

ISSUE

The issue is whether appellant has met his burden of proof to establish greater than 23 percent monaural loss of hearing in the right ear for which he previously received a schedule award.

FACTUAL HISTORY

On December 27, 2016 appellant, then a 60-year-old licensed practical nurse, filed a traumatic injury claim (Form CA-1) alleging that, on December 24, 2016, he sustained facial numbness, hearing loss, and headaches when he was struck in the right side of his face by a patient while in the performance of duty. OWCP accepted the claim for head contusion. On April 4, 2017 it expanded the acceptance of the claim to include tooth fracture. On August 31, 2017 OWCP further expanded acceptance of the claim to include paresthesia of the skin, and mixed conductive and sensorineural hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side.

In a July 13, 2023 report, Dr. Antonio Rozier, a Board-certified physiatrist, related appellant's history of injury on December 24, 2016 and provided a permanent impairment rating for hearing loss and post-concussion headaches. He reviewed a June 5, 2023 audiogram which demonstrated losses of 65, 75, 80, and 75 decibels (dBs) in the in the right ear, and 55, 55, 50, and 50 dBs in the left ear at frequency levels of 500, 1,000, 2,000 and 3,000 Hertz (Hz), respectively. Dr. Rozier found that appellant reached maximum medical improvement (MMI) on June 15, 2023. He referred to the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*),⁴ applied OWCP's standard for evaluating hearing loss to the June 5, 2023 audiogram, and determined that appellant had 73.13 percent right ear monaural hearing, and 41.25 percent left ear monaural hearing loss. To compute the binaural hearing loss. Dr. Rozier calculated 47 percent binaural hearing loss. He further found that appellant had one percent permanent impairment due to post-concussion headaches.

On March 5, 2024 appellant filed a claim for compensation (Form CA-7) for a schedule award.

On July 31, 2024 OWCP referred the medical record and statement of accepted facts (SOAF) to Dr. Jeffrey M. Israel, a Board-certified otolaryngologist, serving as an OWCP district medical adviser (DMA), to determine the extent of appellant's hearing loss and permanent impairment causally related to his employment-related noise exposure.

In an August 6, 2024 report, Dr. Israel, the DMA, reviewed the evidence of record and applied the audiometric data to OWCP's standard for evaluating hearing loss under the sixth edition of the A.M.A., *Guides* to Dr. Rozier's July 13, 2023 report and June 5, 2023 audiology findings. He concurred with the hearing loss calculations, but recommended additional development of the medical evidence.

⁴ A.M.A., *Guides* (6th ed. 2009).

On September 20, 2024 OWCP referred appellant for an audiological evaluation by Angela Anderson, an audiologist. On September 24, 2024 it referred appellant, along with the medical record, a SOAF, and a series of questions, to Dr. Mark D. Gibbons, a Board-certified otolaryngologist, for an audiogram and second opinion examination on October 22, 2024 to determine the nature, extent, and causal relationship of appellant's hearing loss.

On October 16, 2024 Ms. Anderson provided an audiogram.

