

U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

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In the Matter of GEORGE M. TOMKO and DEPARTMENT OF THE ARMY,  
DEPARTMENT OF MILITARY & VETERANS AFFAIRS, Fort Dix, NJ

*Docket No. 00-1991; Submitted on the Record;  
Issued August 16, 2001*

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DECISION and ORDER

Before MICHAEL J. WALSH, DAVID S. GERSON,  
BRADLEY T. KNOTT

The issue is whether appellant has a ratable hearing loss causally related to factors of his federal employment.

On June 10, 1998 appellant, then a 45-year-old maintenance manager, filed a notice of occupational disease and claim for compensation (Form CA-2) alleging that he sustained a high frequency hearing loss in both ears and tinnitus as a result of being exposed to high frequency noise as part of his federal employment.

In support of his claim, appellant filed a medical report dated June 8, 1998 by Dr. Sadeq A. Razvi, a Board-certified otolaryngologist, who found that appellant's hearing test revealed moderate to severe, mid to high frequency hearing loss on both sides, and that he would need hearing aids to correct the problem. Dr. Razvi opined that appellant's hearing loss was most likely caused by loud noises at work. An audiogram of the same date was attached to his report, which indicated hearing loss at 500, 1,000, 2,000 and 4,000 cycles per second at 10, 20, 25 and 30 decibels for the right ear, and 15, 20, 15 and 30 decibels for the left ear, respectively.

In a letter dated December 18, 1998, the Office of Workers' Compensation Programs referred appellant to Dr. Patrick Houston, a Board-certified otolaryngologist. An otologic evaluation of appellant and audiometric testing was conducted on Dr. Houston's behalf on January 7, 1999. Testing at frequency levels of 500, 1,000, 2,000 and 3,000 cycles per second revealed the following losses in the right ear: 15, 15, 15 and 35 decibels; in the left ear the respective hearing losses were 20, 15, 15, and 30 decibels. In his medical report dated January 14, 1999, Dr. Houston noted that appellant's audiogram "shows no significant hearing loss except at the high frequencies consistent with noise-induced neurosensory hearing loss. This is inconsistent with the tuning fork test and the physical examination that would indicate a conductive hearing loss of significant nature consistent with a static, burned out, old infectious disease process." He concluded that appellant did not need amplification at this time, that the hearing loss was work related, but if there was a future worsening of hearing loss, it should be reevaluated to determine the probability of a conductive component totally unrelated to his work.

On March 17, 1999 the Office medical adviser reviewed the January 7, 1999 audiogram and concluded that appellant had a zero percent monaural loss in both ears.

By decision dated March 17, 1999, the Office accepted that appellant had a hearing loss due to his employment-related exposure, but found that the hearing loss was not severe enough to be considered ratable.

By letter received by the Office on April 2, 1999, appellant requested an oral hearing, which was held on October 18, 1999. At the hearing, appellant submitted an affidavit, detailing his current health and professional situation.

On April 20, 1999 appellant received further hearing tests by Dr. Joel D. Jaffe, a Board-certified otolaryngologist, who determined that appellant suffered loss of hearing in the right ear at frequency levels of 500, 1,000, 2,000 and 3,000 (air) of 25, 20, 25 and 35, respectively, and in the left ear of 35, 25, 25 and 35, respectively. Dr. Jaffe found that the hearing test showed a mixed loss with a mild conductive loss in low frequencies and a significant high frequency sensorineural hearing loss in both ears. Dr. Jaffe noted that the high frequency loss would be secondary to noise exposure, and that the low frequency loss would be secondary to middle ear pathology. He thought that appellant could benefit from a hearing aid.

In a letter dated December 9, 1999, the hearing representative remanded the case, as she found that the evidence was not clear with regard to what levels of hearing loss are related to appellant's employment and which were related to ear pathology.

By letter dated March 17, 2000, the Office referred appellant to Dr. Houston for another examination. An audiogram performed under Dr. Houston's direction indicated hearing loss in the right ear at 500, 1,000, 2,000 and 3,000 hertz as 15, 20, 20 and 40 respectively, in the right ear, and 20, 20, 20 and 35 in the left ear. In his report dated April 19, 2000, Dr. Houston stated that the audiogram was identical to the one the prior year and that his conclusions remained unchanged. He further noted that his previous middle ear disease was noncontributory to any hearing loss and that the audiogram is consistent with a high frequency neurosensory hearing loss related to his work environment.

On May 8, 2000 the Office medical adviser evaluated the March 23, 2000 audiogram and opined that appellant had a zero percent binaural hearing loss.

By decision dated May 8, 2000, the Office determined that, although it accepted that appellant had a hearing loss due to employment-related exposure, that hearing loss was not severe enough to be considered ratable. Therefore, the Office denied a schedule award of compensation under the Federal Employees' Compensation Act.

