Chapter 4

RETURNING TO DUTY AFTER MAJOR LIMB LOSS AND THE US MILITARY DISABILITY SYSTEM

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INTRODUCTION

In recent decades, returning to duty after major limb loss has been a rare event in the US military. Today's military service member who wishes to remain on active duty after major limb loss commonly finds a more receptive atmosphere, if not strong encouragement from his or her chain of command. This support is well-founded given advances in amputee care that make it possible for such service members to effectively meet and exceed rigorous performance standards for a wide range of military occupations. This chapter will describe some of the key factors that service members with major limb loss and their families might consider when deciding whether to pursue return to duty or transition into civilian life. The military disability system, with the US Army's system as the prime example, will also be described.

RETURNING TO DUTY

Factors Involved

The severity of limb loss, as well as the nature and extent of associated injuries, has a dramatic impact on an injured service member's ability to return to active military duty. History has many examples of soldiers with major limb loss returning to active duty, including the Invalid Corps of the Union Army during the US Civil War[1] and approximately 1,500 World War II veterans who were recalled to active duty to support the Korean War.[2] While serving as junior officers in Vietnam, General (Retired) Eric Shinseki (a partial foot amputee) and General (Retired) Frederick Franks (a transtibial [below-knee] amputee) suffered major limb loss, yet retired after full active duty, reaching the highest positions of leadership in the US Army.[3] Despite these examples, a study by Kishbaugh et al[4] found that only 11 of 469 US soldiers with limb loss (2.3%) returned to duty in the 1980s, with amputation levels including partial foot, partial hand, and transtibial. More recently, during the global war on terror (GWOT), injured service members from Afghanistan and Iraq with more proximal levels of amputations, including transfemoral (above-knee) and transradial (below-elbow), have remained on active duty and continue to serve successfully.[5] From the onset of GWOT through 2008, approximately 17% to 20% of injured service members with major limb loss, across all US military services, have completed their respective medical board process and been retained on active duty or reserve status.[6,7]

Many factors associated with the traumatic event (commonly a blast injury) responsible for the amputation can make healing and realistic decision-making about return to duty more complex. Some of these factors include complications with the healing limb,[8] multiple limb loss, ongoing residual limb (stump) pain, uncomfortable and limited prosthetic use, decreased functional abilities,[9] traumatic brain injury, delayed psychological adjustment to limb loss,[10] and impaired confidence in one's ability to resume normal-life activities (self-efficacy).[11]

Traits characteristic of amputees who seek to remain on active duty include strong individual motivation for continued military service, anticipated ability to meet the performance standards of their military occupational specialty (MOS), solid support from close family members and friends, and possession of highly valued military-specific skills. In addition, service members most likely to return to duty are those who had strong service records prior to injury and can expect robust unit and command backing, especially after a trial of duty with their previous unit. It is particularly helpful if the unit has special MOS-related needs that the service member can fill. Also, service members are usually wise to remain flexible, with the willingness to consider the possibility of training in another MOS that can better match their current abilities with a valued military job. Amputee service members report that speaking with peer amputee visitors and veterans who have personal experience with the return-to-duty process provides helpful information to guide their own decision making.[12] The Web addresses of organizations with useful resources for injured service members are listed in Table 4-1.

US Army Process

In the US Army, many injured soldiers, especially those returning from overseas, are either assigned or attached to a medical holding company such as the one at Walter Reed Army Medical Center while recovering from their injuries. More recently, such units have been called warrior transition units (WTUs). The WTU acts as the medical and administrative facilitator between the hospital clinicians and the physical evaluation board liaison officer. The WTU further ensures administrative accountability for all soldiers receiving care by assigning a case manager or social worker to support them and their families. The range of support

TABLE 4-1

WEB SITE ADDRESSES OF ORGANIZATIONS HELPFUL TO INJURED SERVICE MEMBERS

Activity	Internet Address
US Army Publication Directorate	www.apd.army.mil
Walter Reed Army Medical Center	www.wramc.amedd.army.mil
Amputee Coalition of America	www.amputee-coalition.org
Department of Veterans Affairs	www.index.va.gov
Disabled Soldier Support System	www.ArmyDS3.org
Disabled American Veterans	www.dav.org
Paralyzed Veterans of America	www.pva.org
Veterans of Foreign Wars	www.vfw.org
American Legion	www.legion.org
Military Order of the Purple Heart of the USA	www.purpleheart.org
American Veterans	www.amvets.org
National Amputation Foundation	www.nationalamputation.org
National Military Family Association	www.nmfa.org
Combat Related Special Compensation	www.crsc.org
Physical Disability Agency	www.hrc.army.mil/site/active/tagd/pda/pdapage.htm

provided includes logistics (lodging), pay and allowances, convalescent and ordinary leave, and military orders. The WTU team of professionals makes certain that patients receive timely clinical appointments and that all required administrative documentation is properly processed.

The WTU also serves as a coordinator between the soldier and the transition office. The transition office prepares the discharge document, DD214, which verifies all periods of military service and character of discharge. The DD214 is required for Department of Veterans Affairs (VA) benefits to begin. In most situations, the soldier's transition out of the unit, and ultimately out of the Army, involves an administrative process that may take weeks, up to several months. For those who are able to return to duty, new orders will direct the soldiers to their next duty station. The length of time a soldier remains with the WTU depends upon his or her unique healthcare situation, individual resources, support system, and administrative needs.

