INSTRUCTIONS TO MEPS:

1) **Date of this Supplemental Guidance: July 2, 2012.**
2) **The regulation is published by Office of the Secretary of Defense (OSD) and is in black.**
3) **Supplemental Guidance (SMPG) is written by USMEPCOM and is in blue. SMPG is offered as an aid in interpreting the regulation. It is not the regulation.**
4) **Changes from previous DoDI 6130.03 are indicated in green.**
5) **When printing, please be absolutely sure to use a color printer so that SMPG can be differentiated from the regulation itself.**

Department of Defense

INSTRUCTION

NUMBER 6130.03
April 28, 2010
Incorporating Change 1, September 13, 2011

USD(P&R)

SUBJECT: Medical Standards for Appointment, Enlistment, or Induction in the Military Services

References: See Enclosure 1

1. PURPOSE: This Instruction:

a. Reissues DoD Directive (DoDD) 6130.3 (Reference (a)) as a DoD Instruction (DoDI) in accordance with the authority in DoDD 5124.02 (Reference (b)) to establish policy, assign responsibilities, and prescribe procedures for physical and medical standards for appointment, enlistment, or induction in the Military Services.

b. Establishes medical standards, which, if not met, are grounds for rejection for military service. Other standards may be prescribed for a mobilization for a national emergency.

c. Incorporates and cancels DoDI 6130.4 (Reference (c)).

2. APPLICABILITY: This Instruction applies to:

a. OSD, the Military Departments (including the Coast Guard at all times, including when it is a service in the Department of Homeland Security by agreement with that Department), the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands, the Office of the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the Department of Defense (hereafter referred to collectively as the "DoD Components").

b. The Reserve Components, which include the Army and the Air National Guards of the United States, in accordance with title 10, United States Code (Reference (d)).

c. The United States Merchant Marine Academy in accordance with section 310.56 of title 46, Code of Federal Regulations (Reference (e)).

3. DEFINITIONS: See Glossary.

4. POLICY: It is DoD policy to:

a. Utilize common physical standards for the appointment, enlistment, or induction of Service personnel and eliminate inconsistencies and inequities based on race, sex, or location of examination in the application of these standards by the Military Services.

b. Precisely define any medical condition that causes a personnel action, such as separation, medical waiver, or assignment limitation, by utilizing the International Classification of Diseases (ICD) (Reference (f)), Current Procedural Terminology (CPT) (Reference (g)), and the Healthcare Common Procedure Coding System (HCPCS) (Reference (h)), and annotate qualification decisions by standard medical terminology, rather than codes. The standards in this Instruction shall be for the acquisition of personnel in the Military Services.

c. Ensure that individuals under consideration for appointment, enlistment, or induction into the Military Services are:

(1) Free of contagious diseases that probably will endanger the health of other personnel.

(2) Free of medical conditions or physical defects that may require excessive time lost from duty for necessary treatment or hospitalization, or probably will result in separation from the Service for medical unfitness.

(3) Medically capable of satisfactorily completing required training.

(4) Medically adaptable to the military environment without the necessity of geographical area limitations.

(5) Medically capable of performing duties without aggravation of existing physical defects or medical conditions.

5. RESPONSIBILITIES.: See Enclosure 2.

6. PROCEDURES: See Enclosure 3 for Medical and Personnel Executive Steering Committee (MEDPERS) information. Procedures and standards for implementation are in Enclosure 4.

7. RELEASABILITY: UNLIMITED. This Instruction is approved for public release and is available on the Internet from the DoD Issuances Website at http://www.dtic.mil/whs/directives.

8. EFFECTIVE DATE: This Instruction is effective immediately.

Clifford L. Stanley
Under Secretary of Defense for
Personnel and Readiness

Enclosures:
1. References
2. Responsibilities
3. Medical and Personnel Executive Steering Committee
4. Medical Standards for Appointment, Enlistment, or Induction

Glossary

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ENCLOSURE 1

REFERENCES

(a) DoD Directive 6130.3, "Physical Standards for Appointment, Enlistment, or Induction," December 15, 2000 (hereby cancelled)
(b) DoD Directive 5124.02, "Under Secretary of Defense for Personnel and Readiness (USD(P&R))," June 23, 2008
(c) DoD Instruction 6130.4, "Medical Standards for Appointment, Enlistment, or Induction in the Armed Forces," January 18, 2005 (hereby cancelled)
(d) Title 10, United States Code
(e) Section 310.56 of title 46, Code of Federal Regulations
(f) International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)[1]
(g) American Medical Association, Current Procedural Terminology (CPT®), Fourth Edition, 2010 Revision, Chicago, IL, 2010[2]
(h) 2010 Healthcare Common Procedure Coding System (HCPCS) Level II Codes from Centers for Medicare and Medicaid Services (CMS)[2]
(i) American National Standards Institute ANSI S3.6-2004, "Specification for Audiometers"[3]
(j) Joint Publication 1-02, "Department of Defense Dictionary of Military and Associated Terms," current edition

[1] Available at http://www.cdc.gov/NCHS/icd/icd9cm.htm.
[2] Available at https://catalog.ama-assn.org/Catalog/cpt/cpt_home.jsp
[3] Available from the American National Standards Institute, 1819 L Street, N.W., Washington D.C. 20036 or on the Internet at http://www.ansi.org/

ENCLOSURE 2

RESPONSIBILITIES

1. PRINCIPAL DEPUTY UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS (PDUSD(P&R)). The PDUSD(P&R), under the authority, direction, and control of the Under Secretary of Defense for Personnel and Readiness (USD(P&R)), shall:

a. Ensure that the standards in Enclosure 4 are implemented throughout the U.S. Military Entrance Processing Command.

b. Eliminate inconsistencies and inequities based on race, sex, or location of examination in the application of these standards by the Military Services.

c. Convene the MEDPERS under the joint guidance of the Deputy Under Secretary of Defense for Military Personnel Policy (DUSD(MPP)) and Principal Deputy Assistant Secretary of Defense for Health Affairs (PDASD(HA)). MEDPERS responsibilities are in Enclosure 3.

2. ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS (ASD(HA)). The ASD(HA), under the authority, direction, and control of the USD(P&R), shall:

a. Review, approve, and issue to the Secretaries of the Military Departments technical modifications to the standards in Enclosure 4.

b. Provide guidance to the DoD Medical Examination Review Board to implement the standards in Enclosure 4.

c. Eliminate inconsistencies and inequities based on race, sex, or location of examination in the application of these standards by the Military Services.

3. SECRETARIES OF THE MILITARY DEPARTMENTS AND COMMANDANT OF THE COAST GUARD. The Secretaries of the Military Departments and Commandant of the Coast Guard shall:

a. Direct their respective Services to apply and uniformly implement the standards contained in this Instruction.

b. Authorize the waiver of the standards in individual cases for applicable reasons and ensure uniform waiver determinations.

c. Authorize the changes in Service-specific visual standards (particularly for officer accession programs) and establish other standards for special programs. Notification of any proposed changes in standards shall be provided to the ASD(HA) at least 60 days before implementation.

d. Ensure that accurate ICD codes are assigned to all medical conditions resulting in a personnel action, such as separation, waiver, or assignment limitation, and that such codes are included in all records of such actions.

e. Eliminate inconsistencies and inequities based on race, sex, or examination location in the application of these standards by the Military Services.

ENCLOSURE 3

MEDPERS

1. MEDPERS convenes quarterly under the joint guidance of the DUSD(MPP) and PDASD(HA).

2. MEDPERS shall:

a. Provide policy oversight and guidance to the accession medical and physical standards setting process through the Accession Medical Standards Working Group.

b. Direct research and studies as necessary to produce evidence-based accession standards utilizing the Accession Medical Standards Analysis and Research Activity.

c. Ensure medical and personnel community coordination when formulating policy changes that affect each community and other relevant DoD and Department of Homeland Security organizations.

ENCLOSURE 4

MEDICAL STANDARDS FOR APPOINTMENT, ENLISTMENT, OR INDUCTION

1. APPLICABILITY: The medical standards in this enclosure apply to:

a. Applicants for appointment as commissioned or warrant officers in the Active and Reserve Components.

b. Applicants for enlistment in the Military Services. For medical conditions or defects predating original enlistment, these standards apply to enlistees' first 6 months of active duty.

c. Applicants for enlistment in the Reserve Components and federally recognized units or organizations of the National Guard. For medical conditions or defects predating original enlistment, these standards apply during the enlistees' initial period of active duty for training until their return to Reserve or National Guard units.

d. Applicants for reenlistment in Regular and Reserve Components and in federally recognized units or organizations of the National Guard after a period of more than 12 months have elapsed since discharge.

e. Applicants for the Scholarship or Advanced Course Reserve Officer Training Corps (ROTC), and all other Military Services' special officer personnel procurement programs.

f. Cadets and midshipmen at the U.S. Service academies and students enrolled in ROTC scholarship programs applying for retention in their respective programs.

g. Individuals on the Temporary Disability Retired List (TDRL) who have been found fit on reevaluation by the Physical Disability Evaluation System (PDES) and who elect to return to active duty or to active status in the Reserve Components within the time standards prescribed by Service Regulations. These individuals are exempt from this Instruction for the conditions for which they were found fit on reevaluation by the PDES.

h. All individuals being inducted into the Military Services.

SMPG: This section is under review. Per Accession Medical Standards Working Group (AMSWG) discussion: prior service applicants MAY be qualified under their service-specific retention standards if all of the following are true:

- ✓ Less than 12 months have elapsed since discharge.
- ✓ Applicant is not going to basic training or airborne training.

ALL prior-service applicants going to basic training or airborne training MUST meet DoDI 6130.03 Change 1 standards.

2. MEDICAL STANDARDS: Throughout this enclosure, ICD, CPT and HCPCS codes are included with most medical conditions and procedures, usually parenthetically, to aid cross-

referencing. Unless otherwise stipulated, the conditions listed in this enclosure are those that do NOT meet the standard by virtue of current diagnosis, or for which the candidate has a verified past medical history. The medical standards for appointment, enlistment, or induction into the Military Services are classified by the general systems described in 3–31 of this enclosure.

3. HEAD:

a. Deformities of the skull, face, or mandible (738.19, 744.9, 754.0) of a degree that shall prevent the individual from the proper wearing of a protective mask or military headgear.

b. Loss, or absence of the bony substance of the skull (756.0 or 738.19) not successfully corrected by reconstructive materials, or leaving any residual defect in excess of 1 square inch (6.45 square centimeters), or the size of a 25-cent piece.

4. EYES:

a. Lids:

(1) Current symptomatic blepharitis (373.0x).
SMPG: Commonly associated with rosacea and seborrheic dermatitis. Anterior blepharitis is around eyelashes and follicles with usual causes being staphylococcal and seborrheic. Posterior involves meibomian gland orifices and can be seen as a component of rosacea.
The applicant meets standard when cured and not on medication to control blepharitis.

(2) Current blepharospasm (333.81).
SMPG: Underlying known causes can include damage to the basal ganglia from concussion, dry eye (aging, regular use of antihistamines/cold remedies), prolonged benzodiazepine use, or anti-Parkinson's medications.
Recurrent blepharospasm requiring PCP evaluation/treatment does not meet standard.

(3) Current dacryocystitis, acute (375.32), or chronic (375.42).
SMPG: Dacryocystitis is an infection of the nasolacrimal sac frequently caused by duct obstruction. In chronic cases, tearing may be the only symptom. Use ICD 375.40 for chronic dacryocystitis.

(4) Defect or deformity of the lids or other disorders affecting eyelid function (374.4x, 374.50, 374.85, 374.89, 743.62), complete, or significant ptosis (374.3x, 743.61), sufficient to interfere with vision or impair protection of the eye from exposure.

(5) Current growths or tumors of the eyelid (173.1, 198.2, 216.1, 232.1, 238.8, 239.89), other than small, non-progressive, asymptomatic, benign lesions.
SMPG: Chalazion & hordeolums must resolve before meeting standard.

b. Conjunctiva:

(1) Current acute or chronic conjunctivitis (372.1x, 077.0). Seasonal allergic conjunctivitis (372.14) DOES meet the standard.
SMPG: Year-round use of medication does not meet the standard.

(2) Current pterygium (372.4x) if condition encroaches on the cornea in excess of 3 millimeters, interferes with vision, is progressive, or a history of recurrence after any prior surgical removal (372.45).

c. Cornea:

Corneal dystrophy or degeneration of any type (371.x), including but not limited to keratoconus (371.6x) of any degree.

SMPG: Keratoconus can be reliably diagnosed by a complete ophthalmologic evaluation and corneal topography.

(2) History of any incisional corneal surgery including, but not limited to, partial or full thickness corneal transplant, radial keratotomy (RK), astigmatic keratotomy (AK), or corneal implants (Intacs®)

(3) Corneal refractive surgery performed with an excimer laser, including but not limited to photorefractive keratectomy (PRK) (HCPCS S0810), laser epithelial keratomileusis (LASEK), and laser-assisted in situ keratomileusis (LASIK) (HCPCS S0900) (ICD-9 code for each is P11.7) if any of the following conditions are met:

(a) Pre-surgical refractive error in either eye exceeded a spherical equivalent of +8.00 or -8.00 diopters.

(b) Pre-surgical astigmatism exceeded 3.00 diopters.
SMPG: If records of pre-surgical refractive error cannot be obtained, the applicant does not meet the standard

(c) For corneal refractive surgery, at least 180 days recovery period has not occurred between last refractive surgery or augmenting procedure and accession medical examination.
SMPG: MEPS exam is not authorized until the 180 day recovery period has passed.

(d) There have been complications and/or medications or ophthalmic solutions, or any other therapeutic interventions such as sunglasses, are required.
SMPG: A complication exists if haze, glare, star burst, halos, ghosts, double images, night vision difficulty, worsening refractive error, infection, or other condition persists beyond the 180 day recovery period. Regular use of ophthalmic solutions or required use of indoor sunglasses beyond the 180 day post-op period does not meet the standard. Keratitis does not meet the standard until treatment is complete. Corneal neovascularization or opacification that is progressive or impairs vision below standards does not meet the standard.

(e) Post-surgical refraction in each eye is not stable as demonstrated by at least two separate refractions at least 1 month apart, with initial refraction at least 90 days post-procedure, and the most recent of which demonstrates more than +/- 0.50 diopters difference for spherical vision and/or more than +/- 0.50 diopters for cylinder vision.
SMPG: If post-op refractions were not done according to the standard, the applicant will provide the FIRST manifest refraction 30 days before processing and the MEPS will consult for the SECOND manifest refraction.

(4) Current or recurrent keratitis (370.xx)

(5) Documented herpes simplex virus keratitis (054.42, 054.43).

(6) Current corneal neovascularization, unspecified (370.60), or corneal opacification (371.00, 371.03) from any cause that is progressive or reduces vision below the standards prescribed in this Instruction.

(7) Current or history of uveitis or iridocyclitis (364.00-364.3).
SMPG: Uveitis is inflammation of the eye between the retina and the sclera (iris, ciliary body, vitreous, and choroid). Iridocyclitis involves the iris and ciliary body. Uveitis is associated with infections, eye injury, and autoimmune disorders, but commonly may be idiopathic.

d. Retina: Current or history of any abnormality of the retina (361.00-362.89, 363.14-363.22), choroid (363.00-363.9) or vitreous (379.2x).

e. Optic Nerve:

(1) Any current or history of optic nerve disease (377.3), including but not limited to optic nerve inflammation (363.05), optic nerve swelling, or optic nerve atrophy (377.12, 377.14).

