United States Department of Labor
Employees' Compensation Appeals Board

J.B., Appellant	)	
and	)	**Docket No. 08-2101**
	)	**Issued: July 1, 2009**
DEPARTMENT OF LABOR, OCCUPATIONAL SAFETY & HEALTH ADMINISTRATION, Sacramento, CA, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On July 25, 2008 appellant filed a timely appeal from decisions of the Office of Workers' Compensation Programs dated December 19, 2007 and April 24, 2008 that denied modification of an April 3, 2007 schedule award decision. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3(e), the Board has jurisdiction over the merits of the schedule award.

ISSUE

The issue is whether appellant has more than 25 percent binaural hearing loss for which he has received a schedule award.

FACTUAL HISTORY

This case has previously been before the Board. By decision dated January 5, 2000, the Board found that the Office improperly denied appellant's request for reconsideration of a claim that he sustained an employment-related ear infection, an ear-drainage condition and hearing loss caused by frequent air travel in 1992. The Board remanded the case to the Office for

determination on the issue of whether these conditions were caused or aggravated by factors of employment.[1] In a decision dated July 2, 2001, the Board remanded the case to the Office for referral to an appropriate medical specialist to be followed by a *de novo* decision.[2] Following appellant's third appeal to the Board, by decision dated February 14, 2003, the Board again remanded the case to the Office. The Board found that the second opinion evaluation relied upon by the Office was not responsive to the Board's July 2, 2001 remand order. The Office was to again refer appellant for an appropriate medical evaluation.[3] The above three decisions were adjudicated under Office file number xxxxxx853. Under Office file number xxxxxx766, by decision dated October 5, 2004, the Board found that appellant failed to establish that he sustained multiple chemical sensitivity or a cervical condition causally related to factors of his federal employment and that his claim for an employment-related noise-induced hearing loss was not in posture for decision. The Board remanded the case to the Office for doubling with file number xxxxxx853. The Office was directed to prepare an updated statement of accepted facts and refer appellant, together with both case records and questions to be answered, to a Board-certified specialist for a detailed opinion regarding whether any of appellant's ear conditions and/or hearing loss were employment related, to be followed by an appropriate decision.[4] On January 3, 2006 the Board affirmed a February 8, 2005 Office decision that found appellant had not sustained an employment related noise-induced hearing loss.[5] The law and the facts of the most recent Board decisions are incorporated herein by reference.

On June 10, 2003 the Office accepted that appellant sustained aggravation of bilateral otitis media with resultant perforations of the bilateral tympanic membranes and secondary conductive hearing loss. Subsequent to the Board's October 5, 2004 decision, the Office doubled files numbered xxxxxx853 and xxxxxx766. It referred appellant, together with a statement of accepted facts, to Dr. Stuart Gherini, Board-certified in otolaryngology, for a second opinion evaluation. In a December 22, 2004 report, Dr. Gherini diagnosed right ear mild low frequency to moderately severe high frequency mixed hearing loss and left ear mild low frequency-to-severe high frequency mixed hearing loss. He provided audiometric results and advised that appellant's sensorineural hearing loss was not due to noise exposure but that the conductive component of his hearing loss was employment related, explaining that the ear infections he had sustained left him with a large thin portion of the pars tensa on the right and a large central tympanic membrane perforation on the left, which led to the conductive component of his hearing loss. Dr. Gherini advised that, in accordance with the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*),[6] appellant had a monaural impairment of 22.5 percent on the right and 35.6 percent on the left or a 24.7 percent binaural impairment.

[1] Docket No. 97-2123 (issued January 5, 2000).

[2] Docket No. 00-2564 (issued July 2, 2001).

[3] Docket No. 02-903 (issued February 14, 2003).

[4] Docket No. 04-625 (issued October 5, 2004).

[5] Docket No. 05-1193 (issued January 3, 2006).

[6] A.M.A., *Guides*; *Joseph Lawrence, Jr.*, 53 ECAB 331 (2002).

In a report dated January 26, 2005, an Office medical adviser agreed with Dr. Gherini's conclusion that appellant's hearing loss was not due to employment-related noise exposure, but caused by damage to his tympanic membranes due to frequent work-related travel. He reviewed Dr. Gherini's audiometric findings, advising that appellant had 25 percent binaural hearing loss and that maximum medical improvement had been reached on December 22, 2004. The Office medical adviser concluded that appellant was eligible for a schedule award and hearing aids.