PHYSICAL DISABILITY EVALUATION SYSTEM

Overview

Each branch of the Department of Defense (DoD) has specific standards by which it determines whether or not an injured or ill member will be continued on active duty, based upon the severity of the condition and the imposed functional limitations. The ensuing text will focus on the US Army physical disability evaluation system (PDES), and specifically the active duty soldier with major limb loss who must navigate the system. The rules and regulations for the reserve soldier, in relation to disability compensation, are different than those for the active duty soldier. However, in terms of the medical evaluation mechanics, once entered into the PDES, active duty, reserve, and National Guard soldiers all flow through the Army disability system in the same manner.

For example, soldiers with major limb loss may be medically retired from the US Army for a physical impairment if it renders them physically unfit for duty.

Fitness for duty is evaluated as a function of the reasonably expected ability to perform the duties of the soldier's primary MOS.[13(p14)] To get to this point, the Army must utilize the medical evaluation board (MEB) and physical evaluation board (PEB). The MEB determines "retention," per Army Regulation (AR) 40-501, Chapter 3.[14] The PEB determines "fitness," based upon MOS. This distinction is extremely important, because the medical treatment facility (MTF) does not and should not comment on the "fitness" of a soldier, but rather whether the amputee meets retention standards, regardless of MOS, based solely on AR 40-501, Chapter 3.[14]

If the soldier's medical condition could potentially be found to not meet the medical retention standards, as outlined in AR 40-501, Chapter 3, it is the treating physician's responsibility to refer the soldier to the MEB. The MEB physician, who receives specialized disability training, then reviews all clinical and administrative evaluations. The MEB physician (civilian or military) is directly employed by or assigned to the MTF, working under the authority of the MTF commander, through the deputy commander for clinical services. The MEB physician's key role is to determine whether or not the referred soldier's medical conditions meet the retention standards of AR 40-501, Chapter 3, regardless of MOS. If the soldier fails to meet retention standards and cannot satisfactorily perform his or her military duties, he or she is referred to the PEB. The PEB, under the authority of the US Army Physical Disability Agency, which manages the Army's PDES and acts on behalf of the secretary of the Army, will consider the recommendations of the MEB and make the determination of fitness or unfitness, rendered with the soldier's MOS in mind.[14]

Developing and implementing a system to best benefit the soldier, while providing for the overall good of the Army, whose "paramount mission is to maintain a fit fighting force," is a difficult and daunting endeavor.[15] A pilot program was established in November 2007 to streamline the process, improve overall customer satisfaction, and rely on the VA for disability rating purposes.[16] This joint effort was born out of the President's Commission on Care for America's Returning Wounded Warriors [Dole-Shalala], which provided an "agenda for moving forward."[17] The goal of the pilot is to streamline and improve the disability evaluation process by providing one medical examination and a single-sourced (VA) disability rating, making for a seamless transition from the care, benefits, and services of the DoD to the VA system, measured by customer satisfaction (Figure 4-1).[16] The PDES Joint Pilot Program was first put into practice at the three Washington, DC-area triservice facilities: Walter Reed Army Medical Center, National Naval Medical Center, and Malcolm Grow Medical Center. The plan has been to expand the pilot program throughout the DoD, worldwide. Army-wide rollout of the pilot has begun with Fort Meade, Maryland, and Fort Belvoir, Virginia, on October 1, 2008.

