United States Department of Labor
Employees' Compensation Appeals Board

P.W., Appellant	)	
and	)	**Docket No. 26-0569**
U.S. POSTAL SERVICE, NORTH SHEPHERD POST OFFICE, Houston, TX, Employer	)	**Issued: September 25, 2026**

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

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On June 2, 2026 appellant filed a timely appeal from an April 3, 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 her burden of proof to establish greater than nine percent permanent impairment of the right upper extremity, for which she previously received schedule award compensation.

FACTUAL HISTORY

On December 7, 1996 appellant, then a 36-year-old letter carrier, filed a traumatic injury claim (Form CA-1) alleging that on that date she injured her right hand when a unit of mailboxes

[1] 5 U.S.C. § 8101 *et seq*.

fell on her while she was in the performance of duty. She did not stop work. OWCP accepted the claim for right wrist and hand sprain.[2]

OWCP authorized a right wrist arthroscopy dorsal capsulodesis with reconstruction of the scapholunate ligament. Appellant underwent that procedure on June 23, 1997. By decision dated May 21, 1998, OWCP granted appellant a schedule award for 10 percent permanent impairment of the right upper extremity due to loss of range of motion (ROM).[3] The period of the award was from February 9 through September 15, 1998.

On September 21, 1998 OWCP expanded its acceptance of the claim to include de Quervain's tenosynovitis and a right wrist surgical release. On October 9, 1998 appellant underwent de Quervain's release of the right hand. OWCP subsequently expanded its acceptance of her claim to include right ganglion cyst of the synovium and right carpal tunnel syndrome.

On August 1, 2023 appellant filed a claim for compensation (Form CA-7) for a schedule award.

By decision dated January 4, 2024, OWCP denied appellant's claim for an increased schedule award as the medical evidence did not support an additional percentage of permanent impairment to the right upper extremity.

On February 23, 2024 appellant requested a review of the written record by a representative of OWCP's Branch of Hearings and Review.

By decision dated March 11, 2024, OWCP denied appellant's request for a review of the written record. It found that the request was not made within 30 days of its January 4, 2024 decision, and, therefore, was untimely filed.

[2] OWCP assigned the present claim OWCP File No. xxxxxx161. Appellant subsequently filed an occupational disease claim (Form CA-2) under OWCP File No. xxxxxx185, which OWCP accepted for right carpal tunnel syndrome.). She underwent an OWCP-authorized decompression of the right carpal tunnel with neurolysis of the median nerve on January 14, 2000. By decision dated August 28, 2000, OWCP denied appellant's schedule award claim. She appealed this decision to the Board. By decision dated August 6, 2001, the Board set aside OWCP's August 28, 2000 decision and remanded the case for OWCP to administratively combine her claims and issue a *de novo* decision. Docket No. 01-0211 (issued August 6, 2001). By decision dated September 13, 2001, OWCP granted appellant a schedule award for an additional 3 percent permanent impairment due to loss of ROM for a total of 13 percent permanent impairment of the right upper extremity. The award covered a period of 65.52 days and ran from March 6 through May 10, 2000. Appellant thereafter filed another Form CA-2 under OWCP File No. xxxxxx360, which OWCP accepted for right cubital tunnel syndrome. On October 1, 2003 appellant underwent an OWCP-authorized anterior transposition of the right ulnar nerve. By decision dated August 27, 2004, OWCP granted appellant a schedule award for one percent permanent impairment of the right upper extremity due to carpal tunnel syndrome. The award covered a period of 3.12 weeks and ran from June 9 through 30, 2004. On July 29, 2020 appellant filed an additional Form CA-2 alleging a repetitive use injury of her right hand in OWCP File No. xxxxxx244 which OWCP accepted for right carpal tunnel syndrome. On November 18, 2022 appellant underwent an OWCP-authorized right endoscopic carpal tunnel release. OWCP has administratively combined OWCP File Nos. xxxxxx360, xxxxxx244, xxxxxx185, and xxxxxx161, with the latter serving as the master file.

