



DEPARTMENT OF THE ARMY  
United States Army Physical Disability Agency  
2900 Crystal Drive, Suite 300  
Arlington, Virginia 22202-3557

REPLY TO  
ATTENTION OF

AHRC-D

20 June 2013

MEMORANDUM FOR

Chief Surgeon, Army National Guard, 111 South George Mason Drive,  
ATTN: ARNG-CSG, Arlington, VA 22204-1373  
United States Army Reserve Command Surgeon, 6075 Goethals Road,  
Building 1901, Fort Belvoir, VA 22060-5231

SUBJECT: Non-Duty Related (NDR) Case Submission to Physical Evaluation  
Board (PEB): Clarification of Procedures and Required Information

1. References:

- a. AR 40-501, (Ch 3, 7, 9-12 b., and 10-25 a) 14 Dec 2007/Rapid Action Revision (RAR) Issue date: 23 August 2010.
- b. AR 635-40, dated 15 August 1990, Rapid Action Revision (RAR) Issue date: 20 March 2012
- c. TAPD-Policy Memorandum #4, Processing Reserve Component (RC) Non- Duty Related Cases, dated 28 February 2005.  
[https://www.hrc.army.mil/site/Active/TAGD/Pda/PM\\_4\\_RC\\_NDR\\_PEB.pdf](https://www.hrc.army.mil/site/Active/TAGD/Pda/PM_4_RC_NDR_PEB.pdf)

2. Each NDR case must include the elements as outlined below. Enclosure 1 is an example of a hypothetical memo addressing these elements. The preparing official should reference and include supporting documents as enclosures.

a. Diagnosis. This is the medical condition the unit has decided does not meet medical retention standards, i.e., the condition that is medically unacceptable. Note *diagnosis* is distinguished from *symptom*. For example: left hip pain is a symptom while the following diagnoses may be associated with (or cause) the symptom of hip pain: labral tear; avascular necrosis of femoral head; and, osteoarthritis.

b. Medical Basis of Diagnosis. The purpose of this section is to provide to the PEB, and as required by Army Regulations, *a clear description of the medical condition(s) that cause the Soldier not to meet retention standards*.

(1) Generally this section will answer the question: On what did the doctor rely when rendering this diagnosis? The answer will depend on the nature of the diagnosis. For example, for any of the above diagnoses associated with symptom

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of hip pain, the physician generally will have relied on imaging studies to render the diagnosis. The PEB requires the results of such imaging studies (or laboratory testing when the diagnosis is made based on or with consideration of such laboratory testing) because the imaging studies or laboratory testing serves as the medical basis of a diagnosis. However, when the diagnosis is one a physician typically makes on a "clinical" basis, i.e., based on history and physical exam findings; and, where general medical principles support rendering a "clinical" diagnosis, the PEB will not require the results of any confirmatory testing if none are of record.

(2) Where the condition is one that has been treated for a long time, treatment records may not reveal/discuss or include how the diagnosis was originally rendered. Where the Soldier or the current provider cannot provide the medical basis of the diagnosis, and where the treatment is specific to a particular diagnosis, the unit may feel comfortable concluding that the diagnosis appears "well-established." In that situation, it is generally acceptable to indicate that "despite lack of medical records indicating the medical basis of diagnosis X, based on the tailored treatment the Soldier is receiving, diagnosis X appears to be a well-established diagnosis." Examples are:

(a) Despite lack of medical records indicating the medical basis of ulcerative colitis, based on the tailored treatment the Soldier is receiving (Remicade), ulcerative colitis appears to be a well-established diagnosis.

(b) While not indicating the DSM-IV criteria to support major depressive disorder, based on the treatment the Soldier is receiving (Zoloft and counseling) major depressive disorder appears to be a well-established diagnosis.

(c) Where the unit is uncomfortable or has reason to question the diagnosis, then they will need to obtain additional information addressing the medical basis of the diagnosis.

c. Basis for Non-Duty Related (vs. Related) process. The purpose of this section is to clarify the basis for "non-duty related" designation.

(1) To be eligible for duty related processing, a Reservist or National Guard Soldier not on active duty must have a medically unacceptable condition; and, that medical condition must be related to service by either having been incurred in; or, when the condition was not incurred while on active duty, *permanently* aggravated by, military service. (Enclosure 2 to this memorandum provides additional information on how to validate a duty related condition absent an approved Line of Duty).

