DEPARTMENT OF THE NAVY
BOARD FOR CORRECTION OF NAVAL RECORDS
2 NAVY ANNEX
WASHINGTON DC 20370-5100

JRE
Docket No: 5912-00
18 September 2001

[redacted]

Dear [redacted]

This is in reference to your application for correction of your naval record pursuant to the provisions of title 10 of the United States Code, section 1552.

A three-member panel of the Board for Correction of Naval Records, sitting in executive session, considered your application on 30 August 2001. Your allegations of error and injustice were reviewed in accordance with administrative regulations and procedures applicable to the proceedings of this Board. Documentary material considered by the Board consisted of your application, together with all material submitted in support thereof, your naval record and applicable statutes, regulations and policies.

After careful and conscientious consideration of the entire record, the Board found that the evidence submitted was insufficient to establish the existence of probable material error or injustice. In this connection, the Board substantially concurred with the rationale of the hearing panel of the Physical Evaluation Board which heard your case on 22 September 1999. A copy of the rationale is enclosed. The Board was not persuaded that the rating you received for your arm condition was inadequate, or that your back condition was unfitting and ratable. Accordingly, your application has been denied. The names and votes of the members of the panel will be furnished upon request.

It is regretted that the circumstances of your case are such that favorable action cannot be taken. You are entitled to have the Board reconsider its decision upon submission of new and material evidence or other matter not previously considered by the Board. In this regard, it is important to keep in mind that a presumption of regularity attaches to all official

records. Consequently, when applying for a correction of an official naval record, the burden is on the applicant to demonstrate the existence of probable material error or injustice.

Sincerely,

W. DEAN PFEIFFER
Executive Director

Enclosure

SAN DIEGO FORMAL PEB RATIONALE
IN THE CASE OF

[redacted]

A medical board met at Naval Medical Clinic, Pearl Harbor, Hawaii on 30 March 1999 with the following diagnoses:

1. Permanent stationary disability left elbow status post Mason III fracture ORIF (8124)
2. Permanent stationary disability L5 disk annular tear (8460)

The informal Physical Evaluation Board found the member unfit for duty on 19 July 1999 under VA Code 5209, rated his condition at 20% disability and separation with severance pay.

This member appeared before the formal Physical Evaluation Board on 22 September 1999 requesting to be found unfit for duty under VA Codes 5209 at 40% and 5295 at 20% for a total of 60% and placed on the TDRL.

Accepted documentary evidence consisted of:

Exhibit A - PEB Case File
Exhibit B - Additional Medical Evidence
Exhibit C - Medical Update from MAJ Meter, MC, USA, dtd 26 Aug 99
Exhibit D - Ltr from CAPT Seybold, USMC, dtd 17 Sep 99
Exhibit E - Various Letters of Support

The member's medical board of 30 March 1999 reports diagnoses of permanent stationary disability left elbow status post Mason III fracture and permanent stationary disability L5 disk annular tear. The member requests ratings for both diagnoses. He was originally injured in a skiing accident in August 1998.

With regard to the member's elbow, the medical board carefully documents the member's injury and his current fixed disability. The range of motion was last reported as a left arm at constant flex of 110 degrees extending only to 30 degrees down with pronation neutral and supination to 45 degrees. There was also reported to be some decreased muscle strength 3+/5 in that arm.

The member requested a rating of 40% under VA Code 5209. This is the appropriate code and the one that was used by the informal board. But this code only has two possible ratings, 20% for a marked cubitus varus or cubitus valgus deformity. This is what the member has. The only other alternative is 60% (for major side) for a flail joint which the member does not have. Thus, the member cannot be rated at 40% and is fairly rated at 20%.

With regard to the member's back, he testified that this is actually the worse injury. He said the biggest problem was with sitting. However,

Enclosure (1)

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the member sat throughout the entire hearing comfortably without changing position. The medical board reports an orthopedic evaluation of 20 January 1999, when the member complained of back pain worsened with prolonged sitting. The medical board also notes that the member does have an annular tear at the L5 level. However, the physical examination in the medical board notes that the member had a negative straight leg raise test and no tenderness to palpation with only limited right rotation. There is no report of decreased strength, abnormal reflexes, or muscle wasting in the lower extremities. Finally, an MRI of 12 February 1999 showed no evidence of nerve impingement or disk herniation.

Exhibit B contains extracts from the member's medical record since the medical board. The member claimed that he was on heavy medication every day and had lost his life because of his back pain. However, there are only two visits recorded in the medical record for low back pain. These were on 20 April 1999 and 10 August 1999. In neither visit is there evidence that the member had abnormal reflexes, muscle wasting, or muscle weakness in his lower extremities. Further, on the 20 April visit, the member was given Roxicet 9 tablets with no refills and Flexoril 9 tablets with no refills. On 10 August, the member was given Roxicet 20 tablets to take every 6 hours or about a 5 day supply. He was also given Motrin 30 tablets to take every 8 hours which would be about a 10 day supply and there is no evidence he was given any refills. Thus, the documentary record suggests that there has never been any significant disability from the member's back pain.

In sum, the member has a permanent stationary disability of his left elbow which has been appropriately rated by the informal board. The member also has evidence of an L5 annular tear that has required occasional pain medications. There is no evidence of any neurologic deficit and no indication that the member requires surgery or any further treatment at this time. There is no indication that this has ever been a separately unfitting condition. Therefore, after careful consideration of all relevant medical evidence, the formal board finds the member unfit for continued naval service and recommends that he be separated and rated under VA Code 5209 at 20% for his stationary disability of his left elbow.

Enclosure (1)