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

BUMEDINST 6000.19A
BUMED-N10
3 Aug 2026

BUMED INSTRUCTION 6000.19A

From: Chief, Bureau of Medicine and Surgery

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

Ref: See Enclosure (1)

Encl: (1) References
(2) Medical Evaluation Board Composition, Functions, and Staffing
(3) Medical Evaluation Board Staffing and Training Guidelines
(4) Pre-Disability Evaluation System and Medical Evaluation Board Phase Workflow
(5) Pre-Disability Evaluation System Phase Workflow

1. Purpose. To clarify and prioritize expectations of the Medical Evaluation Board (MEB) for the Disability Evaluation System (DES), temporary limited duty (LIMDU), Employ, physical fitness assessment (PFA), medical waivers, and administrative separation (ADSEP) for conditions not amounting to a disability (CnD), per references (a) and (b) and as described in enclosure (1). Reference (a) through (y) provides the authority and applicable policy basis for this instruction. 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) and Navy Medicine Readiness and Training Units (NAVMEDREADTRNUNIT) must perform the MEB functions described in enclosure (2), assign MEB roles as described in enclosure (3), and process pre-DES and DES cases, per references (a), (d), (e), (f), and enclosure (4). This instruction is a complete revision and should be reviewed in its entirety.

2. Cancellation. BUMEDINST 6000.19.

3. Scope and Applicability. This instruction is applicable to Naval Medical Forces Atlantic and Naval Medical Forces Pacific healthcare personnel responsible for care of Sailors and Marines in NAVMEDREADTRNCMDs and NAVMEDREADTRNUNITs and includes guidance on integration of operational healthcare providers in the MEB process. This instruction will serve as a reference to other Service providers when caring for Sailors and Marines. In addition, this instruction provides a process to fulfill MEB requirements and deployability assessments as outlined in references (a), (b), (d), (g), (h), and (i) for consideration by Defense Health Agency medical treatment facilities (MTF).

4. Background. NAVMEDREADTRNCMDs and NAVMEDREADTRNUNITs support the Navy and Marine Corps and must prioritize active duty Service members going through the LIMDU and DES process. Navy Medicine (NAVMED) must meet the established quality and timeline metrics, per references (a), and (d) through (j).

5. Responsibilities

a. Director, Clinical Operations, Policy and Standards, Bureau of Medicine and Surgery (BUMED) (BUMED-N10) must:

(1) Review requests from Naval Medical Forces Atlantic and Naval Medical Forces Pacific Force Medical Readiness Directors authorizing delegation of responsibilities for virtual MEB Approving Authorities (MEBAA) to fulfill MEB functions across Naval Medical Forces Atlantic and Naval Medical Forces Pacific commands.

(2) Review requests from Naval Medical Forces Atlantic and Naval Medical Forces Pacific Commanders authorizing delegation of responsibilities of virtual MEBAA(s) to other Service commands.

b. Director, Force Medical Readiness (BUMED-N10D) must:

(1) Develop and maintain standardized LIMDU and DES training for the regions and the NAVMEDREADTRNCMDs and NAVMEDREADTRNUNITs. Some training courses are available within the Joint Knowledge Online platform:

(a) MEB-1 – LIMDU and DES Provider Training (NAVMED: LIMDU DES Provider (DHA-1484-01))

(b) MEBAA and MEB convening authority (CA) – LIMDU, DES, MEBAA, and CA Training (Navy Medicine: MEBAA and CA (DHA-1484-02))

(c) Physical Evaluation Board Liaison Officer (PEBLO) – LIMDU, DES, and PEBLO Training (PEBLO Annual Training (DHA-1484-03))

(d) Deployability care coordinator - Deployability care coordinator training

(e) Command deployability coordinators - Command deployability coordinator training

(2) Develop and maintain dashboards used for visualization of real-time data for LIMDU and DES metrics to ensure successful monitoring and performance of the program.

c. Commanders, Naval Medical Forces Atlantic and Naval Medical Forces Pacific must:

(1) Man, train, and equip NAVMEDREADTRNCMDs and NAVMEDREADTRNUNITs to provide and oversee MEB performance, ensuring compliance with congressionally mandated timelines outlined in reference (k).

(2) When necessary, request authorization from BUMED-N10D to delegate MEBAA(s) or MEB CA(s) between subordinate commands or other Service components, whether virtual or onsite.

(3) When a Service member does not have a clearly assigned NAVMEDREAD-TRNCMD, utilize references (c) and (g) to assign the appropriate NAVMEDREADTRNCMD medical cognizance over the Service member's case. Factors that may determine the assignment of medical cognizance include a Service member's Tri-Service Medical Care (TRICARE) enrollment status, home of record or family support location(s), transfer to another geographic location, and medical capabilities available to the NAVMEDREADTRNCMD or NAVMED-READTRNUNIT.

(4) Coordinate medical responsibility for Sailors and Marines assigned to sites where an MEB CA is unavailable.

(5) Assign Board of Naval Corrections Medical Cognizance (MEDCOG) for members no longer on active-duty service who have been determined by Navy Personnel Command (NAVPERSCOM) to rate an MEB.

d. Commanders and Commanding Officers (CO) NAVMEDREADTRNCMDs and Officers in Charge NAVMEDREADTRNUNITs must:

(1) Per enclosures (2) and (3), oversee staffing, training, and performance of MEB functions.

(2) Assure LIMDU, DES, and Employ cases are properly processed, and medical input finalized by the assigned MEB CA.

(3) Assign a minimum of one MEB CA, one MEBAA, one PEBLO, and one deployability care coordinator. Caseload and full time equivalent (FTE) requirements for these roles are listed in enclosure (3).

(4) Delegate MEB CA and MEBAA position(s) at ratios listed in enclosure (3). The ratios are set to assure required timelines are met, per reference (k), and quality control processes per reference (a).

(5) For personnel on permanent limited duty (PLD):

(a) Assist PLD personnel and their parent command in acquiring appointments on a priority basis.

(b) Ensure Service members continued in PLD status in excess of 12 months receive a medical re-evaluation to be submitted to the Physical Evaluation Board (PEB) a minimum of 6 months prior to the completion of the PLD period. Communication with the Service member's command should be maintained.

(c) Maintain separate case files for PLD personnel to assist in identification, processing, and tracking of the requirements outlined in subparagraph 5d(5)(b).

(6) Review staffing standards and Medical Expense and Performance Reporting System (MEPRS) reports during monthly performance reviews.

(7) Patient administration department, medical readiness clinic, or MEB office will manage access to the Sailor and Marine Readiness Tracker (SMART) for MEB activities and ensure inputs are accurately reflected in the appropriate application, per reference (g).

(8) Ensure providers are documenting a deployability and fitness for duty assessment at every healthcare encounter, per references (h), (j), (l), and (m). This assessment must be completed in the electronic health record (EHR) or other means, per reference (n). Upon completion of a healthcare encounter, the provider, including independent duty corpsmen, per reference (o), will document the medical portion of the determination using the deployability categories (DCAT). DCATs 1 and 2 are considered deployable, while DCATs 3 and 4 are considered non-deployable.

(a) Category One – Fully Deployable. Service members are fully deployable to any operational area or in support of operations.

(b) Category Two – Deployable with Limitations. Service members may be assigned to an operational area with medical restrictions based on geographic and platform limitations, with approval from Service Headquarters (HQ) Deployability Assessment and Assignment Branch (PERS-454) or Manpower Management Division, Separation and Retirements (MMSR-4). Those on light duty may be assessed as DCAT 2 which requires additional medical scrutiny prior to deployment.

