

(2) whether OWCP properly denied appellant's request for reconsideration, finding that it was untimely filed and failed to demonstrate clear evidence of error.

FACTUAL HISTORY

On April 16, 2018, appellant, then a 53-year-old rural carrier associate, filed a traumatic injury claim (Form CA-1) alleging that on March 21, 2018 he experienced pain and a burning sensation in his neck, back, and shoulders, and numbness in his thumbs and forefingers when he moved newspapers from the rear of his vehicle to the front while in the performance of duty.³

By decision dated May 30, 2018, OWCP denied appellant's traumatic injury claim, finding that the medical evidence of record was insufficient to establish causal relationship between his diagnosed conditions and the accepted March 21, 2018 employment incident.

On November 9, 2018, appellant requested reconsideration and submitted medical evidence.

Appellant stopped work on December 17, 2018, and has not returned to work.

By decision dated February 5, 2019, OWCP modified the May 30, 2018 decision to find that appellant had established sprain of cervical spine ligaments; sprain of thoracic spine ligaments; sprain of lumbar spine ligaments; strain of unspecified muscle, fascia and tendon at the right arm shoulder and upper arm level; strain of unspecified muscle, fascia, and tendon at the shoulder and upper left arm; and brachial plexus disorders, as causally related to his accepted March 21, 2018 employment incident.

On April 7, 2020, OWCP referred appellant, along with a statement of accepted facts (SOAF), the medical record, and a series of questions, to Dr. Daniel P. Dare, a Board-certified orthopedic surgeon, for a second opinion examination regarding whether he had continuing work-related disability/residuals.

In a June 15, 2020 report, Dr. Dare reported findings of appellant's physical examination. He opined that appellant's accepted employment condition "appears to have resolved," and that he had no residuals. Dr. Dare further opined that further medical treatment was not necessary for the accepted conditions, but it was necessary for appellant's preexisting cervical and lumbar disc conditions. He advised that appellant could not return to his date-of-injury job, but he could work with restrictions. In an accompanying June 15, 2024 work capacity evaluation (Form OWCP-5c), Dr. Dare listed appellant's permanent work restrictions.

On July 9, 2020, OWCP requested that Dr. Dare clarify whether appellant's work restrictions were related to his preexisting conditions or the accepted employment injury.

³ On August 21, 2017, appellant had previously filed a Form CA-1 alleging that he sustained head, neck and back injuries due to an August 16, 2017 employment-related motor vehicle accident. OWCP assigned File No. xxxxxx302 and accepted the claim for cervical sprain with torticollis, post-concussion syndrome, chronic post-traumatic headache, and insomnia. The claims have not been administratively combined by OWCP.

In an addendum note dated September 8, 2020, Dr. Dare advised that appellant's need for further medical treatment and work restrictions were related to an aggravation of his preexisting conditions.

In a November 4, 2020 notice, OWCP advised appellant that it proposed to terminate his wage-loss compensation and medical benefits based on Dr. Dare's opinion that he no longer had disability or residuals causally related to his accepted March 21, 2018 employment injury. It afforded him 30 days to submit additional evidence or argument, in writing, if he disagreed with the proposed termination.

OWCP thereafter received medical reports dated December 3, 2020 from Dr. John W. Ellis, an attending physician Board-certified in family medicine. In a December 3, 2020 duty status report (Form CA-17), Dr. Ellis noted appellant's accepted conditions and advised that appellant was temporarily totally disabled from work.

In a December 3, 2020 narrative report, Dr. Ellis reviewed appellant's medical records and provided his findings on physical examination. He requested that the acceptance of appellant's claim be expanded to include the additional diagnoses of lumbar and cervical degenerative disc disease, lumbar and cervical radiculopathy, and bilateral carpal tunnel syndrome (CTS). Dr. Ellis advised that appellant was temporarily totally disabled from work due to his work-related injury.

Dr. Ellis, in a December 3, 2020 attending physician's report (Form CA-20), advised that appellant was temporarily totally disabled through the date of his current report.

OWCP also received a March 12, 2019 electromyogram/nerve conduction velocity study (EMG/NCV) of appellant's upper and lower extremities, which revealed severe median neuropathy at both wrists, no cervical radiculopathy, brachial plexopathy or ulnar neuropathy on either side, no lumbosacral radiculopathy on either side, and no generalized peripheral neuropathy.

By decision dated January 29, 2021, OWCP finalized the termination of appellant's wage-loss compensation and medical benefits, effective January 31, 2021, finding that the reports from Dr. Dare were entitled to the weight of the medical evidence and established that he had no continuing residuals or disability from work due to his March 21, 2018 employment injury.

