United States Department of Labor
Employees' Compensation Appeals Board

M.M., Appellant	)	
and	)	**Docket No. 20-0537**
	)	**Issued: September 24, 2020**
DEPARTMENT OF THE NAVY, NAVAL EXPEDITIONARY MEDICAL SUPPORT COMMAND, Williamsburg, VA, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
JANICE B. ASKIN, Judge
PATRICIA H. FITZGERALD, Alternate Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On January 8, 2020 appellant filed a timely appeal from a July 12, 2019 nonmerit decision of the Office of Workers' Compensation Programs (OWCP). As more than 180 days has elapsed from OWCP's last merit decision, dated June 27, 2018, to the filing of this appeal, pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board lacks jurisdiction over the merits of this case.[2]

[1] 5 U.S.C. § 8101 *et seq.*

[2] The Board notes that, following the July 12, 2019 decision, OWCP received additional evidence. However, the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *Id.*

ISSUE

The issue is whether OWCP properly denied appellant's request for reconsideration of the merits of his claim, finding that it was untimely filed and failed to demonstrate clear evidence of error.

FACTUAL HISTORY

On September 2, 2008 appellant, then a 49-year-old inventory management specialist, filed a traumatic injury claim (Form CA-1) alleging that on that day he sustained a right ankle injury when he slipped on loose rocks and twisted his ankle while in the performance of duty. He stopped work on the date of the alleged injury. OWCP accepted appellant's claim for right ankle sprain, deltoid ligament; knee sprain, lateral collateral ligament; and right venous embolism and deep vein thrombosis (DVT) of the right lower extremity.

Appellant continued to receive medical treatment. In a September 16, 2016 office note, Dr. Matthew Hopson, a podiatrist, related appellant's complaints of right ankle pain and noted an onset of 20 years ago. Upon examination of appellant's right ankle, he observed pain on range of motion with instability along the distal portion and varicose veins on the medial aspect of the right ankle. Dr. Hopson related that a right ankle x-ray examination revealed joint space narrowing osteoarthritic changes along the right ankle joint and small old avulsion fractures along the medial lateral aspects of the ankle. He diagnosed post-traumatic osteoarthritis of the right ankle and joint and right ankle and joint pain.

In an October 17, 2016 office note, Dr. Hopson indicated that appellant was seen for follow-up of right ankle pain and noted an onset of 20 years ago. He noted examination findings of right ankle pain and instability along the right ankle joint and assessed post-traumatic osteoarthritis of the right ankle and foot. Dr. Hopson related that appellant was scheduled for a right ankle stabilization procedure and ankle arthroscopy.

In a November 16, 2016 examination report, Dr. John Paschold, a Board-certified internist who specializes in hematology and medical oncology, related that appellant was seen for follow-up of his hypercoagulable state and noted his complaints of DVT. He reviewed appellant's history and conducted an examination. Dr. Paschold diagnosed DVT disorder and factor V leiden mutation disorder.

On March 27, 2017 appellant requested authorization for right ankle arthroscopy surgery.

In a March 28, 2017 letter, OWCP advised appellant that it would be unable to authorize his request for right ankle arthroscopic surgery and repair of the right ankle ligament. It noted that the request was not accompanied by an explanation as to why the requested procedure was necessary to treat the accepted employment injury.

In an April 11, 2017 letter, Dr. Hopson indicated that a 2011 magnetic resonance imaging (MRI) scan of the right ankle verified arthritic changes along the ankle joint and a torn anterior talofibular ligament (ATF) ligament. He related that appellant did not have any MRI scan imaging from the September 2, 2008 sprain to verify if the torn ligament happened during that incident.

Dr. Hopson reported that the last several years with a torn ligament had led to further instability and arthritic changes along the ankle joint. He explained that he proposed to do a lateral ankle stabilization and repair the torn ligament in order to prevent or, at least, slow the process of further osteoarthritic changes in appellant's ankle. Dr. Hopson reported that the surgery would benefit appellant and slow the arthritic process down to hopefully prevent further surgery on the right ankle joint.

In an April 13, 2017 letter, appellant explained that he sprained his ankle while he was on active duty in the Navy in 1985. He also related that he fractured his right ankle in 2003, for which he had an accepted workers' compensation claim under OWCP File No. xxxxxx179.[3]

By decision dated April 20, 2017, OWCP denied authorization for right ankle arthroscopy surgery and repair. It found that the medical evidence of record was insufficient to establish that the proposed surgery was necessary to treat his September 2, 2008 employment injury.

Appellant subsequently submitted additional medical evidence.

In a May 17, 2017 note, Dr. Paschold noted appellant's diagnoses of DVT disorder and factor V Leiden mutation disorder. He reviewed appellant's history and provided examination findings. Dr. Paschold discussed appellant's laboratory and pathology results.

