U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of NEIL M. TAYLOR and DEPARTMENT OF THE NAVY, MARINE CORPS AIR STATION, Cherry Point, NC

Docket No. 03-1671; Submitted on the Record;
Issued September 3, 2003

DECISION and ORDER

Before WILLIE T.C. THOMAS, MICHAEL E. GROOM,
A. PETER KANJORSKI

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

On February 28, 2001 appellant, then a 55-year-old painter leader, filed an occupational disease claim alleging that he sustained binaural loss of hearing, causally related to hazardous noise exposure in the course of his federal employment. In support of his claim, appellant submitted audiograms and audiometric results dating from his baseline testing on December 21, 1971 through December 5, 2000.[1] Appellant retired from federal employment on February 28, 2001.

On April 5, 2001 appellant was referred for a second opinion evaluation to Dr. Walter Sabiston, a Board-certified otolaryngologist. On April 19, 2001 another audiogram was obtained with all of the indices of trustworthiness, which included both air and bone conduction studies, acoustic reflexes and speech reception threshold determinations. Dr. Sabiston determined that appellant's audiogram demonstrated the following hearing levels at 500, 1,000, 2,000 and 3,000 Hertz (Hz); on the left appellant's thresholds were 25, 35, 20 and 50 decibels respectively and on the right 20, 30, 20 and 45 decibels respectively. He indicated that these sensorineural results were consistent between air and bone conduction studies, were noise induced and were causally related to hazardous noise exposure in the course of appellant's federal employment.

On May 16, 2001 the Office of Workers' Compensation Programs accepted that appellant sustained a bilateral hearing loss.

On June 29, 2001 an Office medical adviser used the decibel threshold findings from Dr. Sabiston's April 19, 2001 audiogram and he employed the accepted formula for determining

[1] Significant threshold shifting from his baseline was noted in 1993 and 1994. A new reference audiogram was established for appellant on August 23, 1999.

percentage impairment due to hearing loss. The Office medical adviser added the decibel thresholds for each ear from 500 through 3,000 Hz, divided the total by 4, subtracted a fence of 25 and multiplied the balance by 1.5 to arrive at a monaural loss percentage for each ear. He then multiplied the lesser monaural loss by 5, added the greater loss and divided by 6 to calculate the binaural loss percentage. The Office medical adviser calculated that appellant had a 5.63 percent monaural loss on the right and an 11.25 percent monaural loss on the left for a combined binaural loss of 7 percent.

For schedule award purposes the Office medical adviser determined that appellant had a seven percent permanent impairment due to noise-induced sensorineural hearing loss, causally related to his federal employment.

On January 25, 2002 appellant indicated that he was not satisfied with the benefit amount for a seven percent permanent impairment due to hearing loss as reflected in the benefit statement and that it did not correspond with the oral statement of award that he discussed previously with the Office.

By letter dated June 4, 2002, appellant, through his attorney, requested an oral hearing before an Office hearing representative "and or reconsideration in connection with a letter of May 16, 2001, … and a benefit statement of September 21, 2001," on the amount of his award.

On June 17, 2002 the Office granted appellant a schedule award for a 7 percent permanent impairment due to binaural hearing loss for the period April 19 to July 25, 2001 for a total of 14 weeks of compensation.

By letter dated July 22, 2002 received by the Office on July 24, 2002, appellant, through his attorney, requested reconsideration of his schedule award. In the alternative, appellant requested an amendment of his schedule award to reflect a 15 percent binaural loss of hearing as determined on April 16, 2002 by Coastal ENT (ear nose and throat) and on April 29, 2002 by Avada Audiology and Hearing Care. In support of his request, appellant submitted an April 16, 2002 report by Terry Hall, an audiologist with Coastal ENT, who tested appellant.