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(2) The hallmarks of the non-duty related case include: the condition started when the Soldier was in a non-duty status; *and*, the condition was not permanently service aggravated by military duty. DoDI 1332.38, E2.1.3.2 defines service aggravation as "the permanent worsening of a pre-Service medical condition over and above the natural progression of the condition caused by trauma or the nature of Military Service." DoDI 1332.38, E2.1.19 defines natural progression as "the worsening of a pre- Service impairment that would have occurred within the same timeframe regardless of Military Service."

(3) The following describes a condition that is properly designated as non-duty related.

(a) The (now) medically unacceptable condition started while the Soldier was not on active duty.

(b) Through natural progression, including during the time the Soldier was on active duty, the condition has become medically unacceptable.

(c) There is no evidence that the Soldier sustained permanent worsening *due to* military trauma (vs. due to natural progression).

(d) There is no evidence that the nature of the Soldier's Military Service permanently worsened the condition beyond natural progression.

(4) The unit must process a case as a duty related case when a Soldier has a medically unacceptable condition that started when the Soldier was in a non-duty status *and* the Soldier has experienced a permanent worsening of the condition due to military trauma or the nature of the Soldier's military service. It is an error to process a Soldier's case as non-duty related because the unit believes that the permanent worsening of the condition due to military trauma or service is not the reason the condition is now medically unacceptable.

d. Profile discussion.

(1) As a preliminary matter, the unit must verify the profile submitted with the NDR packet is accurate and complete. The unit may need to revise the current profile when the profile is either incomplete or inaccurate.

(2) Relationship between the Soldier's diagnoses and any DA 3349, physical profile functional activity limitations.

(3) Where the profile is self-explanatory, no discussion may be required. However, where, for example, the Soldier has multiple conditions, this section

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should indicate which diagnoses are associated with which profile limitations. Note: where the profile and medical record review indicates the Soldier has a duty related condition that prevents the Soldier from performing one or more DA 3349 functional activities, the Soldier should have a duty related MEB. See AR 40-501, 3-41. e. (1).

e. Impact on duty (beyond profile limitations). The purpose of this section is to explain the impact of this diagnosis on the Soldier's duty performance. For example: a condition may impact duty performance because the Soldier's condition requires frequent clinical monitoring or requires limitations in duty such as duty in a protected environment. It is possible that the Soldier's condition does not impact duty performance beyond profile limitations.

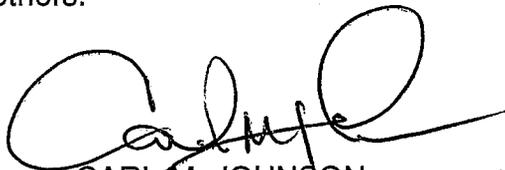
f. Medical retention standard for application. The purpose of this section is to identify the specific AR 40-501, Ch. 3 provision that applies to the Soldier's diagnosis.

g. Tailored discussion explaining why diagnosis does not meet retention standards. The AR 40-501, Ch. 3 provision for application defines the contours of what is required for this section. Properly addressing this element assures the unit meets its obligation to provide the PEB with *a clear description of the medical condition(s) that cause the Soldier not to meet retention standards*. Note: where the evidence does not support a specific AR 40-501, Ch. 3 provision yet prevents the Soldier from performing one or more DA 3349 functional activities; or otherwise interferes with duty performance, consider whether 40-501, 3-41. e. (1) (2) or (3) applies.

h. Competency statement. If the Soldier has a behavioral health diagnosis, the unit should include a mental competency statement. The mental competency statement indicates whether the Soldier is: mentally competent for pay purposes; capable of understanding the nature of, and cooperating in, PEB proceedings; and/or, dangerous to themselves or others.

