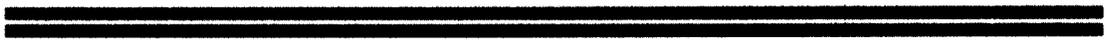


Army Physical Disability Evaluation System Inspection





Army Physical Disability Evaluation System Inspection

- TAB 1 Table of Contents**
- TAB 2 TIG Cover Sheet/Action Memorandum**
- TAB 3 Executive Summary**
- TAB 4 Chapter 1 – Objectives and Methodology**
- TAB 5 Chapter 2 – Findings and Observations**
- TAB 6 Chapter 3 – Best Practices**
- TAB 7 Appendix 1 – Directive**
- TAB 8 Appendix 2 – Detailed Standards**
- TAB 9 Appendix 3 – Acronym List**
- TAB 10 Briefing**



DAIG Inspection of the Army Physical Disability Evaluation System

Table of Contents

<u>Topic</u>	<u>Page</u>	<u>TAB</u>
Secretary of the Army Approval / Release		2
Executive Summary	ES-1	3
<u>Chapter 1 Objectives and Methodology</u>	1-1	4
<u>Chapter 2 Preliminary Findings and Observations</u>	2-1	5
<u>Objective 1</u>	2-1	5
Finding 1.1 -- 30-Day Standard	2-1	5
Finding 1.2 -- 90-Day Standard	2-4	5
Finding 1.3 -- 10% Return Rate Standard	2-6	5
Finding 1.4 -- Soldier Counseling	2-8	5
Finding 1.5 -- Accuracy of Reporting	2-9	5
Finding 1.6 -- Formal Training	2-12	5
Finding 1.7 -- Integrated Policy	2-14	5
Finding 1.8 -- Regulations, Policy and Retention Issues	2-16	5
Observation 1.9 – Position Descriptions	2-17	5
<u>Objective 2</u>	2-18	5
Finding 2.1 -- Regulation Consistency	2-19	5
Finding 2.2 -- Data Management	2-23	5
Finding 2.3 -- 40-Day Standard	2-25	5
Finding 2.4 -- COAD/COAR Requests	2-26	5

Finding 2.5 -- Quality Assurance Program	2-29	5
Finding 2.6 -- Training Standards	2-33	5
Finding 2.7 -- Periodic Examinations	2-36	5
Finding 2.8 -- Legal Representation	2-38	5
Observation 2.9 – USAPDA Caseload Management	2-40	5
Observation 2.10 – Schedule for Rating Disabilities	2-41	5
Observation 2.11 – Knowledge of Regulations and Policies	2-43	5
Observation 2.12 – Knowledge of Disability Ratings	2-44	5
<u>Objective 3</u>	2-45	5
Finding 3.1 – Command and Control for MHO	2-46	5
Finding 3.2 – Formal Training, MHU, MRPU/CBHCO	2-49	5
Finding 3.3 – Soldier Rights and Separation Rights	2-51	5
Finding 3.4 – Duties within Medical Profile Limits	2-53	5
Finding 3.5 – MHO Soldier Accountability	2-55	5
Finding 3.6 – Americans with Disability Act Violations	2-56	5
Observation 3.7 – Staff and Personnel Authorization	2-58	5
Observation 3.8 – Command and Control Structure	2-60	5
Observation 3.9 – Use of Sanctuary Soldiers	2-63	5
Observation 3.10 – APDES Soldier Assignment	2-65	5
Observation 3.11 – CBHCO/MRPU Manning	2-66	5
<u>Objective 4</u>	2-67	5
Finding 4.1 -- LOD Documentation	2-67	5
Finding 4.2 – Medical Documentation	2-70	5

Finding 4.3 – MMRB Conduct	2-72	5
Finding 4.4 – Personal and Organizational Property	2-73	5
Observation 4.5 -- Unnecessary Separation	2-75	5
Observation 4.6 -- MRP Orders	2-76	5
Observation 4.7 -- Transition Center Personnel	2-78	5
Observation 4.8 -- Leadership Knowledge of APDES	2-79	5
Observation 4.9 -- Contact with RC Home Station Units	2-81	5
Observation 4.10 -- Providing Quality Medical Care	2-82	5
<u>Chapter 3 Best Practices</u>	3-1	6
<u>Appendices</u>		
Appendix 1: Inspection Directive	APP 1-1	7
Appendix 2: Detailed Standards List	APP 2-1	8
Appendix 3: Acronym List	APP 3-1	9
<u>APDES Briefing</u>		10

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**DEPARTMENT OF THE ARMY
OFFICE OF THE INSPECTOR GENERAL
1700 ARMY PENTAGON
WASHINGTON DC 20310-1700**

SAIG-ID

6 March 2007

MEMORANDUM FOR UNDER SECRETARY OF THE ARMY

**SUBJECT: Report on the Army Physical Disability Evaluation System (APDES)
Inspection and Follow Up Actions (1 May 2006–17 November 2006)
--ACTION MEMORANDUM**

1. Purpose. To provide the Under Secretary of the Army the report on the APDES Inspection and required follow up actions.
2. Discussion.
 - a. On 18 April 2006, the Secretary of the Army issued a directive to The Inspector General to conduct an inspection of the APDES. The inspection team identified 41 findings and observations and made recommendations for corrective action.
 - b. The inspection revealed issues such as policy incongruities between Department of Defense (DOD) Instructions and Army Regulations, inadequate training of personnel throughout the APDES process, and data and information management inaccuracies. These issues, coupled with the increase in the number of Soldiers entering the APDES, diminish the ability of the evaluation system to meet the needs of Soldiers and the institution of the Army.
 - c. The volume of Medical Evaluation Board (MEB) cases significantly increased from 6,560 cases in Fiscal Year 2002 to approximately 11,000 cases in each of the last two Fiscal Years (2005 and 2006). The number of Physical Evaluation Board (PEB) cases rose from just over 9,000 cases in Calendar Year 2001 to a peak of over 15,000 cases in Calendar Year 2005.
 - d. Army policy is inconsistent and does not fully and accurately integrate DOD policy. DOD and the Army have different standards for processing MEB cases. The Army, acting through the Medical Command (MEDCOM), meets neither DOD nor Army standards. There is not enough formal training for personnel working throughout the APDES process. The Army has not developed a standardized or mandatory course to train and educate the primary staff personnel (Physical Evaluation Board Liaison Officer (PEBLO), MEB physicians and PEB personnel involved in the Army Physical Disability Evaluation System. The Army also lacks an integrated medical and personnel system to provide visibility over injured or ill Soldiers in the APDES. The two APDES databases, the Medical Evaluation Board Internal Tracking Tool (MEBITT) and the Physical Disability Case Processing System (PDCAPS), lack the ability to communicate

with each other. PDCAPS is an antiquated system that needs to be updated and there is not enough quality management and training on the use of MEBITT. These shortcomings have led to inaccurate reporting of the status of Soldiers in the APDES.

3. Recommend that the following guidance concerning the draft report be approved.

a. TIG conduct a comprehensive analysis of the APDES Inspection Report and identify the best practices observed for use by Army leadership in follow-on inspections by DAIG inspection teams. These successful best practices will be incorporated into future action plans. DAIG provides appropriate oversight.

b. TIG provide the preliminary assessment data and a comprehensive briefing to the APDES action teams that will further review the MEB and the PEB. The assessment data will include: preliminary Findings, Observations and Recommendations on the MEB/PEB process, the execution of the Medical Hold/Holdover System to include compliance with DOD and DA policy, and the assessment of the administrative areas on the APDES.

c. TIG provide Army Commands, leadership, and/or appropriate command IGs the inspection tools and guidance for follow-on inspections and reporting.


STANLEY E. GREEN
Lieutenant General, USA
The Inspector General

CF: CSA
VCSA
DAS

APPROVED

DISAPPROVED

SEE ME

EXECUTIVE SUMMARY

The Secretary of the Army directed The Inspector General on 18 April 2006 to conduct an inspection of the Army Physical Disability Evaluation System (APDES) with the purpose of determining if its policies, procedures, and system execution are meeting the needs of Soldiers and the Army. Nine DAIG inspectors augmented by seven subject matter experts from USARC, DCS G1, OSG, OTJAG, NGB, MEDCOM and US Army Physical Disability Agency (USPDA) conducted the inspection.

Findings and recommendations were derived from the conduct of individual interviews and group sensing sessions with 652 leaders, Soldiers, and civilians at 32 installations in CONUS and OCONUS. Further, the team reviewed applicable Army, ACOM, and local unit policies; personnel records; SOPs; tracking systems; and other related documents.

Four inspection objectives were identified as the means to determining the system's effectiveness. Those were as follows.

1. Assess the execution and timeliness of the Medical Evaluation Board (MEB) process to include compliance with DOD and Army policies;
2. Assess the execution and timeliness of the Physical Evaluation Board (PEB) and review processes to include compliance with DOD and Army policies;
3. Assess the execution of the Medical Hold System to include compliance with DOD and Army policies;
4. Assess the impact of other administrative areas on the Army Physical Disability Evaluation System.

The timing of the inspection coincided with an increased number of Soldiers entering the system. The volume of MEB cases significantly increased from 6,560 cases in FY 02 to approximately 11K cases in FY 05 and in FY 06. The number of PEB cases rose from just over 9K cases in CY 01 to over 15K cases in CY 05.

The inspection revealed policy variances between Department of Veterans Affairs, DOD, and Army regulatory guidance; the need for additional training of personnel throughout the APDES process; and insufficient data management systems and information management. These issues coupled with an increasing number of Soldiers entering the APDES, effected the Army's ability to timely meet the needs of both Soldiers and the Army.

The Inspector General will conduct a comprehensive analysis of the APDES Inspection Report and identify the best practices observed for the use of Army leadership. These successful best practices will be used as a role model to be incorporated into the future action plans. The DAIG will provide proper oversight.

The Inspector General will provide the inspection data and a comprehensive briefing to the APDES Action Team that will further review the MEB and the PEB. The inspection data will include: Findings, Observations and Recommendations on the MEB/PEB process, the execution of Medical Hold and Medical Holdover System to include compliance with DoD and DA policy, and the assessment of the administrative areas on APDES.

**THESE FINDINGS AND OBSERVATIONS LED TO
RECOMMENDATIONS FOR IMPLEMENTATION IN CONJUNCTION
WITH THE APDES ACTION TEAMS**

OBJECTIVE 1 - Assess the execution and timeliness of the Medical Evaluation Board process to include compliance with DOD and Army policies.

FINDING 1.1: US Army is not meeting the Department of Defense 30-day standard for processing Medical Evaluation Board cases which measures from the date the physician dictates the Narrative Summary to the date the case is received by the Physical Evaluation Board.

RECOMMEND the APDES Action Team in conjunction with:

a. The Surgeon General, update policy on the start and end date of actions occurring in the Medical Evaluation Board process.

b. Commander, US Army Medical Command, review quality management of the Medical Evaluation Board Internal Tracking Tool database.

FINDING 1.2: The majority of Regional Medical Commands are not meeting the Army 90-day standard for processing Medical Evaluation Boards.

RECOMMEND the APDES Action Team in conjunction with:

a. The Surgeon General update Army Medical policy to include the Army 90-day standard and clarify the action that begins the Medical Evaluation Board process.

b. Commander, US Army Medical Command, develop training standards and educational requirements for PEBLOs, Alternate PEBLOs, and physicians conducting Medical Evaluation Boards.

FINDING 1.3: Most Regional Medical Commands are not meeting the 10% return rate standard for Medical Evaluation Boards returned from the Physical Evaluation Board.

RECOMMEND the APDES Action Team in conjunction with: Commander, US Army Medical Command, develop training standards and certification requirements for PEBLOs, Alternate PEBLOs, and physicians conducting Medical Evaluation Boards.

FINDING 1.4: Most Soldiers in the Medical Evaluation Board process are receiving the required counseling.

RECOMMEND the APDES Action Team in conjunction with: Commander, US Army Medical Command, develop a series of post-counseling surveys to assess the Soldier's understanding of the MEB/PEB processes.

FINDING 1.5: Insufficient quality management of and training on the use of Medical Evaluation Board Internal Tracking Tool (MEBITT) database leads to inaccurate reporting of the status of Soldiers in the Army Physical Disability Evaluation System.

RECOMMEND the APDES Action Team in conjunction with:

a. The Surgeon General clarify policy on the start and end date of actions occurring in the Medical Evaluation Board process.

b. Commander, US Army Medical Command, review current quality management processes and implement stricter internal controls to ensure precise recording of information on the date the permanent profile is issued; the date the Narrative Summary is dictated; and the date the Medical Evaluation Board is received by the Physical Evaluation Board.

c. Commander, US Army Medical Command, develop training standards and certification requirements for PEBLOs, Alternate PEBLOs, and physicians conducting Medical Evaluation Boards.

d. Commander, US Army Medical Command, in coordination with the Army G-3 and Army G-1 develop a formal MEBITT Course for those primary participants involved in DES process.

FINDING 1.6: The Army lacks a formal course of instruction that trains Physical Evaluation Board Liaison Officers, Alternate Physical Evaluation Board Liaison Officers, and Medical Evaluation Board (MEB) Physicians on their duties and responsibilities in processing Soldiers referred to a MEB.

RECOMMEND the APDES Action Team in conjunction with: MEDCOM, in coordination with TRADOC and ASA MR&A, determine the critical individual tasks for the professional development of civilian and military PEBLOs, APEBLOs and MEB Physicians.

FINDING 1.7: Army Regulations do not fully and accurately integrate DOD policy instructions and MEDCOM policy memorandums.

RECOMMEND the APDES Action Team in conjunction with:

a. The Surgeon General update Army Regulation 40-400 and to accurately reflect Department of Defense Instruction 1332.38.

b. The Surgeon General update Army Regulation 40-400 to include MEDCOM's 90-day standard and review the terminology in MEB process.

FINDING 1.8 US Army Medical Command regulations and policies on the Medical Evaluation Board process are keeping pace with most medical retention issues.

RECOMMEND the APDES Action Team in conjunction with: The Surgeon General continue to review AR 40-501 to keep pace with medical condition trends.

OBSERVATION 1.9: Army Military Treatment Facility Commanders are using generic position descriptions to hire Physical Evaluation Board Liaison Officers and Alternate Physical Evaluation Board Liaison Officers.

RECOMMEND the APDES Action Team in conjunction with:

a. The Surgeon General, in coordination with the Army G-1 and Assistant Secretary of the Army for Manpower & Reserve Affairs develop policy and guidance that addresses the standardization of hiring and selection of PEBLOs.

b. Commander, MEDCOM designate critical individual tasks for civilian and military PEBLOs and APEBLOs.

OBJECTIVE 2: Assess the execution and timeliness of the Physical Evaluation Board (PEB) and review processes to include compliance with Department of Defense (DOD) and Army policies.

FINDING 2.1: Army Regulations 10-59 and 635-40 are not consistent with other Army Regulations nor with DOD and Department of Veterans Affairs Policy.

RECOMMEND the APDES Action Team in conjunction with:

a. The Secretary of the Army direct the Assistant Secretary of the Army, for Manpower and Reserve Affairs, in conjunction with Office of the Secretary of Defense, the Surgeon General, and Office of the General Counsel, to review and revise where appropriate, Army policy to align the Army's adjudication of disability ratings to more closely reflect those used by the Department of Veterans Affairs.

b. The Deputy Chief of Staff, G-1, update Army Regulation 10-59 to reflect current Army policy.

c. The Deputy Chief of Staff, G-1, update Army Regulation 635-40 to include changes in the Department of Defense Instructions 1332.38 and 1332.39 and Department of Defense Directive 1332.18.

d. The Deputy Chief of Staff, G-1, update Army Regulation 635-40 to include all US Army Physical Disability Agency policy and Issue and Guidance memorandums.

e. The Deputy Chief of Staff, G-1, examine the Army Disability Rating Review Board as an appeal board and consider replacing it with the Army Board for Correction of Military Records.

f. Army Review Board Agency examine the use of the Army Disability Rating Review Board as disability review board and consider the sole use of the Army Board for Correction of Military Records as the retiree appeal recourse.

g. The Assistant Secretary of the Army, for Manpower and Reserve Affairs, in coordination with the US Army Physical Disability Agency present to the Department of Defense Disability Advisory Council the issue of whether the Department of Defense is properly applying the Veterans Administration Schedule for Rating Disabilities to the military departments.

FINDING 2.2: US Army Physical Disability Agency (USAPDA) uses an insufficient data management program (PDCAPS - Physical Disability Case Processing System) to manage Physical Evaluation Board cases.

RECOMMEND the APDES Action Team in conjunction with: US Army Physical Disability Agency in coordination with CIO G6 implement a real-time data management system that has the ability to communicate with Medical Evaluation Board Internal Tracking Tool and other DA software applications.

FINDING 2.3: The US Army Physical Disability Agency (USAPDA) does not consistently meet the DODI 1332.38 40-day standard for the processing time for a final disability determination.

RECOMMEND the APDES Action Team in conjunction with: Deputy Chief of Staff, G-1 reassess and revise the 40-day standard for disability case processing to reflect the potential time necessary for all levels of Soldier appeals.

FINDING 2.4: Processing Continuation on Active Duty (COAD) and Continuation on Active Reserve (COAR) requests resulted in additional time beyond the DODI 40-day standard in which Soldiers are in the Army Physical Disability Evaluation System.

RECOMMEND the APDES Action Team in conjunction with: Deputy Chief of Staff, G-1, consider an additional time period to process COAD and COAR cases and expand the DODI 40-day timeline standard for those cases.

FINDING 2.5: The USAPDA quality assurance program does not conform to DOD and Army policy.

RECOMMEND the APDES Action Team in conjunction with: US Army Physical Disability Agency establish a quality assurance program that promotes consistency of ratings by all of the Physical Evaluation Boards and provides feedback to the same on a regular basis.

FINDING 2.6: The training of personnel working in the Physical Evaluation Board (PEB) process does not meet the standards as specified in DODI 1332.38, AR 635-40, and US Army Physical Disability Agency's (USAPDA) SOP.

RECOMMEND the APDES Action Team in conjunction with:

a. US Army Physical Disability Agency enforce the requirements of the Army Regulation and Department of Defense Directives and Instructions to provide continuing training to its staff.

b. US Army Physical Disability Agency conduct regular staff assistance visits by the headquarters and Physical Evaluation Board staffs.

c. Office of The Judge Advocate General study the feasibility of sending Staff Judge Advocates in support of the Physical Evaluation Board process to the US Army Physical Disability Agency Senior Adjudicators course.

d. Office of The Surgeon General study the feasibility of sending Physical Evaluation Board Liaison Officers to the US Army Physical Disability Agency Senior Adjudicators course.

FINDING 2.7: Some Soldiers do not return for their required periodic examinations while in a Temporary Disability Retirement List status.

RECOMMEND the APDES Action Team in conjunction with:

a. US Army Physical Disability Agency impose stricter compliance in suspending retirement pay benefits for Soldiers who fail to show for their periodic physicals.

b. US Army Physical Disability Agency abide by the US Code and Department of Defense Instructions concerning cases that are over five years old.

c. US Army Physical Disability Agency consider incorporating the suspension of identification cards and access to TRICARE, in addition to suspending retirement pay benefits for Soldiers who fail to show for their periodic physicals.

FINDING 2.8: The Judge Advocate General (JAG) Corps currently provides quality legal representation to the Soldiers they represent at formal Physical Evaluation Boards.

RECOMMEND the APDES Action Team in conjunction with:

a. Office of The Judge Advocate General continue current staffing levels of full-time Judge Advocate General officers and Department of the Army civilians and provide sufficient training time of the attorneys prior to representing Soldiers before the Physical Evaluation Boards.

b. Office of The Judge Advocate General consider increasing staffing levels at the Physical Evaluation Board sites to permit counseling of Soldiers by experienced attorneys earlier in the Army Physical Disability Evaluation System process.

OBSERVATION 2.9: The US Army Physical Disability Agency (USPDA) and the Physical Evaluation Boards (PEBs) recognized the need for additional personnel to process the increased caseload as a result of the Global War on Terrorism (GWOT) and have made some progress.

RECOMMEND the APDES Action Team in conjunction with:

a. Human Resources Command-Alexandria reassess the Table of Distributions and Allowances; reallocating necessary resources to US Army Physical Disability Agency to assist them in effectively processing physical evaluation board cases.

b. US Army Physical Disability Agency reassess the Table of Distributions and Allowances and requisition the necessary manpower that provides the most effective Table of Distributions and Allowances strength to process physical evaluation board cases.

OBSERVATION 2.10: The Department of Veterans Affairs Schedule for Rating Disabilities does not accurately reflect medical conditions and ratings in today's environment.

RECOMMEND the APDES Action Team in conjunction with: US Army Physical Disability Agency present recommended Veterans Affairs Schedule for Rating Disability changes to Department of Defense Disabilities Advisory Council.

a. US Army Physical Disability Agency present recommended Veterans Affairs Schedule for Rating Disability changes to Department of Defense Disabilities Advisory Council.

b. Department of Veterans Affairs finish the full revision of the Veterans Affairs Schedule for Rating Disabilities and update the revised body function codes.

c. Commander, US Army Medical Command reassess and address the feasibility of having a common physical for use by the Department of the Army and the Department of Veterans Affairs.

OBSERVATION 2.11: Most Physical Evaluation Board (PEB), Judge Advocate General (JAG), and Department of Veterans Affairs (DVA) personnel know and understand the

applicable regulations and policies concerning the PEB process to include the differences between Army and DVA disability ratings.

RECOMMEND the APDES Action Team in conjunction with: Physical Evaluation Boards, installation Staff Judge Advocates, and Department of Veterans Affairs offices maintain the knowledge base of the current workforce and their replacements in order to best provide the correct information to Soldiers going through the Army Physical Disability Evaluation System.

OBSERVATION 2.12: A majority of the Soldiers interviewed do not know or understand the differences between Army and Department of Veterans Affairs (DVA) disability ratings.

RECOMMEND the APDES Action Team in conjunction with:

a. US Army Medical Command, in conjunction with the Regional Medical Commands, ensure quality counseling to Soldiers as set forth in Appendix C, AR 635-40 and conduct a post-counseling survey to verify understanding of the material.

b. US Army Medical Command require Soldiers in the Army Physical Disability Evaluation System to read AR 635-40 early in the process and provide proof that they have done so.

OBJECTIVE 3: Assess the execution of the Medical Hold System to include compliance with Department of Defense and Army policies.

FINDING 3.1: Current Army medical holdover guidance does not fully address the command and control component for medical holdover operations.

RECOMMEND the APDES Action Team in conjunction with:

a. Installation Management Command, in coordination with Assistant Secretary of the Army for Manpower and Reserve Affairs, Deputy Chief of Staff G1, and US Army Medical Command, update the Department of the Army Medical Holdover Consolidated Guidance to specify clear guidance on the command and control, and organizational structure of reserve component Soldiers assigned to Medical Holdover Units on active duty installations.

b. US Army Medical Command, in coordination with Assistant Secretary of the Army for Manpower and Reserve Affairs and Deputy Chief of Staff G1, update the Department of the Army Medical Holdover Consolidated Guidance to specify clear guidance on the command and control, and organizational structure of reserve component Soldiers assigned to Community Based Healthcare Organizations.

c. Installation Management Command, in coordination with Assistant Secretary of the Army for Manpower and Reserve Affairs, Deputy Chief of Staff G1, and US Army Medical Command, develop and implement standing operating procedures for Medical Holdover Operations, specifically for Medical Retention Processing Units.

d. Installation Management Command, with Assistant Secretary of the Army for Manpower and Reserve Affairs, Deputy Chief of Staff G1, and US Army Medical Command, complete development and implement the Medical Holdover Operations Systems Analysis and Review checklist to include by-item definitions and supporting standards of performance.

FINDING 3.2: A majority of Medical Holding Units (MHU) cadre and some Medical Retention Processing Units (MRPU), and Community Based Healthcare Organizations (CBHCO) cadre lack formal training.

RECOMMEND the APDES Action Team in conjunction with:

a. The Office of the Surgeon General develop training criteria for Medical Holding Unit cadre.

b. Assistant Secretary of the Army for Manpower and Reserve Affairs, in coordination with the Office of the Surgeon General, the Installation Management Command and US Army Medical Command, complete a by-position targeted training program for all Medical Holdover organization command and control and medical management cadre.

FINDING 3.3: Some Medical Hold and Medical Holdover Soldiers in the APDES process do not understand their rights and separation entitlements.

RECOMMEND the APDES Action Team in conjunction with:

a. Deputy, Chief of Staff G-1, review Army Regulation 635-40, Physical Evaluation for Retention, Retirement, or Separation, to ensure that Physical Evaluation Board Liaison Officer counseling is meeting the needs of wounded or injured Soldiers.

b. US Army Medical Command review the medical evaluation board briefings given at medical treatment facilities to ensure they meet the needs of wounded or injured Soldiers.

FINDING 3.4: Most medical hold and medical holdover Soldiers have duties within the limits of their medical profiles.

RECOMMEND the APDES Action Team in conjunction with: Medical Holding Units, Medical Retention Processing Units, and Community Based Healthcare Organizations continue ensuring medical hold and medical holdover Soldiers who are able to work have duties within the limits of their profiles.

FINDING 3.5: Medical Retention Processing Units (MRPU) and Community Based Health Care Organization (CBHCO) continuously update personnel and medical automation systems ensuring accurate accountability of medical holdover Soldiers.

RECOMMEND the APDES Action Team in conjunction with:

a. US Army Medical Command in coordination with Human Resources Command complete authorization for data input fields for HRC in Medical Operational Data System (MODS).

b. Medical Retention Processing Units and Community Based Healthcare Organization continue completing eMILPO and MODS transactions in accordance with the Department of Army Personnel Policy Guidance.

FINDING 3.6: A few installations inspected had Americans with Disabilities Act (ADA) violations affecting disabled Soldiers' access to facilities.

RECOMMEND the APDES Action Team in conjunction with:

a. US Army Physical Disability Agency, in coordination with host installations, develop installation support agreements to ensure the Physical Evaluation Board facilities are in compliance with Americans with Disabilities standards.

b. Installation Management Command ensure Medical Retention Processing Unit facilities are in compliance with Americans with Disabilities standards.

c. US Army Medical Command ensure Medical Holding Unit and Community Based Healthcare Organization facilities are in compliance with ADA Standards.

OBSERVATION 3.7: The majority of Medical Holding Units, Medical Retention Processing Units, and Community Based Healthcare Organizations lack authorization for critical staff and service support positions to effectively execute their missions.

RECOMMEND the APDES Action Team in conjunction with:

a. Deputy Chief of Staff, G-1, in coordination with US Army Medical Command and Installation Management Command, examine the possibility of increasing the personnel manning of Medical Holding Units, Medical Retention Processing Units, and Community Based Healthcare Organizations.

b. Deputy Chief of Staff, G-1, in coordination with US Army Medical Command and Installation Management Command, consider providing a Behavioral Health Specialist to the Medical Holding Unit and Medical Retention Processing Unit personnel structures.

OBSERVATION 3.8: The Community Based Healthcare Initiative program includes redundant and unnecessary levels of command and control.

RECOMMEND the APDES Action Team in conjunction with:

a. US Army MEDCOM, in coordination with ASA (M&RA), IMCOM, NGB and Chief, Army Reserve, review the Community Based Healthcare Initiative Transition Plan and eliminate unnecessary layers to command and control.

b. US Army MEDCOM develop a standardized Regional Medical Command organizational structure to provide required functions for Community Based Healthcare Organizations.

OBSERVATION 3.9: Some Medical Retention Processing Unit commanders and leaders indicated the use of sanctuary Soldiers as command and control support cadre hurts unit cohesion.

RECOMMEND the APDES Action Team in conjunction with:

a. Deputy Chief of Staff, G-1, in coordination with Human Resources Command, Installation Management Command, and US Army Medical Command create policy outlining the assignment criteria for command and control support cadre to Medical Retention Processing Units and Community Based Healthcare Organizations.

b. Installation Management Command, in coordination with the US Army Medical Command, develop job descriptions for Medical Retention Processing Unit command and control cadre.

c. US Army Medical Command, in coordination with the Installation Management Command, complete the development of job descriptions for Community Based Healthcare Organizations command and control cadre.

OBSERVATION 3.10: The majority of commanders and leaders indicated that assigning Soldiers in the Army Physical Disability Evaluation System (APDES) to an Installation Garrison Command / Medical Holding Unit (MHU) on their assigned installation would benefit both the Soldiers and units.

RECOMMEND the APDES Action Team in conjunction with:

a. Installation Management Command in coordination with OTSG and FORSCOM review the feasibility of integrating MH (AC) operations with MHO (RC) operations.

b. Installation Management Command in coordination with OTSG, Deputy Chief of Staff G1 and HRC develop a standardized infrastructure to support an Installation Garrison Command in the absorption of select Soldiers in the Army Physical Disability Evaluation System (APDES).

c. Installation Management Command provide the C2, personnel, training and transportation for select Soldiers in the Army physical Disability Evaluation System (APDES).

OBSERVATION 3.11: The Army is not providing timely manning support for Community Based Healthcare Organizations (CBHCOs) and Medical Retention Processing Units (MRPUs) to support the mobilized RC Soldiers who will use those organizations.

RECOMMEND the APDES Action Team in conjunction with: Deputy Chief of Staff, G-3, in coordination with Human Resources Command, Installation Management Command, and US Army Medical Command develop policy that projects, on a regional basis, the assignment of C2 support cadre to Community Based Healthcare Organizations (CBHCO) and Medical Retention Processing Units (MRPU) to match the mobilization and demobilization requirements of RC Soldiers.

OBJECTIVE 4: Assess impacts of other administrative areas on the Army Physical Disability Evaluation System.

FINDING 4.1: Some Soldiers are arriving at Medical Holding Units or Medical Retention Processing Units without a Line of Duty (LOD) or with incomplete LOD documentation.

RECOMMEND the APDES Action Team in conjunction with:

a. US Army commands conduct training to educate commanders and leaders on the importance of completing LODs in accordance with the required regulations/policies.

b. US Army Medical Command review screening procedures at MTFs to ensure identification of wounded or injured Soldiers requiring LODs.

FINDING 4.2: Medical Treatment Facilities are not transferring required medical documentation for Soldiers transferred through the Medical Hold System.

RECOMMEND the APDES Action Team in conjunction with:

a. US Army Medical Command enforce regulatory guidance regarding the transfer of medical documentation.

b. US Army Medical Command continue the fielding of Armed Forces Health Longitudinal Technology Application (AHLTA).

FINDING 4.3: When conducted, commands with MOS/Medical Review Board (MMRB) convening authority conduct MMRBs in accordance with Army Regulations.

RECOMMEND the APDES Action Team in conjunction with:

- a. Commands with MOS/Medical Retention Board (MMRB) convening authority train and educate subordinate commanders and board members on the MMRB and their responsibilities in the process.
- b. Commands with MOS/Medical Retention Board (MMRB) convening authority maintain MMRB statistics in accordance with Army Regulation 600-60.
- c. Deputy Chief of Staff, G-1 and US Army Reserve Command examine ways to improve the timeliness for issuing permanent profiles for USAR Soldiers with physical exams processed through Federal Strategic Health Alliance Program and Human Resource Command-St. Louis.

FINDING 4.4: Most Soldiers interviewed reported successful recovery of their personal and organizational property following medical evacuation from overseas locations.

RECOMMEND the APDES Action Team in conjunction with:

- a. US Army Commands ensure subordinate commanders comply with AR 735-5 and Department of the Army All Army Activities 139/2006 P210236Z July 2006 Message, Policies and Procedures for Handling Personal Effects and Government Property.
- b. US Army MEDCOM and Installation Management Command ensure Medical Holding Units and Medical Retention Processing Units include a briefing during in-processing on how to file claims with the Installation Claims Office for lost personally owned property.

OBSERVATION 4.5: Physical Evaluation Board personnel perceive the Military Occupational Specialty (MOS)/Medical Retention Board is underused resulting in some Soldiers separating through the Army Physical Disability Evaluation System unnecessarily.

RECOMMEND the APDES Action Team in conjunction with:

- a. Deputy Chief of Staff G1 consider revising Army Regulation 635-40 to allow USAPDA to refer Soldiers to a MOS/Medical Retention Board.
- b. Deputy Chief of Staff G1 conduct a study to determine if commands are utilizing the MOS/Medical Retention Board as intended for the Personal Performance Evaluation System.

c. US Army Medical Command ensure physicians are trained and understand when a Soldier should be referred to an MOS/Medical Retention Board versus Medical Evaluation Board.

d. Commands and units with MOS/Medical Retention Board convening authority establish procedures for screening permanent profiles to determine whether to refer a Soldier to an MOS/Medical Retention Board versus Medical Evaluation Board.

OBSERVATION 4.6: Medical Retention Processing Units (MRPU) and Community Based Healthcare Organizations (CBHCO) do not accurately track Reserve Component (RC) Soldiers' Medical Retention Process (MRP) orders and completed packets.

RECOMMEND the APDES Action Team in conjunction with:

a. Installation Management Command in coordination with US Army MEDCOM, and Human Resources Command continue the current implementation plan to conduct bi-annual medical holdover training for Medical Retention Processing Units and Community Based Healthcare Organizations.

b. US Army Medical Command, in coordination with Human Resources Command-Alexandria complete authorization for data input fields in Medical Operational Data System.

OBSERVATION 4.7: Most installation transition centers have additional personnel to handle the increased transition processing workload created by the Global War on Terrorism in order to meet the Army time standards.

RECOMMEND the APDES Action Team in conjunction with:

a. Installation Management Command continue to fund installation transition centers to ensure timely discharge, release from active duty, and retirement orders publishing and disability separation processing.

b. U.S. Army Physical Disability Agency take steps to eliminate the error of placing Soldiers on the wrong installation transition processing notification list.

OBSERVATION 4.8: Most commanders and leaders at brigade level and below do not understand the Army Physical Disability Evaluation System and their responsibilities in the process.

RECOMMEND the APDES Action Team in conjunction with:

a. Training and Doctrine Command include Army Physical Disability Evaluation System training in the brigade and battalion pre-command courses and the sergeants major course.

b. Army Commands include Army Physical Disability Evaluation System training in their company commander and first sergeant courses that includes the unit's role and responsibilities.

c. Office of the Surgeon General develop training materials and programs to educate unit leaders on all aspects of the Army Physical Disability Evaluation System to include their responsibilities.

OBSERVATION 4.9: A majority of Medical Holdover Soldiers have little or no contact with their home station Reserve Component units.

RECOMMEND the APDES Action Team in conjunction with:

a. Deputy Chief of Staff, G1 complete development of a personnel system that allows Reserve Component commanders to track their mobilized Soldiers and subsequently assigned to Medical Holdover status.

b. US Army Reserve Command develop procedures to enable and require Commanders to contact Soldiers and their families while in Medical Holdover status.

c. National Guard Bureau develop procedures to enable and require commanders to contact Soldiers and their families while in Medical Holdover status.

OBSERVATION 4.10: The majority of MTFs, MHUs, MRPU, and CBHCOs inspected feel TRICARE does an excellent job providing quality medical care for Soldiers.

RECOMMEND the APDES Action Team in conjunction with:

a. TRICARE Management Agency review its policy regarding reimbursement of those civilian providers authorized to provide medical treatment to DoD beneficiaries.

b. TRICARE Management Agency review or revise criteria used to certify physicians in remote locations in order to provide care for Soldiers residing there.

BEST PRACTICES

1. Medical Evaluation Board (MEB) Process Organization. Eisenhower Army Medical Center organized its MEB process so that all personnel conducting the MEB process fall under the one chain of command, the DCCS. This centralization of focus replaces the usual two chains of command, the physicians assigned to the DCCS and the PEBLOs

assigned to the DCA. Eisenhower AMC has an experienced MEB physician who runs the MEB process and uses MEBITT data to evaluate the process.

2. Patient Administrative Division (PAD) Assessment Tools. Walter Reed Army Medical Center PAD has developed an excellent internal assessment tool by using MEBITT to track not only the organization's MEB process, but the efficiency of each alternate PEBLO. This modified use of MEBITT allows the display of a large variety of metrics and information on each PEBLO to include: number of MEB cases completed, the number of cases returned, and the processing time of MEB cases. This oversight gives the MTF leadership the ability to evaluate the timeliness, accuracy, and thoroughness of the individual PEBLO.

3. MEDCOM use of the Balanced Score Card. MEDCOM use of the Balanced Score Card is a top down driven assessment of Military Treatment Facilities performance based on metrics derived from MEBITT. It gives the MTF leadership an independent assessment of their MEB process. This is critical for MTF leaders with inexperienced Patient Affairs Directors, since they might not be able to independently verify the data given to them by their PEBLOs.

4. Use of Standardized MEB Psychiatrist Memorandum. Walter Reed Army Medical Center Department of Psychiatry has a standardized MEB Psychiatrist Memorandum. This Narrative Summary template has pull down windows which assist psychiatrists in writing NARSUMs. It does not replace the experience of psychiatrists; it makes the psychiatrists more efficient.

5. Transition Center In-processing Briefing. Fort Gordon Transition Center (TC) conducts a briefing for Soldiers upon in-processing the Medical Holding Unit or Medical Retention Processing Units. The briefing directed Soldiers to complete critical tasks such as gathering documents for DD Form 214, taking leave, starting the ACAP (which includes the VA) process, attending pre-retirement briefings if applicable, and turn-in/clearing of the installation Central Issuing Facility, before their REFRAD or separation determination. The TC also established an agreement with the servicing Medical Treatment Facility (MTF) that when a Soldier's Physical Evaluation Board case has completed all appeals and reviews, the MTF sends the Soldier to the TC to begin the transition process. The briefing and agreement helps in meeting the Army time standards for publishing separation or REFRAD orders and out-processing.

CHAPTER 1

OBJECTIVES AND METHODOLOGY

1. Objectives (Reference Appendix 1-Inspection Directive).
 - a. Assess the execution and timeliness of the Medical Evaluation Board (MEB) process to include compliance with DOD and Army policies.
 - b. Assess the execution and timeliness of the Physical Evaluation Board (PEB) and review processes to include compliance with DOD and Army policies.
 - c. Assess the execution of the Medical Hold System to include compliance with DOD and Army policies.
 - d. Assess the impact of other administrative areas on the Army Physical Disability Evaluation System.
2. Inspection Team.

The inspection team consists of nine members assigned within the U.S. Army Inspector General Agency (USAIGA) Inspections Division and seven augmentees assigned from various organizations US Army MEDCOM, USAPDA, OTJAG, NGB, USAR listed below:

Duty Position	Organization (Area of Expertise)
Detailed Inspector General/Team Chief	USAIGA
Detailed Inspector General	USAIGA
Assistant Inspector General	USAIGA
Assistant Inspector General	USAIGA
Assistant Inspector General	USAIGA
Expert from OTSG/Augmentee	US Army MEDCOM (MEB)
Expert from OTSG/Augmentee	OTJAG
Expert from OTSG/Augmentee	US Army MEDCOM (PAD)
Expert from OTSG/Augmentee	NGB (Personnel Policy)
Expert from OTSG/Augmentee	USAR (Personnel Policy)
Expert from OTSG/Augmentee	USAPDA (PEB)
Expert from OTSG/Augmentee	US Army MEDCOM (PEBLO)

3. Methodology and Scope. The DAIG team has visited 32 locations throughout CONUS and OCONUS.

a. Individual interviews and group sensing sessions were conducted with 652 leaders, Soldiers and civilians at 32 installations CONUS and OCONUS.

b. Document Review. The DAIG team reviewed applicable Army, Major Army Command, and local unit policies, personnel records, standing operating procedures, tracking systems, and other related documents.

NOTE: In the report, quantitative terms, such as "few, some, majority, and most" are used to describe percentile ranges of personnel interviewed, sensed, or surveyed. The terms are also used to represent a percentile of units/organizations inspected linked to specific findings or observations. These terms are defined as:

Few	1% to 25%
Some	26% to 50%
Majority	51% to 75%
Most	76% to 100%

c. Locations and Major Headquarters visited.

Albany / Latham - JFHQ-NY
Austin - JFHQ-TX, TX NG MEDCOM, 36th ID Texas ARNG
Birmingham - 81st RRC, CBHCO Company
Camp Shelby – MRPU
Fort Benning - Martin ACH, MRPU
Fort Bliss - WBAMC, MRPU
Fort Buchanan - 65th RRC, Hybrid CBHCO
Fort Drum - MEDDAC, MRPU
Fort Dix - Medical Retention Processing Unit (MRPU)
Fort Gillem - First US Army
Fort Gordon - Southeast RMC, Eisenhower AMC, MRPU
Fort Hood - III Corps, 1CAV, Darnall AMC, MRPU
Fort Jackson - TF East (CBHCO)
Fort Lewis - I Corps, Western RMC, Madigan AMC, PEB
Fort McCoy - MRPU & Army Reserve Finance Center
Fort McPherson - FORSCOM, USARC
Fort Richardson - MRPU, Hybrid CBHCO
Fort Sam Houston - MEDCOM, Great Plains RMC, BAMC, PEB, Task Force West - CBHCO
Fort Stewart - 3rd ID, Winn ACH, MRPU
Fort Shafter - 9th Regional Readiness Command (RRC) Pacific RMC, Tripler AMC, MRPU
Fort Wainwright - Bassett ACH
Heidelberg - USAREUR, Europe RMC, Units
Landstuhl - Landstuhl RMC

Little Rock - CBHCO Company
Sacramento - CBHCO Company
Schofield Barracks - 25th ID
Troy - 42nd ID NY ARNG
Virginia Beach - Virginia Community Based Health Care Organization (CBHCO)
Company
Walter Reed Army Medical Center (AMC), North Atlantic Regional Medical
Command (RMC), USAPDA, PEB
Watervliet Arsenal - NY NG MEDCOM
Wiesbaden - 1st Armored Division

4. Preliminary Finding/Observation Format.

a. Where a violation of a published standard, policy, law or regulation existed, a preliminary finding statement was developed and is addressed in the following format:

Finding Statement
Standard
Root Cause
Discussion
Recommendations

b. Where there was no violation of a published standard, policy, law, or regulation, but a preliminary observation was made to improve current operations, a preliminary observation statement was developed and is addressed in the following format:

Observation Statement
Discussion
Recommendations

c. Best Practices. Best Practices observed by the inspection team are highlighted as worthy of Army-wide identification and recognition. Best Practices can be found in Chapter 3 of this report.

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CHAPTER 2

FINDINGS AND OBSERVATIONS

The Inspector General will provide the following inspection data and a comprehensive briefing to the APDES Action Teams that will further review the MEB and the PEB. The assessment data will include: Findings, Observations, and Recommendations on the MEB/PEB process, the execution of Medical Hold and Medical Holdover System, to include compliance with DoD and DA policy, and the assessment of the administrative areas on APDES.

OBJECTIVE 1 - Assess the execution and timeliness of the Medical Evaluation Board process to include compliance with DOD and Army policies.

In each of the last two Fiscal Years (2005 and 2006), the US Army Medical Command (MEDCOM) has processed approximately 11,000 Medical Evaluation Board (MEB) cases at 37 Military Treatment Facilities (MTFs) and six Community Based Health Care Organizations (CBHCOs). The volume of MEB cases has significantly increased from the 6,560 cases in Fiscal Year 2002. These MEB cases include the Army's Active and Reserve Components. Most Soldiers in the MEB process receive the required counseling. The medical evaluation portion of MEB cases are usually preformed by designated MEB Physicians (MEBP) while the administrative portions of MEB cases are processed by Physical Evaluation Board Liaison Officers (PEBLOs) and Alternate PEBLOs (APEBLOs). [The term PEBLOs refers to both Primary PEBLOs and APEBLOs.] The Department of Defense (DOD) and Army have different standards for processing MEB cases, yet MEDCOM meets neither the DOD nor Army standards. The DOD 30-day standard is measured from the date the physician dictates the Narrative Summary to the date the case is received by the Physical Evaluation Board (PEB). The Army 90-day standard is measured from the permanent profile signing date to the date the MEB case is forwarded to the PEB. Army policy on MEBs is inconsistent and does not fully and accurately integrate DOD policy. However, Army policy on medical retention standards is keeping pace with most medical retention issues. MEDCOM measures the overall quality of MEB cases based on the amount of cases returned by the PEB. MEDCOM is not meeting the 10% return rate standard for MEB cases. MEDCOM uses the Medical Evaluation Board Internal Tracking Tool (MEBITT) database to track MEB cases. However, there is insufficient quality management of and training on the use of MEBITT, which leads to inaccurate reporting of the status of Soldiers in the Army Physical Disability Evaluation System. Additionally, there is a lack of formal training for MEBPs and PEBLOs on their duties and responsibilities in processing Soldiers referred to a MEB.

FINDING 1.1: US Army is not meeting the Department of Defense 30-day standard for processing Medical Evaluation Board cases which is measured from the date the physician dictates the Narrative Summary to the date the case is received by the Physical Evaluation Board.

STANDARDS:

- a. Department of Defense Directive 1332.18, Separation or Retirement for Physical Disability, 4 November 1996, Paragraph 1.3.
- b. Department of Defense Instruction 1332.38, Physical Disability Evaluation, 14 November 1996, Enclosure 3, Paragraph E3.P1.6.2.1.
- c. Army Regulation 40–400, Patient Administration, 13 October 2006, Paragraph 7-1.
- d. US Army Medical Command Memorandum, Metrics and Procedures for improving Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB) Processing, 20 September 2001, Enclosure 1, Paragraph 1, Subparagraph b.
- e. US Army Medical Command Memorandum, Medical Evaluation Board (MEB)/Physical Evaluation Board (PEB) Referrals Using the DA Form 3349, Physical Profile, 07 October 2004, Paragraph 4.

ROOT CAUSE: The Army through US Army Medical Command (MEDCOM) does not track, report, nor correctly interpret the DOD 30-day standard.

DISCUSSION:

- a. The Army is not meeting the Department of Defense (DOD) 30-day standard for processing the Narrative Summary (NARSUM) portion of MEB Cases. MEDCOM is the Army command responsible for processing NARSUMs. The DOD standard measures from the date the physician dictates the NARSUM to the date the MEB case is received by the PEB. DOD Instruction (DODI) 1332.38, E3.P1.6.2.1, which refers only to duty related medical conditions, states “When a physician initiates a MEB, the processing time should normally not exceed 30 days from the date the MEB report is dictated to the date it is received by the PEB.” In addition to not meeting the DOD standard, Army and MEDCOM policy do not accurately apply the 30-day standard. MEDCOM measures the DOD standard from the date the physician dictates the NARSUM until the MEB case is mailed to instead of received by the PEB.
- b. DAIG analysis of US Army Physical Disability Agency (USAPDA) data reveals that from 1st quarter Calendar Year 2005 through 2nd quarter Calendar Year 2006, a majority (57%) of MEB cases did not reach the PEB within 30 days of NARSUM dictation. Inability to meet the DOD standard has been a continuous problem across the Army’s Military Treatment Facilities (MTFs). Since 2002, a majority (61%) of MTFs did not meet the DOD standard. This data does not include the Community Based Health Care Organizations (CBHCOs) in which most (82%) MEB cases not meet the DOD 30-day standard.

c. DAIG evaluated the quality of record keeping at MTFs and the use of MEDCOM's Medical Evaluation Board Internal Tracking Tool (MEBITT) database. MEDCOM directed the use of MEBITT to track and monitor the DOD 30-day standard. Some (44%) MTFs had notable inaccuracies in how they recorded the NARSUM data. In a few cases, draft NARSUMs were repeatedly revised before the NARSUM was recorded in MEBITT, thus allowing those MTFs an additional week of unreported processing time.

d. Data collection in MEBITT does not conform to the DOD 30-day standard. The data generated by MEBITT is based on an approximate time period. MEBITT uses two data fields to track DOD 30-day standard. One is the date the physician dictates the NARSUM and the other is the date the Physical Evaluation Board Liaison Officer (PEBLO) mails the case to the PEB (with an additional three days added on for mailing time). Since MEBITT does not interface with USAPDA's database, Physical Disability Case Processing System (PDCAPS), the PEBLO uses an approximate date. However, PDCAPS captures the date of the dictation off of the NARSUM and also captures the date USAPDA receives the MEB case.

e. There was confusion at the MTF level about the correct interpretation of the DOD 30-day standard. Specifically, confusion exists about the meaning of the term "dictation," as well as when a dictation occurs. Some PEBLOs, and MEB Physicians (MEBP) stated that dictation occurs when the physician records the results of the MEB Examination into a microphone. Other PEBLOs and MEBPs stated dictation covers the entire process from speaking into the microphone through transcription of the NARSUM and delivery of the complete NARSUM to the MEBP. Using the latter interpretation gives the PEBLO an additional week. The transcription process includes typing the spoken report and sending it to the MEBP who then makes corrections and returns it for retyping. The PEBLO assembles the complete MEB case (MEB administrative data and NARSUM), submits it to the MTF command level for review and approval, and sends it to the PEB.

f. The confusion at the MTF level is related to inconsistent Army and MEDCOM policy. AR 40-400, 13 Oct 06 and a 20 Sep 01 MEDCOM Memorandum inaccurately restate the DOD 30-day standard. As cited above in paragraph a., DODI 1332.38, states "When a physician initiates a MEB, the processing time should normally not exceed 30 days from the date the MEB report is dictated to the date it is received by the PEB." Both AR 40-400 and the 20 Sep 2001 MEDCOM Memorandum incorrectly state that the time metric is from NARSUM dictation to the forwarding/ mailing of the MEB case to the PEB. The 7 Oct 2004 MEDCOM Memorandum correctly states the time metric is from NARSUM dictation to the receipt of the MEB case at the PEB. AR 40-400 is a recent revision and the two MEDCOM memorandums are still considered current policy.

RECOMMENDATIONS. The APDES Action Team in conjunction with:

a. The Surgeon General update policy on the start and end date of actions occurring in the Medical Evaluation Board process.

b. Commander, US Army Medical Command, review quality management of the Medical Evaluation Board Internal Tracking Tool database.

FINDING 1.2: The majority of Regional Medical Commands are not meeting the Army 90-day standard for processing Medical Evaluation Boards.

STANDARDS:

a. Army Regulation 40–400, Patient Administration, 13 October 2006, Paragraph 7-1.

b. US Army Medical Command Memorandum, Metrics and Procedures for improving Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB) Processing, 20 September 2001, Enclosure 1, Paragraph 1, Subparagraph a,

c. US Army Medical Command Memorandum, Medical Evaluation Board (MEB)/Physical Evaluation Board (PEB) Referrals Using the DA Form 3349, Physical Profile, 07 October 2004, Paragraphs 3 and 4

d. Verbal order by Commander, US Army Medical Command, directed that 70% of Medical Evaluation Board cases should be completed within 90 days from issuance of permanent profile through the date the case is forwarded to the Physical Evaluation Board.

ROOT CAUSE: Lack of training on and inconsistent interpretation of the Army standards.

DISCUSSION:

a. The majority (56%) of Regional Medical Commands (RMCs) did not meet the US Army Medical Command's (MEDCOM's) standard of completing 70% of Medical Evaluation Board (MEB) cases within 90 days. There was confusion at the Military Treatment Facility (MTF) level on the correct interpretation of the 90-day standard. The recently revised AR 40-400 cites the DOD 30-day standard but not the Army 90-day standard. Finally, the increased volume of MEB cases has led MEDCOM to augment the MTF staffs conducting the MEB process.

b. Commander, MEDCOM, issued two memoranda and a verbal order, establishing the 90-day standard for completion of the MEB process. The 90 day standard is measured from the permanent profile signing date to the date the MEB case is forwarded to the PEB. RMCs and MTFs are expected to complete 70 % of MEB cases within 90 days. During an 18 month period (3rd quarter Fiscal Year (FY) 2005 through 4th quarter FY 2006), only one RMC consistently met the 70 % standard. Four other RMCs met the standard less than 50 % of the time. During the 18 months, the RMCs processed 15,333 MEB cases, of which 9,638 were processed in FY 2006.

c. There was confusion among PEBLOs and physicians due to inconsistent interpretation of the 90-day standard. Some MTFs used the date the physician signed the permanent profile while other MTFs applied different standards. The standard is stated in the 07 October 2004, MEDCOM Memorandum, paragraph 3, which states "Physicians who identify Soldiers with medical conditions not meeting the medical fitness standards for retention will initiate a DA Form 3349 referring them to the Physical Disability Evaluation System...." Paragraph 4 further clarifies the start of the 90 day period in the second sentence; which states " The date the profiling officer signs the physical profile referring the Soldier to the MEB begins the Medical Command (MEDCOM) 90-day period within which the MEB process must be completed."

d. MTFs interpreted the start of the 90-day period differently. Some MTFs used the date the Deputy Commander for Clinical Services (DCCS) or another approving authority signed the permanent profile. Still other MTFs issued a "letter of intent" which informed the Soldier that they would go through the MEB process. Using either of these two interpretations gives the PEBLO at least one additional week to process the MEB. Due to the different interpretations and variation in start dates, comparison of the 90-day period becomes subjective. Across the MTFs there was a consistent end date; as all MTFs used the day the MEB case was mailed.

e. The recently revised AR 40-400, 13 October 2006, does not include the Army 90-day standard. The only measure cited is the DOD 30-day standard, in paragraph 7-1. This is inconsistent with MEDCOM practices since MEDCOM does not track the DOD 30-day standard. MEDCOM tracks the Army 90-day standard and reports MTFs results in a quarterly Balanced Scorecard report.

f. The timeliness of MEB processing has come to light in part due to the increased number MEB cases, which strains MEDCOM's capacity. The increased number of MEB cases has not led to an equal increase in MEBP, APEBLOs, and training. In response to these issues, MEDCOM has implemented a Lean Six Sigma process to meet timeliness and quality management requirements in the MEB process. Two major issues affecting timeliness of MEBs are a lack of training and resources (PEBLOs and MEB Physicians) at MTFs. The Army has no formal training program for PEBLO operations/functions. Training for PEBLOs and Alternate PEBLOs differs at each MTF. The current system requires extensive OJT and has no educational standards. Physicians learn to do MEBs as a resident in some cases. At a majority (75%) of MTFs, a shortage of physicians, to include specialty physicians, has led to increased waiting time for appointments and longer processing times for the MEB.

g. MEDCOM increased MTF funding and is using GWOT funds to expand Patient Administration Division (PAD) operations to meet the surge in MEBs. Some MTFs use contractors and limited term hires to fill APEBLO positions. At some MTFs these additional personnel are offsetting the increased volume of MEB cases or at least keeping the MTF from falling further behind. The term hire positions last up to three years, which is good, but turnover can be high.

h. Another MEDCOM initiative to improve timeliness of the MEB process is the use of an MEB Physician. Most (81%) of the inspected MTFs had a dedicated MEB physician or were in the process of hiring one. These physicians provide consistency in the MEB process, but, their training is not standardized. Newly hired or assigned MEB physicians require specific training in the nuances of the MEB process, especially the completion of NARSUMs. The Army has no formal training program for physicians conducting MEBs. Although Army physicians may receive some training on MEBs, there are neither measured requirements nor residency program requirements. The specificity of the NARSUM requires practice-based learning.

i. Once the MEB process has begun, the use of a TRICARE provider puts great strain on meeting the 90-day standard. A majority (69%) of the inspected MTFs use TRICARE Network providers to supplement available care and provide care when Army resources are not available. While MEDCOM has made MEB appointments a priority, TRICARE does not have the same appointment timelines. TRICARE has 30 days to get the Soldier seen, so if the Soldier has already started the MEB, there is a potential for the case to languish as the Soldier completes their physical examination or seeks treatment for other medical issues that were not part of the initial diagnosis.

RECOMMENDATIONS. The APDES Action Team in conjunction with:

a. The Surgeon General update Army Medical policy to include the Army 90-day standard and clarify the action that begins the Medical Evaluation Board process.

b. Commander, US Army Medical Command, develop training standards and educational requirements for PEBLOs, Alternate PEBLOs, and physicians conducting Medical Evaluation Boards.

FINDING 1.3: Most Regional Medical Commands are not meeting the 10% return rate standard for Medical Evaluation Boards returned from the Physical Evaluation Board.

STANDARDS:

a. Army Regulation 635-40, Physical Evaluation for Retention, Retirement, or Separation, 8 February 2006, Paragraphs 2-8, subparagraphs a and c.

b. Commander, US Army Medical Command Memorandum, Metrics and Procedures for improving Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB) Processing, 20 September 2001, Enclosure 1, Paragraph 1, Subparagraph c, and Paragraph 8

ROOT CAUSE: Inadequate training of Physical Evaluation Board Liaison Officers and MEB Physicians on the Medical Evaluation Board process.

DISCUSSION:

a. Most (83%) US Army Regional Medical Commands (RMCs) consistently do not meet the 10% return rate standard for Medical Evaluation Boards (MEBs) sent to the Physical Evaluation Board (PEB). The MEDCOM Memorandum dated 20 September 2001 established the return rate standard. MEDCOM uses the MEB case return rate as a metric to gauge the thoroughness and accuracy of the cases sent to the PEB. The return rate metric has the benefit of measuring the completeness of cases and also illuminates Physical Evaluation Board Liaison Officers (PEBLOs) who send incomplete MEB cases to the PEB to make the 90 day standard. MEDCOM, as a whole, does not consistently meet this standard.

b. The DAIG analyzed data from two sources: data provided by the PEB and documents reviewed at the inspection sites. The PEB data covers three 11-month periods. The first is from November 2001 through September 2002. The second period is from November 2004 through September 2005. The third period has some overlapping data; it runs from July 2005 through April 2006. In addition to the PEB data, the DAIG collected and analyzed 490 of the approximately 1600 cases returned to MTFs in Fiscal Year 2006. The 490 cases were returned to Army Medical Centers, Army Health Clinics, Army Community Hospitals, and CBHCOs. The DAIG used this data as a control and found no appreciable differences from the data provided by the PEB.

c. Over the last few years (FY02 – FY06) the overall MEDCOM MEB case return rate has ranged from 16% to 13%. The most recent data from PDCAPS (PEB's database) has MEDCOM at 14%. MEDCOM established the 10% standard in September 2001. MEDCOM does not consider the complexity of MEB cases when evaluating MTFs against this standard.

d. PEB reported the following return rates and number of returned cases:
From Nov 01 - Sep 02 - 16.6% (1403 cases returned of 8465 submitted).
From Nov 04 – Sep 05 - 13.1% (1667 cases returned of 12706 submitted).
From Jul 05 – Apr 06 - 14.4% (1562 cases returned of 10822 submitted).

e. The PEB returns MEB cases for medical and/or administrative reasons. Within these two categories are a variety of reasons (identified by a code) and usually there is more than one code for the returned case. As an example, the most common code for case return is the MEB physical. The breakdown of codes per case for reported periods follows:

From Nov 01 - Sep 02 - 1,403 returns w/ 3,341 codes, 2.4 codes per case.
From Nov 04 – Sep 05 - 1,667 returns w/ 2,394 codes, 1.4 codes per case.
From Jul 05 – Apr 06 - 1,562 returns w/ 2,354 codes, 1.5 codes per case.

f. DAIG analysis of the 490 returned MEB cases revealed that most returned cases were for "Medical" reasons. When the PEB returns a case the PEBLO usually receives

a transmittal memorandum which states the reason(s) for the case return. Over 80% of the returned cases were for medical data.

RECOMMENDATION: The APDES Action Team in conjunction with the Commander, US Army Medical Command, develop training standards and certification requirements for PEBLOs, Alternate PEBLOs, and physicians conducting Medical Evaluation Boards.

FINDING 1.4: Most Soldiers in the Medical Evaluation Board process are receiving the required counseling.

STANDARDS:

a. Department of Defense Directive 1332.18, Separation or Retirement for Physical Disability, 4 November 1996, paragraph 3.2

b. Department of Defense Instruction 1332.38, Physical Disability Evaluation, 14 November 1996, Enclosure 3, Paragraph E3.P1.4

c. Army Regulation 635-40, Physical Evaluation for Retention, Retirement, or Separation, 8 February 2006, Paragraphs 3-8, 4-12, 4-15, 4-20, 4-21, 6-8, 7-5, 7-20, and Appendix C

ROOT CAUSE: Army policy does not require an assessment of the effectiveness of the counseling of Soldiers in the MEB process.

DISCUSSION:

a. Most (94%) inspected MFTs complete the required counseling of Soldiers in the MEB process. Both DOD and Army policy specifically state the minimum counseling a Soldier in the MEB process must receive. The Army has incorporated these counseling requirements into the checklist the PEBLO must fill out and the Soldier must sign before the MEB case can be forwarded to the PEB. A shortfall in the Army counseling process is a lack of post-counseling assessment to measure the effectiveness of the counseling.

b. DOD and Army cover counseling requirements in good detail. DODI 1332.38 paragraph E3.P1.4. "Counseling" states the overall topics that will be covered in counseling. Army policy is specific in what counseling will occur and who will conduct the counseling. AR 40-501, Appendix C, is dedicated to counseling. The Appendix goes into depth about the different counseling that occurs at each stage of the MEB process. The Appendix states who will do the counseling, when a Soldier will be counseled and what the counseling will cover.

c. In 15 of 16 inspected MTFs, the PEBLOs were conducting the required counseling of Soldiers in the MEB and PEB processes. In the one MTF where the PEBLO was not conducting the counseling, the PAD officer conducted the counseling.

While the counseling occurred, it did not occur in accordance with AR 40-501, appendix C which states that the PEBLO will conduct the counseling. At all MTFs, PEBLOs had copies of MEB cases showing where Soldiers had initialed the form that they had received counseling. Furthermore, The PEB will return a MEB case to the MTF if the counseling has not occurred. DAIG examined 490 MEB cases returned by the PEB and none of the cases were for a lack of counseling.

d. The effectiveness of Soldier counseling was hindered by the limited face to face contact between the Soldier and their PEBLO. DOD and Army policy specifically state the minimum amount of counseling a Soldier must receive; however, this may not have been sufficient to meet the needs of the Soldier. The ratio of PEBLO to Soldiers differed at inspected MTFs, with some as high as 50 to 1. At a few inspected MTFs, these manpower issues were mitigated by the hiring of Term Employees for up to a three year period.

e. The DAIG team found little evidence that PEBLOs were conducting post-counseling surveys or post-APDES surveys to measure the effectiveness and impact of the counseling. This lack of verification of the Soldier's understanding of the MEB/PEB processes corresponds with DAIG interviews of Soldiers currently in APDES who state they have not received adequate counseling. The Army process for training Soldiers in any MOS related training is a cooperative effort between the trainer and the Soldier. In MEB/PEB processing, the Soldier gets counseling, but there are no metrics to gauge the Soldier's knowledge proficiency of the MEB/PEB process. The current MEB counseling standards do not require evaluation of the effectiveness of the counseling.

RECOMMENDATIONS. The APDES Action Team in conjunction with:

a. Commander, US Army Medical Command, determine and enforce the maximum PEBLO to Soldier ratio.

b. Commander, US Army Medical Command, develop a series of post-counseling surveys to assess the Soldier's understanding of the MEB/PEB processes.

FINDING 1.5: Insufficient quality management of and training on the use of Medical Evaluation Board Internal Tracking Tool (MEBITT) database leads to inaccurate reporting of the status of Soldiers in the Army Physical Disability Evaluation System.

STANDARDS:

a. Army Regulation 5-1, Total Army Quality Management, 15 March 2002, Paragraph 1-4, Subparagraph (e), and Paragraph 3-1 Subparagraphs (f) (2), and Paragraph 3-3 Subparagraphs (a) (1) and (a) (5).

b. US Army Medical Command Memorandum, Metrics and Procedures for improving Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB) Processing, 20 September 2001, Enclosure 1, Paragraph 9.

c. US Army Medical Command Memorandum, Medical Evaluation Board (MEB)/Physical Evaluation Board (PEB) Referrals Using the DA Form 3349, Physical Profile, 07 October 2004, Paragraph 4.

d. United States Government Accountability Office, Military Disability System - Improved Oversight Needed to Ensure Consistent and Timely Outcomes for Reserve and Active Duty Service Members, March 2006, Page 2, Paragraph 2 and Page 4, Paragraph 2.

ROOT CAUSE: Insufficient quality management and training on the MEBITT database.

DISCUSSION:

a. The 20 September 2001 MEDCOM Memorandum directed the use of MEBITT as the primary database for managing Soldiers in the APDES. However, due to insufficient quality management and training, MEBITT is not an accurate database. A majority (56%) of inspected MTFs use MEBITT to track MEB cases. However, at most (81%) of the same MTFs, PEBLOs entered inaccurate data on permanent profiles or NARSUMs into MEBITT. This inaccurate data is used as the metrics for reporting the status of Soldiers in the MEB portion of the APDES. Additionally, most (81%) inspected MTFs use another database beyond MEBITT to supplement data management and analysis. Finally, a lack of training limits PEBLOs' understanding of and ability to use MEBITT.

b. There are Quality Management shortfalls in the MEBITT data collection process. MEDCOM operates MEBITT and is responsible for oversight of MEBITT. MEDCOM's oversight of MEBITT should include evaluation of the data collection process. AR 5-1, paragraph 3-3, subparagraph a. (5) states "Examine the collection, analyses, and use of performance metrics information to sustain a fact-based system for improving organizational performance excellence." MEDCOM's insufficient organizational assessment of the MEB process leads to unreliable data in MEBITT, thereby impeding accurate measurement and benchmarking. The lack of accurate data hinders continuous improvement, one of the four Total Army Quality principles. Continuous improvement requires setting goals and systematically measuring results.

c. At most (81%) of the inspected MTFs, the data entered into MEBITT contained critical inaccuracies. The 07 October 2004 MEDCOM Memorandum states that MEBITT will track and monitor two MEB process metrics: the MEDCOM 90-day standard and DOD 30-day standard. First, the metrics of the MEDCOM 90-day MEB standard are the date the profiling physician signs the profile though the date the MEB case is forwarded to the PEB. The DAIG found inaccurate permanent profile starting dates at most (81%) MTFs. Second, the metrics of the DOD 30-day MEB standard are the date the physician dictates the NARSUM to the date the MEB case is received at the PEB. Only 63 % of inspected MTFs track NARSUM data and a majority (70%) of those MTFs recorded inaccurate data in MEBITT.

d. Most of the inaccurate data reporting was due to a lack of knowledge of the standards. There was confusion among the PEBLOs and MEB Physicians at the MTF

level about the correct interpretation of MEDCOM's 90-day standard and DOD's 30-day standard (DAIG covers this lack of training on the PDES in Findings 1.1 and 1.2). Whatever the cause of the inaccurate data, the result is unreliable metrics used to evaluate MEB processing.

e. There was limited supervision of data entry into MEBITT at the MTF level. Most Patient Administration Division (PAD) Officers had access to MEBITT (all should) but few of the PAD Officers conducted reliability checks on the data. The PEBLO is the person controlling entry of data into MEBITT, as well as the person responsible when a MTF does not achieve the MEDCOM 90-day standard. If the PEBLO does not know or enforce the standard and the quality of their work is not evaluated, the potential for error is great. The DAIG found similar issues to those identified in the March 2006 Government Accountability Office report on the Military Disability System which repeatedly rated Army data on MEB processing times as "unreliable".

f. The Office of The Surgeon General (OTSG) tracks the MEB process and gives feedback to the MTFs with its quarterly Balanced Scorecard (BSC). The OTSG Patient Administration Division develops the BSC report based on data in MEBITT. Aside from the unreliability issue with MEBITT, another issue occurs at the end of a Fiscal Quarter. The BSC can be manipulated if a PEBLO forwards a large number of MEB cases to the PEB at the end of the quarter. Any returns on these cases would not show up on the reporting quarter's statistics and are not reported as part of the next quarter. Since most PEBLOs were not making the 10% return rate (see Finding 1.3), adding another percent or two would have little negative impact, especially if it meant they could make the MEDCOM 90-day standard.

g. The DAIG found that most (78%) of the interviewed PEBLOs at the inspected MTFs received little or no MEBITT training. MEDCOM requires PEBLOs to input and track data in MEBITT but has provided limited training on the use of MEBITT. MEDCOM has not developed a formal MEBITT training course or any training standards. Any MEBITT training is conducted by PEBLOs at the MTFs and consists of a "Right seat ride" type of training. The MEBITT database has a built-in help/training package as part of the program, but most PEBLOs felt it was insufficient.

h. Most PEBLOs (81%) stated there is a need for a Formal PEBLO training program. A majority of PEBLOs do not have sufficient knowledge of MEBITT to use it as intended. Some of the little or unused capabilities of MEBITT include the following: MEB cases return rate tracking, timeliness tracking, and individual PEBLO workload and return rate. In most (81%) of MTFs inspected by the DAIG, the MTF uses an internal tracking tool as well as MEBITT. These PEBLOs stated that MEBITT is not meeting all of the user needs for managing the MEB process or outcomes (users rely on supplemental databases to produce actionable reports for MTF and Unit Commanders). MTFs that use internal databases and MEBITT are committing limited resources to record all data twice since their internal databases do not feed into MEBITT. A majority of PEBLOs felt the MEBITT database support staff are responsive to MTFs' requests for

support but did not know the support staff could customize the database's reports to an individual MTF's requirements.

RECOMMENDATIONS. The APDES Action Team in conjunction with:

a. The Surgeon General clarify policy on the start and end date of actions occurring in the Medical Evaluation Board process.

b. Commander, US Army Medical Command, review current quality management processes and implement stricter internal controls to ensure precise recording of information on the date the permanent profile is issued; the date the Narrative Summary is dictated; and the date the Medical Evaluation Board is received by the Physical Evaluation Board.

c. Commander, US Army Medical Command, develop training standards and certification requirements for PEBLOs, Alternate PEBLOs, and physicians conducting Medical Evaluation Boards.

d. Commander, US Army Medical Command, in coordination with the Army G-3 and Army G-1 develop a formal MEBITT Course for those primary participants involved in DES process.

FINDING 1.6: The Army lacks a formal course of instruction that trains Physical Evaluation Board Liaison Officers, Alternate Physical Evaluation Board Liaison Officers, and Medical Evaluation Board (MEB) Physicians on their duties and responsibilities in processing Soldiers referred to a MEB.

STANDARDS:

a. Department of Defense Directive 1332.18, Separation or Retirement for Physical Disability, 4 November 1996, paragraph 4.4.4.

b. Department of Defense Instruction 1332.38, Physical Disability Evaluation, 14 November 1996, Enclosure 3, Paragraphs E3.P1.7 and E3.P2.1

c. Army Regulation 635-40, Physical Evaluation for Retention, Retirements, or Separation, 6 February 2006, Paragraphs 3-1, 3-8, 4-10, 4-11, 4-12, 4-13, 4-14, and 4-15.

d. Army Regulation 40-501, Standards of Medical Fitness, 27 June 2006, Paragraph 3-1, 3-2, and 3-3.

e. Training and Doctrine Regulation 350-70, 9 March 1999, Chapter IV-4, Individual Training Design: Individual Training Strategies and Course/Product Design.

ROOT CAUSE: The Army has not developed a formalized course of instruction for PEBLOs, APEBLOs, and MEB Physicians.

DISCUSSION:

a. The Army has not developed a mandatory course to train and educate the primary participants (PEBLOs, APEBLOs, and MEB physicians) involved in the Army Physical Disability Evaluation System (APDES). Paragraph 4.4.4 of DODD 1332.18 requires the Secretaries of the Military Departments to establish policies that ensure MEB physicians are trained to prepare MEBs for physical disability evaluation. A formal U.S. Army Medical Department Center and School (AMEDDCS) developed MEB training course for PEBLOs, APEBLOs, and MEB physicians would enhance the APDES. PEBLOs and Physicians stated they would benefit from training on the critical individual tasks required of MEB participants.

b. MEDCOM has training opportunities for PEBLOs, but none of the training focuses on the critical individual tasks a PEBLO must perform. MEDCOM hosts an annual conference for PEBLOs, a five-week PAD course, virtual teletraining video (including a videotaped block of instruction on Profiles and Boards from the Division/Brigade Surgeon Course), informal on-site mentorship visits for MEB physicians, and a plethora of on-the-job training programs. PEBLOs and MEB physicians stated that even though these training products were produced to educate MEB primary participants, they are insufficient as stand-alone training. They felt the instructional media did not adequately disseminate uniform and doctrinal information via established learning objectives with performance standards for all attendees. Too much variation exists in the current MEDCOM instructions for PEBLOs, APEBLO, and MEB physicians.

c. Underscoring the importance of the Army developing a formal MEB course were numerous PAD personnel, PEBLOs, and Physicians who raised the issue of a standardized program of instruction. The group was comprised of PEBLOs (15), APEBLOs (40), PAD (10), MEBP (34) and DCCS (20). They noted that medical and disability evaluation under the MEB and PEB processes can be one of the most significant events in the life of a disabled or ill Soldier. They felt that a complete, accurate, and fully documented MEB case forms the foundation for fair and equitable disability evaluation. Most (82%) of those interviewed stated that a formal Army MEB course is needed to ensure uniformity in training of primary MEB/PEB participants. They also stated that an MEB course should train MEB/PEB primary participants on the technical aspects of their duties.

d. MEDCOM current instructions do not meet the policy guidance for individual training, including strategies and design of training programs, courses, and products as set forth in Training and Doctrine Regulation 350-70, Chapter IV-4.. APDES is a technical process that requires uniformly trained primary participants who are involved in the MEB process. A formalized course of instructions for PEBLOs, APEBLO, and MEB physicians should follow the TRADOC 350-70 training development model. For PEBLOs and APEBLOs, the course should delineate their core competencies along with their roles, duties, and responsibilities in the APDES process including hands-on

instructions with the Medical Evaluation Board Internal Tracking Tool (MEBITT). MEB Physician training should incorporate a block of instruction on physical profiling. At a minimum, the course of instruction must address the use and issuance of physical profiles by MEB Physicians. It should provide training critical aspects of APDES, including medical examinations, optimal care matters and standards, and clear profiling procedures and guidelines to follow.

e. The DAIG found that most (98%) respondents had not received any formal MEB/PEB training. One-fourth (25%) of the PEBLOs and APEBLOs interviewed indicated that the only APDES training they received was at the annual MEDCOM PEBLO conferences. Even though a majority (60%) claimed they learned a great deal at the annual PEBLO Conferences, they felt they needed even more training to attain/maintain proficiency. Most (82%) of the interviewed PEBLOs and APEBLOs stated that a substantial amount of their training consisted primarily of on-the-job training (OJT), mentoring with the senior or more experienced PEBLO, and/or on-site training by their servicing PEB Office.

f. A majority (69%) of the MEB physicians stated their APDES training consisted primarily of OJT, self-study, and coordination with their counterparts at the PEB. Some (30%) of the interviewed MEB physicians asserted they received little or no APDES training to prepare them for duties as MEBP. In contrast, a few (16%) MEB physicians indicated they received some MEB training during their graduate medical education training (residence training) several years earlier.

g. MEDOCM conducts a five-week course PAD course at the Patient Administration Training Center, Fort Sam Houston, Texas. The course is composed of lecture, practical exercise and hands on automation training. A majority (54%) of the interviewed PAD officers had attended this course before they assumed their PAD duties. Those PAD officers who attended the course were aware of the supervisory skills and knowledge necessary to perform as a Patient or Health Care Administrator. Most (77%) of the interviewed PAD officers who attended the PAD course felt they were better able to provide oversight and guidance to the PEBLO staff.