On April 16, 2002 audiologist Mr. Hall tested appellant and determined that he demonstrated the following decibel thresholds at 500, 1,000, 2,000 and 3,000 Hz: 25, 35, 40 and 55 decibels on the right, respectively and 20, 35, 40 and 55 on the left. He determined, based on his application of the American Academy of Otolaryngology, *Guides for the Evaluation of Hearing Handicap*, that appellant had a monaural impairment on the left of 15 percent and a monaural impairment on the right of 20 percent for a binaural impairment of 15 percent. A possible neurologic condition with an obvious palsy and impaired speech with enunciation problems was also noted.

On April 29, 2002 audiometric testing of appellant revealed the following decibel thresholds at 500, 1,000, 2,000 and 3,000 Hz: 45, 45, 50 and 65 decibels on the right, respectively and 45, 40, 40 and 60 on the left. By letter dated April 30, 2002, the audiology manager at Avada Audiology and Hearing Care indicated that appellant had sensorineural hearing loss with a significantly reduced speech reception threshold.

In a November 8, 2002 letter, Anthony Monaco indicated that appellant had been seen in his office on November 7, 2002 and that he suffered from binaural sensorineural hearing loss with pure tone averages (PTA) in his left ear of 50 decibels and in his right ear of 55 decibels.

Also submitted was a December 2, 2002 letter, introducing November 21, 2002 testing results from Kinston Head & Neck Physicians & Surgeons ostensibly showing progression of appellant's hearing loss. The results, obtained by a trained hearing conservationist tester, were graphically depicted without medical narrative or comment as to their meaning or conclusions. The audiometric tracings revealed hearing threshold levels at 500, 1,000 and 2,000 Hz for the right ear of 35, 40, 40, respectively and no level for 3,000 Hz tested; and for the left ear of 40, 45 and 45 respectively, with no level for 3,000 Hz tested.

A November 21, 2002 progress note from Dr. Sabiston, noted that appellant's subjective test showed slight change in his hearing, which he felt was more in threshold than it was in discrimination score or speech recognition. No ongoing medical illness or disease that would cause any further significant loss was detected and a hearing aid was recommended, as well as hearing protection when around noise.

An oral hearing was held on November 20, 2002 at which appellant testified. Appellant's attorney also submitted a "Hearing Memorandum," in which he argued that appellant's schedule award should be increased to 15 percent binaural impairment based on "progressively worsening" work-related hearing loss as demonstrated by the 2002 audiograms.

By decision dated February 25, 2003, the hearing representative set aside the June 17, 2002 schedule award and remanded the case for further development to determine whether appellant had greater than a seven percent permanent impairment due to a binaural loss of hearing. The hearing representative found that the subsequently submitted reports were sufficiently probative to warrant further development.

Upon return of the record to the Office, it was referred to an Office medical adviser to determine whether appellant had greater than a seven percent permanent impairment due to binaural hearing loss. On March 21, 2003 the Office medical adviser noted that appellant retired from federal employment and, therefore, was removed from federal hazardous noise exposure on February 28, 2001. He was examined by Dr. Sabiston on April 19, 2001 and that study was performed under the strict conditions of Office protocol and was judged to be a valid examination. The Office medical adviser noted that Dr. Sabiston determined from the study results that appellant had a seven percent binaural loss of hearing that could be attributed to noise exposure in his federal employment. The Office medical adviser noted, however, that any deterioration in appellant's decibel threshold levels after removal from source of hazardous noise could not be attributed to his federal employment, which ceased on February 28, 2001 but rather was attributable to other factors. He noted that appellant had other clearly documented neurological symptoms including obvious palsy and difficulty with enunciation. The Office medical adviser concluded that, since any worsening of appellant's binaural loss of hearing after April 19, 2001, was not due to hazardous noise exposure during federal employment, which ended February 28, 2001, there was no justification for increasing appellant's schedule award from 7 to 15 percent. In a supplemental statement, the Office medical adviser explained that "scientifically noise-induced hearing loss is not considered to be progressive in nature"

according to the scientific community and an Ohio State study of world literature commissioned by the Department of Labor. He noted that there were no documented studies supporting progressive deafness due to noise and that the observed pattern of response to noise exposure was a loss followed by partial or total improvement upon removal from noise.

