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

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| **C.B., Appellant** | ) | |
| **and** | ) | **Docket No. 25-0598** |
| | ) | **Issued: November 19, 2025** |
| **DEPARTMENT OF HOMELAND SECURITY, FEDERAL LAW ENFORCEMENT TRAINING CENTER, Glynco, GA, Employer** | ) | |

*Appearances:*
*Wayne Johnson, Esq.,* for the appellant[1]
*Office of Solicitor*, for the Director

*Case Submitted on the Record*

## DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
JANICE B. ASKIN, Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

### ***JURISDICTION***

On June 3, 2025 appellant, through counsel, filed a timely appeal from a December 5, 2024 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.*; *see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

## ***ISSUE***

The issue is whether appellant has met his burden of proof to establish a monaural (left ear) hearing loss and left ear tinnitus causally related to the accepted factors of his federal employment.

## ***FACTUAL HISTORY***

On July 12, 2021 appellant, then a 61-year-old retired training instructor, filed an occupational disease claim (Form CA-2) alleging that he sustained left-sided hearing loss resulting from continuous noise exposure due to factors of his federal employment including instructing students during live fire shooting exercise on the firing range. He noted that he first became aware of his condition on March 20, 2020, and realized its relation to his federal employment on May 17, 2021. On the reverse side of the claim form, the employing establishment noted that appellant had retired on February 28, 2017.

In an accompanying narrative statement, appellant noted his history of employment working as a deputy sheriff from 1991 through 1995 where he was only exposed to noise from firearms once yearly for two hours while wearing double hearing protection during their live fire exercises. He related that he worked as a correctional officer from 1995 through 2003 and was only exposed to noise from firearms once yearly for four hours while wearing double hearing protection during live fire exercises. Appellant reported working for the employing establishment as a firearms instructor from 2003 through 2017. He described his duties as a firearms instructor where he was exposed to employment-related noise from gunfire for four to six hours per day, approximately 20 to 24 hours per week, and would wear double hearing protection during the live fire exercises. Appellant reported no outside hobbies or activities that would expose him to loud noises and no history of hearing problems. He further reported that he was no longer exposed to loud noises since retiring from the employing establishment in February 2017. Appellant complained of hearing loss in his left ear, which he began to notice in June 2019.

In a May 17, 2021 report, Dr. Joseph H. Bee, an osteopath specializing in ophthalmology and otolaryngology, reported that appellant presented with hearing loss left greater than right from longer-term positive loud noise exposure in the past as a firearms instructor.[3] Appellant denied any sudden onset of hearing loss, reporting that he gradually noticed it over several years and after an evaluation with an ear, nose, and throat (ENT) doctor several years ago, was told he may have a viral infection. Dr. Bee diagnosed sensorineural hearing loss of the left ear with unrestricted hearing of the right ear and tinnitus of the left ear.

In a July 27, 2021 development letter, OWCP informed appellant of the deficiencies of his claim. It advised him of the type of factual and medical evidence needed to establish his claim

[3] Dr. Bee's four-page report was missing page 3 of 4 which was received by OWCP on August 23, 2021. In the third page of the May 17, 2021 report, he related that appellant noted undergoing a magnetic resonance imaging (MRI) scan of the brain several years ago when he was first evaluated for asymmetric hearing loss by an ENT and no acoustic neuroma or retrocochlear pathology was found. Dr. Bee opined that appellant was likely suffering from asymmetric hearing loss from loud noise exposure in the past as this was the ear closely associated with the loud noise exposure from the firearms. He reported that appellant could benefit from hearing aid evaluation and adjustment with audiology hearing preservation strategies.

and provided a questionnaire for his completion. By separate development letter of even date, OWCP requested additional information from the employing establishment, including comments from a knowledgeable supervisor on the accuracy of the employees' statements and factual and medical evidence related to appellant's employment-related noise exposure. It afforded both parties 30 days to submit the requested information.

