

U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of PAUL W. LANGFORD and DEPARTMENT OF THE NAVY,
NAVAL AIR STATION, PUBLIC WORKS CENTER, Pensacola, FL

*Docket No. 02-2378; Submitted on the Record;
Issued March 3, 2003*

DECISION and ORDER

Before ALEC J. KOROMILAS, DAVID S. GERSON,
WILLIE T.C. THOMAS

The issue is whether appellant has established that he sustained greater than an 11 percent monaural hearing loss in the left ear, for which he received a schedule award.

On March 10, 1992 appellant, then a 51-year-old carpenter, filed Claim No. 062058538 for bilateral hearing loss with tinnitus which he attributed to exposure to noise from carpentry tools. The employing establishment noted that appellant had an "active hearing loss claim #060590743," with a date of injury of June 1, 1978. Appellant continued to be exposed to hazardous noise at the carpentry shop.

Appellant submitted a history of his exposure to hazardous noise at the employing establishment. He worked as a carpenter from October 1977 to May 1994 at the Naval Air Depot, with no hearing protection until late in 1978. He was exposed to noise from radial arm, miter and power saws, as well as planers and joiners. From May 1994 onward, appellant worked as a carpenter at the Public Works Center, with exposure to noise from circular saws, routers, hammers, jack hammers and heavy lifting equipment. Hearing protection was provided. Appellant noted that he was one to five feet away from noisy equipment.

In an April 27, 1992 occupational health clinic note, Dr. Walter C. Otto, an audiologist, noted appellant's account of tinnitus, with "essentially normal" hearing in the right ear, but a precipitous loss above 2000 hertz (Hz) in [the] left ear: Dr. Otto diagnosed an occupationally-related hearing loss.

Annual employing establishment audiograms from 1992 to March 1998 showed a worsening hearing loss on the left, but no ratable hearing loss in either ear.¹

A February 25, 1999 audiogram performed at the employing establishment showed the following thresholds at 500, 1,000, 2,000 and 3,000 Hz: on the left, 10, 10, 15 and 65 decibels (dBs); on the right; 15, 10, 5 and 15 dBs. February 2000 and May 2001 audiograms showed similar thresholds but no ratable hearing loss.²

In a September 28, 2001 report, Dr. Paul B. Pyle, an attending Board-certified otolaryngologist, noted appellant's history of working in a carpentry shop at the employing establishment since 1977, with no hearing protection issued during his first year of employment, and ear plugs in use thereafter. Dr. Pyle related appellant's symptoms of "progressive hearing loss with bilateral tinnitus" and "some symptoms of vertigo." Dr. Pyle noted that appellant had no history of ear infections, no nonoccupational exposure to hazardous noise and no family history of hearing loss. Dr. Pyle obtained an audiogram showing bilateral high frequency sensorineural hearing loss, worse on the left. In the left ear, the threshold at 3,000 Hz was 65 dBs, at 4,000 Hz 50 dBs and 65 dBs at 8,000 Hz. On the right, Dr. Pyle found normal hearing at 3,000 Hz, with a 50-decibel threshold at 4,000 Hz, 60 dBs at 6,000 and 65 dBs at 8,000 Hz. Dr. Pyle also found 100 percent discrimination at 45 dBs on the right and 88 percent discrimination at 50 dBs on the left. Dr. Pyle diagnosed "high frequency sensorineural hearing loss with secondary tinnitus.... [H]is hearing loss is secondary to noise exposure and his tinnitus is secondary to that hearing loss," and was atypical of presbycusis both in age of onset and pattern of loss. Dr. Pyle commented that appellant's vertigo appeared unrelated to his hearing loss or tinnitus.

