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

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| **C.M., Appellant** | ) | |
| **and** | ) | **Docket No. 08-447** |
| | ) | **Issued: July 9, 2008** |
| **DEPARTMENT OF THE ARMY, ARMY CORPS OF ENGINEERS, Memphis, TN, Employer** | ) | |

*Appearances:*
*Joree G. Brownlow, Esq.,* for the appellant
*Office of Solicitor*, for the Director

*Case Submitted on the Record*

## DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

### ***JURISDICTION***

On December 4, 2007 appellant filed a timely appeal from a September 10, 2007 merit decision of the Office of Workers' Compensation Programs that denied his schedule award claim. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the schedule award issue.

### ***ISSUE***

The issue is whether appellant met his burden of proof in establishing that he had ratable hearing loss entitling him to a schedule award.

### ***FACTUAL HISTORY***

On March 17, 2006 appellant, then a 53-year-old engineer equipment mechanic, filed an occupational disease claim stating that he developed noise-induced hearing loss at work. He did not stop work and his exposure continued. Appellant attributed his hearing loss to noise exposure from engines and air hammers in his work area. His noise exposure began in 1970 and

earplugs did not become customary until the late 1980s. The employing establishment did not require their use until the late 1990s. Appellant noted his noise exposure history since he began working at the employing establishment as a laborer in July 1970 and, since 1974, as an equipment engineer. In a July 29, 2006 statement, the employing establishment noted that appellant was exposed to loud machine noise and was given hearing protection.

The employing establishment provided audiometric testing data from August 9, 1979 and March 17, 2006. A January 31, 2005 employing establishment audiogram showed decibel losses at frequencies of 500, 1,000, 2,000 and 3,000 Hertz (Hz) as 10, 15, 10 15 and 25 for the right ear and 15, 15, 15 and 35 for the left ear. A May 17, 2006 employing establishment audiogram revealed losses of 40, 45, 40 and 50 for the right ear and 50, 40, 40 and 45 for the left ear.

On September 7, 2006 the Office referred appellant to Dr. Samuel H. Lambdin, III, a Board-certified otolaryngologist, for a second opinion examination to determine the cause and extent of appellant's hearing loss. In a September 21, 2006 report, Dr. Lambdin diagnosed bilateral sensorineural hearing loss and opined that appellant's hearing loss was work related. He noted that appellant's hearing was normal prior to his employment and that the level and duration of appellant's noise exposure was sufficient to cause hearing loss. A September 21, 2006 audiogram conducted on Dr. Lambdin's behalf showed appellant's decibel losses at frequencies of 500, 1,000, 2,000 and 3,000 Hz and reflected the following decibel losses: 40, 40, 40 and 35 for the right ear and 35, 40, 35 and 45 for the left ear. The audiologist measured speech reception threshold losses at 10 decibels for the right ear and 15 decibels for the left ear. Dr. Lambdin noted that the pure-tone audiometric testing results and the speech reception threshold testing results did not agree.

In an October 13, 2006 memorandum, an Office medical adviser noted that he doubted the validity of Dr. Lambdin's audiometric testing results because the pure-tone audiometric results and the speech reception threshold results did not agree. He noted that Dr. Lambdin was unable to explain the discrepancy. The medical adviser recommended that appellant return to Dr. Lambdin for another examination.

On December 14, 2006 Dr. Lambdin performed another examination. He again diagnosed bilateral sensorineural hearing loss and opined that the loss was caused by noise exposure in appellant's employment. An audiogram performed on Dr. Lambdin's behalf recorded the following decibel losses at the above-noted frequencies: 40, 35, 35 and 35 for the right ear and 35, 35, 35 and 45 for the left ear. Appellant's speech reception threshold was measured at 5 decibels for the right ear and 10 decibels for the left ear. Dr. Lambdin noted that, although the test was reliable, the pure-tone audiometry and speech reception threshold again did not agree.

In a December 22, 2006 report, the Office medical adviser again noted the discrepancy between appellant's pure-tone audiometry and speech reception threshold results. He indicated that appellant's hearing had markedly worsened between 2005 and 2006 and that Dr. Lambdin had not explained either the discrepancy in the testing data or the rapid deterioration of the hearing loss. On January 11, 2007 the Office asked Dr. Lambdin to address the medical adviser's concerns. On February 16, 2007 Dr. Lambdin stated that the discrepancy between the pure-tone audiometric results and the speech reception thresholds occasionally happened without

good explanation, particularly when the hearing loss was predominantly concentrated in the high frequencies. He indicated that appellant's results were consistent between both audiograms and that the audiologist believed the results to be valid.

