U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of PAUL J. COX and DEPARTMENT OF THE NAVY, PHILADELPHIA NAVAL SHIPYARD, Philadelphia, PA

Docket No. 97-1585; Submitted on the Record;
Issued July 19, 1999

DECISION and ORDER

Before GEORGE E. RIVERS, DAVID S. GERSON, A. PETER KANJORSKI

The issue is whether appellant sustained greater than a 39 percent bilateral permanent hearing loss for which he received a schedule award.

On September 10, 1971 appellant, then a 38-year-old shipfitter, filed a claim for a hearing loss which he attributed to noise exposure at his job. By decision dated May 2, 1977, the Office of Workers' Compensation Programs granted appellant a schedule award for a 33 percent binaural hearing loss.

On June 15, 1993 appellant filed a claim alleging additional work-related hearing loss.

In a January 20, 1994 report, Dr. Herbert Kean, a Board-certified otolaryngologist and Office referral physician, provided a history of appellant's condition and noted that, although appellant had a severe loss of hearing, it did not appear to be a noise-induced occupational injury. Audiometric testing performed on January 13, 1994 at 500, 1,000, 2,000 and 3,000 hertz (Hz) revealed losses of 60, 65, 65 and 65 decibels in the right ear, and in the left ear, 65, 55, 65 and 70 decibels.

By decision dated March 29, 1994, the Office denied appellant's claim for additional hearing loss.

By letter dated April 12, 1994, appellant requested an oral hearing before an Office hearing representative. On September 26, 1994 a hearing was held before an Office hearing representative at which time appellant testified.

By decision dated October 27, 1994, the Office hearing representative remanded the case for further development. He instructed the district Office to combine the case files for appellant's original 1971 hearing loss claim and the 1993 claim and then to provide Dr. Kean with the combined file and ask him to provide a rationalized opinion regarding causal

relationship. He stated that if Dr. Kean was unable or unwilling to submit a supplemental report, the Office should select a new second opinion physician and further develop the case.

The record shows that Dr. Kean submitted a one-page report dated March 7, 1995 in which he provided an opinion as to the cause of appellant's low frequency hearing loss but not the high frequency loss. He stated that he would provide a full report at a later date but there is no such report contained in the record.

By decision dated March 3, 1995, the Office denied appellant's claim for an additional hearing loss.

By letter dated March 13, 1995, appellant requested an oral hearing before an Office hearing representative. On September 7, 1995 a hearing was held before an Office hearing representative at which time appellant testified.

By decision dated November 20, 1995, the Office hearing representative set aside the Office's March 3, 1995 decision and remanded the case for further development, noting that Dr. Kean's report was not complete.

By letter dated January 4, 1996, the Office referred appellant, along with the statement of accepted facts and copies of medical records to Dr. Arnold K. Brenman, a Board-certified otolaryngologist, for an examination and evaluation as to whether appellant had sustained any hearing loss since 1977 causally related to factors of his employment.

In a report dated February 2, 1996, Dr. Brenman stated that he had reviewed the case file and statement of accepted facts, including the reports of Dr. Kean. He provided a history of appellant's condition and the results of audiometric testing performed on January 29, 1996. He stated that because the thresholds were significantly better than those obtained for Dr. Kean on January 13, 1994, he ordered a second audiogram performed by a different audiologist.[1] He stated that all of the thresholds obtained in the two audiograms performed for him on January 29, 1996 were in agreement to within plus or minus 10 decibels except at 8,000 Hz in the right ear. In regard to the difference between the audiometric findings obtained on January 29, 1996 and the October 13, 1994 results obtained for Dr. Kean, he noted that because conductive hearing loss "typically can vary in degree from time to time," its presence represented a reasonable explanation for fluctuation of air conduction thresholds from time to time. Dr. Brenman stated:

> " Regarding the second audiogram, right ear conduction thresholds were noted at ... 35 [decibels] at 500 [Hz], 40 ... at 1,000 [Hz], 65 ... at 2,000 [Hz] , 60 ... at 3,000 [Hz] .... Left ear air conduction thresholds were noted at ... 50 [decibels] at 500 [Hz], 45 ... at 1,000 [Hz], 60 ... at 2,000, 65 ... at 3,000 [Hz]...."

In a January 29, 1996 memorandum, an Office audiologist stated:

> "Today's [January 29, 1996] results are in agreement and appear reliable. I agree with Dr. Brenman in that the fluctuation seen is most likely conductive overlay.

[1] The results of the second audiogram revealed a greater hearing loss than the test results of the first audiogram.

The main portion of the current test results is sensorineural in nature. Test results # 2 for [January 29, 1996] were used for calculating loss figures."

The Office district medical Director stated his agreement with the opinion of the audiologist as to the reason for the difference in test results between Dr. Brenman and Dr. Kean. He then applied the Office's standardized procedures to the January 29, 1996 audiogram obtained for Dr. Brenman. Testing for the right ear at the frequency levels of 500, 1,000, 2,000 and 3,000 cycles per second revealed decibels losses of 35, 40, 65 and 60. The Office medical Director totaled these losses at 200 decibels and divided by 4 to obtain the average hearing loss of 50 decibels. He then reduced the average of 50 decibels by the "fence" of 25 decibels to equal 25 which he multiplied by the established factor of 1.5 to compute a 37.5 percent monaural loss of hearing for the right ear. Testing for the left ear at the same frequency levels revealed decibels losses of 50, 45, 60 and 65. He totaled these losses at 220 decibels and divided by 4 to obtain the average hearing loss at those cycles of 55 decibels. He then reduced the average by the "fence" of 25 to equal 30 which he then multiplied by 1.5 to compute a 45 percent monaural hearing loss in the left ear. According to Office standardized procedures, he then determined the binaural hearing loss by multiplying the lesser loss of 37.5 percent by 5, then added this to the greater loss of 45 percent and divided the total by 6 to arrive at a 39 percent binaural hearing loss.

