



DEPARTMENT OF THE NAVY  
BUREAU OF MEDICINE AND SURGERY  
7700 ARLINGTON BOULEVARD  
FALLS CHURCH VA 22042

IN REPLY REFER TO  
BUMEDINST 6000.19  
BUMED-M3  
1 Oct 2020

BUMED INSTRUCTION 6000.19

From: Chief, Bureau of Medicine and Surgery

Subj: MEDICAL EVALUATION BOARD COMPOSITION, FUNCTION, MANAGEMENT,  
STAFFING, AND STANDARDIZATION

Ref: (a) DoD Instruction 1332.18 of 5 August 2014  
(b) ASN(M&RA) memo of 11 Sep 2018 (NOTAL)  
(c) NAVMED P-117  
(d) DoD Instruction 6130.03 Volumes 1 and 2, Medical Standards for Military Service of  
4 September 2020  
(e) SECNAVINST 1850.4F  
(f) SECNAV M-1850.1  
(g) DTM-18-004, Revised Timeliness Goals for the Integrated Disability Evaluation  
System of 30 July 2018  
(h) DASN(M&RA) memo of 10 Sep 2019 (NOTAL)  
(i) OPNAVINST 1300.20  
(j) NAVPERS 15560D  
(k) ASN(M&RA) memo of 20 Mar 2020 (NOTAL)  
(l) BUMEDINST 1300.2B  
(m) DoD Instruction 6025.18 of 13 March 2019  
(n) DoD Instruction 1332.45 of 30 July 2018  
(o) BUMEDINST 6320.85A  
(p) BUMEDINST 1300.3A  
(q) DoD Instruction 6490.04 of 4 March 2013

Encl: (1) Medical Evaluation Board Composition, Functions, and Staffing  
(2) Medical Evaluation Board Staffing Clarification  
(3) Pre-Disability Evaluation System and Medical Evaluation Board Phase Workflow

1. Purpose. To clarify and prioritize expectations of the Medical Evaluation Board (MEB) for the Disability Evaluation System (DES), temporary limited duty (TLD, also known as LIMDU), and administrative separation (ADSEP) for conditions not amounting to a disability (CnD) per references (a) and (b). This instruction supersedes the process described in reference (c), Manual of the Medical Department, chapter 18, articles 18-2, 18-5, 18-10, and 18-11. Navy Medicine Readiness and Training Commands (NAVMEDREADTRNCMD) must perform the MEB functions described in enclosure (1), staff MEB roles described in enclosure (2), and process DES cases per references (a), (d) through (f), and per the pre-DES and MEB phase workflow in enclosure (3).

2. Scope and Applicability. This instruction is applicable to all healthcare providers delivering care to Sailors or Marines in medical treatment facilities (MTF) and includes guidance on how operational medicine healthcare providers may integrate with MEB processes. In addition, this instruction provides a process to fulfill MEB requirements and deployability assessments outlined in references (a), (b), (d) through (o) for consideration by Defense Health Agency (DHA) MTFs.

3. Background. NAVMEDREADTRNCMDs support the Navy and Marine Corps, and must prioritize LIMDU and DES in support of medical readiness. Navy Medicine must meet the established quality and timeline metrics per references (a), and (d) through (i).

4. Responsibilities

a. Bureau of Medicine and Surgery (BUMED), Assistant Deputy Chief, Medical Operations (BUMED-M3) must:

(1) Review requests from Naval Medical Forces Atlantic and Pacific commanders to authorize and delegate responsibilities of virtual or onsite Medical Evaluation Board Approving Authorities (MEBAA) physician or convening authorities (CA) to fulfill MEB functions across both Naval Medical Forces Atlantic and Pacific regional commands.

(2) Review requests from Naval Medical Forces Atlantic and Pacific commanders to authorize and delegate responsibilities of virtual or onsite MEBAA physician or CA, at other Service MTFs, when identified by Naval Medical Forces Atlantic or Pacific commander.

(3) Support operational forces' readiness and lethality. (Note: Navy Medicine has an obligation to document a deployability assessment at every provider-based healthcare encounter per reference (i) and (n)).

b. Naval Medical Forces Atlantic and Pacific Commanders must:

(1) Oversee staffing, development, training, and performance of MEBs.

(2) Where needed, facilitate authorization and delegation of MEBAA physicians or CAs between subordinate commands, whether virtual or onsite.

(3) Coordinate with BUMED-M3 to request and authorize delegation of MEBAA physicians or CAs between a subordinate command and an external activity.

c. NAVMEDREADTRNCMD Commanders or Commanding Officers (CO) must: Per enclosures (1) and (2), oversee implementation of staffing, development, training, and performance of MEBs and delegate in writing an appropriate number of CAs and MEBAA physicians. Naval Medical Forces Atlantic and Pacific regions must coordinate medical

responsibility for Sailors and Marines assigned to sites where a Navy Medicine CA is unavailable. At these sites, MEBs, DES, and LIMDU cases will be processed by the NAVMEDREADTRNCMD with geographic medical cognizance over the site.

(1) In addition to the needs of the Department of the Navy, factors that may be considered to determine assignment of medical cognizance include: Service member's TRICARE enrollment status, Service member's home of record or family support location(s), MTF medical capabilities, and whether the Service member is being permanently transferred to the overall geographic areas per reference (o).

