U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of BEMIS LOCKLEAR and DEPARTMENT OF THE AIR FORCE, DOBBINS AIR FORCE BASE, Ga.

Docket No. 97-1963; Submitted on the Record;
Issued April 21, 1999

DECISION and ORDER

Before DAVID S. GERSON, WILLIE T.C. THOMAS,
BRADLEY T. KNOTT

The issue is whether appellant has established greater than a two percent hearing loss for which he received a schedule award.

On October 12, 1994 appellant, then a 52-year-old aircraft mechanic, filed an occupational disease claim, alleging hearing loss of which he first became aware on April 6, 1987 and realized was causally related to his federal employment in April 6, 1987 through August 8, 1994. Appellant also asserted that he had additional hearing loss after August 8, 1994. The Office of Workers' Compensation Programs accepted that appellant had an employment-related hearing loss on June 8, 1995. On August 15, 1995 appellant filed a claim for a schedule award.

The Office referred appellant to Dr. A. Parke Avery, a Board-certified otolaryngologist, for examination, including audiometric testing. In a report dated June 22, 1995, Dr. Avery indicated that appellant had sensorineural hearing loss that was work related. He indicated that testing for the right ear at 500, 1,000 and 2,000 cycles per second showed decibel loss of 80, 80 and 90, respectively, while testing for the left ear revealed decibel loss of 80, 85 and 95, respectively. An Office medical adviser reviewed this test and indicated that due to the wide disagreement between speech reception thresholds this test could not be used for determining the permanent hearing loss.

The Office referred appellant to another Board-certified otolaryngologist for another examination and audiometric testing. In a report dated October 13, 1995, Dr. David W. Alexander, indicated that the testing was performed on equipment which was last calibrated on March 29, 1995. He found a hearing loss in both ears and reported that appellant's history of exposure was perfectly compatible with his hearing loss and there was no history of other possible factors. Dr. Alexander indicated that testing for the right ear at 500, 1,000, 2,000 and 3,000 cycles per second showed bone conduction decibel losses of 20, 25, 20 and 40, respectively and air conduction decibel loss of 25, 20, 20 and 40, respectively. Testing for the

left ear revealed bone conduction loss of 20, 25, 25 and 40 respectively while air conduction decibel losses were 20, 15, 25 and 35 respectively.

The Office referred Dr. Alexander's report to an Office medical adviser who used the bone conduction decibel losses for the right ear and the air conduction decibel losses for the left ear to find a two percent monaural loss in the right ear and no loss in the left ear. Specifically, the hearing loss measured frequencies for the right ear equaled 105 which was divided by 4 for an average hearing loss of 26.25 decibels and the 4 measured frequencies of the left ear totaled 95 which was divided by 4 for an average hearing loss of 23.75. After deducting the 25 decibel fence from each average, he concluded that appellant had a 1.875 percent loss, rounded up to 2 percent hearing loss in the right ear and no hearing loss in the left ear.

By decision dated November 16, 1995, the Office granted appellant a schedule award for a 1.04 weeks of compensation for the period of October 13 to 20, 1995 for a 2 percent monaural sensorineural hearing loss. By letter dated January 6, 1996, appellant filed a request for reconsideration, asserting that he had greater than a two percent hearing loss in his right ear. In a decision dated October 22, 1996, the Office denied appellant's request for modification of his schedule award on the grounds that the evidence submitted was not sufficient to establish that modification was warranted.

The Board has duly reviewed the entire case record on appeal and finds that this case is not in posture for decision.

The Office evaluates permanent hearing loss in accordance with the standards contained in the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, using the hearing levels recorded at frequencies of 500, 1,000, 2,000 and 3,000 cycles per second. The losses at each frequency are added up and averaged and a "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 sounds under everyday conditions. Each amount is then multiplied by 1.5. The amount of the better ear is multiplied by five and added to the amount from the worse ear. The entire amount is then divided by six to arrive at a percentage of binaural hearing loss.[1] The Board has concurred in the Office's adoption of this standard for evaluation hearing loss for schedule award purposes.[2]

In the present case, it is unclear why the Office medical adviser used different conduction decibel loss figures from appellant's ears to determine the rate of his hearing loss. The Board notes that while both the air and bone measured frequencies in the right ear equal 105, the bone conduction decibel loss in the left ear equals 110 as opposed to the 95 total used by the Office medical adviser in determining the rate of hearing impairment. In addition, on reconsideration, appellant submitted an audiometric evaluation and report by Dr. McCoy L. Moretz, a Board-certified otolaryngologist, dated October 13, 1994 and December 22, 1995, respectively, which Dr. Moretz reported revealed a 8.6 binaural hearing loss using age corrected calculations. This

[1] A.M.A., *Guides*, p. 166 (third edition, 1987).

[2] *See Daniel C. Goings*, 37 ECAB 781 (1986).

report and audiometric evaluation was reviewed by the Office medical adviser, who found a 19 percent binaural hearing loss but rejected the audiometric evaluation because the report by Dr. McCoy was not sufficient and the improvement in appellant's hearing could be explained by removal of cerumin from appellant's ears. A review of the other audiometric evaluations submitted by appellant on reconsideration reveals that Dr. Moretz's evaluation was in line with other testing performed on appellant. In addition, a review of that test and Dr. Moretz's report reveals that he did examine appellant and his work history just as Dr. Alexander did in his October 1995 report. Thus, given the corroboration of Dr. Moretz's findings by the other audiometric evaluation of record, the lack of documentation that appellant had any procedure which would explain the improvement in his hearing and the equal qualifications of Drs. Moretz and Alexander, the Board finds that these reports are of virtually equal weight and therefore there is conflict in the medical evidence. Section 8123 of the Act[3] provides that if there is a disagreement between the physician making the examination for the Office and the employee's physician, the Office shall appoint a third physician who shall make an examination.[4] Thus, this case must be remanded for the Office medical adviser to recalculate the impairment rating established by Dr. Alexander's report and referral of appellant, together with his medical records to an appropriate specialist for impartial medical examination and report. After such further development as the Office deems necessary, a *de novo* decision shall be issued.

The decision of the Office of Workers' Compensation Programs dated October 22, 1996 is hereby set aside and the case is remanded for further proceedings consistent with this decision.

Dated, Washington, D.C.
April 21, 1999

David S. Gerson
Member

Willie T.C. Thomas
Alternate Member

Bradley T. Knott
Alternate Member

[3] 5. U.S.C. § 8123(a)

[4] *Shirley L. Steib*, 46 ECAB 309 (1994).