RECOMMENDATION. The APDES Action Team in conjunction with: MEDCOM, in coordination with TRADOC and ASA MR&A, determine the critical individual tasks for the professional development of civilian and military PEBLOs, APEBLOs and MEB Physicians.

FINDING 1.7: Army Regulations do not fully and accurately integrate DOD policy instructions and MEDCOM policy memorandums.

STANDARDS:

a. Department of Defense Directive 1332.18, Separation or Retirement for Physical Disability, 4 November 1996, paragraph 1.3

b. Department of Defense Instruction 1332.38, Physical Disability Evaluation, 14 November 1996, Enclosure 3, Paragraph E3.P1.6.2.1

c. AR 400-400, Patient Administration, 13 October 2006, paragraph 7-1.

d. US Army Medical Command Memorandum, Metrics and Procedures for improving Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB) Processing, 20 September 2001, Enclosure 1, Paragraph 1, Subparagraph b,

e. US Army Medical Command Memorandum, Medical Evaluation Board (MEB)/Physical Evaluation Board (PEB) Referrals Using the DA Form 3349, Physical Profile, 07 October 2004, Paragraph 4

ROOT CAUSE: Army policy is inconsistent and OSTG has not updated policy to reflect current DOD policy.

DISCUSSION:

a. Army policy on the MEB process, timelines, and metrics is inconsistent and does not accurately apply DOD policy. DODI 1332.38 establishes the 30-day standard of dictation of the Narrative Summary to receipt by the Physical Evaluation Board. The Army translates this DOD policy in AR 40-400 and MEDCOM Memorandums dated 20 September 2001 and 07 October 2004. However, AR 40-400 and MEDCOM Memorandum dated 20 September 2001 promulgate an Army policy that conflicts with the DOD policy. The MEDCOM Memorandum dated 07 October 2004 correctly applies the DOD policy.

b. DODI 1332.38, Enclosure 3, Paragraph E3.P1.6.2.1 states "When a physician initiates a MEB, the processing time should normally not exceed 30 days from the date the MEB report is dictated to the date it is received by the PEB." The inaccurate Army policy changes the date received by the PEB to the date mailed to the PEB. AR 40-400, Paragraph 7-1 states, "MEB processing will not normally exceed 30 days (beginning on the date of the medical officer's narrative summary through the date forwarded to the PEB)." MEDCOM Memorandum, 20 September 2001, Enclosure 1, Paragraph(b) states, "The MEB should be mailed within 30 days from the dictation of the Narrative Summary..." MEDCOM gains approximately three days of processing time by changing the DOD 30-day completion time from when the MEB is "received" by the PEB to when the MEB is "forwarded" or "mailed" to the PEB.

c. The recent revisions of AR 40-400 do not include the Army's 90 day timeline metrics for processing MEB cases, although the two MEDCOM Memorandums contain the Army 90 day standard. The omission of the Army 90-day conflicts with current Army practice. MEDCOM does not track the DOD 30-day standard. The 90 day standard is the only metric MEDCOM tracks.

d. Finally, Army regulations do not precisely define the metrics and terms used to measure the progress and timeliness of the MEB process, resulting in inaccurate and

inconsistent reporting. Additionally, the imprecise terminology leads to broad interpretations of the policy governing the MEB process. Two examples of this are the imprecise guidelines for the initiation point of the 30 and 90 day timelines for processing MEBs and the confusion of when a NARSUM is considered to have been dictated.

RECOMMENDATIONS. The APDES Action Team in conjunction with:

- a. The Surgeon General update Army Regulation 40-400, to include accurately reflecting Department of Defense Instruction 1332.38.
- b. The Surgeon General update Army Regulation 40-400, to include MEDCOM's 90-day standard and review the terminology in MEB process.

FINDING 1.8 US Army Medical Command regulations and policies on the Medical Evaluation Board process are keeping pace with most medical retention issues.

STANDARD: Army Regulation 40-501, Standards of Medical Fitness, 27 June 2006, Paragraphs 1-4 and 3-1.

ROOT CAUSE: NA.

DISCUSSION:

a. Army Regulation 40-501, Standards of Medical Fitness, states The Surgeon General (TSG) will develop, revise, interpret, and disseminate current Army medical fitness standards and ensure Army compliance with DOD directives pertaining to those standards. A majority (66%) of MEB Physicians interviewed stated that AR 40-501 provides useful guidance in situations when they have to evaluate soldiers for various medical conditions and physical defects which may render a Soldier unfit for further military service.

b. The DAIG interviewed 13 DCCSs and 20 MEB Physicians who sign medical evaluation board documents or dictate MEB narrative summaries at 20 medical evaluation board processing sites. The DCCSs and MEB Physicians stated that AR 40-501 provides useful guidance in situations when they have to evaluate Soldiers for various medical conditions and physical defects which may render a Soldier unfit for further military service.

c. Conversely, despite published definitions and regulatory guidance, some (33%) interviewees said that they need additional definition or clarification in applying AR 40-501, Chapter 3, Medical Fitness Standards for Retention and Separation. These physicians felt the regulation was unclear, not precise enough and/or required use of "judgment" to come to a decision, especially in a "GWOT" environment. They also identified three medical conditions that require additional guidance; sleep apnea, asthma, and psychiatric conditions.

RECOMMENDATION. The APDES Action Team in conjunction with the Surgeon General continue to review AR 40-501 to keep pace with medical condition trends.

OBSERVATION 1.9: Army Military Treatment Facility Commanders are using generic position descriptions to hire Physical Evaluation Board Liaison Officers and Alternate Physical Evaluation Board Liaison Officers.

DISCUSSION:

a. The Army has not developed PEBLO and APEBLO position descriptions (PDs) for MTFs to use in the hiring process. Paragraph 3-8a of AR 635-40 states "MTF commander will name an experienced, qualified officer, noncommissioned officer (NCO), or civilian employee as the PEBLO. At least one additional qualified officer, NCO, or civilian employee will be designated as alternate PEBLO." Although the Army requires MTF commanders to select or designate PEBLOs and APEBLOs as set forth above, the Army has not developed a standard position description (PD) to help MTF commanders hire civilian PEBLOs and APEBLOs at their MTFs. Consequently, the DAIG found that a majority (57%) of the visited MTFs use generic PDs to hire civilian personnel to perform PEBLO and APEBLO duties in support of APDES. The most commonly used PD is General Service (GS) 0962, Contact Representative. This particular PD covers positions in the General Schedule that involve the performance of clerical and administrative support work. It is very general and allows the MTF commander to recruit from a population of civilians and former military personnel who do not always possess appropriate medical or clinic skills to work as PEBLOs and APEBLOs. Moreover, the GS 0962 PD contains common skills, and allows for creditable experiences and education that assist potential candidates in qualifying for PEBLO and APEBLO positions.

b. The lack of standardized PEBLOs and APEBLOs PDs result in MTFs selecting and hiring personnel with a wide range of skills to serve as PEBLOs and APEBLOs. The DAIG found that a majority (68%) of inspected MTFs hired individuals with clerical skills to be PEBLOs and APEBLOs. Some (37%) MTFs selected individuals with medical backgrounds. While a generic PD makes it easier for MTFs to recruit candidates to fill PEBLOs and APEBLOs positions, this ultimately affected the effectiveness and capabilities of the individuals who provide assistance to Soldiers undergoing a MEB/PEB. The DAIG further found that most (79%) of the Army PEBLOs and APEBLOs are Army civilian employees assigned to positions in MTFs. The PDs of those PEBLOs and APEBLOs range in grade from GS-04 to GS-12 based on the CPAC classification of the duties that the MTF Commander delineates in the PDs. The PEBLO and APEBLO job titles varied as well. At 11 visited locations, the PEBLOs were called "Contact Representatives", while at one other location the PEBLO was titled "Medical Records Technicians." The MTFs that assigned noncommissioned officers to PEBLO and APEBLO positions typically chose an NCO with a background in patient administration. Subsequently, the varied position descriptions and job qualifications often had a significant impact on the PEBLO's ability to appropriately document their

work, communicate with the MEB Physicians, and process a Soldiers' MEB/PEB case file in a timely and efficient manner.

RECOMMENDATIONS. The APDES Action Team in conjunction with:

- a. The Surgeon General, in coordination with the Army G-1 and Assistant Secretary of the Army for Manpower & Reserve Affairs, develop policy and guidance that addresses the standardization of hiring and selection of PEBLOs.
- b. Commander, MEDCOM designate critical individual tasks for civilian and military PEBLOs and APEBLOs.

OBJECTIVE 2: Assess the execution and timeliness of the Physical Evaluation Board (PEB) and review processes to include compliance with Department of Defense (DOD) and Army policies.

Since Calendar Year (CY) 01, the United States Army Physical Disability Agency (USAPDA) and its three Physical Evaluation Board (PEB) sites (Washington, DC, Texas, and Fort Lewis) processed over 67,000 PEB cases. The trend over these years indicated a rise in the number of cases from just over 9,000 cases in CY 01 to a peak of over 15,000 cases in CY 05. These numbers represent the total of all PEB cases to include typical informal and formal cases, Temporary Disability Retirement List (TDRL) re-evaluations, re-opened terminated PEB cases, and non-duty related cases. During these years, one PEB consistently experienced a higher workload than the other PEBs. Data from the Physical Disability Case Processing System (PDCAPS) revealed that during this period, the PEBs on average consistently met the internal USAPDA standard of processing a PEB case within 30 days. Their average during this period was 21 days. However, the HQ, USAPDA met its internal standard of 10-days to review a case only once, that being in CY 05. The average processing time for HQ, USAPDA was 15 days. DAIG analysis revealed that processing Continuation of Active Duty (COAD) officer cases took on average 45 days whereas processing COAD enlisted cases took on average only 17 days. Furthermore, Continuation of Active Reserve (COAR) packets for National Guard Soldiers took on average 23 days to process. The combined processing times of a PEB case and either COAD or COAR request clearly exceed the DOD Instruction standard of normally processing a case in 40 days.

In addition to processing issues, the USAPDA is supported by an antiquated database system - PDCAPS and outdated regulations that fail to accurately reflect current Army and DOD policy. For example, the USAPDA quality assurance program does not conform to DOD policy regarding quality assurance. Moreover, USAPDA does not evaluate consistency of ratings among the PEBs, resulting in internal inconsistencies among the PEBs.

In a majority of the interviews conducted during this inspection, Soldiers and leaders going through the Physical Disability Evaluation System did not understand the differences between an Army disability rating and a Department of Veterans Affairs

(DVA) disability rating. Their perception was that a Department of Veterans Affairs disability rating was going to be higher but they did not know why. This perception is due, in part, to the Army and DOD establishing the disability rating based on military service related disability, whereas the DVA rating compensates the Soldier for loss in civilian earning capacity resulting from disease or injury. The difference in the two processes is partly responsible for the different results and leads to confusion among Soldiers and leaders.

FINDING 2.1: Army Regulations 10-59 and 635-40 are not consistent with other Army Regulations nor with DOD and Department of Veterans Affairs Policy.

STANDARDS:

- a. Department of Defense Directive (DODD) 1332.18, Subject: Separation or Retirement for Physical Disability, 4 Nov 96, paragraphs 3.3, and 4.4.
- b. Department of Defense Instruction (DODI) 1332.38, Subject: Physical Disability Evaluation, 14 Nov 96 (with Change 1, 10 Jul 06), paragraph 5.5.
- c. DODI 1332.39, Subject: Application of the Veterans Administration Schedule for Rating Disabilities, 14 Nov 96, paragraphs 4.2 and 5.3.
- d. Army Regulation (AR) 10-59, United States Army Physical Disability Agency, 1 Apr 80, paragraph 5.d.
- e. AR 635-40, Physical Evaluation for Retention, Retirement, or Separation, 8 Feb 06, paragraph 2-4 and Appendix B-1, B-2, B-3.a.
- f. General Order 16, Army Council of Review Boards, 9 Jul 85, paragraph 2.
- g. USAPDA Policy Memorandums, 28 Feb 05.
- h. USAPDA Issue and Guidance Memorandums, Mar-Aug 05.
- i. Title 10, Armed Forces, Chapter 61
- j. Title 38, Veteran's Benefits, Section 4.1

ROOT CAUSE: The proponent for the two regulations has not updated them to reflect current policy in the DODIs and DODD.

DISCUSSION:

- a. AR 10-59, dated 1 May 1980, has been superseded by General Order 16, dated 9 Jul 85. While AR 10-59, paragraph 5.d. states that the Commanding General of the

USAPDA is also the Director of the Army Council of Review Boards under the Army Military Review Boards Agency. General Order 16, dated 9 Jul 85, states the supervision of the Army Council of Review Boards remains assigned to the Deputy Assistant Secretary of the Army (ASA)(DA Review Boards). The Army Council of Review Boards became the Army Review Board Agency (ARBA) under Assistant Secretary of the Army, Manpower and Reserve Affairs.

b. Although the proponent of AR 635-40 issued a rapid action change on 8 Feb 06, the change was limited in scope as stated in its Summary of Change and not a full revision of the regulation. The rapid action change clarified PEB team composition and consolidated policy concerning Continuation of Active Duty (COAD) and Continuation of Active Reserve (COAR) actions. It did not include 1996 changes in DODIs 1332.38 and 1332.39 or DODD 1332.18. There was an attempt to fully revise the regulation beginning in 1997 after the updated 1996 versions of the DODIs and DODD. However, a nonconcurrency in April 1999 by an ASA office halted the staffing process of the fully revised regulation. This ASA office did not agree with adjusting the appeal options available to a Soldier. Internal USAPDA priorities further delayed the process of fully revising the regulation. USAPDA is awaiting the revised DODIs and DODD that are expected in 2007. USAPDA did however publish the above rapid action change to meet senior Army leadership direction for updated guidance on COAD and COAR processing in the interest of retaining disabled Soldiers.

c. There are at least 24 passages in the DODI that are not in the regulation. While Army Regulations are not required to repeat or incorporate relevant DoD guidance, this failure to incorporate key DoD provisions into the Army regulations forces Soldiers, PEBs and Soldier legal counsel to not only reference the regulation but also the DODIs and DODD in order to understand the entire system. When conflicts arise, USAPDA instructed the PEBs that the DODD and DODIs take precedence because the rapid action change did not incorporate the updates. USAPDA sent two memorandums in May 1997 to the PEBs as guidance to address the differences between the regulation and the 1996 revised DODI and DODD.

d. Some examples of inconsistencies follow: the regulation does not address the DODI 1332.38 40-day standard for processing a case at the PEB, USAPDA review, and the transition processing (TRANSPROC) notice. The DAIG also cites the following examples of disconnects between the regulation and higher level policy and/or guidance. AR 635-40, paragraphs 4-19g.(2) and 4-19l.(2)(b) should be clearer and more succinct concerning not in the Line of Duty (LOD) determinations. These paragraphs are ambiguous and are open to incorrect interpretation. USAPDA Policy Memorandum #2, Conditional Adjudication, attempts to clarify the issue in paragraph 4-19l.(2)(b). DODI 1332.38, paragraph E3.P3.5. states that the presumption of fitness rule applies to service members who are pending retirement. AR 635-40 paragraph 3-2.b. allows adjudicators to apply the presumption of fitness rule to those service members retiring or separating. DODI 1332.38 allows enlisted as well as officers to waive referral to the PEB when the Medical Evaluation Board (MEB) opines that the condition Existed Prior to Service (EPTS) without service aggravation and to separate

from the Army without entitlement to benefits. AR 635-40 only allows for enlisted waiving referral to the PEB.

e. USAPDA currently has 17 policy memorandums, dated 28 Feb 05, that address issues not covered in the regulation or that clarify the regulation based on changes in higher level policy and guidance. An analysis of these policy memorandums indicated that nearly all should be incorporated into a full revision of the regulation.

f. USAPDA currently has nine Issue and Guidance (I&G) memorandums posted internally to the agency and the PEBs that clarify or interpret policy. USAPDA began issuing these memorandums in March 2005. These memorandums provide guidance the PEBs are to follow when adjudicating cases. By using these I&Gs, USAPDA is attempting to ensure consistency among the three PEBs. USAPDA has not made these available to all Soldiers via regulations; even though all three PEB sites and their legal counsel offices have access to them and refer to them as needed in providing counsel to the Soldiers. One PEB site felt these I&G memorandums should be incorporated into the revised AR 635-40. Another PEB site perceives there are too many I&G memorandums. Finally, one of the PEB sites wanted more I&G memorandums to assist the PEBs.

g. The current Army and DOD policies used to determine disability ratings apply a military service specific standard for disability ratings, whereas the Department of Veterans Affairs (DVA) rates the Soldier based on his or her loss of civilian earning capacity. The Army rates the unfitting disabilities using the VASRD as amended by Appendix B, AR 635-40, which does not include loss of civilian earning capacity. DODD 1332.18, paragraph 3.3, directs the sole standard used in making determinations of unfitness due to physical disability shall be unfitness to perform the duties of the member's office, grade, rank, or rating because of disease or injury. The DVA uses the VASRD to rate all service connected injuries. Additionally, the DVA rating compensates the Soldier for loss in civilian earning capacity resulting from disease or injury. The difference in the two processes leads to confusion among Soldiers and leaders.

h. Title 10 chapter 61 establishes the DVA's VASRD as the standard for assigning disability ratings. There appears, however, to be a variance between the DVA rules and DOD policy on application of the VASRD. DODI 1332.39, paragraph 4.2 establishes the VASRD as the standard for assigning percentage ratings, but it further indicates that not all VASRD provisions apply to the military departments. This has led to different DVA and DOD and Army disability ratings.

i. The appeals process for a Soldier who does not agree with the USAPDA decision consists of the Army Physical Disability Appeal Board (APDAB) and the Army Disability Rating Review Board (ADRRB) as stated in paragraphs 4-25 and 4-26 in AR 635-40. An APDAB review occurs while a Soldier is still on active duty. The second form of appeal occurs after a Soldier has left the service. General Order 16, dated 9 Jul 85, established both of these boards under the Army Council of Review Boards. This Council, now called ARBA, convenes these boards on an as-needed basis.

j. An analysis of Soldier appeals since FY 01 finds that during the first two years of the Global War on Terrorism (FY 01 and FY 02); ARBA reported that USAPDA sent 23 and 28 cases respectively to APDAB for review. Of these 51 cases, APDAB processed approximately 40 for imminent death. In Fiscal Years 03, 04, and 05, USAPDA only sent 10 cases to APDAB. To put these numbers into perspective, ARBA processed over 17,000 cases in 2005. Four of these cases were APDAB cases which represented only 0.024% of the total ARBA workload. Physical Disability Case Processing System (PDCAPS) data from the USAPDA indicated that in calendar years 02-05, they only sent 45 cases out of approximately 51,000 cases processed to the APDAB for review. By paragraph 4-22.f.(2), USAPDA shall forward cases to the APDAB for review when the Soldier rebuts the findings of the USAPDA review as long as the Soldier submits the rebuttal within prescribed timeframes. What the data shows is that USAPDA only forwarded 0.09% of their cases to APDAB. Concerning ADRRB, there has not been a case before the ADRRB during the period FY 01 - FY 05.

RECOMMENDATIONS. The APDES Action Team in conjunction with:

a. The Secretary of the Army direct the Assistant Secretary of the Army, for Manpower and Reserve Affairs, in conjunction with Office of the Secretary of Defense, the Surgeon General, and Office of the General Counsel, to review and revise where appropriate, Army policy to align the Army's adjudication of disability ratings to more closely reflect those used by the Department of Veterans Affairs.

b. The Deputy Chief of Staff, G-1, update Army Regulation 10-59 to reflect current Army policy.

c. The Deputy Chief of Staff, G-1, update Army Regulation 635-40 to include changes in the Department of Defense Instructions 1332.38 and 1332.39 and Department of Defense Directive 1332.18.

d. The Deputy Chief of Staff, G-1, update Army Regulation 635-40 to include all US Army Physical Disability Agency policy and Issue and Guidance memorandums.

e. The Deputy Chief of Staff, G-1, examine the Army Disability Rating Review Board as an appeal board and consider replacing it with the Army Board for Correction of Military Records.

f. Army Review Board Agency examine the use of the Army Disability Rating Review Board as disability review board and consider the sole use of the Army Board for Correction of Military Records as the retiree appeal recourse.

g. The Assistant Secretary of the Army, for Manpower and Reserve Affairs, in coordination with the US Army Physical Disability Agency present to the Department of Defense Disability Advisory Council the issue of whether the Department of Defense is properly applying the Veterans Administration Schedule for Rating Disabilities to the military departments.

FINDING 2.2: US Army Physical Disability Agency (USAPDA) uses an insufficient data management program (PDCAPS- Physical Disability Case Processing System) to manage Physical Evaluation Board cases.

STANDARDS:

a. DODD 1332.18, Subject: Separation or Retirement for Physical Disability, 4 Nov 96, paragraph 4.4.

b. DODI 1332.38, Subject: Physical Disability Evaluation, 14 Nov 96 (with Change 1, 10 Jul 06), paragraph 5.5.2.

c. AR 635-40, Physical Evaluation for Retention, Retirement, or Separation, 8 Feb 06, paragraphs 2-4.a. and 2-4.b.

d. USAPDA Standing Operating Procedures, 25 Apr 01, paragraph 5-12, and chapter 11.

ROOT CAUSE: USAPDA uses a dBase-III+ system to track the status of Soldiers in the Physical Evaluation Board process.

DISCUSSION:

a. DODI 1332.38, paragraph 5.5.2. states that the Secretaries of the Military Departments shall establish a quality assurance process to ensure uniform interpretation of policies and procedures established by DODD 1332.18. AR 635-40, paragraph 2-4.b. states, "the Commanding General, US Army Physical Disability Agency is to develop the policies, procedures, and programs of the system." USAPDA uses PDCAPS as its data management program. USAPDA reported to the DAIG that a new PDCAPS was originally to be online in October 2004. That date has since slipped repeatedly to December 2006 and once again slipped.

b. The DAIG interviewed 33 personnel that are involved either directly or indirectly with PDCAPS. In every instance, personnel indicated a need for a new system. PDCAPS is a Clipper program designed to operate on Windows NT, Novell, 3-COM local area network, or on a stand-alone IBM compatible personal computer. The Clipper computer language was an outgrowth of the dBase-III+ product from the mid-1980s. It is not Microsoft Windows driven. It does not effectively communicate with the three PEB sites or other DA systems used in the Physical Disability Evaluation System (PDES) process such as Medical Evaluation Board Internal Tracking Tool (MEBITT) or Medical Operational Data System (MODS). Technicians at each of the three PEB sites must send in a file daily to USAPDA in order for USAPDA to update the main PDCAPS database in Washington, DC. The system is not real-time; it is only as good as the last download received by USAPDA from the PEBs. At all times, the USAPDA and PEB could be looking at two different sets of data. Coupled with this, PEBLOs do not even

have "read-only" access to PDCAPS. Therefore, the PEBLOs must contact USAPDA in order to find out the status of a Soldier's case.

c. Another issue with PDCAPS is that a user cannot insert Microsoft Word documents into PDCAPS or export documents into a Microsoft Word document. Administrative assistants must re-type letters into PDCAPS that medical officers or personnel management officers typed using Microsoft Word. This results in a significant duplication of time and effort.

d. PDCAPS fields do not accurately reflect the needed data for regulatory quality management. DAIG requested over 25 data points from USAPDA. USAPDA returned six requests with no action stating that PDCAPS does not track the data. For example, DAIG wanted to measure how often Soldiers met the 10-day time standard in making their election after either their informal or formal board results. The response from PDA was that PDCAPS only captures the date when the PEB sends the letter to the Physical Evaluation Board Liaison Officer (PEBLO), and it captures the date when Soldier signed the Form 199 or 199-1. PDCAPS does not capture the date when the PEBLO contacts the Soldier or the date of return to the PEB. If the MEBITTS and PDCAPS systems communicated with each other, this would not be an issue. These dates are instrumental in determining how long a case takes to process; thus providing an ability to measure the DODI 40-day standard. PDCAPS also does not track why USAPDA sends cases back to the PEBs.

e. When the PDCAPS program is active on a user's computer, Microsoft Outlook and other programs cannot be opened. The user must close PDCAPS first. Another shortcoming is the system does not accurately track the reasons the PEB returned a case to the military treatment facility (MTF). As a result, the USAPDA developed a Microsoft Excel spreadsheet to capture 10 categories of why PEBs returned cases to the MTFs. USAPDA distributed this spreadsheet internally to USAPDA members on a monthly basis. Since DAIG began this inspection, USAPDA informed DAIG that they now use a different tracking tool. A reason cited is that the old tool took too long to compile the data. DAIG did not draw any conclusions on the effectiveness of the new tool as there was not enough data to analyze.

f. USAPDA and PEB Human Resource Assistants stated they do not use the "why" codes for cases returned to the MTFs as they are unreliable, inaccurate, and used sporadically. Personnel expressed concern over the reliability of the PDCAPS database when it comes to finding accurate addresses for Soldiers on the TDRL. Often, these personnel must consult with Defense Finance and Accounting Service (DFAS) to acquire a valid address. Tying any new tracking system into the Army Knowledge Online (AKO) network may alleviate some of the issues with valid mailing addresses.

RECOMMENDATION. The APDES Action Team in conjunction with the US Army Physical Disability Agency in coordination with CIO G6 implement a real-time data management system that has the ability to communicate with Medical Evaluation Board Internal Tracking Tool and other DA software applications.

FINDING 2.3: The US Army Physical Disability Agency (USAPDA) does not consistently meet the DODI 1332.38 40-day standard for the processing time for a final disability determination.

STANDARDS:

- a. DODI 1332.38, Subject: Physical Disability Evaluation, 14 Nov 96 (with Change 1, 10 Jul 06), paragraph E3.P1.6.3.
- b. USAPDA Standing Operating Procedures, 25 Apr 01, paragraph 5-8.a.

ROOT CAUSE: The DODI 40-day standard does not routinely provide sufficient time for the Soldier to make his/her elections and/or appeals.

DISCUSSION:

a. In accordance with DODI 1332.38, paragraph E3.P1.6.3., upon receipt of the Medical Evaluation Board (MEB), the processing time until the determination by the final reviewing authority as prescribed by the Secretary of the Military Department should normally be no more than 40 days. In the USAPDA SOP, paragraph 5-8, USAPDA further breaks this 40-day period into 30 days for the Physical Evaluation Board (PEB) to make its determination and 10 days for USAPDA to review the case. The 40-day standard includes the Soldier's election periods after the informal and formal boards. The DODI does not provide a rationale for the 40-day standard.

b. The DAIG queried the PDCAPS database for all cases during the period from CY 02 - CY 06 (1st two quarters) that underwent all facets of the PEB process to include an informal board and Soldier's rebuttal, a formal board and Soldier's rebuttal, and USAPDA review and Soldier's rebuttal (if applicable). In a majority (94%, 2,327 of 2,468) of these cases, the processing time exceeded the 40-day standard as set forth in the DODI. Some (28%, 11,846 of 41,586 cases) of the time the PEBs and USAPDA did not meet the 40-day standard if one takes into account all cases processed by the PEBs during this same time period. In those years using the USAPDA SOP standard of 30 days for the PEB and 10 days for the USAPDA review, all three PEBs consistently averaged less than the 30-day standard (21 days). However the USAPDA review process failed to meet their 10-day standard (15 days) in CY 02-04. In CY 05 and through the first two quarters of CY 06, USAPDA has, on average, met the standard (eight days).

c. The DODI 40-day standard is unrealistic. DAIG used data provided by USAPDA from the PDCAPS database to construct the following hypothetical case using the timeline standards as set forth in the regulation and using commonly accepted timeframes for scheduling a formal board. This case assumes a formal board and subsequent review by USAPDA. Day one, the PEB administrative personnel receive the case. They check the packet for completeness and accuracy before sending it to the informal board adjudicators. The adjudicators normally complete the informal board

within 24-48 hours (days 2 and 3). The PEB sends the Soldier the resulting DA Form 199 to make his/her election to accept or rebut the informal board's result. The time standard for this is 10 days (days 4-13), but does not include (nor do any of the subsequent examples) any time for the mailing of the DA Form 199 to the PEBLO and then for presentation to the Soldier. He/she may decide to rebut the informal board results, request legal representation, or request a formal board, and may take the full 10 days to make his/her election. After notification of the Soldier's election, the PEB then schedules the formal board at least 7-10 days later. This time period enables the Soldier and his/her chain of command time to prepare temporary duty orders, to arrange travel and lodging, and provides time for the Soldier to consult with legal counsel. In accordance with AR 635-40, the PEB must give the Soldier at least three days before scheduling a formal board. For this example, the formal board is set for 10 days after the return of the DA Form 199 (day 22). The formal board occurs on day 22. The Soldier again has 10 days to accept or rebut the formal board results (days 23-32). If on day 32 the PEB receives the Soldier's DA Form 199 rebutting the formal board decision, reconsideration may take several days to process (days 33-34). If there is no change, the PEB forwards the complete packet to the USAPDA for their review. By USAPDA SOP, the USAPDA has 10 days to review the case (days 35-44). In this example, USAPDA takes the full 10 days. If USAPDA revises the findings, USAPDA notifies the Soldier and the Soldier has 10 days to accept or rebut USAPDA's decision (days 45-54). Mailing of the forms to and from the Soldier each time could add as much as several weeks to the total time. This example does not include any additional time for a case returned by the PEB to the MTF for additional information or from the USAPDA to the PEB for reconsideration of its findings. This example also does not include the additional processing time of a COAD or COAR request as discussed in detail in the following finding. According to this example, the 40-day standard would not be realistic.

RECOMMENDATION: The APDES Action Team in conjunction with the Deputy Chief of Staff, G-1 reassess and revise the 40-day standard for disability case processing to reflect the potential time necessary for all levels of Soldier appeals.

FINDING 2.4: Processing Continuation on Active Duty (COAD) and Continuation on Active Reserve (COAR) requests resulted in additional time beyond the DODI 40-day standard in which Soldiers are in the Army Physical Disability Evaluation System.

STANDARDS:

- a. DODI 1332.38, SUBJECT: Physical Disability Evaluation, 14 Nov 96 (with Change 1, 10 Jul 06), paragraph E3.P1.6.3.
- b. AR 635-40, Physical Evaluation for Retention, Retirement, or Separation, 8 Feb 06, Chapter 6.

c. Memorandum of Understanding (MOU) between the Force Alignment Division (FAD), Human Resources Command (HRC) and US Army Physical Disability Agency (USAPDA), 26 Oct 05.

ROOT CAUSE: The DODI 1332.38 40-day standard for processing a Physical Evaluation Board (PEB) case does not incorporate the time for processing COAD/COAR actions.

DISCUSSION:

a. AR 635-40, Chapter 6, paragraph 6-3 prescribes the criteria and procedures under which Soldiers determined unfit by a PEB may be considered for COAD or COAR as an exception to policy. The COAD applies to officers on the active duty list, Regular Army (RA) enlisted Soldiers, and Soldiers in the Active Guard/Reserve (AGR) or on full-time National Guard duty (FTNGD). The COAR applies to AGR Soldiers requesting to continue as members of the Individual Ready Reserve (IRR) or as a Troop Program Unit (TPU) member, FTNGD Soldiers requesting to continue as traditional (drilling) unit members, ARNG unit members, USAR TPU members, IRR members, and Individual Mobilization Augmentees (IMA).

b. The DODI 1332.38, paragraph E3.P1.6.3 states that, "upon receipt of the Medical Evaluation Board (MEB) or physical examination report by the PEB, the processing time to the date of the determination by the final reviewing authority as prescribed by the Secretary of the Military Department should normally be no more than 40 days." This standard does not address the additional time required to process COAD/COAR applications by USAPDA.

c. The process for an officer COAD request is as follows. The officer submits a COAD request to USAPDA. USAPDA reviews the request and forwards it and the case file to HRC for action. Upon receipt of an officer COAD packet, HRC, Operations and Plans Division (OPD) conducts an initial eligibility and quality control review and forwards the COAD packet to the officer's career branch and/or the reclassification branch if required. The Career Branch Division Chief submits a recommendation and forwards the COAD packet to the COAD review board. This board consists of three members: the Chief of Retirement and Separations Branch, the Chief of Accessions, and the Deputy Chief of OPD. All three members are responsible for reviewing the COAD packet and making a recommendation. The Chief, OPD is the final approval authority for the RA officer COAD packets. OPD disseminates the approved officer COAD packets results to the officer's career branch, which cuts the request for orders on approved packets. They then notify USAPDA and the Military Treatment Facility (MTF) commander of the action and forward him/her, as well as the officer, a copy of the request for orders. OPD forwards a disapproved COAD notification to USAPDA, the MTF Commander, and the appropriate transition center which processes the officer for separation.

d. The DAIG reviewed the 34 officer COAD packets processed between October 2004 through September 2006. The processing time from receipt of the packets by HRC-OPD to completion ranged from one day to 168 days and averaged 45 days overall. This average clearly exceeds the DOD standard of normally processing an entire PEB case in 40 days. Seven cases involved combat related injuries. HRC-OPD approved 15 cases and disapproved 18 cases. In one case, HRC-OPD took no action due to the officer separating from the Army. HRC-OPD indicated their internal standard for processing a packet is 30 days at the officer's branch and 10 days for the HRC-OPD board to render a final adjudication.

e. RA enlisted Soldiers found unfit for retention through the Army Physical Disability Evaluation System (APDES) and who meet the criteria for applying for COAD may also submit a request for COAD. Prior to 2005, USAPDA was the final approval authority for RA enlisted COADs. On 26 Oct 05, Chief of Force Alignment Division (FAD), HRC and USAPDA signed a MOU designating FAD, HRC as the final approval authority for RA enlisted COAD packets. Within FAD, the Reclassification, Retirement and Separation Branch (RRSB) is responsible for receiving, processing, tracking, and responding to RA enlisted Soldier's requests for COAD sent from the USAPDA. The FAD prepares approval/disapproval, dispatches it to the USAPDA, provides a copy to the Soldier's MOS branch, and notifies the MTF of the final disposition.

f. Upon receipt of the enlisted COAD applications, the FAD makes necessary coordination within the Enlisted Personnel Management Directorate (EPMD). The EPMD is responsible for evaluating each application for COAD, making the appropriate recommendation, and returning the packet to RRSB, as well as issuing assignment instructions for those Soldiers granted COAD.

g. The DAIG reviewed 258 RA enlisted COAD cases resulting in 115 disapproved, 85 approved, 21 withdrawn, 1 fit for duty, 32 ineligible, and four cases open covering the period from November 2003 to October 2006. The processing time from receipt of the packets by the FAD to completion ranged from zero days to 195 days and averaged 32 days overall. This average would most likely cause the PEB case to exceed the DOD standard of processing an entire PEB case in 40 days. Despite the agency's efforts to expedite delivery of COAD packets through Federal Express delivery service and hand carrying means, the processing time goal is exceeded in most cases. The FAD's overall standard is to ensure a RA enlisted Soldier's COAD packet is acted upon and returned to USAPDA within 10 working days of receipt by RRSB.

h. The DAIG reviewed 149 National Guard COAR requests which resulted in 98 disapproved, 38 approved, 10 withdrawn, and 3 pending state recommendation. The state processing time ranged from zero to 89 days, with an overall average of 12 days. This average may cause the PEB case to exceed the DOD standard of processing an entire PEB case in 40 days. The HRC total processing time ranged from zero to 116 days, with an overall average of 23 days. Once the respective state adjutant general returns the packet to the approving authority, Soldiers normally have orders within two to four weeks.

i. HRC-St Louis processes USAR COAD/COAR packets. According to interviewed personnel at HRC-St Louis, they do not maintain separate databases for the COAD/COAR packets. In other words, they do not track incoming and outgoing cases effectively. Therefore, there was insufficient data available in order for DAIG to perform an analysis.

j. Most (75 of 97) Soldiers interviewed during sensing sessions stated that they did not receive counseling or briefings on the COAD/COAR process. However, 15 of 15 installations that conducted MEB briefs indicated they either brief Soldiers about the COAD/COAR process at the initial MEB brief or during the on-on-one appointments with the case manager. At the very least, Soldiers must initial DA Form 3947, Item 15 to indicate whether or not they desire to continue on active duty or active reserve under AR 635-40 if found unfit by a PEB.

RECOMMENDATION. The APDES Action Team in conjunction with the Deputy Chief of Staff, G-1, consider an additional time period to process COAD and COAR cases and expand the DODI 40-day timeline standard for those cases.

FINDING 2.5: The USAPDA quality assurance program does not conform to DOD and Army policy.

STANDARDS:

a. DODD 1332.18, Subject: Separation or Retirement for Physical Disability, 4 Nov 96, paragraphs 4.4.1. and 4.4.3.

b. DODI 1332.38, Subject: Physical Disability Evaluation, 14 Nov 96 (with Change 1, 10 Jul 06), paragraphs 5.5.2. and E3.P1.3.5.

c. DODI 1332.39, Subject: Application of the Veterans Administration Schedule for Rating Disabilities, 14 Nov 96, paragraph 5.3.

d. AR 635-40, Physical Evaluation for Retention, Retirement, or Separation, 8 Feb 06, paragraph 4-22.

e. USAPDA Standing Operating Procedures, paragraph 5-14., 25 Apr 01.

f. Government Accounting Office (GAO) Report to Congressional Committees, Military Disability System, 31 Mar 06, pages 19-20.

ROOT CAUSE: DOD has not established quality parameters for the services to follow to evaluate the consistency of PEB decision making.

DISCUSSION:

a. USAPDA is to perform quality assurance (QA) reviews of PEB cases IAW DODI 1332.38 paragraph 5.5.2. Additionally in AR 635-40, paragraphs 4-22 a. and b., USAPDA is to perform reviews of cases under seven different conditions but confine those reviews to the case records, proceedings, and related evidence. Finally in USAPDA's own SOP, paragraph 5-14, Statistical Reports, and Appendix D, Case Review Process, USAPDA is to perform QA reviews of cases submitted. During the inspection, DAIG determined that in fact USAPDA has in place a QA program, but it is limited in scope. AR 635-40 and the working revision of the USAPDA SOP are followed for the required reviews. USAPDA's QA program does not fully meet the intent of the DODI as noted in the GAO Report because it focuses on the accuracy of the determinations in individual cases. While this is an important aspect of a QA program, it does not assess consistency of ratings among the PEBs, which is equally important in order to ensure fairness to all involved Soldiers.

b. USAPDA follows a specific case review procedure. At the beginning of the month, select personnel at USAPDA review all cases sent to them until they meet a predetermined percentage of the total monthly cases sent in from each PEB. The remaining days of the month, USAPDA only reviews cases that are required by regulation or by the working revision of the SOP. With regard to non-mandatory reviews, if the Medical Officer (MO) and Soldier agree with the PEB decision, only the Medical Section reviews the case. The USAPDA Medical Section, the USAPDA Legal Advisor (ALA), and the Deputy Commanding Officer (DCO) conduct mandatory reviews. For 10a/c cases (those involving questions of whether the disability was the result of armed conflict or caused by an instrumentality of war), the ALA is the final arbiter. If the MO and the ALA both disagree with the PEB, USAPDA returns the case to the PEB. A weekly meeting with the MO, ALA, Operations Chief and DCO discusses and acts on cases where the ALA agrees with the PEB. If there is no agreement, the DCO makes the final decision. The feedback received from all PEBs is that USAPDA has not provided any reports with regard to consistency among the PEBs. The PEBs indicated that USAPDA only contacts them for case specific issues. DAIG could not find any evidence of regular USAPDA correspondence/feedback to the PEBs.

c. The USAPDA QA program at one time tracked specific types of cases and produced monthly reports that were sent back to the PEBs. It was felt there was no value added, and they discontinued the practice. If USAPDA notes inconsistencies among the PEBs, they address the issue in multiple ways: video teleconference (VTC), e-mail, phone calls, or I&G memorandums. USAPDA now also provides feedback on written minority opinions. USAPDA issued nine I&G memorandums in 2005 to assure consistency among the PEBs. USAPDA has not issued any I&G memorandums since then.

d. USAPDA developed a monthly spreadsheet that tracked the MTF return rate with ten major categories for return reasons. DAIG could not find where USAPDA promulgated this report to the PEBs. From our inspection, it is a document used at the USAPDA headquarters only. It is not a report queried from PDCAPS. Additionally,

USAPDA notified DAIG that they have since stopped producing this report and developed a new tracking mechanism.

e. USAPDA felt that it is not the individual PEB's job to be looking at the entire system in terms of consistency of ratings. USAPDA Medical Section developed a PDCAPS tool to look at individual codes and see how each PEB rated these codes. USAPDA noted significant differences with respect to non-duty related (NDR) cases in that they discovered one PEB found Soldiers fit if there was no medical evidence to the contrary. USAPDA addressed this discrepancy during a VTC with subsequent improvement in the responsible PEB's performance.

f. Consistency among PEBs: DAIG asked for 14 VASRD codes that, because of their volume, might produce the biggest potential discrepancies among the PEBs for CYs 02-06. A ten percent variation was the threshold used in determining inconsistency among the PEBs. DAIG analysis consisted of three groupings: EPTS (Existed Prior to Service), SWSP (Separate with Severance Pay) (0-20% disability ratings), and PDR (TDRL or 30-100% permanent disability ratings). The total cases received by the individual PEBs during the relevant period were: DC (16,682 cases), TX (24,634 cases) and WA (16,595 cases). The DAIG analysis revealed the following:

(1) For five of the codes (highlighted in light blue, italic in the table below), there were significant inconsistencies among the PEBs. These discrepancies do not necessarily mean that Soldiers in similar circumstances received less favorable ratings from any of the PEBs. One would have to perform a multivariate analysis to reach such a conclusion. One would have to consider factors such as the relative frequency of arm or knee injuries at the respective MTFs in the catchment areas of the PEBs in the first and fourth examples. In the second and third examples, the PEBs may have awarded a similar VASRD code with the same percentage of disability.

(a) Arm, Limitation of Motion (5201): DC PEB used this code to rate more than twice as many cases (151) as the TX PEB (71) and five times as many as the WA PEB (32).

(b) Cervical/Lumbar Strain (5237): TX PEB had the largest workload over the five year period but only rated 212 cases with this VASRD code, while both WA PEB (1,096) and DC PEB (1,220) rated over five times as many cases using this code.

(c) IVD Syndrome (5243): The WA PEB (511) used this coding more often than the TX PEB (470) even though their total case load was smaller. The frequency was over 1 ½ times as often as the DC PEB (327).

(d) Knee, other impairment of (5257): The DC PEB (241) used this code more than twice as often as the WA PEB (114) and 1 ½ times as often as the TX PEB (156).

(e) Sleep Apnea (6847): Both TX PEB (218) and WA PEB (157) far exceeded the DC PEB (27) usage of this code. These numbers are nine times and six times as much, respectively.

(2) Three codes (highlighted in blue, bold italic in the table below) revealed an inconsistency between EPTS vs. Non-PDR ratings.

(a) Sleep Apnea (6847): 39% delta between PEBs for EPTS. 40% delta between PEBs for Non-PDR.

(b) IBS (7319): 32% delta between PEBs for EPTS. 27% delta between PEBs for Non-PDR.

(c) Diabetes (7913): 20% delta between PEBs for EPTS.

(3) Three codes (highlighted in yellow, bold in the table below) revealed an inconsistency between non-PDR vs. TDRL/PDR ratings.

(a) Fibromyalgia (5025): 31% delta among the PEBs for Non-PDR ratings. Twenty-six percent (26%) delta for PDR ratings.

(b) Fusion (5241): 12% delta in Non-PDR ratings.

(c) Asthma (6602): 37% delta Non-PDR ratings and 38% delta PDR ratings.

Table 1: Analysis of Consistency of Ratings between the three PEBs on select VASRD codes

CY02-06 Rollup										
PEB	VASRD	CODE	EPTS	SWSP	TRDL/PDR			EPTS	SWSP	TRDL/PDR
WA	5025		11	87	22		120	9%	73%	18%
TX	5025		11	96	52		159	7%	60%	33%
DC	5025		2	89	7		98	2%	91%	7%
WA	5099	5003	146	2820	2		2968	5%	95%	0%
TX	5099	5003	216	5231	1		5448	4%	96%	0%
DC	5099	5003	266	2567	0		2833	9%	91%	0%
WA	5201		0	27	5		32	0%	84%	16%
TX	5201		1	61	9		71	1%	86%	13%
DC	5201		10	130	11		151	7%	86%	7%
WA	5237		121	973	2		1096	11%	89%	0%
TX	5237		19	193	0		212	9%	91%	0%
DC	5237		132	1088	0		1220	11%	89%	0%
WA	5241		8	167	24		199	4%	84%	12%
TX	5241		4	397	14		415	1%	96%	3%
DC	5241		14	165	18		197	7%	84%	9%

WA	5243		28	478	5	511	5%	94%	1%
TX	5243		12	456	2	470	3%	97%	0%
DC	5243		22	300	5	327	7%	92%	2%
WA	5257		4	94	15	113	4%	83%	13%
TX	5257		10	135	11	156	6%	87%	7%
DC	5257		18	212	11	241	7%	88%	5%
WA	6354		1	4	1	6	17%	67%	17%
TX	6354		5	0	4	9	56%	0%	44%
DC	6354		1	5	1	7	14%	71%	14%
WA	6602		122	38	440	600	20%	6%	73%
TX	6602		182	271	561	1014	18%	27%	55%
DC	6602		155	307	250	712	22%	43%	35%
WA	6847	6847	37	118	2	157	24%	75%	1%
TX	6847	6847	38	177	3	218	17%	81%	1%
DC	6847	6847	15	11	1	27	56%	41%	4%
WA	7005		20	10	8	38	53%	26%	21%
TX	7005		43	42	16	101	43%	42%	16%
DC	7005		25	10	12	47	53%	21%	26%
WA	7319		7	8	1	16	44%	50%	6%
TX	7319		8	34	7	49	16%	69%	14%
DC	7319		3	20	3	26	12%	77%	12%
WA	7913		52	117	16	185	28%	63%	9%
TX	7913		159	195	4	358	44%	54%	1%
DC	7913		62	100	0	162	38%	62%	0%
WA	8045		3	0	1	4	75%	0%	25%
TX	8045		2	0	4	6	33%	0%	67%
DC	8045		0	3	10	13	0%	23%	77%

RECOMMENDATION: The APDES Action Team in conjunction with the US Army Physical Disability Agency establish a quality assurance program that promotes consistency of ratings by all of the Physical Evaluation Boards and provides feedback to the same on a regular basis.

FINDING 2.6: The training of personnel working in the Physical Evaluation Board (PEB) process does not meet the standards as specified in DODI 1332.38, AR 635-40, and US Army Physical Disability Agency's (USAPDA) SOP.

STANDARDS:

a. DODD 1332.18, Subject: Separation or Retirement for Physical Disability, 4 Nov 96, paragraph 4.4.5.

b. DODI 1332.38, Subject: Physical Disability Evaluation, 14 Nov 96 (with Change 1, 10 Jul 06), paragraph E3.P1.7.

c. AR 635-40, Physical Evaluation for Retention, Retirement, or Separation, 8 Feb 06, paragraph 4-17.

d. USAPDA SOP, 25 Apr 01, paragraphs 1-8., 4-4., 4-7., 5-11.

e. USAPDA Policy Memorandum #15, 28 Feb 05.

ROOT CAUSE: Other than a one-week course for adjudicators, USAPDA provides no formal training for their personnel.

DISCUSSION:

a. DODI 1332.38, paragraph E3.P1.7. states that primary participants including the PEB and appellate review members shall be trained in a timely and continuing manner concerning the policies and procedures of the Instruction. DODD 1332.18, paragraph 4.4.5. states that the Secretaries of the Military Departments shall ensure that PEB members and applicable review authorities are trained and certified in physical disability evaluation. While all USAPDA full-time adjudicators attend the one week "senior" adjudicator's course before actively participating in a Board, any subsequent training appears to be on-the-job (OJT). USAPDA previously held conferences for PEB physicians or the Presidents on an annual basis, but these are no longer occurring at regular intervals. There does not appear to be a vehicle for formal training for any other USAPDA/PEB personnel.

b. AR 635-40, paragraph 4-17 states the PEB President will ensure training of all permanent and part-time members before they adjudicate cases. Although USAPDA trains the permanent members as noted above, on the rare occasion that an APDES Soldier requests an enlisted member for a formal board, these individuals generally receive little more than an *ad hoc* briefing on the conduct of a formal board prior to their participation. USAPDA Policy Memorandum #15 requires that PEB personnel brief them on "standards for determining fitness and compensability prior to sitting the board." These are complex issues that PEB personnel cannot adequately address in short briefings. The memorandum also encourages the PEBs to have a standing list of extra members and "a training plan based on the introduction course."

c. USAPDA SOP, paragraph 4-4 requires attendance at the senior adjudicator's course for military attorneys representing Soldiers at formal PEBs and recommends it for Physical Evaluation Board Liaison Officers (PEBLO). Only two of the nine current military attorneys attended the course, and both attended after they had been representing Soldiers. DAIG did not identify any PEBLO that attended the senior adjudicator's course in over two years.

d. Interviewed personnel at all three PEBs indicated they receive no feedback from USAPDA on the quality of their work product except on a case-by-case basis. Beginning in March 2005, USAPDA began providing Issue and Guidance (I&G) memorandums to all of the PEBs in response to recurring concerns at one or more of the PEBs. USAPDA states these "informal communications" represent "good guidance" rather than official policy. However, the PEBs are to follow them as directed in a USAPDA memorandum dated 1 April 2005. At the time of the DAIG inspection, USAPDA provided nine I&G memorandums to the PEBs. While these address specific concerns raised by the PEBs and are meant to ensure uniformity of ratings among them, they do not rise to the level of continuing training required by the above DODI.

e. USAPDA does not follow their own SOP. Paragraph 4-7 of USAPDA's SOP states that "USAPDA publishes a Yearly Operational and Training Plan [Guidance (YOTG)] to facilitate its training strategy". The SOP mandates that the Operations Division publish and maintain a "Yearly Training Calendar to coordinate significant training events." The YOTG for FY 01 was included with the SOP (Appendix E) and USAPDA provided YOTGs dated August 2001 and December 2002. No subsequent YOTGs were available to DAIG. USAPDA provided no Yearly Training Calendars for the years 2002-06, but indicated they present the senior adjudicator's course once or twice each year.

f. According to USAPDA's SOP, paragraph 5-11 the Operations staff is to "perform periodic staff assistance visits (SAV) of USAPDA sub-activities" during which "all areas of support and operations of the PEB will be reviewed." The SOP states the "visits will occur at a minimum of once per year or upon direction of the DCO, USAPDA." These visits have not occurred in at least the past two years.

g. USAPDA's SOP, paragraph 1-8 states: "It is recommended that PEBs conduct periodic assistance visits to servicing MTFs for 'one-on-one' interface with senior health care officials to analyze disability case processing performance." The PEB that consistently provided these SAVs found that the quality of the MEBs from the visited MTFs substantially improved resulting in decreased number of returned cases and improved overall processing times. In all, the PEBs conducted 22 SAVs in the past five years. Funding for these visits as well as availability of personnel to conduct them limit their frequency.

RECOMMENDATIONS. The APDES Action Team in conjunction with:

a. US Army Physical Disability Agency enforce the requirements of the Army Regulation and Department of Defense Directives and Instructions to provide continuing training to its staff.

b. US Army Physical Disability Agency conduct regular staff assistance visits by the headquarters and Physical Evaluation Board staffs.

c. Office of The Judge Advocate General study the feasibility of sending Judge Advocates in support of the Physical Evaluation Board process to the US Army Physical Disability Agency Senior Adjudicators course.

d. Office of The Surgeon General study the feasibility of sending Physical Evaluation Board Liaison Officers to the US Army Physical Disability Agency Senior Adjudicators course.

FINDING 2.7: Some Soldiers do not return for their required periodic examinations while in a Temporary Disability Retirement List status.

STANDARDS:

a. Title 10, Chapter 61, Section 1210, US Code, Members on Temporary Disability Retired List: Periodic Physical Examination; Final Determination of Status., subparagraphs (a) and (h).

b. DODD 1332.18, Subject: Separation or Retirement for Physical Disability, 4 Nov 96, paragraphs 3.10. and 3.11.

c. DODI 1332.38, Subject: Physical Disability Evaluation, 14 Nov 96 (with Change 1, 10 Jul 06), paragraph 5.5.5. and Enclosure 3 Part 6.

d. AR 635-40, Physical Evaluation for Retention, Retirement, or Separation, 8 Feb 06, Chapter 7 and Appendix C-10.

e. USAPDA SOP, 25 Apr 01, paragraph 6-5.

ROOT CAUSE: For Soldiers who do not return for their periodic physical examinations while on the Temporary Disability Retired List (TDRL), the impact of terminating his/her Army retirement pay is insufficient.

DISCUSSION:

a. The purpose of the Temporary Disability Retired List (TDRL) is to provide a mechanism to rate Soldiers for conditions that are not considered stable (conditions that may improve or worsen while the Soldier is on the TDRL). A Soldier may be on this list for up to five years but must have periodic physical examinations to determine if the condition(s) have stabilized enough for the PEB to render a final rating. This final adjudication may result in the Soldier being transferred to permanent disability retirement (PDR) with a disability rating higher than the original adjudication, lower than the original adjudication, separated with separation pay (SWSP) or a finding that the Soldier is fit for duty. Soldiers on the TDRL receive many of the benefits as that of a 20-year retiree. These benefits include access to TRICARE, a retiree ID card, and retirement pay of at least 50% of the Soldier's base pay.

b. Sub-paragraph (a) of Section 1210, 10 USC 61 states that a physician shall examine a member on the TDRL at least every 18 months. If a Soldier fails to report for an examination under this subsection, USAPDA may terminate his disability retired pay after the Soldier's receipt of proper notification. Sub-paragraph (h) states that USAPDA will terminate the disability retired pay of a Soldier on the TDRL after five years. Paragraph 3.10 of DODD 1332.18 explains why a service member is placed on the TDRL and paragraph 3.11 instructs the services to manage the TDRL in accordance with the provisions in Section 1210, 10 USC 61. Paragraph 5.5.5., DODI 1332.38 instructs the Secretaries of the Military Departments to ensure the TDRL is managed to meet the requirements of Section 1210, 10 USC 61 for timely periodic physical examinations, suspension of retired pay, and removal from the TDRL. Paragraph E3.P6.2.6. reiterates the conditions set forth in Section 1210, 10 USC 61.

c. Paragraph 3-9, Chapter 7, AR 635-40 describes in further detail the requirements set forth above concerning TDRL. Paragraph 7-4.c. states that Soldiers who fail to complete a physical examination when ordered will have their disability retired pay suspended. This is more strict than prescribed in Section 1210, 10 USC 61. Additionally in paragraph 7-11.b.(4) if on the fifth anniversary on being on the TDRL the Soldier does not have an accepted medical examination on file, the Soldier shall not be entitled to permanent retirement or separation with severance pay. USAPDA is to administratively remove the Soldier from the TDRL without entitlement to any of the benefits (ID card, TRICARE, retirement pay, etc.) provided by 10 USC 61. PEBLOs are required to counsel the Soldier as to his/her responsibilities while on the TDRL and the consequences for failure to appear for the periodic examinations in accordance with Appendix C-10, AR 635-40.

d. The TDRL Branch of USAPDA maintains the master TDRL in PDCAPS. At the time of the inspection visit to USAPDA, there were over 4,500 names on the list. The process at USAPDA for notifying Soldiers of upcoming physicals is as follows. USAPDA TDRL Branch does not contact the Soldier via the phone or face to face. The PEBLOs at the military treatment facilities (MTFs) perform this function. USAPDA TDRL Branch queries the DFAS database to find the most current Soldier addresses. USAPDA TDRL then mails out the packet to the MTFs/PEBLOs those cases with 18-month physicals within the next 4-6 month time period. USAPDA TDRL also sends a letter to the Soldier reminding him/her of the upcoming physical. USAPDA TDRL has no visibility on the success rate of shows vs. no-shows. USAPDA TDRL does include in the TDRL packet a form for the MTF/PEBLO to fill out once the Soldier attends his physical or is a no-show, but only one installation returns this form to USAPDA regularly.

e. Thirteen of the 20 installations inspected indicated they maintained a TDRL database. Some chose to maintain the database in a stand-alone spreadsheet while others used existing fields in MEBITTS. Nine installations indicated they experienced difficulties in notifying a Soldier of his/her upcoming physical examination. Six installations provided no input regarding issues contacting Soldiers. Three installations

either have no one on their list or another installation handles their TDRL. Two installations indicated they have no problems contacting their Soldiers.

f. A few USAPDA personnel interviewed indicated that USAPDA should strictly enforce the provisions of suspending retired pay. In that same light however, other personnel interviewed said it would make no difference if USAPDA enforced the provision because they perceived the Soldiers did not care about the Army retirement pay as they were already receiving retirement pay from the DVA. Additionally, personnel interviewed also perceived that the Soldiers did not care if they lost their ID card or TRICARE coverage at the five year anniversary of being on the TDRL. USAPDA interviewed personnel also indicated that even though they know they are supposed to administratively terminate the cases at the five year anniversary, they still choose to try to reach final resolution on the cases. It is the opinion of the DAIG that this takes time away from processing other active cases.

RECOMMENDATIONS. The APDES Action Team in conjunction with:

a. US Army Physical Disability Agency impose stricter compliance in suspending retirement pay benefits for Soldiers who fail to show for their periodic physicals.

b. US Army Physical Disability Agency abide by the US Code and Department of Defense Instructions concerning cases that are over five years old.

c. US Army Physical Disability Agency consider incorporating the suspension of identification cards and access to TRICARE, in addition to suspending retirement pay benefits for Soldiers who fail to show for their periodic physicals.

FINDING 2.8: The Judge Advocate General (JAG) Corps currently provides quality legal representation to the Soldiers they represent at formal Physical Evaluation Boards.

STANDARDS:

a. DODI 1332.38, Subject: Physical Disability Evaluation, 14 Nov 96 (with Change 1, 10 Jul 06), paragraph E3.P1.3.3.5.2.

b. AR 635-40, Physical Evaluation for Retention, Retirement, or Separation, 8 Feb 06, paragraph 2-6.

DISCUSSION:

a. DODI 1332.38, paragraph E3.P1.3.3.5.2. affords a Soldier the assistance of a detailed military counsel at no expense when appearing before a formal board. Alternatively, the member has the right to obtain a civilian personal representative at no expense to the Service. AR 635-40, paragraph 2-6 states The Judge Advocate General (TJAG) will train and provide sufficient legal counsel to represent Soldiers appearing

before a PEB. Multiple statutes, DODIs, ARs, and agency policies regulate the complicated APDES system. This aspect of the law receives cursory attention in the training of most military JAGs. While USAPDA SOP requires attendance at their senior adjudicator's course prior to representing Soldiers before a PEB, only two of the current nine military JAGs have done so. Because most of the specific training for these personnel is OJT, it is critical that there be overlap of assignments.

b. The DAIG interviewed over 500 Soldiers and leaders covering 20 installations. Most of those interviewed felt that the JAG Corps attorneys and DA civilians provided both effective and quality legal representation. There was unanimous agreement among those PEB members who adjudicated cases during a formal board that the military attorneys who had at least six months of experience appearing before the formal boards provided outstanding representation for their clients. This contrasted with the nearly unanimous opinion of these individuals that, with rare exception, the civilian attorneys were not familiar with the complicated process and provided less than satisfactory representation to their clients. The adjudicators frequently expressed opinion was that the civilian representation was "not worth the money."

c. Within the past two years, the lack of trained military attorneys dedicated to representing Soldiers before the PEBs caused considerable delays in the processing of cases. At one time, the wait for a formal board at one of the PEBs was over sixty days. Lack of JAG Corps attorney availability was responsible for a significant portion of the time required to schedule a board. Partly because Human Resources Command-Alexandria (HRC-A) has since provided funding for additional JAG Corps attorney support, the current average wait time at the PEBs for a formal board is now less than two weeks. Five of the nine attorneys who represent Soldiers before the PEBs are reserve component (RC) JAG Corps attorneys whose temporary slots are funded by HRC-A. There is no mechanism in place to ensure that funding of RC JAG officers will continue in order to provide this service to Soldiers.

d. At one of the PEB sites, the local Staff Judge Advocate determined that it is in the best interest of the members of the JAG staff to rotate them into different positions after brief (less than one year) periods of time. While this practice may enhance the careers of the JAG officers, it limits their experience level in this complicated system and may result in less than optimal representation of Soldiers.

e. Under the above DODI and AR, the involvement of the JAG Corps attorney does not begin until after the Soldier has elected to have a formal board. It was frequently expressed that if Soldiers had access to a "PDES trained" JAG Corps attorney or other counsel earlier in the process, their understanding of their rights would be enhanced and the number of formal boards requested might be significantly reduced.

f. The DAIG observed several formal boards conducted by video teleconference (VTC). These may be conducted with the military counsel physically in the same room with the Soldier or in the board room with the adjudicators. This option saves the Soldier from having to travel to one of the fixed PEB sites. While a VTC board is

uniformly considered to be superior to one conducted by telephone, it has drawbacks. Representation by an experienced military attorney who argues before the PEB on a daily basis provides the best possible outcome for the Soldier. This may not be who represents the Soldier during a VTC. Counsel naturally prefers to have clients physically present prior to the board in order to adequately prepare them for the hearing. The adjudicators prefer being able to observe the Soldier as he/she enters and exits the board room.

RECOMMENDATIONS. The APDES Action Team in conjunction with:

a. Office of The Judge Advocate General continue current staffing levels of full-time Army attorneys and Department of the Army civilians support staff and provide sufficient training time of the attorneys before representing Soldiers before the Physical Evaluation Boards.

b. Office of The Judge Advocate General consider increasing staffing levels at the Physical Evaluation Board sites to permit counseling of Soldiers by experienced attorneys earlier in the Army Physical Disability Evaluation System process.

OBSERVATION 2.9: The US Army Physical Disability Agency (USPDA) and the Physical Evaluation Boards (PEBs) recognized the need for additional personnel to process the increased caseload as a result of the Global War on Terrorism (GWOT) and have made some progress.

DISCUSSION:

a. USAPDA and PEB personnel interviewed by DAIG felt that their organization desperately needed additional manpower to effectively accomplish their mission. Both versions of FY05 and FY06 Table of Distribution and Allowances (TDA) authorized USAPDA only 29 personnel to manage the PEBs. The TDA authorized all three PEBs to collectively have only 30 personnel to manage all PEB cases. The TDA authorized each PEB one PEB president (AC), one personnel management officer (RC), one adjudicator (GS-13), two medical officers (GS-13), one human resource supervisor (GS-9), and three human resource assistants (GS-7). At one PEB, the TDA authorized an additional human resource assistant (GS-7), while the other two PEBs have a computer assistant (GS-8). The TDA only provides for one attorney and one paralegal specialist at the USAPDA HQ and no legal support authorizations at the PEB level, although legal representation is a limiting factor at the PEBs.

b. As a result of GWOT, the USAPDA's case load continuously increased, placing greater demands for additional personnel. USAPDA HQ and all three PEBs identified the overwhelming need for additional administrative, adjudicator, medical, and legal support to effectively process the approximately 14,000 cases currently managed by USAPDA HQ and the PEBs. Despite an increase of 50% to 70% in their case load, USAPDA HQ has not been funded for additional medical or legal staffing. USAPDA and

the PEBs established ad-hoc manpower support agreements with the US Army Reserve Command, JAG Corps, and HRC-A for additional resources.

c. There are currently seven contractor hires supporting USAPDA HQ (three computer programmers and four human resource assistants). Also, contractor hires support the three PEBs with six human resource assistants (one PEB has one contractor, another PEB has three and the last PEB has two).

d. In recognition of the dramatic increase of the USAPDA yearly caseloads (9,000 to 15,000) due to Soldier injuries received in combat, HRC-A funded civilian term positions in 2004 to provide each of the fixed PEBs with an additional medical officer. Currently, each PEB has three civilian medical officers. A Mobile PEB team consisting of a president (RC), a personnel management officer (PMO)(RC), and a civilian medical member was formed to rotate among the fixed PEBs to reduce the backlogs of formal boards. This significantly reduced wait times for these boards resulting in substantial financial savings. Since August 2004, the Mobile PEB adjudicated over 750 formal boards and over 400 informal boards. This team is also credited with enhancing communication between the fixed PEBs. Concerning legal counsel at the PEB sites, one PEB has four attorneys (three RC and one civilian) and a legal NCO. Another PEB has one military attorney, one civilian attorney and one civilian paralegal specialist. The third PEB has one civilian and two RC attorneys, two legal NCOs, and one civilian paralegal). There are no formal agreements established to maintain this additional support. The legal counsels at the PEB sites do not work for USAPDA.

e. The civilian personnel turnover rate for USAPDA and the PEBs has been relatively low. Although upward promotion mobility is limited for the human resource assistants (GS-7), some were able to compete for higher positions within the Agency.

RECOMMENDATIONS. The APDES Action Team in conjunction with:

a. Human Resources Command-Alexandria reassess the Table of Distributions and Allowances; reallocating necessary resources to US Army Physical Disability Agency to assist them in effectively processing physical evaluation board cases.

b. US Army Physical Disability Agency reassess the Table of Distributions and Allowances and requisition the necessary manpower that provides the most effective Table of Distributions and Allowances strength to process physical evaluation board cases.

OBSERVATION 2.10: The Department of Veterans Affairs Schedule for Rating Disabilities does not accurately reflect medical conditions and ratings in today's environment.

DISCUSSION:

a. Most of the interviewed personnel at all three fixed PEBs, the Mobile PEB, and USAPDA personnel indicated the Veterans Affairs Schedule for Rating Disabilities (VASRD) is out of date and needs to reflect current medical science. Congress mandated the use of the VASRD (1945 version) in Title 38 Part 4 of the US Code. Congress established the VASRD as the standard to assign disability ratings (0% to 100%) for disabled military personnel. Title IV of the Career Compensation Act of 1949 (which is now mainly in 10 USC 61) originally established this document. The DVA updated the VASRD numerous times over the years due to new medical conditions such as Acquired Immune Deficiency Syndrome (AIDS) and Post Traumatic Stress Disorder (PTSD). In the 1990s, DVA began the process of a full revision of the schedule. The schedule consists of codes covering the 13 body systems. To date, DVA updated 12 of the body systems with the musculoskeletal system still pending. DVA recently finished updating both the eye and neurological systems, and they are awaiting their final publishing. Even the 12 that have been completed are now somewhat outdated due to medical advancements within the last 12 years. For the VASRD to undergo a major revision with respect to a body system, the process can take up to two years. The DVA must revise the regulation and to send it through repeated administrative reviews by OMB before it is released. According to DVA, changing just one VASRD code typically takes about a year.

b. The DAIG interviewed personnel (PEB President, Personnel Management Officers, Medical Officers, and Human Resource personnel) from each of the PEBs concerning the validity of the VASRD and how they would go about affecting changes. All PEB sites indicated they send suggestions for change directly to the PDA or through their PEB President for airing at the annual PEB President's/Physicians Conference. One interviewee compared the difficulty of changing the VASRD to changing a Modified Table of Organization and Equipment (MTOE), only worse.

c. The DAIG cites three specific examples of how the VASRD is no longer current with today's advances in medicine and technology. The first example is headaches secondary to trauma. The PEB will rate a Soldier diagnosed with this condition at most a 10% disability. However, a Soldier with migraines could receive up to a 50% permanent disability retirement. The second example is use of the Goldman perimeter eye chart. The VASRD requires its use to delineate visual fields, but it has not represented common medical practice in over 10 years because there are more reliable methods for checking vision today. Due to the requirement to follow the VASRD guidelines, USAPDA will not accept the newer methods. This falls into one of the two body systems fully revised by DVA, but not yet published. The third example of an outdated VASRD concerns the treatment of asthma. Many Soldiers diagnosed with asthma will receive a 30% disability retirement. Today, established medical practice encourages asthmatics to use inhalation medications. When the VASRD was first developed, doctors prescribed inhaled medications for the most resistant cases of asthma. Asthmatic patients today routinely use inhalers as a first line of treatment. There are other areas where the VASRD has not kept pace with medical science:

hyperlipidemia, use of constant positive airway pressure (CPAP), heat injuries, traumatic brain injuries (TBI), and the use of implantable defibrillators (still rated at 100%).

d. The terminology used in the VASRD is not as useful/definitive as it should be. Adjectives, such as mild and moderate, used in the descriptions are not specific. The DVA should define VASRD adjectives numerically. The VASRD is not all inclusive causing the PEBs to apply rating codes analogous to the Soldier's condition, such as in the case of Crohn's Disease.

RECOMMENDATIONS. The APDES Action Team in conjunction with:

a. US Army Physical Disability Agency present recommended Veterans Affairs Schedule for Rating Disability changes to Department of Defense Disabilities Advisory Council.

b. Department of Veterans Affairs finish the full revision of the Veterans Affairs Schedule for Rating Disabilities and update the revised body function codes.

c. Commander, US Army Medical Command reassess and address the feasibility of having a common physical for use by the Department of the Army and the Department of Veterans Affairs.

OBSERVATION 2.11: Most Physical Evaluation Board (PEB), Judge Advocate General (JAG) Corps, and Department of Veterans Affairs (DVA) personnel know and understand the applicable regulations and policies concerning the PEB process to include the differences between Army and DVA disability ratings.

DISCUSSION:

DAIG interviewed 50 PEB, JAG Corps, and DVA personnel covering 20 installations. In nearly every interview (45 of 50), these personnel knew and understood the applicable regulations and policies concerning the PEB process to include the differences between Army and DVA disability ratings. In accordance with AR 635-40, the Army rates the unfitting disabilities using the VASRD as amended by Appendix B, AR 635-40. In accordance with DODD 1332.18, paragraph 3.3, the sole standard used in making determinations of unfitness due to physical disability shall be unfitness to perform the duties of the member's office, grade, rank, or rating because of disease or injury. The rating the Army awards compensates the Soldier for the loss of his/her military career. The DVA uses the VASRD to rate all service connected injuries. Additionally, the DVA compensates the Soldier for loss in civilian earning capacity resulting from disease or injury. Those interviewed understood that an Army rating is permanent and the DVA rating could change periodically.

RECOMMENDATION. The APDES Action Team in conjunction with: Physical Evaluation Boards, installation legal offices, and Department of Veterans Affairs offices

maintain the knowledge base of the current workforce and their replacements in order to best provide the correct information to Soldiers going through the Army Physical Disability Evaluation System.

OBSERVATION 2.12: A majority of the Soldiers interviewed do not know or understand the differences between Army and Department of Veterans Affairs (DVA) disability ratings.

DISCUSSION:

a. The DAIG interviewed over 500 Soldiers and leaders covering 20 installations. In a majority (58%, 289 of 501) of these interviews, Soldiers and leaders did not know or understand the differences between Army and DVA disability ratings. The perception from these Soldiers and leaders was that the DVA rating was going to be higher but they did not know why. AR 635-40, Appendix C, paragraphs C-7 and C-13, states that the PEBLO will counsel Soldiers on Army ratings and DVA compensation respectively. Additionally in paragraph 2-9.a. of the regulation, the unit commander will become thoroughly familiar with the purpose of the PDES. It does not indicate that the commander is to become familiar with the process nor does it state the commander will ensure his/her Soldier understands the PDES process.

b. Per Code of Federal Regulations Title 38: Pensions, Bonuses, and Veteran's Relief, Subpart A-- General Policy in Rating, paragraph 4.1, "This rating schedule is primarily a guide in the evaluation of disability resulting from all types of diseases and injuries encountered as a result of or incident to military service. The percentage ratings represent as far as practicably be determined the average impairment in earning capacity resulting from such diseases and injuries and their residual conditions in civil occupations." In layman's terms, the DVA compensates the Soldier for loss of future potential civilian employment due to service connected injuries.

c. Per DODI 1332.38, paragraph E3.P3.2.1., "a service member shall be considered unfit when the evidence establishes that the member, due to physical disability, is unable to reasonably perform the duties of his or her office, grade, rank, or rating (hereafter called duties) to include duties during a remaining period of Reserve obligation." Also per AR 635-40, paragraph 4-19d(2), "the determination of physical fitness will be made by relating the nature and degree of physical disability of the Soldier to the requirements and duties that the Soldier may be reasonably expected to perform in his or her primary military occupational specialty (MOS)."

d. The PEB assigns a disability rating per AR 635-40 paragraph 4-19.i. The PEB decides the percentage rating for each unfitting compensable disability. In layman's terms, the PEB rating compensates the Soldier for the loss of his or her military career.

e. In most (93%, 14 of 15) of the installations inspected, the Veterans Benefits Advisor (VBA, also known as a Military Service Coordinator) either directly participates

in the MEB briefs conducted by the PEBLO, provides slides to the PEBLO without direct participation, or conducts various other briefings separate from the PEBLO MEB brief concerning DVA benefits. DVA briefings range from twice a week to quarterly. Every installation inspected also conducts the Army Career and Alumni Program (ACAP) briefing in which the DVA is an active participant. At one installation, the VBA neither participates directly or indirectly with the MEB brief nor do they provide a separate brief to the Soldiers. At the four inspected Community Based Healthcare Organizations (CBHCO), the Soldiers did not receive any DVA briefings. Soldiers at the CBHCOs received briefings at their demobilization site, went to the local DVA office on their own, or did not receive a briefing at all. An observation in objective 3 also explains in more detail that Soldiers stated they received too many briefings in a short period and did not retain the information presented, thus contributing to their lack of knowledge of the differences between Army and DVA disability ratings.

RECOMMENDATIONS. The APDES Action Team in conjunction with:

- a. US Army Medical Command, in conjunction with the Regional Medical Commands, ensure quality counseling to Soldiers as set forth in Appendix C, AR 635-40 and conduct a post-counseling survey to verify understanding of the material.
- b. US Army Medical Command require Soldiers in the Army Physical Disability Evaluation System to read AR 635-40 early in the process and provide proof that they have done so.

OBJECTIVE 3: Assess the execution of the Medical Hold System to include compliance with Department of Defense and Army policies.

The Army Medical Hold System consists of both medical hold (MH) operations for active component Soldiers and medical holdover (MHO) operations for mobilized reserve component Soldiers. By definition, MHO includes Medical Retention Processing Units (MRPU) and Community Based Healthcare Organizations (CBHCO). Currently, US Army Medical Command (MEDCOM) has responsibility for MH operations, and is the supported command responsible for synchronizing MHO operations, supported by Installation Management Agency (IMA) and other major commands. The inspection revealed a lack of standardization in both MH and MHO operations in terms of organizational structure and internal operations. While the recently published Department of the Army MHO Consolidated Guidance attempts to standardize MHO operations, the document falls short in regards to command and control and operational components. The DAIG also found shortfalls in cadre training, authorization for critical staff and service support positions, and duty descriptions for MH and MHO (MRPU and CBHCO) units.

This inspection also revealed several other notable findings and observations: Some MH and MHO Soldiers do not fully understand their rights and separation entitlements, a few of the installations inspected had Americans with Disabilities Act

violations, the Community Based Healthcare Initiative program evidences unnecessary levels of command and control, and the use of sanctuary Soldiers as MRPU cadre adversely affects unit cohesion, most MH and MHO Soldiers perform their duties within the limits of their medical profiles, MRPU and CBHCOs maintain continuous updates to personnel and medical automation systems of MHO Soldiers, and the majority of commanders and leaders interviewed feel that Soldiers in the APDES should be assigned to a MTF MHU.