(2) The Deputy Chief, Operations, Plans & Readiness (DC OP&R), may coordinate with DHA directors of other service MTFs to select and authorize Navy healthcare providers to serve as CAs within those facilities, or virtually, as needed.

(3) To monitor compliance, NAVMEDREADTRNCMD commanders or COs should use peer review to ensure deployability assessments are completed at every provider-based healthcare encounter.

(4) Patient Administration Department or MEB office will manage access to LIMDU Sailor and Marine Readiness Tracker (LIMDU SMART) or current system of record.

(5) Patient Administration Department, medical readiness clinic, or MEB office will utilize LIMDU SMART or current system of record for MEB activities and ensure inputs are accurately reflected in the appropriate application:

(a) Assignment of LIMDU or Return to Duty (LIMDU application).

(b) Administrative Separation for Condition not amounting to a disability recommendations (ADSEP CnD application).

(c) Temporary Disability Retired List (TDRL application).

(d) Pre-DES and DES cases (electronic Medical Evaluation Board Report (eMEBR) application).

(e) Active population management of medically restricted personnel (HERCULES application).

d. NAVMEDREADTRNCMD must make a deployability assessment and ensure proper documentation when a Service member is placed in an alternate deployment status.

(1) Each health care encounter represents an opportunity to update a Service member's individual medical readiness and complete a deployability assessment per references (i) and (n).

Upon completion of the encounter, the certifying (or signing) provider; including independent duty corpsman, will make a determination of the Service member's deployability. Specialists may restrict their deployability assessment to the area of their expertise and place the Service member on LIMDU or inform the Service member's primary care manager (PCM) of any deployability concern.

(2) Healthcare providers must utilize the procedures outlined in enclosure (1) to efficiently and effectively document an alternate duty status such as DES, LIMDU, or ADSEP CnD.

5. Contact information. Questions can be directed to the Force Medical Readiness (BUMED-M34) group e-mail at [usn.ncr.bumedfchva.mbx.bumed-medical-readiness@mail.mil](mailto:usn.ncr.bumedfchva.mbx.bumed-medical-readiness@mail.mil). Further assistance is available through headquarters elements of Navy Personnel Command (PERS-454) via e-mail at [mill\\_DAOPers-454@navy.mil](mailto:mill_DAOPers-454@navy.mil) or Marine Corps' Disability, Separation and Retirement Branch (MMSR-4) at [smb.manpower.mmsr4@usmc.mil](mailto:smb.manpower.mmsr4@usmc.mil).

#### 6. Records Management

a. Records created as a result of this instruction, regardless of format or media, must be maintained and dispositioned per the records disposition schedules located on the Department of the Navy Directorate for Administration, Logistics, and Operations, Directives and Records Management Division portal page at <https://portal.secnav.navy.mil/orgs/DUSNM/DONAA/DRM/Records-and-Information-Management/Approved%20Record%20Schedules/Forms/AllItems.aspx>.


b. For questions concerning the management of records related to this instruction or the records disposition schedules, please contact the local records manager or the Department of the Navy Directorate for Administration, Logistics, and Operations, Directives and Records Management Division program office.

7. Review and Effective Date. Per OPNAVINST 5215.17A, BUMED-M34 will review this instruction annually around the anniversary of its issuance date to ensure applicability, currency, and consistency with Federal, DoD, SECNAV, and Navy policy and statutory authority using OPNAV 5215/40 Review of Instruction. This instruction will be in effect for 10 years, unless revised or cancelled in the interim, and will be reissued by the 10-year anniversary date if it is still required, unless it meets one of the exceptions in OPNAVINST 5215.17A, paragraph 9. Otherwise, if the instruction is no longer required, it will be processed for cancellation as soon as the need for cancellation is known following the guidance in OPNAV Manual 5215.1 of May 2016.

8. Forms. The forms listed are available at <https://forms.documentservices.dla.mil/order/>

a. NAVMED 6150/50 Naval Disability Evaluation System Medical Evaluation Board Report

- b. NAVMED 1850/1 Legacy Disability Evaluation System Enrollment Request
- c. NAVMED 1850/2 Initial Entry Training (IET) Legacy Disability Evaluation System Enrollment
- d. NAVMED 6120/9 Temporary Disability Retired List (TDRL) Assessment
- e. NAVMED 6100/5 Abbreviated Medical Evaluation Board Report
- f. NAVMED 6100/6 Return of a Patient to Medically Unrestricted Duty from Limited Duty

  
G. D. SHAFFER  
Acting

Releasability and distribution:

This instruction is cleared for public release and is available electronically only via the Navy Medicine Web site, <http://www.med.navy.mil/directives/Pages/BUMEDInstructions.aspx>

MEDICAL EVALUATION BOARD COMPOSITION, FUNCTIONS, AND STAFFING

1. MEB Composition. Appropriate MEB staffing is essential to ensure quality care as well as meeting the established timeline goals for temporary LIMDU, ADSEP CnD, and DES. In addition, proper MEB staffing is critical for the active management of LIMDU Service members through the temporary LIMDU operations program.

a. The Navy MEB is made up of three members: the junior member or referring provider (MEB-1), senior member or MEBAA physician (MEB-2), and the CA (MEB-3) per references (c) and (e). At least two members of the MEB must be physicians (a doctoral level clinical psychologist can substitute for one of the two physicians for mental health conditions).