Subsequently, OWCP received additional medical evidence, including magnetic resonance imaging (MRI) scans of the cervical, thoracic, and lumbar spines dated April 15, 2019.

On April 13, 2021, appellant requested a telephonic hearing before a representative of OWCP's Branch of Hearings and Review.

By decision dated May 4, 2021, OWCP denied appellant's request for an oral hearing, finding that it was untimely filed, pursuant to 5 U.S.C. § 8124(b). Additionally, it exercised its discretion and concluded that the issue could equally well be addressed by requesting reconsideration and submitting additional evidence.

On December 4, 2023, appellant requested reconsideration of the January 29, 2021 termination decision.

By decision dated December 14, 2023, OWCP denied appellant's December 4, 2023 request for reconsideration, finding that it was untimely filed, and failed to demonstrate clear evidence of error.

OWCP thereafter received an August 31, 2023 report, wherein Dr. Ellis recounted appellant's history of injury, reviewed medical records, and discussed findings of his physical and neurological examination. On examination of appellant's right shoulder, he observed mild atrophy appreciated over the shoulder girdle, tenderness to palpation over the subacromial joint space and subdeltoid bursa, and tenderness to palpation along the bicipital groove. Dr. Ellis also observed decreased range of motion (ROM) and decreased strength noted in all directions, indicating that flexion was 90 degrees, extension was 16 degrees, abduction was 91 degrees, adduction was 6 degrees, internal rotation (with arm abducted at 90 degrees) was 62 degrees, and external rotation (with arm abducted at 90 degrees) was 70 degrees. There was a positive Neer's and Hawkins impingement, positive belly press test, positive empty can, positive shoulder cross over, positive Gerber liftoff, negative Sulcus sign, and negative apprehension. On examination of the left shoulder, Dr. Ellis observed mild atrophy seen diffusely throughout with hollowing, localized tenderness to palpation over the subacromial joint space and subdeltoid bursa, positive Neer's and Hawkins' impingement and empty can tests, positive shoulder cross over palpation over the bicipital groove, negative empty can test, and negative sulcus sign. There was decreased strength and ROM, noting flexion was 87 degrees, extension was 18 degrees, abduction was 91 degrees, adduction was 2 degrees, internal rotation (with arm abducted at 90 degrees) was 29 degrees, and external rotation (with arm abducted at 90 degrees) was 42 degrees. Dr. Ellis noted the accepted conditions of sprain of ligaments of the cervical, thoracic, and lumbar spines; strain/sprain muscle, fascia and tendon at right and left shoulders; and brachial plexus disorder. Regarding permanent impairment to the right upper extremity, he utilized the diagnosis-based impairment (DBI) methodology of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),⁴ Table 15-5 (Shoulder Regional Grid), page 402, and found five percent impairment due to a diagnosis of right shoulder impingement syndrome. Dr. Ellis also applied the ROM rating methodology, Table 15-34, page 475, and found 12 percent impairment. Additionally, he referred to Table 15-23 (Entrapment/Compression Neuropathy Impairment), page 449, and found nine percent impairment of the right upper extremity due to carpal tunnel, median nerve entrapment compression. Dr. Ellis combined the 12 percent ROM impairment rating and 9 percent nerve impairment rating resulting in 20 percent impairment of the right upper extremity. Dr. Ellis concluded that appellant had 20 percent permanent impairment of the right upper extremity. Regarding permanent impairment to the left shoulder, he again utilized the DBI rating methodology, Table 15-5, and found five percent impairment due to left shoulder impingement syndrome. Dr. Ellis also applied the ROM rating methodology, Table 15-34, and found 17 percent impairment. Additionally, he again referred to Table 15-23 and found nine percent impairment due to carpal tunnel, median nerve entrapment compression. Dr. Ellis combined the 17 percent ROM impairment rating and 9 percent nerve impairment rating resulting in 24 percent permanent impairment of the left upper extremity. He concluded that appellant had 24 percent permanent impairment of the left upper extremity. Dr. Ellis found that appellant had reached maximum medical improvement (MMI) as of August 31, 2023, the date of his impairment evaluation.

⁴ A.M.A., *Guides* (6th ed. 2009).

On March 6, 2024, appellant filed a claim for compensation (Form CA-7) for a schedule award.

