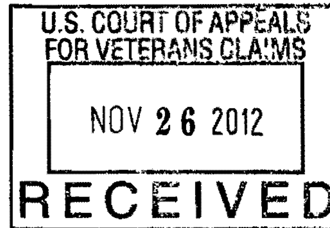
Docket No: 12-0389

Antonio Pacheco

JC 32 420 Trujillo Route

Las Vegas, New Mexico 87701



U.S. Court of Appeals:

This letter is in response to the letter I received on Oct. 8, 2012 (dated Oct.3, 2012). This letter is being typed out for me by my daughter Georgia, on my behalf.

I have been disabled since 1972, when the doctors at the V.A. Hospital (Fort Lyons Medical Center) in Las Animas, Colorado evaluated me as unemployable, (Exhibit B). Physical exams showed impaired hearing, back was Scoloring to the left and the right leg appears to be shorter than the other, and painful. These medical records do not have a page number in the files the V.A. sent me. I will present them as exhibits. Medical records dated 10/27/72 as Exhibit A (2 pages) and Medical Statement, dated 09/30/77, as Exhibit B.

Medical records show a **nexus** to my claims from 1974 when I first applied for service connection disability, for right hip and leg, up to the present time.

I have appealed all the V. A. decisions since 1974 because, even with medical evidence, the V. A. kept denying my claim. An example of this is a medical report from Doctor E.P. Szerlip, dated March 1990. I went to him because my right leg would go numb and I would fall down. I was having pain in my groin and lower back. Doctor Szerlip told me it was due to my injury when in service. I sent these medical records to the V. A. on appeal. The V. A. said it wasn't new material evidence. I had never introduced the medical records from Doctor Szerlip before.

(Exhibits C and D). **These medical records also provide a medical link to my initial application for service connected disability for right leg and hip problems**. I was going to the V. A. in Albuquerque, for my right leg and hip problems for several years. The V.A. was helping me in sending medical records on my appeals to the BVA.

In 1995, I went to the VA for a doctor visit because I was having severe pain in my right hip and groin area and my right leg would go numb. The VA doctor said I might need a hip replacement and sent me for another exam with a specialist. For some reason, I don't see these records for the referral to a specialist from the doctor at the VA. The specialist told my wife and I that my right hip was pretty bad and that I needed surgery. The specialist said that it was due to the injury I received while in service. (All these pre-op records are not in my medical file either.) Why? (nexus?) The specialist set me up for the surgery on May 5, 1995. Medical Records: Exhibits E &F. I have no idea why all these records were not put into my files. Medical evidence between 1990 and 1995 are nowhere in my files, except those that I sent to the court of appeals, and are now attached exhibits to this letter. Medical records of my 1995 total hip replacement surgery, performed by Surgeon William Hayes, (Exhibits G1, G2, G3, and G4, The pathologist report, (Exhibit H), and discharge summary (Exhibit I), are all nexus to my original and consistent complains since I first applied. In the bottom of the first paragraph of page 438 in my file records, states, and I quote, "The VA treatment reports showed you to have severe degenerative joint disease of the right hip and that the arthritis was post-traumatic" unquote. In the bottom part of paragraph two of page 438 in my records states, quote " the examiner then provided an opinion stating that your right hip disorder was the result of the service related injury that occurred in October 1942" unquote.

In paragraph three of page 438 in records also states that a medical link to my in service injury claim was considered with the doctrine of reasonable doubt, 4.3 resolution of reasonable doubt, 3.102. A service connection was then awarded with a 90 percent evaluation. The BVA also stated on that same paragraph, page 438 in record, quote, "A higher evaluation of 100 percent is not warranted unless there has been recent prosthetic replacement of the head of the femur or of the acetabulum", unquote. The BVA faltered to look at the surgeon reports, (exhibits G1, G2, G3, and G4, where it states that these were removed and implants put in. The pathology report, Exhibit H, states that the specimens he received was the right hip bone and Actabulum. The diagnosis of the right hip, right Acetabulum and head was degenerative joint disease. This is a clear and unmistakable error (CUE) on the part of the BVA. These medical records were available to the BVA, and I also sent them copies of them.

I should have received a higher rating because of the facts presented in my medical records in 1995. The 4.3 resolution of reasonable doubt 3.102 should have applied to 1995 and the 1990 medical records. There is also a medical link to my medical records back to 1974 when I first applied.