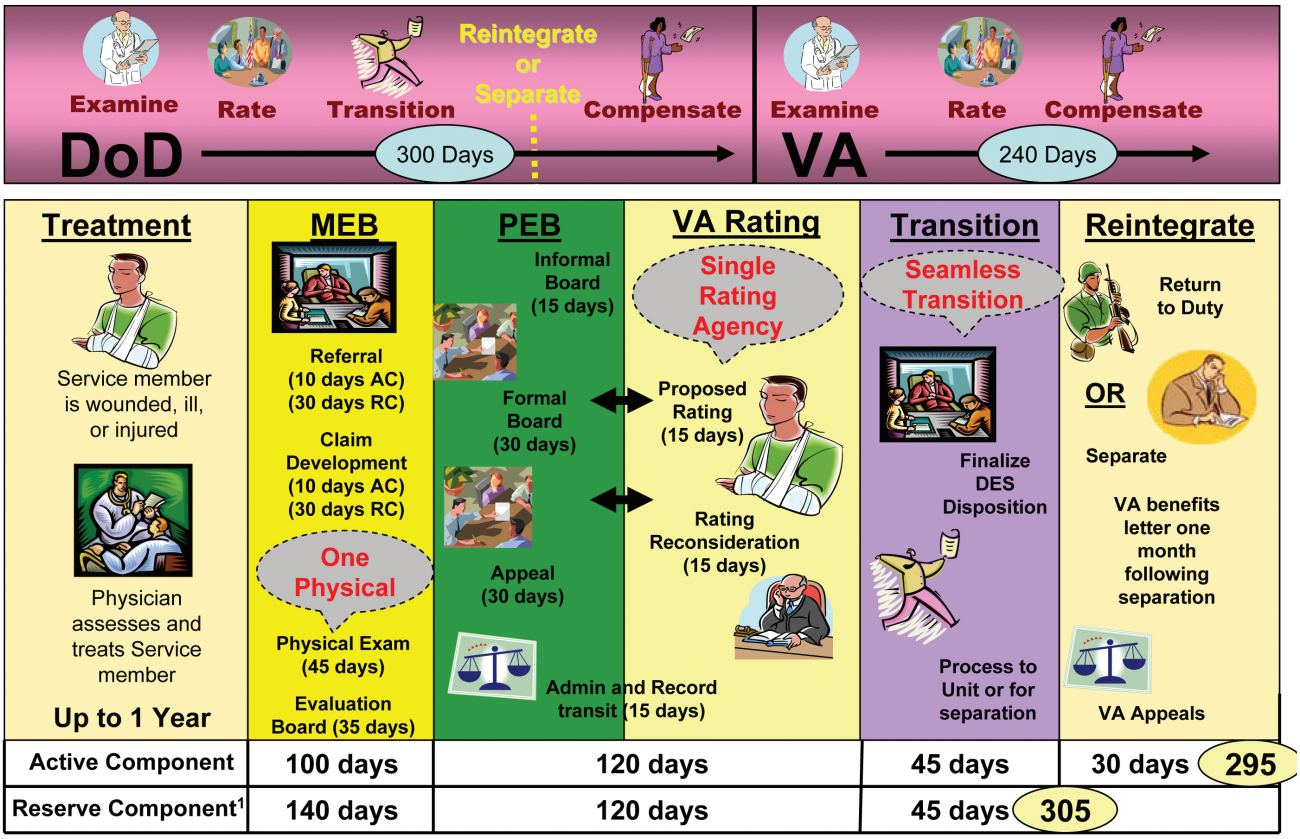
Medical Evaluation Board

Current Legacy System

To understand the Army's proposed changes to the PDES, a closer look at the legacy system is necessary. Currently, an Army infantry soldier with major limb loss found by the MEB to not meet retention standards is referred to the PEB for a fitness determination. When the PEB determines that the limb loss renders the soldier unfit for his or her infantry MOS, a disability rating is generated by the PEB using the VA Schedule for Rating Disabilities (VASRD).[15] Soldiers who receive at least a 30% disability rating from the Army, which is often the case with major limb loss, and do not want to continue in service are medically retired, either temporarily or permanently.[15]

For the now retired soldier to receive disability compensation from the VA with the same limb loss diagnosis already rated by the Army, he or she must restart the medical evaluation process with a new set of clinical examinations by the VA medical providers. After reexamination, the VA, using the same VASRD criteria used by the Army, rates the soldier's service-connected disability, often at a higher percentage. Soldiers may be left wondering (*a*) why they received two separate and different ratings, one from the Army and one from the VA, for the same impairment, and (*b*) why the process takes so long. These two problems with the legacy system deserve further discussion.

First and foremost, the legacy system allows for a discrepancy in the final disability rating, rendered by both the Army and the VA, irrespective of one another, on the exact same diagnoses. The primary reason for this discrepancy is that the two departments follow different rules. The Army is tasked with rating each diagnosis that the MEB found "unacceptable" or "not meeting retention standards" and the PEB also found "unfitting," preventing the soldier's performance within his or her specific military job training.[15] Furthermore, the Army rates an "unfitting condition for present level of severity," much like a snapshot of the soldier's condition, at the time the MEB is conducted.[15] The VA, on the other hand, rates any and all "service-connected conditions," keeping in mind future progression of the disease or injury process,



[1]Reserve component member entitlement to VA disability compensation begins upon release from active duty or separation.

Figure 4-1. Disability evaluation system Joint Pilot Program timeline overview. This graphic is part of the mass briefing provided to WTU members at Walter Reed Army Medical Center by the physical evaluation board liaison officer**.** Note that the treating physician, who generates the permanent "3" or "4" profile, which initiates the PDES, is distinct from the MEB physician, who administratively helps process the MEB.
AC: active component
DES: disability evaluation system
DoD: Department of Defense
MEB: medical evaluation board
PDES: physical disability evaluation system
PEB: physical evaluation board
RC: reserve component
VA: Veterans Administration

with respect to the condition's "adverse impact on employability within the civilian job sector."[15] These distinctions in laws and regulations allow for significantly different rating values. The final disability rating is expressed as a percentage rating between 0% and 100%, resulting from all types of diseases and injuries encountered as a result of, or incident to, military service.[18]

Second, the legacy MEB/PEB process may involve considerable delays for soldiers and their families. For soldiers suffering from multiple and complex "unacceptable" conditions, each requiring a disability evaluation from a separate MTF specialty clinic, delays become inevitable. US Army Physical Disability Agency guidance requires that the disability evaluations of unacceptable conditions be performed no more than 6 months (30–45 days for psychiatric conditions) before submission to the PEB.[19] If the MTF disability evaluation of an unacceptable condition extends beyond the 6-month window before the case reaches the PEB, the soldier needs to be seen again by the particular MTF specialty clinic for an updated assessment and comment on whether or not the condition remains unacceptable. This reevaluation,

a repeat of clinical work, places a tremendous strain on the specialty clinics.

Proposed Pilot System

Regardless of whether they enter the pilot program or remain in the legacy system, wounded soldiers returning from the battlefield are assessed by their inpatient treatment team prior to discharge from the hospital. During transition to the outpatient setting, the soldiers are placed into an established WTU to be cared for safely outside the hospital, since they are not well enough to return to their units. A physician-member of each soldier's interdisciplinary treatment team, serving as a competent medical authority, must determine whether the soldier's conditions are medically stable.[20] Once medically stable, the soldier may be considered for referral to the MEB. For referral, the soldier must have a permanent "3" or "4" profile.[20] A "3" designator signifies that the individual has "significant limitations"; whereas a "4" indicates that his or her "physical defects are to such a severity that performance of military duty must be drastically limited."[14(ch7)] For PDES purposes, the "3" and "4" designators are synonymous, meaning the soldier will not receive additional disability benefit in having a permanent "4" versus a permanent "3."