On February 28, 2007 the medical adviser recommended that the Office refer appellant for a second opinion with a different specialist. The medical adviser noted that Dr. Lambdin offered no explanation for the discrepancy between pure-tone averages and speech reception thresholds or for the substantial worsening of hearing thresholds between the employing establishment examination of January 2005 and the examinations performed on his behalf. On March 21, 2007 the Office noted that Dr. Lambdin's February 14, 2006 report would not be considered based on the medical adviser's recommendation.

On March 30, 2007 the Office referred appellant to Dr. Bryan M. Clay, a Board-certified otolaryngologist, for a second opinion regarding the cause and extent of appellant's hearing loss. In an April 19, 2007 report, he diagnosed bilateral isolated high frequency sensorineural hearing loss and stated that the level and duration of appellant's workplace exposure was sufficient to cause his condition. An April 19, 2007 audiogram conducted on Dr. Clay's behalf showed appellant's decibel losses at frequencies of 500, 1,000, 2,000 and 3,000 Hz. The audiogram reflected the following decibel losses: 15, 20, 20 and 25 for the right ear and 15, 15, 15 and 35 for the left ear. The audiologist noted that, while initial pure-tone testing yielded results inconsistent with results of speech audiometry, appellant was reinstructed and thresholds were obtained using an ascending approach. Dr. Clay and the audiologist opined that the audiometric test results were valid.

In a May 1, 2007 hearing loss medical opinion worksheet, the Office medical adviser applied the American Medical Association, *Guides to the Evaluation of Permanent Impairment*, fifth edition[1] (A.M.A., *Guides*), to Dr. Clay's findings and concluded that appellant had zero percent monaural hearing loss in the right ear, zero percent monaural hearing loss in the left ear, and zero percent binaural hearing loss. The medical adviser noted that Dr. Clay felt that the results were valid.

On May 2, 2007 the Office accepted appellant's claim for bilateral isolated high frequency hearing loss. Appellant claimed a schedule award on June 18, 2007.

By decision dated September 10, 2007, the Office denied appellant's schedule award claim on the grounds that appellant's accepted bilateral hearing loss was not ratable.

## ***LEGAL PRECEDENT***

The schedule award provision of the Act[2] and its implementing regulations[3] 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. However, the Act does not

[1] A.M.A., *Guides* (5th ed. 2001).

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404 (2002).

specify the manner in which the percentage of loss shall be determined. 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. The A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.[4]

The Office evaluates industrial hearing loss in accordance with the standards contained in the A.M.A., *Guides*.[5] Using the frequencies of 500, 1,000, 2,000 and 3,000 Hertz, the losses at each frequency are added up and averaged.[6] 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.[7] The remaining amount is multiplied by a factor of 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; 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.[9] The Board has concurred in the Office's adoption of this standard for evaluating hearing loss.[10]

## ***ANALYSIS***

The Board notes that the Office referred appellant to Dr. Lambdin for a second opinion examination but the audiograms performed on his behalf were not a proper basis on which to rate permanent hearing impairment. The Office medical adviser subsequently applied the Office's standard procedures to the April 19, 2007 audiogram obtained on Dr. Clay's behalf. Appellant's April 19, 2007 audiogram tested decibel losses at the 500, 1,000, 2,000 and 3,000 Hz levels and recorded decibel losses of 15, 20, 20 and 25 respectively for the right ear. The total decibel loss in the right ear is 80 decibels. When divided by 4, the result is an average hearing loss of 20 decibels. The average loss of 20 decibels is reduced by the "fence" of 25 decibels to equal 0 decibels, which when multiplied by the established factor of 1.5, results in 0 percent monaural hearing loss, rounded up to a 0 percent monaural hearing loss for the right ear.

Testing for the left ear at the frequencies of 500, 1,000, 2,000 and 3,000 Hz revealed decibel losses of 15, 15, 15 and 35 decibels respectively, for a total decibel loss of 80 decibels. When divided by 4, the result is an average hearing loss of 20 decibels. The average loss of 20

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[4] *Id.*

[5] A.M.A., *Guides* 250.