(c) Category Three – Temporarily Non-Deployable. Service members cannot deploy to an operational area or in support of operations without Service HQ Commander, Naval Personnel Command or MMSR-4 approval due to temporary restrictions from a medical condition (e.g., referred to DES, LIMDU, hospitalization, pregnancy).

(d) Category Four – Permanently Non-Deployable. Service members are considered permanently non-deployable if they do not meet retention standards, are enrolled in DES, are on PLD or pending a non-duty related line of duty determination or are nondeployable for administrative reasons; these Service members are excluded from deployability reporting and are no longer considered for deployment.

(9) Ensure healthcare providers must utilize the procedures outlined in enclosure (2) to document the appropriate alternate duty status (e.g., LIMDU, Employ, ADSEP CnD, or DES referral) in each encounter, per reference (h).

(10) Ensure specialists restrict their deployability assessment to their scope of practice when initiating return to duty (RTD), LIMDU, ADSEP CnD, or the DES process and notify the Service member's primary care manager (PCM) of the deployability change and any recommended follow-on actions.

(11) To evaluate compliance, peer review may be used to ensure deployability assessments are completed at all provider-based encounters, per reference (h).

(12) Ensure if referred to a case manager (CM), that CM perform responsibilities and duties as they pertain to LIMDU and DES as outlined in enclosure (2).

(13) Ensure MEB staff are trained as outlined in enclosure (2).

6. Contact Information. Questions can be directed to the Naval Medical Forces Atlantic group e-mail, usn.hampton-roads.navmedeastporsva.list.nme-pad@health.mil and Naval Medical Forces Pacific group e-mail, usn.san-diego.navmedwestsanca.list.navmedforpac-medical-readiness-pad@health.mil. Further assistance is available through the BUMED-N10D group e-mail, usn.ncr.bumedfchva.mbx.bumed-medical-readiness@health.mil, PERS-454 e-mail, mill_DAOPers-454@navy.mil and Marine Corps' MMSR-4 e-mail, smb.manpower.mmsr4@usmc.mil.

7. 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 found on 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 Office of the Chief of the Naval Operations (OPNAV) Records Management Program (DNS-16).

8. Review and Effective Date. Per OPNAVINST 5215.17A, BUMED-N10D will review this instruction annually around the anniversary of its issuance date to ensure applicability, currency, and consistency with Federal, Department of War (DoW), Secretary of the Navy 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.

9. Forms. The listed forms are available at https://www.med.navy.mil/Directives/NAVMED-Forms/:

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 Legacy Disability Evaluation System Enrollment.

d. NAVMED 6120/9 Temporary Disability Retired List 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. NAVMED 1300/3 Medical Assignment Screening.

M. CASE
Acting

Releasability and distribution:
This instruction is cleared for public release and is available electronically only via the Navy Medicine Web site, https://www.med.navy.mil/directives/

REFERENCES

(a) DoD Instruction 1332.18 of 10 November 2022
(b) ASN (M&RA) memo of 11 September 2018 (NOTAL)
(c) NAVMED P-117
(d) DoD Instruction 6130.03, Volume 2, of 4 September 2020
(e) SECNAVINST 1850.4F
(f) SECNAV M-1850.1 of September 2019
(g) BUMEDINST 6320.104
(h) BUMEDINST 1300.6
(i) DHA-PI 6025.20 of 27 Aug 2019
(j) OPNAVINST 1300.20A
(k) DoD Manual 1332.18, Volume 1, Disability Evaluation System Manual: Processes, 24 February 2023
(l) DoD Instruction 1332.45 of 30 July 2018
(m) DoD Instruction 6025.19 of 13 July 2022
(n) BUMEDINST 1900.2A
(o) OPNAVINST 6400.1D
(p) BUMEDINST 6010.30
(q) OPNAVINST 6110.1K
(r) MILPERSMAN 1300-1400
(s) DoD Instruction 6490.08 of 6 September 2023
(t) SECNAV memo of 4 Dec 2014 (NOTAL)
(u) ASN (M&RA) memo of 20 March 2020 (NOTAL)
(v) BUMEDINST 1300.2B
(w) Joint Travel Regulation
(x) BUMEDINST 6320.79B
(y) 45 CFR 164.512

MEDICAL EVALUATION BOARD COMPOSITION, FUNCTIONS, AND STAFFING

1. MEB Composition. MEB staffing is essential to ensure thorough evaluations and the ability to meet established timelines for LIMDU, ADSEP CnD, Employ and DES. MEB staffing is critical for the active management of LIMDU Service members through Temporary LIMDU Operations (TEMPO).

a. A MEB must be convened for LIMDU, consecutive PFA medical waivers, Employ, ADSEP CnD, and DES cases. Convening a MEB does not necessarily require a physical or virtual meeting; rather, each member develops and edits the MEB documents via SMART. The referring provider (MEB-1), MEBAA, and CA may be assigned as necessary to complete all functions of the MEB.

b. The MEB is made up of at least two members: the MEB-1 and the MEBAA, per references (a), (c), and (l). Additional MEB members may be required for specialist input into an additional disqualifying condition, if a narrative summary (NARSUM) addendum or countersignature of a NARSUM is needed.

c. For a mental health diagnosis, the MEB must consist of a minimum of one mental health provider (MHP), either a psychiatrist or a doctoral-level psychologist. This MHP may be the provider assigned to perform the evaluation, as required by reference (a). If the MHP on an MEB is a psychologist, at least one of the other MEB members must be a physician.

d. Sailors with two consecutive medical waivers or three in the most recent 4-year period, must be referred to an MEB. MEB findings and unique medical situations will be forwarded to NPC Deployability Assessment and Assignment Branch (PERS-454) for disposition, per reference (p).

2. MEB Staffing and Support

a. The MEB-1 (DoW civilian, DoW contract, or uniformed provider) is a physician, clinical psychologist, physician assistant, nurse practitioner, licensed clinical social worker, dentist, physical therapist, occupational therapist, optometrist, podiatrist, certified nurse midwife, certified registered nurse anesthetist, or an independent duty corpsman. Per reference (q), all providers should function within their scope of clinical privileges. The referring PCM may consult with a specialty provider if necessary to determine fitness for duty; specialty providers may determine deployability within their scope of practice and refer to the MEB. The MEB-1 should consider referral to case management if the Service member would benefit from this resource. Specialty providers may function as MEB-1 for any MEB functions (LIMDU, ADSEP CnD, Employ, or DES) regarding conditions within their scope of practice and should notify the Service member's PCM when restricting a Service member's duties or placing them in a non-deployable status.

b. The MEBAA is the primary overseer of all readiness processes related to LIMDU, TEMPO, Employ, ADSEP CnD, and DES recommendations. MEBAAs are appointed in writing by the NAVMEDREADTRNCMD and NAVMEDREADTRNUNIT COs and must be a board-eligible or board-certified, uniformed, civilian or contract physician. A doctoral level psychologist may serve as MEBAA for MEBs involving mental health conditions, provided at least one other member of the MEB is a physician.

(1) Physicians recommended as MEBAA: occupational medicine, internal medicine, family medicine, aerospace medicine, undersea medicine, and preventive medicine.

