

**United States Department of Labor  
Employees' Compensation Appeals Board**

---

**WILLIAM E. McFARLAND, Appellant**

**and**

**DEPARTMENT OF THE NAVY, PUGET  
SOUND NAVAL SHIPYARD, Brumerton, WA,  
Employer**

---

)  
)  
)  
)  
)  
)  
)  
)  
)  
)  
)

**Docket No. 04-124**

**Issued: March 12, 2004**

*Appearances:*

*William E. McFarland, pro se*

*Office of Solicitor, for the Director*

*Case Submitted on the Record*

**DECISION AND ORDER**

Before:

COLLEEN DUFFY KIKO, Member

DAVID S. GERSON, Alternate Member

WILLIE T.C. THOMAS, Alternate Member

**JURISDICTION**

On October 20, 2003 appellant filed a timely appeal from the Office of Workers' Compensation Programs' merit decision dated September 18, 2003, in which the Office denied appellant's claim for a schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

**ISSUE**

The issue is whether the Office properly denied appellant's claim for a schedule award for hearing loss.

**FACTUAL HISTORY**

On March 15, 2001 appellant, then a 55-year-old foreman, filed a notice of occupational disease and claim for compensation (Form CA-2), alleging that he sustained a permanent hearing

loss while in the performance of duty. Appellant stated that he became aware of his hearing loss on October 27, 1981. He retired on January 30, 1998.<sup>1</sup>

By letter dated June 19, 2001, the Office advised appellant that the information submitted in his claim was not sufficient to determine whether he was eligible for compensation benefits under the Federal Employees' Compensation Act.<sup>2</sup> Further, the Office advised appellant of the additional medical and factual evidence needed to support his claim. The Office directed appellant to provide a comprehensive medical report indicating a firm diagnosis of appellant's condition and a physician's opinion, with medical reasons for such opinion, as to how appellant's work history caused or aggravated the claimed injury.

Appellant submitted reports from Dr. Preston A. Rice, a Board-certified otolaryngologist, dated August 28, 2000 and June 25, 2001. Dr. Rice performed an otologic evaluation of appellant on August 28, 2000 and audiometric testing was conducted on the physician's behalf on the same date. Testing at the frequency levels of 500, 1,000, 2,000 and 3,000, revealed the following: right ear 15, 20, 20 and 60 decibels; left ear 15, 10, 20 and 55 decibels. Dr. Rice advised that appellant has had gradual hearing loss over several years' duration and tinnitus. He noted a work history of exposure to background machinery noise from 1970 to 1998 and diagnosed high frequency sensorineural hearing loss. Dr. Rice determined, in accordance with the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, (A.M.A., *Guides*) (5<sup>th</sup> ed. 2001), that appellant had a 5.6 percent monaural loss on the right side, a 0 percent monaural hearing loss on the left side and a 0.9 percent binaural hearing impairment. In his report dated June 25, 2001, Dr. Rice noted that appellant had been evaluated several times for long-standing hearing loss. He advised that the audiograms confirmed that appellant had high frequency sensorineural hearing loss of 5.6 percent monaural loss in the right ear and 0 percent monaural loss in the left ear.

The employing establishment furnished the Office with copies of appellant's job description, employment records, employee medical reports and audiograms performed at the employing establishment. The audiograms from July 10, 1991 to January 20, 1998 revealed a gradual increase in hearing loss in the right. The records indicate that appellant was exposed to noise from firearms while in the Army from 1963 to 1966 and from air tools for up to 12 hours per day when working in the motor pool as a mechanic from 1970 to 1998.

Appellant was referred for a second opinion examination to Dr. James C. Rockwell, a Board-certified otolaryngologist, for otological examination and audiological evaluation. The Office provided Dr. Rockwell with a statement of accepted facts, available exposure information and copies of all medical reports and audiograms. In a report dated August 14, 2001, Dr. Rockwell advised that he reviewed the records provided to him and performed an otologic evaluation of appellant and that audiometric testing had been conducted on the physician's

---

<sup>1</sup> The record reveals that appellant filed two other notice's of occupational disease and claims for compensation alleging work-related hearing loss on October 27, 1981 and April 21, 1992, claim Nos. A14-0272203 and A14-194031. Both claims were denied by the Office. All of the claims including the present claim before the Board have been consolidated.

