United States Department of Labor
Employees' Compensation Appeals Board

W.E., Appellant	)	
and	)	**Docket No. 26-0322**
	)	**Issued: July 1, 2026**
DEPARTMENT OF LABOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS, Philadelphia, PA, Employer	)	

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On February 18, 2026 appellant filed a timely appeal from a January 20, 2026 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has met his burden of proof to establish greater than five percent permanent impairment of the right upper extremity (arm) and five percent permanent impairment of the left upper extremity (arm), for which he previously received schedule award compensation.

[1] 5 U.S.C. § 8101 *et seq*.

FACTUAL HISTORY

On May 6, 2020 appellant, then a 56-year-old claims examiner, filed an occupational disease claim (Form CA-2) alleging that the pain, tingling, burning, weakness, stiffness, and restricted range of motion in his bilateral fingers, hands, wrists, elbows, shoulders, cervical spine and thoracic spine were due to factors of his federal employment, including 15 years of repetitive computer-based duties. He stated that he first became aware of his condition on December 1, 2019, and that it was caused or related to his federal employment on May 5, 2020. OWCP accepted the claim for bilateral radial neuropathy, bilateral median neuropathy, and occipital neuralgia. It paid appellant wage-loss compensation for partial disability on its supplemental rolls from January 4, 2021. Appellant returned to full-time limited-duty work on April 18, 2022 and resumed full-time, regular-duty work on May 16, 2022.

On September 13, 2022 appellant filed a claim for compensation (Form CA-7) for a schedule award. No medical evidence was received in support of his schedule award claim.

In a September 19, 2022 development letter, OWCP requested that appellant submit a permanent impairment evaluation from his attending physician addressing whether he had reached maximum medical improvement (MMI) and which provided a permanent impairment rating in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[2] It afforded him 30 days to submit the necessary evidence.

On September 26, 2022 appellant advised that his treating physician did not perform permanent impairment evaluations.

On November 16, 2022 OWCP referred appellant, along with the medical record, an October 19, 2022 statement of accepted facts (SOAF), and list of questions, to Dr. Willie E. Thompson, a Board-certified orthopedic surgeon, for a second opinion regarding his work-related conditions, and to provide a permanent impairment rating.

In a December 5, 2022 report, Dr. Thompson reviewed the October 19, 2022 SOAF and medical record, and noted examination findings of the upper extremities. He diagnosed bilateral median neuropathy, left ulnar neuropathy, and right brachial plexopathy, which were supported by conduction delay and sensory/motor deficits. Dr. Thompson noted that appellant reached MMI as of December 5, 2022. For the right upper extremity, he found that under Table 15-23, page 449, of the A.M.A., *Guides*, appellant had five percent permanent impairment for median nerve neuropathy and five percent permanent impairment for ulnar nerve neuropathy. For the left upper extremity, Dr. Thompson again found that under Table 15-23, five percent permanent impairment for ulnar nerve neuropathy and five percent permanent impairment for median nerve neuropathy.

In a January 20, 2023 report, Dr. Nathan Hammel, a Board-certified orthopedic surgeon serving as an OWCP district medical adviser **(**DMA) reviewed the medical evidence, including Dr. Thompson's permanent impairment ratings. He opined that appellant reached MMI on December 5, 2022, the date of Dr. Thompson's evaluation. As the electromyography (EMG)

[2] A.M.A., *Guides* (6th ed. 2009).

showed bilateral carpal tunnel syndrome, he utilized the diagnosis-based impairment (DBI) methodology under Table 15-23 for compression neuropathy to calculate five percent bilateral permanent impairment rating of appellant's upper extremities.

By decision dated February 2, 2023, OWCP granted appellant a schedule award for five percent permanent impairment of the right upper extremity (arm) and five percent permanent impairment of the left upper extremity (arm). The date of MMI was December 5, 2022. The award covered a period of 31.2 weeks and ran from December 5, 2022 through July 11, 2023.

On April 17, 2024 appellant filed a Form CA-7 for an increased schedule award. No medical evidence was received.