(1) The junior or referring provider may include: physicians (to include general medical officers and residency trained physicians), doctorate level clinical psychologists, physician assistants, nurse practitioners, licensed clinical social workers, dentists, physical therapists, occupational therapists, optometrists, podiatrists, certified nurse midwives, certified registered nurse anesthetists, or independent duty corpsman. Providers should only initiate referrals for conditions within their scope of practice.

(2) Operational units may use the type command surgeon (for Fleet Forces) or Marine Expeditionary Force (MEF) surgeon (for Fleet Marine Forces) as MEBAA physicians for LIMDU, and ADSEP CnD. Type command and MEF surgeons may delegate, in writing, the senior member (at the level of chief of clinical services, or department head) or MEBAA physician to a privileged board-certified physician within a subordinate command. NAVMED-READTRNCMDs supporting recruit and officer training are encouraged to appoint MEBAAAs within the clinic supporting IETs.

(3) NAVMEDREADTRNCMDs must coordinate with supported commands to ensure that operational providers receive LIMDU SMART training and are granted the appropriate level of access within LIMDU SMART to initiate LIMDU processing, DES recommendations, and ADSEP CnD recommendations.

b. Before initiating a mental health diagnosis related MEB for LIMDU, ADSEP CnD, or DES, a thorough mental health evaluation must be done and diagnosis confirmed by a mental health provider. This mental health provider may be a psychiatrist, doctorate level clinical psychologist, psychiatric nurse practitioner, or licensed clinical social worker. The mental health provider must complete and sign a narrative summary (NARSUM) using LIMDU SMART or current system of record. A civilian network mental health provider may make the confirmatory diagnosis, allowing a non-mental health military provider to serve as the referring provider for convening an MEB.

c. Generally, most NARSUMs or MEB reports fall under the Military Command Exception provision, 45 CFR 164.512 and separately in reference (m) of this instruction which define

minimum necessary rules, and permits the use and disclosure of protected health information for authorized activities to a commander to include, but not limited to: determining Service member's fitness for duty, disability determination, fitness to perform a particular assignment, or carrying out any other activity essential for military mission. There are certain circumstances where the military command exception provision does not apply. One such circumstance is for restricted military sexual assault cases.

(1) Disclosure will be limited to officials participating in the processing and adjudication of medical evaluation board reports (MEBR) and DES cases and further must not cause a restricted report to become unrestricted. For these circumstances, the information sent to commanding officers should be limited to the diagnosis.

(2) The treating or referring provider must limit documenting detailed information on conditions related to trauma, sexual assault, and other sensitive information in MEBRs, NAVMED 6150/50 Naval Disability Evaluation System Medical Evaluation Board Report and NAVMED 6100/5 Abbreviated Medical Evaluation Board Report, NARSUMs, and official documentation.

(3) The treating or referring provider must use the electronic health record to document and create an encounter with comprehensive details on conditions related to trauma, sexual assault, and protected health information considered clinically sensitive. To convey the appropriate information to the Physical Evaluation Board (PEB), the treating or referring provider can complete all required clinical information in the electronic health record, then annotate the date of the encounter in the MEBR, NAVMED 6150/50 and NAVMED 6100/5, or NARSUM.

## 2. MEB Function and Management

a. LIMDU. LIMDU is defined as the assignment of a Service member in a duty status for a specified time, with certain medical limitations or restrictions concerning the duties the Service member may perform. All LIMDU cases must be entered into the current system of record (i.e., LIMDU SMART). LIMDU is indicated for any medical condition, compensable or non-compensable, where return to full duty is anticipated, or additionally for cases where further clinical workup, testing, treatment, or medical stabilization is needed for assessment of medical retention determination point criteria. Additional guidance can be found in reference (j), Naval Military Personnel Manual.

(1) LIMDU timeframes should be consistent with anticipated duration of recovery, where durations will be tied to the treating or referring provider's estimated timeframe for a Service member to recover and return to a deployable status, as per references (i), (j), and (n). This condition-based duration should ensure sufficient time for recovery established by nationally recognized evidence based clinical guidelines, specialty leader recommendations, or provider experience. LIMDU concludes when a Service member is returned to medically unrestricted duty by the MEB, or is referred into the DES.

(2) Per reference (a), the primary trigger for referral to the DES is a medical condition that prevents the Service member from carrying out the duties of their office, grade, rank, or rating when recovery is not expected or recovery will take more than 12 consecutive months on LIMDU. Extended LIMDU beyond 12 consecutive months must be approved by Service headquarters as described in subparagraph 2a(4) of this enclosure. Importantly, Service headquarter elements may direct the cognizant MTF CA to place a Service member on LIMDU at any time, direct referral to the PEB, or direct ADSEP CnD. If there is a divergence of opinion between the Service headquarters and the MEB, the MEBAA or CA should reach out to the headquarters to seek resolution. If the issue is not resolved, the MEBAA or CA should document that difference of opinion within LIMDU SMART for LIMDU or ADSEP CnD cases or the NARSUM portion of the MEBR delivered to the PEB to inform on their deliberation.