Once the permanent profile has been generated by the treating physician and signed by the designated approving authority, the soldier is recommended for referral into the Joint Pilot Program.[21]

An MEB physician reviews the permanent profile and ultimately determines if the soldier is a suitable candidate for entry into the pilot program, based on a completely new referral standard:

> When a competent medical authority determines a service member has one or more condition(s) which is suspected of not meeting medical retention standards, he or she will refer the service member into the DES at the point of hospitalization or treatment when a member's progress appears to have medically stabilized (and the course of further recovery is relatively predictable) and when it can be reasonably determined that the member is most likely not capable of performing the duties of his office, grade, rank, or rating. Referral will be within 1 year of being diagnosed with a medical condition(s) that does not appear to meet medical retention standards, but may be earlier if the examiner determines that the member will not be capable of returning to duty within 1 year.[20]

A condition is unstable when it has the potential, within 1 year of treatment intervention, to improve to such a degree that the soldier meets medical retention standards.[19] Examples of treatment interventions are condition-improving surgery or medication titrations, warranting a trial of duty prior to stabilization determination. If the MEB physician believes that a medical treatment intervention may improve the soldier's condition to such a degree that he or she will meet retention standards, then the soldier should be maintained on a temporary profile, valid for 3 months, and extendable up to 12 months, prior to consideration of permanency.[14(ch7)] The MEB physician must review all conditions for determination of medical stability before the soldier enters the MEB pilot program. Under no circumstances should any soldier with major limb loss be issued a permanent profile within 4 months of the amputation, per AR 40-501, Chapter 3.[14]

In a hypothetical example of the DES process, a male soldier with a right above-knee (transfemoral) amputation has had his permanent "3" profile reviewed by the MEB physician, and is ready for the pilot program MEB entry. The soldier meets with his assigned physical evaluation board liaison officer (Figure 4-2), who helps the soldier navigate through the disability process, helping him understand the procedural intricacies of the PDES. Next, the soldier is scheduled for medical evaluation with the VA clinical examiners at the regional VA facility. The VA examiners evaluate all conditions claimed by the soldier as well as all chronic conditions and those that have the potential to render the soldier militarily unfit.[22] After the VA clinical examinations, VA worksheets are generated to

Figure 4-2. PEBLO counseling session: Mr Aaron Clemmons (left), Senior PEBLO, meets with SSG Juan Roldan to review all MEB administrative documents and answer procedural questions, prior to forwarding MEB case file to the PEB.
MEB: medical evaluation board
PEB: physical evaluation board
PEBLO: physical evaluation board liaison officer

Figure 4-3. MEB physician encounter: Dr Andrew Rhodes, CPT, MC, USA (center), resolves discrepancy in soldier's medical record by examining SSG Juan Roldan (left), with consultation from Dr Eric Dessain, LTC, MC, USA (right), Disability Evaluation Service Chief, before finalizing the DoD/VA consolidated narrative summary.
DoD: Department of Defense
MEB: medical evaluation board
VA: Department of Veterans Affairs

document focused subjective complaints and objective findings, resulting in a final diagnosis for each claimed condition. The worksheets are returned to the MEB physician, who then prepares a consolidated narrative summary (NARSUM). The NARSUM must resolve any inconsistencies between the soldier's electronic medical record and the VA worksheets (Figure 4-3). The NARSUM also provides the physician with the opportunity to comment on each VA-generated diagnosis, with respect to whether or not the soldier meets retention standards, per AR 40-501, Chapter 3.

In generating the consolidated NARSUM, it is important that the MEB physician is knowledgeable about retention standards.[14] In the case of the soldier with an above-knee amputation, the MEB has no discretion; it must find that the soldier does not meet retention standards, per AR 40-501, Chapter 3, paragraph 13a(1b).[14] Paragraph 12a lists the specific impairment criteria for upper extremity limb loss.[14]

After the soldier with the above-knee amputation has returned from the VA and met with the MEB physician to review his consolidated NARSUM, his case is then officially referred to the MEB, an all-physician panel of at least two doctors, who review the entire case and make the final determination as to whether or not the soldier's conditions meet retention standards, per AR 40-501, Chapter 3.[14,23] The membership composition of the MEB, PEB, and medical MOS retention board (MMRB) is the same, regardless of whether the MTF is involved in the pilot program. Soldiers found by the MEB to have conditions that do not meet retention standards are referred to the PEB for determination of fitness.

Soldiers who do not agree with MEB findings have a new option for further evaluation. A policy memorandum, issued by the under secretary of defense on October 14, 2008, describes the possibility of an independent medical review of MEB findings, prior to submission to the PEB:

> E3.P1.2.6.1.2. Upon request of a Service member referred into the DES, an impartial physician or other appropriate health care professional (not involved in the Service member's MEB process) is assigned to the Service member to offer a review of the medical evidence presented by the narrative summary or MEB findings. In most cases, this impartial health professional should be the Service member's primary care manager (PCM). The impartial health professional will have no more than 5 calendar days to advise the Service member on whether the findings of the MEB adequately reflect the complete spectrum of injuries and illness of the Service member.
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> . . .
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> E3.P1.2.6.1.3. After review of findings with the assigned impartial health care professional, a Service member shall be afforded an opportunity to request a rebuttal of the results of the MEB. A Service member shall be afforded 7 calendar days to prepare a rebuttal to the convening medical authority. The convening medical board authority shall be afforded 7 calendar days to consider the rebuttal and return the fully documented decision to the Service member…The fully documented rebuttal will be included with the MEB information sent to the PEB.[24]