In a March 21, 2024 development letter, OWCP requested that Dr. Ellis submit a detailed medical report based on a recent examination, which included a permanent impairment rating using the sixth edition of the A.M.A., *Guides*, and addressing whether appellant had reached MMI. It afforded Dr. Ellis 30 days to submit the necessary evidence. No response was received.

In a May 7, 2024 report, Dr. Nathan Hammel, a Board-certified orthopedic surgeon serving as an OWCP district medical adviser (DMA), reviewed the medical evidence including Dr. Ellis' impairment findings. He concurred with Dr. Ellis' opinion that appellant had 20 percent permanent impairment of the right upper extremity and 24 percent permanent impairment of the left upper extremity. Regarding permanent impairment to the right upper extremity, Dr. Hammel utilized Table 15-34 on page 475 of the sixth edition of the A.M.A., *Guides* and determined that appellant had 12 percent impairment due to ROM deficits. Alternatively, using the DBI rating methodology, he found, under Table 15-5, page 402, that appellant had five percent impairment of the right upper extremity due to right shoulder impingement syndrome. Dr. Hammel, therefore, found that the ROM methodology was more appropriate as it provided the greater percentage of impairment. Referring to Table 15-23 for carpal tunnel syndrome, he assigned a grade modifier for functional history (GMFH) of 3 for severe symptoms, a grade modifier for physical examination (GMPE) of 3 for atrophy, and a grade modifier for clinical studies (GMCS) of 2 for test results. Dr. Hammel determined that the average value for the three grade modifier values was three and the GMFH allowed for nine percent impairment. He concluded that appellant had a combined right upper extremity permanent impairment of 20 percent. Regarding permanent impairment to the left upper extremity, Dr. Hammel applied Table 15-34 and found 17 percent impairment due to ROM deficits. He also applied the DBI rating methodology and found, under Table 15-5, five percent impairment of the left upper extremity due to left shoulder impingement syndrome. Dr. Hammel, therefore, found that the ROM methodology was more appropriate as it provided the greater percentage of impairment. Utilizing Table 15-23 for carpal tunnel syndrome, he assigned a GMFH of 3 due to severe symptoms, a GMPE of 3 due to atrophy, and a GMCS of 2 due to test results. Dr. Hammel determined that the average value for the three grade modifier values was three and the GMFH allowed for nine percent impairment. He concluded that appellant had a combined left upper extremity permanent impairment of 24 percent. Dr. Hammel determined that appellant had reached MMI on August 31, 2023, the date of Dr. Ellis' impairment evaluation.

By decision dated May 29, 2024, OWCP granted appellant a schedule award for 20 percent permanent impairment of the right upper extremity and 24 percent permanent impairment of the left upper extremity. The period of the award ran for 960.96 weeks from August 31, 2023 through April 17, 2026.

On July 23, 2024, appellant again requested reconsideration of the January 29, 2021 termination decision. He contended that following the issuance of OWCP's notice of proposed termination, he submitted medical evidence, including the March 12, 2019 EMG/NCV report, April 15, 2019 cervical, thoracic, and lumbar spine MRI scan reports, and Form CA-17, Form CA-20, and narrative reports dated December 3, 2020 from Dr. Ellis, which were sufficient to establish that he had continuing disability, required further medical treatment, and sustained additional conditions, causally related to his accepted March 21, 2018 employment injury. Alternatively, appellant contended that there was a conflict in the medical evidence between the opinions

expressed in the above-noted evidence and the opinion of Dr. Dare, OWCP's second opinion examiner, warranting an impartial medical evaluation.

By decision dated July 30, 2024, OWCP denied appellant's July 23, 2024 request for reconsideration of the merits of his claim, finding that it was untimely filed, and failed to demonstrate clear evidence of error.

LEGAL PRECEDENT -- ISSUE 1

The schedule award provisions of FECA⁵ and its implementing regulations⁶ set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss or loss of use of scheduled members or functions of the body. However, FECA does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants. Through its implementing regulations, OWCP adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.⁷ As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).⁸ The Board has approved the use by OWCP of the A.M.A., *Guides* for the purpose of determining the percentage loss of use of a member of the body for schedule award purposes.⁹

In addressing upper extremity impairment, the sixth edition requires identification of the class of diagnosis (CDX), which is then adjusted by grade modifiers or GMFH, GMPE, and GMCS.¹⁰ The net adjustment formula is (GMH - CDX) + (GME - CDX) + (GMS - CDX).¹¹ Under Chapter 2.3, evaluators are directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.¹²

The A.M.A., *Guides* also provide that the ROM impairment method is to be used as a stand-alone rating for upper extremity impairments when other grids direct its use or when no other diagnosis-based sections are applicable.¹³ If ROM is used as a stand-alone approach, the total of motion impairment for all units of function must be calculated. All values for the joint are

⁵ 5 U.S.C. § 8107.

