Attachment (a) to Enclosure (8): MINIMUM REQUIREMENTS FOR MEDICAL EVALUATION BOARD (MEB), ADDENDA AND NARRATIVE SUMMARY WITH ANNOTATIONS

1. Purpose.

This attachment details the minimum medical information requirements to be annotated in any Medical Evaluation Board or addendum. This information must be documented and approved prior to forwarding the case to the Physical Evaluation Board (PEB).

a. Fulfillment of these requirements is a joint responsibility. The physicians must work closely with the Medical Boards Section of the Medical Treatment Facility to ensure compliance with these guidelines.

b. Attachment (c) is an example of a comprehensive MEB report.

2. Medical Evaluation Board (MEB) Documentation

a. Required Information:

(1) Member's name, rank, grade, and social security number.

(2) The name and specialty of the signatory physicians. The name of the physician dictating the report must be marked with an asterisk on the 6100/1.

(3) The Clinical Department and/or service authoring or sponsoring the document.

(4) The Medical Treatment Facility and its location.

(5) Date Medical Evaluation Board (MEB) report was conducted.

(6) A copy of the member's health record should accompany the MEB report. Although helpful, "shadow files" should NOT be submitted in place of the health record. Any supplemental records should be submitted. Any pertinent records of encounters with civilian physicians should be submitted.

(7) Copies of all narrative summaries of hospitalizations and all procedure reports are to be submitted with the medical board. Copies of labs, x-rays, special study reports also should be submitted.

(8) Signatures of the medical board members on the 6100/1, cover sheet. Electronic signatures will not be accepted.

b. On Each Page:

(1) Member's last name, social security number, and date of the MEB on the bottom margin.

(2) Page number will be annotated at the bottom center of the page.

Document is marked “For Offical Use Only – Privacy Act Protected”.

c. Reason For Doing The MEB

(1) The mere presence of a diagnosis is not synonymous with disability. It must be established that the medical disease or condition underlying the diagnosis actually interferes significantly with the member’s ability to carry out the duties of his/her rank and rate.

(2) When assessing the severity of symptoms, evaluate the subjective symptoms in light of objective findings; report discrepancies in addition to positive findings.

d. Eligibility for MEB.

See Enclosure (1), Article 1002, and Enclosure (3), Articles 3405-3408.

e. Military Information

(1) Date of first and most recent entry into service.

(2) Estimated termination of service.

(3) Administrative actions ongoing, pending, or completed (e.g., line of duty investigations, courts-martial, selective early retirement, retirement or separation dates).

f. Chief Complaint. Preferably stated in service member's own words.

g. History Of Present Illness.

Exact details, including pertinent dates regarding illnesses/injuries, how injuries were incurred. Enclose and summarize any pertinent previous MEB reports. The oft used terms “interval history” are inappropriate and assume that the PEB has access to the previous boards which is not always the case. The author of the MEB report must give a complete history chronologically as well as simply event-based.

h. Past Medical History

(1) Past injuries and illnesses.

(2) Prior disability ratings (e.g., given by the DES or Department of Veterans Affairs).

(3) Past hospitalizations and relevant outpatient treatment, including documentation of diagnosis and therapy, pertinent dates, and location should be listed.

(4) Social information pertinent to the member’s condition (e.g., activity level and sports activities engaged in would be pertinent to orthopaedic evaluation; alcohol and drug

usage rates must also be included) should be provided. There is an inclusive list under the specialty specific section for psychiatric disorders.

(5) Illnesses, conditions, and prodromal symptoms, existing prior to service (referred to as EPTS or EPTE conditions).

i. Laboratory And X-Ray Studies.

All studies that support and quantify the diagnosis (es) should be included as should any studies that conflict with the diagnosis (es).

j. Present Condition/Review Of Systems And Current Functional Status

(1) Current clinical condition(s) should be noted including all current complaints and review of systems; required medications and any non-medication treatment regimens (e.g., physical therapy) in progress.

(2) Functional status

(a) The service member's functional status as to the ability to perform his or her required duty should be indicated.

(b) If possible, a summation of the member's ability to perform the civilian equivalent of their assigned duties should be indicated.

(3) A statement should be given regarding the prognosis for functional status after completion of treatment if chronic treatment is not necessary.

(4) A statement should be given regarding the prognosis for functional status in cases requiring chronic treatment.

(5) The stability of the current clinical condition and functional status should be addressed.

(6) Statement of compliance with treatment recommendations and reasonableness of any refusal of recommended treatment procedures, including surgery. NAVMED Form 6100/4 must be submitted when refusal of surgery or treatment is considered unreasonable.