In reports dated October 25 through 26, 2024, Dr. Gibbons noted his review of the SOAF, and the October 16, 2024 audiogram. He also reviewed October 16, 2024 audiology testing, which revealed the following dBs losses at 500, 1,000, 2,000, and 3,000 Hz: 45, 40, 40, and 35 dBs for the right ear, and 25, 20, 20, and 20 dBs for the left ear, respectively. Dr. Gibbons diagnosed bilateral sensorineural hearing loss and opined that appellant's current audiogram was consistent with his reported closed head injury and that the lack of other hearing loss risk factors rendered this injury the most likely etiology of his hearing loss and tinnitus. He referred to the sixth edition of A.M.A., *Guides*, applied OWCP's standard for evaluating hearing loss to the October 16, 2024 audiogram, and determined that appellant had 22.5 percent right ear monaural hearing, 0 percent left ear monaural hearing loss, and 3.75 percent binaural hearing loss to which he added 5 percent permanent impairment due to tinnitus resulting in 8.75 percent binaural hearing loss. Dr. Gibbons reported appellant's right ear hearing loss of 45, 40, 40, and 35 dBs at 500, 1,000, 2,000, and 3,000 Hz, respectively, which totaled 160, and divided by 4, to find an average of 40. He subtracted the 25 dBs fence to reach 15 and then multiplied the remaining 15 balance by 1.5 to calculate 22.5 percent right ear monaural hearing loss. For the left ear, Dr. Gibbons added appellant's hearing loss of 25, 20, 20, and 20 dBs at 500, 1,000, 2,000, and 3,000 Hz, respectively, which totaled 85, and divided by 4 to find an average of 21.25. Subtracting the 25 dBs fence, he found 0 percent left ear monaural hearing loss which he then multiplied by 1.5 to reach 0. To compute the binaural hearing loss, Dr. Gibbons multiplied the lesser loss in the left ear, *i.e.*, 0 percent, by the established factor of five, and added the result to the 22.5 percent loss in the right ear. He divided this sum by the established factor of 6 to calculate 3.75 percent binaural hearing loss. Dr. Gibbons completed a tinnitus handicap inventory (THI) and rated the catastrophic tinnitus diagnosis at five percent. He determined a total binaural hearing loss rating of 8.75 percent due to moderate tinnitus. Dr. Gibbons recommended a trial of hearing aids and concluded that appellant reached MMI on October 26, 2024.

On December 10, 2024 OWCP referred the medical record and SOAF to Dr. Israel, serving as the DMA, to determine the extent of appellant's hearing loss and permanent impairment causally related to his employment-related closed head injury.

In December 17, 2024 report, Dr. Israel, the DMA, reviewed the evidence of record and applied the audiometric data to OWCP's standard for evaluating hearing loss under the sixth edition of the A.M.A., *Guides* to Dr. Gibbons' October 26, 2024 report and October 16, 2024 audiology findings. He determined that appellant sustained a right monaural loss of 22.5 percent, a left monaural loss of 0 percent, and a binaural hearing loss of 3.8 percent. Dr. Israel found a tinnitus award of five percent resulted in 8.8 binaural hearing loss. He averaged appellant's right ear hearing levels of 45, 40, 40, and 35 dBs at 500, 1,000, 2,000, and 3,000 Hz, respectively, by adding the hearing loss at those levels then dividing the sum by 4, which equaled an average of 40. After subtracting the 25 dB fence, Dr. Israel multiplied the remaining 15 balance by 1.5 to calculate 22.5 percent right ear monaural hearing loss. He then averaged

appellant's left ear hearing levels 25, 20, 20, and 20 dBs at 500, 1,000, 2,000, and 3,000 Hz, respectively, by adding the hearing loss at those levels to reach 85 then dividing the sum by four, which equaled 26.25. After subtracting the 25 dB fence, Dr. Israel multiplied the remaining 0 balance by 1.5 to calculate 0 percent left ear monaural hearing loss. He then calculated 3.75 percent binaural hearing loss by multiplying the left ear loss of 0 percent by five, adding the 22.5 percent right ear loss, and dividing this sum by six to reach 3.75 percent binaural hearing loss. Dr. Israel concurred with Dr. Gibbons' calculations. He recommended yearly audiograms, use of noise protection, and hearing aids for hearing loss with integrated tinnitus masking.

By decision dated February 26, 2025, OWCP granted appellant a schedule award for 23 percent monaural loss of hearing in the right ear. The period of the award ran for 11.96 weeks from October 16, 2024 through January 7, 2025.

On March 14, 2025 appellant requested an oral hearing before a representative of OWCP's Branch of Hearings and Review. A hearing was held on September 5, 2025.

By decision dated December 18, 2025, OWCP's hearing representative affirmed the February 26, 2025 decision.