⁶ 20 C.F.R. § 10.404.

⁷ *Id.*; see also *Ronald R. Kraynak*, 53 ECAB 130 (2001).

⁸ See Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); Federal Procedure Manual, Part 2 -- Claims, *Schedule Awards & Permanent Disability Claims*, Chapter 2.808.5a (March 2017).

⁹ *P.R.*, Docket No. 19-0022 (issued April 9, 2018); *Isidoro Rivera*, 12 ECAB 348 (1961).

¹⁰ A.M.A., *Guides* 383-492.

¹¹ *Id.* at 411.

¹² *Id.* at 23-28.

¹³ *Id.* at 461.

measured and added.¹⁴ Adjustments for functional history may be made if the evaluator determines that the resulting impairment does not adequately reflect functional loss and functional reports are determined to be reliable.¹⁵

Regarding the application of ROM or DBI methodologies in rating permanent impairment of the upper extremities, FECA Bulletin No. 17-06 provides:

“As the [A.M.A.,] *Guides* caution that if it is clear to the evaluator evaluating loss of ROM that a restricted ROM has an organic basis, three independent measurements should be obtained and the greatest ROM should be used for the determination of impairment, the CE [claims examiner] should provide this information (*via* the updated instructions noted above) to the rating physician(s).

“Upon initial review of a referral for upper extremity impairment evaluation, the DMA should identify: (1) the methodology used by the rating physician (*i.e.*, DBI or ROM) and (2) whether the applicable tables in Chapter 15 of the [A.M.A.,] *Guides* identify a diagnosis that can alternatively be rated by ROM. *If the [A.M.A.,] Guides allow for the use of both the DBI and ROM methods to calculate an impairment rating for the diagnosis in question, the method producing the higher rating should be used.*”¹⁶ (Emphasis in the original.)

OWCP’s procedures provide that, after obtaining all necessary medical evidence, the file should be routed to a DMA for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the DMA providing rationale for the percentage of impairment specified.¹⁷

ANALYSIS -- ISSUE 1

The Board finds that appellant has not met his burden of proof to establish greater than 20 percent permanent impairment of the right upper extremity and 24 percent permanent impairment of the left upper extremity, for which he received schedule award compensation.

In his August 31, 2023 report, Dr. Ellis opined that appellant had 20 percent permanent impairment of the right upper extremity and 24 percent permanent impairment of the left upper extremity. Under the DBI methodology for both shoulders, he found, under Table 15-5, page 402, of the A.M.A., *Guides*, that appellant had five percent impairment for a CDX of shoulder impingement syndrome. For the right shoulder, under the ROM rating methodology, Dr. Ellis determined that under Table 15-34, page 475, appellant had 12 percent impairment of the right upper extremity. For the left shoulder, under the ROM rating methodology, he determined that under Table 15-34, page 475, appellant had 17 percent impairment of the left upper extremity. Dr. Ellis opined that as the ROM impairment methodology of the A.M.A., *Guides* yielded the

¹⁴ *Id.* at 473.

¹⁵ *Id.* at 474.

¹⁶ FECA Bulletin No. 17-06 (issued May 8, 2017); *V.L.*, Docket No. 18-0760 (issued November 13, 2018).

¹⁷ *See supra* note 7 at Chapter 2.808.6f (March 2017). *See also P.W.*, Docket No. 19-1493 (issued August 12, 2020); *Frantz Ghassan*, 57 ECAB 349 (2006).

greater impairment, appellant had 12 percent impairment of the right shoulder and 17 percent impairment of the left shoulder. He further opined that under Table 15-23, page 449, appellant had nine percent bilateral impairment due to carpal tunnel, median nerve entrapment compression. Dr. Ellis combined the 12 percent ROM impairment rating and 9 percent nerve impairment rating, which yielded 20 percent permanent impairment of the right upper extremity. He also combined the 17 percent ROM impairment rating and 9 percent nerve impairment rating, which yielded 24 percent permanent impairment of the left upper extremity. Dr. Ellis concluded that appellant had 20 percent permanent impairment of the right upper extremity and 24 percent permanent impairment of the left upper extremity.

