BY ORDER OF THE
SECRETARY OF THE AIR FORCE

DEPARTMENT OF AIR FORCE
MANUAL 48-108

5 AUGUST 2021

Aerospace Medicine

PHYSICAL EVALUATION BOARD LIAISON OFFICER (PEBLO) FUNCTIONS: PRE-DISABILITY EVALUATION SYSTEM (DES) AND MEDICAL EVALUATION BOARD (MEB) PROCESSING

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

ACCESSIBILITY: Publications and forms are available for downloading or ordering on the e-Publishing website at **www.e-Publishing.af.mil**.

RELEASABILITY: There are no releasability restrictions on this publication.

OPR: AF/SG3/PF

Certified by: AF/SG3/4
(Maj Gen Robert I. Miller)

Pages: 76

This publication implements Air Force Policy Directive, 48-1, *Aerospace and Operational Medicine Enterprise (AOME)*. It identifies and defines the requirements, policies, procedures, activities, and minimum expectations necessary to ensure a successful Air Force Medical Treatment Facility (MTF) MEB process. This publication describes how to process Department of the Air Force members into the DES MEB process. Organizational alignment of these functions may vary among MTFs. This publication applies to service members of the Regular Air Force, Air Force Reserve (AFR), Air National Guard (ANG) and United States Space Force identified for MEB processing. Ensure all records generated as a result of processes prescribed in this publication adhere to Air Force Instruction 33-322, *Records Management and Information Governance Program*, and are disposed in accordance with the Air Force Records Disposition Schedule, which is located in the Air Force Records Information Management System. Refer recommended changes and questions about this publication to Air Force Medical Readiness Agency (AFMRA)/SG3PF using the Air Force Form (AF Form) 847, *Recommendation for Change of Publication*; route AF Forms 847 from the field through the appropriate functional chain of command. This publication may be supplemented at any level but all publications that implement or supplement this publication must be routed to AFMRA/SG3S for coordination prior to approval. **(T-2).** The authorities to waive wing/unit level requirements in this publication are identified with a Tier **("T-0, T-1, T-2, T-3")** number following the compliance statement. See Department of the Air Force Instruction (DAFI) 33-360, *Publications and Forms Management*, for a description of the authorities associated with the Tier numbers. Submit requests for waivers through the chain of command to the appropriate Tier waiver approval authority, or alternately, to the requestor's commander for non-tiered compliance items. The use of the name or mark of any specific manufacturer, commercial product, commodity, or service in this publication does not imply endorsement by the Air Force. This publication requires the collection and or maintenance of information protected by the Privacy Act of 1974 authorized by Department of Defense Instruction (DoDI) 5400.11, *DoD Privacy and Civil Liberties Programs* and DoDI 1000.30, *Reduction of Social Security Number (SSN) Use within DoD*. The applicable SORN F044 AF SG D, Automated Medical/Dental Record System (August 29, 2003, 68 FR 51998) is available at **http://dpclo.defense.gov/Privacy/SORNs.aspx**. Compliance with Attachments **3 and 4** in this publication is mandatory. This publication replaces Air Force Manual (AFMAN) 41-210, *TRICARE Operations and Patient Administration*, Section 4K, *Medical Evaluation of Service Members for Continued Military Service* and incorporates the inclusion of Airman Medical Readiness Optimization (AMRO) Board and Quality Assurance Program (QAP) Management.

Chapter 1

AIR FORCE DISABILITY EVALUATION SYSTEM (DES) OVERVIEW

1.1. Air Force Disability Evaluation System (DES) Overview.

1.1.1. The purpose of the Air Force DES is to maintain a fit and vital force. Service members who can no longer perform the duties of their office, grade, rank or rating are referred into the DES process. The DES is designed to ensure fair compensation for members whose military careers are shortened due to a service-incurred or aggravated disability. Reference Air Force Instruction (AFI) 36-3212, *Physical Evaluation for Retention, Retirement and Separation* for further information. The first step in the Air Force DES starts with a pre-DES screening review process. A service member identified with a medical condition(s) not consistent with Air Force medical retention standards (potential disability) is deemed not deployable, may be referred to a MEB. The MEB is used by the Informal Physical Evaluation Board (IPEB) to determine if a Regular (active duty) Air Force (RegAF), Air Force Reserve, Air National Guard, or Space Force service members who can no longer reasonably perform the duties of their office, grade, rank or rating should be removed from military service. This manual provides guidance on the DES MEB process and related programs. For DES Physical Evaluation Board (PEB) process and related programs to include the Air Reserve Components (ARC) non-duty related process, reference AFI 36-3212.

1.1.2. **MEB Overview.** The MEB is a part of the DES process designed to determine whether a service member's long-term medical condition prevents him/her from meeting medical retention standards, in accordance with applicable Department of Defense and Air Force policies. The following activities are functions of the DES MEB process: Pre-DES review screening, DES referral, the MEB and rebuttal process. These activities are outlined in detail in this manual.

1.2. Roles and Responsibilities.

1.2.1. **Air Force Personnel Center Medical Retention Standards Office (AFPC/DP2NP).** AFPC/DP2NP is the reviewing body for all RegAF Review-in-Lieu-of (RILO) reviews. AFPC/DP2NP is the final authority for Airman Medical Transition Unit (AMTU) assignments (**Chapter 7**), active duty Assignment Limitation Code-C (**Chapter 5**), medical hold, and non-emergent surgery requests during a service member's final six months of service (defined as surgery which while necessary is not required urgently or emergently to save life, limb, or eyesight). In addition, to meet Department of Defense (DoD) established timelines, AFPC/DP2NP has sole authority to approve all non-emergent surgery requests for service members who are referred to, or undergoing DES processing. AFPC/DP2NP is the office of primary responsibility for implementing AF/SG policy on medical standards for continued active duty service, and may provide interpretations of areas of ambiguity within this AF Manual consistent with current AF/SG intent. AFPC/DP2NP will provide oversight of standardized templates and other guides utilized in the RILO and MEB phase of the DES process.

1.2.2. **AFMRA Integrated Disability Evaluation System (IDES) Compliance and Quality Assurance Branch (AFMRA/SG3PF).** AFMRA/SG3PF oversees execution and implementation of the DoD and Air Force Surgeon General policies concerning the DES MEB

process in supporting Secretary of Defense non-deployable retention policy for Air Force expeditionary capabilities and national security strategy. AFMRA/SG3PF provides expert consultative leadership support to over 75 military treatment facilities PEBLOs by providing PEBLO training and advisory support. AFMRA/SG3PF coordinate best processes, data analysis, policy expertise, and Staff Assistance Visits (SAV) if requested or needed.

1.2.3. **Air Force Reserve Command Surgeon (AFRC/SGO) or National Guard Bureau Air Surgeon Office (NGB/SGP).** AFRC/SGO or NGB/SGP is the reviewing body for all ARC RILO reviews. For ARC personnel, the respective ARC SG's office is the approval authority for Assignment Limitation Code, medical hold decisions, and non-emergent surgery requests made within the final six months of a period of active duty service.

1.2.4. **Airman Medical Readiness Optimization (AMRO) Board.** The AMRO Board is comprised of a team of medical professionals that meet at least monthly to review service members with a duty limiting condition that affects mobility, retention, or long-term physical fitness. It enables Warfighter Care Teams (WCTs) to optimally medically manage their service members.

1.2.4.1. Activities include timely scheduling of specialty consultations, appropriate follow up with the WCT, troubleshooting barriers to care, and monitoring service members adherence to treatment plans. In addition, AMRO Board promotes collaborating with Commanders, both for awareness of deployable unit forces, and to create mutual dialogue to accelerate service members returning to duties or referral into the DES process.

1.2.4.2. AMRO Board members (identified in AFI 48-133, *Duty Limiting Conditions*), are responsible for reviewing the condition, treatment, progress and prognosis and determining whether or not the service member requires evaluation for potential referral to the DES. **(T-1).** If so, the AMRO Board will refer the case to AFPC/DP2NP office for review. **(T-1).** (For ARC service members, appropriate ARC SG's office for review).

1.2.4.3. AMRO Board members will utilize retention standards as outlined in DoDI 6130.03, Volume 2, *Medical Standards for Military Service: Retention*, DAFMAN 48-123, *Medical Examinations and Standards*, and its accompanying Medical Standards Directory (MSD), for retention standards determinations. **(T-0).**

1.2.5. **Deployment Availability Working Group (DAWG).** The DAWG provides oversight of AMRO Boards and monitors medically operational readiness metrics to the Aerospace Medicine Council, and subsequently to the Executive Staff. **(T-1).**

1.2.6. **Physical Evaluation Board Liaison Officer (PEBLO).** Trained with the knowledge of the DES program, PEBLOs are instrumental in the DES and will act as the liaison for the service member. **(T-0).** The PEBLO is the main point of contact between the service member, the family, the chain of command, the Department of Veterans Affairs (VA), and the PEB throughout the DES process. This includes providing a multidisciplinary brief (MDB). **(T-0).** A MDB will be completed prior to the service member meeting individually with the VA Military Service Coordinator or within 10 days of referral into the Legacy DES. The MDB will establish service member expectations, prepare member for each stage of the DES process and inform members of what is expected of them during the DES process as outlined in DTM 19-001, *Policy for the Disability Evaluation System (DES)*. **(T-0).**

1.2.6.1. PEBLOs communicate with medical providers, commanders, Office of Disability Counsel or civilian acquired counsel, VA Military Service Coordinators, Air Force Personnel Center Disability Division case managers, Recovery Care Coordinators, next of kin and other MTF PEBLOs.

1.2.6.2. PEBLOs assemble and submit RILO cases to AFPC/DP2NP (for ARC members, to appropriate ARC/SG office) for review and; are responsible for compiling all the information from the service member, their physicians, their commander, and any other source that is necessary to submit MEB cases to AFPC/DPFD for Informal PEB adjudication.

1.2.6.3. PEBLOs assist with medical hold and non-emergent surgery requests.

1.2.7. **The Recovery Care Coordinator (RCC).** The Recovery Care Coordinator serves as an independent advocate for wounded, ill and injured service members. The RCC assists the service member to ensure the member and his/her family understand the various aspects of DES process and communicate DES information to the member and their family. Recovery Coordination Program management guidance is provided in DAFI 34-1101, *Warrior and Survivor Care.* **(T-0).**

1.2.8. **Wing Commander.** The Wing Commander will initiate an A-Team to support service members who are given temporary duty orders or for those who are permanently assigned to an AMTU. To ensure an effective delivery of care and support, A-Team members will be identified and can include: Medical Support Squadron Commander (or other AMTU Commander as determined by the MTF Commander), First Sergeant, Family Liaison Officer, Patient Liaison, Case Manager, PEBLO, and representatives from Base Support Agencies including, but not limited to, Comptroller Squadron, Military Personnel Flight, Airman & Family Service Flight, Wing Judge Advocate Office, and Logistics Readiness Squadron. A-team position roles must be identified at all AF installations hosting an MTF that could receive AMTU patients, regardless of size. **(T-3).** (Reference AFI 36-3212.)

1.2.9. **Unit Commanders.** Commanders will provide an assessment of service member's ability to perform their assigned duties with the potentially unfitting condition(s) and provide support to the member throughout the DES process. **(T-0).**

1.2.9.1. Commanders consult with member's primary care manager (PCM) to address any questions or concerns regarding member's ability to perform certain tasks. **(T-3).**

1.2.9.2. Commanders ensure service members are available to attend all required DES related appointments. **(T-3).**

1.2.10. **Service Member** . Member must be available throughout the DES process and attend all DES related appointments and counseling sessions. **(T-3).** Service members undergoing the DES process may request legal counsel from the Office of Disability Counsel (ODC) or civilian acquired counsel. Service member must inform PEBLO of any circumstances that could prevent him/her from making MEB-related appointments (e.g. approved leave, surgery, etc.). **(T-1).**

Chapter 2

PRE-IDES SCREENING REVIEW

2.1. Eligibility for Disability Evaluation Processing. Eligibility requirements for disability processing are referenced in DoDI 1332.18, *Disability Evaluation System (DES).*

2.2. Entrance into the IDES. The IDES process integrates the Air Force DES with the VA, and delivers the advantage of single-sourced disability ratings that are accepted by both the DoD and the VA, so the member will receive VA benefits shortly after separation or retirement.

2.2.1. One purpose of the IDES is to carefully screen service members for potentially unfitting conditions, so they are appropriately referred into the DES to determine if a return to duty adjudication is appropriate.

2.2.2. In order to minimize inappropriate referrals, there is a two-step DES pre-screening process for all potential MEB cases. The first step is a preliminary AMRO Board review, in which the AMRO Board may determine an initial review in lieu of (IRILO). The second step, if required, is accomplished by AFPC/DP2NP or the appropriate ARC SG's Office (for ARC members). Cases that AFPC/DP2NP or ARC/SG direct for a MEB are referred into the DES. AFPC/DP2NP or ARC SG's disposition may result in a return to duty decision. AFPC/DP2NP or ARC SG's office is the final disposition authority on return to duty determinations in the DES pre-screening process. For referral of ARC members due to non-duty related condition(s), refer to AFI 36-3212.

2.3. Trigger Events that Require Preliminary AMRO Board Review. Trigger events are conditions or occurrences which may indicate a service member has medical or mental health conditions that are inconsistent with retention standards or deployability. After a provider recognizes a trigger event, the provider must notify the MTF PEBLO and obtain a summary of the member's information from the Medical Standards Management Element (MSME), Armed Forces Health Longitudinal Technology Application (AHLTA), etc., for preliminary presentation at the next scheduled AMRO Board meeting. **(T-3).**

2.3.1. Each AMRO Board should establish procedures and guidelines for reporting trigger events at its respective MTF. **(T-1).** Trigger events include, but are not limited to, the following:

2.3.1.1. A provider (PCM or specialist) identifies a service member with a definitive diagnosis which does not meet retention standards for continued military service per DoDI 6130.03 V2, DAFMAN 48-123, or the MSD. The provider that initially identifies the case will be the referring provider and will be responsible for coordinating the clinical aspects of AMRO Board review. **(T-3).** The provider will contact the PEBLO and/or the MSME who will advise the provider on what actions are needed to present the case to the AMRO Board. **(T-3).** For service members from other services, AMRO Board will coordinate with and send required medical documents to the appropriate Service MTF or medical retention standards office for review of member's fitness for duty. **(T-1).** (See **paragraph 3.7**)

2.3.1.2. If during Assignment Availability Code (AAC) 31 (temporary medical deferment) surveillance, the AMRO Board identifies a service member with a long-standing AAC 31 and the medical condition appears unlikely to resolve within 300 cumulative calendar days

of initiation of the AAC 31, the AMRO Board will request consultation with the provider that initiated the AAC 31. **(T-1).**

2.3.1.3. When a service member's commander requests evaluation due to poor duty performance or deployment concerns stemming from a potential medical or mental health condition.

2.3.1.4. A permanent change of station (PCS), temporary duty (TDY), or deployment is cancelled for a medical or mental health reason.

2.3.1.5. AFPC/DP2NP or ARC SG's office directs an IRILO.

2.3.2. Once a preliminary AMRO Board case is identified, the referring provider must provide the service member with the following information:

2.3.2.1. Identification of the Trigger Event leading to the requirement for a referral to the AMRO Board. **(T-1).**

2.3.2.2. Identification of the medical or mental health standard that is the primary reason for referral to the AMRO Board. **(T-1). Note**: If there are multiple standards leading to referral, every effort should be made to provide that information to the service member.

2.3.2.3. Information about the AMRO Board process, the potential outcomes of the AMRO Board, and a target date for presenting the IRILO to the AMRO Board. **(T-1).**

2.3.2.4. The name and phone number of the PEBLO who will assist in the collection of required documents for the AMRO Board Review.

2.3.3. Once a preliminary AMRO Board case is identified, the PEBLO will coordinate activities to retrieve information required for the AMRO Board review. **(T-3).** Appropriate information might include medical record entries in AHLTA or hard copy, consultant or special examination reports, the applicable AF Form 469, *Duty Limiting Report*, the most recent AF Form 422, *Notification of Air Force Member's Qualification Status* or any other information deemed relevant by the medical providers.

2.3.4. Preliminary review of a trigger event should occur at the next scheduled AMRO Board, and not more than 45 calendar days after the case is referred to the PEBLO or the MSME by the provider (for ARC 90 days). The AMRO Board will review each case following guidance provided in AFI 48-133. **(T-1).** The review can result in the following:

2.3.4.1. **Case Dismissal.** If the service member is found to be fit for continued military service and mobility based on the information considered, the AF Form 469 profile will be updated appropriately and the case dismissed to routine medical care. Case dismissal does not preclude the service member from being considered for AMRO Board review again in the future for the same condition if the member's status changes. A note will be placed in the member's medical record indicating that the condition was reviewed for possible MEB and found to meet retention standards without need for IRILO review or submittal of MEB. **(T-3).**

2.3.4.2. **Application of AAC 37 and IRILO.** The application of an AAC 37 (pending potential MEB/PEB) will be directed by the AMRO Board Chair, and applied in Aerospace Services Information Management System (ASIMS) by the MSME as soon as the case is identified for IRILO. **(T-3).** Only the AMRO Board, AFPC/DP2NP or ARC SG's office

may direct an AAC 37 be assigned to a service member. **(T-1).** Once applied, the AAC 37 will remain in effect until AFPC/DP2NP or ARC/SG office directs removal via the Air Force Personnel Center, Form Letter 4 (AFPC/FL 4). For ARC service members, the ARC SG's office and/or AMRO Board chair will apply AAC 37 after verification on the service member's qualification for disability processing. **(T-1). Note**: In rare situations, as outlined in AFI 48-133 the AMRO Board may direct a removal of an AAC 37 (where the service member's medical condition has significantly improved such that the service member no longer is disqualified for medical retention standards and the IRILO NARSUM has not been forwarded to AFPC/DP2NP for disposition).