(3) LIMDU administrative guidelines

(a) The NAVMEDREADTRNCMD CA approves all LIMDU requests for any Service member if a period of LIMDU will not result in an extension of LIMDU beyond 12 consecutive months and the Service member is expected to return to a medically unrestricted duty status at the completion of the LIMDU period. If the duration of recovery is less than 12 consecutive months, then the only required action is entry into LIMDU SMART. If the Service member is recommended for additional periods of LIMDU exceeding 12 consecutive months or more by the MTF, the case must be forwarded to PERS-454 or MMSR-4 for review and recommendations for extended LIMDU, referral into DES, or appropriate disposition. When Service members on LIMDU recover, their return to duty (RTD) status must be documented in LIMDU SMART which automatically completes the NAVMED 6100/6 Return of a Patient to Medically Unrestricted Duty From Limited Duty. With the signature of the cognizant NAVMEDREADTRNCMD CA in the system, LIMDU SMART automatically completes the NAVMED 6100/5 Abbreviated Medical Evaluation Board Report. No more than 5 working days may elapse from the date of RTD, CA signature, and Service headquarters notification by the NAVMEDREADTRNCMD.

(b) No later than 30 days prior to the end of the Service member's LIMDU period, the treatment team must make a duty determination:

(1) Medical assessment for ability of Service member to RTD.

(2) Completion of updated NAVMED 6100/5, recommending an additional period of LIMDU for cases requiring additional recovery period.

(3) Refer Service member to PEB for a fitness determination when period of LIMDU exceeds 12 consecutive months.

(4) Recommend ADSEP CnD.



(c) Temporary Limited Duty Operations (TEMPO)

(1) Monthly reviews of all LIMDU cases will be conducted by a multidisciplinary team, chaired by the MEBAA physician or the CA. The team will include senior NAVMED-READTRNCMD and operational providers, command representatives (at the chair's discretion), a case manager, Patient Administration Department staff, a physical evaluation board liaison officer (PEBLO), and a deployability coordinator.

(2) The monthly reviews enable the ability to actively manage the LIMDU population, which can result in treatment recommendations, case management interventions, early return to duty, and early referral to the PEB.

(3) Any recommendation made by the team will be returned to the treating or referring provider for consideration. RTD actions can be completed independently by the MEBAA physician or CA. DES referrals can be initiated if medical retention determination point criteria is met and all potentially referable conditions have been considered. During the monthly reviews, the team will focus on the following clinical questions: Do we have the correct diagnosis? Do we have an appropriate and aggressive treatment plan? What additional treatment or therapeutic interventions would result in an earlier RTD? Is the patient ready to RTD now? Does the Service member meet criteria for referral to the DES?

(4) Provider LIMDU guidelines. At any time during a period of LIMDU, the general medical officer, Service member's PCM or attending medical officer can make one of these determinations:

- (a) Service member is able to RTD.
- (b) Service member requires additional LIMDU.
- (c) Convening of a MEB for referral of the Service member to the PEB.

(5) Retention Waiver for Non-deployability. Service members who are on LIMDU for greater than 12 consecutive months must be reviewed for retention by Service headquarters (PERS-454 or MMSR-4).

(a) LIMDU SMART will automatically send a notification to the member's Service Headquarters when their LIMDU exceeds 12 consecutive months for retention waiver review and determination.

(b) Recommendation for retention will be based on the likelihood that the medical condition will improve sufficiently to permit the Service member to perform military duties and deploy commensurate with his or her office, grade, rank, or rating. If the medical condition is unlikely to resolve, the Service member must be directed to the DES or recommended for ADSEP.

(6) DES and overseas and remote duty locations. Per references (a), (f), (k), and (p), early return of the Service member must be coordinated with Service headquarters.

(a) MEB providers must provide a concise clinical summary through placement on LIMDU using NAVMED 6100/5, automated via LIMDU SMART and annotate referral to DES PEB.

(b) The treating or referring provider, and patient administration department or MEB office must coordinate with receiving NAVMEDREADTRNCMD to ensure appropriate clinical and administrative handoffs occur upon transfer.

(c) If the Department of Veterans Affairs is capable of offering compensation and pension examinations outside the continental United States (OCONUS), and the full DES process with benefits and services are available to Service members and their families, the Services will use discretion for Service members to remain in their OCONUS or remote location.

(d) The Service member's duty station must include access to legal consultation, a PEBLO, and a Department of Veterans Affairs military service coordinator (at an MTF) while going through the DES process.

(e) The Service member can elect processing through the Legacy Disability Evaluation System OCONUS or in remote duty locations, as compensation and pension examinations are not required.

b. DES. At least one member of the MEB (junior, senior, or CA) must be a psychiatrist or doctorate-level clinical psychologist for a DES referral involving a mental health condition. The MEB must contain at least two physicians, where a doctoral psychologist can substitute for one of the physicians for cases involving a mental health diagnosis. MEB providers must use NAVMED 6150/50 for DES case processing and Veterans Tracking Applications (VTA) for tracking. NAVMED 6150/50 can be automated via current systems (i.e., LIMDU SMART).

(1) For the DES, a new critical role is the MEBAA. The MEBAA physician serves to ensure Service members referred to DES have completed an evaluation on all potentially referable conditions. This evaluation is accomplished through a medical retention determination point which includes a comprehensive review of the Service treatment record, review of current retention standards (i.e., reference (d)), and consultations with treating, referring, or specialty providers, as well as the CA.

(2) Medical Retention Determination Point. A medical retention determination point is a comprehensive medical records review and evaluation by an MEBAA physician to determine whether medical retention determination point criteria have been met for referral into the DES

PEB. The Service member's PCM or treating and referring providers submit DES recommendation packages to the MEBAA physician for review and determination of an appropriate disposition.

