.36 days in the last audit.

* The average processing time for 149 abbreviated medical boards reviewed was 0.56 days, a decrease from 1.38 days in the last audit.

5. ***Naval Hospital Groton (November1996 Report)***

* Approximately 277 Navy medical boards were processes in the past year.

* Average processing time from date of dictation to signature by the CA for 54 dictated medical boards was 14.8 days, an increase from 13.8 days in the last audit.

* The average processing time for 61 abbreviated medical boards reviewed was 0.80 days, a decrease from 1.01 days in the last audit.

6. ***Naval Hospital Great Lakes (October 1997 Report)***

* Approximately 342 Navy medical boards were processed in the past year.

* Average processing time from date of dictation to signature by the CA for 222 dictated medical boards was 18.68 days, an increase from 17.50 days in the last audit.

* The average processing time 49 abbreviated medical boards reviewed was one day.

- The NMC Portsmouth allows only 24 hours for a member to sign a board. Since the member is in the MHC or a nearby TPU this goal is not unreasonable and compliance has not been difficult. [Ref. 18] Also, they do not prepare a draft medical board report. The evaluating physician is sent the final report for signature and minor ink changes by the physician are permitted directly on the report. The medical board clerk is authorized to makes the indicated changes. The report is re-routed only if major changes are necessary. [Ref. 18]

b. Department Review Process

- The majority of TLD medical boards at the Naval Medical Center (NMC) Portsmouth are locally approved by the CA rather than Department

Review. Most Department Review referrals are the result of TLD extensions from the LIMDU reevaluation. [Ref. 18] This would suggest a small number of sailors in ACC 355 pending the results of medical board action from the Department Review. The member would be retained in ACC 105 pending Department Review if due to a LIMDU reevaluation.

- The MTF's interviewed as well as BUMED and TMU suggested that cases sent for Department Review were seldom returned to the MTF disapproving the recommended TLD period. The extended TLD periods were approved, or less frequently, referred for a PEB, and at times the PEB referral was inappropriate because the condition was non-ratable. The overall sense of the Department Review was that it provided a "rubber stamp" review: as long as the TLD period wasn't over 24 months the Department Review would approve it. The MBTS was unable to provide data on the finding of a Department Review.

- There is not a medical department member involved in the Department Review process. This may result in reluctance at the Department Review to challenge a medical board's opinion or cause them to refer cases inappropriately to PEB instead of processing the member for unsuitability discharge.

- The Marine Corps forwards TLD medical boards for service headquarters review if the period exceeds 6 months.

c. Authorized TLD Period

- There is some criticism regarding the maximum time allowed for TLD. The maximum TLD has been 24 months since 1988 at which time it was 18 months. Changing back to 18 months is currently under discussion due to the belief that there is a decreased probability of returning to full duty if a condition requires 24 months of TLD. Many orthopedic and psychiatric cases that require long rehabilitative treatment have a lower likelihood of returning to full duty than other medical conditions [Ref. 20]. The Head of Orthopedics at NMC Portsmouth agreed that capping the maximum TLD period at 18 months would help to streamline the LIMDU process. However, 24 months should be allowed for the exception such as severe musculoskeletal injuries that have a complicated treatment course.

- The interpretation at Department Review for the maximum allowed TLD is 24 months total. However the Manual of the Medical Department, Chapter 18 states the maximum is 24 months for a given condition.

Pers - 821/271 retains the option to disapprove any TLD amount greater than 24 months and forward for a PEB. [Refs. 6 and 20]

d. Training

- Despite the requirement that physicians convening medical boards are trained and "certified" in medical board and DES/PEB procedures [Refs. 6 and 7]. There was no evidence of any structured training for physicians. BUMED has the responsibility for ensuring that each MTF provide this training. The MTFs and BUMED readily acknowledge the need for physician training, especially in the area of medical boards referring the member for a PEB. However, unpredictable and variable physician work schedules often prevent achievement of training requirements.

e. Convening Authority

- The CA at many MTFs may not be screening medical boards for appropriate recommendations or completeness. At the larger MTF's CA's are required to review and sign a large number of medical boards. The CA for the Orthopedic Department at NMC Portsmouth receives 250-300 medical boards monthly and would be unable to review each board and meet the 20-day processing goal. [Ref. 24] The CA will generally rely exclusively on the judgment of the senior member of the medical board.

f. Processing Delays

- The most common factors cited for contributing to delays in case processing were the LODI/LODD, Non-Medical Assessment, and addenda. These will be discussed further in Chapter VI because these items are required for a PEB but not a TLD medical board.

- The Medical Board Section at the three naval hospitals visited have junior hospital corpsmen functioning in the role of medical board case managers. This role requires a high degree of process knowledge, tracking of board processing, coordinating patient appointments, obtaining patient rebuttals and surrebuttals, and problem-solving with senior medical officers. Finding the opportunity to discuss and resolve medical board issues with surgical residents is often difficult due to long hours surgeons spend in the operating room. National NMC Bethesda has the added challenge of locating psychiatric residents who are away from the MTF due to a shared facility arrangement with other medical facilities in the area. The Medical Board Department supervisors shared the common opinion that the

demands of the position were excessive for an E-3/E-4 and which at times contributed to processing delays.

g. Reevaluations

- Members often cancel their own appointments, or do not report for scheduled appointments. At times it is difficult to coordinate communication between the MTF, PSD, and the member's command, particularly in responding to PSD requests to schedule the reevaluation appointments.

- TMU reports indicate all MTFs have a single point of contact to schedule reevaluation appointments. However, not all MTFs respond within 10 days to PSD's requests to schedule a reevaluation appointment. Often this results in an expired LIMDU status and delaying a determination to return the member to full duty or referral to a PEB. [Ref. 23] NMC Portsmouth has a relatively higher rate of repeat reevaluation requests. A contributing factor to this may be that Norfolk has 8 different servicing PSD's which requires a lot of coordination [Ref. 10].

- NMC San Diego's MBTS report for the period January 1997 to September 1997 reveals that 789 LIMDU reevaluation appointments were scheduled, and there were 351 LIMDU reevaluation repeat requests due to "no shows."

- The Naval Hospital Jacksonville's Orthopedic Clinic was commended in a TMU report for expeditious resolutions of a member's LIMDU status through use of a medical board database and proactive approach to LIMDU reevaluation appointments where they do not wait for PSD to notify them. [Ref. 23]

h. Other Findings for Medical Boards

- Findings of our interviews with TMU are consistent with findings of the CNA study (September 1996) regarding delays in the availability and detailing process. The median wait for placement on LIMDU was 45 days and for return to full duty was 53 days. An analysis of these delays is beyond the scope of this thesis.

- The TMU reports also indicate that some MTFs have personnel who have awaited results of Department Review or PEB action for more than 60 days. [Ref. 23]

- Most rebuttals are a result of members not thoroughly understanding the medical jargon, or due to poor advice from "sea lawyers" that more should be documented in the board. Rarely is the rebuttal to dispute the LIMDU recommendation. [Ref. 25] The Medical Board Departments interviewed did not find the surrebuttal step a significant factor in delaying processing.

- It is a rare occurrence for a member to be in MHC greater than 60 days without having a board dictated [Ref. 10].

- BUMED does not place any restrictions on the number of times a member can be placed on LIMDU utilizing the Abbreviated Temporary Limited Duty Medical Board. BUPERS does not want to allow an abbreviated board for a second condition fearing the potential for abuse by the member is high if he/she seeks care from different physicians for related conditions. Some MTFs choose to restrict its use and will not authorize the abbreviated board for any member previously placed on TLD for a different, related, or same condition. These differing policies for the abbreviated board cause problems for some MTFs when the physicians desire to use the abbreviated board for a second condition and a policy with criteria for its use is not available in writing. [Refs. 17, 20, and 26]

- MTF's appear to utilize the Abbreviated Temporary Medical Board frequently. [Refs. 18, 26 and 27] NMC San Diego MBTS reports for the period between January 1997 though September 1997 showed between 40 and 62 percent of medical boards completed were abbreviated.

3. New Programs

a. The NMC Portsmouth Orthopedic Department has recently initiated a new program for sailors who continue to complain of musculoskeletal pain after completion of standard treatment protocols, but who lack objective physical findings to support a diagnosis of an anatomical defect. An example might be the junior sailor with an ongoing complaint of back pain or knee pain with no good clinical measure of the amount of disability the condition causes. Such a condition is considered nondisabling and is not appropriate for a referral to the PEB for a disability determination. The CNA

study (September 1996) determined that bad backs constituted eight percent of the LIMDU cases in 1995 and 44 percent of these were eventually medically separated, more than for any for other LIMDU medical condition.

Following a period of at least four months (and no more than six months) on TLD, the attending physician can return the member to a FFFD status and recommend an administrative separation for unsuitability. (Appendix A contains the policy and procedure). This policy is consistent with MILSPERSMAN 3620200 which states that CHNAVPERS may authorize the separation of enlisted members for physical or mental conditions which do not constitute a physical disability but which interfere with a member's performance of duty or pose a threat to their safety, and may further render the member incompatible with naval service. [Refs. 25 and 28]

The Head of Orthopedics, NMC Portsmouth claims that the program has been well received by fleet commanders, and effective in minimizing TLD durations and inappropriate referrals to the PEB. It is his opinion that the majority of sailors continue to voice complaints of back pain despite a standarized treatment regime because they are motivated to get out of the service prior to the expiration of their enlistment - "Ninety percent of people with back pain are better in six weeks. Why do we [Navy] have so many that don't get better...nine out of ten have a secondary gain."

b. The Sea Duty Screening Program was initiated in early 1995 and tasked MTFs to screen members transferring from shore commands to sea for unsuitable pre-existing medical or dental conditions. To assess the impact on the receiving ship, a

medical officer or Independent Duty Corpsman screens members for sea duty and physician oversight is not required. The receiving ship must have the level of care and authorized medical allowance list to take care of any pre-existing medical problems. Surface Medicine (MED-22) provides guidance on suitability of specific medical conditions for sea duty.

The Sea Duty Screen is intended to ensure the member is fit for full duty, and to ensure immunizations, physical exam, dental status, HIV, and other medical requirements are up to date. The screen involves a health record review, so the member's medical board findings are available. The screen specifically addresses whether the member has a history of medical boards and recent LIMDU with follow-up required. [Ref. 29] BUMED (MED-02) sent a message to all commanding officers and OICs of MTFs stating that if any condition is found that might not be manageable at sea, or in another operational unit, it is the responsibility of the screening MTF to contact the gaining command to ensure the medical department can manage the condition. If the gaining command indicates the medical condition can be managed aboard, then the Sea Duty Screen should be medically approved. [Ref. 30]

The Branch Medical Clinic at the Naval Station Norfolk, Virginia conducts a significant number of Sea Duty Screens and in September of 1996 found that while over 90 percent of personnel screened needed one of the basic requirements, most were able to fulfill requirements prior to their PCS and less than five percent were ultimately found unsuitable for sea duty. Most of those found unsuitable were due to

limiting orthopedic conditions. [Ref. 29] Despite the small percentage found unsuitable for sea duty, BUMED (MED-02) sent another message in August 1997 asserting that some limited duty personnel found FFFD at the LIMDU reevaluation are made available for orders, receive orders for sea duty and then fail the Sea Duty Screen. The message directed the immediate policy that all LIMDU personnel found FFFD at their reevaluation will undergo a Sea Duty Screen prior to being made available for orders. [Ref. 31]

It takes about five days to get a Sea Duty Screen appointment, but if the clinic doing the Sea Duty Screen isn't organized to complete all that is required in one visit, it may take more than one appointment to complete the screen. [Ref. 18] The member remains in the LIMDU population while undergoing the Sea Duty Screen process.

This change impacts every sailor coming off LIMDU, not just those known to be going to sea. Also, the screener is unable to resolve questions with the receiving command. Although the sea duty screener has access to the medical board findings, often the member will voice a complaint different from the condition related to the medical board, possibly resulting in a failed Sea Duty Screen. The screener may not agree with the medical board's findings regarding fitness to serve on a ship so they do not medically approve the member for sea duty. Then the member takes the results of the screen to PSD and informs PSD he/she cannot go to sea. Some of these sailors recycle

back to the MTF hospital for another TLD board or a recommendation to send member for a PEB.

c. Another new BUMED program is authorization of general medical officers (GMO) assigned to fleet and fleet marine force (FMF) units to conduct LIMDU boards as an augment to the MTFs. CA's may now authorize fleet/FMF based medical officers to *initiate* temporary limited duty medical boards. The intent of the new program is to allow more personal management of sailors facing medical board action and remove some workload from the MTFs. [Ref. 32] The boards initiated by the GMO's will be forwarded to to the supporting MTF for clinical review and signature by the cognizant CA.

BUMED and the MTFs claim this program is working well to get members off of the ship faster and to expedite the temporary limited duty medical board process. The lengthy wait for clinic appointments is eliminated and the GMO's have the benefit of observing the member on board ship and being familiar with their performance and medical history.

Chapter VI offers recommendations to improve the efficiency and effectiveness of medical board processing and the TLD assignment process based on these findings. It discusses the likely impact the recommended changes may have on the LIMDU and ACC 355 populations. The following chapter also discusses the referral of a member into the DES for a PEB, and the member's right to an appeals process if the member does not accept the findings of the PEB. It also discusses our findings about

DES process time parameters and the impact of certain DES policies on MTF medical board processing and the LIMDU population. The administrative procedures for convening and processing a medical board, management of LIMDU personnel, and ACC-related actions are the same as those discussed in this chapter. Some of the policy and procedures specific to the PEB process are reiterated to facilitate understanding of the process.

LIST IV-A

DEFINITIONS: MEDICAL BOARDS AND THE TEMPORARY LIMITED DUTY ASSIGNMENT PROCESS

The processes involved in convening a medical board for the purposes of assigning a service member to temporary limited duty and, or, referral to the Disability Evaluation System for a Physical Evaluation Board are convoluted and complicated by numerous variables. An understanding of the process-specific terminology is essential to optimize clarity on how these processes are distinct and how they are often interdependent.

- Abbreviated Medical Board - The abbreviated medical board is a single physician board convened to assign temporary limited duty for an uncomplicated injury or illness and return to full duty is anticipated following a TLD period of 12 months or less. The MTF may use an abbreviated version of the Medical Board Report. Processing time is 1 day. Any medical board requiring department review or referral to the PEB must be a regular medical board. [Refs. 13 and 14]

- Accepted Medical Principals - "Fundamental deductions, consistent with medical facts, which are so reasonable as to create a virtual certainty that they are correct." [Ref. 7]

- Accounting Category Code - Dictates action required to process through the transient pipeline. [Ref. 8]
- Availability Report - A formatted report that contains the necessary information for assigning/reassigning personnel. This report must be processed before orders can be issued. [Ref. 21]

- Convening Authority - Commanding Officers of all naval hospitals and naval medical clinics may convene a medical board upon any member of the Armed Forces. A convening authority may delegate signatory responsibility for approving or disapproving recommendations and

findings of board members. Delegation may not go beyond the directorate level at hospital commands or the executive officer at medical clinics. [Ref. 6]

- Competency Board - "A board consisting of at least three medical officers or physicians, in which one must be a psychiatrist, convened to determine whether a member is capable of making a rational decision regarding personal or financial affairs." [Ref. 33]

- Departmental Review - This is an administrative review by BUPERS (Pers-271) of the medical board report's disposition recommendation based on the clinical information, submissions by the sailor, and needs of the Navy. [Ref. 8]

- Disposition of Medical Board - Dictates or recommends action to be taken affecting a sailor's status within the naval service. The term "disposition" when referring to a *medical board* convened at a *Medical Treatment Facility* means one of the following:

  a. Continuation or return to full duty in a fit for duty status

  b. Assignment to temporary limited duty

  c. Referral to the Disability Evaluation System for a Physical Evaluation Board [Ref. 6]

- Light Duty - MTF's can recommend to sailors' commands that they be placed on light duty when they have a temporary medical condition which limits their ability to perform certain activities, or when performance of certain activities would compromise recovery from a medical condition. Light duty can not exceed 30 days for the same condition; a medical board must be convened if the sailor is still not fit for full duty after 30 days. [Refs. 6 and 8]

- Limited Duty - The assignment of sailor in a duty status for a specified period of time, following a medical board determination a sailor is temporarily not physically qualified to perform full duty. Return to full duty is anticipated. The LIMDU sailor shall be assigned to a non-deploying activity and to duties that will not aggravate the temporary limitation. The term "limited duty" "LIMDU" and "temporary limited duty" are often used interchangeably. [Refs. 6 and 21]

- Limited Duty Coordinator - The point of contact responsible for tracking and counseling LIMDU personnel and coordinating with other commands involved in processing the LIMDU population. Each command with LIMDU personnel assigned, cognizant PSD's and MTF's shall have a LIMDU Coordinator. [Ref. 21]

- Line of Duty Investigation - When an the injury may result in a permanent disability or prevent a member from performing duties for more than 24 hours, responsible commands will conduct investigations to determine if an injury was incurred or aggravated while in a duty status; and whether it was due to the member's intentional misconduct or willful negligence, the PEB will not accept medical boards without an accompanying LODI when they are required. For the purposes of a medical board, a full LODI is not always necessary. A NAVJAG 5800/15 Injury Report will suffice in cases where it is obvious the injury was incurred in the line of duty and not due to misconduct. [Refs. 7 and 33]

- Medical Board - Medical boards are convened at a Medical Treatment Facility, and consist of a 2-3 physician review/signature. The board evaluates and reports on the diagnosis; prognosis for return to full duty; plan for further treatment, rehabilitation, convalescence; estimates the length of further disability; and provides medical recommendations for disposition. The findings of a medical board may affirm the physical qualification of a sailor for assignment to full duty, however, the determination of unfit for duty is not within the cognizance of a medical board. Expected processing time is 20 days. Medical boards can be "abbreviated" if the medical condition is uncomplicated and does not require department review or a PEB referral. [Ref. 6]

- Medical Board Report - Medical Board Statement of Patient - (Form: NAVMED 6100/2) A medical administrative document reporting clinical findings, opinions, and recommendations of the medical board regarding the sailor's physical fitness of duty. Requires the sailor's witnessed signature.
- Addendum - Amending the original medical board report with new or additional findings or recommendations. The sailor must review and be allowed to make a statement. [Ref. 6]

- Medical Board Tracking System - Provides a standardized automated system for the management of medical board information within Navy MTF's. MBTS is installed in 39 MTF's worldwide and manages the following functions: status of sailors pending medical boards at the MTF;

management of reports data collection; automated generation of administrative medical board forms; automated generation of total entitlement in a format necessary for DES counseling documentation. [Ref. 34]

- Medical Holding Company - Medical Holding Companies are under the cognizance of MTF's with the purpose of housing enlisted active-duty patients whose current condition precludes them from returning to full duty. They are in the MHC, for a period not to exceed 60 days, to complete outpatient medical treatment or awaiting medical board action. [Refs. 8 and 22]

- Mental Incompetence - The condition of a sailor who has been found by a medial board convened in accordance with MANMED Chapter 18, to be mentally incapable of managing his or her own financial or personal affairs. [Ref. 7]

- Naval Medical Treatment Facility - "An activity of the Naval establishment assigned the primary mission of providing medical care, such as Naval Hospitals, Branch Hospitals, Clinics, Branch clinics." [Ref. 21]

- Non-Medical Assessment - A statement from the sailor's commanding officer assessing the impact of the sailor's medical condition on his/her ability to perform their normal military duties and to deploy or mobilize as applicable. This statement is required for all PEB's except in cases of critical illness/injury in which return to duty is not expected. [Ref. 35]

- Outpatient Medical Boards - Applies to sailors assigned to type-2 or type-4 (sea/deploying units/neutral duty) commands who have not been transferred to the MTF (including MHC) in a TEMDU status to await medical board action because they are ambulatory and have no hospital required nursing procedures, dietary care, or special treatment; are not in need of convalescent leave; and berthing is not available at the MHC. These sailors will be transferred to the TPU/Other activity nearest the Naval Hospital in a TEMDU status awaiting results of a medical board. [Ref. 21]

- Permanent Limited Duty - An assignment authorized by BUPERS, if found unfit by a PEB, to a limited duty status to complete 20 years of service, or remain on active duty until a specific date, in a shore assignment. The PLD assignment would be indicated for a lasting medical condition that prevents the sailor from being worldwide assignable and is

incompatible with sea duty, but the condition is quite manageable ashore. This assignment is generally limited to senior sailors. Permanent Limited Duty is coded by a limited duty designator (L-4/L-5) and is accounted for in ACC 105. [Refs. 7 and 21]

- Physical Disability - Any impairment due to disease or injury, regardless of degree, which reduces or precludes a sailor's actual or presumed ability to engage in gainful or normal activity, and is of such a nature as to interfere with the member's ability to adequately perform his or her military duties. [Ref. 32] The term excludes the condition of behavioral and personality disorders, alcoholism, and obesity. Members with these conditions are subject to administrative separation. [Ref. 7]

- Reevaluation Appointment - A medical appointment scheduled no later than 60 days prior to the end of the TLD period to permit the medical officer to make a determination if the sailor is qualified for full duty, requires another period of TLD, or needs a referral to the PEB. [Ref. 6]

- Surrebuttal - When a sailor submits a statement in rebuttal to the findings of the medical board, the board must review the rebuttal and any new information raised by the sailor. A surrebuttal must be issued and included in the medical board report package when the findings of the board still stand. [Ref. 6]

- Temporary Limited Duty - Assignment of a sailor to a LIMDU status for a specified period, not to exceed 24 months, authorized at a Medical Treatment Facility by a medical board or by BUPERS (Pers-271), for cases in which the prognosis is that the sailor can be restored to full duty within the specified time. Cases where the LIMDU status exceeds 24 months must be referred to the Physical Evaluation System. Temporary limited duty is accounted for in ACC 105. [Ref. 6]