On August 23, 2021 the employing establishment reviewed appellant's Form CA-2 statement and concurred with his responses. It also submitted an official position description for appellant's job.

In an August 14, 2021 statement, received on August 23, 2021, appellant responded to OWCP's questionnaire and provided additional details regarding his left-sided hearing loss. He reported that in 2017 he first noticed pain in his ears when on a flight and was evaluated by an allergist in reference to his ear pain who examined his sinuses, ears, and throat and found his results to be negative. Appellant further explained that he was initially evaluated by Dr. Steven Y. Ho, a Board-certified otolaryngologist, in May 2020 when he was experiencing dizziness and ringing in his left ear. He reported that after visiting Dr. Bee, in May 2021, and through extensive discussions about his employment as a firearms instructor where he was exposed to loud noise for over 14 years, he reflected on the fact that as he taught firearms trainings, that approximately 95 percent of his students were right-handed and his approach would be to stand by their right hand, which put his left ear close to the weapons during the live fire exercises. Appellant reported that following his retirement, he was hired as a security guard from 2017 through 2019 where the source of noise was everyday conversations.

Along with his statement, appellant submitted additional medical evidence in support of his claim. In a May 11, 2020 audiogram, Maija Sweeney, an audiologist, reported that appellant's testing revealed severe left-sided sensorineural hearing loss and right sided mild-to-normal hearing.

In a partial report dated December 14, 2020, Dr. Ho noted his treatment of appellant on December 14, 2020 for complaints of hearing loss in the left ear, which may have appeared somewhat suddenly on April 20, 2020. He noted that appellant was a firearms instructor but reported wearing strict hearing protection at work. Dr. Ho reported a history of treatment noting that his initial evaluation on May 11, 2020, identified findings suggestive of a sudden left-sided profound sensorineural hearing loss. At that time, appellant was placed on a high dose oral steroid for treatment and sent for an MRI scan of the internal auditory canal (IAC), which ruled out a retrocochlear pathology. Dr. Ho reported evaluating appellant in May 2020 because the left-sided hearing loss had appeared, and again in October 2020 due to an increased right aural fullness. An evaluation on October 19, 2020 identified significant right middle ear underventilation and appellant was placed on a course of antibiotics and intra-nasal steroid therapy. Over the following three weeks, he reported improved symptoms with a follow-up audiogram on November 9, 2020 showing stable right ear results. Dr. Ho reported that appellant was continued on eustachian tube dysfunction treatment and reported no new symptoms.

OWCP received audiograms and hearing conservation data dated August 26, 2003 through August 9, 2016 as part of the employing establishment's hearing conservation program. Appellant's August 26, 2003 audiogram demonstrated at 500, 1,000, 2,000, and 3,000 Hertz (Hz):

0, 0, 10, and 10 decibels (dBs) for the right ear and 0, 0, 0, and 0 dBs for the left ear, respectively. His August 9, 2016 audiogram demonstrated at 500, 1,000, 2,000, and 3,000 Hz: 0, 0, 10, and 5 dBs for the right ear, and 15, 5, 0, and 5 dBs for the left ear, respectively.

In a letter dated September 1, 2021, OWCP requested that the employing establishment provide additional information regarding when appellant was last exposed to the work factors that caused his injury and whether he was working full-time full duty prior to his retirement date, noting that he was no longer exposed to hazardous noise as of February 28, 2017, when he retired. No response was received.

On September 8, 2021 OWCP referred appellant, along with the medical record, a statement of accepted facts (SOAF), and a series of questions, to Dr. Stephen Yavelow, a Board-certified otolaryngologist serving as a second opinion physician, regarding the nature and extent of appellant's hearing loss, and whether there was any causal relationship between appellant's diagnosed hearing loss and his accepted employment exposure.