FINDING 3.1: Current Army medical holdover guidance does not fully address the command and control component for medical holdover operations.

STANDARDS:

- a. Department of the Army Personnel Policy Guidance (PPG) for Contingency Operations in support of GWOT, updated 16 August 2006, Chapter 10-11.
- b. Annex Q to HQDA OPORD 04-01, 22 Jan 04.
- c. Department of the Army Medical Holdover (MHO) Consolidated Guidance, 24 July 2006.
- d. FORSCOM Implementation Plan for Community Based Healthcare Initiative (CBHCI), 20 January 2004.
- e. MEDCOM Operations Order 06-03, Community Based Healthcare Organizations (CBHCO) Medical Holdover Operations (MHO).

ROOT CAUSE: The Army has not developed doctrine that clearly addresses the command and control (C2) component of medical holdover operations.

DISCUSSION:

- a. For the purpose of this inspection the DAIG divided medical holdover operations into two key components: command and control (C2) and medical management (M2).

(1) While the Department of the Army (DA) Medical Holdover (MHO) Guidance established C2 responsibilities along with processing personnel administrative functions for MHO Soldiers, it falls short in providing definitive guidance or doctrine on how to execute the C2 component of medical holdover operations. The DA MHO guidance directs the Installation Management Command (IMCOM), to “perform command and control through Garrison Commanders of medical holdover Soldiers receiving treatment on IMA installations. Ensure that Soldiers are available for medical care, provided with adequate billeting, and supported with personnel administrative and logistical support.” It further directs US Army Medical Command (MEDCOM), through its Regional Medical Commands (RMCs), to provide, “C2, personnel, logistical, fiscal, legal, chaplain, and

communications coordination and support..." to reserve component (RC) MHO Soldiers assigned to Community Based Healthcare Organizations (CBHCO).

(2) M2 consists of MEDCOM personnel such as physicians, Physical Evaluation Board Liaison Officers (PEBLOs), and case managers involved in managing the medical care of Soldiers. The DA MHO Consolidated Guidance directs MEDCOM to conduct medical evaluations, make decisions on treatment type and location, refer MHO Soldiers to the Army Physical Disability Evaluation System (APDES) in accordance with Army policy, and exercise technical supervision and quality control of all aspects of the medical holdover operations. Army Regulations 40-400 and 40-501 provides MEDCOM guidance on how to execute the M2 component of medical holdover operations.

b. According to the Office of the Assistant Secretary of the Army for Manpower and Reserve Affairs (ASA M&RA), MHO operations have been, since their inception, considered contingency operations and had no published guidance until the Deputy Chief of Staff, G-1, published the DA MHO Consolidated Guidance on 24 July 2006. The intent of the consolidated guidance according to ASA (M&RA) was a one source document for the conduct of medical holdover operations for the Army. After review of the DA MHO Consolidated Guidance, DAIG concluded this document only clearly addresses the personnel (S-1) node of MHO operations. The DAIG found that some of the interviewed Medical Retention Processing Unit (MRPU) and CBHCO cadre felt the consolidated guidance falls short of providing MRPU and CBHCO commanders clear guidance on how to conduct daily operations outside of personnel administrative actions. These issues are documented by the following information from interviews and sensing sessions. Some interviewed commanders and leaders indicated that the consolidated guidance does not address the daily operational aspects of a MHO unit. The DA MHO Consolidated Guidance gave IMCOM responsibility for developing standard operating procedures (SOPs) for MRPU MHO operations. The DAIG however, found no evidence IMCOM has completed these SOPs.

c. Many of the interviewed medical holdover leaders and Soldiers indicated there is a lack of standardization in how MRPU and CBHCOs conduct daily operations. These personnel informed the DAIG that as Soldiers move through the medical holdover system from one MRPU to another, differences in unit operations are readily apparent. For example at some MRPU, Soldiers stated they attended college courses instead of assigned daily duties. At other MRPU, the commanders would not even consider the option. The lack of uniformity across MHO organizations creates a perception of unfair or unequal treatment.

d. Some of the MRPU cadre interviewed perceive a lack of clear C2 guidance results in their units receiving external taskers from their garrison commands, which negatively impact daily operations. Upon inception, MRPU were ad hoc units and had two basic purposes: 1) to expeditiously and effectively evaluate, treat, return to duty, 2) to administratively process out of the Army and refer to the appropriate follow-on health care system the Soldiers with medical conditions identified, incurred, or aggravated while mobilized. As a result, MRPU use a manning document that is adjusted

depending on the medical holdover population, and thus do not have the organizational structure of regular Army units. Therefore when MRPU's fill taskings for funeral details, warrior task testing lanes, and weapons ranges it takes away from their ability to effectively C2 their MHO Soldiers. All of the interviewed MRPU's commanders and leaders agreed that MHO Soldiers are a unique population of Soldiers who have three or four times the number of personal and/or medical issues than non-injured soldiers. Interviewed MRPU cadre recommended the Army publish guidance or policy clearly outlining the appropriate roles for MRPU support cadre.

e. IMCOM is currently focusing its efforts to develop and/or document the standards necessary for the processes and procedures that play a major role in the MHO program. IMCOM is currently fine-tuning the ASA (M&RA) Systems Analysis & Review (SAR) team checklist, and is providing a standard that clearly defines each item on the checklist. Some of these standards may already be defined in existing Army regulations, DOD directives and/or instructions, or Department of the Army pamphlets. Those standards not already defined will be established and included in future IMCOM MHO policy documents.

RECOMMENDATIONS. The APDES Action Team in conjunction with:

a. Installation Management Command, in coordination with Assistant Secretary of the Army for Manpower and Reserve Affairs, Deputy Chief of Staff G1, and US Army Medical Command, update the Department of the Army Medical Holdover Consolidated Guidance to specify clear guidance on the command and control, and organizational structure of reserve component Soldiers assigned to Medical Holdover Units on active duty installations.

b. US Army Medical Command, in coordination with Assistant Secretary of the Army for Manpower and Reserve Affairs and Deputy Chief of Staff G1, update the Department of the Army Medical Holdover Consolidated Guidance to specify clear guidance on the command and control, and organizational structure of reserve component Soldiers assigned to Community Based Healthcare Organizations.

c. Installation Management Command, in coordination with Assistant Secretary of the Army for Manpower and Reserve Affairs, Deputy Chief of Staff G1, and US Army Medical Command, develop and implement standing operating procedures for Medical Holdover Operations, specifically for Medical Retention Processing Units.

d. Installation Management Command, with Assistant Secretary of the Army for Manpower and Reserve Affairs, Deputy Chief of Staff G1, and US Army Medical Command, complete development and implement the Medical Holdover Operations Systems Analysis and Review checklist to include by-item definitions and supporting standards of performance.

FINDING 3.2: A majority of Medical Holding Units (MHU) cadre and some Medical Retention Processing Units (MRPU), and Community Based Healthcare Organizations (CBHCO) cadre lack formal training.

STANDARDS:

- a. Army Regulation 40-400, Patient Administration, 12 March 2001, Chapter 8
- b. Department of the Army Medical Holdover (MHO) Consolidated Guidance 24 July 2006, Section(s) 8 c-d.

ROOT CAUSES:

- a. There is no regulatory requirement for the training of medical holding unit cadre.
- b. MHO Cadre (MRPU and CBHCO) do not have a formal, position-specific training program addressing duty descriptions and critical skill training objectives.

DISCUSSION:

a. Army Regulation 40-400, addresses Medical Holding Unit (MHU) functions, but does not outline the training requirements for MHU cadre. The majority (57%) of MHU cadre interviewed stated they did not receive formal training on their duties or training on the Army Physical Disability Evaluation System (APDES) before assignment to the MHU. A majority (89%) of the MHU cadre interviewed stated they needed additional training on the APDES, managing medical hold Soldiers, and daily MHU operations. The cadres assigned to these MHUs are taken from clinics within the Medical Treatment Facilities. Some (44%) inspected MHU commanders also concurrently commanded other units; the position of MHU commander was merely an additional duty.

b. A majority (65%) of MRPU and a few (17%) of the CBHCO cadres interviewed indicated they were not formally trained on their assigned duties or on the Army Physical Disability Evaluation System (APDES). None of the inspected MRPU units had sustainment training for the cadre who do not attend the MHO training conducted at the Professional Education Center (PEC) at Camp Robinson, Arkansas. These MRPU used on the job training (OJT), and the crawl, walk, and run techniques to phase-in their new cadre into their new positions. A majority (64%) of interviewed MRPU cadre who attended the MHO training at PEC indicated the training was inadequate and needed revision. The training is currently CBHCI focused and does not include MRPU operations. These interviewed MRPU cadre stated the training sessions were not beneficial and the training they received at PEC did not prepare them to execute their daily MRPU duties. They also did not receive any training on the APDES. The cadre recommended future MHO training include more hands-on tasks with automation systems and how to operate a MRPU. They also recommended that additional training led by current and past MRPU leaders and MHO Soldiers would allow them to evaluate and update lessons learned. Currently, the MHO training focuses on cadre experiences

at CBHCOs, and does not train MRPU cadre on their individual duties and responsibilities.

c. The cadre assigned to MHUs, MRPU and CBHCOs indicated a need for better initial training that provides them a solid foundation in medical hold and medical holdover operations. The following are some examples of additional training requested by cadre members:

(1) Cadre (especially platoon sergeants) training on common medication interactions and their effects on work and leisure activities.

(2) Cadre training on how to manage medical hold and MHO Soldiers with mental health issues.

(3) Cadre medical management training on issues such as suicide prevention, wellness counseling, and disability evaluation processing.

d. A few (17%) of the interviewed CBHCO cadre indicated they were not formally trained on their duties, or the APDES. A few (20%) of the inspected CBHCOs had formal training for the cadre who did not attend MHO training at the Professional Education Center (PEC). Most (80%) of the inspected CBHCOs used on the job training (OJT) and mentoring techniques to phase their new cadre into their new positions. The interviewed CBHCO cadre informed the DAIG that PEC training needs to be updated; it is currently just an overview of operations. These interviewed CBHCO cadre stated that the training sessions offered little value, and what they received at PEC did not prepare them to execute their daily missions. They also stated they did not receive any meaningful training on the APDES process. This represents a significant potential for key MHO cadre being unable to execute the critical tasks of managing MHO Soldiers adequately. Finally, the interviewed CBHCO cadre recommended that the MHO training needs less lecture and more hands-on, experiential coursework, including medical tracking automation systems and operating a CBHCO.

e. MEDCOM has instituted a 5-day training course for case managers at Fort Sam Houston, Texas to keep their personnel informed and trained on the current issues that pertain to the M2 of RC Soldiers in the MHO program. ASA (M&RA), IMCOM and MEDCOM hosted a training conference for MRPU, CBHCO C2 and M2 cadre in October 2006. One focus of this training was to establish duty descriptions for MHO unit C2 and M2 support cadre, and to develop training objectives for upcoming bi-annual training events. The creation of duty descriptions will allow IMCOM and MEDCOM to target training for each critical skill that MHO unit M2 and C2 cadre perform daily. The October 2006 conference created duty descriptions for platoon sergeants, first sergeants, command sergeants major, battalion commanders, company commanders, administrative personnel, and case managers. IMCOM and MEDCOM are currently conducting their analysis of these duty descriptions, and are preparing targeted training for their next conference.

RECOMMENDATIONS. The APDES Action Team in conjunction with:

a. The Office of the Surgeon General develop training criteria for Medical Holding Unit cadre.

b. Assistant Secretary of the Army for Manpower and Reserve Affairs, in coordination with the Office of the Surgeon General, the Installation Management Command and US Army Medical Command, complete a by-position targeted training program for all Medical Holdover organization command and control and medical management cadre.

FINDING 3.3: Some medical hold and medical holdover Soldiers in the APDES process do not understand their rights and separation entitlements.

STANDARDS:

a. Department of Defense Directive 1332.18, November 4, 1996, paragraph 3.13.

b. Department of Defense Instruction 1332.38, November 14, 1996, Enclosure E3 P1.4.

c. Army Regulation 40-400, 12 March 2001, paragraph 7-17.

d. Army Regulation 635-40, 8 February 2006, paragraph(s) 3-8 and 4-12, and Appendix C.

ROOT CAUSE: Physical Evaluation Board Liaison Officer (PEBLO) counseling techniques do not meet the needs of some MH and MHO Soldiers.

DISCUSSION:

a. Army Regulation 635-40, Physical Evaluation for Retention, Retirement, or Separation, dated 8 February 2006, paragraph 3-8a, Counseling provided to Soldier, states "The appointed Physical Evaluation Board Liaison Officer (PEBLO) at the military treatment facility (MTF) is responsible for counseling Soldiers (or the next of kin or legal guardian in appropriate cases) concerning their rights and privileges at each step in disability evaluation, beginning with the decision of the treating physician to refer the Soldier to a Medical Evaluation Board (MEBD) and until final disposition is accomplished. Physical Evaluation Board Liaison Officers' will use the Disability Counseling guide (app C) to assist them in providing thorough counseling. Counseling will be documented and at a minimum will cover the following areas:

(1) Legal rights (including the sequence of and the nature of disability processing).

(2) Effects and recommendations of Medical Evaluation Board (MEB) and Physical Evaluation Board findings.

(3) Estimated disability retired or severance pay (after receipt of Physical Evaluation board findings and recommendations).

(4) Probable grade upon retirement.

(5) Potential veteran's benefits.

(6) Recourse to and preparation of rebuttals to Physical Evaluation board findings and recommendations.

(7) Disabled Veterans Outreach Program (DVOP).

(8) Post retirement insurance programs and Survivor Benefit plan (SBP)."

b. The patient administration divisions (PAD) at the inspected medical treatment facilities visited use a mass briefing for Soldiers referred to a MEB. The purpose of this mass briefing was to provide information about many of the PEBLO required counseling areas. However, some (27%) of MH (AC) and MHO (RC) Soldiers interviewed and sensed indicated they did not understand their rights and separation entitlements. The DAIG found during sensing sessions, and direct observations that the mass Army Physical Disability Evaluation System (APDES) briefings conducted at inspected medical treatment facilities communicated too much information in too short a time for Soldiers to absorb, and the availability of a Department of Veteran's Affairs (DVA) representative at these briefings varied by location. When a DVA counselor was not a part of the briefing, many (75%) inspected medical hold and medical holdover units required their Soldiers to attend a separate DVA briefing. The DAIG found that when the briefings were mandatory, the Soldiers who attended possessed a clearer understanding of veterans' affairs or transition entitlements.

c. Although only some (28%) of the MH and MHO Soldiers complained about their counseling, these Soldiers admitted to not taking responsibility for researching the policies and regulations that pertain to the APDES. To ensure that Soldiers get the correct information about the Army's Physical Disability Evaluation System (APDES), inspected Medical Holding Units (MHU) and Medical Retention Processing Units (MRPU) hold an in-processing briefing for their medical hold and medical holdover Soldiers. Additionally, MHO Soldiers also received a copy of a MHO Soldier's handbook. This handbook outlines the rules and policies for medical holdover unit daily operations, and provides a listing of the regulations that govern the APDES. MRPU require all RC Soldiers to read the handbook in its entirety and pass the test provided in the rear of the handbook. Unlike MRPU, a majority (82%) of the inspected MHUs were not giving detailed briefing on the medical hold unit operations. Any information the medical hold Soldiers (AC) acquired on unit operations had to be researched by the Soldier or passed from peer to peer.

d. A DAIG review of completed MEB/PEB cases indicated most MTFs the DAIG inspected were conducting the required counseling of Soldiers in the MEB and PEB processes. However, a few (6%) of the inspected medical hold and MHO Soldiers indicated an inability to get one on one counseling and clear explanations of their concerns about their cases from the PEBLO. These Soldiers felt strongly that their rights and entitlements were not being protected. These Soldiers also informed the DAIG that in their opinion, counseling is not being conducted as part of a systematic process by the Army to quickly push them through the APDES. The DAIG found that some (28%) interviewed MH and MHO Soldiers' expectations of counseling as defined in military regulations are not being met. The perception of these MH and MHO Soldiers after their medical evaluation board counseling is that the PEBLOs do not have the Soldiers' best interests at heart. These Soldiers offered the following specific examples of their concerns:

(1) PEBLOs do not give them the MEB counseling checklist and have Soldiers initial several blocks on the counseling form without explanation of the initialed items.

(2) PEBLOs do not inform Soldiers of their rights or entitlements for the use of transition and vocational retraining programs.

(3) Some MHO Soldiers assigned to MRPU were not initially briefed on the eligibility criteria for assignment to a CBHCO.

RECOMMENDATIONS. The APDES Action Team in conjunction with:

a. Deputy, Chief of Staff G-1, review Army Regulation 635-40, Physical Evaluation for Retention, Retirement, or Separation, to ensure that Physical Evaluation Board Liaison Officer counseling is meeting the needs of wounded or injured Soldiers.

b. US Army Medical Command review the medical evaluation board briefings given at medical treatment facilities to ensure they meet the needs of wounded or injured Soldiers.

FINDING 3.4: Most medical hold and medical holdover Soldiers have duties within the limits of their medical profiles.

STANDARDS:

a. Army Regulation 40-400, Patient Administration, 12 March 2001, paragraph 8-13.

b. Army Regulation 40-501, Standards of Medical Fitness, 16 February 2006, paragraph 7-3e.

c. Department of the Army Medical Holdover Consolidated Guidance, 24 July 2006, paragraph 2-10d(4).

ROOT CAUSE: N/A

DISCUSSION:

a. The DAIG interviewed commanders, leaders, and cadre members from 10 Medical Hold Units (MHU), 13 Medical Retention Processing Units (MRPU), and four Community Based Health Care Organizations (CBHCO). Additionally, the DAIG reviewed internal Standing Operations Procedures (SOPs), handouts, and automation databases from these organizations. The interviews and reviews revealed that most (94%) medical hold (MH) and medical holdover (MHO) Soldiers who are medically able to work have duties, and those duties did not conflict with the Soldiers' medical care or recovery. Sensing sessions with 463 MH and MHO Soldiers supported this information. Most (92%) MH and MHO Soldiers sensed stated they have duties, and those duties did not violate their medical profiles or conflict with their medical care.

b. While most MH and MHO Soldiers have duties within the limits of their profiles, a few Soldiers (10%) perceived their assigned duties were menial and a form of "make-work" designed to keep Soldiers busy. These Soldiers particularly felt their duties were not commensurate to their rank, education, and military experience. They recommended allowing Soldiers to attend college courses or vocational rehabilitation in lieu of other duties if there was no meaningful work available for them within the limits of their profiles. A best practice found at one location was MH and MHO Soldiers working in jobs that take full advantage of their combat experiences such as the planning of Warfighter Exercises or working at the Improvised Explosive Device Task Force.

c. The document and database reviews revealed that the MHUs, MRPU, and CBHCOs have effective systems for tracking Soldiers' work assignments and medical appointments. Most (85%) MHUs, MRPU, and CBHCOs inspected use an internal work assignment tracking database or spreadsheet, usually administered by the platoon sergeants (PSGs) and monitored by the First Sergeant. Although these tracking systems are not standardized and varied widely, they commonly contained information such as the Soldier's name, duty location, supervisor's name, POC contact information, brief duty description, profile limitations, and performance information.

d. The methods used to ensure Soldiers are present for duty at work assignments also varied by location. Some MHUs, MRPU, and CBHCOs contact work sites on a daily basis, while others have work site supervisors call the PSGs when Soldiers do not show up for work. PSGs at still other locations periodically visit work sites and discuss issues with supervisors. The most effective system the DAIG team saw was an automated tracking spreadsheet in conjunction with a weekly Soldier time-sheet showing duty performed and signed by the supervisor. Another best practice is the use of memorandums of agreement (MOAs) between the MHUs, MRPU, or CBHCOs and the Soldier's work supervisor codifying medical treatment priorities, profile constraints, stakeholder responsibilities, and duty hours.

e. The DAIG determined that most (88%) units inspected have effective tracking systems to ensure Soldiers attend their medical appointments. The primary tracking systems are the Composite Health Care System for appointments at Medical Treatment Facilities and locally generated spreadsheets for appointments with civilian health care providers. When a MHO Soldier misses an appointment, he or she receives counseling regarding their responsibility to attend all appointments upon entering MRP status.

f. DAIG also observed that many of the MHU, MRPU, and CBHCO command and control (C2) and medical management (M2) leaderships conducted regular meetings. These two groups typically met weekly. They interfaced with primary care managers, PEBLO counselors, and case managers to discuss Soldiers' duties while in APDES, appointments, profile restrictions, medical care concerns, and MEB/PEB issues. Interviews with personnel at locations that featured these regularly established C2 and M2 meetings revealed the two leadership groups communicated and coordinated Soldier medical care effectively and synchronized the status of Soldiers in the MEB/PEB process. This significantly reduced conflicting information on each Soldier in the APDES process. In turn, this enhanced overall Soldier care and assisted in meeting timelines required for the APDES process.

RECOMMENDATION. The APDES Action Team in conjunction with: Medical Holding Units, Medical Retention Processing Units, and Community Based Healthcare Organizations continue ensuring medical hold and medical holdover Soldiers who are able to work, have duties within the limits of their profiles.

FINDING 3.5: Medical Retention Processing Units (MRPU) and Community Based Health Care Organization (CBHCO) continuously update personnel and medical automation systems ensuring accurate accountability of medical holdover Soldiers.

STANDARDS:

a. Department of the Army Personnel Policy Guidance (PPG) for Contingency Operations in Support of GWOT, 17 August 2006, paragraph 3-3.

b. Department of the Army Medical Holdover Consolidated Guidance, 24 July 2006, paragraph 2-12.

c. FORSCOM Implementation plan for Community Based Healthcare Initiative (CBHCI), 12 February 2004, Annex D and Appendix 2.

ROOT CAUSE: N/A

DISCUSSION:

a. The Army personnel and medical automation systems used for accountability of medical holdover Soldiers (MHO) Soldiers are Electronic Military Personnel Office (eMILPO) and Medical Operational Data Systems (MODS). eMILPO is the personnel

administrative tool to assist Human Resources Command-Field Systems Division (HRC-FSD) and Installation Management Agency (IMA) in tracking all Active Component and Mobilized Reserve Component Soldiers. MODS is the US Army Medical Command (MEDCOM) tool for accountability and tracking the medical care of MHO Soldiers on Medical Retention Processing (MRP) orders. The DAIG conducted interviews with key administrative personnel along with document reviews at 13 MRPU, four CBHCOs, and HRC-FSD. These interviews and document reviews revealed completion of eMILPO and MODS transactions in accordance with the Army Personnel Policy Guidance (PPG).

b. HRC-FSD stated that before February 2006 the MRPU, CBHCOs and HRC experienced difficulty maintaining Soldier accountability through eMILPO due to different levels of command making several transactions on one Soldier. In January 2006, IMA and HRC-FSD implemented a plan by which each CBHCO is paired with one Army installation concerning Soldiers transactions such as release from active duty and disability transition processing. HRC-FSD stated that since February 2006 there have only been a few incidents where transactions from the field required correction. HRC-FSD added the overall problem is resolved and eMILPO now provides accurate accountability information.

c. The MHO Guidance states "The MODS MHO module is the Army's sole tracking and reporting database for MHO Soldiers." MEDCOM maintain MODS. MODS not only accounts for all Soldiers on MRP orders, but monitors their progress through the Army's Physical Disability Evaluation System (APDES). Interviews with key personnel of these commands involved with MODS revealed the most of the transactions are in accordance with the DA PPG and MHO Guidance. All functional areas of the APDES feed into MODS, except for HRC's administrative piece such as MRP initial orders and extensions. As a result, the MRPU and CBHCOs must manually input the administrative data. According to HRC-FSD, MEDCOM has authorized data input fields in MODS for HRC use with projected implementation by January 2007. Authorizing HRC access to MODS data input fields will complete the MEDCOM goal of having MODS as the sole tracking tool for MHO Soldiers.

RECOMMENDATIONS. The APDES Action Team in conjunction with:

a. US Army Medical Command in coordination with Human Resources Command (HRC), complete authorization for data input fields for HRC in Medical Operational Data System (MODS).

b. Medical Retention Processing Units and Community Based Healthcare Organization continue completing eMILPO and MODS transactions in accordance with the Department of Army Personnel Policy Guidance.

FINDING 3.6: A few installations inspected had Americans with Disabilities Act (ADA) violations affecting disabled Soldiers' access to facilities.

STANDARDS:

- a. American Disabilities Act of 1990, Public Law 101-336, 26 June 1990, Section 1, Title III, §303.
- b. Army Regulation 415-15, Army Construction and Nonappropriated-Funded Construction Program Development and Execution, 12 June 2006, Appendix F, paragraph 21.

ROOT CAUSE: The root cause for this finding is two-fold. First, installation support agreements do not identify access requirements for disabled Soldiers at Physical Evaluation Board (PEB) facilities. Second, US Army Physical Disability Agency (USAPDA) is not informing the local Installation Management Agency (IMA) and garrison commanders of needed upgrades to PEB facilities to meet accessibility standards for disabled Soldiers.

DISCUSSION:

- a. The Americans with Disabilities Act (ADA) of 1990 prohibits discrimination on the basis of disability by public accommodations and requires places of public accommodation and commercial facilities be designed, constructed, and altered to be readily accessible and usable by individuals with disabilities. The ADA requirement is for both newly constructed facilities as well as structures existing before the implementation of the act in 1990.
- b. The DAIG found that the all three PEB sites have ADA violations for disabled accessibly design requirements. All three PEB sites were located in pre-existing facilities. All three facilities provided either a wheelchair ramp or an elevator leading into the building. The wheelchair lifting device at one PEB site, however, has been inoperable for approximately two years. At two of the PEB buildings, disabled Soldiers with ambulatory issues experienced difficulty accessing restrooms because they were either located in the basement with no elevator access or the restroom was inaccessible by wheelchair.
- c. According to USAPDA and PEB personnel interviewed, there are two underlying reasons for the ADA violations. First, USAPDA is not doing an adequate job of informing IMA or the garrison commanders of the ADA violations at their PEB facilities and their affect on disabled Soldiers. Second, the installation support agreements between the installation and tenant units (PEBs) fail to state the need for PEB facilities to be accessible by disabled personnel. As of this report, there are initiatives to upgrade two of the three PEBs in the near future. However, the third PEB is located on an installation scheduled for closure by the 2005 Base Realignment and Closure Commission and is scheduled to receive upgrades upon relocation.
- d. While the DAIG did not specifically look for ADA compliance at Medical Holding Units (MHU), Medical Retention Processing Units (MRPU), and Community Based

Healthcare Organizations (CBHCO) facilities inspected, the team observed some ADA violations at various locations. According to Soldiers at one installation, the case manager offices were located at the opposite end of the building from the elevator in the basement of the Medical Treatment Facility (MTF) and it took an inordinate amount of time for disabled Soldiers to traverse the long corridor. One MRP building inspected had ramps to the entrances; however, the facilities had a gravel parking lot and no sidewalks, making it nearly impossible for Soldiers in wheelchairs and difficult for Soldiers using crutches and canes to access the buildings without assistance.

RECOMMENDATIONS. The APDES Action Team in conjunction with:

- a. US Army Physical Disability Agency, in coordination with host installations, develop installation support agreements to ensure the Physical Evaluation Board facilities meet Americans with Disabilities Act (ADA) standards.
- b. Installation Management Command ensure Medical Retention Processing Unit facilities meet ADA standards.
- c. US Army Medical Command ensure Medical Holding Unit and Community Based Healthcare Organization facilities meet ADA standards.

OBSERVATION 3.7: The majority of Medical Holding Units, Medical Retention Processing Units, and Community Based Healthcare Organizations lack authorization for critical staff and service support positions to effectively execute their missions.

DISCUSSION:

- a. Currently, there is no Table of Distribution and Allowances (TDA) or approved manning document for the staffing of a MHU. A majority (70%) of the MHU leadership indicated they did not have adequate personnel assigned to their units which affected their unit's ability to provide Soldiers the level of attention and support they required to complete their medical care. A key personnel issue the MHU leaders addressed was the lack of platoon sergeant positions assigned to the MHU. Some MTFs use hospital personnel to staff the MHU platoon sergeant positions, which takes away from the MTF's capability to staff the facility and provide required medical care to DOD beneficiaries. At two of the MHUs inspected, the administrative clerks and/or supply sergeants also performed the duties of platoon sergeants. One MHU inspected experienced a 1:110 platoon sergeant to MHU Soldier ratio at one point during the last year.
- b. Several locations inspected use medical hold (MH) Soldiers assigned to the MHU to augment their staff. These MH Soldiers have a wide range of duties to support the MHU. Assigned duties included working as unit administrative assistants, duty drivers, escorts for psychiatric patients and platoon sergeants. One MHU established a Memorandum of Understanding (MOU) with a divisional unit on the installation in which

the division would provide the MHU additional personnel to manage the MH Soldiers. The MOU staffed the MHU with an Executive Officer and one senior NCO platoon sergeant for every 50 divisional MH Soldiers assigned to the MHU. Both the MHU and the divisional unit considered the MOU a win-win situation since it provided the MHU the additional cadre needed for C2 of the MH Soldiers while allowing the divisional unit the opportunity to request replacements for those Soldiers.

c. The DAIG also found at some (40%) of the MHUs inspected, the MHU commanders concurrently commanded other units. Two MHU commanders interviewed commanded both the MHU and the Medical Treatment Facility's (MTF) Troop/Medical Company. At another MHU, the commander, in addition to commanding the Troop/Medical Company and MHU, also commanded the MTF Student Company.

d. The majority (54%) of MRPU leaders interviewed stated MRPU cadre manning authorizations were inadequate for them to execute their mission. Like the MHUs, platoon sergeant shortages caused them the most concern in executing their mission effectively. The MRPU leaders stated additional platoon sergeants would enhance the unit's ability to manage its assigned medical holdover Soldiers. Some (46%) of the MRPU leaders inspected felt their platoon sergeant to MHO Soldier ratio was too high and used MHO Soldiers to augment their staff by using them to assist platoon sergeants or assigning them platoon sergeant duties. At several MRPU sensing sessions, platoon sergeants expressed concern that the platoon sergeant to Soldier ratio of 1:25 could be overwhelming at times. They indicated managing MHO Soldiers requires more resources and time than Soldiers in a normal unit so a reduced Platoon Sergeant to Soldier ratio would allow better support to the Soldiers. In addition, some of the assigned platoon sergeants reported being tasked to perform other administration and transportation-related duties. The majority of platoon sergeants recommended adding more platoon sergeants to reduce the platoon sergeant to MHO Soldier ratio to 1:15 or add squad leader positions to the MRPU manning authorization to reduce their workload and enhance the unit's ability to support its assigned MHO Soldiers.

e. Some of the MRPU and MHU commanders and cadre felt their organizations needed a Behavior Health Specialist on their staff. These personnel acknowledged a need for an additional staff member capable of identifying Soldiers with mental health problems such as depression or suicidal behavior. This Behavior Health Specialist would also assist the MHU and MRPU cadre in managing Soldiers who suffer from Post Traumatic Stress Disorder (PTSD). Many MRPU platoon sergeants stated they currently provide MHO Soldiers social work related assistance despite having no training to perform that function.

f. Half of the CBHCO Commanders and First Sergeants interviewed stated their units lacked authorization for staff positions they perceived as key to effectively execute their mission. Some commented about the need for additional platoon sergeants and/or adding squad leaders to their staff. The current CBHCO personnel structure manning document provides for six platoon sergeants per CBHCO to meet the 1:60 Platoon Sergeant to Soldier ratio. CBHCO leaders claim it is difficult for their platoon sergeants

to manage 40-50 Soldiers without additional assistance much less the recommended 1:60 ratio per the manning document. The leaders pointed out that medical holdover (MHO) Soldiers are a unique population of Soldiers who have three to four times the amount of personal administrative and/or medical issues as non-injured Soldiers in regular Army units. Many of those issues involve complex and sometimes multiple medical/psychiatric conditions which require unit leadership to expend more time to manage. They felt adding more platoon sergeants and/or adding squad leaders to their staff would decrease the workload of the platoon sergeants and allow each platoon sergeant more time to spend assisting Soldiers. The additional cadre will also allow them the flexibility to handle surges in their MHO population.

RECOMMENDATIONS. The APDES Action Team in conjunction with:

a. Deputy Chief of Staff, G-1, in coordination with US Army Medical Command and Installation Management Command, examine the possibility of increasing the personnel manning of Medical Holding Units, Medical Retention Processing Units, and Community Based Healthcare Organizations.

b. Deputy Chief of Staff, G-1, in coordination with US Army Medical Command and Installation Management Command, consider providing a Behavioral Health Specialist to the Medical Holding Unit and Medical Retention Processing Unit personnel structures.

OBSERVATION 3.8: The Community Based Healthcare Initiative program includes redundant and unnecessary levels of command and control.

DISCUSSION:

a. The Community Based Healthcare Initiative (CBHCI) is part of Medical Holdover Operations). Annex Q (Medical Holdover Operations) to HQDA OPORD 04-01 established CBHCI on 20 January 2004 to allow MHO Soldiers to receive treatment and recuperate at or near their homes using locally available health care options. The Community Based Health Care Organization (CBHCO) was a task-organized element staffed by mobilized Reserve Component (RC) Soldiers to coordinate health care, process Medical Evaluation Boards (MEB), and command and control (C2) for medical holdover (MHO) Soldiers serviced through the CBHCI. US Army Forces Command (FORSCOM) was initially the Army Command responsible for C2 and execution of the CBHCI program. FORSCOM developed the CBHCO structure, command and control hierarchy, administrative and logistics support lines. At inception of CBHCI, FORSCOM implemented five levels of C2. FORSCOM served as the overarching command followed by two CONUSAs (1A and 5A), a brigade-level joint task force (JTF) under the CONUSA, a battalion-level Cluster Headquarters under the TF, and the CBHCOs. The FORSCOM CBHCI Implementation Plan was written to provide implementing guidance for the CBHCI program, however did not describe the mission, responsibilities, functions, TDA structure, or manning requirements of the TF or Cluster Headquarters.

b. Ownership of the CBHCI transferred to US Army Medical Command (MEDCOM) on 17 January 2006. This included dedicated assets, tasking authority, funding, transfers, and changes in Derivative Unit Identification Codes (DUICs) for all CBHCOs and TFs in the CBHCI program. MEDCOM Operations Order 06-03 modified several levels of C2 in the CBHCI structure. Regional Medical Commands (RMCs) replaced the CONUSAs, geographic (east and west) Task Forces (TFs) replaced the JTFs, and the Cluster Headquarters were deleted. Figure 1 below shows the current MEDCOM C2 structure. MEDCOM Operations Order 06-03 also discussed C2 and support relationships in both the east and the west geographic regions that were redundant. This was especially true with the primary RMCs, the supporting RMCs and the associated TFs. Both supporting RMCs and TFs provided similar administrative, operational and logistical assistance to their respective CBHCOs.

c. Over the first and second quarters of fiscal year 2007, MEDCOM plans to expand C2 from two to four geographic RMCs. The proposed C2 configuration is illustrated in figure 2. This illustration does not include the Hybrid CBHCOs in Alaska, Hawaii, and Puerto Rico. These organizations are actually Medical Retention Processing Units, which also conduct CBHCO-like operations and fall under IMA through the garrison C2 at their respective active duty installations.

d. DAIG reviewed the manning rosters for both the current CONUS RMCs and proposed CBHCO TFs. Although the CBHCO TF will drop from 25 to 18 personnel, many of the positions are comparable to the personnel structure for the RMCs. A review of MEDCOM Regulation 10-1 (Organization and Policy) suggests that functions currently performed by the TF could consolidate with the duties and responsibilities of the RMC. Additionally, the proposed C2 structure includes four RMCs and four TFs which equates to a net increase of 22 personnel from the current 130. Many of the current and additional positions are senior NCOs and officers, representing a significant financial outlay to maintain two similar layers of C2. After comparing the functional areas of both RMCs and TFs, it appears that the proposed MEDCOM CBHCO C2 structure exhibits multiple layers of C2 representing redundant manning positions, duties, and responsibilities, which could reasonably integrate within the RMC's scope.

e. MEDCOM representatives stated the command is presently examining the necessity of the TFs based on MEDCOM Commanding General's recommendation to have the CBHCOs come under direct control of the RMCs. As of this report, the final CBHCI C2 structure under MEDCOM is still pending senior Army leadership decisions. The key factors affecting these decisions are how long the current contingency operations will continue and what funding is available for the CBHCI program.

f. DAIG inspected four CBHCOs and two TFs. The feedback received from interviews conducted at all locations supports streamlining the overall MEDCOM CBHCO C2 structure. Comments centered on the belief that too many layers of C2 cause an inordinate expenditure of time to pass Soldier-related issue back and forth among the multiple layers until finally resolved. Although not specifically measured, this equated to time spent waiting for an issue to resolve while taking time away from

moving a Soldier more efficiently and expediently through the medical care and physical disability evaluation process. Most (75%) CBHCO commanders and leaders interviewed agreed that there are too many layers of C2. They commonly stated, "TFs, MRPU, garrison commands, MTFs and now RMCs make it difficult to execute Soldier issues in a timely manner." Most (75%) of the commanders and leaders stated the TF is an unnecessary level of command with functions that could easily be conducted at the RMC level. They stated this additional layer complicates the completion of personnel administrative functions, Soldier transfers, and medical-related issues. As a result, this prolongs the time a Soldier remains in a CBHCO, costing the Army more money to retain the Soldier on active duty unnecessarily. While the TFs provide chaplain, legal and financial support, most (75%) commanders and leaders interviewed felt the RMCs could easily absorb these positions.

Figure 1. Current MEDCOM CBHCO C2 Structure

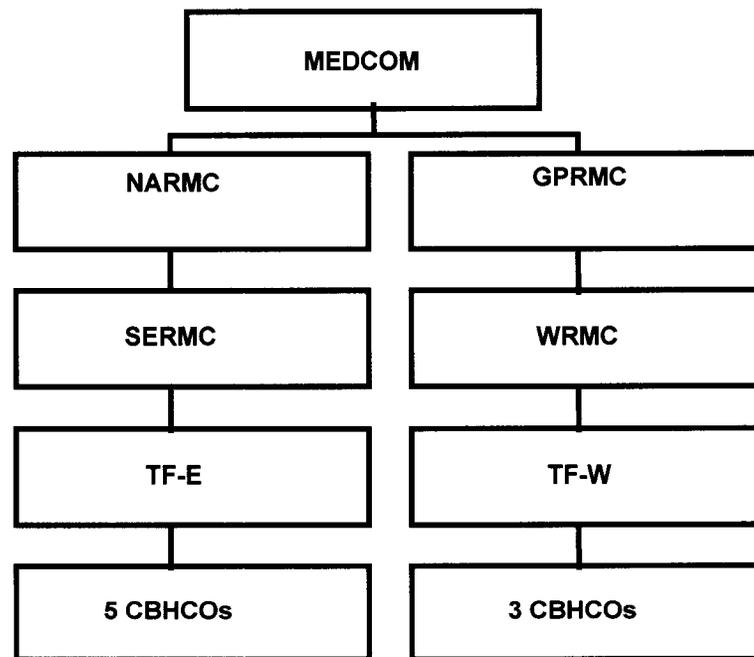
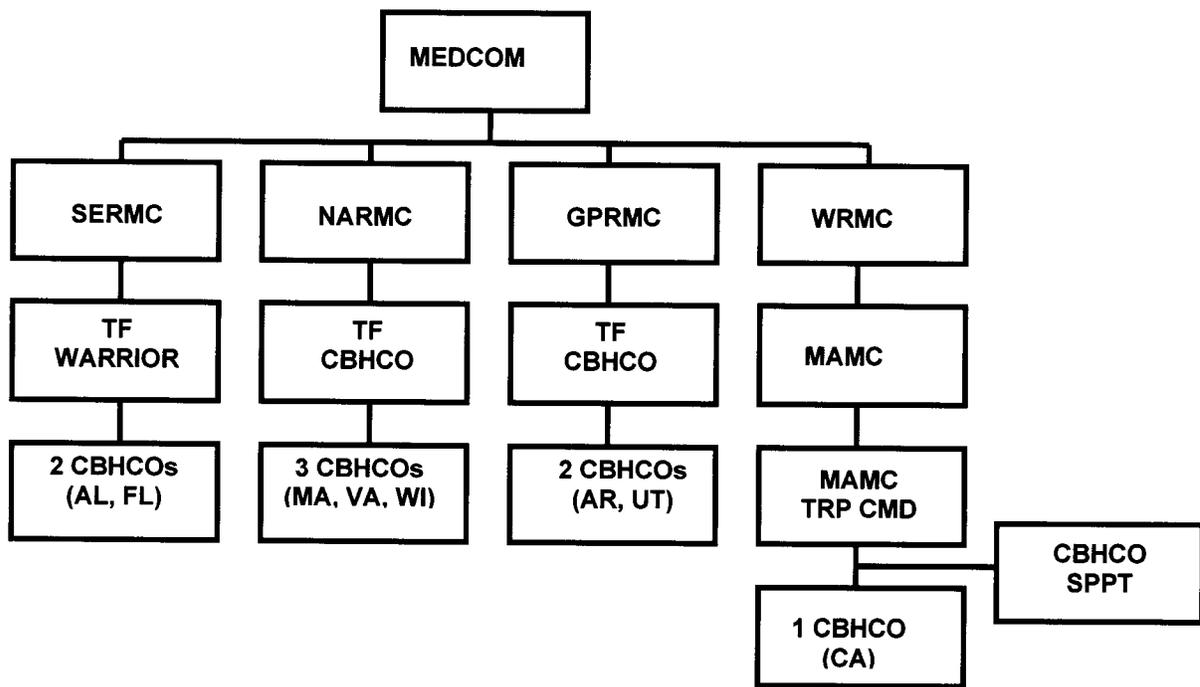


Figure 2. CBHCO C2 – Proposed (After Transition)



RECOMMENDATIONS. The APDES Action Team in conjunction with:

a. US Army MEDCOM, in coordination with ASA (M&RA), IMCOM, NGB and Chief, Army Reserve, review the Community Based Healthcare Initiative Transition Plan and eliminate unnecessary layers to command and control.

b. US Army MEDCOM develop a standardized Regional Medical Command organizational structure to provide required functions for Community Based Healthcare Organizations.

OBSERVATION 3.9: Some Medical Retention Processing Unit commanders and leaders indicated the use of sanctuary Soldiers as command and control support cadre hurts unit cohesion.

DISCUSSION:

a. The Army Sanctuary Program, in accordance with Title 10 United States Code (USC) 12686a, is used for reserve component Soldiers who are mobilized under provisions of 10 USC 12302, and have achieved 18 or more years of Active Federal Service (AFS). These Soldiers are retained on active duty to achieve 20 years of AFS and become eligible for retirement if they so choose. According to the Department of the Army Personnel Policy Guidance (PPG) for Contingency Operations in Support of

GWOT, Soldiers retained on active duty under the Sanctuary Program will be assigned based on the needs of the Army.

b. Some (40%) of interviewed Medical Retention Processing Units (MRPU) commanders and leaders indicated the use of sanctuary Soldiers to fill C2 support cadre positions hurts unit cohesion. The common points echoed by the commanders and leaders were that the sanctuary Soldiers were not focused on leading, managing, and providing quality care for medical holdover (MHO) Soldiers. They indicated that the sanctuary Soldiers seemed more focused on retiring than their MRPU duties. Additionally, some (40%) interviewed MRPU's commanders and leaders deemed the leadership abilities of the sanctuary Soldiers assigned did not meet to Army Standards. All of the interviewed MRPU's commanders and leaders agreed that MHO Soldiers are a unique population of Soldiers who need strong and focused leaders to manage them. The DAIG found the MHO Soldiers assigned to the inspected MRPU's have three to four times the number of personal and/or medical issues as a non-injured soldier would have. The MRPU C2 cadre assigned to manage MHO Soldiers must be seasoned leaders. Because of their exposure to MHO Soldiers 24 hours a day, they must possess the leadership experience and qualities to work independently while still producing positive results. Some (40%) of the inspected MRPU's commanders strongly felt sanctuary Soldiers should not be assigned to their units' critical leadership positions, because MRPU commanders and leaders do not have the time to professionally develop the sanctuary Soldiers.

c. A majority (57%) of interviewed cadre assigned to MRPU's and CBHCOs indicated their units do not have professional development programs. Department of the Army Pamphlet 350-50, Leader Development for America's Army, dated 13 October 1994, defines leader development programs as, "A program designed to train leaders. It incorporates formal and informal training; progressive and sequential duty assignments; and assessment, counseling, coaching, and feedback to maximize a leader's potential." MRPU's function as ad hoc units. They are created to expeditiously and effectively evaluate, treat, return to duty, and/or administratively process out of the Army, and refer to the appropriate follow-on health care system, reserve component Soldiers with medical conditions identified, incurred, or aggravated while mobilized on USC 12302 orders in support of contingency operations. MRPU's do not have the organizational structure of regular Army units. Some (45%) MRPU C2 cadre reported having a small degree of on the job training (OJT) before being assigned to manage MHO Soldiers. They added there is no time in the MRPU's daily schedule for professional development programs.

d. Human Resources Command-Alexandria (HRC-A) currently assigns sanctuary Soldiers to MRPU's under the provisions of military occupational specialty immaterial, provided there is a rank/grade match for the MRPU position. There currently is no policy from the Deputy Chief of Staff, G-1 (DCS, G-1) governing the assignment of sanctuary Soldiers to MRPU's. Therefore, HRC-A does not have a formal selection process for MRPU command and control cadre. The DCS, G-1 published the Department of the Army MHO Consolidated Medical Holdover Guidance on 24 July

2006. Under Chapter 2, Section 8 Responsibilities, the consolidated guidance states "Medical Command (MEDCOM) will develop job descriptions for CBHCO C2 cadre, Senior Case Managers, and Case Managers." The guidance further states "Installation Management Command (IMCOM) will develop job description for MRPU cadre." The creation of these duty descriptions will help identify critical skills necessary for MRPU and CBHCO C2 support cadre. A condensed version of the position descriptions will also be used by HRC-A when IMCOM, and MEDCOM requests volunteers (sanctuary Soldiers and/or retiree recalls) to fill vacant cadre positions. This control measure will ensure that volunteers will have specific skills needed by C2 support cadre prior to assignment into the MHO program.

RECOMMENDATIONS. The APDES Action Team in conjunction with:

- a. Deputy Chief of Staff, G-1, in coordination with Human Resources Command, Installation Management Command, and US Army Medical Command create policy outlining the assignment criteria for command and control support cadre to Medical Retention Processing Units and Community Based Healthcare Organizations.
- b. Installation Management Command, in coordination with the US Army Medical Command, develop job descriptions for Medical Retention Processing Unit command and control cadre.
- c. US Army Medical Command, in coordination with the Installation Management Command, complete the development of job descriptions for Community Based Healthcare Organizations command and control cadre.

OBSERVATION 3.10: The majority of commanders and leaders indicated that assigning Soldiers in the Army Physical Disability Evaluation System (APDES) to an Installation Garrison Command / Medical Holding Unit (MHU) on their assigned installation would benefit both the Soldiers and units.

DISCUSSION:

- a. AR 40-400, paragraph 8-1 states, "Each MTF having inpatient capabilities, except those functioning in a contingency zone operation, will maintain an MHU company/detachment." The regulation also established the requirements Soldiers must meet for assignment to a MTF MHU, to include Soldiers in the APDES. The regulation states "MTF commanders are not authorized to enter into agreements to automatically assign members to the MHU while undergoing physical disability processing. Soldiers will normally receive MEB/PEB processing on an outpatient basis while assigned to their parent organization. Assignment to the MHU will not be used to facilitate the early requisitioning of replacement personnel. Rather, members undergoing physical disability processing are to contribute to mission accomplishment at the parent unit to the degree possible."

b. The majority (69%) of unit commanders and leaders interviewed strongly agreed the requirements outlined in AR 40-400 for assigning Soldiers to an MTF MHU are too restrictive and should be changed. While many commanders and leaders preferred to keep soldiers under their command, they stated that with today's high operational tempo, assigning Soldiers in the APDES to the MTF MHU benefits both the Soldiers and the unit. Most (93%) Soldiers assigned to these units in the APDES overwhelmingly agreed that they preferred assignment to a MTF MHU.

c. Commanders and leaders felt assigning Soldiers in the APDES to a MTF MHU benefits Soldiers by providing them a chain of command focused on their medical care, which can promote completing medical care and the APDES process quicker. The Soldiers agreed with the commanders and leaders on that point, but also added they feel ostracized while in their units and receive little to no support from their chains of command, which would not be an issue if assigned to the MTF MHU.

d. Although a common and popular benefit for the unit is the ability to request a replacement for the Soldier, commanders, leaders, and Soldiers agreed the primary benefit for the unit is eliminating conflicting priorities between unit warfighting preparation and the medical care of these Soldiers. They stated commanders and leaders have difficulty balancing all events or tasks necessary for deployment while at the same time ensuring those events or tasks do not impact on the medical care or functions for those Soldiers in the APDES.

RECOMMEND the APDES Action Team in conjunction with:

a. Installation Management Command in coordination with OTSG and FORSCOM review the feasibility of integrating MH (AC) operations with MHO (RC) operations.

b. Installation Management Command in coordination with OTSG, Deputy Chief of Staff G1 and HRC develop a standardized infrastructure to support an Installation Garrison Command in the absorption of select Soldiers in the Army Physical Disability Evaluation System (APDES).

c. Installation Management Command provide the C2, personnel, training and transportation for select Soldiers in the Army physical Disability Evaluation System (APDES).

OBSERVATION 3.11: The Army is not providing timely manning support for Community Based Healthcare Organizations (CBHCOs) and Medical Retention Processing Units (MRPUs) to support the mobilized RC Soldiers who will use those organizations.

DISCUSSION:

During the course of the Army Physical Disability Evaluation System (APDES) inspection the DAIG team found that the Army was not providing timely manning

support to regional CBHCOs and MRPU to match the mobilization and demobilization requirements of RC Soldiers. The DAIG team found that manning document increases normally could not be requested until a medical holdover (MHO) unit reached a certain threshold. That threshold varied by location. Further, once an additional command and control (C2) support cadre was requested, it would take approximately five months to assign a person and train them to conduct daily unit operations autonomously. Most MHO unit leaders complained that by the time the additional cadre came on board, the surge was over. MHO unit leaders want the Army to do a better job in projecting the staffing needs of their MHO units; this will also better prepare MHO leaders to conduct their intended mission without any detriment to the injured Soldiers and leaders that they manage.

RECOMMENDATIONS. The APDES Action Team in conjunction with: Deputy Chief of Staff, G-3, in coordination with Human Resources Command, Installation Management Command, and US Army Medical Command develop policy that projects, on a regional basis, the assignment of C2 support cadre to Community Based Healthcare Organizations (CBHCO) and Medical Retention Processing Units (MRPU) to match the mobilization and demobilization requirements of RC Soldiers.

OBJECTIVE 4: Assess impacts of other administrative areas on the Army Physical Disability Evaluation System.

The DAIG looked at several administrative areas that impact the Army Physical Disability Evaluation System. While the DAIG found improvement in the areas inspected, there are areas that need improvement. These include completion of Line of Duty Investigations for Soldiers arriving at MHUs and MRPU, transfers of medical documentation, ineffective use of the MOS/Medical Retention Board, tracking and publishing of Medical Retention Processing orders and extensions, and comprehension of the APDES by leaders at the brigade level and below.

Most Soldiers stated they were successful recovering personal and organizational property following medical evacuation from theater, however the majority of MHO Soldiers had little to no contact with their home station unit or chain-of-command. The majority of locations inspected reported an excellent performance on the part of TRICARE for Soldiers and most installation transition centers stated they have sufficient personnel to cover the increased workload created by the Global War on Terrorism.

FINDING 4.1: Some Soldiers are arriving at Medical Holding Units or Medical Retention Processing Units without a Line of Duty (LOD) or with incomplete LOD documentation.

STANDARDS:

- a. Army Regulation (AR) 600-8-4, Line of Duty Policy, Procedures, and Investigations, 15 April 2004, paragraphs 2-1, 2-2d, and 3-1.

b. Army Regulation 600-8-101, Personnel Processing (In-, Out-, Soldier Readiness, Mobilization, and Deployment Processing), 12 March 2001, paragraph 7-3(e).

c. DA Pamphlet 600-8-101, Personnel Processing (In-, Out-, Soldier Readiness, Mobilization, and Deployment Processing), paragraph 7-3(d), 28 May 2002.

d. Department of the Army Personnel Policy Guidance (PPG) for Contingency Operations in Support of GWOT, 16 June 2006, paragraphs 10-2c and 10-10a (2).

e. MILPER MSG 04-341, Line of Duty (LOD) Contingency Operations Policy, 16 December 2004.

f. MILPER MSG 05-161, Completion of Line of Duty Investigations (LODIs) For Mobilized Reserve Component Soldiers, 30 June 2005.

ROOT CAUSE: Unit commanders are not aware of the requirement to generate a LOD on injured or ill Soldiers.

DISCUSSION:

a. LOD determinations are a critical component of a Soldier's Medical Evaluation (MEB)/Physical Evaluation Board (PEB) packet for the Army Physical Disability Evaluation System (APDES) process. AR 600-8-4 paragraph 2-1 states "Line of duty determinations are essential for protecting the interest of both the individual concerned and the US Government where service is interrupted by injury, disease or death."

b. According to AR 600-8-101, commanders must initiate a line of duty investigation using DA Form 2173 for every injury that may result in a future claim against the government, including possible referral into the APDES. The Department of the Army Personnel Policy Guidance (PPG) for Contingency Operations in Support of Global War on Terrorism (GWOT) addresses administrative action requirements that units must complete for all Soldiers before their redeployment from a contingency theater Area of Operations (AOR). One of the critical items required is the initiation of a "line of duty (LOD) investigation or presumptive LOD determination as required for Soldiers prior to their departure from theater."

c. Military Personnel Message 05-161 established the requirement for completing LODs, both Informal and Formal, by the Mobilized Reserve Component (RC) Soldier's chain of command prior to the Soldier arriving at the demobilization site. It further states "RC soldiers with medical conditions that may recur once they return to a drilling status must have an LOD to protect them after demobilization. Failure to complete the LOD prior to demobilization delays required medical care or compensation once the Soldier leaves active duty."

d. Lack of LOD documentation or inadequate information generates additional work for the staff of the Medical Holding Units (MHUs), Medical Retention Processing Units

(MRPUs), and Community Based Healthcare Organization (CBHCOs). Time spent trying to contact a Soldier's commander and/or requesting documentation to substantiate LOD requirements takes away from the staff's primary duties. The servicing Medical Treatment Facility's (MTF) Patient Administration Division also has to process the generated LOD resulting in additional workload. The LOD also plays a role in the MTF meeting MEB/PEB processing time standards. Delays in completing a LOD can delay the APDES process and extend a Soldier's time spent in the medical hold system.

e. The DAIG inspected 10 Medical Hold Units (MHU), 13 Medical Retention Processing Units (MRPU), and four Civilian Based Healthcare Organizations (CBHCO) during the inspection. Some (44%) of the MHU, MRPU and CBHCO cadre interviewed in these units commented that they experienced issues with Soldiers arriving without an LOD or with improper LOD documentation. Observations garnered from the interviews indicated unit commanders are not generating/providing LOD documentation from point of injury/incident. Instances also occurred where LOD documentation arrived with inadequate information for the MHU, MRPU, or CBHCO to process the LOD.

f. A few (23%) MRPU cadres stated that missing/incorrect LODs were a significant problem. The perception was that the problem existed at the unit level and that RC units did not know what constituted a proper LOD and/or the criteria required to initiate a LOD. Several locations inspected reported that most Soldiers arriving at their unit came without a LOD. Missing LODs force the MRPU staff to expend time and resources in tracking down the LOD or documentation required to substantiate an LOD.

g. In some cases, complaints from the MHUs regarding lack of LOD documentation involved Soldiers returning from GWOT deployments because of injury or illness and Soldiers from OCONUS duty locations such as Korea. Two MHUs encountered a problem with units trying to send their Soldiers to the MHU without initiating a LOD, while others had problems with Soldiers arriving with incomplete LOD documentation. MHU leadership or staff then had to contact or attempt to contact the Soldier's unit for corrections or additional information. If attempts to contact the units were unsuccessful, the MHU generated a LOD to ensure the Soldier received continued medical care. As with the MRPU, lack of LOD documentation requires the MHU staff and MTF to expend time and resources to complete the LOD.

h. CBHCOs encountered some of the same issues regarding missing LOD documentation. One CBHCO Task Force inspected reported preparing 203 LODs in the last year for MHO Soldiers attached to their CBHCOs despite the PPG requirement that a Soldier's LOD must be complete in order to meet the criteria for transfer from a MRPU to a CBHCO. Two CBHCOs reported initially receiving between three to eight Soldiers per day at the CBHCOs without signed LODs, if any LOD at all. Again, time and resources are spent generating and processing LODs.

RECOMMENDATIONS. The APDES Action Team in conjunction with:

- a. US Army commands conduct training to educate commanders and leaders on the importance of completing LODs in accordance with the required regulations/policies.
- b. US Army Medical Command review screening procedures at MTFs to ensure identification of wounded or injured Soldiers requiring LODs.

FINDING 4.2: Medical Treatment Facilities are not transferring required medical documentation for Soldiers transferred through the Medical Hold System.

STANDARDS:

- a. Army Regulation 40-66, Medical Record Administration and Health Care Documentation, 21 June 2006, paragraphs 5-2.c.3, 5-26, 5-28.c.1, and 9-10a.
- b. Management MHO Health Records Memorandum, HQDA MSG, 13 November 2003.

ROOT CAUSE: Medical Treatment Facilities not complying with established policies for transfer of medical documentation.

DISCUSSION:

a. AR 40-66 states that when a patient transfers to a US Medical Treatment Facility (MTF) or a Veterans Administration (VA) Medical Center, a copy of the Inpatient Treatment Record (ITR) accompanies the patient. The transferred ITR will then become a part of the receiving MTF's Inpatient Treatment Record. The AR also states that when the MTF transfers a patient, the patient administrator will forward the Health Record (HREC) with a copy of the inpatient record to the gaining MTF via mail or courier. "Both parts (treatment and dental) of a military member's HREC transfer when a Soldier transfers or changes MTFs. When a member transfers to another unit or station, the military personnel officer of the losing unit will receive both parts of the HREC from their custodians."

b. During the inspection, the DAIG interviewed leaders, case managers, and Soldiers assigned to Medical Holding Units (MHU), Medical Retention Processing Units (MRPU), and Civilian Based Healthcare Organizations (CBHCO) regarding the transfer of medical documentation. A majority (69%) of these locations reported problems with Soldiers arriving without or with incomplete medical documentation. In many cases, delays in MEB processing stemmed from medical documentation missing from Soldiers' HREC. A few Soldiers stated that their records or medical documentation were lost sometime during their travels from treatment at point of injury to their current assignment in the MRPU or MHU.

c. The chief complaint regarding lack of medical documentation came from the CBHCOs. Oftentimes, the CBHCO received a copy of a Soldier's HREC, which became a problem if a Soldier was referred into the APDES because the servicing PEB did not accept a photocopy of the medical documentation. The CBHCO staff then had to rebuild as much of the Soldier's medical record as possible for the Soldier to complete the APDES process. Case managers (CM) at CBHCOs stated they sometimes encountered difficulty receiving all the medical documentation from the Soldier's transferring MTF. Difficulties encountered range from MTFs taking weeks to respond to a request for a Soldier's medical documentation to receiving incremental documentation and thus having to make multiple requests for additional information. This impacts a Soldier's medical care because his Primary Care Manager (PCM), located at the CBHCO, requires all of a Soldier's medical documentation to provide an appropriate course of treatment. This included any operative reports and discharge summaries. In addition, providers want to ensure proper documentation of a Soldier's case for continuity of care and a Soldier's future eligibility for VA compensation.

d. Complaints also addressed problems CBHCOs had receiving copies of X-ray films and MRI results. Some physicians will often not see a Soldier until the physician receives the Soldier's medical documentation/tests. This results in the medical staff having to reorder many of the medical tests, which adds processing time and taxes the unit's budget. Cases involving Soldiers with Post Traumatic Stress Disorder (PTSD) or Soldiers with mental health conditions may complicate the receipt of proper documentation. Although AR 40-400 directs that when a Soldier's MEB case is forwarded to a PEB, a copy of his psychiatric treatment record will be included in his HREC, access to psychiatric related documentation may be more difficult to achieve.

e. Some units have access to the Armed Forces Health Longitudinal Technology Application, referred to as AHLTA. AHLTA "is a medical and dental clinical information system that will generate and maintain a comprehensive, lifelong, computer-based patient record for every Soldier, sailor, airman, and marine; their family members; and others entitled to DOD military health care." As of this report, 99% of planned DOD health care facilities have AHLTA, but the system only offers access and input to beneficiaries' outpatient treatment records. Inpatient treatment record and ancillary services will be added in upcoming years to meet the DOD intent of a system that allows providers access to a Soldier's Electronic Health Record (EHR).

f. An EHR is a patient's medical record in an electronic format, accessible by computers on a network for the primary purpose of providing health care and health-related services. Information in a EHR includes documents relating to the past, present or future physical and mental health and condition of a patient, medical test reports or multimedia images, and financial and demographic information.

g. AHLTA implementation should reduce the DOD's dependence on paper documentation and allow health care providers ready access to Soldier health information. At this point, AHLTA only provides information inputted into the system at those MTFs where the system has been deployed/fielded. Hard copy documentation

contained in a Soldier's HREC or inpatient treatment record is currently not included in AHLTA. At some installations, AHLTA has enhanced the staff's access to Soldier health information. A few CBHCOs have experienced connectivity issues or lack of access to AHLTA, which has impacted their retrieval of Soldiers' medical documentation.

RECOMMENDATIONS. The APDES Action Team in conjunction with:

a. US Army Medical Command enforce regulatory guidance regarding the transfer of medical documentation.

b. US Army Medical Command continue the fielding of Armed Forces Health Longitudinal Technology Application (AHLTA).

FINDING 4.3: When conducted, commands with MOS/Medical Review Board (MMRB) convening authority conduct MMRBs in accordance with Army Regulations.

STANDARD: Army Regulation 600-60, 25 June 2002, paragraphs 4-7 through 4-21.

ROOT CAUSE: N/A

DISCUSSION:

a. The DAIG inspected five active component (AC), three United States Army Reserve (USAR), and two Army National Guard (ARNG) commands with MOS/Medical Retention Board (MMRB) convening authority. Interviews with key leaders of these commands involved in the MMRB process along with document reviews revealed that the commands conduct MMRBs in accordance with AR 600-60 regarding the board packet content, board member composition, board recommendations, and post-board documentation and actions.

b. While boards are conducted in accordance with regulation in the areas mentioned above, personnel interviews and document reviews revealed some Soldiers in these commands did not appear before an MMRB within the time standard (60 days for active duty Soldiers and 120 days for drilling USAR and ARNG Soldiers) after receiving their permanent profile. Most personnel interviewed stated the main problem the commands have in meeting the time standard is a lack of understanding by unit commanders and leaders of the MMRB process and their responsibilities. This causes delays in gathering the required documentation for the MMRB board packet. Document reviews showed that all inspected commands had Soldiers requiring a MMRB that were outside the time window because of an incomplete MMRB case packet.

c. Some USAR Soldiers in three USAR commands inspected thought the process for determining a permanent profile and requirement to appear before a MMRB was too lengthy. These commands referred USAR Soldiers who received periodic physicals through the Federal Strategic Health Alliance Program (FEDS_HEAL). Documentation

was then processed through Human Resource Command-St Louis (HRC-STL) for review. HRC-STL is the profile-approving authority and the USAR commands maintain that the documentation is not processed in a timely manner. A review of 15 MMRB cases at these commands for the past year revealed that it took on average 10 months for a Soldier to complete a physical exam through FEDS_HEAL and have a permanent profile issued by HRC-STL. While the personnel interviewed agreed the FEDS_HEAL program helps improve medical readiness, they felt that this process is too long. They also state Soldiers can be in a Trainee, Transient, Holdee, or Student (TTHS) status for approximately one year after the physical exam while waiting for their MMRB.

d. There are areas for improvement for all commands inspected. They include maintaining required statistics on the time segments of the MMRB process and the training of board members. Without maintaining the time segment statistics, the commands could not properly monitor the efficiency and timeliness of their MMRB processing from date of profile to final disposition, final reclassification action, or dictation of Medical Evaluation Board. While not required by Army Regulation, none of the commands inspected had an established training program to train MMRB voting and non-voting members on the purpose of the MMRB and board members' roles and responsibilities. Most of the commands only provided training to the MMRB President. Both ARNG commands inspected did, however, have internally developed MMRB guides for unit commanders and board members to review prior to the board.

RECOMMENDATIONS. The APDES Action Team in conjunction with:

a. Commands with MOS/Medical Retention Board (MMRB) convening authority train and educate subordinate commanders and board members on the MMRB and their responsibilities in the process.

b. Commands with MOS/Medical Retention Board (MMRB) convening authority maintain MMRB statistics in accordance with Army Regulation 600-60.

c. Deputy Chief of Staff, G-1 and US Army Reserve Command examine ways to improve the timeliness for issuing permanent profiles for USAR Soldiers with physical exams processed through Federal Strategic Health Alliance Program and Human Resource Command-St. Louis.

FINDING 4.4: Most Soldiers interviewed reported successful recovery of their personal and organizational property following medical evacuation from overseas locations.

STANDARDS:

a. AR 735-5, 10 June 2002, paragraphs 12-1a and 14-27a.

b. DA ALARACT 139/2006 P210236Z Jul 06 Message, Policies and Procedures for Handling Personal Effects (PE) and Government Property, paragraphs 3.e, 5, 6.a, and 6.b.

ROOT CAUSE: N/A.

DISCUSSION:

a. The DAIG interviewed 463 MH and MHO Soldiers and 401 of them reported no problems with recovering personal and organizational property. On the whole, this is a success story. It is noteworthy, however, that the remaining 62 Soldiers stated they experienced hardships with recovering their personal and organizational property following medical evacuation from outside continental United States (OCONUS) locations. These problems developed either after medical evacuation from theater and other OCONUS installations or while assigned to the medical hold system.

b. Although the percentage of Soldiers reporting problems with missing property is relatively low, the problem can significantly affect individual Soldier finances. Soldiers stated replacing missing personal property can amount to hundreds of dollars. Those Soldiers interviewed with missing property perceived their property was lost because their units failed to safeguard the personal and organizational property following medical evacuation, resulting in stolen property. The Soldiers also felt their units were unable or unwilling to ship the Soldiers' property and required the individual Soldier to pay the shipping unless the Soldier wanted to wait until the unit redeployed. Adding to the problem for those Soldiers who can not recover personal property is a lack of awareness of the claims process. The DAIG found many MH and MHO Soldiers along with Medical Holding Unit or Medical Retention Processing Unit cadre who did not know about procedures for filing claims for missing personally owned property through Installation Claims Offices.

c. A few (7%) Soldiers interviewed admitted having difficulty clearing the installation Central Issue Facility (CIF) because of problems recovering Organizational Clothing & Individual Equipment (OCIE). All of these cases involved Soldiers medically evacuated from theater who were unable to recover their property through no fault of their own. The Soldiers, however, were required to reimburse the government for the value of property that should have been safeguarded by their units or their units should have initiated relief of responsibility procedures in accordance with AR 735-5, chapter 13, Report of Survey. For example, the value of missing organizational property for two Soldiers interviewed at one location had a total value of \$1,069. Overall, most of the Soldiers interviewed with missing OCIE stated they obtained relief of responsibility through Reports of Survey initiated by the installation CIF.

RECOMMENDATIONS. The APDES Action Team in conjunction with:

a. US Army Commands ensure subordinate commanders comply with AR 735-5 and Department of the Army All Army Activities 139/2006 P210236Z July 2006

Message, Policies and Procedures for Handling Personal Effects and Government Property.

b. US Army MEDCOM and Installation Management Command ensure Medical Holding Units and Medical Retention Processing Units include a briefing during in-processing on how to file claims with the Installation Claims Office for lost personally owned property.

OBSERVATION 4.5: Physical Evaluation Board personnel perceive the Military Occupational Specialty (MOS)/Medical Retention Board is underused resulting in some Soldiers separating through the Army Physical Disability Evaluation System unnecessarily.

DISCUSSION:

a. The MOS/Medical Retention Board (MMRB) is part of the Physical Performance Evaluation System (PPES). According to AR 600-60, the PPES uses the MMRB to evaluate Soldiers issued a permanent physical profile with a numerical designator of 3 or 4 (P3 or P4) to determine if they have the physical ability to satisfactorily perform their primary military occupational specialty worldwide and in a field environment. The MMRB is an administrative screening board to ensure continuity of effort among commanders, physicians, personnel managers, and the Army Physical Disability Evaluation System (APDES). It provides commands with MMRB convening authority the flexibility to determine a Soldier's deployability, reclassification potential, or referral to the APDES. Soldiers who receive a P3 or P4 profile and meet medical retention standards of AR 40-501 must be referred to a MMRB. When the underlying medical condition for the P3 or P4 profile results in the Soldier not meeting medical retention standards, the Soldier is directly referred to the APDES.

b. Physical Evaluation Board (PEB) members interviewed at all three PEB sites agreed that in many instances a MMRB could have resolved the disability case versus a PEB adjudication. They opined that instead of a MMRB to evaluate whether a Soldier could perform other MOSs, commanders and physicians should refer Soldiers directly to the APDES. As a result, the Army separates Soldiers with good knowledge and skills because of a condition considered unfitting for their current military duty, even though they could still perform other types of duties. The PEB members recommended a change to AR 600-60 that would enable the US Army Physical Disability Agency (USAPDA) to refer a Soldier back to a MMRB for reclassification into another MOS.

c. The DAIG could not determine through document reviews at the commands inspected if or how many Soldiers may have been referred to the APDES unnecessarily. However, interviews with commanders and leaders at multiple levels revealed there is the potential for this to occur. The majority (67%) of AC commanders and leaders interviewed opined the MMRB is an unnecessary board which only delays separating Soldiers who cannot physically serve. Thus, unit commanders were more likely to

request physicians to refer nondeployable Soldiers with a P3 or P4 profiles to the APDES rather than a MMRB to get the Soldiers off their unit manning rosters sooner. This allows the unit to request replacements.

d. Patient Administration Division personnel and unit surgeons interviewed stated physicians' lack of understanding of the profile system contributes to this issue. They stated that not all physicians understand the difference between retention standards and the ability to perform in a MOS. As a result, physicians document the requirement for a Medical Examination Board (MEB) instead of a MMRB on the Physical Profile Form (DA Form 3349). To overcome a physician's lack of understanding, those interviewed suggested unit commanders establish a process for screening profiles before a determination is made to refer a Soldier to an MMRB or MEB. The DAIG found only one inspected unit with MMRB convening authority that had such a screening process in place. This unit's process required the unit surgeon to screen all permanent profiles before determining whether to send the Soldier to a MMRB or MEB. Review of MEB cases at this unit's supporting medical treatment facility revealed this unit had fewer Soldiers in the APDES than other units of similar size.

RECOMMENDATIONS. The APDES Action Team in conjunction with:

a. Deputy Chief of Staff G1 consider revising Army Regulation 635-40 to allow USAPDA to refer Soldiers to a MOS/Medical Retention Board.

b. Deputy Chief of Staff G1 conduct a study to determine if commands are using the MOS/Medical Retention Board as intended for the Personal Performance Evaluation System.

c. US Army Medical Command ensure physicians are trained and understand when a Soldier should be referred to an MOS/Medical Retention Board versus Medical Evaluation Board.

d. Commands and units with MOS/Medical Retention Board convening authority establish procedures for screening permanent profiles to determine whether to refer a Soldier to an MOS/Medical Retention Board versus Medical Evaluation Board.

OBSERVATION 4.6: Medical Retention Processing Units (MRPU) and Community Based Healthcare Organizations (CBHCO) do not accurately track Reserve Component (RC) Soldiers' Medical Retention Process (MRP) orders and completed packets.

DISCUSSION:

a. Historically, MRPU, CBHCO and HRC-A have not consistently processed MRP order requests for MHO Soldiers. This specifically involves those MHO Soldiers originally mobilized on 10 US Code (USC) 12302 orders and then required to remain on active duty to complete their medical evaluation, treatment, and disposition through the

Army Physical Disability Evaluation System (APDES). Previously, there was no overarching Army collective or regulatory guidance consolidating all aspects of MHO. In response, Headquarters, Department of the Army, G1 developed and published the MHO Consolidated Guidance, dated 24 July 2006. Chapter 2 of that document deals extensively with the instructions for identification, referral, and processing of RC Soldiers for the MHO program for MRP orders.

b. Most (76%) MRPU and CBHCOs inspected used an internal spreadsheet, an internal database, or pulled data from Medical Operational Data Systems (MODS) to track MRP order extensions. Most (76%) MRPU and CBHCOs found that MODS assisted with tracking when Soldiers needed an MRP extension. Without key tracking systems, a Soldier's orders can expire, which can cause the Soldier to have a no-pay due. Additionally, when a Soldier falls off the Defense Eligibility and Enrollment Reporting System (DEERS), there is a significant impact on Soldier and family TRICARE healthcare benefits. Cancelled medical appointments can affect the timeliness of the APDES process for the MHO Soldier.

c. A majority (53%) of the MRPU and CBHCOs inspected stated HRC-A does not timely process MRP order extensions. However, they also stated that HRC-A will work with them if they have a Soldier who "falls through the cracks" and needs a next-day or same-day turnaround to avoid expiration of the Soldier's MRP orders. Although MHO Consolidated Guidance states HRC-A will publish MRP orders within 72 hours of receipt of extension request, HRC-A generally processes the requests within 24 hours. HRC-A was unable to produce statistics on the total of number Soldiers that have fallen off orders. In addition, they could not provide information on their average turn-around time on producing orders to the requesting agencies.

d. A few (17%) MRPU and CBHCOs stated that if they send requests forward too early, HRC-A will hold onto the packet and wait to cut the orders until 10-15 days from expiration. This can cause Soldiers to have problems with TRICARE eligibility because they, in turn, fall off DEERS and/or have pay issues if their unit submits the order for pay after the Defense Finance and Accounting System (DFAS) cut off date for the pay period. HRC-A stated they process completed MRP extension packets no more than 60 days before the MRP order expiration date. HRC-A can not process an incomplete packet, even if the Soldier has fallen off orders. HRC-A returns incomplete packets to the submitting agency with no action taken until the packet is complete. HRC-A stated the majority of incomplete packets from the CBHCOs lack medical documentation. Civilian providers, who do not understand Army specifications concerning retention standards and the Army profile system, are responsible for completing the majority of this documentation. As a result, delays in the orders process occur because the medical documentation often fails to meet the specific requirements outlined in the MHO Consolidated Guidance. HRC-A was unable to provide DAIG figures on the percentage of late or incomplete packets received and how many were from CBHCOs versus MRPU.

e. According to the MHO Guidance, MODS is intended to be the "Army's sole tracking and reporting database for MHO Soldiers." MEDCOM maintains MODS. MODS not only accounts for all Soldiers on MRP orders, but also monitors their progress through the Army's Physical Disability Evaluation System (APDES). To temporarily alleviate problems in the field with extensions, HRC-A sends a 30/60/90 day report to regional case managers (RCM) on a monthly basis to ensure extension packets are prepared correctly. The packets are then sent to HRC-A within 30 days before the order expiration date. HRC-A will soon be online with MODS; this will help HRC-A and subordinate field units to better track the process, orders, and extensions produced for MHO Soldiers. HRC-A stated the MHO Consolidated Guidance is still very new to the field and with time, the guidelines and processes will become clearer to the field units. Concurrently, the Installation Management Agency (IMA) now conducts bi-annual MHO training for case managers, MRPU, CBHCO cadre, and personnel who deal with MHO Soldiers.

f. During this inspection HRC-A could not provide data to support their statements. HRC-A just recently began using an internal spreadsheet to track the packets received from the field until they are on line with MODS.

