United States Department of Labor
Employees' Compensation Appeals Board

L.H., Appellant	)	
and	)	**Docket No. 26-0639**
	)	**Issued: September 30, 2026**
U.S. POST SERVICE, POST OFFICE, Houston, TX, 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
PATRICIA H. FITZGERALD, Deputy Chief Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On June 30, 2026 appellant filed a timely appeal from a May 13, 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 25 percent permanent impairment of the left upper extremity and/or 7 percent permanent impairment of the right upper extremity, for which she previously received schedule award compensation.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On May 19, 1998 appellant, then a 41-year-old data entry clerk, filed an occupational disease claim (Form CA-2) alleging that she sustained injury due to factors of her federal employment. She stopped work in March 1998. OWCP accepted the claim for bilateral carpal tunnel syndrome, lesion of the left radial nerve, and lesion of the right ulnar nerve, and it paid appellant wage-loss compensation for periods of disability from work.

On April 22, 2025 appellant filed a claim for compensation (Form CA-7) for a schedule award.

In a development letter dated May 6, 2025, OWCP informed appellant of the deficiencies of her schedule award claim. It advised her of the type of evidence needed, including an attending physician's rating of permanent impairment under the standards of the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).[2] OWCP afforded appellant 30 days to respond.

Appellant subsequently submitted a May 30, 2025 report, wherein Dr. Marcos V. Masson, a Board-certified orthopedic surgeon, documented physical examination findings and noted that appellant had a prior permanent impairment rating which found 25 percent permanent impairment of the left upper extremity and 7 percent permanent impairment of the right upper extremity. Dr. Masson did not provide his own impairment rating.

On June 6, 2025 OWCP received a December 8, 2022 report wherein Dr. Fernando Levaro, a Board-certified orthopedic surgeon, documented physical examination findings, noting that appellant reported tingling and numbness in her upper extremities and that her *Quick*DASH score was 77. Dr. Levaro diagnosed bilateral carpal tunnel syndrome, status post bilateral carpal tunnel releases, bilateral cubital tunnel syndrome, status post bilateral cubital tunnel releases, bilateral radial tunnel syndrome, and status post bilateral radial tunnel releases. He provided a diagnosis-based impairment (DBI) rating utilizing Table 15-21 (Peripheral Nerve Impairment: Upper Extremity Impairment) on pages 436-44 of the sixth edition of the A.M.A., *Guides* to identify the class of diagnosis (CDX) related to median nerve deficits below the mid-forearm (entire nerve) and ulnar deficits above the mid-forearm, and Table 15-7 (Functional History Adjustment: Upper Extremities) on page 406 and Table 15-14 (Sensory and Motor Severity) on page 425 to identity grade modifiers. For the left upper extremity, Dr. Levaro noted that the moderate sensory deficit of the median nerve fell under Class 2, grade C, with a default value of 17 percent, and that the mild motor deficit of the ulnar nerve fell under Class 1, grade C, with a default value of 6 percent. He assigned a grade modifier for functional history (GMFH) of 3 for the median nerve sensory deficit, and a GMFH of 1 for the ulnar nerve motor deficit.[3] Applying the net adjustment formula on page 411, Dr. Levaro indicated that the median nerve sensory

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

[3] With respect to all of his grade modifier determinations, Dr. Levaro noted that a grade modifier for physical examination (GMPE) was not applicable because physical findings were used to determine the CDX, and that a grade modifier for clinical studies (GMCS) was not applicable because electromyogram/nerve conduction velocity (EMG/NCV) study findings were not available.

deficit moved to the grade D value of 20 percent, and that the ulnar nerve motor deficit remained at the grade C default value of 6 percent. Utilizing the Combined Values Chart on page 604, he combined the 20 percent and 6 percent values to find total permanent impairment of the left upper extremity of 17 percent.