Medical Military Occupational Specialty Retention Board

There are a few instances in which a soldier with limb loss can meet retention standards, including the loss of toes or fingers. In the case of amputated toes, to fail to meet retention standards, the impairment must preclude the soldier's "abilities to run or walk without a perceptible limp and to engage in fairly strenuous jobs," as listed under 3-13a(1a).[14] In the case of lost fingers, to be considered as not meeting retention standards, the loss must be greater than or equal to: "a) a thumb proximal to the interphalangeal joint; b) two fingers of one hand, other than the little finger, at the proximal interphalangeal joints; [or] c) one finger, other than the little finger, at the metacarpophalangeal joint and the thumb on the same hand at

the interphalangeal joint," as defined under 3-12a(1a-c).[14] An infantry soldier missing the trigger and little fingers on the same hand, resulting from a traumatic blast injury, is by regulation, if no other impairments exist, still able to meet retention standards.[14] Since this soldier requires "significant functional limitations," specifically being unable to fire a weapon, the soldier is issued a permanent "3" profile. However, because the soldier meets retention standards, he or she should be referred to an MMRB.[14(ch7)]

Soldiers may be referred to an MMRB if they have at least a permanent "3" designator for a condition that meets retention standards.[14(ch7)] The MMRB has the option of returning the soldiers to their units, placing them on medical probationary status, reclassifying them into another MOS, or referring them to the MEB.[25] The MMRB consists of five members, some voting and some nonvoting. The voting members include a colonel, either in combat arms, combat support, or combat service-support, serving as president; a field grade Medical Corps officer or MTF commander-designated civilian medical doctor; and an additional voting member who, if possible, is in the same branch, specialty, or primary MOS as the soldier appearing before the board.[25] The nonvoting members are a personnel advisor and recorder.[25] Treating physicians should be familiar with the options available for their injured soldiers.

Physical Evaluation Board

The Army PEB is composed of three voting members: a colonel, serving as the board president; a field grade personnel management officer; and a senior physician, either a Medical Corps officer or an Army civilian doctor.[24] The PEB first meets informally, meaning the soldier is not present, and also that the recommendations made at this meeting may later be changed. The three board members determine fitness by majority vote, taking into consideration the following: clinical evidence presented in the soldier's MEB; performance standards of the soldier's primary MOS; and the soldier's personnel records, including but not limited to his or her record brief, evaluation reports, and commanders' statements.[15] Under the pilot program, the PEB records its informal factual findings for each diagnosis, along with its recommendation for fitness determination, on DA Form 199 (Election to Formal Physical Evaluation Board Proceedings).[15] No rating determinations appear on Form 199; rather, for those conditions labeled as unfitting, the form has an explanation of the condition followed by a qualifier, signifying that the rating generated for the unfitting condition is to be completed by the VA. The VA rating board then evaluates the soldier's referred and claimed conditions, providing a rating percentage with rationale to the PEB within 15 calendar days of notification by the PEB that a soldier is unfit.[22] At this time, the soldier must request a copy of his or her VA rating for each claimed condition (generated by a VA regional office).[22]

In the pilot program, the Army is bound by the VA rating for those conditions found to be unfitting. In other words, if the Army finds the soldier unfit for a particular condition, the rating for that condition is determined by the rating provided by the VA.[22] For example, the soldier with the right above-knee amputation, whose only condition is major limb loss, is found to not meet retention standards, per AR 40-501, Chapter 3, Paragraph 13a(1b).[14] The soldier's primary MOS is 11B, infantry. He is found unfit for service, based on his injury and inability to satisfactorily perform the duties within his primary MOS. A soldier is physically unfit when a medical impairment prevents reasonable performance of the duties required of the soldier's office, grade, rank, or rating.[15] In this example, the soldier's residual limb length, as measured from the perineum, is found to be one-third of the distance from perineum to knee joint, when compared to the left, unaffected side. Thus, the right above-knee amputation transects the upper third of the femur bone. Per disability code 5161, as found in the VASRD, the VA rates his condition at 80% disability.[18] Under the pilot program, the Army is now bound by this 80% disability rating, whereas in the legacy disability system, the Army provides a disability rating independent of the VA rating.

After the informal PEB has convened and rendered DA Form 199, the soldier is entitled to government-appointed legal counsel (if not already obtained[24]) and has the following election options: (*a*) concur with the informal findings and recommendations; (*b*) request a formal administrative hearing, either with or without a personal appearance; or (*c*) nonconcur and submit a written appeal in lieu of proceeding with a formal board.[15] The formal PEB is administrative, fact-finding, and nonadversarial, meaning no government representative appears to oppose or counter the soldier's position at the hearing.[15] Because the informal PEB recommendations may be changed, the soldier may be found fit with a condition previously considered unfitting. Soldiers typically request a formal hearing to argue that conditions found to be fitting should be reconsidered as unfitting. Also, some soldiers found unfit for service request a formal hearing to argue that they are fit for duty, based upon duty performance, as substantiated by their chain of command.[15] Thus, before a soldier requests a formal hearing, it is extremely important for him or her to understand the VA rating, which will ultimately drive the subsequent Army dis-

ability disposition.

The end result is that the soldier receives a disability rating from the VA and a disability disposition from the Army. The VA rates all claimed service-connected conditions based upon its evaluations. The Army renders a disposition of the soldier, based upon the VA rating, for those conditions found unfitting by the PEB. If the soldier has less than 20 years of active federal service and reaches at least a 30% disability rating, the Army may place the soldier on either permanent disability retirement (PDR) or the temporary disability retirement list (TDRL). PDR applies when the soldier's condition is stable and not expected to improve or deteriorate in the next 18 months. TDRL applies to those conditions where the converse is believed to be clinically true: the condition will likely change in the next 18 months.[15] Soldiers on the TDRL are reexamined at 12 to 18 months following Army discharge. The soldier can be maintained on TDRL for a maximum of 5 years, with reexaminations at the 3- and 5-year marks, if the condition remains unstable and continues to meet the minimum criteria for at least a 30% rating.[15] If the soldier's unfitting condition has not stabilized in 5 years, the PEB will provide a disability rating based upon the level of severity at that point in time.[15] The legacy disability system applies to the TDRL, in that the reevaluations are conducted at the MTF and the disability rating can be adjusted by the PEB, independent of the VA.

