

FACTUAL HISTORY

This case has previously been before the Board. The facts and circumstances of the case as set forth in the Board's prior decision are hereby incorporated by reference.²

On January 7, 1983 appellant, then a 34-year-old clerk, sustained a right knee contusion and synovitis and permanent aggravation of degenerative disease of the right knee in the performance of duty. The Office paid medical and compensation benefits.

In a statement of accepted facts dated November 7, 2005, the Office noted that appellant was injured on January 7, 1983 when he was pulling a nutting truck and the pulley on the end of the truck struck his right leg. The statement of accepted facts noted that appellant's claim had been accepted for synovitis of the right knee and meniscus tear and repair of the right knee. The statement also noted that his claim for a March 5, 1984 injury was accepted for cervical sprain/strain and right shoulder contusion and was later accepted for lumbosacral strain and lumbar herniated nucleus pulposus. The statement noted that appellant was currently receiving temporary total disability benefits.

The Office referred appellant to Dr. Martyn A. Goldman, a Board-certified orthopedic surgeon, for a second opinion. Dr. Goldman was asked to address the relationship of his current right knee condition to the January 7, 1983 injury and to note the extent of any remaining disability. In a January 10, 2006 assessment, she opined that changes in appellant's right knee were the result of his medial meniscectomy in 1981, his excess weight and the apparent proclivity to osteoarthritis changes perhaps of a genetic nature. Appellant did not find any medical restrictions as a result of the January 7, 1983 injury, noting that the condition in his right knee was due to his preexisting injury to his right knee as well as osteoarthritic changes of the spine as a result of the normal aging process.

On January 30, 2006 the Office referred appellant for an impartial medical examination to Dr. Stanley William Collis, a Board-certified orthopedic surgeon and impartial medical examiner, to determine the extent of disability remaining as a result of the work-related injury that occurred on January 7, 1983. Specifically, it asked Dr. Goldman to determine if the work-related conditions of synovitis and meniscus tear/repair of the right knee, cervical sprain/strain and right shoulder contusion had resolved. In his report of March 24, 2006, Dr. Collis made the following diagnoses with regard to appellant's right knee: postmeniscectomy of the medial meniscus on the right knee due to the 1981 nonwork-related injury; and temporary synovitis on the right knee due to the January 7, 1983 incident at work, which had resolved. He specifically noted that appellant's right knee arthritis and chondroplasty were not the result of appellant's January 7, 1983 work injury, found that the temporary synovitis of the right knee due to the

² See Docket No. 06-1869 (issued March 17, 2006) (the Board found that the Office's decision denying appellant's request for reconsideration of a decision denying his claim for an emotional injury or injuries to his jaw and ankle was untimely filed and failed to demonstrate clear evidence of error); Docket No. 03-1382 (issued November 28, 2003) (Order Dismissing Appeal as identical issues were addressed by the Board in Docket No. 03-1276); Docket No. 03-1276 (issued October 23, 2003) (the Board found that appellant had not established that he sustained injuries to his jaw and ankle or an emotional condition causally related to the accepted injuries. The Board also affirmed the Office's decision denying reconsideration); Docket No. 00-2068 (issued June 3, 2002) (the Board remanded the case for the Office to consider appellant's request for reconsideration as it was timely filed).

accepted injury had resolved and concluded that appellant no longer had any employment-related impairment restrictions.

On July 18, 2006 the Office terminated appellant's wage-loss compensation and medical benefits effective that date. In the Board's decision dated December 19, 2008,³ it affirmed the Office's termination of medical and compensation benefits effective July 18, 2006. The Board further found that appellant had not met his burden of proof to establish that he had any continuing disability after July 18, 2006.

By letter dated January 12, 2010, appellant, through his attorney, requested reconsideration. Appellant's attorney argued that none of the physicians were properly instructed in statements of accepted facts that appellant's claim had been accepted for permanent aggravation of degenerative disease of the right leg and there was nothing in the record to indicate that his permanent aggravation was vacated. Appellant's attorney acknowledged that the appeal was filed over one year from the last merit decision, but stated that the legal basis for the last decision was incorrect. He contended that this was not a factual matter but a matter of law.