(2) Specialty physicians may be assigned within their scope of practice and should notify the Service member's PCM when restricting a Service member's duties or placing them in a non-deployable status.

(3) BUMED employs MEBAAs through a virtual MEB contract; these providers are allocated to function as MEBAAs at any NAVMEDREADTRNCMD or NAVMEDREAD-TRNUNIT as determined by BUMED, or the Navy Medicine region, BUMED-N10D office.

c. Operational units may use the type command surgeon or Marine Expeditionary Force surgeon as MEBAA. Type command and Marine Expeditionary Force surgeons may delegate, in writing, a senior privileged and board-certified physician within a subordinate command as MEBAA.

(1) For mental health conditions, the force mental health officer is preferred, consistent with MEB requirements. Any MEB listing a behavioral health diagnosis must contain a thorough behavioral health evaluation by a military MHP and include the signature of a psychologist with a doctorate in psychology, or a board-certified or board-eligible psychiatrist, per reference (a). If the MHP performing the evaluation is a doctoral level psychologist, one (1) of the remaining members must be a physician.

(2) NAVMEDREADTRNCMDs and NAVMEDREADTRNUNITs must coordinate with supported commands to ensure operational providers receive SMART training. Once training is complete, the NAVMEDREADTRNCMD or NAVMEDREADTRNUNIT with medical cognizance over the process will determine if the provider is adequately trained. The NAVMEDREADTRNCMD or NAVMEDREADTRNUNIT will grant appropriate access and controls.

d. NAVMEDREADTRNCMDs or NAVMEDREADTRNUNITs supporting recruit and officer training are encouraged to appoint MEBAA(s) in initial entry medical support facilities.

e. The MEB CA is a senior medical officer appointed, in writing, by the NAVMEDREAD-TRNCMD or NAVMEDREADTRNUNIT CO, and is responsible for assembling an MEB. Though not a member of the MEB, the MEB CA serves as the final endorsement signature for LIMDU, Employ, ADSEP CnD, and DES processing.

(1) The MEB CA must be O-4 (select) or above and a uniformed or DoW civilian board-eligible or board-certified, privileged physician or doctoral level psychologist. The MEB CA should have experience comparable to a department head, director, or chief of clinical services. Operational experience is highly recommended.

(2) Psychologists may be MEB CA for cases purely for mental health conditions.

(3) The MEB CA should have knowledge of standards of medical fitness for duty, retention standards, and disability separation processing. The MEB CA should also be familiar with the Veteran's Affairs Schedule for Rating Disabilities (VASRD).

(4) Contract physicians are not eligible to serve as a MEB CA.

f. MEB CAs and MEBAAs may have dual designations, however, one person may not assume both roles on a single case.

g. PEBLO. The PEBLO is the primary liaison between the Service member and other DES team members and is responsible for coordinating all aspects of DES and Temporary Disability Retired List (TDRL) case processing and customer service. PEBLOs must use NAVMED 6150/50 for processing of DES cases. See references (a), (e), and (f) for comprehensive roles and responsibilities for PEBLOs.

h. Case Management. Case Management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet a Service member's health care needs. CMs are licensed registered nurses or licensed clinical social workers who may provide case management for Service members. It is a voluntary program where a Service member may request or be recommended by a provider for services. The provider must document CM recommendation and rationale. If a Service member declines services, this must be documented in the Service member's EHR.

(1) A CM may attend TEMPO meetings and assist with identification of Service members that may benefit from case management services.

(2) For those Service members who have been referred and accepted by case management services, the CM should actively engage in TEMPO meetings. The CM may provide updates in collaboration with the MEB-1 or MEBAA. The CM will:

(a) Facilitate timely access to care, treatment, and services requiring support for Service members, particularly those with complex care requirements.

(b) Coordinate transfer of information when Service members require care outside the Direct Care System (DCS). This will ensure effective care coordination, seamless transitions, continuity of care, and assurance that documentation of care encounters outside the DCS are collected in the EHR.

(c) Collaborate with the MEBAA on the Medical Readiness Determination Point (MRDP) assessment, as the CM may have the most comprehensive information on the Service member.

i. Contact Representative. Recommended personnel that work closely with PEBLOs for administrative support functions related to DES case processing.

j. Deployability Care Coordinator. Preferably, the deployability care coordinator should have a clinical background (i.e., hospital corpsman). Duties may also be fulfilled by a civilian health system specialist. Responsibilities are outlined in reference (r).

k. Command Deployability Coordinator. Command deployability coordinator is a member of the Service member's command and must be appointed in commands with 50 or more Service members in a medically restricted status. Specific responsibilities of the command deployability coordinators and additional guidance can be found in reference (r).

3. MEB Process

a. LIMDU. For Service members with a medical condition that limits their ability to perform the duties of their office, grade, rank, or military occupational specialty, or when performance of their duties would compromise recovery from a medical condition, LIMDU must be considered. LIMDU is required for medical conditions that limit duties for greater than 90 days, or conditions that limit deployability for greater than 30 days, per reference (i). All LIMDU cases must be entered into SMART, noting the anticipated period of LIMDU required for RTD. Additional guidance can be found in references (r).

(1) The primary purpose of LIMDU is to provide a Service member adequate time to receive care and recover from their medical condition in order to return to a full duty status. LIMDU may also be utilized to complete medical workup to determine whether the Service member has the potential to return to full duty. In these cases, the assessment period of LIMDU should be relatively short.

(a) An active LIMDU case is defined as a case wherein a Service member is currently assigned to LIMDU within SMART.

(b) An inactive LIMDU case is defined as a case wherein a Service member has completed the assigned LIMDU but has not received a signature for RTD or deployable status.

(2) At time of LIMDU referral, the MEB-1 will screen the Service member to determine if case management services are warranted.

(3) Condition-based LIMDU. Condition-based LIMDU is a recommended period of LIMDU for a particular diagnosis based on the expected duration of recovery, per references (j) and (s). LIMDU recommendations beyond condition-based LIMDU guidelines should occur on a case-by-case basis and reasoning should be documented in SMART and in the EHR.

(4) The MEB CA approves all LIMDU requests in SMART if the period of LIMDU is less than 12 months. A LIMDU period(s) exceeding 12 consecutive months for the same condition are automatically forwarded to Service HQ for review through SMART.

(5) At each follow-up encounter for a Service member on LIMDU, the attending medical provider must make one of the recommendations as outlined in subparagraphs 3a(5)(a) through 3a(5)(f).

(a) Continue LIMDU.

(b) RTD. Prior to RTD, the MEB CA must ensure all deployment limiting conditions have been considered. If the Service member has other deployment limiting conditions, the Service member cannot be returned to full duty. If the Service member is deemed fit for full duty, RTD status must be entered into SMART. This will automatically generate the NAVMED 6100/6. The form is considered complete with the signature of the MEB CA. MEB CA signature and Service HQ notification by the NAVMEDREADTRNCMD or NAVMEDREAD-TRNUNIT must occur within 5 days of the RTD date listed on the NAVMED 6100/6. If at any point during the LIMDU period, it becomes clear that the Service member will not be able to return to a full duty status or will remain in a restricted duty or nondeployable status for greater than 12 consecutive months, the MEB should transition to DES or ADSEP CnD, as appropriate. This is the MRDP.

(c) LIMDU for pre-DES phase initiation. This phase is explained in more detail in subparagraph 3e of this enclosure.

(d) Employ (Navy only). Reference (r) provides guidance on the Navy's Employ program. The Service member must concur with the nomination to Employ.