I have been in a wheelchair since 1996. My son had to quit his job to care for me and my ailing wife. To this day my son continues to help me because of my physical problems and the inability to do for myself. I applied for aid and attendance, but was not given any. My son and I kept appealing my case for service connection disability, but I was constantly denied, even with all the medical reports that were sent on appeals. I got tired and hired an attorney, who finally got the BVA to pay me my service connection disability. I had to pay him 20% of what I received in back pay.

The rating decision on January 20, 2006, gave me a rating of 100 percent for service connection compensation, SMC K-1 for loss of use of one foot, and L-1 for the need of regular aid and attendance. (exhibits K1, K2). The BVA didn't give me anything for being house bound or a higher rating for the removal of my right hip bone, Acetabulum head and for the femoral cement restrictor that were replaced with implants. A veteran alone who is 100 percent disabled, according to the VA rating scale, should receive, for 2011, $2,769.00 a month and for SMC for 2011, at an L-1 rating should be receiving $3,446.00 a month, and $96.00 for a k rating. An additional $141.00 should have been added for aid and attendance. This is a total of $6,452.00. According my bank direct deposit statement, (Exhibit J), I receive $3,545.00 a month for being 100 percent service connected, and aid and attendance. I need care around the clock, **I am house bound, in need of help for dressing, bathing, eating, need help in getting in and out of bed and my wheel chair**. The VA should have given me a higher rating for service connected disability and a higher rating for SMC, and aid and attendance, due to the facts and medical records in my case file. I have been house bound since 1988 when I couldn't drive anymore because my right leg and foot would go numb and pain to my right hip.

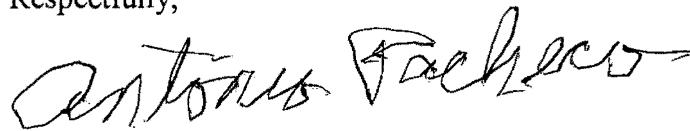
I believe that paying close attention to records on file, (especially page 438) and exhibits, I have been able to prove the CUE on the part of the BVA.

CUE, on the part of the BVA, happened before, and that is why I was able to finally get my 100 percent service connected disability in 2006. My attorney at the time, found this, and is stated in my records.

In the codes of Federal Regulations, the following apply to my case. [CITE: 38 CFR 4.67, 38 CFR 4.59, 38 CFR 4.1, 4.3, 4.6, 4.10,.4.15 and 4.16. CITE: 4:44, 4.40 4.41, 4.45, 4.59, 4.61, 4.63, and 4.67.

Besides medical record that I am adding as Exhibits, I am sending a copy of page 438 of my case file. The reason for this is because there are duplicate and triplicate pages in my case file that the VA sent me and some page numbers are the same as another. There are medical records without file numbers. This is the main reasons I am submitting them. These are not new evidence, they are just without page numbers and some were submitted with appeals when they were omitted from my medical files in my case.

Respectfully,



Antonio Pacheco

Enclosures:

Standard Form 506
Revised August 1954
Bureau of the Budget
Circular A-32 (Rev.)

Exhibit A

10-27-72

CLINICAL RECORD — **PHYSICAL EXAMINATION**

DATE OF EXAM	HEIGHT	WEIGHT — AVERAGE	WEIGHT — MAXIMUM	WEIGHT — PRESENT	TEMPERATURE	PULSE	BLOOD PRESSURE
10/27/72	5'5"			124	98.4	74	120/60

INSTRUCTIONS.—Describe (1) General Appearance and Mental Status; (2) Head and Neck (General); (3) Eyes; (4) Ears; (5) Nose; (6) Mouth; (7) Throat; (8) Teeth; (9) Chest (General); (10) Lungs; (11) Cardiovascular; (12) Abdomen; (13) Hernia; (14) Genitalia; (15) Rectum; (16) Prostate; (17) Back; (18) Extremities; (19) Neurological; (20) Skin; (21) Lymphatics.

1. General Appearance and Mental Status: In all admissions, readmissions and physical examinations, etc., done in this hospital, please document these findings fully in Doctor's Progress Notes, VA Form 509.

See progress notes

2. Head and Neck (General): No exostoses, no tenderness
Main different from normal

3. Eyes and visual Acuity: Refraction

4. Ears:
impaired hearing

5. Nose:
mucosa is normal

6. Mouth:
mucosa is normal

7. Throat:
Normal

8. Teeth:
Several pieces are missing

9. Chest (General):
expansion equal and regular

10. Lungs: Clear to A & P.

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

REGISTER NO. | WARD NO.