By decision dated March 24, 2010, the Office denied appellant's request for reconsideration as it was not timely filed and failed to establish clear evidence of error.

LEGAL PRECEDENT

To be entitled to a merit review of an Office decision denying or terminating a benefit, a claimant must file his application for review within one year of the date of that decision.⁴ The Board has found that the imposition of the one-year limitation does not constitute an abuse of the discretionary authority granted the Office under section 8128(a) of the Act.⁵

The Office, however, may not deny an application for review solely on the grounds that the application was not timely filed. When an application for review is not timely filed, the Office must nevertheless undertake a limited review to determine whether the application establishes clear evidence of error.⁶ Office regulations and procedure provide that the Office will reopen a claimant's case for merit review, notwithstanding the one-year filing limitation set forth in 20 C.F.R. § 10.607(a), if the claimant's application for review shows clear evidence of error on the part of the Office.⁷

³ Docket No. 08-780 (issued December 19, 2008).

⁴ 20 C.F.R. § 10.607(a).

⁵ 5 U.S.C. § 8128(a); *Leon D. Faidley, Jr.*, 41 ECAB 104, 111 (1989).

⁶ *See* 20 C.F.R. § 10.607(b); *Charles J. Prudencio*, 41 ECAB 499, 501-02 (1990).

⁷ 20 C.F.R. § 10.607(b); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Reconsiderations*, Chapter 2.1602.3d (January 2004). Office procedure further provides the term clear evidence of error is intended to represent a difficult standard. The claimant must present evidence which on its face shows that the Office made an error (for example, proof that a schedule award was miscalculated). Evidence such as a detailed, well-rationalized medical report which, if submitted before the denial was issued, would have created a conflict in medical opinion requiring further development, is not clear evidence of error. *Id.* at Chapter 2.1602.3c.

To establish clear evidence of error, a claimant must submit evidence relevant to the issue which was decided by the Office.⁸ The evidence must be positive, precise and explicit and must manifest on its face that the Office committed an error.⁹ Evidence which does not raise a substantial question concerning the correctness of the Office's decision is insufficient to establish clear evidence of error.¹⁰ It is not enough merely to show that the evidence could be construed so as to produce a contrary conclusion.¹¹ This entails a limited review by the Office of how the evidence submitted with the reconsideration request bears on the evidence previously of record and whether the new evidence demonstrates clear error on the part of the Office.¹² To show clear evidence of error, the evidence submitted must not only be of sufficient probative value to create a conflict in medical opinion or establish a clear procedural error, but must be of sufficient probative value to *prima facie* shift the weight of the evidence in favor of the claimant and raise a substantial question as to the correctness of the Office decision.¹³

ANALYSIS

The Board finds that the Office properly determined that appellant failed to file a timely request for reconsideration. The Office's procedures provide that the one-year-time limitation period for requesting reconsideration begins on the date of the original Office decision.¹⁴ However, a right to reconsideration within one year also accompanies any subsequent merit decision on the issues¹⁵ including a merit decision of the Board.¹⁶ The most recent merit decision was the December 19, 2008 decision of the Board. Appellant had one year from the date of this decision to make a timely request for reconsideration. Since he did not file a request until January 12, 2010, the Board finds that his request was filed outside the one-year time period.

As appellant's request was untimely, he must submit evidence or argument that shows clear evidence of error in the Office's decision denying reconsideration. In requesting reconsideration, appellant did not submit any new factual evidence. However, a letter from appellant's attorney was received wherein he argues that the physicians, including the impartial medical examiner, were not made aware that the Office accepted appellant's claim for permanent aggravation of degenerative joint disease and that, accordingly, the case was not properly developed.

⁸ See *Dean D. Beets*, 43 ECAB 1153, 1157-58 (1992).