2.3.4.3. AMRO Boards should initiate a code 37 immediately upon determination that a service member does not meet retention standards. AMRO Boards should not wait to initiate code 37s until the IRILO package is ready to submit to meet the 30 day submission requirement. If IRILO packages are not ready to submit within 30 days of code 37 placement because of need for further medical evaluation, stabilization, or other legitimate reasons, then documentation in ASIMS and the AMRO Board minutes is acceptable and appropriate.

2.3.4.4. For ARC members, referral into the Non-Duty DES. See DoDI 1332.18 and AFI 36-3212 for further information on the referral process.

2.3.4.5. Defer decision for a certain period of time, maximum 90 days.

2.4. Initial Review-In-Lieu-Of (IRILO). Airman who have conditions that may render them unfit for continued military service in accordance with DAFMAN 48-123, or are found to be unable to deploy must undergo an IRILO. **(T-1).** The IRILO is an initial review of medical records in lieu of a full medical examination. In addition to those conditions specifically listed in DAFMAN 48-123, service members may require an IRILO due to a duty limiting condition which has resulted or likely will result in a mobility restriction for 365 days or longer. Additionally, other diseases or defects not specifically listed in DAFMAN 48-123 may also be cause for an IRILO based upon the medical judgment of the examining physician and concurrence of the AMRO Board.

2.4.1. IRILO processing. Once an IRILO case has been identified, the PEBLO must:

2.4.1.1. Notify the member they are being referred for a potential MEB. **(T-0).**

2.4.1.2. Contact the member's commander to request completion of AF Form 1185, *Commander's Impact Statement for Medical Evaluation Board*. **(T-0).** The service member's commander will complete the form and send it back to the PEBLO. **(T-0).** RegAF commanders must return the AF Form 1185 in five (5) calendar days to the PEBLO. **(T-1).** ARC commanders are contacted via ARC fulltime staff and have until the next unit training assembly weekend to complete the AF Form 1185 and send it back to the PEBLO. **Note**: If the service member moved to an AMTU (PCS/PCA) when identified for IRILO processing, the AMTU commander is responsible for completing the AF Form 1185. The AMTU commander must use information obtained from member's previous commander, career field functional, AFPC assignments team, etc., for more information to appropriately complete the AF Form 1185 detailing member's ability to perform the duties of their office, grade, rank, or rating and deployability.

2.4.1.3. Contact the provider (or providers, in cases where multiple specialty consult narratives are required) to request a copy of the NARSUM, supporting consultant notes/studies, and current AF Form 469 profile prior to the next scheduled AMRO Board. **(T-2).** For ARC units, the ARC may write the NARSUM for medical cases, if a full time provider is available. For all mental health cases, the MTF shall make arrangements for the mental health NARSUM to be accomplished. **(T-1).**

2.4.1.3.1. **Narrative Summary (NARSUM).** The same format is used for both IRILO and MEB case files. Approved NARSUM templates (medical and mental health) can be found on the AFPC/DP2NP Medical Retention Standards page of the Air Force Medical Service (AFMS) Knowledge Exchange (KX) website at **https://kx.health.mil/kj/kx8/AFPCMedicalRetentionStandards/Pages/home.aspx**. A single NARSUM format is used throughout the process to alleviate the need for complete NARSUM rewrites if an IRILO is later directed for a MEB. Additional NARSUM training is available in the NARSUM Training Guide located on DP2NP KX Website at **https://kx.health.mil/kj/kx8/AFPCMedicalRetentionStandards/Pages/home.aspx**. This comprehensive checklist ensures the NARSUM writer adheres to all DoD and Air Force policies concerning accuracy and consistency within the NARSUM.

2.4.1.3.2. **Consultant Notes and/or Special Studies.** Include the latest consultant note and/or update in the package. **Note**: Additional consultant notes and/or studies not directed as described may be included in the IRILO package at the discretion of the referring provider; however inclusion of these additional notes should not delay processing of the case. The consultation reports or updates shall not be older than 180 calendar days when received at AFPC/DPFD. (T-1). See **Attachment 2** for a list of conditions and the required consultation note and/or specialist studies needed for inclusion into the RILO package.

2.4.1.3.3. **AF Form 469 profile.** If the AF Form 469 is more than 30 calendar days old, the provider must review the profile restrictions, updating restrictions as needed to ensure clear and accurate portrayal of the current restrictions (specifically relating to the potentially unfitting condition(s)). **(T-1).** A comment will then be made in the Restrictions section, "Provider reviewed restrictions and they are deemed accurate and appropriate on (date inserted)." **(T-1).**

2.4.2. Within 30 calendar days after the pre-screening package, the IRILO is reviewed by the AMRO Board. **(T-1).** Any extenuating circumstances must be documented in the AMRO Board minutes. **(T-1).** In unique circumstances, the AMRO Board chair may request provider expedite the package and/or may call an ad hoc (done for a specific purpose) Board meeting for expedited case review. These circumstances must also be documented in Board minutes. **(T-1).**

2.4.3. IRILO package. The IRILO is compiled using the appropriate standardized IRILO Cover Sheet Checklist located on the AFMRA IDES website at **https://kx.health.mil/kj/kx2/ides/Pages/home.aspx**. The entire package must be reviewed by the AMRO Board and signed by the SGP (Preferably) or SGH (if the SGP is unavailable) to ensure that it is complete and accurate. **(T-1).**

2.4.3.1. AMRO Board IRILO recommendations can recommend:

2.4.3.1.1. **MEB Recommended.** It is determined that service member has medical conditions that will potentially prevent him/her from reasonably performing the duties of his/her office, grade, rank or rating. A standardized coversheet checklist is available in the AFMS Knowledge Exchange website at **https://kx.health.mil/kj/kx8/AFPCMedicalRetentionStandards/Pages/home.aspx**. The AMRO Board chair must sign the standardized coversheet, stating the package is recommended for the MEB. **(T-1).**

2.4.3.1.2. **Return to Duty Recommended.** Member has a condition listed in DAFMAN48-123 and/or the current MSD that may limit or preclude deployment, yet the member is most likely capable of performing the duties of his/her office, grade, rank or rating and the condition(s) is/are stable, controlled, and with a low risk of sudden deterioration. The package is forwarded to AFPC/DP2NP or appropriate ARC/SG's office by the PEBLO for disposition. The AMRO Board chair must sign the standardized coversheet, stating the package is recommended for a return to duty decision. **(T-1).**

2.4.3.2. Once the IRILO package is signed by the SGP or SGH, the PEBLO will forward the package to AFPC/DP2NP or appropriate ARC SG's office within 3 calendar days, as applicable for disposition, with a recommendation from the AMRO Board for either MEB processing or return to duty. **(T-1).** When the package is submitted to AFPC/DP2NP, the PEBLO will also use the appropriate ASIMS tab within the member's profile section to annotate that the package was submitted. **(T-1). Note**: This recommendation is not binding on the disposition by AFPC/DP2NP or ARC AG's office.

2.4.4. AFPC/DP2NP or ARC/SG's office will make a decision on the case and return the results to the PEBLO within 10 calendar days. **(T-1).** When the PEBLO receives the results, the AMRO Board shall be advised. **(T-3).**

2.4.4.1. If AFPC/DP2NP or the appropriate ARC SG's office directs the service member to undergo an MEB after an IRILO review, the member is entered into the DES (IDES or Legacy Disability Evaluation System (LDES)). If member is entered into IDES, the referral stage starts on the date the referring provider signs and dates the VA Form 21-0819, *DoD Referral to Integrated Disability Evaluation System (IDES)* and ends on the date the PEBLO provides the service member's complete service treatment record, including the service member's entrance physical and VA Form 21-0819 to the VA MSC. This form is available at **https://www.va.gov/find-forms/about-form-21-0819/**. The provider will forward the form to the PEBLO who will then enter the initial case information into the DoD IDES system of record, currently the Veteran's Tracking Application (VTA), within 3 calendar days. **(T-1).** Any future IDES case data that becomes available will be entered into VTA within 24 hours or by the next business day. **(T-1).** For LDES, the timeline begins once DP2NP has determined member is to undergo MEB processing via Form Letter 4. See **paragraph 3.1.1.2** for the list of dispositions by AFPC/DP2NP or appropriate ARC SG's office after IRILO review. Refer to DTM 18-004, *Revised Timeliness Goals for the Integrated Disability Evaluation System (IDES).*

2.4.4.2. AFPC/DP2NP or ARC/SG's office (for ARC service members) will provide final disposition instructions, (e.g. assignment of Assignment Limitation Code-C, appropriate Deployment Availability Code, or referral into either the IDES via MEB or non-duty

related condition(s) process), to the PEBLO (for ARC members, the disposition is sent to member's supporting ARC and supporting MTF PEBLO). **(T-1).**

Chapter 3

ADMINISTERING THE RILO AND MEB PROCESS

3.1. AFPC/DP2NP Medical Retention Standards Branch (or ARC equivalent SG'S office). AFPC/DP2NP is responsible for referring active duty (RegAF) and Space Force (RegSF) members (ARC SG's office for ARC members) into the MEB process (or, for ARC members, into the non-duty related condition(s) process) via an IRILO/Modified RILO (MRILO) process. The RILO will be used as the pre-IDES screening process. Cases submitted for pre-IDES screening will be referred to as an IRILO and will contain a NARSUM, associated consult reports and/or studies, a current AF Form 469 profile (reviewed AFI 48-133, an AF Form 1185 and a standardized cover sheet checklist found on the AFPC Medical Retention Standards Branch page of the AFMS Knowledge Exchange at **https://kx.health.mil/kj/kx8/AFPCMedicalRetentionStandards/Pages/home.aspx**. (For ARC members, the appropriate RILO checklist is located on the AFMRA IDES KX website at **https://kx.health.mil/kj/kx2/ides/Pages/home.aspx**. **(T-3).** A MRILO can also be used to obtain an expedited case disposition when needed (e.g. separation, retirement, pending assignments, pending deployments, etc.) and does not require a commander's letter unless directed by DP2NP or ARC equivalent office for ARC members. MRILOs are also used as recurring updates (e.g. Annual RILO; see **Chapter 5**) for members with an Assignment Limitation Code-C and who do not require commander's letters unless requested by DP2NP (or equivalent ARC SG's office for ARC members). MRILOs, at a minimum, will contain a NARSUM (or robust AHTLA/Specialist notes), AF Form 469 profile and Annual/Modified RILO PEBLO Checklist as the coversheet.

3.1.1. AFPC/DP2NP or ARC equivalent SG's office shall review and disposition of IRILO/MRILO as follows:

3.1.1.1. Following AMRO Board review of an IRILO, cases are forwarded to AFPC/DP2NP or ARC equivalent SG's office for ARC members for disposition. Disposition shall be forwarded to the base PEBLO via the AFPC/ Form Letter 4. **(T-1).**

3.1.1.2. AFPC/DP2NP or ARC equivalent SG's office determinations are final and have the same effect and authority as a MEB. Dispositions are:

3.1.1.2.1. Return to duty (with/without an Assignment Limitation Code) and remove AAC 37.

3.1.1.2.2. Direct a MEB (or the non-duty related process for ARC) and maintain AAC 37.

3.1.1.2.3. Direct a MEB (or the non-duty related process for ARC) at another MTF and maintain AAC 37.

3.1.1.2.4. Returned without Action (reason and disposition of AAC 37 will be specified).

3.1.1.2.5. Continued Military Medical Observation and Care (Con Care) and maintain AAC 37.

3.1.1.3. If a MEB (for ARC members, referral into the non-duty related condition(s) process) is required on a flag officer, AFPC/DP2NP (or ARC equivalent SG's office for ARC members) will designate a MTF to conduct the MEB. **(T-1).** AFPC/DP2NP will

forward initial notification to AF/DSG and AF/SG by electronic secure transmission and provide final notification when the MEB/PEB action is complete if the flag officer is returned to duty. **(T-1).** AFPC/DPFD will make the final notification if the flag officer is medically separated or retired. **(T-1).**

3.1.1.4. Presumption of Fitness. For service members with an approved retirement date within 12 months, the case will begin with a presumption that the member is fit (known as a "presumption of fitness") during the AFPC/DP2NP or ARC equivalent SG's office review disposition process. This may result in a return to duty decision without a full MEB. Presumption of fitness applies to retirement, not to separation of members who are not eligible for retirement, and will also be applied to cases for ARC members who have been non-retained. **(T-1).** These members will be reviewed for return to duty decision unless they overcome the presumption of fitness. **(T-0).** Refer to DoDI 1332.18, Enc. 3.

3.1.1.5. Only AFPC/DP2NP, ARC SG's office, AFPC/DPFD (Informal and Formal PEB), and the Secretary of the Air Force Personnel Council (SAFPC) may invoke presumption of fitness (fit for duty). MTF providers, the DAWG, and MTF MEB members are prohibited from using or claiming presumption of fitness to deny a service member MEB consideration. **(T-1).**

3.1.1.6. Service members shall not refuse, decline, nor stop any RILO, MEB, PEB, or fitness for duty evaluation except in accordance with DoDI 1332.18. Waiver must be approved by the Secretary of the Air Force (SecAF) or appropriate designee. Service members approved for voluntary early separation from active duty and will incur a Reserve obligation may not waive MEB processing. (See DoDI 1332.18, Enclosure 3, Appendix 1, para 7.) **(T-0).** However, in cases where the MEB/PEB processing would take an enlisted member beyond the date of separation or retirement, and the member does not consent to medical hold, member may be discharged (separate/retire) from military service without completing the MEB/PEB process.

3.1.1.7. Medical hold is a method of retaining a service member beyond an established retirement or separation date for reasons of disability processing, when presumption of fitness does not apply. It may be necessary to place members on medical hold if AFPC/DP2NP (or appropriate ARC SG's office for ARC members) directs a MEB, and the member is within 60 calendar days of separation or retirement. It will not be used for the purpose of evaluating or treating chronic medical conditions, performing diagnostic studies, elective treatment of remedial defects, non-emergent surgery or its subsequent convalescence, civilian employment issues, preservation of terminal leave, or for any other condition which does not warrant termination of active duty. Separation or retirement processing continues until medical hold is approved.

3.1.1.7.1. Medical hold is requested by a provider (generally the PCM) directly contacting AFPC/DP2NP for AD service members or the appropriate ARC unit for ARC service members. For ANG service members, ANG/SGP is the approval authority. For AFR service members, Air Force Reserve Command (AFRC)/Chief of Medical Operations (SGO) is the approval authority. The requesting physician should have the following information readily available, in addition to being familiar with the medical aspects of the case:

3.1.1.7.1.1. Date of projected separation or retirement.

3.1.1.7.1.2. RegAF/RegSF ONLY. Whether IRILO processing has been initiated, and if so, the estimated time until the package will be ready for submission to AFPC/DP2NP.

3.1.1.7.1.3. Whether administrative separation or court-martial charges are pending.

3.1.1.7.1.4. Servicing military personnel section implementing separation or retirement.

3.1.1.7.1.5. Whether service member desires to be retained in duty status for disability processing.

3.1.1.7.1.6. Service member's air force specialty code (AFSC).

3.1.1.7.1.7. Confirmation that the PEBLO and either the MTF/SGH or SGP has been notified of the provider's intent to request medical hold.

3.1.1.7.2. Service members already referred into DES that are within 60 days of their date of separation or retention control point/expiration of term of service only require a consent memorandum be sent to AFPC/DP2NP office for placement on medical hold to continue with the DES process.

3.1.1.7.3. Enlisted service members may refuse medical hold beyond their date of separation or expiration of term of service, and must agree, in writing, to a medical hold. **(T-1).** For officers, medical hold does not require consent, but AFPC/DP2NP may request consent in writing. The PEBLO must contact AFPC/DP2NP immediately when notified that a service member may decline medical hold. **(T-1).** A medical hold template memorandum may be found on the AFPC/DP2NP Medical Retentions Standards AFMS KX website at **https://kx.health.mil/kj/kx8/AFPCMedicalRetentionStandards/Pages/home.aspx**.

3.1.1.7.4. AFPC/DP2NP (or ARC SG's office) may direct a modified (expedited) RILO prior to approving medical hold.

3.1.2. When AFPC/DP2NP IRILO results are returned to the MTF:

3.1.2.1. If the service member is return to duty with or without an Assignment Limitation Code (C1, C2 or C3), the PEBLO is notified by DP2NP (or ARC/SG equivalent office) via the AFPC/FL 4. In turn, the PEBLO notifies the PCM and the MSME. AF Forms 422 and 469 will be generated or updated as indicated in accordance with AFI 48-133. **(T-1).**

3.1.2.2. If DP2NP directs a MEB, the PEBLO is notified via AFPC/FL4. The PEBLO, in turn, notifies the PCM, the AMRO Board chair, and the SGH and the service member. **(T-1).** The PCM (or alternate provider if PCM is unavailable) will complete the VA Form 21-0819 and return it to the PEBLO. **(T-2).** The date the provider signs the VA Form 21-0819 is the date that the member officially enters into the IDES. **(T-1).**

3.1.3. Leave/Temporary Duty. Once the service member is notified by the PEBLO that a MEB has been directed, the service member must be available throughout the IDES process, to include all appointments and counseling sessions. **(T-3).** MTFs must develop local processes and procedures with unit commanders to ensure the member's availability. **(T-3).** As the approval authority, before approving leave requests, the unit commander should

coordinate all requests with the PEBLO who will, in turn, notify the PCM and AFPC/DPFD (if case has been sent to the PEB) to ensure there is no conflict with the DES process. **(T-3).**

3.2. Initiation of the IDES.

3.2.1. The service member's date of entry into the IDES (referral date) is the date the provider signs the VA Form 21-0819. DES (LDES and IDES) timeliness goals are detailed in DoD manuals associated with DODI 1332.18 and DTM 18.004, *Revised Timeliness Goals for the Integrated Disability Evaluation System (IDES).*

3.2.2. Once the VA medical evaluations have been completed in the form of the VA compensation and pension (C&P) evaluation, the PEBLO receives the C&P exam results and provides them to the PCM/referring provider, or a provider assigned by the AMRO Board.