In a report dated October 4, 2021, Dr. Yavelow noted his review of the SOAF, history of injury, and medical evidence of record. He noted that appellant had normal hearing in 2003; that his left-sided hearing loss suddenly developed in March 2020, which was documented in May 2020; and that an August 2016 audiogram revealed normal findings. Dr. Yavelow noted that appellant's right-sided hearing was normal, and his MRI scan revealed normal findings. Audiometric testing obtained on October 4, 2021 at the frequencies of 500, 1,000, 2,000, and 3,000 Hz revealed losses at 25, 15, 5, and 5 dBs for the right ear, respectively; and 85, 80, 75, and 75 dBs for the left ear, respectively. He diagnosed severe left sensorineural hearing loss and left tinnitus. Dr. Yavelow opined that appellant's left sensorineural hearing loss was not due to noise exposure encountered in his federal employment and that his "left[-]sided hearing loss was sudden, most likely viral in etiology and not related to noise exposure in the workplace." He recommended hearing aids. When reviewing the audiometric test results, Dr. Yavelow noted that there was a marked audiometric discrepancy between each ear but noted that it was not likely due to noise exposure. He further found that appellant reached maximum medical improvement (MMI) on October 4, 2021, and sustained 83 percent monaural hearing loss of the left ear and 14 percent binaural hearing loss, which included four percent for tinnitus.

By decision dated October 18, 2021, OWCP denied appellant's occupational disease claim, finding that the medical evidence of record was insufficient to establish causal relationship between the monaural (left ear) hearing loss and left ear tinnitus and the accepted factors of his federal employment. Therefore, it concluded that the requirements had not been met to establish an employment-related injury or condition.

On November 17, 2021 appellant requested an oral hearing before a representative of OWCP's Branch of Hearings and Review. A hearing was held on March 21, 2022.

By decision dated May 25, 2022, OWCP's hearing representative affirmed the October 18, 2021 decision.

On May 25, 2023, appellant, through counsel, requested reconsideration.

In a June 23, 2022 audiogram, Nicole Derda, an audiologist, reported that appellant's testing revealed left ear mild-to-severe sensorineural hearing loss at 500 Hz and above while the right ear revealed hearing within normal limits. In a report of even date, she diagnosed left ear sensorineural hearing loss with unrestricted hearing on the contralateral side, left ear tinnitus, bilateral ear pressure sensation, and dizziness.

In a June 23, 2022 report, Dr. James Atkins, a Board-certified neurotologist and otolaryngologist, reported a history of injury. He reviewed the findings of the audiogram conducted on that date and diagnosed unilateral left ear sensorineural hearing loss with unrestricted hearing on the contralateral side and dizziness.

By decision dated May 30, 2023, OWCP denied modification of the May 25, 2022 decision.

On May 30, 2024 appellant, through counsel, requested reconsideration, and submitted a May 20, 2020 MRI scan of the brain, which demonstrated no evidence of intracranial bleed, contrast-enhancing mass, or acute infarction; possible old left lacunar infarct or prominent asymmetric Virchow Robin space; no evidence of abnormal enlargement or enhancement of the 7th 8th nerve complexes to suggest schwannoma, neuritis or labyrinthitis; no evidence of abnormal enlargement of the endolymphatic ducts to suggest Meniere's disease; and mild primarily ethmoid mucous thickening.

In a completed copy of the December 14, 2020 report, Dr. Ho reported that appellant's left ear examination revealed normal findings while the right ear revealed an intact status with significant dullness. He reviewed appellant's audiogram, which demonstrated mild 8,000 Hz right-sided hearing loss while the left-sided hearing loss was severe-to-profound with a word recognition score of zero percent. Dr. Ho reported that the May 2020 MRI scan of the brain demonstrated no evidence of an IAC lesion, visible left middle ear and mastoid area showed normal aeration, and an old left lacunar infarct or prominent asymmetric Virchow Robin space. He diagnosed chronic eustachian salpingitis of the right ear, sudden idiopathic hearing loss of the left ear, tinnitus of the left ear, and dizziness and giddiness.