PACHECO, ANTONIO

PHYSICAL EXAMINATION

Exhibit A2 continued

PHYSICAL EXAMINATION

11. Cardiovascular: no murmur, no ankle edema

12. Abdomen: no palpable [illegible] no tenderness

13. Hernia: none

14. Genitalia: normal male

15. Rectum: not examined

16. Prostate: not examined

17. Back: Scoliosis to the left

18. Extremities: L leg appears to be shorter than the other [illegible]

19. Neurological: Cranial nerves are intact

20. Skin: within normal limits

21. Lymphatics: no lymphadenopathy

22. Remarks (Use for additional information if necessary)

INITIAL IMPRESSION

[illegible]

Copied From C-File
VARO Albuquerque, NM

CVA-7 Rev. 4/72

Exhibit B

VETERAN'S NAME Antonio Pacheco
ADDRESS 248 [illegible]
SN#
C#

MEDICAL STATEMENT

A physical examination of the above-captioned applicant on 9-30 1977 disclosed the following:

(1) Brief History
Sleeping poorly, actions in arms & legs

(2) Physical Findings
tremor
[illegible] weakness

(3) Diagnosis or Diagnoses
[illegible]
Parkinsonism or other CNS disorder

(4) Prognosis
unknown

(5) In your opinion, is this veteran able to obtain and retain substantially gainful employment?

Yes____ No ✓

I hereby certify that the foregoing statement is true and correct to the best of my knowledge and belief and that the above conditions were found on the date as indicated.

[signature] MD
SIGNATURE OF EXAMINING PHYSICIAN

Willard R. Wright
NAME OF EXAMINING PHYSICIAN

P.O. Box 438 Las Animas, Col.
(STREET) (CITY) (STATE)

REMARKS:

For additional remakrs use reverse side of form.

IN THE APPEAL OF
ANTONIO PACHECO

Exhibit C

legs, reports that the veteran was first admitted to that hospital in November 1972 for diagnoses to include osteoarthritis of both hips.

In March 1978, the RO denied service connection for malaria and for a right leg disorder as not shown by the evidence of record. The veteran was informed of this denial that same month.

The veteran attempted to reopen his claims for service connection for malaria and for a right leg disorder in April 1982, but he was informed by the RO that his claim was essentially a duplicate of previously filed claim. It was noted that he had not presented new and material evidence and no change in previous determinations was warranted.

He again filed to reopen these claims in November 1985. Numerous attempts were made to obtain the veteran's SMRs. The claims were ultimately denied in January 1989 and March 1989 as the only evidence added to the record was duplicate morning reports, already considered.

In an October 1989 statement, the veteran reiterated that he sustained a right leg injury when he jumped into a trench. He also repeated that he suffered his first bout of malaria when he was in New Guinea, and was flown out for treatment.

In January 1990 the RO denied the claims for service connection for malaria and for a right lower extremity disorder in that the veteran's statement did not constitute new and material evidence.

In a March 1990 statement, E. P. Szerlip, M.D., noted that he had seen the veteran primarily for complaints of pain across the right groin and lower back. He also note that the veteran reported that he had been falling more frequently because his right leg went out from under him.

In May 1990, the RO determined that Dr. Szerlip's statement was not new and material evidence, and the claims for service connection for malaria and a right leg

So How is this not a New medical evidence

IN THE APPEAL OF
ANTONIO PACHECO

Exhibit D

disorder were denied. In January 1992, the Board denied the veteran's attempts to reopen his claim in that a timely substantive appeal was not filed.

In March 1996, the veteran filed a claim for service connection for malaria and for a right hip disorder. Evidence added to the claims file includes VA outpatient and hospital treatment reports from 1995 through 1996 reflecting that the veteran underwent a total right replacement in May 1995. In a March 1996 rating decision, the RO determined that this evidence was inadequate to reopen the claims on appeal. It was pointed out that this evidence did not show that the veteran had malarial episodes or that even if he was treated during service for malaria, no current impairment of health was demonstrated. Additionally, it was noted that the evidence did not establish that the postservice right hip replacement was the result of any inservice injury.

Added to the record in 1987 were statements by the veteran's brother and sister attesting to the fact that the veteran was treated for malaria in 1947.

At a March 1998 personal hearing, the veteran testified that he received extensive treatment (including hospitalization) during service for malaria beginning in 1943. After service, he experienced malarial attacks between the years 1946 to 1951, but that he did not seek treatment at that time or subsequently. His brothers recalled that the veteran had malarial attacks in 1946 and 1947. The veteran's wife testified that he suffered from malarial attacks after they were married in 1950, and that these had continued until 1951. At the hearing, the veteran submitted copy of book regarding World War II and requested that an excerpt be considered as evidence. This excerpt is of record. The referenced pages reflect that during the fighting to secure Port Moresby, the Allied forces were half starved, sick with fevers and disease of the jungle, and were without quinine or Atabrine for malaria.