[6] *Id.*

[7] *Id.*

[8] *Id.*

[9] *Id.*

[10] *Donald E. Stockstad*, 53 ECAB 301 (2002), *petition for recon. granted* (*modifying prior decision*), Docket No. 01-1570 (issued August 13, 2002).

decibels is reduced by the "fence" of 25 decibels, to equal 0 decibels, which when multiplied by the established factor of 1.5, results in 0 percent monaural hearing loss for the left ear.

The Board finds that the Office medical adviser applied the proper standards to the findings stated in Dr. Clay's April 19, 2007 report and audiogram. The result is no ratable hearing loss. Thus, appellant's hearing loss is not compensable for schedule award purposes.

Regarding Dr. Lambdin's reports and the audiograms performed on his behalf, the Board notes that, in both the September 21 and December 14, 2006 audiograms, appellant's pure-tone average and speech discrimination threshold did not agree. The Office medical adviser initially questioned the validity of the September 21, 2006 audiogram for this reason and because Dr. Lambdin did not explain the discrepancy. The Office properly had Dr. Lambdin retest appellant. After the December 14, 2006 audiometric findings again indicated that pure-tone audiometry and speech reception thresholds did not agree, the Office medical adviser questioned why Dr. Lambdin did not explain this discrepancy in the testing data or the rapid deterioration of appellant's hearing between 2005 and 2006. The Office asked Dr. Lambdin to further address the medical adviser's concerns. On February 16, 2007 Dr. Lambdin did not address the worsening of appellant's hearing loss between 2005 and 2006 and only postulated that the discrepancy between the pure-tone audiometric results and the speech reception thresholds occasionally happened without good explanation when the hearing loss was predominantly concentrated in the high frequencies. On February 28, 2007 the medical adviser recommended that the Office refer appellant to another specialist.

The Board has previously recognized that a discrepancy between the pure-tone average and the speech discrimination threshold may call into question the validity of an audiogram.[11] Office procedures provide that, where initial testing is inadequate, the physician will be asked to conduct additional tests or retests.[12] However, as noted, the additional testing performed for Dr. Lambdin did not resolve this discrepancy and he did not provide a reasoned response to the medical adviser's request to explain the discrepancy between pure-tone averages and speech reception thresholds. Dr. Lambdin did not at all address the medical adviser's concerns regarding a substantial worsening of appellant's hearing thresholds between 2005 and 2006. While the September 21 and December 14, 2006 audiometric results obtained by Dr. Lambdin show greater hearing loss than the subsequent audiogram obtained by Dr. Clay, the Board finds that the Office medical adviser's reports set forth appropriate reasons for not using Dr. Lambdin's reports as a basis for an impairment calculation.[13]

The Office properly referred appellant to Dr. Clay for another second opinion. The Board further notes that, while the audiologist who performed testing on behalf of Dr. Clay also noted that initial pure-tone testing yielded results inconsistent with the result of speech

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[11] *See Luis M. Villanueva*, 54 ECAB 666 (2003).

[12] Federal (FECA) Procedure Manual, Part 3 -- Medical, *Requirements for Medical Reports*, Chapter 3.600.8(a)(3) (September 1994).

[13] When several audiograms are in the 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. *S.G.*, 58 ECAB ___ (Docket No. 07-30, issued February 26, 2007).

audiometry, she noted that appellant was reinstructed and that new threshold results were obtained using an ascending approach. Dr. Clay and the audiologist opined that the results were valid and representative of appellant's hearing sensitivity. The Office medical adviser also found the April 19, 2007 audiogram a proper basis for rating appellant's hearing loss. Consequently, the Board finds that the Office properly relied on the April 19, 2007 testing performed on behalf of Dr. Clay as a valid representation of appellant's hearing in determining appellant's hearing impairment.[14]

## ***CONCLUSION***

The Board finds that appellant has not established that he has a ratable hearing loss entitling him to a schedule award.

## ***ORDER***

**IT IS HEREBY ORDERED THAT** the September 10, 2007 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: July 9, 2008
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

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

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

[14] Following the Office's September 10, 2007 decision, appellant submitted additional medical evidence. The Board, however, notes that it cannot consider this evidence for the first time on appeal because the Office did not consider this evidence in reaching its final decision. The Board's review is limited to the evidence in the case record at the time the Office made its final decision. 20 C.F.R. § 501.2(c).