RECOMMENDATIONS. The APDES Action Team in conjunction with:

a. Installation Management Command in coordination with US Army MEDCOM, and Human Resources Command continue the current implementation plan to conduct bi-annual medical holdover training for Medical Retention Processing Units and Community Based Healthcare Organizations.

b. US Army Medical Command, in coordination with Human Resources Command-Alexandria complete authorization for data input fields in Medical Operational Data System.

OBSERVATION 4.7: Most installation transition centers have additional personnel to handle the increased transition processing workload created by the Global War on Terrorism in order to meet the Army time standards.

DISCUSSION:

a. The DAIG inspected nine installation transition centers during the inspection. Interviews with transition center personnel revealed most (7 of 9) installations received funding from Installation Management Agency to hire additional DA civilian or contract personnel due to the increased transition processing workload for those Soldiers found "unfit" by the physical evaluation board (PEB). Prior to hiring the additional personnel, the seven transition centers noted above had difficulty meeting the Army standard for publishing discharge, REFRAD, or retirement orders within three days, and the subsequent goal of separating or retiring Soldiers in five working days. Those interviewed stated the centers' staffing was based on a peacetime workload, usually

four or five disability separations per month. During GWOT however, the transition centers received six to eight transition processing notifications for disability separations a week. Transition center personnel interviewed stated that with the added personnel, they are meeting the Army standards. Reviews of transition centers' internal tracking documents from before and after the additional staffing supported this assertion.

b. Although staffed to meet the mission, transition center personnel stated there are still some challenges ensuring Soldiers complete transition processing is in accordance with the Army standard. They cited the most common reason for delays results from the US Army Physical Disability Agency (USAPDA) placing Soldiers on the wrong installation Transition Processing (TRANSPROC) list. If USAPDA places a Soldier on the wrong TRANSPROC list, it can delay the Soldier's transition processing by weeks. This is a particular problem in Germany, which has over 20 different transition points. A review of TRANSPROC lists at some of the transition centers revealed that approximately 20-25% of the Soldiers on the lists were not located at that installation.

RECOMMENDATIONS. The APDES Action Team in conjunction with:

a. Installation Management Command continue to fund installation transition centers to ensure timely discharge, release from active duty, and retirement orders publishing and disability separation processing.

b. U.S. Army Physical Disability Agency take steps to eliminate the error of placing Soldiers on the wrong installation transition processing notification list.

OBSERVATION 4.8: Most commanders and leaders at brigade level and below do not understand the Army Physical Disability Evaluation System and their responsibilities in the process.

DISCUSSION:

a. The DAIG interviewed 46 Active Component (AC) unit commanders, command sergeants major, and first sergeants, at company through brigade level during the inspection. Most (87%) of those leaders interviewed did not know or understood the purpose or process of the Army Physical Disability Evaluation System (APDES). When asked to explain their responsibilities for Soldiers in their units undergoing the PDES process, most (85%) of the company commanders and first sergeants interviewed did not know the unit's requirement to provide a Commander's Performance Evaluation Letter, evaluation reports, line of duty determinations, and other administrative documentation required for the case packet. A common response was "Just ensure the Soldiers make all medical appointments." Additionally, the majority (67%) of brigade and battalion commanders interviewed did not know the responsibilities their subordinate company commanders have in the process. Commanders and leaders added they do not have good visibility of Soldiers going through the APDES because

they have no access to tracking systems or do not receive timely feedback/updates from patient administrators, PEBLOs, or case managers.

b. Sensing sessions with 169 AC Soldiers in the APDES supported this finding. The Soldiers continually stated their chains of command provided little or no assistance in helping them understand the APDES process, the possible outcomes, or the documentation required for the Soldiers' case packets. Soldiers in one sensing session stated their chains of command, "know all the myths, but none of the facts." Additionally, most of the Soldiers stated they received little support from their unit leaders in getting through the APDES process because they are a low priority to the chain of command.

c. Although the DAIG did not interview Reserve Components (RC) brigade and below commanders and leaders, commanders and command sergeants major from the Joint Force Headquarters and Regional Readiness Commands inspected stated they were confident in saying their subordinate commanders down to company level were just as unfamiliar with the APDES as their AC counterparts. Additionally, they felt that RC leaders know very little about the APDES to include their role and responsibilities in the process.

d. The DAIG team also interviewed medical treatment facility personnel involved in the APDES process, such as Patient Administrators, Physical Evaluation Board Liaison Officers, and case managers. These personnel stated that because unit commanders play an important role in the disability processing of Soldiers, commanders must have knowledge of the entire APDES process from issuing permanent profiles through the MEB and PEB boards to transition out of the Army. Many of these personnel stated commanders did not know their role as evidenced in the documentation submitted for Soldiers' MEB case packet, particularly the commander's performance evaluation letter. They noted the commander's performance evaluation is one of the most important documents the unit provides for the APDES because it gives the board members information on how a Soldier's medical condition affects his or her duty performance and deployability status. But, they stated the commander's letter often did not contain enough detail to provide the board members a clear picture of what duties the Soldier can perform and what duties the Soldier is currently performing.

RECOMMENDATIONS. The APDES Action Team in conjunction with:

a. Training and Doctrine Command include Army Physical Disability Evaluation System training in the brigade and battalion pre-command courses and the sergeants major course.

b. Army Commands include Army Physical Disability Evaluation System training in their company commander and first sergeant courses that includes the unit's role and responsibilities.

c. Office of the Surgeon General develop training materials and programs to educate unit leaders on all aspects of the Army Physical Disability Evaluation System to include their responsibilities.

OBSERVATION 4.9: A majority of Medical Holdover Soldiers have little or no contact with their home station Reserve Component units.

DISCUSSION:

a. The DAIG interviewed 320 Reserve Component (RC) Medical Holdover (MHO) Soldiers assigned to Medical Retention Processing Units (MRPU) and Community Based Health Care Organizations (CBHCO). Of those Soldiers interviewed, 237 (74%) stated that neither they nor their families had been contacted by their home station US Army Reserve (USAR) or Army National Guard (ARNG) unit since transferring to MHO status. Some of the Soldiers interviewed were medically evacuated from theater and thus their units redeployed after they did and the unit did not know the Soldiers were in MHO status. Some of the Soldiers contacted by their RC unit stated the reason for the contact was not to check on the Soldiers' well being, but to find out why the Soldiers were not at their weekend Inactive Duty Training with their units. The Soldiers stated this resulted in the unit leaving them and their families out of unit welcome home ceremonies, awards ceremonies, and other events. They also felt punished for being on MHO status.

b. The DAIG determined that there is no mechanism for RC commanders to readily track their Soldiers or their status once they are on Title 10 orders. The Army National Guard uses the Standard Installation/Division Personnel System (SIDPERS) database, the US Army Reserve uses Regional Level Applications Software (RLAS), and the active component uses Electronic Military Personnel Office (eMILPO). With three disparate systems that do not exchange information, RC commanders can not identify when their Soldiers transfer to MHO status. Regardless of the personnel system shortfalls, there are methods for RC commanders to locate their Soldiers while in a MHO status. Assistant Secretary of the Army for Manpower and Reserve Affairs (ASA(M&RA)) has a single source cell for tracking MHO Soldiers. The cell has two tracking systems: Soldier Patient Tracker and Soldier Patient Locator. RC units can contact the ASA(M&RA) cell to determine the location of a Soldier once they determine the Soldier is in MHO Status.

c. A possible solution to the personnel system shortfall is currently in the development stage. According to the Office of the Undersecretary of Defense for Personnel Management website, the Defense Integrated Military Human Resources System (DIMHRS) currently under development for use by all Army components will, "ensure visibility and accountability of military personnel and provide timely as well as

accurate human resources information to authorized users.” DIMHRS is intended for use by all Army components and should give RC commanders the capability to track Soldiers.

RECOMMENDATIONS. The APDES Action Team in conjunction with:

- a. Deputy Chief of Staff, G1 complete development of a personnel system that allows Reserve Component commanders to track their mobilized Soldiers and subsequently assigned to Medical Holdover status.
- b. US Army Reserve Command develop procedures to enable and require Commanders to contact Soldiers and their families while in Medical Holdover status.
- c. National Guard Bureau develop procedures to enable and require commanders to contact Soldiers and their families while in Medical Holdover status.

OBSERVATION 4.10: The majority of MTFs, MHUs, MRPU, and CBHCOs inspected feel TRICARE does an excellent job providing quality medical care for Soldiers.

DISCUSSION:

- a. TRICARE Management Activity establishes the access standards for DOD beneficiaries enrolled in its managed care system. Enrolled TRICARE Prime beneficiaries receive appointments within the following time limits:
 - (1) The wait time for an urgent care appointment will not exceed 24 hours.
 - (2) The wait time for a routine appointment will not exceed one week.
 - (3) The wait time for a specialty care appointment or wellness visit will not exceed four weeks (28 days).
- b. The DAIG inspected 16 MTFs, 10 MHUs, 13 MRPU, and four CBHCOs during the inspection. The majority (72%) of Health Benefits Advisors (HBA), case managers, and Soldiers interviewed stated Soldiers receive appointments within the TRICARE access standard and the standard of care is commensurate with care provided at MTFs. However, some (28%) expressed problems with Soldiers receiving specialty appointments. Access to specialty services appears limited or was non-existent at some locations, especially OCONUS locations. Lack of access to specialty care affects not only the Soldiers medical care but also delays the APDES process. Delays in receiving specialty appointments prolong the completion of the MEB and thus affect the timelines required to finalize the APDES process.
- c. Units provided various reasons as to why Soldiers did not receive timely specialty care. One TRICARE representative stated the availability of some specialty care

(urology, neurology) was an issue because of the absence of providers. Another representative voiced concern about the absence of Eye, Nose, and Throat (ENT), neurosurgery and orthopedic capabilities at her installation. Lack of medical specialists at those installations caused a problem in meeting appointment access standards for some Soldiers. Another TRICARE representative stated that many physicians at her installation deployed in support of GWOT and/or civilian physicians were not available. As a result, they often did not meet the TRICARE standard for referral appointments.

d. Three of the four CBHCOs visited stated the lack of specialty care access stems from TRICARE reimbursement fees. Case managers at all three CBHCOs stated some civilian providers in their regions refused to continue providing TRICARE services because the TRICARE maximum allowable charges were too low for the providers to accept. One CBHCO stated that some of the neurology surgeons at their location refused to take TRICARE because of inadequate reimbursement rates.

e. The DAIG team was informed that Soldiers living in American Samoa have significant problems in not only receiving specialty care but also in receiving standard medical treatment. Medical personnel stated Soldiers in American Samoa have no medical facilities available where they live and must be brought back on orders and returned to an MTF located in Hawaii. In addition, TRICARE will not certify most of the physicians located in American Samoa, which further hinders Soldiers requiring medical care. If a Soldier sees a non-certified TRICARE provider, the Soldier pays out-of-pocket for treatment. The expense and time required to bring a Soldier to Hawaii and return him/her home also strains MTF's resources.

RECOMMENDATIONS. The APDES Action Team in conjunction with:

a. TRICARE Management Agency review its policy regarding reimbursement of those civilian providers authorized to provide medical treatment to DoD beneficiaries.

b. TRICARE Management Agency review or revise the criteria it uses to certify physicians in remote locations to provide care for Soldiers living there.

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CHAPTER 3

BEST PRACTICES

1. Medical Evaluation Board (MEB) Process Organization. Eisenhower Army Medical Center organized its MEB process so that all personnel conducting the MEB process fall under the one chain of command, the DCCS. This centralization of focus replaces the usual two chains of command, the physicians assigned to the DCCS and the PEBLOs assigned to the DCA. Eisenhower AMC has an experienced MEB physician who runs the MEB process and uses MEBITT data to evaluate the process.

2. Patient Administrative Division (PAD) Assessment Tools. Walter Reed Army Medical Center PAD has developed an excellent internal assessment tool by using MEBITT to track not only the organization's MEB process, but the efficiency of each alternate PEBLO. This modified use of MEBITT allows the display of a large variety of metrics and information on each PEBLO to include: number of MEB cases completed, the number of cases returned, and the processing time of MEB cases. This oversight gives the MTF leadership the ability to evaluate the timeliness, accuracy, and thoroughness of the individual PEBLO.

3. MEDCOM use of the Balanced Score Card. MEDCOM use of the Balanced Score Card is a top down driven assessment of Military Treatment Facilities performance based on metrics derived from MEBITT. It gives the MTF leadership an independent assessment of their MEB process. This is critical for MTF leaders with inexperienced Patient Affairs Directors, since they might not be able to independently verify the data given to them by their PEBLOs.

4. Use of Standardized MEB Psychiatrist Memorandum. Walter Reed Army Medical Center Department of Psychiatry has a standardized MEB Psychiatrist Memorandum. This Narrative Summary template has pull down windows which assist psychiatrists in writing NARSUMs. It does not replace the experience of psychiatrists; it makes the psychiatrists more efficient.

5. Transition Center In-processing Briefing. Fort Gordon Transition Center (TC) conducts a briefing for Soldiers upon in-processing the Medical Holding Unit or Medical Retention Processing Units. The briefing directed Soldiers to complete critical tasks such as gathering documents for DD Form 214, taking leave, starting the ACAP (which includes the VA) process, attending pre-retirement briefings if applicable, and turn-in/clearing of the installation Central Issuing Facility, before their REFRAD or separation determination. The TC also established an agreement with the servicing Medical Treatment Facility (MTF) that when a Soldier's Physical Evaluation Board case has completed all appeals and reviews, the MTF sends the Soldier to the TC to begin the transition process. The briefing and agreement helps in meeting the Army time standards for publishing separation or REFRAD orders and out-processing.

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APPENDIX 1



SECRETARY OF THE ARMY WASHINGTON

18 APR 2006

MEMORANDUM FOR THE INSPECTOR GENERAL

SUBJECT: Directive for the Inspection of the Army's Physical Disability Evaluation System.

1. You are directed to conduct an inspection of the Army Physical Disability Evaluation System.
2. This inspection will focus on the following objectives:
 - a. Assess the execution and timeliness of the Medical Evaluation Board process to include compliance with DoD and Army policies.
 - b. Assess the execution and timeliness of the Physical Evaluation Board and review processes to include compliance with DoD and Army policies.
 - c. Assess the execution of the Medical Hold System to include compliance with DoD and Army policies.
 - d. Assess the impact of other administrative areas on the Army Physical Disability Evaluation System.
3. You are authorized unlimited access to Army activities, organizations, and all information sources required to ensure the successful accomplishment of this inspection, including access to ongoing and previously conducted investigations and inspections.
4. You are authorized to task the Army Staff and subordinate headquarters and to conduct this inspection as an approved exception to the HQDA Short Notice Tasking Policy dated 031353Z Jan 01.
5. You will provide me a report at the conclusion of the inspection.


Francis J. Harvey

APPENDIX 2

DETAILED STANDARDS LISTING

OBJECTIVE 1 - Assess the execution and timeliness of the Medical Evaluation Board process to include compliance with DOD and Army policies.

FINDING 1.1: US Army is not meeting the Department of Defense 30-day standard for processing Medical Evaluation Board cases which measures from the date the physician dictates the Narrative Summary to the date the case is received by the Physical Evaluation Board.

STANDARDS:

a. Department of Defense Directive 1332.18, Separation or Retirement for Physical Disability, 4 November 1996, Paragraph 1.3 states:

“Authorizes procedures under DoD Instruction 1332.38 reference (e)) and DoD Instruction 1332.39 (reference (f)) for the DoD Disability Evaluation System (DES).”

b. Department of Defense Instruction 1332.38, Physical Disability Evaluation, 14 November 1996, Enclosure 3, Paragraph E3.P1.6.2.1 states:

“Duty-Related. When a physician initiates a MEB, the processing time should normally not exceed 30 days from the date the MEB report is dictated to the date it is received by the PEB.”

c. Army Regulation 40–400, Patient Administration, 13 October 2006, Paragraph 7-1 states:

“**General**

MEBs are convened to document a Soldier’s medical status and duty limitations insofar as duty is affected by the member’s medical status. MEBs must be completed expeditiously. MEB appointments and consultations will receive priority access over all other categories of nonemergent patients. For duty related cases, MEB processing will not normally exceed 30 days (beginning on the date of the medical officer’s narrative summary through the date forwarded to the PEB). Military occupational specialty/medical retention board (MMRB) results requiring referral to an MEB should be transmitted expeditiously to the MTF commander (AR 600-60). An MEB should be initiated within 30 days upon receipt of an approved MEB referral from an MMRB. Decisions regarding unfitness for further military duty because of physical or mental disability are prerogatives of PEBs (AR 635-40). MEBs will not express conclusions or recommendations regarding such matters. However, entrance physical standards

boards (EPSBDs) will make decisions as to the member's fitness or unfitness for enlistment or induction.”

d. US Army Medical Command Memorandum, Metrics and Procedures for improving Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB) Processing, 20 September 2001, Enclosure 1, Paragraph 1, Subparagraph b states:

“The MEB should be mailed within 30 days from dictation of the Narrative Summary (Department of Defense Instruction 1332.38., Physical Disability Evaluation). The 30 day Department of Defense (DoD) standard is a sub-component of the MEDCOM standard.”

e. US Army Medical Command Memorandum, Medical Evaluation Board (MEB)/Physical Evaluation Board (PEB) Referrals Using the DA Form 3349, Physical Profile, 07 October 2004, Paragraph 4 states:

“The MEB must be completed expeditiously; thus the physical profile must be forwarded immediately to the PEBLO on the date of referral. The date the profiling officer signs the physical profile referring the Soldier to an MEB begins the Medical Command (MEDCOM) 90-day period within which the MEB process must be completed. The 90-day MEB processing metric measures the time from the date the physician signs the physical profile to the date the MEB is forwarded to the PEB. Evaluation of the processing timelines of MEBs referred by the MMRB begins on the date the Soldier's packet is received at the military treatment facility from the MMRB Convening Authority. The DoDI 30-day MEB processing metric measures the time from the dictation of the narrative summary to receipt of the case at the PEB.”

FINDING 1.2: The majority of Regional Medical Commands are not meeting the Army 90-day standard for processing Medical Evaluation Boards.

STANDARDS:

a. Army Regulation 40–400, Patient Administration, 13 October 2006, Paragraph 7-1 states:

“General

MEBs are convened to document a Soldier's medical status and duty limitations insofar as duty is affected by the member's medical status. MEBs must be completed expeditiously. MEB appointments and consultations will receive priority access over all other categories of nonemergent patients. For duty related cases, MEB processing will not normally exceed 30 days (beginning on the date of the medical officer's narrative summary through the date forwarded to the PEB). Military occupational specialty/medical retention board (MMRB) results requiring referral to an MEB should be transmitted expeditiously to the MTF commander (AR 600-60). An MEB should be initiated within 30 days upon receipt of an approved MEB referral from an MMRB.

Decisions regarding unfitness for further military duty because of physical or mental disability are prerogatives of PEBs (AR 635-40). MEBs will not express conclusions or recommendations regarding such matters. However, entrance physical standards boards (EPSBDs) will make decisions as to the member's fitness or unfitness for enlistment or induction."

b. US Army Medical Command Memorandum, Metrics and Procedures for improving Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB) Processing, 20 September 2001, Enclosure 1, Paragraph 1, Subparagraph a states:

"The MEB should be completed and mailed within 90 days from physician initiation (MEDCOM standard)."

c. US Army Medical Command Memorandum, Medical Evaluation Board (MEB)/Physical Evaluation Board (PEB) Referrals Using the DA Form 3349, Physical Profile, 07 October 2004, Paragraphs 3 and 4 state:

"3. Physicians who identify Soldiers with medical conditions not meeting the medical fitness standards for retention will initiate a DA Form 3349 referring them to the Physical Disability Evaluation System. The DA Form 3349 is used to record both permanent and temporary profiles. Commanders will ensure designated profiling officers are familiar with AR 40-501, Chapter 3, which lists the various conditions and physical defects that may render Soldiers unfit for further military service. The profiling officer will determine if a Soldier with a permanent profile meets retention standards of Chapter 3. Soldiers issued a permanent profile with a numerical designator 3 or 4 in one of the physical profile factors are referred to either the Military Occupational Specialty/Medical Retention Board (MMRB) or the Physical Evaluation Board Liaison Officer (PEBLO) to initiate an MEB."

"4. The MEB must be completed expeditiously; thus the physical profile must be forwarded immediately to the PEBLO on the date of referral. The date the profiling officer signs the physical profile referring the Soldier to an MEB begins the Medical Command (MEDCOM) 90-day period within which the MEB process must be completed. The 90-day MEB processing metric measures the time from the date the physician signs the physical profile to the date the MEB is forwarded to the PEB. Evaluation of the processing timelines of MEBs referred by the MMRB begins on the date the Soldier's packet is received at the military treatment facility from the MMRB Convening Authority. The DoDI 30-day MEB processing metric measures the time from the dictation of the narrative summary to receipt of the case at the PEB."

d. Verbal order by Commander, US Army Medical Command, establishing seventy percent of Medical Evaluation Board cases should be completed within 90 days from issuance of permanent profile through the date the case is forwarded to the Physical Evaluation Board.

FINDING 1.3: Most Regional Medical Commands are not meeting the 10% return rate standard for Medical Evaluation Boards returned from the Physical Evaluation Board.

STANDARDS:

a. Army Regulation 635-40, Physical Evaluation for Retention, Retirement, or Separation, 8 February 2006, Paragraphs 2-8, subparagraphs a and c state:

“The commander, Medical Treatment Facility (MTF) will—“

“a. Provide a thorough and prompt evaluation when a Soldier’s medical condition becomes questionable in respect to physical ability to perform duty.”

“c. Ensure medical evaluation board (MEBD) proceedings referred to the PEB are complete, accurate, and fully documented as outlined in AR 40-400, chapter 7, and chapter 4 of this regulation.”

b. Commander, US Army Medical Command Memorandum, Metrics and Procedures for improving Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB) Processing, 20 September 2001, Enclosure 1, Paragraph 1, Subparagraph c, and Paragraph 8 state:

“(c) The percentage of returned cases should not exceed 10 percent of cases mailed. Returned cases should be resubmitted to the PEB within 30 days of receipt.”

“8. Returned Cases: The DCCS or the designated MEB approving official should review all cases returned by the PEB. Returned cases will be expeditiously returned to the PEB with the required corrections within 30 days. The return case rate should not exceed 10 percent of cases processed.”

FINDING 1.4: Most Soldiers in the Medical Evaluation Board process are receiving the required counseling.

STANDARDS:

a. Department of Defense Directive 1332.18, Separation or Retirement for Physical Disability, 4 November 1996, paragraph 3.2 states:

“3.2. The DES shall consist of four elements: medical evaluation; physical disability evaluation, to include appellate review; counseling; and final disposition.”

b. Department of Defense Instruction 1332.38, Physical Disability Evaluation, 14 November 1996, Enclosure 3, Paragraph E3.P1.4 states:

“E3.P1.4. Counseling

E3.P1.4.1. Purpose. The counseling element of DES shall afford Service members undergoing evaluation by the DES the opportunity to be advised of the

significance and consequences of the determinations made and the associated rights, benefits, and entitlements.

E3.P1.4.2. Topics. Counselors shall counsel on such matters as:

E3.P1.4.2.1. The sequence and nature of the steps in processing.

E3.P1.4.2.2. Statutory and regulatory rights.

E3.P1.4.2.3. Effect of findings and recommendations.

E3.P1.4.2.4. Recourse to rebuttals.

E3.P1.4.2.5. Estimated retired or severance pay based upon the PEB's findings and recommendations.

E3.P1.4.2.6. Probable retired grade.

E3.P1.4.2.7. Potential veterans benefits.

E3.P1.4.2.8. Post-retirement insurance programs and the Survivor Benefit Plan in accordance with DoD Directive 1332.27 (reference (g)) if appropriate.

E3.P1.4.2.9. Applicable transition benefits under DoD Directive 1332.35 (reference (h)).

E3.P1.4.2.10. Prior to acting on a Service member's request for a formal PEB, review with the member the applicable standard detailed in the VASRD or DoD Instruction 1332.39 (reference (i)), which would have to be recognized in order to increase the percentage of disability.

E3.P1.4.3. Ready Reserve Members. Ready Reserve members pending separation for physical disability should be counseled by the MTF Physical Evaluation Board Liaison Officer concerning their rights under the DES as established by section E3.P1.3. of Part 1 and section E3.P2.1. of Part 2.

E3.P1.4.4. Incompetent Members. When a Service member has been determined incompetent, his or her primary next of kin, or court appointed guardian shall be counseled and afforded the opportunity to assert the rights granted to the Service member, unless prohibited by law.

E3.P1.4.5. Pre-Separation Counseling. Service members on a call to active duty of more than 30 days shall not be separated or retired because of physical disability prior to completion of pre-separation counseling under reference (h). Though counseling is normally accomplished 90 days before separation, the date of separation or retirement of members determined unfit need not be extended to provide a minimum of 90 days between counseling and separation or retirement."

c. Army Regulation 635-40, Physical Evaluation for Retention, Retirement, or Separation, 8 February 2006, Paragraphs 3-8, 4-12, 4-15, 4-20, 4-21, 6-8, 7-5, 7-20, and Appendix C state:

"3-8. Counseling provided to Soldier

a. Physical Evaluation Board Liaison Officer counseling. The appointed Physical Evaluation Board Liaison Officer (PEBLO) at the MTF is responsible for counseling Soldiers (or the next of kin or legal guardian in appropriate cases) concerning their rights and privileges at each step in disability evaluation, beginning with the decision of the treating physician to refer the Soldier to a MEBD and until final disposition is accomplished. For this purpose, the MTF commander will name an experienced, qualified officer, noncommissioned officer (NCO), or civilian employee as the

PEBLO. At least one additional qualified officer, NCO, or civilian employee will be designated as alternate PEBLO. Only personnel whose duties will not conflict with their counseling responsibilities will be selected. The MTF commander will notify the recorder of the applicable PEB, of the name and telephone number of the PEBLO and alternate PEBLO. PEBLOs will use the Disability Counseling Guide (app C) to assist them in providing thorough counseling. Counseling will be documented (see para 4–20d).

Counseling will cover as a minimum, the following areas:

- (1) Legal rights (including the sequence of and the nature of disability processing).
 - (2) Effects and recommendations of MEBD and PEB findings.
 - (3) Estimated disability retired or severance pay (after receipt of PEB findings and recommendations).
 - (4) Probable grade upon retirement.
 - (5) Potential veteran's benefits.
 - (6) Recourse to and preparation of rebuttals to PEB findings and recommendations.
 - (7) Disabled Veterans Outreach Program (DVOP).
 - (8) Post-retirement insurance programs and the Survivor Benefit Plan (SBP).
- b. Legal counseling. Counseling by the appointed legal counsel is provided when the Soldier requests a formal hearing.”

“4–12. Counseling Soldiers who have been evaluated by a medical evaluation board

a. The PEBLO will advise the Soldier of the results of the MEBD. The Soldier will be given the opportunity to read and sign the MEBD proceedings. If the Soldier does not agree with any item in the medical board report or NARSUM, he or she will be advised of appeal procedures.

b. The decisions below are exclusively within the province of adjudicative bodies. Neither the PEBLO nor the attending medical personnel will tell the Soldier that—

- (1) The Soldier is medically or physically unfit for further military service.
- (2) The Soldier will be discharged or retired from the Army because of physical disability.
- (3) A given percentage rating appears proper.
- (4) A LD decision is final (unless final approval has been obtained according to AR 600–8–4).”

“4–15. Action following approval of a medical evaluation board [r]eport

The MTF commander will notify the unit commander of the planned referral of a Soldier to a PEB and obtain from the commander the written statement described in paragraph e, below. If further action is not barred, the original and two copies of the MEBD proceedings and allied documents described below, as applicable, will be forwarded to the PEB.

a. DA Form 5889–R (PEB Referral Transmittal Document). This document serves as the forwarding memorandum. It identifies the documents forwarded and provides unit and home addresses and telephone numbers for the PEB to contact the Soldier as required. DA Form 5889–R will be locally reproduced on 8 1/2 by 11 inch paper. A copy of the form for reproduction purposes is located at the back of this regulation.

b. Documents submitted by Soldier to accompany MEBD as evidence of physical ability to adequately perform military duties (letters, efficiency reports, or personal statements).

c. DA Form 3947 (Medical Evaluation Board Proceedings) with SF 502 (Medical Record—Narrative Summary Clinical Survey) as enclosure 1 and DA Form 3349 (Physical Profile) as enclosure 2.

d. In cases where the Soldier has been determined mentally incompetent, a statement confirming the name, address, telephone number, and relationship of individual authorized to act in behalf of the Soldier; whether this person is available for counseling following PEB action; and whether the person has been advised of the referral to a PEB. If the next-of-kin is not known or cannot be located and no court-appointed guardian exists, include a summary of the attempts to identify or locate the next-of-kin. To establish the individual having authority to act for an incompetent Soldier, in the absence of a valid and pertinent power of attorney or a court order authorizing an individual to act for an incompetent Soldier, follow the guidelines below. The person authorized to act is the person highest in the line of authority listed below.

(1) Spouse, even if a minor.

(2) Adult sons or daughters in order of seniority. An individual is an adult upon reaching the age of majority under the state law of the individual's legal residence.

(3) Parent in order of seniority, unless legal custody was granted to another person by reason of court decree or statutory provision. The person to whom custody was granted remains as next of kin although the individual has reached the age of majority.

(4) Blood or adoptive relative who was granted legal custody of the person by reason of a court decree or statutory provision. The person to whom custody has been granted remains the nearest next of kin although the individual has reached age of majority.

(5) Adult brother and sisters in order of seniority.

(6) Grandparents in order of seniority.

(7) Other relatives in order of relationship to the individual and according to the laws of the Soldier's domicile. A Soldier's domicile is the Soldier's legal residence. It is not necessarily where the Soldier is actually living, the Soldier's home of record, or where the Soldier is stationed.

(8) Persons who stand in place of a parent. Seniority in age will control when the persons are of equal relationship.

e. Statement from Soldier's commander confirming whether any adverse personnel action is being considered against the Soldier and describing the Soldier's current duty performance. The description of duty performance should address the following:

(1) The Soldier's most recent performance of duty.

(2) Any special limitation of duty due to the Soldier's physical condition.

(3) The Soldier's ability to adequately perform the duties normally expected of an individual of the Soldier's office, grade, rank, or rating.

(4) The Soldier's current duty assignment, anticipated future assignments, branch, age, and career specialities.

f. A copy of the document reflecting the approved LD decision (AR 600-8-4) if the disability is the result of injury; the result of disease secondary to injury or due to misconduct; or the result of disease when the case is that of a Soldier performing duty

for 30 days or less. Provide either a DD Form 261, DA Form 2173, or similar LD reports from the Navy or Air Force. If the documents are not available, the MTF commander will send a request for LD decision, well in advance of a preparation of the MEBD report, to the Soldier's unit of assignment at the time of injury or disease.

Include a copy of the request in the case file sent to the PEB and send a copy to USA HRC (AHRC-PED-S). The request will provide the following information:

- (1) Name, grade, and social security number (SSN).
 - (2) Date and place of injury.
 - (3) Short summary of circumstances of injury, including the identity of MTF where the Soldier was treated.
 - (4) Unit of assignment when the Soldier was injured.
 - (5) Statement that the LD determination is required for disability processing.
- g.* Orders or training schedule under which the Soldier was performing active duty, active duty for training, or inactive duty training when the Soldier is subject to disability processing under chapter 8. If the Soldier is retained for medical care beyond termination date of active duty for training, include a copy of the affidavit required by AR 135-381. If referral to a PEB occurs during rehospitalization for treatment of residuals of an injury, provide a copy of the authorization for rehospitalization required by AR 40-400, para 3-2d(2).
- h.* Copy of memorandum approving COAD/COAR when case is that of a Soldier previously continued on duty under the COAD program. If available, include a copy of the DA Form 199 related to the previous COAD action.
- i.* Soldier's request for COAD/COAR under chapter 6 of this regulation.
- j.* Soldier's statement or statement of PEBLO when a soldier has 18, but less than 20, years of active federal service, or an RC Soldier has 18, but less than 20 years of qualifying service for nonregular retirement, declines to request COAD or COAR, as applicable.
- k.* Copy of decision by the GCMCA to waive administrative separation under AR 635-200, chapter 14 for referral of Soldier to a PEB. Requirement applies even if a general discharge is directed under AR 635-200, chapter 14. Requirement is not applicable to Soldiers pending separation under AR 635-200, chapter 13.
- l.* Statement from the custodian of the Soldier's personnel records confirming whether one of the circumstances below is applicable at the time the Soldier is referred to a PEB.
- (1) Voluntary or mandatory retirement processing.
 - (2) Expiration of term of service without reenlistment.
 - (3) Expiration of term of service with bar to reenlistment.
 - (4) Involuntary release from active duty due to DA board action.
 - (5) Qualitative management denial for reenlistment.
 - (6) Adverse personnel action.
- m.* Document authorizing Soldier's retention beyond scheduled separation or retirement date. (See AR 600-8-24 or AR 635-200.)
- n.* If available, DA Form 2 (Personnel Qualification Record—Part I) and DA Form 2-1 (Personnel Qualification Record—Part 2). If the documents are not available, use alternative sources to obtain the required personnel data if the information is reliable. Examples include requesting the Military Personnel Office (MILPO) to extract a DA

Form 2A (Personnel Qualification Record, Parts I and II) from SIDPERS and asking the Soldier to furnish the information directly. The use of alternative sources does not relieve the PEBLO of the requirement to initially request a copy of the DA Form 2 and DA Form 2-1.

o. If available, a statement explaining the reason for reduction to the lower grade when the Soldier is serving in a grade below the highest grade held. When the information is available, include a statement explaining the circumstance precluding advancement to private or private first class under the provisions of AR 600-200 (NGR 600-200 or AR 140-158 for Soldiers in the Reserve Components) if—

(1) The current grade is private (pay grade E-1), and the Soldier has completed more than 6 month's service.

(2) The current grade is private (pay grade E-2), and the Soldier has completed more than 12 months service.

p. Copy of request for VA hospital bed designation, if applicable.

q. Copy of orders moving patient to a VA hospital for continued hospitalization, if applicable.

r. Copy of letter(s) to proper state authorities, as applicable.

s. Copy of the request for Statement of Service when Soldier is a member of the Reserve Components (fig 4-1).

t. Copy of Soldier's latest leave and earning statement (DFAS Form 702)."

"4-20. Informal board

a. *Procedure.* Each case is first considered by an informal PEB. Informal procedures reduce the overall time required to process a case through the disability evaluation system. An informal board must ensure that each case considered is complete and correct. The rapid processing intended by the use of informal boards must not override the fundamental requirement for detailed and uniform evaluation of each case. All evidence in the case file must be closely examined and additional evidence obtained if required. The PEB will consider each case using the policies of chapter 3 and the criteria provided in paragraph 4-19.

b. *DA Form 199.* The findings and recommendations of the informal PEB are recorded on DA Form 199 according to the procedures described in appendix D. If the Soldier is on active duty, the original form, signed by the president of the PEB, the Soldier's copy, and the MTF's copy will be promptly forwarded to the MTF commander concerned using the fastest means of transmission available. If the DA Form 199 is not received by the PEBLO, the PEB will prepare new copies and forward them promptly.

c. *Soldier's election.*

(1) DA Form 199, block 13, lists the election options available to the Soldier for informal determinations. These include the following:

(a) Concurrence with the findings and recommendations and waiver of a formal hearing.

(b) Nonconcurrence with the findings and recommendations; submission of a rebuttal explaining the Soldier's reasons for nonconcurrence; and waiver of a formal hearing.

(c) Demand for a formal hearing with or without personal appearance.

(d) Choice of counsel if a hearing is demanded.

(2) Soldiers indicate their elections by checkmark in block 13 and sign and date the original and MTF copies of DA Form 199.

(3) The election must be received at the PEB within 10 days from the Soldier's receipt of the informal findings. See paragraph 4–20f below for procedures when elections and rebuttals are received after the required time.

d. Physical evaluation board liaison officer. In all informal cases, the PEBLO of the MTF having control of the Soldier will be the counselor for the Soldier. As such, the PEBLO is primarily concerned with the Soldier's interests. The PEBLO should consult with, and obtain advice as needed from the local legal office, the legal counsel at the nearest PEB, or the Agency Judge Advocate. Upon receipt of the informal proceedings, the PEBLO will accomplish the following actions:

(1) Counsel the Soldier according to appendix C. The Soldier will be made fully aware of the election options available to him or her, the processing procedures, and the benefits to which he will be entitled if separated or retired for physical disability. As needed, the PEBLO should consult with the local finance officer and the installation Retirement Services Officer (RSO) when counselling on benefits. DA Form 5892–R (PEBLO Estimated Disability Compensation Worksheet) will be provided to the Soldier as an estimate only of disability compensation. DA Form 5892–R will be locally reproduced on 8 1/2 and 11 inch paper. A copy of the form for reproduction purposes is located at the back of this regulation.

(2) After the Soldier completes block 13, the PEBLO will complete block 14 of the original and MTF copies of DA Form 199. If the Soldier fails or declines to make an election, the PEBLO will prepare a brief statement describing the circumstances, indicating the date the Soldier was first informed of, and counselled on, the informal board's action. The PEBLO will then forward the DA Form 199 and the statement to the PEB.

(3) In deleterious-type cases or others involving mental incompetence, the PEBLO will contact the next-of-kin or legal guardian (if one has been appointed) and request that person to act in behalf of the Soldier. If one cannot be located, the PEBLO will prepare a statement reflecting all actions taken to identify and contact a responsible person to act on behalf of the Soldier and forward the statement for inclusion with the case. (See para 4–15a for guidance on establishing the next of kin.)

(4) If Soldier elects formal hearing, forward Soldier's medical records to the PEB if they were not submitted with MEBD proceedings for the informal PEB.

(5) Complete DA Form 5893–R (PEBLO Counseling Checklist/Statement). This form will be used to document counseling. At the time of the Soldier's final election to PEB determinations, the PEBLO and Soldier will sign the form. A copy will be forwarded to the PEB for inclusion in the record of proceedings. DA Form 5893–R will be locally reproduced on 8 1/2 and 11 inch paper. A copy of the form for reproduction purpose is located at the back of this regulation.

e. Disposition by the physical evaluation board. Upon receipt of the Soldier's completed DA Form 199 from the PEBLO, the PEB will take the following actions as applicable.

(1) If the Soldier accepts the findings and recommendations of the informal PEB, the recorder will assemble the records as required by table 4–1. The proceedings will be approved for the SA and forwarded to USA HRC for final disposition.

(2) If the Soldier nonconcurrs with the findings without submitting a rebuttal, the PEB will approve the proceedings for the SA and forward the case to USA HRC for final disposition.

(3) If the Soldier fails or declines to make an election within the prescribed time and the PEB has not received from the PEBLO the statement described in 4-20d(2), above, the PEB will contact the PEBLO to confirm the status of the Soldier's election. When the PEBLO confirms the Soldier has been informed of the findings and recommendations but has not made an election, the PEB will proceed as if the Soldier has accepted the findings and recommendations. The proceedings will be forwarded to USA HRC for final disposition. The forwarding memorandum will document the circumstances resulting in the waiver of election (see fig 4-2). The PEB will forward a copy of the memorandum to the Soldier through the PEBLO.

(4) In deleterious-type cases or those involving mental incompetence in which the next-of-kin or guardian fails to make an election on behalf of the Soldier, the PEB will appoint legal counsel to act on behalf of the Soldier. The counsel will prepare a memorandum documenting the results of his or her action (see fig 4-3).

(5) If the Soldier nonconcurrs and submits a statement or rebuttal to the recommended findings without asking for a formal hearing, the PEB president will respond in writing to the Soldier, normally within 3 days. When the Soldier's rebuttal does not result in a change to the PEB's findings, the response will acknowledge receipt of the rebuttal and explain the PEB's decision to adhere to the earlier findings. The Soldier will be advised that the rebuttal will be included in the case file and considered in the review action by USAPDA. A copy of the PEB president's letter will be included in the case file.

(6) If the Soldier nonconcurrs with the findings and recommendations with a statement of rebuttal and demands a formal hearing, the PEB may reconsider their findings and recommendations in the light of the Soldier's statement of rebuttal. Should the PEB agree with the Soldier and modify their findings and recommendations, the PEB will initiate a new DA Form 199 informing the Soldier through the MTF commander of the results. If the Soldier accepts them, the case will be processed as in paragraph 4-20e(1), above. Otherwise, the case will be scheduled for a formal hearing. The PEB will inform the appointed legal counsel of the pending action. If the Soldier (in demanding a formal hearing) has elected to be represented by individual counsel, the appointed PEB counsel in coordination with the PEB president will make arrangements for the hearing with the individual counsel. If the Soldier is at some location other than that of the PEB, the commanding officer will promptly issue necessary temporary duty (TDY) orders for travel of the Soldier using locally available funds.

(7) Whenever more than one hearing (including a reconsideration) is held on a case, a copy of the DA Form 199 for each hearing will be attached to the final DA Form 199 to reflect and explain the multiple considerations. For example, a copy of an informal board's DA Form 199 attached to the copy of the formal board's DA Form 199 will record the Soldier's demand for a formal hearing without further comment or explanation.

f. Rebuttals. Rebuttals received after the allotted time or after initial election of concurrence.

(1) In those instances when a rebuttal from a Soldier is received after the allotted time for submission of a rebuttal, or after a Soldier has initially agreed with the findings and recommendations of the PEB and the case has been approved for the SA and forwarded to USA HRC for final disposition, the PEB will respond to the Soldier as set forth below.

(a) If the rebuttal does not result in a change to the findings and recommendations, the PEB will advise the Soldier in writing that no change is warranted and the rebuttal, together with the reply, has been forwarded to USA HRC for inclusion in the case proceedings. The Soldier retains the right to one formal hearing prior to final disposition by USA HRC if the Soldier is otherwise entitled and requests the hearing.

(b) When the rebuttal results in a change to the PEB's findings or recommendations, the PEB will recall the case and effect the necessary changes by preparing a new DA Form 199. The new findings will be furnished to the Soldier. Normal processing procedures apply.

(2) Notwithstanding the above, when additional medical evidence or an addendum to the MEBD is received after the PEB has forwarded the case and the PEB determines that such evidence would change any finding or recommendation, the case will be recalled by the PEB and a new DA Form 199 issued. Normal procedures apply following the preparation of a new DA Form 199."

"4-21. Formal board

a. Formal hearing. A Soldier is entitled to a formal hearing if requested after informal consideration by a PEB. The Soldier may waive this right by concurring in the findings and recommendations of the informal board. If the Soldier is incompetent, the right to waive a formal hearing may be exercised by next-of-kin or legal counsel. After demanding a formal hearing, a Soldier may later withdraw the demand and accept the informal board's decision, in which case, the counsel will inform the PEB. The case will be forwarded to USA HRC. The Soldier must be counseled on the right to demand a formal board. If the Soldier demands a formal hearing, he or she is entitled to counsel as provided in paragraph 3-10*d* and *h*, below. A formal board will be convened when—

(1) A Soldier (next-of-kin or legal guardian) demands it after electing not to accept the findings and recommendations of an informal board.

(2) The case file has been forwarded to USA HRC for issuance of retirement or separation instructions and the Soldier demands a formal hearing before USA HRC action is final.

(3) After an informal board, the president of the PEB decides that a formal hearing is in the best interest of the Soldier or the Army.

b. Formal board membership. A formal hearing will normally be conducted before a board composed of the same members who considered the Soldier's case informally. The purpose of a formal hearing is to afford the Soldier the opportunity to present views, testimony, and new evidence. The board members must consider these matters with open minds despite their earlier decisions. For this reason the challenge of a voting member, solely because the member took part in the informal board, ordinarily should be denied. If the Soldier is able to establish that a member of the formal board is not impartial, that board member will be replaced. If a replacement for the successfully challenged member is not available, the CG, USAPDA will appoint another member to

the PEB panel for the formal hearing. If an original voting member of the informal board is not available for the formal hearing, that member may be replaced with another who is qualified to sit. The new member must become thoroughly acquainted with all pertinent records before the formal hearing is convened.

c. Hearing room. Locally available space will dictate the arrangement of the hearing room. The minimum requirement gives room for three board members, the recorder, the Soldier whose case is to be heard, counsel for the Soldier, and the reporter. Proper decorum consistent with the purpose of the hearing is important; however, every effort should be made to maintain a relaxed and courteous environment. Avoid any implication of adversary proceedings in the case.

d. Scheduling hearing. The president of the PEB will establish the date, time, and place of the hearing subject to the following:

(1) The Soldier (next-of-kin or legal guardian) will be allowed a minimum of 3 working days to prepare for the hearing.

(2) The Soldier may waive the 3-day period or any portion of it.

(3) If more time is required to prepare the case, the Soldier will forward a written request for an extension to the president of the PEB. The president, in turn, will endorse the request to the Soldier indicating approval or disapproval and forward a copy of the response to the Soldier's counsel. In deciding whether to approve the request, the president must consider whether the Soldier would be unable to receive a full and fair consideration of his case if a delay were not granted. The date and time of any rescheduled hearing will be specified in the endorsement. If, in the judgment of the PEB president, the Soldier or counsel are attempting to delay the hearing without valid reasons, the formal hearing will be held with or without the presence of the Soldier and selected counsel.

(4) Ample travel time will be allowed if the Soldier will be represented by his or her next-of-kin or legal guardian in those cases where the member is mentally incompetent or the physician determines that divulging information to the Soldier would be harmful to his or her well being. Funded travel is authorized under the provisions of C6000 of the Joint Federal Travel Regulation (JTFR). The MTF will issue invitational travel orders authorizing travel for one person.

(5) The PEB will—

(a) Notify the Soldier (next-of-kin or legal guardian) of the scheduled hearing. Figures 4-4 and 4-5 show notification to the Soldier based on Soldier's selection of counsel. Figure 4-6 shows notification to the next-of-kin. DA Form 5890-R (Acknowledgment of Notification of Formal Physical Evaluation Board Hearing) will be enclosed with the letter of notification to the Soldier or next-of-kin. DA Form 5890-R will be locally reproduced on 8 1/2- and 11-inch paper. A copy of the form for reproduction purposes is located at the back of this regulation.

(b) Notify the board members, witnesses, counsel, reporter, and interpreter (if needed) of the date, time, and place of the hearing.

(c) Arrange for the attendance of all available military witnesses or, under appropriate circumstances, obtain depositions and other evidence.

(d) Ensure that the Soldier's records are furnished to medical witnesses for review before hearing.

(e) Present all available evidence and witnesses to the board.

e. Soldier's rights.

(1) Certain rights accrue to a Soldier whose case is under evaluation by a PEB. A counsel must be aware of these rights. When communicating with the Soldier (next-of-kin or legal guardian), counsel must ensure the Soldier knows and understands the rights that apply to the circumstances of the Soldier's case. Although certain rights apply in all cases, some are particularly applicable during formal hearings, especially when the Soldier is present at the hearing.

These rights are described below:

(a) The Privacy Act of 1974 applies to information of a personal nature requested of the Soldier during a formal hearing.

(b) The Soldier may testify as a witness under oath in his or her own behalf, in which case the Soldier may be cross-examined as any other witness.

(c) The Soldier or the Soldier's counsel may introduce witnesses, depositions, documents, or other evidence in his or her own behalf, and cross-examine witnesses who have been examined by the PEB including witnesses who have specific knowledge of the Soldier's case and whose conversations have been summarized for the record.

(d) The Soldier or Soldier's counsel may make unsworn statements, orally, or in writing, or both, without being subject to cross-examination.

(e) The Soldier may remain silent. The choice not to make a statement or answer questions is not to be considered adverse to the Soldier's interests.

(2) Appointed counsel will use DA Form 5891-R (Acknowledgment of Counseling on Legal/Procedural Rights) to counsel the Soldier on his or her procedural rights and to provide a record of such counseling. DA Form 5891-R informs the Soldier of the rights described above, and requests acknowledgment by Soldier's signature. A copy will be included in the record of formal proceedings and provided to the Soldier. DA Form 5891-R will be locally reproduced on 8 1/2- and 11-inch paper. A copy of the form for reproduction purposes is located at the back of this regulation.

f. Failure to appear. If a Soldier who has elected to appear at a formal hearing fails to do so, the president of the PEB will take the following actions:

(1) Suspend the hearing and determine the reason for the Soldier's absence. Subject to the provisions of (2) below, if no reasonable excuse is apparent for the Soldier's absence, the hearing may proceed. The president will include in the record a statement of circumstances. Should the Soldier later appear before the hearing has been concluded, the president may recess the hearing. He may permit the counsel to brief the Soldier on proceedings up to that point. The hearing will then proceed.

(2) A formal hearing may not proceed if the Soldier's individually selected counsel (if the Soldier has one and who has been determined to be available to represent the Soldier) is absent, unless the appointed counsel is present in open session.

g. Waiver of appearance. A Soldier may waive, in writing, his or her appearance at a formal hearing. In such a case, the appointed counsel (or individually selected counsel if the Soldier has one) must be present. The counsel will represent the Soldier during all open sessions of the hearing, and perform the duties required of counsel during post-hearing actions.

h. Counsel. For formal hearings at which the Soldier will be present, each Soldier will be represented by counsel unless representation is specifically declined in writing.

(1) *Representation.* The appointed PEB counsel, other military counsel if reasonably available and released by the counsel's command for this purpose, or civilian counsel of the Soldier's choice will represent the Soldier. A Soldier may arrange for civilian counsel of the Soldier's own choice at no expense to the Government. The Soldier may present his or her case without counsel, in which case the Soldier must conform to all procedural rules. The Soldier must sign a statement specifically excusing appointed PEB counsel. The statement will be made a part of the record. The PEB president will require appointed counsel to remain in the hearing room even if counsel is released by the Soldier in writing, except when counsel of choice is present. Appointed counsel will act as co-counsel when the Soldier chooses another counsel unless excused by the Soldier.

(2) *Duties.* The counsel safeguards the legal rights of the Soldier. He or she remains in attendance at all open sessions of the board unless excused, in writing, by the Soldier. Counsel's duties are to—

(a) Confer with the Soldier and advise the Soldier of his or her rights.

(b) Prepare the Soldier's case for presentation to the board.

(c) Request the PEB arrange for the attendance of available witnesses or obtain their depositions or other specifically desired evidence in support of the Soldier's position.

(d) Examine and cross-examine witnesses and otherwise assist the Soldier in presenting their case.

(e) Submit oral or written arguments.

(f) Counsel the Soldier on the board's findings.

(g) Upon request, assist in the preparation of the rebuttal.

(3) *Mentally incompetent and deleterious-type cases.* The appointed legal counsel will serve as counsel when the next-of-kin (or legal guardian) acts for the Soldier in a case of this type unless replaced by special counsel. Funded travel is authorized as described in paragraph d(4), above. In the absence of the next-of-kin, the PEB counsel must be present, even though special counsel is representing the Soldier, unless excused by the next-of-kin or special counsel in writing.

i. Records review by Soldier. All records assembled for use during the hearing, including those furnished by HQDA and by other official sources, will be made available to the Soldier and his or her counsel for review. The assembled records will include memoranda of conversations with individuals who have specific knowledge of the Soldier's case, including, but not limited to, the Soldier's chain of command or treating physician. In cases involving mental incompetence or deleterious-type cases, only the counsel and, if present, the next-of-kin or legal guardian may examine the records. The Soldier (next-of-kin or legal guardian) and counsel may make notes from the records to prepare the Soldier's case properly. However, the PEB president may withhold from civilian counsel, next-of-kin, or legal guardian, any security information.

j. Challenges.

(1) The recorder will announce the names and grades of the members of the board present. Any member of the board or counsel who is aware of any facts that the member believes to be grounds for challenge against himself or any other member, including the president of the board, will state such facts. If it appears a member is

subject to challenge for cause, and the fact is not disputed, the member will be excused and replaced. The recorder is not subject to challenge.

(2) The statutory right to a full and fair hearing includes the right to challenge for cause. Grounds for challenge may be made by a statement of any fact indicating any member should not sit as a member of the board in the interest of having the hearing and later proceedings free from substantial doubt as to legality, fairness, and impartiality. Not more than one member will be challenged at one time. Later challenges may be made against other members of the board after a ruling is made on a previous challenge.

(3) A challenge may be withdrawn at any time. If a challenge is not withdrawn, the board will give the Soldier the opportunity to introduce evidence, examine the challenged member under oath, and make an argument as to why the challenge should be granted. The PEB will decide if the challenge should be granted by majority vote of the remaining members following discussion in closed deliberation. If the challenged member is the president of the board, the next senior nonmedical board member will preside in the case. A tie vote will sustain the challenge. Upon reopening the board, the president of the board will announce whether the challenge has been sustained. This announcement will be reflected in the record. If the challenge is sustained, the proceedings will be suspended until a replacement for the challenged member is provided.

k. Verifying Soldier's rights. When the hearing begins, the PEB president will assure himself or herself that the Soldier has been informed of his or her rights. If it appears the Soldier has not been so informed, the PEB president will recess the hearing and allow the counsel time to advise the Soldier.

l. Proof of facts.

(1) *General.* Facts and circumstances relevant to the matter under investigation are most often proved or disproved, either directly or through inferences, by real (tangible) evidence, documentary evidence, testimony or statements of witnesses, and matters of which official notice may be taken without proof.

(2) *Real evidence.* A tangible object (for example, brace, crutch) which is material and relevant to the subject of the inquiry is real evidence. Whenever an item of real evidence would aid in establishing the existence or nonexistence of a fact, that item, or a photograph, description, or other suitable reproduction of it, should be included in the report of proceedings, together with any statement of witnesses necessary to identify the item and verify the accuracy of the reproduction. Board members should not overlook their own observations respecting real evidence. If a board member observes an item and gains impressions not adequately portrayed by a photograph, chart, or other representation, he or she should ensure that an appropriate description of the item is made and included in the report.

(3) *Documentary evidence.* Documentary evidence consists of records, reports, letters, and other written, printed, or graphic materials which indicate the existence or nonexistence of a fact. Boards should be alert to discover all such evidence relevant to the matter under inquiry and to include the originals or copies in the record.

(4) *Testimony or statements of witnesses.* Oral or written accounts of matters within the personal knowledge of individuals usually constitute an indispensable part of the evidence considered by a board. Because, unlike real or documentary evidence, such

evidence is not fixed as to form or substance, obtaining a witness' testimony or statement requires careful advance analysis of relevant matters of which the witness is expected to have knowledge and preparation of questions to elicit that knowledge without distorting its substance. A preliminary interview of the witness to clarify what information can be elicited is often appropriate, especially by the Soldier's counsel and the recorder. Voting members, however, may not conduct separate interviews of witnesses.

(5) *Official notice.* Some facts are of such common knowledge that there is no need to obtain specific evidence to prove them (for example, general facts and laws of nature; general facts of history; location of major elements of the Army; organization of the Department of Defense and its components).

m. Rules of evidence.

(1) *General.* Proceedings of the PEB are administrative and not judicial in nature; therefore, a board is not bound by the rules of evidence prescribed for trials by court-martial or for court proceedings generally. Accordingly, except as limited in (3,) below, anything which in the opinions of reasonable persons is relevant and material to an issue, may be accepted as evidence. All evidence will be given such weight as is warranted under the circumstances.

(2) *Best evidence.* A board is not precluded from considering any evidence merely because there may be better evidence available to prove the same fact. Generally, however, an effort should be made to obtain the best evidence reasonably available, considering factors such as time, importance, and expense as well as the availability and reliability of substitute evidence. Although hearsay evidence may always be accepted, the personal statement or recent deposition of a witness is usually better evidence than an earlier written statement by that witness or having someone else state what the witness said.

(3) *Limitations.* Administrative proceedings governed by this regulation generally are not subject to exclusionary rules precluding the use of relevant evidence. However, the following does apply with regard to evidence which may be accepted and considered in a board.

(a) *Privileged communications.* The rules concerning privileged communications between client-attorney, and penitent-clergyman, apply to PEBs.

(b) *"Off the record" statements.* Findings and recommendations of the board must be supported by evidence contained in the record. Accordingly, witnesses should not be allowed to make statements "off the record" to board members in formal proceedings.

(c) *Statements regarding disease or injury.* Title 10, United States Code, Section (10 USC 1219) provides that a Soldier may not be required to sign a statement relating to the origin, incurrence, or aggravation of a disease or injury that the Soldier has suffered. Before any signed, written statement against the Soldiers interest may be considered, it must be determined that such a statement was made voluntarily. Any statement signed after the Soldier has been advised of the right not to make a statement is presumed to be voluntary and is valid for consideration. (This restriction does not include oral testimony.)

(d) *Self-incrimination.* Military witnesses will not be compelled to incriminate themselves, or to answer any question to which the answer might tend to incriminate them, or to make a statement or produce evidence if the statement or evidence is not

material to the issue and might tend to degrade them (Article 31, Uniform Code of Military Justice (UCMJ, Art. 31)). Any witness not subject to the UCMJ, will not be required to make a statement or produce evidence which would deprive them of their rights under the Fifth Amendment of the United States Constitution.

n. Administering oaths. Voting members of a PEB, the recorder, counsel, and others who regularly take part in PEB evaluations and have no vested interest in the outcome of cases considered need not be sworn before performing their duties. Officers are required in their oath of office to “carefully and diligently discharge the duties of the office to which appointed.” Civilian employees are sworn to perform their duties faithfully. A high standard of performance is to be expected, therefore, of individuals assigned to these duties.

(1) A Soldier appearing in his or her own behalf is not sworn unless the Soldier elects to testify under oath. If the Soldier chooses to be sworn, the oath or affirmation prescribed in (2), below, will be used.

(2) Witnesses will sometimes have a vested interest in a case, often adverse to the Soldier’s or the Army’s interest. Because this partiality is not evident initially, any person who is to testify will first be sworn. In deleterious-type cases or those involving mental incompetence, the next-of-kin or guardian will be sworn. If the witness desires to affirm rather than swear, the words “so help you God” will be omitted. The recorder will administer the following oath:

“Do you swear (or affirm) that the evidence you shall give in the case now in hearing shall be truth, the whole truth, and nothing but the truth? (So help you God)?”

o. Attendance of witnesses. The board will summon available witnesses needed for the hearing. Either the Soldier or the PEB may request attendance of a witness. Whether a witness is available depends on the conditions described below.

(1) Members and employees of the armed services located at the same installation as the PEB are usually available. If available, the commander or supervisor will ensure that they appear.

(2) Members and employees of the armed services located at other installations may be available. The PEB president will decide whether the presence of such witnesses is required for a full and fair hearing. If the PEB president decides the testimony of such a witness is needed and that alternative forms of evidence cannot be substituted for the personal presence of the witness, the commander or supervisor must ensure the witness is present.

(3) The Soldier is responsible for arranging for the attendance of witnesses who are not members or employees of the armed forces. Such witnesses attend hearings at no expense to the Government. Additionally, the Soldier is entitled to present the testimony of any other Soldier or employee of the Army, or other armed services, whom the Soldier obtains at no expense to the Government, and whom is given leave to attend.

(4) Witnesses summoned by the PEB who are members or employees of the armed services are entitled to travel expenses and per diem allowances authorized by Joint Federal Travel Regulations. The commander of the command to which the witness belongs is responsible for these costs. If command funds are not available, and the PEB president still considers personal testimony by the witness essential, funds available to the PEB may be used to pay the costs.

(5) The PEB president may decide that the witness need not appear in person to testify. If so, he or she may authorize the Soldier's military counsel to take the deposition at the witness' location. The counsel may take the deposition either personally or by arranging with the Soldier's representative to do so. If the counsel is to take the deposition in person and TDY is involved, the counsel will provide the PEB president a summary of the information he or she expects to discover and how it relates to the case. If the PEB president approves the TDY, the PEB will pay costs from travel funds available to the PEB. The deponent may be at a distance so that the military counsel is unable to take the deposition in person. If so, the Soldier's counsel may request assistance from the staff Judge Advocate nearest the deponent's location. Should expenditure of per diem or travel funds be involved, the counsel will make his or her request through the PEB president who is considering the case. A summary of the information to be discovered will be included. If no expenditure of public funds is involved, the receiving PEB president will approve the request and refer it for action to the appropriate Staff Judge Advocate. If the requested action involves payment of TDY costs, expenses will be paid from funds available to the PEB president requesting the deposition. A counsel may believe that a deposition is required and it cannot be obtained as described above. If so, the counsel may make a request to the officer exercising GCMCA over the installation at which the PEB is located. If the GCMCA approves taking the deposition, he or she will refer the request to the GCMCA in the area in which the deponent is located for action. The deponent will return the deposition through the referring GCMCA. Depositions may be taken on oral or written questions. Depositions will be prepared as provided in rule 703, Military Rules of Evidence, Manual for Courts-Martial (MCM), United States, 2005.

p. Procedural objections. The Soldier (the Soldier's next-of-kin, legal guardian, or counsel) may object to any actions taken or proposed to be taken by the board or to the admission of evidence. When an objection is made, it will be recorded as part of the record. The president of the board will rule on objections. If any board member dissents from the president's ruling, however, the board will be closed for deliberation and the objection will be ruled upon by majority vote. Upon reopening of the board, the ruling of the board will be announced in open session and recorded as part of the record.

q. Closed deliberations. Upon completing an open hearing, the board is closed for deliberation. The voting members decide the findings and recommendations according to policies stated in chapter 3 and criteria in this chapter.

r. Findings and recommendations.

(1) The board, upon completion of deliberations, will reopen and inform the Soldier of the findings and recommendations. (In cases of mental incompetence or in deleterious-type cases, the board will inform the Soldier's counsel, next-of-kin, or legal guardian.) If the Soldier (Soldier's next-of-kin or legal guardian) is not present at the hearing, notice of the findings and recommendations will be provided to them in writing. (See figs 4-7 and 4-8 respectively show a sample notification to the Soldier and the next-of-kin.)

(2) The PEB may change, modify, or correct its findings and recommendations at any time before the record of proceedings is delivered to the CG, USAPDA or Commander, USA HRC. When such changes are made in previously announced findings or recommendations, the PEB will inform the Soldier (Soldier's next-of-kin,

counsel, or legal guardian) in writing, of the proposed change. The PEB will afford the Soldier the opportunity to accept or rebut the proposed change.

(3) When the Soldier personally appears before the board, the DA Form 199 will be prepared immediately following the conclusion of the hearing and a copy provided to the Soldier. The Soldier will be afforded the opportunity to make an election at this time but may choose to take the full time-period permitted for reaching a decision. When the Soldier does not appear at the hearing, the DA Form 199 and election form will be transmitted to the commander of the applicable MTF within 24 hours of the adjournment of the hearing. The actual date of delivery to the Soldier will be documented in the case file.

s. Soldier's response. DA Form 199–1 (Election to Formal Physical Evaluation Board Proceedings) will be provided to the Soldier as the election statement to formal proceedings. This form is distributed from the Army Publication Center solely to PEBs.

(1) The DA Form 199–1 and the letter of rebuttal must be received at the PEB within 10 days from the Soldier's receipt of the formal findings unless the President of the PEB approves a request for an extension of time. A request for an extension must be received within 10 days of the Soldier's receipt of the DA Form 199. If the request for extension is denied, the original time frame remains applicable. A copy of the PEB's decision on the request for extension will be sent to the Soldier's counsel.

(2) If the Soldier's statement of election or a request for an extension of time is not received within the required time, the PEB will deem that the Soldier has waived the right to an election. The proceedings will be forwarded to USA HRC for final disposition. The forwarding memorandum will document the circumstances resulting in the waiver of election (see fig 4–2). The PEB will forward a copy of the memorandum to the Soldier through the PEBLO.

(3) A Soldier who fails to make an election or to submit a statement of rebuttal to formal proceedings within the allotted time if he or she is in disagreement with the findings and recommendations, will forfeit the opportunity for USAPDA review of his or her case (see para 4–21*t*, below).

t. Rebuttals. Letters of rebuttal to the findings and recommendation of formal proceedings (to include the recommended disability percentage) must be prepared and processed according to the following guidance.

(1) A rebuttal may only be based upon one or more of the issues listed below and must provide rationale in support of the issue.

(a) The decision of the PEB was based upon fraud, collusion, or mistake of law.

(b) The Soldier did not receive a full and fair hearing.

(c) Substantial new evidence exists and is submitted which, by due diligence, could not have been presented before disposition of the case by the PEB.

(2) If a letter of rebuttal is received within the required time frame, the PEB will respond to the Soldier, or his representative, normally within 3 days confirming that the rebuttal has been received and considered. If consideration of the rebuttal does not affect the outcome of any portion of the PEB decision, the response will include the reasons why the rebuttal does not support a change to the findings and recommendations. The Soldier will be informed that the rebuttal will be forwarded with the case file to USAPDA for review (based on the Soldier's election of nonconcurrency with submission of a rebuttal). The response by the PEB president will be included in

the case file and a copy will be furnished to the Soldier's legal counsel or other representative.

(3) If a Soldier submits a letter of rebuttal after having initially made an election of concurrence and the rebuttal is submitted within the required time frame, the procedures of paragraph 4-21f(2), above, apply. If the case has been forwarded to USA HRC for final disposition based upon the Soldier's initial concurrence, the PEB will recall the case. If the letter of rebuttal is received after the required time frame, the procedures of paragraph 4-2f(4), below, apply.

(4) If a letter of rebuttal is received by the PEB after the Soldier's case has been forwarded to USA HRC for final disposition (based upon the Soldier's failure to make an election within the required time frame or nonconcurrence without submission of a rebuttal) the PEB will consider the rebuttal as set forth below.

(a) If consideration of the rebuttal does not result in a change to the findings and recommendations, the PEB will advise the Soldier, in writing, that no change is warranted and the rebuttal, together with the reply, has been forwarded to USA HRC for inclusion in the case proceedings. A copy of the reply will be forwarded to the Soldier's legal counsel or other representative. Review of proceedings by USAPDA is not required.

(b) When the consideration of the rebuttal results in a change to the PEB's findings and recommendations, the PEB will recall the case and effect the necessary changes by preparing a new DA Form 199. The new DA Form 199 will be furnished to the Soldier according to normal processing procedures.

(5) Notwithstanding the above, when additional medical evidence or an addendum to the MEBD is received after the PEB has forwarded the case to USAPDA or USA HRC and the PEB determines that such evidence would change any finding or recommendation, the case will be recalled by the PEB and a new DA Form 199 issued. Normal procedures apply following the preparation of a new DA Form 199.

u. Mental incompetency. Formal proceedings of cases involving mental incompetency or nonappearance because of the MTF commander's decision that it would be detrimental for the Soldier's well being to appear, will be processed as follows:

(1) The DA Form 199 and DA Form 199-1 with all exhibits will be forwarded by certified mail, return receipt requested, to the Soldier's guardian or next-of-kin (see fig 4-8). A copy of the forwarding letter will be provided to the Soldier's legal counsel or representative.

(2) The transmittal letter will advise the individual of the following:

(a) The individual has the right to make an election (DA Form 199-1) and to submit a letter of rebuttal to any finding or recommendation.

(b) The election (DA Form 199-1) and rebuttal must be received at the PEB within 10 days of receipt of the DA Form 199 unless, within the 10-day period, the president of the PEB has approved a request for extension.

(c) A rebuttal submitted within the allotted time must be considered and the individual notified of the PEB's determination.

(d) Upon failure of the individual to submit an election within 10 days, the appointed military counsel will take proper action in behalf of the Soldier.

(3) The PEB will not forward the case for disposition until the DA Form 199–1 has been received or counsel has acted in behalf of the Soldier. Counsel’s action will be documented by memorandum, a copy of which will be included in the case proceedings (see fig 4–3).”

“6–8. Special counseling

a. Application. Before the Soldier completes an application for COAD or COAR, the PEBLO will counsel the Soldier according to appendix C. The PEBLO will specifically inform the Soldier of the following:

(1) Before a COAD or COAR application is forwarded to the approval authority, the PEB will process the case to completion, to include the following:

(a) Convening a formal hearing, if requested.

(b) Determining a percentage rating.

(c) Recommending a disposition that will apply if application for continuation is disapproved.

(2) Of the eligibility criteria for requesting continuation.

(3) That if continuation is approved, the Soldier must be referred to the PDES before expiration of the continuation period unless Soldier waives in writing the final referral.

(4) That the final PDES evaluation could result in a fit finding under the guidance at paragraph 6-6 above.

(5) That if the request for continuation is disapproved, the approval authority will notify the MTF and HQUSAPDA. The HQUSAPDA will notify the applicable Transition Center that the Soldier is to be separated or retired for disability, as applicable. If the case is that of a Ready Reserve not on active duty, HQUSAPDA will prepare the orders.

b. Soldiers with 18 active or qualifying years of service. When the PEBLO has a case of an active Army Soldier with 18 years but less than 20 years of active service, or an RC soldier with 18 but less than 20 years of qualifying service, a declination to request a COAD or COAR, as applicable, should be in writing and attached to the MEB proceeding. If the Soldier refuses to indicate in writing his declination of COAD or COAR, the PEBLO will prepare and sign a statement that he or she counseled the Soldier on continuation, and the Soldier declined to request continuation.”

“7–5. Counseling

“The PEBLO is responsible for counseling the Soldier until the informal PEB is completed. The Soldier may demand a formal hearing. If so, the regularly appointed PEB counsel is responsible for the counseling unless the Soldier elects a different counsel. Counseling will be according to appendix C. Soldiers on the TDRL are more difficult to counsel because they are not as readily available to the counselor as are Soldiers on active duty. Nevertheless, they must be counseled to the same extent required for active duty Soldiers.”

“7–20. Physical evaluation board processing

a. Deficiencies in report of examination. The PEB will resolve deficiencies in a report of periodic examination to the extent possible with MTF commander. A case file will not be returned to USA HRC because of deficiencies or need for further information except through USAPDA.

b. Changes in a Soldier's condition while on the temporary disability retired list. The combined percentage rating approved at the time the Soldier was placed on the TDRL cannot be changed by the PEB throughout the period the Soldier is on the TDRL. Adjustment will be made at the time of removal from the TDRL to reflect the degree of severity of those conditions rated at the time of placement on the TDRL and any ratable conditions identified since placement on the TDRL. An EPTS factor may be added, modified, or eliminated at this time if additional evidence is obtained that was not previously available or apparent during the initial evaluation; or placement on the TDRL was due to fraud, mistake of law, or mathematical miscalculation.

c. Retention on the temporary disability retired list. A Soldier may be retained on the TDRL if disabilities causing placement on the TDRL have not become stable, and either of the following occurs:

(1) The combined rating at the time of re-evaluation is at least 30 percent.

(2) The Soldier has at least 20 years of service if the combined rating is less than 30 percent.

d. Entries on DA Form 199. Entries on DA Form 199 will reflect the Soldier's condition at the time of the most recent periodic examination. When the Soldier is recommended for retention, the DA Form 199 will record any new conditions but will not list a disability rating. When a Soldier is recommended for permanent retirement, entries must be made for all conditions present whether or not previously recorded. The DA Form 199 will include the reason for variation between the original action (findings, recommendations, or ratings) causing the Soldier's placement on the TDRL and current action removing him or her from the list. Explanations need not be lengthy, but must be understandable. Procedures for administrative relief pertaining to a correction or adjustment of the percentage of physical disability while a Soldier is on the TDRL are contained in paragraphs 4-25 and 4-26.

e. Notice to Soldier.

(1) If the PEB recommends removal from the TDRL, the PEB will forward to the Soldier DA Form 199 and letter of explanation by certified mail, restricted delivery, return receipt requested. The letter will inform the Soldier of his or her rights and responsibilities. It will provide the name, location, and telephone number of the PEBLO (see fig 7-1). The Soldier will sign the original copy of the DA Form 199 and return it after giving his or her choice of options in block 13. The copy of the DA Form 199 is the Soldier's copy.

(a) If the certified mail receipt is not returned, or if the correspondence is returned undelivered, the PEB will try to verify the Soldier's address by contacting USA HRC, the MTF, the U.S. Army Finance and Accounting Center (USAFAC), or the VA regional office. If a new address is obtained, the PEB will try to deliver the notice. If not, a memorandum waiving the Soldiers right of election will be prepared (see fig 7-2).

(b) If the receipt is returned but no election is received, the PEB president will prepare a memorandum waiving the Soldier's right of election for failure to respond (see fig 7-3). The certified mail receipt will be included in the case file as proof that the Soldier was notified.

(c) The PEB president will forward the case file to USA HRC (AHRC-PDB) for final disposition.

(2) If the PEB recommends retention on the TDRL, the PEB will forward the DA Form 199 and a letter advising that there will be no change in the Soldier's status or retired pay as long as the Soldier remains on the TDRL. Notification will be by ordinary mail (see fig 7-4). The DA Form 199 will include a statement that failing to notify USA HRC of the current mailing address will result in the suspension of disability retired pay if the Army is prevented from properly notifying the retiree of a scheduled examination.

(3) The PEBLO of the MTF responsible for the periodic medical examination is responsible for counseling the Soldier. Therefore, the PEB will provide the PEBLO a copy of the letter and DA Form 199 (with enclosures)."

“Appendix C Counseling Section I Introduction

C-1. Purpose

This appendix outlines the responsibilities and duties of the PEBLO and the appointed Legal Counsel who represents Soldiers before the formal PEB. It provides a guide for counseling Soldiers who are being processed within the Physical Disability Evaluation System.

C-2. Scope

a. The PEBLO will counsel each Soldier (or the next-of-kin or legal guardian, when appropriate) throughout physical disability processing. Counseling will be based upon the individual circumstances of each case and will be designed to serve the Soldier's best interest. Answers to questions about MEBD and PEB procedures will be provided in detail. The PEBLO must reassure the Soldier that counseling will continue, as needed, as the case progresses within the disability system. Soldiers should be encouraged to ask questions during case processing. All Soldiers should be advised of benefits and training provided by the Department of Veterans Affairs, Department of Labor, and Social Security Administration.

b. Federal law (10 USC 1214) provides that no Soldier of the Armed Forces may be retired or separated without a full and fair hearing if demanded. If the Soldier requests a formal hearing, an Army attorney will be appointed as counsel to represent the Soldier at the formal hearing. The attorney is responsible for counseling the Soldier on all matters relating to the formal hearing.

C-3. Stages of counselling

a. The PEBLO will provide counseling at the following stages of case processing.

(1) Upon referral of the Soldier's case to a MEBD.

(2) When approved findings and recommendations of the MEBD are received by the Soldier or next-of-kin.

(3) When the findings and recommendations of the PEB informal hearing are received by the Soldier or next-of-kin.

(4) When the Soldier demands a formal PEB hearing.