In a May 23, 2024 report, Dr. Atkins provided a history of injury and discussed appellant's medical history, audiology results, and examination findings. He opined that appellant's left-sided hearing loss was consistent with his employment exposure as his students were predominantly right-handed causing him to stand on their right side, which would be on his left resulting in noise exposure to the left ear. Dr. Atkins diagnosed left-ear sensorineural hearing loss, which was caused by exposure to loud noises, noting that all medical causes for hearing loss were ruled out. He further disagreed with Dr. Yavelow's opinion that appellant's hearing loss was caused by a viral infection, explaining that an infection would affect the middle ear. Dr. Atkins went on to explain that there was a correlation between firearm use and hearing loss, noting that he had evaluated individuals that used firearms recreationally, and as part of their occupation, and hearing loss would occur even with hearing protection, especially with someone who has had significant, continued exposure over a long period of time. He opined that appellant's sensorineural hearing loss in the left ear was a direct result of his workplace noise exposure.

On June 17, 2024 the employing establishment provided a noise survey report where it compiled previous noise studies completed at various firearm ranges at the employing establishment where firearms noise levels were tested. The study noted that the noise levels range from up to 140 dBs with peaks up to 165 dBs depending on weapons used in firearms classes.[4] It noted that double hearing protection with noise reduction ratings (NRR) of 26 or greater are required to be worn during firearms classes and calculated estimated employee exposure monitoring results average 65 to 85 dBs for eight-hour TWA according to weapons used and properly worn double hearing protection. The noise survey report further stated that firearms classes were two to eight hours per day with actual firearms shooting time of 45 minutes to 4 hours per day. When describing the type of ear protection used, the employing establishment noted that double hearing protection with NRR of 26 or greater were required to be worn during firearms classes, but also noted that some people have bone conduction or other factors that predispose them to hearing loss that hearing protection cannot prevent.

On June 18, 2024 OWCP determined that a conflict in the medical opinion evidence existed between Dr. Yavelow, the second opinion physician, and Dr. Atkins, appellant's treating physician, regarding whether appellant's left-sided hearing loss was causally related to noise exposure in his former federal employment.

On October 3, 2024 OWCP referred appellant, along with the medical record, a SOAF, and a series of questions, to Dr. David Greene, a Board-certified otolaryngologist, for an impartial medical examination, to resolve the conflict in medical opinion.

In a November 15, 2024 report, Dr. Greene, serving as the impartial medical examiner (IME), reviewed appellant's history of injury, medical treatment, and the SOAF. He examined appellant and provided physical examination findings. Dr. Greene diagnosed left sudden sensorineural hearing loss, documented in March 2020, with onset three years after retirement in 2017. He opined that the cause of the hearing loss was viral or idiopathic and not noise induced. Dr. Greene explained that appellant's hearing loss did not meet the criteria for noise-induced hearing loss as the onset was three years after retirement, there was no latency to noise-induced hearing loss or acoustic trauma, it did not develop in a delayed manner, and progression ended when exposure ended in 2017 and, therefore, hearing loss with onset three years after retirement was not caused by on-the-job noise exposure. Rather, he reported that appellant asserted that the timing was sudden, which was consistent with left-sided viral sudden sensorineural hearing loss *versus* idiopathic hearing loss but was not consistent with noise-induced hearing loss. Dr. Greene further noted that audiogram configuration of his left hearing loss was not consistent with noise causation as there was no noise notch after appellant had sudden hearing loss. As such, he opined that appellant was not exposed to high-frequency noise and did not have high-frequency sensorineural hearing loss. Dr. Greene further opined that appellant had flat hearing loss, worse in the low tones, which was consistent with sudden sensorineural hearing loss and not with noise-induced hearing loss. He disagreed with Dr. Atkins' report and with his opinion as there was no noise notch on the audiogram, he failed to account for the three-year delayed onset of hearing loss. Dr. Greene reported that he agreed with Dr. Yavelow's opinion that appellant did not sustain noise-

[4] The study noted that these were not eight-hour time-weight average (TWA) levels but actual noise levels of weapons.

induced hearing loss. He concluded that this was consistent with sudden sensorineural hearing loss that was viral or that it could be idiopathic as well.