(2) Any optic nerve anomaly.

f. Lens:

(1) Current aphakia (379.31, 743.35), history of lens implant (V45.61, V43.1) (CPT 66982-66986), or current or history of dislocation of a lens (379.32-379.34, 743.37).

(2) Current or history of opacities of the lens (366.xx), including cataract (366.9).

g. Ocular Mobility and Motility:

(1) Current or recurrent diplopia (368.2).
SMPG: Brown Syndrome (abnormal superior oblique muscle or tendon) will often result in diplopia when looking upwards and towards the affected side. Duane Syndrome (absence of cranial nerve VI – abducens nerve) will typically result in abduction deficiency of the affected eye, but sensory adaptation will often not result in subjective diplopia. Both conditions do not meet the standard. (see tropias below)

(2) Current nystagmus (379.5x) other than physiologic "end-point nystagmus."

(3) Esotropia (378.0x), exotropia **(**378.1x), and hypertropia (378.31): For entrance into Service academies and officer programs, the individual Military Services may set additional requirements. The Military Services shall determine special administrative criteria for assignment to certain specialties.
SMPG: Tropias (lazy eye, wandering eye, cross-eye, walleye, squint) are constant visible misalignment of the eyes. Grossly visible tropias do not meet the standard.

Phorias are latent tendencies for misalignment of the eyes held in check by the brain in order to maintain fusion. The cover-uncover test can reveal a phoria. Phorias meet the standard.

Esotropia is a form of strabismus in which one or both eyes turn inward ("cross-eye"). Exotropia is a form of strabismus in which the eyes are deviated outward ("walleye"). Hypertropia is a form of strabismus in which the visual axis of one eye is higher than the other. Hypertropia and exotropia are seen in Duane and Brown Syndromes.

In a Mayo Clinic study of 407 children with strabismus published in 2008, exotropia was associated with a three-fold increased risk for developing mental illness. Esotropia was not associated with increased risk.
CHANGE: DoDI qualification criteria changed from 40 prism diopters of tropia to any tropia in 2005; however, USMPECOM Supplemental Guidance continued to mention the 40 prism dipoter standard. The Supplemental Guidance is now more restrictive in order to comply with the DoDI.

h. Miscellaneous Defects and Diseases:

(1) Current or history of abnormal visual fields (368.9) due to diseases of the eye or central nervous system (368.4x), or trauma.

(2) Absence of an eye (V43.0, V45.78), clinical anophthalmos, unspecified congenital (743.00) or acquired, or current or history of other disorders of globe (360.xx).
SMPG: Clinical anophthalmos is the presence of an eye without vision

(3) Current unilateral or bilateral exophthalmoses (376.21-376.36).

(4) Current or history of glaucoma (365.xx), ocular hypertension, pre-glaucoma (365.0-365.04), or glaucoma suspect.
SMPG: Non-contact tonometry (puff test) done in the MEPS, which results in a measured IOP greater than 21 mmHg, requires an eye consult with contact tonometry to rule out ocular hypertension. Non-contact tonometry lacks the specificity to make the diagnosis.

(5) Any abnormal pupillary reaction to light (379.4x) or accommodation (367.5x).

(6) Asymmetry of pupil size greater than 2mm.

(7) Current night blindness (264.5, 368.6x).

(8) Current or history of intraocular foreign body (360.50-360.69, 871.x).

(9) Current or history of ocular tumors (190.0, 190.8-190.9, 198.4, 224.0, 224.8-224.9, 234.0, 238.8, 239.89, V10.84).

(10) Current or history of any abnormality of the eye (360) or adnexa (376, 379.9), not specified in subparagraphs 4.h.(1)-(9) of this enclosure, which threatens vision or visual function V41.0-V41.1, V52.2, V59.5).

5. VISION:

a. Current distant visual acuity of any degree that does not correct with spectacle lenses to at least one of the following (367):

(1) 20/40 in one eye and 20/70 in the other eye (369.75).

(2) 20/30 in one eye and 20/100 in the other eye (369.75).

(3) 20/20 in one eye and 20/400 in the other eye (369.73).

b. Current near visual acuity of any degree that does not correct to 20/40 in the better eye (367.1-367.32).

c. Current refractive error (hyperopia (367.0), myopia (367.1), astigmatism (367.2x)), in excess of -8.00 or +8.00 diopters spherical equivalent or astigmatism in excess of 3.00 diopters.
SMPG: Spherical equivalent refraction is a way to describe the "average" error in the curvature of a cornea. Spherical equivalent (SE) is an algebraic calculation:

SE = sphere + ½ (cylinder)

Examples: The SE in both of these examples is +2.50.

Method	Sphere	Cylinder	Axis
Plus-cylinder Notation	+2.00	+1.00	150°
Minus-cylinder Notation	+3.00	-1.00	60°

d. Any condition requiring contact lenses for adequate correction of vision, such as corneal scars and opacities (370.0x) and irregular astigmatism (367.22).

e. Color vision (368.5x) requirements shall be set by the individual Services.
SMPG: Color deficiency or color blindness meets the standard. In the United States, 7% of the male population is color blind. 0.4% of females are color blind.

6. EARS:

a. Current atresia of the external ear (744.02) or severe microtia (744.23), congenital or acquired stenosis (380.5x), chronic otitis externa (380.15-380.16, 380.23), or severe external ear deformity (380.32, 738.7, 744.01, 744.3) that prevents or interferes with the proper wearing of hearing protection.
SMPG: Atresia is the absence of a completely formed external auditory canal and does not meet the standard. Microtia is an underdeveloped outer ear; when severe, does not meet the standard. Congenital or acquired stenosis of the external auditory canal severe enough to prevent adequate visualization of the TM does not meet the standard.

Other external ear deformities (i.e. large holes in the ear lobe from piercings/ear gauges, traumatic loss of part of an external ear, or "cauliflower ear") meet the standard if hearing protection can be worn.

b. Current or history of Ménière's Syndrome or other chronic diseases of the vestibular system (386.xx).
SMPG: Meniere's Syndrome can be caused by Meniere's disease, acoustic neuroma, MS, thyroid disease, or other conditions. Symptoms are:
- ✓ Rotational vertigo
- ✓ Fluctuating, progressive hearing loss
- ✓ Tinnitus
- ✓ Sensation of fullness or pressure in the ear

Isolated tinnitus secondary to noise exposure meets the standard.

c. History of cochlear implant.

d. Current or history of cholesteatoma (385.3x)

e. History of any inner (P20) (CPT 69801-69930) or middle (P19) (CPT 69631-69636, 69676) ear surgery excluding successful tympanoplasty (CPT 69635) performed during the preceding 180 days.

f. Current perforation of the tympanic membrane (384.2x) or history of surgery to correct perforation during the preceding 180 days (P19) (CPT 69433, 69436, 69610, 69631-69646).

g. Chronic Eustachian tube dysfunction as evidenced by retracted tympanic membrane, or recurrent otitis media, or the need for pressure-equalization (PE) tube within the last 3 years.
SMPG: Current otitis media does not meet the standard until resolved.

7. HEARING: All hearing defects are coded with ICD-9 code 389.xx.

a. Audiometric hearing levels are measured by audiometers calibrated to the standards in American National Standards Institute (ANSI S3.6-2004) (Reference (i)) and shall be used to test the hearing of all applicants.

b. Current hearing threshold level in either ear greater than that described in subparagraphs 7.b.(1)-(3) of this enclosure does not meet the standard:

(1) Pure tone at 500, 1000, and 2000 cycles per second for each ear of not more than 30 decibels (dB) on the average with no individual level greater than 35 dB at those frequencies.

(2) Pure tone level not more than 45 dB at 3000 cycles per second or 55 dB at 4000 cycles per second for each ear.

(3) There is no standard for 6000 cycles per second.

c. Current or history of hearing aid use (V53.2).

8. NOSE, SINUSES, MOUTH, and LARYNX:

a. Current cleft lip or palate defects (749.xx) not satisfactorily repaired by surgery or that interfere with use or wear of military equipment, or that prevent drinking from a straw.
SMPG: Applicants with a history of cleft palate will not have a MEPS-directed ear lavage. If the repair meets the standard, but a speech impediment remains, refer to 29-m.

b. Current ulceration of oral mucosa, including tongue (528.6), excluding apthous ulcers.
SMPG: Oral leukoplakia is a patch of keratosis commonly associated with tobacco use. It is not an ulcerative lesion of the mucosa; thus, it meets the standard. Apthous ulcers meet the standard, provided they are not secondary to an underlying condition which does not (i.e. Lupus, Crohn's, etc).

c. Current chronic conditions of larynx including vocal cord paralysis (478.3x) or history of laryngeal papillomatosis.

d. History of non-benign polyps, (478.4) chronic hoarseness (78.49), chronic laryngitis (476.0) or spasmodic dysphonia.

e. Current anosmia or parosmia (781.1).
SMPG: Anosmia is absent sense of smell. Parosmia is distorted sense of smell.

f. History of recurrent epistaxis with more than one episode per week of bright red blood from the nose occurring over a 3-month period (784.7) within the last 3 years.

g. Current nasal polyp or history of nasal polyps (471.x), unless more than 12 months have elapsed since nasal polypectomy (CPT 30110, 30115, 31237-31240) and/or sinus surgery, and asymptomatic.

h. Current perforation of nasal septum (478.1, 478.19, 748.1).
SMPG: Piercings of the septum must be healed to meet the standard.

i. Current chronic sinusitis (473) as evidenced by chronic purulent discharge, symptoms requiring frequent medical attention, or computed tomography (CT) scan.

j. Current or history of deformities, or conditions or anomalies of the upper alimentary tract (750.9), mouth (750.26), tongue (750.1x), palate, throat, pharynx, larynx (748.3), and nose (748.1), that interfere with chewing (V41.6), swallowing, speech, or breathing.
SMPG: Applicants with any signs of pharyngitis are referred to their PCP for evaluation of infectious and non-infectious causes. Applicants with infectious mononucleosis do not meet the standard until after a 6 week recovery period. For speech disorders See 29-m

9 DENTAL:

a. Current diseases or pathology of the jaws or associated tissues that prevent normal functioning. Those diseases or conditions include but are not limited to temporomandibular disorders (524.6x) and/or myofascial pain (784.0). A minimum of 6 months healing time must elapse for any individuals completing surgical treatment of any maxillofacial pathology lesions.

b. Current severe malocclusion (524.00-524.29, 524.4), which interferes with normal chewing or requires immediate and protracted treatment, or a relationship between the mandible and maxilla that prevents satisfactory future prosthodontic replacement.

c. Eight or more grossly (visually) cavitated and/or carious teeth (521.0x). Applicants who are edentulous must have functioning dentures. Lack of a serviceable prosthesis that prevents adequate biting and chewing of a normal diet. Individuals undergoing endodontic care are acceptable for entry into the Delayed Entry Program (DEP) only if a civilian or military dentist or endodontist provides documentation that active endodontic treatment shall be completed prior to being sworn to active duty.
SMPG: Applicants with fewer than 20 teeth require functioning dentures to meet the standard. Ill-fitting or malfunctioning dentures (partial or complete; removable or fixed) does not meet the standard until corrected. Dental implants meet the standard.

d. Current orthodontic appliances (mounted or removable i.e. Invisalign®) for continued active treatment (V53.4). Permanent or removable retainers are permissible. Individuals undergoing active orthodontic care are acceptable for accession (including DEP) only if a civilian or military orthodontist provides documentation that active orthodontic treatment shall be completed prior to being sworn into active duty. Entrance to active duty will not occur until all orthodontic treatment is documented to be completed.

10 NECK:

a. Current symptomatic cervical ribs (756.2).

b. Current congenital cyst(s) (744.4x) of branchial cleft origin or those developing from the remnants of the thyroglossal duct (759.2).

c. Current contraction (723.5, 754.1)) of the muscles of the neck, spastic or non-spastic, or cicatricial contracture of the neck to the extent it interferes with the proper wearing of a uniform or military equipment, or is so disfiguring as to interfere with or prevent satisfactory performance of military duty.

11. LUNGS, CHEST WALL, PLEURA, AND MEDIASTINUM:

a. Current abnormal elevation of the diaphragm (either side) 756.6). Any nonspecific abnormal findings on radiological and other examination of body structure, such as lung field (793.1) or other thoracic or abdominal organ (793.2).

b. Current abscess of the lung (513.0) or mediastinum (513.1).

c. Current or history of recurrent acute infectious processes of the lung, including but not limited to viral pneumonia (480.x), pneumococcal pneumonia (481), bacterial pneumonia (482.xx), pneumonia due to other specified organism (483.x), pneumonia infectious disease classified elsewhere (484.x), bronchopneumonia (organism unspecified) (485), and pneumonia (organism unspecified) (486).

d. Airway hyper responsiveness including asthma (493.xx), reactive airway disease, exercise-induced bronchospasm (519.11) or asthmatic bronchitis (493.90, reliably diagnosed and symptomatic after the 13th birthday.

(1) Reliable diagnostic criteria may include any of the following elements: substantiated history of cough, wheeze, chest tightness, and/or dyspnea which persists or recurs over a prolonged period of time, generally more than 12 months.

(2) Individuals DO MEET the standard if within the past 3 years they meet ALL of the criteria in subparagraphs 11.d.(2)(a)-(d).

(a) No use of controller or rescue medications (including, but not limited to inhaled corticosteroids, leukotriene receptor antagonists, or short-acting beta agonists).

(b) No exacerbations requiring acute medical treatment.

(c) No use of oral steroids.

(d) A current normal spirometry (within the past 90 days), performed in accordance with American Thoracic Society (ATS) guidelines and as defined by current National Heart, Lung, and Blood Institute (NHLBI) standards.
SMPG: MEPS are authorized to obtain methacholine tests when requested by Service Waiver Authority.
CHANGE: Added word "DO"

e. Chronic obstructive pulmonary disease (491).

(1) Current or history of bullous or generalized pulmonary emphysema (492).

(2) Current bronchitis (490), acute or chronic symptoms over 3 months occurring at least twice a year (491).

f. Current or history of bronchiectasis (494). Bronchiectasis during the first year of life is not disqualifying if there are no residual or sequelae.

g. Current or history of bronchopleural fistula (510.0), unless resolved with no sequelae.

h. Current chest wall malformation (754.89), including but not limited to pectus excavatum (754.81) or pectus carinatum (754.82), if these conditions interfere with vigorous physical exertion.
SMPG: In children, young adults, or adults no deaths have been attributed to the isolated deformity although complaints of exercise intolerance are common. History of participation in athletic activities may be helpful. PFT's that are normal do not exclude the possibility of cardiopulmonary limitation during exercise. Exercise testing may be used to assess cardiopulmonary limitation.

i. History of empyema (510.9).

j. Pulmonary fibrosis (515).

k. Current foreign body in lung (934.8, 934.9), trachea (934.0), or bronchus (934.1).

l. History of thoracic surgery (32-33), (CPT 32035-32999, 33010-33999, 43020-43499) including open and endoscopic procedures.

m. Current or history of pleurisy with effusion (511.9) within the previous 2 years.

n. Current or history of pneumothorax (512) occurring during the year preceding examination if due to trauma (860) or surgery, or occurring during the 2 years preceding examination from spontaneous (512.8) origin.
SMPG: Pneumothorax from surgery or procedure meets the standard after 1 year if not a thoracic surgery (see 11-*l*). A single spontaneous pneumothorax meets the standard after 2 years.

o. Recurrent spontaneous pneumothorax (512.8).

p. History of chest wall surgery (34-34.9), including breast (85-85.9), during the preceding 6 months, or with persistent functional limitations.
SMPG: If the operating surgeon has cleared the applicant for unrestricted activity, MEPS exam is authorized before the recovery period has passed. When an applicant processes at the MEPS prior to the end of the recovery period, they are assigned a 3P and forwarded to the service to facilitate waiver consideration. Do not use 3T.