(a) The medical retention determination point criteria are met when the Service member's progress appears to have medically stabilized; the course of further recovery is relatively predictable; and where it can be reasonably determined that the Service member is most likely not capable of performing the duties required of his or her office, grade, rank, or rating. The MEBAA physician will review all DES recommendations to ensure that the medical retention determination point has been achieved prior to initiating a DES case and coordinate inappropriate DES recommendations back to the treating or referring provider for appropriate disposition, and assist the CA in reconciling any questions. For conditions requiring additional treatment or workup to be medically stabilized, where further recovery is relatively predictable, the Service member will continue on LIMDU and upon completion, the medical retention determination point will be reassessed. The medical retention determination point may be reached during the monthly TEMPO reviews or separately when receiving DES recommendations from the treating or referring provider.

(b) When medical retention determination point criteria are met, the MEBAA physician will initiate the DES referral for each referred condition using NAVMED 6150/50 (automated in LIMDU SMART or subsequent system that replaces it). The MEBAA physician will also write NARSUMs for specialty care conditions from network providers based on clinical encounters and information in the electronic health record.

(c) When medical retention determination point criteria are not met, the MEBAA physician will recommend one listed:

(1) LIMDU assignment for medical stabilization.

(2) LIMDU assignment for medical retention determination point assessment pre-DES workup requirements (diagnostic testing, treatment, etc.) needed to assess one or more conditions for medical retention determination point criteria. The maximum duration of medical retention determination point assessment must not exceed 60 days.

(3) ADSEP CnD recommendation when non-disabling medical condition(s) interfere with performance of duties, subparagraph 2c of this enclosure provides clarification.

(4) Service headquarters directed DES referral.

(5) RTD, when the Service member meets criteria as fully deployable or deployable with limitations.

(d) For cases where one or more DES referable conditions rise to the level of disability, meet medical retention determination point criteria, and other DES referable condition(s) are pending additional treatment or clinical workup, etc., the MEBAA physician will:

(1) Recommend placement on LIMDU for medical retention determination point assessment (up to 60 days), for condition(s) where a definitive diagnosis has not been established, condition(s) does not have a predictable course or prognosis, condition is not medically stable, and thereafter refer the Service member into the DES. For medical retention determination point assessments beyond 60 days, the MEBAA physician must consult with Service headquarters (facilitated by BUMED-M34, as required).

(2) Refer Service member into the DES, without placement on LIMDU for medical retention determination point assessment, for conditions when pending treatment or clinical workup is still indicated and condition is medically stable, has a predictable prognosis, and where Service member has a documented history of similar treatment care protocols (electronic health record, LIMDU SMART, and other system).

(3) In cases of Service headquarters directed DES where there is a divergence of opinion in the fitness of duty determination for a Service member, the MEBAA physician or CA must consult with Service headquarters (see paragraph 5 of the basic instruction) and annotate in the electronic Medical Evaluation Board Report (eMEBR) or current system of record for consideration by the PEB.

(4) TDRL. Service members whom PEB have determined to be unfit for continued naval service with a disability rating by the Department of Veterans Affairs of 30 percent or greater are eligible for disability retirement. A Service member whose condition is not stable may be placed on the TDRL for up to 3 years, if placed into the program after January 1, 2017 or 5 years if placed into the program prior to January 1, 2017. A Service member is placed on the TDRL when the Service member meets the requirements for permanent disability retirement except that the disability is not stable, and may be permanent. NAVMED 6120/9 Temporary Disability Retired List (TDRL) assessment should be used for TDRL assessments. TDRL assessments, also known as periodic physical examinations, can be completed virtually when face to face examination or testing is not required.

(a) Conversion from the TDRL to the permanent disability retired list is not automatic. The PEB is required, by statute and policy, to review examinations concerning the condition(s) for which Service members were placed on the TDRL in order to assign a final disability percentage per the Department of Veterans Affairs Schedule for Rating Disabilities. If there are no examinations, Defense Finance and Accounting Services automatically terminates benefits, to include healthcare eligibility, at the end of the TDRL tenure.

(b) The Service member must have a periodic physical examination (PPE) at least every 18 months during the TDRL period to determine the continued existence and extent of their disability.

(c) The PEB will accept TDRL PPE completed virtually for conditions not requiring physical examinations. The PEB will identify those conditions that require a physical examination and determine how to address those requirements on a case-by-case basis.

(d) The physician must perform a general physical examination and preventive screening, and counseling, as appropriate, for age and gender. This includes a comprehensive evaluation of the condition for which the member was placed on the TDRL.

(1) A TDRL PPE does not require the convening of a MEB, thus there is no requirement for a MEBR cover sheet, a second physician's signature, or the CA's signature.

(2) Use NAVMED 6120/9 to complete TDRL PPE, including documenting any limitations regarding physical examinations. Healthcare providers may document in the electronic health record, provided they address the form's questions for the applicable condition and general information required for all TDRL assessments.

c. ADSEP CnD. Service members with conditions that interfere with the performance of duty that are specifically listed as compensable under the Department of Veterans Affairs Schedule for Rating Disabilities may be referred into the DES for that ratable condition. Service members with conditions that interfere with the performance of duty, but are not specifically listed as compensable under the Department of Veterans Affairs Schedule for Rating Disabilities may be considered for ADSEP CnD. If the Service member has both types of conditions, referral to the DES is required.