In April 1998, the RO determined that new and material evidence had not been submitted that was sufficient to reopen the claims for service connection for malaria and for a right hip disorder.

***** MAS Medical Records Room Distribution *****

Exhibit E

RADIOLOGY CONSULTATION
VAMC ALBUQUERQUE

ID: [redacted]
Name: PACHECO,ANTONIO
Ward/Clinic: 4D ORTHO
Procedure: HIP AP ONLY

Case #: 38948 Elig: NSC
Requestor: ECHOLS,PAUL G (MD)
Printed: MAY 16,1995 09:15

Exam Modifiers : RIGHT, LATERAL

Clinical History:
pre-op ORTHO admit "DJD RIGHT HIP" *************** PLEASE SEND ALL FILMS TO 4D WITH PATIENT ************* Thanks, ~Ben

Report:
RIGHT HIP/PELVIS, 5/4/95.

Status: VERIFIED

DICTATED 5/9/95.

FINDINGS: NO COMPARISON FILMS AVAILABLE.

EXAM PERFORMED OPN 5/4/95 IS PRESENTED FOR INTERPRETATION ON 5/9/95.

THERE IS MARKED DIFFUSE JOINT SPACE NARROWING OF THE RIGHT HIP WITH SUBCHONDRAL LUCENCIES AND SCLEROSIS COMPATIBLE WITH MARKED OSTEOARTHROSIS. MILD OSTEOARTHRITIC CHANGES ARE IDENTIFIED WITHIN THE PUBIC SYMPHYSIS. THERE ARE DEGENERATIVE DISC CHANGES IN THE LOWER LUMBAR SEGMENTS WHICH ARE VISUALIZED. SPINA BIFIDA OCCULTA IS ALSO NOTED IN THE LOWER LUMBAR SEGMENT.

Impression:
DEGENERATIVE DISC DISEASE IN THE LOWER LUMBAR SPINE AND MARKED OSTEOARTHROSIS OF THE RIGHT HIP.

Name: PACHECO,ANTONIO
ID: [redacted]
Exam: HIP AP ONLY
Exam Date: MAY 4,1995 08:49

VAF 10-9034 VICE SF 519B RADIOLOGY REPORT

Exhibit F

MEDICAL RECORD — OPERATION REPORT — PAGE 1

CASE # 17767

Preoperative Diagnosis:
Primary: DJD RIGHT HIP — ICD9 Code: 715.95

Surgeon: HAYES,WILLIAM M — Surgical Priority: ELECTIVE
Attend Surgeon: ECHOLS,PAUL G (MD) — Attend Code: 1. ATTENDING IN O.R.
1st Assistant: ECHOLS,PAUL G (MD) — 2nd Assistant: MAYFIELD,PATRICIA C

Other Scrubbed Assistants: NONE ENTERED

Anesthetist: YEW,DAVID (MD) — Asst Anesthetist: HESS,JOHN H
Attending Anesthesiologist: MINTON,GORDEN
Anesthesia Supervisor Code: 4. STAFF ASSISTING RESIDENT

Perfusionist: N/A — Asst. Perfusionist: N/A

OR Support Personnel:
Scrubbed: PRIME,NANCY Y (FULLY TRAINED)
Circulating: GRIEGO,CYNTHIA M (FULLY TRAINED)

Anesthesia Technique(s):
SPINAL (PRINCIPAL)
Agent: NONE ENTERED

Anesthesia Begin: MAY 05, 1995 08:45 — Anesthesia End: MAY 05, 1995 12:35
Operation Begin: MAY 05, 1995 10:00 — Operation End: MAY 05, 1995 12:29

Tubes and Drains:
HEMOVAC 1/4 IN, FOLEY 18F, 5CC BALLOON

Tourniquet: N/A

Material Sent to Laboratory for Analysis:
Specimens:
1. RT. HIP BONE.
Cultures: N/A

Postoperative Diagnosis:
Primary: DJD RIGHT HIP — ICD9 Code: 715.95

Major Operations Performed:
Primary: RIGHT THA CPT Code: 27130

Concurrent Procedure(s): N/A

Date/Time of Dictation: NOT ENTERED
Date/Time Transcribed: NOT ENTERED

Indications for Operation:
DJD RIGHT HIP

Surgeon's Dictation: N/A

SURGEON'S SIG: — MAY 11, 1995 10:22
PACHECO,ANTONIO — AGE: 75 ID#: [redacted]
WARD: 4D REHAB — ROOM-BED: 4D141-2
VAMC: ALBUQUERQUE, NM — REPLACEMENT FORM 516

Exhibit G.