(5) After the PEB president announces the findings and recommendation of the formal hearing.

(6) When the USAPDA informs the Soldier or next-of-kin of a proposed modification to the findings and recommendations of the PEB.

(7) When the results of an appeal to the APDAB are received by the Soldier or next-of-kin.

b. Major duties of the appointed legal counsel are outlined in paragraph 4–21*h*. Counsel will ensure that each Soldier who elects a formal hearing has been properly counseled. Counsel will contact the Soldier within 3 days of being detailed by the PEB. The Soldier will be advised of the following rights:

(1) Rights under the Privacy Act of 1974 and its application to the formal hearing.

(2) To testify or to remain silent. Remaining silent is not considered adversely by the board.

(3) To introduce witnesses, depositions, documents, or other relevant evidence in the Soldier's behalf.

(4) To question all witnesses including those called by the PEB.

(5) To make unsworn statements, orally, in writing, or both, without being subject to questioning by the board.

(6) To decline to make any statement touching on the origin or aggravation of any disease or injury.

(7) That no Soldier may be separated or retired for physical disability without a full and fair hearing, and that counsel is present to safeguard the legal rights of the Soldier.

C–4. Overview of PEBLO counseling

a. In order to fully execute required responsibilities, PEBLOs must have a thorough knowledge of the policies, regulations, and directives applicable to the Physical Disability Evaluation System. Section II contains further guidance for counseling purposes.

b. Although specific details will vary with each case, PEBLOS will include the following topic areas when explaining PEB findings and recommendations and applicable benefits.

(1) Rights of the Soldier—MEBD and PEB (see paras C–6 and C–7)

(2) Findings and recommendations—MEBD and PEB (see paras C–6 and C–7)

(3) Case review (see paras C–8 and C–9)

(4) Pay and related benefits (see para C–12)

(5) Grade determination (see para C–12)

(6) VA benefits (see para C–13)

(7) Social Security benefits (see para C–14)

(8) TDRL regulatory requirements (see para C–10)

(9) Rights of retired Soldiers (see para C–11)

(10) Benefits under the Department of Labor DVOP (see para C–15)

c. At all stages of counseling, PEBLOs will advise Soldiers of the necessity of obtaining sufficient documentation (medical and non-medical) concerning the Soldier's ability to perform military duties and the severity of the Soldier's disease or injury. If additional documentation to support the Soldier's case is required, the PEBLO will assist in identifying the type of information needed and will assist in obtaining the required information. In unique or complex cases the PEBLO is authorized direct contact with the PEB appointed legal counsel to determine what type of additional information will be most useful to the Soldier. The PEBLO will ensure that all additional information received is promptly included in the Soldier's case file as supporting evidence.

d. PEBLOs will maintain close coordination with the PEB during the processing of all cases and will advise the PEB of all matters which have an impact upon the prompt and efficient processing of disability cases.

e. Counseling and assistance will be provided by the PEBLO to Soldiers on the TDRL who are undergoing periodic examination or related evaluations.

f. If found unfit, each Soldier will be counseled by the PEBLO about the approximate date of release from active duty (see app E). This will be accomplished at the initial counseling session following the MEBD or PEB processing in order to facilitate an orderly transition from the service.

g. The PEBLO will coordinate with the installation RSO and the Transition Point in arranging for briefings on benefits and programs for which the Soldier may be eligible. If possible, the PEBLO should arrange for interviews with VA, Social Security, and DVOP representatives. Appointments should be scheduled as far ahead of estimated separation date as is possible to allow the Soldier adequate time to assimilate the information.

h. PEBLO's must ensure that the case file of a Soldier being placed on TDRL contains a current mailing address for Soldier's location upon departure from unit.

Section II Counseling Guides

C-5. Publications for physical disability processing

Listed below are publications that relate to the processing and entitlements of Soldiers undergoing physical disability processing. PEBLO'S should obtain these publications in order to counsel Soldiers thoroughly.

a. AR 37-104 (Finance series).

b. AR 40-400.

c. AR 40-501.

d. AR 600-8-4.

e. AR 600-20.

f. AR 600-50.

g. AR 608-9.

h. AR 608-25.

i. AR 635-40.

j. DA Pam 360-539.

k. DA Pam 600-5.

l. Veterans Administration Schedule for Rating Disabilities (VASRD).

C-6. Medical Evaluation Board (MEBD)

a. The MEBD may find that a Soldier does not meet Army medical retention standards and refer the Soldier to a PEB for disability processing. MEBD findings and recommendations are not binding on the PEB. At this stage Soldiers often have questions requiring PEBLO assistance. PEBLOS should inform the Soldier that additional documentation regarding the Soldier's ability to perform military duties may be necessary. Assistance should be provided by the PEBLO to obtain this information. Such documentation may include letters, performance evaluations, efficiency reports, or additional medical information. Copies of efficiency reports may be obtained upon request from the following locations:

(1) *Officers*. Records Branch, HQDA (DAPC-POS), 200 Stoval Street, Alexandria, VA 22331-0476.

(2) *Enlisted*. U.S. Army Enlisted Records Center, Fort Benjamin Harrison, IN 46249–5301.

(3) *USAR personnel*. Commander, ARPERCEN, ATTN: DARP–PRP–P, 9700 Page Boulevard, St. Louis, Missouri 63132–5200.

b. If not already part of the MEBD proceedings, PEBLO's should request a statement from Soldier's commander describing current duty performance. This statement should address the following:

- (1) The Soldier's most recent performance of duty.
- (2) Any special limitation of duty due to the Soldier's physical condition.
- (3) The Soldier's ability to adequately perform the duties normally expected of an individual of the Soldier's office, grade, rank, or rating.
- (4) The Soldier's current duty assignment, anticipated future assignments, branch, age, and career specialties.

c. Upon receipt of the MEBD findings and recommendations, PEBLOs will—

- (1) Review and become thoroughly familiar with the DA Form 3947. Check all entries for completeness and accuracy.
- (2) Ensure that the medical terminology is explained to the Soldier in terms that the Soldier can understand.
- (3) Confirm that the Narrative Summary accurately represents the Soldier's condition.
- (4) Promptly contact and arrange to counsel the Soldier on the MEBD findings and recommendations.

d. During the counseling session with the Soldier, PEBLOs will—

- (1) Give the Soldier ample time to read the MEBD report and the narrative summary and ensure that both are understood by the Soldier.
- (2) Ask the Soldier whether all medical conditions and physical defects appear in the report, and whether they have been adequately described. If not, discuss with the Soldier the possibility of submitting an appeal or contacting the physician to obtain an addendum.
- (3) Inform the Soldier of the requirements and procedures for requesting discharge under the provisions of chapter 5 (when applicable), and COAD (chap 6), and the probable effect of each.

(4) Explain to the Soldier the following:

- (a) How more evidence may be presented for consideration by the MEBD.
- (b) The options of the appointing authority who will either approve the findings and recommendations or return the proceedings to the MEBD for reconsideration.
- (c) How the Soldier completes the medical board proceedings in order to indicate a desire to appeal.
- (d) How the Soldier can obtain assistance in writing an appeal, if desired, and how clerical support is provided.
- (e) The meaning and effect of an adverse line of duty decision at any stage of the proceedings.

(f) The effect of being under investigation for an offense which could result in discharge under other than honorable conditions.

(5) Describe for the Soldier the course of physical disability processing through the PEB and USAPDA. Inform the Soldier that once the PEB makes findings and

recommendations at the formal hearing the Soldier should again see the PEBLO for additional counseling. Furnish the Soldier with publications which answer often asked questions and encourage the Soldier to call if any questions arise which have not been answered.

e. PEBLOs or physicians may not inform any Soldier of the following before PEB action:

- (1) That the Soldier has been found physically fit or unfit for duty.
- (2) That the Soldier will be discharged or retired from the service.
- (3) What disability percentage rating the Soldier will receive for his condition.

C-7. Physical Evaluation Board

a. The PEB must make findings and recommendations based upon the MEBD proceedings, evaluations of duty performance, and any other available relevant evidence. The PEB must first decide whether the Soldier is physically fit or unfit for duty. A Soldier ultimately found fit is returned to duty. If the Soldier is found unfit, the PEB will—

(1) Decide whether the disability was incurred while the Soldier was entitled to basic pay and in line of duty when the case is that of a Soldier on orders for more than 30 days of active duty. Decide whether the disability was the proximate result of performing duty and incurred in line of duty when the case is that of a Reservist performing duty for 30 days or less. (See para 3-1 and 4-19g concerning line of duty and 8-2 concerning eligibility of Reservists performing duty for 30 days or less.)

(2) Assign a percentage rating to the disability if the Soldier otherwise qualifies. (See appendix B for the method of computing combined ratings for multiple disabilities, and for an explanation of both the amputation rule and the rule prohibiting pyramiding.)

(3) In reference to the Dual Compensation Act and Civil Service employment, determine whether the disability resulted from an injury or disease received in the line of duty as a direct result of armed conflict, or was caused by an instrumentality of war and incurred in the line of duty during a period of war. (See paras 4-19j and C-12.)

(4) In reference to tax exemption, determine:

(a) Whether the Soldier was a member or obligated to become a member of an armed force or Reserve thereof, or the National Oceanic and Atmospheric Administration (NOAA) or the U.S. Public Health Service on 24 September 1975. (See paras 4-19k and C-12.)

(b) Whether the disability resulted from a combat related injury. (See paras 4-19k and C-12.)

b. The Soldier does not personally appear at or take part in, the PEB informal hearing. The board bases its findings and recommendations solely on the available evidence of record. Upon receipt of the PEB informal findings and recommendations, PEBLOs will—

(1) Review and become thoroughly familiar with the PEB findings and recommendations.

(a) Compare the PEB findings with the Soldier's MEBD, the VASRD, and appendix B. (If the Soldier has been found fit, consult AR 40-501, chap 3 and chaps 2 and 4 of this regulation.) Verify that PEB has not overlooked any condition that may substantially alter the Soldier's benefits.

(b) Various means of rating a disability exist. For example, a joint injury may involve nerve or muscle damage and limitation of motion. Check each to assure the member has been rated the most advantageous way. However, give attention to the amputation rule (see para B-18) and the prohibition of pyramiding (para B-5).

(2) Compute and prepare an estimate of retirement or severance pay, tax benefits, and VA compensation.

(3) Contact the Soldier and make an appointment to counsel the Soldier about the findings and recommendations of the PEB.

c. During the scheduled counseling session with the Soldier PEBLOs will—

(1) Inform the Soldier of the PEB informal findings and recommendations, the benefits which apply, (using the prepared estimates), and the possible courses of action available to the Soldier.

(2) Advise the Soldier that an election to either concur or nonconcur with the results of the PEB informal hearing must be received at the PEB within 10 days from receipt of the DA Form 199, and that if no election is made within the authorized time the Soldier will be considered to have agreed with the informal PEB decision.

(3) Fully explain the Soldier's possible elections. Election choices include—

(a) Concurrence and waiver of the formal hearing.

(b) Nonconcurrence and waiver of the formal hearing with a statement of rebuttal.

(c) Nonconcurrence and a demand for the formal hearing. The Soldier may personally appear or choose not to appear.

(4) Fully explain the guidelines for submission of a statement of rebuttal and the process of review of USAPDA.

(5) Fully explain the Soldiers representational options for the hearing. Possible representatives include the following:

(a) Regularly appointed PEB Legal Counsel (Judge Advocate General's Corps attorney).

(b) Other military counsel if reasonably available.

(c) Civilian counsel of the Soldier's choice at no expense to the Government.

(d) A counselor of an accredited veteran's service organization.

(e) A DA attorney specifically assigned PEB legal counsel duties and made available to represent Soldiers.

(6) If the Soldier chooses to nonconcur, determine whether the nonconcurrence is due to a misunderstanding of benefits. Recheck the MEBD (or contact the physician) to insure that all diagnosed conditions are recorded and properly described. Seek an addendum if necessary. Compare the symptomology related by the Soldier and contained in the MEBD with the requirements of the VASRD, and appendix B. Advise the Soldier of the merits of the nonconcurrence.

(7) If the Soldier still nonconcur, notify the PEB so a formal hearing can be scheduled and arrangements can be made for the Soldier to consult with the PEB Legal Counsel.

(8) Prepare a summary of the Soldier's reasons for nonconcurring and forward the summary with the Soldier's election.

d. When a Soldier demands a formal hearing, PEBLO's will advise the Soldier—

(1) That the Soldier may personally appear at the hearing.

(2) Of all the representational options.

(3) That the Soldier or counsel may question any witnesses called to testify at the hearing.

(4) That the Soldier may request the PEB to summon witnesses who are members or employees of the Army or another Armed Service who are reasonably available, and who are essential to the presentation of the Soldier's case. The PEB president (according to AR 635-40, para 4-21) decides whether the presence of such witnesses is essential. The Soldier is responsible for the attendance of witnesses who are not members or employees of the Armed Forces at no expense to the Government. Additionally, the Soldier is entitled to present the testimony of any Soldier or employee of the Army or other armed service obtained at own expense, and who is given leave to attend.

(5) That any statement required to be signed by the Soldier against the Soldier's interest concerning the origin, incurrence, or aggravation of a disease or injury will be excluded from consideration. Any such statement against the Soldier's interest, signed by the Soldier, before he or she is advised that he or she need not make a statement, or any written statement obtained under circumstances indicating that it was involuntary, is invalid.

(6) That the Soldier may submit a written rebuttal or appeal of the PEB formal findings and recommendations according to guidelines in paragraph 4-21f.

(7) That if the Soldier elects not to concur with the PEB formal findings and recommendations, the case will be reviewed by the agency providing the election and a statement of rebuttal is received within the prescribed time.

e. PEBLO's will also advise Soldiers that—

(1) Pay computations are merely estimates.

(2) PEB findings and recommendations are not final until approved for the SA. If a modification is made by USAPDA, the Soldier should again contact the PEBLO. (Proceedings of general officers and medical corps officers found physically unfit must be approved by ASD(HA)).

(3) Soldiers to be retired should read DA Pam 600-5 and DA Pam 360-539.

(4) Contact should be made with appropriate representatives from the VA, Social Security Administration, DVOP, and RSO. Claims should be filed at the time of separation where applicable.

(5) VA compensation is payable as an alternative to Army payments while social security is payable in addition to Army or VA compensation for qualified veterans.

(6) The Soldier should determine if other disability insurance exists on any outstanding indebtedness which might relieve the Soldier of further payments.

(7) Disabled veterans receive a 10-point job performance in Federal Employment (under some circumstances the preference may be claimed by a spouse). Veterans preference provides a waiver of age and physical requirements and it gives retention preference except to those Soldiers retired with 20 or more years of service.

(8) If a Soldier of the RC, at least one voting member of the PEB will be a Reserve Officer.

f. PEBLOs will explain that the Soldier has a duty to keep his home and work telephone numbers current so that the PEBLO can contact him promptly regarding his case.

g. If a Soldier is recommended for the TDRL, explain the TDRL rights listed in paragraph C-10.

C-8. U.S. Army Physical Disability Agency

a. USAPDA reviews those cases designated in paragraph 4-22. When as a result of review, USAPDA modifies the findings and recommendations of the PEB, certain rights accrue to the Soldier. In order to properly counsel Soldiers, the PEBLO must—

(1) Review and become thoroughly familiar with the USAPDA modification and the rationale for the action.

(2) Compare the modification with the findings and recommendations of the PEB, the Soldier's medical board proceedings, the VASRD, and appendix B.

b. The PEBLO will notify the Soldier of the USAPDA modification by telephone or certified mail. Counseling will cover the following:

(1) The effect of the modification on disposition, compensation, and the benefits applicable to DA Form 199, Block 10.

(2) The election options pertaining to USAPDA modification. These include—

(a) Concurrence.

(b) Demand for a formal hearing (if not already held).

(c) Submission of a rebuttal

(3) The rationale for the modification.

(4) The fact that the PEBLO is available to assist in making an election and pursuing the course of action the Soldier elects.

(5) The fact that the election and rebuttal must be received by USAPDA within 10 days of the Soldier's notification of the modification unless an extension has been granted by USAPDA.

c. If the Soldier elects to demand a formal hearing, the PEBLO will—

(1) Notify the PEB who will detail counsel. PEB counsel will contact Soldier within 3 days of being detailed.

(2) Advise the Soldier that the PEB Recorder will provide notification of the date and time of the hearing.

d. If the Soldier nonconcur and plans to submit a rebuttal, the PEBLO will advise the Soldier that—

(1) The PEBLO is available to assist the Soldier in the preparation of the rebuttal. If the Soldier has been ordered home on a permanent change of station (PCSH), it may be more convenient for the Soldier to work with a PEBLO or PEB Legal Counsel near the PCS location.

(2) The rebuttal must meet the same guidelines as a rebuttal to formal proceedings.

(3) Rebuttals are directed to the Commander, USAPDA, Forest Glen Section — WRAMC, Washington DC, 20307-5001.

e. After counseling the Soldier on the modification, complete the counseling statement on the DA Form 199.

C-9. Army Physical Disability Appeal Board (APDAB)

The APDAB reviews cases when the Soldier has elected to rebut a proposed modification and the CG, USAPDA did not agree with the rebuttal. If the APDAB arrives at findings and recommendations different from those of the PEB or USAPDA, the Soldier has the right to be informed of the revision by the APDAB and to submit a rebuttal. In those cases, the PEBLO will—

a. Advise the Soldier of the meaning and effect of the new findings and recommendations.

b. Assist the Soldier in preparing a rebuttal statement if the Soldier so elects. (Send rebuttals to the APDAB for reconsideration.)

C-10. Temporary Disability Retired List

Soldiers recommended for placement on the TDRL will be advised by PEBLOs that—

a. TDRL status is authorized for a maximum of 5 years, but permanent disposition may be made at an earlier date.

b. Payment while on the TDRL is computed according to section 1401 and 1407, title 10, United States Code (10 USC 1401 and 1407).

(1) For those Soldiers who entered active duty prior to 8 September 1980, the minimum payment is 50 percent of base pay.

(2) For those Soldiers who first entered active duty after 7 September 1980, the minimum payment is 50 percent of the monthly retired pay base (para C-12).

c. No changes will be made in the disability percentage rating while the Soldier is retained on the TDRL even if the disability becomes materially better or worse (see para 7-20b).

d. TDRL retired pay will be suspended when the Soldier fails to report for a periodic examination even though the fifth anniversary of placement on the TDRL has not been reached.

e. A Soldier will not be removed from the TDRL without processing through the PEB unless the fifth anniversary of placement on the TDRL has occurred and the Soldier has failed to obtain the required periodic evaluation.

f. Periodic medical examinations are required at least every 18 months. The Soldier will receive instructions detailing where and when to report. If the Soldier fails to respond, Army retired pay will be stopped. If the Soldier is unable to make the appointment for cogent reasons, the PEBLO must be notified so that a new appointment may be made. Prior to examination PEBLOs will ascertain whether the Soldier has been treated by a VA hospital, other military hospital, civilian hospital or a private physician since the last medical evaluation. If the Soldier was recently seen for a service connected disability, the PEBLO will make every effort to obtain copies of any records of the treatment and evaluation.

g. Each periodic examination report is referred to a PEB for a determination as to whether the Soldier is to be retained on, or removed from, the TDRL.

h. Final disposition may result in permanent retirement with the same, greater, or lesser disability percentage rating; separation with severance pay (if less than 20 years service); or a finding of physical fitness.

i. A finding of fit for duty by the PEB results in one or more of the following actions:

(1) A Soldier of the Regular Army upon the Soldier's consent, will be reappointed, reenlisted, or discharged. A Soldier in the RC may, upon the Soldier's consent, reenter the RC without active duty or be discharged.

(2) If the Soldier elects to return to active duty, time spent on the TDRL counts for pay purposes.

(3) If the Soldier elects to be discharged, the finding of fit does not necessarily effect the Soldier's standing with the VA or the entitlement to VA compensation.

j. The Soldier must notify Commander, USA HRC, ATTN: AHRC-PDB, 2461 Eisenhower Avenue, Alexandria VA 22331-04772 of every change of address. Failure to do so or to report for a scheduled examination will result in the suspension of retired pay beginning with the month following the missed examination.

C-11. Rights of retired Soldiers

Soldiers retired for physical disability have the same rights as those retired for years of service. Possession of DD Form 2 (United States Uniformed Services Identification Card (Retired)) is all that is required for most. Dependents require DD Form 1173 (Uniformed Services Identification and Privilege Card). In summary benefits include—

a. Commissary, Post Exchange, and other installation privileges for retiree, spouse and dependent children. (Dependency is determined under applicable regulations.)

b. Medical care for the retiree, spouse and dependent children, if reasonably available, at any service installation.

c. Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). Refer the Soldier to the MTF CHAMPUS advisor (or the installation Retirement Services Officer). Briefing should include the issue of CHAMPUS supplemental insurance.

d. VA hospital treatment and other VA benefits.

C-12. Compensation and Related Benefits

Computation of disability compensation pay can be complicated by the numerous laws governing it, the various types of creditable service, and other factors. Care should be taken to advise Soldiers that computations provided by the PEBLO are estimates only, and that the U.S. Army Finance and Accounting Center (USAFAC) will make the official computation of compensation. Normally a Soldier's retired pay will be computed using the method of computation most favorable to the Soldier. One method is based on multiplying percentage of disability by the retired pay base and the other is based on multiplying the years of creditable service by the retired pay base. (See para c below.) Estimates of compensation will be provided to the Soldier using DA Form 5892-R (PEBLO Estimated Disability Compensation Worksheet.)

a. *Severance pay.* In computing pay for those with less than 20 years' active service and a disability percentage of less than 30 percent, figure 2 months' basic pay for every year of active duty with a maximum of 12 years service.

Consider 6 months or more as a whole year for computing years of service as a multiplier. A Soldier with less than 6 months' service cannot receive severance pay. The Soldier may apply to the VA for disability compensation. (Years of service for members of the RC is computed in accordance with 10 USC 12732)

b. *Retired pay base.* The DOD Authorization Act of 1981, now codified in section 1407, title 10, United States Code (10 USC 1407) changed the method of computing the retired pay base.

(1) Retired pay for Soldiers who entered active duty on or prior to 7 September 1980 is computed on the highest grade "satisfactorily" held or current grade. DA makes the final grade decision.

(2) For Soldiers who first became members of the Armed Forces after 7 September 1980, retired pay is computed on 1/36 of the total amount of monthly basic pay received for the high-36 months of active duty. When the period of active duty is less than 36 months, the amount equal to the total amount of basic pay received divided by the number of months (including any fraction thereof) equals the retired pay base.

c. Retired pay. A Soldier is eligible for disability retired pay if he has a rating of less than 30 percent and has 20 years of active service for retirement (19 years and 6 months of active service is not 20 years for retirement) or a disability rating of 30 percent or more. The percentage multiplier is either the total disability percent rating or $2\frac{1}{2}$ percent of the total years of service (including any fraction thereof, that is, 7 months equals $\frac{7}{12}$ and disregard any fraction of a month). Use the higher percentage of the two, but not more than 75 percent, as a multiplier of the retired pay base to arrive at the retired pay entitlement. (Years of service for Soldiers of the RC is computed according to 10 USC 12733).

(1) *Example 1.* A Soldier with 23 years and 7 months of service is entitled to $(23\frac{7}{12} \times 2.5)$ 58.9 percent of his retired pay base as retired pay. If he is rated as 90 percent disabled, he is entitled to 75 percent as a multiplier. All of the retired pay may be tax free (see *d*, below).

(2) *Example 2.* A Soldier with 19 years and 6 months of service and 30 percent or more disability is retired because of disability. His retired pay entitlement ($19\frac{6}{12} \times 2.5$ percent) is 48.7 percent of his retired pay base. If his disability rating is less than 48.7 percent, only that portion (retired pay base times the disability rating of his retired pay) may be tax free (see *d* below).

d. Tax exemption. A Soldier separated or retired because of a physical disability may be entitled to certain Federal income tax benefits. The Internal Revenue Service will make the final decision on Federal tax entitlements. (Federal tax entitlements may not be applicable to state income tax exemptions). Federal tax entitlements include—

(1) Severance pay and that portion of military retired pay based upon the disability rating is not taxable under Federal tax laws if—

(a) Payable to a Soldier who, on 24 September 1975, was serving in an armed force of any country or Reserve thereof, the National Oceanic and Atmospheric Administration ((NOAA) formerly the Coast and Geodetic Survey), the U.S. Public Health Service (USPHS), or was under binding written agreement to become such a member.

(b) The disability was incurred as the result of a combat-related injury (para 4–19k).

(2) On application to the VA, the Soldier is entitled to receive VA compensation.

e. Survivor Benefit Plan (SBP).

(1) Retired Soldiers are automatically covered under the SBP unless a specific election is made by both Soldier and spouse either not to participate or to participate at less than maximum level.

(2) Under Title 10, United States Code, Section 1455, the Soldier and the spouse are required to be informed of the election options under SBP and the effects of such elections. The PEBLO will refer the Soldier or next-of-kin when the Soldier is mentally incompetent, to the installation RSO for SBP counseling and the completion of the required documents. In order to accomplish the administrative requirements to comply with the law, referral to the RSO must be made concurrent with the PEBLO's notification to the Soldier of the PEB's finding.

f. Dual compensation. Retired Soldiers may fall within the limitations of two "dual compensation" laws if they go to work for the Federal Government.

(1) The Dual Compensation Act of 1964 applies only to retired Regular Army (RA) officers and warrant officers. This Act limits retired pay according to the following

formula—(retired pay minus the exempt amount) divided by two equals the amount by which retired pay is reduced.

(2) The Civil Service Reform Act applies to all Soldiers regardless of component or rank who retired on or after 11 January 1979. The exceptions are Reservists who were employed by the Federal Government on or before 13 October 1978 with no subsequent break in service of three days or more, and were eligible for retired pay on that date except for the fact they were not yet age 60). This Act reduces retired pay by the amount (if any) that the combined annual rates of civilian salary and retired pay exceed level V of the Executive Schedule.

(3) The above reductions do not apply if retired pay is computed, in whole or in part, based on disability resulting from injury or disease received in line of duty as a direct result of armed conflict or caused by an instrumentality of war (see para 4–19j).

g. Civil Service employment. Special advantages are provided to individuals who are veterans and disabled veterans, in qualifying for civil service employment. These may include preference eligible status, non-competitive appointment, and retention rights. The Office of Personnel Management (OPM) administers the special advantages and rights.

h. Servicemen's Group Life Insurance (SGLI). Soldiers are covered under SGLI for 120 days following separation or retirement with no additional premium during the 120-day period. Those Soldiers who are totally disabled at separation retain SGLI coverage up to one year or until the disability ceases to be total in degree, whichever occurs first, with no additional premium cost during this period. This extension is not automatic but must be applied for by contacting Office of Servicemen's Group Life Insurance, 212 Washington Street, Newark, N.J. 07102.

i. Veterans Group Life Insurance (VGLI). SGLI may be converted to a 5-year term coverage. This program is administered by the Office of Servicemen's Group Life Insurance and is supervised by the Veterans Administration. Coverage may be in amounts from \$10,000 to 50,000 but not more than the amount of SGLI that the member had in force at the time of separation. At the end of the 5 year period, VGLI may be converted to a permanent plan commercial life insurance policy without a physical examination or other proof of health or physical condition. Application should be made before the end of the 120-day period following the date of separation or retirement. Unless totally disabled, if application and premium is not submitted within 120 days, VGLI may be granted provided initial premium and evidence of insurability are submitted within 1 year after SGLI coverage is determined. Soldiers with full-time SGLI coverage who are totally disabled and whose service makes them eligible for VGLI may purchase this insurance while remaining totally disabled up to 1 year following separation.

j. Assistance to PEBLOs. PEBLOs should seek the assistance of the local finance officer and Legal Assistance Officer concerning pay and tax issues as needed.

C–13. Department of Veterans Affairs (VA)

The VA program for disability benefits is separate and distinct from the Army disability system. The PEBLO will counsel Soldiers on VA benefits, stressing that none are automatic, that the Soldier must start the action by filing a claim with the VA. The PEBLO will attempt to arrange for the Soldier an interview with the VA representative

servicing the MTF or installation. Specifically the PEBLO will advise the Soldier of the facts below.

a. Soldiers have the right to file a claim with the VA at the time of separation or retirement outprocessing, after separation or retirement, or not at all. It is to the Soldier's advantage to file the claim at the time of outprocessing so that the required medical records will accompany the claim to the applicable VA Regional Office. When a claim is filed after separation or retirement, processing by the VA is delayed awaiting for receipt of medical records from the official records custodian.

b. The VA makes its own decisions concerning entitlement to disability compensation and ratings based on the statutes and regulations which govern its operations. The VA is not bound by decisions of the Army; and likewise, the Army is not bound by VA decisions. The Army disability system must first determine whether a Soldier is physically unfit before the provisions of the VASRD are applied and is restricted to rating only those conditions which are unfitting or contribute to unfitness. The VA may rate any service-connected disability. Army ratings are permanent; VA ratings may fluctuate depending upon the future severity of the disability. The amount of military disability compensation is based on set rates by percentage. In addition, for ratings of 30 percent or higher, compensation is increased for each eligible dependent.

c. Because of the differences in the two systems, greater benefits may be available from the VA, especially for lower ranking Soldiers who are higher rated by the VA. Although there is no assurance that VA benefits will be greater, the Soldier is not bound in any case to accept them. For this reason, a claim should be submitted whether or not the Soldier will ultimately use any VA benefits.

d. Compensation may be received from either the Army, the VA, or both. However, the law provides that the whole amount of service retirement pay and VA disability compensation may not be collected at the same time. In other words, the amount received from the VA and military retired pay may not exceed the total of whichever payment is larger.

e. VA compensation is exempt from income tax. In those instances where the military disability retired pay is not tax exempt, the Soldier may waive that amount of service disability pay equal to the amount of VA compensation. Election of choice of compensation may be changed at any time.

f. When a Soldier receives disability severance pay and is subsequently rated by the VA, the VA will deduct the entire amount of severance pay from any VA compensation received. At the discretion of the VA, the Soldier may repay the entire amount in one lump sum, or the VA may withhold the monthly compensation (or a portion thereof if the VA rates higher) until the total amount withheld equals the amount of disability severance pay received.

g. *Service-Disabled Veterans Insurance (RH)*. Soldiers who are granted a service-connected disability but are otherwise in good health may apply to the VA for Service-Disabled Veterans Insurance (RH) for up to \$10,000 coverage at standard insurance rates within 1 year from date the VA notifies the veteran that the disability has been rated as service connected.

h. Other potential VA benefits include the following:

(1) A rehabilitation program which may include tuition, fees, books, and monthly subsistence for qualified Soldiers.

(2) Employment assistance.

(3) Home loans.

(4) Extensive medical care benefits for veterans and, in some cases, dependents.

C-14. Social Security

a. Soldiers who become disabled may be entitled to social security benefits. Every Soldier should file a claim if any possibility exists that the Soldier will receive benefits.

b. In order to fully advise Soldiers about social security benefits, PEBLOs will—

(1) Set up and maintain close liaison with managers and officers of social security district offices.

(2) Supply information concerning the social security disability program.

(3) Assist Soldiers in setting up appointments or contact with the social security administration.

(4) Advise Soldiers that social security compensation is generally tax free and is payable in addition to, and without deduction from, Army or VA disability compensation.

C-15. Disabled Veterans' Outreach Program (DVOP)

a. The program is administered and funded by the Office of the Assistant Secretary of Labor for Veterans' Employment and Training. DVOP staff are located in most State Employment Service Agencies (JOB SERVICE) and are available to assist and help the employment needs of veterans, especially disabled veterans, veterans of the Vietnam era, and veterans who are economically or educationally disadvantaged. DVOP staff are also located in many Veterans Administration facilities, Veterans Readjustment Counseling Centers, and other approved facilities such as major veterans organizations.

b. PEBLO's will contact the local DVOP liaison or the state Employment Service Agency (JOB SERVICE) to arrange an interview for Soldier's being separated or retired for physical disability.

C-16. PEBLO Counseling checklist

The PEBLO will use DA Form 5893-R (PEBLO Counseling Checklist/Statement) to counsel Soldiers. This document will be signed by the PEBLO and the Soldier at the time of the Soldiers final election and forwarded to the PEB for inclusion in the record of proceedings."

FINDING 1.5: Insufficient quality management of and training on the use of Medical Evaluation Board Internal Tracking Tool (MEBITT) database leads to inaccurate reporting of the status of Soldiers in the Army Physical Disability Evaluation System.

STANDARDS:

a. **Army Regulation 5-1, Total Army Quality Management, 15 March 2002, Paragraph 1-4, Subparagraph (e), and Paragraph 3-1 Subparagraphs (f) (2), and Paragraph 3-3 Subparagraphs (a) (1) and (a) (5) state:**

"1-4. Responsibilities

e. *Commanders and Directors of Headquarters, Department of the Army, MACOMs, Field Operating Agencies (FOAs), Army National Guard of the United States*

(ARNGUS), and U.S. Army Reserve Command (USAR)— will incorporate management processes that conform to the core principles in paragraph 3–1. As a minimum,

(1) Implement a systematic strategic and customer-focused approach toward continuous process improvement based on measurable performance results.

(2) Develop and periodically update, as appropriate, macro-level, cross-functional strategic plans that support continuous organizational performance improvement based on customer requirements and feedback.

(3) Direct the conduct of organizational self-assessment, using criteria that meet the requirements in paragraph 3–3a.

(4) Promote participation in Army programs that encourage empowerment and recognize performance excellence.

(5) Develop and implement programs that foster an environment of innovation, teamwork, customer and human resources focus.”

“3–1. Total Army Quality (Definition and Principles)

f. Continuous improvement: No organization or process is perfect and customer requirements change over time. These two factors drive the need for continuous improvement within all organizations. Change takes place at both the process level and the organizational level.

(2) Change management at the organizational level is the responsibility of senior leadership. They provide long-range vision, goals and plans for the future, and define areas and expectations for improvement. By setting strategic goals and systematically measuring results, leaders focus change efforts to meet current and future customer needs.”

“3–3. Organizational assessment

a. To adequately measure continuous improvement, organizations must use a set of assessment criteria such as the APIC, which is the Army’s recommended strategic framework for leading change and assessing performance, that:

(1) Highlight the leader’s role in setting organizational direction, goals, and reviewing results.

(5) Examine the collection, analyses, and use of performance metrics information to sustain a fact-based system for improving organizational performance excellence.”

b. US Army Medical Command Memorandum, Metrics and Procedures for improving Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB) Processing, 20 September 2001, Enclosure 1, Paragraph 9 states:

“9. Medical Evaluation Board Internal Tracking Tool (MEBITT): The MEBITT has been fielded to all MTFs and will be the primary database for managing Soldiers in the PDES. The MEBITT provides MTFs with access to real time and retrospective data. Additionally, it provides MTFs the ability to conduct data analysis, provide unit commanders status updates, and identifies when cases have exceeded the standards.”

c. US Army Medical Command Memorandum, Medical Evaluation Board (MEB)/Physical Evaluation Board (PEB) Referrals Using the DA Form 3349, Physical Profile, 07 October 2004, Paragraph 4 states:

“4. The MEB must be completed expeditiously; thus the physical profile must be forwarded immediately to the PEBLO on the date of referral. The date the profiling officer signs the physical profile referring the Soldier to an MEB begins the Medical Command (MEDCOM) 90-day period within which the MEB process must be completed. The 90-day MEB processing metric measures the time from the date the physician signs the physical profile to the date the MEB is forwarded to the PEB. Evaluation of the processing timelines of MEBs referred by the MMRB begins on the date the Soldier's packet is received at the military treatment facility from the MMRB Convening Authority. The DoDI 30-day MEB processing metric measures the time from the dictation of the narrative summary to receipt of the case at the PEB.”

d. United States Government Accountability Office, Military Disability System - Improved Oversight Needed to Ensure Consistent and Timely Outcomes for Reserve and Active Duty Service Members, March 2006, Page 2, Paragraph 2 and Page 4, Paragraph 2 state:

Page 2, Paragraph 2

“To address the first two objectives covering DOD and three branches of the service, we reviewed relevant legislation, policy guidance, and literature; interviewed officials from DOD, Army, Navy, Air Force, Reserves, and National Guard; and visited Lackland and Randolph Air Force Bases, Fort Sam Houston and Walter Reed Army Medical Center, Washington Navy Yard and Bethesda Naval Hospital and interviewed relevant officials.² We chose these sites because the services conduct physical disability evaluations at these locations. In addition, we interviewed officials from military treatment facilities (MTF), including Brooke Army Medical Center and Wilford Hall Medical Center. We limited the scope of the third objective to the Army because it currently processes the most military disability cases. To determine if outcomes for active duty and reserve disability cases were statistically consistent, we analyzed data provided by the Army. Based on our assessment of the quality of the Army's data, we concluded that data on disability determinations and ratings were sufficiently reliable for our analyses. On the other hand, the Army's data on processing times were not reliable for our analyses. Except for the Army data used in our analyses, we did not test the reliability of other data we received from the services and DOD. While GAO has noted in its *21st Century Challenges* report that eligibility criteria for disability programs need to be brought into line with the current state of science, medicine, technology and labor market conditions, this study does not examine the basic eligibility criteria for military disability benefits. We conducted our review from June 2005 through January 2006 in accordance with generally accepted government auditing standards. A detailed description of our scope and methodology is provided in appendix I.”

Page 4, Paragraph 2

“While our review of the military disability evaluation system’s policies and oversight covered three branches of the service, we most closely examined data from the Army’s disability evaluation process to better understand how disability decisions and processing times compare for reserve component and active duty soldiers. Our analyses of ratings from the Army disability evaluation system from calendar year 2001 to 2005 indicated that, after taking into account many of the differences between reserve and active duty soldiers, among soldiers who received disability ratings, Army reservists received ratings comparable to their active duty counterparts. The results of our analyses of military disability benefit decisions for soldiers were less definitive, but suggest that Army reservists with impairments that made them unfit for duty were less likely to receive either permanent disability retirement or lump sum disability severance pay than their active duty counterparts. However, data on all possible reasons for this difference, such as whether the condition existed prior to service, were not available for our analysis. With regard to disability evaluation processing times, we did not compare processing times for Army reserve and active duty cases because we found that the data in the Army’s electronic database needed to calculate processing times were unreliable. The Army’s own statistics indicate that from fiscal year 2001 through 2005, more than half of all reservists’ cases took longer than 90 days to process as compared to about one third of active duty soldiers’ cases.”

FINDING 1.6:

The Army lacks a formal course of instruction that trains Physical Evaluation Board Liaison Officers, Alternate Physical Evaluation Board Liaison Officers, and Medical Evaluation Board (MEB) Physicians on their duties and responsibilities in processing Soldiers referred to a MEB.

STANDARDS:

a. Department of Defense Directive 1332.18, Separation or Retirement for Physical Disability, 4 November 1996, paragraph 4.4.4 states:

“4.4. The Secretaries of the Military Departments shall:

“4.4.4. Ensure that physicians who serve on MEBs are trained in the preparation of MEBs for physical disability evaluation.”

b. Department of Defense Instruction 1332.38, Physical Disability Evaluation, 14 November 1996, Enclosure 3, Paragraphs E3.P1.7 and E3.P2.1 state:

“E3.P1.7. Training and Education.

Those Service members designated by the Secretary concerned as primary participants in the DES shall be trained and educated in a timely and continuing manner concerning the policies and procedures of this Instruction. Primary participants in the DES include, but are not limited to, medical officers who prepare MEBs, patient administration officers, disability counselors, PEB and appellate review members, and judge advocates.”

“E3.P2.1. Criteria for Referral.

Service members on active duty or in the Ready Reserve shall be eligible for referral into the DES when the member:

E3.P2.1.1. Has a medical condition that is cause for referral into the DES as established by enclosure 4 of this Instruction or by the respective Service’s supplemental medical standards, and the member has received optimal medical treatment benefits; or

E3.P2.1.2. Will be unable to return to full military duty within one year of diagnosis of the medical condition; or

E3.P2.1.3. Was previously determined unfit, continued in a permanent limited duty status, and the period of continuation has expired; and

E3.P2.1.4. Is not disqualified under section E3.P2.4. of Part 2.

E3.P2.1.5. Is a member of the regular component of the Armed Forces entitled to basic pay; or any other member of the Armed Forces entitled to basic pay who has been called or ordered to active duty for more than 30 days; or any other member of the Armed Forces, after September 23, 1996, who is on active duty but is not entitled to basic pay under 37 U.S.C. 502(b) (reference (d)) due to authorized absence to participate in an educational program, or for an emergency purpose, as determined by the Secretary concerned.”

c. Army Regulation 635-40, Physical Evaluation for Retention, Retirements, or Separation, 6 February 2006, Paragraphs 3-1, 3-8, 4-10, 4-11, 4-12, 4-13, 4-14, and 4-15 state:

“3-1. Standards of unfitness because of physical disability

The mere presences of an impairment does not, of itself, justify a finding of unfitness because of physical disability. In each case, it is necessary to compare the nature and degree of physical disability present with the requirements of the duties the Soldier reasonably may be expected to perform because of their office, grade, rank, or rating.

a. Objectives of standards. To ensure all Soldiers are physically qualified to perform their duties in a reasonable manner, medical retention qualification standards have been established in AR 40-501, chapter 3. These standards include guidelines for applying them to fitness decisions in individual cases. These guidelines are used to refer Soldiers to a MEBD. The major objective of these standards is to achieve uniform disposition of cases arising under the law. These retention standards and guidelines should not be interpreted to mean that possessing one or more of the listed conditions or physical defects signifies automatic disability retirement or separation from the Army. The fact that the Soldier has one or more defects sufficient to require referral for evaluation, or that these defects may be unfitting for Soldiers in a different office, grade, rank, or rating, does not justify a decision of physical unfitness.

b. Considering the overall effect of disabilities. The overall effect of all disabilities present in a Soldier whose physical fitness is under evaluation must be considered. The effect will be considered both from the standpoint of how the disabilities affect the Soldier’s performance and the requirements imposed on the Army to maintain and protect him or her during future duty assignments. A Soldier may be unfit because of physical disability caused by a single impairment or physical disabilities resulting from

the overall effect of two or more impairments even though each of them, alone, would not cause unfitness.

c. Evaluating the Soldier's fitness to perform duties. All relevant evidence must be considered in evaluating the fitness of a Soldier. Findings with respect to fitness or unfitness for military service will be made on the basis of the preponderance of the evidence. Thus, if the preponderance of evidence indicates unfitness, a finding to that effect will be made. For example, when a referral for physical evaluation immediately follows acute, grave illness or injury, the medical evaluation may have the greater weight. This is particularly true if medical evidence establishes the fact that continued service would be harmful to the Soldier's health or would prejudice the best interests of the Army. A Soldier may be referred for physical evaluation under other circumstances. If so, evaluations of the performance of duty by supervisors (letters, efficiency reports, or personal testimony) may provide better evidence than a clinical estimate by the Soldier's physician describing the physical ability to perform the duties of the office, grade, rank, or rating. Thus, if the evidence establishes the fact that the Soldier adequately performed the normal duties of his or her office, grade, rank, or rating until the time of referral for physical evaluation, the Soldier might be considered fit for duty. This is true even though medical evidence indicates the Soldier's physical ability to perform such duties may be questionable. However, inadequate duty performance should not be considered as evidence of physical unfitness unless a cause and effect relationship exists between the inadequate duty performance and the presence of physical disabilities.

d. Deciding the Soldier's unfitness to perform duties. Initial enlistment, induction, or commissioning physical standards are not relevant to deciding unfitness for continued military service. Once a Soldier has been enlisted, inducted, or commissioned, the fact that the Soldier may later fall below initial entry physical standards does not, in itself, authorize separation or retirement unless it is also established that the Soldier is unfit because of physical disability as described above. Likewise, a lack of special skills in demand, inability to meet physical standards established for specialized duty such as flying, or transfer between components or branches within the Army, does not, in itself, establish eligibility for disability separation or retirement. Although the ability of a Soldier to reasonably perform his or her duties in all geographic locations under all conceivable circumstances is a key to maintaining an effective and fit force, this criterion (world-wide deployability) will not serve as the sole basis for a finding of unfitness.

e. Prior-service disabilities. Prior-service medical conditions are to be considered according to the following standards and limitations.

(1) Despite any other provisions of this regulation, after a Soldier has been enlisted, inducted, and appointed or commissioned, the Soldier will not be declared physically unfit for military service because of disabilities known to exist at the time of the Soldier's acceptance for military service that have remained essentially the same in degree since acceptance, and have not interfered with the Soldier's performance of effective military service.

(2) Notwithstanding the above, when a Soldier enters the military with a waiver for a medical condition or physical defect, and the condition represents a decided medical risk which would probably prejudice the best interests of the Government were the Soldier to remain in military service, separation without benefits may be appropriate, if

initiated within 6 months of initial entry on active duty. Entry physical standards will be used in separating individuals with preexisting medical conditions. Such cases will be referred to a PEB to determine if the pre-existing condition has been service-aggravated.”

“3–8. Counseling provided to Soldier

a. Physical Evaluation Board Liaison Officer counseling. The appointed Physical Evaluation Board Liaison Officer (PEBLO) at the MTF is responsible for counseling Soldiers (or the next of kin or legal guardian in appropriate cases) concerning their rights and privileges at each step in disability evaluation, beginning with the decision of the treating physician to refer the Soldier to a MEBD and until final disposition is accomplished. For this purpose, the MTF commander will name an experienced, qualified officer, noncommissioned officer (NCO), or civilian employee as the PEBLO. At least one additional qualified officer, NCO, or civilian employee will be designated as alternate PEBLO. Only personnel whose duties will not conflict with their counseling responsibilities will be selected. The MTF commander will notify the recorder of the applicable PEB, of the name and telephone number of the PEBLO and alternate PEBLO. PEBLOs will use the Disability Counseling Guide (app C) to assist them in providing thorough counseling. Counseling will be documented (see para 4–20*d*). Counseling will cover as a minimum, the following areas:

- (1) Legal rights (including the sequence of and the nature of disability processing).
- (2) Effects and recommendations of MEBD and PEB findings.
- (3) Estimated disability retired or severance pay (after receipt of PEB findings and recommendations).
- (4) Probable grade upon retirement.
- (5) Potential veteran’s benefits.
- (6) Recourse to and preparation of rebuttals to PEB findings and recommendations.
- (7) Disabled Veterans Outreach Program (DVOP).
- (8) Post-retirement insurance programs and the Survivor Benefit Plan (SBP).

b. Legal counseling. Counseling by the appointed legal counsel is provided when the Soldier requests a formal hearing.”

“4–10. The medical evaluation board

The medical evaluation boards (MEBD) are convened to document a Soldier’s medical status and duty limitations insofar as duty is affected by the Soldier’s status. A decision is made as to the Soldier’s medical qualification for retention based on the criteria in AR 40–501, chapter 3. If the MEBD determines the Soldier does not meet retention standards, the board will recommend referral of the Soldier to a PEB. For MEBD’s rules for documentation, recommendations, and disposition of the evaluated Soldier, see AR 40–400, chapter 7.”

“4–11. Narrative summary

The Narrative summary (NARSUM) to the MEBD is the heart of the disability evaluation system. Incomplete, inaccurate, misleading, or delayed NARSUMs may result in injustice to the Soldier or to the Army.

a. Physicians who prepare cases for the MEB and PEB should be familiar with the DVA physical examination worksheets to describe physical defects. This helps to ensure consistency in reporting similar conditions and assists the boards of the disability system in their review and evaluation process. (See AR 40–400, chap 7.)

b. In describing a Soldier’s conditions, a medical diagnosis alone is not sufficient to establish that the individual is unfit for further military service. The history of the Soldier’s illness, objective findings on examination, results of Xray and laboratory tests, reports of consultations, response to therapy, and subjective conclusions with rationale must be addressed.

c. A correlation must be established between the Soldier’s medical defects and physical capabilities. (This is important when a chronic condition is the basis for referral to a PEB and no change in severity of the condition has occurred or when referral of the case to a PEB appears controversial.)

d. The date of onset of a medical impairment may be questionable because of relatively short military service and the nature of the impairment, for example, a mental disease. If so, the NARSUM should address the results of inquiry into the pre-service background (family, relatives, medical, and community) of the Soldier in sufficient detail to overcome substantive question concerning the date of onset.

e. When a Soldier is diagnosed with a mental disorder, the NARSUM must include a statement indicating whether the Soldier is mentally competent for pay purposes and capable of understanding the nature of, and cooperating in, PEB proceedings.

f. NARSUMs will not reflect a conclusion of unfitness. Therefore, diagnoses must not be qualified by such terms as “unfitting”, “disqualifying”, “ratable”, “not ratable”.

g. When disclosure of medical information would adversely affect the Soldier’s physical or mental health, the NARSUM should include a statement to that fact.

h. The NARSUM should include the date of the physical examination conducted for purposes of physical disability evaluation.

i. The MEBD proceedings from other than Army MTF’s must be forwarded through the designated Army facility (AR 40–400, chap 7).”

“4–12. Counseling Soldiers who have been evaluated by a medical evaluation board

a. The PEBLO will advise the Soldier of the results of the MEBD. The Soldier will be given the opportunity to read and sign the MEBD proceedings. If the Soldier does not agree with any item in the medical board report or NARSUM, he or she will be advised of appeal procedures.

b. The decisions below are exclusively within the province of adjudicative bodies. Neither the PEBLO nor the attending medical personnel will tell the Soldier that—

(1) The Soldier is medically or physically unfit for further military service.

(2) The Soldier will be discharged or retired from the Army because of physical disability.

(3) A given percentage rating appears proper.

(4) A LD decision is final (unless final approval has been obtained according to AR 600–8–4).”

“4–13. Referral to a physical evaluation board

a. The MEBD will recommend referral to a PEB those Soldiers who do not meet medical retention standards. Those who apply for COAD under the provisions of chapter 6 will be included. Do not refer Soldiers to a PEB who request discharge under the provisions of chapter 5. A Soldier being processed for nondisability separation will not be referred to a PEB unless the Soldier has medical impairments that raise substantial doubt as to his or her ability to continue to perform the duties of his or her office, grade, rank, or rating. Soldiers previously found unfit and retained in limited assignment duty status under chapter 6, or a previous authority, will be referred to a PEB.

b. A Soldier may provide additional information to the MTF commander to forward to the PEB. The information may be from the unit commander, supervisor, or other persons who have knowledge regarding the effect the condition has on the Soldier's ability to perform the duties of the office, grade, rank, or rating.

c. Personnel processing actions for Soldiers referred to a PEB will be according to appendix E."

"4-14. Psychiatric and spinal cord injury patients requiring continuing hospitalization

a. Army regulation 40-400 provides for transfer of psychiatric and spinal cord injury patients to a VA medical facility.

(1) Psychiatric patients requiring continuing hospitalization may be transferred after completion of MEBD action. To ensure timely processing, the MEBD proceedings must be referred to the PEB immediately after transfer of the patient.

(2) Spinal cord injury patients requiring continuing hospitalization will be expeditiously transferred to the VA Spinal Cord Injury Center, regardless of whether the MEBD is completed. The MTF that has responsibility for patients in the particular VA Spinal Cord Injury Center will coordinate the completion and processing of the MEBD.

b. The PEBLO of the MTF that has responsibility for the completion of the MEBD will provide disability counseling to the Soldier or the Soldier's next-of-kin when the Soldier is mentally incompetent. The PEBLO will also notify the Installation Retirement Services Officer of the Soldier's transfer to the VA hospital; and in cases of mental incompetence, provide the RSO the name and address of the next of kin in order to coordinate counseling on SBP as required under Title 10, United States Code, Section 1455, (10 USC 1455)."

"4-15. Action following approval of a medical evaluation board [r]eport

The MTF commander will notify the unit commander of the planned referral of a Soldier to a PEB and obtain from the commander the written statement described in paragraph e, below. If further action is not barred, the original and two copies of the MEBD proceedings and allied documents described below, as applicable, will be forwarded to the PEB.

a. DA Form 5889-R (PEB Referral Transmittal Document). This document serves as the forwarding memorandum. It identifies the documents forwarded and provides unit and home addresses and telephone numbers for the PEB to contact the Soldier as required. DA Form 5889-R will be locally reproduced on 8 1/2 by 11 inch paper. A copy of the form for reproduction purposes is located at the back of this regulation.

b. Documents submitted by Soldier to accompany MEBD as evidence of physical ability to adequately perform military duties (letters, efficiency reports, or personal statements).

c. DA Form 3947 (Medical Evaluation Board Proceedings) with SF 502 (Medical Record—Narrative Summary Clinical Survey) as enclosure 1 and DA Form 3349 (Physical Profile) as enclosure 2.

d. In cases where the Soldier has been determined mentally incompetent, a statement confirming the name, address, telephone number, and relationship of individual authorized to act in behalf of the Soldier; whether this person is available for counseling following PEB action; and whether the person has been advised of the referral to a PEB. If the next-of-kin is not known or cannot be located and no court-appointed guardian exists, include a summary of the attempts to identify or locate the next-of-kin. To establish the individual having authority to act for an incompetent Soldier, in the absence of a valid and pertinent power of attorney or a court order authorizing an individual to act for an incompetent Soldier, follow the guidelines below. The person authorized to act is the person highest in the line of authority listed below.

(1) Spouse, even if a minor.

(2) Adult sons or daughters in order of seniority. An individual is an adult upon reaching the age of majority under the state law of the individual's legal residence.

(3) Parent in order of seniority, unless legal custody was granted to another person by reason of court decree or statutory provision. The person to whom custody was granted remains as next of kin although the individual has reached the age of majority.

(4) Blood or adoptive relative who was granted legal custody of the person by reason of a court decree or statutory provision. The person to whom custody has been granted remains the nearest next of kin although the individual has reached age of majority.

(5) Adult brother and sisters in order of seniority.

(6) Grandparents in order of seniority.

(7) Other relatives in order of relationship to the individual and according to the laws of the Soldier's domicile. A Soldier's domicile is the Soldier's legal residence. It is not necessarily where the Soldier is actually living, the Soldier's home of record, or where the Soldier is stationed.

(8) Persons who stand in place of a parent. Seniority in age will control when the persons are of equal relationship.

e. Statement from Soldier's commander confirming whether any adverse personnel action is being considered against the Soldier and describing the Soldier's current duty performance. The description of duty performance should address the following:

(1) The Soldier's most recent performance of duty.

(2) Any special limitation of duty due to the Soldier's physical condition.

(3) The Soldier's ability to adequately perform the duties normally expected of an individual of the Soldier's office, grade, rank, or rating.

(4) The Soldier's current duty assignment, anticipated future assignments, branch, age, and career specialities.

f. A copy of the document reflecting the approved LD decision (AR 600-8-4) if the disability is the result of injury; the result of disease secondary to injury or due to misconduct; or the result of disease when the case is that of a Soldier performing duty

for 30 days or less. Provide either a DD Form 261, DA Form 2173, or similar LD reports from the Navy or Air Force. If the documents are not available, the MTF commander will send a request for LD decision, well in advance of a preparation of the MEBD report, to the Soldier's unit of assignment at the time of injury or disease. Include a copy of the request in the case file sent to the PEB and send a copy to USA HRC (AHRC-PED-S). The request will provide the following information:

(1) Name, grade, and social security number (SSN).

(2) Date and place of injury.

(3) Short summary of circumstances of injury, including the identity of MTF where the Soldier was treated.

(4) Unit of assignment when the Soldier was injured.

(5) Statement that the LD determination is required for disability processing.

g. Orders or training schedule under which the Soldier was performing active duty, active duty for training, or inactive duty training when the Soldier is subject to disability processing under chapter 8. If the Soldier is retained for medical care beyond termination date of active duty for training, include a copy of the affidavit required by AR 135-381. If referral to a PEB occurs during rehospitalization for treatment of residuals of an injury, provide a copy of the authorization for rehospitalization required by AR 40-400, para 3-2d(2).

h. Copy of memorandum approving COAD/COAR when case is that of a Soldier previously continued on duty under the COAD program. If available, include a copy of the DA Form 199 related to the previous COAD action.

i. Soldier's request for COAD/COAR under chapter 6 of this regulation.

j. Soldier's statement or statement of PEBLO when a soldier has 18, but less than 20, years of active federal service, or an RC Soldier has 18, but less than 20 years of qualifying service for nonregular retirement, declines to request COAD or COAR, as applicable.

k. Copy of decision by the GCMCA to waive administrative separation under AR 635-200, chapter 14 for referral of Soldier to a PEB. Requirement applies even if a general discharge is directed under AR 635-200, chapter 14. Requirement is not applicable to Soldiers pending separation under AR 635-200, chapter 13.

l. Statement from the custodian of the Soldier's personnel records confirming whether one of the circumstances below is applicable at the time the Soldier is referred to a PEB.

(1) Voluntary or mandatory retirement processing.

(2) Expiration of term of service without reenlistment.

(3) Expiration of term of service with bar to reenlistment.

(4) Involuntary release from active duty due to DA board action.

(5) Qualitative management denial for reenlistment.

(6) Adverse personnel action.

m. Document authorizing Soldier's retention beyond scheduled separation or retirement date. (See AR 600-8-24 or AR 635-200.)

n. If available, DA Form 2 (Personnel Qualification Record—Part I) and DA Form 2-1 (Personnel Qualification Record—Part 2). If the documents are not available, use alternative sources to obtain the required personnel data if the information is reliable. Examples include requesting the Military Personnel Office (MILPO) to extract a DA

Form 2A (Personnel Qualification Record, Parts I and II) from SIDPERS and asking the Soldier to furnish the information directly. The use of alternative sources does not relieve the PEBLO of the requirement to initially request a copy of the DA Form 2 and DA Form 2-1.

o. If available, a statement explaining the reason for reduction to the lower grade when the Soldier is serving in a grade below the highest grade held. When the information is available, include a statement explaining the circumstance precluding advancement to private or private first class under the provisions of AR 600-200 (NGR 600-200 or AR 140-158 for Soldiers in the Reserve Components) if—

(1) The current grade is private (pay grade E-1), and the Soldier has completed more than 6 month's service.

(2) The current grade is private (pay grade E-2), and the Soldier has completed more than 12 months service.

p. Copy of request for VA hospital bed designation, if applicable.

q. Copy of orders moving patient to a VA hospital for continued hospitalization, if applicable.

r. Copy of letter(s) to proper state authorities, as applicable.

s. Copy of the request for Statement of Service when Soldier is a member of the Reserve Components (fig 4-1).

t. Copy of Soldier's latest leave and earning statement (DFAS Form 702)."

d. Army Regulation 40-501, Standards of Medical Fitness, 27 June 2006, Paragraph 3-1, 3-2, and 3-3 state:

"3-1. General

This chapter gives the various medical conditions and physical defects which may render a Soldier unfit for further military service and which fall below the standards required for the individuals in paragraph 3-2 below."

"3-2. Application

These standards apply to the following individuals (see chaps 4 and 5 for other standards that apply to specific specialties):

a. All commissioned and warrant officers of the Active Army, ARNG/ARNGUS, and USAR.

b. All enlisted Soldiers of the Active Army, ARNG/ARNGUS, and USAR.

c. Students already enrolled in the HPSP and USUHS programs.

d. Enlisted Soldiers of the ARNG/ARNGUS or USAR who apply for enlistment in the Active Army.

e. Commissioned and warrant officers of the ARNG/ARNGUS or USAR who apply for appointment in the Active Army.

f. Soldiers of the ARNG/ARNGUS or USAR who re-enter active duty under the "split-training option." (However, the weight standards of tables 2-1 and 2-2 apply to split option trainees.)

g. Retired Soldiers recalled to active duty."

"3-3. Disposition

Soldiers with conditions listed in this chapter who do not meet the required medical standards will be evaluated by an MEB as defined in AR 40–400 and will be referred to a PEB as defined in AR 635–40 with the following caveats:

a. USAR or ARNG/ARNGUS Soldiers not on active duty, whose medical condition was not incurred or aggravated during an active duty period, will be processed in accordance with chapter 9 and chapter 10 of this regulation.

b. Soldiers pending separation in accordance with provisions of AR 635–200 or AR 600–8–24 authorizing separation under other than honorable conditions who do not meet medical retention standards will be referred to an MEB. In the case of enlisted Soldiers, the physical disability processing and the administrative separation processing will be conducted in accordance with the provisions of AR 635–200 and AR 635–40. In the case of commissioned or warrant officers, the physical disability processing and the administrative separation processing will be conducted in accordance with the provisions of AR 600–8–24 and AR 635–40.

c. A Soldier will not be referred to an MEB or a PEB because of impairments that were known to exist at the time of acceptance in the Army and that have remained essentially the same in degree of severity and have not interfered with successful performance of duty.

d. Physicians who identify Soldiers with medical conditions listed in this chapter should initiate an MEB at the time of identification. Physicians should not defer initiating the MEB until the Soldier is being processed for nondisability retirement. Many of the conditions listed in this chapter (for example, arthritis in para 3–14b) fall below retention standards only if the condition has precluded or prevented successful performance of duty. In those cases when it is clear the condition is long standing and has not prevented the Soldier from reaching retirement, then the Soldier meets the standard and an MEB is not required.

e. Soldiers who have previously been found unfit for duty by a PEB, but were continued on active duty (COAD) under the provisions of AR 635–40, chapter 6, will be referred to a PEB prior to retirement or separation processing.

f. If the Secretary of Defense prescribes less stringent standards during partial or full mobilization, individuals who meet the less stringent standards but do not meet the standards of this chapter will not be referred for an MEB or a PEB, until the termination of the mobilization or as directed by the Secretary of the Army.”

e. Training and Doctrine Regulation 350-70, 9 March 1999, Chapter IV-4, Individual Training Design: Individual Training Strategies and Course/Product Design states

“VI-4-1. Chapter Overview

Introduction a. This chapter provides policy and guidance on designing individual training, to include individual training strategies and design of training programs, courses, and products.

Note: Give prime consideration to using distance learning techniques when establishing the short-range individual training strategies and

designing the training.

Chapter Index b. This chapter covers the following:

Context	Paragraph
Administrative Information	<u>VI-4-2</u>
Process Description and Requirements	<u>VI-4-3</u>
Career Development Model	<u>VI-4-4</u>

VI-4-2. Administrative Information

Purpose a. Individual training design is the process used to--

- (1) Establish long- and short-range individual training strategies (to include development of supporting plans and related career models).
- (2) Translate tasks into learning objectives (LOs).
- (3) Design individual training products and courses.

References b. Required **regulatory** references are as follows:

- (1) AR 351-1, Individual Military Education and Training
- (2) DA Pam 600-3, Commissioned Officer Development and Career Management
- (3) DA Pam 600-11, Warrant Officer Professional Development
- (4) DA Pam 600-25, US Army Noncommissioned Officer Professional Development Guide
- (5) Other chapters, this regulation:
 - (a) Chapter II-5, Training Aids, Devices, Simulators, and Simulations (TADSS) Training Development and Management
 - (b) Chapter II-6, Training Development and Management for New Materiel Systems
 - (c) Chapter IV-2, Combined Arms Training Strategy (CATS)

(d) Chapter VI-6, Training Course Design

Definitions c. See Acronyms/Glossary for TD-related terms in this chapter.

Responsibilities d. See Appendix B, Responsibilities, for top-level responsibilities. TRADOC Training/TD (Task) Proponent responsibilities specific to individual training design are as follows:

(1) Establish long-range training strategies based on valid needs analysis.

(2) Establish short-range training strategies based on critical individual task analysis.

(3) Include peacetime, mobilization, and refresher training strategies.

(4) Develop or maintain current supporting plans and related career models.

(5) Design/Revise training courses in accordance with Chapter VI-6, Training Course Design, as needed.

VI-4-3. Process Description and Requirements

Description a. Designing individual training is the process used to determine the most cost efficient and effective training strategy for a job, task, or system. It involves development of both long- and short-range individual training strategies, along with supporting plans/ models, to determine who, what, when, where, and how each critical individual task (and terminal learning objectives [TLOs] for training courses) will be trained. Once the strategies have identified the products (including training aids, devices, simulators, and simulations [TADSS]) and training courses required to train the tasks, training developers continue the design process by designing the products and courses to ensure sequential, progressive training. A process overview would appear as follows:

L-R Strategies (3-20 years after execution year)	S-R Strategies (1-2 years after execution year)	Program/product design(execution year)
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Outputs b. Individual training design is a **minimum essential requirement** before development of all individual training products. Required outputs:

(1) Long-range training strategies and supporting plans/career models.

(2) Short-range training strategies for each critical task and supporting plans/models.

(3) Determination of resource requirements for development and implementation of training and training products.

(4) Designed individual training products (to include TADSS or embedded system training of individual critical tasks) and courses identified as part of the short-range individual training strategy.

Individual Training Strategy c. Individual Training Strategy is a cradle-to-grave description of the methods and resources required to develop and implement individual training. It determines who (soldiers), what (tasks), where (site), when, how (methods and media), and at what cost the training will be developed and implemented. There are long-range and short-range individual training strategies.

Long-range Individual Training Strategies Start Point d. Triggering circumstances, such as field input, proponent school evaluations, and Requirements Determination solutions, feed into needs analysis to determine if there is a TD requirement to revise or develop training/training products. If so, training developers begin development of long-range training strategies to determine career field, job, or system training.

Short-range Individual Training Strategies Start Point e. Development of short-range training strategies begins upon completion of individual task analysis. Training developers use the task analysis data to conduct media/ method/site selection and determine the most cost efficient and effective way to train each task.

Course/Product Design Start Point f. Needs analysis or a new/revised short-range individual training strategy identifies the requirement to design or redesign a particular training course or product in order to train critical task(s) and supporting skills and knowledge. Course/product design begins at the identification of the requirement.

Note: See appropriate chapters in this regulation and supporting procedural guidance for design requirements. Many products have a predetermined format (e.g., Soldier Training Publications [STPs]) while others will require design (e.g., computer based instruction [CBI] or Army correspondence courses).

Individual Training Design Procedure

g. Major design functions appear in the following table.

Note: A key function of individual training design is the **determination of resource requirements** for both development and implementation of training and training products. This involves identification of all formal training and evaluation resource requirements (instructors, support personnel, buildings, classrooms, labs, training areas, ranges, OPTEMPO, ammunition, equipment, etc.).

Major Functions	Major Activities
(1) Establish the design team.	(a) Include the same individuals who conducted the analysis. (b) Use the same team for development also.
(2) Establish or revise individual long-range training strategies.	(a) Determine long-range Total Army peacetime/mobilization individual training requirements based on needs analysis. (b) Identify long-range resource requirements.
(3) Document milestones and long-range training requirements in appropriate supporting plans/models.	Develop/revise as appropriate: (a) Systems Training Plan (STRAP). (b) Individual Training Plan (ITP). Note: The ITP, along with the Course Administrative Document (CAD) and Program of Instruction (POI), essentially become the proponent's CATS institutional strategy. (c) Proponent TD Plan. (d) Career Development Model (Parts 1 and 2) and related models.
(4) Establish or revise short-range individual training strategies.	Consider for each critical individual task-- (a) Total Army Training System (TATS) Courses using the same media.

	<p>(b) Resident/non-resident training.</p> <p>(c) Peacetime/mobilization training.</p> <p>(d) Sustainment/refresher training requirements.</p> <p>(e) Quantity of personnel to be trained.</p> <p>(f) Technical complexity.</p> <p>(g) Training constraints (e.g, availability of equipment, training devices, ranges, facilities, and training material).</p> <p>(h) Safety, training risk, and environmental impact.</p> <p>(i) Resource requirements.</p> <p>(j) Resource constraints on product development.</p> <p>(k) Methods of instruction (conference, practical exercise, field exercise, correspondence course, etc.).</p> <p>(l) Techniques of instruction (small group instruction, group-paced training, self-paced training, etc.).</p> <p>(m) Most effective and cost efficient media and training site, including TADSS.</p> <p>Note: Use of the TRADOC-produced Media Elimination and Design Intelligent Aid (MEDIA) software provides a suggested list of media, methods, learning strategies, etc. The user guide provides guidance on events and activities.</p>
<p>(5) Document milestones and short-range training requirements in appropriate plans/models.</p>	<p>(a) Establish/revise milestones and resource requirements for design and development of TD products (including TADSS) and courses.</p> <p>(b) Update appropriate long-range plans and related career models.</p> <p>(c) Develop/revise short-range plans/models:</p> <p style="padding-left: 40px;">1 Project Management Plans.</p>

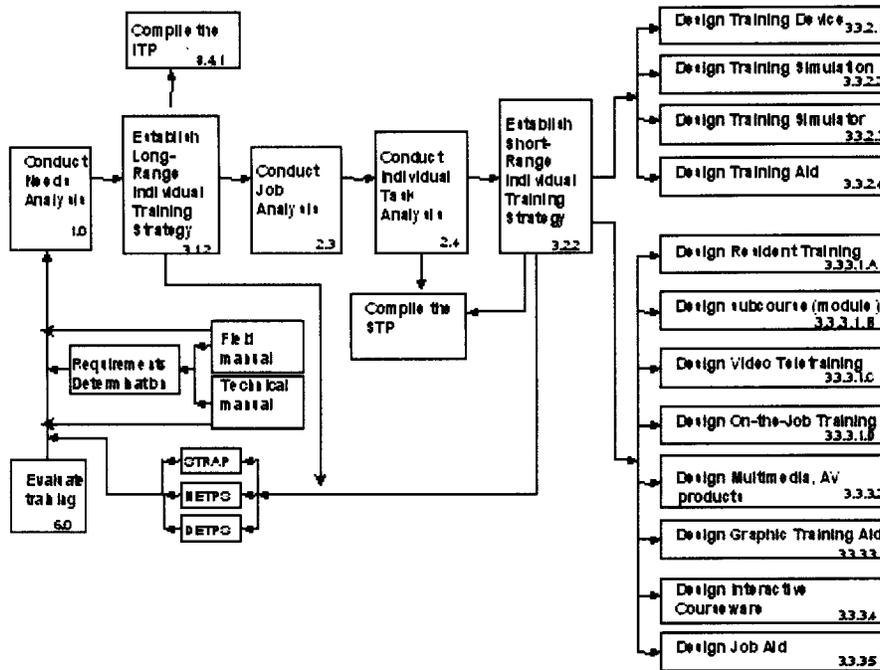
	<p><u>2</u> POI.</p> <p><u>3</u> Military occupational specialty (MOS)/Area of concentration (AOC) (i.e, job) Training Plan.</p> <p><u>4</u> Career Development Model (Part 3) and related models.</p>
(6) Design training media/product.	Design/Revise training media/products as required per TLO.
(7) Design training courses.	<p>Follow procedures in Chapter VI-6, Training Course Design.</p> <p>Note: Determine course implementation resource requirements.</p>

Note: Strategies should be reviewed periodically to ensure the most efficient use of training media as well as horizontal and vertical alignment of tasks. Examples of optimum times to review and revise strategies include--

- Review of Active Component (AC) and Reserve Component (RC) courses when making TATS Course considerations.
- Major course modifications due to equipment updates, doctrine changes, and MOS consolidations.

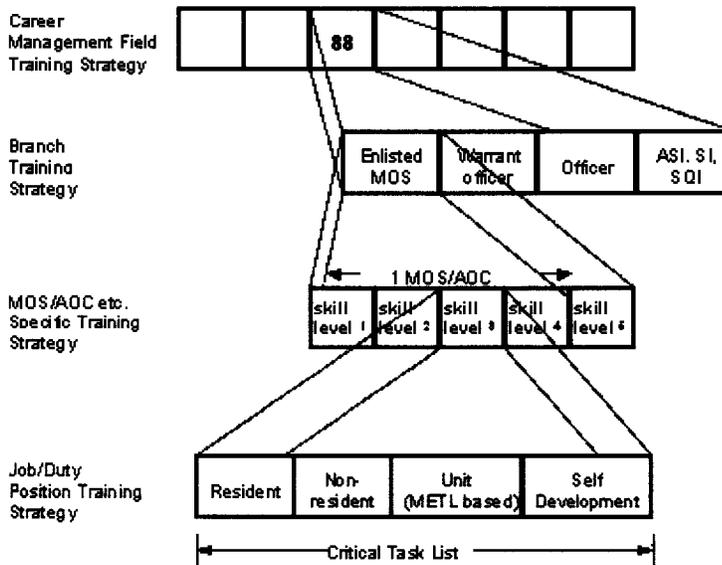
Process Completion h. Training design is complete upon approval by a command-appointed individual of long- and short-range supporting plans as well as the product or training course design

Flow Diagram i. The relationship of the individual long- and short-range training strategies and training course/product design is as follows:



Training Strategy Levels

j. The following diagram shows levels of individual training strategies and their relationships.



Strategy Level	Shows the
1	Army's Career Management Field (CMF) structure as determined by Department of the Army (DA).

2	Top-level, long-range, branch training strategy. The proponent determines the overarching training strategy for the career field, jobs, and systems training strategy for the branch. The decisions are reflected in ITPs and STRAPs.
3	Long-range training strategy for an entire MOS/AOC. These strategies are reflected in supporting plans, e.g., ITPs.
4	Short-range training strategy for a particular job. It details training site, mobilization, sustainment, and training media/products requirements for each critical task for that job. The training may take place in resident, school, unit (through STPs and training support packages [TSPs]), colleges (self-development), or even in the soldier's home. This training strategy is reflected in supporting plans, e.g., MOS/AOC (Job) Training Plan; Career Development Model (see. "Career Development Model," this chapter).

Note: Civilian career programs will have similar levels of individual training strategies.

Common Soldier/Skill Level Short-range Individual Training Strategy Development (k) HQ TRADOC (with input from Executive Agents (Eas), Cadet Command, and Training/TD (Task) Proponents determines the short-range training strategy for common critical task candidates. The following tables depict criteria (one or more of this [these] must be met) for selecting the most effective training strategy for a new requirement.

Note: If training design indicates a need for a different training strategy, Training/TD (Task) Proponent coordinates recommendations with HQ TRADOC for approval.

Strategy	Description	Criteria: The training--
(1) Initial Training	(a) Programmed training. The training of a critical task or supporting skills and knowledge. It includes all of the academic instruction that is in the course (reflected in the POI) and applies to resident and non-resident instruction. It includes common or shared task TSPs forwarded to non-proponent schools for inclusion in a formal course	<u>1</u> Is-- <u>a</u> Conducted in resident or non-resident training. <u>b</u> Trained to standard. <u>c</u> Essential as it serves as the foundation for other

	<p>of instruction as a stand-alone lesson with a separate lesson number (POI file number) and specific LOs.</p>	<p>training in the course.</p> <p><u>d</u> A qualification training requirement.</p> <p><u>e</u> Evaluated during instruction.</p> <p>Note: For common or shared task TSPs, it evaluates task performance during instruction under conditions prescribed in the TSPs.</p> <p><u>2</u> May require specific equipment.</p>
	<p>(b) <u>Integrated Training.</u> Training of a critical task or supporting skills and knowledge. It is integrated into existing course academic instruction (reflected in the POI) and applies to resident and non-resident instruction. It includes common or shared task TSPs forwarded to non-proponent schools for integration into an existing lesson. The task MAY be one in which the performer has received prior training, i.e., it is best used to sustain/refine previously acquired skills.</p>	<p><u>1</u> Must be applicable to the block of instruction in which it is integrated.</p> <p><u>2</u> Trains the task to standard.</p> <p><u>3</u> Evaluates task performance during instruction under conditions prescribed in common or shared task TSPs.</p>
<p>(2) Refresher (Sustainment)</p>	<p>Used to reinforce previous training and/or</p>	<p>(a) Is related to course-specific training objectives,</p>

Training	sustain/regain previously acquired skills and knowledge.	<p>performed under prescribed conditions, and must meet prescribed performance standards.</p> <p>(b) May take place in a course during/outside of POI time.</p> <p>(c) Usually takes place in the unit to sustain or retrain a previously required proficiency level; may be trained to prepare an individual for institutional training, i.e., meet prerequisite training requirements.</p>
(3) Awareness Training	<p>Training used to disseminate information that provides an individual with the basic knowledge/understanding of a policy, program, or system, not a critical task or supporting skill or knowledge. The proponent school identifies the most efficient and economical media to disseminate the awareness training and disseminates as part of a TSP with supporting administrative information. An example is the annual security briefing.</p>	<p>(a) May not be related to course-specific training objectives and takes place outside of POI academic time (although the training material may be passed out during POI time).</p> <p>(b) Can be disseminated as handouts, supplemental reading, orientations, etc.</p> <p>(c) Is not formally evaluated.</p>

VI-4-4. Career Development Model

Model Description (a) Individual training strategies are portrayed in supporting plans or models. The Career Development Model illustrates individual training strategies for enlisted, warrant officer, commissioned officer, and civilian career paths. It is valuable as a tool to--

(1) Aid in the development of Total Army Training System (TATS)

Courses and MOS restructuring/consolidation.