LEGAL PRECEDENT

The schedule award provisions of FECA,⁵ and its implementing federal regulations,⁶ 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. FECA, however, does not specify the manner in which the percentage loss of a member shall be determined. The method used in making such a determination is a matter which rests in the discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants. The sixth edition of the A.M.A., *Guides*⁷ has been adopted by OWCP for evaluating schedule losses and the Board has concurred in such adoption.⁸

A claimant seeking compensation under FECA has the burden of proof to establish the essential elements of his or her claim.⁹ With respect to a schedule award, it is the claimant's burden of proof to establish permanent impairment of a scheduled member or function of the body as a result of his or her employment injury.¹⁰

⁵ 5 U.S.C. § 8107.

⁶ 20 C.F.R. § 10.404.

⁷ *Supra* note 4.

⁸ *W.R.*, Docket No. 22-0051 (issued August 9, 2022); *J.R.*, Docket No. 21-0909 (issued January 14, 2022); *H.M.*, Docket No. 21-0378 (issued August 23, 2021); *V.M.*, Docket No. 18-1800 (issued April 23, 2019); *J.W.*, Docket No. 17-1339 (issued August 21, 2018).

⁹ *D.H.*, Docket No. 20-0198 (issued July 9, 2020); *John W. Montoya*, 54 ECAB 306 (2003).

¹⁰ *R.R.*, Docket No. 19-0750 (issued November 15, 2019); *Edward Spohr*, 54 ECAB 806, 810 (2003); *Tammy L. Meehan*, 53 ECAB 229 (2001).

OWCP's procedures require referral to a second opinion physician in hearing loss cases when the attending physician's examinations and reports do not provide the specific evidence that OWCP requires for adjudication¹¹ in compliance with the specifications outlined in Federal (FECA) Procedure Manual Chapter 3.0600.¹² This provision specifically requires both an audiological and otological examination by appropriately certified medical professionals¹³ including that the medical examination should be performed by a Board-certified otolaryngologist.¹⁴

OWCP evaluates industrial hearing loss in accordance with the standards contained in the A.M.A., *Guides*.¹⁵ Using the frequencies of 500, 1,000, 2,000, and 3,000 Hz, the losses at each frequency are added up and averaged.¹⁶ Then, the fence of 25 dBs is deducted because, as the A.M.A., *Guides* points out, losses below 25 dBs result in no impairment in the ability to hear everyday speech under everyday conditions.¹⁷ The remaining amount is multiplied by a factor of 1.5 to arrive at the percentage of monaural hearing loss.¹⁸ 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.¹⁹ The Board has concurred in OWCP's adoption of this standard for evaluating hearing loss.²⁰

OWCP's procedures provide that, after obtaining all necessary medical evidence, the file should be routed to OWCP's 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.²¹ It may follow the advice of its medical adviser or consultant where he or she has properly utilized the A.M.A., *Guides*.²²

¹¹ Federal (FECA) Procedure Manual, Part 2 -- Claims, *Developing and Evaluating Medical Evidence*, Chapter 2.810.9.b(2) (June 2015)

¹² *Id.* at Part 3 -- Medical, *Requirements for Medical Reports*, Chapter 3.600 Exhibits 4-6 (September 1996). See also *P.N.*, Docket No. 24-0918 (issued October 28, 2024).

¹³ *Id.*

¹⁴ *Id.* at Chapter 3-0600.8.a.3 (October 1990).

¹⁵ *Supra* note 4.

¹⁶ *Id.* at 250.

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ See *E.S.*, 59 ECAB 249 (2007); *Donald Stockstad*, 53 ECAB 301 (2002), *petition for recon. granted* (modifying prior decision), Docket No. 01-1570 (issued August 13, 2002).

²¹ See *D.J.*, Docket No. 19-0352 (issued July 24, 2020).

²² See *B.B.*, Docket No. 25-0789 (issued September 19, 2025); *Ronald J. Pavlik*, 33 ECAB 1596 (1982).

Regarding tinnitus, the A.M.A., *Guides* provides that tinnitus is not a disease, but rather a symptom that may be the result of disease or injury.²³ If tinnitus interferes with activities of daily living, including sleep, reading (and other tasks requiring concentration), enjoyment of quiet recreation and emotional well-being, up to five percent may be added to a measurable binaural hearing impairment.²⁴

Following medical evaluation of a claim, if the hearing loss is determined to be nonratable for schedule award purposes, other benefits such as hearing aids may still be payable if any employment-related hearing loss exists.²⁵

Neither FECA nor its implementing regulations provide for the payment of a schedule award for the permanent loss of use of the back/spine, brain, head, or the body as a whole.²⁶

ANALYSIS

The Board finds that appellant has not met his burden of proof to establish greater than 23 percent monaural loss of hearing in the right ear for which he previously received a schedule award.