- Transient Monitoring Unit - Monitors the movement of personnel through the TPP&H pipelines. An agent for the CHNAVPERS, the unit is responsible for conducting on-site audits and assist visits of transient personnel processing activities (includes MTF's and TPU's) to ensure proper administration and management procedures are in place, and transients move through the pipelines as rapidly as possible. Additionally, TMU is responsible for monitoring of LIMDU personnel and recommending changes to policies and procedures covering both transient and LIMDU personnel. [Ref. 21]

- Transient Personnel Unit - An activity comprised of sailors moving through the transient pipeline. Sailors awaiting results of a medical board, findings of a PEB, and awaiting a LIMDU assignment are often assigned to a TPU. [Ref. 8]

V. THE DISABILITY EVALUATION SYSTEM

The Department of Defense Disability Evaluation System (DES) is the mechanism for implementing retirement or separation because of physical disabilities in accordance with Chapter 61 of Title 10 United States Code. The Navy's DES has two primary objectives: (a) to maintain a physically fit and combat ready Navy and Marine Corps, including reserve components; and (b) to provide equitable consideration of government and individual service member interests. [Ref. 7] The DES was established to ensure that physical disability evaluations are conducted using timely and consistent procedures in applying DES standards to members of the active duty and reserve components. The total cases referred to the DES during the years 1971 through 1997 are shown in Figure 17. Although the total cases include Navy and Marine Corps Active Duty, eligible Reservists, and members on the Temporary Disability Retirement List undergoing a periodic review, the focus of this thesis is on the referral of active duty enlisted members of the Naval service.[37] The number of cases declined from the mid 1970's until 1984, and then increased again after 1984 until 1989. The reason for these trends remain unclear. The number of cases entering the system since 1990 has been decreasing and is likely related to force downsizing and a declining LIMDU population.[38]

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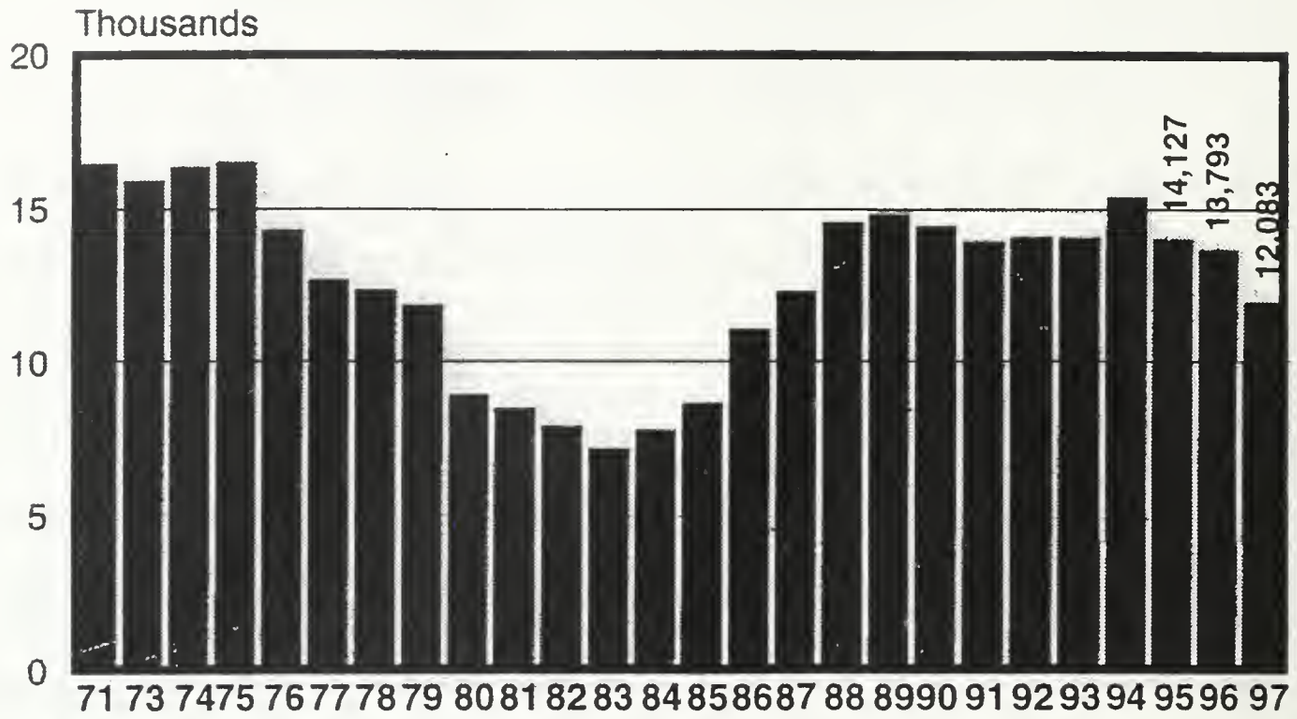
[37] Assignment of a member to the Temporary Disability Retirement List (TDRL) will be discussed in Section L of this chapter.

[38] The LIMDU population refers to members assigned to temporary limited duty. A significant proportion of members referred into the DES are on a LIMDU status. The LIMDU population is discussed in detail in Chapter IV.



Total cases: Active Duty, Reserve, TDRL

Figure 17. Total Cases Received Entering the System Disability Evaluation for a PEB

Each case referred into the DES is unique, and the processes involved in reviewing each case and finalizing the member's disposition are complex. The following sections of this chapter provide a detailed description of these processes. These elements include: disability conditions and documentation requirements for a medical board referred to the DES; determinations made by Informal and Formal Physical Evaluation Boards (PEB); service member rights to a Hearing Panel and Petition for Relief proceedings; case processing time standards; and the role of Disability Evaluation System Counselors. This chapter will conclude with findings based on review of applicable instructions, interviews with members of the PEB and Medical Board Departments at

three Medical Treatment Facilities (MTF), and data provided by the DES Joint Disability Tracking System (JDETS). An Appendix is provided at the end of this chapter which contains definitions of terms and concepts relevant to the DES and PEB process.

A. DES OVERVIEW

As a general rule, an active duty member is referred for a disability evaluation only by a medical board that has found a member's fitness for continued active service questionable due to a physical disability.[39] The case enters the DES when a medical board convened at an MTF is forwarded and accepted by the Physical Evaluation Board (PEB).[40] The PEB conducts a records review of the case. This step in the PEB process is referred to as the Informal Board, also known as the Record Review Panel (RRP). The member is notified of the RRP's findings (preliminary findings), and is then allowed 15 days to accept the findings. If the member unconditionally accepts the preliminary findings, the case is finalized and the appropriate disposition of the member is approved by BUPERS. If the member does not accept the preliminary findings, he/she can request to be heard before a Hearing Panel, the Formal Board of the PEB. If a Hearing Panel (HP) hears the case it makes a finding of "fit" or "unfit," and (conditional on any legal reviews), the case is finalized. If the member also disagrees with the findings of the HP,

[39] In cases where it is not practical to have a medical board convened on the member, such as when the member is hospitalized in a non-military hospital, the case can be referred to the PEB by cognizant authority when medical records reveal the member's fitness is questionable.

[40] Requirements for a medical board referred for a PEB will be discussed in section D (1).

he/she can petition for relief of action to the Director, Naval Council of Personnel Boards (DNCPB), or if already separated from service, to the Board for Correction of Naval Records (BCNR).[41] Figure 18 shows the general flow of the process.

The sailor's accounting code category (ACC) upon referral depends on whether he/she is referred as the result of a LIMDU reevaluation, or of an initial medical board, determining that a PEB is necessary. A LIMDU reevaluation is conducted on sailors nearing the end of a period of temporary limited duty (TLD) assigned by a medical board and the evaluating physician makes a determination to continue the TLD period, return the member to full duty, or refer the member to a PEB. At this point a sailor is referred into the DES upon determination that the maximum medical benefit was attained during the TLD period and fitness remains questionable. Sailors are accounted for in ACC 105 while on TLD. Consequently, they will remain in ACC 105 upon referral to a PEB, and the ACC does not change until the findings of the PEB are finalized.[42] Sailors can be granted TLD for a total of 24 months at which point a referral to the PEB is required, unless the member can be returned to full duty at that time. A new medical board should be convened when referring a member for a PEB after a period a TLD to ensure the information reviewed by the PEB is current. Sometimes, the evaluating physician does not conclude that continued medical treatment during a period of TLD will increase the sailor's likelihood of being returned to full duty and the case is referred for a PEB upon diagnosis of the condition and dictation of the medical board. In this case, the sailor

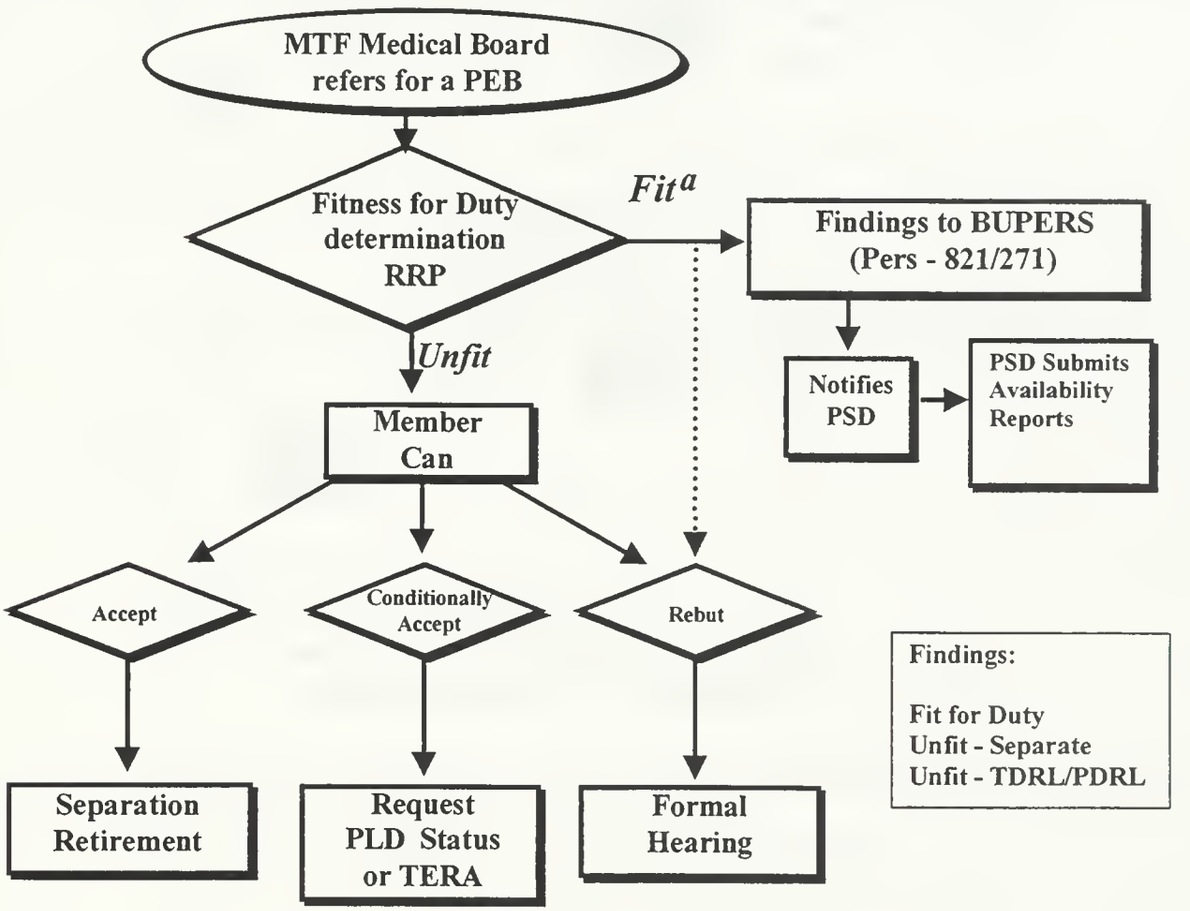
[41] Each step of the process will be discussed in more detail throughout this chapter.

[42] Findings are considered finalized upon acceptance of the determination in the Findings Letter, or the determination is issued by the Director, Naval Council of Personnel Boards (DNCPB).

remains in ACC 355 (Pending Results of a Medical Board or PEB) and the ACC will not change until the findings of the PEB are finalized.[43] Figure 19 shows points in the medical board process when a member is referred into the DES.

B. RESPONSIBILITIES FOR THE DES

A brief description of oversight responsibilities within the DES is important for identifying stakeholders and understanding differences in management between this and the Temporary Limited Duty assignment process. The Under Secretary of Defense for



[a]*Member authorized to request hearing to appeal a fit for duty finding*

Figure 18. DES – General Overview

[43] If the sailor is assigned to shore duty (Type 1), then the ACC remains 100 until the PEB is finalized. Figure 13 in Chapter IV reviews ACC changes.

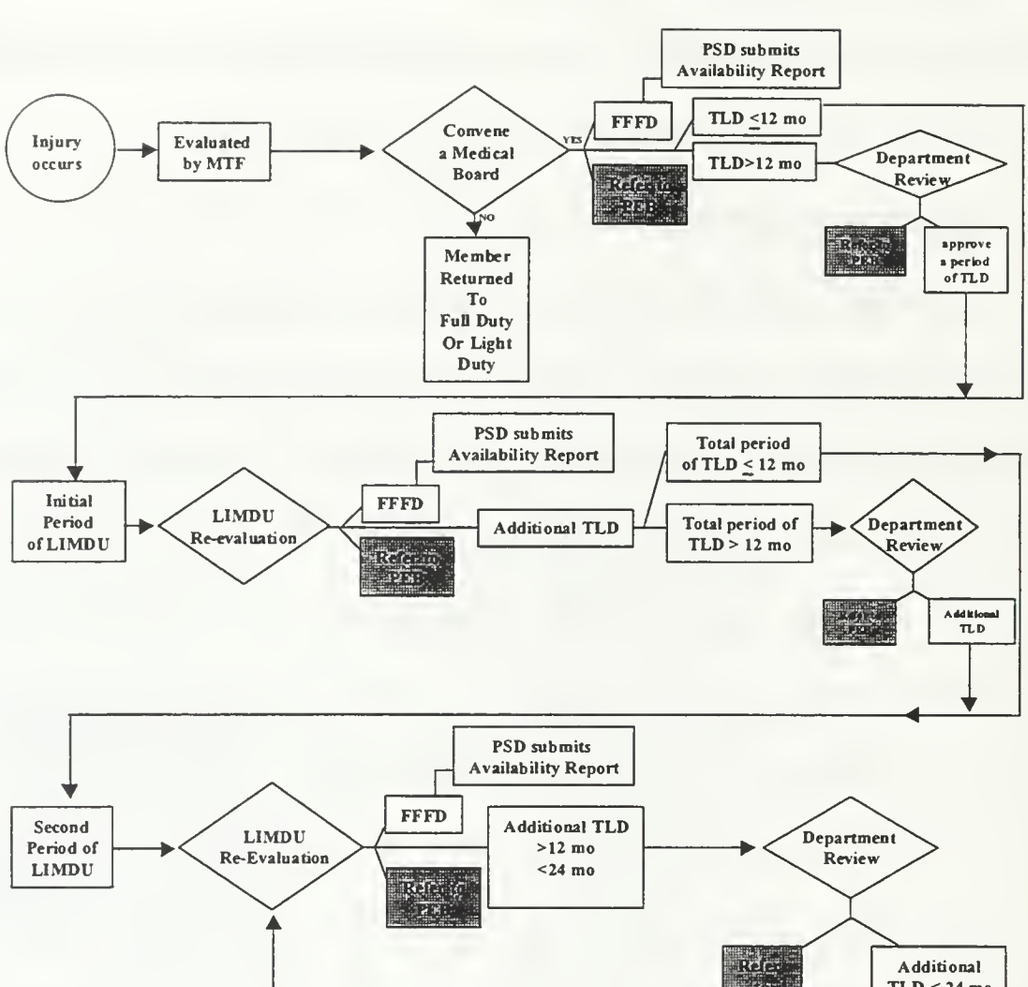


Figure 19. Medical Board Process Timeline Not to Exceed 24 Months

Personnel and Readiness has cognizance and oversight of the DOD DES, and makes the final decision on requests from the Services for exceptions to DES policy. The Assistant Secretary of Defense (ASD) for Force Management Policy has cognizance of laws, policies, and regulations effecting the DES, and issues guidance to govern the policy and procedures of the DES components. The ASD Force Management Policy also:

1. Establishes reporting requirements to monitor and assess the performance of the DES;

2. Coordinates with the ASD for Health Affairs in developing procedures for medical issues relevant to physical disability evaluations;

3. Coordinates with the ASD for Reserve Affairs, and;

4. Reviews DES policy and procedure changes proposed by the Services effecting the uniformity of standards for separation or retirement for unfitness because of physical disability.

The ASD for Health Affairs makes recommendations for a final decision by the Secretary of Defense on the unfit findings on all officers in pay grade 0-7 or higher and medical officers of any grade, and reviews changes proposed by the Services in their medical standards concerning medical conditions causing a referral to the DES. The Assistant Secretary of the Navy (ASN) for Manpower and Reserve Affairs (M&RA) reports to the Secretary of the Navy (SECNAV) and is responsible for management oversight of the DON DES. Specifically, the ASN (M&RS):

1. Ensures appropriate counseling of members referred into the DES;

2. Establishes a quality assurance process to ensure uniform application of DOD DES policy and procedures;

3. Makes determination of unfitness because of physical disability;

4. Approves entitlement to assignment of a disability percentage rating at time of medical separation or retirement;

5. Approves entitlement to disability retired or severance pay;

6. Ensures the TDRL is managed to meet the requirements of Title 10 U.S.C for timely periodic physical evaluations, suspension of retired pay, and removal from the TDRL evaluations; [Ref. 33]

7. Resolution of special interest cases referred to SECNAV. All cases involving flag or medical officers determined unfit by PEB are special

interest cases due to statutory or regulatory handling requirements. Also, the DNCPB can designate a case as special interest. [Ref. 7]

As the SECNAV's principle agent in overseeing the DES, the DNCPB is responsible for conduct of the DES within SECNAV guidelines and is assigned overall responsibility for the management, integrity, and efficiency of the DES. Accordingly, the DNCPB issues internal instructions within the DES to further interpret, implement, and govern PEB procedures. The DNCPB may propose, in coordination with the CNO, changes to the DES, and request the ASN (M&RA) to recommend to ASD Health Affairs (HA) changes to DOD directives that will better serve the needs of naval personnel. The DNCPB can stop action and refer any case to the ASN (M&RA) for resolution if the Director disagrees with the PEB's disposition. The DNCPB supervises the activities of the President, PEB; ensures training of the DESC and collateral duty counselors at the MTFs and ensures the training of line and medical officers assigned to the PEB. [Ref. 7] Additionally, the DNCPB maintains liaison with the Navy, Marine Corps, JAG, Surgeon General, DOD and other governmental agencies in matters relating to the DES. Any legal issue determination made by the Judge Advocate General (JAG) is binding on the DNCPB. If the JAG determines that insufficient facts support a finding, the DNCPB may accept the legal opinion and order appropriate action, return the case to the cognizant authority for additional information, or appeal the decision to the SECNAV for a final resolution. [Ref. 7]

The CNO is responsible for the management of MTFs, line of duty investigations, and Permanent Limited Duty (PLD) and TDRL members. The Surgeon General is

responsible for professional medical support of the DES and ensuring conformity with the Manual of the Medical Department. [Ref. 7]

The Chief of Naval Personnel (CHNAVPERS) oversees specific personnel management actions in support of DES policy. Specifically the CHNAVPERS:

1. Can withdraw a case from the PEB, providing the member consents;
2. Provide access to performance evaluations for review by the PEB;
3. Accomplish appropriate final disposition processing of members whose disability evaluation is completed and;
4. Act on requests for TERA and continuation on active duty in a PLD status;
5. Provide counseling on details of final disposition upon member's request;
6. Maintain a list of at least four alternate line officers for service on the PEB;
7. Administer the TDRL
8. Recommend changes to DES policies to the ASN (M and RA) via the DNCPB.

The Chief, Bureau of Medicine and Surgery (CHBUMED) is responsible for the efficiency of processing medical boards and quality of medical board packages forwarded to the PEB. Specifically, CHBUMED:

1. Provide medical and medical personnel support to the DES;
2. Advises the SECNAV;
3. Provide medical board reports to the PEB, and additional information to assist a determination by the PEB, when requested;
4. Establish medical board procedures;

5. Nominate Medical Corps officers to serve on the PEB;

6. Recommend changes to the DES to the ASN (M and RA) via the DNCPB.

The Office of the JAG (OJAG) provides legal resources to support the DES. Specifically, the OJAG:

1. Review every case where an officer is retired for a physical disability;

2. Review every case involving incompetence;

3. Review for legal correctness when:

- The member exercises the right to a hearing panel;
- The President, PEB questions LODD requirements;
- The basis of an unfit determination is mental impairment;
- The member petitions the DNCPB for relief of action;
- The SECNAV, DNCPB, or President, PEB requests a JAG review;
- Case involves a flag or medical officer.