On March 11, 2005 appellant submitted a schedule award claim and audiometric evaluations dated November 9, 1993 to April 6, 2005, and medical reports dated May 16, 2003 to October 17, 2006 from Dr. Michael J. Kearns, a Board-certified otolaryngologist, who provided examination findings and diagnosed chronic external otitis, tympanic membrane perforation and conductive and sensorineural hearing loss.

By decision dated April 3, 2007, appellant was granted a schedule award for a 25 percent binaural hearing loss.

On May 28, 2007 appellant requested reconsideration and submitted a February 26, 2007 report in which Dr. Kearns reiterated his previous findings and conclusions. In a May 16, 2007 report, Dr. Kearns advised that appellant had been his patient for a number of years and provided a March 15, 2007 audiogram. He advised that, in accordance with the A.M.A., *Guides*, appellant had 31.9 percent impairment on the right and 46.9 percent impairment on the left, or a 34.4 percent binaural hearing impairment.

By decision dated July 18, 2007, the Office denied modification of the April 3, 2007 decision, finding that the March 15, 2007 audiogram was of diminished probative value as there was no evidence that it comported with Office procedural requirements.

On August 10, 2007 appellant again requested reconsideration and submitted a July 23, 2007 report in which Dr. Kearns advised that appellant had not been exposed to noise for 16 hours prior to the testing and reiterated his conclusion that, in accordance with the fifth edition of the A.M.A., *Guides*, appellant had a 31.9 percent hearing impairment on the right, a 46.9 percent impairment on the left and a binaural impairment of 34.4 percent. He advised that the audiometer had been calibrated in April 2006 and April 2007 and resubmitted the March 15, 2007 audiogram.

In an August 26, 2007 report, an Office medical adviser noted that Dr. Kearns' statement that the audiometer had been calibrated was not adequate under Office procedures and that there was no indication that appellant had an otologic evaluation on March 15, 2007. He further advised that, if the above issues were resolved, the issue of whether the worsened hearing loss was due to the accepted condition would have to be determined. The Office medical adviser concluded that the March 15, 2007 audiogram and Dr. Kearns' July 23, 2007 report were insufficient to establish greater impairment.

By decision dated September 14, 2007, the Office denied modification of the prior decisions. It found that the weight of the medical evidence was represented by opinions of Dr. Gherini and the Office medical adviser.

On September 30, 2007 appellant again requested reconsideration. In a March 15, 2007 report, Dr. Kearns provided examination findings and noted that audiometry was performed that day. He diagnosed sensorineural and conductive hearing loss, resubmitted the March 15, 2007 test results and a certificate of audiometer calibration dated April 6, 2007. In a November 18, 2007 report, an Office medical adviser noted that the certificate of calibration postdated the March 15, 2007 audiogram and that the record did not include an opinion that appellant's hearing had worsened due to the accepted condition. By decision dated December 19, 2007, the Office denied modification of the prior decisions.

On February 3, 2007 appellant again requested reconsideration and submitted a January 31, 2008 report, in which Dr. Kearns advised that he performed otologic examination on January 30, 2008, noting that appellant was last exposed to noise on January 23, 2008. Dr. Kearns provided examination findings, and advised that, after a long discussion with appellant, it was not their contention that his hearing loss had worsened due to the accepted condition, rather, that the January 26, 2005 audiogram relied upon by the Office in rendering the April 3, 2007 schedule award did not accurately reflect appellant's hearing level. He enclosed audiograms dated April 29, 2004, April 6, 2005 and January 30, 2008 and advised that, in accordance with the A.M.A., *Guides*, these demonstrated bilateral hearing losses of 44.7, 26.9 and 31.9 percent respectively.

In a March 7, 2008 report, an Office medical adviser noted that the event causing appellant's accepted aggravation of bilateral otitis media with resultant perforations of the bilateral tympanic membranes and secondary conductive hearing loss, occurred in 1992, and that any worsening hearing loss after that time would be due to presbycusis, not the ear infection in 1992. He opined that Dr. Kearns' opinion that appellant had a hearing loss greater than the 25 percent awarded was not supported by medical rationale, noting that the audiograms provided by Dr. Kearns showed great variability in test results which raised real concerns regarding validity and credibility issues. The Office medical adviser concluded that the schedule award should not be modified.