By decision dated December 5, 2024, OWCP denied modification of the May 30, 2023 decision. It found that the special weight of the medical evidence rested with the opinion of Dr. Greene serving as the IME.

## ***LEGAL PRECEDENT***

An employee seeking benefits under FECA[5] has the burden of proof to establish the essential elements of his or her claim, including that the individual is an employee of the United States within the meaning of FECA, that the claim was timely filed within the applicable time limitation of FECA,[6] that an injury was sustained in the performance of duty as alleged, and that any disability or medical condition for which compensation is claimed is causally related to the employment injury.[7] These are the essential elements of each and every compensation claim, regardless of whether the claim is predicated upon a traumatic injury or an occupational disease.[8]

To establish that an injury was sustained in the performance of duty in an occupational disease claim, an employee must submit the following: (1) a factual statement identifying employment factors alleged to have caused or contributed to the presence or occurrence of the disease or condition; (2) medical evidence establishing the presence or existence of the disease or condition for which compensation is claimed; and (3) medical evidence establishing that the diagnosed condition is causally related to the employment factors identified by the employee.[9]

Causal relationship is a medical question that requires rationalized medical opinion evidence to resolve the issue.[10] A physician's opinion on whether there is causal relationship between the diagnosed condition and the implicated employment factor(s) must be based on a complete factual and medical background.[11] Additionally, the physician's opinion must be expressed in terms of a reasonable degree of medical certainty, and must be supported by medical

[5] *Supra* note 1.

[6] *E.K.*, Docket No. 22-1130 (issued December 30, 2022); *F.H.*, Docket No. 18-0869 (issued January 29, 2020); *J.P.*, Docket No. 19-0129 (issued April 26, 2019); *Joe D. Cameron*, 41 ECAB 153 (1989).

[7] *S.H.*, Docket No. 22-0391 (issued June 29, 2022); *L.C.,* Docket No. 19-1301 (issued January 29, 2020); *J.H.,* Docket No. 18-1637 (issued January 29, 2020); *James E. Chadden, Sr.,* 40 ECAB 312 (1988).

[8] *E.H.,* Docket No. 22-0401 (issued June 29, 2022); *P.A.,* Docket No. 18-0559 (issued January 29, 2020); *K.M.,* Docket No. 15-1660 (issued September 16, 2016); *Delores C. Ellyett,* 41 ECAB 992 (1990).

[9] *R.G.*, Docket No. 19-0233 (issued July 16, 2019); *see also Roy L. Humphrey*, 57 ECAB 238, 241 (2005); *Ruby I. Fish*, 46 ECAB 276, 279 (1994); *Victor J. Woodhams*, 41 ECAB 345 (1989).

[10] *S.M.*, Docket No. 22-0075 (issued May 6, 2022); *S.S.*, Docket No. 19-0688 (issued January 24, 2020); *A.M.,* Docket No. 18-1748 (issued April 24, 2019); *Robert G. Morris,* 48 ECAB 238 (1996).

[11] *M.V.*, Docket No. 18-0884 (issued December 28, 2018).

rationale explaining the nature of the relationship between the diagnosed condition and appellant's specific employment factor(s).[12]

Section 8123(a) of FECA provides that, if there is a disagreement between the physician making the examination for the United States and the physician of an employee, the Secretary shall appoint a third physician (known as a referee physician or IME) who shall make an examination.[13] This is called a referee examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[14] When there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an IME for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently rationalized and based upon a proper factual background, must be given special weight.[15]

## ***ANALYSIS***

The Board finds that appellant has not met his burden of proof to establish monaural (left ear) hearing loss and left ear tinnitus causally related to the accepted factors of his federal employment.