(1) All ADSEP CnD recommendations must be entered into LIMDU SMART or the current system of record.

(2) If a Service member with both a ratable condition and a CnD is referred to the DES and found fit for continued service by the PEB, that Service member cannot be administratively separated for the fit condition(s). However, after the PEB finding, they could be administratively separated for the CnD if it interferes with the performance of their duty.

(3) When a MEB is convened for ADSEP CnD recommendations, they must be comprised of at least two physicians, where a doctoral psychologist may substitute for a physician in cases with mental health conditions.

3. MEB Staffing and Standardization. Staffing for the DES MEB consists of: an MEBA physician, CA, PEBLO, contact representative, and deployability care coordinator.

a. Staffing Overview

(1) Staffing ratios are outlined further in enclosure (2) and are subject to updates from continuous assessments. Changes will be promulgated as appropriate from BUMED.

(2) Each NAVMEDREADTRNCMD will delegate the MEBAA physician and CA positions at ratios listed in MEB staffing clarification per enclosure (2) in order to prioritize readiness of Sailors and Marines and address timeline and quality control for the MEB process. The MEBAAs spend most of their time overseeing MEB functions in support of LIMDU, DES, and ADSEP CnD recommendations, whereas the CA does not.

(3) Report time supporting DES, LIMDU, and MEB using the “FEDC” (or FEDB for PEBLOs) code in the Medical Expense Reporting System (MEPRS). LIMDU, DES, MEB staffing standards and MEPRS reporting will be reviewed during the monthly performance review.

b. MEBAA Physician

(1) The MEBAA physician is the primary overseer of all readiness processes related to LIMDU, DES, and ADSEP CnD recommendations and represents MEB-2 for purposes of convening an MEB. The MEBAA physician responsibilities:

(a) Consults and does not provide treatment for the purposes of MEB functions. This role must be a physician with a requisite knowledge base and experience to adjudicate retention determination and potential combined effects of multiple conditions.

(b) Consults with providers, where applicable, for the Service member’s condition(s) that are beyond his or her medical scope or capacity (i.e., mental health, orthopedics, neurology, etc.) for purposes of MEB functions.

(c) The MEBAA physician or CA chairs monthly TEMPO reviews for all cases of LIMDU (active and inactive LIMDU cases) and will ensure all members with conditions that meet medical retention determination point criteria are referred into the DES, initiate RTD actions, or initiate additional period of LIMDU, as appropriate.

(d) Can serve in the role of CA when not adjudicating on the same case. If anticipated to assume the functional role as a Navy Medicine CA, the MEBAA physician is appointed in writing from the commanding officer and must meet criteria outlined in subparagraph 3c of this enclosure.

(e) Prefer these types of physicians: occupational medicine, internal medicine, family medicine, and preventative medicine. Specialty physicians may be recommended by exception. Those adjudicating musculoskeletal or surgical cases need not be surgeons, but should have extensive understanding of the underlying conditions.

(f) Will directly communicate with PERS-454 or MMSR-4 on cases where there is disagreement on headquarters directed DES.

(g) Endorses NARSUMs completed by PCMs or treating or referring providers and writes NARSUMs for specialty care conditions from network providers based on clinical encounters and information in the electronic health record.

(2) The MEBAAs physician can be staffed by uniformed, civilian, or contract physicians.

c. Navy Medicine CA. A delegation of authority from the NAVMEDREADTRNCMD commanding officer to carry out MEB activities and limited to uniformed or civilian personnel. CAs are physicians, at a level of director of clinical services or department head, appointed in writing by commanding officers and represent MEB-3 or final endorsing signature for LIMDU and DES case processing.

d. PEBLO. PEBLOs are the primary liaison between the military member and other agencies. Responsible for all aspects of DES and TDRL case processing and customer service. Must use NAVMED 6150/50 for processing of DES cases. See references (e) and (f) for comprehensive roles and responsibilities for DES cases.

e. Contact Representative. These members work closely with PEBLOs for administrative support functions related to DES case processing.

f. Deployability Care Coordinator. Members with a clinical background (i.e., Hospital Corpsman or medic preferred) where duties can be fulfilled by a health system specialist series position description.

#### 4. Supplemental Guidance on NAVMED Forms

a. NAVMED 6150/50 Naval Disability Evaluation System Medical Evaluation Board Report will be used when Service members are recommended for DES by referring provider or referred into DES by the MEBAAs physician, directed by Service Headquarters elements (PERS 454 or MMSR-4). NAVMED 6150/50 is automated in LIMDU SMART and should be default method of completing the Naval Disability Evaluation System Medical Evaluation Board Report. When portable document format fillable NAVMED 6150/50 is used, the completed document must be uploaded into eMEBR application in LIMDU SMART.

b. NAVMED 1850/1 Legacy Disability Evaluation System Enrollment Request will be used for DES case referrals when non-IET Service members elect Legacy DES. When portable document format fillable NAVMED 1850/1 is used, the completed document must be uploaded into eMEBR application in LIMDU SMART.

c. NAVMED 1850/2 Initial Entry Training (IET) Legacy Disability Evaluation System Enrollment will be used for DES referrals where the member's commanding officer directs Legacy DES on IET Service members. When portable document format fillable NAVMED 1850/2 is used, the completed document must be uploaded into eMEBR application in LIMDU SMART.