(2) Establish/Show the following information about each critical task: who receives the training, courses and training products, means quality of training, sources for the training/training products, and required training frequency for task performance sustainment.

(3) Ensure--

(a) Horizontal and vertical alignment of training across related career paths.

(b) Non-duplication of training and training products.

(c) Efficient use of training media/technology.

Other characteristics are as follows:

Characteristic	Details
(1) 3 Pillars of Leader Development	<p>The model depicts the three pillars of leader development: institutional training and education, operational assignments, and self-development.</p> <p>Note 1: Each column represents aligned institutional training, surrounded by operational assignments which provide hands-on experience with progression in soldier self-development.</p> <p>Note 2: The courses shown on the model prepare students for the given ranks.</p>
(2) Horizontal / Vertical Alignment of Training	<p>Individual training must be aligned horizontally and vertically.</p>
(3) Parts	<p>(a) Part 1: Integrated Training and Education Pillars</p> <p>(b) Part 2: Self-Development</p> <p>(c) Part 3: Critical Task Matrix</p>
(4) Functions	<p>The model reflects--</p> <p>(a) How and where each individual critical task is trained as well as sustainment training requirements.</p>

	<p>(b) New individual training strategies.</p> <p>(c) Redesign needs of current training strategies.</p>
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Note: The model does not have to be developed in its entirety or as a formal document (it is optional). Computer applications will permit transfer of data to other plans, models, e.g., the noncommissioned officer (NCO), Warrant Officer (WO), and officer models; the Training Guide found in STPs.

Development b. Use the chart below to assist in developing each of the three parts of Procedures the model to reflect proponent individual training strategies.

Part	Activities
<p>(1) Part 1: Integrated Training and Education Pillars (Long-range Individual Training Strategy)</p>	<p>This represents the CATS Long-range Individual Training Strategy. Align related courses per career paths to reflect progressive institutional training requirements that will prepare Army personnel for career-long assignments and duties.</p> <p>(a) Institutional training includes resident and distance learning instruction and serves as the foundation for task performance and supporting skills and knowledge acquisition.</p> <p>(b) Training takes place during each phase of personnel development and prepares leaders and soldiers for their next assignments.</p> <p>Note 1: Model should also reflect civilian training, additional skill identifiers (ASIs), skill identifiers (SIs), language identifier codes (LICs), skill qualification identifiers (SQI), etc.</p> <p>Note 2: Self-development and experience (operational assignments) are depicted in the upper part of the Integrated Training and Education Pillars to show integration of the three.</p> <ul style="list-style-type: none"> • Self-Development (See Part 2 description). • Operational assignments allow repetitive performance of tasks to broaden knowledge and refine skills as well as performance of tasks in a wide range of situations under

	<p>conditions that change frequently to expand/refine individual experience. These assignments promote confidence by providing assignments to more complex duties in higher level positions.</p>
<p>(2) Part 2: Self Development (Long-range Individual Training Strategy)</p>	<p>This represents the CATS Long-range Self-development Training Strategy.</p> <p>(a) Assess personnel to identify personal developmental needs. Needs are identified during performance assessments and validated during counseling sessions.</p> <p>(b) Use DA Pam 600-3, DA Pam 600-11, and DA Pam 600-25 to guide development for officers, warrant officers, and noncommissioned officers, respectively; use Army Civilian Training, Education, and Development System (ACTEDS) plans for civilian career programs and fields.</p> <p>(c) Use developmental action plan to lay out actions to improve performance and achieve maximum growth and potential.</p>
<p>(3) Part 3: Critical Task Matrix (CATS Short-range Individual Training Strategy)</p>	<p>This represents the CATS Short-range Individual Training Strategy. For each career path per echelon (skill level), show--</p> <p>(a) How each individual critical task will be trained by identifying courses and training products that focus training on achieving individual task performance proficiency.</p> <p>(b) Means quality of training.</p> <p>(c) Source that provides the training or training product.</p> <p>(d) Training frequency for sustainment/refresher training.</p> <p>Note: See Chapter IV-2, CATS, for specific guidance in development of the Short-range Individual Training Strategy Matrix.</p>

Sample Model

c. A sample Career Development Model follows:

FINDING 1.7: Army Regulations do not fully and accurately integrate DOD policy instructions and MEDCOM policy memorandums.

STANDARDS:

a. Department of Defense Directive 1332.18, Separation or Retirement for Physical Disability, 4 November 1996, paragraph 1.3 states:

“1. REISSUANCE AND PURPOSE

This Directive:

1.3. Authorizes procedures under DoD Instruction 1332.38 reference (e)) and DoD Instruction 1332.39 (reference (f)) for the DoD Disability Evaluation System (DES).”

b. Department of Defense Instruction 1332.38, Physical Disability Evaluation, 14 November 1996, Enclosure 3, Paragraph E3.P1.6.2.1 states:

“E3.P1.6.2.1. Duty-Related. When a physician initiates a MEB, the processing time should normally not exceed 30 days from the date the MEB report is dictated to the date it is received by the PEB.”

c. AR 400-400, Patient Administration, 13 October 2006, paragraph 7-1 states:

“7-1. General

MEBs are convened to document a Soldier’s medical status and duty limitations insofar as duty is affected by the member’s medical status. MEBs must be completed expeditiously. MEB appointments and consultations will receive priority access over all other categories of nonemergent patients. For duty related cases, MEB processing will not normally exceed 30 days (beginning on the date of the medical officer’s narrative summary through the date forwarded to the PEB). Military occupational specialty/medical retention board (MMRB) results requiring referral to an MEB should be transmitted expeditiously to the MTF commander (AR 600-60). An MEB should be initiated within 30 days upon receipt of an approved MEB referral from an MMRB. Decisions regarding unfitness for further military duty because of physical or mental disability are prerogatives of PEBs (AR 635-40). MEBs will not express conclusions or recommendations regarding such matters. However, entrance physical standards boards (EPSBDs) will make decisions as to the member’s fitness or unfitness for enlistment or induction.”

d. US Army Medical Command Memorandum, Metrics and Procedures for improving Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB) Processing, 20 September 2001, Enclosure 1, Paragraph 1, Subparagraph b states:

“The MEB should be mailed within 30 days from dictation of the Narrative Summary (Department of Defense Instruction 1332.38., Physical Disability Evaluation). The 30

day Department of Defense (DoD) standard is a sub-component of the MEDCOM standard.”

e. US Army Medical Command Memorandum, Medical Evaluation Board (MEB)/Physical Evaluation Board (PEB) Referrals Using the DA Form 3349, Physical Profile, 07 October 2004, Paragraph 4 states:

“The MEB must be completed expeditiously; thus the physical profile must be forwarded immediately to the PEBLO on the date of referral. The date the profiling officer signs the physical profile referring the Soldier to an MEB begins the Medical Command (MEDCOM) 90-day period within which the MEB process must be completed. The 90-day MEB processing metric measures the time from the date the physician signs the physical profile to the date the MEB is forwarded to the PEB. Evaluation of the processing timelines of MEBs referred by the MMRB begins on the date the Soldier's packet is received at the military treatment facility from the MMRB Convening Authority. The DoDI 30-day MEB processing metric measures the time from the dictation of the narrative summary to receipt of the case at the PEB.”

FINDING 1.8 US Army Medical Command regulations and policy on the Medical Evaluation Board process are keeping pace with most medical retention issues.

STANDARD:

Army Regulation 40-501, Standards of Medical Fitness, 27 June 2006, Paragraphs 1-4 and 3-1 state:

“1–4. Responsibilities

a. The Surgeon General (TSG) will develop, revise, interpret, and disseminate current Army medical fitness standards and ensure Army compliance with Department of Defense (DOD) directives pertaining to those standards. TSG has the authority to issue exceptions to policies that are contained in this regulation.

b. Director, Department of Defense Medical Examination Review Board (DODMERB); Director, Army National Guard; Chief, U.S. Army Reserve (USAR); Superintendent, U.S. Military Academy (USMA), Director, Uniformed Services University of the Health Sciences (USUHS), and commanders of the U.S. Military Entrance Processing Command (MEPCOM), U.S. Army Recruiting Command (USAREC), U.S. Training and Doctrine Command, U.S. Army Medical Command (USAMEDCOM), U.S. Army Human Resources Command (AHRC), State Adjutants General, and all Army military treatment facilities (MTFs) worldwide, will implement policies prescribed in this regulation applicable to all Active Army and Reserve Component (RC) personnel and applicants for appointment (including all officer procurement programs), enlistment, and induction.

c. Commanders and military personnel officers at all levels of command will implement administrative and command provisions of chapters 5, 7, 8, 9, and 10.”

“3–1. General

This chapter gives the various medical conditions and physical defects which may render a Soldier unfit for further military service and which fall below the standards required for the individuals in paragraph 3–2 below.”

OBJECTIVE 2: Assess the execution and timeliness of the Physical Evaluation Board (PEB) and review processes to include compliance with Department of Defense (DOD) and Army policies.

FINDING 2.1: Army Regulations 10-59 and 635-40 are not consistent with other Army Regulations, nor DOD and Department of Veterans Affairs Policy.

STANDARDS:

a. Department of Defense Directive (DODD) 1332.18, Subject: Separation or Retirement for Physical Disability, 4 Nov 96, paragraphs 3.3 and 4.4.

3.3. The sole standard to be used in making determinations of unfitness due to physical disability shall be unfitness to perform the duties of the member's office, grade, rank or rating because of disease or injury. In addition, retirement or separation because of physical disability requires determinations that the disability:

3.3.1. Further:

3.3.1.1. In the case of a member on active duty for more than 30 days, was incurred while the member was entitled to basic pay, or any other member of the Armed Forces, after September 23, 1996, who is on active duty but is not entitled to basic pay under 37 U.S.C. 502(b) (reference (g)) due to authorized absence to participate in an educational program, or for an emergency purpose, as determined by the Secretary concerned; or

3.3.1.2. In the case of a member on active duty for 30 days or less, is the proximate result of, or was incurred in line of duty after September 23, 1996, as a result of:

3.3.1.2.1. Performing active duty or inactive duty training;

3.3.1.2.2. Traveling directly to or from the place at which such duty is performed; or

3.3.1.2.3. After September 23, 1996, an injury illness, or disease incurred or aggravated while remaining overnight, between successive periods of inactive duty training, at or in the vicinity of the site of the inactive duty training, if the site is outside reasonable commuting distance of the member's residence.

3.3.2. Is of a permanent nature.

3.3.3. Was not the result of intentional misconduct or willful neglect and was not incurred during a period of unauthorized absence.

4.4. The Secretaries of the Military Departments shall:

4.4.1. Ensure compliance with Chapter 61 of 10 U.S.C. (reference (b)), this Directive, and Instructions and guidance issued under the authority of this Directive.

4.4.2. Establish the Service-specific DES to consist of the four components designated in paragraph 3.2., above.

4.4.3. Manage the Service-specific DES to ensure physical disability evaluation is accomplished in a timely manner with uniform application of the governing laws and DOD policy.

4.4.4. Ensure that physicians who serve on MEBs are trained in the preparation of MEBs for physical disability evaluation.

4.4.5. Ensure that PEB members and applicable review authorities are trained and certified in physical disability evaluation.

4.4.6. Ensure all matters raising issues of fraud within the DES are investigated and resolved as appropriate.

4.4.7. Defer a determination of disability retirement of any officer who is being processed for, is scheduled for, or has received non-disability retirement for age or length of service until such determination is approved by the Under Secretary of Defense (Personnel and Readiness) on the recommendation of the ASD(HA) under Section 1216(b) of reference (b).

b. Department of Defense Instruction (DODI) 1332.38, Subject: Physical Disability Evaluation, 14 Nov 96 (with Change 1, 10 Jul 06), paragraphs 4.2 and 5.5.

4.2. Standard. Chapter 61 of reference (b) establishes the Department of Veterans Affairs' (DVA) Veterans Administration Schedule for Rating Disabilities (VASRD) (reference (d)) as the standard for assigning percentage ratings. The percentage ratings represent, as far as can practicably be determined, the average impairment in civilian occupational earning capacity resulting from certain diseases and injuries, and their residual conditions. However, not all the general policy provisions in Sections 4.1 - 4.31 of the VASRD are applicable to the Military Departments. Many of these policies were written primarily for DVA rating boards, and are intended to provide guidance under laws and policies applicable only to the DVA. This Instruction replaces these sections of the VASRD. The remainder of the VASRD is applicable except those portions that pertain to DVA determinations of Service connection, refer to internal DVA procedures or practices, or are otherwise specifically identified in Enclosure 2 as being inapplicable.

5.5. The Secretaries of the Military Departments shall:

5.5.1. Ensure that members with conditions that may be cause for referral into the DES are counseled at appropriate stages on the DES process and the member's rights, entitlements, and benefits.

5.5.2. Establish a quality assurance process to ensure that policies and procedures established by DOD Directive 1332.18 (reference (a)) and this Instruction are interpreted uniformly.

5.5.3. Make determinations on unfitness because of medical disqualification or physical disability; entitlement to assignment of percentage of disability at the time of retirement or separation because of physical disability; and, except as limited by 10 U.S.C. 1216(d) (reference

(b)), entitlement to and payment of disability retired and severance pay.

5.5.4. Ensure that the record of proceedings for physical disability cases supports the findings and recommendations made.

5.5.5. Ensure the Temporary Disability Retired List (TDRL) is managed to meet the requirements of 10 U.S.C. 1210 (reference (b)) for timely periodic physical examinations, suspension of retired pay, and removal from the TDRL.

5.5.6. Designate a Military Department representative to serve as the Department representative for the Disability Evaluation System.

5.5.7. Ensure all matters raising issues of fraud on the DES by members are investigated and resolved as appropriate.

c. DODI 1332.39, Subject: Application of the Veterans Administration Schedule for Rating Disabilities, 14 Nov 96, paragraph 5.3.

5.3. The Secretaries of the Military Departments shall ensure their respective physical disability evaluation systems apply the VASRD in accordance with this Instruction.

d. Army Regulation (AR) 10-59, United States Army Physical Disability Agency, 1 Apr 80, paragraph 5.d.

5. Command and staff relationships.

d. The CG, USAPDA is also the Director of the Army Council of Review Boards under the Army Military Review Boards Agency.

e. AR 635-40, Physical Evaluation for Retention, Retirement, or Separation, 8 Feb 06, paragraph 2-4 and Appendix B-1, B-2, B-3a.

2-4. Commanding General, U.S. Army Physical Disability Agency

The Commanding General (CG), U.S. Army Physical Disability Agency (USAPDA), under the operational control of the CDR, USA HRC, will operate the Army Physical Disability Evaluation System, to include—

a. Interpreting and implementing policies coming from higher authority.

b. Developing the policies, procedures, and programs of the system.

c. Coordinating with other military departments to ensure applicable laws, policies, and directives are interpreted uniformly. (A uniform interpretation is required to ensure that a Soldier of the Army will be granted substantially the same benefits as a member of another Service under similar conditions.)

d. Commanding and managing the subordinate elements of the USAPDA.

e. Reviewing Physical Evaluation Board (PEB) proceedings to ensure that Soldiers are given uniform and fair consideration under applicable laws, policies, and directives.

f. Making the final decision whether a Soldier is unfit because of physical disability except when such decisions are reserved to higher authority. Included as higher authority are the Office of the Secretary of the Army (OSA) and the Office of the Secretary of Defense (OSD).

g. Determining percentage rating and disposition.

Appendix B Section I General Rating Policies

B-1. Purpose of the Department of Veterans Affairs Schedule for Rating Disabilities (VASRD)

a. Congress established the VASRD as the standard under which percentage rating decisions are to be made for disabled military personnel. Such decisions are to be made according to Title IV of the Career Compensation Act of 1949 (Title IV is now mainly codified in 10 USC 61.)

b. Percentage ratings in the VASRD represent the average loss in earning capacity resulting from these diseases and injuries. The ratings also represent the residual effects of these health impairments on civil occupations.

B-2. Policy application

Not all of the general policy provisions of the VASRD apply to the Army. Section I replaces or modifies paragraph 1-31 of the VASRD, which pertain to VA determination of service-connected disabilities, internal VA procedures or practices, and other paragraphs that do not apply to the Army. Rating policies that apply to the Army but are not made clear by the VASRD are addressed.

B-3. Essentials of rating disabilities

a. *Application of the VASRD.* The VASRD is primarily 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 Army and VA applications of rating policies, differences in ratings may result. Unlike the VA, the Army must first determine whether or not a Soldier is fit to reasonably perform the duties of his office, grade, rank, or rating. Once a Soldier is determined to be physically unfit for further military service, percentage ratings are applied to the unfitting conditions from the VASRD. These percentages are applied based on the severity of the condition.

f. General Order 16, Army Council of Review Boards, 9 Jul 85, paragraph 2.

2. Army Council of Review Boards. a. *Supervision of the Army Council of Review Boards remains assigned to the Deputy Assistant Secretary of the Army (DA Review Boards, Personnel Security, and Equal Employment Opportunity Compliance and Complaints Review).*

b. *The Army Council of Review Boards will administer the following military review boards associated with the Office of the Secretary of the Army:*

Army Board of Review for Eliminations.

Army Disability Rating Review Board.

Army Disability Review Board.

Army Discharge Review Board.

Army Grade Determination Review Board.

Army Physical Disability Appeal Board.

Army Security Review Board.

g. USAPDA Policy Memoranda, 28 Feb 05.

h. USAPDA Issue and Guidance Memoranda, Mar-Aug 05.

i. Title 10, Armed Forces, Chapter 61

TITLE 10--ARMED FORCES

Subtitle A--General Military Law
PART II--PERSONNEL

CHAPTER 61--RETIREMENT OR SEPARATION FOR PHYSICAL DISABILITY

Sec. 1201. Regulars and members on active duty for more than 30 days: retirement

(a) Retirement.--Upon a determination by the Secretary concerned that a member described in subsection (c) is unfit to perform the duties of the member's office, grade, rank, or rating because of physical disability incurred while entitled to basic pay or while absent as described in subsection (c)(3), the Secretary may retire the member, with retired pay computed under section 1401 of this title, if the Secretary also makes the determinations with respect to the member and that disability specified in subsection (b).

(b) Required Determinations of Disability.--Determinations referred to in subsection (a) are determinations by the Secretary that--

(1) based upon accepted medical principles, the disability is of a permanent nature and stable;

(2) the disability is not the result of the member's intentional misconduct or willful neglect, and was not incurred during a period of unauthorized absence; and

(3) either--

(A) the member has at least 20 years of service computed under section 1208 of this title; or

(B) the disability is at least 30 percent under the standard schedule of rating disabilities in use by the Department of Veterans Affairs at the time of the determination; and either--

(i) the member has at least eight years of service computed under section 1208 of this title;

(ii) the disability is the proximate result of performing active duty;

(iii) the disability was incurred in line of duty in time of war or national emergency; or

(iv) the disability was incurred in line of duty after September 14, 1978.

(c) Eligible Members.--This section and sections 1202 and 1203 of this title apply to the following members:

(1) A member of a regular component of the armed forces entitled to basic pay.

(2) Any other member of the armed forces entitled to basic pay who has been called or ordered to active duty (other than for training under section 10148(a) of this title) for a period of more than 30 days.

(3) Any other member of the armed forces who is on active duty but is not entitled to basic pay by reason of section 502(b) of title 37 due to authorized absence (A) to participate in an educational program, or (B) for an emergency purpose, as determined

by the Secretary concerned.

TITLE 10--ARMED FORCES

Subtitle A--General Military Law

PART II--PERSONNEL

CHAPTER 61--RETIREMENT OR SEPARATION FOR PHYSICAL DISABILITY

Sec. 1203. Regulars and members on active duty for more than 30 days: separation

(a) Separation.--Upon a determination by the Secretary concerned that a member described in section 1201(c) of this title is unfit to perform the duties of the member's office, grade, rank, or rating because of physical disability incurred while entitled to basic pay or while absent as described in section 1201(c)(3) of this title, the member may be separated from the member's armed force, with severance pay computed under section 1212 of this title, if the Secretary also makes the determinations with respect to the member and that disability specified in subsection (b).

(b) Required Determinations of Disability.--Determinations referred to in subsection (a) are determinations by the Secretary that--

(1) the member has less than 20 years of service computed under section 1208 of this title;

(2) the disability is not the result of the member's intentional misconduct or willful neglect, and was not incurred during a period of unauthorized absence;

(3) based upon accepted medical principles, the disability is or may be of a permanent nature; and

(4) either--

(A) the disability is less than 30 percent under the standard schedule of rating disabilities in use by the Department of Veterans Affairs at the time of the determination, and the disability was (i) the proximate result of performing active duty, (ii) incurred in line of duty in time of war or national emergency, or (iii) incurred in line of duty after September 14, 1978;

(B) the disability is less than 30 percent under the standard schedule of rating disabilities in use by the Department of Veterans Affairs at the time of the determination, and the member has at least eight years of service computed under section 1208 of this title, or

(C) the disability is at least 30 percent under the standard schedule of rating disabilities in use by the Department of Veterans Affairs at the time of the determination, the disability was neither (i) the proximate result of performing active duty, (ii) incurred in line of duty in time of war or national emergency, nor (iii) incurred in line of duty after September 14, 1978, and the member has less than eight years of service computed under section 1208 of this title on the date when he would otherwise be retired under section 1201 of this title or placed on the temporary disability retired list under section 1202 of this title.

TITLE 10--ARMED FORCES
Subtitle A--General Military Law
PART II--PERSONNEL

CHAPTER 61--RETIREMENT OR SEPARATION FOR PHYSICAL DISABILITY
Sec. 1212. Disability severance pay

(a) Upon separation from his armed force under section 1203 or 1206 of this title, a member is entitled to disability severance pay computed by multiplying (1) his years of service, but not more than 12, computed under section 1208 of this title, by (2) the highest of the following amounts:

(A) Twice the amount of monthly basic pay to which he would be entitled if serving (i) on active duty on the date when he is separated and (ii) in the grade and rank in which he was serving on the date when his name was placed on the temporary disability retired list, or if his name was not carried on that list, on the date when he is separated.

(B) Twice the amount of monthly basic pay to which he would be entitled if serving (i) on active duty on the date when his name was placed on the temporary disability retired list or, if his name was not carried on that list, on the date when he is separated, and (ii) in any temporary grade or rank higher than that described in clause (A), in which he served satisfactorily as determined by the Secretary of the military department or the Secretary of Homeland Security, as the case may be, having jurisdiction over the armed force from which he is separated.

(C) Twice the amount of monthly basic pay to which he would be entitled if serving (i) on active duty on the date when his name was placed on the temporary disability retired list or, if his name was not carried on that list, on the date when he is separated, and (ii) in the permanent regular or reserve grade to which he would have been promoted had it not been for the physical disability for which he is separated and which was found to exist as a result of a physical examination.

(D) Twice the amount of monthly basic pay to which he would be entitled if serving (i) on active duty on the date when his name was placed on the temporary disability retired list or, if his name was not carried on that list, on the date when he is separated, and (ii) in the temporary grade or rank to which he would have been promoted had it not been for the physical disability for which he is separated and which was found to exist as a result of a physical examination, if his eligibility for promotion was required to be based on cumulative years of service or years in grade.

(b) For the purposes of subsection (a), a part of a year of active service that is six months or more is counted as a whole year, and a part of a year that is less than six months is disregarded.

(c) The amount of disability severance pay received under this section shall be deducted from any compensation for the same disability to which the former member of the armed forces or his dependents become entitled under any law administered by the Department of Veterans Affairs. However, no deduction may be made from any death compensation to which his dependents become entitled after his death.

j. Title 38, Veteran's Benefits, Section 4.1

TITLE 38--VETERANS' BENEFITS

Part 4—Schedule for Rating Disabilities

Authority: 38 U.S.C. 1155.

Source: 29 FR 6718, May 22, 1964, unless otherwise noted.

Subpart A—General Policy in Rating

§4.1 Essentials of evaluative rating.

This rating schedule is primarily a guide in the evaluation of disability resulting from all types of diseases and injuries encountered as a result of or incident to military service. The percentage ratings represent as far as can practicably be determined the average impairment in earning capacity resulting from such diseases and injuries and their residual conditions in civil occupations. Generally, the degrees of disability specified are considered adequate to compensate for considerable loss of working time from exacerbations or illnesses proportionate to the severity of the several grades of disability. For the application of this schedule, accurate and fully descriptive medical examinations are required, with emphasis upon the limitation of activity imposed by the disabling condition. Over a period of many years, a veteran's disability claim may require reratings in accordance with changes in laws, medical knowledge and his or her physical or mental condition. It is thus essential, both in the examination and in the evaluation of disability, that each disability be viewed in relation to its history

FINDING 2.2: U.S. Army Physical Disability Agency uses an insufficient data management program (PDCAPS- Physical Disability Case Processing System) to manage Physical Evaluation Board cases.

STANDARDS:

a. DODD 1332.18, Subject: Separation or Retirement for Physical Disability, 4 Nov 96, paragraph 4.4.

4.4. The Secretaries of the Military Departments shall:

4.4.1. Ensure compliance with Chapter 61 of 10 U.S.C. (reference (b)), this Directive, and Instructions and guidance issued under the authority of this Directive.

4.4.2. Establish the Service-specific DES to consist of the four components designated in paragraph 3.2., above.

4.4.3. Manage the Service-specific DES to ensure physical disability evaluation is accomplished in a timely manner with uniform application of the governing laws and DOD policy.

4.4.4. Ensure that physicians who serve on MEBs are trained in the preparation of MEBs for physical disability evaluation.

4.4.5. Ensure that PEB members and applicable review authorities are trained and certified in physical disability evaluation.

4.4.6. Ensure all matters raising issues of fraud within the DES are investigated and resolved as appropriate.

4.4.7. Defer a determination of disability retirement of any officer who is being processed for, is scheduled for, or has received non-disability retirement for age or length of service until such determination is approved by the Under Secretary of Defense (Personnel and Readiness) on the recommendation of the ASD(HA) under Section 1216(b) of reference (b).

b. DODI 1332.38, Subject: Physical Disability Evaluation, 14 Nov 96 (with Change 1, 10 Jul 06), paragraph 5.5.2.

5.5.2. Establish a quality assurance process to ensure that policies and procedures established by DOD Directive 1332.18 (reference (a)) and this Instruction are interpreted uniformly.

c. AR 635-40, Physical Evaluation for Retention, Retirement, or Separation, 8 Feb 06, paragraphs 2-4.a. and 2-4.b.

2-4. Commanding General, U.S. Army Physical Disability Agency

The Commanding General (CG), U.S. Army Physical Disability Agency (USAPDA), under the operational control of the CDR, USA HRC, will operate the Army Physical Disability Evaluation System, to include—

a. Interpreting and implementing policies coming from higher authority.

b. Developing the policies, procedures, and programs of the system.

d. USAPDA Standing Operating Procedures, 25 Apr 01, paragraph 5-12. and Chapter 11.

5-12. DATA ACCURACY AND INTEGRITY. "The PDCAPS system is only as good as the person who enters the data into the system." Although this statement bears truth, the PDCAPS system is yet an infant to the many requirements of accurate data analysis. Improvements to the system require the assistance of all users. Each user is also responsible for the information entered into the PDCAPS system. Accuracy checks should occur by PEB Presidents at a minimum of monthly, and by HQ Agency analysts, quarterly. Manual records should be reconciled with computer records on a regular basis to ensure accuracy of computer data and integrity of information.

CHAPTER 11

PHYSICAL DISABILITY CASE PROCESSING SYSTEM (PDCAPS)

11-1. **PURPOSE.** PDCAPS is a compiled Clipper program that is designed to operate on Window NT, Novell or 3-COM local area network or on a stand alone IBM compatible personal computer.

11-2. **APPLICABILITY.** All users on the local area network can use PDCAPS. The military personnel clerks use PDCAPS to automate their work and view the case status of soldiers in our system. The adjudicators use PDCAPS for case status and use the reports for analysis. Some of the PEBLOs use a stand-alone version of PDCAPS to input the personnel data, which is then sent to the PEB in diskette form followed by the hard copy.

11-3. **GENERAL.**

a. PDCAPS effectively automates the disability process by providing a user friendly system which permits the PEBs to enter, update and report on case information as required, establishes telecommunication links to automate the transfer of information between the PDA and the PEBs, and develops standard reports which may be generated to review the overall process of disability case processing.

b. PDCAPS was developed using a rapid prototype methodology combined with highly structured program modules to facilitate modification to meet user needs and changing policies and procedures in the Army physical disability process. The system makes extensive use of lookup tables to store variable entries so System Administrators have an ongoing capability to update these tables through simple menu picks. This capability enables PDCAPS to remain current with Army policy and procedure.

c. PDCAPS has one module available to the PEBLOs. It is the PEB Liaison Officer (PEBLO) Module. This is a specialized module in which the PEBLO enters the basic personnel data that initiates a physical disability case and starts the automated processing system.

d. The Physical Disability Agency has prepared a list of proposed modifications to the PDCAPS system. These modifications are being reprogrammed by a contract programmer under the TAPSYS II contract.

e. PDCAPS is an unclassified system. It does, however, contain sensitive personnel information pertaining to soldiers that must be safeguarded against unauthorized access.

FINDING 2.3: The US Army Physical Disability Agency (USAPDA) does not always meet the DODI 1332.38 40-day standard for the processing time for a final disability determination.

STANDARDS:

a. DODI 1332.38, Subject: Physical Disability Evaluation, 14 Nov 96 (with Change 1, 10 Jul 06), paragraph E3.P1.6.3.

E3.P1.6.3. PEB. Upon receipt of the MEB or physical examination report by the PEB, the processing time to the date of the determination of the final reviewing authority as prescribed by the Secretary of the Military Department should normally be no more than 40 days.

b. USAPDA Standing Operating Procedures, 25 Apr 01, paragraph 5-8.a.

5-8. TIME STANDARDS

a. The Department of the Army goal for processing disability cases within the PEB/PDA is 40 days. In an effort to achieve this goal, time objectives have been established for each phase of the disability process. They are as follows:

PEB – 30 days
Opns Div – 5 days
PDB – 5 days

FINDING 2.4: Processing Continuation on Active Duty (COAD) and Continuation on Active Reserve (COAR) requests resulted in additional time beyond the DODI 40-day standard in which Soldiers are in the Army Physical Disability Evaluation System.

STANDARDS:

a. DODI 1332.38, SUBJECT: Physical Disability Evaluation, 14 Nov 96 (with Change 1, 10 Jul 06), paragraph E3.P1.6.3.

E3.P1.6.3. PEB. Upon receipt of the MEB or physical examination report by the PEB, the processing time to the date of the determination of the final reviewing authority as prescribed by the Secretary of the Military Department should normally be no more than 40 days.

b. AR 635-40, Physical Evaluation for Retention, Retirement, or Separation, 8 Feb 06, Chapter 6.

Chapter 6

Continuation on Active Duty and Continuation on Active Reserve Status of Unfit Soldiers

6-1. General

- a. This chapter prescribes the criteria and procedures under which Soldiers who have been determined unfit by the PDES may be continued on active duty (COAD) or in active reserve status (COAR) as an exception to policy. (This provision is referred to as “permanent limited duty” in DODD 1332.18 and DOD Instruction 1332.38.)
- b. With the exception of this subparagraph, this chapter does not pertain to RC Soldiers in a nonactive duty status who have been medically disqualified for medical impairments incurred in a nonduty status. (An example of this situation is a Troop Unit Program (TPU) Soldier injured on his or her civilian job to the degree that the Soldier falls below medical retention standards of AR 40-501, chapter 3.). These Soldiers may request continuation under the provisions of AR 40-501, para 9-10b (USAR) or 10-26 (ARNGUS) upon notification of medical disqualification. If the Soldier defers such a request pending the outcome of his or her voluntary referral to a nonduty-related PEB, and the PEB determines that the Soldier is unfit, the Soldier’s application should cite the provisions of DODD 1332.18, para 3.12, in addition to the applicable para of AR 40-501 and include the findings of the PEB with the documentation required by AR 40-501.

6-2. Objective

- a. The primary objective of this program is to conserve manpower by effective use of needed skills or experience. A Soldier who is physically unqualified for further military service has no inherent or vested right to continuation.
- b. Continuation in a military status is generally subject to the Soldier’s consent. However, the Secretary of the Army (SA), or their designee, may involuntarily continue Soldiers determined unfit by the PDES in consideration of their service obligation or special skill and experience.

6-3. Duty statuses eligible for continuation on active duty and continuation on active Reserve status

- a. The COAD applies to—
- (1) Officers on the active duty list.
 - (2) Regular Army enlisted Soldiers.
 - (3) Soldiers in the Active Guard/Reserve (AGR) or on full-time National Guard duty (FTNGD) requesting continuation as AGR or FTNGD.
- b. The COAR applies to—
- (1) The AGR Soldiers requesting to continue as members of the Individual Ready Reserve (IRR) or as TPU member. (The approving authority will coordinate the request with the AGR manager.)
 - (2) The FTNGD Soldiers requesting to continue as traditional (drilling) unit members. (The approving authority will coordinate the request with the State Joint Forces Headquarters Human Resources Officer (HRO)).
 - (3) ARNG unit members, USAR TPU members, IRR members, and Individual Mobilization Augmentees (IMA’s). These Soldiers may request COAR in any of these statuses.
- c. RC Soldiers determined unfit while mobilized may only request continuation in their pre-mobilization status or in the IRR. They are ineligible for COAD, or otherwise being

accessed onto the active duty list as a COAD. The Soldier may return to a mobilized status subject to mobilization policy.

6-4. The period for which continuation on active duty and continuation active Reserve status may be approved

a. Normally, a COAD will be for any period of time up to the last day of the month in which the Soldier attains 20 years of active federal service for purposes of qualifying for length of service retirement under Title 10, United States Code, Section 3911 or 3914 (10 USC 3911 or 3914). Normally, a COAR will be for any length of time up to the minimum time required for the Soldier to be issued and receive the 20-year letter of qualifying service for purposes of qualifying for nonregular retirement under Title 10, United States Code, Section 12731 (10 USC 12731).

b. A Soldier who was approved for COAD/COAR for a period less than that described in subparagraph a above may reapply for another period of COAD/COAR when found unfit by the follow-on PDES evaluation related to the current COAD/COAR.

c. Normally, a Soldier who was COAD/COAR to the applicable 20-year period described in "a", above, and who is found unfit upon referral to the Physical Disability Evaluation System (PDES), will not be approved for another period of continuation. Any request for further continuation must include endorsement from the Soldier's command or organization at no less than the 0-6 level. The request must fully justify the organization's continued need for the Soldier's experience and skills.

6-5. Precedence of continuation on active duty and continuation on active Reserve status to enlistment contracts or other obligated service

a. Soldiers approved for COAD or COAR are authorized retention. Soldiers not serving on an indefinite reenlistment are required to reenlist and/or extend to meet the approved COAD or COAR end date. Soldiers serving on an indefinite reenlistment commitment require no additional action. Soldiers are authorized to serve to contractual ETS, unless separated earlier. A Soldier found fit during the final disability evaluation upon expiration of COAD/COAR period may continue to serve to contractual ETS or re-enlist if otherwise qualified.

b. For purposes of any required re-enlistment during the COAD/COAR period, the Soldier is not required to meet medical retention standards for the disabilities for which he or she was continued. However, if these disabilities have worsened to the degree to make further service questionable, or if the member is diagnosed with new conditions which fall below the medical retention standards of AR 40-501, chapter 3, the Soldier may be denied re-enlistment. If reenlistment is denied, the Soldier must be referred to the PDES.

6-6. Referral to the physical disability evaluation system prior to expiration of continuation period

a. Generally, Soldiers approved for a COAD of greater than six months will be referred to the PDES before expiration of the COAD. Final PDES evaluation may be waived for retirement for length of service. The Soldier must sign a waiver statement acknowledging that by foregoing final disability processing he or she is forgoing a potential disability retirement and the potential benefits related thereto (such as greater retired pay, or tax advantages, or certain benefits pertaining to employment under Federal Civil Service, depending upon the individual case circumstances). This waiver must be made a part of the Soldier's military health record.

b. Generally, a Soldier approved for a COAD of six months or less to attain eligibility for active service retirement will not be referred to the PDES. The Soldier will be retired for physical disability upon the expiration of COAD. However, if the Soldier consents to referral and the Soldier has incurred a new, acute, grave illness or injury, or has suffered grave deterioration of the condition for which the Soldier was continued, the Soldier will be referred to the PDES.

c. The final PDES evaluation will be under the fitness and ratings standards in effect at that time.

(1) If the disability has healed or improved so that the Soldier is capable of performing his or her primary MOS or specialty code duties in other than a limited duty status, the Soldier may be found fit. The ability to perform duties with prosthetics, however, does not constitute a healing or improvement of a Soldier's medical condition for purposes of a fit finding at the time of final PDES evaluation.

(2) If the disability has remained unchanged or increased in severity, the PEB will find the Soldier unfit because of physical disability.

(3) The PEB may not make a finding of unfit or determine the disability rating based on how the disability may impact on the Soldier's future ability to perform his or her PMOS or specialty code duties. The determinations must be based on the Soldier's current ability to perform these duties.

(4) The presumption of fitness rule will not be applied to the disabilities for which the Soldier was continued, since unfitness was established by the earlier disability evaluation. Other diagnoses are subject to the rule.

d. Generally, RC Soldiers approved for COAR under this chapter will be referred to the PDES prior to the expiration of the COAR.

(1) When expiration of the COAR period provides the Soldier with 20 qualifying years of service for nonregular retirement, the Soldier may waive final referral to the PDES and be transferred to the Retired Reserve by the component. To waive final referral, the Soldier must execute a written waiver acknowledging that transfer to the Retired Reserve without final PDES evaluation will result in not electing the provisions of 10 USC 1209 or could result in loss of an immediate disability retirement if the outcome of the waived PDES evaluation were a finding of unfit and the member would be awarded a disability rating of at least 30 percent or the member has 20 years of service as computed under 10 USC 1208. The waiver must be provided to AHRC St Louis with the member's request to transfer to the Retired Reserve without final PDES evaluation.

(2) For COAR cases which complete final disability evaluation, any increase in the disability rating may be denied if a preponderance of evidence reflects that the worsening of the severity of the RC Soldier's unfitting condition resulted from intervening events between periods of active duty and IDT. The presumption of fitness rule will not be applied to the disabilities for which the Soldier was continued but will be applied to any other diagnoses.

6-7. Qualification and process for continuation on active duty and continuation on active Reserve status

a. To be considered for COAD or COAR, a Soldier must be—

(1) Determined unfit by the PDES for a disability that was not the result of intentional misconduct nor willful neglect, nor incurred during a period of unauthorized absence.

(2) Basically stable or have a disability that is of slow progression according to accepted by medical principles. It must not be deleterious to the Soldier's health or prejudicial to the best interest of the Soldier or the Army. For example, the disability must not require undue loss of time from duty for medical treatment. It must not pose a risk to the health or safety of other Soldiers.

(3) Physically capable of performing useful duty in an MOS for which currently qualified or potentially trainable (to include re-classification).

(4) Eligible under one or more of the criteria listed below:

(a) For COAD, have 15 but less than 20 years of active federal service. For COAR, have a total of 15, but less than 20 years of qualifying service for nonregular retirement.

(b) Qualified in a critical skill or shortage MOS. Such qualification must be confirmed in writing by the applicable personnel office and attached to the request; or

(c) Disability resulted from combat or terrorism.

b. The application must be forwarded with either the MEB or with the Soldier's election to the informal findings within the prescribed election time frame. (See fig 6-1 for COAD and fig 6-2 for COAR.)

6-8. Special counseling

a. *Application.* Before the Soldier completes an application for COAD or COAR, the PEBLO will counsel the Soldier according to appendix C. The PEBLO will specifically inform the Soldier of the following:

(1) Before a COAD or COAR application is forwarded to the approval authority, the PEB will process the case to completion, to include the following:

(a) Convening a formal hearing, if requested.

(b) Determining a percentage rating.

(c) Recommending a disposition that will apply if application for continuation is disapproved.

(2) Of the eligibility criteria for requesting continuation.

(3) That if continuation is approved, the Soldier must be referred to the PDES before expiration of the continuation period unless Soldier waives in writing the final referral.

(4) That the final PDES evaluation could result in a fit finding under the guidance at paragraph 6-6 above.

(5) That if the request for continuation is disapproved, the approval authority will notify the MTF and HQUSAPDA. The HQUSAPDA will notify the applicable Transition Center that the Soldier is to be separated or retired for disability, as applicable. If the case is that of a Ready Reserve not on active duty, HQUSAPDA will prepare the orders.

b. *Soldiers with 18 active or qualifying years of service.* When the PEBLO has a case of an active Army Soldier with 18 years but less than 20 years of active service, or an RC soldier with 18 but less than 20 years of qualifying service, a declination to request a COAD or COAR, as applicable, should be in writing and attached to the MEB proceeding. If the Soldier refuses to indicate in writing his declination of COAD or COAR, the PEBLO will prepare and sign a statement that he or she counseled the Soldier on continuation, and the Soldier declined to request continuation.

6-9. Processing by medical treatment facility

The MTF commander should ensure that—

a. Item 16 of DA Form 3947 is completed indicating whether COAD or COAR is medically advisable.

- b. Item 3 of DA Form 3349 documents the assignment limitations.
- c. The required documents per paragraph 4-15 are attached. The commander's statement should include a recommendation for or against approval of continuation.

6-10. Physical evaluation board processing

- a. *Policy.* The fact that a Soldier has or has not applied for COAD/COAR will not influence the determination of fitness or percentage of the disability rating.
- b. *DA Form 199.* If the Soldier is found physically unfit, the following statement will be added in block 8. "Soldier has applied for COAD or COAR. The recommended disposition in block 9 applies if Soldier's application for continuation is denied."

6-11. Headquarters, U.S. Army Physical Disability Agency action

- a. The HQUSAPDA will forward the case file to the applicable approving authority listed in paragraph 6-12 below upon completion of review of the PEB proceedings, as required. A suspense file will be maintained.
- b. When the case concerns a finding of unfit for a General or Medical Corps officer subject to the provisions of 10 USC 1216, HQUSAPDA will obtain review by OASD(HA) prior to forwarding the case file for consideration of continuation.

6-12. Action by approving authority

- a. The approving authority listed in (1) through (7), below will act on the Soldier's request for continuation. However, the DCS, G-1, is the disapproval authority for applications from Soldiers tracked by the Army Wounded Warrior program, formerly known as the Disabled Soldier Support System.

(1) *Regular Army enlisted.* Commander, U.S. Army Human Resources Command – Alexandria (AHRC-EP), Hoffman II, 2461 Eisenhower Avenue, Alexandria, VA 22332-0450. The condition causing the Soldier's physical unfitness is such that more frequent examination is indicated.

(2) *Regular Army officers.* Commander, U.S. Army Human Resources Command – Alexandria (AHRC-PDT-PM), 200 Stovall Street, Alexandria, VA 22332-0418. The applications of AMEDD officers will be coordinated with HQDA, Office of the Surgeon General (DASG-PTZ), 5109 Leesburg Pike, Falls Church, VA 22041.

(3) *USAR Officers on the ADL.* Commander, Human Resources Command (AHRC-PDT-PM), 200 Stovall Street, Alexandria, VA 22332-0418. (See (2) above, for applications of AMEDD officers.)

(4) *Chaplains (Active Army).* HQDA (DACH-PZB), Pentagon, Room 1E417, Washington, DC 20310-2206.

(5) *Judge Advocate General's Corps Officers (Active Army).* HQDA (DAJA-PT), Pentagon, Room 2E443, Washington, DC 20310-2206.

(6) *Active Status USAR officers and enlisted, to include USAR Soldiers in the Active Guard Reserve (AGR) program.* Commander, Human Resources Command – St. Louis (Command Surgeon), 9700 Page Avenue, St. Louis, MO 63132-5200.

(7) *Army National Guard of the United States (ARNGUS) officers and enlisted, to include Army National Guard of the United States Soldiers in the Army Guard Reserve (AGR) Program (Title 10 and Title 32).* Chief, National Guard Bureau, Army National Guard Readiness Center (NGB-ARS), 111 S. George Mason Drive, Arlington, VA 22204-1382.

- b. If the Soldier's application is approved, the approving authority will—

(1) Notify the MTF commander of the action and furnish assignment orders or instructions, if appropriate.

(2) Provide a copy of the Soldier's DA Form 3349 to the servicing Personnel Service Center (PSC). DA Form 3349 will be used as the source document to show—

(a) The profile serial (AR 40-501, table 7-1) and COAD profile code X (AR 40-501, table 7-2) to be entered into the Electronic Military Personnel Office (eMILPO) Readiness Module. This will update the enlisted and officer records brief (ERB/ORB) section IV.

(b) That the assignment limitations detailed on DA Form 3349 must be followed.

(3) Furnish an information copy of the action to HQUSAPDA, and for Active Army Soldiers, to CDR, HRC –Indianapolis (PCRE-FS), Fort Benjamin Harrison, IN 46249-5301.

c. If the Soldier's application is disapproved, the disapproving office will notify the MTF commander promptly so that the Soldier may be informed. The disapproving office will furnish HQUSAPDA with information copies of the letter of disapproval. The disapproving office will forward the original DA Form 199 and enclosures, less medical records, without delay to Commander, USAPDA (AHRC-DPD-B), WRAMC, Bldg 7, 6900 Georgia Avenue, NW,

Washington DC 20307-5001. HQUSAPDA will take appropriate separation action.

6-13. Consideration for reclassification (enlisted) or branch transfer (officers)

A Soldier approved for COAD or COAR may be considered for reclassification or branch transfer subject to reclassification and retention management policy in effect at the time of his or her request. Accordingly, the enlisted Soldier's request for continuation should list in order of preference three MOSs for reclassification consideration. The officer's request for continuation should list three specialty/functional areas for consideration. Reclassification or branch transfer or award of new specialty could result in a finding of fit at time of final PDES evaluation. (See para 6-6.)

6-14. Medical reevaluation

a. *Periodic medical evaluation.* Commanders of Soldiers with approved COAD/COAR will refer the Soldier for a physical no less than every two years to confirm whether the Soldier's disability has worsened to the degree that the continuation would be deleterious to the Soldier's health or prejudicial to the best interests of the Soldier or the Army. Earlier evaluation is warranted when any one of the following criteria is met.

(1) The condition causing the Soldier's physical unfitness is such that more frequent examination is indicated.

(2) The Soldier has been rehospitalized because of worsening of the unfitting condition.

(3) The Soldier has been rehospitalized because of some other condition impacting on the Soldier's ability to perform duty.

b. *Responsibilities of the managing physician.* The managing physician must give special attention to the stability of the Soldier's unfitting condition. The physician will—

(1) If severity increases, estimate the impact on the Soldier's ability to perform duty.

(2) If degradation of the Soldier's condition occurs so as to further impair performance of duty, note such findings and conclusions on the DD Form 2808.

(3) Notify the Soldier's commander.

c. *Referral to physical evaluation board.* If the managing physician believes it is necessary, or the Soldier's commander requests it, the Soldier will be referred to a MEB and PEB.

c. Memorandum of Understanding (MOU) between the Force Alignment Division (FAD), Human Resources Command (HRC) and USAPDA, 26 Oct 05.



DEPARTMENT OF THE ARMY
US TOTAL HUMAN RESOURCES COMMAND
2461 EISENHOWER AVENUE
ALEXANDRIA VA 22331-0450

26 October 2005

MEMORANDUM OF UNDERSTANDING
BETWEEN
FORCE ALIGNMENT DIVISION (FAD), HUMAN RESOURCES COMMAND (HRC)
AND THE PHYSICAL DISABILITY AGENCY (PDA)

SUBJECT: Processing of Continuance on Active Duty Applications

1. Purpose. To outline FAD and PDA responsibility in the processing of Continuance on Active Duty (COAD) applications for Regular Army Soldiers.

2. Issue. Force Alignment Division will assume approval authority for COAD applications from PDA.

3. Understanding.

a. PDA is responsible for:

(1) Receiving the COAD and ensuring Soldier meets the basic eligibility requirements.

(2) Providing the COAD application to FAD for eligible applicants only.

b. FAD is responsible for:

(1) Receiving COAD application from PDA and coordinating request within the Enlisted Personnel Management Directorate (EPMD).

(2) If COAD is approved FAD will

(a) Prepare approval memorandum and dispatch to PDA
(b) Provide copy to MOS branch, for assignment as appropriate

(c) Update the Total Army Personnel Database with PULHES, Physical Category code and remarks section to reflect COAD approval.

(3) If COAD is disapproved FAD will

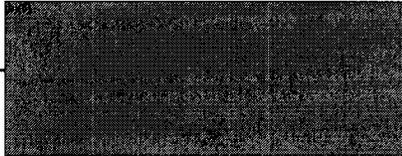
PDA (a) Prepare disapproval memorandum and dispatch to
(b) Provide copy to MOS branch
(c) Update the Total Army Personnel Database with PULHES, Physical Category code and remarks section to reflect COAD disapproval.

(4) Notifying the Medical Treatment Facility (MTF) of final disposition.

5. This agreement is effective 31 October 2005.



26 Oct 05
Date



27 Oct 05
Date

FINDING 2.5: The USAPDA quality assurance program does not conform to DOD and Army policy.

STANDARDS:

a. DODD 1332.18, Subject: Separation or Retirement for Physical Disability, 4 Nov 96, paragraphs 4.4.1. and 4.4.3.

4.4. The Secretaries of the Military Departments shall:

4.4.1. Ensure compliance with Chapter 61 of 10 U.S.C. (reference (b)), this Directive, and Instructions and guidance issued under the authority of this Directive.

4.4.3. Manage the Service-specific DES to ensure physical disability evaluation is accomplished in a timely manner with uniform application of the governing laws and DOD policy.

b. DODI 1332.38, Subject: Physical Disability Evaluation, 14 Nov 96 (with Change 1, 10 Jul 06), paragraphs 5.5.2. and E3.P1.3.5.

5.5.2. Establish a quality assurance process to ensure that policies and procedures established by DOD Directive 1332.18 (reference (a)) and this Instruction are interpreted uniformly.

E3.P1.3.5. Quality Assurance. Quality assurance review shall be conducted as necessary to ensure compliance with the laws, directives, and regulations governing physical disability evaluation.

c. DODI 1332.39, Subject: Application of the Veterans Administration Schedule for Rating Disabilities, 14 Nov 96, paragraph 5.3.

5.3. The Secretaries of the Military Departments shall ensure their respective physical disability evaluation systems apply the VASRD in accordance with this Instruction.

d. AR 635-40, Physical Evaluation for Retention, Retirement, or Separation, 8 Feb 06, paragraph 4-22.

4-22. Review by U.S. Army Physical Disability Agency

a. Required review. The USAPDA will review the following cases:

- (1) General and Medical Corps officers found unfit.
- (2) Informal proceedings when the Soldier nonconcurrs with the PEB findings and recommendations, waives a formal hearing, submits a statement of rebuttal within the required time frame, and consideration of the rebuttal by the PEB does not result in a change to its findings and recommendations.
- (3) Formal proceedings when the Soldier nonconcurrs with the PEB findings and recommendations, submits a statement of rebuttal within the required time frame, and consideration of the rebuttal by the PEB does not result in a change to its findings and recommendation.
- (4) Cases in which a voting member of the PEB submits a minority report.
- (5) Any case previously forwarded to USAPDA for review and approval and which has been returned to the PEB for reconsideration or rehearing.
- (6) Cases designated by the CG, USAPDA for review.
- (7) Cases of Soldiers assigned to USAPDA.

b. Purpose of review. The review will be confined to the case records and proceedings and related evidence. The review will ensure that the following criteria have been satisfied.

- (1) The Soldier received a full and fair hearing.
- (2) The proceedings of the medical evaluation board and the PEB were conducted according to governing regulations.
- (3) The findings and recommendations of the MEBD and PEB were just, equitable, consistent with the facts, and in keeping with the provisions of law and regulations.
- (4) Due consideration was given the facts and requests contained in any rebuttal to the PEB findings and recommendations submitted by, or for, the Soldier being evaluated.
- (5) Records of the case are accurate and complete.

c. Determinations. Based upon review of the PEB proceedings, USAPDA may take the following actions:

- (1) Concur with the findings and recommendations of the PEB or make minor changes or corrections that do not affect the recommended disposition of the Soldier or lower the combined percentage rating.
- (2) Return the case to the PEB for reconsideration, clarification, further investigation, a formal hearing, or other action when the case records show such action is in the best interests of the Soldier or the Army. A detailed explanation for the reasons for return of the case will be provided to the PEB.
- (3) Issue revised findings providing for a change in disposition of the Soldier or change in the Soldier's disability rating.
- (4) Refer the case to the APDAB.

d. Revised findings. USAPDA, will take the following actions when modifying PEB findings and recommendations.

- (1) Furnish the Soldier (next-of-kin or legal guardian) a copy of the revision by certified mail, return receipt requested. The letter of transmittal will state the reason for the change. Information copies will be provided to the PEBLO and to the Soldier's counsel.
- (2) Advise the Soldier (next-of-kin or legal guardian) that his or her election or rebuttal to the revision must be received by USAPDA within 10 days from the Soldier's receipt of the revised findings unless a request for extension is received and approved within the same time frame.
- (3) Return the case records to the PEB if the Soldier is eligible for and requests a formal hearing or if one is directed under the provisions of 4-22c(2), above. Processing will be according to paragraph 4-21.

e. Consideration of rebuttal.

- (1) After considering the Soldier's rebuttal to the revised findings, USAPDA will make one of the following determinations:
 - (a) Accept the rebuttal; issue new findings and recommendations according to the rebuttal; and forward the case to USA HRC for final action.
 - (b) Concur with the original recommendations of the PEB; forward the case to USA HRC for final action.
 - (c) Adhere to the revised findings and recommendations and forward the case to APDAB.
- (2) The USAPDA will inform the Soldier in writing of the results of its consideration of the rebuttal.

f. Soldier's response.

- (1) If the Soldier concurs with the revised findings and recommendations, USAPDA will approve the case for the Secretary of the Army and forward the case to USA HRC for final disposition.
- (2) If the Soldier nonconcur and submits a statement of rebuttal explaining their reasons for disagreement, and the consideration of the rebuttal does not result in a change to the revised findings, USAPDA will forward the case to APDAB for review unless (3), below is applicable.
- (3) If the Soldier fails to submit an election within the allotted time, USAPDA will deem that the Soldier has waived their right to file a rebuttal. The proceedings will be forwarded to USA HRC for final action.

g. The U.S. Army Physical Disability Agency disposition.

(1) The proceedings of general and medical corps officers found physically unfit will be forwarded to the Assistant Secretary of Defense (Health Affairs) (ASD(HA)) for review prior to disposition by USA HRC. This is not required if the finding is fit.

(2) If the case file is to be forwarded to APDAB for appeal action, USAPDA will prepare a cover letter explaining the reasons for referral and note that final decision is deferred to the APDAB. If the APDAB's decision is unfit, and if the Soldier has requested continuance on active duty (COAD) under chapter 6, APDAB will forward the file to the appropriate office for COAD review. When the case is that of a General or Medical Corps officer, APDAB will return

the case to USAPDA for forwarding to ASD(HA). If the General or Medical Corps officer has requested COAD, USAPDA will forward the case for COAD review upon confirmation of unfit determination by ASD(HA).

(3) When proper authority (AR 600-8-4) has made an unfavorable LD determination on the Soldier's unfitting condition, USAPDA will modify the PEB findings and recommendations. USAPDA will notify the Soldier that the modification resulted from a final LD decision by HQDA and that neither USAPDA nor APDAB are the approving authority for an appeal of the LD decision. LD appeal are governed by AR 600-8-4. This does not preclude an appeal of the determination of physical unfitness. Nor does it preclude the right to a formal PEB hearing if the Soldier has not had a formal hearing (see para 4-19g(2)). If the case file is forwarded to USA HRC (AHRC-PED-S) to await a final LD decision, USAPDA will reflect in the cover letter the result of review subject to the final LD decision.

(4) If notice is received that a Soldier whose case is in the disability system is AWOL, USAPDA will suspend further action on the case. If the Soldier has been AWOL for 10 days or more, USAPDA will verify the fact of AWOL and return the case file, less PEB proceedings, to the MTF to which the Soldier belongs. USAPDA will cancel PEB proceedings and notify the PEB and applicable MTF. If the case file has been forwarded to USA HRC, USAPDA will recall the case for return to the MTF.

(5) With the exception of those cases noted above, USAPDA will approve revised findings for the Secretary of the Army and forward the case to USA HRC for disposition.

e. USAPDA Standing Operating Procedures, 25 Apr 01, paragraph 5-14.

5-14. STATISTICAL REPORTS.

a. Performance data regarding PEB and PDA activities will be captured and reviewed monthly and quarterly by the Operations Division. These reports will be distributed to the

Agency Staff and PEB Presidents. Quarterly statistics will be distributed to the Agency staff, PEB Presidents, MEDCOM, and the Operations Officer.

b. Statistical reports resulting from special status studies directed by DCO, USAPDA normally will be prepared on a one-time basis. Such reports will not become recurring reports unless otherwise directed by CG, USAPDA.

c. Special statistical reports prepared for Agency briefings will be developed by the Operations Division.

f. Government Accounting Office (GAO) Report to Congressional Committees, Military Disability System, 31 Mar 06, pages 19-20.

In addition, DOD has not established quality parameters for the services to follow to evaluate the consistency of decision making. As a result, the services generally lack a robust quality assurance process. In our past work on federal disability programs, we have recommended that quality assurance have two components: (1) the use of multivariate regression analysis examining disability decisions along with controlling factors to determine whether the decisions are consistent and (2) an in depth independent review of a statistically valid group of case files to determine what factors may contribute to inconsistencies. However, the services were unable to provide any evidence that they are conducting statistical reviews – such as multivariate regression analysis – on their data to determine the consistency of decision making for service members with similar characteristics. Furthermore, while we found that the Army is conducting independent reviews of 25 to 30 percent of its PEB cases, the Navy and Air Force conduct these reviews only when a service member appeals the PEB's decision. Additionally, these reviews reflect how a single case's medical evidence supports the dispositions made (accuracy) rather than the degree to which decisions in cases, in general, with similar impairments and characteristics compare (consistency). Without such an analysis the services are unable to assure that adjudicators are making consistent decisions in reservist and active duty cases with similar characteristics.

Officials from the services said that it was very difficult to examine outcomes for consistency because each disability decision is unique and there are a multitude of factors considered when rendering a disability decision, some of which could not be captured in a database. For example, individuals' pain tolerance varies, along with their motivation to adhere to treatment programs. Nonetheless, other federal disability programs face the same challenges, have acknowledged the importance of determining consistency of decision making, and have taken some initial steps to develop quality assurance systems. For example, the VA selects a random sample of files for

independent review using a standard methodology and compiles the results of these reviews.16

FINDING 2.6: The training of personnel working in the Physical Evaluation Board process does not meet the standards as specified in DODI 1332.38, AR 635-40, and US Army Physical Disability Agency's SOP.

STANDARDS:

a. DODI 1332.38, Subject: Physical Disability Evaluation, 14 Nov 96 (with Change 1, 10 Jul 06), paragraph E3.P1.7.

E3.P1.7. Training and Education.

Those Service members designated by the Secretary concerned as primary participants in the DES shall be trained and educated in a timely and continuing manner concerning the policies and procedures of this Instruction. Primary participants in the DES include, but are not limited to, medical officers who prepare MEBs, patient administration officers, disability counselors, PEB and appellate review members, and judge advocates.

b. DODD 1332.18, Subject: Separation or Retirement for Physical Disability, 4 Nov 96, paragraph 4.4.5.

4.4. The Secretaries of the Military Departments shall:

4.4.5. Ensure that PEB members and applicable review authorities are trained and certified in physical disability evaluation.

c. AR 635-40, Physical Evaluation for Retention, Retirement, or Separation, 8 Feb 06, paragraph 4-17.

4-17. Physical evaluation boards

a. Purpose. The PEBs are established to evaluate all cases of physical disability equitably for the Soldier and the Army. The PEB is not a statutory board. Its findings and recommendations may be revised. It is a fact-finding board for the following:

- (1) Investigating the nature, cause, degree of severity, and probable permanency of the disability of Soldiers whose cases are referred to the board.
- (2) Evaluating the physical condition of the Soldier against the physical requirements of the Soldier's particular office, grade, rank, or rating.
- (3) Providing a full and fair hearing for the Soldier as required by under Title 10, United States, Section 1214, (10 USC 1214).
- (4) Making findings and recommendations required by law to establish the eligibility of a Soldier to be separated or retired because of physical disability (10 USC 61).

b. Composition. Except as provided by para 4-17c, below, individual case adjudication (informal and formal) will be accomplished by a 3-member panel of the PEB comprised of a Presiding Officer, Personnel Management Officer, and Medical Member. Members of a three-member panel will be experienced officers who have been trained on

adjudication standards and procedures. The Presiding Officer acts as the PEB President for the case over which he or she presides. The CG, USAPDA, will appoint PEB members from assigned personnel for full-time duty. Part-time members may be appointed by the CG, USAPDA, with the consent of the commander having jurisdiction over the member. Part-time members supplement or temporarily replace full-time members, as needed, for the prompt processing of disability cases. The Presiding Officer and Personnel Management Officer for the panel will be either a DA Civilian Adjudication Officer assigned to the PEB or a field grade officer of any component, in any authorized duty or training status, and of any branch except the Medical Corps. The medical member for the panel will be a MC officer or DA civilian physician, preferably with uniformed service MC experience. The medical member must not have served in any capacity as the Soldier's physician or as a member of the Soldier's MEB.

c. One-member informal physical evaluation board. Under exigent circumstances, the CG, USAPDA, or their designee, may direct that informal PEBs be accomplished by a one-member PEB. The one-member, referred to as the Adjudication Officer, will normally be a permanent, nonmedical member of the PEB. A part-time, nonmedical member may serve as the Adjudication Officer if no permanent, nonmedical member is reasonably available. The medical member will serve as a nonvoting advisor and will provide a case opinion to the Adjudication Officer before informal adjudication is completed. All one-member adjudications not followed by a formal PEB will be reviewed by HQUSAPDA, unless exceptional circumstances preclude the review.

d. President of the physical evaluation board. The CG, USAPDA, will name as the President of the PEB an active duty, senior field grade officer. The President must be assigned for full time duty to USAPDA. The President may be of any branch except the Medical Corps (MC). The PEB President is the administrator of the PEB, responsible for the leadership and management of day-to-day PEB affairs. The PEB President will ensure that all permanent and part-time members are trained before they adjudicate cases. The PEB President will ensure that members added to a panel to constitute a five-member board for purposes of providing requested female, minority, or enlisted representation are briefed on the standards applicable to physical disability adjudication prior to the convening of the board. The senior, nonmedical member who is on active duty will serve as President of the PEB when the President is absent. The PEB President may serve as the Presiding Officer for an informal or formal PEB panel.

e. Reserve Component member. When a Soldier of the Reserve Components (RC) is being evaluated, one of the PEB members must be a Reserve officer who is otherwise qualified for duty as a member of the PEB.

f. Disqualification. The PEB voting members must disqualify themselves if they have had a personal or professional relationship with the Soldier being evaluated.

g. Disability evaluation of the physical evaluation board members. When members of the PEB are referred into the physical disability system, they will be evaluated by other than the PEB to which assigned. After PEB evaluation such cases will be forwarded to USAPDA for review.

h. Female or minority representation.

(1) When requested, the PEB will substitute a female or minority Soldier of the same minority group for one of the regular members of the board, if the requested

representation is reasonably available. Request for female or minority representation should be made in writing at the time of request for a formal hearing. The substitute must meet the qualifications for regular voting members. The PEB president will determine if the requested representation is reasonably available. The proceedings will include a statement of the request and whether the representation was or was not provided, that is, "Minority (or female) representation was requested and provided" or "Minority representation (or female) was requested and not reasonably available and, therefore, was not provided."

(2) When an enlisted Soldier is being evaluated, the PEB will upon written request of the Soldier, include enlisted representation if reasonably available. Request for enlisted representation should be in writing at the time of request for a formal hearing. The enlisted representation must be in the ranks of sergeants first class to sergeants major and senior to the Soldier being evaluated. The PEB president will determine if enlisted representation is reasonably available. The proceedings will include a statement of the request and whether the representation was or was not provided as described in paragraph (1), above. When enlisted representation is provided, the PEB will increase to five members, all of whom will have a vote. The fifth member may be enlisted or officer.

i. Counsel. An Army attorney will be appointed as counsel to represent Soldiers at formal PEB hearings. The attorney will not be a voting member of the PEB or an advisor to the PEB, but will represent the Soldier as required when the Soldier requests a formal hearing. The attorney will counsel the Soldier until formal disability proceedings are completed. The appointed counsel may also advise PEBLOs of MTFs that refer cases to the PEB.

j. Recorder. The appointing authority will assign a permanent recorder for the PEB. The recorder will be a commissioned officer, warrant officer, or civilian employee of equivalent grade of any branch or career field except those listed below.

(1) Medical Corps.

(2) Dental Corps.

(3) Army Nurse Corps.

(4) Army Medical Specialist Corps.

(5) The Judge Advocate General's Corps.

k. Reporter. The appointing authority will assign permanent qualified reporters to the PEB.

l. Support. A PEB is a tenant of the installation where located. The CG, USAPDA enters into agreements providing for administrative and logistical support with installation and MTF commanders.

d. USAPDA SOP, 25 Apr 01, paragraphs 1-8., 4-4., 4-7., 5-11.

1-8. LIAISON VISITS TO CONUS MTF. It is recommended that PEBs conduct periodic assistance visits to servicing MTFs for "one-on-one" interface with senior health care officials to analyze disability case processing performance. PEBs will notify CDR, USA Medical Health Command, ATTN: MEDCOM, Fort Sam Houston, Texas 78234, of proposed official (normal day to day activity with the MTFs are not affected) MTFs visits. The proposed schedule, including dates and facilities to be visited, as well as the purpose of the visit, will be provided. PEBs will coordinate with MTFs to ascertain an acceptable date and availability of persons to be visited with MTF Commanders. -

4-4. INTRODUCTION TO THE DES/ ADJUDICATORS COURSE.

a. The Introduction to the DES/ Adjudicator's Course is a 40-hour Program of Instruction (POI) designed to train new adjudicators in governing law (Title 10, Chapter 61), directives (DODD 1332.18), regulations (Army) and any policies. It is an interactive program that allows active dialogue on a wide range of topics spanning the entire Physical Disability Evaluation System. The course is required for newly assigned personnel within USAPDA (prior to their adjudicating cases), military attorneys representing soldiers at formal PEBs; and is recommended for personnel from DOD and other uniformed services, Department of Veterans Affairs personnel, Disabled Veterans of America, Physical Evaluation Board Liaison Officers (PEBLOs) and others desiring to understand the physical disability evaluation process.

b. The USAPDA will issue certificates to all individuals who successfully complete the course requirements.

4-7. YEARLY OPERATIONAL AND TRAINING GUIDANCE. USAPDA publishes a Yearly Operational and Training Plan to facilitate its training strategy and set key initiatives designed to improve quality and timeliness of the PDES. Each new member of the organization should familiarize his/herself with the most current guidance. In conjunction with this guidance, the Agency Operations Division publishes and maintains a Yearly Training Calendar to coordinate significant training events.

5-11. ASSISTANCE VISITS. In accordance with the Agency's Yearly Operational and Training Guidance, the Operations staff will perform periodic staff assistance visits of USAPDA sub-activities. All areas of support and operations of the PEB will be reviewed. The assistance visits will occur at a minimum of once per year or upon direction of the DCO, USAPDA.

e. USAPDA Policy/Guidance Memorandum # 15, 28 Feb 05.



DEPARTMENT OF THE ARMY
UNITED STATES ARMY PHYSICAL DISABILITY AGENCY
BUILDING 7 WRAMC
WASHINGTON DC 20307-5001

AHRC-DZB

FEB 28 2005

MEMORANDUM FOR PHYSICAL EVALUATION BOARD PRESIDENTS

SUBJECT: Policy/Guidance Memorandum #15: Adjudication Training

1. Purpose: To establish training requirements for physical disability case adjudicators of the Physical Evaluation Board (PEB), case reviewers at Headquarters, United States Army Physical Disability Agency (HQUSAPDA), and substitute and additional members to accommodate requests for enlisted, female, or minority representation.
2. Reference: DoD Directive 1332.18, para 4.4.5.
3. Policy:
 - a. Permanent and alternate members of the PEB and HQUSAPDA case reviewers who act on Soldier appeals, propose case modifications, or conduct quality assurance reviews must be trained on military disability adjudication before they act on cases.
 - b. Except as provided in subpara "c" below, PEB Adjudicators and HQUSAPA case reviewers must attend the Senior Adjudicators Course before they act on cases. To be credited with course attendance, the Sample Case Adjudication block of instruction must be completed.
 - c. The Deputy Commander (DCO), HQUSAPDA, under exigent circumstances as determined by the DCO, may designate an alternate training plan to allow a PEB adjudicator or HQUSAPDA case reviewer to act on cases prior to completion of the Senior Adjudicators Course. An example of an alternate plan would be completion of the CD, Introduction to the Disability Evaluation System, followed by a minimum two-week period of working cases as a nonvoting member.
 - d. When members not assigned to the PEB as adjudicators are added to the formal board to constitute a 5-member board for purposes of requested enlisted, female, or minority representation, the PEB President will ensure the additional members are briefed on the standards for determining fitness and compensability prior to sitting the board. These members are not required to attend the course or complete the CD. However, when such is possible, the PEBs are encouraged to have a standing list of such extra members and a training plan based on the introduction course.
 - e. When a request for female or minority representation can be fulfilled by substituting the requested representation for one of the members of a 3-member panel, the substituted member must meet the training requirements for PEB adjudicators.

AHRC-DZB

SUBJECT: Policy/Guidance Memorandum #15: Adjudication Training

4. Point of contact: [REDACTED] DSN [REDACTED] and commercial [REDACTED]
782-3064.

FOR THE COMMANDER:



CR:
HOUSAPDA Senior Staff
DASG-HPS [REDACTED]
APDAB [REDACTED]

FINDING 2.7: Some Soldiers do not return for their required periodic examinations while in a Temporary Disability Retirement List status.

STANDARDS:

a. Title 10, Chapter 61, Section 1210, U.S. Code, Members on Temporary Disability Retired List: Periodic Physical Examination; Final Determination of Status., sub-paragraphs (a) and (h).

b. DODD 1332.18, Subject: Separation or Retirement for Physical Disability, 4 Nov 96, paragraphs 3.10. and 3.11.

3.10. A Service member shall be placed on the TDRL when the member meets the requirements for permanent disability retirement, except that the member's disability is not determined to be stable. A disability shall be determined to be stable when the preponderance of medical evidence indicates the severity of the condition will probably not change within the next five years so as to warrant an increase or decrease in the disability rating percentage.

3.11. The TDRL shall be managed to meet the requirements under Chapter 61 of 10 U.S.C. (reference (b)) for periodic physical examination, suspension of retired pay, and prompt removal from the TDRL.

c. DODI 1332.38, Subject: Physical Disability Evaluation, 14 Nov 96 (with Change 1, 10 Jul 06), paragraph 5.5.5. and Enclosure 3 Part 6.

5.5.5. Ensure the Temporary Disability Retired List (TDRL) is managed to meet the requirements of 10 U.S.C. 1210 (reference (b)) for timely periodic physical examinations, suspension of retired pay, and removal from the TDRL.

E3.P6. ENCLOSURE 3 PART 6 TDRL MANAGEMENT

E3.P6.1. Placement on the TDRL.

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

E3.P6.1.1. A disability shall be considered unstable when the preponderance of medical evidence establishes that accepted medical principles indicates the severity of the condition will change within the next five years so as to result in an increase or decrease of the disability rating percentage or a finding of fit.

E3.P6.1.2. Except for cases processed under imminent death procedures, members with unstable conditions rated at a minimum of 80 percent and which are not expected to improve to less than an 80% rating, shall be permanently retired.

E3.P6.2. TDRL Reevaluation

E3.P6.2.1. Administrative Finality. During TDRL reevaluation, previous determinations concerning application of any presumption established by this Instruction, line of duty, misconduct, proximate result, and whether a medical impairment was service-incurred or preexisting and aggravated shall be considered administratively final for those conditions for which the member was placed on the TDRL unless there is evidence of fraud; a change of diagnosis that warrants the application of accepted medical principles for a preexisting condition; or correction of error in favor of the member.

E3.P6.2.2. New Diagnoses. A fitness and compensable determination shall be made on all diagnoses presenting during the period of TDRL evaluation. When a member is determined fit for the condition for which he or she was placed on the TDRL, but unfit for a noncompensable condition incurred while on the TDRL, the member shall be separated from the TDRL without entitlement to disability benefits.

E3.P6.2.3. Member Medical Records. The Service member shall provide to the examining physician, for submission to the PEB, copies of all his or her medical records (civilian, Department of Veterans Affairs, and all military medical records) documenting treatment since the last TDRL reevaluation.

E3.P6.2.4. Compensability of New Diagnoses. Conditions newly diagnosed during TDRL periodic physical examinations shall be compensable when:

E3.P6.2.4.1. The condition is unfitting; and

E3.P6.2.4.2. The condition was caused by the condition for which the member was placed on the TDRL, or directly related to its treatment; or

E3.P6.2.4.3. The evidence of record establishes that the condition was either incurred while the member was entitled to basic pay or as the proximate result of performing duty, whichever is applicable, and was an unfitting disability at the time the member was placed on the TDRL. Otherwise, such conditions shall be deemed unfitting due to the natural progression of the condition and noncompensable under Chapter 61 of 10

U.S.C. (reference (b)), although the member may be eligible for benefits for these conditions under the DVA.

E3.P6.2.5. Current Physical Examination. Service members on the TDRL shall not be entitled to permanent retirement or separation with disability severance pay without a current TDRL or DVA periodic physical examination acceptable to the Service Secretary.