Soldiers who are found unfit by the PEB but receive a combined VA rating of less than 30% for their service-connected conditions are separated with a one-time, lump-sum, severance payment.[15] The exact disability rating, whether 0%, 10%, or 20%, makes no difference in the calculation of severance pay. The disability severance payment amount is calculated by doubling the soldier's monthly basic pay, multiplying it by the number of combined years of federal service (not to exceed 12 years), and then adding this number to the inactive duty points, per AR 635-40, Appendix C.

Continuation on Active Duty

The Army provides an administrative procedure—continuation on active duty (COAD)—to determine whether or not the unfit soldier suffering major limb loss should be continued on active duty. The study by Kishbaugh et al,[4] which found that only 2.3% of soldiers in the 1980s remained on active duty after amputation, did not discern whether the soldiers remaining on active duty were found fit or were granted a continuation on active duty. However, it is important to note that none of the 79 soldiers with above-knee amputations were retained on active duty.[4] "Soldiers with hand and/or finger amputations (54.5%) constituted the majority of the return-to-duty group, with the remainder made up of foot and/or toe amputees (27.3%) and below-knee amputees (18.2%)."[4]

Over the past year, all soldiers with combat-related limb loss referred by the Walter Reed Army Medical Center MEB who failed to meet retention standards (per AR 40-501, Chapter 3) were found unfit. AR 635-40, Chapter 6, prescribes the criteria by which soldiers with major limb loss who have been found unfit by the PEB may be continued on active duty or on active reserve status.[13(ch6)]

In the example of the active duty soldier with above-knee amputation, to be considered for COAD, he must meet one of the following criteria:

- have 15, but less than 20, years of active federal service, or
- be qualified in a critical skill or shortage MOS, or
- possess a disability resulting from combat or terrorism. [13(ch6)]

Per Army Regulation, the soldier does not have an inherent or vested right to continuation on active duty; the primary objective of the COAD program is to conserve personnel by effective use of needed skills or experience. [13(ch6)] If approved by the Human Resources Command, the COAD for soldiers with major limb loss lasts for any period of time up to the last day of the month in which they obtain 20 years of active federal service. [13(ch6)] If the disability precludes continuation in a limited duty status within the soldier's current primary MOS, the soldier may request reclassification into another MOS, listing three alternatives, in order of preference.[13(ch6)] A soldier approved for COAD longer than 6 months is referred to the PDES before the continuance expires.[13(ch6)] During the final PDES evaluation, soldiers whose disabilities have healed or improved to such a degree that they are capable of performing their primary MOS may be found fit; however, the ability to perform duties with prostheses does not constitute healing or improvement of a soldier's condition for purposes of a fit finding. [13(ch6)]

RETIREMENT AND DISABILITY COMPENSATION

Soldiers considering a return to duty should clearly understand the nuances of a COAD and reaching regular/longevity retirement after a minimum of 20 years of active duty service. If a COAD is approved and the soldier retires after at least 20 years, the soldier must be reevaluated with a new MEB at the time of retire-

ment or separation. The same applies for soldiers with an approved continuation on active reserve (COAR) and 20 qualifying years for reserve retirement. The final MEB/PEB does not affect longevity retirement benefits, to which every soldier with over 20 years of service is entitled. However, the percentage of retirement pay may be increased because of a disability causing unfitness for duty, and receipt of additional VA disability compensation as well as potential tax-free military retirement monies may be affected, as described below.

Retired amputee service members *may* be eligible to receive both military retirement and VA disability compensation (known as concurrent receipt [CR]), if they are found by a PEB to have at least 30% disability, or if their COAD or COAR is approved and they qualify for longevity retirement. A longevity retirement, which requires completion of at least 20 years of active duty service, or 20 years of accumulated required retirement points for reserve or National Guard service, is the basis for either CR or combat-related special compensation (CRSC). Service members may also be eligible for CR if they have over 20 years of active duty service and are retiring because of disability, without ever having a COAD or COAR.

Military retirement pay is taxable income unless the soldier's injuries are combat-related as determined by the PEB. All VA benefits are nontaxable. Current law requires that military retirement pay (taxable income) be reduced dollar-for-dollar for each dollar of VA compensation (nontaxable income) paid. However, CR and CRSC are designed to replace that offset. To qualify for CR, a veteran must retire with 20 or more years of service and be rated with a 50% or more service-connected disability by the VA. CR increases taxable retirement pay, but not nontaxable VA compensation. Payment of CR is automatic for qualified retirees; however, the benefit is being phased-in over a 10-year period, and full CR will not be achieved until January 2014. CRSC is a DoD program designed to correct the offset when all or some of the service-connected conditions are the result of combat or combat-type injuries or illnesses. Veterans must apply to their service for CRSC after they receive a disability rating from the VA. CRSC does not increase or replace retirement pay; it is a special nontaxable compensation. Qualifying veterans have the choice of either CR or CRSC, and both programs are capped at the amount equal to full retirement pay. Service members and veterans should contact the Defense Finance and Accounting service or a VA benefits counselor for specific information about their situation. Amputee service members who do not qualify for longevity retirement still qualify for VA benefits.