By decision dated April 8, 1996, the Office granted appellant a schedule award for an additional six percent binaural hearing loss. Added to the 33 percent awarded in the Office's May 2, 1977 decision, the total schedule award granted to appellant was for a 39 percent hearing loss.

By letter dated April 15, 1996, appellant requested an oral hearing before an Office hearing representative.

On November 19, 1996 a hearing was held before an Office hearing representative at which time appellant testified. He argued that his additional schedule award should be determined by Dr. Kean's January 13, 1994 audiogram because it was taken closer in time to appellant's retirement in 1993. Alternatively, he argued that there was a conflict in the medical opinion evidence between Dr. Kean and Dr. Brenman as to the degree of appellant's hearing loss.

By decision dated January 2, 1997, the Office hearing representative affirmed the Office's April 8, 1996 decision.

The Board finds that appellant sustained no greater than a 39 percent permanent hearing loss for which he received a schedule award.

The Federal Employees' Compensation Act schedule award provisions set forth the number of weeks of compensation to be paid for permanent loss of use of members of the body that are listed in the schedule.[2] The Act, however, does not specify the manner in which the

[2] 5 U.S.C. § 8107.

percentage loss of a member shall be determined. The method used in making such a determination is a matter which rests in the sound discretion of the Office.[3] However, as a matter of administrative practice the Board has stated, "For consistent results and to insure 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."[4]

The Office evaluates industrial hearing loss in accordance with the standards contained in the American Medical Association, *Guides to the Evaluation of Permanent Impairment*.[5] Using the frequencies of 500, 1,000, 2,000 and 3,000 cycles per second, the losses at each frequency are added up and averaged.[6] Then, the "fence" of 25 decibels is deducted because, as the A.M.A., *Guides* points out, losses below 25 decibels result in no impairment in the ability to hear everyday speech under everyday conditions.[7] The remaining amount is multiplied by a factor of 1.5 to arrive at the percentage of monaural hearing loss.[8] The binaural loss is determined by calculating the loss in each ear using the formula for monaural loss; the lesser loss is multiplied by five, then added to the greater loss and the total is divided by six to arrive at the amount of the binaural hearing loss.[9] The Board has concurred in the Office's adoption of this standard for evaluating hearing loss.[10]

In a report dated February 2, 1996, Dr. Brenman stated that because the thresholds in the audiometric testing performed for his evaluation were significantly better than those obtained for Dr. Kean on January 13, 1994, he ordered a second audiogram performed by a different audiologist.[11] He stated that all of the thresholds obtained in the two audiograms performed for him on January 29, 1996 were in agreement to within plus or minus 10 decibels except at 8,000 Hz.[12] In regard to the difference between the audiometric findings obtained on January 29, 1996 and the October 13, 1994 results obtained for Dr. Kean, he noted that because conductive hearing loss "typically can vary in degree from time to time," its presence represented a reasonable explanation for fluctuation of air conduction thresholds from time to time.

[3] *Danniel C. Goings*, 37 ECAB 781, 783 (1986); *Richard Beggs*, 28 ECAB 387, 390-91 (1977).

[4] *Henry L. King*, 25 ECAB 39, 44 (1973).

[5] *George L. Cooper*, 40 ECAB 296, 302 (1988).

[6] A.M.A., *Guides*, 224-25 (4th ed. 1993).

[7] *Id*.

[8] *Id*.

[9] *Id*.

[10] *Donald A. Larson*, 41 ECAB 947, 951 (1990).

[11] The results of the second audiogram revealed a greater hearing loss than the test results of the first audiogram. Although appellant stated on appeal that the first audiogram was not in the record, the Board notes that it can be found in the record on the page immediately preceding the second audiogram.

[12] As noted above, the Office's standardized procedures for determining hearing loss include only the test results. at 500, 1,000, 2,000 and 3,000 Hz. Test results at 8,000 Hz are not considered in hearing loss calculations.

Dr. Brenman provided the results of the second audiogram which reflected a greater hearing loss than the first audiogram.

As noted above, the Office district medical Director reviewed the otologic and audiologic testing performed on appellant by Dr. Brenman and applied the Office's standardized procedures to this evaluation to arrive at a 39 percent bilateral hearing loss. The Office's district medical Director also provided his rationale for selecting Dr. Brenman's audiogram over Dr. Kean's audiogram.

Regarding appellant's argument that Dr. Kean's January 13, 1994 audiogram should have been used to determine his hearing loss, the record shows that in his January 20, 1994 report, Dr. Kean, a Board-certified otolaryngologist and Office referral physician, opined that appellant's additional hearing loss was not related to his employment. The Office then provided Dr. Kean with a consolidated case file containing the documents pertaining to appellant's original hearing loss claim and his claim for additional hearing loss and asked him to provide a supplemental report with a rationalized medical opinion as to whether appellant had any additional work-related hearing loss. In a one-page report dated March 7, 1995, Dr. Kean provided an opinion as to the cause of appellant's low frequency hearing loss but not the high frequency loss. He stated that he would provide a full report at a later date but there is no such report contained in the record. Due to these deficiencies in Dr. Kean's reports, the Board finds that the Office properly determined that the weight of the medical evidence rested with Dr. Brenman who provided a thorough and rationalized evaluation of appellant's hearing loss.

The January 2, 1997 and April 8, 1996 decisions of the Office of Workers' Compensation Programs are affirmed.

Dated, Washington, D.C.
July 19, 1999

George E. Rivers
Member

David S. Gerson
Member

A. Peter Kanjorski
Alternate Member