United States Department of Labor
Employees' Compensation Appeals Board

L.S., Appellant	)	
and	)	**Docket No. 07-1361**
	)	**Issued: November 13, 2007**
DEPARTMENT OF LABOR, MINE SAFETY & HEALTH ADMINISTRATION, Harlan, KY, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
ALEC J. KOROMILAS, Chief Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On April 25, 2007 appellant filed a timely appeal from the January 29, 2007 decision of the Office of Workers' Compensation Programs denying modification of his schedule award for hearing loss. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has established that he has greater than four percent hearing loss in his left ear causally related to factors of his federal employment.

FACTUAL HISTORY

On December 12, 2000 appellant, then a 63-year-old coal mine inspector, filed an occupational disease claim alleging that he sustained increased hearing loss as a result of his federal duties. The claim was assigned file number 110183222. On March 7, 2001 appellant's

claim was accepted for left ear hearing loss and on April 9, 2001 the Office issued a schedule award for the four percent impairment of his left ear.

On January 19, 2004 appellant filed an occupational disease claim alleging that his hearing loss had worsened since retiring from the employing establishment. The claim was assigned file number 112020096. Robert Rhea, appellant's former supervisor, stated that appellant had been employed by the employing establishment from October 1989 to January 2003. He stated that appellant had been provided with hearing protection. Daniel Johnson, appellant's supervisor from May 2002 until his retirement on January 12, 2003, stated that appellant was exposed to a wide range of noise levels while working underground five days a week and that he had been provided with hearing protection. The Office also provided the result of audiometric testing and exposure hours from 1989 to 2003.

On February 12, 2004 the Office requested additional information about appellant's condition. On March 15, 2004 appellant stated that his last exposure to hazardous noise at work occurred in June 2002 and that his only other exposure to loud noise was shooting a shotgun, which occurred 6 to 10 times a year.

On July 7, 2004 the Office referred appellant to Dr. Kevin Kavanagh, a Board-certified otolaryngologist, for a second opinion examination. On July 30, 2004 Dr. Kavanagh reported that appellant had a history of high blood pressure, heart disease, heart surgery and diabetes and that his hearing loss got much worse over the previous year. He found that appellant's ear canals were open bilaterally, but found air and fluid levels behind the right ear drum. In tuning fork testing, appellant lateralized to the right side at 256 hertz (Hz) and 512 Hz and, in Rinne testing, he was positive bilaterally at 256 Hz and 512 Hz, but negative at 1,024 Hz. Dr. Kavanagh noted that the audiometric tests revealed that appellant's sensorineural hearing loss was severe in the high frequencies and mild in the low frequencies. He found that, the right ear loss included a significant conductive component of 20 to 25 decibels. Dr. Kavanagh opined that appellant's hearing loss had progressed significantly since 2001. He noted that appellant's speech to reception threshold (SRT) had increased from 5 to 35 decibels in the left ear and from 5 to 50 decibels in the right ear, though 15 to 20 decibels of the right side loss was related to inner ear fluid. Dr. Kavanagh found that the progression of the inner ear portion of the hearing loss strongly suggested that it was not caused by noise. He stated that once noise exposure stops, hearing loss due to that noise progresses in the same manner as presbycusis. Dr. Kavanagh opined that the probable etiology of appellant's increased hearing loss was small vessel disease secondary to heart disease and diabetes. He noted that the conductive hearing loss in the right ear also indicated pathology besides noise-induced hearing loss. Dr. Kavanagh stated that appellant's hearing loss was not due to occupational noise exposure. He provided the results of the audiometric testing and testing verification.

The Office medical adviser reviewed and concurred with Dr. Kavanagh's findings.

By decision dated August 13, 2004, the Office denied appellant's claim on the grounds that Dr. Kavanagh's report did not establish that his hearing loss was employment related. The Office noted that the audiometric tests submitted by the employing establishment were not sufficient to establish that the hearing loss was caused by his employment. It stated, however,

that appellant remained entitled to medical treatment, including hearing aids, under file number 110183222.

On November 8, 2004 appellant requested reconsideration. On October 5, 2004 Dr. Samir Guindi, a Board-certified otolaryngologist, stated that appellant had complained of hearing problems for several years, especially in situations with background noise or more than one person talking. He stated that appellant had worked around noise for 30 years, 15 of which were with the employing establishment. Dr. Guindi reported that appellant had no history of ear infection, though he previously had tubes in his ears for fluid. On examination, he noted that appellant's tympanic membranes were intact and clear, but that the tympanogram for his right ear was Type B. Appellant's audiogram showed speech recognition threshold at 40 decibels in his right hear and 30 decibels in his left ear. The speech recognition scores were 90 percent for 65 decibels in the right ear and 72 percent for 60 decibels in the left ear. Dr. Guindi concluded that appellant had noise-induced sensorineural hearing loss that equaled 15 percent whole person impairment under the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001). He also stated that appellant would benefit from a hearing aid.[1]

Dr. Frank Mongiardo, a Board-certified otolaryngologist, provided audiograms conducted on August 24 and September 27, 2004. The identity of the audiologist is unclear. In the August 24, 2004 report, the audiologist noted that the right ear had mixed loss and the left ear had moderate to severe sensorineural hearing loss. The tympanograms were Type C for the right ear and Type A (normal) for the left ear. The speech results were in agreement with the audiogram results. The audiologist recommended hearing aids and annual evaluations and stated that appellant needed to see a physician about the conductive hearing loss in his right ear. On September 27, 2004 the audiologist noted continuing mixed right ear hearing loss with high frequency sensorineural hearing loss, probably noise induced. Tympanograms for the right ear were Type C and for the left ear were Type A/B. Speech responses were in agreement with the audiogram and hearing levels. Dr. Mongiardo found that appellant's hearing loss was mixed and included both sensorineural and noise-induced losses.