In an April 29, 2024 development letter, OWCP advised appellant of the evidence required to support his schedule award claim. It afforded him 30 days to submit the requested evidence.

In a May 3, 2024 note, appellant requested that OWCP schedule a second opinion examination as his physician did not perform permanent impairment ratings.

On October 21, 2024 OWCP referred appellant, along with the medical record, a September 10, 2024 updated SOAF, and list of questions, to Dr. Frank Corrigan, a Board-certified orthopedic surgeon, for a second opinion evaluation to obtain an assessment of appellant's work-related condition, and to determine any additional increase in permanent impairment of the upper extremities.

In a November 18, 2024 report, Dr. Corrigan noted his review of the September 10, 2024 updated SOAF and the medical record. He opined that appellant had reached MMI. Dr. Corrigan noted the accepted conditions of bilateral radial neuropathy and bilateral median neuropathy. He stated that the November 11, 2020 EMG showed appellant had a right brachial plexopathy, bilateral carpal tunnel syndrome and left cubital tunnel syndrome. Dr. Corrigan found that appellant had three percent permanent impairment for right brachial plexopathy, three percent permanent impairment for right carpal tunnel syndrome, three percent permanent impairment for left carpal tunnel syndrome, and three percent impairment for left cubital tunnel syndrome. As multiple neuropathies were present, he reduced the impairments sequentially at 100 percent for the most impairing impairment, 50 percent for the second impairment, and 0 percent for the third impairment. For the right upper extremity, Dr. Corrigan found the carpal tunnel was the most impairing impairment and rated it at 100 percent or 3 percent impairment; the second impairing condition of brachial plexopathy was rated at 50 percent or 1.5 percent impairment, for a total impairment rating of 4.5 percent. For the left upper extremity, he rated appellant's carpal tunnel syndrome as the most impairing impairment at 100 percent or 3 percent impairment, and he rated the second impairing condition of left ulnar neuropathy at 50 percent or 1.5 percent impairment, for a total impairment rating of 4.5 percent. Dr. Corrigan indicated that as there were no abnormalities with range of motion (ROM) on examination of the shoulders, elbows, wrists, and hands, an impairment rating based on ROM methodology was not applicable. He opined that appellant had no additional impairment as his bilateral permanent impairment ratings of 4.5 percent was not in addition to the previously awarded 5 percent bilateral impairment.

In a February 21, 2025 report, Dr. Hammel, the DMA, reviewed the medical record, including Dr. Corrigan's November 18, 2024 permanent impairment report. For carpal tunnel syndrome, he found under Table 15-23, three percent permanent impairment of the right upper extremity, and three percent permanent impairment of the left upper extremity. For cubital tunnel syndrome, Dr. Hammel found under Table 15-23, three percent impairment of the right upper extremity and three percent impairment of the left upper extremity. As the cubital tunnel syndrome was the second compression neuropathy, he reduced the impairment values in half to reflect 1.5 percent impairment, which he then rounded to 2 percent impairment for the right upper extremity and 2 percent impairment for the left upper extremity. Utilizing Appendix A of the A.M.A., *Guides*, Dr. Hammel combined the three percent impairment for the carpal tunnel syndrome and two percent impairment for the cubital tunnel syndrome and found five percent upper extremity impairment for both the right and left upper extremities. He explained that while Dr. Corrigan had assigned an impairment rating for a previous unrelated brachial plexopathy, this was an additional compression neuropathy which would be rated at zero percent impairment as the impairing conditions were reduced sequentially. Thus, Dr. Hammel stated that he had arrived at the same impairment as Dr. Corrigan but with a different impairment calculation. He further opined that there was no additional impairment as this award was identical to the prior award.

By decision dated March 18, 2025, OWCP denied appellant's claim for an increased schedule award.

On April 7, 2025 appellant requested a review of the written record by a representative of OWCP's Branch of Hearings and Review. Duplicative evidence previously of record was submitted by appellant.