<sup>2</sup> 5 U.S.C. §§ 8101-8193.

behalf the same day. Testing at the frequency levels of 500, 1,000, 2,000 and 3,000, revealed the following: right ear 10, 10, 15 and 50 decibels; left ear 10, 10, 15 and 30 decibels. Dr. Rockwell determined that appellant sustained a zero percent right monaural hearing loss, a zero percent left monaural hearing loss and a zero percent binaural hearing loss. He diagnosed moderate high frequency sensorineural hearing loss of the left ear and severe high frequency sensorineural hearing loss in the right ear. The physician opined that this hearing loss was due to occupational noise exposure during appellant's federal employment from 1966 to 1998.

On October 4, 2001 an Office medical adviser, Donald G. Harvey, Ph.D., audiology consultant, reviewed Dr. Rockwell's report and the audiometric test of August 14, 2001. The medical adviser determined that, after applying the Office's current standards for evaluating hearing loss to the results of the August 14, 2001 audiology test, appellant's hearing loss was not severe enough to be ratable for a schedule award as he had a zero percent monaural hearing loss in the left ear and zero percent monaural hearing loss in the right ear and no binaural hearing loss.

By decision dated October 18, 2002, the Office determined that appellant's hearing loss was employment related but not severe enough to be considered ratable for purposes of a schedule award.<sup>3</sup>

By letter dated July 9, 2003, appellant requested reconsideration of the Office decision and submitted an audiologist's report dated June 9, 2003. The audiologist determined that appellant sustained moderate, high frequency, sensorineural hearing loss of the left ear and severe high frequency hearing loss of the right ear consistent with noise-induced hearing loss. The audiogram was not signed by a physician.

In a letter dated July 28, 2003, the Office requested that the Office medical adviser determine whether the August 14, 2001 or the June 9, 2003 audiogram best represented appellant's work-related hearing loss. On August 11, 2003 Dr. Harvey, the Office medical adviser, indicated that the most accurate measure of appellant's hearing loss is the audiogram closest to his retirement date; therefore, the August 14, 2001 audiogram would best represent his hearing when appellant retired. In a letter dated August 13, 2003, the Office requested that the Office medical adviser explain why the August 4, 2001 audiogram better represented appellant's work-related hearing loss than the audiogram performed in August 28, 2000, which was closer to appellant's retirement date in 1998. In a report dated September 3, 2003, the Office medical adviser indicated that appellant's hearing loss had fluctuated somewhat over time since his retirement. He noted that "there has been some overall improvement in his hearing with his August 4, 2001 audiogram as the best measure of his current hearing as well as his hearing at retirement."

An Office memorandum dated September 5, 2003, memorialized a discussion between the Office medical adviser and an Office claims examiner. It indicated that the Office medical adviser believed the August 14, 2001 audiogram produced the best representation of appellant's work-related noise-induced hearing loss. The medical adviser stated that, although the

---

<sup>3</sup> The record reflects that the district medical adviser authorized appellant to be fitted for a hearing aid for his right ear.

August 28, 2000 audiogram was closer to appellant's last exposure in 1998, it demonstrated a greater hearing loss than the 2001 audiogram and he indicated that appellant's hearing loss did not improve over time. The medical adviser opined that, since the 2001 reading revealed a hearing loss less than that in 2000, he believed the former was a more accurate representation of appellant's loss. Therefore, he dismissed the 2000 audiogram as erroneous. He further advised that the 2003 audiogram was farther removed from appellant's last exposure and also indicated a greater hearing loss and, therefore, was not considered the best representation of appellant's noise-induced hearing loss.

In a decision dated September 18, 2003, the Office denied modification of the prior decision, again finding that appellant failed to establish that he had a ratable hearing loss.