12. HEART:

a. History of valvular repair or replacement (CPT 33400-33478).

(1) Current or history of the following valvular conditions as defined by the current American College of Cardiology and American Heart Association guidelines:

SMPG: Diastolic murmurs and continuous murmurs almost always require further cardiac evaluations.

A mid-systolic murmur found on auscultation to accentuate with valsava maneuvers or standing is concerning for hypertrophic cardiomyopathy. "Sudden Death in Young Athletes: Screening for the Needle in a Haystack", by O'Connor, Kugler and Oriscello published in the America Family Physician; June 1, 1998, is an excellent cardiac screening reference.

Any murmur found on exam suspicious for disease requires an echocardiogram and cardiology referral.

The following valvular diagnoses are based on echocardiogram findings:

(a) Severe pulmonic regurgitation.

(b) Severe tricuspid regurgitation.

(c) Moderate pulmonic regurgitation unless documented mean pulmonary artery pressure is less than 25 mmHg.

(d) Moderate tricuspid regurgitation unless documented mean pulmonary artery pressure is less than 25 mmHg.

(e) Moderate or severe mitral regurgitation.

(f) Mild, moderate, or severe aortic regurgitation.

(2) The following are considered normal variants that meet accession standards:

(a) Trace or mild pulmonic regurgitation.

(b) Trace or mild tricuspid regurgitation.

(c) Trace or mild mitral regurgitation in the absence of mitral valve prolapse.

(d) Trace aortic insufficiency.

b. Mitral valve prolapsed (396.3) with normal exercise tolerance not requiring medical therapy DOES meet the standard.

c. Bicuspid aortic valve (746.4), in the absence of stenosis or regurgitation as in subparagraphs 12.a.(1)(a)-(f), DOES meet the standard.
CHANGE: Corrected reference

d. All valvular stenosis (396).

e. Current or history of atherosclerotic coronary artery disease (410).

f. Current or history of pacemaker or defibrillator implantation (CPT 3320-33249).

g. History of supraventricular tachycardia (427.0).

(1) History of recurrent atrial fibrillation (427.31) or flutter 427.32).

(2) Supraventricular tachycardia (427.0) associated with an identifiable reversible cause and no recurrence during the preceding 2 years while off all medications DOES meet the standard.

(3) Those with identified atrioventricular nodal reentrant tachycardia or atrioventricular reentrant tachycardia (such as Wolff-Parkinson-White (WPW) syndrome) (426.7) who have undergone successful ablative therapy with no recurrence of symptoms after 3 months and with documentation of normal electrocardiograph (ECG) meet the standard.

h. Premature atrial or ventricular contractions sufficiently symptomatic to require treatment, or result in physical or psychological impairment.

i. Abnormal ECG patterns (794.31):

(1) Long QT (426.82).

(2) Brugada pattern.

(3) WPW syndrome (426.7) pattern unless associated with low risk accessory pathway by appropriate diagnostic testing.

j. Current or history of ventricular arrhythmias (427.1) including ventricular fibrillation, tachycardia, or multifocal premature ventricular contractions. Occasional asymptomatic unifocal premature ventricular contractions meet the standard.

k. Current or history of conduction disorders, including but not limited to disorders of sinus arrest, asystole, Mobitz type II second-degree atrioventricular (AV) block (426.12), and third-degree AV block (426.0).

l. In the absence of cardiovascular symptoms, the following meet the standard:

(1) Sinus arrhythmia.

(2) First degree AV block (426.11).

(3) Left axis deviation of less than -45 degrees.

(4) Early repolarization.

(5) Incomplete right bundle branch block.

(6) Wandering atrial pacemaker (427.89) or ectopic atrial rhythm (427.89).

(7) Sinus bradycardia (427.81).

(8) Mobitz type I second-degree AV block (426.13).

m. Current or history of conduction disturbances such as left anterior hemiblock (426.2), right or left bundle branch block (426.4) do not meet the standard unless asymptomatic with a normal echocardiogram.

n. Current or history of cardiomyopathy (425), cardiomegaly, hypertrophy (defined as septal wall thickness of 15 mm or greater), dilation (429.3), or congestive heart failure (428).

o. History of myocarditis (422) or pericarditis (420) unless the individual is free of all cardiac symptoms, does not require medical therapy, and has normal echocardiography for at least 1 year.

p. Current persistent tachycardia (785.0) (as evidenced by average heart rate of 100 beats per minute or greater over a 24-hour period of continuous monitoring).
SMPG: Tachycardia is defined as a pulse rate of 100 beats per minute or greater. Use of any medications directed at reducing heart rate does not meet standard. An elevated pulse of 100 to 110 beats per minute is commonly seen during MEPS examination. MEPS is authorized to do three heart automated heart rate readings and a fourth by a MEPS provider; all results will be recorded in Applicant's record. Evaluate pulses above 120 beats per minute with EKG. Applicants with initial tachycardia meet the standard if their pulse decreases below 100 beats per minute while at the MEPS. If their pulse does not decrease below 100 beats per minute, refer the applicant to their PCP for heart rate checks on 2 successive days with three heart rate readings obtained at least 15 minutes apart. Normal pulse checks at the PCP's office meet the standard.

Applicants with symptomatic tachycardia are sent to the ER for evaluation.

q. Current or history of congenital anomalies of heart and great vessels (746). The following conditions meet the standard with an otherwise normal current (within 6 months) echocardiogram.

(1) Dextrocardia (746.87) with situs inversus (759.3) without any other anomalies.

(2) Ligated or occluded patent ductus arteriosus (747.0).

(3) Corrected atrial septal defect (745.9) or patent foramen ovale (745.5) without residua.

(4) Corrected ventricular septal defect (745.4) without residua.

r. History of recurrent syncope and or presyncope (780.2), including black out, fainting, loss or alteration of level of consciousness (excludes vasovagal reactions with identified trigger such as venipuncture) unless there has been no recurrence during the preceding 2 years while off all medication.

s. Unexplained ongoing or recurring cardiopulmonary symptoms (to include but not limited to syncope, presyncope, chest pain, palpitations, and dyspnea on exertion) that impairs a physically active lifestyle.

t. History of rheumatic fever (390).

13. ABDOMINAL ORGANS AND GASTROINTESTINAL SYSTEM:
SMPG: For situs inversus see 12-q.

a. Esophageal Disease

(1) Current or history of esophageal disease (530.0-530-9), including but not limited to ulceration, varices, fistula, or achalasia.

(2) Gastro-Esophageal Reflux Disease (GERD) (530.81), with complications,

(a) Stricture or B-ring.

(b) Dysphagia.

(c) Recurrent symptoms or esophagitis despite maintenance medication.

(d) Barrett's esophagitis.

(e) Extraesophageal complications; reactive airway disease; recurrent sinusitis or dental complications.
SMPG: Current or history of uncomplicated GERD meets the standard if the applicant is asymptomatic while taking maintenance medication.
CHANGE: Expanded description of complications to include B-ring, dysphagia, recurrence, Barrett's, and extraesophageal sequalae – sinusitis and dental. Dysmotility disorders removed from list of complications and addressed below.

(3) History of surgical correction (fundoplication or dilation) for GERD within 6 months (45.89).
SMPG: Fundoplication with or without pyloroplasty meets the standard after 6 months, if no complications exists. Applicants with "gas bloat syndrome", dysphagia, dumping syndrome, achalasia, or recurrence of symptoms after the 6 month recovery period do not meet the standard.
CHANGE: Replaced esophageal, stomach, and intestinal corrections with fundoplication.

(4) Current or history of dysmotility disorders to include diffuse esophageal spasm, nutcracker esophagus, non-specific motility disorder, and achalasia.
CHANGE: Expanded list of disorders. Esophagitis removed and addressed above

(5) Eosinophilic esophagitis.
CHANGE: New

(6) Other esophageal strictures, for example lye or other caustic ingestion.
CHANGE: New

b. Stomach and Duodenum

(1) Current dyspepsia requiring medication; or history of dyspepsia lasting 3 or more consecutive months requiring medication within the preceding 12 months.
SMPG: Dyspepsia refers to chronic pain or recurrent pain or discomfort centered in the upper abdomen. Patients with predominant or frequent (occurring more than once a week) heartburn or acid regurgitation are considered to have GERD not dyspepsia.
Use ICD 536.8.

The following dyspepsia scenarios do not meet the standard:

- Any current dyspepsia requiring medication (prescription of OTC) even on an intermittent basis during the last 3 months;
- Any history of dyspepsia requiring medication (Rx or OTC) for at least three consecutive months in the last 12 months;

Any EGD proven gastritis requiring medication in the last year does not meet the standard.
This topic is currently under review for clarity and interim guidance.

Continued alcohol use after a diagnosis of alcohol gastritis may indicate underlying alcohol dependence. Refer to the DSM-IV for alcohol dependence criteria.
CHANGE: Specific mention of gastritis removed. More restrictive – history of dyspepsia from any cause lasting longer than 3 consecutive months in last year and requiring medication in last year now disqualifying.

(2) Gastric or duodenal ulcers:

(a) Current ulcer or history of treated ulcer within the last 3 months.

(b) Recurrent or complicated by bleeding, obstruction, or perforation within preceding 5 years confirmed by endoscopy.
SMPG: Applicants medically treated for a single uncomplicated ulcer (suspected or confirmed) meet the standard when all of the following are true:

- ✓ remain asymptomatic after the 3 month recovery period
- ✓ are not taking any medications
- ✓ are not on any restrictions
- ✓ are released from follow up care

CHANGE: Removed requirement to be confirmed by X ray or endoscopy. Less restrictive – can now qualify applicants with a history of a single uncomplicated ulcer medically treated more than 3 months ago.

(3) History of surgery for peptic ulceration or perforation (533.0-599.9).
SMPG: Endoscopic treatment is considered “surgery”.

(4) History of gastroparesis.
CHANGE: New

(5) History of bariatric surgery of any type (e.g. lap-band or gastric bypass for weight loss)

SMPG: Also see 13-g
CHANGE: New item more restrictive – previously surgery for "obesity" was disqualifying. Now all weight loss surgery is disqualifying.

(6) History of gastric varices.
CHANGE: New

c. Small and Large Intestine

(1) Current or history of inflammatory bowel disease, including but not limited to indeterminate (558.9), Crohn's disease (555), ulcerative colitis (556), or ulcerative proctitis (556.2).
SMPG: Other forms of inflammatory bowel disease (IBD) include collagenous colitis, lymphocytic colitis, and ischemic colitis. All IBD does not meet the standard.
CHANGE: Minor changes to listed types of IBD – unspecified IBD replaced with indeterminate IBD; regional enteritis removed.

(2) Current infectious colitis not otherwise specified (009.1).
SMPG: All current infectious colitis, regardless of etiology, does not meet the standard.
CHANGE: New

(3) Current or history of intestinal malabsorption syndromes (579.9), including but not limited to celiac sprue, pancreatic insufficiency, post-surgical and idiopathic (579). Lactase deficiency does not meet the standard only if of sufficient severity to require frequent intervention, or to interfere with normal function.
SMPG: Applicants with lactose intolerance, who avoid lactose containing food or use lactase supplements, meet the standard. All other malabsorption syndromes do not meet the standard.
CHANGE: Minor changes to listed malabsorption syndromes – added celiac sprue and pancreatic insufficiency

(4) Current or history of gastrointestinal functional and motility disorders within the past 2 years, including but not limited to pseudo-obstruction, megacolon, history of volvulus, or chronic constipation (564.0) and or diarrhea (787.91), regardless of cause, persisting or symptomatic in the past 2 years.

(5) History of gastrointestinal bleeding (578), including positive occult blood (792.1), if the cause has not been corrected. Meckel's diverticulum (751.0), if surgically corrected more than 6 months prior DOES meet the standard.

(6) Current or history of irritable bowel syndrome (564.1) of sufficient severity to require frequent intervention or prescription medication or to interfere with normal function.
SMPG: A diagnosis of irritable bowel syndrome (IBS) does not meet the standard if it required medical treatment after diagnosis or resulted in lost time from school or work. IBS managed by lifestyle modification and OTC's/dietary supplements meets the standard. Because IBS is a diagnosis of exclusion, the work-up period can be extensive and trials of several medical therapies may have been done before arriving at the final diagnosis. Applicants may have even

undergone surgery due to a misdiagnosis. Other diagnoses, which may have been entertained in the differential and intermittently recorded in the applicant's past medical records, do not need to be viewed as separate past medical conditions when they can easily be explained as undiagnosed IBS.
CHANGE: Added prescription medication to disqualifying factors

(7) History of bowel resection (CPT 44202-44203) within the past 5 years or at any age with persistent or recurrent complications of the surgery to include but not limited to functional bowel disorders or chronic abdominal pain.
SMPG: Use V45.72. Uncomplicated bowel resection meets the standard if 5 yrs have elapsed and the primary diagnosis that led to the bowel resection also meets the standard. Complicated bowel resection, regardless of etiology, does not meet the standard.
CHANGE: Less restrictive – allows some bowel resections to be qualified.

(8) Current or history of symptomatic diverticular disease of the intestine (562).
SMPG: Symptomatic diverticular disease may present as a spectrum of painless diverticular bleeding (diverticulosis) – sometimes requiring monitoring for blood loss, blood transfusions or, ultimately, colectomy to prevent further hemorrhage. Alternatively, diverticular disease can present as a spectrum of inflammation (diverticulitis) – from mild to moderate pain with a systemic inflammatory response and a requirement for antibiotics, to contained abscess formation requiring surgical drainage, or to gross perforation requiring a colectomy.

(9) Personal or family history of familial adenomatous polyposis syndrome or hereditary non-polyposis colon cancer syndrome.
CHANGE: New

d. Hepatic-Biliary Tract

(1) Current acute or chronic hepatitis, hepatitis carrier state (070), hepatitis in the preceding 6 months or persistence of symptoms after 6 months, or objective evidence of impairment of liver function.

(2) Current or history of cirrhosis (571), hepatic cysts (573.8), abscess (572.0), or sequelae of chronic liver disease (571.3).
SMPG: Any applicant with chronic liver disease will be disqualified.

(3) Current or history of symptomatic cholecystitis (575.10), unless successfully surgically corrected, postcholecystectomy syndrome; or other disorders of the gallbladder and biliary system (576). Cholecystectomy DOES meet the standard if performed more than 6 months prior to examination and patient remains asymptomatic. Endoscopic procedure to correct choledocholithiasis, if performed more than 6 months prior to examination and patient remains asymptomatic, MAY meet the standard.
SMPG: History of symptomatic cholelithisias, cholecystitis, or biliary dyskinesia meets the standard if:
- ✓ cholecystectomy was completed
- ✓ 6 month recovery period has passed with no recurrence of symptoms

- ✓ no complications

Asymptomatic cholelithiasis (stones in the gallbladder found incidentally) meets the standard.

