U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of MICHAEL K. WOODROME and DEPARTMENT OF LABOR, MINE SAFETY & HEALTH ADMINISTRATION, Vincennes, IN

Docket No. 03-1578; Submitted on the Record;
Issued September 30, 2003

DECISION and ORDER

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

The issue is whether appellant sustained more than a 10 percent hearing loss for which he had received a schedule award.

On August 20, 1998 appellant, then a 44-year-old electrical and supervisory mine inspector, filed a claim for occupational disease alleging that his hearing loss was caused by his employment exposure to high noise levels around coal mines. On April 15, 1999 the Office of Workers' Compensation Programs denied the claim. On September 7, 1999 appellant requested reconsideration. On March 15, 2000 the Office referred appellant, his medical records, a statement of accepted facts and specific questions to Dr. Dennis G. Pappas, Sr., a Board-certified otolaryngologist, for a second opinion evaluation.[1]

In a report dated April 4, 2000, Dr. Pappas diagnosed appellant with mild sensorineural hearing loss, moderate in the high frequencies and rated him with an 8.65 percent binaural hearing loss. Audiometric testing that day revealed the following decibels losses at 500, 1,000, 2,000 and 3,000 cycles per second: 30, 25, 25 and 45, decibels on the right and 30, 35, 30 and 40 decibels on the left. In a report dated May 30, 2000, a clinical audiologist noted that the audiometric equipment used in appellant's April 4, 2000 report had been calibrated on August 25, 1999 and that appellant had been last exposed to noise on April 3, 2000 at 5:00 p.m.

On May 24, 2000 the employing establishment submitted a March 10, 2000 fitness-for-duty audiogram test and a May 5, 2000 screening audiogram conducted under the employing establishment's hearing conservation program.

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[1] In a statement of accepted facts dated March 9, 2000, the Office stated that appellant was typically exposed to underground mining equipment which generated noise levels that regularly exceeded 95 decibels and reached levels as high as 117 decibels and to surface mine equipment which generated noise levels from 95 decibels to 115 decibels. Exposure averaged four to six hours a day, five to six days a week. Appellant began work with the employing establishment in February 1987 and his last day of exposure was August 19, 1998.

In a report dated June 7, 2000, the Office medical adviser applied Dr. Pappas' evaluation to the American Medical Association, *Guides to the Evaluation of Permanent Impairment* and determined that appellant had a 10 percent binaural hearing loss.

On June 12, 2000 the Office vacated its prior decision and accepted appellant's claim for binaural hearing loss. The Office also authorized hearing aids. On June 21, 2000 appellant filed a claim for a schedule award.

On July 21, 2000 the Office referred appellant to Dr. Jack Aland, a Board-certified otolaryngologist, his medical record, a statement of accepted facts and a list of specific questions for an audiometric testing and otological evaluation. In a report dated September 28, 2000, Dr. Aland reviewed appellant's August 8, 2000 audiogram and noted severe to profound neurosensory hearing loss in both ears "most likely secondary to the prolonged noise exposure he had while working the mines." He noted that appellant's last exposure to noise was on August 5, 2000. Audiometric testing results revealed the following decibel losses at 500, 1,000, 2,000 and 3,000 cycles per second: 100, 100, 110 and 115 decibels on the right and 110, 105, 105 and 120 decibels on the left. Dr. Aland noted that appellant had an audiogram performed in his office in May 2000.[2]

On October 26, 2000 the Office medical adviser rejected Dr. Aland's report because it indicated a vast hearing loss over a short time period with no rational explanation as to how it could have occurred. He opined that "the testing equipment was faulty or that the claimant or audiologist misrepresented the claimant's severity of hearing loss."

On October 26, 2000 the Office referred appellant, his medical records, a statement of accepted facts and specific questions to Dr. Grayson K. Rodgers, a Board-certified otolaryngologist, for another hearing loss evaluation.