3.2.3. **NARSUM Review, Update, and Completion.** A mental health provider will review the C&P exams for members referred into IDES for a mental health condition. **(T-0).** If the C&P exams contain any non-mental health claimed conditions further review of the non-mental health claimed medical conditions must be completed by a non-mental health credentialed provider (e.g. primary care physician, nurse practitioners, physician assistant) and the provider will co-sign the NARSUM Addendum specifying whether any of the non-mental health claimed medical conditions are unfitting using the NARSUM Addendum Template found on the AFPC/DP2NP Medical Retention Standards KX website at: **https://kx.health.mil/kj/kx8/AFPCMedicalRetentionStandards/Pages/home.aspx**. **(T-2).**

3.2.3.1. If the member is referred for a non-mental health medical condition and after C&P reconciliation review it is determined that member has a mental health (behavioral disorder) that requires referral the mental health NARSUM template must be used. **(T-2).** The mental health NARSUM template is available on the DP2NP KX Website at: **https://kx.health.mil/kj/kx8/AFPCMedicalRetentionStandards/Pages/home.aspx**.

3.2.3.2. The preparing and reviewing physicians will not include in the NARSUM any verbal or written comments that refer to disability process results. **(T-3).** A review of all referred/claimed conditions must be completed to ensure that the conditions, either individually or collectively, did or did not make the service Member potentially unfit. **(T-0).**

3.3. Non-physician providers preparing the NARSUM. DES NARSUMs may be signed by privileged physicians or non-physicians (e.g. physician assistant, nurse practitioner) and do not require a physician co-signature. This includes NARSUMs required for IRILO, MEB and compensation and pension examination reconciliation activities. IRILO, MEB, and DES NARSUMs for mental health conditions must be prepared and signed by credentialed mental health providers (e.g. psychiatrists, mental health physician assistants, mental health nurse practitioners, clinical psychologists, and licensed clinical social workers) and do not require physician co-signature. **(T-1).** For ARC, either a psychiatrist or a psychologist with a doctorate must sign NARSUMs for mental health diagnoses that require non-duty related full case processing to the PEB. **(T-2).**

3.4. Conducting the Local MTF MEB. After the NARSUM is reviewed, updated and the completed NARSUM has been returned to the PEBLO, the MEB is convened.

3.5. Location of the MEB.

3.5.1. Service member MEBs should be processed at the MTF where they receive the majority of their care, or at the MTF closest to their duty location. However, if the identified MTF cannot provide the necessary care or assessment, the MTF may, upon acceptance by an alternate MTF, refer the case to a MTF with appropriate services.

3.5.2. If a RegAF service member is hospitalized away from the installation of assignment or in a non-Air Force facility, the member's PCM and home MTF will still be responsible for writing the NARSUM and conducting the MEB, and processing a line of duty determination. (See AFI 36-2910, *Line of Duty Determination, Medical Continuation (MEDCON), and Incapacitation (INCAP) Pay.)* **(T-3).** The nearest Air Force MTF will assist in gathering information on the member while hospitalized if it is appropriate because of relative proximity. **(T-3).**

3.5.3. Commanders at all levels, and officers who have convening and approval authority for medical Boards, will not have their own MEB or their clinical evaluation and Board processing at a MTF that is within their command and control or official influence. In this circumstance, AFPC/DP2NP will designate a MTF to accomplish the MEB. **(T-1).**

3.5.4. Any MTF-assigned officer requiring a MEB shall not meet the Board at the officer's own MTF without a policy waiver from AFPC/DP2NP (for ARC members, ARC/SG equivalent office). **(T-1).** The MTF commander may submit a waiver request detailing why a MEB should be conducted at the officer's own facility, as well as why the commander has no concern for a conflict of interest. Also, consideration may be needed for another MTF to prepare the MTF-assigned officer's NARSUM for the pre-DES RILO if a potential conflict exists and there is a high possibility member will be referred into the MEB process.

3.5.5. Personnel at a MTF will not conduct a MEB on an assigned enlisted or officer staff member who has been or is currently a disciplinary problem (received adverse administration actions such as Article 15, Unfavorable Information File, court-martial, etc.), or when there would be concern for a conflict of interest. **(T-1).** If a waiver is requested from AFPC/DP2NP, the MTF commander or director is required to include a brief statement indicating the nature of the disciplinary problem. **(T-1).** Once received, AFPC/DP2NP will respond with disposition instructions.

3.6. MEB Support for service members assigned to Geographically Separated Unit (GSU) or enrolled to TRICARE Prime Remote locations. If unique circumstances mandate that some or all DES requirements be accomplished via TRICARE Prime Remote network providers, then the AMRO Board at the MTF member is Personnel Accounting Symbol (PAS) coded must approve the use of those providers. **(T-1).**

3.6.1. The AMRO Board must review the status of GSU service members undergoing pre-IDES workup every 30 calendar days. **(T-1).**

3.6.2. The PEBLO will (1) notify the Defense Health Agency (DHA) -Great Lakes Case Management Division that the service member's pre-IDES medical care will be provided by TRICARE/TRICARE Prime Remote network providers; (2) obtain medical release authorization from the patient and contact the civilian provider(s) every 30 calendar days for written clinical updates/consults; and (3) notify the DHA-Great Lakes of the MEB outcome. **(T-1).**

3.6.3. The AMRO will assign a provider to write the NARSUM once all relevant medical documents (specialty consults/notes, labs, radiological exams, etc.,) are received from the TRICARE Prime Remote network providers. **(T-3).**

3.7. Processing MEBs for Service Members from other Military Departments.

3.7.1. Air Force MTFs have the authority to conduct cross-service fitness for duty activities in support of non-Air Force MTFs and providers. The PEBLO at the receiving Air Force MTF collects required documentation and forwards it to the AMRO Board to review for accuracy and completeness. If additional documentation is required, the PEBLO should request it. After AMRO Board review, the AMRO Board will coordinate with the service member's appropriate MTF or medical retention standards office and sends all medical documentation for review of members fitness for duty case.

3.7.2. It is the responsibility of a service member's appropriate Service to make the fitness for duty decision.

3.7.3. Air Force MTFs will forward all requested medical and MEB support documentation to member's MTF MEB or PEB office for conducting fitness for duty activities. **(T-1).** Air Force MTF PEBLOs may support counseling activities to the service member for MEB/PEB results to the extent of providing information consistent with all Services. For additional Service specific information the member will need to be counseled by their parent MTF PEBLO.

3.8. Composition of the Local MTF MEB.

3.8.1. Only physicians may participate as voting members. The Board is normally comprised of three privileged (qualified to perform specific services) physicians; ideally AD medical corps officers of the United States Uniformed Services. Two-member boards are acceptable. (For two-member boards, if there is a split opinion, a third physician is assigned as a board member to provide the majority vote.) Physician interns and residents are not authorized members. Civilian physicians, consultants, and retired medical officers who hold privileges at the MTF may serve as board members. Any MEB listing a behavioral health diagnosis must include the signature of at least one psychiatrist or psychologist with a doctorate in psychology. **(T-0).**

3.8.2. Before initially serving as a member of the MEB, the SGP will provide training to board members on the duties of MEB board members and the IDES process. **(T-3).** The training will be documented locally (e.g. AF Form 797, *Job Qualification Standard Continuation/Command JQS*, TRICARE Operations and Patient Administration Training Records or the member's Provider Activity File). The SGH is encouraged to contact AFMRA/SGH staff to obtain the latest training information. Physicians are also encouraged to attend PEBLO training courses (when offered).

3.8.3. The SGP will serve as the MEB President, with the SGH acting as an alternate when the SGP is unavailable. **(T-1).** The Deputy SGP and Deputy SGH, when appointed by the MTF commander or director in writing, are authorized the same MEB authority as the permanent or primary officials in absence of the primary official.

3.9. Required Medical Documentation for the local MTF MEB. Each local MTF MEB package shall contain, at a minimum, the following documentation.

3.9.1. NARSUM. **(T-1).**

3.9.2. Consultation Notes. Notes created by providers or medical specialists (family practitioner, orthopedist, neurologist, etc,) after a service member's visit for consultation or treatment. **(T-1).**

3.9.3. AF Form 1185. For regular Air Force and Space Force members, PEBLO ensures the AF Form 1185 is no more than 30 days old when received by AFPC/DP2NP, Medical Retention Standards office (AD). **(T-1).** For ARC members, ensure the form is no more than 60 days old when received by the appropriate ARC SG's office. **(T-1).**

3.9.4. AF Form 469. **(T-1).**

3.9.5. DAF Form 618, *Medical Board Report*. **(T-1).**

3.10. Convening the Local MTF MEB.

3.10.1. The MEB members shall review the case together and discuss the merits of potential dispositions. **(T-3).** Exceptions can only be granted by the MTF/SGH or SGP.

3.10.2. Personal appearance of the service member is not required when the MEB convenes to determine a recommendation. However, the member may request an Impartial Medical Review (IMR) and/or Rebuttal after receiving the MEB's recommendation via DAF Form 618. (See paragraphs **3.12, 3.13 and 3.14**) Service members may consult with the Office of Disability Council when requesting an IMR and/or Rebuttal of the MEB.

3.10.3. MEB recommendations. The MEB membership may choose from the following two actions: (1) return to duty or (2) Refer to IPEB. **Note**: Even though the MEB was initially directed by AFPC/DP2NP following IRILO, rare instances may arise where new information may become available (e.g. condition changes, updated consults, information from C&P exams, updated commander's letter, etc.) that result in a "return to duty" instead of a "Refer to IPEB" decision. When the MEB results in a "return to duty", the PEBLO will forward the complete case file to AFPC/DP2NP or ARC SG's office equivalent, instead of AFPC/DPFD (IPEB). **(T-2).** AFPC/DP2NP or ARC SG's office equivalent (for ARC members) will review the case again for either a "return to duty" or "Refer to IPEB" decision. **(T-2).** AFPC/DP2NP or ARC SG's equivalent office (for ARC Service members) is a final decision.

3.10.4. MEB members shall sign DAF Form 618, Block 26. **(T-3).** In accordance with DoDI 1332.18, either a psychiatrist or a psychologist with a doctorate must sign the DAF Form 618 as one of the required MEB providers for cases involving a mental health diagnoses. **(T-0).**

3.10.5. Whenever discussion does not result in a unanimous decision, the Board recorder documents the vote tally and the reason for the disagreement on the continuation sheet of the DAF Form 618.

3.10.6. The following applies to Boards for a mental health diagnosis or when cognitive dysfunction is expected:

3.10.6.1. Whenever a psychiatrist or psychologist is a member of the Board mark an "X" in the box to the right of the signature on DAF Form 618 block 26(b). **(T-3).**

3.10.6.2. The MEB members must ensure that special provisions for reporting psychiatric cases have been followed. **(T-0).**

3.10.6.3. Psychiatric evaluations must include the degree of social and industrial impairment for civilian life, and degree of impairment for military service. **(T-3).** When

describing the degree of impairment for civilian, social and industrial adaptability for all Boardable diagnosis (diagnosis that may render a member fit/unfit for continued service), use of terms for the level or degree of disability is limited to: Total, Severe, Considerable, Definite, Mild, or None. For degree of impairment of military service, use the following terms to describe the degree of the service member's current and projected impairment for military service: No Impairment, Minimal, Moderate, or Marked.

3.10.7. Competency Boards and Sanity Boards. In a case where a service member's competency for pay and records is called into question, or in a court-martial case where a service member's sanity is called into question, the MEB must be composed of three Uniformed Services Medical Corps officers, one of whom must be a psychiatrist. **(T-1).** For Competency Boards, in addition to signing the DAF Form 618, the Board determines whether the attending physician was correct in the determination of the member's competence and annotates this in block 23a of the DAF Form 618.

3.10.7.1. If the member is comatose, the member is presumed incompetent and no psychiatrist is required. However, if the member is declared incompetent for pay and records, check "OTHER" in block 22A, and add "AFMAN 65-116 V1." For Sanity Boards, findings are annotated in block 24 of the DAF Form 618. The psychiatrist on the MEB must be identified by marking an "X" in the box to the right of the signature on DAF Form 618, block 26. **(T-3).** For information/procedures for handling mentally incompetent individuals for pay purposes refer to Chapter 50 of AFMAN 65-116 V1, *Defense Joint Military Pay System Active Component (DJMS-AC) Financial Management Flight (FMF) Procedures.*

3.10.7.2. If a service member is found incompetent, send an additional copy of the DAF Form 618 to Accounting and Finance without delay. **(T-1).** Failure to safeguard the pay of members declared mentally incompetent to manage their own affairs could cause serious hardship to members and their families.

3.10.8. Refusal by service members of required professional care, medical care, dental care or other necessary treatment.

3.10.8.1. Service members who refuse service for required professional, medical, dental or other necessary care may be required to undergo MEB processing. Member is referred to an MEB when all of the following exist:

3.10.8.1.1. The service member was clearly advised of the necessary course of treatment, therapy, medication, or duty limiting or physical restriction.

3.10.8.1.2. The service member's failure or refusal was willful or negligent and not the result of mental disease or of physical inability to comply.

3.10.8.1.3. The service member refuses to submit to medical, surgical, or dental treatment or diagnostic procedures. If the refusal is based on religious grounds, arrange for the appointment of a military chaplain as a special advisor to the Board.

3.10.8.2. The MEB determines:

3.10.8.2.1. Whether or not the Service member requires the procedure in order to properly perform military duties or establish medical qualification for continued service.

3.10.8.2.2. Whether or not the procedure, according to accepted medical or dental principle, will be likely to produce the desired results. If analysis confirms the required procedure or treatment is necessary to continue military service and if the required procedure or treatment will likely achieve the desired effect, and the service member still refuses, forward the IRILO to DP2NP or ARC SG equivalent.

3.11. Local MTF MEB Review and Approval Authority. Clinical sufficiency review authority rests with the MTF/SGH and SGP. The MEB President, whether the SGP or SGH, must review each completed MEB package before it is submitted to AFPC/DPFD (IPEB), attesting to the final review. **(T-1).**

3.11.1. The service member's potential Service-disqualifying medical condition and associated healthcare, has been adequately documented in the NARSUM. The NARSUM will not be older than 30 calendar days when received by AFPC/DPFD. Also, any attached consults will not be older than 180 calendar days when received by AFPC/DPFD. **(T-1).**

3.11.2. A provider's review of the C&P exams recorded via an addendum. A NARSUM with updated comments, or with a dated statement that no additions or clarifications were required, or a continuation statement, is substituted if multiple NARSUMs are present. Also, a statement must be included that all referred/claimed conditions were considered to ensure that the conditions, either individually or collectively, did or did not make the service member potentially unfit.

3.11.3. The AF Form 1185 should clearly describe how the unfitting condition(s) affect the member's ability to perform the duties of office, rank, grade and/or rating. The AF Form 1185 will not be more than 180 calendar days old when received by AFPC/DPFD.

3.11.4. The AF Form 469 profile has been reviewed by a physician, preferably the PCM and/or the provider submitting the NARSUM, within the last 30 calendar days, and a dated statement of review is located in the restrictions section of the AF Form 469. See **paragraph 2.4.1.3.3**.

3.11.5. Service member's hospitalization or treatment progress appears to have medically stabilized (and the course of further recovery is relatively predictable), and it is unlikely that the member would be capable of returning to duty within 12 months.

3.12. Notification of Local MTF MEB Results to Service Member. Following the recommendation of the Local MTF MEB, the PEBLO must ensure that blocks 1-27 of DAF Form 618 are completed. **(T-2).** The PEBLO will meet with the service member, provide a copy of the DAF Form 618 and NARSUM/consults and AF Form 1185 to the member. **(T-0).** The PEBLO will explain the findings of the MEB (without speculating on potential PEB outcome) and answer any questions the service member may have regarding the content. **(T-0).** Also, PEBLO will advise member of their right to legal counsel provided by the ODC or civilian representation. **(T-0).**

3.12.1. The PEBLO will explain the options of the IMR and/or Rebuttal Letter. **(T-0).** The member must decide if he/she wants (1) an IMR (with or without subsequent Rebuttal Letter); (2) to decline the IMR and submit a Rebuttal Letter, or (3) to decline the IMR and the Rebuttal Letter options altogether. **(T-2).** If member chooses, he/she can submit a Letter of Concern to the IMR physician, which informs the IMR physician of any concerns the member may have before the IMR physician reviews the MEB package, and/or submit a Rebuttal letter. The Letter of Concern and/or Rebuttal Letter must be completed within the 7 calendar day timeline

per DTM 18-004. **(T-0).** Service members may consult legal counsel from the ODC or civilian acquired counsel before requesting an IMR or submitting a Rebuttal.

3.12.2. If the service member declines to elect an IMR or submit a Rebuttal Letter, member will sign and date the DAF Form 618, blocks 27(a) and 27(b) signifying that they have been informed of the findings and recommendations of the MEB. **(T-2).** After the member signs the DAF Form 618, the PEBLO assembles and forwards the MEB package to the Informal PEB.

3.13. Impartial Medical Review (IMR). If the service member requests an IMR, an impartial physician or other appropriate healthcare professional (not involved in the service member's MEB process) must be assigned to offer a review of the medical evidence presented by the NARSUM and associated consults. **(T-0).**

3.13.1. The member may provide a Letter of Concern detailing the reasons for the IMR request and any issues they may have concerning the MEB findings.

3.13.2. The IMR provider shall advise the service member within three calendar days on whether the MEB findings adequately reflect the complete spectrum of injuries and/or illnesses. **(T-0).**

3.13.2.1. For cases in which the IMR does not validate the MEB findings, the IMR provider will contact and provide written response for the MEB President (SGP or SGH) to consider. **(T-1).** Also, the IMR provider will concurrently notify the service member. **(T-3).**

3.13.2.2. In such cases that an IMR physician provided a recommended change to the NARSUM, DAF Form 618 or other relevant medical documents within the MEB, the MEB President must consider whether changes to the MEB package are warranted, and whether to reconvene the MEB once changes have been documented. **(T-3).**

3.14. Rebuttal Letters. Armed with the decision of the MEB and, if requested, the information from the IMR, the service member may choose to submit a Rebuttal Letter to the MEB Convening Medical Authority (CMA).