OWCP properly referred appellant to Dr. Gibbons for a second opinion examination relative to his right monaural hearing loss. Dr. Gibbons' October 25 and 26, 2024 reports related October 16, 2024 audiogram findings and concluded that appellant's hearing loss was due to his workplace traumatic injury. He found right ear monaural hearing loss of 23 percent.

On December 26, 2024 Dr. Israel, a DMA, reviewed Dr. Gibbons' report and concurred that appellant had sustained employment-related hearing loss. He found that testing for the right ear at the frequency levels of 500, 1,000, 2,000, and 3,000 Hz revealed losses of 45, 40, 40, and 35dBs, respectively. These dBs were totaled at 160 and were divided by 4 to obtain an average hearing loss at those cycles of 40 dBs. The average of 40 dBs was then reduced by 25 dBs (the first 25 dBs were discounted as discussed above) to equal 15, which was then multiplied by 1.5 to equal 22.5 percent hearing loss for the right ear. The policy of OWCP is to round the calculated percentage of impairment to the nearest whole number. Results should be rounded down for figures less than 0.5 and up for 0.5 and over.²⁷ Therefore for schedule award purposes,

²³ A.M.A., *Guides*, 249.

²⁴ *Id.*; *R.H.*, Docket No. 10-2139 (issued July 13, 2011); *see also Robert E. Cullison*, 55 ECAB 570 (2004).

²⁵ *J.S.*, Docket No. 22-0274 (issued September 13, 2022); *R.B.*, Docket No. 19-1466 (issued April 9, 2020); *J.M.*, Docket No. 16-0526 (issued May 13, 2016); *see F.D.*, Docket No. 10-1175 (issued January 4, 2011).

²⁶ 5 U.S.C. § 8107(c); 20 C.F.R. § 10.404(a) and (b); *see A.G.*, Docket No. 18-0815 (issued January 24, 2019); *Jay K. Tomokiyo*, 51 ECAB 361, 367 (2000). There is no provision under FECA for adding organs to the compensation schedule on a case-by-case basis. The terms of FECA are specific as to the method and amount of payment of compensation; neither OWCP nor the Board has the authority to enlarge the terms of FECA or to award benefits under any terms other than those specified in the statute. *See S.G.*, Docket No. 09-0521 (issued November 17, 2009); *Gary M. Goul*, 54 ECAB 702 (2003).

²⁷ Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.3b (January 2010); *see also R.R.*, Docket No. 20-0245 (issued June 22, 2020); *V.M.*, Docket No. 18-1800 (issued April 23, 2019); *M.F.*, Docket No. 16-0565 (issued March 15, 2017).

appellant has 23 percent monaural hearing loss in the right ear in accordance with OWCP procedures.

The Board finds that OWCP properly relied upon the opinion of Dr. Israel, serving as the DMA, as he appropriately applied the methodology found in the sixth edition of the A.M.A., *Guides* in determining that appellant has 23 percent permanent monaural loss of hearing in the right ear.

In his July 13, 2023 report, Dr. Rozier determined that appellant had one percent permanent impairment due to post-concussive headaches. The Board notes that the head and the brain are not scheduled members and a claimant is not entitled to a schedule award for headaches, loss of memory or cognitive dysfunction as a result of an employment injury.²⁸

Appellant may request a schedule award or increased schedule award based at any time on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased permanent impairment.

CONCLUSION

The Board finds that appellant has not met his burden of proof to establish greater than 23 percent monaural loss of hearing in the right ear, for which he previously received a schedule award.

²⁸ *Supra* note 26.

ORDER

IT IS HEREBY ORDERED THAT the December 18, 2025 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: May 1, 2026
Washington, DC

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

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

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