By decision dated April 24, 2008, the Office denied modification of the prior decisions.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act[7] specifies the number of weeks of compensation to be paid for permanent loss of use of specified members, functions and organs of the body.[8] The Act does not, however, specify the manner by which the percentage loss of a member, function or organ shall be determined. The method used in making such a determination is a matter which rests in the sound discretion of the Office. 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.[9] The Office evaluates industrial hearing loss in accordance with the standards

[7] 5 U.S.C. §§ 8101-8193.

[8] *Id.* at § 8107(c).

[9] *Renee M. Straubinger*, 51 ECAB 667 (2000).

contained in the A.M.A., *Guides*.[10] Using the frequencies of 500, 1,000, 2,000 and 3,000 cycles per second, the losses at each frequency are added and averaged.[11] The "fence" of 25 decibels is then 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.[12] The remaining amount is multiplied by a factor of 1.5 to arrive at the percentage of monaural hearing loss.[13] 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.[14] The Board has concurred in the Office's adoption of this standard for evaluating hearing loss.[15]

Office procedures provide that both audiometric and otologic examination be performed; that the audiometric testing precede the otologic examination; that the audiometric testing be performed by an appropriately certified audiologist, that the otologic examination be performed by an otolaryngologist certified or eligible for certification and that the audiometric and otologic examination be performed by different individuals as a method of evaluating the reliability of the findings. Office procedures require that all audiological equipment meet the calibration protocol contained in the accreditation manual of the American Speech and Hearing Association and that audiometric test results include bone conduction and pure tone air conduction thresholds, speech reception thresholds and monaural discrimination scores. The otolaryngologist report must include: date and hour of examination; date and hour of employee's last exposure to loud noise, a rationalized medical opinion regarding the relation of the hearing loss to the employment-related noise exposure and a statement of the reliability of the tests.[16]

When several audiograms are in the case record and all are made within approximately two years of one another and are submitted by more than one physician, the Office should give an explanation for selecting one audiogram over the others.[17]

ANALYSIS

In this case, the record contains numerous audiograms dated September 3, 1991 to January 30, 2008. There are only two audiograms, however, that meet the calibration protocol required under Office procedures. A certification must accompany each audiological battery indicating that the instrument calibration and the environment in which the tests were conducted

[10] A.M.A., *supra* note 6.

[11] *Id.* at 250.

[12] *Id*.

[13] *Id*.

[14] *Id*.

[15] *Horace L. Fuller*, 53 ECAB 775 (2002).

[16] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Requirements for Medical Reports*, Chapter 3.600.8(a) (September 1995). *See J.H.*, 59 ECAB ____ (Docket No. 07-2304, issued March 6, 2008).

[17] *Paul M. Sawko*, 50 ECAB 365 (1999).

met specified accreditation standards.[18] The two audiograms that are in compliance are the December 22, 2004 report from Dr. Gherini and the January 30, 2008 report from Dr. Kearns.[19]

In a report dated January 26, 2005, the Office medical adviser noted his review of Dr. Gherini's report and audiometric findings. He authorized hearing aids and applied the Office's standardized procedures to the December 22, 2004 audiogram performed on Dr. Gherini's behalf which recorded frequency levels at the 500, 1,000, 2,000 and 3,000 cycles per second levels and revealed decibel losses of 25, 30, 45 and 60 respectively in the right ear for a total decibel loss of 160 on the right. The Office medical adviser then followed established procedures and divided this total by 4 which resulted in an average loss of 40 decibels and subtracted the fence of 25 decibels to equal 15 decibels, multiplied this by the established factor of 1.5, to result in a 22.5 percent monaural hearing loss for the right ear. He properly followed the same procedure on the left, noting that the test results for the left ear at the frequencies of 500, 1,000, 2,000 and 3,000 cycles per second revealed decibel losses of 25, 50, 50 and 70 decibels respectively, for a total of 195 decibels. The Office medical adviser divided this by 4, for an average hearing loss of 48.75 decibels, subtracted the fence of 25 decibels to equal 23.75 decibels, and multiplied this by the established factor of 1.5, for a 36.625 percent monaural hearing loss for the left ear. He then multiplied the 22.5 percent monaural hearing loss for the right ear by 5, as it was the lesser loss, to find a product of 112.5. As the procedures provide, the Office medical adviser then added the 112.5 to the 36.625 percent hearing loss for the left ear, to obtain a total of 149.125 which was divided by 6 in order to calculate a binaural hearing loss of 24.854 percent which, when rounded up, yielded a 25 percent binaural hearing loss.[20]