In a November 20, 2017 report, Dr. Hopson related appellant's complaints of worsening right ankle pain. He reviewed appellant's history, noted examination findings, and discussed diagnostic testing results. Dr. Hopson assessed right ankle post-traumatic osteoarthritis and right ankle pain. He reported that appellant may no longer be a candidate for an ankle joint arthroscopy, but may need to have the ankle joint fused or replaced.

Appellant underwent a right ankle computerized tomography (CT) scan on November 30, 2017, which revealed moderate ankle joint osteoarthritis, chronic ossifications suggestive of remote anterior inferior tibiofibular (AITF), ATF, deep deltoid ligament injury, and mild posterior and middle subtalar joint osteoarthritis.

In a December 5, 2017 report, Dr. Hopson indicated that appellant's CT scan revealed osteoarthritic changes along the right ankle joint and the chronic ossifications along the ATF ligament consistent with the old ankle sprain injury, which has subsequently sclerosis. He explained that after lengthy discussion about an ankle implant *versus* ankle joint fusion due to the arthritic condition of the subtalar joints, appellant opted for the joint replacement.

In a January 3, 2018 report, Dr. Michael E. Landis, a Board-certified vascular surgeon, recounted that appellant had a history of remote right ankle injury, recurrent chronic right lower extremity DVT, and chronic venous insufficiency with ulceration. He indicated that appellant continued to have moderate right lower extremity trophic changes adjacent to the medial malleolux and intermittent ulcerations. Dr. Landis noted that appellant was supposed to have right ankle

[3] Under File No. xxxxxx179, OWCP accepted that on February 7, 2003 appellant fractured his right ankle when he stepped into a hole while inspecting a vehicle while in the performance of duty. It accepted his claim for right ankle fracture. Appellant's claims have not been administratively combined.

surgery, but it had been delayed such that now Dr. Hopson was recommending joint replacement. He noted examination findings and opined that appellant appeared to be doing well clinically.

A January 18, 2018 right lower extremity venous insufficiency duplex study showed no evidence of DVT in the right common femoral, femoral, or popliteal veins.

In progress notes January 24 to March 27, 2018, Dr. Landis noted examination findings and appellant's history of venous insufficiency, DVT, and right lower leg stasis ulceration. He diagnosed chronic venous insufficiency with recurrent stasis ulceration of the right lower extremity DVT and right ankle degenerative joint disease following remote trauma. Dr. Landis noted that appellant was scheduled for right ankle joint repair/replacement with Dr. Hopson in March.

Appellant underwent additional diagnostic testing. A February 27, 2018 post-ablation venous duplex revealed successful right perforator vein closure and acute and occlusive DVT in the adjacent right 1 of 2 distal posterior tibial veins. A March 9, 2018 lower extremity venous duplex scan report revealed chronic, focal, nonocclusive deep venous thrombosis of the right popliteal vein, acute, occlusive DVT of the right distal posterior tibial and vein of the right calf.

In a March 9, 2018 examination report, Dr. Paschold noted right lower extremity examination findings of right ankle pain. He assessed DVT disorder, factor V Leiden mutation disorder, and ankle pain.

OWCP received a series of diagnostic laboratory results dated April 10, 2017 to May 9, 2018.

On June 18, 2018 appellant requested reconsideration. He asserted that while he had a 20-year-history of previous ankle injuries, his current ankle conditions were a result of his accepted September 2, 2008 right ankle sprain injury.

In a March 9, 2018 letter to Dr. Hopson, Dr. Paschold indicated that he had been treating appellant since approximately 2010 for right ankle pain. He explained that he initially thought appellant's condition may be more related to peripheral vascular disease and/or postphlebitic syndrome, but now he felt that there was probably an orthopedic component as well.

In a May 23, 2018 letter, Dr. Hopson indicated that appellant had been his patient since late 2016 and suffered from unstable ankle as a result of ATF, talofibular, and deltoid ligament damage. He explained that the damaged ligaments and instability had led to development of arthritis in the ankle joint. Dr. Hopson related that appellant's ankle joint had deteriorated to the point that repair was no longer an option and he now recommended right ankle replacement surgery. He opined that the sprain that occurred in September 2008 was a contributing factor to appellant's condition. Dr. Hopson noted that appellant's ankle condition continued to deteriorate. He concluded that ankle replacement surgery was the best option to treat appellant's current ankle condition, which had continued to deteriorate as a result of the 2008 sprain.

By decision dated June 27, 2018, OWCP denied modification of the April 20, 2017 decision.

OWCP subsequently received laboratory testing results dated July 5, 2018 to April 1, 2019.