By decision dated April 16, 2003, the Office denied appellant's claim for modification of his schedule award finding that any additional hearing loss after the April 19, 2001 examination was not due to his federal employment, which ceased February 28, 2001, but was due to some other progressive condition and, therefore, was not compensable under the Federal Employees' Compensation Act.

The Board finds that appellant has no more than a seven percent permanent impairment, for which he received a schedule award.

The Act's schedule award provisions set forth the number of weeks of compensation to be paid for permanent loss of use of the members of the body that are listed in the schedule.[2] Where the loss of use is less than 100 percent, the amount of compensation is paid in proportion to the percentage loss of use.[3] 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.[4] However, as a matter of administrative practice, the Board has stated: "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 a uniform standard applicable to all claimants."[5]

The Office evaluates industrial hearing loss in accordance with the standards contained in the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment,*[6] (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 and the "fence" of 25 decibels is deducted since, as the A.M.A., *Guides* points out, losses below 25 decibels result in no impairment in the ability to hear everyday speech in everyday conditions.[7] The remaining amount is multiplied by 1.5 to arrive at the percentage of monaural hearing loss.[8] The binaural loss is determined by calculating the loss in each ear using the formula for monaural loss.[9] The lesser loss is multiplied by 5, then added to the greater loss and the total is divided by 6 to arrive

[2] 5 U.S.C. § 8107(c)(19).

[3] 5 U.S.C. § 8107(c).

[4] *Richard Beggs*, 28 ECAB 387 (1977).

[5] *Henry L. King*, 25 ECAB 39 (1973); *August M. Buffa*, 12 ECAB 324 (1961).

[6] A.M.A., *Guides* at 246, 247 (5th ed. 2001).

[7] *Id.*

[8] *Id.*

[9] *Id.*

at the amount of the binaural hearing loss. The Board has concurred in the Office's adoption of this standard for evaluating hearing loss.[10]

An Office medical adviser applied the Office's standardized procedures to the audiogram from Dr. Sabiston dated April 19, 2001. Testing for the right ear at the frequency levels of 500, 1,000, 2,000 and 3,000 revealed decibel losses of 20, 30, 20 and 45 respectively. These decibels were totaled at 115 decibels and were divided by 4 to obtain the average hearing loss at those cycles of 28.74 decibels. The average of decibels was then reduced by 25 decibels (the first 25 decibels were discounted as discussed above) to equal 3.75, which was multiplied by the established factor of 1.5 to compute a 5.63 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 revealed decibel losses of 25, 35, 20 and 50 respectively. These decibels were totaled at 130 decibels and were divided by 4 to obtain the average hearing loss at those cycles of 32.50 decibels. The average of 32.50 decibels was then reduced by 25 decibels (the first 25 decibels were discounted as discussed above) to equal 7.5, which was multiplied by the established factor of 1.5 to compute an 11.25 percent loss of hearing for the left ear. The Office medical adviser computed the binaural hearing loss by multiplying the lesser loss, 5.63, by 5 and adding to the greater loss, 11.25 and then dividing by 6 to equal 6.56 percent binaural loss, which was rounded up to 7 percent permanent impairment.

The Board finds that the Office medical adviser correctly applied the Office's standards to Dr. Sabiston's audiogram in determining that appellant had a 7 percent binaural loss of hearing. There was no medical evidence at that time that supported that appellant had any greater binaural loss of hearing.

Following the issuance of the schedule award, appellant submitted audiograms, which were obtained by audiologists, which showed a greater binaural loss of hearing. However, neither of these two audiograms were complete with the indices of trustworthiness required by the Office. They lacked complete calibration data and indices of trustworthiness and they were unaccompanied by concomitant examination by a Board-certified otolaryngologist or any interpretation or certification by a physician of any sort. Consequently, they are of reduced probative value.

[10] *Id.*

Accordingly, the decision of the Office of Workers' Compensation Programs dated April 16, 2003 is hereby affirmed.

Dated, Washington, DC
September 3, 2003

Willie T.C. Thomas
Alternate Member

Michael E. Groom
Alternate Member

A. Peter Kanjorski
Alternate Member