Choledocholithiasis (stone in the common bile duct) requires TWO procedures. Sometimes these are done within days of each other and sometimes months or more apart. Occasionally, patients do not follow up for the second procedure. Careful consideration is needed to ensure BOTH were accomplished. Applicants meet the standard if

- ✓ cholecystectomy was done
- ✓ a procedure to definitively clear the common duct (ERCP or intra-operative common duct exploration with extraction of stone (s)) was done. Magnetic resonance cholangiopancreatography (MRCP) is an imaging study only and not a therapeutic procedure
- ✓ 6 month recovery period has passed with no recurrence of symptoms
- ✓ No complications

It is common for post-cholecystectomy patients to notice a mild increase in frequency of bowel movements (BM) around the 4-6 wk post-op period. This is not a complication and resolves before 6 months.

Post-cholecystectomy syndrome (PCS) is a complex of heterogeneous symptoms including persistent abdominal pain and dyspepsia that recur and persist after cholecystectomy.

Post-cholecystectomy diarrhea involves 3 or more BM's per day accompanied by urgency, persists chronically past 6 months, and can be disabling. This does not meet the standard.

Cholecystectomy complicated by a common duct or hepatic duct injury does not meet the standard. Gallstone pancreatitis does not meet the standard (see pancreatitis below).
CHANGE: Wording clarified for choledocholithiasis treated with ERCP

(4) History of sphincter of Oddi dysfunction.
CHANGE: New

(5) Choledochocyst.
SMPG: Current or history of choledochal cyst does not meet standard.
CHANGE: New

(6) Primary biliary cirrhosis or primary sclerosing cholangitis.
CHANGE: New

(7) Current or history of pancreatitis, acute (577.0) or chronic (577.1).
SMPG: All forms of pancreatitis, including gallstone pancreatitis, do not meet the standard.

(8) Pancreatic cyst.
SMPG: Current or history of pancreatic cyst does not meet standard
CHANGE: New

(9) History of pancreatic surgery.
CHANGE: New

(10) Current or history of metabolic liver disease, including but not limited to hemochromatosis (275.0), Wilson's disease (275.1), or alpha-1 anti-trypsin deficiency (273.4). Gilbert's syndrome DOES meet the standard.
SMPG: To be sure that the diagnosis of Gilbert's is correct, records review is warranted.
CHANGE: Less restrictive – Gilbert's syndrome is no longer disqualifying

(11) Current enlargement of the liver from any cause (789.1).
SMPG: A physical examination finding of hepatomegaly does not meet standard; further imaging or laboratory work-up is not required by CMO to make decision. Refer applicant to PCP for work-up.

e. Anorectal

(1) Current anal fissure or anal fistula (565).

(2) Current or history of anal or rectal polyp (569.0), prolapse (569.1), stricture (569.2), or fecal incontinence (787.6), within the last 2 years. History of removal of juvenile or inflammatory polyp DOES meet the standard.
SMPG: Juvenile polyposis syndrome (JPS) is often defined as the occurrence of 10 or more juvenile polyps and does not meet standard.
CHANGE: Less restrictive – Juvenile and inflammatory polyps are no longer disqualifying

(3) Current hemorrhoid (internal or external), when large, symptomatic, or with a history of bleeding (455) within the last 60 days.
CHANGE: Spleen moved to Section 23.

f. Abdominal Wall

(1) Current hernia (except for small or asymptomatic umbilical hernias), including but not limited to uncorrected inguinal (550) and other abdominal wall hernias (553).

(2) History of open or laparoscopic abdominal surgery (CPT 22900-22999, 43500-49999) during the preceding 6 months (P54). Uncomplicated laparoscopic appendectomies (CPT) 44970) meet the standard after 3 months.
SMPG: If the operating surgeon has cleared the applicant for unrestricted activity, MEPS exam is authorized before the recovery period has passed. When an applicant processes at the MEPS prior to the end of the recovery period, they are assigned a 3P and forwarded to the service to facilitate waiver consideration. Do not use 3T.

g. Obesity. History of any gastrointestinal procedure for the control of obesity (CPT 43644-43645, 43770-43775, 43842-43848, 43886-43888) or artificial openings, including but not limited to ostomy (V44).

14. FEMALE GENITALIA:

a. Current or history of abnormal menstruation unresponsive to medical management within the last 12 months, including but not limited to menorrhagia, metrorrhagia, or polymenorrhea.

SMPG: Applicants on medical management resulting in a return to a normal cycle meet the standard. Abnormal menstrual cycle while on medical management within last year does not meet the standard. Oligormenorrhea is bleeding occurring at intervals of 45 days or greater and may be qualified, depending on etiology.

Per www.emedicine.medscape,com, a normal cycle is 21-35 days in duration with a single episode of bleeding lasting an average of 7 days and flow measuring 25-80 mL. In practice, measuring menstrual blood loss is difficult, so when reviewing treatment records for the above conditions, the duration of cycle and bleeding episode are the only objective data. Flow is determined subjectively by the applicant's self-reported history.

When considering whether an applicant with a history of heavy periods might be currently anemic, know that the World Health Organization reports 18 million women aged 30-55 years perceive their menstrual bleeding to be exorbitant. Only 10% of these women experience blood loss severe enough to cause anemia or have clinically defined menorrhagia. Look for objective clinical signs of anemia and refer to primary care provider if clinically indicated.

CHANGE: "Uterine bleeding" replaced with "menstruation". Less restrictive – abnormal menstruation responsive to medical management now qualified. Less burdensome – only need to review treatment records for last 12 months to make decision.

b. Primary amenorrhea (626.0).

CHANGE: More restrictive – all primary amenorrhea is now disqualifying

c. Current unexplained secondary amenorrhea (626.0).

SMPG: Amenorrhea secondary to contraceptive use (i.e. Depo Provera, Seasonale) meets the standard.

CHANGE: New

d. Current dysmenorrhea (625.3) that is unresponsive to medical therapy and is incapacitating to a degree recurrently requiring absences of more than a few hours from routine activities.

SMPG: Current dysmenorrhea is that which has occurred in the last 6 months. Medical therapy for dysmenorrhea resulting in no more than 3 hours of absence from routine activities each cycle meets the standard.

Applicants with untreated dysmenorrhea causing recurrent absences from routine activities of more than 3 hours per menstrual cycle do not meet standard.

CHANGE: Less restrictive – all past dysmenorrhea is now qualified. Current dysmenorrhea responsive to medical therapy is now qualified.

e. Endometriosis (617) that is unresponsive to medical therapy.
SMPG: Endometriosis is considered responsive to medical therapy when applicant is completely asymptomatic (from pain) or it meets the 3 hours per cycle standard for dysmenorrhea (above) for the past 12 months, regardless of the presence of extra-uterine endometrial lesions
CHANGE: Less restrictive – all past endometriosis is now qualified. Current asymptomatic endometriosis and symptomatic endometriosis which responds to medical therapy is qualified.

f. History of major abnormalities or defects of the genitalia including but not limited to change of sex (P64.5) (CPT 55970, 55980), hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis (752.7).
CHANGE: Minor wording, no substantive change

g. Persistent or clinically significant ovarian cyst(s) (620.2).
SMPG: An ovarian cyst is considered persistent if present for more than 60 days. A cyst is considered clinically significant if any of these are true:
- ✓ greater than 3 cm
- ✓ results in abnormal menstruation (see 14-a)
- ✓ under medical treatment
- ✓ causes pelvic pain

CHANGE: Less restrictive – all past ovarian cysts are now qualified.

h. Polycystic ovarian syndrome (256.4) with metabolic complications.
SMPG: Metabolic complications are diabetes, obesity, hypertension, and hypercholesterolemia. The following are not metabolic complications: virilization, menstrual cycle changes, infertility, and acne. Applicants with suspected polycystic ovarian syndrome (PCOS) are referred to their primary care provider for evaluation. Confirmed PCOS meets the standard if the applicant's primary care provider has evaluated and ruled out metabolic complications in the last two years.
CHANGE: New

i. Pelvic inflammatory disease (614) within the preceding 30 days.
CHANGE: Less restrictive – all pelvic inflammatory disease (PID) more than 30 days in past is now qualified. Chronic pelvic pain removed from PID item.

j. Chronic pelvic pain or unspecified symptoms associated with female genital organs (625.9).
CHANGE: Taken out of PID item. Less restrictive – all past chronic pelvic pain and unspecified symptoms associated with genitals is now qualified.

k. Pregnancy (V22), through 6 months after the completion of the pregnancy CPT 59150, 59151, 59400, 59409, 59510, 59514, 59610, 59612, 59812-59857).
SMPG: MEPS exam is not authorized until completion of pregnancy. Applicants do not meet the standard until 6 months AFTER the completion of pregnancy. Lactating breast do not meet standard

CHANGE: Minor wording, no substantive change

CHANGE: Less restrictive – history of congenital absence of the uterus is removed and no longer disqualifying

l. Symptomatic uterine enlargement due to any cause (621.2).
SMPG: This item refers to non-pregnancy causes. Symptomatic uterine enlargement is most commonly caused by uterine myomas (fibroids). Adenomyosis (think endometriosis within the wall of the uterus) is a common benign cause of asymptomatic uterine enlargement, but it can occasionally become symptomatic. Endometrial cancer is unlikely to be seen in an applicant under 50 years old.
CHANGE: Less restrictive – "current" changed to "symptomatic.

m. Current or history of genital infection or ulceration, including but not limited to herpes genitalis (054.11) or condyloma acuminatum (078.11), if of sufficient severity to require frequent intervention or to interfere with normal function. Herpes does not meet the standard if:

(1) Current lesions are present.

(2) Chronic suppressive therapy is needed.

(3) There are three or more outbreaks per year.

(4) Any outbreak in the past 12 months interfered with normal function.

(5) Treatment included hospitalization or intravenous therapy.
SMPG: Current condyloma acuminatum lesions meet the standard if normal physiology is preserved and treatments have been required less than once per year.
CHANGE: Added herpes criteria, which is the same wording as past supplemental guidance, so no significant change.

n. Abnormal gynecologic cytology within the preceding 2 years, including but not limited to unspecified abnormalities of the Papanicolaou smear of the cervix (795.0), excluding atypical squamous cells of undetermined significance without human papillomavirus (079.4) and confirmed low-grade squamous intraepithelial lesion (622.9). For the purposes of this Instruction, confirmation is by colposcopy or repeat cytology.
SMPG: For applicants with a history of abnormal Papanicolaou smear (PAP), obtain last abnormal PAP and all subsequent gynecology records.

PAP's which meet the standard:
- ✓ Normal
- ✓ Atypical squamous cells of undetermined significance (ASCUS) without human papillomavirus (HPV)
- ✓ Low-grade squamous intraepithelial lesion (LGSIL/LSIL) confirmed by colposcopy (CIN1) or repeat PAP.

Any other PAP finding in last 12 months does not meet the standard. If last PAP was more than twelve months ago and the result is not one of the three listed above, the applicant is sent to their primary care provider for evaluation. They meet the standard if an updated PAP results in one of the three findings listed above (it does not have to be "normal"). LGSIL/LSIL must be confirmed by a second test to meet the standard.

Why are there multiple designations for similar findings - LGSIL/LSIL/CIN1? LGSIL is synonymous with LSIL. LGSIL/LSIL correlates to CIN1 histology – i.e. LGSIL/LSIL cells come from CIN1 tissue. PAP looks at cytology – scraped off cells floating around randomly. Colposcopy looks at the histology of a biopsy specimen – chunk of tissue with cells in their usual architectural arrangement. The Bethesda System is used to classify PAP cytology, with LGSIL and LSIL being variations in nomenclature for the same classification. The corresponding histology grade for a biopsy specimen from a patient with LGISL is CIN1. PAP is not reported using histology grades, just as a colposcopy is not reported using cytology classifications; however, they are related.
CHANGE: Less restrictive and less burdensome requirement to come to a qualification decision – generally PAP older than two years is ignored

15. MALE GENITALIA:

a. Absence of one or both testicles, congenital (752.89) or undescended (752.51).
SMPG: A missing testicle from any cause does not meet the standard. Undescended testicle surgically placed into the scrotum meets the standard.
CHANGE: More restrictive – "unilateral loss of a testis, unrelated to cancer" qualification has been removed.

b. Current or history of epispadias (752.62)
CHANGE: More restrictive – all epispadias now disqualified. Hypospadias removed from item and expanded below.

c. Current or history of surgery for proximal hypospadias (752.61).
CHANGE: New

d. Distal (coronal) hypospadias without history of surgery DOES meet the standard.
CHANGE: New

e. Distal (coronal) hypospadias treated with surgery when accompanied by evidence of urinary tract infection, urethral stricture, or voiding dysfunction.
CHANGE: No change – previously disqualified. Added "treated with surgery" as surgery for this is largely cosmetic surgery

f. Current enlargement or mass of testicle, epididymis (608.9), or spermatic cord.
SMPG: Average testicle size after puberty is 5 x 2 x 3 cm. Varicocele is one cause of an enlarged spermatic cord, but is addressed separately below (15-n,o,p). The spermatic cord may also appear enlarged if there is an inguinal hernia present (see 13-f (1))
CHANGE: More restrictive – a Added spermatic cord

g. Current or history of recurrent orchitis or epididymitis (604.90).
CHANGE: More restrictive – added history of recurrent orchitis and epididymitis

h. History of penis amputation (878.0) (CPT 54125, 54130-54135)

i. Current penile curvature if associated with pain.
CHANGE: New

j. Current or history of genital infection or ulceration, including but not limited to herpes genitalis (054.13) or condyloma acuminatum (078.11), if of sufficient severity to require frequent intervention or to interfere with normal function. Herpes does not meet the standard if:

(1) Current lesions are present.

(2) Use of chronic suppressive therapy is needed.

(3) There are three or more outbreaks per year.

(4) Any outbreak in the past 12 months interfered with normal function.

(5) Treatment included hospitalization or intravenous therapy.

SMPG: Current condyloma acuminatum lesions meet the standard if normal physiology is preserved and treatments were required less than once per year.
CHANGE: Added herpes criteria, which is the same wording as past supplemental guidance, so no significant change.

k. Current or history of urethral condyloma acuminatum.
CHANGE: New

l. Current acute prostatitis (601.0), chronic prostatitis (601.1) or chronic pelvic pain syndrome.
CHANGE: More restrictive - added chronic pelvic pain syndrome

m. Current hydrocele (603) or spermatocele associated with pain or which precludes a complete exam of the scrotal contents.
CHANGE: Less burdensome - removed measurement criteria and added wording to facilitate evaluation by your clinical exam.

n. Left varicocele (456.4), if painful or symptomatic, or associated with testicular atrophy, or varicocele larger than the testis.
SMPG: Grade III varicocele is easily visible. Grade II varicocele is palpable, but not visible. Grade I varicocele is only palpable with valsalva.
CHANGE: Added "painful". No substantive change because pain was already disqualified by "symptomatic".

o. Left varicocele (456.4) that does not reduce or decompress completely when supine.
SMPG: With the applicant supine, elevate the testicle on the affected side and palpate for reduction in the size of the varicocele. Any reduction in size meets the standard. Complete decompression is less likely in the clinical setting – this usually occurs overnight while sleeping.
CHANGE: New

p. Bilateral or right varicocele (456.4).
CHANGE: Added "bilateral". No substantive change because bilateral was already disqualified by "right".

q. Current or history of chronic or recurrent scrotal pain or unspecified symptoms associated with male genital organs (608.9).
CHANGE: Added "recurrent".

r. History of major abnormalities or defects of the genitalia such as change of sex (P64.5) (CPT 55970, 55980), hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis (752.7).