4. Return legally insufficient cases to the DNCPB for action. [Ref. 7]

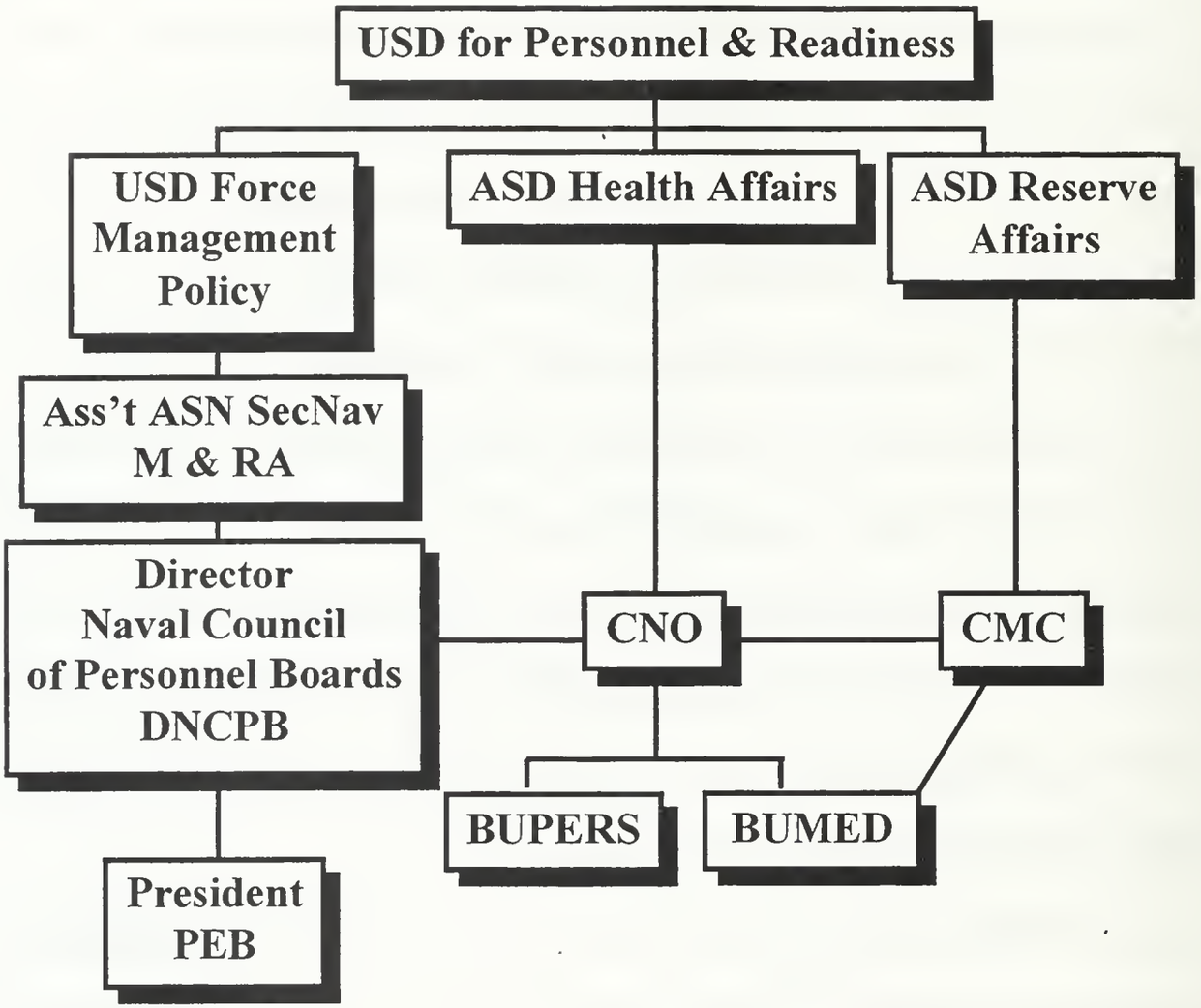
On behalf of the SECNAV, the President, PEB issues the final determination in routine disability cases in a Findings letter and the DNCPB issues the final determination in special interest cases and in cases where relief is granted on the basis of a Petition for Relief (PFR). Once the case is finalized, the member's name is forwarded to BUPERS for discharge action, consideration of PLD and TERA requests, or return to duty. See Figure 20 for a representation of oversight structure for the DES within the DOD and DON.

C. CRITERIA FOR REFERRAL INTO THE DES

Enclosure 4 of DOD Instruction 1332.38 provides an extensive listing, mainly by body system, of medical conditions and physical defects which can cause referral into the DES. The listing is not all-inclusive and even though a service member has one or more of the listed conditions it cannot be automatically assumed the member is unfit. For some conditions, a reasonable course of medical treatment in a temporary limited duty status (to allow the member to receive optimal benefit) is often warranted before a referral. Also, some conditions may not preclude the adequate performance of duty in all cases. The SECNAV is authorized to modify the guidelines regarding the listed conditions to fit the needs of the Navy and to develop Service supplemental standards. These modifications should be directed to conditions that would significantly interfere with the reasonable fulfillment of military employment, seriously compromise health of the member if he/she remained on active duty (dependence on medications, severe dietary restrictions, frequent medical treatments or monitoring), or prejudice the best interests of the Navy if the member remained on active duty. [Ref. 33]

Regardless of the conditions listed in enclosure 4 of DOD Instruction 1332.38 or the supplemental standards, a member is eligible for referral into the DES when: (a) the evaluating physician believes that the member will be unable to return to full duty within one year of diagnosis of a disabling medical condition, (b) the member was previously determined unfit, retained in a PLD status, and the period of PLD has expired. All active duty members referred into the DES are entitled to basic pay, and if not entitled to basic pay it must be due to an authorized absence in accordance with Title 37 U.S.C. Further

eligibility criteria for referral into the DES relating to reserve status, non-duty and duty-related impairments, members entering the service with medical waivers, and Gulf War cases is beyond the scope of this thesis. However, it is important to mention a significant change in DES policy effective 15 May 1997 involving nonwaived medical



Source: DES Brief, October 1997.

Figure 20. DES Responsibilities

conditions that existed prior to entry (EPTE): *In the absence of service aggravation,* EPTE conditions are *not ratable* regardless of length of service. [Ref. 35] Members with EPTE conditions may be administratively separated without a referral into the DES if the condition is identified within 180 days of entry on active duty, not service aggravated, and if the EPTE condition is not a cause for referral under DOD Instruction 1332.38 enclosure 4 or supplemental standards. [Ref. 33] The PEB does review cases involving nonwaivered medical conditions that existed prior to entry when a medical board recommends separation and the member claims the condition was service aggravated.

Certain medical conditions and defects are designated by the Secretary of Defense as not constituting a physical disability and are *not ratable in the absence of an underlying ratable causative disorder*. Such conditions should be handled by appropriate administrative action. Enclosure 5 of the DOD Directive 1332.38 provides a listing of conditions which do not constitute a ratable physical disability. A selection of those conditions follows:

- Personality, Sexual, Adjustment, Substance-related Disorders; Learning Disabilities; Disorders of impulse control. These conditions may render a member administratively unable to perform duties rather than medically unable, and should be the basis for administrative separation.
- Obesity.
- Attention Deficit Hyperactivity Disorder.
- Medical contraindication to the Administration of Required Immunizations.
- Certain Anemias.

When the evaluating physician determines a member has a medical condition that is referable to the DES, it is imperative that the report of the medical board make a clear statement of its finding that the member's fitness for continued service is questionable by reason of a physical disability. The questionable fitness must be supported by objective medical data displaying the nature and degree of the disability. [Ref. 7]

D. ELEMENTS OF THE DES

The DES consists of four elements: (1) A medical evaluation by a medical board, and the periodic physical examinations required for personnel on the TDRL; (2) A physical disability evaluation by the informal and formal PEBs, and appropriate legal reviews; (3) Counseling of the service member; and (4) Implementation of the final disposition as determined by the President, PEB, or the DNCPB.[44] [Ref. 33]

1. Medical Evaluation

A medical board is convened at an MTF to initiate the referral into the DES when the evaluating physician determines that it is unlikely the member will be able to return to active duty and perform their military duties.[45] The medical board can refer the case for a PEB immediately upon diagnosis of the medical condition, or any time while the

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[44] The Petition for Relief proceedings is discussed within the context of the DES, however, it is separate from the PEB process and not identified as an *element* of the DES. The findings issued by the President, PEB are considered the final findings of the PEB and under certain circumstances, the member may petition for relief of final action by the PEB.

[45] Chapter IV of this thesis discusses the medical board process in detail, including decision points for referral for a PEB.

member is on temporary limited duty.[46] If the medical board feels the member should be kept on active duty, the PEB recommends that a period of limited duty and continued medical treatment is provided by a Temporary Limited Duty medical board before referring the member. The PEB makes the fitness determination based on the current medical condition, consequently it is in the member's best interest to enter a LIMDU status if return to full duty is likely with appropriate and reasonable medical treatment. When the member has been on temporary limited duty a new medical board is convened to ensure current information is provided to the PEB. If the member has been on temporary limited duty for 24 months and the evaluating physician is unable to return the member to full duty, the case must be referred for a PEB.

The medical board must document complete clinical information of all medical conditions and state whether each condition is cause for referral into the DES. Documentation of duty limitations is equally important. The clinical information needs to include a medical history, a complete physical examination, medical tests (and their results), medical and surgical consults as indicated, diagnoses, treatment, and prognosis. If the member was determined to be incompetent to handle his/her personal affairs, the results of a Incapacitation Board must be included with the medical board.[47] (The requirements of clinical documentation for medical boards will be further discussed in Section D(2)(a) pertaining to the informal PEB, the Record Review Panel). The medical

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[46] BUPERS (Pers-821/271) reviews all medical boards recommending temporary limited duty (TLD) greater than 12 months, and can subsequently disapprove the TLD and refer the case for a PEB if deemed appropriate.

[47] The PEB also requires an Incapacitation Board for severe head trauma and mental disorders. [Ref. 13]

board cannot state a conclusion of unfitness because of a physical disability, assignment of a disability rating, or state a final disposition. The PEB has sole authority to conclude a member is unfit. [Ref. 33]

Specific non-medical documentation must accompany the medical board. The MTF has the responsibility to obtain a copy of the Line of Duty Determination (LODD) from the member's parent command when appropriate. The LODD assists the PEB and legal review in meeting the statutory requirements under Chapter 61 of Title 10 U.S.C for separation or retirement for physical disability. (The requirements and procedures for LODD's are discussed in Section H of this chapter). Effective 15 May 1997, all medical boards referred for a PEB require a Non-Medical Assessment (NMA) completed by the member's immediate commanding officer. This document provides the PEB with an assessment by the commanding officer of the impact of the member's medical condition on the ability to perform his/her normal military duties, and to deploy or mobilize. If the member has been reassigned to a Medical Holding Company (MHC) or a Transient Personnel Unit (TPU), the MTF obtains the NMA from the member's former unit commander. (List V-A of this chapter provides an example of the questions and comments required). Exceptions to the NMA requirement involve cases of critical illness or injury where return to duty is not expected. [Ref. 10]

The President, PEB may defer acceptance of case into DES when accompanying clinical documentation (or the LODD) lack detailed information required for determination of fitness, eligibility, combat-related injury, and mental competence. Recorders at the PEB screen cases for completeness and the RRP may deny review of a case if

information is incomplete. The President, PEB has the authority to task the MTF, the member's command, or the cognizant general court-martial convening authority (GCMCA) to correct document deficiencies or supply the required information. Generally, the PEB tasks the MTF with ensuring that commands comply. Additional clinical information requested is provided as an addendum. The MTFs are tasked with responding to PEB requests within 10 days.

2. Physical Disability Evaluation

Physical Evaluation Boards (Informal PEB and Formal PEB) conduct physical disability evaluations. The PEB is the SECNAV authority for making determinations of fitness for duty, entitlement to benefits, disability ratings, and disposition of service members referred to it. [Ref. 7] The mission of the PEB is to determine fitness of service members with medical impairment to perform the duties of their office, grade, rank, or rating. Personnel will not be found unfit if they can be expected to perform in an assignment appropriate to their grade, qualifications and experience. [Refs. 8, 33, and 35] (Determination of unfitness is further discussed in Section I of this chapter). Additionally, the PEB's objective is to afford service members a right to a full and fair hearing; protect the interest of the government; maintain a fit military force; and appropriately compensate for injuries/illnesses incurred or aggravated while entitled to basic pay. [Refs. 8 and 33]

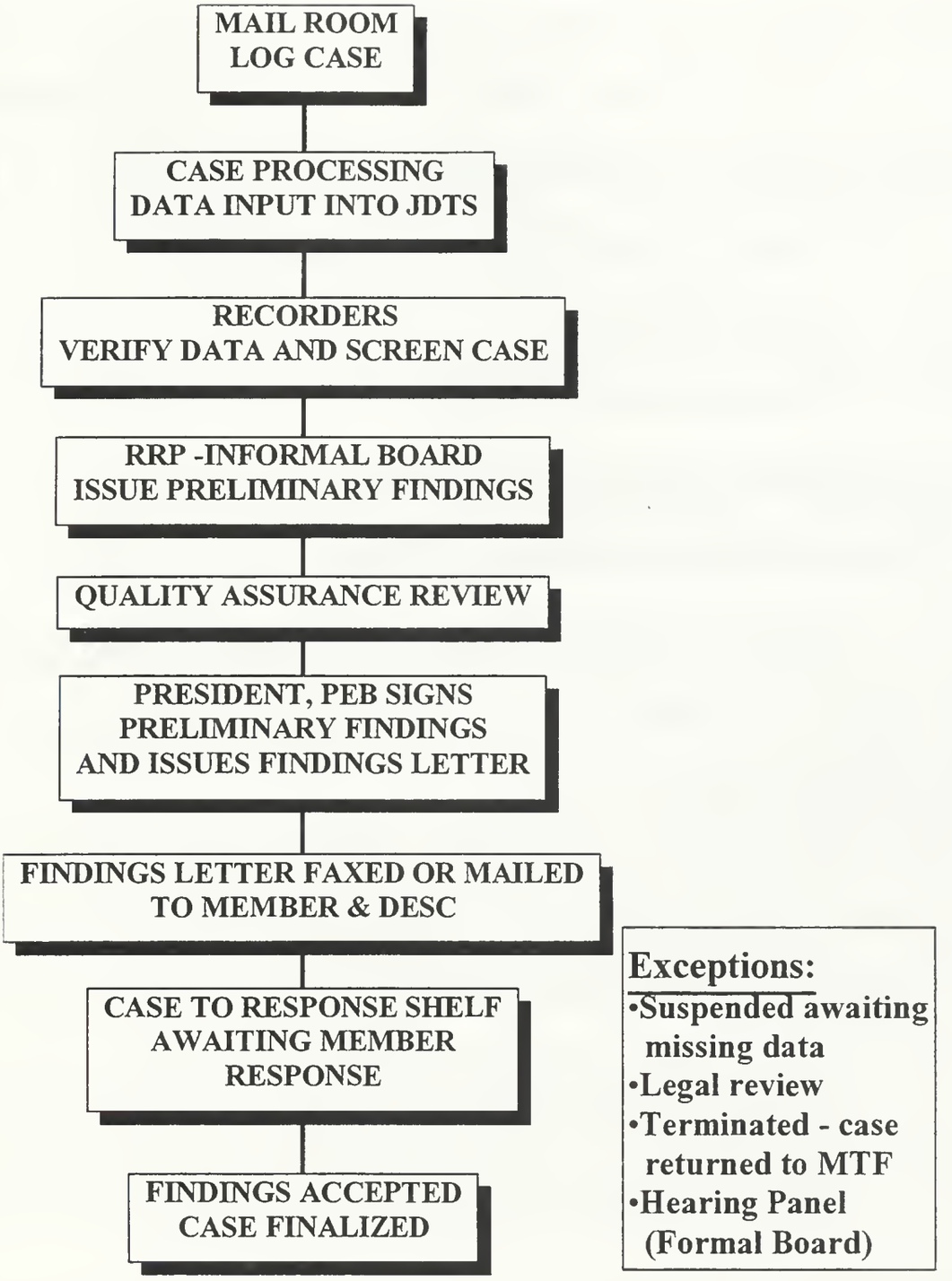
When the PEB office receives a medical board, it is received in the Mailroom and information is inputted into the Joint Disability Tracking System (JDETS). The case is designated as a "New Case" and forwarded to Recorders for an initial administrative

screen of the case before it is sent to the Informal PEB. The screening process checks for completeness of the medical board, specifically that all required clinical and non-medical documentation is included. Medical boards that do not contain required LODD's, NMA's, or clinical information, will be suspended pending response from the MTF and will not be reviewed by the Record Review Panel until the information is obtained. The MTF is expected to obtain the required documentation and return to the PEB within 10 days. In cases where the MTF is unable to provide the required information, the case is terminated, and a new medical board is convened to refer the case again for a PEB. Figure 21 shows the routine case flow for an active duty case.

a. Informal PEB

Once a medical board has been accepted, an Informal PEB, the Record Review Panel (RRP) is convened. The RRP will conduct a documentary review of the complete medical board without the presence of the member and provide preliminary findings and recommendations. Specifically the RRP will:

- Evaluate fitness for duty based on member's current condition;
- Apply rule of presumption of fitness and presumption of service aggravation;
- Apply EPTE rule;



Source: DES Brief October 1997.

Figure 21. PEB Process
Active Duty Case Flow (Preliminary Findings Accepted)

- Determine entitlement to benefits;[48]
- Decide percentage of disability according to the Veterans Administration
- Schedule for Rating Disability (VASRD);[49]
- Assign VA Code(s) for classification of condition;
- Assign a disposition;
- Consider the LODD and NMA;[50]
- Make a combat related determination; and
- Promulgate the preliminary findings letter. [Refs. 8 and 33]

Preliminary findings are signed by the President, PEB and then a Findings Letter is issued to the member and a copy is forwarded to a DES counselor who then counsels the member regarding their options.

If the preliminary findings are fit for duty, the member may:

- Unconditionally accept the findings and return to duty. The preliminary findings of the RRP will be final;
- Rebut the findings and request reconsideration if the member has new medical information for the RRP to consider. The member must state if a Hearing Panel is desired if the RRP does not change previous findings. If the RRP finding on reconsideration remains FIT, the member is returned to duty because he/she does not have the right to a hearing. If the finding

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[48] The member needs to be in receipt of basic pay and if a reservist, a notice of eligibility must be included. If the member is undergoing disciplinary action for misconduct or UA such that an OTH may result, the PEB is suspended, and if the member is not exonerated, the PEB is terminated. If the PEB is completed prior to disciplinary action, BUPERS determines appropriate discharge. A PEB may remain in progress while member being processed for an administrative separation. The administrative separation may be completed prior to the PEB. [Ref. 16]

[49] See definition in List V-A of this chapter.

[50] The RRP is not bound by the LODD. The RRP can override the LODD's finding of "not due to misconduct" and deny a rating to the disability on the basis of misconduct. [Ref. 16]

is changed to unfit, the member is then entitled to receive a new Findings Letter and is offered the applicable options. [Refs. 7 and 8]

- Rebut the findings and request a Hearing Panel (Formal PEB). If the member does not request a Hearing Panel, or the request is denied by the DNCPB, then the preliminary findings of the RRP will be final.

If the preliminary findings are unfit, the member may:

- Unconditionally accept the findings and waive the right to a Hearing Panel.[51]

- Conditionally accept the findings dependent upon granting special handling of separation, such as a deferment, TERA, or a PLD status. The member must indicate if a hearing is desired if the conditions are not approved;

- Rebut the findings and exercise right to a Hearing Panel. [Refs. 7 and 8]

A Record Review Panel is composed of three senior (0-6) military members: a Navy line officer, a Marine Corps officer, and a Medical Corps officer. The Navy line and Marine Corps officers review 100 percent of the cases. There are five medical officers assigned to the PEB and each reviews 1/5th of the cases. [Ref. 16] The medical officers assigned to the RRP should possess a broad cross-section of clinical experience. The members are nominated by CHBUMED, assigned by the DNCPB, and report to the President, PEB. [Ref. 7] An alternate member in the grade of 0-5 or above may sit on the panel if a principal member is absent, however, no more than one alternate can be used at a time. CHNAVPERS and BUMED provide the alternate members.

[51] An individual found unfit for duty and unconditionally accepts the findings may request to be placed in a home- awaiting- orders status, subject to approval by his/her commanding officer.

It is essential that the medical board contain all the relevant clinical evidence to support the diagnosis and the reasons the condition should render the member unfit. Objective medial evidence is necessary to justify a ratable disability. Previously, any diagnosis supported only by subjective complaints was not ratable.[52] The "overall effect" discussed in DOD Instruction 1332.38 now allows for a disability rating of certain conditions supported only by subjective pain. Clinical information considered essential for the RRP in making a fitness and compensation determination include:

- Complete physical examination with attention focused on the disability, hand dominance must be stated;
- Brief chronology of events including history of present injury/illness, prior treatment/surgery, LIMDU;
- Description of specific signs and symptoms related to disability
- Statement of competency for all psychiatric cases, and competency board for all incompetent patients;
- Past medical history;
- Family and social histories, include psychological stressors;
- All pertinent laboratory and radiological results;
- Consultations from medical specialties;[53]
- Medication history;
- Diagnosis should not be prefaced with "possible", "probable", or "rule-out."

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[52] An example would be the member with complaints of a headache or back pain without medical evidence to support a clinical diagnosis.

[53] Evaluations by a Rheumatologist is required for Chronic Fatigue Syndrome and Persian Gulf Syndrome.