(7) Requirement for monitoring including frequency of indicated treatment and/or therapy visits and associated operational assignment limitations.

k. Conclusions

(1) Treatment recommendations including medications, procedures, and behavior and/or lifestyle modifications. Include a statement concerning the member's compliance. If non-compliant, indicate whether the non-compliance is reasonable.

(2) Under no circumstances is the narrative to indicate that the member is Unfit, nor recommend a disability percentage rating. It is the PEB's responsibility to determine fitness

and disability percentage ratings. The MEB report may state something to the effect, "the member is referred to the PEB because we are of the opinion that the member's condition may interfere with the performance of his or her duties because the member does not meet medical retention standards as described in..." [indicate location as appropriate].

l. Drug Therapy.

There may be certain instances where a specific drug therapy may in and of itself preclude the full performance of duties. This must be stated specifically if it is the reason for the board.

m. Limited Duty.

The authoring physician should not only address previous periods of limited duty (and what they were for) but also consider whether a member might obtain greater benefit by being referred to a LIMDU Board for placement on LIMDU vice direct submission to the Informal PEB.

n. Surrebuttal.

When the member submits a rebuttal to a medical board or an addendum, the authoring physician MUST address the member's specific issues. If necessary, this will include referral through the medical board section of all necessary departments.

o. Referral of hospitalized patients.

Referral to PEB while a member is still hospitalized. The MEB report will cite the reasons for continued retention in the hospital:

(1) When it is necessary that a member be transferred to a VA hospital for continued, extended treatment and he/she is not ready to be released on his/her own recognizance, the evidence presented in the MEB report will support taking these actions and the rating will most likely be between 50 and 100 percent.

(2) If a member is retained in the hospital for transfer to a VA facility as a convenience for transition to civilian care and life without anticipated problems, the rating will generally be a minimum of 30 percent and not more than 50 percent.

(3) For members who are hospitalized for an acute psychiatric emergency, the MEB report should include a mental status exam and statement of functional status within 30 days of submission of the medical board.

p. Competency Statements.

Where a member's competency is in question, an incapacitation board must be held and reports submitted to the PEB. This board must consist of three physicians including a psychiatrist.

q. Trauma.

Severe trauma and acute clinical, fulminant presentations. In clinical situations where the level of impairment could possibly to change significantly within or over the

following 2 to 4 months, submission of the MEB report should be delayed until this period of time has elapsed.

(1) It is important that the MEB report be dictated at the latest possible time prior to submission. This is particularly important when the MEB report is done and then months pass while waiting for completion of the LODI. If the MEB report has previously been dictated, an addendum should be included stating current condition. Statements such as "There has been no change since the previous medical board was dictated" are generally insufficient, especially since they are not usually correct.

(2) Ensure that all of the member's complaints/conditions are addressed by the appropriate specialty in attached addenda. The authoring service in conjunction with the Medical Boards Department of the MTF is responsible for ensuring that all required addenda and non-medical information are included in the original package.

r. Submission Of Photographs.

Current photographs are essential in burn cases and very useful in cases with significantly disfiguring scars. Photographs submitted should be certified, by the medical photography department, to have been taken within 1 month of the date of dictation of the MEB report. Each photo must be dated with the date the photo was taken.

s. Organ Transplants.

When the MTF has opted to retain the member to receive his/her transplant, the MTF will place the member on a Limited Duty Status pending the transplant. MEB report referral to the PEB should be delayed until the procedure has been done and the maximum benefit of treatment has been achieved.

t. "Death Imminent" Cases.

When it is anticipated that a member will die within 72 hours, the case may be submitted as a "death imminent" case for rapid processing. The physicians must explain why the member is deteriorating so rapidly (see enclosure (12) for full details). The need for an LODI in these cases is addressed in other sections of this document. A competency statement is required for complete processing of the case when a member is deemed incompetent to manage their personal and financial affairs. The MEB report in these cases will be signed by three physicians, one of whom will be a psychiatrist. Death imminent cases will be placed on the TDRL, not PDRL in accordance with policies in this instruction. "Death Imminent" should not be used to simply expedite a case.

u. TDRL Evaluations.

Physicians performing TDRL evaluations are responsible for knowing the information contained in enclosure (3), part 6 that addresses TDRL.

3. References.

Physicians and medical board personnel should be familiar with the pertinent instructions, some of which are:

(1) The Manual of the Medical Department

(2) Secretary of the Navy Instructions. Those governing TDRLs and the Disability System.

(3) DVA's physician's guide for Disability Evaluation Examinations

4. Physical Examination (PE).

A complete physical examination must be recorded in the MEB report and have been conducted within 6 months of the date of the MEB report. For all conditions, hand dominance must be stated. Height and weight must be documented in all MEBs (in the narrative).