[3] The record reflects that appellant has received schedule award compensation for 14 percent permanent impairment of her right upper extremity in accordance with the fourth and fifth editions of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*). A.M.A., *Guides* (4th ed. 1993); A.M.A., *Guides* (5th ed. 2001).

On May 30, 2024 appellant alleged that the 1998 schedule award for 10 percent permanent impairment of the right upper extremity was never processed. She requested a second opinion evaluation for a permanent impairment rating.

On July 7, 2025 OWCP referred appellant, along with the medical record, and a June 10, 2025 statement of accepted facts (SOAF), and list of questions, to Dr. Aaron Levine, a Board-certified physiatrist, for a permanent impairment rating. The SOAF listed appellant's other accepted claims, but did not mention the May 21, 1998 schedule award for 10 percent permanent impairment of the right upper extremity or the September 13, 2001 schedule award for an additional 3 percent permanent impairment of the right upper extremity awarded in OWCP File No. xxxxxx185.

In a July 28, 2025 impairment rating evaluation report, Dr. Levine listed the diagnosed conditions as ganglion cyst, ligamentous repair, and carpal tunnel syndrome. He obtained ROM figures for appellant's right wrist in accordance with Table 15-32, *Wrist Range of Motion*, page 473 of the sixth edition of the A.M.A., *Guides,*[4] including 50 degrees of palmar flexion, a three percent permanent impairment of the right upper extremity, 55 degrees of dorsiflexion, 15 degrees of radial deviation, and 30 degrees of ulnar deviation which are not ratable impairments. Dr. Levine utilized the diagnosis-based impairment (DBI) methodology Table 15-3, *Wrist Regional Grid*, page 395 of the A.M.A., *Guides* for the diagnoses of ganglion cyst and wrist sprain. He found for the class of diagnosis (CDX) for a ganglion cyst, a Class 1 impairment with a default value of two percent permanent impairment of the right wrist. Dr. Levine found that in accordance with the DBI methodology wrist sprain/strain was a Class 1 impairment with a default value of one percent permanent impairment of the right upper extremity. He found a grade modifier for functional history (GMFH) of 2 based on a *Quick*DASH score of 45, a grade modifier for physical examination (GMPE) of 0 for ROM deficits, and that a grade modifier for clinical studies (GMCS) was not applicable. Dr. Levine applied the net adjustment formula and reached a final rating of two percent permanent impairment of the right upper extremity due to the ganglion cyst and one percent permanent impairment of the right upper extremity due to wrist sprain.

Dr. Levine then applied Table 15-23, *Entrapment/Compression Neuropathy Impairment*, page 449 of the A.M.A., *Guides* for compression neuropathy of carpal tunnel syndrome, finding median motor and sensory delays. He calculated test grade 1, history grade 1, and physical findings grade 2, averaging to 1 resulting in three percent permanent impairment rating of appellant's right upper extremity. Dr. Levine then combined the median sensory and motor impairments of three percent to reach six percent permanent impairment of the right upper extremity. He combined his listed impairment ratings to reach nine percent permanent impairment of the right upper extremity.

In a September 4, 2025 report, Dr. William Tontz, Jr., a Board-certified orthopedic surgeon serving as an OWCP DMA reviewed the medical evidence, including Dr. Levine's July 28, 2025 report. He applied the ROM methodology and found that, under Table 15, 50 degrees of palmar flexion was three percent permanent impairment of the right upper extremity in accordance with Table 15-23, page 473 of the A.M.A., *Guides.* The DMA also applied the DBI methodology to the diagnoses of ganglion cyst and wrist sprain to reach three percent permanent impairment of the right upper extremity. He concurred with Dr. Levine's impairment rating for carpal tunnel syndrome of six percent permanent impairment. The DMA found that appellant had nine percent

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

permanent impairment of the right upper extremity, that she had previously received a schedule award for one percent permanent impairment of the right upper extremity, entitling her to a schedule award for an additional eight percent permanent impairment of the right upper extremity. He determined that appellant reached MMI on July 28, 2025, the date of Dr. Levine's examination.