Additional information necessary to determine fitness, entitlement, and percentage rating include:

- Statement on the functional status regarding the ability to perform required duties;
- Statement regarding stability and prognosis of functional status;
- Statement regarding stability of current clinical condition;
- Rebuttals and surrebuttals must be included;
- Statement of compliance with treatment recommendation and reasonableness of treatment refusals;
- Statement addressing the requirement for monitoring, frequency of treatments/therapy, and the associated operational assignment limitation;
- Informed opinion as to the member's ability to meet medical retention standards: that is, why the disability prevents the member from performing duties. Failure to perform the PRT is not sufficient reason to determine inability to perform duties.[54] Under no circumstances is the medical board summary to indicate the member is unfit or recommend a disability rating. The medical board should 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 performance of duties because the member does not meet medical retention standards as described in Manual of the Medical Department, Chapter 15, based on the above findings..." [Ref. 33]
- For diagnosis unsupported with objective medical evidence, such as headaches, include documentation to support impact of impairment (i.e., amount of work missed, SIQ chits, emergency room visits);
- LODD and NMA's when appropriate;
- Statement of member;
- Performance evaluations supplied by CHNAVPERS.

[54] See definition for retention standards in List V-A of this chapter.

Findings of the RRP are reached by a majority vote and are recorded in summary form and attached to the record. The preliminary findings are be to determine that the member is Fit or Unfit for Duty because of the physical disability. If the finding is "fit," then the RRP evaluation is complete. If the finding is "unfit," then the panel must further conclude if the disability (a) was incurred or aggravated while in receipt of basic pay, (b) was the result of intentional misconduct or incurred during unauthorized absence, (c) has stabilized, (d) is ratable and at what percentage, and (e) is combat-related. The preliminary findings are signed by the President, PEB and a Findings Letter is hand delivered or mailed to the member to serve as notification of the findings and to provide the member with their options. The findings are considered final at this point if the member accepts Fit for Duty findings or waives the right to a Hearing Panel for a finding of Unfit for Duty. If the member does not respond to the Findings Letter within 15 days of receipt of the letter, then acceptance of findings is presumed.

b. Hearing Panel

Title 10 U.S.C. Section 1214 requires that service members are provided at least one opportunity for a full and fair hearing when being separated or retired with a physical disability. This requirement is met by the Formal PEB, the Hearing Panel (HP). Personnel determined unfit by the RRP have the right to go before a Hearing Panel. Since a finding of "fit" does not result in an involuntary separation or retirement, the member is not entitled to a hearing. In such cases, the member may request a hearing, and the decision to grant the request lies with the DNCPB. Generally, the DNCPB directs or grants requests for a hearing only if there is a legitimate concern of error or

injustice. When members exercise their right to a hearing or when granted by the DNCPB, a Hearing Panel is conducted. The Hearing Panel may advise the member of its conclusion at the end of the hearing session before the President, PEB issues the final determination in a Findings Letter. At the Hearing Panel, the member is entitled to address any issue affecting their benefits, and they are encouraged to submit a rebuttal identifying the issues of disagreement with the RRP's findings and recommendations. [Ref. 33] Disagreement with PEB opinion on combat-relatedness/taxability only is not grounds for the right to a HP. That does not affect the ultimate disposition of the case and therefore does not prevent finality. These issues are resolved by requesting an opinion from the JAG. Accordingly such cases are treated as acceptance of findings. [Ref. 7]

The member has the opportunity to present additional information to support their case. This includes providing witnesses, depositions, documents, sworn affidavits, unsworn statements, and or other evidence in their behalf. The proceedings in a formal hearing are non-adversarial and formal rules of evidence do not apply. The members of the Hearing Panel are tasked with determining fitness and eligibility for disability benefits while considering the interests of both the individual and government. Once the HP is convened, the findings of the RRP are voided. Consequently, the previous findings are of no precedential value to the panel or the member, and the member could actually have his/her disability percentage rating decreased. When the testimony presented at the hearing indicates that the member claims disabilities not disclosed by the official medical records, or presents evidence sharply in conflict with

official medical records, and the discrepancy cannot be readily resolved by the actual observation of the panel, the HP will be adjourned until further clinical examinations or studies can be completed.

The composition of the HP is the same as that of an RRP. Qualifications for alternate members are also similar except those alternate members must observe at least one full hearing before actually sitting as panel members. In addition, each panel is assigned at least two judge advocates to act as counsel for the member, and a judge advocate may be assigned as counsel for the panel. [Ref. 7]

Findings of the HP are reached by a majority vote of panel members, signed by the Presiding Officer and then referred to the President, PEB for review and issuance to the member. The panel considers the following information in determining a finding:

- Physical evidence presented;
- Statements of the member, member's counsel, and/or witness testimony;
- Medical board reports and required accompanying documents;
- LODD and NMA's;
- Statements of service;
- Special consultation reports;
- Performance evaluations provided by CHNAVPERS;

The Hearing Panel determines if the member is Fit or Unfit and further classifies the disability in the same manner as the RRP. Typically members that

personally appear before a hearing panel are notified verbally of the panel's findings, or by the member's counsel, before leaving the site. Before the findings and the panel's rationale are signed by the President, PEB and issued to the member, the HP's findings are automatically reviewed for legal errors. Upon receipt of the final PEB findings in a Findings Letter signed by the President, PEB, the member has 15 days to either unconditionally accept, conditionally accept, or request a Petition for Relief (PFR). Acceptance will be assumed 15 days after the member is notified. BUPERS is notified of the final findings and member's disposition by means of a Notification of Decision Letter and can have the member processed for discharge within 20 days. If the member intends to petition the DNCPB for relief of final action, he/she should submit the PFR immediately because, once BUPERS has begun processing a member for separation or retirement, the member will need to appeal to the Board for Correction of Naval Records. [Refs. 7 and 33]

Currently, hearings are held at two sites: NMC San Diego and NNMC Bethesda. Members are issued Temporary Additional Duty (TEMADD) orders by their parent command to appear in person at one of the hearing sites, as determined by the Joint Federal Travel Regulations (JFTR). Restrictions in the JFTR prevent sending a member authorized to attend a hearing at one site to the other site even though doing so would expedite the hearing process. Consequently, if a sailor assigned to the Portsmouth, Virginia area requests a formal hearing and there are delays at the hearing site at NNMC Bethesda, the member is not authorized TEMADD orders to NMC San Diego. Members have the right to waive their personal appearance before a Hearing Panel, in which case

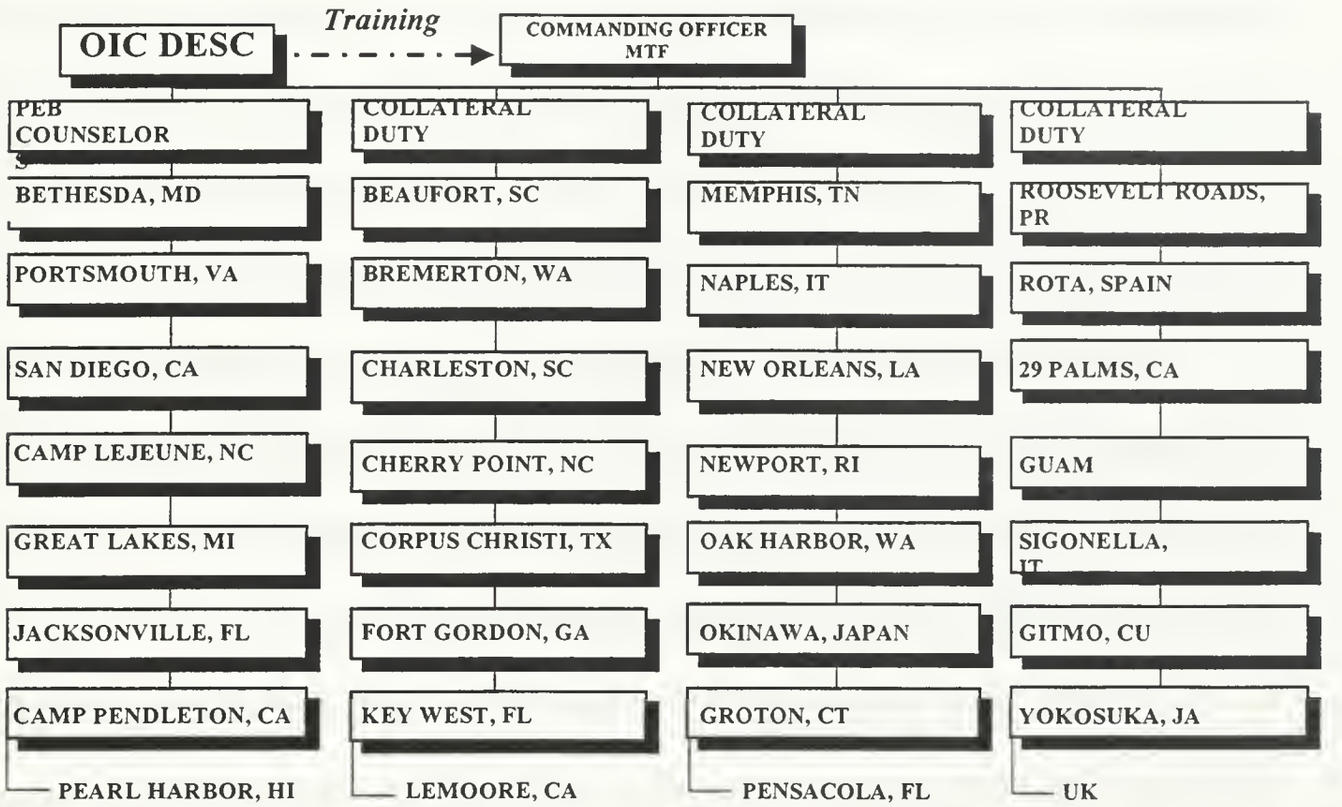
the member must be represented by Counsel. The member also has the right to appear by means of video teleconferencing. The date for a formal hearing is to be scheduled by a Hearing Panel administrator within 30 days of receiving the referred case, and the goal for concluding the hearing is within 45 days following receipt of the case at the hearing site. [Ref. 7] Findings of the PEB are final upon issuance by the President, PEB and when found unfit by the RRP and a hearing is waived. The findings cannot be changed, set aside, or reopened, except for correction of error by means of a PFR. Petitions for Relief of final action are requested or directed through the DNCPB.

3. Counseling

The counseling element of the DES affords the member the opportunity to be advised of the significance and consequences of the determinations made by the PEB, and the associated rights, benefits, and entitlements. [Ref. 33] Specifically, the counselors discuss the sequence and nature of the steps in the DES process; statutory and regulatory rights; effect of findings and recommendations; recourse to rebuttals, estimated retired or severance pay based on the PEB's findings and recommendations; probable retired grade; potential veteran benefits, post-retirement insurance programs and the Survivor Benefit Plan; applicable transition benefits; and, prior to acting on the member's request for a formal hearing, review the applicable VASRD standard which would have to be recognized in order to increase the percentage of disability rating.

Counselors for members undergoing case processing in the DES are either assigned to the DES and work directly for the OIC, Disability Evaluation System Counselors, or they are personnel assigned to the Medical Board Department of an MTF

and perform in the role of counselor as a collateral duty. Counselors assigned to the DES are located at one of the eight MTF's which provide the majority of the cases referred to the PEB and which warrant a full-time counselor. The collateral duty counselors are located at the remaining 24 MTFs. Figure 22 shows the MTFs and the corresponding



Source: DES Brief, October 1997.

Figure 22. DES Counselor

type of counselor assigned. [Refs. 7 and 16] Counselor training for DES and collateral duty counselors are provided by annual conference training and a Counselor's Manual. The DNCPB is responsible for conducting the training, and the MTF to which the counselors are assigned, is responsible for funding the travel. [Ref. 7]

4. Final Disposition of Members

Generally, members found unfit by the PEB will be retired, if eligible for retirement, or if not eligible, separated.[55] Unfit members who receive a disposition of separation for a physical disability with 15 but less than 20 years of active service are afforded the opportunity to elect separation or request a non-disability retirement under the Temporary Early Retirement Authority (TERA) during the period beginning October 1993 and ending October 1999. The same opportunity is afforded to members recommended for placement on or separation from the TDRL. [Ref. 33]

When the member has at least 20 years of service or the disability rating is at least 30 percent under the VASRD the member is assigned a disability retirement. If the condition is stable and permanent, the member is assigned to the PDRL; if the condition is not stable and permanent, the member is assigned to the TDRL.

Stability of the medical condition is not a factor for the disposition of separation with disability severance pay. An unfit member with a compensable disability is separated when the member has less than 20 years of service and the disability is rated at less than 30 percent, to include 0 percent.[56] [Ref. 33]

Members who are found unfit for a disability incurred as a result of intentional misconduct, willful neglect, or during a period of unauthorized absence are not entitled to

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[55] An exception is unfit members approved for PLD. Disciplinary and administrative separations are not held in abeyance of PEB proceedings.

[56] Members with less than six months of active duty service do not receive disability severance pay.

disability benefits. Additionally, if the disability existed prior to service and was not permanently aggravated by service, the disability is not compensable.[57] [Ref. 33]

Members that are found Fit for Duty are either returned to duty in their previous rating or, if necessary and feasible, reclassified to a different rating. The finding of Fit for Duty does not necessarily mean the member can be immediately deployed or assigned OCONUS. The medical standards for retention have precedence over the medical standards for deployability and worldwide assignability. This is further discussed in Section J pertaining to the determination of fitness.

E. PETITION FOR RELIEF (PFR) WITHIN THE DES

When the final findings of the PEB have been issued, or a member has been verbally advised of a Hearing Panel's findings, members who have not been discharged or separated may petition the DNCPB for relief of final action.[58] A request to petition for relief (PFR) is a nonautomatic appeal procedure authorized by SECNAV Instruction 1850.4C. If the member has already been separated or permanently retired he/she will need to petition the BCNR for relief of final action.[59] The only reasons that support petitioning the DNCPB or the BCNR are: (a) new discovered evidence that is not merely

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[57] Members with six months or less than 20 years of active duty service not entitled to disability compensation are still entitled to separation pay due to an involuntary discharge. [Ref. 33]

[58] TDRL personnel may also PFR.

[59] The BCNR does not have a medical review section so the cases are sent back to the RRP to answer specific questions regarding the previous determination, such as if any necessary consults were omitted that may have affected the disability rating determination. [Ref. 36]

cumulative or corroborative, and would have warranted a different finding; (b) fraud, misrepresentation, or other misconduct of such a nature that its absence would have warranted a different finding; or (c) a mistake of law. The only requirement for the petition's format is that it must be in writing. [Ref. 7] Members are allowed 15 days upon receipt of a Findings Letter after a Hearing Panel to file the PFR. The member's name will not be sent to BUPERS for processing if he/she files a PFR before 15 days. However, since BUPERS could have the member separated within 20 days of the date the President, PEB issues the Notification of Findings Letter, members should file the PFR immediately after being verbally informed of the HP's findings. [Ref. 7] The determination is final upon issuance of findings by the DNCPB. The DCNPB will make a determination on each PFR based on the merits of the case, and will advise the member by certified mail, with copies sent to the President, PEB and CHNAVPERS. Figure 23 shows the case flow through the entire process, including PFR.

F. TIME STANDARDS FOR CASE PROCESSING

The DOD Instruction 1332.38 states that it is not within the mission of the Military Departments to retain members on active duty to provide prolonged, definitive medical care when it is not probable the member will return to full military duty. Therefore members should be referred into the DES as soon that probability is ascertained. The DOD Directive further states that members "shall be referred for evaluation within one year of the diagnosis of their medical condition if they are unable to return to duty." Once a physician initiates a medical board, the processing time should

not exceed 30 days from the date the medical board report is dictated to the date it is received by the PEB. This period of time includes the time allowed to obtain all required accompanying documents, such as the LODD and NMA. [Ref. 33] According to the SECNAV Instruction on the DES, the final decision based on the RRP's finding should be issued by the President, PEB within 45 days, and the final decision based on the formal hearing should be issued within 90 days. This is in conflict with the DOD Directive 1332.38, which states the processing time to the date of final determination should be no more than 40 days. The standards for case processing cited by the President, PEB are consistent with the SECNAV Instruction. [Ref. 36] The final reply to a PFR should be issued within 45 days of receipt of the PFR request. These time standards suggest a case should be processed through the level of a PFR within five months, including the 15 days allowed for the member to respond to findings from the RRP and the HP. When a formal hearing is scheduled, an appointment should be scheduled within 30 days and the hearing process completed within 45 days.

G. PROCESSING IMMINENT DEATH CASES

When it is determined that a member's death is expected within 72 hours, the member may be expeditiously referred and processed through the DES. However, even in these cases if the member is a flag or medical officer, then higher authority approval is necessary. To protect the interest of the Service and the member, the member is placed on the TDRL in the event the medical condition improves and death is no longer imminent. The member cannot be retired after death or before completion of a required

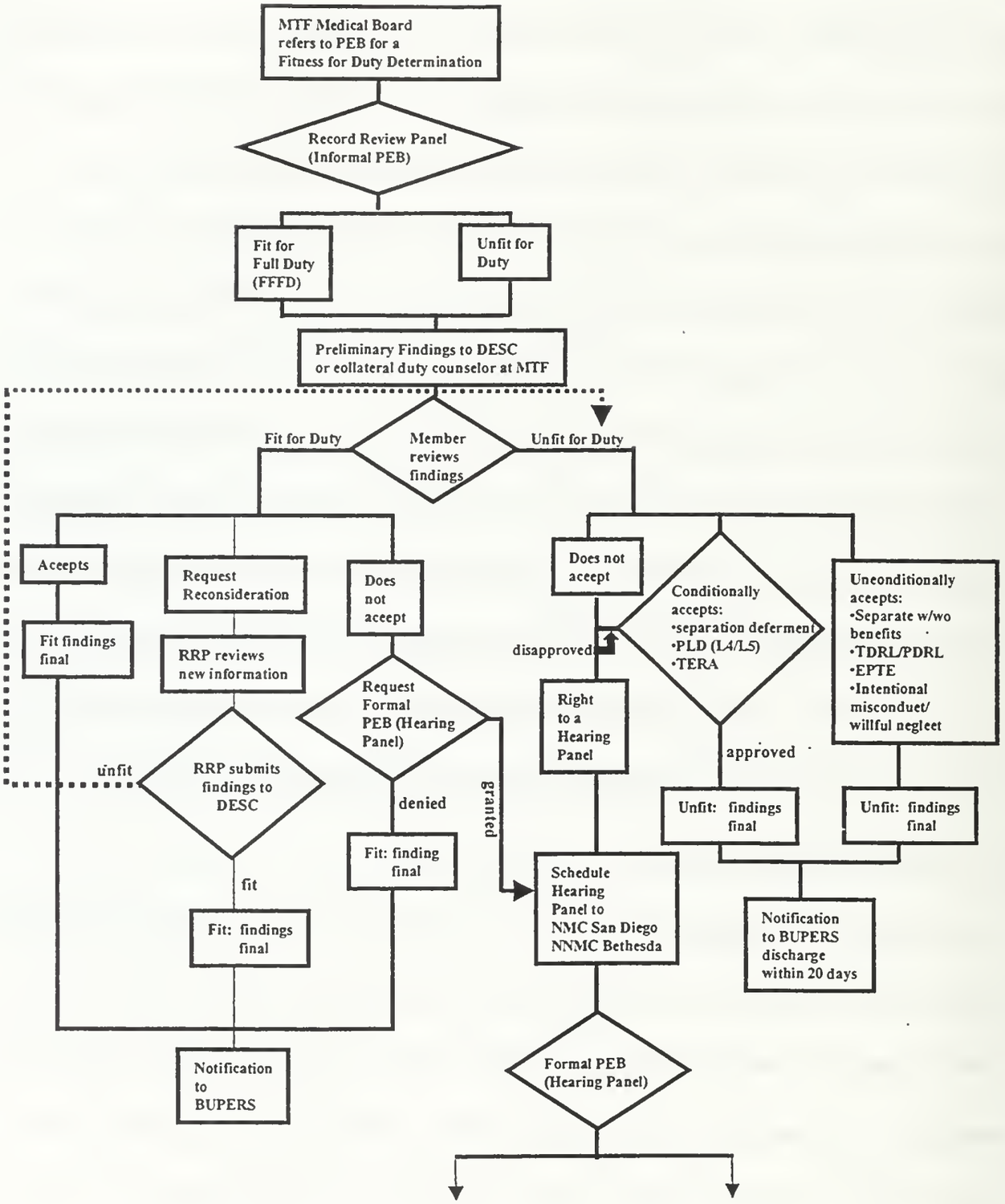

Figure 23a. DES Process

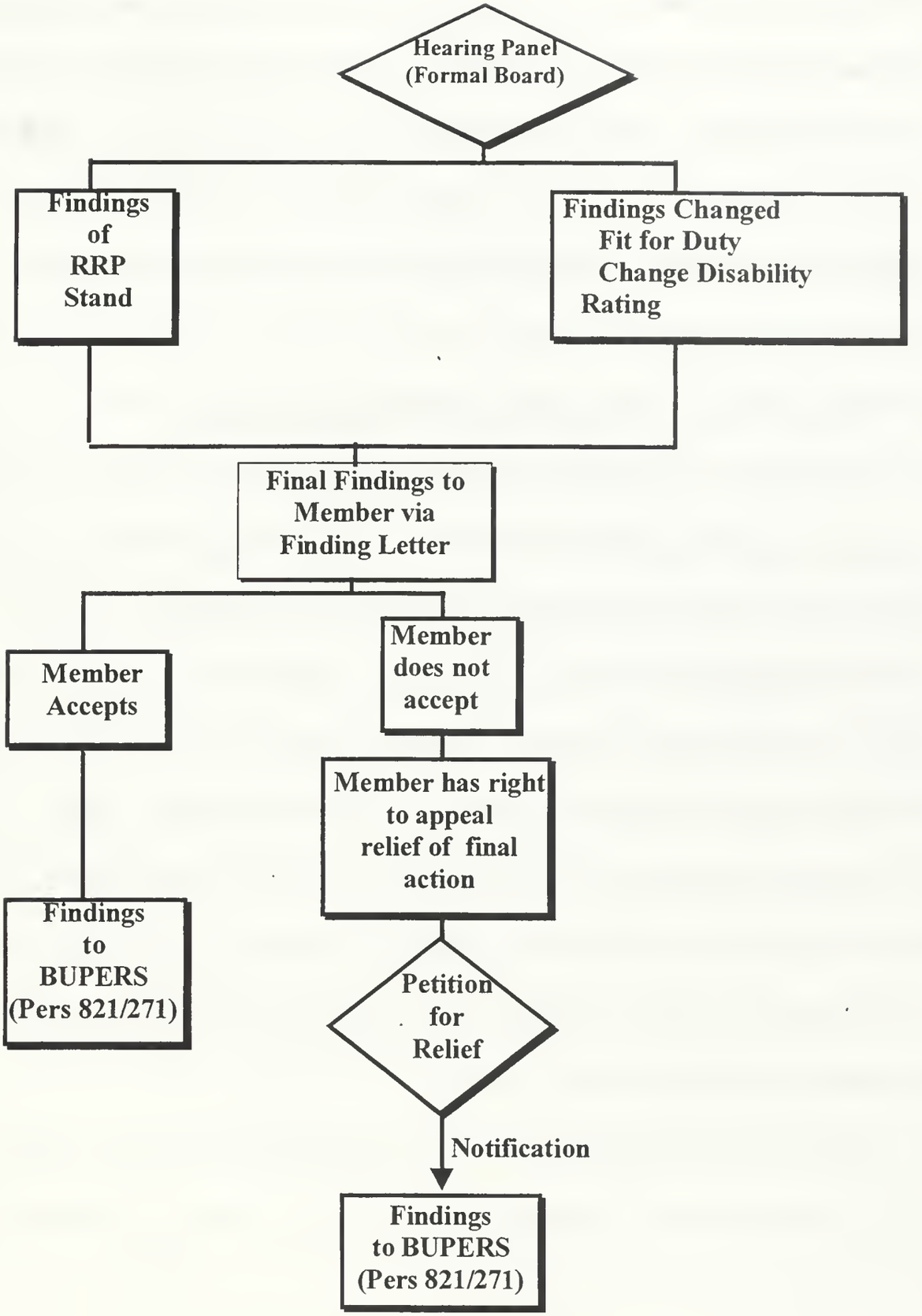

Figure 23b. DES Process (Continued)

LODD. [Ref. 33] There are several issues surrounding delays in processing Imminent Death cases that have resulted in death before a determination and disposition was made. It is very difficult to process these cases on a 24-hour basis because of all the entities involved, yet that is what is needed to ensure expeditious processing. These issues are currently under review by the DNCPB, President, PEB, BUMED, and CHNAVPERS, but are beyond the scope of this thesis.