5. Selected Specialty-Related Considerations And Guidelines

a. Cardiology

(1) Results of special studies to support and quantify the cardiac impairment should be noted e.g., treadmill and thallium stress tests, angiography, and other special studies.

(2) General Information. Evaluation and reporting of cardiovascular function should be in terms of METs of energy expended to produce a certain level of symptoms.

(3) The Functional Therapeutic Classification of the cardiac condition must be included. Either the New York or Canadian classification system may be used (see enclosure (9) attachment (b), table (3))

(a) Objective measurements of the level of physical activity, expressed as METs (metabolic equivalents), at which cardiac symptoms develop is the main method of evaluating cardiovascular entities now.

(b) Exercise capacity of skeletal muscle depends on the ability of the cardiovascular system to deliver oxygen to the muscle, and measuring exercise capacity can, therefore, also measure cardiovascular function. The most accurate measure of exercise capacity is the maximal oxygen uptake, which is the amount of oxygen, in liters per minute, transported from the lungs and skeletal muscle at peak effort. Because measurement of the maximal oxygen uptake is impractical, multiples of resting oxygen consumption (or METs) are used to calculate the energy cost of physical activity. One MET is the energy cost of standing quietly at rest and represents an oxygen uptake of 3.5 milliliters per kilogram of body weight per minute. The calculation of work activities in multiples of METs is a useful measurement for assessing disability and standardizing the reporting of exercise workloads when different exercise protocols are used.

(c) Alternative methods of evaluating function are provided for situations where treadmill stress testing is medically contraindicated – the examiner's estimation of the level of activity, expressed in METs and supported by examples of specific activities, such

as slow stair climbing or shoveling snow that results in dyspnea, fatigue, angina , dizziness or syncope is acceptable.

b. Gastroenterlogy

Service members with fecal incontinence should have recorded findings of rectal examination e.g., digital exam, manometric studies as indicated, and radiographic studies. The degree and frequency of the incontinence should be noted as well as the incapacitation caused by the condition.

c. Neurosurgery / Neurology

(1) For Vertebral Disc problems, radicular findings on PE should be supported by laboratory studies such as CAT scan, MRI, EMG, NCV. In cases where surgery has been performed, both pre- and postoperative deep tendon reflexes should be documented.

(2) General

(a) DEMENTIA AND HEAD TRAUMA. Neuropsychiatric or neuropsychological assessment should be accomplished in all head injury cases. Results should be included. Neuropsychiatric or neuropsychological measurements should be performed as early as possible. Current tests (performed within 6 weeks of submission of the board) are also required.

(b) MIGRAINE HEADACHES. The number of incapacitating episodes (those that require the individual to stop the activity in which engaged and seek medical treatment) per week, month or year should be noted and verified by a physician. Other pertinent information: 1. Types and names of medications tried (i.e. prophylactic or abortive), response, reason why changed, etc.) 2. Effect has on performance of duties.

(c) SEIZURE DISORDER. The evaluation will be done by a neurologist. An EEG, MRI/CT will be included in the initial examination. When subsequent seizure episodes occur while on medical therapy, blood levels of prescribed medication(s) will be determined.

(d) NEUROPATHIES. EMG and nerve conduction studies will be performed.

(e) MULTIPLE SCLEROSIS. Appropriate MRI(s) will be performed.

(f) INDUSTRIAL AND (INDUSTRIALLY RELATED) SOCIAL IMPAIRMENT. Estimate the degree of impairment that will be incurred by the service member.

(g) IMAGING STUDIES. For all neurological and neurosurgical conditions appropriate imaging studies should be obtained in concert with current standards of practice. Copies of all studies must be submitted.

d. Ophthalmology

(1) If standards are not met for reasons related to vision, visual fields must be included in the PE and verified by an ophthalmologist. Specialist examination should include uncorrected and corrected central visual acuity. Snellen's test or its equivalent will be used and if indicated, measurements of the Goldmann Perimeter chart will be included.

(2) Visual Field Deficits must be documented on a Goldmann Field chart using the III-4-e objective. Cases of diplopia must be documented using a Goldmann Perimeter Chart plotting the fields of diplopia.

e. Orthopaedics

(1) Range of Motion (ROM) measurements must be documented for injuries to the extremities. The results of the measurement should be validated and the method of measurement and validation should be stated. Attachment (d) to enclosure (8) gives appropriate reference points for reporting the ROM measurements.