3.14.1. The CMA is the MTF commander, director or a senior medical officer appointed by the MTF commander or director. The CMA should have detailed knowledge of directives pertaining to standards of medical fitness and disposition of patients, disability separation processing, and be familiar with the VA Schedule for Rating Disabilities. The CMA or acting CMA should not be one of the three physicians who served on the MEB and should not be the IMR Provider for the case being rebutted.

3.14.2. If the service member requested an IMR, and elects to submit a Rebuttal letter, submit it to the MEB CMA. **(T-3).** The MEB CMA will consider the Rebuttal Letter and return the fully documented decision to the service member. **(T-3).**

3.14.3. If the service member does not request an IMR, but elects to submit a Rebuttal Letter, it will be submitted to the MEB CMA. **(T-3).** The MEB CMA will consider the Rebuttal Letter and return the fully documented decision to the service member. **(T-3).** In cases where the CMA has made any recommended changes (e.g. NARSUM, 618, etc.) the MEB President must consider whether changes to the MEB package are warranted, and whether to reconvene the MEB once changes have been documented. **(T-3).**

3.14.4. If the service member submits a Rebuttal Letter, the MEB results shall not be forwarded to the PEB until the Rebuttal process is finalized and MEB results indicate the service member may be unfit for duty. The Rebuttal Letter must state the reasons for rebuttal submission. All documents to include the response will be included with the MEB package and PEBLO will forward it to the PEB. **(T-2).** Exceptions to timelines may be granted by an authority appointed by the SecAF.

3.14.5. At the conclusion of the IMR and/or Rebuttal process, the PEBLO will inform the service member of the results and ask the member to sign and date the DAF Form 618, blocks 27(a) and 27(b) signifying that the member has been informed of the findings and has received the response to their IMR and/or Rebuttal, and recommendations of the MEB. **(T-0).** The IMR/Rebuttal process should not exceed 7 calendar days. After the PEBLO meets with the service member, the PEBLO assembles the package and forwards it to the Informal PEB.

3.14.6. If the service member has been determined to be incompetent (blocks 22 and 23 of DAF Form 618), the MEB recorder or PEBLO addresses the above mentioned action to the service member's legally authorized representative, who is entitled to the same rights, privileges, and counseling benefits as the service member.

3.14.7. The service member has the right to legal counsel concerning the IMR and/or Rebuttal process and should contact the Office of Disability.

3.15. PEBLO MEB Special Considerations. The following paragraphs detail special considerations that may be necessary for processing a MEB.

3.15.1. For privileged providers undergoing MEB processing, the MTF/SGH will submit a statement regarding the current status of the privileges. **(T-2).** A simple memorandum format is acceptable, although a DD Form 2499, *Healthcare Practitioner Action Report*, is recommended if the provider is unlikely to return to full and unrestricted duty. For non-credentialed providers enrolled to Graduate Medical Education training programs, the Program Director will provide this statement for the package.

3.15.2. A copy of AFPC/DP2NP waiver approval to conduct MEB locally for service members assigned to the MTF must be included in the MEB case file before sending to AFPC/DPFD for Informal PEB review. Refer to paragraphs **3.5.3** - **3.5.5** of this manual for a list of members that require a waiver.

3.15.3. AF Form 565, *Record of Inpatient Treatment* if applicable.

3.15.4. Other applicable reports relevant to the MEB process as needed or requested for ARC service members.

3.15.5. Cases returned from AFPC/DPFD due to the need for additional information or correction. PEBLO must immediately notify the SGH or SGP of cases returned from AFPC/DPFD for additional information or correction, ensuring MEB case files have included the additional information or correction prior to sending back to AFPC/DPFD. **(T-1).** AFPC determines the package return suspense date. **(T-3).**

3.15.6. The MTF commander or designee will advise members of the MEB and examining physician that the case was returned, the reason for its return, and suspense any requests. **(T-3).**

3.15.7. Report any changes in condition/new condition in service Members to AFPC/DP2NP (before MEB is sent to AFPC/DPFDD)

3.15.7.1. If a service member, for whom a MEB case has already been sent to the Informal PEB, is diagnosed with a new Boardable condition, the case may require a recall of the previously submitted case. A Boardable condition is a condition that may render a member fit/unfit for continued service. If a recall is required, the MTF commander or director or designee will contact AFPC/DPFD in writing per AFI 36-3212, chapter 2, to request the recall. **(T-1).**

3.15.7.2. If a service member receives or possesses orders for separation or retirement as a result of a disability determination, and the service member has not yet been released from AD and then experiences a significant clinical change in their condition, the medical group commander or designee will contact AFPC/DPFD (not DP2NP) to ascertain whether retirement or separation orders should be revoked and another MEB be initiated. **(T-1).**

3.15.8. Unit Commander Notification of DES Findings Process:

3.15.8.1. The PEBLO will enter the commander, first sergeant, or designee email address into Right Now Technology (RNT) via myPers . This allows the commander, first sergeant, or designee to receive RNT notifications via electronic mail from the Air Force Personnel Center notifying recipients of the service member's case status throughout the DES process.

3.15.8.2. Once the PEB findings are received, within 24 hours of receipt, the PEBLO must notify the commander, first sergeant, or designee prior to providing the service member their PEB (Informal or Formal) or Secretary of the Air Force Personnel Council findings. **(T-1).**

3.16. MTF Commander or Director Responsibilities in the DES. Every MTF commander or director must establish and maintain a viable MEB process. **(T-3).** MTF Commanders or directors will ensure personnel involved in the DES process (PEBLOs, medical providers, etc.) receive DES training in accordance with DoD standard and implement local processes and procedures to ensure case processing is completed within DoD goals. **(T-0).** Also, the MTF commander or director will appoint in writing a primary and secondary Convening Medical Authority. **(T-3).**

3.16.1. MTF MEB office will ensure copies of current appointment letters (CMA, PEBLO, MEB members) will be updated, at least annually, and whenever new members are appointed. **(T-3).** Letters are maintained by the PEBLO. Copies are forwarded to AFPC/DP2NP Medical Retention Standards office, AFPC/DPFDD Disability Operations Branch and AFMRA/SG3PF, DES Compliance and Quality office. The MTF is responsible for maintaining all written appointment orders, formal appointment letters, and Convening Medical Authority delegation orders for at least three calendar years from the date of the appointment or delegation. Maintain these documents within the record files in the Flight and Operational Medicine (FOM) Flt/PEBLO's office.

3.16.2. Each MTF commander should appoint in writing an experienced enlisted, officer, federal civilian employee or contract employee (with commensurate experience and/or skill level) as the PEBLO. It is recommended MTFs consider the importance of continuity when identifying a PEBLO. The FOM Flt/CC or NCOIC will notify AFPC/DP2NP and AFMRA/SG3PF of any PEBLO changes. **(T-1).** The MTF shall maintain all initial and current

annual PEBLO proof of formal training documents (copies of training certificates and/or letters of training certification or validation). **(T-3).** Maintain these documents within the FOM's Flight records for the duration of the PEBLO's tenure.

3.16.2.1. The primary reference points for PEBLO responsibilities include this DAFMAN, AFI 36-3212, AFI 48-133, and various other reference materials and tools that can be found on the AFMS KX in the AFMRA Health Benefits site at **https://kx.health.mil/kj/kx2/ides/Pages/home.aspx** and the DP2NP Medical Retention Standards KX website at **https://kx.health.mil/kj/kx8/AFPCMedicalRetentionStandards/Pages/home.aspx**.

3.16.2.2. PEBLO Training. PEBLO responsibilities are varied and numerous. Minimal, core PEBLO training requirements are outlined in DODI 1332.18. PEBLOs will be provided formal training prior to being assigned to perform DES duties and certified annually. **(T-0).** Other various training venues, to include web-based platforms, can be used to provide PEBLO training. Regardless of venue, the MTF should have a means to periodically measure and document each PEBLO's proficiency level. All formal training documentation will be maintained in the member's training records for at least three years or the duration of the PEBLO's assignment. **(T-3).**

3.16.3. Upon assignment, each new PEBLO will spend at least one full work week working with an experienced PEBLO before assuming fulltime PEBLO duties. **(T-0).** If no experienced PEBLO is available within the MTF to provide required training, the MTF commander should consider the alternative to, a) arrange for the new PEBLO to travel to another MTF to receive training or, b) sponsor a PEBLO from another MTF to travel to their MTF to provide required training. For Air Force members assigned as PEBLOs, on-the-job training will be documented and specifically targeted to meet the requirements identified on a standardized AF Form 797. **(T-3).** Verification of required initial and annual PEBLO training is maintained by AFMRA/SG3PF as oversight and for reporting.

3.16.4. Integrated Care Coordination for service members in the DES.

3.16.4.1. When service members enter into, and as they progress through the phases of the DES, their care, guidance, and support is entrusted to the WCT. The WCT consists of the MTF privileged provider, along with assigned nurse/technician(s), who are primarily involved in managing the medical/mobility restricting issue(s) for the service members. Mental health or a specialist provider should be considered the lead WCT for a patient when that patient has no condition driving the mobility restriction other than those conditions for which the service member is seeing a mental health/specialty provider. Refer to AFI 48-133, for further WCT guidance. Other care management team members may consist of the Recovery Care Coordinator, Veterans Affairs Medical Service Coordinator, PEBLO, Medical Case Manager, Non-medical Case Manager, other medical providers and key personnel. (Refer to DAFI 34-1101 for more guidance.)

3.16.4.2. The MTF commander or director will develop processes to ensure integrated coordination of care for service members entered into and/or progressing through the DES at their MTF. **(T-1).** The primary means to accomplish this coordination will be to ensure a single nexus point—physical or virtual—which promotes the following best practices:

3.16.4.2.1. Centralized access - To the greatest extent possible, provides service members easy access to all members of the Care Management Team to conduct services in a single visit and/or location (i.e. one stop resolution).

3.16.4.2.2. Warm hand-offs - Referral practices allowing the transfer of care/support between two members of the Care Management Team. Preferably, the hand-off occurs in front of the service member in real time.

3.16.4.2.3. Intake meetings/process - A coordinated approach that aligns expectations, achieved by an initial meeting which outlines the roles of each member of the Care Management Team, and considers the goals of the service member.

3.16.4.2.4. Case tracking - A method/technique to bring transparency to a process allowing all Care Management Team members and the service member to remain informed of when an activity is taking place, reducing confusion, and ensuring accountability.

3.16.4.2.5. Cross-functional communication - Encourages each member of the Care Management Team to bring their functional expertise to work towards the common goal of assisting the service member through Continuum of Care processes.

3.17. Performance Reporting and Oversight. Mandatory DoD quarterly and annual DES reporting requirements were established by DoDI 1332.18. Other reporting requirements may be established by agencies within the DoD. Guidance for those requirements should be provided by the requesting agency.

3.17.1. Mandatory DES Quarterly Reports:

3.17.1.1. Caseload & Training Reporting. AFMRA/SG3PF provides monthly, quarterly and annual reporting to DHA WCP and other agencies. This is accomplished by making each MTF PEBLO responsible for ensuring correct data for each MEB case they are processing is properly updated into the VTA database system. AFMRA/SG3PF runs ad hoc query reports from VTA and compiles the data for use in various reports. Reports consist of:

3.17.1.1.1. The total number of cases (separated by category) for active MEB, Temporary Disability Retired List, RILO (Initial and Modified), and IDES pre-screening cases.

3.17.1.1.2. LDES case data.

3.17.1.1.3. The number of assigned PEBLOs.

3.17.1.1.4. The percentage of assigned PEBLOs who are 100% trained.

3.17.1.1.5. MEB quality performance reporting.

3.17.1.2. Officials at AFMRA/SG3PF will consolidate the MEB data into various monthly, quarterly and annual reports. **(T-1).** AFMRA/SG3PF forwards applicable reports to AFPC/DPFD for inclusion of PEB data before final reports are sent to DHA (WCP) and other agencies as required.

3.17.2. Mandatory DES Annual Report. Following the close-out of each fiscal year, each Service is required to submit an Annual DES Report to Office of the Under Secretary of

Defense for Personnel and Readiness (USD PR). In addition to validating composite data for the entire year, any additional queries requested from Personnel and Readiness are provided. The Annual Report will be sent to AFPC/DPFD and any other appropriate agencies for collaboration and completion of the report. **(T-1).**

3.17.3. Internal Metrics/Tracking Systems. Each MTF will create metrics to identify and monitor delays in the medical Board process. **(T-3).** MTFs will document and track causes for delays until corrected. **(T-3).** MTFs are required to report any extenuating circumstances to AFMRA/SG3PF for delays in MEB case files processing (non-availability of PEBLO(s), systems downtime issues for several days, etc.,) and what actions have been taken to resolve the delay in case processing. **(T-3).** AFMRA/SG3PF will maintain centralized IDES timeliness metrics for all MTFs.

3.18. VA Office. See benefits eligibility guidance based on service member's status in AFI 36-3026_IP Volume 1, *Identification Cards for Members of the Uniformed Services, their Eligible Family Members, and other Eligible Personnel.* The VA should be contacted directly for counseling on available benefits.

3.18.1. Request for Bed. If required, a VA bed may be obtained for a service member if prolonged hospitalization will be required. This request is processed through the TRANSCOM Regulating and Command & Control Evacuation System ($TRAC^2ES$).

3.18.2. Patient Status. Active Component service members who must be treated at a VA Hospital before retirement are ordered PCS without PCA. **(T-3).** The servicing military personnel section retains responsibility. If a service member has a PCS to a VA hospital, they will be assigned to the nearest Air Force MTF AMTU. **(T-3).**

3.19. The Recovery Care Coordinator (RCC).

3.19.1. RCC is to ensure that recovering service members and families understand the likely path of the member's recovery, the types of care and services that will be needed and provided, and how much time recovery may take. RCC work with Medical Care Case Manager and PEBLO to assist in activities associated with the IDES process. Further responsibilities may be found in DoDI 1300.24, *Recovery Coordination Program.*

3.19.1.1. For the convenience of the recovering service member, RCCs are often provided office space within the MTF. However, RCCs perform services in furtherance of personnel activities, and do not function in roles of Treatment, Payment, or Healthcare Operations on behalf of the MTF. Because they are neither healthcare personnel nor healthcare business associates, RCCs are not mandated to complete Health Insurance Portability and Accountability Act (HIPAA) training.

3.19.1.2. Disclosures of protected health information (PHI) to RCCs personnel fall under the category of 'Required by Law,' and must be properly documented in the PHI Management Tool or the AFMS approved disclosure accounting tool. **(T-0).** The recovering service member does not have to give authorization for disclosure of the PHI as part of the initial referral process. RCC access to PHI is limited to recovering service members participating in the Recovery Coordination Program, therefore, no disclosure of PHI should occur beyond the recovering service member's tenure in the program, nor should disclosure of PHI occur for those recovering service members who decline participation in the program. As an alternative to accounting for each disclosure, MTFs

may use the recurring event provision found in AFI 41-200, *Health Insurance Portability and Accountability Act (HIPAA)* to avoid logging each disclosure. MTF HIPAA privacy officers may obtain additional information on proper use of this provision by contacting the AFMS HIPAA Support Team.

3.19.1.3. To alleviate concerns MTF staff members may have about limiting disclosure of PHI to the relevant requirements of the law under AFI 41-200, recovering service members may be asked to sign a DD Form 2870, *Authorization for Disclosure of Medical or Dental Information*. However, they may not be ordered to sign the form. Service members should be appropriately advised about their rights concerning disclosure of their medical or dental information. A signed and valid DD Form 2870 provides the RCC broad access to PHI, to the full extent of the recovering service member's authorization in Section II of the form. A signed DD Form 2870 should eliminate any dispute between the MTF staff and the RCC regarding the scope of information needed by the RCC.

3.19.2. Eligible service members can be referred to the RCP by their Commander, medical care provider, warrior care program, or the Wounded Warrior Resource Center; or, the service member may request to be in the RCP. To optimize teamwork, care coordination, and the recovery process of recovering service members participating in the Recovery Coordination Program, the MTF commander or director shall:

3.19.2.1. Establish procedures to verify the identity of recovering service members participating in the Recovery Coordination Program. **(T-3).**

3.19.2.2. Establish effective communication processes with local RCCs to ensure timely referrals of recovering service members who might benefit from the program's services. **(T-3).**

3.19.2.3. Ensure Healthcare Providers and Medical Care Case Manager are well-versed with the Recovery Coordination Program. **(T-3).**

3.19.2.4. Ensure PEBLOs develop a solid partnership with the RCCs assigned to work with recovering service members at their MTF, location, or region and keep the RCCs advised of the recovering service member's status throughout the IDES process. **(T-3).**

3.19.2.5. Ensure RCCs are invited to meetings in which the cases of recovering service members participating in the Recovery Coordination Program are discussed. **(T-3).**

3.20. Temporary Disability Retired List (TDRL).

3.20.1. A Service member will be placed on the TDRL when the member meets the requirements for permanent disability retirement except that the disability is not determined to be stable but may be permanent. A disability will be determined stable when the preponderance of medical evidence indicates the severity of the condition will probably not change enough within the next 3 years to increase or decrease the disability rating percentage.

3.20.2. Title 10, United States Code (USC) § 1210, *Members on temporary disability retired list: periodic physical examination; final determination of status*, requires reexamination of all members on TDRL at least once every 18 months from placement on TDRL to monitor changes in the condition(s). Reference AFI 36-3212 for further information. The medical facility conducts the examination according to DAFMAN 48-123. AFPC/DPFD schedules the initial examination at no later than 16 months after placing the member on TDRL so the

medical facility can complete it before the end of the 18th month. Schedule the exams at the Air Force medical facility, with the required capability, nearest to the member's home, or the nearest DoD medical facility if indicated by the member's medical condition. Extensive guidance is located in AFI 36-3212. See further sponsor service affiliation for Defense Enrollment Eligibility Reporting System (DEERS) enrollment, eligibility, and medical entitlement in AFI 36-3026_IP Volume 1.