H. LINE OF DUTY DETERMINATION REQUIREMENTS

Line of Duty Determinations (LODD) assist the PEB in meeting the statutory requirements under Chapter 61 of Title 10 U.S.C, and Chapter II of the JAGMAN requires LODD for injuries which may result in permanent disabilities. A medical board CA referring a case for a PEB is to include a copy of the LODD with the medical board report. The MTF requests cognizant commands to send LODD's with endorsement by the GCMCA within 10 days of receipt of the request.[60] The request should be no later than the date the medical board is convened. When the member's command at the time of injury is unknown, the individual is incapable of conducting a proper investigation, or if the investigation is unduly delayed or not being conducted, the medical board CA can request assistance from the GCMCA. [Ref. 7]

The JAGMAN authorizes use of the "Injury Report" (NAVJAG 5800/15) for reporting LODDs when the medical officer and the member's commanding officer concur

[60] The GCMCA endorsement is a change from the methods MTFs used in the past to request LODDs.

that the injury was incurred "in the line of duty and not as a result of the member's own misconduct." Any injury incurred by a member while operating a motor vehicle with a Blood Alcohol Concentration of 0.1 percent or greater requires a full investigation [Ref. 7]

The laws and regulations governing the DES entitle members to receive disability retirement or separation benefits for a disabling condition rendering the member unfit for duty if the condition was incurred or aggravated while entitled to basic pay. However, if the physical disability resulted from the member's own misconduct or during a period of unauthorized absence, the member is not entitled to these benefits. [Ref. 7]

Normally, the PEB accepts the command LODD with a GCMCA endorsement as binding. However, with reasonable cause the PEB can challenge the credibility of the LODD's determination. The case is forwarded to the DNCPB via the President, PEB for a review of the LODD determination. During this review the case is conditionally adjudicated as though the injury did not occur due to misconduct. The case is not considered final until the review is complete. The DNCPB's decision regarding the LODD determination is final and is not subject to appeal by higher authority. [Ref. 7]

When a LODD is required, it needs to be accomplished before forwarding a case to the PEB. A LODD is presumed to be in the line of duty without an investigation in the following cases:

- Disease;
- Injuries incurred as result of enemy attack;

- Injuries while a passenger in common commercial or military carriers.

At a minimum, LODD are required when:

- The injury, disease, or medical condition occurs under doubtful circumstances such that it may be due to member's intentional misconduct or willful negligence, or incurred during unauthorized absence;

- The injury involves the abuse of alcohol or other drugs;

- The injury is self-inflicted.

The medical board CA can forward a case for a PEB without a required LODD when:

1. The date of injury is more than 2 years prior to the date of the medical board. The board can presume a finding of "in line of duty and not due to member's own misconduct." The PEB should continue to process the case without further efforts to obtain the LODD;

2. The date of injury is less than two years from the date of the medical board and:

- The medical board CA has requested a Line of Duty Investigation (LODI) but the LODD with the GCMCA is not yet completed. The case can be forwarded with a copy of the LODI;

- The medical board CA obtains a copy of a health record entry containing the LODD and includes it as part of the medical board package;

- The medical board CA obtains a statement from the cognizant GCMCA stating that a LODD is not required or could not be obtained (i.e. witnesses not available for investigation).

If the PEB receives a medical board from which does not contain a required LODD and the injury occurred less then two years from the date the board was convened, the PEB should forward the case for a legal review. If the legal reviews determine a LODD is not necessary, the PEB should process the case presuming the injury occurred

in the line of duty. Otherwise, the PEB suspends the case and tasks the MTF for action as stated in sub-paragraph two above. [Ref. 7]

I. CONTINUANCE OF UNFIT MEMBERS ON ACTIVE DUTY

Generally, service members found Unfit for Duty due to a physical disability will be separated or retired. However, members can be retained on active duty when found unfit in a Permanent Limited Duty (PLD) status if the SECNAV determines that an unfit member's service obligation, skill, or experience justifies their continuance in a limited assignment. [Ref. 33] The CHNAVPERS retains members in a PLD status on a case by case basis and the member's length of service is not supposed to be a controlling factor.[61] The PLD status is approved by CHNAVPERS for a specified period of time to meet shortages against authorized strength in an enlisted skill, competitive category, designator, or specialty, provided the member can perform required duties in an authorized billet for that skill. Members may be retained in a PLD status to complete a current tour of duty or to provide continuity in key billets pending relief and to complete service obligations for training programs.[62] Additionally, PLD can be approved at the request of the commanding officer of an MTF to allow a member to complete a current episode of treatment at a specific MTF to preserve continuity of care because the care is not available in the VA system, or because transportation to another facility is

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[61] CHNAVPERS does look favorably upon requests for voluntary retention by unfit members with 18-20 years of active duty service when such retention is in the best interest of the service and the member. [Ref. 7]

[62] SECNAV 1850 requires members be retained in PLD status to complete active duty obligation for training received unless disability precludes adequate performance in *any* billet.

contraindicated. [Refs. 7 and 33] Members who are retirement eligible are not retained on a PLD status unless their continuation is justified as being of value to the Navy. [Ref. 33]

Service members found Unfit for Duty by a PEB and who desire to continue on active duty in a PLD status submit a request to the President, PEB. The PLD status request is a condition of accepting an unfit finding, and so the member also needs to indicate if he/she will desire a hearing if the request for a PLD status is not approved. When the President, PEB receives a PLD status request before issuing the final determination the disposition action is suspended and the request is forwarded to CHNAVPERS. Any planned hearing will be delayed for 30 days from receipt of the request for continuation, unless the member had already traveled to a hearing site when the request was submitted. In this situation, the case processing continues before the HP and the PLD request can still be submitted in advance of the HP findings. The CHNAVPERS should act on PLD status requests within 20 days.

When CHNAVPERS authorizes PLD for six months or less, the President, PEB indicates the authorized PLD status in the Notification of Decision Letter and directs the appropriate separation and disability rating effective immediately after the last day of PLD. When the PLD is authorized for more than six months the President, PEB will advise that a disability separation and rating determination be deferred until the end of the PLD period, at which time the member is reevaluated at an MTF and referred for another PEB. [Ref. 7] Members are retained in the PLD status for the specified period of time unless the condition deteriorates to the point where the member can no longer perform the

duties in the limited assignment. If CHNAVPERS does not authorize the PLD status, then the President, PEB completes processing of the case.

The member continued on a PLD status will normally be found unfit at the expiration of the PLD period, unless the member's condition has improved to the extent that the member would be capable of performing his/her duties in other than a limited assignment. [Ref. 33]

Personnel retained in a PLD status are accounted for in ACC 105 and are further categorized by a limited designator, L-4 or L-5. Sailors in the L-4 and L-5 category are disqualified for all combatant vessels, or any duty which involves flying, submarines, and auxiliary vessels. The L-5 category further restricts the sailor from duty on foreign shore.[63] Generally, the management and tracking of personnel on PLD is somewhat separate from personnel on temporary limited duty (TLD), primarily because personnel on TLD are expected to return to the fleet. Personnel on TLD are usually referred to as the LIMDU population, while personnel on PLD are referred to as the L-4/L-5 population. The majority of personnel in the ACC 105 are in the LIMDU population. According to January 1998 Limited Duty Tracking Reports, there were 4,804 sailors in the LIMDU population and only 65 sailors on PLD. Trends in the L-4/L-5 population are briefly discussed in section D (1) of Chapter IV and again in section O of this chapter. However, further discussion of this category of sailors is beyond the scope of this thesis.

[63] See the definition for Limited Duty Designator in List V-A of this chapter.

J. DETERMINATION OF FITNESS AND UNFITNESS

The *sole* standard in making determinations of unfitness due to physical disability shall be unfitness to perform duties of the member's office, grade, rank, or rating because of disease or injury incurred or aggravated while entitled to basic pay. [Refs. 7 and 37] Each case is reviewed to assess the nature and degree of the disability and the extent it prevents the member from performing those duties reasonably expected of his/her grade or rating. [Ref. 7] All relevant evidence is considered by the PEB in assessing a sailor's fitness, including the NMA and adequacy of performance of duties up until the time referred for a PEB. If there is evidence the member has performed in an adequate manner until the time of the referral a member may be considered fit for duty even though medical evidence indicates questionable physical ability to perform duty. Particularly in cases of chronic illness, documentation on performance by the member's supervisor will be considered an accurate reflection of the member's ability to perform duties despite the physical disability. At the same time, inadequate performance is not evidence of unfitness due to one or more physical disabilities sufficient to require a PEB referral, unless a cause and effect relationship is established. [Ref. 33]

When the PEB determines a sailor is Fit for Duty, it does not necessarily mean the sailor will be able to deploy with a unit or a ship. A sailor convalescing from an illness or injury who is likely to recover to a degree which would permit him/her to perform all of his/her duties in the near future (even though not currently), will be considered Fit for Duty. Conversely, if the physical disability renders a member unable to perform the duties he/she would *normally* be assigned by virtue of his/her grade or rating may be

considered Unfit for Duty, even though capable of performing all duties *currently* assigned. [Ref. 7] The determination that a member can reasonably perform military duties includes consideration of the following:

1. Whether the member is unable to reasonably perform the common military tasks associated with the duties of his/her grade or rating due to the physical disability.

2. Whether the member is medically prohibited from taking the required physical fitness test. The mere inability to pass the PFT cannot be used as criteria to make a determination of unfitness.

3. The inability to qualify for specialized duties requiring a high degree of physical fitness, such as flying, diving, submarine, or those designated for hazardous duty pay will not be used as criteria to make a determination of unfitness. Where feasible, consideration to reassign or reclassify a member to a military specialty, or rating for which would be Fit for Duty, is given before processing for disability separation or retirement. [Ref. 7]

4. When a sailor's grade or rating requires deployability or the condition prevents positioning the sailor as part of a unit outside CONUS, the inability to perform their duties in every geographical location and under every conceivable circumstance, *will not* be the *sole* basis for a finding of unfit.

An important determination by the PEB is *authorized* according to DOD Instruction 1332.38: if the member is determined Fit for Duty by the RRP or the HP, the service may request that findings include a statement of whether the member is deployable. However, it can only be requested when "Service regulations require such a determination and deployability is defined and uniformly applied to the office, grade, rank, or rating in both the Active and Reserve components of that Service." [Ref. 33]

K. PRESUMPTION OF FITNESS

The statutes directing the DES are designed to ensure compensation for service members who due to a physical disability are unable to complete their military careers and who qualify for *normal retirement benefits.* Consequently, when a member continues to perform their normal duties until commencing processing for *non-disability retirement or separation,* the member will be presumed fit for duty.[64] This presumption can be overcome if: (a) a previously existing medical condition has deteriorated beyond normal progression within the last 12 months; (b) the member suffered an acute and life threatening illness or injury immediately prior to or coincidentally with processing the non-disability retirement or separation; or (c) the member was inappropriately retained on duty because he/she had been physically unable to adequately perform duties. [Ref. 16]

L. TEMPORARY DISABILITY RETIREMENT LIST (TDRL) MANAGEMENT

Service members are assigned a disposition by the PEB of Temporary Disability Retirement when the disability is not of a permanent nature and it is not stable. A disability is considered unstable when the severity of the condition will change over the next five years such that a final disability rating, or a finding of fit, cannot be determined.[65] The member is placed on the Temporary Disability Retirement List (TDRL), managed by CHNAVPERS, and returns for periodic examinations every 18

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[64] A member within 12 months of a mandatory or voluntary retirement date is presumed fit.

[65] An exception is members with an unstable condition rated at a minimum of 80 percent which is not expected to improve to less than that rating. In such cases, the member is permanently retired. [Ref. 33]

months for no more than five years. The periodic examinations are completed by an appropriate MTF and then a medical report is forwarded to the PEB within 30 days. The report will include a comprehensive physical examination identifying impairments from which the member has recovered, newly acquired impairments, and information on the condition's current stability and likelihood of significant change in the remaining statutory time. Members on TDRL will not be entitled to permanent disability retirement or separation with severance pay unless they have a current medical examination acceptable to the PEB. The TDRL member collects disability retirement pay unless they waived retired pay in order to receive compensation from the Veterans Administration. Members who fail to report to MTFs for scheduled periodic examinations can have their retired pay (or retired pay account if retired pay waived) terminated. [Ref. 33]

The PEB evaluates the medical reports of each periodic examination and takes action based on a determination of stability and/or time remaining on the TDRL:

1. The condition has not stabilized and the member is not near five years on the TDRL and the PEB does not find a change in status is warranted.
    - PEB notifies CHNAVPERS that member will remain on TDRL (until the next periodic evaluation or administrative removal);
    - The percentage rating will not be lowered or raised;
    - The member does not have the right to a Hearing Panel.
2. The condition has stabilized or the member is near five years on the TDRL
    - The case is processed like a regular case referred for a PEB, except that any determination of retirement must be a transfer to the permanent retired list;

- The final disability rating may be the same, higher, or lower. [Ref. 33]

The PEB can remove the member from the TDRL if upon evaluation of the periodic medical report it is determined that (a) the member is Fit for Duty; (b) even if the condition remains unstable, the disability is currently ratable at less than 30 percent and the member has less than 20 years of active service; or (c) maximum improvement has been achieved and the disability is considered permanent. In any case, the case must be finalized by the end of the five-year period. The member's name will also be removed from the TDRL when CHNVPERS takes the appropriate administrative action at the end of the five year period, or the member fails to report for periodic exams.

When the PEB determines that a member is Fit for Duty the TDRL status and disability retired pay is terminated and the member has the option to reenlist provided he/she is otherwise qualified to reenlist. Regardless of the condition's stability, the member can be removed from the list and separated if the disability is ratable at less than 30 percent and the member has less than 20 years of active service. Under the same circumstances, if the member has at least 6 months of active service, he/she is entitled to severance pay. If, at a periodic examination or the final determination, the disability is considered permanent, and the member has at least 20 years of active service, the member's name is removed from the list and he/she is permanently retired. The member is also retired if, under the same circumstances, the member has less than 20 years of active service, but the disability is ratable at 30 percent or more. [Ref. 7]

A recent change in TDRL management concerns the evaluation of new diagnoses presented during the period on the TDRL. The periodic examinations need to identify and evaluate all medical impairments diagnosed since the member was placed on the TDRL. [Ref. 35] When a member is determined fit for the original condition placing the member on the TDRL, but unfit for a noncompensable condition incurred while on the TDRL, the member is separated without entitlement to disability benefits. [Ref. 11] However, new diagnoses may be compensable when the condition is unfitting and: (a) directly caused by the original diagnosis or related treatment, or (b) incurred or aggravated while entitled to basic pay and if so, the condition would have been a cause for referral into the DES at the time placed on the TDRL. [Refs. 32 and 35]

M. RATINGS OF DISABILITIES UNDER THE VASRD

Disabilities that render a member physically unfit and that are compensable according to policies governing the DES are assigned a percentage rating. The VASRD 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 DOD and DVA application of rating policies for specific cases, differences in ratings may result. Unlike the DVA, the military must first determine whether a service member is fit to reasonably perform the duties of his/her grade or rating. Once it is determined that the member is not physically fit for further military service, the VASRD percentage ratings are applied to the unfitting condition, and the percentages are based on the severity of the condition. [Ref. 38] The DOD compensates

for a loss of future military earnings and the DVA determines service connection and compensates for loss of civilian earning capacity. [Ref. 16] The DOD Instruction for the application of the VASRD clarifies the differences in DOD and DVA rating polices. The details of rating policies and application to unfitting and compensable disabilities is beyond the scope of this thesis. The reader is referred to DOD Instruction 1332.39 for a further explanation of disability percentage ratings.

N. ADMINISTRATIVE PROCEDURES FOR TRACKING MEMBERS IN THE DES AND ACC-RELATED ACTIONS

The responsibilities for tracking members in the DES lies primarily with cognizant PSDs and LIMDU Coordinators at TPUs and activities with LIMDU personnel. Appropriate tracer action and ACC-related action was discussed in Chapter IV, Section B. Specific procedures pertaining to members awaiting results of a PEB while in ACC 355 or ACC 105 status are repeated here to facilitate understanding of the processes for tracking a member from the point of convening a medical board to completion of the case by a PEB (and, when indicated, the DNCPB).

Personnel enter the DES in either ACC 355, ACC 105, or ACC 100 status as previously discussed. The appropriate tracer action is submitted to the DESC, and when indicated, the DNCPB, to monitor movement through the DES and PEB process. The member's servicing PSD notifies the DESC at the MTF where the medical board originated if the results of the board have not been received after 60 days of CA signature. If there is no response from the DESC within 30 days, the DNCPB is notified. The CHNAVPERS should have a member processed for discharged within 20 days of

receiving the Notification of Decision Letter. Tracer action is submitted after 30 days from the date of unconditional acceptance of the preliminary findings (if retirement/ separation authority has not been received).

The member is in ACC 355 status while a medical board is in progress to refer him/her to the PEB. Upon completion of the medical board the member is transferred to the nearest TPU/Other activity and remains in ACC 355 pending final PEB action. Members on LIMDU and subsequently referred to a PEB stay in ACC 105 pending final PEB action. Members assigned to shore commands (not assigned to temporary limited duty) stay in ACC 100 pending final PEB action. When the member is in ACC 355,105, or 100 there are several outcomes. If the member unconditionally accepts the findings of the PEB and the request for Home Awaiting Orders is approved, the servicing PSD (for the TPU/Other activity or LIMDU assignment activity) changes the ACC to 381. If the final actions of the PEB is separation or retirement, then the servicing PSD changes the ACC to 380. If the PEB finding is Fit for Duty, then upon processing by CHNAVPERS, the servicing PSD changes the ACC to 320 and submits an availability report to effect the change to ACC 100.[66] If the member is discharged due to an EPTE physical disability, the servicing PSD changes the ACC to 380 and effects discharge within 7 days.

O. FINDINGS

1. DES Population

a. According to interviews with Patient Administration at BUMED, Healthcare Operations and the Executive Assistant, PEB, the majority of cases referred to

[66] Members already in ACC 100 the change to 320 is dependent on the member's PRD.

the DES for a PEB are in a LIMDU status. In these typical cases the initial medical board assigns the member to temporary limited duty and the determination at the LIMDU reevaluation is that optimal medical treatment has been obtained yet the member's fitness remains questionable, so the case is referred to the PEB. The CNA study (Garcia and Gasch, September, 1996) suggested that members referred to the PEB typically had been on LIMDU for approximately eight months. The problem of tracking an accurate change in the ACC raises questions about the reliability of that LIMDU duration and the JDTS does not have a field to track LIMDU history. However, it is reasonable to state that the majority of members referred for a PEB have been in LIMDU for a period of at least six months because administrators at the PEB encourage the assignment of TLD before a referral.[67] Temporary limited duty is encouraged because the PEB makes a fitness determination based on the member's *current* condition. Consequently, if the evaluating physician feels that the member will likely return to duty after a reasonable convalescent or rehabilitation period, a PEB referral is not necessary.

b. Given the assumption that the majority of personnel undergoing a PEB are in a LIMDU status, then it follows that the majority will be in ACC 105 (Limited Duty) until the case is finalized and the member is either processed to return to duty, or discharged from naval service.[68] If they were assigned to a shore command, members on LIMDU will be in ACC 100 until findings are finalized.