(2) In cases involving back pain, the use of Waddell's signs should be included in assessing the severity and character of the pain. (Waddell G, McCulloch JA, Kummel E, Venner RM. Non-organic physical signs in low back pain. Spine . 1980;5:117125. Waddell G. Somerville D, Henderson I, Newton M. Objective clinical evaluation of physical impairment in chronic low back pain. Spine. 1992;17:617-628.)

(3) For Vertebral Disc problems, radicular findings on PE should be supported by laboratory studies such as CAT scan, MRI, EMG, NCV. In cases where surgery has been performed, both pre- and postoperative deep tendon reflexes should be documented.

f. Otolaryngology

Audiograms must include speech discrimination scores. Current and entry level audiograms must also be included.

g. Psychiatry

(1) Particular attention should be paid to documenting all prior psychiatric care. Supportive data should be obtained for verification of the patient's verbal history.

(2) Psychiatric hospitalization is not prima facie evidence of an unfitting psychiatric disorder. It may, however, be evidence that the condition is administratively unsuiting.

(3) Psychometric assessment should be carried out if such assessment will help quantify the severity of certain conditions and allow a reference point for future evaluation.

(4) The Diagnostic and Statistical Manual of Mental Disorders (most recent edition) will be used for diagnostic terminology. The Multiaxial System of Assessment will be used to include Axes I-V. The degree of industrial and industrially related social impairment must be individually determined and documented, for each Axis I and Axis II diagnosis, and correlated to the service member's clinical manifestations. Increased severity of symptoms due to transient stressors associated with the PEB and prospect of separation, retirement,

relocation or re-employment will not be considered in determining the degree of impairment. The service member's total impairment for civilian industrial adaptability from all sources (Axes I, II, III) should be determined and documented. The contribution of each condition to the total adaptability impairment should then be individually noted and correlated with the service member's clinical manifestations.

(5) Every effort must be made to distinguish symptoms and impairment resulting from personality disorder or maladaptive traits from impairments based on other psychiatric conditions. The MEB report must specifically address the issues of relative contribution of not compensable conditions (e.g., personality disorders, adjustment disorder, impulse control disorder, substance abuse etc.).

(6) Documentation shall be submitted addressing the following:

(a) Living arrangements (e.g., by oneself, with spouse and children, with parents and siblings).

(b) Marital status. Single, married, separated, divorced, and the type of relationship (harmony or strife).

(c) Leisure activity. Sports, hobbies, TV, reading.

(d) Acquaintances. Male, female, both sexes, many, few.

(e) Substance use or abuse. Alcohol, drugs.

(f) Police encounters/record.

h. Pulmonary

When the MEB is held for restrictive or obstructive pulmonary disease, rating is usually based upon Pulmonary Function Tests (PFTs) measuring residual function. There must be a minimum of one set of PFTs.

(1) Studies should be performed both before and after medication.

(a) Pre-bronchodilator PFTs. When the results are normal, post-bronchodilator studies are not required.

(b) In all other cases, post-bronchodilator studies should be done unless contraindicated (because of allergy to medication, etc.) or if a patient was on bronchodilators before the test and had taken his/her medication within a few hours of the study.

1. A physician who determines that a post-bronchodilator study should not be done in a given case should provide an explanation.

2. The members of the Informal PEB shall request either the

explanation when not provided or a repeat of the studies.

3. The post-bronchodilator results will be used in applying the evaluation criteria in the rating schedule. There is a small group of patients (5 percent or less) in whom there may be a paradoxical reaction to bronchodilators; i.e., the post-bronchodilator results will be poorer than the pre-bronchodilator results. When there is a paradoxical response, the better (pre-bronchodilator) values will be used in the rating.

4. When there is disparity between the results of different tests (FEV-1, FVC, etc.) so that the level of evaluation would differ depending on which test result is used, the test with the better (higher) values (i.e., that would give the lower evaluation) will be used. This is because such tests are effort-dependent, and such a difference is ordinarily due to a difference in effort from test to test. However, if there is a substantial disparity in the results, the MEB physician may be asked for an explanation and/or request that the test be repeated if there is no clear reason.

5. When the FEV-1 is greater than 100 percent, an FEV-1/FVC ratio that is below normal should be considered a physiological variant rather than an abnormal value.

(2) Where warranted, the member should have a methcholine challenge, especially when the original set of PFTs are “normal”.

(3) In cases of exercise-induced asthma, PFTs after exercise should be performed.

i. Urology

(1) Cases involving neurogenic bladder must include studies that document the condition.

(2) All cases involving incontinence must include studies that document the condition.

(3) Cases involving incontinence and/or neurogenic bladder should have documentation regarding severity as indicated by the number of times self catheterization is required, the number and type of pads required in a day, or the soilage frequency.