SURGEON: HAYES,WILLIAM

FIRST ASST: ECHOLS,PAUL

SECOND ASST:

Anesthetist:
Anesthetic: Spinal

Time Began:
Time Ended:

Circulating Nurse:
Scrub Nurse:
Time Operation Began:
Time Operation Complete:

Preoperative Diagnosis: Marked degenerative joint disease right hip.
Operative Diagnosis: Same.
Drains:
Sponge Count Verified:
Material Forwarded to Laboratory for Examination:

Operation Performed: Right total hip arthroplasty.
Date of Operation: 5/5/95

Estimated blood loss: 700 cc.
Total fluids: 2500 cc. of Crystalloid, 500 cc. colloid.

IMPLANTS:
Size 3 Endurance cobalt-chrome stem. Acetabulum was a 60 millimeter with a 10 degree liner lip, 20 millimeter head, 1.5 femoral cement restrictor size 3.

INDICATIONS FOR PROCEDURE:
The patient is a 75-year-old gentleman with severe degenerative changes to his right hip which is refractory for nonoperative intervention. He was electively consented for operative intervention. Given the risks and benefits, he decided on proceeding with the surgery.

DESCRIPTION OF THE PROCEDURE IN DETAIL:
After informed consent the patient was brought to the operating room and transferred to the operating table. A spinal anesthetic was induced in the usual fashion without difficulty. After allowing

Signature & Titles: ______________________
HAYES,WILLIAM

Date: Signed

Ward:

Patient Name: PACHECO, ANTONIO

SSN: [redacted]

DOB:

VAMC, ALBUQUERQUE, NM

SF 516 OPERATION REPORT
March 1993

Date Dictated: 05/05/95

Exhibit 6z

adequate time for the spinal anesthetic to take effect, the patient was carefully positioned in the lateral decubitus position with the affected hip facing up. The down leg was carefully padded, as well as careful padding around the axilla with pillows. The down leg was checked for pulse and found to have bounding pulses. Careful padding was directed throughout the patient's body. A Foley catheter had been placed prior to embarking on our procedure and it was taped to the down leg. The right lower extremity was prepped and draped in a standard sterile fashion. One gram of I.V. Ancef was introduced 20 minutes prior to our surgical incision.

Using the landmarks of the femur and the greater trochanter, a standard posterolateral incision was made and the approach was undertaken through skin and subcutaneous tissue, identifying the fascia lata, splitting this anterior to the insertion of the gluteus maximus and continuing our gluteal split proximally. Self-retaining Charnley retractor was placed with moistened lap pads. The sciatic nerve was visualized and was carefully protected throughout our procedure.

The trochanteric bursa was resected. The hip was internally rotated and the interval between the abductors and the pyriformis was identified and developed. Once this was performed the pyriformis and the remainder of the short external rotators were incised off the bone with electrocautery. One-quarter of the insertion of the gluteus maximus was gently elevated also. The capsule was identified and was preserved in a single layer. A T-shaped capsulotomy was performed. Next, the hip was dislocated. Our preoperative templating planned out cuts. We made our femoral neck cut along the preoperative templating. The head was measured between 54 and 56.

Next, our attention was directed for acetabular exposure. Three retractors were placed, one anterior, one posterior and one inferior. The labrum was incised sharply. Debris from the ________ and other debris in the acetabulum was gently cleaned out with a curet. Pulse lavage confirmed that we had excellent exposure.

Reaming was commenced starting at 54 all the way up to 58. We chose to place a 60 acetabulum. Using the alignment guide to confirm our

Exhibit G3

anteversion and alignment in the vertical and horizontal planes, the acetabulum was placed. A trial liner was placed and our attention was directed next to the femoral preparation.

Femoral preparation was done using the cookie cutter followed by IM initiator drill. Our reaming was started with hand reaming to go down the femoral canal and we went up in a segmental fashion up to an 11, which corresponded to our preoperative templating of a size 3 stem. Broaching was next begun in a sequential with a 1, then a 2 and then finally a 3, paying careful attention to our anteversion. Once we were happy with the 3, the calcar reaming was performed and we were happy with this. A trial head was placed and we liked the 1.5 head, with excellent stability. We chose the #3 stem. Next, our attention was directed at prepping the canal for cementing.