### **LEGAL PRECEDENT**

The schedule award provision of the Act<sup>4</sup> and its implementing regulation<sup>5</sup> 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, the Act 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 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. The A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.<sup>6</sup>

The Office evaluates industrial hearing loss in accordance with the standards contained in the A.M.A., *Guides*.<sup>7</sup> 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.<sup>8</sup> 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.<sup>9</sup> The remaining amount is multiplied by a factor of 1.5 to arrive at the percentage of monaural hearing loss.<sup>10</sup> The binaural loss is determined by calculating the loss in each ear using the formula for monaural loss; the lesser loss is multiplied by 5, then added to the greater loss and the total is

---

<sup>4</sup> 5 U.S.C. § 8107.

<sup>5</sup> 20 C.F.R. § 10.404 (1999).

<sup>6</sup> A.M.A., *Guides* (5<sup>th</sup> ed. 2001); *Joseph Lawrence, Jr.*, 53 ECAB \_\_\_\_ (Docket No. 01-1361, issued February 4, 2002).

<sup>7</sup> A.M.A., *Guides* at 250.

<sup>8</sup> *Id.*

<sup>9</sup> *Id.*

<sup>10</sup> *Id.*

divided by 6 to arrive at the amount of the binaural hearing loss.<sup>11</sup> The Board has concurred in the Office's adoption of this standard for evaluating hearing loss.<sup>12</sup>

### ANALYSIS

The Board finds that there is a conflict in medical opinion between the Office medical adviser, Dr. Rockwell, an Office referral physician and Dr. Rice, appellant's treating physician, both of whom are Board-certified specialists, in their respective fields. In his report dated August 28, 2000, Dr. Rice determined, in accordance with the A.M.A., *Guides* that appellant had a 5.6 percent monaural loss on the right side, a 0 percent monaural hearing loss on the left side and a 0.9 percent binaural hearing impairment. In his report dated June 25, 2001, Dr. Rice noted that appellant had been evaluated several times for long standing work-related hearing loss. He advised that the audiograms confirmed that appellant had high frequency sensorineural hearing loss of 5.6 percent monaural loss in the right ear and zero percent monaural loss in the left ear.<sup>13</sup> By contrast, the Office referral physician, Dr. Rockwell indicated that in a report dated August 14, 2001, that appellant sustained work-related moderate high frequency sensorineural hearing loss of the left ear and severe high frequency sensorineural hearing loss in the right ear. He noted that appellant had a zero percent monaural hearing loss in the left ear and zero percent monaural hearing loss in the right ear and no binaural hearing loss.<sup>14</sup>

---

<sup>11</sup> *Id.*

<sup>12</sup> *Donald E. Stockstad*, 53 ECAB\_\_\_ (Docket No. 01-1570, issued January 23, 2002), *petition for recon. granted (modifying prior decision)* (issued August 13, 2002).

<sup>13</sup> 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 15, 20, 20 and 60 respectively. These decibels were totaled at 115 and were divided by 4 to obtain an average hearing loss at those cycles of 28.8 decibels. The average of 28.8 decibels was then reduced by 25 decibels (the first 25 decibels were discounted as discussed above) to equal 3.8, which was multiplied by the established factor of 1.5 to compute a 5.6 percent loss of hearing for the right ear. Testing for the left ear at the frequency levels of 500, 1,000, 2,000 and 3,000 cycles per second revealed decibels losses of 15, 10, 20 and 55 respectively. These decibels were totaled at 100 and were divided by 4 to obtain the average hearing loss at those cycles of 25 decibels. The average of 25 decibels was then reduced by 25 decibels (the first 25 decibels were discounted as discussed above) to equal 0, which was multiplied by the established factor of 1.5 to compute a 0 percent hearing loss for the left ear. The binaural hearing impairment is determined by multiplying 5 times the impairment of the better ear and 1 multiplied by the poorer ear divided by 6, which equals a 0.9 percent binaural hearing loss.