By decision dated August 18, 2025, OWCP's hearing representative affirmed the March 18, 2025 decision.

On August 26, 2025 appellant filed a Form CA-7 for an increased schedule award. No medical evidence was received.

In an August 27, 2025 development letter, OWCP advised appellant regarding the evidence required to support his schedule award claim. It afforded him 30 days to submit the requested evidence.

On September 22, 2025 appellant alleged that his conditions were worsening. He requested that OWCP schedule a second opinion examination.

By decision dated January 20, 2026, OWCP denied appellant's claim for an increased schedule award.

LEGAL PRECEDENT

The schedule award provisions of FECA[3] and its implementing regulations[4] 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 of a member shall be determined. For consistent results and to ensure equal justice under the law for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[5] As of May 1, 2009, the sixth edition of the A.M.A., *Guides*, is used to calculate schedule awards.[6]

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[7] In Table 15-23, grade modifiers levels (ranging from zero to four) are described for the categories of test findings, history, and physical findings. The grade modifier levels are averaged to arrive at the appropriate overall grade modifier level and to identify a default rating value. The default rating value may be modified up or down based on functional scale, an assessment of impact on daily living activities.[8]

OWCP issued FECA Bulletin No. 17-06 to explain the use of the DBI methodology *versus* the ROM methodology for rating of upper extremity impairments.[9] FECA Bulletin No. 17-06 provides:

> "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*."[10] (Emphasis in the original).

In determining impairment for the upper extremities under the sixth edition of the A.M.A., *Guides*, an evaluator must establish the appropriate diagnosis for each part of the upper extremity to be rated. With respect to the fingers and hand, the relevant portions of the arm for the present

---

[3] *Supra* note 1.

[4] 20 C.F.R. § 10.404.

[5] *Id.*; *see also Jacqueline S. Harris*, 54 ECAB 139 (2002).

[6] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (March 2017); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[7] A.M.A., *Guides* (6th ed. 2009) 449.

[8] *Id.* at 448-49.

[9] FECA Bulletin No. 17-06 (issued May 8, 2017).

[10] *Id.*

case, reference is made to Table 15-2 (Digital Regional Grid) beginning on page 391. After the CDX is determined from the appropriate regional grid (including identification of a default grade value), the net adjustment formula is applied using a GMFH, a GMPE, and/or a GMCS. The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to its 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.[11]

ANALYSIS

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

In support of his August 26, 2025 schedule award, on September 22, 2025 appellant requested that OWCP refer him to a second opinion physician for another permanent impairment evaluation as his condition had worsened. It is, however, appellant's burden of proof to establish an increased schedule award.[12] He did not submit medical evidence to support a worsening condition. OWCP procedures indicate that if the claimant does not provide an impairment evaluation from his/her physician when requested, and there is an indication of permanent impairment in the medical evidence of file, the claims examiner should refer the claimant for a second opinion evaluation. The claims examiner may also refer the case to the DMA prior to scheduling a second opinion examination to determine if the evidence in the file is sufficient for the DMA to provide an impairment rating.[13] As appellant did not submit any medical evidence of a worsening condition, there was no indication that a referral for a second opinion examination or review by the DMA was warranted in this case.[14] Thus, the Board finds that there is no current medical evidence of record supporting greater than five percent permanent impairment of the right upper extremity and five percent permanent impairment of the left upper extremity, for which appellant previously received schedule award compensation. The Board therefore finds that OWCP's decision was proper under the facts and law of this case.[15]

[11] *Supra* note 6 at Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (March 2017).

[12] *Edward W. Spohr*, 54 ECAB 806, 810 (2003).

[13] *Supra* note 6 at Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6f (March 2017).

[14] OWCP may require an examination as frequently and at the times and places as may reasonably be required. 5 U.S.C. § 8123(a).

[15] *J.B.*, Docket No. 11-73 (issued August 22, 2011).

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

CONCLUSION

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

ORDER

IT IS HEREBY ORDERED THAT the January 20, 2026 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: July 1, 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