In accordance with its procedures,¹⁸ OWCP properly routed the case record to its DMA, Dr. Hammel. In his May 7, 2024 report, Dr. Hammel concurred with Dr. Ellis' 20 percent permanent impairment of the right upper extremity and 24 percent permanent impairment of the left upper extremity. He found the date of MMI to be August 31, 2023, the date of Dr. Ellis' report.

The Board finds that OWCP properly determined that appellant has not established greater than 20 percent permanent impairment of the right upper extremity and 24 percent permanent impairment of the left upper extremity based on the clinical findings and reports of Dr. Ellis and Dr. Hammel.¹⁹ There is no probative medical evidence of record demonstrating greater impairment than that previously awarded.²⁰

Appellant may request a schedule award or increased schedule award based at any time on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased permanent impairment.

LEGAL PRECEDENT -- ISSUE 2

Pursuant to section 8128(a) of FECA, OWCP has the discretion to reopen a case for further merit review.²¹ This discretionary authority, however, is subject to certain restrictions. For instance, a request for reconsideration must be received within one year of the date of OWCP's decision for which review is sought.²² Timeliness is determined by the document receipt date *i.e.*,

¹⁸ *Id.*

¹⁹ See *K.M.*, Docket No. 23-0500 (issued November 22, 2023); *A.H.*, Docket No. 23-0335 (issued July 28, 2023); *B.L.*, Docket No. 22-0068 (issued October 12, 2022); *D.S.*, Docket No. 20-0670 (issued November 2, 2021); *J.S.*, Docket No. 19-1567 (issued April 1, 2020); *J.M.*, Docket No. 18-1334 (issued March 7, 2019).

²⁰ See *K.M.*, *id.*; *A.H.*, *id.*; *B.L.*, *id.*; *D.S.*, *id.*; *D.F.*, Docket No. 17-1474 (issued January 26, 2018); *A.T.*, Docket No. 16-0738 (issued May 19, 2016).

²¹ 5 U.S.C. § 8128(a); *L.W.*, Docket No. 18-1475 (issued February 7, 2019); *Y.S.*, Docket No. 08-0440 (issued March 16, 2009).

²² 20 C.F.R. § 10.607(a).

the “received date” in OWCP’s Integrated Federal Employees’ Compensation System (iFECS).²³ Imposition of this one-year filing limitation does not constitute an abuse of discretion.²⁴

When a request for reconsideration is untimely, OWCP undertakes a limited review to determine whether the request demonstrates clear evidence that OWCP’s most recent merit decision was in error.²⁵ Its procedures provide that it will reopen a claimant’s case for merit review, notwithstanding the one-year filing limitation set forth in 20 C.F.R. § 10.607, if the claimant’s request for reconsideration demonstrates “clear evidence of error” on the part of OWCP.²⁶ In this regard, OWCP will limit its focus to a review of how the newly submitted evidence bears on the prior evidence of record.²⁷

To demonstrate clear evidence of error, a claimant must submit evidence relevant to the issue which was decided by OWCP.²⁸ The evidence must be positive, precise, and explicit and must manifest on its face that OWCP committed an error. Evidence which does not raise a substantial question concerning the correctness of OWCP’s decision is insufficient to demonstrate clear evidence of error. It is not enough merely to show that the evidence could be construed so as to produce a contrary conclusion. 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 error on the part of OWCP.²⁹

OWCP’s procedures note that the term clear evidence of error is intended to represent a difficult standard.³⁰ The claimant must present evidence which on its face demonstrates that OWCP made an error. 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.³¹ The Board makes an independent determination of whether a claimant has demonstrated clear evidence of error on the part of OWCP.³²

²³ Federal (FECA) Procedure Manual, Part 2 -- Claims, *Reconsiderations*, Chapter 2.1602.4 (September 2020).

²⁴ *W.B.*, Docket No. 23-0473 (issued August 29, 2023); *G.G.*, Docket No. 18-1072 (issued January 7, 2019); *Leon D. Faidley, Jr.*, 41 ECAB 104 (1989).

²⁵ See 20 C.F.R. § 10.607(b); *R.C.*, Docket No. 21-0617 (issued August 25, 2023); *M.H.*, Docket No. 18-0623 (issued October 4, 2018); *Charles J. Prudencio*, 41 ECAB 499 (1990).

²⁶ *L.C.*, Docket No. 18-1407 (issued February 14, 2019); *M.L.*, Docket No. 09-0956 (issued April 15, 2010). See also *id.* at § 10.607(b); *supra* note 23 at Chapter 2.1602.5 (September 2020).