SMPG: Hypogonadism does not meet the standard (see 25-l)

16. URINARY SYSTEM:

a. Current or history of chronic recurrent cystitis (595) interstitial cystitis, or painful bladder syndrome.

SMPG: Cystitis in a female is meets the standard if:

- ✓ Two episodes per year or less
- ✓ Each episode resolved with antibiotic treatment for 10 days or less
- ✓ Did not require antibiotic prophylaxis
- ✓ One year asymptomatic since completion of last treatment (see 16-c)

Any cystitis in a male, unless it was related to an indwelling catheter during a hospitalization (also see 16-d), does not meet the standard.

CHANGE: Added "interstitial cystitis" and "painful bladder syndrome". Wording changed from "chronic or recurrent" to "chronic recurrent"

b. Current urethritis, or history of chronic or recurrent urethritis (597.80).

SMPG: Urethritis meets the standard if:

- ✓ STD-related
- ✓ Multiple occurrences represent unique re-infections with STD's
- ✓ Each episode resolved with antibiotic treatment for 10 days or less
- ✓ Not associated with skin pustules, petechia, septic arthritis, meningitis, or endocarditis
- ✓ One year asymptomatic since completion of treatment (see 16-c)

For recurrent episodes of herpes urethritis refer to herpes items (14-m, 15-j). If urethritis was present at the same time as cystitis, use cystitis criteria (16-a).

c. History or treatment of the following voiding symptoms within the previous 12 months:

(1) Urinary frequency or urgency more than every 2 hours on a daily basis.

(2) Nocturia more than two episodes during sleep period.

(3) Enuresis (788.30).

(4) Incontinence of urine, such as urge or stress.

(5) Urinary retention.

(6) Dysuria.

SMPG: Urinary frequency (788.41), nocturia (788.43), incontinence (788.3), retention (788.2), dysuria (788.1)

CHANGE: Major revision. Less restrictive for enuresis and incontinence – all more than 1 yr prior now qualified. More restrictive for added symptoms and conditions – frequency, nocturia, retention, dysuria.

d. History of need for urinary catheterization with intermittent or indwelling catheter for any period greater than 2 weeks.
SMPG: Includes indwelling urinary catheter for non-urinary causes (i.e. prolonged stay in ICU)
CHANGE: New

e. History of bladder augmentation, urinary diversion, or urinary tract reconstruction.
CHANGE: New

f. Current or history of abnormal urinary findings:

(1) Gross hematuria (599.7).

(2) Microscopic hematuria (3 or more red blood cells per high-powered field on 2 of 3 properly collected urinalyses).

(3) Pyuria (6 or more white blood cells per high-powered field in 2 or 3 properly collected urinalyses).
SMPG: This section is NOT used for diagnosed cystitis (16-a), urethritis (16-b), pyelonephritis (16-h(4)), acute nephritis and kidney disease (16-h(8)), acute kidney injury (16-h(9)), or urolithiasis (16-h(11-13)) as specific criteria are already given. Any other causes of hematuria or pyuria are evaluated by this section.
CHANGE: Unclear significance of disqualifying laboratory findings that are common clinical features of several conditions which can be qualified by other criteria. Added differentiation between gross and microscopic hematuria, which results in no change as both were previously disqualified under "hematuria".

g. Current or recurrent urethral or ureteral stricture (598) or fistula (599.1) involving the urinary tract.
CHANGE: More restrictive – expanded item to cover entire urinary tract

h. Conditions associated with the kidneys, including:

(1) Current absence of one kidney, congenital (753.0) or acquired (V45.73) (CPT 50220-50236).

(2) Asymmetry in size or function of kidneys.
CHANGE: New

(3) History of renal transplant.
CHANGE: New

(4) Current chronic or recurrent pyelonephritis (590.0) or any other unspecified infections of the kidney (590.9).
CHANGE: Word order. No substantive difference

(5) Current or history of polycystic kidney (753.1).

(6) Current or history of horseshoe kidney (753.3).

(7) Current or history of hydronephrosis (591).
SMPG: Hydronephrosis noted during pregnancy may be a normal finding if there is proof of post-partum resolution.

(8) Current or history of acute (580) nephritis or chronic (582) kidney disease of any type.
CHANGE: More restrictive – expanded chronic nephritis to chronic kidney disease

(9) History of acute kidney injury requiring dialysis.
CHANGE: New

(10) Current or history of proteinuria (791.0) with a protein-to-creatinine ratio greater than 0.2 in a random urine sample more than 48 hours after strenuous activity. Benign orthostatic proteinuria MEETS the standard.
SMPG: Trace protein on dipstick is the upward limit of normal and meets the standard. If urine protein > trace, question applicant about strenuous activity in last 48 hrs. If applicant has not engaged in strenuous activity in last 48 hours, order urine protein/creatinine ratio that day or at earliest convenience. Applicant needs to remain at rest until lab is completed. If strenuous activity in last 48 hrs, the applicant is left open, instructed to rest, and a MEPS dipstick test is repeated after 48 hrs have elapsed. Repeat trace protein meets the standard. If repeat test >trace, obtain urine protein/creatinine ratio to make determination.

Urine dipstick preferentially detects albumin and is less sensitive to abnormal proteins, such as globulins and Bence-Jones proteins, excreted in multiple myeloma. False positives dipsticks can result from current use of penicillins or sulfonamides, and within three days of exposure to radiographic contrast. False negative dipsticks result from extremely alkaline or dilute urine.
CHANGE: Less burdensome – removed results of a 24 hour urine collection from criteria. Less restrictive – benign orthostatic proteinuria qualified regardless of lab result.

(11) Current or history of symptomatic urolithiasis (592) within the preceding 12 months.

(12) History of stone greater than 4mm in size, recurrent calculus, nephrocalcinosis, or bilateral renal calculi at any time.

(13) History of urolithiasis requiring surgical treatment or intervention requiring hospitalization.

SMPG: Outpatient procedures, such as lithotripsy are considered “intervention requiring hospitalization”.
CHANGE: More restrictive – stones >4mm and need for intervention now disqualifying.

17. SPINE AND SACROILIAC JOINTS:

a. Ankylosing spondylitis or other inflammatory spondylopathies (720).
SMPG: See 26-m for more detailed description.

b. Current or history of any condition, including but not limited to the spine or sacroiliac joints, with or without objective signs, if:

(1) It prevents the individual from successfully following a physically active vocation in civilian life (724), or is associated with local or referred pain to the extremities, muscular spasms, postural deformities, or limitation in motion.

(2) It requires external support.

(3) It requires limitation of physical activity or frequent treatment.

c. Current deviation or curvature of spine (737) from normal alignment, structure, or function if:

(1) It prevents the individual from following a physically active vocation in civilian life.

(2) It interferes with the proper wearing of a uniform or military equipment.

(3) It is symptomatic.

(4) There is lumbar or thoracic scoliosis greater than 30 degrees, or kyphosis and lordosis greater than 50 degrees when measured by the Cobb Method.

d. History of congenital fusion (756.15) involving more than two vertebral bodies or any surgical fusion of spinal vertebrae (P81.0) (CPT 22532-22812).
SMPG: Identical to 26-g.

e. Current or history of fracture or dislocation of the vertebra (805).

(1) Vertebral fractures that do NOT meet the standard:

(a) Compression fractures involving more than or equal to 25 percent of a single vertebra.

(b) Compression fractures involving less than 25 percent of a single vertebra occurring within the past 12 months or it is symptomatic.

(b) Any compression fracture that is symptomatic.

(2) Vertebral fractures that DO MEET the standard:

(a) Compression fractures involving less than 25 percent of a single vertebra if it occurred more than 1 year before the accession examination and the applicant is asymptomatic.

(b) A history of fractures of the transverse or spinous process IF the applicant is asymptomatic.

f. History of juvenile epiphysitis (732.6) with any degree of residual change indicated by X-ray or kyphosis.

g. Current herniated nucleus pulposus (722) or history of surgery to correct (CPT 63001-63200). A surgically corrected asymptomatic single-level lumbar or thoracic diskectomy with full resumption of unrestricted activity DOES meet the standard.

h. Current or history of spina bifida (741) when symptomatic, when there is more than one vertebral level involved, or with dimpling of the overlying skin. History of surgical repair of spina bifida.

i. Current or history of spondylolysis congenital (756.10-756.12) or acquired (738.4).

j. Current or history of spondylolisthesis congenital (756.12) or acquired (738.4).

18. UPPER EXTREMITIES:

a. Limitation of Motion: Current active joint ranges of motion less than:

(1) Shoulder (726.1)

(a) Forward elevation to 90 degrees.

(b) Abduction to 90 degrees.

SMPG: The range of motion values for the shoulder is currently under review for interim guidance. Full active ROM of the shoulder for forward elevation/flexion is 180 degrees and abduction is 180 degrees.

(2) Elbow (726.3)

(a) Flexion to 130 degrees.

(b) Extension to 15 degrees.

(3) Wrist (726.4). A total range of 60 degrees (extension plus flexion), or radial and ulnar deviation combined arc 30 degrees.

(4) Hand (726.4)

(a) Pronation to 45 degrees.

(b) Supination to 45 degrees.

(5) Fingers and Thumb (726.4). Inability to clench fist, pick up a pin, grasp an object, or touch tips of at least three fingers with thumb.

b. Hand and Fingers:

(1) Absence of the distal phalanx of either thumb (885).

(2) Absence of any portion of the index finger.

(3) Absence of distal and middle phalanx of the middle or ring finger of either hand irrespective of the absence of the little finger (886).

(4) Absence of more than the distal phalanx of any two of the following: index, middle, or ring finger of either hand (886).

(5) Absence of hand or any portion thereof (887), except for specific absence of fingers as noted in subparagraphs 18.b.(1)-(4).

SMPG: The only missing parts of a hand that meets the standard:

- ✓ distal phalanx of the middle finger
- ✓ distal phalanx of the ring finger

(6) Current polydactyly (755.0).

(7) Intrinsic paralysis or weakness of upper limbs, including but not limited to nerve paralysis, carpal tunnel and cubital syndromes, lesion of ulnar, median, or radial nerve (354), sufficient to produce physical findings in the hand such as muscle atrophy and weakness.

c. Residual Weakness and Pain. Current disease, injury, or congenital condition with residual weakness or symptoms that prevents satisfactory performance of duty, including but not limited to chronic joint pain associated with the shoulder (719.41), the upper arm (719.42), the forearm (719.43), and the hand (719.44); or chronic joint pain as a late effect of fracture of the upper extremities (905.2), as a late effect of sprains without mention of injury (905.7), and as late effects of tendon injury (905.8).

19. LOWER EXTREMITIES:

a. General.

(1) Current deformities, disease, or chronic joint pain of pelvic region, thigh (719.45), lower leg (719.46), knee (717.9), ankle and or foot (719.47) that have interfered with function to such a degree as to prevent the individual from following a physically active vocation in civilian life, or that would interfere with walking, running, weight bearing, or the satisfactory completion of training or military duty.

(2) Current leg-length discrepancy resulting in a limp (736.81).

b. Limitation of Motion. Current active joint ranges of motion less than:

(1) Hip (due to disease (726.5) or injury (905.2))

(a) Flexion to 90 degrees.

(b) No demonstrable flexion contracture.

(c) Extension to 10 degrees (beyond 0 degrees).

(d) Abduction to 45 degrees.

(e) Rotation of 60 degrees (internal and external combined).

(2) Knee (due to disease (726.6) or injury (905.4))

(a) Full extension to 0 degrees.

(b) Flexion to 110 degrees.

(3) Ankle (due to disease (726.7) or injury (905.4) or congenital)

(a) Dorsiflexion to 10 degrees.

(b) Planter flexion to 30 degrees.

(c) Subtalar eversion and inversion totaling 5 degrees.

c. Foot and Ankle:

(1) Current absence of a foot or any portion thereof (896).

(2) Absence of a single lesser toe or any portion thereof that is asymptomatic and does not impair function DOES meet the standard.

(3) Deformity of the toes (735.9) that prevents the proper wearing of military footwear or impairs walking, marching, running, maintaining balance, or jumping.

(4) Symptomatic deformity of the toes (acquired (735) or congenital (755.66)), including but not limited to conditions such as hallux valgus (735.0), hallux varus (735.1), hallux rigidus (735.2), hammer toe(s) (735.4), claw toe(s) (735.5), or overriding toe(s) (735.8).

(5) Clubfoot (754.70) or pes cavus (754.71) that prevents the proper wearing of military footwear or causes symptoms when walking, marching, running, or jumping.

(6) Rigid or symptomatic pes planus (acquired (734) or congenital (754.61)).
SMPG: The use of custom fitted or over-the-counter orthotics does NOT imply pes planus is symptomatic. An applicant with pes planus who reports NO pain limiting symptoms due to walking, marching, running or jumping (with or without orthotics) activities meets standard.

(7) Current ingrown toenails (703.0), if infected or symptomatic.

(8) Current or history of recurrent plantar fasciitis (728.71).

(9) Symptomatic neuroma (355.6).

d. Leg, Knee, Thigh, and Hip:

(1) Current loose or foreign body in the knee joint (717.6).

(2) History of uncorrected anterior (717.83) or posterior (717.84) cruciate ligament injury.

(3) History of surgical reconstruction of knee ligaments (P81.4) (CPT 27427-27429) DOES meet the standard if 12 months has elapsed since reconstruction, and the knee is asymptomatic and stable.

(4) Recurrent ACL reconstruction (CPT 27427, 27407).

(5) Symptomatic medial (717.82) or lateral (717.42) meniscal injury. The following DOES meet the standard if asymptomatic and released to full and unrestricted activity:

(a) Meniscal repair (CPT 27403), more than 6 months after surgery.

(b) Partial meniscectomy (CPT 27332-27333) more than 3 months after surgery.

(6) Meniscal transplant (CPT 29868).

(7) Symptomatic medial (844.1) and lateral (844.0) collateral ligament instability.

(8) Current or history of congenital dislocation of the hip (754.3), osteochondritis of the hip (Legg-Calve-Perthes Disease) (732.1), or slipped capital femoral epiphysis of the hip (732.2).

(9) Hip dislocation (835) within 2 years preceding examination. Hip dislocation after 2 years DOES meet the standard if asymptomatic and released to full unrestricted activity.

(10) Symptomatic osteochondritis of the tibial tuberosity (Osgood-Schlatter Disease) (732.4) within the past year.

(11) Stress fractures (733.95, V13.52), recurrent or single episode during the past year.