(e) DES referral. Per reference (l), the primary trigger for referral is LIMDU exceeding cumulative 12 months for the condition which initially warranted LIMDU. DES referral can begin any time the medical care team believes a duty or deployment-limiting condition to be permanent or is expected to persist greater than 12 months. The requirement for DES referral can be waived by Service HQ, per references (b) and (d). Additionally, Service HQ retains the authority to direct Service members to LIMDU or DES and may do so earlier than the 12-month period. Any divergence of opinion may be discussed with Service HQ or outlined in the electronic MEB Report (eMEBR) in SMART for consideration by the PEB.

(f) ADSEP CnD recommendation. ADSEP is the appropriate recommendation when a Sailor or Marine has a medical condition which limits their ability to perform the duties of their office, grade, rank, or military occupational specialty. The condition is believed to be permanent or expected to persist greater than 12 months, and when the condition is not listed among the VASRD diagnoses appropriate for Veteran's Affairs (VA) disability rating.

(6) When medical care and services required exceed local capabilities, the Service member may be transferred to a continental United States (CONUS) site where capabilities and infrastructure are adequate to provide appropriate medical care or to process DES cases per Service member command policy. The treating provider will detail this information in the treatment plan section of SMART and further annotate that the Service member should return to CONUS. A case management referral should be considered in these situations to ensure a seamless transition of TRICARE enrollment and continuity of primary and specialty care.

(7) When a Service member who is on LIMDU executes permanent change of station (PCS) orders, there is often a disruption in their medical care and treatment. Much of this is avoidable with effective planning and coordination. NAVMEDREADTRNCMD and NAVMEDREADTRNUNIT MEBs and MEB support offices who are aware of a Service member on LIMDU will arrange a "warm hand-off" to the Service member's gaining command medical officer, if applicable, and the NAVMEDREADTRNCMD or NAVMEDREAD-TRNUNIT with MEDCOG over the Service member's gaining command, including:

(a) Expedited TRICARE enrollment and PCM assignment at the new location.

(b) Provider-to-provider communication with the pending PCM, summarizing the Service member's current status, ongoing health care needs, and any consults required to continue care.

(c) Early entry of specialty consults in the new location to minimize gaps in care and Integrated Disability Evaluation System (IDES) processing.

(d) Provider-to-provider communication with the receiving MEB providing details of the Service member's clinical status, specialty care and therapy needs, and IDES case recommendation, to include a preliminary NARSUM. If SMART is used to write the NARSUM in eMEBR, the case must be transferred to the new NAVMEDTREADTRNCMD.

(e) Case management referral is recommended to facilitate these steps.

(8) LIMDU is concluded when the period has expired, the Service member has RTD, or the Service member has been referred to ADSEP CnD or DES. This determination should be addressed at least 30 days prior to expiration of LIMDU in the TEMPO review.

(9) TEMPO. Review of LIMDU cases must be conducted by a multidisciplinary team and chaired by a MEBAA or MEB CA. The team may consist of NAVMEDREADTRNCMD or NAVMEDREADTRNUNIT staff, operational providers, CM, deployability care coordinator, MEB support staff, PEBLO, specialty providers as appropriate, command representative, and command deployability coordinator at the Chair's discretion.

(a) Conducting TEMPO reviews is imperative to maintaining consistent, efficient, and effective LIMDU management. TEMPO meetings afford the opportunity to actively manage the LIMDU population and should result in treatment recommendations, case management interventions, and appropriate dispositions of Service members for RTD, LIMDU, Employ, pre-DES or DES.

(b) The frequency of TEMPO meetings should be conducted based on the size of the LIMDU population. Priority should be given to reviewing cases that are due to expire within 30 to 60 days. If resources permit, a complete review of all cases each month is preferred.

(c) During TEMPO meetings the MEB-1 or MEBAA will review cases, evaluate progress, identify additional resource needs, and determine if continued LIMDU is appropriate, or another disposition is required. These findings will be entered into SMART by the MEB-1, evaluated by the MEBAA, and adjudicated by the MEB CA.

(d) During reviews, team discussion should include, but is not limited to, the key clinical questions: Do we have the correct diagnosis? Do we have an appropriate and effective treatment plan? Is the Service member's treatment progressing as expected? If not, what are the barriers? What additional treatment or therapeutic interventions would result in an earlier RTD? Is the patient ready to RTD now? Does the Service member meet the criteria for referral to the DES or ADSEP CnD? Is the Service member a potential candidate for Employ? Has the Service member attended follow up visits? Have in-service referrals and all outstanding studies been scheduled? Should the command be included more consistently? Should a referral to case management be initiated?

(e) The Service member must be notified of the TEMPO recommendation via local policy. Should a follow-up appointment be required, an appropriate MEB representative (deployability care coordinator, CM, or MEB-1) will assist the Service member in scheduling an appointment for follow-up actions with the MEB-1.

(10) Retention Waiver for Non-Deployability. Service members who are on LIMDU, or who are recommended for LIMDU, for greater than 12 consecutive months must be reviewed for retention by Service HQ.

(a) SMART will automatically send a notification to the Service member's Service HQ when 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. When the medical condition(s) will not allow a Service member to return to medically unrestricted duty, the Service member should be referred to the DES, considered for ADSEP CnD, or nominated for Employ.

b. MRDP. The MRDP is the point when a member of the MEB determines that the prognosis of a Sailor or Marine's medical condition has become clear enough to state that he or she will not be able to return to a medically unrestricted status or will have to remain in a medically restricted status for a total of more than 1 calendar year. This determination triggers submission of a retention waiver to Service HQ, referral into the DES, referral to the Employ program, or recommendation for ADSEP CnD.

c. Employ. Employ is an NPC program providing medically non-deployable Sailors with expanded opportunities for continued naval service. Employ works to identify, retain, and assign Sailors, prior to a referral to DES, who may continue to perform the duties required of his or her office, grade, rank, or rate or an alternate rate in a non-deployable status. MEB-1 providers may nominate a medically non-deployable Sailor for the Employ program if the Sailor is expected to complete the requirements of a non-operational tour only, with the Sailor's consent and command support. All Employ cases must be entered into SMART. Upon acceptance to the Employ program, the Sailor's LIMDU case must be closed; either by the local NAVMEDREADTRNCMD or NAVMEDREADTRNUNIT deployability care coordinator or PERS-454. Providers who have nominated Sailors for Employ will receive a notification within SMART to complete a re-evaluation within 12 months to determine if the member is fit for RTD. If the Sailor remains limited in the full duties of rate and rank, the member may be nominated for an additional Employ term or a referral to DES should be initiated. If the Sailor is no longer capable of performing in rate, they must be referred to the DES per reference (r). More information about the Employ program and process can be found in reference (o).

d. DES. DES is the Service HQ mechanism for determining fitness for continued service. Outcomes of the DES include RTD, fit for full duty, RTD with limitations, permanent LIMDU, separation, or retirement due to disability. A Service member must be referred to the DES when the MEB determines the Service member has a VA ratable medical condition or conditions that individually, collectively, or through combined effect may prevent the Service member from permanently carrying out the duties of their office, grade, rank, or rating for greater than 12 consecutive months. The MEB may also refer Service member into the DES if the Service member has a VA ratable condition(s) representing an obvious medical risk to the health of the Service member, the health or safety of other Service members, or imposes unreasonable requirements to maintain or protect the Service member. The VASRD is the authoritative list of VA ratable conditions, and it can be found at: https://www.ecfr.gov/current/title-38/chapter-I/part-4. Review of conditions is required as

some conditions may be similar to those listed in the VASRD. Additionally, unlisted conditions might be encountered and could form the basis for a referral into DES as the VA will find it permissible to rate under a closely related disease or injury in which not only the functions affected, but the anatomical localization and symptomatology are closely analogous.