3.20.3. Procedures for Periodic Examinations.

3.20.3.1. Approximately 60 calendar days prior to the reporting date, Air Force Personnel Center, Directorate of Airman and Family Care (AFPC/DPFDC) will send the previous TDRL medical records and instructions to the examining facility and request a TDRL medical appointment. **(T-1).** The MTF must respond within 14 calendar days and provide date and time of the appointment. **(T-1).** If the medical facility cannot conduct the examination, it must return the records within 10 calendar days of receiving the request to AFPC/DPFDC. **(T-1).** The member shall provide to the examining physician, for submission to the PEB, copies of all medical records (civilian, VA and all military medical records) documenting treatment since the last examination. **(T-1).** If the TDRL member fails to report for the examination on the scheduled reporting date, the medical facility must advise AFPC/DPFDC immediately. **(T-1).**

3.20.3.2. The MTF commander or designee (SGH/SGP) ensures the examination is completed as quickly as possible. The DoD requirement is to provide medical reports to AFPC/DPFD within 30 calendar days of examination and ensure all laboratory studies and consultations have been completed and included in the report. **(T-0).** The commander advises AFPC/DPFD in writing of any delay and provides an estimated date of report completion. **(T-2).**

3.20.3.3. If the member was mentally incompetent when last examined and there has been a change in competency since then, or if there is a question as to mental competency, the examining military facility must convene a competency Board in accordance with DoDI 1332.18 and further specific guidance contained within AFMAN 65-116 V1, **Chapter 50**. (Also, see **para 3.10.7**) **(T-0).**

3.20.3.4. TDRL members who are imprisoned or confined by civil authorities must also have a periodic examination. **(T-0).** AFPC/DPFD will request a report of disability examination through the nearest MTF from the appropriate authorities, along with a copy of the commitment order from the confinement institution. **(T-0).** In the event of no report, or an inadequate report, is received, AFPC/DPFDC will make documented efforts to obtain an acceptable report. **(T-0).** If the report received contains sufficient information, the PEB will use it to evaluate the member. **(T-1).**

3.20.4. If a military retiree on TDRL requires a mental competency status determination, AFPC/DPFD will designate a MTF to conduct this Board. Further, the MTF will conduct the TDRL periodic evaluation.

3.20.5. Travel and Per Diem Allowance. Service members traveling to a medical facility for examination, or to JBSA-Randolph Air Force Base, TX for the formal PEB, receive travel and per diem (including meals and lodging) allowance based on their retired grade (Joint Travel Regulation). **(T-0).** Also, reference AFI 36-3212, Chapter 8 for further information.

3.20.5.1. The service member is authorized an escort to the place of examination only when the member is not physically or mentally able to travel without help.

3.20.5.2. Approximately 20-30 calendar days prior to the reporting date, AFPC/DPFD sends travel orders to the member. The order indicates the exact date, time and place to report and includes the authority for payment of travel costs.

3.20.5.3. The medical facility endorses the order to verify whether they examined the service member as an inpatient or outpatient, as well as the dates and times the member reported and was released after completing the examination.

3.20.5.4. If the examination was in outpatient status, indicate whether the member occupied government quarters. The examining facility must ensure the service member has an endorsed order to submit the claim for reimbursement. **(T-3).** The service member submits a travel voucher for reimbursement. Reference the Joint Travel Regulation for further travel entitlement information.

Chapter 4

ADMINISTRATION FOR AIR RESERVE COMPONENT (ARC) SERVICE MEMBERS

4.1. Air Reserve Command Surgeon or Air Surgeon. For ARC personnel, the respective ARC SG's office is the approval authority for Assignment Limitation Code, medical hold decisions, and non-emergent surgery requests within final six months of service. AD MTFs should contact the appropriate ARC SG's office when confronted with these issues involving ARC personnel.

4.1.1. **Procedures for ARC Service Members.** MEBs for ARC service members entitled to disability evaluation processing shall be convened at AD MTFs. **(T-3).** Refer to AFI 36-3026_IP Volume 1 for further sponsor service affiliation for DEERS enrollment, eligibility, and medical entitlement.

4.1.2. Determining Eligibility and pre-MEB Case Processing. MEB initiation or case processing cannot begin for any ARC service member without a properly completed line of duty determination on an AF Form 348, *Line of Duty Determination*, DD Form 261, *Report of Investigation Line of Duty and Misconduct Status,* or appropriate administrative LOD. A service member's line of duty must be finalized prior to referral into the DES. This includes any member initiated appeal of a line of duty determination under AFI 36-2910. Whenever an ARC service member is referred for a MEB, the PEBLO will establish contact with the medical Air Reserve Technician or ANG Health System Technician at the ARC service member's supporting ARC unit. **(T-2).** In cases where the ARC service member is on Medical Continuation orders and is processing through IDES (see AFI 36-2910, Chapter 5), the PEBLO will also contact the ARC Case Management Division. **(T-2).** The medical Air Reserve Technician, ANG Health Services Technician, and PEBLO will maintain contact with the ARC service member to obtain all required documents and arrange for medical TDY. **(T-2).** The PEBLO will notify the Air Reserve Technician or ANG Fulltime Point of Contact prior to initiating the MEB. **(T-3).** If the PEBLO is unable to contact the medical Air Reserve Technician or ANG Fulltime Point of Contact, the PEBLO shall contact the respective ARC Command level Medical Support (Surgeon General) or SGP office for assistance. **(T-2).** (For IMAs, contact HQ RIO office.)

4.1.2.1. Line of Duty (LOD). A completed AF Form 348, DD Form 261 or administrative LOD determination with an "In Line of Duty" determination is required before any ARC service member can be considered for disability. **(T-2).** If the necessary Line of Duty determination form is not in the medical records, or if the Line of Duty determination is unclear or confusing, the ARC service member will be referred to the supporting ARC appropriate authority for Line of Duty review. (Refer to AFI 36-2910.) **(T-2).** Once entitlement to disability processing has been established, only the medical diagnoses (resulting from known actions, events, origin, or etiology) determined to be "In Line of Duty" following completion of the AF Form 348, or DD Form 261, shall be identified on the DAF Form 618 as the reason for MEB processing. **(T-2).** (Reference AFI 36-2910, further guidance.)

4.1.2.2. The appropriate administrative Line of Duty representative at the ARC service member's unit must contact the DHA-Great Lakes and inform the service office that the ARC service member has been referred for MEB review. Also, the representative will furnish the service office a completed copy of the Line of Duty report. **(T-2).**

4.1.2.3. Medical Records on ARC service members undergoing MEB or RILO will be forwarded along with the MEB report, the commander's letter and other supporting documentation, and the following:

4.1.2.3.1. A copy of the orders or other directives placing a member in a duty status at the time of onset of illness, injury, or disease.

4.1.2.3.2. A completed and signed copy of the AF Form 348, or DD Form 261, including any and all formal LOD reports and written opinions from the ARC LOD Determination Boards, as appropriate.

4.1.2.3.3. Medical documentation and comprehensive medical information unique to ARC personnel to include civilian medical records.

4.1.2.4. Expedited Processing of ARC MEB Continuation Cases at 59th Medical Wing, Joint Base San Antonio-Lackland, TX.

4.1.2.4.1. ARC service members who are injured or become ill while on USC, Title 10 military orders may be eligible for Medical Continuation orders while receiving treatment for their condition. (Reference *AFI 36-2910* for further guidance.)

4.1.2.4.2. During the treatment process, it may be determined that the ARC service member requires a MEB. It is at this time that the MTF historically responsible for providing the majority of medical support to the ARC military unit, should be responsible for processing the MEB.

4.1.2.4.3. The objective of Medical Continuation is to enhance utilization and readiness of personnel while preserving their health and preventing further injury or illness. Medical Continuation extends AD for ARC service members when further medical evaluation is warranted, as set forth in DAFMAN 48-123. Refer to AFI 36-2910 for information regarding policy, responsibilities, and procedures for authorizing Medical Continuation orders.

4.1.2.4.4. Processing ARC MEB cases can prove to be difficult for MTFs with limited direct care capabilities or limited TRICARE network medical specialty availability. In an effort to alleviate caseload build-up at those MTFs due to limitations, some select ARC MEB case processing may shift from the primary MTF to another Medical Wing with appropriate resources available to process the ARC MEB case. Medical centers, hospitals, and clinics with the necessary medical capability and available TRICARE network specialties, within a reasonable distance from the MTF, will be expected to continue the MEB process locally.

4.1.2.4.5. The criteria established for expedited processing of Medical Continuation cases at the 59th Medical Wing are as follows:

4.1.2.4.5.1. Cases identified for imminent MEB processing AAC 37 personnel status – with a completed Line of Duty determination.

4.1.2.4.5.2. Appointments required but not available at the local MTF or within a reasonable one day's travel (by automobile) at a TRICARE network provider. Unavailable appointments may be any of the following types; medical, surgical, or mental health.

4.1.2.4.6. ARC personnel with significant medical conditions that require persistent clinical care may be attached, not assigned, to a MTF AMTU during MEB processing.

4.1.2.4.7. The MTF commander will notify the appropriate ARC command surgeon when a MEB is required for an ARC flag officer. **(T-2).**

4.1.2.4.8. The list below contains contact information for the appropriate ARC SG's office:

4.1.2.4.8.1. Air Force Reservists. HQ AFRC/SGO, 135 Page Road, Robins Air Force Base, GA 31098, **AFRC.SGP@us.af.mil**

4.1.2.4.8.2. Individual Mobilization Augmentees (IMAs). ARPC/RIO SG, 18420 E. Silver Creek Ave, Bldg 390 MS68, Buckley AFB CO 80011

4.1.2.4.8.3. Air National Guardsmen. HQ NGB/SGPA, 3500 Fetchet Avenue, Joint Base Andrews MD 20762-5157

4.2. AFR members not entitled to disability processing will be evaluated in accordance with DAFMAN 48-123 and AFR medical policy guidance. ANG members not entitled to disability processing will be evaluated in accordance with DAFMAN 48-123, and ANG medical policy guidance. For ARC service members, forward non-duty related case to the PEB for a fitness only determination IAW AFI 36-3212. For mission purposes, commanders and their designees, to include personnel offices, must receive comprehensive medical information. **(T-2).** Only the minimum necessary will be provided. If disclosures of this information have not been previously authorized by the ARC service member, the MTF will account for the disclosures in accordance with AFI 41-200. **(T-0).**

Chapter 5

ASSIGNMENT LIMITATION CODE (ALC)

5.1. Definition. Assignment limitations, permanent or semi-permanent, are used to alert personnel managers of long term constraints on assignment or utilization of service members. They broadly restrict, or limit the selection of service members for assignment to or from certain duties or areas and apply to a duration longer than just to the current duty assignment. Reference AFI 36-2110, *Total Force Assignments*. When an AD member has been returned to duty by the Air Force DES as fit, DP2NP will review the case to determine if an ALC needs to be placed in the Personnel Data System. This action is taken by the appropriate ARC SG's office when the member is an ARC service member. The ALC restricts assignment and deployment availability to only Continental United States (CONUS), Alaska (Elmendorf), and Hawaii assignments, and will prevent reassignment anywhere else without prior approval by designated approval authorities described in detail further in this section. The intent of the ALC is to protect members from being placed in an environment where they may not receive adequate medical care for a possible life-threatening medical condition and to prevent the assignment of non-qualified personnel to overseas locations. This will further ensure the safe and effective accomplishment of the Air Force mission.

5.1.1. **Authority.** AFPC/DP2NP retains sole authority to assign or remove the ALC on AD members, while the respective ARC SG's office is the authority to assign or remove the ALC or Deployment Availability (DAV) Code-42 for ARC service members. DP2NP (or the appropriate ARC authority) assigns the appropriate ALC stratification code to the service member based on risk and medical requirement. The ALC is valid indefinitely, and a review is performed at least annually to renew the currency of the ALC, change to a different ALC, or remove the ALC.

5.1.1.1. ALC-C1 Stratification: This stratification will be used primarily to identify individuals with temporary or mild conditions requiring medical follow-up but whose condition is clinically quiescent (inactive or unlikely to cause serious impact) if untreated or treatment is limited to primary care during periods of deployment or assignment. ALC-C1 code is identified in Military Personnel Data System (MiLPDS) as an "X" code.

5.1.1.2. ALC-C2 Stratification: This stratification will be used for medical conditions for which specialist medical care and referral within one year is likely but who could be deployed or reassigned Outside CONUS or to non-fixed environments if appropriate specialty care is available, or for short periods of time. ALC-C2 code is identified in MiLPDS as a "Y" code.

5.1.1.3. ALC- C3 Stratification: This stratification designates members who should not be deployed or assigned away from specialty medical capability required to manage their unique medical condition. ALC-C3 code is identified in MiLPDS as a "C" code.

5.1.2. DP2NP (or ARC SG's office) will assign the appropriate ALC stratification during IRILO review when disposition is return to duty, after a PEB finding of return to duty, and during each annual RILO review if warranted.

5.1.3. AD and ARC MTF commanders/directors are responsible for tracking and keeping wing commanders updated on those members of the command who are on an ALC or DAV Code-42 and will assure timely medical review as specified by DP2NP or the appropriate ARC

SG's office during the year indicated. **(T-3).** Medical reviews are conducted periodically, as specified by the appropriate authority, depending on the diagnosis.

5.2. Requests to Allow Deployment or Overseas Assignment for service members with an Assignment Limitation Code. The ALC is designed to limit, but not prevent deployment and/or overseas assignments. It is designed to ensure that service members with medical conditions are assigned and/or deployed to the appropriate location where care is available. This requires that waiver coordination between the losing base and the medical waiver approval authority occur in a timely manner.

5.2.1. Initiation of Waiver Requests. When a service member who carries an ALC restriction is notified of an overseas assignment (PCS or deployment), the member's garrison MTF must initiate and process an ALC waiver request in an expeditious manner. **(T-3).** The MTF may become aware of the service member's selection for deployment/PCS via notification from the member, the member's commander, the military personnel section, or other source. It is recommended that the appropriate point of contact in the MTF validate the possible overseas assignment with an official source (e.g. the member's unit First Sergeant or deployment manager) to avoid unnecessary processing of waivers. (Reference DAFI 48-122, *Deployment Health*, Chapter 2 for more information concerning processing ALC and medical waivers for deploying service members.) The waiver review package will contain the following information**:**

5.2.1.1. The most recent RILO narrative. **(T-3).**

5.2.1.2. A current AF Form 469 with all duty and deployment limitations reviewed/validated within the last 30 calendar days. **(T-3).**

5.2.1.3. The most recent medical record entry (typically from AHLTA) or similar electronic system) that addresses the condition for which the service member was issued an ALC. **(T-3).** If the most recent medical record entry is greater than 30 calendar days old, the PCM will add an addendum to the most recent note updating the member's currently known clinical status, to include any specialty consults or laboratory or radiology study results since the medical record entry (copies of these results may be included). **(T-3).** Such results should include routine maintenance testing (e.g. HgbA1C values for diabetics; the most recent Peak Flow, spirometry, and/or pulmonary function tests for asthma; etc.). The PCM should include an assessment of the stability of the condition, any need for clinical follow-up or testing, and the impact of the condition upon the member's duty performance and ability to meet deployment criteria. If there have been no changes or updates of any manner, the provider may indicate this fact in the addendum. A clinical encounter with the PCM is not required, but may be accomplished within the 10-day window if the PCM feels it is required.

5.2.1.4. A memo, cover letter, or appropriate transmission that includes information on the assignment, such as projected departure date, duration of assignment, and location of assignment (with appropriate management of classified information). **(T-3).** For example, for deployments, inclusion of the Unit Line Number will allow the waiver authority to specifically assess the deployed assignment.

5.2.2. Within 10 duty days of MTF notification of the assignment, the Deployment Waiver Manager will forward the waiver review package to the appropriate waiver authority. **(T-3).** If

it is determined that additional testing or evaluation is required to fully assess the service member's ability to meet the assignment requirements, the package may be delayed for an additional 10 duty days, upon approval of the MTF/SGH or SGP, in order to accomplish these clinical evaluations. However, if obtaining these additional evaluations will take longer than 20 total calendar days from initial assignment notification, the waiver package will be sent to the waiver authority within the first 10 calendar days of initial notification with an explanation of how long it is projected for the evaluations to be completed. **(T-3).**

5.2.2.1. If the service member is being followed by specialists, the most recent specialty note should also be included, if not fully detailed in the RILO. Do not delay in sending the waiver request to the waiver authority in order to update or repeat a specialty consultation if there has been no change in the member's condition since the last consult. If the PCM determines that the member's condition is of questionable stability, and requires a new specialty consult in order to assess the condition, the package can be delayed up to ten (10) additional duty days before it is submitted to the waiver authority, but only with approval from the SGH or SGP. The PCM will notify the PEBLO. The PEBLO will work with the TRICARE Operations and Patient Administration office to ensure that the member's consult for deployment clearance is expedited. **(T-3).**

5.2.2.2. Approvals for delayed (greater than 10 duty days) ALC waiver request submissions must be documented in the DAWG minutes. **(T-3).** For any delayed waiver request, The DAWG must track the time from initial request, to submission of the waiver to the appropriate waiver approval authority. **(T-3).** Any time submission of a waiver request exceeds 20 (twenty) duty days, the PEBLO must contact (1) the office that initiated the waiver request and (2) the service member's commander, to inform them of the delay in processing the waiver. **(T-3).**

5.2.3. Waivers for service Members with ALC-C1 "X" Stratification. All ALC waiver requests will be documented in the next DAWG meeting by the PEBLO with explanations of any delays in processing. **(T-3).** However, it is not necessary to delay processing a waiver package until the next DAWG meeting. This will allow the DAWG to monitor trends in this process.