20. MISCELLANEOUS CONDITIONS OF THE EXTREMITIES:

a. Current or history of chondromalacia (717.7), including but not limited to chronic patello-femoral pain syndrome and retro-patellar pain syndrome (719.46), osteoarthritis (715.3), or traumatic arthritis (716.1).

b. Current joint dislocation if unreduced, or history of recurrent dislocation, subluxation or instability of the hip (835), elbow (832), ankle (837), or foot.

b. History of any dislocation, subluxation or instability of the knee (718.86) or shoulder.
SMPG: The issue of a non-recurrent single patella subluxation event where no residual knee limiting activity or physical exam findings or symptom history is present is currently under review.

Anatomically speaking, a shoulder dislocation or subluxation event represents a glenohumerol injury or condition. However, a shoulder separation is indicative of an acromioclavicular injury or condition. For clarity purposes, the history of a shoulder separation is not the same, nor does it imply, a shoulder dislocation or subluxation event occurred.

d. Current or history of osteoarthritis (715.3) or traumatic arthritis (716.1) of isolated joints that has interfered with a physically active lifestyle, or that prevents the satisfactory performance of military duty.

e. Fractures:

(1) Current malunion or non-union of any fracture (733.8) (except asymptomatic ulnar styloid process fracture).

(2) Current retained hardware (including plates, pins, rods, wires, or screws) used for fixation that is symptomatic or interferes with proper wearing of equipment or military uniform. Retained hardware is not disqualifying if fractures are healed, ligaments are stable, and there is no pain.
SMPG: Hardware in the clavicle, malleolus, or olecranon does not meet the standard.

f. Current orthopedic implants or devices to correct congenital or post-traumatic orthopedic abnormalities (V43).

g. Current or history of contusion of bone or joint (923, 924), ; an injury of more than a minor nature that shall interfere or prevent performance of military duty, or shall require frequent or prolonged treatment, without fracture, nerve injury, open wound, crush, or dislocation, that occurred in the preceding 6 months and recovery has not been sufficiently completed or rehabilitation resolved.

h. History of joint replacement or resurfacing of any site (V43.6) (CPT 24363, 27130-27132, 27447).

i. Current or history of neuromuscular paralysis, weakness, contracture, or atrophy (728) of sufficient degree to interfere with or prevent satisfactory performance of military duty, or requires frequent or prolonged treatment.

j. Current symptomatic osteochondroma or history of multiple osteocartilaginous exostoses (727.82).

k. Current osteoporosis (733.0) as demonstrated by a reliable test such as a dual energy x-ray absorptiometry scan (DEXA).
SMPG: See 25k

l. Current osteopenia (733.9) until resolved.
SMPG: See 25k

m. Current osteomyelitis (730.0) or history of recurrent osteomyelitis.

n. Current or history of osteochondral defect, formerly known as osteochondritis dissecans (732.7).
CHANGE: Clarification of equivalent medical terminology

o. History of cartilage surgery, including but not limited to cartilage debridement, chondroplasty, microfracture, or cartilage transplant procedure (CPT 20910, 20912, 21230, 21235, 27412, 27415, 29866-29867).

p. Current or history of any post-traumatic (958.9) or exercise-induced (729.7-79) compartment syndrome.

q. Current or history of avascular necrosis of any bone.

r. Current or history of recurrent tendon disorder, including but not limited to tendonitis, tendonopathy, tenosynovitis.

21. VASCULAR SYSTEM:

a. Current or history of abnormalities of the arteries (447), including but not limited to aneurysms (442), arteriovenous malformations, atherosclerosis (440), or arteritis (such as Kawasaki's disease) (446).

b. Current or medically managed hypertension (401). Hypertension is defined as systolic pressure greater than 140 mmHg and or diastolic pressure greater than 90 mmHg confirmed by manual blood pressure cuff averaged over two or more properly measured, seated, blood pressure readings on each of 2 or more consecutive days (isolated, single-day blood pressure elevation is not disqualifying unless confirmed on 2 or more consecutive days).
SMPG: If a machine-measured blood pressure (BP) is above 140/90, a single manual BP will be taken by the CMO/ACMO/FBP after the applicant has been seated for at least 5 mins. The manual BP does not need to be done immediately following the machine test. A manual BP 140/90 or below meets the standard. If the manual BP is above 140/90, the applicant's profile is left open and they are sent to their PCP for evaluation of manual blood pressure on two separate days.

Continued medical processing is authorized if asymptomatic with systolic<180 and diastolic<120.

Following evaluation by PCP, the MEPS single manual BP and the two manual BP's done by the PCP will be averaged. If the average is 140/90 or less, the applicant meets the standard. If the average is >140/90 the applicant is diagnosed with HTN and referred to their PCP.

Hypertensive emergency is defined as systolic >180 and/or diastolic >120 WITH signs of acute organ damage:
- ✓ Cardiovascular – chest pain, arrhythmia, dyspnea
- ✓ CNS – headache, pre-syncope, vertigo, severe anxiety, agitation, altered mental status, paresthesia
- ✓ Other – nausea, vomiting, epistaxis

Applicants exhibiting signs of hypertensive emergency will be sent to the ER for evaluation.

If no signs of organ damage and systolic >180 and/or diastolic >120, stop processing and send applicant to their PCP for evaluation of hypertensive crisis. Hypertensive crisis is not an emergency.

c. Current or history of peripheral vascular disease (443.9), including but not limited to diseases such as Raynaud's Disease (443.0) and vasculidities.

d. Current or history of venous diseases, including but not limited to recurrent thrombophlebitis (451), thrombophlebitis during the preceding year, or evidence of venous incompetence, such as large or symptomatic varicose veins, edema, or skin ulceration (454).

SMPG: Thrombophlebitis is a superficial venous thrombosis, not a deep venous thrombosis (21-e).

e. Current or history of deep venous thrombosis (453.40).

f. History of operation or endovascular procedure on the arterial or venous systems, including but not limited to vena cava filter, angioplasty, venoplasty, thrombolysis, or stent placement (CPT 34001-37799).

g. History of Marfan's Syndrome (759.82).

SMPG: If Marfan's is suspected on an applicant with Marfanoid features, use two maneuvers to demonstrate arachnodactyly. The thumb sign is positive if the thumb, when completely opposed within the clenched fist, projects beyond the ulnar border. The wrist sign is positive if the distal phalanges of the thumb and little finger overlap when wrapped around the opposite wrist.

Revised Ghent critera for systemic involvement (which can be detected on a MEPS exam)

- ✓ Positive wrist AND thumb sign = 3 pts
- ✓ Positive wrist OR thumb sign = 1 pt
- ✓ Pectus carinatum = 2 pts
- ✓ Pectus excavatum or chest asymmetry = 1 pt
- ✓ Hindfoot deformity = 2 pts
- ✓ Pes planus = 1 pt
- ✓ H/o pneumothorax = 2 pts
- ✓ Arm span-to-height ratio greater than 1.05 AND no severe scoliosis = 1 pt
- ✓ Scoliosis or thoracolumbar kyphosis = 1 pt
- ✓ Elbow extension less than 170 degrees = 1 pt
- ✓ 3 of 5 facial features - think Mr Burns from The Simpsons (long, narrow head; deep set eyes; downslanting palpebral fissures; malar hypoplasia; retrognathia) = 1 pt
- ✓ Skin striae = 1 pt
- ✓ Myopia greater than 3 diopters = 1pt
- ✓ Murmur = 1 pt

If there are 7 or more systemic points, obtain echocardiogram to measure aortic root diameter. Aortic diameter Z-score of 2 or greater AND 7 or more systemic points is diagnostic for Marfan Syndrome.

22. SKIN AND CELLULAR TISSUES:

a. Current diseases of sebaceous glands including severe and or cystic acne (706), or hidradenitis suppurativa (704-705), if extensive involvement of the neck, scalp, axilla, groin, shoulders, chest, or back is present or shall be aggravated by or interfere with the proper wearing of military equipment. Applicants under treatment with systemic retinoids, including, but not limited to isotretinoin (Accutane®), do not meet the standard until 8 weeks after completion of therapy.

b. Current or history of atopic dermatitis (691) or eczema (692.9) after the 12th birthday.

(1) Atopic Dermatitis. Active or history of residual or recurrent lesions in characteristic areas (face, neck, antecubital and or popliteal fossae, occasionally wrists and hands).

(2) Non-Specific Dermatitis. Current or history of recurrent or chronic non-specific dermatitis to include contact (692) (irritant or allergic), or dyshidrotic dermatitis (705.81) requiring more than treatment with over the counter medications.

c. Cysts if:

(1) The current cyst (706.2) (other than pilonidal cyst) is of such a size or location as to interfere with the proper wearing of military equipment.
SMPG: The presence of redness, warmth, or tenderness does not meet the standard (see 22-f).

(2) The current pilonidal cyst (685) is evidenced by the presence of a tumor mass or a discharging sinus, or is a surgically resected pilonidal cyst (CPT 11770-11772) that is symptomatic, unhealed, or less than 6 months post-operative.
SMPG: Press firmly around any pilonidal sinus and observe for discharge or tenderness

d. Current or history of bullous dermatoses (694), including but not limited to dermatitis herpetiformis, pemphigus, and epidermolysis bullosa, (757.39). Resolved bullous impetigo DOES meet the standard.

e. Current or chronic lymphedema (457.1).

f. Current or history of furunculosis or carbuncle (680) if extensive, recurrent, or chronic.

g. Current or history of severe hyperhidrosis of hands or feet (705.2, 780.8) unless controlled by topical medications.
SMPG: Hyperhidrosis involving other anatomical areas meets the standard.

h. Current or history of congenital (757) or acquired (216) anomalies of the skin, such as nevi or vascular tumors that interfere with function, or are exposed to constant irritation. History of Dysplastic Nevus Syndrome (232).
SMPG: See 30a.

i. Current or history of keloid formation (701.4), including but not limited to pseudofolliculitis and keloidalis nuchae (706.1), if that tendency is marked or interferes with the proper wearing of military equipment.
SMPG: Hypertrophic scar meets the standard if it does not interfere with the proper wearing of military equipment.

j. Current lichen planus (cutaneous and/or oral) (697.0).

k. Current or history of neurofibromatosis (Von Recklinghausen's Disease) (237.7).
SMPG: Any TWO of the following clinical findings on exam is diagnostic:
- ✓ Two or more cutaneous or subcutaneous fleshy nodules (neurofibroma)
- ✓ Freckling of axilla or groin
- ✓ Six or more café au lait macules
- ✓ Pseudoarthrosis of clavicle, radius, or tibia
- ✓ First degree relative with neurofibromatosis, type 1

Applicants with any ONE of the above findings are referred to their PCP for evaluation.

l. History of photosensitivity (692.72), including but not limited to any primary sun-sensitive condition, such as polymorphous light eruption or solar urticaria, or any dermatosis aggravated by sunlight, such as lupus erythematosus.

m. Current or history of psoriasis (696.1).

n. Current or history of radiodermatitis (692.82).

o. Current or history of scleroderma (710.1).

p. Current or history of chronic urticaria lasting longer than 6 weeks or recurrent episodes of urticaria (708.8) within the past 24 months not associated with angioedema, hereditary angioedema (277.6), or maintenance therapy for chronic urticaria, even if not symptomatic.

q. Current symptomatic plantar wart(s) (078.19).
SMPG: Plantar warts with surrounding redness are symptomatic.

r. Current scars (709.2), or any other chronic skin disorder of a degree or nature that requires frequent outpatient treatment or hospitalization, which in the opinion of the certifying authority shall interfere with proper wearing of military clothing or equipment, or which exhibits a tendency to ulcerate or interferes with the satisfactory performance of duty.

s. Prior burn (949) injury involving 18 percent or more body surface area (including graft sites), or resulting in functional impairment to such a degree, due to scarring, as to interfere with the satisfactory performance of military duty due to decreased range of motion, strength, or agility.

SMPG: Rule of 9's:

- ✓ Head = 9%
- ✓ Chest anterior = 9%
- ✓ Abdomen anterior = 9%
- ✓ Upper/mid back = 9%
- ✓ Low back and buttocks = 9%
- ✓ Each arm = 9% (4.5% anterior, 4.5% posterior)
- ✓ Each leg = 18% (9% anterior, 9% posterior)
- ✓ Groin = 1%
- ✓ For irregular burns, the surface area of the patient's palm can be used = approx 1%

t. Current localized types of fungus infections (117), interfering with the proper wearing of military equipment or the performance of military duties. For systemic fungal infections, refer to paragraph 24.q. of this enclosure.

CHANGE: Reference corrected.

23. BLOOD AND BLOOD-FORMING TISSUES:

a. Current hereditary or acquired anemia, which has not been corrected with therapy before appointment or induction. ICD-9 codes for diagnosed anemia include hereditary hemolytic anemia (282), sickle cell disease (282.6), acquired hemolytic anemia (283), aplastic anemia (284), or unspecified anemias (285).
SMPG: Hereditary spherocytosis meets the standard if the applicant underwent spenectomy (See 23-d). All other hereditary anemias do not meet the standard. Acquired anemia meets the standard when corrected.

b. Current or history of coagulation defects (286), including but not limited to von Willebrand's Disease (286.4), idiopathic thrombocytopenia (287), ~~or Henoch-Schönlein Purpura (287.0).~~
SMPG: For Henoch-Schonlein Purpura (HSP) see 26-f. Per LTC Ponder at OSD, this reference should have been deleted. New guidance for HSP in Section 26 is the correct version.

c. Current or history of diagnosis of any form of chronic or recurrent agranulocytosis and/or leukopenia (288.0).

d. Spleen:

(1) Current splenomegaly (789.2).
SMPG: Applicants with infectious mononucleosis do not meet the standard until after a 6 week recovery period.

(2) History of splenectomy (P41.5) (CPT 38100-38129), except when accomplished for trauma or conditions unrelated to the spleen, or for hereditary spherocytosis (282.0).
CHANGE: Less restrictive – splenectomy for hereditary spherocytosis and other non-splenic conditions now qualified.

24. SYSTEMIC:

a. Current or history of disorders involving the immune mechanism, including immunodeficiencies (279).

b. Presence of human immunodeficiency virus or serologic evidence of infection (042, V08) or false-positive screening test(s) with ambiguous results on confirmatory immunologic testing.
CHANGE: SLE, RA, CREST, etc moved to new Rheumatology Section (26)

c. Tuberculosis (010)

(1) Current active tuberculosis or substantiated history of active tuberculosis in any form or location, regardless of past treatment, in the previous 2 years.
SMPG: Active tuberculosis is characterized by chronic cough, hemoptysis, fever, night sweats, and weight loss.

(2) Current residual physical or mental defects from past tuberculosis that shall prevent the satisfactory performance of duty.

(3) Individuals with a past history of active tuberculosis more than 2 years before appointment, enlistment, or induction meet the standard if they have received a complete course of standard chemotherapy for tuberculosis.

(4) Current or history of untreated latent tuberculosis (positive Purified Protein Derivative with negative chest X-ray) (795.5). Individuals with a tuberculin reaction in accordance with ATS and United States Public Health Service (USPHS) guidelines are eligible for enlistment, induction, and appointment, provided they have received chemoprophylaxis in accordance with ATS and USPHS guidelines. A negative QuantiFERON®-TB Gold (QFT®-G) with a positive tuberculin skin test DOES meet the standard.
SMPG: For applicants with a history of positive PPD, request records of TB testing, previous chest X-rays, records of treatment, or BCG vaccination.