d. NAVMED 6120/9 Temporary Disability Retired List (TDRL) Assessment will be used by providers when performing required periodic physical exams (physical or virtual encounters as applicable) for Service members placed on TDRL.

e. NAVMED 6100/5 Abbreviated Medical Evaluation Board Report is a detailed summary of the member's medical condition(s), dictated by the attending physician, and used to request initial and or additional LIMDU in excess of 12 months, returning a Service member to duty, pre-DES workup on condition(s) requiring further evaluation to assess for medical retention determination point criteria, recommending DES referrals overseas, recommending early return of Service member, or for endorsing local MEB activities not otherwise captured (i.e., physical assessment wavier). NAVMED 6100/5 is automated in LIMDU SMART and should be the default method of completion of form. When portable document format fillable NAVMED 6100/5 is used, the completed document must be uploaded into LIMDU application in LIMDU SMART.

f. NAVMED 6100/6 Return of a Patient to Medically Unrestricted Duty from Limited Duty will be used to return a member to duty. The MEBAA physician can return a member to duty in lieu of the CA. NAVMED 6100/6 is automated in LIMDU SMART and should be the default method of completion of form. When portable document format fillable NAVMED 6100/6 is used, the completed document must be uploaded into LIMDU application in LIMDU SMART.



MEDICAL EVALUATION BOARD STAFFING CLARIFICATION

This table provides minimum staffing ratios, definitions, calculations, and examples, for the MEB to illustrate the number of staff each site must fulfill.

<b>POSITION</b>	<b>RATIO</b>	<b>DES and ADSEP CnD</b>	<b>LIMDU and TEMPO</b>	<b>CLINICAL (Training and Patient Care)</b>
<b>MEBAA – MIL</b>	1:200 patients	Full-Time Equivalent (FTE) 0.4	FTE 0.4	FTE 0.2
<b>MEBAA – CIV and CTR</b>	1:240 patients	FTE 0.4	FTE 0.4	FTE 0.2
<b>CA – MIL</b>	1:120 patients	FTE 0.1	FTE 0.1	Local policy
<b>CA – CIV</b>	1:120 patients	FTE 0.1	FTE 0.1	Local policy
<b>PEBLO</b>	1:25 DES cases			
<b>DES Contact Representative</b>	1:3 PEBLOs			
<b>Deployability Care Coordinator</b>	1:150 LIMDU cases			

The staffing ratios are based on the number of cases under management at a given time (defined below). Because there may be seasonal variability, commands may elect to use the annual average of open cases rather than a snapshot in time. Virtual MEBAA's and CAs may be used to fulfill staffing requirements, per subparagraphs 4a and 4b of the basic instruction.

Case Definition:

- Active LIMDU Case = patient currently assigned to LIMDU within LIMDU SMART.
- Inactive LIMDU Case = patient who has completed the assigned LIMDU, but has not received a signature to RTD or deployable status (Note: these were previously referred to as “expired” cases before LIMDU SMART logic changed from two-signatures to only one-signature required to RTD or deployability).
- Active DES Case = entered into VTA, but not complete with MEB phase.
- Open DES Case = completed MEB phase, but pending final PEB adjudication.

Staffing Calculations:

- MEBAA-MIL = sum (active and inactive LIMDU cases + active and open DES cases) /200
- MEBAA-CIV and CTR = sum (active and inactive LIMDU cases + active and open DES cases) /240
- CA = sum (active and inactive LIMDU cases + active and open DES cases) /120
- PEBLO = sum (active and open DES cases) /25
- Deployability Care Coordinator = (active and open DES cases) /150

Additional Notes: Commands must have a minimum of one CA, one MEBAA physician, one PEBLO, and one deployability care coordinator. If designated by the commanding officer, a CA may also serve as an MEBAA physician and vice-versa, but they may not sign as both roles on the same patient's case.

Small volume (sum of LIMDU and DES cases) site: Example-1

For a site that has 30 active LIMDU cases, 5 inactive or expired LIMDU cases, 25 active DES cases, and 7 open DES cases:

- The MEBAA physician and CA caseload is 67 cases; site merits one MEBAA physician and one CA.
- The PEBLO caseload is 32 cases; site merits one PEBLO. This site does not have the minimum threshold number of three PEBLOs to merit a DES contact representative.
- The LIMDU caseload for this site is 35; site merits one deployability care coordinator.

Medium volume (sum of LIMDU and DES cases) site: Example-2

For a site that has 150 active LIMDU cases, 50 inactive or expired LIMDU cases, 35 active DES cases and 16 open DES cases:

- The MEBAA physician and CA caseload is 251 cases; site merits one MEBAA physician and two CAs.
- The PEBLO caseload is 51 cases; site merits two PEBLOs. This site does not have the minimum threshold number of three PEBLOs to merit a DES contact representative.
- The LIMDU caseload for this site is 200; site merits one deployability care coordinator.