Reserve component amputee service members whose COAR is approved face unique challenges with benefits. While in inactive status, they have no personal or family TRICARE benefits or military income. Healthcare can be received at any MTF, but only with a line-of-duty statement. Travel to and from an MTF is generally not reimbursed. COAR-approved amputee service members can apply for VA benefits and receive VA compensation and medical care, but their monthly VA disability compensation is offset by their monthly military compensation.

VETERANS AFFAIRS BENEFITS

Besides understanding the PDES, service members with major limb loss should also be familiar with the range of potential VA benefits available to them as they consider whether or not to remain on active or reserve duty (see Chapter 3, Department of Veterans Affairs System of Care for the Polytrauma Patient). VA counselors are available to discuss each of the following benefits:

- compensation and pension payments,
- home loan guaranty (VA loan funding fee waived for disabled veterans),
- life insurance,
- tuition assistance,
- vocational rehabilitation and employment opportunities,
- medical care for all service-connected conditions,
- civil service preference, and
- special grants (some available to active duty disabled service members and retired veterans alike), such as:
  - a special adaptive housing grant (up to $50,000),
  - an automobile grant (up to $11,000),
  - automobile adaptive equipment,
  - annual clothing allowance, and
  - aide and attendant's care.

Vocational rehabilitation benefits (see Chapter 6, Vocational Rehabilitation of the Combat Amputee) are especially important, for service members with major limb loss will at some time likely transition to the civilian workforce. Assessment of service members' vocational aptitudes and interests, as well as individual training services, can start while they are still on active duty; however, the financial stipend cannot be paid until a DD214 is issued and a VA service-connected disability rating is obtained. Specific training benefits include tuition, books, fees and supplies, a monthly stipend, transportation support, and any necessary adaptive equipment.

WAY FORWARD

According to the Armed Forces Amputee Care Program database at the time of this writing, the US Army retained over 15% of soldiers with major limb loss in uniform. Further research is required to more fully assess this cohort and the significant factors that influenced their decisions to stay in the military, the duration and quality of their subsequent military service, and their eventual transition to civilian life. In addition, studies to compare the amputee care treatment and policies related to military retention between US military personnel with major limb loss and their counterparts in allied militaries may lead to further improvements in US military healthcare and personnel systems.

The PDES pilot program is the first attempt to merge complicated and separate military and VA disability systems across the entire DoD. Soldiers in the pilot program no longer have to repeat Army disability evaluations at the VA. This relieves some of the burden of the MTF specialty clinics; without sole responsibility for providing the disability evaluation, they are able to focus more on soldiers' treatment and continuity of care.

Challenges remain, including differences in VA and military disability terminology and the responsibilities assigned to an already overburdened VA disability system. The pilot program has not yet reformed the compensation system. The Dole-Shalala Commission recommended that service members found unfit because of their combat-related injuries should receive comprehensive healthcare for themselves and their dependents through the DoD TRICARE program, regardless of rating percentage.[17] The Commission also recommended that the VA reform the VASRD to reflect current understanding of the impact of disability on quality of life, such as described in the civilian American Medical Association *Guides to Evaluation of Permanent Impairment*.[17]

Another proposed idea is to shorten the time soldiers remain on TDRL by having the VA clinicians, rather than MTF physicians, provide the medical determination of whether a condition is stable, once, at 18 months after retirement, as opposed to numerous times. In October 2008 a change was made to TDRL policy for service members found unfit secondary to a mental disorder sustained from a traumatic stress, the prime examples being posttraumatic stress disorder and traumatic brain injury with its resultant sequelae; a rating of not less than 50% is assigned and the soldier is automatically placed into TDRL, with reevaluation within 6 months.[24] Reworking the entire TDRL policy will allow for greater efficiency, consistency, and overall patient-provider satisfaction.

Customer satisfaction is the driving force behind the PDES pilot program, as evidenced by the *Report to Congress on the Current Status of the Department of Defense and Department of Veterans' Affairs Disability Evaluation System Pilot Program*, prepared by the Wounded, Ill, and Injured Overarching Integrated Product Team on November 20, 2008.[26] This team was established by an oversight committee cochaired by the deputy secretaries of DoD and VA, which also developed eight workgroups to focus on specific care areas for wounded, injured, or ill service members entering the PDES, within each service. The care areas ranged from case management and disability evaluation of service members to compensation and benefits to overall collaboration between the DoD and VA. Process and outcome measures were established, with the evaluation and assessment of the pilot program based on a balanced score card approach, focusing on four dimensions: (1) process improvement, (2) customer satisfaction, (3) financial management, and (4) learning and growth. To determine measurable results that can be used to assess the program's success, specific parameters have been established, including a continuing process improvement effort, a cost-benefit analysis, participant and stakeholder surveys, and a mechanism to track the duration of the process for service members, in relation to their location and DoD/VA regional treatment facilities. Feedback initiatives that provide service members and their families a voice throughout the disability process are intended to improve the overall satisfaction and understanding of the process. An online data-capturing tool has been implemented to track each service member through the process, allowing for management review and oversight. Preliminary indications are favorable that the pilot program is improving the disability system, yet data is limited and further efforts to collect information are needed.[26]

SUMMARY

Soldiers who sustain traumatic injuries, including major limb loss, are challenged with a complex recovery process that unfolds over weeks to years. The personal decision of whether to pursue return-to-duty or transition into civilian life requires a realistic appraisal of one's clinical, psychological, and functional progress, in light of the demands of self, family, and ultimate reentry into a military or civilian occupation. Effectively navigating the PDES requires an awareness of the military and VA disability systems.