By decision dated April 3, 2026, OWCP granted appellant an additional schedule award for eight percent permanent impairment of the right upper extremity, for a total award of nine percent permanent impairment of the right upper extremity (right arm). The date of MMI was listed as August 26, 2025. The award covered a period of 24.96 weeks and ran from August 26, 2025 through February 16, 2026. OWCP accorded the weight of the medical evidence to the reports of Dr. Levine and Dr. Tontz, the DMA.

LEGAL PRECEDENT

The schedule award provisions of FECA[5] and its implementing regulations[6] 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.[7] As of May 1, 2009, the sixth edition of the A.M.A., *Guides*, is used to calculate schedule awards.[8]

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[9] 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.[10]

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.[11] 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

[5] *Supra* note 1.

[6] 20 C.F.R. § 10.404.

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

[8] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (version 1, issued March 16, 2026); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (version 1, issued March 16, 2026).

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

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

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

> 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*."[12] (Emphasis in the original).

OWCP's regulations provide that an employee's schedule award benefits will be reduced by compensation paid under the schedule for an earlier injury if the impairment is to the same body part or function or different parts of the same part or function; and compensation payable for the later impairment in whole or in part would duplicate the earlier payment.[13]

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.[14]

ANALYSIS

The Board finds that this case is not in posture for decision.

OWCP obtained a July 28, 2025 second opinion report by Dr. Levine, who found a total of nine percent permanent impairment of the right upper extremity. The Board notes, however, that the June 10, 2025 SOAF provided to Dr. Levine was incomplete, as it failed to include information about the May 21, 1998 schedule award for 10 percent permanent impairment of the right upper extremity due to limited motion of the right wrist and fingers and the 3 percent permanent impairment of the right upper extremity due to limited motion of the wrist under OWCP File No. xxxxxx185. OWCP's procedures dictate that, when an DMA for OWCP, second opinion specialist, or impartial medical examiner renders a medical opinion based on a SOAF which is incomplete or inaccurate, or does not use the SOAF as the framework in forming his or her opinion, the probative value of the opinion is seriously diminished or negated altogether.[15]

It is well established that proceedings under FECA are not adversarial in nature, and while the employee has the burden of proof to establish entitlement to compensation, OWCP shares responsibility in the development of the evidence.[16] Once OWCP undertook development of the

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[12] *Id*.

[13] *See* 20 C.F.R. § 10.404(d)(1)-(2); *M.P.*, Docket No. 17-0150 (issued June 21, 2017).

[14] *Supra* note 8 at Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5a (version 1, issued March 16, 2026).

[15] *See M.A.,* Docket No. 26-0003 (issued February 27, 2026); *T.W.*, Docket No. 25-0800 (issued December 17, 2025); *M.T.*, Docket No. 24-0457 (issued June 6, 2024); *R.S.*, Docket No. 23-1093 (issued March 12, 2024); *N.P.*, Docket No. 19-0296 (issued July 25, 2019); *M.D.*, Docket No. 18-0468 (issued September 4, 2018); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Requirements for Medical Reports*, Chapter 3.600.3 (version 1, issued March 16, 2026).

[16] *See M.A., id.*; *T.W.*, *id*.; *M.T.*, *id*.; *W.W.*, Docket No. 18-0093 (issued October 9, 2018); *Donald R. Gervasi*, 57 ECAB 281, 286 (2005); *William J. Cantrell*, 34 ECAB 1233, 1237 (1983).

evidence, it had an obligation to do a complete job and obtain a proper evaluation and a report that would resolve the issue in this case.[17]

The case shall therefore be remanded for further development. On remand, OWCP shall refer appellant, along with the case record and a complete and accurate updated SOAF, to a new physician in the appropriate field of medicine for a second opinion relative to permanent impairment. Following this and other such further development as deemed necessary, OWCP shall issue a *de novo* decision.

CONCLUSION

The Board finds that this case is not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the April 3, 2026 decision of the Office of Workers' Compensation Programs is set aside. The case is remanded for further proceedings consistent with this decision of the Board.

Issued: September 25, 2026
Washington, DC

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

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

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

[17] *J.K.*, Docket Nos. 19-1420 & 19-1422 (issued August 12, 2020); *Francesco C. Veneziani*, 48 ECAB 572 (1997).