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[67] The initial period of temporary limited duty is assigned for six months.

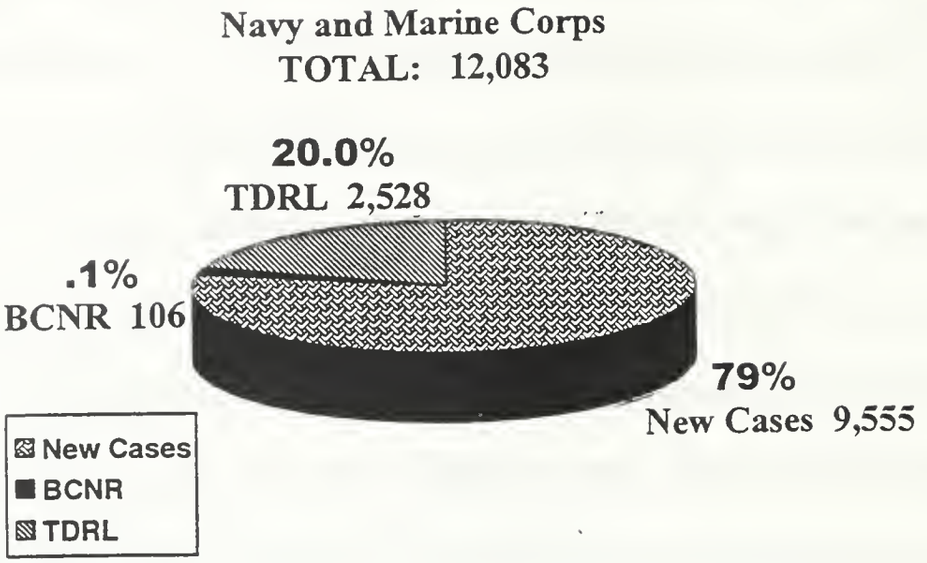
[68] The ACC will not change until the member has accepted findings issued in the Findings Letter or findings have been issued from the DNCPB.

c. Data were not available to identify the proportion of personnel who are in ACC 355 (Pending results of a medical board/PEB) are awaiting final action of a PEB because the initial medical board referred the case into the DES. Some personnel in ACC 355 are awaiting results of a TLD medical board. Given the previous assumption, the number of personnel remaining in ACC 355 until final action of the PEB is probably small relative to the number pending action from the MTF Convening Authority or Department Review (Pers-821/271) regarding a TLD medical board. Again, members assigned to shore commands and referred to the PEB upon the initial medical board, will be in ACC 100 pending final PEB findings.

d. We were unable to determine the actual ACC status of members in the DES and PEB process (i.e., ACC 105, ACC 100, or ACC 355).

e. There were 12,083 cases received by the PEB in FY 97. This includes Navy and Marine Corps active duty, Reservists, and TDRL cases. Figure 24 shows the number of new cases received compared to the number of TDRL periodic evaluations and BCNR cases reviewed by the RRP. A comparison of total cases received in FY 97 with FY 95 shows a decrease of 2,044 cases: The total number of cases received in FY 96 was 13,793, and the total received in FY 95 was 14,127.

f. NMC Portsmouth submitted the greatest number of active duty cases (Navy and Marine Corps) for fiscal years 94 -97, followed by NMC San Diego, then NH Camp Lejune. The NNMC Bethesda, NH Jackonsville, and NH Camp Pendleton varied as the fourth and fifth ranking MTF. [Ref. 39]



Source: DES Brief, October 1997.

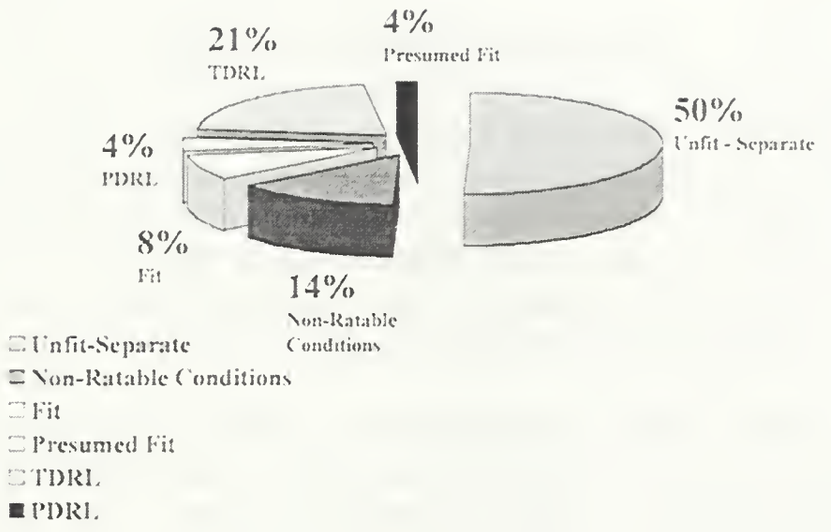
Figure 24. PEB Cases Received (FY 97)

2. Case Dispositions

a. The dispositions of the new Navy cases for FY 97 is shown in Figure 25, and 75 percent were found unfit. The largest percentage of dispositions are separations, but the TDRL disposition represents a relatively significant proportion at 21 percent. The non-ratable conditions due to EPTE is approximately 5 percent. [Ref. 16]

b. The number of personnel in a PLD status in January 1998 was 65 and the total has been decreasing since December 1994. Figure 16 from Chapter IV showed the trend in the PLD population over the period of May 1991 to January 1998.

Total New Cases: 9,555
USMC - 39%
USN - 61%



Source: DES Brief, October 1997.

Figure 25. USN - New PEB Case Dispositions (FY 97)

c. Administrators of the PEB assert that the requests for PLD have decreased due to the availability of the TERA option for those with 15 -20 years of active duty service. The most recent PLD authorizations have been for those within two years of retirement eligibility. [Ref. 16]

d. Personnel who are retirement eligible are not supposed to be retained on PLD unless it is in the best interest of the Navy. As of January 1998, 23 percent of the PLD population had 20 or more years of active duty service. Despite the option for TERA, 71 percent had between 15 and 20 years of active duty service. [Ref. 3]

e. The President, PEB may authorize up to 90 days PLD for Navy service members. This option is used to decrease the incentive to request a Hearing Panel

because of a desire to remain on active duty a little longer, largely to attend to personnel matters. [Ref. 16]

3. Case Processing Delays

a. Case Suspensions and Terminations

(i) In FY 97, approximately 25 percent of cases were suspended and only two percent were terminated. [Ref. 36] This is an improvement over recent years: The number of cases terminated in FY 95 and FY 96 was six percent and three percent, respectively, of the total cases received. [Ref. 40]

(ii) The PEB will suspend a case while it awaits additional information or documents from the MTF. The MTF has 10 days to respond to the request. After 10 days the President, PEB can terminate the case, in which case a new medical board will need to be submitted to refer the case again. The President, PEB typically extends the 10 day suspension period if the MTF provides reasonable assurance the requested information will arrive in no more than 10 additional days. [Refs. 16 and 36]

(iii) The most common reasons cited for case suspension and termination are missing LODDs, NMAs, essential clinical information, and to a lesser extent, incomplete physicals. [Refs. 16, 20, and 41]

(iv) The MTF's state that more assistance from the PEB's legal support is necessary to obtain required LODD's from the member's command. [Refs. 18, 26, and 27] The MTF is expected to make three attempts to obtain the LODD before the medical board can be sent to the PEB without it. [Ref. 18] The LODI and LODD should be initiated immediately upon the injury; however, MTF's observe that some commands are not initiating the LODI and LODD until requested by the MTF upon convening a medical board for a PEB referral. This causes delays when the MTF is trying to obtain an LODD and the unit has deployed. [Ref. 20]

(v) If the member has a temporary limited duty medical board rather than immediately referred for a PEB, an LODD is

not required. If later (at a LIMDU reevaluation) the case is referred for a PEB, the case should not be sent to the PEB until the LODD is obtained. If the case is forwarded upon Department Review without an LODD the case will be suspended or possibly terminated until the MTF can obtain the LODD.

(vi) At times LODIs are forwarded to the physician specialist, instead of the physician who initially evaluated the member for the injury (emergency room, sick call, or primary care physician), to answer medical related questions. Additionally, information needed for the physician to answer the questions has not always been adequately provided by the command. [Refs. 24 and 25]

(vii) The NMA is a new requirement for a PEB and is also a difficult document to obtain from the member's command. If a unit is deployed, it is not uncommon for the MTF to wait several weeks for a response. [Refs. 18, 26, and 27]

(viii) The delays caused by not requesting a NMA for a member on LIMDU until he/she is referred for a PEB is the same as those noted for the LODD. Additionally, at times the NMA is requested from the commanding officer of the TPU or the member's LIMDU assignment activity. The intent of the NMA is to assess to a member's ability to perform their *normal* duties and the impact of the disability on *deployability*. Accordingly, the member's former unit commander should complete the NMA. [Refs. 10 and 37] Delays associated with requesting a NMA from the former unit commander when the member has been on LIMDU for awhile are similar to those requested of deployed units. [Refs. 18 and 27]

(ix) NMC Portsmouth and NNMC Bethesda send guidelines for completing the NMA when the MTFs message the request and state this action has improved response time. [Refs.18 and 27]

(x) The MTF's claim that the PEB continually task them with requests for additional clinical information (addenda). Depending on the nature and number of requests, it can be as time consuming as processing a medical board, and

hence unreasonable to expect a response in 10 days. [Refs. 18, 26, and 27]

b. Hearing Panel Delays

(i) Once the case has been accepted by the President, PEB, the most significant factor in case processing delays is the wait for a Hearing Panel date. A two-four month delay to receive a hearing date at the NNMC Bethesda hearing site is common. The hearing site at NMC San Diego also experiences delays, but not as frequently or as lengthy. The greatest number of active duty cases come from NMC Portsmouth and due to restrictions on authorized travel in the JFTR, if a hearing is granted, the case must go before a Hearing Panel at NNMC Bethesda. The case cannot be forwarded to the hearing site in NMC San Diego even if no scheduling delays exist. [Refs. 36 and 42]

(ii) Case processing can extend to 180 days if the case goes for a Hearing Panel due to waits at hearing sites. [Ref. 16]

(iii) In FY 97 1,028 cases went to the hearing site at NNMC Bethesda and 510 to the hearing site at NMC San Diego. This represents 12 percent of the 12.083 total cases received. The trend remained virtually unchanged from FY 95 and FY 96.

c. Case Processing Time

(i) There has not been a significant delay at the RRP for the last 12 months. Cases are reviewed and findings determined within approximately 11 days. Members assigned to the PEB believe this trend is due largely to a fall in the number of cases received over the last year. The average processing time (including member response time) is 37 days. This is within the policy time parameters of 45 days. [Ref. 36]

(ii) The Executive Assistant, PEB claims that approximately 85 percent of the total cases received are accepted at the level of the Informal PEB (RRP) over the period of FY 95-97. [Refs. 36 and 40]

(iii) A small proportion of cases are granted a "Petition for Relief". In FY 97 only 10 requests were granted, representing 0.1 percent of the total case received. This is a decrease from FY 95 and FY 96, where the PFR requests were 1 percent and 1.2 percent of total cases received, respectively. [Refs. 36 and 40]

(iv) The average time to process a case for a PFR is 21 days. [Refs. 36 and 40]

(v) All cases receive a Quality Assurance review to verify compliance with policy and procedure such as ensuring a member with less than 20 years of active duty service is not assigned a disposition of TDRL. Approximately 25 percent of cases require a legal review. [Ref. 36]

(vi) The President, PEB is requesting separation authority to expedite final disposition and discharge. This may be applied only to Death Imminent cases. The change is being requested in the SECNAV Instruction 1850.4C revision. [Ref. 36]

(vii) The submission of tracer action allows 2 months for a PEB finding to be received at the cognizant PSD. This facilitates tracking of cases that may be delayed due to suspensions; however, if a case is referred for a hearing, it is not likely a finding would be sent within 60 days.

4. Training Issues

(i) Little training is provided to physicians who refer members for a PEB on the mission and objectives of the PEB, or requirements for medical board documentation. The only evidence of training for physicians performing medical boards on members referred to the DES is a periodic two-hour DES Seminar offered at selected MTFs by the President, PEB, Executive Assistant, PEB, Recorder, PEB, and a medical officer for the RRP. The DES Seminar presented at NMC San Diego in October 1997 was sparsely attended by medical officers. The MTFs and BUMED deny any current structured training programs are in place to ensure compliance with DOD and SECNAV guidance on training of physicians referring cases for a PEB.

(ii) According to DOD Instruction 1332.38, physicians who prepare medical boards for referral into the DES are encouraged to use the Department of Veterans Administration (DVA) Physician Guide for Disability Evaluation Examinations to describe the nature and degree of severity of the member's condition. It appears this does not happen. The MTFs, physicians, and PEB staff interviewed, claim they had not seen or used the guide. Further, the PEB is required to assess a member's status based on the VASRD. Thus, DOD Instruction 1332.39 states that it is imperative that the medical board: (a) quantify the contribution of each medical condition to the overall work related impairment manifested by the service member, and (b) use diagnostic terminology which correlates with the VASRD. Currently, physicians do not receive training on the VASRD. The DES Seminar at NMC San Diego did not include any information specific to the DVA Physician Guide or the VASRD.

(iii) Medical officers assigned to the RRP prefer that physicians preparing medical boards for the PEB do not use terminology specific to rating criteria or quantify a medical condition in terms of a disability rating. The concern is that physicians may inadvertently, or intentionally, bias the medical board in favor of a disability rating or disposition they would like to see the member assigned. [Refs. 16 and 42]

(iv) The President, PEB is evaluating the need and feasibility of addressing medical corps officers at the Staff Corps Indoctrination Course, New Port, Rhode Island. [Ref. 36]

(v) Due to the training requirements, utilizing alternative members for the Hearing Panel is not viewed as a very practical option. Designated alternate members rarely observe a Hearing Panel or receive training on the VASRD and PEB process. [Refs. 36 and 42]

(vi) There is no structured training for line command Executive Officers on the mission, objectives, and requirements of the PEB, especially regarding the importance of timely submissions of LODDs and NMAs.

(vii) Training for counselors is conducted annually by the OIC, Disability Evaluation System Counselors. This appears to be the only structured and consistently available training for members involved in the DES process.

5. Issues of Fitness

(i) Some members found Fit for Duty by the PEB are not currently deployable and are restricted to nondeploying commands. A statement regarding the deployability status of a member found fit is not required by the SECNAV, and the PEB does not provide it as part of its finding. [Ref. 36]

(ii) A finding of Fit for Duty when the member cannot receive orders to a ship or other deploying unit has received a significant amount of criticism from Pers-405C, TMU, and line commanders. Pers-405C may issue the member orders for an assignment he/she cannot accept. At times this is not discovered until a failed Sea Duty Screen. Line commanders are concerned that nondeployable personnel are causing manning shortages in the fleet and impacting deployability requirements. [Refs. 2, 10, 20, 42, and 43] Additionally, this issue affects the MTF workload if a medical board previously referred the member for a PEB due to questionable fitness, and the member is recycled back to the MTF for another medical board because of a failed Sea Duty Screen, or because the command discovers the member is not deployable.

(iii) We were unable to identify data indicating the number of Fit for Duty findings that warranted a statement regarding limitations on deployability, or how many members actually could not accept sea/deployable unit assignments immediately after a fit finding.

(iv) The proportion of Fit for Duty findings that subsequently fail a Sea Duty Screen is small, but it still results in a significant impact on the fleet's perception of the PEB process. [Ref. 10]

6. Important Recent Changes to DES Policy Effective May 1997

(i) A complete physical examination is required for all PEB cases. A physical examination is current for a period of five years and can be submitted in fulfillment of the physical examination requirement. A physical examination requires different scheduling methods at the MTF. An additional appointment is necessary because physical examinations are not done by the specialist physician performing the medical board. Consequently, the exam adds time to the medical board process. Cases suspended due to missing physical examinations should decrease as the new requirement is integrated into MTF procedure. [Refs. 16 and 18]

(ii) The NMA is a recent requirement and currently not all commands are familiar with the tasking and the type of information necessary. [Ref. 16]

(iii) Conditions that EPTE must be aggravated by military service to qualify as a ratable disability. Until knowledge of this policy is well disseminated, the PEB may receive some unnecessary referrals from the MTF and Department Review (Pers-821/271).

(iv) Periodic examination for members on the TDRL now address all medical impairments since assignment to the TDRL. Although including new diagnosis will not effect processing time of a PEB case, it will increase the MTF workload because it may take more than one appointment to adequately address new complaints. The inclusion of a new diagnosis also may affect the member's subsequent disposition. [Ref. 16]

(v) Service member's diagnosed as HIV positive are no longer automatically assigned a 30 percent disability. It is now based on the degree of HIV symptoms. A separate HIV board is normally convened, but, that program is currently on hold pending the clarification of policy guidelines. [Ref. 16]

7. Counselors

(i) The counselors assigned to the OIC, DESC are at eight MTF's that account for approximately 80 percent of the PEB caseload. However, they are not tasked to screen the medical boards referred to the PEB. The staff assigned to the MTF Medical Board Department conduct the screening of all medical boards for completeness before sending to the PEB. [Ref. 42]

(ii) The counselors assigned to the OIC, DESC are attached to the MTF but are not co-located at the MTF with the Medical Board Department staff. They are located in other areas within the facility or in another building. This interferes with their active involvement in the process. [Refs. 36 and 44]

8. Other

(i) According to DOD Instruction 1332.38, members should be referred to the DES one year after the diagnosis of a disabling medical condition and the member is not able to return to full duty. This contradicts the maximum 24-month period of temporary limited duty authorized by BUPERS, which was designed to ensure the member received optimal medical treatment benefit.

(ii) The main reason members request a Hearing Panel is to obtain an increase in the disability rating not to change an "unfit" finding to "Fit for Duty." If the member with less than 20 years of service can get the rating to at least 30 percent, then he/she can be assigned to the TDRL or PDRL. The risk in requesting a hearing is that it is a De Novo hearing, so the rating could actually be decreased. Also, assignment to the TDRL doesn't guarantee disability retirement because the periodic TDRL evaluation may decrease the rating, in which case the member would be separated with severance pay. [Ref. 36]

(iii) The MBTS does not interface with the JDTS. All information from a medical board desired by the PEB is input manually into the JDTS. An electronic transfer of information would only reduce case processing by 1-2 days. [Ref. 41]

Chapter VI will discuss our findings and offer recommendations to improve the efficiency and effectiveness of the DES and PEB process based on these findings, and the probable impact the recommended changes might have on the LIMDU (ACC 105) transient (ACC 355 and ACC 320) populations.

LIST V-A

DEFINITIONS: THE DISABILITY EVALUATION SYSTEM

The processes involved in convening a medical board for the purposes of assigning a service member to temporary limited duty and, or, referral to the Disability Evaluation System for a Physical Evaluation Board are convoluted and complicated by numerous variables. An understanding of the process-specific terminology is essential to optimize clarity on how these processes are distinct and how they are often interdependent.

- Compensable Disability -" A medical condition determined to be unfitting by reason of physical disability and which meets the statutory criteria under Chapter 61 of Title 10 U.S.C. for entitlement to disability retired or severance pay." [Ref. 33]

- Director, Naval Council of Personnel Boards - "Assigned as the Secretary of the Navy's principal agent for overall responsibility for the management, integrity, and efficiency of the Disability Evaluation System." [Ref. 7]

- Disability Benefits - "Disability retirement pay and severance pay authorized by Title 10 U.S.C., Chapter 61, provided for members, who, if otherwise qualified, become Unfit for Duty because of physical disability acquired or aggravated while entitled to receive basic pay." [Ref. 7]

- Disability Evaluation System - Established to conduct physical disability evaluation in a consistent and timely manner. The Under Secretary of Defense for Personnel and Readiness exercises cognizance and oversight of the DES. Under the supervision of the Secretary of the Navy the DES consists of four components: 1. A medical evaluation (MEDBD) to document the severity of the medical condition, and the medical status and duty limitations of the service member. This medical board is necessary to refer the member into the DES. Includes TDRL periodic physical examinations; 2. Physical disability evaluation by Physical Evaluation Boards which includes the Record Review Panel (Informal Board), a Hearing Panel (Formal Board) and legal review; 3. Service member counseling to provide advice on PEB findings, rights, benefits, and

entitlements; 4. Final disposition issued by final reviewing authority [Ref. 33]

- DES Counselor - Assigned by the DNCPB to MTF's where the PEB case volume warrants a full-time counselor to provide counseling regarding the PEB proceedings, findings, and member's rights. [Ref. 7]

- Deployability - "A determination that the member is free of a medical condition that prevents positioning the member individually or as part of a unit, with or without prior notification to a location outside CONUS for an unspecified period of time." [Ref. 33]

- Disability Retired Pay - "The regular periodic compensation a member receives who is retired because of disability from active service." [Ref. 7]

- Disability Severance Pay - "The one-time compensation a member receives who is discharged because of disability resulting from active service." [Ref. 7]

- Existed Prior to Entry - Any member may be processed for separation when diagnosed as having a physical condition which existed prior to entry on active service when the condition would have disqualified the member if discovered at the time of enlistment. It must be shown that the condition interferes with the sailor's ability to perform current duties, or duties likely to be assigned, before a medical board is convened. In the absence of service aggravation, conditions that existed prior to entry are *not ratable* regardless of length of service. Prior to 180 days of active service, the member shall be administratively separated without the right to a PEB. [Ref. 7]

- Final Reviewing Authority - "The final approving authority for the findings and recommendations of the PEB" [Ref. 33] Final reviewing authority is the President, PEB for informal and formal PEB findings, and the DNCPB for Petition for Relief findings.