5.2.3.1. ALC "X" with C1 Stratification: Deployable/Assignable to Global DoD fixed facilities with intrinsic Medical Treatment Facilities (except for the locations listed in **paragraph 5.2.3.2**), without an ALC waiver. For a list of fixed MTFs, refer to AFPC/DFP2NP Medical Retention Standards office for a complete list.

5.2.3.2. ALC "X" with C1 Stratification requires a waiver for PCS, Deployment or TDY to any isolated or remote installations overseas, including bases at Soto Cano, Moron, Diego Garcia, Thule, Al Udeid, Izmir, etc. Lajes Field, Eielson Air Force Base, and the installations in Korea also fall into this category; even though these bases may have "fixed MTFs," these locations are considered to be particularly remote and/or are generally considered to be "deployed" installations. Service members with an ALC-C1 "X" identifier require a waiver to be assigned.

5.2.3.3. ALC "X" with -C1 Stratification does NOT require a waiver for PCS/TDY to other fixed bases like those in Germany, England, Japan, Guam, or Italy, or to Elmendorf or Hickam.

5.2.3.4. The waiver approval authority for service members with ALC "X" with C1 Stratification is usually the gaining MTF commander or director (may be delegated to SGH or SGP). If no MTF is co-located, the gaining major command (MAJCOM) or Air Force Component of the Geographical Combatant Command (GCC) is the waiver authority. **Note**: The waiver approval authority for all PCS, Deployment and TDY to Southwest Asia is the Air Forces Central Command (AFCENT) command surgeon's office, not the specific gaining MTF.

5.2.4. Waivers for Service Members with ALC "Y" with C2 Stratification. Waiver authorities may approve or deny the waiver upon receipt of the initial waiver review package, or they may agree to wait for the additional clinical information. Additionally, the waiver authority may direct additional information (e.g. a new/updated RILO review by DP2NP or ARC SG's office). The MTF should make every effort to keep the service member's unit (commander, first sergeant, unit deployment manager/commander's support staff deployment monitor for example) updated on the progress of the waiver package, particularly estimates on completion of any additional requirements of the waiver authority.

5.2.4.1. ALC "Y" with C2 Stratification: Deployable/Assignable to CONUS installations with intrinsic fixed MTFs (TRICARE Network availability assumed) without a waiver, but requires a waiver for PCS, Deployment or TDY anywhere overseas.

5.2.4.2. ALC "Y" with C2 Stratification does not require a waiver for Elmendorf or Hickam Air Force Base assignments.

5.2.4.3. The Waiver Approval Authority for those with ALC "Y" with C2 Stratification is the gaining MAJCOM or GCC command surgeon (may be delegated to MAJCOM/GCC SGH or SGP).

5.2.5. Waivers for Service Members with ALC "C" with C3 Stratification.

5.2.5.1. ALC "C" with C3 Stratification: Limited to duty at specific CONUS installations, as well as Elmendorf or Hickam Air Force Bases, based on medical need. Requires a waiver for PCS, Deployment, or TDY anywhere else overseas.

5.2.5.2. The Waiver Approval Authority for those with ALC "C" with C3 Stratification is AFPC/DP2NP Medical Retention Standards Branch, 550 C Street West, Suite 26, Joint Base San Antonio-Randolph, TX 81150-4718 (for AD members) or sent to the appropriate ARC SG's office (for ARC members).

5.2.5.2.1. Special Requirements for ALC "C" with C3 Stratification - Waiver Packages. In addition to the requirements for ALC waiver packages noted above, there are special requirements for those with ALC "C" with C3 Stratification. Because ALC "C" with C3 Stratification is assigned to service members with unique, more serious condition(s), waivers are only granted when the benefit of deploying or assigning the service member overseas outweighs the potential risks.

5.2.5.2.2. The waiver request must be in the form of a memorandum, written or endorsed, by a General Officer, wing commander, or civilian equivalent, preferably from the gaining command. **(T-3).** It should indicate that the commander is aware of the service member's ALC "C" code, and that despite this, the service member is the best one qualified and available for the job, essential for mission accomplishment, and

that the member will not be forward-deployed from the gaining location (unless another waiver is submitted). **(T-3).** The memo must also state that care for the member's condition has been coordinated with the gaining MTF and MAJCOM/GCC command surgeons. **(T-2).** Gaining Surgeon General must provide a corroborating statement indicating that care is available to meet the member's needs. **(T-2).**

5.3. MTF Action for return to duty with an Assignment Limitation Code. The MTF will complete an AF Form 469 appropriate for the service member's current condition, code and stratification. In completing the AF Form 469, the MTF will adhere to the following guidance:

5.3.1. ALC "X" with C1 Stratification:

5.3.1.1. Worldwide (mobility) Restrictions will be marked. **(T-1).**

5.3.1.2. The release date will be dashed or left blank. **(T-1).**

5.3.1.3. The "Remarks" section will contain the phrase "Service member has been returned to duty with the following restrictions: Member may be assigned or deployed only to DoD facilities with fixed medical treatment facilities. Member may be assigned to a mobility position." **(T-1).** The gaining MTF or MAJCOM SGH or SGP must approve exceptions to this restriction in writing. **(T-1).**

5.3.2. ALC "Y" with C2 Stratification:

5.3.2.1. Worldwide (mobility) Restrictions will be marked. **(T-1).**

5.3.2.2. The release date will be dashed or left blank. **(T-1).**

5.3.2.3. The "Remarks" section will contain the phrase "Service member has been returned to duty with the following restrictions: Member may be assigned or deployed to CONUS, (Hickam and Elmendorf included) facilities with fixed medical treatment facilities and appropriate treatment or referral capability." **(T-1).** Member should not occupy a mobility position but may be deployed with approval of the gaining MAJCOM SGH or SGP. The MAJCOM or GCC Surgeon General must approve exceptions to this restriction in writing. **(T-1).**

5.3.3. ALC "C" with C3 Stratification:

5.3.3.1. Worldwide (mobility) Restrictions will be marked. **(T-1).**

5.3.3.2. The release date will be dashed or left blank. **(T-1).**

5.3.3.3. The "Remarks" section will contain the phrase "Service member has been returned to duty with the following restrictions: Member may be assigned only to CONUS, (Hickam and Elmendorf included) facilities with fixed medical treatment facilities and appropriate treatment capability." **(T-1).** Member is non-deployable and may not occupy a mobility position. Exceptions to this restriction must be approved in writing by AFPC/DP2NP. **(T-1).**

5.3.4. The appropriate ARC SG's Office must coordinate all Palace Chase/Front assignment actions into the ARC prior to final approval. **(T-1).** ALCs (C1, C2 and C3) must be reviewed by DP2NP or ARC SG's office periodically. **(T-1).** PEBLO will submit an annual RILO at the time, and with the specialty consultation, specified on the most recent FL-4 sent by DP2NP or the ARC SG's office. **(T-1).**

5.4. ARC service members are placed on ALC or DAV Code-42 by the appropriate ARC SG's office. The appropriate ARC SG's office will provide profiling instructions and other guidance on AF Form 422 or AF Form 469 completion. **(T-1).**

Chapter 6

MEB QUALITY ASSURANCE PROGRAM (QAP)

6.1. Program Requirements. The MEB QAP consists of internal and external reviews of MEB cases for consistency and accuracy within the MEB stage before MEB case is sent to AFPC/DPFDD for Informal PEB review.

6.1.1. **DES Quality Assurance Program Background.** Public Law 112-239, *National Defense Authorization Act for Fiscal Year 2013,* Section 524, *Quality Review of Medical Evaluation Boards, Physical Evaluation Boards, and Physical Evaluation Board Liaison Officers* directed the DoD to standardize, assess, and monitor the Military Departments' DES quality assurance programs. Department of Defense Manual (DoDM) 1332.18, Volume 3, *Disability Evaluation System (DES) Manual: Quality Assurance Program (QAP)* assigns responsibilities for conducting the QAP review process and procedures for data submission and quality improvement activities.

6.1.2. When fully implemented, the DES QAP will (1) standardize disability evaluation quality assurance requirements; (2) enable DoD to assess, monitor, and improve the accuracy and consistency of the determinations and decisions of MEBs and PEBs; and (3) ensure that MEBs, PEBs and PEBLOs properly perform their duties.

6.2. MEB Case Review (MCR). The MEB QAP MCR measures the accuracy and consistency of MEB determinations. This process identifies rejection rates to estimate MEB accuracy and consistency and quality check the administration of the cases.

6.2.1. A predetermined checklist will be used for quality review of the MEB case. (See **paragraph 6.3**)

6.2.2. The Physical Disability Board of Review (PDBR) has been designated as the office to perform MCR of MEBs before the case is sent to the PEB.

6.2.3. A sampling plan is used to determine the MEB cases that will be selected for the MCR. The selection criteria is an assessment of a sample of actual MEB case files taken at predetermined points in the MEB process. This assessment of sampled cases will provide a more robust analysis of MEB application as it pertains to DoD policy.

6.2.3.1. A certain number of cases, determined by the PDBR, will be sampled per month and a report of findings is sent to the Office of Warrior Care Policy (WCP).

6.2.3.2. Further internal MCRs may be performed by designated authorities for further sampling of MEB cases.

6.3. MEB QAP Checklist. The PDBR or designated authorities use the checklist to evaluate the findings of each MEB case being reviewed. The MEB QAP checklist (See **Attachment 3**) will continue to evolve as additional criteria for evaluation are identified or changes are made to DoD policy. The checklist contains two types of questions:

6.3.1. **Accuracy.** Questions designed to support the accuracy metric address the ultimate determinations made by the PEB with implications to the service member's fitness for duty, level of compensation, and final disposition. If any of the accuracy questions receive a negative response (e.g. "No"), the case did not receive an accurate DES outcome.

6.3.2. **Consistency.** Questions supporting the consistency metric evaluate the intra-agency consistency of MEB findings. Consistency questions contribute to the Consistency score as an average of "Yes" and "No" answers

6.4. Sample Case Review. The objective is to ensure accuracy and consistency of MEBs. The Public Law 112-239, Section 524 required the DoD to standardize, assess, and monitor the quality assurance programs of the military departments to evaluate their performance in various areas to include MEBs. The targeted review consists of a PDBR or designated authority reviewing 16 randomly selected MEB cases each month to meet Office of the Secretary of Defense MEB QAP requirements. PDBR or designated authority will report discrepancies found in the course of their review to AFMRA/SG3PF. **(T-0).**

6.4.1. Responsibilities.

6.4.1.1. The PDBR or designated authority coordinates with AFPC/DPFD on the timing of case reviews and provide the MEB QAP monthly report

6.4.1.2. AFPC/DPFD provides access to case management tracking system to the PDBR or designated authorities and authorizes access to selected cases on the dates/times requested for MEB case review.

6.4.1.3. AFMRA/SG3PF MEB Quality Assurance Program Office will be the liaison for all potential accuracy findings (errors) between AFMRA clinical Point of Contact (SGH/SGP) and Health Services Policy and Oversight (HSP&O) or designated authority. SG3PC ensures the VTA MEB End Date field is correct for all cases returned to AFMRA for potential errors.

6.4.2. MCR Process Steps. See **Attachment 4** for step-by-step MEB case review process steps.

Chapter 7

AIRMAN MEDICAL TRANSITION UNIT (AMTU)

7.1. AMTU Attachment (TDY) and Assignment (PCS). This section contains the authority and requirements for attaching (TDY) or assigning (PCS) RegAF service members to an MTF on an Air Force installation for the purpose of obtaining medical care at the MTF or in the local or regional healthcare network associated with the MTF. An AMTU can be established at any MTF on an Air Force installation, regardless of size of the MTF. The overall process is described below. Also, refer to the current AMTU Guide located on the AFPC/DP2NP Medical Retentions Standards AFMS KX website at **https://kx.health.mil/kj/kx8/AFPCMedicalRetentionStandards/Pages/home.aspx**.

7.1.1. In accordance with AFI 36-3212, Wing commanders establish a process to receive monthly updates on AMTU members, and appoint members to an installation A-team. (See **paragraph 1.2.8**)

7.1.1.1. On behalf of the Wing commander, the MTF commander or director identifies and appoints MTF service members to the installation A-Team, and assigns operational roles to the appointed MTF service members.

7.1.1.2. Once an AMTU has been established, the MTF commander or director may designate it as a flight, or a section of the Operational Medical Readiness Squadron or the Medical Support Squadron TRICARE Operations and Patient Administration flight.

7.1.1.2.1. In the case of assignment (PCS) to an AMTU, MTF commander or director shall assume command authority over officers and enlisted service members assigned to this unique unit. **(T-1).** The MTF commander or director may appoint an officer under the commander's or director's command to serve as the AMTU commander.

7.1.1.2.2. AMTU commander will ensure staff orientation is completed by all personnel upon appointment to installation A-Team, with assignment of AMTU operational roles. **(T-3).** Additionally, it is highly recommended that AMTU commanders verify completion of staff orientation prior to receiving a service member into the AMTU at their MTF.

7.1.1.2.3. AMTU commander ensures annual AMTU Table Top Exercise is completed using approved CONOPS. **(T-3).**

7.1.2. SGH at the sending/losing MTF will utilize approved templates and processes to attach (TDY) or assign (PCS) service members to an AMTU at the receiving/gaining MTF on an Air Force installation. **(T-1).** These templates and processes facilitate communication of critical items including, but not limited to the service member's status, any special requirements and anticipated length of treatment.

7.1.3. For situational awareness and support, the AMTU commander will notify the wing commander (or equivalent) when service members are assigned or attached to the AMTU. **(T-3).**

7.2. Attachment (TDY) to an AMTU. Attaching service members to an AMTU does not require AFPC/DP2NP approval; however, AFPC/DP2NP can be consulted for lengthy TDYs or if TDY turns into a PCS. Unless a PCS action occurs, the service member remains assigned and

accountable to their home (e.g. sending) unit. Service members undergoing pre-DES screening or DES processing, who are TDY to an AMTU remain the responsibility of the PEBLO at the sending MTF. Attachment to an AMTU must be considered when any of the following criteria apply:

7.2.1. TDY exceeds or is expected to exceed 20 days.

7.2.2. Delivery of care while a service member is TDY will take place at or near an AF installation with a permanent AMTU [**Note**: medical TDY of short duration (e.g. < 20 days), for routine evaluations or assessments in the absence of other factors identified below may not always warrant AMTU Attachment (TDY)]: Travis AFB (David Grant Medical Center), JBSA Lackland (Wilford Hall Ambulatory Surgical Center/SAAMC or associated facilities), Joint Base Andrews (Walter Reed National Military Medical Center or associated facilities) are considered permanent AMTU locations.

7.2.3. Service members Home Station PCM, Medical Management Team member, or SGH determine the condition requiring treatment while TDY to be high acuity, examples include but are not limited to: advanced stage cancer, and polytrauma requiring extensive treatment/rehabilitation.

7.2.4. Service members Home Station PCM, mental health provider or SGH identify and communicate to receiving provider(s) at TDY location all risk factors requiring close oversight and coordination of care during TDY, examples include, but are not limited to: current or history of traumatic brain injury, current or history of substance use disorder, current or history of suicidal ideation or attempt, TDY is for mental health and/or substance use disorder partial hospitalization program, TDY is for mental health and/or inpatient hospitalization

7.2.5. Required by law or regulation [Note: when a service members is sent to a civilian facility as an inpatient, TRICARE Operations and Patient Administration at the service member's home station is required to send Absent Sick notification to the nearest Air Force MTF]

7.2.6. Comments by the service members Commander or any member of the service member's warfighter care team that it would be in the service member's best interest to be attached to a permanent AMTU while receiving treatment in a TDY status elsewhere will be taken under consideration. **(T-3).**

7.3. Assignment to an AMTU. AFPC/DP2NP is the sole approving authority for RegAF AMTU PCS assignments and will base assignments on current AF/SG and AFPC policy. When AFPC/DP2NP assigns/directs a service member to an AMTU, the member is relocated via official orders in either PCS or PCA) capacity.

7.3.1. The appointed AMTU commander assumes administrative oversight and the Uniform Code of Military Justice authority for assigned service members who are PCS'd to their unit.

7.3.2. Generally, assignment (PCS or PCA) to an AMTU will be limited to the following situations:

7.3.2.1. Required medical care is not available at local MTFs or reasonably available in the local or regional areas.

7.3.2.2. The service member is incapacitated, is unable to serve the current line unit in any capacity, and is not likely to be retained on active duty in continued military service.

7.3.2.3. When hospitalization beyond the service member's date of separation is expected. Contact AFPC/DP2NP to request a medical hold.

7.3.2.4. For overseas service members; when hospitalization beyond the member's Date Eligible for Return from Overseas is expected.

7.3.2.5. When a service member undergoes prolonged and/or intensive treatment, and requires proximity to a family support network.

7.3.3. Permanent Assignment Process: The requesting MTF/SGH initiates an AMTU PCS assignment by completing an AMTU PCS worksheet and submitting it to AFPC/DP2NP. The AMTU PCS worksheet is available on the DP2NP Medical Retentions Standards AFMS KX website at **https://kx.health.mil/kj/kx8/AFPCMedicalRetentionStandards/Pages/home.aspx**.

7.3.4. Special Circumstances.

7.3.4.1. Officers pending judicial or adverse administrative action may not be assigned to an AMTU unless approved by the court-martial convening authority or discharge authority.

7.3.4.2. Enlisted members pending judicial or adverse administrative actions are attached (TDY) or assigned (PCS) without PCA to the AMTU unless PCA is approved by the court-martial convening authority or discharge. The AMTU commander in each case above will become the notifying commander for the judicial or adverse administration actions. **(T-3).**

7.3.4.3. PCS action does not apply to ARC members who may travel to a MTF to receive Line of Duty related, pre-MEB diagnostic treatment, and/or MEB case processing. While at the MTF, ARC service members are considered attached to the MTF.