(1) The MEB-1 may recommend a Service member meeting MRDP criteria to the MEBAA for DES referral.

(2) The PEBLO will build a case file. The MEB CA must convene the MEB using information that is received from the PEBLO and MEB-1, per reference (k). If the DES referral includes a mental health diagnosis, the MEB must consist of at least one (1) mental health specialist, preferably as MEB-1.

(3) The MEBAA serves to ensure that the MRDP has been achieved for a VA ratable medical condition prior to approving a DES referral. The MEBAA may consult with treating, referring, or specialty providers.

(a) If the MEBAA concurs with the DES recommendation, the MEBAA will initiate a DES referral using NAVMED 6150/50 in SMART. The MEB-1 will compose the NARSUM in SMART for the MEBAA's review. The MEBAA will review and edit the NARSUM as necessary and may write or direct additional NARSUM(s) for any other conditions impacting the Service member's ability to reasonably perform their duties and for which the MRDP criteria is met deployability or would warrant DES referral. The DES referral is then routed to the military service coordinator and VA via SMART.

(b) The MEBAA will assist the MEB CA in reconciling disparities in DES recommendations, for example, in case of disagreement between MEB-1 and MEBAA on disposition, or concerns regarding a PERS-directed DES referral.

(c) Alternatively, when DES is not the appropriate next step, the MEBAA must recommend one of the recommendations as outlined in subparagraph 3d(c)1 through 3d(c)4.

1. RTD, should the Service member meet criteria and is determined to be fully deployable.

2. Nomination to employ with Service member concurrence and command recommendation.

3. ADSEP CnD recommendation when non-compensable medical condition(s) interferes with the performance of duties.

4. Initiation of the pre-DES phase via continuation on or referral to LIMDU to fully assess for MRDP. In most circumstances, the maximum duration of MRDP assessment should not exceed 60 days. If more than 60 days are needed, communication between MEB-1, MEBAA, MEB CA (and PERS if indicated) is recommended to minimize excessive delays in dispositioning cases.

(4) PEBLOs must use SMART and veterans tracking applications for tracking DES processing.

(5) Service member certifications consist of review of eMEBR, CO non-medical assessment, and VA exam results. The Service member may agree with the information and completeness of the documents or elect rebuttal or an impartial medical review. Following military service coordinator and VA processing of the case, it is then forwarded by the PEBLO to the MEB CA for review and signature. Once MEB CA has reviewed and signed in SMART, the PEBLO will forward the case to the PEB.

(6) A DES referral can be directed by Service HQ at any time. In cases of Service HQ-directed DES, if there is a divergence of opinion in the fitness of duty determination for a Service member, the MEBAA or MEB CA must consult with Service HQ and annotate in the NAVMED 6150/50 for consideration by the PEB.

(7) An active DES case is defined as one entered into veterans tracking applications without a completed MEB phase.

(8) An open DES case is defined as a case with a completed MEB phase and pending final PEB adjudication.

(9) Elective surgery after referral to DES.

(a) Per reference (f), elective surgery is defined as surgery that is not essential, especially surgery to correct a condition that is not life-threatening or required for survival.

(b) Military facilities should be cognizant of the Service member's status and not initiate treatment or a procedure after a Service member has begun the DES process if the intervention can be safely or reasonably deferred.

(c) Per reference (c), there are instances when the decision of what constitutes "elective" may be disputed among clinicians. In this situation, according to the facility's policy, the senior medical officer, chief medical officer, or MEB CA will be the final arbiter of whether the surgery may be classified as elective.

(d) Prior to any elective procedure at a military facility, the Service member must receive written counseling by the PEBLO that the DES process may be suspended or terminated. Should the elective procedure take place at a network location, even at the Service member's

own expense, the Service member must also be counseled regarding the risk of ineligibility for compensation for any adverse event or residual complication. In either situation, the member's PCM must be informed immediately. Per reference (t), the member must be also counseled by the PCM, which will be documented in the EHR. The PCM will inform the Service member's CO or representative to determine the potential for individual or mission readiness impact. Written approval from the Service member's CO is required prior to the procedure taking place. If this is not obtained, the Service member may face disciplinary or adverse administrative action.

(e) The PEB may determine that a Service member who elects to have surgery after referral into the DES process may result in suspension or termination of the process, particularly if recovery is likely to take longer than 60 days.

(10) DES and Overseas, Deployable, and Remote Duty Locations. In many outside the continental United States (OCONUS) or remote duty stations, offices that support the full IDES process with benefits and services (e.g., specialty care, PEBLOs, VA military service coordinator, DES counsel, veterans tracking applications access, Healthcare Artifact and Image Management Solution (HAIMS) access) may not be available to Service members and their families. In these situations, it is appropriate to coordinate early return of the Service member with Service HQ per references (a), (f), (r), (u), and (v). If the full spectrum of services is available, the NAVMEDREADTRNCMD, NAVMEDREADTRNUNIT and MTF, in collaboration with the Service member's command, will determine if the Service member and family are to remain in the OCONUS or remote location to continue IDES processing.

(a) When recommending PCS orders from Service HQ for DES processing in the CONUS, the local MEB must utilize NAVMED 6100/5 in SMART to place the Service member on LIMDU.

(b) When a Service member undergoes PCS for purposes of entering the DES, the local MEB will arrange a "warm handoff" to the NAVMEDREADTRNCMD or NAVMEDREADTRNUNIT with MEDCOG over the Service member's gaining command, including:

1. Expedited TRICARE enrollment and PCM assignment at the new location.

2. Early entry of specialty consults in the new location to minimize gaps in care and IDES processing.

3. Provider-to-provider communication with the receiving MEB providing details of the Service member's clinical status, specialty care and therapy needs, and IDES case recommendation, to include a preliminary NARSUM. If SMART is used to write the NARSUM in eMEBR, the case must be transferred to the new NAVMEDTREADTRNCMD.

4. Case management referral is recommended to facilitate these steps.

(c) Any travel required as part of IDES case processing is the responsibility of the Service member's command, per reference (w).

(d) The Service member may elect to process through the Legacy Disability Evaluation System (LDES) from OCONUS or remote duty locations. In the LDES process, compensation and pension examinations are not required, per reference (k).

(e) If LDES is preferred by the Service member and the full LDES process (to include specialty care, PEBLOs, DES counsel, veterans tracking applications access, etc.) is available to Service member and their family, the NAVMEDREADTRNCMD or NAVMED-READTRNUNIT, in collaboration with Service member's command, will determine whether Service member and family should remain OCONUS or in a remote location to continue LDES case processing.

(f) Transfer of the member is a command responsibility. Should the Service member require transfer from a deployable command or overseas duty, the transferring command should refer to reference (r).