<sup>14</sup> 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 10, 10, 15 and 50 respectively. These decibels were totaled at 85 and were divided by 4 to obtain an average hearing loss at those cycles of 21.25 decibels. The average of 21.25 decibels was then reduced by 25 decibels (the first 25 decibels were discounted as discussed above) to equal 0, which was multiplied by the established factor of 1.5 to compute a 0 percent loss of hearing for the right ear. Testing for the left ear at the frequency levels of 500, 1,000, 2,000 and 3,000 hertz revealed decibels losses of 10, 10, 15 and 30 respectively. These decibels were totaled at 65 and were divided by 4 to obtain the average hearing loss at those cycles of 16.25 decibels. The average of 16.25 decibels was then reduced by 25 decibels (the first 25 decibels were discounted as discussed above) to equal 0, which was multiplied by the established factor of 1.5 to compute a 0 percent hearing loss for the left ear.

Dr. Rice has consistently supported that appellant sustained a 5.6 monaural hearing loss of the right ear and a 0.9 percent binaural hearing loss, while the Office referral physician and Office medical adviser found that appellant sustained 0 percent monaural hearing loss of both the right and left ears and 0 percent binaural hearing loss.<sup>15</sup>

The Board further notes that the Office medical adviser did not adequately explain why the August 14, 2001 audiogram performed by the Office referral physician was the best representation of appellant's hearing loss opposed to the audiogram performed on behalf of Dr. Rice on August 28, 2000. The Office medical adviser noted that on August 11, 2003 that the most accurate measure of appellant's hearing loss was the audiogram closest in time to appellant's retirement date. However, the medical adviser chose the August 28, 2001 audiogram as representative of appellant's hearing loss at the time of retirement opposed to the August 28, 2000 audiogram, which was closer to the retirement date of January 30, 1998. The medical adviser discounted the August 28, 2000 audiogram, which determined a ratable hearing impairment, as "erroneous" and chose the August 4, 2001 audiogram as the best representation of appellant's hearing loss at the time of retirement noting that "there has been some overall improvement in his hearing with his August 4, 2001 audiogram as the best measure of his current hearing as well as his hearing at retirement." However, the Board notes that the audiogram performed on behalf of Dr. Rice on August 28, 2000 would allow for an impairment rating greater than the zero percent as set forth by the Office referral physician and accepted by the Office medical adviser. Moreover, this audiogram is closest in time to appellant's retirement in January 1998, which the medical adviser initially noted would make it the most accurate audiogram for determination of appellant's impairment. The Board concludes that the Office medical adviser did not provide adequate rationale in support of his impairment determination in accordance with the A.M.A., *Guides*.<sup>16</sup>

Section 8123 of the Act<sup>17</sup> provides that if there is a disagreement between the physician making for the Office and the employee's physician, the Office shall appoint a third physician who shall make an examination<sup>18</sup> In view of the conflict in medical evidence, appellant and the case record should be examined by a Board-certified impartial medical specialist, who should be requested to submit a rationalized report regarding the extent of appellant's employment-related hearing loss. The Office should then make such further development of the case record as may be warranted and issue a *de novo* decision.<sup>19</sup>

---

<sup>15</sup> See Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.0700.30(3) (April 1993).

<sup>16</sup> See Federal (FECA) Procedure Manual, Chapter 2.808.6(d) (March 1995) (these procedures contemplate that, after obtaining all necessary medical evidence, the file should be routed to an Office medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified, especially when there is more than one evaluation of the impairment present).

<sup>17</sup> 5 U.S.C. § 8123(a).

<sup>18</sup> *Theresa Goode*, 51 ECAB 650 (2000).

<sup>19</sup> *Id.*

**CONCLUSION**

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

**ORDER**

**IT IS HEREBY ORDERED THAT** the decision of the Office of Workers' Compensation Programs dated September 18, 2003 is remanded to the Office for further proceedings consistent with this decision of the Board.

Issued: March 12, 2004  
Washington, DC

Colleen Duffy Kiko  
Member

David S. Gerson  
Alternate Member

Willie T.C. Thomas  
Alternate Member