Dr. Kearns submitted a January 30, 2008 audiogram that a 33 percent binaural hearing loss.[21] In an accompanying report, however, he advised that, after a long discussion with appellant, it was not their contention that appellant's hearing loss had worsened due to the accepted condition but that the January 26, 2005 audiogram relied upon by the Office in its April 3, 2007 schedule award did not accurately reflect appellant's hearing level. Dr. Kearns also enclosed audiograms dated April 29, 2004 and April 6, 2005.

[18] *Vernon Brown*, 54 ECAB 376 (2003).

[19] Dr. Gherini provided a calibration certificate dated December 14, 2004 and Dr. Kearns a certificate dated April 6, 2007.

[20] Office procedures provide that in computing binaural hearing loss percentages should not be rounded until the final percent for award purposes is obtained and fractions should be rounded down from .49 or up from .50. Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.4.b(2)(b) (March 2005). It is also well established that, if calculations based on the monaural loss for each ear would result in greater compensation than calculations for binaural loss, then the monaural hearing loss calculations should be used. *Reynaldo R. Lichtenberger*, 52 ECAB 462 (2001). In this case appellant's compensation is greater under the procedures used for calculating binaural loss.

[21] The January 30, 2008 audiogram recorded frequency levels at the 500, 1,000, 2,000 and 3,000 hertz levels and revealed decibel losses of 30, 30, 60 and 60 respectively in the right ear for a total decibel loss of 180 on the right and decibel losses of 30, 55, 60 and 75 decibels on the left, for a total of 220 decibels. Established procedures yielded a binaural hearing loss of 24.854 percent, rounded up to a 25 percent binaural hearing loss.

In a March 7, 2008 report, the Office medical adviser noted that, as the event causing the accepted conditions and secondary conductive hearing loss, occurred in 1992, any worsening hearing loss after that time would be due to presbycusis. He advised that Dr. Kearns' opinion that appellant had a hearing loss greater than the 25 percent awarded was not supported by adequate medical rationale, noting that the audiograms provided by Dr. Kearns showed great variability in test results which raised concern regarding the test validity and credibility issues. The Office medical adviser concluded that the schedule award should not be modified.

The record contains numerous audiograms done for Dr. Kearns. Those dated May 2, 2003, April 29 and June 25, 2004, April 6, 2005 and March 15, 2007 demonstrate bilateral hearing losses of 20, 43, 49, 27, and 34 percent respectively. While none of these conform to the procedural requirements for audiographic study, they do demonstrate wide variability as noted by the Office medical adviser. The audiograms performed in January and November 1993 and April 1995, closer in time to the events causing the conductive hearing loss, demonstrated a 0 percent, 6 percent and 10 percent binaural hearing loss.

The Board finds the weight of the medical evidence rests with the opinions of Dr. Gherini and the Office medical adviser. Dr. Gherini's audiological report complied with Office procedural requirements. While Dr. Kearn's January 30, 2008 audiogram was also in compliance, he did not provide a rationalized explanation to either show that the Office erred in relying on Dr. Gherini's December 22, 2004 audiogram or that any worsening of appellant's binaural hearing loss was due to the accepted conductive hearing loss. Therefore, based on the evidence of record, appellant has not established that he is entitled to a binaural hearing loss greater than the 25 percent awarded.

CONCLUSION

The Board finds that appellant did not meet his burden of proof to establish that he is entitled to a schedule award for his employment-related hearing loss greater than the 25 percent awarded.

ORDER

IT IS HEREBY ORDERED THAT the decisions of the Office of Workers' Compensation Programs dated April 24, 2008 and December 19, 2007 be affirmed.

Issued: July 1, 2009
Washington, DC

Alec J. Koromilas, Chief Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board