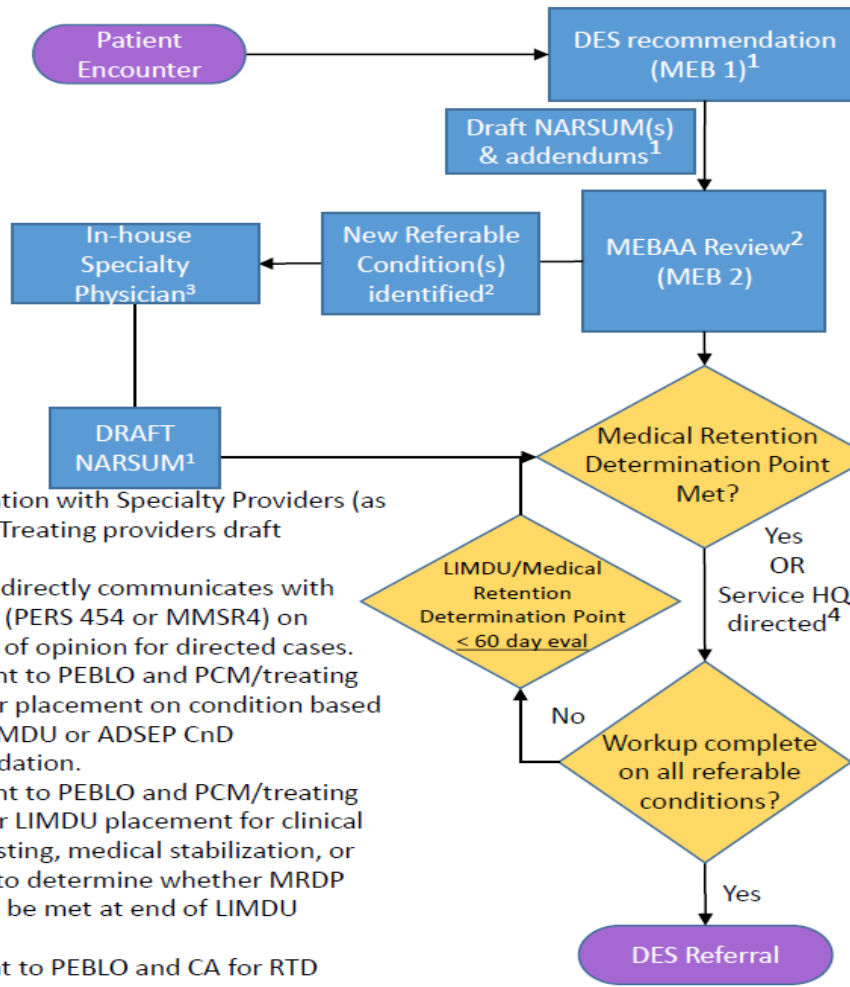
Large volume (LIMDU and DES) site: Example-3

For a site that has 1,000 active LIMDU cases, 150 inactive or expired LIMDU cases, 75 active DES cases and 25 open DES cases:

- The MEBAA physician and CA caseload is 1,250 cases; site merits six MEBAA physicians (uniformed) or five MEBAA physicians (CIV and CTR) and ten CA.
- The PEBLO caseload is 100 cases; site merits four PEBLOs. This site meets or exceeds the minimum threshold number of three PEBLOs to merit one DES contact representative.
- The LIMDU caseload for this site is 1250; site merits 8 deployability care coordinators.

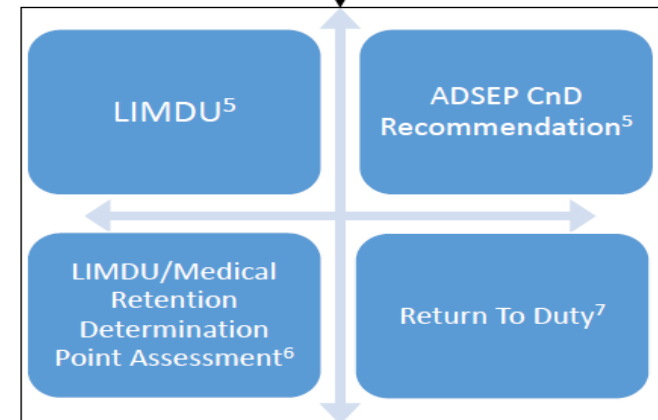
PRE-DISABILITY EVALUATION SYSTEM AND MEDICAL EVALUATION BOARD PHASE WORKFLOW

**Pre-DES Workflow**



3- Consultation with Specialty Providers (as required). Treating providers draft NARSUMs.  
 4- MEBAA directly communicates with Service HQ (PERS 454 or MMSR4) on divergence of opinion for directed cases.  
 5- Case sent to PEBLO and PCM/treating provider for placement on condition based duration LIMDU or ADSEP CnD recommendation.  
 6- Case sent to PEBLO and PCM/treating provider for LIMDU placement for clinical workup, testing, medical stabilization, or treatment to determine whether MRDP criteria can be met at end of LIMDU period.  
 7- Case sent to PEBLO and CA for RTD actions.

1- PCM or referring provider. Non-Physician providers may submit draft NARSUM(s) for review and endorsement by MEBAA physician.  
 2- MEBAA physician writes NARSUMs for specialty care conditions from network providers through consultations, review of clinical encounters, and electronic health record. MEBAA is endorsing/final signature for NARSUMs.  
 -MEBAA physician performs comprehensive review and assessment (Labs, Rads, Clinical encounters, service treatment record, etc.) for ALL potentially ratable/referable conditions and assesses for medical retention determination point criteria. Consultations with specialty providers (and Convening Authority) as required for conditions beyond scope of practice.



**MEB Phase Workflow**