In a report dated November 16, 2000, Dr. Rodgers stated that appellant had a bilateral sensorineural hearing loss which was likely related to longstanding noise exposure. However, he noted that appellant's conversational responses were inconsistent with audiometric documentation and that the degree of hearing loss was "in question as [appellant's] audiometric results have varied so much over the now four testing intervals." The audiologist annotated the evaluation stating that "patient communicates easily without his hearing aids on. Feels thresholds are exaggerated." Audiometric testing results revealed the following decibel losses at 500, 1,000, 2,000 and 3,000 cycles per second: 70, 65, 65 and 85 decibels on the right and 70, 75, 70 and 80 decibels on the left.

The Office medical adviser stated, in a report dated May 16, 2001, that Dr. Rodgers stated that appellant misrepresented the severity of his hearing loss and thus, the testing results were spurious and could not be relied on to process a schedule award.

In a report dated August 29, 2001, Curtis Smith reviewed and evaluated appellant's August 21, 2001 audiogram and found that he had considerable hearing loss for hearing speech.

[2] The May 5 and August 8, 2000 audiograms were performed by ENT Associates.

On September 18, 2001 the Office awarded appellant a schedule award for a 10 percent binaural hearing loss for 20 weeks of compensation from April 4 to August 21, 2000.

By letter dated October 15, 2001, appellant requested an oral hearing. On April 8, 2002 an Office hearing representative determined that the September 18, 2001 decision was premature and remanded the case to the Office. The hearing representative, citing *John C. Messick*,[3] stated that Office procedures require that audiograms which come from different specialists should be evaluated to determine the percentage of loss shown by each audiogram and, if there is a conflict in the losses, a rationale should be given to choosing one audiogram over the others. The hearing representative found that the Office did not provide a rationale to explain why it relied on the April 4, 2000 audiogram of Dr. Pappas "as the best measure of the claimant's hearing ability" and required the Office medical adviser to provide a reasoned opinion as to whether any audiograms were of sufficient probative value to form the basis for determining the extent of the claimant's hearing loss.[4]

In a report dated April 26, 2002, the Office medical adviser stated that the May 5, 2000 audiogram was not valid because it revealed a deterioration of 50 decibels of hearing loss in a little more than a month, which the doctor opined was medically impossible; that there was no documentation to determine when the audiometric equipment had been standardized and that appellant had not had an ear, nose and throat evaluation performed by an otolaryngologist at the time of the assessment. The Office medical adviser further noted that the August 21, 2001 audiogram was a screening evaluation which had no adjudicative value. He also noted that there was no documentation regarding the audiometric equipment used in that evaluation and that the record failed to indicate whether appellant was free from noise exposure for 16 hours preceding the evaluation, nor is the test accompanied by an assessment of an audiologist.

In a decision dated June 4, 2002, the Office denied modification of its September 18, 2001 decision on the grounds that the audiogram evaluations dated May 5, 2000 and August 21, 2001 were insufficient to warrant modification.

By letter dated January 17, 2003, appellant requested reconsideration. He submitted documents establishing that the audiometric equipment used in his August 2001 evaluation was properly calibrated.

In a decision dated March 31, 2003, the Office denied appellant's request for reconsideration on the grounds that the new evidence was insufficient to warrant modification of the June 4, 2002 decision.

The Board finds that appellant failed to establish that he sustained more than a 10 percent hearing loss for which he had received a schedule award.

[3] 25 ECAB 333 (1974).

[4] The hearing representative noted that the March 10, 2000 audiometric testing resulted in a 49 percent binaural hearing loss and the May 5, 2000 evaluation resulted in an 86 percent binaural hearing loss.