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

The schedule award provision of the Act provides for compensation to employees sustaining impairment from loss, or loss of use of, specified member of the body.<sup>1</sup> The Act,

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<sup>1</sup> 5 U.S.C. § 8107.

however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such determination is a matter which rests in the sound discretion of the Office.<sup>2</sup> 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 a uniform standard applicable to all claimants.<sup>3</sup> The A.M.A., *Guides* have been adopted by the Office,<sup>4</sup> and the Board has concurred in such adoption, as an appropriate standard for evaluating schedule losses.<sup>5</sup>

Under the A.M.A., *Guides*, hearing loss is evaluated by determining decibel loss at the frequency levels of 500, 1,000, 2,000 and 3,000 hertz. The losses at each frequency are added up and averaged and a “fence” of 25 decibels is deducted since, as the A.M.A., *Guides* points out, losses below 25 decibels result in no impairment in the ability to hear everyday sounds in everyday listening conditions.<sup>6</sup> The remaining amount is multiplied by 1.5 to arrive at the percentage of monaural hearing loss. The binaural loss is determined by calculating the loss in each year using the formula for monaural loss. The lesser loss is multiplied by five, and then added to the greater loss and the total is divided by six to arrive at the amount of the binaural hearing loss.<sup>7</sup>

The Office medical consultant applied the Office’s standardized procedures to the May 4, 2000 audiogram by Dr. Houston. Testing for the right ear at the frequency levels of 500, 1,000, 2,000 and 3,000 hertz revealed losses of 15, 20, 20 and 40 decibels, respectively. These losses were totaled at 95 decibels and were divided by 4 to obtain the average hearing loss at those cycles of 23.75 decibels. The average loss of 23.75 decibels, when reduced by 25 decibels amounts to a number less than 0. Testing for the left ear at the frequency levels of 500, 1,000, 2,000 and 3,000 hertz revealed decibel losses of 20, 20, 20, and 35, for a total of 95 decibels, which when divided by 4 also results in 23.75, which again, is less than 0. Therefore, the Office medical adviser determined that there was no ratable hearing loss.

However, the Board notes that in determining that appellant had not suffered a ratable hearing loss, the Office never considered other audiograms of record, most significantly, the April 20, 1999 audiogram conducted under the supervision of Dr. Jaffe. The Board notes that an evaluation of this audiogram would result in a ratable hearing loss.<sup>8</sup>

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<sup>2</sup> See *Arthur E. Anderson*, 43 ECAB 691 (1992).

<sup>3</sup> See *Henry L. King*, 25 ECAB 39 (1973); *August M. Buffa*, 12 ECAB 324 (1961).

<sup>4</sup> FECA Program Memorandum No. 272 (issued February 24, 1986); see *Jimmy B. Newell*, 39 ECAB 181 (1987).

<sup>5</sup> *Danniel C. Goings*, 37 ECAB 781 (1986).

<sup>6</sup> *Id.* at 224.

<sup>7</sup> *Id.*

<sup>8</sup> Although Dr. Jaffe pointed out that the low frequency hearing loss was due to inner ear pathology and not employment-related exposure, this does not preclude the Office from using his report, as whenever a factor of employment aggravates, accelerates or otherwise combines with a preexisting, nonoccupational pathology, the claimant is entitled to compensation. No attempt should be apportion a condition between federal and nonfederal

In cases where there were several audiograms of record, all made within approximately two years of each other, and submitted by more than one specialist, the Board has held that the Office must have all such audiograms evaluated to determine the percentage loss of each. The Office should not arbitrarily select one audiogram without explanation, even if the one selected is the most recent of record.<sup>9</sup>

In its decision of May 8, 2000, the Office failed to explain why it failed to use the audiogram of Dr. Jaffe in making its determination that appellant suffered no ratable hearing loss. Therefore, the Board remands this case for further consideration. On remand, the Office must determine whether a conflict exists in the audiograms in the case record. If so, it may either give rationale for selecting one audiogram over the others or have another evaluation made of appellant's hearing to resolve the conflict.<sup>10</sup>

The decision of the Office of Workers' Compensation Programs dated May 8, 2000 is vacated, and the case is remanded for further proceedings as set forth above, to be followed by a *de novo* decision.

Dated, Washington, DC  
August 16, 2001

Michael J. Walsh  
Chairman

David S. Gerson  
Member

Bradley T. Knott  
Alternate Member

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cases. *See Henry Klaus*, 9 ECAB 470 (1954) (aggravation of preexisting disease or defect is as compensable as an original or new injury).

<sup>9</sup> *See Harry Frank*, 33 ECAB 261, 263 (1981).

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