(g) If the Service member has elected LDES, and medical care and services required DO NOT exceed local capabilities, the MEB-1 will initiate the pre-DES phase work-up requirements (see enclosure (4), pre-DES workflow) to include specialty evaluations, treatment, and draft a NARSUM for each referred unfitting condition. The MEB-1 should consider a case management referral and document consideration and reasoning in the EHR.

e. Pre-DES. MRDP criteria are met for pre-DES when a comprehensive review of all medical records indicate that a Service member has medically stabilized, the course of further recovery is relatively predictable, and 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. Pre-DES phase is intended to address whether the Service member can be RTD, should be referred to DES, or should be recommended for ADSEP CnD.

(1) The MEB-1 may recommend a DES referral for all potentially disabling or impairing VA compensable conditions that have met MRDP, which individually or collectively may prevent the Service member from carrying out the duties and responsibilities within their office, grade, rank, and rating. The MEB-1 must compose a draft NARSUM within their scope of practice and must request a secondary NARSUM from a specialty provider when appropriate. The case and NARSUM(s) are then submitted to the MEBAA within SMART. Refer to enclosure (4) for pre-DES flow chart.

(2) When the MEBAA is in concurrence with the MEB-1's recommendation and verifies MRDP has been met, the MEBAA will finalize the DES referral in SMART.

(3) Members in pre-DES phase that are on operational platforms may be placed on LIMDU to receive PCS orders and an accounting category code change, per reference (r), to ensure the member's billet may be filled at the earliest opportunity per Service protocol. Operational providers are not required to place the DES referral directly into SMART to initiate LIMDU for pre-DES and should coordinate with the receiving PCM to facilitate "a warm hand-off" to prevent delays in DES initiation.

(4) The duration of this MRDP assessment must not exceed 60 days.

f. ADSEP CnD. ADSEP CnD may be considered for a condition(s) that interferes with a Service member's performance of duty but is not specifically listed as VA compensable under the VASRD, or which cannot be rated by the PEB in the absence of a VA rating.

(1) ADSEP CnD recommendations must be entered into SMART.

(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 ratable condition(s) for which the member was found fit for continued service. However, the Service member may still be administratively separated for the CnD if it interferes with the performance of duty.

(3) When an MEB is convened for ADSEP CnD recommendation regarding a mental health condition, it must be comprised of at least one physician, who may be a psychiatrist. If no psychiatrist is available, a doctoral-level psychologist may participate; however, one physician is still required for the MEB.

(4) Ensure ADSEP CnD process and protocols are followed, per reference (n).

4. PEB. The PEB is a performance-based board operating under the Secretary of the Navy Council of Review Boards that determines a Service member's fitness for continued Naval Service. Details about PEB processes are found in reference (f). PEB determinations include fit for continued service; unfit, medically separated; unfit, medically retired to TDRL; unfit, medically retired to the permanent disability retired list.

a. Fit. A member found fit by the PEB will be returned to duty in a medically unrestricted status.

b. Medical Separation with Disability Severance Pay. Service members whom the PEB has determined to be unfit for continued service, has less than 20 years of creditable military service, and has a disability rating by the VA of less than 30 percent. There are no follow-on or re-assessment requirements of the MEB in these cases.

c. TDRL. Service members whom the PEB has determined to be unfit for continued service with a disability rating by the VA 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. A Service member may be placed on the TDRL when they meet the requirements for permanent disability retirement except when the disability is not stable and may be permanent. NAVMED 6120/9 should be used for TDRL assessments. For Service members found unfit because of a behavioral disorder due to traumatic stress and placed on the TDRL, a re-examination must be scheduled within 6 months from the date of placement on the TDRL but completed no earlier than 90 days after placement on the TDRL.

(1) The Service member is required to undergo a TDRL assessment, also known as a periodic physical examination (PPE) every 18 months during the TDRL period to evaluate for continued existence and extent of disability. TDRL assessments are performed by MTF providers and forwarded to the MEDCOG MEB. The assessments can be completed virtually when face to face examination or testing is not required. Refer to reference (x) for further details. If there are no examinations recorded in the EHR or the current system of record, all benefits including retired pay and healthcare will be terminated, per reference (x).

(2) The PEB will accept TDRL PPEs completed virtually, when appropriate, using NAVMED 6120/9, as the default documentation for completing these examinations for submission directly to the PEB.

(3) Conversion from the TDRL to the permanent disability retired list is not automatic. The PEB is required, by statute and policy, to review PPE regarding the condition(s) for which the Service member was placed on the TDRL to assign a final disability percentage per the VASRD.

(4) For full details on TDRL PPE process, refer to reference (x).

d. Permanent Disability Retirement. If a Service member is determined to be unfit by the PEB with a permanent or stable disability and has a VA rating of 30 percent or greater are eligible for disability retirement. Additionally, a Service member who has more than 20 years of creditable service who is found unfit by the PEB will be permanently retired on disability, irrespective of their VA disability rating. Reference (f) has additional information regarding unfit findings. There are no follow-on or re-assessment requirements of the MEB in these cases.

5. Mental Health

a. Prior to initiating a MEB package for LIMDU, Employ, ADSEP CnD, or DES with a mental health diagnosis, a thorough mental health evaluation must be completed by a DOW MHP. A civilian network MHP may make a diagnosis; however, the Service member must be evaluated by a DoW MHP to conduct a diagnostic and fitness for duty evaluation. This provider may be a psychiatrist, licensed clinical psychologist, psychiatric nurse practitioner, or licensed

clinical social worker. For the DES, the MHP must complete and sign a NARSUM in SMART. Per reference (l), at least one member of the MEB must be a psychiatrist or doctorate-level clinical psychologist for mental health conditions being referred to the DES.

b. Health Insurance Portability and Accountability Act (HIPAA) Privacy considerations. Most NARSUMs or MEB MEBR fall under the military command exception provision, per reference (y). There are certain circumstances in which the military command exception provision does not apply, and the minimum necessary rule applies. One such circumstance is for restricted reporting of military sexual assault cases. Reference (y) defines the minimum necessary rule and permissions for disclosure of information and to whom the information may be disclosed. This includes, but is not limited to, determining the Service member's fitness for duty, disability determination, fitness to perform a particular assignment, or ability to carry out any other activity essential for military mission.

(1) Command notification requirements to dispel stigma in providing mental health care to a Service member are provided in references (y) and (s). In addition, the references outline criteria for disclosure of protected information and highlight the sensitivity of any information that would specifically identify or reveal the circumstances of an individual's history as a victim of abuse, neglect, or domestic violence. As such, providers must limit the information in the ADSEP CnD, LIMDU, or DES application in SMART strictly to the diagnostic criteria of the condition(s), brief treatment history, and duty limitations. For individuals with a history of trauma conditions not considered unfitting and following solely from pre-service trauma, an explanation should be provided in the EHR with the documentation noted in this paragraph. Alternatively, the clinician may acknowledge the presence of a concurrent trauma condition in the CnD module but should limit discussion to the fact that it is not unfitting and related solely to pre-service trauma.

(2) The treating provider or MEB-1 must limit the documentation regarding conditions related to sexual trauma, sexual assault, harassment, and domestic or intimate partner violence and other sensitive information in MEBR, NAVMED 6150/50, NAVMED 6100/5, NARSUMs, and official documentation. Additionally, the MEB-1 must use the EHR to document comprehensive and relevant details including the complex decision-making rationale involving clinically sensitive protected health information considered sensitive or exceeding minimal disclosure requirements. The encounter date must be recorded in official forms to convey the appropriate information to the PEB.