Through military and VA counseling, self-education, and early involvement of military-appointed legal counsel or other soldier advocate groups, injured soldiers can best understand the options afforded to them and their families. With the commitment of support from the highest levels of the DoD and VA, more service members with amputations can be expected to successfully return to duty.

REFERENCES

1. Pelka F, ed. *The Civil War Letters of Colonel Charles F. Johnson, Invalid Corps*. Amherst, Mass: University of Massachusetts Press, 2004: 336.

2. Callison L. Army will call back amputees back to active duty: regulation is break for handicapped. *Washington Times-Herald*. November 11, 1951:13.

3. Greve F. 50% of Walter Reed amputees want to return to active duty. *McClatchy Newspapers*. June 22, 2007.

4. Kishbaugh D, Dillingham TR, Howard RS, Sinnott MW, Belandres PV. Amputee soldiers and their return to active duty. *Mil Med*. 1995;160:82–84.

5. Rozelle D. *Back in Action: An American Soldier's Story of Courage, Faith, and Fortitude*. Washington, DC: Regnery Publishing Inc; 2005.

6. US Army Military Amputee Care Data Base. Washington, DC: Walter Reed Army Medical Center.

7. Wingert P, Gegax T. Back to the front: soldiers who lost limbs in Iraq and Afghanistan are doing the unthinkable, going back to battle. *Newsweek*. 2005;145(11):38–41.

8. Dougherty PJ. Transtibial amputees from the Vietnam War: twenty-eight year follow-up. *J Bone Joint Surg Am.* 2001;83A:383–389.

9. Steinbach T. Total rehabilitation for amputees in special conditions. *Prosthet Orthot Int*. 1977;1:125–126.

10. Pasquina PF, Gambel J, Foster LS, Kim A, Doukas WC. Process of care for battle casualties at the Walter Reed Army Medical Center: Part III. Physical Medicine and Rehabilitation Service. *Mil Med*. 2006;171:206–208.

11. Mackenzie EJ, Bosse MJ. Factors influencing outcome following limb-threatening lower limb trauma: lessons learned from the Lower Extremity Assessment Project (LEAP). *J Am Acad Orthop Surg*. 2006;14:S205–210.

12. Gambel J, Mayer J, Lourake A, Downs F. Peer visitor support of recent U.S. military amputees. *inMotion*. 2004;Nov–Dec:26–27.

13. US Department of the Army. *Personnel Separations: Physical Evaluation for Retention, Retirement, or Separation*. Washington, DC: DA, 2006. Army Regulation 635-40.

14. US Department of the Army. *Standards of Medical Fitness*. Washington, DC: DA; 2008. Army Regulation 40-501, Chapter 3.

15. Webb RE, White DC. Physical disability separation. Louisville Law, Kentucky Legal Resources on the Internet. Available at: http://louisvillelaw.com/federal/physical_disbility_sep_1.htm. Accessed June 2006.

16. Mansfield GH, Deputy Secretary of Veterans Affairs; England G, Deputy Secretary of Defense. *Department of Defense (DoD) and Department of Veterans' Affairs (DVA) Implementation of Recommendations of the President's Commission on Care for America's Returning Wounded Warriors (Dole/Shalala Report)*. DoD/VA Wounded, Ill, and Injured Senior Oversight Committee Memorandum, 07 August 2007.

17. Dole R, Shalala D. *Serve, Support, Simplify: Report of the President's Commission on Care for America's Returning Wounded Warriors*. Washington, DC: President's Commission on Care for America's Returning Wounded Warriors; 2007.

18. 38 CFR, Part 4, § 4.71a.

19. US Department of the Army. US Army Physical Disability Agency. Guidance for medical evaluation board (MEB) physicians, guidance for MEB examiners. Available at: https://www.hrc.army.mil/site/Active/TAGD/Pda/pdapage.htm. Updated November 25, 2008. Accessed January 15, 2009.

20. Chu DSC, Under Secretary of Defense. *Policy Memorandum on Implementing Disability-Related Provisions of the National Defense Authorization Act of 2008 (Pub L. 110-181)*. Memorandum for Secretaries of the Military Departments, Chairman of the Joint Chiefs of Staff, General Counsel of the Department of Defense, Inspector General of the Department of Defense, 14 October 2008.

21. Chu DSC, Under Secretary of Defense. *Policy Guidance for the Disability Evaluation System and Establishment of Recurring Directive-Type Memoranda*. Memorandum for Secretaries of the Military Departments, Chairman of the Joint Chiefs of Staff, General Counsel of the Department of Defense, Inspector General of the Department of Defense, and Director, Administration and Management, 03 May 2007.

22. Under Secretary of Defense. *Policy and Procedural Directive-Type Memorandum (DTM) for the Disability Evaluation System (DES) Pilot Program*. Washington, DC: DoD; 21 November 2007.

23. US Department of the Army. *Medical Services: Patient Administration*. Washington, DC: DA; 2008. Army Regulation 40-400: Chap 7.

24. Under Secretary of Defense. *Policy Memorandum on Implementing Disability-Related Provisions of the National Defense Authorization Act of 2008 (Pub L. 110-181)*. Washington, DC: DoD; 14 October 2008.

25. US Department of the Army. *Physical Performance Evaluation System*. Washington, DC: DoD; 2008. Army Regulation 600-60: Chap 4.

26. Wounded, Ill, and Injured Overarching Integrated Product Team. *Report to Congress on the Current Status of the Department of Defense and Department of Veterans' Affairs Disability Evaluation System Pilot Program*. Washington, DC: Department of Defense, Department of Veterans Affairs; 2008.