¹ A March 17, 1994 audiogram performed at the employing establishment showed the following thresholds at 500, 1,000, 2,000 and 3,000 Hz: on the left, 10, 5, 5 and 55 dBs; on the right; 0, 5, 0 and 5 dBs. An April 10, 1995 audiogram performed at the employing establishment showed the following thresholds at 500, 1,000, 2,000 and 3,000 Hz: on the left, 5, 5, 5 and 60 dBs; on the right; 5, 10, 5 and 5 dBs. April 1, 1996 occupational health clinic note, Jack Friend, a physician's assistant, noted a history of occupational complaints of tinnitus. Mr. Friend obtained an audiogram showing the following thresholds at 500, 1,000, 2,000 and 3,000 Hz: on the left, 5, 5, 10 and 65 dBs; on the right; 5, 5, 5 and 10 dBs. A February 26, 1997 audiogram showed the following thresholds at 500, 1,000, 2,000 and 3,000 Hz: on the left, 5, 10, 5 and 60 dBs; on the right; 10, 5, 0 and 10 dBs. A March 23, 1998 audiogram performed at the employing establishment showed the following thresholds at 500, 1,000, 2,000 and 3,000 Hz: on the left, 10, 10, 10 and 65 dBs; on the right; 10, 10, 5 and 15 dBs.

² A February 14, 2000 audiogram performed at the employing establishment showed the following thresholds at 500, 1,000, 2,000 and 3,000 Hz: on the left, 5, 10, 10 and 65 dBs; on the right; 10, 10, 5 and 15 dBs. A May 29, 2001 audiogram showed the following thresholds at 500, 1,000, 2,000 and 3,000 Hz: on the left, 10, 10, 10 and 65 dBs; on the right; 15, 10, 0 and 20 dBs.

On October 24, 2001 appellant claimed a schedule award for hearing loss and tinnitus.³

In a March 19, 2002 report, Dr. Pyle noted obtaining an audiogram showing “a high frequency sensorineural hearing loss. The left ear dropped to 80 dBs at 3000 Hz and rose up to 65 dBs at 8000 Hz which is characteristic for a noise induced hearing loss.” Regarding causal relationship, Dr. Pyle opined that appellant’s hearing loss was “related to noise exposure.... Tinnitus occurs in a patient with hearing loss because of abnormal firing of the hair cells of the inner ear. There [is] heavy logic data to support this and his tinnitus is the result of his hearing loss.” Dr. Pyle noted that was no significant family history of early onset hearing loss.

On May 14, 2002 the Office of Workers’ Compensation Programs referred appellant, the record and a statement of accepted facts to Dr. John Keebler, an otolaryngologist, for a second opinion evaluation. The Office noted that appellant had worked and continued to work “around saws, drills, hammers, routers, etc.”

In a June 18, 2002 report, Dr. Keebler reviewed the record and acknowledged appellant’s work history. Dr. Keebler obtained an audiogram showing the following thresholds at 500, 1,000, 2,000 and 3,000 Hz: on the left, 25, 15, 20 and 70 dBs; on the right; 20, 15, 5 and 25 dBs. Speech reception thresholds were at 15 dbS bilaterally, with auditory discrimination scores of 84 percent on the right and 1,000 percent on the left. Dr. Keebler stated that audiograms since 1992 showed a progressive decrease in hearing greater than that expected due to age. He also noted appellant’s symptoms of tinnitus, with vertigo requiring further evaluation. Dr. Keebler diagnosed a bilateral high frequency sensorineural hearing loss, due to occupational noise exposure. He explained that appellant had more than 20 years of noise exposure at work, and that the specific loss at 4000 Hz and above was indicative of noise-induced hearing loss. Dr. Keebler recommended that appellant wear ear protection at all times, “avoid noise,” “mask tinnitus,” and undergo an evaluation for vertigo.