Additionally, appellant submitted an August 7, 2018 office visit note, wherein Dr. Hopson indicated that appellant was treated for follow-up of worsening right ankle pain. He reviewed appellant's history and provided examination findings. Dr. Hopson noted continued pain along the right ankle joint and no joint tenderness, instability, or decreased mobility. He assessed right ankle joint pain and right ankle post-traumatic osteoarthritis.

In a November 27, 2018 office note, Dr. Paschold reviewed appellant's history and noted examination findings of right medial malleolus hyperpigmentation varicosities in the extremities. He assessed DVT disorder, factor V Leiden disorder, and ankle pain.

In a May 14, 2019 report, Dr. Landis related appellant's history of chronic venous insufficiency, recurrent DVT, and arthritis in his right ankle. He indicated that appellant had been scheduled to undergo a total joint replacement, but it was canceled due to insurance constraints. Dr. Landis recounted appellant's ongoing complaints of pain and discomfort on the dorsum of his foot. He opined that this appeared to be musculoskeletal in nature, and not related to either arterial or venous insufficiency.

On June 28, 2019 appellant requested reconsideration. In a letter dated June 24, 2019, appellant requested information on how to change his doctor since Dr. Hopson no longer wanted to treat his ankle injury. He also requested that his current claim be combined with his accepted February 6, 2003 ankle injury claim because connecting the two claims would address the concerns expressed about the history of his ankle injury. Appellant also contended that three physicians had provided a well-rationalized opinion that his diagnosed post-traumatic osteoarthritis was a direct result of the 2003 fracture and the 2008 sprain. Furthermore, citing to the Federal (FECA) Procedure Manual, he alleged that his ankle sprain and subsequent post-traumatic osteoarthritis conditions were clear-cut traumatic injury claims, which did not require a fully-rationalized medical opinion.

Appellant submitted a July 8, 2011 report by Dr. Loel Z. Payne, a Board-certified orthopedic surgeon, who diagnosed talar dome osteochondritis dissecans. Dr. Payne opined that the diagnosed condition "is due to his previous inversion sprain injury several years ago." He noted that appellant remained symptomatic and recommended an MRI scan and possible surgical intervention in the form of an arthroscopic chondroplasty.

Appellant also submitted an October 22, 2018 note by Dr. Aasta Pedersen, a Board-certified orthopedic surgeon, who related appellant's complaints of left knee pain from compensating on his right ankle and continued right ankle pain. Dr. Pederson reported diagnosed conditions of left knee osteoarthritis and right ankle and foot post-traumatic osteoarthritis.

By decision dated July 12, 2019, OWCP denied appellant's reconsideration request. It found that his reconsideration request was untimely filed and failed to demonstrate clear evidence of error.

LEGAL PRECEDENT

To be entitled to a merit review of an OWCP decision denying or terminating a benefit, a request for reconsideration must be received by OWCP within one year of the date of OWCP's

decision for which review is sought.[4] Timeliness is determined by the document receipt date of the request for reconsideration as is indicated by the "received date" in the Integrated Federal Employees' Compensation System.[5] The Board has found that the imposition of the one-year time limitation does not constitute an abuse of the discretionary authority granted OWCP under section 8128(a) of FECA.[6]

OWCP may not deny a request for reconsideration solely because it was untimely filed. When a request for reconsideration is untimely filed, it must nevertheless undertake a limited review to determine whether the request demonstrates clear evidence of error.[7] OWCP regulations and procedures provide that OWCP 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 request demonstrates clear evidence of error on the part of OWCP.[8]

To demonstrate clear evidence of error, a claimant must submit evidence relevant to the issue decided by OWCP. The evidence must be positive, precise, and explicit, and it must manifest on its face that OWCP committed an error.[9] It is not enough merely to show that the evidence could be construed so as to produce a contrary conclusion.[10] This entails a limited review by OWCP of how the evidence submitted with the reconsideration request bears on the evidence previously of record and whether the new evidence demonstrates clear evidence of error.[11] The Board makes an independent determination of whether a claimant has demonstrated clear evidence of error on the part of OWCP such that it abused its discretion in denying merit review in the face of such evidence.[12]

OWCP's procedures further provide that the term clear evidence of error is intended to represent a difficult standard.[13] The claimant must present evidence that on its face shows that OWCP made an error (for example, proof that a schedule award was miscalculated). Evidence such as a detailed, well-rationalized medical report that, if submitted before the denial was issued,

[4] 20 C.F.R. § 10.607(a).

[5] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Reconsideration*, Chapter 2.1602.4(b) (February 2016).

[6] *G.L.*, Docket No. 18-0852 (issued January 14, 2020).

[7] 20 C.F.R. § 10.607(b); *R.S.*, Docket No. 19-0180 (issued December 5, 2019).