2 Encls  
1. Sample Memorandum  
prepared in NDR Case Format  
2. Instructions for submission

CF  
RC SMSC (w/encl)  
IDES Service Line (w/encl)

  
CARL M. JOHNSON  
COL, AG  
Director, US Army Physical  
Disability Agency

**SAMPLE**



REPLY TO  
ATTENTION OF

**DEPARTMENT OF THE ARMY**  
Sample Unit in the US Army  
123123 Sample Street  
Fort Snuffy, Texas 55555

ABCD-Z

3 June 2013

MEMORANDUM FOR Commander, US Army Physical Disability Agency, Suite 300, 2900 Crystal Drive, Arlington, VA 22202

SUBJECT: Memorandum prepared in accordance with NDR case format regarding Smith, Samuel LTC, xxx-xx-1234

1. Diagnosis. Lumbar disc disease.
2. Medical Basis of Diagnosis. MRI findings 6 NOV 2011. **L4-5 disk level:** Broad-based central disc protrusion contacting L5 nerve roots in lateral recess, left > right. Mild facet joint degenerative changes, right > left. No significant canal stenosis. Mild bilateral foraminal narrowing. **L5-S1 disk level:** disc desiccation with loss of disc height; small broad-based right paracentral disc protrusion contacting both L5 nerve roots and at L5/S1 contacting the right S1 nerve root. See attached MRI report.
3. Basis for Non-Duty Related (vs. Duty Related) process. Soldier reported onset of back pain while working in civilian status in approx AUG 2011 without trauma or known inciting event. He relates pain with running and carrying more than 20 lbs. Pain seemed to get a little better then recurred and progressed. Soldier sought care and was diagnosed NOV 2011. In MARCH 2012, Soldier began experiencing intermittent symptoms of pain radiating down right leg. Review of the Soldier's records does not indicate any history of back pain while on active duty status. Soldier has not been on active duty since the condition had its onset.
4. Profile discussion. As a result of this condition, Soldier has an L3. The condition prevents Soldier from performing functional activities 5 a-f, i, and j.
5. Impact on duty (beyond profile limitations). Beyond profile limitations, Soldier's condition precludes Soldier from doing many PMOS duties associated with lifting and bending including preparing, and stowing ammunition on scout vehicles.
6. Medical retention standard for application. AR 40-501 Ch. 3-39 e.
7. Tailored discussion explaining why diagnosis does not meet retention standards.

**SAMPLE**

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a. Ch. 3-39 e. applies because despite remedial measures, herniation of nucleus pulposis causes significant symptoms and objective findings to demonstrate interference with satisfactory performance of duty. See 4 and 5 (above).

b. Remedial measures prescribed by neurosurgeon included Physical therapy (PT) for 4 months. This brought some relief but symptoms worsened when Soldier attempted to increase physical activity. Despite PT and core strengthening, at times pain aggravated simply by "moving wrong". Pain ranges from dull and constant to more severe. Severe pain makes it difficult for Soldier to bend forward. With flares, condition associated with physical findings of positive straight leg raising at 45 degrees and severe spasm of paraspinal muscles. Intact neuro exam (motor/sensory). Radicular pain intermittent and (only) with flairs. (Last episode JULY 2012.) See attached treatment summary notes.

8. Competency statement. Not applicable because the Soldier does not have a behavioral health diagnosis.

9. Point of contact is LTC James T. McCormick, telephone 555-555-4565 or email [james.t.mccormick1234.mil@mail.mil](mailto:james.t.mccormick1234.mil@mail.mil).

Encl

THOMAS P. JONES  
LTC, AR  
Commanding

**SAMPLE**

Enclosure 2 to Memo, SUBJECT: Non-Duty Related (NDR) Case Submission to Physical Evaluation Board (PEB): Clarification of Procedures and Required Information, dated 20 June 2013

Determining Line of Duty absent DA Form 2173 or DD Form 261

1. If Soldier has at least one condition that is considered to be an ILOD condition, a completed LOD *should be* included in case file (See AR 600-8-4 for LOD criteria and whether informal or formal LOD is required).

2. When the evidence indicates that the present condition originated, was incurred, or aggravated on previous AD period, but no LOD was completed, processing of the case may be possible without completing a LOD DA Form 2173 or DD 261 based on criteria found in presumption of LOD memorandum issued by HRC ("Clarification of Requirement for Line of Duty Investigations (LODI) for Soldiers Being Referred into the Physical Disability Evaluation System (PDES)").

Example: Soldier deployed to Iraq in 2009 and now complains of PTSD symptoms while a reservist/NG not on AD. If diagnosis of PTSD is based on combat stressor while on AD deployment, and orders confirm deployment and there is no contradictory evidence, no LOD may be necessary. If this is the case, memorandum indicating that no LOD is required because of the presumption criteria being met should be included.