⁹ See *Leona N. Travis*, 43 ECAB 227, 240 (1991).

¹⁰ See *Jesus D. Sanchez*, 41 ECAB 964, 968 (1990).

¹¹ See *Leona D. Travis*, *supra* note 9.

¹² See *Nelson T. Thompson*, 43 ECAB 919, 922 (1992).

¹³ *Leon D. Faidley, Jr.*, *supra* note 5.

¹⁴ 20 C.F.R. § 10.607(a); see *A.F.*, 59 ECAB 714 (2008); *Alberta Dukes*, 56 ECAB 247 (2005).

¹⁵ *D.G.*, 59 ECAB 455 (2008); *Robert F. Stone*, 57 ECAB 292 (2005).

¹⁶ See Federal (FECA) Procedure Manual, *supra* note 7.

The Office accepted appellant's claim for permanent aggravation of degenerative joint disease of the right knee. In a statement of accepted facts dated November 7, 2005, it noted that appellant's claim had been accepted for synovitis of the right knee and meniscus tear and repair of the right knee as a result of his January 7, 1983 claim. The Office also noted that his claim for a March 5, 1984 employment injury was accepted for cervical sprain/strain and right shoulder contusion and was later accepted for lumbosacral strain and lumbar herniated nucleus pulposus. However, this statement of accepted facts does not mention that appellant's claim was accepted for permanent aggravation of degenerative joint disease. On December 13, 2005 the Office referred appellant to Dr. Goldman for a second opinion. In his opinion, Dr. Goldman, *inter alia*, advised that changes in appellant's right knee were the result of his medial meniscectomy in 1981, his excess weight and the apparent proclivity to osteoarthritis changes perhaps of a genetic nature. He did not find that appellant had any medical restriction as a result of the January 7, 1983 employment injury, noting that these would be due to the preexisting injury to the right knee and his osteoarthritic changes of the spine as a result of the normal aging process. When the Office referred appellant to the impartial medical examiner, Dr. Collis, on January 30, 2006, it asked him to determine if the work-related conditions of synovitis and meniscus tear/repair of the right knee, cervical sprain/strain and right shoulder contusion had resolved but did not ask about the degenerative joint disease in the right knee. In his March 24, 2006 report, Dr. Collis found that appellant's work-related conditions of synovitis/meniscectomy repair of the right knee, cervical sprain/strain and right shoulder contusion had resolved. Neither Dr. Goldman nor Dr. Collis made any indication that they understood that appellant's claim had been accepted for permanent aggravation of degenerative joint disease of the right knee. The Board finds that the Office's failure to provide an accurate statement of accepted facts to the second opinion physician and the impartial medical examiner, advising these physicians that appellant's claim was accepted for permanent aggravation of degenerative disease of the right knee constituted error. Pursuant to the Office's regulations, a statement of accepted facts must clearly and accurately address the relevant information.¹⁷ An essential element of the statement of accepted facts is listing the accepted conditions.¹⁸ As pointed out by counsel, the statement of accepted facts did not contain a complete list of accepted conditions, the second opinion physician and the impartial medical examiner did not have the complete information to make a reasoned and informed opinion.

The evidence submitted has a precise and explicit bearing on the evidence previously of record. As such, the Board finds that such information raises a substantial question as to the correctness of the Office decision and therefore has sufficient probative value to shift the weight in favor of appellant.¹⁹

CONCLUSION

The Board finds that appellant has established clear evidence of error on the part of the Office and that the case must be remanded for consideration of the merits.

¹⁷ *Id.* at Chapter 2.809.2 (September 2009).

¹⁸ *Id.* at Chapter 2.0809.5(g).

¹⁹ *Pasquale C. D'Arco*, 54 ECAB 560 (2003).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated March 24, 2010 is reversed and remanded for additional development of the medical evidence consistent with this decision of the Board.

Issued: April 26, 2011
Washington, DC

Alec J. Koromilas, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board