While the cement was being prepared on the back table, the canal was pulse lavaged and brushed x 3. Careful attention was directed for copious irrigation followed by excellent drying technique with suction followed by a lap packed into the canal and then later removed. The stem was placed and had excellent fit, with careful attention maintaining our alignment that we had preoperatively templated, as well as we had with our broach. We also ensured that we went very lateral with this to prevent a varus alignment of our stem. After allowing the cement to dry, a trial was performed and we chose the 1.5 head. Prior to placing our definitive head we cleaned off the acetabulum and placed the definitive acetabular liner with the lip being posterior and inferior. After this copious irrigation with pulse lavage was introduced. The stem was dried impeccably and then the head was placed in the usual fashion. The hip was reduced and we were happy with the alignment, as well as the stability in all planes.

A 1/4 inch Hemovac drain was placed. The wound was closed with the pyriformis and the short external rotators being reapproximated to their insertions with #1 Vicryl. This was after the capsule was loosely approximated with #1 Vicryl. The stitch to reapproximate the external rotators all the way down to the gluteus maximus was a running #1 Vicryl suture. Next, the fascia lata was closed with #1 Vicryl, with careful attention to prevent inadvertent suturing of the drain. We tested the drain prior to leaving the operating room. After closure of the fascia lata, 0 Vicryl was used to close the deeper layer, followed by 2-0 undyed Vicryl, followed by staples for

Exhibit G4

skin. A standard sterile dressing was placed. The patient tolerated the procedure well and was gently rolled into the supine position. The down leg had excellent pulses, as well as color. An adduction pillow was placed. The patient was transferred to the recovery room in stable condition.

PLANS FOR THE PATIENT:
Weightbearing as tolerated on the right lower extremity, maintaining hip precautions at all times. The patient is aware of these directions and expresses understanding of the above.

JOB:3855 D:05/05/95 T:05/09/95

Signature & Titles: HAYES,WILLIAM Date: Signed Ward:

Patient Name: PACHECO, ANTONIO SSN: [redacted] DOB:

VAMC, ALBUQUERQUE, NM

SF 516 OPERATION REPORT
March 1993

Exhibit H

SURGICAL RECORD | SURGICAL PATHOLOGY Pg 1

Submitted by: OR Date obtained: MAY 5, 1995 09:00

Specimen (Received MAY 5, 1995 14:11):
1. RT. HIP BONE & ACETABULUM

Brief Clinical History:
RIGHT THA.

Preoperative Diagnosis:
SAME.

CHART

Operative Findings:
SAME.

Postoperative Diagnosis:
SAME.

Surgeon/physician: WILLIAM M HAYES

PATHOLOGICAL REPORT

Laboratory: VAMC ALBUQUERQUE,NM Accession No. S-95 2428

Gross description: Pathology Resident: MADHU DAHIYA md

RECEIVED IN FORMALIN, LABELED WITH THE PATIENT'S NAME AND NUMBER AND "RIGHT HIP BONE", IS A PORTION OF THE RIGHT FEMORAL HEAD MEASURING 4.5 X 4.5 X 5.1 CM. THE ARTICULAR SURFACES ARE EBURNATED AND THE CUT SURFACES REVEAL HOMOGENEOUS, YELLOW TO RED, CORTICAL BONE. REPRESENTATIVE SECTIONS SUBMITTED FOR DECALCIFICATION IN ONE CASSETTE. (MD)

COPY

Microscopic exam/diagnosis:
CROSS SECTIONS OF BONE SHOW MARKED EBURNATION AND FIBRILLATED DEGENERATIVE AREAS OF HYALIN CARTILAGE OVERLYING CORTICAL AND TRABECULAR BONE. ^SUBCHONDRAL CYST IS PRESENT AND FIBROUS PANNUS EXTENDS WITHIN THE MARROW SPACES. NO HEMATOPOIETIC TISSUE IS SEEN. THE TRABECULAR BONE IS FOCALLY SCLEROTIC. NO SIGNIFICANT INFLAMMATION AND NO MALIGNANCY IS SEEN.