In a June 24, 2002 report, an Office medical adviser reviewed Dr. Keebler’s June 18, 2002 report. For the right ear, the Office medical adviser totaled the frequency losses of 20, 15, 5 and 25 dBs to total 65 dBs. He then divided the total of 65 by four, resulting in 16.25 dBs. The adviser then subtracted the “fence” of 25 dBs, leaving a monaural loss of zero percent. For the left ear, the Office medical adviser totaled the 25, 15, 20 and 70-decibel losses to equal 130 dBs. He then divided the total of 130 by 4, to equal 32.50 dBs. The adviser then subtracted the “fence” of 25 dBs, to equal 7.5. When multiplied by the 1.5 monaural loss factor, this equaled an 11.25 percent monaural loss of hearing in the left ear, rounded down to 11 percent.

³ On October 24, 2001 at the direction of the Office, appellant also filed a notice alleging a recurrence of disability beginning May 21, 2001 related to Claim No. 06-0590743. Appellant asserted that a continued deterioration of his hearing was attributable to exposure to hazardous noise in the workplace from June 1, 1978 onward. The employing establishment stated that appellant continued to be exposed to hazardous noise at work, but was provided with earplugs. In a May 3, 2002 letter, Judy B. Kerr, administrator of the employing establishment’s injury compensation program, noted that appellant had “an active hearing loss claim, Claim No. 060590743,” with an injury date of June 1, 1978. Appellant then filed a claim for “hearing loss with tinnitus, which was diagnosed as early as April 1992.” Ms. Kerr noted that appellant had continuous occupational exposure to hazardous noise since May 1994 and was still working in that position.

The Office medical adviser therefore determined that appellant was entitled to a schedule award for an 11 percent permanent monaural loss of hearing in the left ear.

On June 25, 2002 the Office accepted that appellant sustained a bilateral hearing loss in the performance of duty. The Office noted that “[m]edical documentation fail[ed] to support the need for hearing aids at this time.”

By decision dated September 16, 2002, the Office awarded appellant a schedule award for an 11 percent permanent monaural hearing loss in the left ear. The award, equivalent to 5.75 weeks of compensation at the 3-quarters rate, ran from June 11 to July 21, 2002.

The Board finds that appellant has not established that he sustained greater than an 11 percent monaural hearing loss in the left ear, for which he received a schedule award.

The schedule award provisions of the Federal Employees’ Compensation Act⁴ and its implementing regulation⁵ set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss, or loss of use, of members or functions of the body listed in the schedule. The Act, however, does not specify the manner in which the percentage loss of a member shall be determined. To ensure equal justice to all claimants and consistent results, good administrative practice necessitates the use of a uniform standard, a single set of tables applicable to all claimants. The American Medical Association, *Guides to the Evaluation of Permanent Impairment* has been adopted by the implementing regulations as the appropriate standard in evaluating schedule losses.⁶ as the uniform standard applicable to all claimants.⁷

The Office evaluates hearing loss in accordance with the standards set forth in the A.M.A., *Guides*.⁸ Using the frequencies of 500, 1,000, 2,000 and 3,000 Hz (cycles per second), the losses at each frequency are added up and averaged.⁹ Then, the “fence” of 25 dBs is subtracted from that total, because, as the A.M.A., *Guides* points out, losses below 25 dBs do not impair the ability to hear everyday speech under everyday conditions.¹⁰ The losses at each frequency are added up and averaged and a “fence” of 25 dBs is deducted since, as the A.M.A., *Guides* points out, losses below 25 dBs result in no impairment in the ability to hear everyday speech in everyday conditions.¹¹ The remaining amount is multiplied by 1.5 to arrive at the

⁴ 5 U.S.C. § 8107. See generally 5 U.S.C. §§ 8101-8193.

⁵ 20 C.F.R. § 10.404 (1999).

⁶ *Id.*

⁷ *Jimmy B. Newell*, 39 ECAB 181 (1987).

⁸ A.M.A., *Guides* at 250 (5th ed. 2001).