(3) For trauma or assault of a non-sexual nature, specifics must be limited to those medically relevant for assessing disability. Details germane to the individual's condition and relevant to the assessment of fitness for continued service and disability determination must be addressed in the NARSUM and documented in the MEBRs, NAVMED forms, and official documentation, per DoD Manual 6025.18 of 13 March 2019, parts 4 through 6, Implementation of the HIPAA Privacy Rules in DoW Health Care Programs.

(4) Disclosure of sensitive information must be limited to officials participating in the processing and adjudication of MEBR and DES cases. Further, this must not cause a restricted report to become unrestricted. For these circumstances, any information sent to COs should be limited to diagnosis only.

6. NAVMED Forms. The MEBAA and MEB CA must ensure all deployment limiting conditions are captured in NAVMED Forms 6100/5, 6100/6, and 6150/50 in SMART when processing LIMDU, Employ, ADSEP CnD, and DES cases.

a. NAVMED 6150/50 will be used when a Service member is recommended for DES by a referring provider, or DES referral is directed by Service HQ.

b. NAVMED 1850/1 will be used for DES case referrals when non-initial entry training Service members elect LDES. When portable document format fillable NAVMED 1850/1 is used, the completed document must be uploaded into the eMEBR application in SMART.

c. NAVMED 1850/2 will be used for DES referrals where the CO of a member who is in initial entry training directs LDES, noting the individualized and compelling rationale for such direction. The completed document must be uploaded to the eMEBR application in SMART.

d. NAVMED 6120/9 will be used by providers when performing required TRDL PPE (in-person or virtual encounters as applicable) described in subparagraph 4d of this enclosure.

e. NAVMED 6100/5 is a detailed summary of the Service member's medical condition(s) and duty or deployment limitations, dictated by the attending physician, and used to request initial or additional LIMDU in excess of 12 months, returning a Service member to duty, initiating LIMDU for pre-DES workup on condition(s) requiring further evaluation to assess for MRDP criteria, recommending DES referrals overseas, recommending early return of Service member, or for endorsing local MEB activities not otherwise captured (e.g., NAVMED 6100/4 Physical Fitness Assessment Medical Clearance Waiver,), per reference (r).

f. NAVMED 6100/6 should be used to return a member to duty. The MEBAA can return a member to duty in lieu of the MEB CA.

g. NAVMED 1300/3 must be completed by military providers after a Service member has received a finding of "fit for continued naval service" or when disqualified from any special duty program due to medical limitations by the PEB and forwarded to PERS-454. It is not required when a Service member RTD from LIMDU. For additional clarification, refer to reference (r).

MEDICAL EVALUATION BOARD STAFFING AND TRAINING GUIDELINES

1. Recommended Staffing Ratios and FTE Offsets. The table in this paragraph indicates the time requirements to meet various MEB functions. These may be used to identify appropriate readiness FTE offsets for active duty providers performing MEB roles or to determine FTE hiring of civilian providers to perform MEBAA functions.

Position	Ratio
MEB-1 - Military (MIL)	0.1 FTE for every 10 monthly LIMDU, Employ, DES, or ADSEP CnD cases
MEB-1 - Civilian (CIV) or Contractor	0.1 FTE for every 10 monthly LIMDU, Employ, DES, or ADSEP CnD cases
MEBAA - MIL	0.3 FTE for LIMDU management (includes TEMPO participation) 0.1 FTE for every 10 monthly Employ, DES or ADSEP CnD cases
MEBAA - CIV and Contractor	0.3 FTE for LIMDU management (includes TEMPO participation) 0.1 FTE for every 10 monthly Employ, DES or ADSEP CnD cases
MEB CA - MIL	0.2 FTE for LIMDU management (includes TEMPO) 0.1 FTE for every 30 monthly Employ, DES or ADSEP CnD case
MEB CA - CIV	0.2 FTE for LIMDU management (includes TEMPO) 0.1 FTE for every 30 monthly Employ, DES or ADSEP CnD case
PEBLO	Per reference (a), maximum 34 DES cases
DES Contact Representative	1 DES Contact Representative for every 3 PEBLOs
Deployability Care Coordinator	1:100 LIMDU cases overall

Please Note: The majority of CIV and Contractor MEB-1 providers are under DHA. As such, this deduction is a suggestion.

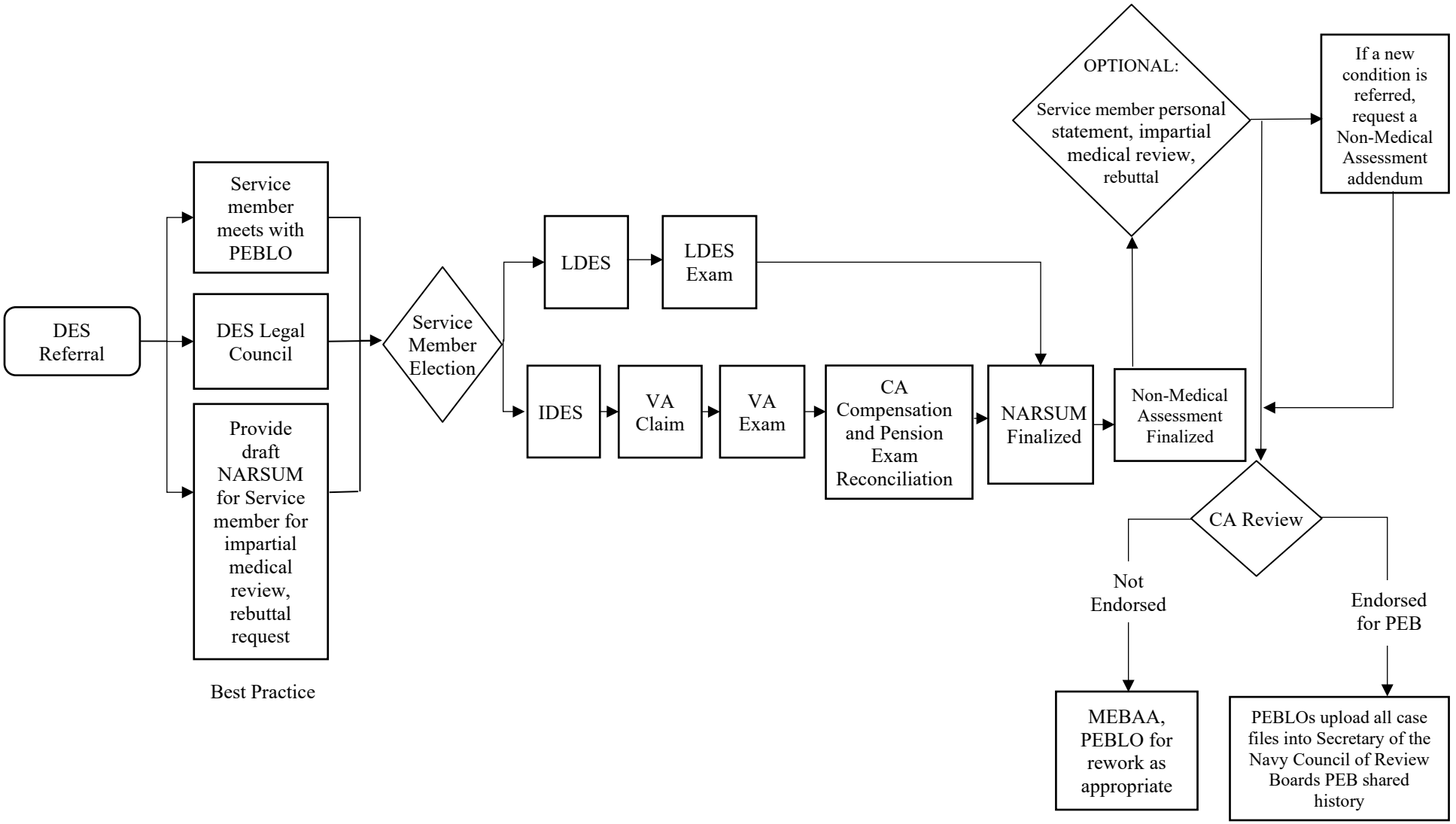
a. There may be seasonal variability, thus commands may elect to use the annual average of open cases rather than a particular point in time. Commands may request virtual MEBAAs through the regions from BUMED to fulfill staffing requirements.

b. Should a ratio exceed the recommended offset by half, the FTE should increase to reflect increased cases.