²⁷ *S.D.*, Docket No. 23-0626 (issued August 24, 2023); *J.M.*, Docket No. 19-1842 (issued April 23, 2020); *Robert G. Burns*, 57 ECAB 657 (2006).

²⁸ *J.M.*, Docket No. 22-0630 (issued February 10, 2023); *S.C.*, Docket No. 18-0126 (issued May 14, 2016); *supra* note 23 at Chapter 2.1602.5a (September 2020).

²⁹ *L.J.*, Docket No. 23-0282 (issued May 26, 2023); *C.M.*, Docket No. 19-1211 (issued August 5, 2020); *J.M.*, Docket No. 19-1842 (issued April 23, 2020); *Robert G. Burns*, *supra* note 27.

³⁰ See *G.G.*, *supra* note 24; see also 20 C.F.R. § 10.607(b); *supra* note 23 at Chapter 2.1602.5 (September 2020).

³¹ *J.S.*, Docket No. 16-1240 (issued December 1, 2016); *id.* at Chapter 2.1602.5a (September 2020).

³² *G.B.*, Docket No. 19-1762 (issued March 10, 2020); *D.S.*, Docket No. 17-0407 (issued May 24, 2017); *George C. Vernon*, 54 ECAB 319 (2003).

ANALYSIS -- ISSUE 2

The Board finds that OWCP properly denied appellant's request for reconsideration, finding that it was untimely filed and failed to demonstrate clear evidence of error.

The last merit decision was issued by OWCP addressing the termination of appellant's compensation benefits, effective January 31, 2021, was January 29, 2021. As appellant's request for reconsideration was not received by OWCP until July 23, 2024, more than one year after the January 29, 2021 decision, pursuant to 20 C.F.R. § 10.607(a), the request for reconsideration was untimely filed. Consequently, he must demonstrate clear evidence of error by OWCP in denying the claim.³³

On reconsideration, appellant contended that the March 12, 2019 EMG/NCV report, April 15, 2019 cervical, thoracic, and lumbar spine MRI scan reports, and December 3, 2020 reports from Dr. Ellis were sufficient to establish that he had continuing disability, required further medical treatment, and sustained additional conditions, causally related to his accepted March 21, 2018 employment injury. Alternatively, he contended that there was a conflict in the medical evidence between the opinions expressed in the above-noted evidence and the opinion of Dr. Dare, OWCP's second opinion examiner, warranting an impartial medical evaluation. The Board finds that although the evidence referenced by appellant addressed his current conditions and provided an opinion that he was temporarily totally disabled from work and that the acceptance of his claim should be expanded to include additional conditions, it is insufficient to demonstrate clear evidence of error. As noted above, clear evidence of error is intended to represent a difficult standard.³⁴ The Board has long held that even 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.³⁵ It is merely not enough to establish that the evidence could be construed so as to produce a contrary conclusion.³⁶ Therefore, for these reasons, the Board finds that appellant's contentions are insufficient to raise a substantial question concerning the correctness of OWCP's January 29, 2021 decision.

As appellant's July 23, 2024 request for reconsideration did not show on its face that OWCP's January 29, 2021 decision contained an error, the Board finds that it fails to demonstrate clear evidence of error.³⁷

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish greater than 20 percent permanent impairment of the right upper extremity and 24 percent permanent impairment

³³ 20 C.F.R. § 10.607(b); *D.Z.*, Docket No. 25-0422 (issued June 26, 2025); *S.C.*, Docket No. 20-1537 (issued April 14, 2021); *R.T.*, Docket No. 19-0604 (issued September 13, 2019); see *Debra McDavid*, 57 ECAB 149 (2005).

³⁴ *Supra* note 30.

³⁵ *Id.*

³⁶ *Id.*

³⁷ See *L.F.*, Docket No. 25-0566 (issued August 14, 2025); *J.M.*, Docket No. 22-0630 (issued February 10, 2023); *L.N.*, Docket No. 20-0742 (issued October 26, 2020); *B.C.*, Docket No. 16-1404 (issued April 14, 2017).

of the left upper extremity, for which he received schedule award compensation. The Board further finds that OWCP properly denied appellant's request for reconsideration, finding that it was untimely filed and failed to demonstrate clear evidence of error.

ORDER

IT IS HEREBY ORDERED THAT the May 29 and July 30, 2024 decisions of the Office of Workers' Compensation Programs are affirmed.

Issued: February 26, 2026
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

Janice B. Askin, Judge
Employees' Compensation Appeals Board

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