- Finality of the PEB - A final decision shall be construed as having been issued by the PEB when:

- The member accepts the findings of the PEB, subject to approval,

- The President, PEB, issues a Findings Letter following a formal hearing, or

- A Petition for Relief is acted on by the Director, Naval Council of Personnel Board or higher authority. [Ref. 7]

- Findings Letter - A letter from the President, PEB, DNCPB, or SECNAV to the member being processed within the DES informing him or her of the findings of the PEB. [Ref. 7]

- Hearing Panel (Formal Board) - Members found Unfit for Duty by the Records Review Panel (Informal Board) have the right to a formal hearing before being medically retired or separated. A hearing panel reports to the President, PEB, is considered non-adversarial, and formal rules of evidence do not apply. A hearing provides an opportunity for the member to present additional material to support his or her case. Preliminary findings of the Record Review Panel are null and void upon convening a hearing panel. Findings of the hearing panel are issued by the President, PEB. [Refs. 7 and 33]

- Joint Disability Tracking System - An standardized automated system for record-keeping and tracking of cases in the DES.

- Limited Duty Designator- Directives provide for retention on active duty of enlisted members whose physical condition falls below the standard normally acceptable for retention. When these members are retained on active duty, they will be assigned to duty after classification by BUPERS, and this classification is used for service members in a permanent limited duty status. L-4: Category for sailors who are disqualified for all combatant vessels, duty involving flying, submarines, and auxiliary vessels, but *qualified for foreign shore and U.S. shore.* L-5 : Category for sailors who are disqualified for all combatant vessels, duty involving flying, submarines, auxiliary vessels, and foreign shore, but *qualified for U.S. shore.* [Ref. 21]

- Line of Duty Investigation - When an the injury may result in a permanent disability or prevent a member from performing duties for more than 24 hours, responsible commands will conduct investigations to determine if an injury was incurred or aggravated while in a duty status; and whether it was due to the member's intentional misconduct or willful negligence, The PEB will not accept medical boards without an accompanying LODI when they are required. For the purposes of a medical board, a full LODI is not always necessary. A NAVJAG 5800/15 Injury Report will suffice in cases where it is obvious the injury was incurred in the line of duty and not due to misconduct. [Refs. 7 and 33]

- Medical Board Report - Medical Board Certificate Relative to a PEB Hearing - (Form: NAVMED 6100/3) Signed by the sailor to indicate that he/she has been informed of the medical board's disposition to discharge by reason of erroneous enlistment because of an EPTE physical condition not aggravated by service, and does or does not desire to submit a statement in rebuttal, and does or does not desire to have his/her case presented to the PEB. [Ref. 6]

- Non-Medical Assessment - A statement from the sailor's commanding officer assessing the impact of the sailor's medical condition on his/her ability to perform their normal military duties and to deploy or mobilize as applicable. This statement is required for all PEB's except in cases of critical illness/injury in which return to duty is not expected. [Ref. 35]

- Notification of Decision - A document issued by the President, PEB or DNCPB informing BUPERS of the final decision and disposition in a member's case. [Ref. 7]

- Petition for Relief - If a member disagrees with the findings of a hearing panel, he or she may submit a Petition for Relief. The only basis for relief of final action by means of Petition are new/newly discovered medical evidence; fraud, misrepresentation; mistake of law. Cases are reviewed by a medical officer and a legal officer in the grade of 0-6 or above. Findings are issued by the DNCPB. [Ref. 7]

- Permanent Limited Duty - An assignment authorized by BUPERS, if found unfit by a PEB, to a limited duty status to complete 20 years of service, or remain on active duty until a specific date, in a shore assignment. The PLD assignment would be indicated for a lasting medical condition that prevents the sailor from being worldwide assignable and is incompatible with sea duty, but the condition is quite manageable ashore. This assignment is generally limited to senior sailors. Permanent Limited Duty is coded by a limited duty designator (L-4/L-5) and is accounted for in ACC 105. [Refs. 7 and 21]

- Physical Evaluation Board - Established to act on behalf of the Secretary of the Navy in making determinations of fitness for duty (based on retention standards), disability rating and entitlement to benefits, and dispositions of service members referred into the DES. The mission of the PEB is to compensate members who are unable to complete their careers and qualify for normal retirement benefits. The President, PEB shall issue findings. Dispositions/findings from a PEB will mean the following:

- Fit for Full Duty
- Continue or return to full duty
- Removal from the TDRL

- Unfit for Full Duty:
  - Retained on active duty in a limited duty status (PLD)
  - Assign a disability rating and separate with severance pay
  - Assign a disability rating and separate without severance pay
  - Assign a disability rating and medically retire with a transfer or continuation on the Temporary Disability Retired List
  - Assign a disability rating and transfer to the Permanent Retired List with disability retired pay
  - Assign a disability rating and transfer to the Permanent Retired List without disability retired pay [Refs. 7 and 33]

- Presumed Fit - Officer and enlisted personnel within 12 months of a mandatory or voluntary retirement date will be presumed fit by the PEB. Proof to support the presumption is not necessary, but evidence to the contrary may be presented to rebut the presumption of fitness. [Ref. 33]

- Record Review Panel (Informal Board) - A panel, reporting to the President, PEB, composed of three officers (a Navy line, Marine Corps, and Medical Corps officer) to screen incoming cases for acceptance, and if accepted, perform the *initial* physical disability evaluation on the basis of documentary review of case records (the medical board package forwarded from the MTF's. Issues preliminary findings to the member. [Ref. 7]

- Retention Standards - "Physical standards or guidelines which establish those medical conditions or physical defects that may render a member unfit for further military service and are therefore cause for referral of the member into the DES." [Ref. 33] A member is ordinarily considered fit for duty unless there is a physical disability or a combination of disabilities which interfere with the performance of the duties the member may *reasonably* be expected to perform. A determination of fitness or unfitness must depend upon the member's ability to perform duties in such

a manner as to fulfill *reasonably* the purpose of the member's employment on active duty. The inability to meet the physical standards for initial entry into the service or inability to physically qualify for specialized duty are not used as a basis for considering a member physically unfit for retention in the naval service. [Ref. 45]

- Temporary Disability Retired List - Service Secretaries are required to place members on a list when BUPERS authorizes a recommendation by the PEB to place a member on temporary medical retirement. This occurs when the PEB determines a member Unfit for Duty due to an unstable (not permanent) physical disability. Members are provided physical examinations at least every 18 months to determine the continued existence and extent of their disability. BUPERS will remove a member from the list at any time the PEB determines fit for duty, or disability rating changes to less than 30% and the member has less than 20 years of active service, or the disability stabilizes such that the rating should not change. The Temporary Disability Retirement status can not exceed 5 years, at that time the member's case must be finalized. [Ref. 46]

- Unfit for Duty - The mere presence of a physical disability does not, in itself, require a finding of Unfit for Duty. A member is determined Unfit for Duty by the PEB when he or she is unable, because of injury or illness, to perform duties of grade and billet in such a manner as to *reasonably* fulfill the purpose of employment on active duty. It is important to note that the inability to perform the duties of grade or billet in every geographic location and under every conceivable circumstance will not be the sole basis for a finding of unfitness. [Refs. 7 and 33]

- Veterans Administration Schedule for Rating Disabilities - Primarily used as a guide for evaluating disabilities resulting from all types of illnesses and injuries encountered as a result of, or incident to, military service. Once determined unfit for further military service, VASRD percentage ratings are applied to the unfitting condition(s), and are based on the severity. [Ref. 38]

VI. CONCLUSIONS AND RECOMMENDATIONS

A. DISCUSSION OF FINDINGS AND RECOMMENDATIONS

The two processes discussed in this thesis are complicated; they affect both Transient and LIMDU personnel management, and involve assessing a medical condition to determine if treatment in a limited duty status will return a member to full duty, and if return to duty is unlikely, determine an appropriate compensation for a ratable disability. Numerous factors impact the effective flow of cases through the two systems. Various options are available to medical boards, Department Reviews, Record Review Panels, Hearing Panels, and the service member, creating a process flow that is uncertain and difficult to control. The requirements and objectives of medical boards are different for assigning TLD or referring a case to the PEB. The member's account category status while in the DES is dependent upon whether or not the member is initially assigned to TLD. Further, the account category status does not change from ACC 100 to 355 if the member is assigned to a shore command and is awaiting the results of a medical board or PEB. Members in a LIMDU status due to an assignment to temporary limited duty can be referred to the PEB at the end of a LIMDU period, or before a LIMDU expiration. However, a frequent perception is that they have been in the PEB process during the entire LIMDU period. This misunderstanding regarding the LIMDU population promotes the perception that personnel are in the DES for an excessive time and that the PEB process is inefficient. These and other distinctions are not clearly understood by all those involved or affected by the TLD assignment and DES processes. The following

discussion of our conclusions and recommendations attempts to clarify important process relationships and provide insight into factors that may reduce or improve the efficiency and effectiveness of the two processes.

1. Impact on ACC 355

Confusion about the two processes has led to the assertion that a significant cost savings could be recognized in the TPPH account category 355 if the DES process were streamlined. However, we find that changes to the procedures for processing a medical board or processing a PEB case are unlikely to significantly reduce the costs associated with ACC 355. There are several reasons for this conclusion. First, the number of personnel in ACC 355 represent less than one percent of the enlisted population and only a proportion of that number is actually affected by a referral to the PEB. Second, member's assigned to sea/deployable units remain categorized as ACC 355 throughout the DES process only if the medical board refers them for a fitness determination at the initial medical board evaluation. If the medical board assigns the member to a period of TLD and subsequently refers him/her to the PEB at the LIMDU reevaluation, then the member will remain in ACC 105 until PEB findings are finalized. Although data were not available to determine the exact number of cases referred to the PEB initially, the MTFs, BUMED, and the PEB conclude that most cases are referred after a period of TLD. To prevent a premature determination of "unfit" the PEB encourages physicians to achieve optimal medical benefit and prefers an initial period of TLD before a referral. Consequently, policy changes affecting the DES process and case processing times for a PEB will impact the number in the Force Structure account, ACC 105, to a much greater

extent than the Individual Account, specifically the TEMDU-Transient ACC 355. However, for the small proportion of cases that are referred initially to the PEB, the case processing time and finalization of PEB findings could be expedited, which would shorten the time spent in ACC 355. These factors will be discussed in this chapter.

Third, members evaluated by a medical board for TLD remain in ACC 355 until the board is either locally approved by the Convening Authority or approved by Department Review. Generally, processing time for a medical board at the MTFs is quite good, rarely exceeding the 20-30 day limit. Changes in member response time or medical board report preparation, would likely only reduce processing time by a few days.

Fourth, delays occur at Department Review. The MTFs interviewed claim most Department Reviews occur because an extension of TLD beyond 12 months is recommended at the LIMDU reevaluation. Consequently, most Department Review delays impact the ACC 105 more than ACC 355. If a medical board contains a surrebuttal or a statement of non-concurrence from the CA, then it is forwarded for a Department Review, regardless of the length of the TLD period. In which case, delays at the Department Review will effect the ACC 355.

2. Impact on ACC 320

The other TEMDU-Transient account category impacted by members being assigned to a LIMDU status or returning to duty from a LIMDU status is ACC 320. Delays in this process were identified in the CNA studies and by our interviews with the TMU. When an Availability Report is submitted to make a member available for limited duty or full duty, the ACC changes to 320 (TEMDU-Pending Further Assignment).

When the LIMDU orders are received the ACC changes to either 105, or to 100 if full duty orders are received. Consequently, promptly acting on LIMDU availability reports will reduce the number in ACC 320. Further analysis of the availability and detailing process however is beyond the scope of this thesis.

3. Streamlining the Medical Board Process to Assign TLD or Refer to the PEB

Medical board processing for assigning temporary limited duty or a PEB referral has a few areas that could be streamlined. As previously stated, the data on processing time for a medical board at the MTF (from dictation to CA signature) indicates that the process is efficient. However, process delays are not always reflected in the data. Most significant delays for a medical board that refers a member to the PEB arise from obtaining an LODD, NMA, and additional clinical information (addenda). The delays associated with medical boards that recommend temporary limited duty are minimal, unless the board is forwarded for a Department Review.

Approximately 25 percent of PEB cases are suspended due primarily to missing LODDs, NMAs, physical examinations, and complete clinical information. The MTF may send out a medical board to the PEB within 20-30 days but without the aforementioned requirements. Medical boards held in suspension at the PEB until the medical board package is complete do not impact MTF data on medical board processing time.

The MTFs cite problems in obtaining the required LODD and NMA from former unit commands in a timely manner. The delays are even more pronounced when PEB

cases are due to referrals at the LIMDU reevaluation or when the unit is deployed. A quicker response time from the member's command in providing LODDs and NMAs would significantly reduce the processing time for medical boards referring to the PEB, and reduce the frequency of case suspensions and terminations. The PEB claims the information provided by the NMA is highly relevant to making a fitness determination. Unfortunately, many commands are unfamiliar with the NMA and its requirement. The NMA is intended to provide information from the former unit commander on the member's ability to perform the requirements of their rating/specialty, potential for continued service despite the medical condition, and compliance with therapy regimens. However, if the member was sent to the Medical Holding Company or Transient Personnel Unit, shortly or immediately after the illness or injury, the former unit commander would be unable to provide information specific to the medical condition. When the member is in a LIMDU status and reassigned to a valid non-operational shore billet the NMA is at times sent to the commander of the shore facility, who may not be qualified to provide all the information. The shore facility commander could not assess the member's ability to perform in his/her rating, despite the medical condition, because the member would be assigned to a job that accommodates the illness or injury. The LODD is critical for an appropriate decision on the entitlement to disability benefits and commands need to respond promptly to such requests. MTFs often need to initiate two or three requests to get a response from line commands. If the MTF sends the medical board without the required LODD or NMA, the President, PEB will authorize suspension of the case for up to 10-20 days and require the MTF to obtain the information; if the

information cannot be obtained, the case will be terminated. A terminated case cannot reenter the DES unless a new medical board is convened. This creates an increased workload for the MTF and delays a fitness determination. The requirement for a complete physical examination is recent and additional time is required to schedule the necessary appointments. However, delays associated with this requirement are not expected to continue.

The time a medical board spends at Department Review does not impact data on the medical board processing time. However, a delay in response of 30 days is permitted before tracer action is initiated and TMU reports indicate delays do exist. For example, Department Review response to some medical boards exceed 60 days after the CA's signature. Prompt processing at Department Review could significantly reduce the time waiting for an approval on a TLD disposition (which will reduce expired and prolonged LIMDU periods), and expedite a final fitness determination. Based on MTF and BUMED interviews it appears the majority of initial medical boards are not forwarded for Department Review because most initial TLD periods are assigned for six months. The rate of referrals from an initial medical board due to surrebuttals and CA non-concurrence is unknown. The time required to respond to a member's rebuttal and to provide a surrebuttal varies, but generally those steps do not prevent processing a medical board within 20-30 days. However, a surrebuttal is cause for a Department Review. Delays associated with referrals for a Department Review at a LIMDU reevaluation may result in a prolonged and expired LIMDU status. It should be mentioned that this thesis did not include extensive interviews at Pers-821/271 regarding the procedures or criteria utilized

at Department Review, and data were not available on the rate of medical boards forwarded for a Department Review, or reasons for referral, disposition, or on processing times. The conclusions surrounding the efficiency and effectiveness of the Department Review process are based solely upon interviews with the MTFs, BUMED, and the TMU.

4. Streamlining PEB Case Processing

The delays in processing a case for a PEB depend on delays at the MTF in acquiring the required information, delays in the Hearing Panel process, and to a lesser extent the time allowed for a member's response to findings. Delays at the MTF were previously discussed. The PEB case processing time up to the Informal Board (RRP) is commendable. It is unknown whether this is due to improvements in process efficiency or to the declining trend in referrals over recent years. Fortunately, approximately 80 percent of the RRP's findings are accepted. A relatively small proportion of cases are authorized to proceed to a Petition for Relief (1.2 percent), and the average time pending findings from the DNCPB is 21 days. Reduction in PEB case processing could be achieved at the Formal Board. The most significant delays in the PEB process are generated by the 12-13 percent of cases that are granted a Formal Board (Hearing Panel). When a member is found "fit" the option exists to request a Hearing panel and if found "unfit" the member has the *right* to a Hearing Panel. Data were not available to distinguish the reason a member went before a Hearing Panel. Delays of 2-4 months exist at Hearing Panel sites, most notably at NNMC Bethesda. The PEB's position is that additional panel staffing is required to manage the case load. Additionally, assignment

to a hearing site is restricted by the JFTR. Members required to attend a Hearing at NNMC Bethesda cannot attend the site at NMC San Diego, even if a delay does not exist there. The JFTR has a serious impact when delays exist at the Bethesda site because the PEB receives the majority of its cases from NMC Portsmouth.

Members have 15 days to respond to the findings of the RRP as well as from the Hearing Panel. This period of time may seem excessive but the time is intended to provide the member with sufficient opportunity to schedule an appointment with the appropriate physician specialists and gather the documents required to support the request for an appeal. Reducing member response time could potentially streamline the current case processing flow by one to two weeks.

5. Factors that Contribute to the Size of the LIMDU Population

While the absolute number in the LIMDU population has decreased since May 1994, it has risen as a portion of the enlisted population which has dropped due to force downsizing. The decline in members on LIMDU since 1995 may be due to the availability of TERA. The incidence of LIMDU as a percentage of the active duty enlisted force increased by 0.6 percent between 1985 and 1995 and the percentage of sailors on LIMDU in both September 1995 and December 1997 was 1.5 percent.

Why has the LIMDU population risen? Interviews with the MTFs, BUMED, and the PEB do not support the CNA finding that medical boards are subject to high scrutiny at Department Review. Just the reverse seems more likely. Department Review rarely results in disapproval of a TLD extension in favor of forwarding the case to the PEB. This raises the question of whether the Department Review is providing an effective

screening process and, consequently, whether members are remaining on LIMDU for longer than is necessary. The maximum allowable TLD period has been 24 months since 1988 despite the conclusion by BUMED that most cases requiring 24 months of rehabilitative treatment have a lower likelihood of returning to full duty. Authorization of a 24-month period may not be necessary given that the average time on TLD is less than 12 months. Although the maximum TLD period may still be appropriate for certain medical conditions, the LIMDU population has not fallen. The force downsizing resulted in aging of the force. Personnel in the E5-E9 population remained on temporary limited duty the longest in FY93 and it would seem reasonable to assume that an older force would suffer from medical conditions requiring longer treatment regimes. Also there may be a tendency to do everything possible to allow career progression for a more senior sailor. In addition, the force downsizing also targeted the E7-E9 population. This group has the lowest rate of LIMDU and consequently a significant decrease in the LIMDU population would not be observed by discharging them from naval service.

Note, there is no incentive for an enlisted member not to be on temporary limited duty. They are eligible for advancement, authorized to take advancement examinations, apply for training programs, and are temporarily exempt from sea duty. Furthermore, if the enlisted member is referred to the PEB, the opportunity still exists to receive a Fit for Duty status and yet remain restricted to shore assignments. There are even members on temporary limited duty who are retirement-eligible. This group of sailors should be referred to the PEB for a fitness determination and retired if unable to perform duties in other than a limited duty assignment. The data suggests several problems with the

LIMDU reevaluation process, specifically, missed appointments and delays in scheduling, that ultimately result in an extended and expired LIMDU status without an appropriate disposition. Members who would have been determined Fit for Duty at the reevaluation appointment will remain in ACC 105 until another reevaluation is scheduled and completed. The local Transient Personnel Units have recently increased their efforts to promptly assign transient personnel to valid shore activities. Upon receipt of orders for a LIMDU assignment the member's ACC changes from ACC 320 to ACC 105. Therefore, a more efficient LIMDU assignment process results in members more expeditiously entering the LIMDU population.

Whereas the incidence of temporary limited duty does not appear to reflect force downsizing, the available data regarding LIMDU duration indicates the time spent on temporary limited duty is decreasing. Data for the period of January 1995 and January 1998 finds the average LIMDU duration is approximately 7 months. This is a decrease from the average duration between 1985 and 1994 of between 8 and 10 months. This trend suggests that the method for processing LIMDU personnel for a LIMDU reevaluation and a PEB have improved over time and that medical treatment regimes may be more appropriate and effective.

6. PEB Referrals and Dispositions

The number of referrals into the DES for a PEB is decreasing. The majority of cases referred to the PEB are in a LIMDU status, hence this trend is consistent with the decreasing LIMDU population. Recently, the PEB determined that 75 percent of the members evaluated for fitness were "unfit." Of those found "unfit," 50 percent were

separated, 21 percent were placed on the TDRL, and four percent were permanently retired (PDRL). Only eight percent were determined "fit." This suggests a high rate of appropriate referrals to the PEB. Some critics argue that the time members spend in temporary limited duty is too long and cases should be more expeditiously referred to the PEB. However, it also could be argued that an increase in the number of "unfit" findings would not be an indicator of an increase in appropriate referrals. Rather, the increase in "unfit" findings would occur because cases are referred before the optimal medical benefit is achieved. The significant involvement of the Convening Authority and Department Review is essential to determine and monitor appropriate PEB referrals. Since the PEB evaluates the member's *current* condition when making a fitness determination, evaluating the member before optimal benefit is obtained may result in inappropriate "unfit" findings and more appeals to the PEB's Hearing Panel.