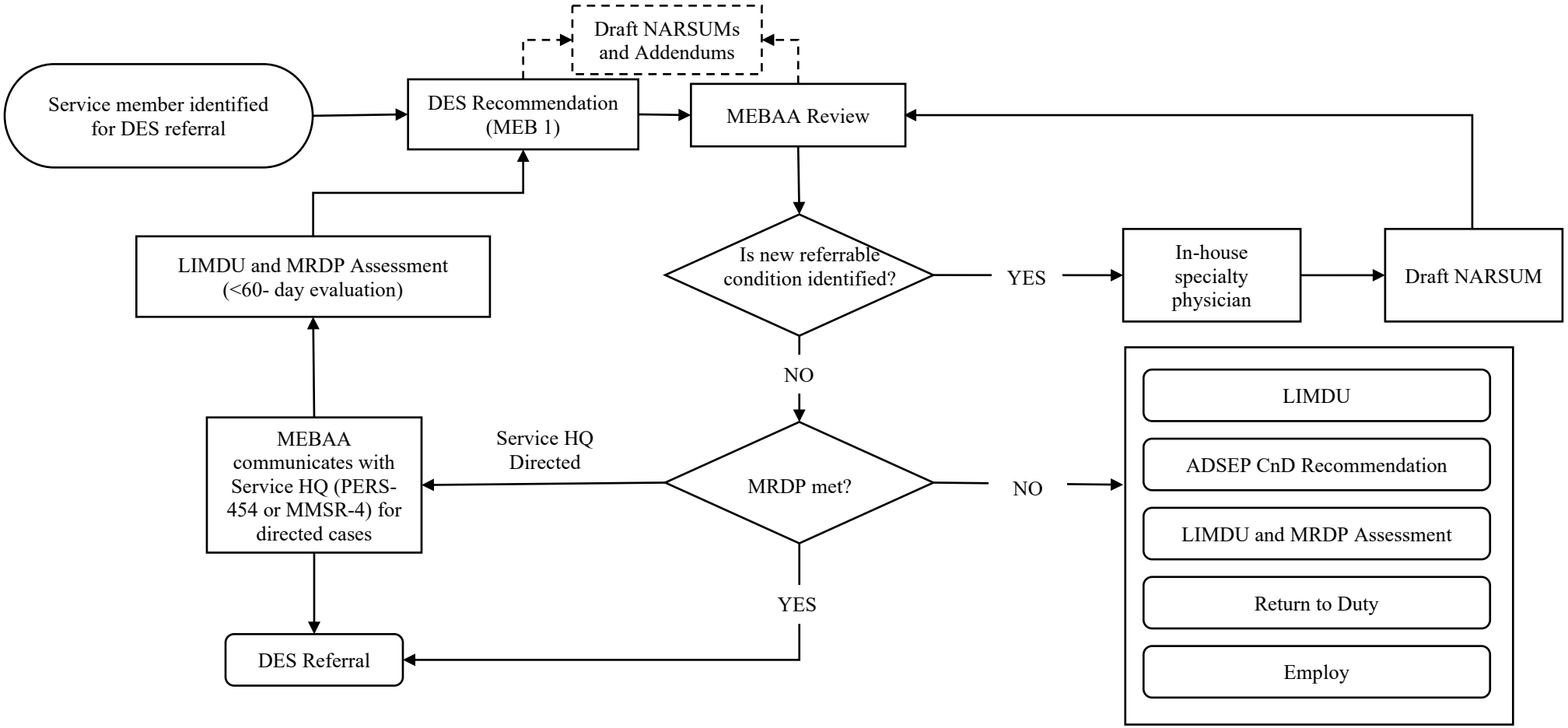
2. Training Requirements. Existing LIMDU and DES personnel will be required to complete the training aligned to their role, upload their certificate, and document the date of completion into the Limited Duty Sailor and Marine Readiness Tracker (LIMDU SMART) system, then subsequently renew their training every 3 years. All new LIMDU and DES personnel must complete the training aligned to their role prior to requesting access to LIMDU SMART. If a staff member has lost access to LIMDU SMART for over 180 days and their certificate was

completed over 365 days, they will be required to retake the training and upload a new LIMDU and DES training certificate into LIMDU SMART. If the staff member's LIMDU and DES training certificate is within 365 days, they will not be required to retake the training. Key DES personnel are required to satisfy training requirements.

MEDICAL EVALUATION BOARD PHASE WORKFLOW



PRE-DISABILITY EVALUATION SYSTEM PHASE WORKFLOW



1. Legend For Pre Disability Evaluation System and Medical Evaluation Board Phase Workflow:

a. DES Recommendation (MEB 1): PCM, treating or referring provider submit draft NARSUM(s) for review and endorsements by MEBAA physician.

b. Draft NARSUM: PCM, treating or referring provider submit draft NARSUM(s) for review and endorsements by MEBAA physician.

c. MEBAA Review: MEBAA physician writes NARSUMs for specialty care conditions from network providers through consultations, review of clinical encounters, and electronic health records. MEBAA physician performs comprehensive review (laboratory, radiology, clinical encounters, etc.) for all potentially ratable, referrable conditions and assesses for medical retention determination point criteria.

d. Is the new referrable condition identified? MEBAA physician writes NARSUMs for specialty care conditions from network providers through consultations, review of clinical encounters, and electronic health records. MEBAA physician performs comprehensive review (labs, rads, clinical encounters, etc.) for all potentially ratable, referrable conditions and assesses for medical retention determination point criteria.

e. In-house Specialty Physician: Consultation with specialty providers as required. Treating providers draft NARSUMs.

f. MEBAA communicates with Service HQ (PERS-454 or MMSR-4) for directed cases. MEBAA directly communicates with Service HQ (PERS-454 or MMSR-4) on divergence of opinions for directed cases.

g. LIMDU: Case sent to PEBLO and PCM or treating provider for placement on condition based LIMDU or ADSEP CnD recommendation.

h. ADSEP CnD Recommendation: Case sent to PEBLO and PCM or treating provider for placement on condition based LIMDU or ADSEP CnD recommendation.

i. LIMDU and MRDP Assessment: Case sent to PEBLO and PCM or treating provider for LIMDU placement for clinical workup, testing, medical stabilization, or treatment to determine whether MRDP criteria can be met at the end of LIMDU period. MRDP assessment should not exceed 60 days.

j. Return to Duty: Case sent to PEBLO and CA for RTD actions.

k. Employ: Provider recommended Service member consent, command endorsement, and PERS-454 approval.