E3.P6.2.6. Refusal or Failure to Report. As provided under Chapter 61 of reference (b), when a Service member on the TDRL refuses or fails to report for a required periodic physical examination or to provide his or her medical records in accordance with Enclosure 3 Part 6, Paragraph E3.P6.2.3., his or her disability retired pay may be terminated. If the member later reports for the physical examination, retired pay will be resumed retroactively, to the date the examination was actually performed. If the Service member subsequently shows just cause for his or her failure to report, disability retired pay may be paid retroactively for a period not to exceed one year prior to the actual performance of the physical examination. If the member does not undergo a periodic physical examination after disability retired pay has been terminated, he or she will be administratively removed from the TDRL on the fifth anniversary of placement on the list and separated without entitlement to any of the benefits under reference Chapter 61 of 10 U.S.C. (reference (b)).

E3.P6.2.7. Priority. TDRL examinations, including hospitalization in connection with the conduct of the examination, shall be furnished on the same priority as given to active duty members.

E3.P6.2.8. Reports from Non MTFs. MTFs designated to conduct TDRL periodic physical examinations may use reports of medical examinations from medical facilities of another Service, the DVA, other Government Agencies, and authorized civilian medical facilities and physicians to complete the examination. The designated MTF remains responsible for the adequacy of the examination and the completeness of the report. The report must include the information specified in subsection E3.P1.2.4. of Part I.

E3.P6.2.9. Incarcerated Members. A report of medical examination shall be requested from the appropriate authorities in the case of a Service member imprisoned by civil authorities. In the event no report, or an inadequate report, is received, documented efforts will be made to obtain an acceptable report. If an examination is not received, disposition of the case shall be in accordance with subsection E3.P6.6., above. The member shall be advised of the disposition and that remedy rests with the respective Service's Board for Correction of Military Records.

d. AR 635-40, Physical Evaluation for Retention, Retirement, or Separation, 8 Feb 06, Chapter 7 and Appendix C-10.

Chapter 7
Temporary Disability Retired List
Section I
Introduction
7-1. Overview

This chapter outlines procedures for administration and processing of Soldiers whose names are on the TDRL.

7-2. Reasons for placement on the temporary disability retired list

- a.* A Soldier's name may be placed on the TDRL when it is determined that the Soldier is qualified for disability retirement under 10 USC 1201 but for the fact that his or her disability is determined not to be of a permanent nature and stable.
- b.* A Soldier with a hereditary or congenital condition that is unfitting and known to be progressive will not be placed on the TDRL unless there is unstabilized service aggravation and the Soldier is qualified as described above. If upon removal from the TDRL, there is no evidence of residual aggravation, the Soldier may be found to be ineligible for disability benefits.
- c.* The TDRL will not be used for convalescence. When a Soldier's correct rating is less than 30 percent, a rating will not be increased to 30 percent solely for the purpose of making a Soldier eligible for TDRL.

7-3. Information reflected on the temporary disability retired list

The TDRL will list names of all Soldiers temporarily retired. The list, as a minimum, will reflect—

- a.* The identity of the Soldier.
- b.* The date the Soldier was placed on the TDRL.
- c.* The month and year in which the next medical examination is required.
- d.* Current address and phone number.

7-4. Requirement for periodic medical examination and physical evaluation board evaluation

A Soldier on the TDRL must undergo a periodic medical examination and PEB evaluation at least once every 18 months to decide whether a change has occurred in the disability for which the Soldier was temporarily retired.

- a.* Soldiers who have waived retired pay to receive compensation from the VA, continue to be retired Army Soldiers. These Soldiers must undergo examinations when ordered by Commander, USA HRC, acting on behalf of the SA.
- b.* Soldiers recalled to active duty while still on the TDRL must also undergo a periodic examination when ordered by the Commander, USA HRC.
- c.* Soldiers who fail to complete a physical examination when ordered will have their disability retired pay suspended.
- d.* Soldiers on the TDRL will notify Commander, HQUSAPDA (AHRC-PDB), Building 7, WRAMC, 6900 Georgia Avenue, NW, Washington, DC 20307-5001, of any change in their current mailing address.

7-5. Counseling

The PEBLO is responsible for counseling the Soldier until the informal PEB is completed. The Soldier may demand a formal hearing. If so, the regularly appointed PEB counsel is responsible for the counseling unless the Soldier elects a different counsel. Counseling will be according to appendix C. Soldiers on the TDRL are more difficult to counsel because they are not as readily available to the counselor as are Soldiers on active duty. Nevertheless, they must be counseled to the same extent required for active duty Soldiers.

7-6. Prompt processing

To prevent the Soldier suffering severe financial and other hardships, processing delays will be avoided. All portions of the medical examination will be conducted on a priority basis. All involved agencies and personnel will ensure that cases of Soldiers nearing expiration of 5-year TDRL tenure are identified and given priority processing.

7-7. Prompt removal from temporary disability retired list

Medical examiners and adjudicative bodies will carefully evaluate each case. They will recommend removal of the Soldier's name from the TDRL as soon as the Soldier's condition permits. Placement on the TDRL confers no inherent right to remain for the entire 5-year period allowed under Title 10, United States Code, Section 1210 (10 USC 1210).

Section II

Administration

7-8. Individual temporary disability retired list file

Commanding General, USA HRC will maintain an active file for each Soldier on the TDRL. The file will contain the following:

- a. Complete identification, grade, and a statement of total active service when placed on the TDRL; orders placing the Soldier on the TDRL; the Soldier's current mailing address.
- b. Original copy of PEB proceedings with exhibits, less medical and health records; original reports of periodic medical examinations and evaluations.
- c. Record of current location of clinical, medical, and health records to make the next periodic medical examination easier.
- d. Significant correspondence with the former Soldier and medical treatment facility in order to support suspension of pay for failure to report for scheduled reexaminations or to show that reasonable efforts were made to notify the Soldier.

7-9. U.S. Army Human Resource Command's letter of instruction to the medical treatment facility commander on periodic medical examination

- a. *Procedural instructions.* The USA HRC will issue a letter of instructions to the MTF commander responsible for the medical examination 4 months before the month during which the examination is to be carried out. The USA HRC will coordinate with the U.S. Army Health Services Command (HSC) in issuing the letter. The letter will include—
- (1) Name and address of the Soldier requiring examination.
 - (2) A statement that the periodic medical examination is required during the month prescribed.
 - (3) Location of medical records, if known (the MTF commander will obtain all medical records).
 - (4) Instructions on completing the enclosed travel order as to the exact place and date of the examination.
 - (5) Authority for the MTF commander to arrange for the examination to be conducted. Another U.S. Government MTF, a civilian medical facility, or civilian physician(s), including medical consultants, may conduct the examination. The examination will be conducted as close to the Soldier's home as circumstances and requirements of the case permit.
 - (6) Specific guidance governing conduct of the examination needed.

b. *Preparation of orders.* The USA HRC will prepare travel orders to accompany the letter of instructions. The travel orders permit payment for TDY only for the period

needed to complete the TDRL examination. These orders do not provide for periods of medical treatment after the examination.

c. Supporting documents. The following documents will accompany the letter of instructions:

(1) Proceedings of the PEB and supporting documents that placed the Soldier on the TDRL.

(2) A copy of the letter notifying the Soldier of the examination.

d. Final temporary disability retired list examination. The USA HRC will initiate processing action no later than 6 months before the fifth anniversary date of the Soldier being placed on the TDRL. The MTF commander and the Soldier will be advised that the final examination must be expedited to ensure removal from the TDRL before the Soldier's completion of 5 years on the list.

7-10. U.S. Army Human Resources Command's letter of instruction to the Soldier

The USA HRC will notify the Soldier of the forthcoming medical examination. The letter will include the information below:

a. Name, address, and telephone number of the appointed MTF closest to the Soldier's home.

b. Name and telephone number of the PEBLO who will assist the Soldier during and after the medical examination.

c. The Soldier may telephone the MTF collect to resolve any problems.

d. The MTF will arrange for and schedule the medical examination. Every effort will be made to schedule the examination for the Soldier's convenience; however, the medical examination must be carried out within the month prescribed.

e. At the discretion of USA HRC an escort may accompany a Soldier who is unable to travel alone to the place of examination. One person may travel with the Soldier upon request when the record clearly shows that the Soldier is not physically or mentally able to travel without help. The attendant is entitled to file a claim for expenses according to JFTR, volume I, chapter 7, part I. If a private conveyance is used for travel, only the retired Soldier may be reimbursed for transportation cost. Request for attendant must be approved by USA HRC, (AHRC-PDB) in advance of travel.

f. The MTF will forward the following:

(1) Travel orders issued by USA HRC if needed.

(2) Facts for obtaining transportation request and collection of approved travel expense.

(3) Per diem allowance if applicable.

g. Failure to make or follow through with arrangements with the hospital for carrying out the medical examination during the required month may result in the suspension of disability retirement pay.

h. The Soldier must inform the MTF of visits to civilian or military physicians or other Federal medical facilities for treatment while on the TDRL and give permission to obtain records of such visits if available.

7-11. Disposition of the temporary disability retired list Soldier

a. Action following periodic PEB evaluation or on fifth anniversary. The USA HRC will remove a Soldier from the TDRL as described below on the fifth anniversary of the date the Soldier's name was placed on the list, or sooner on the approved recommendation of a PEB.

(1) *Permanent retirement.* If the Soldier meets the criteria below, the Soldier will be removed from the TDRL, permanently retired for physical disability, and entitled to receive disability retired pay:

(a) The Soldier is unfit.

(b) The disability causing the Soldier's name to be placed on the TDRL has become permanent.

(c) The disability is rated at 30 percent or more under the VASRD, or the Soldier has at least 20 years of active Federal service.

(2) *Separation.* A Soldier will be removed from the TDRL and separated with severance pay if the Soldier—

(a) Has less than 20 years of service.

(b) Is unfit because of the disability for which the Soldier was placed on the TDRL; and either the disability has stabilized at less than 30 percent; or the disability, although not stabilized, has improved so as to be ratable at less than 30 percent. A former RA enlisted Soldier who would be separated under this authority may request a waiver to reenlist. (See AR 601–210, chap 4.)

(3) *Fit for duty.* If a Soldier is determined physically fit to perform the duties of their office, grade, rank or rating (and is otherwise administratively qualified), the following procedures apply:

(a) Former RA officers and warrant officers, subject to their consent, will be recalled to active duty. Action will be started to effect reappointment to the active list in the regular grade held when placed on the TDRL, or the next higher grade. If the officer does not consent to be called to active duty, TDRL status and disability pay will be ended as soon as possible.

(b) Former RA enlisted Soldiers, subject to their consent, will be reenlisted in their regular component in the grade held on the day before the date placed on the TDRL, or in the next higher grade. If the Soldier does not consent to reenlistment, TDRL status and disability pay will be ended as soon as possible.

(c) Former Soldiers of the U.S. Army Reserve (USAR), subject to their consent, will be reappointed or reenlisted in the USAR in the grade held on the day before the date placed on the TDRL, or in the next higher grade or transferred to the Retired Reserve, if eligible. They may request active duty, under USAR regulations.

(d) Former Soldiers of the Army National Guard of the United States (ARNGUS), subject to their consent, may be reappointed or reenlisted in the ARNGUS in the grade held on the day before the date placed on the TDRL, or in the next higher grade if the proper State authorities reappoint or reenlist them in the Army National Guard (ARNG) of the State concerned. They may request active duty. If the Soldier cannot be reappointed or reenlisted in the ARNG, and subject to the Soldier's consent, he or she will be reappointed or reenlisted in the USAR or transferred to the Retired Reserve, if eligible.

(e) If the Soldier in (a) thru (d), above, has completed 20 years of active service when placed on TDRL, and does not consent to return to active duty upon being found fit for duty, the Soldier may request voluntary retirement by reason of length of service upon removal from the TDRL.

(f) If the Soldier in (c) and (d), above, has completed at least 20 qualifying years of service computed under Title 10, United States Code, Section 12732, (10 USC 12732),

the Soldier may request if otherwise eligible transfer to the Retired Reserve under section 10 USC 10146.

(4) Unfit—not in line of duty disability.

(a) A Soldier may recover from the disability resulting in placement on the TDRL. If while on the TDRL, the Soldier incurs another unfitting disability, the Soldier may be separated without benefits.

(b) If the Soldier mentioned in (a), above, was RA and had completed 20 years or more of active service when placed on the TDRL, the Soldier may request voluntary retirement.

(c) If the Soldier mentioned in (a) above, was USAR and had completed at least 20 qualifying years of service computed under Title 10, United States Code, Section 12732 (10 USC 12732) when placed on the TDRL, the Soldier may request transfer to the Retired Reserve or retirement if qualified under 10 USC 3911.

b. Periodic examination not performed. The USA HRC will take the actions described below when a periodic examination cannot be carried out.

(1) *Soldier's failure to report or reply.* If a Soldier fails to respond to correspondence concerning the medical examination or fails or refuses to complete a medical examination, USA HRC will make an effort to discover the reason. If such action cannot be justified and the fifth anniversary of placement on the TDRL has not been reached, USA HRC will notify the Soldier and the Chief, Retired Pay Operations, U.S. Army Finance and Accounting Center (USAFAC), to suspend retired pay. USA HRC will keep the Soldier's name on the TDRL until the fifth anniversary unless it is removed sooner by other action.

(2) *Unable to locate Soldier.* When reasonable efforts to locate the Soldier are unsuccessful, USA HRC will take the action prescribed in (1), above.

(3) *Soldier imprisoned by civil authorities.* A report by the responsible MTF commander may indicate that examination of a Soldier is not possible because the Soldier is imprisoned and civil authorities will not permit the examination. If so, USA HRC will take the action prescribed in (1), above.

(4) *Removal on fifth anniversary.* Soldiers on the TDRL shall not be entitled to permanent retirement or separation with severance pay without a current acceptable medical examination, unless just cause is shown for failure to complete the examination. Six months before the fifth anniversary of placement on the TDRL, USA HRC will make a final attempt to contact the Soldier ((1) and (2), above) or proper civil authorities ((3) above) and arrange a final examination. If this fails and the Soldier does not undergo a physical examination, USA HRC will administratively remove him or her from the TDRL on the fifth anniversary of placement on the list without entitlement to any of the benefits provided by 10 USC 61.

7-12. Restoring eligibility

The USA HRC may restore the Soldier's eligibility to receive disability retirement pay if, after failure to report for and complete the required periodic examination, the Soldier later satisfactorily meets the examination requirements. The USA HRC will notify the Chief, Retired Pay Division, USAFAC, to restore disability retired pay retroactive to the date the Soldier undergoes the examination provided the Soldier is still qualified for retention on the TDRL. The Soldier's eligibility to receive retired pay may be made retroactive, not to exceed 1 year, if the soldier can show just cause for failure to respond

to official notice or orders. A Soldier's name may have been removed from the list as provided in paragraph 7-11b(4). If so, the Soldier may take application to the Army Board for Correction of Military Records (ABCMR).

Section III

Periodic Medical Examination

7-13. Responsible of the medical treatment facility

The commander of the MTF, notified as provided in paragraph 7-9, is responsible for reexamining the Soldier. If the MTF was obviously or apparently incorrectly selected, the commander will promptly notify USA HRC to transfer the case file to another MTF.

7-14. Selection of examining facilities

a. Other locations. Upon review of the medical records, the MTF commander or his or her designee will arrange to have the portions of the examination that cannot be accomplished at the Army MTF conducted at one of the locations below. These locations are listed in the order of preference.

(1) Another uniformed service MTF.

(2) Other Federal medical facility at, or near, the Soldier's home.

(3) Civilian-operated clinic or hospital at, or near, the Soldier's home.

b. Hospitalization. Examination of a Soldier on an out-patient basis is preferred. When hospitalization is foreseen, however, or when extensive tests or observations require hospitalization, the Soldier will be ordered to report to the MTF designated, or if more appropriate, to a Federal MTF near the Soldier's home. If the Soldier is hospitalized at the

time the examination is scheduled, a NARSUM from the hospital facility providing his or her care may suffice to meet the needs of a report of periodic examination.

c. Costs. The cost of medical examinations carried out at Government MTFs, including consultations from civilian sources, are payable from funds available to operate MTFs. Costs of medical examinations carried out at civilian MTFs or by civilian physicians at, or near, the Soldier's home will be handled according to AR 40-400.

7-15. Medical records

The commander of the MTF responsible for the medical examination will promptly initiate a request for the Soldier's medical records from information provided by USA HRC or by the Soldier. The commander will ensure that the medical records are available to the examining physician before the periodic medical examination. The examining physician must return all records furnished with the report of medical examination to the MTF commander for forwarding to the proper PEB.

7-16. The medical treatment facility commander's duties in notifying the Soldier

The MTF commander will provide to the Soldier the information specified in paragraph 7-10. Confirmation of the date of examination should be made by certified mail, return receipt, restricted delivery. If the notification is returned as undelivered or Soldier fails to report as directed, the MTF commander will notify USA HRC (AHRC-PDB).

7-17. Examination of the Soldier

a. Purpose of medical examination. The purpose of the TDRL periodic medical examination is to—

(1) Determine the Soldier's condition at the time of the examination.

(2) Decide if a change has occurred in the disability for which the Soldier was placed on the TDRL.

(3) Decide if the disability has become stable enough to permit removal from the TDRL.

(4) Identify any new disabilities while the Soldier has been on the TDRL.

b. Extent of the examination. The medical examination must be objective and complete. One or more physicians will conduct the examination. Proceedings of previous PEB actions and all medical records will be made available to the examiner. Diagnostic, laboratory, and radiological procedures, including photographs, should be used to the extent needed to establish and describe the Soldier's current physical condition accurately. Detailed requirements for medical examinations for disability evaluations are contained in the DVA Physical Examination worksheets and the VASRD. (See AR 40–400.)

c. Consultants. Advice of professional consultants may be obtained whenever needed during periodic medical examinations.

d. Soldiers physically unable to travel or mentally incompetent. When the responsible hospital commander determines that a Soldier is physically unable to travel (for example, bedridden) or is mentally incompetent, the commander will make all reasonable efforts to have the Soldier examined. Bringing the Soldier to the hospital by ambulance or arranging for a visit by a physician to the Soldier's residence is included when the effort is in the best interests of the Government. If the Soldier is under medical treatment, current medical records from the MTF, or the physician treating the Soldier, may provide adequate clinical data for the report of periodic examination.

e. Soldiers imprisoned by civil authorities. When a Soldier is found to be imprisoned by civil authorities, the appointed MTF commander will request the confinement facility, or other proper authority, to have the Soldier medically examined and to provide a report of the Soldier's current medical state. The report will be processed in the normal manner upon receipt and forwarded to the PEB for adjudication. If an examination is impossible or no report is received, the MTF commander will return the medical records to USA HRC with a summary of efforts to obtain adequate information. The USA HRC will take action prescribed in paragraph 7–11*b*.

7–18. Report of the medical examination

a. The report of periodic medical examination may be prepared using a letter or SF 502. The guidance in paragraph 4–11 applies. In addition, the following information will be provided:

(1) An estimate of change since the previous examination.

(2) A medical appraisal of all defects incurred, or discovered, after the Soldier was placed on the TDRL. The report must clearly show the etiology of defects found during the examination so a decision can be made as to whether they relate to a condition that existed or was incurred while the Soldier was on active duty, or was incurred while the Soldier was on the TDRL.

(3) An opinion on whether the conditions have become stable. If not stable, provide an opinion as to the progress of the disability and a suggested time frame (not to exceed 18 months) for the next examination.

b. The report requires only the signature of the medical officer or physician appointed to conduct the medical examination. Forward the report to the commander of the MTF for review and approval.

7–19. Review and forwarding the report of the examination

a. The MTF commander, or designee, will ensure the completed report clearly describes the Soldier's present condition and functional impairments. MEBDs are not required for TDRL periodic physical examinations; however, the MTF commander may refer a TDRL examination to a MEBD, especially one presenting a problem or dispute.

b. The MTF commander will give the Soldier the opportunity to review and comment on the report of examination before forwarding it to the PEB. The Soldier will sign the report of examination acknowledging receipt. If the Soldier does not agree with the report of examination, the MTF commander will review and act on any objections. The MTF commander has the right of final approval; however, any written appeal or objection prepared by or for the Soldier will be attached to the medical examination report.

c. The MTF commander or his designee will approve and forward the report to the servicing PEB.

d. The Soldier's correct mailing address, area code, and telephone number will be confirmed to the PEB. A copy of the transmittal document will be provided to USA HRC (AHRC–PDB).

Section IV

Physical Disability Decision

7–20. Physical evaluation board processing

a. *Deficiencies in report of examination.* The PEB will resolve deficiencies in a report of periodic examination to the extent possible with MTF commander. A case file will not be returned to USA HRC because of deficiencies or need for further information except through USAPDA.

b. *Changes in a Soldier's condition while on the temporary disability retired list.* The combined percentage rating approved at the time the Soldier was placed on the TDRL cannot be changed by the PEB throughout the period the Soldier is on the TDRL. Adjustment will be made at the time of removal from the TDRL to reflect the degree of severity of those conditions rated at the time of placement on the TDRL and any ratable conditions identified since placement on the TDRL. An EPTS factor may be added, modified, or eliminated at this time if additional evidence is obtained that was not previously available or apparent during the initial evaluation; or placement on the TDRL was due to fraud, mistake of law, or mathematical miscalculation.

c. *Retention on the temporary disability retired list.* A Soldier may be retained on the TDRL if disabilities causing placement on the TDRL have not become stable, and either of the following occurs:

(1) The combined rating at the time of re-evaluation is at least 30 percent.

(2) The Soldier has at least 20 years of service if the combined rating is less than 30 percent.

d. *Entries on DA Form 199.* Entries on DA Form 199 will reflect the Soldier's condition at the time of the most recent periodic examination. When the Soldier is recommended for retention, the DA Form 199 will record any new conditions but will not list a disability rating. When a Soldier is recommended for permanent retirement, entries must be

made for all conditions present whether or not previously recorded. The DA Form 199 will include the reason for variation between the original action (findings, recommendations, or ratings) causing the Soldier's placement on the TDRL and current action removing him or her from the list. Explanations need not be lengthy, but must be understandable. Procedures for administrative relief pertaining to a correction or adjustment of the percentage of physical disability while a Soldier is on the TDRL are contained in paragraphs 4-25 and 4-26.

e. Notice to Soldier.

(1) If the PEB recommends removal from the TDRL, the PEB will forward to the Soldier DA Form 199 and letter of explanation by certified mail, restricted delivery, return receipt requested. The letter will inform the Soldier of his or her rights and responsibilities. It will provide the name, location, and telephone number of the PEBLO (see fig 7-1). The Soldier will sign the original copy of the DA Form 199 and return it after giving his or her choice of options in

block 13. The copy of the DA Form 199 is the Soldier's copy.

(a) If the certified mail receipt is not returned, or if the correspondence is returned undelivered, the PEB will try to verify the Soldier's address by contacting USA HRC, the MTF, the U.S. Army Finance and Accounting Center (USAFAC), or the VA regional office. If a new address is obtained, the PEB will try to deliver the notice. If not, a memorandum waiving the Soldier's right of election will be prepared (see fig 7-2).

(b) If the receipt is returned but no election is received, the PEB president will prepare a memorandum waiving the Soldier's right of election for failure to respond (see fig 7-3). The certified mail receipt will be included in the case file as proof that the Soldier was notified.

(c) The PEB president will forward the case file to USA HRC (AHRC-PDB) for final disposition.

(2) If the PEB recommends retention on the TDRL, the PEB will forward the DA Form 199 and a letter advising that there will be no change in the Soldier's status or retired pay as long as the Soldier remains on the TDRL. Notification will be by ordinary mail (see fig 7-4). The DA Form 199 will include a statement that failing to notify USA HRC of the current mailing address will result in the suspension of disability retired pay if the Army is prevented from properly notifying the retiree of a scheduled examination.

(3) The PEBLO of the MTF responsible for the periodic medical examination is responsible for counseling the Soldier. Therefore, the PEB will provide the PEBLO a copy of the letter and DA Form 199 (with enclosures).

7-21. Travel orders for formal hearing

a. When the Soldier elects to appear in person at the hearing, the recorder of the PEB will endorse the original travel orders according to AR 600-8-105. If a new fiscal year starts between the time the Soldier completes the TDRL medical examination and the scheduled formal hearing, the PEB will endorse the orders using the new fiscal year fund cite. The new fiscal year fund cite can be obtained from USA HRC, (AHRC-PDB). The PEB will inform the Soldier in writing of the date, time, and place of the hearing, to include building and room number. If Soldier lives in an area from which travel to the PEB is "local", as defined by the JFTR chapter 3, part F, orders are not required.

b. The PEB will provide one copy of the endorsed travel order to USA HRC (AHRC–PDB). USA HRC will commit the funds. The endorsement of orders and the commitment of funds must occur in advance of the Soldier’s travel for reimbursement of travel expense to be approved.

c. An attendant may accompany a Soldier who is unable to travel alone to the formal hearing. The attendant is entitled to file a claim for expenses according to JFTR, volume I, chapter 3, part I. If a private conveyance is used for travel, only the retired Soldier may be reimbursed for transportation cost. The Soldier must contact the PEB in advance of travel to request travel orders for the attendant. If orders were issued for an attendant in connection with travel to the periodic exam, the PEB will endorse the orders and forward one copy to USA HRC (AHRC–PDB). If no previous orders were issued or a different individual is serving as attendant, the PEB will contact USA HRC for approval and fund cite. The PEB will forward one copy of the orders to USA HRC (AHRC–PDB).

7–22. Review of the temporary disability retired list cases

When a PEB completes its action, the case file will be disposed of as prescribed in chapter 4.

C–10. Temporary Disability Retired List

Soldiers recommended for placement on the TDRL will be advised by PEBLOs that—

a. TDRL status is authorized for a maximum of 5 years, but permanent disposition may be made at an earlier date.

b. Payment while on the TDRL is computed according to section 1401 and 1407, title 10, United States Code (10 USC 1401 and 1407).

(1) For those Soldiers who entered active duty prior to 8 September 1980, the minimum payment is 50 percent of base pay.

(2) For those Soldiers who first entered active duty after 7 September 1980, the minimum payment is 50 percent of the monthly retired pay base (para C–12).

c. No changes will be made in the disability percentage rating while the Soldier is retained on the TDRL even if the disability becomes materially better or worse (see para 7–20*b*).

d. TDRL retired pay will be suspended when the Soldier fails to report for a periodic examination even though the fifth anniversary of placement on the TDRL has not been reached.

e. A Soldier will not be removed from the TDRL without processing through the PEB unless the fifth anniversary of placement on the TDRL has occurred and the Soldier has failed to obtain the required periodic evaluation.

f. Periodic medical examinations are required at least every 18 months. The Soldier will receive instructions detailing where and when to report. If the Soldier fails to respond, Army retired pay will be stopped. If the Soldier is unable to make the appointment for cogent reasons, the PEBLO must be notified so that a new appointment may be made. Prior to examination PEBLOs will ascertain whether the Soldier has been treated by a VA hospital, other military hospital, civilian hospital or a private physician since the last medical evaluation. If the Soldier was recently seen for a service connected disability, the PEBLO will make every effort to obtain copies of any records of the treatment and evaluation.

- g.* Each periodic examination report is referred to a PEB for a determination as to whether the Soldier is to be retained on, or removed from, the TDRL.
- h.* Final disposition may result in permanent retirement with the same, greater, or lesser disability percentage rating; separation with severance pay (if less than 20 years service); or a finding of physical fitness.
- i.* A finding of fit for duty by the PEB results in one or more of the following actions:
- (1) A Soldier of the Regular Army upon the Soldier's consent, will be reappointed, reenlisted, or discharged. A Soldier in the RC may, upon the Soldier's consent, reenter the RC without active duty or be discharged.
 - (2) If the Soldier elects to return to active duty, time spent on the TDRL counts for pay purposes.
 - (3) If the Soldier elects to be discharged, the finding of fit does not necessarily effect the Soldier's standing with the VA or the entitlement to VA compensation.
- j.* The Soldier must notify Commander, USA HRC, ATTN: AHRC-PDB, 2461 Eisenhower Avenue, Alexandria VA 22331-04772 of every change of address. Failure to do so or to report for a scheduled examination will result in the suspension of retired pay beginning with the month following the missed examination.

e. USAPDA SOP, 25 Apr 01, paragraph 6-5.

6-5. TDRL MANAGEMENT. The TDRL Section manages the following activities:

a. Maintains the TDRL database, which lists all former soldiers who have been placed on the TDRL and have not yet been removed. The data fields will include:

- (1) ID information.
- (2) Current mailing address.
- (3) Date placed on the TDRL.
- (4) Date of the next re-exam (from DA Form 199).
- (5) Date of the last re-exam.
- (6) Date of the last re-exam plus 18 months.
- (7) Hospital code identifying the MTF.

(8) A remarks section showing the status of the re-exam process for that member. Removals from and additions to the TDRL database and DRAS will be done daily. DRAS is a Defense Retain Tracking System managed by DFAS.

b. Manages the re-examination suspense and notifications for TDRL members.

(1) Uses the electronic database and the manual suspense system to identify TDRL members whose re-exam date is coming up. Particular care must be taken to identify members that have been on the list for more than five years or are approaching five years; members that have not had a re-exam by the re-exam date; and members that have not had a re-exam in 18 months.

(2) Notifies, by letter, the member and the MTF of the upcoming re-exam date. This letter establishes month and the year of the re-exam. The MTF, in coordination with the soldier, establishes the day.

(3) Produces attachment orders so the member may travel to the MTF and be examined at government expense. These orders are normally endorsed by the MTF to reflect the exact date. The orders may also be endorsed by any PEB to bring the member to the PEB for a formal board appearance.

c. Manages pay terminations.

(1) The retired pay of members on TDRL will be terminated when they fail to appear for a re-exam without just cause. Normally, the member will be given a 30-day grace period during which the exam that was missed can be rescheduled. If an explanation is not provided by the 31st day, a notification letter to DFAS will terminate the member's pay.

(2) If a member whose pay has been terminated eventually gets a re-exam, the pay will be reinstated from the date of the termination of eligibility.

d. Manages administrative removals.

(1) When a member has been on the TDRL for longer than five years, and all efforts to contact him/her have failed, the member's status on the TDRL will be terminated administratively. This action is accomplished without benefit of a recent medical exam or PEB adjudication.

(2) The TDRL section will recommend to the Branch Chief that a member be removed when efforts to contact the member have failed and are documented. The Branch Chief will then approve the removal.

(3) The TDRL section completes the case and returns it to the Control Clerk.

e. Case file documentation is essential to accurate and fair TDRL processing. Every effort should be made to ascertain the accuracy of the soldier's address. All phone call and conversations regarding the case must be documented and made a part of the case file. Decision/actions related to the TDRL cases should be confirmed in writing by letter or e-mail (hard copies in case file).

FINDING 2.8: The Judge Advocate General (JAG) Corps currently provides quality legal representation to the Soldiers they represent at formal Physical Evaluation Boards.

STANDARDS:

a. DODI 1332.38, Subject: Physical Disability Evaluation, 14 Nov 96 (with Change 1, 10 Jul 06), paragraph E3.P1.3.3.5.2.

E3.P1.3.3.5.2. The right to the assistance of a detailed military counsel provided at no expense to the member or a personal representative provided at no expense to the Service. This right extends to Reserve component members who request a formal hearing pending separation for medical disqualification.

b. AR 635-40, Physical Evaluation for Retention, Retirement, or Separation, 8 Feb 06, paragraph 2-6.

2-6. The Judge Advocate General

The Judge Advocate General (TJAG) will—

- a. Interpret laws and regulations governing the Army Physical Disability Evaluation System.
- b. Train and provide sufficient legal counsel to represent Soldiers appearing before a PEB.
- c. Train Army attorneys in disability law.

OBJECTIVE 3: Assess the execution of the Medical Hold System to include compliance with Department of Defense (DOD) and Army policies.

FINDING 3.1: Current Army medical holdover guidance does not fully address the command and control component of MHO operations.

STANDARD:

a. Department of the Army Personnel Policy Guidance (PPG) for Contingency operations in support of GWOT, updated 16 August 2006.

Chapter 10-11, Medical Holdover, states:

"a. General:

(1) Medical Holdover (MHO) operations consist of three critical components that FORSCOM must synchronize across ASCCs for the benefit of Soldiers in MHO status.

- MEDCOM conducts medical evaluation, makes decision on treatment type and location, and has the technical supervision and quality control of all medical aspects of the MHO operations.
- Installation Management Agency (IMA) performs command and control of MHO Soldiers receiving treatment on active Army installations to ensure that they are available for medical care, are provided with adequate living conditions, and provided with personnel support.

- FORSCOM, MEDCOM, and Physical Disability Agency conducts MEB/PEB in accordance with current Army policy.

e. Community Based Health Care Initiative (CBHCI):

Effective 20 January 2004, FORSCOM was assigned as executive agent and command and control element for the Community Based Health Care Initiative (CBHCI). CBHCI was designed to reduce the workload at mobilization sites in the event that demand for housing or medical care exceeds available resources. RC soldiers can receive medical care near their homes even if full capacity was not reached at the mobilization sites. A major benefit of this program is the opportunity for RC soldiers to transition back to their civilian communities while remaining on active duty.

f. Community Based Health Care Organization (CBHCO):

(1) Effective 17 January 2006, the Commander MEDCOM assumed command and control of CBHCO operations (reference ALARACT 005/2006). When treatment through a CBHCO is approved, the Soldier will be converted to active duty orders under the provision of 10 USC 12301(d) prior to departing his/her current installation for the CBHCO location. A Soldier converted to 10 USC 12301(d) orders and assigned to a CBHCO will be authorized roundtrip, command-directed travel expenses when government transportation is not available.

(2) CBHCOs are designed to coordinate and manage the medical evaluation and treatment of Soldiers with unresolved medical conditions, conduct medical evaluation boards (MEBs) for Soldiers who don't meet retention standards, and provide command and control and administrative support to assigned Soldiers. Detail information can be found at <https://freddie.forscom.army.mil/g1-cbhco/default.htm>."

b. Annex Q to HQDA OPORD 04-01, 22 Jan 04.

"3. B. Concept of Operations. MHO operations consist of three critical components that FORSCOM must synchronize across MACOMS for the benefit of the Soldiers in MHO status: 1) MEDCOM conducts medical evaluation, makes decision on treatment type and location, and has technical supervision and quality control of all aspects of the MHO operations. 2) Installation Management Agency (IMA) performs command and control (C2) of MHO Soldiers receiving treatment on active duty installations to ensure that they are available for medical care, are provided with adequate living conditions, and are supported with administrative personnel, finance, and logistical support. 3) FORSCOM, MEDCOM, and Human Resources Command (HRC) conduct MEB and Physical Evaluation Board (PEB) in accordance with (IAW) current Army policy as amended to accommodate the CBHCI.

3. B. 1. CBHCO Concept of operations. FORSCOM performs overall C2 and synchronizes the efforts of MEDCOM, National Guard Bureau (NGB), Office, Chief Army Reserve (OCAR), and other agencies in support of CBHCO operations. CBHCO

coordinates medical care, prepares reports, assists Soldiers with medical claims processing, maintains MHO Soldier status in designated data systems, initiates MEB, and performs command and control of MHO Soldiers who are attached to them under the provisions of ADME.

3. C. Tasks to MACOMS and other HQDA staff elements.

3. C. 1. FORSCOM

3. C. 1. A. Provides overall C2 and synchronizes MHO operations, supported by MEDCOM, IMA, and other MACOMs.

3. C. 2. Commander, MEDCOM / The Surgeon General (TSG)

3. C. 2. A. Responsible for all medical policy and support associated with MHO operations, to include screening, referral, treatment, tracking, and follow-up.

3. C. 3. Director, Installation Management Agency (IMA).

3. C. 3. B. Through Garrison commanders, perform C2 of MHO soldiers on active component and USAR army installations.

3. C. 3. F. ICW FORSCOM, MEDCOM, NGB, USARC, and other MACOMS develop procedures for transfer of MHO Soldiers from active Army installation C2 element to CBHCO.

3. C. 7. Chief, Army Reserve (CAR) / Commanding General, United States Army Reserve Command (USARC).

3. C. 7. A. ICW FORSCOM, HQDA G-1, MEDCOM/OTSG, CNGB participate in personnel and medical policy development for all planning and execution in support of MHO operations.

3. C. 8. Chief, National Guard Bureau (CNGB)

3. C. 8. A. ICW FORSCOM, HQDA G1, MEDCOM/OTSG, and DARNB, participates in personnel and medical policy development for all planning and execution in support of MHO operations.

3. C. 8. C. Direct that all CBHCO case managers and selected command and control personnel from the 13 CBHCO attend required training at the Professional Education Center, Little Rock, Arkansas on 14-21 February 2004. Mobilized Soldiers will attend in a mobilized status, all other Soldiers will attend in a directed annual training status.

3. C. 9. All other MACOMS be prepared to support FORSCOM, MEDCOM and IMA in the execution of MHO operations..."

c. Department of the Army Medical Holdover (MHO) Consolidated Guidance, 24 July 2006.

Chapter 1, paragraph 1, states,

"1. Purpose: To provide a consolidated Army policy and procedure document for managing Medical Holdover (MHO) Soldiers. This document standardizes Army guidance. A MHO Soldier is defined as a Reserve Component (RC) Soldier mobilized on 10 United States Code (USC) 12302 orders in support of contingency operations and diverted from his/her normal mobilization mission, demobilization processing, or medically evacuated (MEDEVAC) from theater, who is in need of medical evaluation, treatment, and disposition including definitive health care for medical conditions identified, incurred, or aggravated while in an active duty (AD) status in support of the Global War on Terrorism (GWOT). "

d. FORSCOM Implementation Plan for Community Based Health Care Initiative (CBHCI), 20 January 2004.

"GENTEXT/SITUATION/1. In accordance with paragraph 3.b.1., 3.c.1.a., And 3.d.10., of ANNEX Q to HQDA OPORD 04-01, FORSCOM has direct coordinating and tasking authority as executing agent for the Community Based Health Care Initiative (CBHCI) program.//

GENTEXT/MISSION/2. FORSCOM tasks the following MACOMS and Army agencies to provide the requested information NLT 29 January 2004. The material provided will be incorporated into the FORSCOM implementing instructions for the community based health care Initiative, with a suspense to stand up the first Community Based Health Care Organization (CBHCO) in Florida on 1 march 2004.//

AMPN/CONCEPT OF OPERATIONS: FORSCOM performs overall command and control and synchronizes the efforts of MEDCOM, National Guard Bureau (NGB) Office, Chief Army Reserve (OCAR), and other agencies in support of CBHCO operations. CBHCO coordinates medical care, prepares reports, assists soldiers with medical claims processing, maintains medical holdover (MHO) soldier status in designated data systems, initiates Medical Evaluation Boards (MEB), and performs command and control of MHO soldiers Who are attached or assigned to them under the provisions of ADME.//

3.b. MEDCOM will provide implementing instructions and training guidance for medical functions and responsibilities to be incorporated into FORSCOM instructions.

3.d. CONUSAs will provide command and control model, functions and responsibilities, and training guidance."

e. MEDCOM Operations Order 06-03, (Community Based Health Care Organizations Medical Holdover Operations (MHO)).

"3. EXECUTION:

a. Concept of Operation.

(1) The MEDCOM, through the Regional Medical Commands (RMC) and Task Forces East and West, will provide command and control (C2), personnel, logistical, fiscal, legal, chaplain and communications coordination and support to CBHCO to ensure the success of the Army's CBHCO initiative.

(2) Task Forces East and West are provisional units comprised of RC Soldiers assigned to MEDCOM as a result of the transfer of authority (TOA) of the Community Based Health Care Initiative (CBHCI) from FORSCOM to MEDCOM. The North Atlantic Regional Medical Command (NARMC) and the Great Plains Regional Medical Command (GPRMC) will provide C2 for the Task Forces identified as Task Force East and Task Force West respectively. See Annex A (Task Organization).

c. Tasks to Subordinate Units.

(1) North Atlantic Regional; Medical Command.

(a) Assume command of Task Force East and all CBHCOs aligned to Task Force East.

(b) Provide command and control and oversight to CBHCO operations in the NARMC and Southeast Regional Medical Command (SERMC).

(2) Southeast Regional Medical Command. Supports NARMC in conducting its CBCHO operations responsibilities within SERMC.

(3) Great Plains Regional Medical Command.

(a) Assume command of Task Force West and all CBHCOs aligned to Task Force West.

(b) Provide command and control and oversight to CBHCO operations in the GPRMC and Western Regional Medical Command (WRMC).

(4) Western Regional Medical Command. Supports GPRMC in conducting its CBCHO operations responsibilities within WRMC.

(5) Task Force East.

(a) Provide C2 for all CBHCO designated sites throughout NARMC and SERMC area of responsibility (AOR).

(b) Coordinate and maintain a support relationship for office, billeting, and mess support for CBHCO cells.

(c) Provide training opportunities for soldiers assigned to the CBHCO while on active duty as the operational tempo permits.

(6) Task Force West.

(a) Provide C2 for all CBHCO designated sites throughout GPRMC and WRMC AOR.

(b) Coordinate and maintain a support relationship for office, billeting, and mess support for CBHCO cells.

(c) Provide training opportunities for soldiers assigned to the CBHCO while on active duty as the operational tempo permits.

5. COMMAND AND SIGNAL:

a. Command. Effective 17 January 2006 MEDCOM assumed command and control of CBHCO operations.

(1) Task Force East.

(a) Assigned to NARMC for command and control.

(b) SERMC is a supporting command to NARMC for CBHCO operations in SERMC's AOR.

(c) Task Force East boundaries are NARMC and SERMC plus Iowa and Minnesota.

(2) Task Force West.

(a) Assigned to GPRMC for command and control.

(b) WRMC is a supporting command to GPRMC for CBHCO operations in WRMC's AOR.

(c) Task Force West boundaries are GPRMC and WRMC minus Iowa and Minnesota."

FINDING 3.2: A majority of Medical Holding Units cadre and some Medical Retention Processing Units (MRPU), and Community Based Healthcare Organizations (CBHCO) cadre lack formal training.

STANDARD:

a. Army Regulation 40-400, Patient Administration, 17 March 2001.

Chapter 8, Medical Holding Unit, states,

"8-1. General

Each MTF having inpatient capabilities, except those functioning in a contingency zone operation, will maintain an MHU company/detachment. Patients that do not meet the medical criteria of this chapter are not attached or assigned to the MHU. Military personnel are not attached or assigned to the MHU for compassionate reasons.

8-2. Notification of admission and discharge

a. The patient administrator of an MTF where a patient is first admitted will immediately notify the commander of the patient's unit. The notification will include the time and date of admission. Another notification is made when the patient is returned to duty or another disposition is made.

b. When a patient is admitted while en route overseas, the patient administrator will notify the ATAC. The patient administrator will indicate the probable length of hospitalization and whether the patient is expected to be assigned to the MHU. (See para 8-4c.)

8-3. Attachment of AD Army personnel to a medical holding unit

a. All AD Army patients admitted directly or by transfer are attached to the MHU. The CHCS automated AAD report is authorized for use as the attachment order.

b. When an AD Army soldier is admitted to an other-than-Army MTF, the Army MTF having geographic responsibility will place the soldier in the status of absent sick. The MHU will prepare an attachment order and forward it to the soldier's assigned unit and the MTF at which the soldier is hospitalized.

c. AD Army inpatients attached to an MTF may be referred to another MTF for short-term treatment and returned to the originating MTF. This may include referral of a patient from an overseas MTF to a CONUS MTF at the discretion of the overseas MTF commander.

d. Attachment to an MHU for soldiers in an outpatient status is only authorized when the MTF commander/ physician determines that continuous treatment is required

and that the soldier cannot be managed by his or her unit. That is, the MTF is not located within daily traveling distance to the soldier's unit.

8-4. Assignment of AD Army personnel to a medical holding unit

AD Army soldiers may be assigned to an MHU in an inpatient or outpatient status. The MHU will issue assignment orders.

a. While assigned to the MHU, the patient may undergo further treatment, convalescence, subsisting out (see para 5-7), and start MEB processing. While in an assigned outpatient status, patient progress will be monitored and the patient will be added to the medical hold/patient squadron roster when appropriate.

b. Unit commanders will ensure that soldiers undergoing disability evaluation processing are available for all necessary MEB/PEB processing. Soldiers should not be assigned to medical hold unless they meet one of the requirements in c below. MTF commanders are not authorized to enter into agreements to automatically assign members to the MHU while undergoing physical disability processing. Soldiers will normally receive MEB/PEB processing on an outpatient basis while assigned to their parent organization. Assignment to the MHU will not be used to facilitate the early requisitioning of replacement personnel. Rather, members undergoing physical disability processing are to contribute to mission accomplishment at the parent unit to the degree possible.

c. Patients will be assigned to the MHU as in (1) through (7) below.

(1) Upon evacuation from a combat area to an MTF maintaining an MHU.

(2) When or as soon as the MTF commander determines that a patient will be hospitalized in excess of 90 days. The 90-day period refers to the total period of continuous hospitalization; it is not limited to a specific MTF.

(3) Upon hospitalization in a VA treatment facility with SCIs or brain injuries, or other long-term care requiring PEB action, these patients will be assigned to the MHU of the responsible Army MTF. They will then be processed as a PCS to the VA treatment facility. The Army MTF having administrative responsibility will provide accountability, clinical monitoring, and final administrative processing of the patient until fit for duty and reassigned or separated from Service.

(4) When an overseas MTF commander determines that a patient exceeds the theater length of treatment practices or requires special services not available and must be evacuated and not returned to duty.

(5) When the MTF commander determines that a patient, whose unit or numbered shipment is scheduled for more than a local move, will not be returned to duty before the date of departure of the unit or numbered shipment. If so, within proper

security limits, commanders of such units or numbered shipments will keep the MTF commander advised of the expected date of departure.

(6) When the MTF commander determines that—

(a) A patient en route overseas will require hospitalization over 30 days beyond his or her scheduled reporting date.

(b) A patient hospitalized at an MTF serving an aerial POE will require hospitalization over 30 days beyond his or her normal shipment date. The reporting date will be computed and established per AR 600-8-105. Distribution of orders will be according to AR 600-8-105. Care will be taken so that all organizations having personnel accountability for the patient are included. A patient transferred from one Army MTF to another in an assigned status will be carried in an assigned status by the receiving MTF.

(7) When outpatients do not require inpatient care and are unable to perform even limited duty at their assigned unit.

d. The following patients are ineligible for assignment to an MHU:

(1) Members of the other Uniformed Services, if hospitalized in an Army MTF, require tracking and reporting to the applicable Service.

(2) Special RC program personnel (AR 600-8-6) may not be assigned.

(3) Personnel assigned to a CONUS organization who are hospitalized while temporarily in an overseas command may not be assigned. If such personnel will be evacuated to CONUS, they will be evacuated in an attached status.

(4) General officers will not be relieved from duty assignment and assigned to MHUs without the approval of the DCSPER, HQDA.

(5) Military personnel who are under investigation, courts-martial charges or sentence, nonjudicial punishment, or administrative separation proceedings-other than those authorized by AR 635-40-will not be assigned from a local unit without concurrence of the MHU commander and PAD chief.

8-5. Individual records and clothing

a. Personnel and pay records of patients attached to an MHU will be kept in the patient's assigned organization. The MTF commander may request copies of records required for the study and evaluation of a patient.

b. When reassignment orders are issued, a copy of the order is sent immediately to the soldiers's prior organization to expedite receipt of personnel and pay records.

c. When the servicing military personnel officer receives a reassigning order, the soldier's personnel and pay records will be forwarded to the MTF within 5 working days (AR 600-8-104). Individual clothing will be sent according to AR 700-84.

8-6. Return to duty of attached patients

a. Attached patients may be returned to duty or duty with profile limitations after hospitalization.

b. Attached patients enroute overseas at the time of admission will—

(1) If preparation of replacements for overseas movement (POR) qualified, be furnished a statement of the period of hospitalization and directed to the installation port call/transportation movements office.

(2) If no longer POR qualified, will be reported for assignment instructions according to paragraph 8-8. The ATAC serving the aerial POE will be notified of the action taken.

8-7. Disposition of assigned patients in CONUS

a. Except as provided in b below, all patients who are medically fit for duty and assigned to an MHU will be reported by the MTF commander for assignment instructions. (See para 8-8.)

b. Upon discharge from the hospital, patients in the categories described in (1) through (6) below will be reassigned by the MTF commander without reporting to PERSCOM.

(1) Persons who, when hospitalized, were undergoing basic combat training or advanced individual training and who are hospitalized in the MTF serving the installation where training was interrupted will be reassigned to their former training activity.

(2) Persons who are medically fit for duty under AR 40-501 but will be returned to duty with a recommendation for separation (para 5-3e(1)) will be reassigned to their former units. The MTF commander may make exceptions to this policy if it is determined that other action will better serve the interests of the Government. Reassignment instructions will be requested per paragraph 8-8 or separate action may begin at the MTF.

(3) Persons awaiting trial by courts-martial will be reassigned to their former units or to the unit or installation where the trial will be held. The local SJA or legal officer will be consulted.

(4) Persons awaiting the results of investigation or clearance will be reassigned to their former units if a request for this action has been made by the commander concerned. Normally, patients will not remain assigned to an MHU solely to await the results of these actions. If assignment instructions cannot be obtained, the person will be placed on duty as outlined in paragraph 8-9.

(5) Persons eligible under existing criteria for release from AD or discharge will be processed at the MTF if facilities exist. If not, processing will be according to AR 635-10.

(6) Officers medically fit for duty who have applied for or are scheduled for retirement within 60 days or who have submitted a tender of resignation will remain assigned to the MHU until instructions are received from PERSCOM. The MTF commander will promptly report such officers to Commander, PERSCOM (TAPC-PDT-R), Alexandria, VA 22332-0400. If the officer has appeared before an MEB, a copy of the board proceedings will accompany the report. When practicable, officers awaiting instructions under this subparagraph will be placed on duty according to paragraph 8-9.

8-8. Requests for assignment instructions

When a patient is to be returned to duty, the MTF commander or his or her designated representative will request assignment instructions. The request will be sent to PERSCOM not later than 15 days before the estimated date of discharge from the hospital. All MTF commanders are responsible for monitoring the progress of assigned patients. MTF commanders will make every effort to render an accurate forecast of the expected date of return to duty. This is necessary to avoid delay in returning a patient to duty. (AR 614-100 contains officer and warrant officer assignment policies and AR 614-200 contains enlisted personnel assignment policies.)

a. The following information will be included in requests for duty assignments for officers other than general officers and warrant officers:

(1) Name, grade, and SSN.

(2) Branch of Service for Judge Advocate General's Corps and Chaplain Corps officers, corps for AMEDD officers, and control branch for others.

(3) Category and expiration date.

(4) Amount of leave desired, if any.

(5) Estimated date of completion of hospitalization.

(6) Physical profile and assignment limitations, if any.

b. Enlisted personnel will be reported to PERSCOM according to instructions in AR 614-200.

c. In exceptional circumstances, it may not be possible to predict the date of return to duty within the 15-day time requirement. Assignment instructions will be requested from PERSCOM through the most expeditious means available.

d. When a patient is to be returned to other than full duty, the request for assignment instructions will state the type of disposition recommended. It will also contain the following information as appropriate:

(1) The date on which the person will revert to full duty or the date of return to an MTF for examination, treatment, or reevaluation.

(2) The type and degree of functional impairment involved and any control measures which should be considered in a duty assignment.

(3) The type(s) of duty recommended.

(4) Geographic or climatic assignment limitation recommended.

(5) Physical limitation to POR qualification.

(6) Status of any applications for compassionate reassignment submitted under AR 614-100 for officer personnel and AR 614-200 for enlisted personnel.

(7) Whether current medical condition may result in removal or denial of security clearance.

(8) Patient's preference for area of assignment.

e. When a person cannot be assigned as directed within 30 days after the previously estimated date of completion of hospitalization, this information will be sent by electrical message, facsimile, or other electronic means to the office that issued the assignment instructions. The message will include a reference to the initial request for assignment instructions.

8-9. Duty for assigned patients awaiting orders in CONUS

a. Assignment instructions may not have been received when a patient is released from the hospital. In this case, the MTF commander will issue orders attaching the patient to duty with a unit designated by the installation commander. When this is not medically sound, the MTF commander may place the person on duty with the MTF duty unit. (See AR 635-40.) Such a person will not be charged against the MTF personnel allotment or manning table.

b. CONUS installation commanders will designate (regardless of command jurisdiction) a unit where the MTF commander may place patients on duty where their abilities can be used. Preferably, these units will be other than MTFs, but will be located as near to the MTF as possible.

8–10. Disposition of patients in overseas MTFs

A recovered patient in an overseas MTF will be returned to duty under instructions issued by the major overseas commander. For MTFs in Alaska and Hawaii, instructions will be issued by the member's major commander.

8–11. Separation of enlisted personnel assigned to medical holding units

AR 635–200 addresses special separation provisions.

8–12. Disposition of Reserve Component personnel

RC personnel hospitalized when their orders are for 30 days or less will not be assigned to the MHU, but can remain in the MTF in a patient status and draw pay and allowances; they will not be on AD (AR 135-381). RC soldiers on AD orders for 31 days or more may be extended on AD upon recommendation of their physician.

8–13. Performance of duty while in patient status

AD soldiers may be assigned temporary duties in and about the MTF or in a unit or local post when such duties do not interfere with their availability for medical care requirements. Physical condition, past training, and acquired skills must all be considered before assigning any patient to a given task. Patients will not be assigned duties outside the limits of their physical profile (AR 40-501).

8–14. Prolonged definitive medical care for AD military patients who are unlikely to return to duty

Prolonged definitive care is not provided for AD soldiers who are unlikely to return to duty. The time at which a patient should be processed for disability separation must be determined on an individual basis. The interests of both the patient and the Government should be considered. The long-term patient roster generated by CHCS will be used by the MTF utilization managers to monitor the progress of patients undergoing prolonged definitive treatment. This roster lists all inpatients with 30 or more continuous days of hospitalization. In addition, the MTFs utilization management committee (AR 40-68) will also be provided a separate roster for the management of medical hold patients not in an inpatient status and for all patients undergoing MEBs at the MTF."

b. Department of the Army Medical Holdover (MHO) Consolidated Guidance 24 July 2006.

Section(s) 8 c-d, Responsibilities, states:

"c. Medical Command (MEDCOM) will:

(1) Serve as the Supported Command synchronizing MHO operations, supported by IMA and other MACOMs.

(2) Develop and implement medical standards and policy to support MHO operations, to include provision of clinical care, case management, monitoring outcomes, treatment tracking, ensuring appropriate and adequate clinical resources and support, and providing staff orientation and education.

(3) Provide overall technical supervision and quality control over all medical aspects of the MHO Program.

(8) Establish technical procedures to conduct quality assurance (QA) review of MHO program, to include the Medical Evaluation Board (MEB) and Physical Evaluation Board Liaison Officer (PEBLO) functions.

(12) Evaluate CBHCI program adequacy and continually evaluate CBHCO program resourcing, location, and effectiveness.

(13) Develop job descriptions for CBHCO C2 cadre, Senior Case Managers, and Case Managers.

(14) Develop SOPs for CBHCO and case management operations.

(15) Develop procedures utilizing the MODS that provide real time visibility and accountability of MHO Soldiers assigned and attached to MRPU and CBHCOs in coordination with IMA and HRC-A.

(17) Coordinate with the Army Reserve Surgeon office to provide USAR Liaison to each CBHCO.

(18) Coordinate with Chief, National Guard Bureau for Soldiers to fill CBHCO cadre positions.

(19) Develop eligibility criteria for attaching MHO Soldiers to CBHCO with assistance from IMA, and HRC-A.

(31) Assist HQDA, DCS G-1 in developing personnel policy for MHO operations in coordination with ASA (M&RA), IMA, HRC-A, PDA, CNGB, CAR, US Army Finance Command, and DFAS.

(32) Assist ASA (M&RA) in conducting periodic assistance visits of MRPU and CBHCO sites to ensure compliance with established operational standards in coordination with IMA and HRC-A.

d. Installation Management Agency (IMA) will:

(5) Support Commander, MEDCOM, by participating in the on-site certification of the MRPU sites, ensuring they are mission-ready before accepting MHO Soldiers.

(6) Assist HQDA, DCS G-1 in developing personnel policy for MHO operations in coordination with ASA (M&RA), MEDCOM, HRC-A, PDA, CNGB, CAR, US Army Finance Command, and DFAS.

(8) Assist ASA (M&RA) in conducting on-site assistance visits of the MRPU and CBHCO sites in coordination with MEDCOM and HRC-A.

(10) Support MRPU and CBHCO commanders with installation personnel administrative processes.

(11) Develop job descriptions for MRPU C2 cadre.

(12) Develop SOPs for MRPU MHO operations.

(13) Provide training to MRPU C2 and cadre to ensure their competency to perform their assigned duties. This training is not limited to, but must include instruction in finance and personnel management and strength accounting procedures."

FINDING 3.3: Some medical hold and medical holdover Soldiers in the APDES process do not understand their rights and separation entitlements.

STANDARDS:

a. **Department of Defense Directive 1332.18, November 4, 1996.**

Paragraph 3.13, states:

"3.13. Service members referred for physical disability evaluation shall be afforded, at appropriate stages of processing, comprehensive counseling on the significance of the actions proposed and the related rights, entitlements, and benefits."

b. **Department of Defense Instruction 1332.38, November 14, 1996, Enclosure E3.P1.4. Counseling states,**

"E3.P1.4.1. Purpose. The counseling element of DES shall afford Service members undergoing evaluation by the DES the opportunity to be advised of the

significance and consequences of the determinations made and the associated rights, benefits, and entitlements.

E3.P1.4.2. Topics. Counselors shall counsel on such matters as:

E3.P1.4.2.1. The sequence and nature of the steps in processing.

E3.P1.4.2.2. Statutory and regulatory rights.

E3.P1.4.2.3. Effect of findings and recommendations.

E3.P1.4.2.4. Recourse to rebuttals.

E3.P1.4.2.5. Estimated retired or severance pay based upon the PEB's findings and recommendations.

E3.P1.4.2.6. Probable retired grade.

E3.P1.4.2.7. Potential veterans benefits.

E3.P1.4.2.8. Post-retirement insurance programs and the Survivor Benefit Plan in accordance with DoD Directive 1332.27 (reference (g)) if appropriate.

E3.P1.4.2.9. Applicable transition benefits under DoD Directive 1332.35 (reference (h)).

E3.P1.4.2.10. Prior to acting on a Service member's request for a formal PEB, review with the member the applicable standard detailed in the VASRD or DoD Instruction 1332.39 (reference (i)), which would have to be recognized in order to increase the percentage of disability.

E3.P1.4.3. Ready Reserve Members. Ready Reserve members pending separation for physical disability should be counseled by the MTF Physical Evaluation Board Liaison Officer concerning their rights under the DES as established by section E3.P1.3. of Part 1 and section E3.P2.1. of Part 2.

E3.P1.4.4. Incompetent Members. When a Service member has been determined incompetent, his or her primary next of kin, or court appointed guardian shall be counseled and afforded the opportunity to assert the rights granted to the Service member, unless prohibited by law.

E3.P1.4.5. Pre-Separation Counseling. Service members on a call to active duty of more than 30 days shall not be separated or retired because of physical disability prior to completion of pre-separation counseling under reference (h). Though counseling is normally accomplished 90 days before separation, the date of separation or

retirement of members determined unfit need not be extended to provide a minimum of 90 days between counseling and separation or retirement."

c. Army Regulation 40-400, 12 March 2001.

Paragraph 7-17 states:

"7-17. Counseling members concerning medical board results

a. Upon completion of the MEB and approval of the proceedings, the member will be counseled concerning the findings. If the member disagrees with the board, the member has 3 working days to prepare a written appeal for submission to the appointing authority. If no action is taken by the member within 3 working days, the board results will be forwarded, as if approved by the member, to the Service reviewing authority for further action.

b. After approval by the Service reviewing authority and a disposition is recommended, the member will be advised of the proposed disposition. The member will be afforded the opportunity to appeal the decision of the reviewing authority. The member will ordinarily have 3 working days in which to submit an appeal."

d. Army Regulation 635-40, 8 February 2006

Paragraph 3-8, Counseling provided to Soldiers, states"

"a. *Physical Evaluation Board Liaison Officer counseling.* The appointed Physical Evaluation Board Liaison Officer (PEBLO) at the MTF is responsible for counseling Soldiers (or the next of kin or legal guardian in appropriate cases) concerning their rights and privileges at each step in disability evaluation, beginning with the decision of the treating physician to refer the Soldier to a MEBD and until final disposition is accomplished. For this purpose, the MTF commander will name an experienced, qualified officer, noncommissioned officer (NCO), or civilian employee as the PEBLO. At least one additional qualified officer, NCO, or civilian employee will be designated as alternate PEBLO. Only personnel whose duties will not conflict with their counseling responsibilities will be selected. The MTF commander will notify the recorder of the applicable PEB, of the name and telephone number of the PEBLO and alternate PEBLO. PEBLOs will use the Disability Counseling Guide (app C) to assist them in providing thorough counseling. Counseling will be documented (see para 4-20d). Counseling will cover as a minimum, the following areas:

(1) Legal rights (including the sequence of and the nature of disability processing).

(2) Effects and recommendations of MEBD and PEB findings.

(3) Estimated disability retired or severance pay (after receipt of PEB findings and recommendations).

(4) Probable grade upon retirement.

(5) Potential veteran's benefits.

(6) Recourse to and preparation of rebuttals to PEB findings and recommendations.

(7) Disabled Veterans Outreach Program (DVOP).

(8) Post-retirement insurance programs and the Survivor Benefit Plan (SBP).

b. Legal counseling. Counseling by the appointed legal counsel is provided when the Soldier requests a formal hearing."

Army Regulation 635-40, 8 February 2006 paragraph 4-12, "Counseling Soldiers who have been evaluated by a medical evaluation board states,

a. The PEBLO will advise the Soldier of the results of the MEBD. The Soldier will be given the opportunity to read and sign the MEBD proceedings. If the Soldier does not agree with any item in the medical board report or NARSUM, he or she will be advised of appeal procedures.

b. The decisions below are exclusively within the province of adjudicative bodies. Neither the PEBLO nor the attending medical personnel will tell the Soldier that—

(1) The Soldier is medically or physically unfit for further military service.

(2) The Soldier will be discharged or retired from the Army because of physical disability.

(3) A given percentage rating appears proper.

(4) A LD decision is final (unless final approval has been obtained according to AR 600-8-4)."

Appendix C, Counseling, states:

"Section I
Introduction

C-1. Purpose

This appendix outlines the responsibilities and duties of the PEBLO and the appointed Legal Counsel who represents Soldiers before the formal PEB. It provides a guide for counseling Soldiers who are being processed within the Physical Disability Evaluation System.

C-2. Scope

a. The PEBLO will counsel each Soldier (or the next-of-kin or legal guardian, when appropriate) throughout physical disability processing. Counseling will be based upon the individual circumstances of each case and will be designed to serve the Soldier's best interest. Answers to questions about MEBD and PEB procedures will be provided in detail. The PEBLO must reassure the Soldier that counseling will continue, as needed, as the case progresses within the disability system. Soldiers should be encouraged to ask questions during case processing. All Soldiers should be advised of benefits and training provided by the Department of Veterans Affairs, Department of Labor, and Social Security Administration.

b. Federal law (10 USC 1214) provides that no Soldier of the Armed Forces may be retired or separated without a full and fair hearing if demanded. If the Soldier requests a formal hearing, an Army attorney will be appointed as counsel to represent the Soldier at the formal hearing. The attorney is responsible for counseling the Soldier on all matters relating to the formal hearing.

C-3. Stages of counseling

a. The PEBLO will provide counseling at the following stages of case processing.

(1) Upon referral of the Soldier's case to a MEBD.

(2) When approved findings and recommendations of the MEBD are received by the Soldier or next-of-kin.

(3) When the findings and recommendations of the PEB informal hearing are received by the Soldier or next-of-kin.

(4) When the Soldier demands a formal PEB hearing.

(5) After the PEB president announces the findings and recommendation of the formal hearing.

(6) When the USAPDA informs the Soldier or next-of-kin of a proposed modification to the findings and recommendations of the PEB.

(7) When the results of an appeal to the APDAB are received by the Soldier or next-of-kin.

b. Major duties of the appointed legal counsel are outlined in paragraph 4–21*h*. Counsel will ensure that each Soldier who elects a formal hearing has been properly counseled. Counsel will contact the Soldier within 3 days of being detailed by the PEB. The Soldier will be advised of the following rights:

(1) Rights under the Privacy Act of 1974 and its application to the formal hearing.

(2) To testify or to remain silent. Remaining silent is not considered adversely by the board.

(3) To introduce witnesses, depositions, documents, or other relevant evidence in the Soldier's behalf.

(4) To question all witnesses including those called by the PEB.

(5) To make unsworn statements, orally, in writing, or both, without being subject to questioning by the board.

(6) To decline to make any statement touching on the origin or aggravation of any disease or injury.

(7) That no Soldier may be separated or retired for physical disability without a full and fair hearing, and that counsel is present to safeguard the legal rights of the Soldier.

C–4. Overview of PEBLO counseling

a. In order to fully execute required responsibilities, PEBLOs must have a thorough knowledge of the policies, regulations, and directives applicable to the Physical Disability Evaluation System. Section II contains further guidance for counseling purposes.

b. Although specific details will vary with each case, PEBLOS will include the following topic areas when explaining PEB findings and recommendations and applicable benefits.

(1) Rights of the Soldier—MEBD and PEB (see paras C–6 and C–7)

(2) Findings and recommendations—MEBD and PEB (see paras C–6 and C–7)

(3) Case review (see paras C–8 and C–9)

(4) Pay and related benefits (see para C–12)

- (5) Grade determination (see para C-12)
- (6) VA benefits (see para C-13)
- (7) Social Security benefits (see para C-14)
- (8) TDRL regulatory requirements (see para C-10)
- (9) Rights of retired Soldiers (see para C-11)
- (10) Benefits under the Department of Labor DVOP (see para C-15)

c. At all stages of counseling, PEBLOs will advise Soldiers of the necessity of obtaining sufficient documentation (medical and non-medical) concerning the Soldier's ability to perform military duties and the severity of the Soldier's disease or injury. If additional documentation to support the Soldier's case is required, the PEBLO will assist in identifying the type of information needed and will assist in obtaining the required information. In unique or complex cases the PEBLO is authorized direct contact with the PEB appointed legal counsel to determine what type of additional information will be most useful to the Soldier. The PEBLO will ensure that all additional information received is promptly included in the Soldier's case file as supporting evidence.

d. PEBLOs will maintain close coordination with the PEB during the processing of all cases and will advise the PEB of all matters which have an impact upon the prompt and efficient processing of disability cases.

e. Counseling and assistance will be provided by the PEBLO to Soldiers on the TDRL who are undergoing periodic examination or related evaluations.

f. If found unfit, each Soldier will be counseled by the PEBLO about the approximate date of release from active duty (see app E). This will be accomplished at the initial counseling session following the MEBD or PEB processing in order to facilitate an orderly transition from the service.

g. The PEBLO will coordinate with the installation RSO and the Transition Point in arranging for briefings on benefits and programs for which the Soldier may be eligible. If possible, the PEBLO should arrange for interviews with VA, Social Security, and DVOP representatives. Appointments should be scheduled as far ahead of estimated separation date as is possible to allow the Soldier adequate time to assimilate the information.

h. PEBLO's must ensure that the case file of a Soldier being placed on TDRL contains a current mailing address for Soldier's location upon departure from unit."

FINDING 3.4: Most medical hold and medical holdover Soldiers have duties within the limits of their medical profiles.

STANDARD:

a. Army Regulation 40-400, Patient Administration, 12 March 2001.

Paragraph 8-13, Performance of duty while in patient status, states"

"AD Soldiers may be assigned temporary duties in and about the MTF or in a unit or local post when such duties do not interfere with their availability for medical care requirements. All Soldiers shall be referred for disability separation evaluation within 1 year of the diagnosis of their medical condition if they are unable to return to military duty. Patients will not be assigned duties outside the limits of their physical profile (AR 40-501).

b. Army Regulation 40-501, Standards of Medical Fitness, 16 February 2006, paragraph 7-3e.

7-3. Physical profile serial system

e. Anatomical defects or pathological conditions will not of themselves form the sole basis for recommending assignment or duty limitations. While these conditions must be given consideration when accomplishing the profile, the prognosis and the possibility of further aggravation must also be considered. In this respect, profiling officers must consider the effect of their recommendations upon the Soldier's ability to perform duty. Profiles must be realistic. All profiles and assignment limitations must be legible, specific, and written in lay terms. If the commander has questions about a profile or is unable to use the Soldier within the profile, the procedures in paragraph 7-12 will apply.

(1) Determination of individual assignment or duties to be performed are command/administrative matters. Limitations such as "no field duty," or "no overseas duty," are not proper medical recommendations. (However, they are included as administrative guidelines in pregnancy profiles.) Profiling officers should provide enough information regarding the Soldier's physical limitations to enable the nonmedical commander and AHRC to make a determination on individual assignments or duties.

(2) It is the responsibility of the commander or personnel management officer to determine proper assignment and duty, based upon knowledge of the Soldier's profile, assignment limitations, and the duties of his or her grade and MOS.

(3) Table 7-1 contains the physical profile functional capacity guide.

(4) See TB MED 287 for profiling Soldiers with pseudofolliculitis.

c. Department of the Army Medical Holdover Consolidated Guidance, 24 July 2006, paragraph 2-10d(4).

10. CBHCO SELECTION CRITERIA:

d. The following criteria will be addressed by the command to qualify and select an MHO Soldier for CBHCO attachment:

(4) Availability of appropriate duties at an appropriate work site or place of duty within limits of physical profile and within commuting distance from residence, normally within 50 miles of residence. [Soldiers who are physically capable of work are to perform duties primarily in support of Title 10 mission. If performing work in a Title 32 organization, the majority of duties must support Title 10 versus Title 32 functions.]

FINDING 3.5: Medical Retention Processing Units (MRPU) and Community Based Health Care Organization (CBHCO) continuously update personnel and medical automation systems ensuring accurate accountability of medical holdover Soldiers.

STANDARDS:

a. Department of the Army Personnel Policy Guidance (PPG) for Contingency Operations in Support of GWOT, 17 August 2006.

Paragraphs 3-3g(3)(a)9 and 3-3(3)(b)3, state:

3-3. Military Orders

g. Medical Holdover and Medical Retention Processing Orders:

(3) (a) 9. MODS is updated by the Case Manager for clinically related issues, HRC-A updates the order portion of MODS, admin specialist updates remaining pertinent modules in MODS.

- (3) (b). 3. HRC-A will electronically distribute copies of extension orders to:
- IMA (MRPU commander)
 - OTSG/MEDCOM (CBHCO commander)
 - ARNGFSC
 - Army National Guard Finance Service Center, 8899 E 56th St, Indianapolis, IN 46249
 - Electronic Military Personnel Office, (eMILPO),

b. Department of the Army Medical Holdover Consolidated Guidance, 24 July 2006. Paragraph 2-12, MHO Soldier Accountability and Well Being, states:

"a. Installation Garrison Commander, MRPU Commander, and CBHCO Commander responsibility:

(1) The installation Garrison Commander is responsible for the accountability and well being of all MHO Soldiers assigned to his or her command. This includes in-patient and out-patient MHO Soldiers.

(2) The MRPU Commander is responsible for accountability and well being of MHO Soldiers assigned and attached to his or her command at the installation MRPU or MTF.

(3) The CBHCO Commander is responsible for the accountability and well being of all MRP Soldiers attached to his or her command.

b. The MODS MHO Module:

(1) Initial entry of RC Soldier data into the MODS MHO module is the trigger that enters the Soldier in the MHO process for accountability and tracking purposes.

(2) The MODS MHO module provides real-time visibility and accountability of RC Soldiers assigned to MRPU and attached to CBHCOs. The MODS MHO module is the Army's sole tracking and reporting database for MHO Soldiers. The MODS MHO module is maintained by OTSG/MEDCOM.

(3) MODS MHO database input:

(a) The MRPU and CBHCO Commanders are ultimately responsible for the accuracy of MODS administrative and clinical data fields for the MHO Soldiers assigned or attached to their command.

(b) Case Managers are responsible to ensure the clinical information for the RC Soldier entered into MODS at the time he or she becomes a MHO Soldier and for maintaining accuracy of the clinical data fields throughout the time a RC Soldier is in the MHO system.

(c) HRC-A is responsible for updating administrative order related data fields when MHO Soldiers orders are issued or modified.

c. The MRPU and CBHCO Commanders will maintain a 100% accountability of the MHO Soldiers assigned or attached to their commands.

d. The MTF Patient Administration Department (PAD) section will ensure installation MRPU commanders are notified within 24 hours of arrival of any in-patient RC Soldier at the MTF."

c. FORSCOM Implementation plan for Community Based Healthcare Initiative (CBHCI), 12 February 2004.

Annex D, paragraphs 5j(1), 5k(1), and 5k(3), states:

"5. RESPONSIBILITIES:

j. Installations where soldier transitioned to MRP status.

(1) In coordination with MTF commander, coordinate with CBHCO units to identify reporting locations, POCs and telephone numbers for MRP soldiers. Installation will, complete maximum separation processing to include ACAP, publish TCS orders and execute appropriate eMILPO transactions.

k. CBHCO units.

(1) Maintain coordination lines with mobilization/support installation, and provide personnel status changes to support accountability in eMILPO.

(3) Ensure soldiers status is current in eMILPO."

FINDING 3.6: A few installations inspected had Americans with Disabilities Act (ADA) violations affecting disabled Soldiers' access to facilities.

STANDARDS:

a. American Disabilities Act of 1990, Public Law 101-336, 26 June 1990.

"Section 1, Title III, §303, NEW CONSTRUCTION AND ALTERATIONS IN PUBLIC ACCOMMODATIONS AND COMMERCIAL FACILITIES, states:

"(a) Application of Term.--Except as provided in subsection (b), as applied to public accommodations and commercial facilities, discrimination for purposes of section 302(a) includes--

(1) a failure to design and construct facilities for first occupancy later than 30 months after the date of enactment of this Act that are readily accessible to and usable by individuals with disabilities, except where an entity can demonstrate that it is structurally impracticable to meet the requirements of such subsection in accordance with standards set forth or incorporated by reference in regulations issued under this title; and

(2) with respect to a facility or part thereof that is altered by, on behalf of, or for the use of an establishment in a manner that affects or could affect the usability of the facility or part thereof, a failure to make alterations in such a manner that, to the maximum extent feasible, the altered portions of the facility are readily accessible to and usable by individuals with disabilities, including individuals who use wheelchairs. Where the entity is undertaking an alteration that affects or could affect usability of or access to

an area of the facility containing a primary function, the entity shall also make the alterations in such a manner that, to the maximum extent feasible, the path of travel to the altered area and the bathrooms, telephones, and drinking fountains serving the altered area, are readily accessible to and usable by individuals with disabilities where such alterations to the path of travel or the bathrooms, telephones, and drinking fountains serving the altered area are not disproportionate to the overall alterations in terms of cost and scope (as determined under criteria established by the Attorney General).