American Thoracic Society (ATS) and United States Public Health Service (USPHS) guidelines:
- ✓ Isoniazid 9 month course with QD or BID dosing (preferred)
- ✓ Isoniazid 6 month course with QD or BID dosing (acceptable alternative)
- ✓ Rifampin 4 month course with QD dosing (acceptable alternate)

Applicants never treated for latent TB are referred to their PCP for evaluation.

Negative QFT-G (blood test) after a positive TB skin test is correctly interpreted as a false positive skin test; no treatment is indicated.

d. Current untreated syphilis (097).

e. History of anaphylaxis (995.0).

SMPG: Symptoms of anaphylaxis:

- ✓ Skin reactions, including hives along with itching, flushed, or pale skin
- ✓ Nasal congestion, wheezing, cough, stridor, or slurred speech
- ✓ Difficulty swallowing or breathing
- ✓ Syncope, pre-syncope, or dizziness
- ✓ Abdominal pain, cramping, nausea/vomiting, or diarrhea
- ✓ Anxiety, confusion, or palpitations

Also see 24-e(8) below

(1) History of anaphylaxis to stinging insects (989.5). A cutaneous only reaction to a stinging insect under the age of 16 DOES meet the standard. Applicants who have been treated for 3-5 years with maintenance venom immunotherapy DO meet the standard.

(2) History of systemic allergic reaction to food or food additives (995.60-995.69). Systemic allergic reaction may be defined as a temporally related, systemic, often multi-system, reaction to a specific food. The presence of a food-specific immunoglobulin E antibody without a correlated clinical history DOES meet the standard.

SMPG: Urticaria, hives, edema, anaphylaxis, or other systemic allergic reactions do not meet the standard.

(3) Oral allergy syndrome.

SMPG: Oral allergy syndrome commonly presents as itching or burning sensation in the lips, mouth, ear canal, or pharynx within minutes of eating a trigger food. Swelling of the tongue and oral mucosa is less common. Approximately 2% of patients with oral allergy syndrome progress to anaphylaxis.

(4) Hypersensitivity to latex (V15.07).

(5) Exercise-induced anaphylaxis (with or without food).

(6) Idiopathic anaphylaxis (995.0).

(7) Acute, early, or immediate anaphylactic onset.

(8) History of systemic allergic reaction or angioedema.

SMPG: Any systemic allergic reaction to any substance does not meet the standard.

f. Current residual of tropical fevers, including but not limited to fevers, such as malaria (084) and various parasitic or protozoan infestations that prevent the satisfactory performance of military duty.

g. History of malignant hyperthermia (995.86).

h. History of industrial solvent or other chemical intoxication (982) with sequelae.

i. History of motion sickness (994.6) resulting in recurrent incapacitating symptoms or of such a severity to require pre-medication in the previous 3 years.

j. History of rheumatic fever (390).

k. Current or history of muscular dystrophies (359) or myopathies.

l. Current or history of amyloidosis (277.3).

m. Current or history of eosinophilic granuloma (277.8) and all other forms of histiocytosis (202.3). Healed eosinophilic granuloma, when occurring as a single localized bony lesion and not associated with soft tissue or other involvement, DOES meet the standard.

n. Current or history of polymyositis (710.4) or dermatomyositis complex (710.3) with skin involvement.

o. History of rhabdomyolysis (728.88).

p. Current or history of sarcoidosis (135).

q. Current systemic fungus infections (117). For localized fungal infections, refer to paragraph 22.t. of this enclosure.

25. ENDOCRINE AND METABOLIC :

a. Current or history of adrenal dysfunction (255).
CHANGE: Less restrictive – history of now qualified.

b. Diabetes mellitus (250) disorders, including:
SMPG: The DoDI references WHO criteria for blood sugar (slightly less strict than ADA criteria):
- ✓ Normal: Fasting glucose < 110 AND 2-hr glucose <140
- ✓ Impaired fasting glycemia: Fasting glucose 110-125 AND 2-hr glucose <140
- ✓ Impaired glucose tolerance: Fasting glucose <126 AND 2-hr glucose 140-199
- ✓ Diabetes mellitus: Fasting glucose 126 or greater, OR 2-hr glucose 200 or greater

(1) Current or history of diabetes mellitus (250).

(2) Current or history of pre-diabetes mellitus defined as fasting plasma glucose 110-125 milligrams per deciliter (mg/dL) and glycosylated hemoglobin greater than 5.7 percent.
SMPG: Impaired fasting glycemia and impaired glucose tolerance are both pre-diabetic states (see 25-b) and do not meet the standard.

Pre-diabetes is a state in which some, but not all, of the diagnostic criteria for diabetes is met. The DoDI references pre-diabetes by the WHO criteria for fasting blood sugar (above) and the recently added ADA criteria (2010) for Hgb A1C:
- ✓ Pre-diabetes: Hgb A1C 5.7% - 6.4%
- ✓ Diabetes: Hgb A1C 6.5% or greater

Any current or history of pre-diabetes, regardless of current lab values, does not meet the standard.

(3) History of gestational diabetes mellitus.

(4) Current persistent glycosuria, when associated with impaired glucose tolerance (250) or renal tubular defects (271.4).
SMPG: Applicants with initial glycosuria on dipstick at the MEPS are tested for diabetes with a fasting glucose followed by a 2-hr glucose tolerance test. If serum glucose testing is negative for diabetes, repeat the urine glucose test. If the fasting serum glucose and 2-hr serum glucose meet the criteria in 25-b; and repeat urine glucose dipstick is normal, they meet the standard.

A second positive urine dipstick in the absence of diabetes indicates persistent renal glycosuria; refer to their PCP for further evaluation/work-up. Persistent renal glycosuria requires an adequate work up by the applicant's PCP to differentiate renal tubular defects from benign renal glycosuria:
- ✓ Urinalysis with microscopy

- ✓ Serum electrolytes, bicarbonate, phosphorus, and uric acid levels
- ✓ 24-hr urine collection for amino acids
- ✓ Fractional excretion of phosphorus, uric acid, sodium, potassium, and bicarbonate

Benign renal glycosuria is the diagnosis of exclusion that meets the standard if medical records indicate the above work-up was completed with no evidence of pathology.
CHANGE: More restrictive – expanded to include pre-diabetes, gestational diabetes, and glycosuria associated with impaired glucose tolerance or renal tubular defects.

c. Current or history of pituitary dysfunction (253), to include history of growth hormone use. Non-functional microadenoma (less than 1cm) DOES meet the standard.
CHANGE: History of growth hormone use now disqualified. Non-functional microadenoma now qualified

d. Current or history of diabetes insipidus.
CHANGE: New

CHANGE: Gout moved to Rheumatology

e. Current or history of hyperparathyroidism (252.0) or hypoparathyroidism (252.1).

f. The following thyroid disorders:

(1) Current goiter (240). Symmetrical simple goiter less than two times normal size with no nodules by ultrasound and normal thyroid function tests DOES meet the standard.
SMPG: New goiter detected on MEPS exam is referred to applicant's PCP for evaluation. "Normal thyroid function tests" are two normal thyroid stimulating hormone tests in the last 6 months, at least 6 weeks apart.
CHANGE: Less restrictive – some goiters are qualified

(2) Thyroid nodule (241.0). A solitary thyroid nodule less than 5mm, or less than 3cm with benign histology or cytology DOES meet the standard.
SMPG: New nodules detected on MEPS exam are referred to applicant's PCP for evaluation. For nodules 5mm or greater, if biopsy or fine needle aspirate was not done, obtain available records and refer to service for waiver consideration.
CHANGE: New

(3) Current hypothyroidism (244). Individuals with two normal thyroid stimulating hormone tests within the preceding 6 months DOES meet the standard.
SMPG: Thyroid stimulating hormone (TSH) tests must be at least 6 weeks apart. Applicants without two TSH tests in last 6 months will obtain one at least 6 weeks prior to medical processing. If only one recent TSH level is known (between 6 weeks and 6 months ago) and was normal, the applicant may process and the MEPS is authorized to order the second TSH test. If the second TSH level is abnormal, the applicant is referred to their PCP for evaluation. The MEPS is not authorized to order any additional TSH tests.
CHANGE: Added TSH qualification criteria

(4) Current or history of hyperthyroidism (242.9). In remission off of anti-thyroidal medication with normal thyroid function tests for a minimum of 12 months DOES meet the standard.
SMPG: "Normal thyroid function tests" are two normal thyroid stimulating hormone tests in the last 6 months, at least 6 weeks apart, after being off medication for at least 12 months.
CHANGE: Less restrictive – added qualification criteria for cases that go into remission.

CHANGE: Removed current thyroiditis.

g. Current nutritional deficiency diseases, including but not limited to beriberi (265.0), pellagra (265.2), and scurvy (267).
SMPG: An asymptomatic, incidental finding of a low vitamin level on routine labs ordered by the applicant's primary care provider (PCP) meets the standard. If an applicant had a vitamin level measured as part of a work up for a symptom and the PCP's working hypothesis is that their symptom is related to that vitamin deficiency, the applicant does not meet the standard until treatment is discontinued and the lab value has normalized.

CHANGE: Current persistent glycosuria moved to 25-b.

h. Current or history of acromegaly, including but not limited to gigantism (253.0), or other disorders of pituitary function (253).

i. Dyslipidemia with low-density lipoprotein (LDL) greater than 200mg/dL or triglycerides greater than 400 mg/dL. Dyslipidemia requiring more than one medication or LDL greater than 190 mg/dL on therapy. All those on medical management must have demonstrated no medication side effects (such as myositis, myalgias, or transaminitis) for a period of 6 months.
SMPG: MEPS is authorized to order AST, ALT, and CK for applicants taking statins.
CHANGE: Less restrictive – more than one medication is now qualified if no side effects. Criteria for LDL and triglycerides added

j. Metabolic syndrome beyond the 35th birthday. Metabolic syndrome is defined in accordance with NHLBI and American Heart Association (2005) as any three of the following:

(1) Medically controlled hypertension or elevated blood pressure of greater than 130 mmHg systolic or greater than 85 mmHg diastolic.

(2) Waist circumference greater than 35 inches for women and greater than 40 inches for men.

(3) Medically controlled dyslipidemia or triglycerides greater than 150 mg/dl.

(4) Medically controlled dyslipidemia or high-density lipoprotein less than 40 mg/dl in men or less than 50 mg/dl in women.

(5) Fasting glucose greater than 100 mg/dl.

SMPG: Routine laboratory testing of all applicants > 35 for metabolic syndrome is not authorized. If an applicant is over 35 and any single criteria is abnormal on MEPS exam or medical records, the MEPS is authorized to complete further testing for the remaining criteria – i.e. fasting glucose (8hr) and fasting lipids (12 hr).

Fasting lipids and glucose are valid for two years.

k. Metabolic bone disease:

(1) Osteopenia, osteoporosis, or low bone mass with history of fragility fracture.

(2) Paget's disease.

(3) Osteomalacia.

(4) Osteogenesis imperfecta.

SMPG: Osteoporosis does not meet the standard. Osteopenia meets the standard when resolved. Low bone mass meets the standard if no history of pathological fracture. See 20-k,l.
CHANGE: New

l. Male hypogonadism.
CHANGE: New

26. RHEUMATOLOGIC:

a. Current or history of lupus erythematosus (710.0) or mixed connective tissue disease variant (710.9).

b. Current or history of progressive systemic sclerosis (710.1), including calcinosis, Raynaud's disease or phenomenon, esophogeal dysmotility, sclerodactyly, telangiectasia (CREST) variant.

c. Current or history of Reiter's disease (099.3).

d. Current or history of rheumatoid arthritis (714.0).

e. Current or history of Sjögren's syndrome (710.2).

f. Current or history of vasculitis, including but not limited to polyarteritis nodosa and allied conditions (446.0), arteritis (447.6), Behçet's (136.1), and Wegener's granulomatosis (446.4). Henoch-Schonlein Purpura occurring before the age of 19 with 2 years remission and no sequelae DOES meet the standard.
CHANGE: Less restrictive – some Henoch_Schonlein Purpura (HSP) can be qualified. Per LTC Ponder at OSD, disqualifying reference to HSP in 23-b is an error.

g. History of congenital fusion (756.15) involving more than two vertebral bodies or any surgical fusion of spinal vertebrae (P81.0).
CHANGE: Added to Rheumatology Section; however, identical to 17-d in Spine Section

h. Current or history of gout (274).
CHANGE: Moved from Endocrinology section unchanged

i. Current or history of inflammatory myopathy including polymyositis or dermatomyositis.
CHANGE: New

j. Current or history of non-inflammatory myopathy to include but not limited to metabolic myopathy such as glycogen storage disease, lipid storage disease, and mitochondrial myopathy.
CHANGE: New

k. Current or history of fibromyalgia, myofascial pain, or chronic wide-spread pain.
CHANGE: New

l. Current or history of chronic fatigue syndrome.
CHANGE: New

m. Current or history of spondyloarthritis including ankylosing spondyloarthritis, psoriatic arthritis, reactive arthritis, or spondyloarthritis associated with inflammatory bowel disease.
CHANGE: More detailed version of 17-a.

n. Current or history of joint hypermobility syndrome.
CHANGE: New

o. Current or history of hereditary connective tissue disorders including but not limited to Marfan's syndrome, Ehlers-Danlos syndrome, and osteogenesis imperfecta.
CHANGE: New

27. NEUROLOGIC:

a. Current or history of cerebrovascular conditions, including but not limited to subarachnoid (430) or intracerebral (431) hemorrhage, vascular stenosis, aneurysm, stroke, transient ischemic attack or arteriovenous malformation (437).

b. History of congenital or acquired anomalies of the central nervous system (742) or meningocele (741.9).

c. Current or history of disorders of meninges, including but not limited to cysts (349.2). Asymptomatic incidental arachnoid cyst demonstrated to be stable by neurological imaging over a 6-month or greater time period DO meet the standard.

d. Current or history of neurodegenerative disorders, including but not limited to those disorders affecting the cerebrum (330), basal ganglia (333), cerebellum (334), spinal cord (335), peripheral nerves (337), or muscles (728).

e. History of headaches (784.0), including but not limited to migraines (346) and tension headaches (307.81) that:

(1) Are severe enough to disrupt normal activities (such as loss of time from school or work) of more than twice per year in the past 2 years.

(2) Require prescription medications more than twice per year within the last 2 years.

f. Migraine (346) or migraine variant (346.2) associated with neurological deficits other than scotoma.

g. Cluster headaches (339.0).

h. History of head injury (854.0) if associated with:

(1) Post-traumatic seizure(s) occurring more than 30 minutes after injury.

(2) Persistent motor, sensory, vestibular, visual, or any other focal neurological deficit.

(3) Persistent impairment of cognitive function.

(4) Persistent alteration of personality or behavior.

(5) Unconsciousness of 24 hours or more post-injury

(6) Amnesia or disorientation of person, place, or time of 7 days duration or longer post-injury.

(7) Cerebral traumatic findings, including but not limited to epidural, subdural, subarachnoid, or intracerebral hematoma on neurological imaging until resolved and 12 months has elapsed since injury.

SMPG: These conditions meet the standard if:

- ✓ No surgical treatment was required
- ✓ The finding is no longer visible on imaging
- ✓ At least 12 months have elapsed since injury

(8) Associated abscess (326) or meningitis (958.8).