The schedule award provisions of the Federal Employees' Compensation Act[5] provide for compensation to employees sustaining impairment from loss or loss of use of, specified members of the body. The Act, 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. 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 A.M.A., *Guides* has been adopted by the Office as a standard for evaluation of schedule losses and the Board has concurred in such adoption.[6]

The Office evaluates industrial hearing loss in accordance with the standards contained in the A.M.A., *Guides.* Using the frequencies of 500, 1,000, 2,000 and 3,000 cycles per second, the losses at each frequency are added up and averaged. Then, the "fence" of 25 decibels is 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. The remaining amount is multiplied by a factor of 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. The Board has concurred in the Office's adoption of this standard for evaluating hearing loss.[7]

In this case, the Office medical adviser properly applied the Office's standardized procedures to the April 4, 2000 audiogram performed for Dr. Pappas. Testing for the right ear revealed decibel losses of 30, 25, 25 and 45 respectively. These decibel losses were totaled at 125 and divided by 4 to obtain the average hearing loss at those cycles of 31.25. The average of 31.25 decibels was then reduced by 25 decibels (the first 25 decibels were discounted as discussed above) to equal 6.25 decibels for the right ear. The 6.25 was multiplied by 1.5 resulting in a 9.375 loss. The 9.375 loss was properly rounded down to a nine percent monaural (right ear) loss. Testing for the left ear at frequency levels of 500, 1,000, 2,000 and 3,000 cycles per second revealed decibel losses of 30, 35, 30 and 40 decibels respectively. These decibel losses were totaled at 135 decibels and divided by 4 to obtain the average hearing loss at those cycles of 33.75 decibels. The average of 33.75 decibels was then reduced by 25 decibels (the first 25 decibels were discounted as discussed above) to equal 8.75 decibels for the left ear. The 8.75 was multiplied by 1.5 resulting in a 13.125 loss. To determine binaural hearing loss, the lesser loss, 9.375, is multiplied by 5 and then added to the greater loss, 13.125. This result, 60, is divided by 6 for a binaural hearing loss estimate of 10 percent.

The other audiograms of record include a March 10, 2000 fitness-for-duty audiogram, which is insufficient to establish a hearing loss under the Act because appellant had not had an ear, nose and throat evaluation performed by an otolaryngologist at the time of the assessment. The May 5, 2000 screening assessment is likewise insufficient to establish a hearing loss under

[5] 5 U.S.C. §§ 8101-8193.

[6] *Jacqueline S. Harris*, 54 ECAB ___ (Docket No. 02-203, issued October 4, 2002).

[7] *Jerome L. Simpson*, 54 ECAB ___ (Docket No. 02-1465, issued October 4, 2003).

the Act because it represents an average of over a 50 decibel increase in hearing loss from the April 4, 2000 evaluation of Dr. Pappas without a rational explanation. Likewise, the August 8, 2000 audiogram conducted for Dr. Aland, an Office consultant, represented an 80 decibel increase in hearing loss for the right ear and an 85 decibel increase in hearing loss for the left ear. However, Dr. Aland did not provide a rationalized medical opinion to explain the dramatic increase in hearing loss.[8] Further, Dr. Rodgers, who reviewed a November 16, 2000 audiogram, which resulted in total bilateral hearing loss, noted that appellant's conversational responses were inconsistent with the audiogram results and that his audiologist noted that the audiogram threshold results were exaggerated. This report likewise has limited probative value.

The Board finds that the Office medical adviser properly selected Dr. Pappas' audiogram test results and also properly excluded Drs. Aland and Rodgers' audiogram results. Although the Office medical adviser did not specifically exclude the May 5, 2000 audiogram test results, the Board finds that the May 5, 2000 audiogram test results have little probative value because it was not accompanied by a rationalized opinion to explain a 50 decibel increase in hearing loss in one month.[9] Further the March 10, 2000 audiogram was not accompanied by a medical report and failed to indicate if appellant had undergone an ear, nose and throat examination prior to the audiogram. The August 2001 audiogram is likewise of limited probative value because it was not reviewed by a medical doctor. Therefore, the April 4, 2000 report of Dr. Pappas represents the weight of the medical evidence.

[8] Dr. Aland's August 2002 data results in a total bilateral hearing loss finding. Dr. Pappas's data from an April 2000 report, resulted in a 10 percent hearing loss.

[9] *See Roger Wilcox*, 45 ECAB 265 (1993).

The March 31, 2003 decision of the Office of Workers' Compensation Programs is affirmed.

Dated, Washington, DC
September 30, 2003

Alec J. Koromilas
Chairman

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member