(b) Elevator.--Subsection (a) shall not be construed to require the installation of an elevator for facilities that are less than three stories or have less than 3,000 square feet per story unless the building is a shopping center, a shopping mall, or the professional office of a health care provider or unless the Attorney General determines that a particular category of such facilities requires the installation of elevators based on the usage of such facilities."

b. Army Regulation 415-15, Army Construction and Nonappropriated-Funded Construction Program Development and Execution, 12 June 2006.

Appendix F, paragraph 21, Barrier-free design, states:

"a. Facilities will be barrier free, with as few obstacles (for example, doors, elevation, grade changes) as possible. The Architectural Barriers Act of 1968, Public Law 90-480, requires certain Army facilities be accessible to and usable by disabled individuals. These provisions will be part of the project cost. Only facilities operated and used solely by able-bodied military or civilian personnel, or where great hazards exist, may be exempt from this requirement.

b. DOD policy requires that, in addition to meeting the Uniform Federal Accessibility Standards (UFAS) requirements, the Americans with Disabilities Act Accessibility Guidelines requirements that provide equal or greater accessibility than those of the UFAS must also be met in the facilities subject to UFAS.

c. Army buildings and facilities involving new construction, additions, or alterations worldwide that are open to the public, or which may be visited by the public, will be accessible to disabled individuals. This includes MWR facilities, other NAF facilities, or any facilities where civilian workers may be employed. Every building and facility will be designed to ensure such accessibility, unless the facility is restricted to use by able-bodied military and civilian personnel, or classified as a facility housing hazardous occupations.

d. At least 5 percent of the total military family housing inventory, guest housing inventory, and Army Lodging constructed since 7 August 1984 (no less than one unit of each) of an installation will be designed and built to be either accessible, or readily and easily modifiable to be accessible, to disabled individuals.

e. TI 800–01 provides implementing instructions for UFAS and Americans with Disabilities Act Accessibility Guidelines. If a waiver to these criteria is needed, a waiver request including sufficient data to analyze the request will be submitted to HQDA (DAIM–FD and will be granted only in extraordinary circumstances."

OBJECTIVE 4: Assess impacts of other administrative areas on the Army Physical Disability Evaluation System.

FINDING 4.1: Some Soldiers are arriving at Medical Holding Units or Medical Retention Processing Units without a Line of duty (LOD) or with incomplete LOD documentation.

STANDARDS:

a. Army Regulation (AR) 600-8-4, Line of Duty Policy, Procedures, and Investigations, 15 April 2004.

Paragraph 2-1, General, states:

"Line of duty determinations are essential for protecting the interest of both the individual concerned and the U.S. Government where service is interrupted by injury, disease, or death. Soldiers who are on active duty (AD) for a period of more than 30 days will not lose their entitlement to medical and dental care, even if the injury or disease is found to have been incurred not in LD and/or because of the soldier's intentional misconduct or willful negligence, Section 1074, Title 10, United States Code (10 USC 1074). A person who becomes a casualty because of his or her intentional misconduct or willful negligence can never be said to be injured, diseased, or deceased in LD. Such a person stands to lose substantial benefits as a consequence of his or her actions; therefore, it is critical that the decision to categorize injury, disease, or death as not in LD only be made after following the deliberate, ordered procedures described in this regulation."

Paragraph 2-2d, Reasons for conducting line of duty investigations, states:

"*d. Disability retirement and severance pay.* For soldiers who sustain permanent disabilities while on AD to be eligible to receive certain retirement and severance pay benefits, they must meet requirements of the applicable statutes. One of these requirements is that the disability must not have resulted from the soldier's "intentional misconduct or willful neglect" and must not have been "incurred during a period of unauthorized absence" (10 USC 1201, 1203, 1204, 1206, and 1207). Physical Evaluation Board determinations are made independently and are not controlled by LD determinations. However, entitlement to disability compensation may depend on those facts that have been officially recorded and are on file within the Department of the Army (DA). This includes reports and investigations submitted in accordance with this regulation."

Paragraph 3-1, General, states:

"The unit commander will conduct an informal LOD investigation when the circumstances warrant or require one."

b. Army Regulation 600-8-101, Personnel Processing (In-, Out-, Soldier Readiness, Mobilization, and Deployment Processing), 12 March 2001.

Paragraph 7-3(e), Battalion-/unit level redeployment processing requirements, states:

"e. If a line of duty investigation is pending on a soldier, the soldier is not redeployable until the investigation has been initiated. A line of duty investigation using DA Form 2173 must be initiated for every injury that may result in a future claim against the government, including possible referral into the Physical Disability Evaluation System."

c. Department of the Army Pamphlet 600-8-101, Personnel Processing (In-, Out-, Soldier Readiness, Mobilization, and Deployment Processing), 28 May 2002.

Paragraph 7-3(d), Battalion S1/Unit Commander deployment processing procedure, states:

"d. Determining if a soldier has any injuries that may result in a future claim against the Government, including possible referral into the Physical Disability Evaluation System. If any such injuries are found, a line of duty investigation using DA Form 2173 is initiated before the soldier departs the theater/TCS station."

d. Department of the Army Personnel Policy Guidance (PPG) for Contingency Operations in Support of GWOT, 16 June 2006.

Paragraph 10-2c, Administrative Action Requirements, states:

"c. Administrative Action Requirements: AR 600-8-101, Chapter 7 and DA Pamphlet 600-8-101 prescribe the administrative actions that must be completed for all Soldiers before their redeployment from the contingency theater AOR. The following items are critical:

- Initiate line of duty (LOD) investigations or presumptive line of duty determinations as required for Soldiers prior to their departure from theater.
- Post personnel actions that occurred during deployment to Soldiers' personnel records in their deployment packets and/or to E-MILPO.
- Update medical and dental records to reflect medical or dental treatment or changes during deployment.

- Collect equipment from Soldiers that were issued in theater/AOR and must remain in theater/AOR.
- Ensure Soldiers settle debt issues with the Army or affiliated activities (e.g., post exchange; MWR fund manager; Army Emergency Relief (AER); etc.) prior to theater departure. If unable to settle, properly record alleged debts and ensure a report of survey is initiated for loss or damage of Army property."

Paragraph 10-10a(2), Line of Duty (LOD), states:

"To ensure Soldiers receive appropriate medical care after leaving active duty, commanders must complete an LOD investigation or prepare a presumptive (that is, one that may be subject to further review and is not necessarily administratively final) LOD determination memo for Soldiers who incur or aggravate injuries, illnesses, or diseases while on active duty.

a. Exceptions to Policies:

The following exceptions to policy apply for the LOD processing for Soldiers participating in contingency operations.

(1) Final approval authority. The first general officer in a Soldier's chain of command may approve LOD determinations whether or not he/she is a general court martial convening authority.

(2) The final approval authority or the military treatment facility (MTF) commander is authorized to issue presumptive LD determinations for Soldiers when a LOD investigation (DA Form 2173 – informal or DD Form 261 – formal) was not completed at the time of the Soldier's injury, illness or disease, or aggravation thereof, and the Soldier would be REFRAD without an LOD determination."

e. MILPER MSG 04-341, Line of Duty (LOD) Contingency Operations Policy, 16 December 2004.

Paragraph 2 states:

"2. A line of duty finding is required for all injuries and diseases that a Soldiers incurred or aggravated while on active duty and that will require continuing medical care, or may result in a future medical claim, after REFRAD. When required, a Soldier's commander at the time of an injury or disease is normally responsible for completing a LOD investigation. This policy should be followed whenever possible. Not all injuries or diseases require a LOD investigation, e.g. combat related injuries and diseases generally do not require the commander to conduct a LOD investigation. To ensure that after REFRAD each Soldier is provided medical care for injuries and diseases sustained or aggravated in line of duty (ILD) while on active duty, a LOD investigation will be completed when required before the Soldiers leaves active duty. Recognizing the many unique situations arising from demobilizing Soldiers not covered in the existing policy,

this paragraph provides certain exceptions to current LOD policy. The intent of these exceptions to policy is to expedite LOD investigations for Soldiers being REFRAD who would otherwise not receive a LOD finding before REFRAD if current policy was followed.

a. Final Approving Authority. As an exception to current policy, the first or higher general officer in a Soldier's chain of command may approve LOD investigations as the final approving authority whether or not he or she has General Court Martial convening authority. These general officers may delegate signature authority of "By Authority of the Secretary of the Army" to field grade officers or DA civilians in the grade of GS-12 or above who also have authority to sign "For the Commander." This authority expires 31 December 2006 unless sooner rescinded by HQDA.

b. A ILD finding will be made on DA Form 2173 or/and DD Form 261 when all the following criteria are satisfied:

(1) The injury or disease occurred while the Soldier was ordered to active duty for more than 30 days and was on active duty on or after 11 September 2001.

(2) The injury or disease may result in a future claim for disability or incapacitation pay or is expected to require continuing medical care after authorized medical care expires.

(3) There is no indication of abuse of alcohol or drugs.

(4) There is no indication of intentional misconduct or willful neglect.

(5) There is no indication the soldier was AWOL at the time of the injury or disease.

c. Distribution of LOD documentation in addition to current distribution requirements, completed LOD documentation, will be distributed as follows:

(1) Soldier's OMPF.

(2) Copy to the soldier.

(3) Copy placed in the soldier's field personnel file.

(4) Copy placed in the soldier's medical record.

(5) Copy to the soldier's reserve component unit."

f. MILPER MSG 05-161, Completion of Line of Duty Investigations (LODIs) For Mobilized Reserve Component Soldiers, 30 June 2005.

Paragraphs 2 through 4 state:

"2. Line of Duty Investigations (LODs) both Informal and Formal in accordance with AR 600-8-4 are required to be completed by the Mobilized Reserve Component Soldiers Chain of Command prior to the Soldier arriving at the SRP site for demobilization.

3. LODs are not required for superficial injuries such as cuts and scratches nor are they required for Direct Combat Related injuries. However when deciding if an LOD is required or not (for non combat related injuries) consideration will be given to the question on Part II of the DA form 2173 "is this likely to result in future claim against the Government", anytime that the medical condition is severe enough that the answer should be "yes", an LOD must be completed. RC soldiers with medical conditions that may recur once they returned to a drilling status need an LOD to protect them after Demobilization. Failure to complete the LOD prior to Demobilization delays needed medical care or compensation once the Soldier is released from Active Duty.

4. If an RC Soldier who was injured while mobilized arrives at the SRP site without an LOD, it is the SRP sites responsibility to complete the LOD prior to the Soldier being released from Active Duty."

FINDING 4.2: Medical Treatment Facilities are not transferring required medical documentation for Soldiers transferred through the Medical Hold System.

STANDARDS:

a. Army Regulation 40-66, Medical Record Administration and Health Care Documentation, 21 June 2006.

Paragraph 5-2.c.3, Use of the health record, states:

" c. Use in inpatient medical care

(3) When a patient is released from the MTF, the patient administrator will forward the HREC as described in (a) through (h), below.

(a) Attached patients returned to duty (RTD). Mail or courier the HREC to the record custodian of the MTF or DTF that provides the person with primary outpatient or dental care. If the MTF is not known, mail or courier the HREC to the MEDDAC or DENTAC or MEDCEN commander of the person's assigned installation.

(b) Assigned patients RTD. Mail or courier the HREC to the military personnel officer of the person's assigned unit. If the person is locally reassigned, mail or courier the HREC to the custodian as in (a), above.

(c) *Patients transferred to another MTF.* Mail or courier the HREC with a copy of the inpatient record to the other MTF.

(d) *Deceased patients.* Mail or courier the HREC to the casualty affairs officer holding the patient's personnel file.

(e) *Patients transferred to VA Medical Centers.* Mail or courier the HREC to the correct center. Also mail or courier a copy of the patient's inpatient records unless they have been sent to the physical evaluation board (PEB) for examination (AR 635-40).

(f) *Other patients separated from service.* Mail or courier the HREC to the military personnel officer handling the separation at the transition point. He or she will dispose of them as stated in paragraph 5-29.

(g) *Patients AWOL longer than 10 days.* Mail or courier the HREC to the officer holding the person's personnel file.

(h) *RC patients in the Active Army or on Active Guard Reserve duty.* Mail or courier the HREC to the unit health record custodian."

Paragraph 5-26, Transferring health records, states:

"a. *Sending HRECs.* Both parts (treatment and dental) of a military member's HREC are transferred when a Soldier is transferred or changes MTFs. When a member is to be transferred to another unit or station, the military personnel officer of the losing unit will receive both parts of the HREC from their custodians. The HREC will be transferred except when—

(1) The losing and gaining units receive primary (outpatient type) care from the same MTFs and DTFs. In this case, the military personnel officer will inform the HREC custodians about the unit change. The person's unit designation will be changed on the folders of both the treatment and dental records.

(2) An inpatient is assigned to a medical holding unit that already has the HREC. The MTF commander will inform the military personnel officer that the MTF has the HREC. When requesting the personnel file, the MTF commander will also request the dental record.

(3) The HREC custodian sends the records directly to the gaining custodian. If the HREC custodian feels a person should not hand-carry his or her HREC, it will be sent directly to the commander of the person's next MTF. When this action is done, the servicing military personnel officer will be promptly informed that the HREC will be sent and not carried. If the custodian does not know the address of the person's next MTF or

DTF, the HREC will be sent to the servicing military personnel officer, who will send it to the person's next HREC custodian."

Paragraph 5-28c.1, Filing health records, states:

"c. Handling identifiable HRECs and medical forms. A record or form is an identifiable form if it contains enough information to identify it as belonging to a specific person. To keep files current, identifiable HRECs and forms will be handled as follows:

(1) When a Soldier outprocesses at an MTF/DTF, the MTF/DTF will mail the serving MILPO the Soldier's HREC. The Soldier may not handcarry the HREC to the gaining MTF/DTF. Both sections should be mailed or couriered with the personnel file to the new custodian according to paragraph 5-26a."

Paragraphs 9-10a, Disposition of inpatient treatment records, states:

"a. Inpatient transfer. When a patient is transferred to a U.S. Army MTF, an Air Force or Navy MTF, or a VA Medical Center, a copy of the ITR will be sent along and will become a part of the receiving MTF's ITR (para 9-2b(2)). At a minimum, this copy should include SF 513, DD Form 2161, SF 504 (Clinical Record—History—Part I), SF 505 (Clinical Record—History—Parts II and III), SF 506 (Clinical Record—Physical Examination), SF 535 (Clinical Record—Newborn), DA Form 7389, SF 515, SF 509 (2 weeks prior to transfer), DA Form 3647, CHCS, CHCS II, or CIS electronic equivalent, SF 502, lab reports, and diagnostic reports (radiology, ultrasound, echocardiography, and EKG tracings). When a patient is moved to another type of MTF, extracts, summaries, or copies of the ITR will be sent; the original ITR will be kept by the Army MTF and disposed of in accordance with AR 25-400-2, file numbers 40-66f (military ITRs), 40-66g (civilian ITRs), and 44-66i (NATO personnel ITRs). (See table 3-1.)"

b. Management MHO Health Records Memorandum, HQDA MSG, 13 November 2003, states:

"1. Department of Defense policy states that patients are not allowed to handcarry their original Health Records (HRECs). When MHO Soldiers are transferred to a Community Based Health Care Organization (CBHCO), their HRECs are being mailed to the CBHCO. In many cases, the Soldier's HREC arrives after the Soldier has departed the CBHCO for their home of record. This delays development of a treatment plan and prolongs the Soldier's time in the Medical Retention Program.

2. Effective immediately, MHO Soldiers cannot physically transfer from a Medical Treatment Facility (MTF) to a CBHCO until one of two conditions are met: either the Soldier possess a complete photocopied HREC to handcarry to the CBHCO, or the MTF must verify that the CBHCO has received the mailed original HREC and have it in their possession."

FINDING 4.3: When conducted, commands with MOS/Medical Review Board (MMRB) convening authority conduct MMRBs in accordance with Army Regulations.

STANDARD: Army Regulation 600-60, 25 June 2002, paragraphs 4-7 through 4-21.

"4-7. General membership requirements

"a.. The MMRBCA will appoint an MMRB as required. (See fig 4-1.)

b. The MMRB will consist of five voting members (see para 4-8) and nonvoting members (see para 4-9). While minimum ranks are specified for the voting members, with the exception of warrant officer representation, there is no requirement for the voting members to be senior in grade or date of rank to the soldier appearing before the MMRB (See para 4-8.).

c. In the case of a female or minority soldier, the MMRB will, upon the written request of the soldier, include a female or minority voting member, if reasonably available, as determined by the MMRBCA.

d. If the soldier appearing before the board is a member of the Active Army, at least one voting member of the MMRB will be a member of the Active Army. If the soldier appearing before the board is a member of the USAR or ARNGUS, at least one voting member of the MMRB will be a member of the same component (USAR or ARNGUS) as appropriate."

4-8. Voting members

a. *President.* The board president will be a combat arms, combat support, or combat service-support colonel (06). This includes a lieutenant colonel frocked to colonel. The President need not be senior in date of rank to other colonels appearing before the board.

b. *Medical member.* The medical member will be a field grade Medical Corps officer or a civilian medical doctor designated by the MTF commander when a Medical Corps officer is not reasonably available. RC Medical Corps officers in the Ready Reserve or the Standby Reserve, Active Status, may serve as the medical member but must be in a duty status (Inactive Duty Training, to include for points only, active duty, or full-time National Guard duty).

c. *Additional voting members.* Three board members, as described below, will be appointed. If reasonably available, one member will be of the same branch, specialty, or PMOS as the soldier appearing before the board. Otherwise, the three members will be from the Combat Arms, Combat Support, or Combat Service Support branches, unless the MMRBCA approves a request for exception based upon military exigencies.

(1) When officers appear before the MMRB, the three members will be field grade officers.

(2) When warrant officers appear before the MMRB, one of the board members must be a chief warrant officer three, four, or five and senior to the warrant officer under evaluation, unless the MMRBCA approves an exception. The other two members may be field grade or warrant officers. If more than one warrant officer serves, one may represent the required rank and the other, the MOS. To the maximum extent possible, one warrant officer should be of the same MOS as the warrant officer appearing before the board.

(3) When enlisted soldiers appear before the board, one member will be a sergeant major (E-9), preferably a command sergeant major (CSM), if a CSM is reasonably available. The other two members must be enlisted soldiers in the pay grade of E-8 or E-9.

4-9. Nonvoting members

a. Personnel advisor. The personnel advisor will normally be a commissioned officer, warrant officer, senior personnel sergeant, or a DA civilian no less than grade level GS-7. The personnel advisor will advise the MMRB concerning personnel policy and procedure, the soldier's PMOS duties, and common tasks related to the performance of the soldier's PMOS duties in a field environment.

b. Recorder. The recorder will normally be an enlisted soldier or DA civilian and will assist the president in assembling records for the board and preparing a record of the proceedings.

c. Other. The convening authority may appoint additional nonvoting members to the board to ensure a fair hearing.

4-10. Pre-hearing actions

When an MMRB is appointed, the actions listed below will take place prior to the hearing.

a. The MMRBCA or his or her delegate will refer the soldier to the MMRB.

b. The recorder, as the official representative of the MMRBCA, will ensure all necessary administrative actions are accomplished.

c. The recorder is authorized to obtain all military health records and personnel records, excluding the restricted and service portions of the official military personnel file (OMPF).

d. The recorder will officially request the MTF or RC unit, as applicable, to assemble and screen the health record to determine if the permanent profile is current. Profiles older than 1 year will be validated by the appropriate medical authority designated by AR 40–501, chapter 7. If during the medical screen of the record, medical authorities determine that the soldier’s medical condition does not meet the medical retention standards of AR 40–501, chapter 3, the soldier will bypass MMRB evaluation and be referred directly into the PDES or be processed for medical disqualification as appropriate. (See glossary for definitions of duty-related cases, nonduty-related cases, and medical disqualification).

e. The recorder will prepare an MMRB worksheet for each board member prior to the hearing. The purpose and use of the MMRB worksheet is covered in paragraphs 4–13 and 4–14, below.

f. The recorder for the MMRB will—

- (1) Notify the soldier in writing of the scheduled hearing. (See fig 4–2.)
- (2) Notify the voting board members and the personnel advisor of the date, time, and place of the hearing.
- (3) Assemble the personnel records documents, medical records, commander’s evaluation of the soldier’s performance, and any other pertinent documents for board review.
- (4) Obtain a written acknowledgment from the soldier of notification of the scheduled MMRB. The soldier must appear before the MMRB. (See fig 4–3.)
- (5) For enlisted soldiers, excluding nondrilling IRR members, obtain from the soldier’s unit the counseling statement advising of the potential effect of MMRB findings on NCOES progression. This counseling statement may be combined with the notification acknowledgement. (See para 4–12 and fig 4–4.)
- (6) Provide the soldier a copy of commander’s evaluation and other pertinent documents.

4–11. Scheduling of the hearing

a. *Sequencing.* The MMRB recorder will schedule the sequence of appearance of soldiers before an MMRB.

b. *Geographical considerations.* In areas where soldiers are not geographically located with their commands, procedures should be coordinated with other convening authorities to allow the boarding of these soldiers at the nearest installation or command. (See para 4–3.)

4-12. Required statements

a. Commander's statement. The soldier's immediate commander will write an evaluation of the soldier's physical capability, addressing the impact of the profile limitations on the soldier's ability to perform the full range of PMOS or specialty code duties. (See fig 4-4.) For enlisted soldiers this includes consideration of the common tasks in STP 21-1-SMCT and the physical requirements contained in DA Pam 611-21. In those circumstances when the commander is junior in grade to the soldier being evaluated, comments provided by the soldier's supervisor or rater are appropriate. Senior commanders may also provide forwarding comments, if appropriate. (See fig 4-5.)

b. Counseling statement. Enlisted soldiers below the grade of sergeant major will be counseled by the unit first sergeant (or the detachment noncommissioned officer in charge (NCOIC) if there is no first sergeant) on the impact of an MMRB decision of retention on the soldier's attendance at NCOES courses and career progression. (The commander or officer in charge (OIC) will counsel the first sergeant or detachment sergeant.) (See fig 4-3.) The statement of counseling will be submitted with the commander's letter for inclusion in the MMRB record of proceedings. The statement will inform the soldier that—

(1) Retention by the MMRBCA or by the PDES does not exempt the soldier from meeting the physical requirements for graduation from NCOES.

(2) Attendance at NCOES is a prerequisite for promotion to sergeant through sergeant major.

(3) Soldiers who do not meet the graduation requirements due to a medical condition will not be promoted to the next higher grade or retain conditional promotion.

(4) Per AR 600-8-19, enlisted soldiers pending evaluation by the MMRB or PDES are in a nonpromotable status.

4-13. Conduct of proceedings

a. The MMRB is an administrative screening board. It will be conducted formally. However, a written transcript of the oral testimony of the proceedings is not required.

b. The personnel advisor will—

(1) Ensure the board members have an MMRB worksheet on each soldier.

(2) Ensure the board members have a copy of the pertinent personnel records (such as the DA Form 2-1, DA Form 4037, and DA Form 3349, commander's evaluation, or any pertinent personnel information).

(3) Provide the board a brief verbal summary of each soldier appearing before the board. This summary should include the PMOS or specialty code, current assignment, common tasks relevant to performance of the PMOS in a field environment, and other pertinent facts so as to familiarize the board with each soldier. The MMRB worksheet may be used in part or total to facilitate the summary process.

c. The medical officer will brief the MMRB on the pertinent aspects of the soldier's physical profile prior to the soldier appearing before the board to familiarize the board with all information relevant to the soldier's medical condition.

d. The president will advise each soldier appearing before the board of the purpose of the MMRB and how the board will be conducted.

e. Each member of the board will review all documents and other correspondence that applies to the soldier's case.

f. Each soldier will appear before the board separately. Each soldier may elect to have present a spokesperson of his or her choosing with that person's consent. There is no entitlement to legal counsel. The soldier may present facts and call witnesses relevant to his or her physical performance, current MOS retention, and MOS reclassification preference. (See fig 4–6.) Each soldier appearing before the board will be encouraged to talk freely so that all pertinent facts are revealed. However, a soldier will not be required to make an oral or written statement relating to the origin, occurrence, or aggravation of a disease or injury that he or she has.

g. If necessary, the board may have individuals appear during the MMRB proceedings who can provide the necessary insight into the physical requirements of a particular officer or enlisted specialty.

h. The board may defer action or reschedule a case until it has enough information to submit a recommendation.

4–14. Deliberations

On completion of the hearing, the board will be closed for deliberation. The voting members will decide the findings and recommendations according to policies stated in this regulation. Voting will be conducted in a closed session. The majority of the five voting member votes will constitute the board's findings and recommendations. Each board member should record specific comments about the case in the comments section of the MMRB worksheet and will record his or her vote in the appropriate space at the bottom of the worksheet. The recorder will collect the MMRB worksheet from each board member for use in preparing the summary of board proceedings. A minority report by dissenting board members may be submitted in writing with the findings and recommendations.

4–15. Soldier notification

The president of the board, after deliberation, will verbally inform the soldier of the findings and recommendations. The board will advise the soldier that the board's action will not become final until it has been reviewed and then approved by the MMRBCA or his or her designee (see para 4–6). The president will inform the soldier that a written rebuttal to any of the findings or recommendations may be submitted to the MMRBCA. (See fig 4–7.) For active duty and AGR soldiers, the rebuttal will be in writing and be submitted to the recorder within 2 working days after the board adjourns. For other RC soldiers, the MMRBCA will establish the appropriate rebuttal time frame. A summary of the board proceedings will be provided to the soldier upon request.

4–16. Summary of board proceedings

A summary of the board proceedings along with any board member minority reports will be forwarded to the MMRBCA. Because a written transcript of oral testimony is not required, the summary of board proceedings is the single most important document produced by the MMRB. When a soldier is retained in PMOS or specialty, the summary and decision are filed permanently in the soldier's OMPF. If a soldier is recommended for reclassification, change in specialty, or referred to the PDES, a detailed summary provides invaluable information necessary for the Army to make a final decision concerning the soldier. See figure 4–8. As a minimum the summary must include—

- a. A detailed explanation of the board's rationale for its recommendation.
- b. When recommending reclassification, change in specialty, or referral to the PDES, the circumstances or evidence that documents how the soldier's medical condition has prevented performance in PMOS or specialty.
- c. Concurrence or nonconcurrence with the commander's or supervisor's evaluation of the soldier's ability to perform and the reason.

4–17. Recommendation: Retain in current PMOS or specialty code

This recommendation is appropriate when the soldier's medical condition does not preclude satisfactory performance of PMOS or specialty code physical requirements in a worldwide field environment and when the soldier's profile does not preclude those common tasks identified at paragraph 4–2. (See para 4–22 for personnel actions.)

4–18. Recommendation: Be placed in a probationary status

a. *Justification.* The MMRB will recommend probationary status when the board determines that the soldier's disease or injury may be improved enough through a program of rest, rehabilitation, and/or physical therapy for the soldier to become deployable worldwide.

b. Time period. The probationary period will not exceed a 6-month period for active duty and AGR soldiers. The MMRBCA will establish an appropriate period for RC soldiers other than AGR, not to exceed 1 year. (See para 4–23 for personnel actions.)

c. Interim evaluation. The MMRB may recommend that the soldier be reevaluated by medical authorities at specific intervals during the probationary period. The unit commander will evaluate the soldier's progress after 90 days or as directed by the MMRBCA.

d. Re-referral to the MMRB.

(1) The soldier's commander may refer the soldier back to the MMRB before expiration of the probationary period if the soldier does not make progress or the soldier's condition improves or deteriorates so as to warrant an earlier reevaluation.

(2) To the maximum extent possible, re-referral should be to the same convened MMRB that originally recommended probation. An inability to do so because of the absence of one or all members of the prior MMRB will not preclude referral to a different MMRB. However, in such cases, available members from the previous board should be appointed to the MMRB to which the soldier is referred.

(3) At the end of the probationary period, the MMRB must make a recommendation to—

(a) Retain the soldier in the PMOS or specialty code.

(b) Reclassify or change specialties, if otherwise qualified.

(c) Refer the soldier to the Army's PDES or the RC medical disqualification process.

4–19. Recommendation: Reclassification or change in specialty

a. Considerations. In recommending reclassification or change in specialty, the MMRB will consider—

(1) Expected value to the Army in a new PMOS or specialty.

(2) Commander's comments.

(3) Worldwide deployability.

(4) Ability to perform in another MOS in a field environment.

(5) Past and present job performance.

(6) Prior military and civilian training and experience.

(7) Armed Services Vocational Aptitude Battery (ASVAB) or Armed Forces Classification Test (AFCT) scores (for enlisted soldiers only).

(8) Ability to perform the minimum common tasks listed in paragraph 4–2.

b. Action offices. If reclassification or change in specialty code is the appropriate course of action, the MMRB will provide justification and recommendations to the MMRBCA for forwarding to the appropriate action office. (See para 4–24 for personnel actions.)

4–20. Recommendation: Refer to the PDES/RC medical disqualification process

a. Referral of the soldier to the PDES for conduct of MEB and PEB or for processing for medical disqualification under RC regulations is the appropriate recommendation when the soldier's assignment limitations or medical condition precludes satisfactory performance in the soldier's PMOS or shortage/balanced MOS, or specialty code in a worldwide field environment. Included are soldiers whose physical profiles include inability to perform any of the common military tasks listed in paragraph 4–2.

b. The MMRB will refer AGR and USAR soldiers ordered to active duty for longer than 30 days to MEB/PEB. For other RC cases, the MMRB recommendation will be, "Refer for appropriate medical evaluation process under RC regulations." This is necessary because the RC must determine whether RC soldiers not in the AGR program or ordered to active duty for longer than 30 days are eligible to be referred into the PDES as a duty-related case or as a nonduty-related case. Nonduty-related cases are ineligible for conduct of a MEB. See the glossary for definition of duty-related and nonduty-related cases. Also, see paragraph 4–25.

c. Referral to the PDES by the MMRB does not mean the soldier will be found unfit, or if found unfit, will be entitled to military disability compensation. The criteria for determining fitness and eligibility for disability compensation for purposes of retirement or separation for physical disability are set forth in Department of Defense Instruction (DODI) 1332.38 and AR 635–40.1 *Note.* 1. The DODI changes certain provisions in the current AR 635–40.

4–21. Convening authority action

a. The convening authority will ensure all cases forwarded by the MMRB are reviewed. The review of the cases may be delegated to an officer on the MMRBCA's staff in the grade of major or higher or Chief Warrant Officer Four. In addition, the MMRBCA may delegate decision authority to the soldier's SPCMCA per paragraph 4–6

b. The review will ensure that—

- (1) The soldier received a full and fair hearing.
- (2) Proceedings of the MMRB were conducted in accordance with this regulation.
- (3) Records of the case are accurate and complete.

c. After consideration of the MMRB's findings and recommendations and any rebuttal, the convening authority may—

(1) Approve the findings and recommendations of the MMRB and forward the case to the soldier's servicing MPD or PSC for further processing. (See fig 4–8.)

(2) Disapprove the findings and recommendations and return the case to the same or another MMRB for clarification, further investigation, more facts, or other action as appropriate.

(3) Disapprove the findings and recommendations and take other action, as appropriate. The convening authority will then forward the case to the soldier's servicing MPD or PSC for further processing."

FINDING 4.4: Most Soldiers interviewed reported successful recovery of their personal and organizational property following medical evacuation from overseas locations.

STANDARD:

a. **AR 735-5, Policies and Procedures for Property Accountability, 10 June 2002.**

Chapter 12-1a, General actions to protect Government property, states:

" a. *Administrative action.* Administrative measures available to commanders to ensure enforcement of property accountability. When property becomes lost, damaged, or destroyed, use one of the adjustment methods discussed in this regulation.

(1) The methods discussed below are designed to protect the right of the U.S. Government to obtain reimbursement for the loss, damage, or destruction (LDD) of Government property caused by negligence or misconduct. These methods:

(a) Are materiel accounting oriented and are not appropriate for, nor intended to be used as corrective action or punishment, when negligence or willful misconduct is known or suspected to have contributed to the LDD of Government property.

(b) Do not constitute a punishment.

(c) Do not and should not preclude the use of adverse administrative or disciplinary measures.

(2) Commanders who determine that the cause of LDD warrants adverse administrative or disciplinary action should take appropriate action. These actions include, but are not limited to—

(a) An oral or written reprimand.

(b) Appropriate remarks in officer's, noncommissioned officer's, and civilian's evaluation reports.

(c) MOS reclassification.

(d) Bar to reenlistment.

(e) Action under the UCMJ. ARNG members who are not in the Federal service are not subject to the UCMJ; they are subject to the military codes of their State.

(f) Adverse actions against civilian personnel as authorized."

Chapter 14-27a, Personal clothing and organizational clothing and individual equipment (OCIE), states:

" a. The commanders of active Army, USAR and ARNG members, and ROTC cadets are responsible for initiating financial liability investigations of property loss when property issued from a Central Issue Facility (CIF) becomes lost, damaged, or destroyed, and none of the methods cited in chapter 12 can be used to obtain relief from responsibility. Additionally, the commanders of USAR and ARNG members, and ROTC cadets are responsible for initiating financial liability investigations of property loss when property issued from a clothing initial issue point (CIIP) becomes lost, damaged, or destroyed."

b. DA ALARACT 139/2006 P210236Z Jul 06 Message, Policies and Procedures for Handling Personal Effects (PE) and Government Property.

Paragraph 3.e states,

"3.e. Commanders will appoint a commissioned officer or a commissioned warrant officer as a summary court marshal officer (SCMO) immediately upon notification of death, missing status, or hospitalization, rather than the 48 hours as prescribed in REF C. The SCMO's mandatory duties, defined in REF B, consist of collecting and safeguarding the individuals PE and government property found in places under Army jurisdiction or control.

3.e.1 The SCMO will immediately safeguard all PE and equipment of the individual except the PE, protective gear, and OCIE retained by the medical personnel.

3.e.2 The SCMO will perform an inventory within 12 hours using two-person control of all safeguarded equipment.

3.e.3 The SCMO will record the inventory of PE using DD Form 1076, Military Operations Record of Personal Effects of Deceased Personnel. If the individual is wounded or missing and is not deceased, line through the "of deceased personnel" portion of the form. Note: The next update of the form will not contain the deceased personnel wording.

3.e.4. The SCMO will record the inventory of personal military clothing (considered PE) using DA Form 3078 (Procedures in AR 700-84, paragraph 12-14), and OCIE using DA Form 3645/3645-1 (Procedures contained in DA PAM 710-2-1, paragraph 10-18).

3.e.5. The SCMO will sign and date the forms. Place the originals with the property and file copies with the unit absentee files. Place a copy of the DA Form 4160 from the MTF in unit absentee files to document the property that was retained at the MTF. Secure the inventoried PE and OCIE in unit facilities.

3.e.6. The SCMO will turn in all unit-issued government equipment (such as weapon, mask, radio, etc) to the supply room and ensure the individuals hand receipt is updated.

Paragraph 5 states:

"5. If appointed, the home station SCMO ensures that the individual is cleared of any hand receipts at home station, including OCIE records from a CIF, coordinating with JPED and deployed unit as required from the completed DA Form 4160 and DA Forms 3645/3645-1. The JPED will supply the home station SCMO with copies of all documentation received to aid in the clearing of the individuals open home station hand receipts. OCIE records are to be adjusted using the DA Form 4160 from the MTF."

Paragraph 6.a states:

" 6.a. Financial liability investigation of property loss (DD Form 200) will be initiated for all government property not cleared from the individuals hand receipts (both in theater and at home station) using procedures in AR 735-5."

Paragraph 6b states:

"6.b. Financial liability investigating officers and approving authorities must carefully evaluate the proximate cause of loss, damage, or destruction of property remaining on an individual's hand receipt. The proximate cause of equipment lost, damaged, or destroyed due to combat, emergency conditions, or medical treatment may often not be linked to the deceased, missing, or medical evacuated individuals culpability and

therefore should not be associated to personal liability. Individuals are not to be charged for OCIE retained by the MTF."

APPENDIX 3

ABBREVIATIONS AND ACRONYMS

ABCMR	Army Board for the Correction of Military Records
AC	Active Component
ADA	Americans with Disabilities Act
ADRRB	Army Disability Rating Review Board
AFS	Active Federal Service
AGR	Active Guard/Reserve
AKO	Army knowledge Online
AHLTA	Armed Forces Health Longitudinal Technology Application
AL	Alabama
ALA	Agency Legal Advisor
AMEDDCS	U.S. Army Medical Department Center and School
APDAB	Army Physical Disability Appeal Board
APDES	Army Physical Disability Examination System
APDRB	Army Physical Disability Review Board
AR	Army Regulation
ARBA	Army Review Board Agency
ARNG	Army National Guard
ASA	Assistant Secretary of the Army
ASA (M&RA)	Assistant Secretary of the Army (Manpower and Reserve Affairs)
C2	Command and Control
CA	California
CBHCI	Community Based Health Care Initiative
CBHCO	Community Based Health Care Organization
CIF	Central Issue Facility
CM	Case Manager
COAD	Continuation of Active Duty
COAR	Continuation of Active Reserve
CONUSA	Continental U.S. Army
CY	Calendar Year
DA	Department of the Army
DAIG	Department of the Army Inspector General
DC	District of Columbia
DCO	Deputy Commanding Officer
DCCS	Deputy Commander for Clinical Services
DEERS	Defense Enrollment Eligibility Reporting System
DFAS	Defense Finance and Accounting System
DIMHRS	Defense Integrated Military Human Resources System
DOD	Department of Defense
DODD	Department of Defense Directive
DODI	Department of Defense Instruction
DUIC	Derivative Unit Identification Code
DVA	Department of Veterans Affairs

DVOP	Disabled Veterans Outreach Program
EHR	Electronic Health Record
eMILPO	Electronic Military Personnel Office
ENT	Eye, Nose, and, Throat
EPMD	Enlisted Personnel Management Division
EPTS	Existed Prior to Service
FAD	Force Alignment Division
FEDS_HEAL	Federal Strategic Health Alliance Program
FL	Florida
FORSCOM	U.S. Army Forces Command
FTNGD	Full Time National Guard
FY	Fiscal Year
G-1	Personnel Office
GPRMC	Great Plains Regional Medical Center
GS	General Service
GWOT	Global War on Terrorism
HQDA	Headquarters Department of the Army
HRC	Human Resources Command
HRC-A	Human Resources Command-Alexandria
HRC-STL	Human Resources Command-St Louis
HREC	Health Record
I&G	Issue and Guidance
IMA	Installation Management Agency
IMCOM	U.S. Army Installation Management Command
IRR	Individual Ready Reserve
ITR	Inpatient Treatment Record
JAG	Judge Advocate General
JTF	Joint Task Force
LOD	Line of Duty
LODI	Line of Duty Investigations
M2	Medical Management
MA	Massachusetts
MAMC	Madigan Army Medical Center
MEB	Medical Examination Board (current)
MEBD	Medical Examination Board (previous)
MEBP	Medical Examination Board Physician
MEDCOM	U.S. Army Medical Command
MEBITT	Medical Evaluation Board Internal Tracking Tool
MH	Medical Hold
MHO	Medical Holdover
MHU	Medical Holding Unit
MMRB	MOS/Medical Review Board
MOA	Memorandum of Agreement
MODS	Medical Operational Data System
MOS	Military Occupational Specialty
MOU	Memorandum of Understanding

MRPU	Medical Retention Processing Unit
MSG	Message
MTF	Military Treatment Facility
MTOE	Modified Table Organization and Equipment
NCO	Noncommissioned Officer
NARMC	North Atlantic Regional Medical Center
NARSUM	Narrative Summary
OCIE	Organizational Clothing & Individual Equipment
OCONUS	Outside Continental United States
OJT	On-The-Job-Training
OMD	Operations Management Division
OPD	Operations and Plans Division
OPORD	Operations Order
OTSG	Office of the Surgeon General
PAD	Patient Administration Division
PCM	Primary Care Manager
PDCAPS	Physical Disability Case Processing System
PDES	Physical Disability Evaluation System
PDR	Permanent Disability Retirement
PE	Personal Effects
PEB	Physical Evaluation Board
PEBLO	Physical Evaluation Board Liaison Officer
APEBLO	Alternate Physical Evaluation Board Liaison Officer
PEC	Professional Education Center
PPG	Personnel Policy Guidance
PSG	Platoon Sergeant
PTSD	Post Traumatic Stress Disorder
QA	Quality Assurance
REFRAD	Release from Active Duty
RLAS	Regional Level Applications Software
RMC	Regional Medical Command
RPAS	Retirement Points Accounting Statement
RRSB	Reclassification, Retirement, and Separation Branch
S-1	Personnel Office
SAB	Special Actions Branch
SAR	Systems Analysis & Review
SERMC	Southeast Regional Medical Center
SIDPERS	Standard Installation/Division Personnel System
SOP	Standing Operating Procedures
SBP	Survivor Benefit Plan
SPPT	Support
TC	Transition Center
TDA	Table of Distributions and Allowances
TDRL	Temporary Disability Retirement List
TF	Task Force
TF-E	Task Force-East

TF-W	Task Force-West
TPU	Troop Program Unit
TRANSPROC	Transition Processing
TRP CMD	Troop Command
TSG	The Surgeon General
TX	Texas
USAPDA	U.S. Army Physical Disability Agency
USAR	U.S. Army Reserve
USC	United States Code
VA	Veterans' Administration
VA	Virginia
VASRD	Veterans Affairs Schedule for Rating Disabilities
WA	Washington
WI	Wisconsin
VTC	Video Teleconference
WRMC	Western Regional Medical Center
YOTG	Yearly Operational Training Guidance

Army Physical Disability Evaluation System Inspection



Purpose of Briefing

To provide an overview on the findings and recommendations of the Army Physical Disability Evaluation System Inspection (APDES).

To gain approval to release the inspection report and to provide a comprehensive brief to the APDES Action Team for use in their on-going assessment.



Agenda

- **Inspection Purpose**
- **Inspection Objectives**
- **DAIG Team Organization**
- **Inspection Locations**
- **Findings & Observations**
- **Road Map**
- **Way Ahead**



Inspection Purpose

To inspect the Army's Physical Disability Evaluation System to determine if policies, procedures, and execution meet the needs of Soldiers and the institution of the Army.



Objectives

- Assess the **execution** and **timeliness** of the **Medical Evaluation Board (MEB)** process to include compliance with DoD and Army policies.
- Assess the **execution** and **timeliness** of the **Physical Evaluation Board (PEB)** and review processes to include compliance with DoD and Army policies.
- Assess the execution of the **Medical Hold System** to include compliance with DoD and Army policies.
- Assess the impact of other **administrative areas** on the Army Physical Disability Evaluation System.



Inspection Locations

Commands

FORSCOM USAREUR
MEDCOM USARC
First US Army HRC

North Atlantic Regional Medical Command (NARMC)

- ★ Walter Reed - RMC & WRAMC (MEB/PEB/MHU)
- ★ Virginia Beach - Virginia CBHCO
- ★ Fort Dix - MHU
- Fort Drum - ACH (MEB/MHU), 10th MTN DIV
- Troy, NY - JFHQ-NY, 42ID (NY ARNG)

Great Plains Regional Medical Command (GPRMC)

Fort Sam Houston - RMC, BAMC (MEB/PEB/MHU), TF West
Fort Bliss - AMC (MEB/MHU)
Fort Hood - ACH (MEB/MHU), III Corps/1st CAV DIV
Little Rock - Arkansas CBHCO
Austin, TX - JFHQ-TX, 36th ID (TX ARNG)
Fort McCoy - PPP (MHU), ARFC

South East Regional Medical Command (SERMC)

Fort Gordon - RMC, EAMC (MEB/MHU)
Fort Stewart - ACH (MEB/MHU), 3rd ID
Fort Benning - ACH (MEB/MHU), CRC
Fort Jackson - ACH (MEB/MHU), TF East
Birmingham - 81st RRC, Alabama CBHCO
Fort Buchanan (PR) - 65th RRC, ACH (MEB/MHU)
Camp Shelby - PSP (MHU)

Europe Regional Medical Command (ERMC)

Heidelberg - USAREUR, RMC
Landstuhl - LARMC (MEB/MHU)
Wiesbaden – 1AD

Western Regional Medical Command (WRMC)

Fort Lewis - RMC, AMC (MEB/PEB/MHU)
Sacramento, CA - California CBHCO

Pacific Regional Medical Command (PRMC)

Hawaii - RMC, AMC (MEB/MHU), 25th ID, 9th RRC
Alaska - 172nd SBCT, ACH (MEB/MHU)

★ = Pre-inspection location



Bottom Line

- **Army policy deviates from DOD policy.**
 - **DODI 1332.38 to AR 40-400**
 - AR does not accurately reflect timeline for the DOD 30 day standard.
 - **DODIs 1332.38/39 to AR 635-40**
 - 24 passages from the DODIs not included in the AR.
- **Time standards are not being met.**
 - **DOD 30 day (MEB) - 43% of MEB cases did not arrive at the PEBs in 30 days. (1st QTR 05 to 2nd QTR 06).**
 - **DOD 40 day (PEB) - 94% (2,327 of 2,468) of cases that went through all facets of the PEB process did not meet the 40 day standard. (CY 02 to 2nd QTR CY 06).**
 - **Army 90 day (MEB) - Only one of six RMCs consistently met the 90 day standard. (3rd QTR 05 to 4th QTR 06).**
 - **Army 10% Return Rate (MEB) - MEB cases return rate ranged from 13% to 16%. (Nov 01 thru Apr 06).**



Bottom Line

- **Training is not standardized.**
 - **There is no formal or standardized training for:**
 - **Commanders**
 - **MEBPs/PEBLOs/APEBLOs**
 - **USAPDA Personnel**
 - **Medical Hold and Medical Holdover Cadre**
- **Databases used to track information are inadequate and unreliable.**
 - **PDCAPS is an antiquated system.**
 - **There is insufficient quality management of MEBITT.**
 - **PDCAPS and MEBITT databases are not synchronized or reliable.**
 - **No one system to track Soldiers in the APDES.**



Objective 1

Assess the execution and timeliness of the Medical Evaluation Board (MEB) process to include compliance with DoD and Army policies.

- **Increased volume has placed a strain on the MEB process**
- **Army MEB policy not in line with DOD policy**
- **MEB Training is inadequate**
- **The Army through MEDCOM, does not consistently meet the DOD or Army standards**
- **Inconsistent oversight and use of MEBITT database**



OBJECTIVE 1: Assess the execution and timeliness of the Medical Evaluation Board process to include compliance with DoD and Army policies.

- **FINDING:** The Army is not meeting the Department of Defense 30-day standard for processing Medical Evaluation Board cases which measures from the date the physician dictates the Narrative Summary to the date the case is received by the Physical Evaluation Board.

 - **RECOMMEND the APDES Action Team in conjunction with:**
 - The Surgeon General update policy on the start and end date of actions occurring in the Medical Evaluation Board process.
 - Commander, US Army Medical Command, review quality management of the Medical Evaluation Board Internal Tracking Tool database.
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- **FINDING:** The majority of Regional Medical Commands are not meeting the Army 90-day standard for processing Medical Evaluation Boards.

 - **RECOMMEND the APDES Action Team in conjunction with:**
 - The Surgeon General update Army Medical policy to include the Army 90-day standard and clarify the action that begins the Medical Evaluation Board process.
 - Commander, US Army Medical Command, develop training standards and educational requirements for PEBLOs, Alternate PEBLOs, and physicians conducting Medical Evaluation Boards.
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OBJECTIVE 1 (CONTINUED): Assess the execution and timeliness of the Medical Evaluation Board process to include compliance with DoD and Army policies.

- **FINDING:** The Army lacks a formal course of instruction that trains Physical Evaluation Board Liaison Officers, Alternate Physical Evaluation Board Liaison Officers, and Medical Evaluation Board (MEB) Physicians on their duties and responsibilities in processing Soldiers referred to a MEB.
 - **RECOMMEND the APDES Action Team in conjunction with:**
 - MEDCOM, in coordination with TRADOC and ASA MR&A, determine the critical individual tasks for the professional development of civilian and military PEBLOs, APEBLOs and MEB and ensure these tasks are incorporated into all aspects of training.
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- **FINDING:** Insufficient quality management of and training on the use of the Medical Evaluation Board Internal Tracking Tool (MEBITT) database leads to inaccurate reporting of the status of Soldiers in the Army Physical Disability Evaluation System.
 - **RECOMMEND the APDES Action Team in conjunction with:**
 - The Surgeon General clarify policy on the start and end date of actions occurring in the Medical Evaluation Board process.
 - Commander, US Army Medical Command, review current quality management processes and implement stricter internal controls to ensure precise recording of information on the date the permanent profile is issued; the date the Narrative Summary is dictated; and the date the Medical Evaluation Board is received by the Physical Evaluation Board.
 - Commander, US Army Medical Command, develop training standards and certification requirements for PEBLOs, Alternate PEBLOs, and physicians conducting Medical Evaluation Boards.
 - Commander, US Army Medical Command, in coordination with the Army G-3 and Army G-1 develop a formal MEBITT Course for those primary participants involved in DES process.



Objective 2

Assess the execution and timeliness of the Physical Evaluation Board (PEB) and review processes to include compliance with DoD and Army policies.

- **Increased volume has placed a strain on the 3 PEBs**
- **Physical Disability Case Processing System (PDCAPS) is an antiquated system that requires updating**
- **USAPDA quality assurance program does not conform to DOD policy regarding quality assurance**



OBJECTIVE 2 (CONTINUED): Assess the execution and timeliness of the Physical Evaluation Board (PEB) and review processes to include compliance with Department of Defense (DOD) and Army policies.

- **FINDING:** US Army Physical Disability Agency (USAPDA) uses an inadequate data management program (PDCAPS- Physical Disability Case Processing System) to manage Physical Evaluation Board cases.
 - **RECOMMEND the APDES Action Team in conjunction with:**
 - US Army Physical Disability Agency in coordination with CIO G6 implement a real-time data management system that has the ability to communicate with Medical Evaluation Board Internal Tracking Tool and other DA software applications.
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- **FINDING:** The US Army Physical Disability Agency (USAPDA) does not consistently meet the DODI 1332.38 40-day processing time standard for a final disability determination.
 - **RECOMMEND the APDES Action Team in conjunction with:**
 - Deputy Chief of Staff, G-1 reassess and address the feasibility of the 40-day standard for disability case processing to reflect the potential time necessary for all levels of Soldier appeals.
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- **FINDING:** The USAPDA quality assurance program does not conform to DOD and Army policy.
 - **RECOMMEND the APDES Action Team in conjunction with:**
 - US Army Physical Disability Agency establish a quality assurance program that promotes consistency where possible, of ratings by all of the Physical Evaluation Boards and provides feedback to the same on a regular basis.
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OBJECTIVE 2 (CONTINUED): Assess the execution and timeliness of the Physical Evaluation Board (PEB) and review processes to include compliance with Department of Defense (DOD) and Army policies.

- **FINDING:** The training of personnel working in the Physical Evaluation Board (PEB) process does not meet the standards specified in DODI 1332.38, AR 635-40, and US Army Physical Disability Agency's (USAPDA) SOP.
- **RECOMMEND the APDES Action Team in conjunction with:**
 - US Army Physical Disability Agency enforce the requirements of the Army Regulation and Department of Defense Directives and Instructions to provide continuing training to its staff.
 - US Army Physical Disability Agency conduct regular staff assistance visits by the headquarters and Physical Evaluation Board staffs.
 - The Judge Advocate General study the feasibility of sending Army attorneys supporting the Physical Evaluation Board process to the US Army Physical Disability Agency Senior Adjudicators course.
 - The Surgeon General study the feasibility of sending Physical Evaluation Board Liaison Officers to the US Army Physical Disability Agency Senior Adjudicators course.



OBJECTIVE 2 (CONTINUED): Assess the execution and timeliness of the Physical Evaluation Board (PEB) and review processes to include compliance with Department of Defense (DOD) and Army policies.

- **OBSERVATION:** The Department of Veterans Affairs Schedule for Rating Disabilities does not accurately reflect medical conditions and ratings in today's environment.
 - **RECOMMEND the APDES Action Team in conjunction with:**
 - US Army Physical Disability Agency present recommended Veterans Affairs Schedule for Rating Disability changes to Department of Defense Disabilities Advisory Council.
 - Department of Veterans Affairs finish the full revision of the Veterans Affairs Schedule for Rating Disabilities and update the revised body function codes.
 - Commander, US Army Medical Command reassess and address the feasibility of having a common physical for use by the Department of the Army and the Department of Veterans Affairs.
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- **OBSERVATION:** A majority of the Soldiers interviewed do not know or understand the differences between Army and Department of Veterans Affairs (DVA) disability ratings.
 - **RECOMMEND the APDES Action Team in conjunction with:**
 - US Army Medical Command, in conjunction with the Regional Medical Commands, ensure quality counseling to Soldiers as set forth in Appendix C, AR 635-40 and conduct a post-counseling survey to verify understanding of the material.
 - US Army Medical Command develop a survey to verify that Soldiers understand the Army's Physical Disability Evaluation System, specifically, the process for establishing disability ratings.
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Objective 3

Assess the execution of the Medical Hold System to include compliance with Department of Defense and Army policies.

- **MH (AC) and MHO (RC) cadre training and staffing are inadequate**
- **Some MH (AC) and MHO (RC) Soldiers do not fully understand their rights and separation entitlements**
- **Community Based Health Care Organization (CBHCO) C2 needs streamlining**
- **A few installations had Americans with Disabilities Act violations**



OBJECTIVE 3: Assess the execution of the Medical Hold System to include compliance with Department of Defense and Army policies

- **FINDING:** A majority of Medical Holding Units (MHU) cadre and some Medical Retention Processing Units (MRPU), and Community Based Healthcare Organizations (CBHCO) cadre lack formal training.
 - **RECOMMEND the APDES Action Team in conjunction with:**
 - The Office of the Surgeon General develop training criteria for Medical Holding Unit cadre.
 - US Army Medical Command, in coordination with Installation Management Command and Assistant Secretary of the Army for Manpower and Reserve Affairs complete a by-position targeted training program for all Medical Holdover organization command and control and medical management cadre.
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- **FINDING:** Some medical hold and medical holdover Soldiers in the APDES process do not understand their rights and separation entitlements.
 - **RECOMMEND the APDES Action Team in conjunction with:**
 - Deputy, Chief of Staff G-1, review Army Regulation 635-40, Physical Evaluation for Retention, Retirement, or Separation, to ensure that Physical Evaluation Board Liaison Officer counseling is meeting the needs of wounded or injured Soldiers.
 - US Army Medical Command review the medical evaluation board briefings given at medical treatment facilities to ensure they meet the needs of wounded or injured Soldiers.
 - US Army Medical Command, develop a series of post-counseling surveys to assess the Soldier's understanding of separation rights and entitlements.



OBJECTIVE 3 (CONTINUED): Assess the execution of the Medical Hold System to include compliance with Department of Defense and Army policies.

- **FINDING:** A few installations inspected had Americans with Disabilities Act (ADA) violations affecting disabled Soldiers' access to facilities.
 - **RECOMMEND the APDES Action Team in conjunction with:**
 - US Army Physical Disability Agency, in coordination with host installations, develop installation support agreements to ensure the Physical Evaluation Board facilities are in compliance with Americans with Disabilities standards.
 - Installation Management Command ensure Medical Retention Processing Unit facilities are meeting ADA standards.
 - US Army Medical Command ensure Medical Holding Unit and Community Based Healthcare Organization facilities are meeting ADA Standards.
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- **OBSERVATION:** The Community Based Healthcare Initiative program includes redundant and unnecessary levels of command and control.
 - **RECOMMEND the APDES Action Team in conjunction with:**
 - US Army MEDCOM, in coordination with ASA (M&RA), IMCOM, NGB and Chief, Army Reserve, review the Community Based Healthcare Initiative Transition Plan and eliminate unnecessary layers to command and control.
 - US Army MEDCOM expedite the development and implementation of a standardized Regional Medical Command organizational structure to provide required functions for Community Based Healthcare Organizations.



OBJECTIVE 3 (CONTINUED): Assess the execution of the Medical Hold System to include compliance with Department of Defense and Army policies.

- **OBSERVATION:** The majority of commanders and leaders indicated that assigning Soldiers in the Army Physical Disability Evaluation System (APDES) to an Installation Garrison Command / Medical Holding Unit (MHU) would benefit both the Soldiers and units.
 - **RECOMMEND the APDES Action Team in conjunction with:**
 - Installation Management Command in coordination with OTSG and FORSCOM review the feasibility of integrating MH (AC) operations with MHO (RC) operations.
 - Installation Management Command in coordination with OTSG, Deputy Chief of Staff G1 and HRC develop a standardized infrastructure to support an Installation Garrison Command in the absorption of select Soldiers in the APDES.
 - Installation Management Command provide the C2, personnel, training and transportation for select Soldiers in the APDES.
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- **OBSERVATION:** The Army is not providing timely manning support for Community Based Healthcare Organizations (CBHCOs) and Medical Retention Processing Units (MRPUs) to support the mobilized RC Soldiers who will use those organizations.
 - **RECOMMEND the APDES Action Team in conjunction with:**
 - The APDES Action Team in conjunction with: Deputy Chief of Staff, G-3, in coordination with Human Resources Command, Installation Management Command, and US Army Medical Command develop policy that projects, on a regional basis, the assignment of C2 support cadre to Community Based Healthcare Organizations (CBHCO) and Medical Retention Processing Units (MRPU) to match the mobilization and demobilization requirements of RC Soldiers.
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Objective 4

Assess the impact of other administrative areas on the Army Physical Disability Evaluation System.

- **Most leaders at the brigade level and below do not understand the APDES**
- **The majority of MHO Soldiers had little to no contact with their home station unit or chain-of-command**



OBJECTIVE 4: Assess the impact of other administrative areas on the Army Physical Disability Evaluation System.

- **OBSERVATION:** Most commanders and leaders at brigade level and below do not understand the Army Physical Disability Evaluation System and their responsibilities in the process.
 - **RECOMMEND the APDES Action Team in conjunction with:**
 - Training and Doctrine Command include Army Physical Disability Evaluation System training in the brigade and battalion pre-command courses and the sergeants major course.
 - Army Commands include Army Physical Disability Evaluation System training in their company commander and first sergeant courses that includes the unit's role and responsibilities.
 - Office of the Surgeon General develop training materials and programs to educate unit leaders on all aspects of the Army Physical Disability Evaluation System to include their responsibilities.
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- **OBSERVATION:** A majority of Medical Holdover Soldiers have little or no contact with their home station Reserve Component units.
 - **RECOMMEND the APDES Action Team in conjunction with:**
 - Deputy Chief of Staff, G1 complete development of a personnel system that allows Reserve Component commanders to track their mobilized Soldiers and subsequently assigned to Medical Holdover status.
 - US Army Reserve Command develop procedures to enable and require Commanders to contact Soldiers and their families while in Medical Holdover status.
 - National Guard Bureau develop procedures to enable and require commanders to contact Soldiers and their families while in Medical Holdover status.
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Way Ahead

- **Provide the inspection data and a comprehensive briefing to the APDES Action Team to include:**
 - Findings, Observations and Recommendations on the MEB/PEB process,
 - execution of Medical Hold and Medical Holdover System
 - the inspection of the administrative areas on APDES
 - Identify best practices



Army Physical Disability Evaluation System Inspection



Back up Slides



OBJECTIVE 1 (CONTINUED): Assess the execution and timeliness of the Medical Evaluation Board process to include compliance with DoD and Army policies.

- **FINDING:** Most Regional Medical Commands are not meeting the 10% return rate standard for Medical Evaluation Board cases returned from the Physical Evaluation Board.
 - **RECOMMEND the APDES Action Team in conjunction with:**
 - Commander, US Army Medical Command, develop training standards and certification requirements for PEBLOs, Alternate PEBLOs, and physicians conducting Medical Evaluation Boards.
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- **FINDING:** Most Soldiers in the Medical Evaluation Board process are receiving the required counseling.
- **RECOMMEND the APDES Action Team in conjunction with:**
 - Commander, US Army Medical Command, determine and enforce the maximum PEBLO to Soldier ratio.
 - Commander, US Army Medical Command, develop a series of post-counseling surveys to assess the Soldier's understanding of the MEB/PEB processes.



OBJECTIVE 1 (CONTINUED): Assess the execution and timeliness of the Medical Evaluation Board process to include compliance with DoD and Army policies.

- **FINDING:** Army Regulations do not fully and accurately integrate DOD policy instructions and MEDCOM policy memorandums.
 - **RECOMMEND the APDES Action Team in conjunction with:**
 - The Surgeon General update Army Regulation 40-400 to accurately reflect Department of Defense Instruction 1332.38.
 - The Surgeon General update Army Regulation 40-400 to include MEDCOM's 90-day standard and review the terminology in MEB process.
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- **FINDING:** US Army Medical Command regulations and policies on the Medical Evaluation Board process are keeping pace with most medical retention issues.
 - **RECOMMEND the APDES Action Team in conjunction with:**
 - The Surgeon General continue to review AR 40-501 to keep pace with medical condition trends.
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- **OBSERVATION:** Army Military Treatment Facility Commanders are using generic position descriptions to hire Physical Evaluation Board Liaison Officers and Alternate Physical Evaluation Board Liaison Officers.
 - **RECOMMEND the APDES Action Team in conjunction with:**
 - The Surgeon General, in coordination with the Army G-1 and Assistant Secretary of the Army for Manpower & Reserve Affairs develop policy and guidance that addresses the standardization of hiring and selection of PEBLOs.
 - Commander, MEDCOM designate critical individual tasks for civilian and military PEBLOs and APEBLOs and ensure these tasks are incorporated into all aspects of training.
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OBJECTIVE 2: Assess the execution and timeliness of the Physical Evaluation Board (PEB) and review processes to include compliance with Department of Defense and Army policies.

- **FINDING:** Army Regulations 10-59 and 635-40 are not consistent with other Army Regulations nor with DOD and Department of Veterans Affairs Policy.
- **RECOMMEND the APDES Action Team in conjunction with:**
 - The Secretary of the Army direct the ASA(M&RA), in conjunction with Office of the Secretary of Defense, the Surgeon General, and Office of the General Counsel, to review and revise where appropriate, Army policy to align the Army's adjudication of disability ratings to more closely reflect those used by the Department of Veterans Affairs.
 - The Deputy Chief of Staff, G-1, update Army Regulation 10-59 to reflect current Army policy.
 - The Deputy Chief of Staff, G-1, update Army Regulation 635-40 to include all changes in the Department of Defense Instructions 1332.38 and 1332.39 and Department of Defense Directive 1332.18.
 - The Deputy Chief of Staff, G-1, update Army Regulation 635-40 to include all US Army Physical Disability Agency policy and Issue and Guidance memorandums.
 - The Deputy Chief of Staff, G-1, examine the Army Disability Rating Review Board as an appeal board and consider replacing it with the Army Board for Correction of Military Records.
 - Army Review Board Agency examine the use of the Army Disability Rating Review Board as disability review board and consider the sole use of the Army Board for Correction of Military Records as the retiree appeal recourse.
 - The ASA(M&RA) in coordination with the USAPDA present to the DOD Disability Advisory Council the issue of whether the Department of Defense is properly applying the Veterans Administration Schedule for Rating Disabilities to the military departments.



OBJECTIVE 2: Assess the execution and timeliness of the Physical Evaluation Board (PEB) and review processes to include compliance with Department of Defense (DOD) and Army policies.

- **FINDING:** Processing Continuation on Active Duty (COAD) and Continuation on Active Reserve (COAR) requests resulted in additional time beyond the DODI 40-day standard in which Soldiers are in the Army Physical Disability Evaluation System.
- **RECOMMEND the APDES Action Team in conjunction with:**
 - Deputy Chief of Staff, G-1, consider an additional time period to process COAD and COAR cases and expand the DODI 40-day timeline standard for those cases.



OBJECTIVE 2 (CONTINUED): Assess the execution and timeliness of the Physical Evaluation Board (PEB) and review processes to include compliance with Department of Defense (DOD) and Army policies.

- **FINDING:** Some Soldiers do not return for their required periodic examinations while in a Temporary Disability Retirement List status.
 - **RECOMMEND the APDES Action Team in conjunction with:**
 - US Army Physical Disability Agency impose stricter compliance in suspending retirement pay benefits for Soldiers who fail to show for their periodic physicals.
 - US Army Physical Disability Agency abide by the US Code and Department of Defense Instructions concerning cases that are over five years old.
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- **FINDING:** The Judge Advocate General (JAG) Corps currently provides quality legal representation to the Soldiers they represent at formal Physical Evaluation Boards.
- **RECOMMEND the APDES Action Team in conjunction with:**
 - The Judge Advocate General continue current staffing levels of full-time Army attorneys and Department of the Army civilians and provide sufficient training time of the attorneys prior to representing Soldiers before the Physical Evaluation Boards.
 - The Judge Advocate General consider increasing staffing levels at the Physical Evaluation Board sites to permit counseling of Soldiers by experienced attorneys earlier in the Army Physical Disability Evaluation System process.



OBJECTIVE 2 (CONTINUED): Assess the execution and timeliness of the Physical Evaluation Board (PEB) and review processes to include compliance with Department of Defense (DOD) and Army policies.

- **OBSERVATION:** The US Army Physical Disability Agency (USPDA) and the Physical Evaluation Boards (PEBs) recognized the need for additional personnel to process the increased caseload as a result of the Global War on Terrorism (GWOT) and have made some progress.
 - **RECOMMEND the APDES Action Team in conjunction with:**
 - Human Resources Command-Alexandria reassess the Table of Distributions and Allowances, reallocating necessary resources to US Army Physical Disability Agency to assist them in effectively processing physical evaluation board cases.
 - US Army Physical Disability Agency reassess the Table of Distributions and Allowances and requisition the necessary manpower that provides the most effective Table of Distributions and Allowances strength to process physical evaluation board cases.
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- **OBSERVATION:** Most Physical Evaluation Board (PEB), Judge Advocate General (JAG) Corps, and Department of Veterans Affairs (DVA) personnel know and understand the applicable regulations and policies concerning the PEB process to include the differences between Army and DVA disability ratings.
- **RECOMMEND the APDES Action Team in conjunction with:**
 - Physical Evaluation Boards, installation legal offices, and Department of Veterans Affairs offices maintain the knowledge base of the current workforce and their replacements in order to best provide the correct information to Soldiers going through the Army Physical Disability Evaluation System.



OBJECTIVE 3: Assess the execution of the Medical Hold System to include compliance with Department of Defense and Army policies

- **FINDING:** Current Army medical holdover guidance does not fully address the command and control component for medical holdover operations.
- **RECOMMEND the APDES Action Team in conjunction with:**
 - Installation Management Command, in coordination with Assistant Secretary of the Army for Manpower and Reserve Affairs, Deputy Chief of Staff G1, and US Army Medical Command, update the Department of the Army Medical Holdover Consolidated Guidance to specify clear guidance on the command and control, and organizational structure of reserve component Soldiers assigned to Medical Holdover Units on active duty installations.
 - US Army Medical Command, in coordination with Assistant Secretary of the Army for Manpower and Reserve Affairs and Deputy Chief of Staff G1, update the Department of the Army Medical Holdover Consolidated Guidance to specify clear guidance on the command and control, and organizational structure of reserve component Soldiers assigned to Community Based Healthcare Organizations.
 - Installation Management Command, in coordination with Assistant Secretary of the Army for Manpower and Reserve Affairs, Deputy Chief of Staff G1, and US Army Medical Command, develop and implement standing operating procedures for Medical Holdover Operations, specifically for Medical Retention Processing Units.
 - Installation Management Command, with Assistant Secretary of the Army for Manpower and Reserve Affairs, Deputy Chief of Staff G1, and US Army Medical Command, complete development and implement the Medical Holdover Operations Systems Analysis and Review checklist to include by-item definitions and supporting standards of performance.



OBJECTIVE 3 (CONTINUED): Assess the execution of the Medical Hold System to include compliance with Department of Defense and Army policies.

- **FINDING:** Medical Retention Processing Units (MRPU) and Community Based Health Care Organization (CBHCO) continuously update personnel and medical automation systems ensuring accurate accountability of medical holdover Soldiers.
 - **RECOMMEND the APDES Action Team in conjunction with:**
 - US Army Medical Command in coordination with Human Resources Command complete authorization for data input fields for HRC in Medical Operational Data System (MODS).
 - Medical Retention Processing Units and Community Based Healthcare Organization continue completing eMILPO and MODS transactions in accordance with the Department of Army Personnel Policy Guidance.
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- **OBSERVATION:** The majority of Medical Holding Units, Medical Retention Processing Units, and Community Based Healthcare Organizations lack authorization for critical staff and service support positions to effectively execute their missions.
 - **RECOMMEND the APDES Action Team in conjunction with:**
 - Deputy Chief of Staff, G-1, in coordination with US Army Medical Command and Installation Management Command, examine the possibility of increasing the personnel manning of Medical Holding Units, Medical Retention Processing Units, and Community Based Healthcare Organizations.
 - Deputy Chief of Staff, G-1, in coordination with US Army Medical Command and Installation Management Command, consider providing a Behavioral Health Specialist to the Medical Holding Unit and Medical Retention Processing Unit personnel structures.
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OBJECTIVE 3 (CONTINUED): Assess the execution of the Medical Hold System to include compliance with Department of Defense and Army policies.

- **OBSERVATION:** Some Medical Retention Processing Unit commanders and leaders indicated the use of sanctuary Soldiers as command and control support cadre hurts unit cohesion.
 - **RECOMMEND the APDES Action Team in conjunction with:**
 - Deputy Chief of Staff, G-1, in coordination with Human Resources Command, Installation Management Command, and US Army Medical Command create policy outlining the assignment criteria for command and control support cadre to Medical Retention Processing Units and Community Based Healthcare Organizations.
 - Installation Management Command, in coordination with the US Army Medical Command, develop job descriptions for Medical Retention Processing Unit command and control cadre.
 - US Army Medical Command, in coordination with the Installation Management Command, complete the development of job descriptions for Community Based Healthcare Organizations command and control cadre.
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- **FINDING:** Most medical hold and medical holdover Soldiers have duties within the limits of their medical profiles.
- **RECOMMEND the APDES Action Team in conjunction with:**
 - Medical Holding Units, Medical Retention Processing Units, and Community Based Healthcare Organizations continue ensuring medical hold and medical holdover Soldiers who are able to work are assigned duties within the limits of their profiles.



OBJECTIVE 4: Assess the impact of other administrative areas on the Army Physical Disability Evaluation System.

- **FINDING:** Some Soldiers are arriving at Medical Holding Units or Medical Retention Processing Units without a Line of Duty (LOD) or with incomplete LOD documentation.
 - **RECOMMEND the APDES Action Team in conjunction with:**
 - US Army commands conduct training to educate commanders and leaders on the importance of completing LODs in accordance with the required regulations/policies.
 - US Army Medical Command review screening procedures at MTFs to ensure identification of wounded or injured Soldiers requiring LODs.
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- **FINDING:** Medical Treatment Facilities are not transferring required medical documentation for Soldiers transferred through the Medical Hold System.
 - **RECOMMEND the APDES Action Team in conjunction with:**
 - US Army Medical Command enforce regulatory guidance regarding the transfer of medical documentation.
 - US Army Medical Command continue fielding of Armed Forces Health Longitudinal Technology Application (AHLTA).



OBJECTIVE 4: Assess the impact of other administrative areas on the Army Physical Disability Evaluation System.

- **FINDING:** When conducted, commands with MOS/Medical Review Board (MMRB) convening authority conduct MMRBs in accordance with Army Regulation.
- **RECOMMEND the APDES Action Team in conjunction with:**
 - Commands with MOS/Medical Retention Board (MMRB) convening authority train and educate subordinate commanders and board members on the MMRB and their responsibilities in the process.
 - Commands with MOS/Medical Retention Board (MMRB) convening authority maintain MMRB statistics in accordance with Army Regulation 600-60.
 - Deputy Chief of Staff, G-1 and US Army Reserve Command examine ways to improve the timeliness for issuing permanent profiles for USAR Soldiers with physical exams processed through Federal Strategic Health Alliance Program and Human Resource Command-St. Louis.



OBJECTIVE 4: Assess the impact of other administrative areas on the Army Physical Disability Evaluation System.

- **OBSERVATION:** Physical Evaluation Board personnel perceive the Military Occupational Specialty (MOS)/Medical Retention Board is underused resulting in some Soldiers separating through the Army Physical Disability Evaluation System unnecessarily.
- **RECOMMEND the APDES Action Team in conjunction with:**
 - Deputy Chief of Staff G1 consider revising Army Regulation 635-40 to allow USAPDA to refer Soldiers to a MOS/Medical Retention Board.
 - Deputy Chief of Staff G1 conduct a study to determine if commands are using the MOS/Medical Retention Board as intended for the Personal Performance Evaluation System.
 - US Army Medical Command ensure physicians are trained and understand when a Soldier should be referred to an MOS/Medical Retention Board versus Medical Evaluation Board.
 - Commands and units with MOS/Medical Retention Board convening authority establish procedures for screening permanent profiles to determine whether to refer a Soldier to an MOS/Medical Retention Board versus Medical Evaluation Board.



OBJECTIVE 4: Assess the impact of other administrative areas on the Army Physical Disability Evaluation System.

- **OBSERVATION:** Medical Retention Processing Units (MRPU) and Community Based Healthcare Organizations (CBHCO) do not accurately track Reserve Component (RC) Soldiers' Medical Retention Process (MRP) orders and completed packets.
 - **RECOMMEND the APDES Action Team in conjunction with:**
 - Installation Management Command in coordination with US Army MEDCOM, and Human Resources Command continue the current implementation plan to conduct bi-annual medical holdover training for Medical Retention Processing Units and Community Based Healthcare Organizations.
 - US Army Medical Command, in coordination with Human Resources Command-Alexandria complete authorization for data input fields in Medical Operational Data System.
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- **OBSERVATION:** Most installation transition centers have additional personnel to handle the increased transition processing workload created by the Global War on Terrorism in order to meet the Army time standards.
- **RECOMMEND the APDES Action Team in conjunction with:**
 - Installation Management Command continue to fund installation transition centers to ensure timely discharge, release from active duty, and retirement orders publishing and disability separation processing.
 - U.S. Army Physical Disability Agency take steps to eliminate the error of placing Soldiers on the wrong installation transition processing notification list



OBJECTIVE 4: Assess the impact of other administrative areas on the Army Physical Disability Evaluation System.

- **FINDING:** Most Soldiers interviewed reported successful recovery of their personal and organizational property following medical evacuation from overseas locations.
 - **RECOMMEND the APDES Action Team in conjunction with:**
 - US Army Commands ensure subordinate commanders comply with AR 735-5 and Department of the Army All Army Activities 139/2006 P210236Z July 2006 Message, Policies and Procedures for Handling Personal Effects and Government Property.
 - Medical Command and Installation Management Command ensure Medical Holding Units and Medical Retention Processing Units include a briefing during in-processing on how to file claims with the Installation Claims Office for lost personally owned property.
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- **OBSERVATION:** The majority of MTFs, MHUs, MRPU, and CBHCOs inspected feel TRICARE does an excellent job providing quality medical care for Soldiers.
- **RECOMMEND the APDES Action Team in conjunction with:**
 - TRICARE Management Agency review its policy regarding reimbursement of those civilian providers authorized to provide medical treatment to DoD beneficiaries.
 - TRICARE Management Agency review or revise criteria used to certify physicians in remote locations in order to provide care for Soldiers residing there.