(9) Cerebrospinal fluid rhinorrhea (349.81) or otorrhea (388.61) persisting more than 7 days.

(10) Penetrating brain injury to include radiographic evidence of retained foreign body or bony fragments secondary to the trauma and/or operative procedure in the brain.

SMPG: Any intracranial injury necessitating trepanation (burr hole), craniotomy, craniectomy, or other neurosurgical intervention does not meet the standard.

i. History of moderate head injury (854.03).

(1) Moderate head injuries are defined as:

(a) Unconsciousness of more than 30 minutes but less than 24 hours, or

(b) Amnesia, or disorientation of person, place, or time, alone or in combination, more than 24 hours but less than 7 days duration post-injury, or

(c) Linear skull fracture.

(2) After 12 months post-injury, applicants may be qualified if neurological examination shows no residual dysfunction or complications.

j. History of mild head injury (854.02).

(1) Mild head injury is defined as:

(a) Unconsciousness of less than 30 minutes post-injury.

(b) Amnesia or disorientation of person, place, or time, alone or in combination, of less than 24 hours post-injury.

(2) After 1 month post-injury, applicants may be qualified if neurological examination shows no residual dysfunction or complications.

k. History of persistent post-concussive symptoms (310.2) that interfere with normal activities or have duration of more than 1 month. Such symptoms include but are not limited to headache, vomiting, disorientation, spatial disequilibrium, impaired memory, poor mental concentration, shortened attention span, dizziness, or altered sleep patterns.

l. Current or history of infectious processes of the central nervous system, including but not limited to meningitis (322), encephalitis (323), neurosyphilis (094), or brain abscess (324), if occurring within 1 year before examination, required surgical treatment, or if there are residual neurological defects.

m. Current or history of paralysis, weakness, lack of coordination, chronic pain (including but not limited to chronic regional pain syndrome or neuralgias), or sensory disturbance or other specified paralytic syndromes (344), including but not limited to Guillain-Barre Syndrome (357.0).

n. Any seizure occurring beyond the 6th birthday, unless the applicant has been free of seizures for a period of 5 years while taking no medication for seizure control, and has a normal sleep-deprived electroencephalogram and normal neurology evaluation while taking no medications for seizure control.

o. Chronic nervous system disorders, including but not limited to myasthenia gravis (358.0), multiple sclerosis (340), tremor (333.1), and tic disorders (307.20) (e.g., Tourette's (307.23)).

p. Current or history of central nervous system shunts of all kinds (V45.2).

q. Syncope or atraumatic loss of consciousness. History of recurrent syncope or presyncope (780.2), including blackout, fainting, loss or alteration of level of consciousness (excludes single episode of vasovagal reaction with identified trigger such as venipuncture), unless there has been no recurrence during the preceding 2 years while off all medication for treatment of this condition.

28. SLEEP DISORDERS:

a. Chronic insomnia (780.5). Within the past year, had difficulty sleeping, or used medications to promote sleep for more than 3 nights per week, over a period of 3 months.

b. Sleep-related breathing disorders (327). Current diagnosis or treatment of sleep-related breathing disorders, including but not limited to sleep apnea (327.2).
SMPG: Surgical procedures to correct obstructive sleep apnea meet the standard, provided the applicant no longer requires treatment (CPAP, etc).

c. Current or history of narcolepsy, cataplexy (347-347.11), or other hypersomnia disorders (327.13-19).

d. Circadian rhythm disorders requiring treatment (307.45).

e. Current or history of parasomnia (327.44, 327.49), including but not limited to sleepwalking, ~~enuresis,~~ or night terrors (307.46), after the age of 15.
SMPG: Per LTC Ponder at OSD, enuresis was supposed to have been removed from this item. Enuresis is addressed in 16-c.

f. Current diagnosis or treatment of sleep-related movement disorders to include restless leg syndrome (327.5).

29. LEARNING, PSYCHIATRIC, AND BEHAVIORAL:

a. Attention Deficit Hyperactivity Disorder (ADHD) (314) UNLESS the following criteria are met:

(1) The applicant has not required an Individualized Education Program or work accommodations since the age of 14.

(2) There is no history of comorbid mental disorders.

(3) The applicant has never taken more than a single daily dosage of medication or has not been prescribed medication for this condition for more than 24 cumulative months after the age of 14.

(4) During periods off of medication after the age of 14, the applicant has been able to maintain at least a 2.0 grade point average without accommodations.

(5) Documentation from the applicant's prescribing provider that continued medication is not required for acceptable occupational or work performance.

(6) Applicant is required to enter service and pass Service-specific training periods with no prescribed medication for ADHD.
SMPG: Request school transcripts, IEP, medication records, and counseling records.

b. History of learning disorders (315), including but not limited to dyslexia (315.02), UNLESS applicants demonstrated passing academic and employment performance without utilization of academic and or work accommodations at any time since age 14.
SMPG: Request school transcripts and IEP.

c. Pervasive developmental disorders (299 series) including Asperger Syndrome, autistic spectrum disorders, and pervasive developmental disorder-not otherwise specified (299.9).

d. Current or history of disorders with psychotic features such as schizophrenic disorders (295), delusional disorders (297), or other and unspecified psychoses (298).

e. History of bipolar disorders (296.4-7) and affective psychoses (296.8).

f. History of depressive disorders, including but not limited to major depression (296), dysthymic disorder (300.4), and cyclothymic disorder requiring outpatient care for longer than 12 months by a physician or other mental health professional (to include V65.40), or any inpatient treatment in a hospital or residential facility.

g. Depressive disorder not otherwise specified (311), or unspecified mood disorder (296.90), UNLESS:

(1) Outpatient care was not required for longer than 24 months (cumulative) by a physician or other mental health professional (to include V65.40).

(2) The applicant has been stable without treatment for the past 36 continuous months.

(3) The applicant did not require any inpatient treatment in a hospital or residential facility.

h. History of a single adjustment disorder (309) within the previous 3 months, or recurrent episodes of adjustment disorders.

i. Current or history of disturbance of conduct (312), impulse control (312.3), oppositional defiant (313.81), other behavior disorders (313), or personality disorder (301).

(1) History (demonstrated by repeated inability to maintain reasonable adjustment in school, with employers or fellow workers, or other social groups), interview, or psychological testing revealing that the degree of immaturity, instability, of personality inadequacy, impulsiveness, or dependency shall likely interfere with adjustment in the Military Services.

(2) Recurrent encounters with law enforcement agencies (excluding minor traffic violations) or antisocial behaviors are tangible evidence of impaired capacity to adapt to military service.

SMPG: Refer to the DSM-IV for the specific criteria needed to make these diagnoses. If the applicant does not meet the criteria for a specific disorder, but, in your opinion, they are not suitable for military service on psychiatric grounds, use the unsuitability diagnosis and ICD-9 code 796.9. (See 29-t and 31-m)

j. Encopresis (307.7) after 13th birthday.

k. History of anorexia nervosa (307.1) or bulimia (307.51).

l. Other eating disorders (307.50; 52-54) including unspecified disorders of eating (307.59) occurring after the 13th birthday.

m. Any current receptive or expressive language disorder, including but not limited to any speech impediment or stammering and stuttering (307.0) of such a degree as to significantly interfere with production of speech or the ability to repeat commands.

CHANGE: Minor wording, no substantive difference.

n. History of suicidal behavior, including gesture(s) or attempt(s) (300.9) or history of self-mutilation or injury used as a way of dealing with life and emotions.

SMPG: The standard is based on intent – "used as a way of dealing with life or emotions". When obvious marks of cutting or burning behavior are visible and the applicant will not disclose their intent, will not admit to the acts, or provides an irrational explanation, they do not meet the standard.

o. History of obsessive-compulsive disorder (300.3) or post-traumatic stress disorder (309.81).

p. History of anxiety disorders (300.01), anxiety disorder not otherwise specified (300.00), panic disorder (300.2), agoraphobia (300.21, 300.22), social phobia (300.23), simple phobias (300.29), other acute reactions to stress (308) UNLESS:

(1) The applicant did not require any treatment in an inpatient or residential facility.

(2) Outpatient care was not required for longer than 12 months (cumulative) by a physician or other mental health professional (to include V65.40).

(3) The applicant has not required treatment (including medication) for the past 24 continuous months.

(4) The applicant has been stable without loss of time from normal pursuits for repeated periods even if of brief duration; and without symptoms or behavior of a repeated nature that impaired social, school, or work efficiency for the past 24 continuous months.

q. Current or history of dissociative, conversion, or factitious disorders (300.1), depersonalization (300.6), hypochondriasis (300.7), somatoform disorders (300.8), or pain disorder related to psychological factors (307.80 and .89).

r. Current or history of psychosexual conditions (302), including but not limited to transsexualism, exhibitionism, transvestism, voyeurism, and other paraphilias.
SMPG: This item is not a contradiction of the repeal of "Don't Ask, Don't Tell". Homosexuality was removed from the DSM classification of psychosexual conditions in 1973.

s. Current or history of alcohol dependence (303), drug dependence (304), alcohol abuse (305.0), or other drug abuse (305.2 thru 305.9).
SMPG: Refer to DSM IV criteria when assigning these diagnoses.

t. Current or history of other mental disorders (all 290-319 not listed) that, in the opinion of the civilian or military medical examiner, shall interfere with or prevent satisfactory performance of military duty.

u. Prior psychiatric hospitalization for any cause.

30. TUMORS AND MALIGNANCIES:

a. Current benign tumors or conditions that interfere with function, prevent the proper wearing of the uniform or protective equipment, shall require frequent specialized attention, or have a high malignant potential, such as Dysplastic Nevus Syndrome.
SMPG: See 22-h.

b. Current or history of malignant tumors (V10).
SMPG: Includes malignant tumors "in solution" – i.e. leukemia et al.

c. Skin cancer (other than malignant melanoma) that is removed with no residual DOES meet the standard.
SMPG: Current or history of malignant melanoma does not meet the standard.

31. MISCELLANEOUS:

a. Current or history of parasitic diseases, if symptomatic or carrier state, including but not limited to filariasis (125), trypanosomiasis (086), schistosomiasis (120), hookworm (uncinariasis) (126.9), or unspecified infectious and parasitic disease (136.9).

b. Current or history of other disorders, including but not limited to cystic fibrosis (277.0) or porphyria (277.1), that prevent satisfactory performance of duty, or require frequent or prolonged treatment.
SMPG: "Other disorders" refers to other metabolic and genetic disorders such as phenylketonuria, G6PD deficiency, glycogen storage diseases, etc. not previously specifically mentioned.

c. Current or history of cold-related disorders, including but not limited to frostbite, chilblain, immersion foot (991), or cold urticaria (708.2).

d. Current residual effects of cold-related disorders (991.9), including but not limited to paresthesias, easily traumatized skin, cyanotic amputation of any digit, ankylosis, trench foot, or deep-seated ache.

e. History of angioedema, including hereditary angioedema (277.6).

f. History of receiving organ or tissue transplantation (V42).
SMPG: History of receiving blood or blood products related to trauma or surgery meets the standard.

g. History of pulmonary (415) or systemic embolization (444).

h. History of untreated acute or chronic metallic poisoning, including but not limited to lead, arsenic, silver (985), beryllium (985.3), or manganese (985.2), or current complications or residual symptoms of such poisoning.

i. History of heat pyrexia (992.0), heatstroke (992.0), or sunstroke (992.0).

j. History of three or more episodes of heat exhaustion (992.3).

k. Current or history of a predisposition to heat injuries (992.0-992.8), including disorders of sweat mechanism (705.0-705.9), combined with a previous serious episode.

l. Current or history of any unresolved sequelae of heat injury (992.0-992.8), including but not limited to nervous, cardiac, hepatic, or renal systems.

m. Current or history of any condition that, in the opinion of the medical officer, shall significantly interfere with the successful performance of military duty or training (should use specific ICD code whenever possible, or 796.9).
SMPG: "The Wastebasket". A clear rationale for why the applicant does not meet the standard MUST be described on the DD2807/2808

n. Any current acute pathological condition, including but not limited to acute communicable diseases, until recovery has occurred without sequelae.
SMPG: Applicants with body temperature > 100.5 or signs/symptoms of systemic illness do not meet the standard. Applicants with infectious mononucleosis do not meet the standard until after a 6 week recovery period.

GLOSSARY

PART I

ABBREVIATIONS AND ACRONYMS

ADHD	Attention Deficit Hyperactivity Disorder
ANSI	American National Standards Institute
ASD(HA)	Assistant Secretary of Defense for Health Affairs
ATS	American Thoracic Society
AV	atrioventricular
CPT	Current Procedural Terminology
CREST	Calcinosis, Raynaud's phenomenon, Esophogeal dysmotility, sclerodactyly, telangiectasia
dB	decibel
DEP	Delayed Entry Program
DoDD	Department of Defense Directive
DoDI	Department of Defense Instruction
DUSD(MPP)	Deputy Under Secretary of Defense for Military Personnel Policy
ECG	electrocardiograph
GERD	Gastro-Esophageal Reflux Disease
HCPCS	Healthcare Common Procedure Coding System
HHS	Department of Health and Human Services
ICD	International Classification of Diseases
LASEK	laser epithelial keratomileusis
LASIK	laser-assisted in situ keratomileusis
LDL	low-density lipoprotein
LTBI	latent tuberculosis infection
MEDPERS	Medical and Personnel Executive Steering Committee
mg/dl	milligrams per deciliter
mmHg	millimeters of mercury
NHLBI	National Heart, Lung, and Blood Institute
NIH	National Institutes of Health

PRK	photorefractive keratectomy
PDASD(HA)	Principal Deputy Assistant Secretary of Defense for Health Affairs
PDES	Physical Disability and Evaluation System
PDUSD(P&R)	Principal Deputy Under Secretary of Defense for Personnel and Readiness
QFT®-G	QuantiFERON®-TB Gold
ROTC	Reserve Officer Training Corps
USD(P&R)	Under Secretary of Defense for Personnel and Readiness
USPHS	United States Public Health Service
WPW	Wolff-Parkinson-White

PART II

DEFINITIONS

Unless otherwise noted, these terms and their definitions are for the purpose of this Instruction.

Anemia. A hemoglobin level of less than 13.5 for males and less than 12 for females.

Department of Health and Human Services (HHS). The U.S. Government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.

Military Department. Defined in Joint Publication 1-02 (Reference (j)).

Military Service(s). Defined in Reference (j)).

NHLBI. An agency within the National Institutes of Health (NIH) that provides global leadership for a research, training, and education program to promote the prevention and treatment of heart, lung, and blood diseases and enhance the health of all individuals so that they can live longer and more fulfilling lives.

NIH. An agency within the HHS that serves as the steward of medical and behavioral research for the Nation. Its mission is science in pursuit of fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to extend healthy life and reduce the burdens of illness and disability.

QFT®-G. An in vitro laboratory diagnostic test using a whole blood specimen. It is an indirect test for Mycobacterium tuberculosis-complex (i.e., M. tuberculosis, M. bovis, M. africanum, M. microti, M. canetti) infection, whether tuberculosis disease or latent tuberculosis infection (LTBI). It cannot distinguish between tuberculosis disease and LTBI, and is intended for use in conjunction with risk assessment, radiography, and other medical and diagnostic evaluations.