7.3.4.4. Service members in a non-Air Force MTF who meet requirements for assignment to an AMTU are administratively attached to the nearest Air Force MTF AMTU. For guidance, contact AFPC/DP2NP.

7.3.5. When AFPC/DP2NP dispositions (makes a determination) the case of a member currently assigned to an AMTU via modified or initial RILO meets medical retention standards, AFPC/DP2NP will notify the appropriate officer or enlisted assignment department at AFPC to send a message to the local military personnel section with assignment instructions. **Note**: Service members must meet minimum PCS retainability requirements. **(T-2).**

7.3.6. Service members are not retained as hospital patients for rehabilitation in order to gain retention on active duty.

7.3.7. Service members are not placed in an AMTU in order to preserve terminal leave or otherwise to retain a member beyond the member's date of separation or retirement without specific guidance from AFPC/DP2NP. Once a service member is placed on terminal leave, the member is not permitted to change duty status without prior approval for medical hold or approval from DP2NP for a non-emergent procedure.

7.3.8. A service member is not assigned (PCS) to an AMTU when a Line of Duty (LOD) determination (formal or informal) is pending.

7.3.9. When a service member is undergoing pre-DES screening or DES processing, and is assigned (PCS) to an AMTU, the losing commander will send a Commander's Impact Statement (CIS) to the gaining AMTU commander. **(T-3).** The gaining AMTU commander

retains this document as a record of the service member's performance in their primary AFSC. Once a service member is assigned (PCS) to an AMTU, their AFSC becomes patient.

7.4. AMTU Staff Responsibilities.

7.4.1. **AMTU staff will:**

7.4.1.1. Verify the TDY/PCS orders of each service member to ensure proper assignment and attachment, and assist the patient in correcting errors. **(T-3).**

7.4.1.2. Notify the First Sergeant of newly assigned or attached personnel. **(T-3).**

7.4.1.3. Assist the service member with unit, group, and wing in-processing requirements. **(T-3).**

7.4.1.4. Refer the service member to case management and other departments as appropriate. **(T-3).**

7.4.1.5. Ensure the service member is briefed on entitlements by responsible base support agencies. **(T-3).**

7.4.1.6. Provide appropriate updates on the service members status to the AMTU commander and Chief of Medical Staff. If the member is attached (TDY), keep the home unit updated on the member's status also. **(T-3).**

7.4.1.7. Maintain daily accountability and tracking of all personnel assigned and attached. **(T-3).**

7.4.1.8. Assist, as necessary, with lodging and resolving related issues. **(T-3).**

7.4.1.9. Assist, as necessary, with pay/finance issues. **(T-3).**

7.4.1.10. Assist, as necessary, with career milestones activities such as promotion and retirements ceremonies. **(T-3).**

7.4.1.11. Ensure service members go to their scheduled medical appointments and if necessary, assist them in getting to their appointments. **(T-3).**

7.4.1.12. Provide service members with a 24-hour point of contact for the AMTU. **(T-3).**

7.4.1.13. Mentor/counsel service members as needed. **(T-3).**

7.4.2. In coordination/approval by the AMTU commander, may place both assigned and attached service members in a MTF or external line unit work center provided:

7.4.2.1. The service member is physically and/or mentally capable of completing reasonable normal daily activities.

7.4.2.2. The temporary placement of a service member within a work center can be safely accomplished without interfering with the member's treatment, MEB, or clinical or non-clinical case processing.

7.4.2.3. The service member's attending provider supports the decision, and duty restrictions are documented on the AF Form 469.

7.4.2.4. The member is able to wear the service uniform (shoe waiver may be used).

7.4.2.5. The AMTU commander is able to secure placement approval or permission to place the service member within the work center.

DOROTHY A. HOGG
Lieutenant General, USAF, NC
Surgeon General

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

10 USC § 1210, *Members on temporary disability retired list: periodic physical examination; final determination of status*

10 USC § 9013, *Secretary of the Air Force*

Public Law 110-181, *National Defense Authorization Act for Fiscal Year 2008*, Section 1612, *Medical evaluations and physical disability evaluations of recovering service members*

Public Law 112-239, *National Defense Authorization Act for Fiscal Year 2013*, Section 524, *Quality review of Medical Evaluation Boards, Physical Evaluation Boards, and Physical Evaluation Board Liaison Officers*

DoDI 5400.11, *Department of Defense Privacy and Civil Liberties Programs,* 29 January 2019, 2014

DoDI 1000.30, *Reduction of Social Security Number (SSN) Use Within DoD*, 15 April 2020

DoDI 1300.24, *Recovery Coordination Program,* 1 December 2009

DoDI 1332.18, *Disability Evaluation System (DES)*, 17 May 2018

DoDI 6130.03, Volume 2, *Medical Standards for Military Service: Retention*, 4 September 2020

DoDM 1332.18, Volume 1, *Disability Evaluation System (DES) Manual: General Information and Legacy Disability Evaluation System (LDES) Time Standards*, 21 August 2020

DoDM 1332.18, Volume 2, *Disability Evaluation System (DES) Manual: Integrated Disability Evaluation System (IDES)*, 21 August 2020

DoDM 1332.18, Volume 3, *Disability Evaluation System (DES) Manual: Quality Assurance Program (QAP)*, 21 November 2014

DoDM 6025.18, *Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DoD Health Care Programs,* 13 March 2019

DTM-18-004, *Revised Timeliness Goals for the Integrated Disability Evaluation System (IDES)*, 30 July, 2018, IC 2, 19 September, 2019

DTM-20-001, *Policy Revisions for the Disability Evaluation System (DES),* 12 February, 2020

AFPD 48-1, *Aerospace & Operational Medicine Enterprise (AOME),* 6 June 2019

DAFMAN 48-123, *Medical Examinations and Standards,* 8 December 2020

AFMAN 41-210, *TRICARE Operations and Patient Administration*, 9 September 2019

AFMAN 65-116 V1, *Defense Joint Military Pay System Active Component (DJMS-AC) Financial Management Flight (FMF) Procedures,* 22 October 2019

DAFI 33-360, *Publications and Forms Management*, 1 December 2015

DAFI 34-1101, *Warrior and Survivor Care*, 29 April 2019

DAFI 48-122, *Deployment Health*, 9 October 2020

AFI 33-322, *Records Management and Information Governance Program*, 23 March 2020

AFI 36-2110, *Total Force Assignments*, 4 October 2018

AFI 36-2910, *Line of Duty (LOD) Determination, Medical Continuation (MEDCON), and Incapacitation (INCAP) Pay*, 8 October 2015

AFI 36-3026_IP Volume 1, *Identification Cards for Members of the Uniformed Services, Their Eligible Family Members, and Other Eligible Personnel*, 4 August 2017

AFI 36-3212, *Physical Evaluation for Retention, Retirement, and Separation*, 15 July 2019

AFI 41-200, *Health Insurance Portability and Accountability Act (HIPAA)*, 24 July 2017

AFI 48-133, *Duty Limiting Conditions*, 7 August 2020

DAF Guidance Memorandum 2020-01, 7 August 2020

Joint Travel Regulations, 1 January 2021, **https://www.dfas.mil/militarymembers/travelpay/regulations.html**

Integrated Disability Evaluation System Air Force Medical Service Knowledge Exchange website, **https://kx.health.mil/kj/kx2/AFMOAHealthBenefits/Pages/home.aspx**

Air Force Personnel Center Medical Retention Standards (AFPC/DP2NP) Air Force Medical Service Knowledge Exchange website, **https://kx.health.mil/kj/kx8/AFPCMedicalRetentionStandards/Pages/home.aspx**

Prescribed Forms.

DAF Form 618, *Medical Board Report*

Adopted Forms.

AF Form 348, *Line of Duty Determination*

AF Form 422, *Notification of Air Force Member's Qualification Status*

AF Form 469, *Duty Limiting Condition Report*

AF Form 565, *Record of Inpatient Treatment*

AF Form 797, *Job Qualification Standard Continuation/Command JQS*

AF Form 847, *Recommendation for Change of Publication*

AF Form 1185, *Commander's Impact Statement for Medical Evaluation Board*

DD Form 261, *Report of Investigation Line of Duty and Misconduct Status*

DD Form 2499, *Healthcare Practitioner Action Report*

DD Form 2870, *Authorization for Disclosure of Medical or Dental Information*

VA Form 21-0819, *DoD Referral to Integrated Disability Evaluation System (IDES)*

Abbreviations and Acronyms.

AAC—Assignment Availability Code

AFI—Air Force Instruction

AFMRA—Air Force Medical Readiness Agency

AFMS—Air Force Medical Service

AFR—Air Force Reserve

AFRC—Air Force Reserve Command

AFSC—Air Force Specialty Code

AHLTA—Armed Forces Health Longitudinal Technology Application

ALC—Assignment Limitation Code

AMRO—Airman Medical Readiness Optimization

AMTU—Airman Medical Transition Unit

ANG—Air National Guard

ARC—Air Reserve Component

ASIMS—Aerospace Services Information Management System

CONUS—Continental United States

C&P—Compensation and Pension

CMA—Convening Medical Authority

DAV—Deployment Availability Code

DAWG—Deployment Availability Working Group

DEERS—Defense Enrollment Eligibility Reporting System

DES—Disability Evaluation System

DHA—Defense Health Agency

DoD—Department of Defense

DoDI—Department of Defense Instruction

DoDM—Department of Defense Manual

FOM—Flight and Operational Medicine

GCC—Geographical Combatant Command

GSU—Geographically Separated Unit

HIPAA—Health Insurance Portability and Accountability Act

HSP&O—Health Services Policy and Oversight

IDES—Integrated Disability Evaluation System

IMR—Impartial Medical Review

IPEB—Informal Physical Evaluation Board

IRILO—Initial Review In Lieu Of

KX—Knowledge Exchange

LDES—Legacy Disability Evaluation System

MAJCOM—Major Command

MEB—Medical Evaluation Board

MRILO—Modified Review In Lieu Of

MSD—Medical Standards Directory

MSME—Medical Standards Management Element,

MTF—Military Treatment Facility

NARSUM—Narrative Summary

ODC—Office of Disability Counsel

PAS—Personnel Accounting Symbol

PCA—Permanent Change of Assignment

PCM—Primary Care Manager

PCS—Permanent Change of Station

PDBR—Physical Disability Board of Review

PEB—Physical Evaluation Board

PEBLO—Physical Evaluation Board Liaison Officer

PHI—Protected Health Information

QAP—Quality Assurance Program

RCC—Recovery Care Coordinator

RegAF—Regular Air Force

RegSF—Regular Space Force

RILO—Review In Lieu Of

RNT—Right Now Technology

SecAF—Secretary of the Air Force

SGH—Chief of Medical Staff

SGP—Chief of Aerospace Medicine

TDY—Temporary duty

USC—United States Code

VA—Department of Veterans Affairs

VTA—Veteran's Tracking Application

WCT—Warfighter Care Teams

Terms

Active Duty—Defined in the Office of the Chairman of the Joint Chiefs of Staff, "*DoD Dictionary of Military and Associated Terms*," current edition.

AHLTA—The Department of Defense legacy electronic health record, is a clinical information system that generates, maintains, stores and provides secure electronic access to comprehensive patient medical records.

Air Reserve Component (ARC)—Units, organizations, and members of the ANG and the AFR.

Attending Physician—The physician who has the primary responsibility for the medical diagnosis and treatment of the patient.

Business Associate—As defined in DoDM 6025.18, *Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DoD Health Care Programs*.

Chronic Medical Condition—A medical condition that active medical treatment cannot cure or control. Chronic conditions may involve periodic acute episodes and may require intermittent inpatient care. Sometimes medical treatment may control a chronic medical condition sufficiently to permit continuation of daily living activities such as work, or school.

Commander—The principle commissioned officer responsible for all activities, operations, and resources under the officer's control. Synonymous with commanding officer and commanding officer in charge.

Competency Board-—A board consisting of at least three medical officers or physicians (including one psychiatrist) convened to determine whether a member is competent (capable of making a rational decision regarding his or her personal and financial affairs).

Comprehensive Medical Information—Patient's name, rank, age, status (e.g. AD, RC) unit of assignment or government occupational position, date of admission and/or date of treatment, diagnosis, current medical status, whether the admission was routine or happened under emergent circumstances, and the projected length of stay.

Consultation Notes-—Notes created by medical providers or specialists (family practitioner, orthopedist, neurologist, etc,) after a Service member's visit for consultation or treatment.

Continental United States (CONUS)—United States territory, including the adjacent territorial waters, located within North America between Canada and Mexico (Alaska and Hawaii are not part of CONUS).

Convalescent (Convalescence) Leave—An authorized leave status granted to AD uniformed service members while under medical or dental care that is a part of the care and treatment prescribed for a member's recuperation or convalescence.

Definitive Diagnosis—For purposes of a Medical Evaluation Board evaluation, any condition that significantly interferes with performance of duties appropriate to a service member's office, grade, rank, or rating.\

Disability-—Any condition due to disease or injury, regardless of degree, that reduces or prevents an individual's actual or presumed ability to engage in gainful employment or normal activity. The term "disability" or "physical disability" includes mental disease, but not such inherent defects as developmental or behavioral disorders. A medical condition, mental disease, or physical defect standing alone does not constitute a disability. To constitute a disability, the medical condition, mental disease, or physical defect must be severe enough to interfere with the Service member's ability to adequately perform his or her duties.

Disability Evaluation System—The DoD mechanism for determining return to duty, separation, or retirement of Service members because of disability in accordance with United States Code, Title 10, **chapter 61**. A process maintained by the military Services to ensure a fit and vital force by determining a Service member's fitness for continued military service. The DES should include a medical evaluation board, a physical evaluation board, an appellate review process, and a final disposition.

Disposition—The removal of a patient from a MTF because of a return to duty or to home, transfer to another MTF, death, or other termination of medical care. The term may also refer to change from inpatient to outpatient status (for example, inpatient to subsisting elsewhere or convalescent leave).

Inactive Duty Training—Authorized training performed by a member of a RC not on published active orders and consisting of regularly scheduled unit training assemblies, additional training assemblies, periods of appropriate duty of equivalent training, and any special additional duties for RC personnel that an authority designated by the Secretary concerned, and performed by them in connection with the prescribed activities of the organization in which they are assigned with or without pay. Does not include work or study associated with correspondence courses.

Integrated Disability Evaluation System—The joint DoD VA process by which DoD determines whether ill or injured Service members are fit for continued military service and DoD and VA determine appropriate benefits for Service members who are separated or retired for disability. The Integrated Disability Evaluation System integrates the DES with the VA, and delivers the advantage of single-sourced disability ratings that are accepted by both the DoD and the VA, so the member will receive a VA benefits decision shortly after separation or retirement.

LDES—-A DES process by which DoD determines whether eligible wounded, ill, or injured Service members are fit for continued military service and determines appropriate benefits for Service members who are separated or retired for disability. Service members processed through the LDES may also apply for veterans' disability benefits through the VA pre-discharge Benefits Delivery at Discharge or Quick Start programs, or upon attaining veteran status.

LOD determination-—An inquiry to determine whether an injury or illness was incurred when the Service member was in a military duty status. If the Service member was not in a military duty status, whether it was aggravated by military duty; or whether it was incurred or aggravated due to the Service member's intentional misconduct or willful negligence.

MEB convening authority-—A senior medical officer, appointed by the MTF commander, who has detailed knowledge of standards of medical fitness and disposition of patients and disability separation processing and who is familiar with the VASRD.

MEB process-—For Service members entering the DES, the MEB conducts the medical evaluation on conditions that potentially affect the Service member's fitness for duty. The MEB

documents the Service member's medical condition(s) and history with an MEB narrative summary as part of an MEB packet.

Medical Impairment Condition-—Any disease or residual of an injury that results in a lessening or weakening of the capacity of the body or its parts to perform normally, according to accepted medical principles.

Medical Care—Inpatient, outpatient, dental care, and related professional services.

Military Patient—A patient who is a member of the Uniformed Services of the United States on AD, or RC status eligible for military care, or an AD member of a foreign government eligible for military care.

Military Treatment Facility—A military treatment facility is every fixed facility established for the purpose of furnishing medical and/or dental care to eligible individuals, including all operations of each such facility and all health care delivery associated with each such facility.

Military Treatment Facility Commander—The person appointed on orders as the commanding officer of the MTF.

Office-—A position of duty, trust, and authority to which an individual is appointed.

Grade-—A step or degree in a graduated scale of office or military rank that is established and designated as a grade by law or regulation.

Rank-—The order of precedence among members of the military services.

Rating-—The name (such as "Boatswain's Mate") prescribed for service members of a military service in an occupational field.

PEBLO—-The non-medical case manager who provides information, assistance, and case status updates to the affected service member throughout the DES process.

Personnel Accounting Symbol (PAS) Code—The PAS code is a unique eight character code assigned to each individual unit of the U.S. Air Force. Each person who is assigned to a specific Air Force unit will share the same PAS code.

Retention Standards-—Guidelines that establish medical conditions or physical defects that could render a service member unfit for further military service and may be cause for referral of the service member into the DES.

Reserve Components—Reserve components of the Armed Forces of the United States are: the ANG of the United States, the AFR, the Army National Guard of the United States, the Army Reserve, the Naval Reserve, the Marine Corps Reserve, and the Coast Guard Reserve. For the purpose of this manual, the term also includes the reserve members of the commissioned corps of the United States Public Health Service and National Oceanic and Atmospheric Administration.

Retiree—A former member of a uniformed service who is entitled to retired, retainer, or equivalent pay, based on duty in a uniformed service.

Service Treatment Record—-The chronologic record of medical, dental, and mental health care received by Service members during the course of their military career. It includes documentation of all outpatient appointments (i.e. without overnight admittance to a hospital, clinic, or treatment facility), as well as summaries of any inpatient care (discharge summaries) and care received while in a military theater of operations. The service treatment record is the official record used to

support continuity of clinical care and the administrative, business-related, and evidentiary needs of the DoD, the VA, and the individual.