DIAGNOSIS: BONE, HIP, RIGHT ACETABULUM AND HEAD; EXCISION:
- DEGENERATIVE JOINT DISEASE

SNOMED code(s):
T-02000: skin of lower extremity
N-50000: degeneration
T-11700: bone of lower extremity
N-50000: degeneration

EHaeemo
5-17-95

ELISA R HALL MD

(End of report)
sej: Date MAY 17, 1995

PACHECO,ANTONIO STANDARD FORM 515
ID: [redacted] , SEX:M DOB:11/26/19 AGE:75 LOC:4D ORTHO
ADM:MAY 4, 1995 DX:DJD RIGHT HIP WILLIAM M HAYES

PATIENT NAME	AGE	SEX	RACE	SSN	CLAIM NUMBER
PACHECO,ANTONIO	75	M	HISP	[redacted]	

ADM DATE	DISC. DATE	TYPE OF RELEASE	INP	ABS	WARD NO
MAY 04, 1995	MAY 19, 1995	NON-SERV (OPT-NSC)	15	0	4D REHAB

MAY 18, 1995 ADDENDUM:

NOTE: This discharge summary covers the period of 5/8/95 to 5/19/95.

ADMITTING DIAGNOSIS: Osteoarthritis, right hip.

BRIEF HISTORY: Antonio Pacheco is a 75-year-old Hispanic-American male with complaint of right hip pain which has been progressive over several years. He reports pain located in the groin which radiates to the right thigh. The pain is constant and is increased by exercise, walking or lying on the right hip. Additionally, sitting causes exacerbation of pain. He currently uses a cane and also reports that the hip sometimes gives out. He also has a history of night pain. Nonsteroidal anti-inflammatories were not helpful. He has donated two units of autologous blood prior to admission.

The patient also reports of having a history being positive for RPR as well as having a history of antihepatitis C globulin present. He denies, however, any knowledge of having syphilis or hepatitis.

PAST MEDICAL HISTORY: (Per patient) Positive RPR, and positive anti-HBC.

PAST SURGICAL HISTORY: Lumbar diskectomy.

ALLERGIES: NO KNOWN DRUG ALLERGIES.

MEDICATIONS: None.

SOCIAL HISTORY: Positive tobacco use, one pack per day times 60 years.

PHYSICAL EXAMINATION: General, alert and oriented times four male, afebrile. Vital signs stable. Chest is clear to auscultation bilaterally. Cardiovascular rate and rhythm are regular without murmurs, gallops or rubs. Abdomen, positive bowel sounds, flat, soft, nontender, nondistended. Extremities, right hip incisions without drainage, erythema or signs and symptoms of infection. There is active hip flexion extension as well as active knee and ankle dorsiflexion, plantar flexion. Dorsalis pedis pulses are +2/4.

HOSPITAL COURSE: The patient was transferred to the Physical Medicine and Rehabilitation Service on 5/8/95 where he continued his

Community 1ST Bank Las Vegas
P.O. Box 100 / 600 Douglas
N.M. 87701

A FULL SERVICE BANK

exhibit 5

Date 4/10/12 Page 1
** Duplicate Statement

Each depositor insured to at least $250,000 FDIC

If you haven't seen our new website or tried some of its new features, please stop by www.cfblv.com. We are also going "GREEN" with the introduction of E-statements later this year.

---- CHECKING ACCOUNTS ----

---- DEPOSITS ----

3/30	XXVA BENEF US TREASURY 310 3111036002 03/30/12 TRACE #-111036006232554	3,545.00

---- DESCRIPTIVE DEBITS ----

Exhibit K1

Rating Decision	*Department of Veterans Affairs ALBUQUERQUE REGIONAL OFFICE*			Page 1 08/02/2006	
NAME OF VETERAN: Antonio Pacheco	VA FILE NUMBER: [redacted]	SOCIAL SECURITY NR: [redacted]	POA: PRIVATE ATTORNEY WITH EXCLUSIVE CONTACT		COPY TO

ACTIVE DUTY			
EOD	RAD	BRANCH	CHARACTER OF DISCHARGE
01/06/1942	11/02/1945	Army	Honorable

LEGACY CODES			
ADD'L SVC CODE	COMBAT CODE	SPECIAL PROV CDE	FUTURE EXAM DATE
	1	4	None

JURISDICTION: New Claim Received 01/20/2006

ASSOCIATED CLAIM(s): 020; Special Monthly Compensation; 01/20/06

SUBJECT TO COMPENSATION (1. SC)

5054 RESIDUALS FROM INJURY; TOTAL RIGHT HIP REPLACEMENT (CLAIMED AS RIGHT HIP (LEG) DISORDER)
Service Connected, World War II, Incurred
90% from 01/23/2002

5275 PELVIC ASYMMETRY PRODUCING A MECHANICAL SHORT LEFT LEG ASSOCIATED WITH RESIDUALS FROM INJURY, TOTAL RIGHT HIP REPLACEMENT (CLAIMED AS RIGHT HIP (LEG) DISORDER)
Service Connected, World War II, Secondary
10% from 01/23/2002

COMBINED EVALUATION FOR COMPENSATION :

100% from 01/23/2002 (Bilateral factor of 9.1 Percent for diagnostic codes 5054, 5275)

SPECIAL MONTHLY COMPENSATION :

K-1 Entitled to special monthly compensation under 38 U.S.C. 1114, subsection (k) and 38 CFR 3.350(a) on account of loss of use of one foot from 01/23/2002.