For the right upper extremity, Dr. Levaro noted that the mild motor deficit of the median nerve fell under Class 1, grade C, with a default value of one percent, and that the severe sensory deficit of the ulnar nerve fell under Class 1, grade C, with a default value of five percent. He assigned a GMFH of 1 for the median nerve motor deficit, and a GMFH of 3 for the ulnar nerve sensory deficit. Applying the net adjustment formula on page 411, Dr. Levaro indicated that the median nerve motor deficit remained at the grade C default value of one percent, and that the ulnar nerve sensory deficit moved to the grade E value of six percent. Utilizing the Combined Values Chart on page 604, he combined the one percent and six percent values to find total permanent impairment of the right upper extremity of seven percent. Dr. Levaro found no impairment associated with the radial nerves of the upper extremities and determined that appellant had reached maximum medical improvement (MMI). He concluded that appellant had 25 percent permanent impairment of the left upper extremity and 7 percent permanent impairment of the right upper extremity.

On August 21, 2025 OWCP referred the medical record and a statement of accepted facts (SOAF) to Dr. William Tontz, Jr., a Board-certified orthopedic surgeon serving as an OWCP district medical adviser (DMA), for an evaluation and opinion on permanent impairment.

In a September 9, 2025 report, Dr. Tontz advised that he agreed with the impairment rating conducted by Dr. Levaro on December 8, 2022, noting that he appropriately carried out his impairment rating under the DBI rating methodology by utilizing the appropriate standards of the sixth edition of the A.M.A., *Guides.* Regarding the left upper extremity, he noted that appellant had 20 percent permanent impairment due to median nerve sensory deficit and 6 percent permanent impairment due to ulnar nerve motor deficit, which yielded a total permanent impairment of the left upper extremity of 17 percent when these values were combined. Regarding the right upper extremity, Dr. Tontz indicated that appellant had one percent permanent impairment due to median nerve motor deficit and six percent permanent impairment due to ulnar nerve sensory deficit, which yielded a total permanent impairment rating for the right upper extremity of seven percent when these values were combined. He opined that appellant had reached MMI on December 8, 2022, the date of Dr. Levaro's examination, and concluded that, utilizing the sixth edition of the A.M.A., *Guides*, appellant had 25 percent permanent impairment of the left upper extremity and 7 percent permanent impairment of the right upper extremity.

By decision dated May 13, 2026, OWCP granted appellant a schedule award for 25 percent permanent impairment of the left upper extremity and 7 percent permanent impairment of the right upper extremity. The award ran for 99.84 weeks from December 8, 2022 through November 5, 2024. OWCP based the award on the impairment ratings of Drs. Levaro and Tontz.

LEGAL PRECEDENT

The schedule award provisions of FECA,[4] and its implementing federal regulation,[5] 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 for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[6] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[7]

In addressing impairment of 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.[8] After a CDX is determined (including identification of a default grade value), the impairment class is then adjusted by a GMFH, GMPE, and/or GMCS.[9] The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[10]

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.[11]

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish greater than 25 percent permanent impairment of the left upper extremity and/or 7 percent permanent impairment of the right upper extremity, for which she previously received schedule award compensation.

In a December 8, 2022 report, Dr. Levaro provided a DBI rating utilizing Table 15-21 of the sixth edition of the A.M.A., *Guides* to identify the CDX related to median nerve deficits

[4] 5 U.S.C. § 8107.

[5] 20 C.F.R. § 10.404.

[6] *Id. See also A.T.,* Docket No. 26-0447 (issued August 7, 2026); *T.T.,* Docket No. 18-1622 (issued May 14, 2019).

[7] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5 (version 1.2, issued May 4, 2026); *id.* at Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (version 1.2, issued May 4, 2026).

[8] *See J.A.,* Docket No. 21-1201 (issued November 3, 2022); *M.D.*, Docket No. 20-0007 (issued May 13, 2020).

[9] *See supra* note 2 at 383-492.

[10] *Id.* at 411.

[11] *See supra* note 7 at Chapter 2.808.6f (version 1.2, issued May 4, 2026); *see also J.T.*, Docket No. 17-1465 (issued September 25, 2019); *C.K.*, Docket No. 09-2371 (issued August 18, 2010); *Frantz Ghassan,* 57 ECAB 349 (2006).