[8] *Id.*; Federal (FECA) Procedure Manual, *supra* note 5 at Chapter 2.1602.5(a).

[9] 20 C.F.R. § 10.607(b); *B.W.*, Docket No. 19-0626 (issued March 4, 2020); *Fidel E. Perez*, 48 ECAB 663, 665 (1997).

[10] *See G.B.*, Docket No. 19-1762 (issued March 10, 2020); *Leona N. Travis*, 43 ECAB 227, 240 (1991).

[11] *B.W.*, *supra* note 9.

[12] *Id.*; *Cresenciano Martinez*, 51 ECAB 322 (2000); *Thankamma Matthews*, 44 ECAB 765, 770 (1993).

[13] Federal (FECA) Procedure Manual, *supra* note 5 at Chapter 2.1602.5(b).

would have created a conflict in medical opinion requiring further development, is not clear evidence of error.[14]

Section 8124(a) of FECA provides that OWCP shall determine and make a finding of fact and make an award for or against payment of compensation.[15] Section 10.126 of Title 20 of the Code of Federal Regulations provides that a decision shall contain findings of fact and a statement of reasons.[16] The Board has held that the reasoning behind OWCP's evaluation should be clear enough for the reader to understand the precise defect of the claim and the kind of evidence which would overcome it.[17]

ANALYSIS

The Board finds that OWCP properly determined that appellant's request for reconsideration was untimely filed.

OWCP received appellant's request for reconsideration on June 28, 2019, which was more than one year after the last merit decision, dated June 27, 2018. As appellant's request for reconsideration was untimely filed, he must demonstrate clear evidence of error on the part of OWCP.[18]

The Board further finds, however, that OWCP did not make findings regarding the evidence that appellant submitted in support of the reconsideration request.[19]

In support of his untimely request for reconsideration, appellant submitted a July 8, 2011 report from Dr. Payne, who diagnosed talar dome osteochondritis dissecans "due to his previous inversion sprain injury several years ago." He recommended an MRI to be followed by a determination as to whether surgery was warranted. Additionally, appellant submitted an August 7, 2018 report from Dr. Hopson, an October 22, 2018 report from Dr. Pedersen, a November 27, 2018 report from Dr. Paschold, and a May 14, 2019 report from Dr. Landis regarding the medical treatment he received for his right ankle pain, DVT disorder, and right ankle post-traumatic osteoarthritis. Although OWCP acknowledged appellant's submission of the aforementioned evidence in its July 12, 2019 decision, the only report it analyzed in explaining why appellant had failed to demonstrate clear evidence of error was that of Dr. Hopson. It

[14] *G.B., supra* note 10; *A.R.*, Docket No. 15-1598 (issued December 7, 2015).

[15] 5 U.S.C. § 8124(a).

[16] 20 C.F.R. § 10.126.

[17] *C.M.*, Docket No. 19-1211 (issued August 5, 2020); *L.M.*, Docket No. 13-2017 (issued February 21, 2014); Federal (FECA) Procedure Manual Part 2 -- Claims, *Disallowances*, Chapter 2.1400.5 (February 2013) (all decisions should contain findings of fact sufficient to identify the benefit being denied and the reason for the disallowance).

[18] *Supra* note 8.

[19] *See Order Remanding Case, J.K.*, Docket No. 20-0556 (issued August 13, 2020); *Order Remanding Case, C.D.*, Docket No. 19-1962 (issued June 29, 2020).

provided no discussion relative to the remainder of the new evidence submitted by appellant.[20] Thus, the Board finds that OWCP did not comply with the review requirements of FECA and its implementing regulations.[21] Appellant, therefore, could not understand the precise defect of the claim and the kind of evidence which would overcome it.[22]

The Board will therefore set aside OWCP's July 12, 2019 decision and remand the case for findings of fact and a statement of reasons, to be followed by an appropriate decision on appellant's untimely reconsideration request.

CONCLUSION

The Board finds that OWCP properly determined that appellant's request for reconsideration was untimely filed. The Board further finds, however, that the case is not in posture for decision regarding whether appellant's reconsideration request has demonstrated clear evidence of error.

ORDER

IT IS HEREBY ORDERED THAT the July 12, 2019 decision of the Office of Workers' Compensation Programs is affirmed in part and set aside in part, and the case is remanded for further proceedings consistent with this decision of the Board.

Issued: September 24, 2020
Washington, DC

Janice B. Askin, Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Alternate Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board

[20] *See R.T.*, Docket No. 19-0604 (issued September 13, 2019); *J.K., id.*

[21] *See C.M., supra* note 17.

[22] Federal (FECA) Procedure Manual, *supra* note 17 at Chapter 2.1400.5.