Treatment—A procedure or medical service that medical persons expect to lead to or assist in the patient's recovery.

TRICARE—The military's managed healthcare program, overseen by the DoD in cooperation with regional civilian contractors. TRICARE uses the MHS as the main delivery system augmented by a civilian network of providers and facilities serving AD (including Reservists/National Guard), their families and retired military/families and survivors world-wide.

TRICARE Prime Remote—TRICARE Prime Remote provides healthcare coverage through civilian providers for those United States Uniformed Service Members and their families who are on remote assignment. It applies to members of the Army, Navy, Marine Corps, Air Force, Coast Guard, United States Public Health Service, and National Oceanic and Atmospheric Administration. Eligible beneficiaries must live and work more than 50 miles or approximately one hour's drive time from the nearest MTF. TRICARE Prime Remote is offered in the 50 United States only.

Uniformed Services—The Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanic and Atmospheric Administration, and United States Public Health Service.

Veteran—A person who served in the active military, Army, Navy, Coast Guard or Air Force. A person who originally enlisted in a regular component of the Armed Forces after 7 September 1980, or who entered AD after 16 October 1981, is not eligible for benefits from the Department of Veterans Affairs unless the member completes the lesser of 24 continuous months of AD or the full period for which the person was called or ordered to duty. This provision does not apply to veterans who have a compensable service-connected disability or who were discharged close to the end of an enlistment term because of hardship, or a disability incurred or aggravated in line of duty.

Attachment 2

CONSULT NOTES AND SPECIALTY STUDIES GUIDE

Table A2.1. Consult Notes And Specialty Studies Guide.

Diagnosis	Required Consults	Required Studies/Info
Asthma	Pulmonology (ONLY if Complicated)	Spirometry (MCT or HC if diagnosis in doubt)
Burns		% BSA, ROM, Photographs of affected areas
Collagen Vascular Disease	Rheumatology	
Arthritis	Rheumatology	
Fibromyalgia	Rheumatology	Trigger point summary
Coronary Artery Disease	Cardiology	ETT, Echo or Cath, NYHA class
Diabetes	Endocrinology if Insulin Dependent	FBS, A1C, Optometry or Ophthalmology
Hearing	ENT	Audiogram
Eyes	Ophthalmology	Visual Acuity and Visual Field exam
Neuromuscular	Orthopedics (PT if available)	ROM (percent), Strength, Function, EMG if appropriate
Musculoskeletal	Orthopedics (PT if available)	ROM (percent), Strength, Function
Cancer (Brain)	Oncology, neurosurgery, & psych	5 year prognosis
Cancer (Skin)	Dermatology	5 year prognosis
Cancer (Head and Neck)	ENT	5 year prognosis
Cancer (renal or GU)	Urology	5 year prognosis
Cancer (other)	Oncology	5 year prognosis
Multiple Sclerosis	Neurology	MRI, spinal tap
Headache	Neurology	MRI, Log with # prostrating HA's last 12 months
Seizure	Neurology	EEG, MRI, Log of seizure frequency
Renal	Neurology	Lab progression over time
Crohn's/Ulcerative	GI	Scope/Biopsy, Log of flare freq &

Colitis		severity
Psych	MD/DO Psych review and cosign	Military & Social-Industrial Impairment
Traumatic Brain Injury	Neuropsychiatry	MRI, Military & Social-Industrial Impairment, Competency Statement

Attachment 3

MEB ACCURACY AND CONSISTENCY QAP CHECKLIST

Table A3.1. MEB Accuracy And Consistency QAP Checklist.

Checklist Question	Responses	(a) Yes	(b) No	(c) Policy Ref.	(d) Page	(e) Metric
1. Did the MEB confirm the medical diagnosis for each of the Service member's pertinent (referred and claimed) medical condition(s) that will prevent the member from performing the duties of his office, grade, rank, or rating, regardless of whether each condition is cause for referral to a PEB?	**Yes**: The MEB accurately confirmed diagnosis of the Service member's pertinent (referred and claimed) medical conditions and their severity.			DoDI 1332.18 Change 1 E3 P 2.f.(2)	17 - 18	
	No: The MEB did not accurately confirm the diagnoses for at least one of the Service member's pertinent medical conditions and their severity.					ACC
2. Did the MEB	**Yes**: The MEB documented the full clinical information of			DoDI	17	

document the full clinical information of each of the Service member's pertinent medical condition(s) that will prevent the member from performing the duties of his office, grade, rank, or rating, regardless of whether each condition is cause for referral to a PEB? [Note: "Document" does not necessarily mean all the information is summarized in the Narrative Summary (NARSUM) — the NARSUM could contain references to clinical	each of the Service member's pertinent medical condition(s) that may prevent the member from performing the duties of his/her office, grade, rank, or rating, regardless of whether each condition is cause for referral to a PEB.			1332.18 Change 1 E3 P 2.f.(2)	- 18	
	No: The MEB did not document the full clinical information of each of the Service member's pertinent medical condition(s) that will prevent the member from performing the duties of his/her office, grade, rank, or rating, regardless of whether each condition is cause for referral to a PEB.					A CC

information elsewhere in the case file.]						
3. Did the MEB make an accurate decision whether the Service member's medical condition(s), either individually or collectively, may prevent the Service member from performing the duties of their office, grade, rank, or rating?	**Yes:** The MEB made an accurate decision whether the Service member's medical condition(s), either individually or collectively, may render the member unfit to perform the duties of the member's office, grade, rank, or rating.			DoDM 1332.18 V2 A5 to E4 P a	24	ACC
	No: The MEB made an inaccurate decision on whether the Service member's medical condition(s), either individually or collectively, may render the member unfit to perform the duties of the member's office, grade, rank, or rating.					

Checklist Question	**Responses**		**(b) No**	**(c) Policy Ref.**	**(d) Page**	**(e) Metric**

4. Did the MEB include the results of a competency board in the MEB package, if applicable?	**Yes:** The MEB included the results of the Service member's competency board.			DoDI 1332.18 Change 1 E3 P 2.g	18	CON
	No: The MEB did not include the results of the Service member's competency board.					
5. Does the MEB package (excluding the NARSUM) include the following required medical and non-medical information?				DoDM 1332.18, V 2 E 9 P a, c-i	44	
	a. Cover sheet with MEB convening authority signature and MEB decision (added after the MEB).					
	b. Examinations that meet minimum disability examination criteria for all medical conditions that could, individually or collectively, prevent the Service member from performing the duties of his office, grade, rank, or rating.					
	c. Complete medical record (to include medical profile, and appropriate ancillary test and evaluation results).					
	d. Commander's non-medical assessment letter.					ACC
	e. MEB addendums.					

	f. Line of duty (LOD) determinations when required by Military Department regulations.						
	g. Service member rebuttal and MEB surrebuttal if the member submits a rebuttal.						
	h. Competency statement if psychiatric consideration exists.						
Checklist Question	**Responses**	**(a) Yes**	**(b) No**	**(c) Policy Ref.**	**(d) Page**	**(e) Metric**	
6. Does the NARSUM include the following required information?				DoDM 1332.18, V2 E9 P b. DoDM 1332.18, V2 E5 P 1	44 36	CON	
	a. The medical history and current clinical condition.						
	b. The impact on required duty and associated operational assignment limitations.						
	c. Whether the medical conditions are likely to improve sufficiently for the member to perform the full duties of the member's office, grade, rank, or rating within 12 months.						
	d. How the severity of the member's medical conditions are likely to change						

	within the next 3 years.[1]					
	e. The requirement to monitor or provide treatment for the member's chronic conditions beyond the next 12 months.					
7. Did the MEB accurately determine whether more current information was needed to substantiate the existence or severity of conditions?	**Yes:** The MEB accurately determined whether more current information was needed to substantiate the existence or severity of conditions.			DoDI 1332.18 Change 1 E3 P 2.f.(1)	17	ACC
	No: The MEB inaccurately determined whether more current information was needed to substantiate the existence or severity of conditions.					
8. Did the MEB consider all documentation when making a recommendation on retention [to include any Impartial Medical Reviews, MEB rebuttals, and the VA Compensation & Pension (C&P) Exam]?	**Yes**: The MEB considered all documentation when making a recommendation on retention (to include any Impartial Medical Reviews, MEB rebuttals, and the VA C&P Exam).			DoDI 1332.18 Change 1 E3 P 2.a	16	ACC
	No: The MEB did not consider all documentation when making a recommendation on retention (to include any Impartial Medical Reviews, MEB rebuttals, and the VA C&P Exam).					

Checklist Question	**Responses**	**(a) Yes**	**(b) No**	**(c) N/A**	**(d) Policy Ref.**	**(e) Page**	**(f) Metric**
9. If applicable, did	**Yes:** The MEB included any required				DoDM	24	

the MEB include any required psychiatrists or psychologists with a doctoral degree in psychology, or other specialists as appropriate to the condition as specified in Service regulations?	psychiatrists or psychologists with a doctoral degree in psychology on the MEB.				1332.18 V2 A5 to E4 P a		
	No: The MEB did not include required psychiatrists or psychologists with a doctoral degree in psychology on the MEB.						CON
	N/A: The conditions did not necessitate the inclusion of any mental health or other specialists on the MEB.						

Checklist Question	Policy Reference
1. Did the MEB confirm the medical diagnosis for each of the Service member's pertinent (referred and claimed) medical condition(s) that may prevent the member from performing the duties of his office, grade, rank, or rating, regardless if each condition is cause for referral to a PEB?	DoDI 1332.18 Change 1, Encl. 3, para 2.f.(2) (2) MEBs will confirm the medical diagnosis for and document the full clinical information, including history, treatment status, and potential for recovery of the Service member's medical conditions that, individually or collectively or through combined effect, will prevent the Service member from performing the duties of his office, grade, rank, or rating and state whether each condition is cause for referral to a PEB.

2. Did the MEB document the full clinical information of each of the Service member's pertinent medical condition(s) that may prevent the member from performing the duties of his office, grade, rank, or rating, whether each condition is cause for referral to a PEB? [Note: "Document" does not necessarily mean all the information is summarized in the Narrative Summary (NARSUM) — the NARSUM could contain references to clinical information elsewhere in the case file.]	DoDI 1332.18 Change 1, Encl. 3, para 2.f.(2) (2) MEBs will confirm the medical diagnosis for and document the full clinical information, including history, treatment status, and potential for recovery of the Service member's medical conditions that, individually or collectively or through combined effect, will prevent the Service member from performing the duties of his office, grade, rank, or rating[2] and state whether each condition is cause for referral to a PEB.
3. Did the MEB make an accurate decision whether the Service member's medical condition(s), either individually or collectively, may prevent the Service member from performing the duties of their office, grade, rank, or rating?	DoDM 1332.18 Vol 2, App. 5 to Encl. 4, para a. a. [The Military Departments concerned will:] Assemble an MEB in accordance with Enclosure 3 of Reference (b) [DoDI 1332.18] and Military Department regulations, using the information the PEBLO provides in the DES case file. MEB members will consult and decide whether the Service member has medical conditions that, individually or collectively, may render the member unfit to perform the duties of the member's office, grade, rank, or rating. Any MEB listing a psychiatric diagnosis must contain a thorough psychiatric evaluation and include the signature of at least one psychiatrist or psychologist with a doctorate degree in psychology.

Checklist Question	Policy Reference
4. Did the MEB include the results of a competency board in the MEB package, if applicable?	DoDI 1332.18 Change 1, Encl. 3, para 2.g. g. Competency. When the Service member's ability to handle his or her financial affairs is unclear, the MEB or TDRL packet will include the results of a competency board.

5. Does the MEB package (excluding the NARSUM) include the following required medical and non-medical information?	DoDM 1332.18 Vol. 2, Encl. 9, para a, c-i. MINIMUM MEB ELEMENTS. MEB results will include the elements listed in paragraphs 1a through 1i of this enclosure, at a minimum. The Military Services may require additional elements (e.g., performance assessments). a. Cover sheet with MEB convening authority signature and MEB decision (added after the MEB). c. Examinations that meet minimum disability examination criteria for all medical conditions that could, individually or collectively, prevent the Service member from performing the duties of his office, grade, rank, or rating. d. Complete medical record (including medical profile, and appropriate ancillary test and evaluation results). e. Commander's non-medical assessment letter. f. MEB addendums. g. LOD determinations when required by Military Department regulations. h. Service member rebuttal and surrebuttal if the member submits a rebuttal. i. Competency statement if psychiatric consideration exists.

Checklist Question	Policy Reference

6. Does the NARSUM include the following required information?	DoDM 1332.18, Vol. 2, Encl. 9, para b. b. Narrative summary describing history, present status, and prognosis. For medical conditions that, individually or collectively, may render the member unfit to perform the duties of the member's office, grade, rank, or rating, the MEB results will describe: (1) The medical history and current clinical condition. Document whether additional medical exams or diagnostic tests were performed due to the results substantially affecting identification of the existence or severity of potentially unfitting conditions. (2) The impact on required duty and associated operational assignment limitations. (3) Whether the medical conditions are likely to improve sufficiently for the member to perform the full duties of the member's office, grade, rank, or rating within 12 months. (4) How the severity of the member's medical conditions are likely to change within the next 5 years. (5) The requirement to monitor or provide treatment for the member's chronic conditions beyond the next 12 months DoDM 1332.18, Vol. 2, Encl. 5, para 1. 1. PEB INITIAL ADJUDICATION. IPEBs must forward the cases of unfit Service members to the D-RAS and must include a medical assessment prepared by a DoD clinician as to whether each unfitting condition will most likely improve,

	remain stable, or worsen based on accepted medical principles and the clinician's findings.

7. Did the MEB accurately determine whether more current information was needed to substantiate the existence or severity of conditions?	DoDI 1332.18 Change 1, Encl. 3, para 2.f.(1) (1) Medical information used in the DES must be sufficiently recent to substantiate the existence or severity of potentially unfitting conditions. The Secretaries of the Military Departments will not perform additional medical exams or diagnostic tests if more current information would not substantially affect identification of the existence or severity of potentially unfitting conditions.

Checklist Question	**Policy Reference**
8. Did the MEB consider all documentation when making a recommendation on retention [to include any Impartial Medical Reviews, MEB rebuttals, and the VA Compensation & Pension (C&P) Exam]?	DoDI 1332.18 Change 1, Encl. 3, para 2.a. (2) Purpose. An MEB reviews all available medical evidence, to include any examinations completed as part of DES processing, and documents the medical status and duty limitations of Service members who meet referral eligibility criteria in Appendix 1 to this enclosure.

9. If applicable, did the MEB include any required psychiatrists or psychologists with a doctoral degree in psychology, or other specialists as appropriate to the condition as specified in Service regulations?	DoDM 1332.18 Vol 2. App. 5 to Encl. 4, para a. a. Assemble an MEB in accordance with Enclosure 3 of Reference (b) and Military Department regulations, using the information the PEBLO provides in the DES case file. MEB members will consult and decide whether the Service member has medical conditions that, individually or collectively, may render the member unfit to perform the duties of the member's office, grade, rank, or rating. Any MEB listing a psychiatric diagnosis must contain a thorough psychiatric evaluation and include the signature of at least one psychiatrist or psychologist with a doctorate degree in psychology.

Attachment 4

MEB CASE REVIEW (MCR) PROCESS STEPS

A4.1. MEB Case Review (MCR) Process Steps.

A4.1.1. The PDBR or designated authority case reviewer assigns RNT case to themselves during the period of review in the RNT-IPEB Inbox by name. Initial case review is completed within same duty day as assigned. If case presents to be a complex case, the PDBR or designated authority reviewer may need to check out case beyond duty day. In event a complex case extends beyond duty day, AFMRA/SG3PF will remove the date from the MEB End Date field.

A4.1.2. The PDBR Case reviewer or designated authority unassigns RNT case if error free. Places a note in the RNT case communication thread that the case review is complete. AFMRA validates/corrects VTA MEB end date. **Note**: If the case is returned to IPEB RNT queue the same day it was reviewed, then there is no need to change MEB end date.

A4.1.3. The PDBR Case reviewer or designated authority notifies AFMRA/SG3PF immediately if an accuracy error is identified. Case is downloaded from RNT and sent via SAFE/Encryption Wizard with error explanation. Case reviewer remains assigned to the case in RNT and places a note in the case communication thread stating the case was sent back to AFMRA for review of the identified error.

A4.1.4. HSP&O-returned cases are sent to AFMRA clinical POCs (SGH/SGP) for concurrence/non-concurrence with error. Clinical POCs have 3 duty days to answer the HSP&O accuracy finding. If errors are administrative in nature (Question #5/6 of MEB QA Checklist), AFMRA/SG3PF will determine seriousness of error and provide direction to HSP&O within 24 hours.

A4.1.5. If AFMRA believes the error may adversely impact the accurate adjudication of the case, SG3PC notifies HSP&O and requests return of the case without action). The PDBR notifies AFPC/DPFD of the return without action in RNT (changes the status detail to “See communication thread”) and unassigns the RNT case. AFMRA ensures the VTA MEB end date is removed.

A4.1.6. AFPC/DPFD closes the RNT ticket. The PEBLO will submit a new RNT ticket with the complete MEB file once the errors are corrected.

A4.1.7. If AFMRA believes the error will not adversely impact the accurate adjudication of the case, SG3PC notifies HSP&O via email of the explanation and requests the case move forward to the IPEB.

A4.1.8. The PDBR case reviewer unassigns RNT case, changes the status detail to “See Communication Thread” and places a note in the communication thread that the case review is complete. AFMRA validates/corrects VTA MEB end date.

A4.1.9. AFPC/DPFD reviews case per QA In-Process Review (Pre-Adjudication) SOP to include ensuring the MEB end date is accurate.

A4.1.10. The PDBR provides a monthly MEB QAP report to AFMRA. AFMRA compiles a quarterly report to be sent to DHA (WCP).