⁹ *Id.*

¹⁰ *Id.*

¹¹ *Id.*

percentage of monaural hearing loss.¹² 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.¹³ The Board has concurred in the Office's adoption of this standard for evaluating hearing loss.¹⁴

Under the A.M.A., *Guides*, hearing loss is evaluated by determining decibel loss at the following frequency levels: 500, 1,000, 2,000 and 3,000 Hz. The losses at each frequency are added up and averaged and a "fence" of 25 dBs is deducted since, as the A.M.A., *Guides* points out, losses below 25 dBs result in no impairment in the ability to hear everyday speech in everyday conditions.¹⁵ 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 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.¹⁶

The Office medical adviser applied the Office's standardized procedures to the June 18, 2002 audiogram performed for Dr. Keebler. Testing for the right ear at the frequency levels of 500 1,000 2,000 and 3,000 Hz revealed decibel losses of 20, 15, 5 and 25. These dBs were totaled at 65 dBs and were divided by four to obtain the average hearing loss at those cycles of 16.25 dBs. The average of 16.25 dBs was then reduced by 25 dBs (the first 25 dBs 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 Hz revealed decibel losses of 25, 15, 20 and 70. These dBs were totaled at 130 dBs and were divided by four to obtain the average hearing loss at those cycles of 32.50 dBs. The average of 32.50 dBs was then reduced by 25 dBs (the first 25 dBs were discounted as discussed above) to equal 7.50, which was multiplied by the established factor of 1.5 to compute an 11 percent loss of hearing for the left ear. Accordingly, pursuant to the Office's standardized procedures, the Office medical adviser determined that appellant had a nonratable hearing loss in the right ear and an 11 percent loss of hearing in the left ear.

Appellant contends on appeal that he has greater than the 11 percent loss of hearing on the left, and a ratable hearing loss on the right. However, the Board finds that the Office medical adviser applied the proper standards to the findings stated in Dr. Keebler's June 18, 2002 report and audiometric evaluation, resulting in a calculation of an 11 percent hearing loss on the left

¹² *Id.*

¹³ *Id.*; see also *Danniel C. Goings*, 37 ECAB 781, 784 (1986).

¹⁴ *Donald E. Stockstaad*, 53 ECAB ____ (Docket No. 01-1570, issued January 23, 2002), *petition for recon. granted* (modifying prior decision), Docket No. 01-1570 (issued August 13, 2002).

¹⁵ A.M.A., *Guides* at 250 (5th ed. 2001).

¹⁶ *Id.*; see also *Danniel C. Goings*, *supra* note 13.

and a zero percent hearing loss on the right. As noted above, the standards applied to appellant's case are the same standards applied to all employees in hearing loss claims under the Act.¹⁷

Consequently, appellant has not established that he sustained greater than an 11 percent hearing loss on the left or a ratable hearing loss on the right, as he has not submitted any medical evidence indicating a greater percentage of hearing loss that already awarded.¹⁸

The decision of the Office of Workers' Compensation Programs dated September 16, 2002 is hereby affirmed

Dated, Washington, DC
March 3, 2003

Alec J. Koromilas
Chairman

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member

¹⁷ Appellant remains entitled to appropriate medical benefits for his work-related condition.

¹⁸ On appeal, appellant asserts that he is entitled to an additional schedule award for the condition of tinnitus. The Office has not accepted the condition of tinnitus as work related, only the hearing loss. Also, there is no provision under the Act for a schedule award for the condition of tinnitus. The Board notes that the A.M.A., *Guides* states that "tinnitus in the presence of unilateral or bilateral hearing impairment may impair speech discrimination. Therefore, add up to five percent for tinnitus in the presence of measurable hearing loss if the tinnitus impacts the ability to perform activities of daily living." A.M.A., *Guides* (5th ed. 2001) Chapter 11.2a, "Criteria for Rating Impairment Due to Hearing Loss," page 246. However, the Office has not accepted the condition of tinnitus. Arguendo, appellant has not submitted evidence that his tinnitus has impacted his "ability to perform activities of daily living."