7. Fit For Duty Does Not Always Mean "Fit for Deployment"

A Fit for Duty finding by the PEB does not mean fit for deployment or world-wide assignment. Physicians and CA's at an MTF claim a sailor is found "fit" only if he/she can deploy. Conversely, a finding of "fit" by the PEB does not mean the member is capable of deployment for the next set of orders. In fact, the PEB is specifically guided by both DOD and SECNAV Instructions that ability to perform or deploy in every possible location is not to be utilized as the sole factor for a fitness determination. The PEB is authorized to find a member Fit for Duty utilizing *medical retention standards* and the non-medical information provided by the former unit commander. The PEB is not required to utilize criteria for deployment. The number of sailors found Fit for Duty,

but not deployable, is not known. However, when such findings occur it undoubtedly provokes a lack of confidence in both the DES process and the medical community's ability to support fleet readiness requirements. Additionally problems occur when members who are found "fit," receive sea duty orders but cannot execute those orders. An example would be when a member is found "fit" by the PEB then fails a Sea Duty Screen, passes the screen but the ship Medical Officer determines the member is unfit for duty on the ship and sends the member back to the MTF for a medical board.

DOD Instruction 1332.38 provides for the requirement of a statement regarding deployability of a sailor found "fit" if the service headquarters request it of the PEB. This is not required by SECNAV Instruction 1850.4C. Currently, the DON accepts the restrictions on deployment of personnel found "fit" by the PEB. The responsibility rests with the member's command to administratively separate the member for military unsuitability, if necessary. Inclusion of this statement would clarify the member's true duty status, prevent detailing to inappropriate commands, allow identification of trends in PEB findings that adversely impact readiness, and provide a more accurate assessment of nondeployable personnel.

8. Issues with the Sea Duty Screen

A recent change concerning the Sea Duty Screening process has recently been implemented. The number of personnel who fail sea duty screens resulting in non-execution of their orders has not been significant (likely less than five percent). Nonetheless, a change was directed by BUMED (MED-02) in August 1997 to require that every member found Fit for Duty at a LIMDU reevaluation undergo a sea duty screen

before they are made available for orders. This change may increase the number in the LIMDU population and increase the costs associated with processing members for sea duty orders. Previously, only members who received sea duty orders were required to undergo a sea duty screen. Consequently, all personnel returning to duty from a LIMDU status will remain in ACC 105 longer to await completion of the screen and submission of an availability report can be submitted.

Although further examination of the Sea Duty Screening process is beyond the scope of the thesis, it seems important to introduce the following concerns. The Sea Duty Screen is intended as a tool to ensure that the member is ready to go to sea, that immunizations are up to date, that medications for known medical conditions are available at the gaining ship's medical department, and that any condition resulting in a physical limitation has been previously evaluated by a physician. Therefore, the Sea Duty Screen should not be the place where unsuitability for sea is determined when a medical board or PEB has already evaluated the member and determined the member to be "fit." Additionally, the lack of a deployability statement issued by the PEB, and the differing capabilities of each ship to manage medical conditions, have probably contributed to members failing Sea Duty Screens after being found Fit for Duty.

9. Tracking ACC Status

Tracking the member's status as they move from a transient status to a limited duty status is complicated by the fact that existing tracking systems do not adequately identify changes in the ACC. If the member's command assignment doesn't change then a change in the ACC is not entered. The effective date of an ACC change entered into the

PSD Source Data System (SDS) cannot be accessed by the LIMDU tracking system at BUPERS (Pers-821/271). Consequently, the LIMDU reports are limited to tracking the changes in ACC status that change when a member is received at a new command. The true period a member is in a LIMDU status is overstated when the member is assigned to a shore command when placed on LIMDU, or the member remains at a shore command (at which they were assigned during the LIMDU period), once found "fit." This has resulted in LIMDU reports identifying members on LIMDU for greater than two years, and some for as much as four, five, or six years. These reports do not accurately depict the time members spend in a LIMDU status, and they promote the perception that the processes are not expeditiously returning members back to the fleet or discharging them from naval service.

The available data for the period of January 1995 and January 1998 states the average LIMDU duration is approximately 7 months. Although there are deficiencies in tracking the change to and from ACC 105, this data is consistent with our interviews with the MTFs, BUMED, and the PEB. This tracking issue is not applicable to the member who is assigned to a sea/deployable unit and is then assigned to temporary limited duty, and once found "fit" is returned to a sea/deployable unit. In this case, the change in command assignments will correspond to the effective date of change to/from ACC 105. This is consistent with the CNA findings that nondeployabilty record keeping is more accurate when it is immediately operationally relevant. Unfortunately, individual records must be reviewed to determine if the change to and from ACC 105 represents the true time assigned to LIMDU. The Navy has never monitored the day-to-day deployability

status of sailors in a shore-rotation. [Ref. 1] The new SECNAV reporting requirements on deployability and the annual Congressional reports on assignment limitations (required in the 1995 Defense Authorization Act), will need a tracking system that can identify ACC changes for personnel assigned to sea and shore in order to accurately account for deployable personnel. Additionally, members assigned to shore commands who are awaiting the results of a medical board or PEB do not change to ACC 355. They remain in ACC 100. Consequently they are not appropriately identified as nondeployable due to medical reasons.

10. Existing Automated Information Systems

The MTFs and PEB have some indicators to identify the time elapsed for successful process outcomes. They can track the number of dictated medical boards, abbreviated medical boards, cases sent for a Hearing Panel and Petition for Relief, and their corresponding average processing time. However, this information is not adequate for identification and analysis of deficiencies in the medical board TLD assignment and PEB processes. The MBTS is antiquated and does not interface with JDTS. The staff in the Medical Board Departments have to manually compute totals and averages over time. Once a case has been referred to the PEB the MTF does not track the member's final disposition or the frequency and workload impact of PEB requests for additional information. Cases are received at the PEB and information is manually inputted into the JDTS before it is ready as a "new case." The JDTS at the PEB does not track any historical information about the member's status prior to the referral, such as if the member is on LIMDU. Although JDTS thoroughly tracks the individual case status

throughout the PEB case processing, aggregating the data to analyze trends is time consuming and not possible for some data fields.

11. Physician Training

DOD, SECNAV, and BUMED guidance require that physicians who convene medical boards receive training on medical board requirements and especially on the objectives and requirements of the PEB and the use of DVA and VASRD evaluation and diagnostic terminology. Currently, structured training and verification of process knowledge in these areas does not exist. This lack of physician training may impede expedient referrals into the DES for a PEB, and contribute to suspensions and terminations when medical boards do not contain (or adequately describe) relevant clinical information. There is a concern by members of the RRP that if physicians use terminology specific to rating criteria they may inadvertently, or intentionally, bias the medical board toward the desired disability rating. This is a legitimate concern; however, effectiveness of the DES process is reduced when physicians and CAs are not trained on the PEB mission and unique clinical documentation requirements. The responsible use of disability rating knowledge could be emphasized in a training program and continually evaluated.

12. Abbreviated Temporary Limited Duty Medical Board

Currently BUMED does not impose any restrictions on the number of times a member can be placed on LIMDU utilizing an abbreviated medical board. This conflicts with BUPERS unofficial policy that abbreviated medical boards should not be used for a second medical condition, whether the condition is the same, related or unrelated.

BUPERS position is that the abbreviated medical board affords a member the opportunity to remain on LIMDU without review by the Convening Authority or a Department Review. Most MTFs utilize a policy that is consistent with BUPERS' perspective. It is feasible, especially in a large MTF, that a member could seek continued assignment to temporary limited duty through a different physician specialist for a different complaint for an ongoing period of time. This could result in a member cumulating over 12 months (or possibly over 24 months) total TLD without approval by Department Review. This discrepancy leads to problems at the MTF because physicians prefer the abbreviated medical board. It does not require a detailed clinical narrative report, the physician can generally complete it during the member's evaluation appointment, and the Medical Board Department can complete processing in approximately one day. A member may present for evaluation of an uncomplicated medical condition within a year of having been assigned to TLD for a previous uncomplicated medical condition and the physician may not be authorized to initiate another abbreviated medical board. This restrictive policy may not assist the goal of reducing medical board processing times and MTF workload.

13. Function of the PEB's Disability Evaluation System Counselor

Disability Evaluation System Counselors under the authority of the President, PEB are assigned to the eight MTFs which generate 80 percent of PEB case referrals. These counselors are rarely located in the Medical Board Department. They are located in another area within the MTF facility, or another building. This does not facilitate their involvement in the PEB process at the MTF. An expanded DESC role could improve the

efficiency of processing medical boards for a PEB in two ways: by participating in the screening of board packages before sending to the PEB and by providing training support. Currently, the counselors assigned to the other 24 MTFs perform the role of DESC as a collateral duty and are responsible for screening the board packages going to the PEB. The collateral duty counselor's primary incentive is to get the board sent before 30 days has elapsed and a later suspension due to an incomplete package may not be a prevailing concern. The PEB's counselors are evaluated by the President, PEB and therefore would have an incentive to ensure board packages are received complete. Accordingly it would seem appropriate to involve those DESCs in the MTF screening process and impact 80 percent of the PEB case load.

B. RECOMMENDATIONS

The findings and conclusions of the thesis must be considered preliminary. The recommendations are intended to suggest potential areas where beneficial changes may be implemented. However, further study is required to evaluate their feasibility and potential overall benefit of the recommended changes. What follows is a list of the recommended changes.

1. Elimination of the members option to rebut the findings of a medical board would reduce the number of surrebuttals and hence the number of boards requiring Department Review. This would expedite assignment from a transient to a LIMDU status. Assignment to TLD is not an adverse action, such that eliminating the option would not violate the member's legal right IAW Title 10 U.S.C.

2. Eliminate the Hearing Panel request option for "fit" findings. It is not an adverse action and the greatest delays in the PEB process involve the Hearing Panel process. Further study is needed to identify the proportion of requests that are granted and the impact if this option is eliminated.

3. Eliminate the option for Petition for Relief. It is likely to have minimal impact on case processing time given the small proportion of PFR cases. Eliminating the PFR option will not violate the intent of section 1214 Title 10 U.S.C.

4. Develop a Hearing Panel site at NMC Portsmouth or increase staffing at current Hearing Panel sites to reduce the 2-4 month delays. The NMC Portsmouth refers the largest number of cases to the PEB and many delays are associated with JFTR.

5. Reduce member response time regarding RRP and Hearing Panel findings by one week at each opportunity. If the member chooses to appeal then afford the member additional time, to gather the necessary clinical documents to support an appeal request. A 15-day response time is not warranted for 80 percent of the cases since they are accepted at the level of the RRP. If the Hearing Panel and PFR request options are eliminated, the need for a 15-day response time is further reduced.

6. An Expired LIMDU status prolongs time in a LIMDU status and delays appropriate medical evaluation and treatment, the member's return to the fleet, and referral into the DES for final fitness determination. Improvements are needed in both the MTF's response to PSD requests for LIMDU reevaluation appointments and the command's response to missed appointments. The MTF's need to ensure repeat LIMDU reevaluation requests and missed appointments are monitored as a quality indicator for management of their LIMDU personnel.

7. Further review of the Department Review process is required. Elimination of the Department Review or several changes are warranted: (a) Criteria should be established at Department Review to ensure TLD extensions are appropriate. This is especially important since the CA does not have to review a LIMDU reevaluation recommendation for a TLD extension; (b) It appears processing time at Department Review could be reduced. Allowing 30 days after CA signature for a response before initiating tracer action seems unnecessary; (c) The Department Review process may benefit from including a medical corps officer.

8. Retaining members who are nondeployable in a Fit for Duty status generates additional workload for the MTFs and Pers-40, increases the op-tempo for those who can deploy, contributes to excess manning of shore billets, and results in an underestimation of nondeployable personnel. A statement on a member's deployment status should be required in the

findings of the PEB. Follow-up on the 1992 Army study on discrepancies in deployment and retention criteria is needed.

9. To minimize delays associated with obtaining LODDs at LIMDU reevaluations or when a unit deploys, the MTFs should consider requesting LODDs (when indicated) for all medical boards rather than only those boards which initially refer to the PEB.

10. The member's command should promptly identify the need for a LODI/LODD and promptly comply to requests from the MTF. This should not increase the workload for commands because the requirement should already be included in the SOP. Further study may want to evaluate the appropriate use of the "Injury Report" in lieu of a formal LODI/LODD. Substituting "Injury Reports" could minimize delays that are currently associated with obtaining LODDs.

11. Consult with OJAG to evaluate the possibility of allowing NLSO support in conducting and endorsing LODDs when a member's unit is deployed.

12. To minimize delays associated with obtaining the NMA, the PEB should accept the member's last evaluation as the former unit commander's input. When additional information is needed to make a fitness determination the PEB should contact the appropriate command (current LIMDU activity or former unit).

13. All MTFs should provide specific guidelines for completing NMAs in the message request.

14. Clarification and agreement is required between BUPERS and BUMED regarding the maximum allowable TLD period. The maximum period is defined by BUMED as 24 months per given condition, and by BUPERS as 24 months cumulatively. Additionally, there is disagreement about treating a "related" condition as a "different" or a "same" condition.

15. Change the maximum allowable TLD period to 18months. Provide an exception for an additional 6 months for medical conditions that respond well to prolonged treatment, but only if they are associated with a high probability of returning the member to full duty.

16. Adopt the Marine Corps policy of requiring a Department Review for greater than six months vice twelve months TLD. This would only be effective in expediting appropriate referrals into the DES or a return to the fleet if Department Review rigorously assesses recommendations to

extend the TLD period. If the member does not have a strong probability of returning to duty a TLD extension may not be appropriate.

17. Establish a date field in the Transient and LIMDU tracking systems to identify and monitor the effective date of an ACC change.

18. If a member is retirement-eligible, then he/she should be referred to the PEB rather than be allowed to remain on temporary limited duty. The reasons why 149 personnel with over 20 years of active duty service(as of January 1998) are on TLD should be investigated. Additionally, the rate of retirement-eligible personnel retained in a Permanent Limited Duty (PLD) status should be examined. In January 1998, 23 percent of the personnel designated as L-4/L-5 had 20 or more years of active duty service.

19. Further research may be needed to evaluate the feasibility of restructuring specific divisions within the PEB, BUPERS, and BUMED toward a matrix structure. The various process owners and stakeholders require a higher degree of lateral integration to facilitate communication and shared decision making regarding the many policy issues on medical boards, LIMDU personnel management, and the PEB.

20. Update the information and tracking capabilities of the MBTS and JDTS. The Systems should interface and track a member from the beginning of a medical board to the final disposition of a TLD medical board and/or a PEB. An integrated automated system should provide the MTF and PEB the capability to monitor quality indicators, capture true workload requirements, and provide analysis of processing delays and trends in dispositions. Electronic retrieval by the PEB of the required basic member information and clinical and non-medical reports would reduce time and workload requirements for the MTF and PEB. An assessment of automated information system capabilities exceeds the scope of this thesis. However, important information not currently available from either tracking system is listed below and further research is needed on the feasibility of implementing an integrated automated tracking system.

    a. The number of medical boards that are initially referred to the PEB rather than assigned a period of TLD, and the number of PEB referrals after a period of TLD, needs to be identified to better evaluate the medical board process and impacts on ACC 355 and ACC 105.

    b. The number of medical boards forwarded for Department Review due to (a) an initial recommendation of TLD greater than 12

months; (b) an extension is recommended at the LIMDU reevaluation; (c) a surrebuttal; and (d) non-concurrence of the CA, needs to be identified.

c. The number of medical boards forwarded to the PEB, approvals of TLD extensions, and processing time, at the Department Review, needs to be identified to better evaluate the effectiveness of this administrative screen.

d. The frequency and duration of delays associated with obtaining requirements for a PEB (LODD, NMA, addenda) needs to be identified.

e. The frequency of case suspensions and the time required to respond to PEB requests needs to be identified and tracked as medical board processing time.

f. The frequency of case terminations that result in convening a new medical board needs to be identified. The cause of case termination and suspension needs to be tracked to evaluate the specific areas of medical board preparation that require improvement .

g. A member's LIMDU history when referred to the PEB should be available and identified by the PEB's automated tracking system.

h. The proportion of Hearing Panel and Petition for Relief requests that are granted needs to be identified to evaluate the frequency and the impact on process delays.

21. The program implemented at the NMC Portsmouth Orthopedic Department for conditions not considered a physical disability should be instituted at additional MTFs. The Portsmouth program recommends an administrative separation for members who continue to complain of back or knee pain without objective findings to support a documentable physical disability. These members should not be referred to the PEB because the lack of objective evidence renders them ineligible for a disability determination. The program has been effective in providing commands a viable option to separate a "fit" member for unsuitability, reduces the number remaining in the LIMDU population beyond 6 months, and prevents erroneous referrals to the PEB for non-ratable conditions. The high incidence of eventual medical separations for "bad backs" lends strong support for the value of this program.

22. Several changes need to be made in physician training: (a) Procedures need to be implemented to identify specific physician training needs. (b) The feasibility of providing introductory training on the DES and PEB process to medical corps officers at the Staff Indoctrination Course, Newport, Rhode Island should be evaluated. (c) The feasibility of providing training to reporting physicians on the DES and PEB process at MTF check-in/orientation should be evaluated. The DES Counselors could provide training support.

23. Expand the role of the DES Counselors (under the authority of the President, PEB) to include medical board package screening before the case is sent to the PEB and to provide training support for the medical board and physician staff. Currently, one DESC is assigned at each of eight MTFs. Given the workload generated for the PEB at those MTFs, the number of DESC per MTF would need to increase.

24. Develop an official policy for the use of the Abbreviated Temporary Limited Duty Medical Board and include procedures for monitoring cumulative TLD periods exceeding 12 months.

25. Further evaluation is needed on delays in the availability and detailing process to and from LIMDU.

26. The impact and benefits of screening all personnel removed from LIMDU for sea duty should be further evaluated. The screen will be conducted without knowledge of the medical capabilities of the gaining ship, or whether the member is going to a ship. Given the small number who fail a screen and then are ultimately found unsuitable for their sea duty orders, the cost of conducting more screens and delaying the availability for full duty may not result in a net benefit to the operational forces.

27. Large MTFs should evaluate existing CA review processes. It is unlikely there is any value added in a CA review if time constraints and workload demands preclude a thorough review for board completeness and appropriate findings and recommendations.

APPENDIX A.

NMC Portsmouth Orthopaedic Department
Conditions Not Considered A Physical Disability
Final Disposition - Policy and Procedure

A substantial number of patients seen in the Orthopaedic Department continue to complain of musculoskeletal pain after completion of standard treatment protocols, while all objective testing is normal. In the opinion of most physicians, these individuals do not have a documentable physical disability. Therefore, they are not candidates for disability determination. Any Navy or Marine enlisted service member, who continues to complain of back or knee pain after fulfilling the following criteria, will be offered a choice of "release to full duty" or release to their parent command with a finding of "fit for full duty with consideration of administrative separation".

- Evaluation by a staff physician in the Orthopaedic Department

- Completion of at least four months on a limited duty board

- No objectively documentable physical examination findings of an anatomical defect or normal variant felt substantial enough to be responsible for symptomatology

- No clinically significant finding on objective testing including x-ray and MRI which is felt to contribute to or result in the stated symptoms

- Completion of a standard regimen of Physical Therapy

- Treatment of symptoms with non-steroidal anti-inflammatories unless contra-indicated

If the service member chooses consideration of administrative separation, the overprint SF-600 and letter of notification to the command, which correspond to this condition, will be completed by the attending physician. The service member shall be advised, by the attending physician, of this being a medical recommendation only. Actual administrative action is at the discretion of his/her commanding officer.

All final dispositions of "fit for full duty with consideration of administrative separation" will be considered pending until approved by the Orthopaedic Department Head.

This policy is consistent with directives found in Manual of the Medical Department 18-25 and MILPERSMAN 3620200. This policy and procedure is effective 1 August 1997 and is subject to revision.

APPENDIX B.

From: Commanding Officer
To: Medical Treatment Facility

Subj: NON-MEDICAL ASSESSMENT; CASE OF _____
_____

Ref: (a) DOD Inst 1332.38

1. Reference (a) requires a Non-Medical evaluation to be included in all medical boards forwarded to the Physical Evaluation Board (PEB). The following assessment is submitted to assist the PEB in their determination of Fitness/Unfitness:

a. Information to fill in:

1) Service member's Rating/NEC/MOS/Specialty_____.

2) Service member's current job assignment is _____. This assignment is appropriate for their grade and rank. Y/N

3) Describe member's physical and/or mental conditions as observed by the command _____.

4) Describe any essential requirements of MOS/Rating that the member is unable to perform due to his/her physical and or mental condition? _____
_____

5) Member has not been in a full duty status since_____.

b. Answer the following questions yes (Y) or no (N).

1) Member is currently working out of his/her specialty because of the medical condition. Y/N

Subj: NON-MEDICAL ASSESSMENT; CASE OF _____
_____

2) Member took and passed the most recent PFT/PRT. Y/N
Last date the member took PRT/PFT _____.

3) To your knowledge the member has followed the therapy regimen prescribed by medical authorities for the medical board condition/s. Y/N

4) Member's condition has required time away from duties for treatment/evaluation/recuperation. Y/N
If so, estimate the average number of hours per week the member is absent from command duties._____

5) Member's medical condition precludes firing a weapon, if required for qualification. Y/N

6) Member stands required military watches. Y/N

7) Member is pending disciplinary action. Y/N

8) Considering his/her medical current medical condition/s, the service member is worldwide assignable. Y/N

9) Member has good potential for continued service in present physical and mental condition. Y/N

10) Member is motivated for continued active duty. Y/N

c. Any other comments or elaboration of above items:_____
_____
_____

d. I recommend:

1) This member be allowed to remain on active duty in a limited duty status to allow sufficient time for recovery. Y/N

2) This member be authorized another limited duty period.

2. POC this command is _____ at __(phone)__

CO's Signature

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