OWCP properly referred appellant, pursuant to 5 U.S.C. § 8123(a), to Dr. Greene for an impartial medical examination and opinion in order to resolve the conflict in the medical opinion evidence between appellant's treating physician Dr. Atkins, and OWCP's second opinion physician, Dr. Yavelow, as to whether appellant's left-sided hearing loss was causally related to noise exposure in his federal employment.

In his November 15, 2024 report, Dr. Greene, the IME, discussed appellant's history of injury, reviewed the SOAF, and medical evidence, and conducted a physical examination. He diagnosed left-sided sensorineural hearing loss which he opined was consistent with sudden viral hearing loss or that it could be idiopathic as well, but concluded that it was not caused by occupational noise exposure. In support of this conclusion, Dr. Greene explained that appellant's hearing loss did not meet the criteria for noise-induced hearing loss as the onset was three years after retirement, there was no latency to noise-induced hearing loss or acoustic trauma, it did not develop in a delayed manner, and progression ended when exposure ended in 2017 and, therefore, hearing loss with onset three years after retirement was not caused by on-the-job noise exposure. Rather, he exclaimed that appellant's own assertion that the timing of the hearing loss was sudden was supportive for left-sided viral sudden sensorineural hearing loss *versus* idiopathic hearing loss but was not consistent with noise-induced hearing loss as there was no noise notch on appellant's

[12] *J.D.*, Docket No. 22-0935 (issued December 16, 2022); *T.L.,* Docket No. 18-0778 (issued January 22, 2020); *Y.S.,* Docket No. 18-0366 (issued January 22, 2020); *Victor J. Woodhams, supra* note 9.

[13] *Supra* note 1 at § 8123(a); *M.W.,* Docket No. 19-1347 (issued December 5, 2019); *C.T.,* Docket No. 19-0508 (issued September 5, 2019); *R.S.,* Docket No. 10-1704 (issued May 13, 2011); *S.T.,* Docket No. 08-1675 (issued May 4, 2009).

[14] 20 C.F.R. § 10.321; *S.W.,* Docket No. 23-0513 (issued September 28, 2023).

[15] *K.C.,* Docket No. 19-0137 (issued May 29, 2020); *Darlene R. Kennedy,* 57 ECAB 414 (2006); *Gloria J. Godfrey,* 52 ECAB 486 (2001); *James P. Roberts,* 31 ECAB 1010 (1980).

audiogram configuration of his left ear hearing loss. Dr. Greene opined that appellant had flat hearing loss, worse in the low tones, which was consistent with sudden sensorineural hearing loss and not with noise-induced hearing loss. He further asserted that the exposures were made less intense by the use of appropriate double ear protection and while peak noise could reach 165 dB, appellant was not exposed to more than 65 to 85 dBs. Dr. Greene opined that as appellant did not have hearing loss at the time he retired from the employing establishment in 2017, his subsequent hearing loss was not due to occupational noise exposure. The Board finds that Dr. Greene's opinion, as the IME, is accorded the special weight of the medical evidence.[16]

In situations where the case is referred to an IME for the purpose of resolving a medical conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[17] As Dr. Greene's opinion was well rationalized and based on an accurate history, the SOAF, and his examination findings, the Board finds that it is entitled to the special weight of the medical evidence.[18] As such, appellant has not met his burden of proof.

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

## ***CONCLUSION***

The Board finds that appellant has not met his burden of proof to establish monaural (left ear) hearing loss and left ear tinnitus causally related to the accepted factors of his federal employment.

[16] *H.V.,* Docket No. 17-0492 (issued June 19, 2017).

[17] *See C.L.,* Docket No. 24-0249 (issued April 15, 2024); *C.W.,* Docket No. 17-0918 (issued January 5, 2018); *Patricia J. Glenn,* 53 ECAB 159 (2001).

[18] *See C.L., id.*; *P.F.,* Docket No. 16-0693 (issued October 24, 2016).

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the December 5, 2024 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: November 19, 2025
Washington, DC

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

Janice B. Askin, Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board