L-1 Entitled to special monthly compensation under 38 U.S.C. 1114, subsection (l) and 38 CFR 3.350(b) on account of being so helpless as to be in need of regular aid and attendance while not hospitalized at U.S. government expense from 01/20/2006.

Exhibit K2

Rating Decision	*Department of Veterans Affairs ALBUQUERQUE REGIONAL OFFICE*	Page 2 08/02/2006

NAME OF VETERAN	VA FILE NUMBER	SOCIAL SECURITY NR	POA	COPY TO
Antonio Pacheco			PRIVATE ATTORNEY WITH EXCLUSIVE CONTACT	

EFFECTIVE DATE	BASIC	HOSPITAL	LOSS OF USE	ANAT. LOSS	OTHER LOSS
01/23/2002	01	01	13	00	0
01/20/2006	04	49	00	00	4

NOT SERVICE CONNECTED/NOT SUBJECT TO COMPENSATION (8.NSC World War II)

5299-5201 IMPAIRMENT, RIGHT ARM
Not Service Connected, Not Incurred/Caused by Service

6100 HEARING LOSS
Not Service Connected, Not Incurred/Caused by Service
0%

6304 MALARIA
Not Service Connected, Not Incurred/Caused by Service
0%

PENSION ENTITLEMENT DECISIONS (2 PT, 9 NOT PT, 11A, and 11B)

Permanent and Total for NSC from 01/01/1974

SPECIAL MONTHLY PENSION:

Veteran A&A - Not At Government Expense from 09/14/1998

DISABILITIES CONSIDERED FOR PENSION PURPOSES ONLY

5111 LOSS OF USE OF LEFT HAND AND OF LEFT LEG, CERVICAL SPONDYLITIC MYELOPATHY
Pension
100%

COMBINED EVALUATION FOR PENSION: 100% (Bilateral factor of 9.1 Percent for diagnostic codes 5054, 5275)

ANCILLARY DECISIONS

Basic Eligibility under 38 USC Ch 35 from 01/23/2002

5. Did the Board apply the wrong **law or regulation** in making its decision? _______ If so, what law or regulation should the Board have applied?

6. Are there any **other reasons** why you think the Board decision is wrong? _______ If so, what are those reasons?

7. What **action** do you want this Court to take?

8. Did you attach any extra pages to this brief? yes If so, how many pages? 21

Date: 11/16/12

Appellant's signature: Antonio Pacheco

Address: 31 C 32 Box 420 Trujillo Route Las Vegas. N.M. 87701

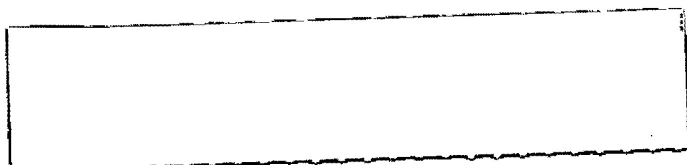
Phone No.: 575-641-3807

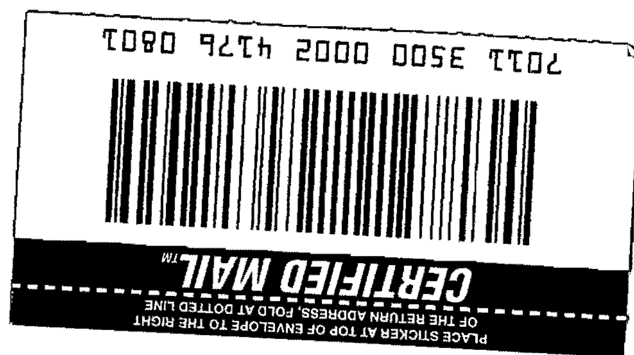
Mail this completed form to:

U.S. Court of Appeals for Veterans Claims
625 Indiana Avenue, NW, Suite 900
Washington, DC 20004

Form 9
(Rev. 9/11)

Antonio Pacheco
HC 32 BOX 420
LAS Vegas. N.M. 87701





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for Veterans Claims
625 Indiana Avenue N.W Suite 900
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