below the mid-forearm (entire nerve) and ulnar deficits above the mid-forearm,[12] and Table 15-7 and Table 15-14 to identity grade modifiers.[13] For the left upper extremity, he noted that the moderate sensory deficit of the median nerve fell under Class 2, grade C, with a default value of 17 percent, and that the mild motor deficit of the ulnar nerve fell under Class 1, grade C, with a default value of 6 percent. Dr. Levaro assigned a GMFH of 3 for the median nerve sensory deficit, and a GMFH of 1 for the ulnar nerve motor deficit.[14] Applying the net adjustment formula, he indicated that the median nerve sensory deficit moved to the grade D value of 20 percent, and that the ulnar nerve motor deficit remained at the grade C default value of 6 percent.[15] Utilizing the Combined Values Chart, Dr. Levaro combined the 20 percent and 6 percent values to find total permanent impairment of the right upper extremity of 17 percent.[16] For the right upper extremity, he noted that the mild motor deficit of the median nerve fell under Class 1, grade C, with a default value of one percent, and that the severe sensory deficit of the ulnar nerve fell under Class 1, grade C, with a default value of five percent. Dr. Levaro assigned a GMFH of 1 for the median nerve motor deficit, and a GMFH of 3 for the ulnar nerve sensory deficit. Applying the net adjustment formula, he indicated that the median nerve motor deficit remained at the grade C default value of one percent, and that the ulnar nerve sensory deficit moved to the grade E value of six percent. Utilizing the Combined Values Chart, Dr. Levaro combined the one percent and six percent values to find total permanent impairment of the right upper extremity of seven percent. He opined that appellant had reached MMI and concluded that appellant had 25 percent permanent impairment of the left upper extremity and 7 percent permanent impairment of the right upper extremity.

Consistent with its procedures, OWCP properly referred the case record to Dr. Tontz, serving as DMA, for an opinion regarding appellant's permanent impairment in accordance with the sixth edition of the A.M.A., *Guides*.[17]

In a September 9, 2025 report, Dr. Tontz advised that he agreed with the impairment rating conducted by Dr. Levaro on December 8, 2022, noting that he appropriately carried out his impairment rating under the DBI rating methodology by utilizing the appropriate standards of the sixth edition of the A.M.A., *Guides*.[18] Regarding the left upper extremity, he noted that appellant had 20 percent permanent impairment due to median nerve sensory deficit and 6

[12] *See supra* note 2 at 436-44 (Table 15-21).

[13] *Id*. at 406 (Table 15-7); 425 (Table 15-14).

[14] With respect to all his grade modifier determinations, Dr. Levaro appropriately found that a GMPE was not applicable because physical findings were used to determine the CDX, and that a GMCS was not applicable because EMG/NCV study findings were not available. *See id*. at 405-09.

[15] *Id*. at 411.

[16] *Id*. at 604 (Combined Values Chart).

[17] *See supra* note 11. *See also* K.B., Docket No. 23-0824 (issued October 24, 2024).

[18] It is noted that Table 15-21 does not provide an alternate rating methodology based on range of motion, and thus the DBI rating methodology was appropriately applied to rate permanent impairment of the upper extremities. *See supra* note 2 at 436-44 (Table 15-21).

percent permanent impairment due to ulnar nerve motor deficit, which yielded a total permanent impairment of the left upper extremity of 17 percent when these values were combined. Regarding the right upper extremity, Dr. Tontz indicated that appellant had one percent permanent impairment due to median nerve motor deficit and six percent permanent impairment due to ulnar nerve sensory deficit, which yielded a total permanent impairment of the right upper extremity of seven percent when these values were combined. He opined that appellant reached MMI on December 8, 2022, the date of Dr. Levaro's examination, and concluded that appellant had 25 percent permanent impairment of the left upper extremity and 7 percent permanent impairment of the right upper extremity.

Dr. Levaro and Dr. Tontz properly applied the A.M.A., *Guides* to the examination findings to calculate appellant's permanent impairment. As their reports are detailed, well rationalized, and based on a proper factual background, their opinions on permanent impairment represent the weight of medical evidence.[19]

As the record is insufficient to establish greater than 25 percent permanent impairment of the left upper extremity and/or 7 percent permanent impairment of the right upper extremity, for which she previously received schedule award compensation, the Board finds that appellant has not met her burden of proof.

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 her burden of proof to establish greater than 25 percent permanent impairment of the left upper extremity and/or 7 percent permanent impairment of the right upper extremity, for which she previously received schedule award compensation.

[19] *See J.C.,* Docket No. 21-0541 (issued August 25, 2025).

ORDER

IT IS HEREBY ORDERED THAT the May 13, 2026 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: September 30, 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