On October 5, 2005 Angela Morris, a Board-certified audiologist, performed an audiometric examination. She noted that appellant could hardly concentrate because of tinnitus, that he had a tube in his right ear and that he had diabetes. Ms. Morris found moderate to profound sensorineural hearing loss bilaterally and noted mild SRT loss, but good speech discrimination bilaterally. She found that appellant's tympanogram for the right ear was normal Type A and that his left ear was flat Type B with a large valve or tube.[2]

On December 6, 2004 the Office provided the new medical evidence to the Office medical adviser for an evaluation of whether modification of appellant's schedule award was warranted. On December 19, 2004 the Office medical adviser stated that, according to the record, appellant retired from the employing establishment in January 2003 but that his hearing did not start to get worse until approximately July 2003, which was "long after" his noise

[1] Dr. Guindi did not state why appellant had not received hearing aids under his earlier claim.

[2] It appears that Ms. Morris switched the right and left ears in her tympanogram analysis as she noted elsewhere in the report that appellant had a valve in his right ear.

exposure had ended. He stated that Dr. Kavanagh had indicated that sensorineural hearing loss due to noise exposure ceases when the exposure ceases. The Office medical adviser noted that the July 26, 2004 audiogram indicated that appellant's hearing loss was mildly sloping in the left ear and profound in the right ear. Dr. Zimmerman concurred with Dr. Kavanagh's finding that the loss from 250 to 2,000 Hz could not be due to noise exposure, and was more likely caused by small vessel disease, related to appellant's heart disease and diabetes, as well as right-side conduction losses. He found that Dr. Guindi provided no rationale for his opinion and did not account for the 15 to 20 decibel conduction hearing loss in the right ear or the possibility of small vessel disease found by Dr. Kavanagh. Dr. Zimmerman stated that Dr. Guindi did not provide a thorough medical history or explain the delay in the onset of the hearing loss. He stated that the October 5, 2004 audiogram was not acceptable. There was no indication of whether Dr. Zimmerman reviewed the audiometric reports from Dr. Mongiardo.

By decision dated January 3, 2005, the Office denied modification of its August 13, 2004 decision.

On February 5, 2005 appellant requested reconsideration. He contended that the Office had not considered the audiometric reports of Dr. Mongiardo. Appellant also challenged Dr. Kavanagh's statement that he had reported significant worsening only in the previous year; he stated that he had informed Dr. Kavanagh that his hearing worsened over several years. He provided copies of the 1998, 2001 and 2002 audiometric examinations submitted by the employing establishment. The 1998 report stated that pure-tone testing indicated mild to profound hearing loss on the right and threshold losses from mild to severe from 2,000 to 8,000 Hz on the left. In the 2001 report, the audiologist stated that appellant had high-frequency moderate to severe loss from 3,000 to 8,000 Hz on the right and moderate to profound loss from 2,000 to 8,000 Hz on the left. In the 2002 report, the audiologist found mild to profound hearing loss on the right and borderline normal hearing with profound loss from 2,000 to 8,000 Hz on the left.

In a January 18, 2005 report, Dr. Frank Little, a Board-certified otolaryngologist, stated that appellant had a myringotomy tube in his right tympanic membrane to treat chronic Eustachian tube dysfunction, but that his canals and membranes were otherwise normal. He stated that the audiogram showed bilateral mild to profound sloping sensorineural hearing loss in both ears with a mild conductive component in the low frequencies in the right ear. Dr. Little reviewed past audiograms, which showed progressive worsening of appellant's sensory hearing loss from the time he began working at the employing establishment. He opined that the noise levels to which appellant was exposed were too high for the protection he was given and that the work environment significantly worsened his hearing loss to the point of needing hearing aids.

On February 28, 2005 at the request of the Office, Dr. Zimmerman reviewed the newly submitted medical evidence and found that it was not sufficient to revise appellant's schedule award because it appeared that the audiometric tests of October 5, 2004 and January 18, 2005 were not conducted according to Office protocol.

By decision dated April 20, 2005, the Office denied modification of appellant's schedule award.

On June 27, 2005 appellant requested reconsideration of the Office's decision. He requested that the Office review his old audiograms, specifically those from 2000 and 2002, and consider a new report from Dr. Mongiardo. On May 4, 2005 Dr. Mongiardo stated that appellant had continuing mixed hearing loss and Type C tympanogram for the right ear and borderline normal to moderately severe sensorineural hearing loss in the left ear. He reported that appellant continued to complain of tinnitus. Dr. Mongiardo noted no abnormalities on the external auditory meatus or tympanic membrane. He diagnosed sensorineural hearing loss and stated that, according to the American Academy of Otolaryngology and the American Council of Otolaryngology, appellant had an impairment of 60 percent in his right ear, 30 percent in his left ear and binaural impairment of 35 percent. No audiometric tests results were attached.

On September 12, 2005 Dr. Zimmerman found that the 2002 audiometric report did not support a revision of appellant's schedule award because it did not contain the documentary elements required by the Office. He did not address Dr. Mongiardo's report.

By decision dated September 28, 2005, the Office denied modification of its April 20, 2005 decision. The Office stated that Dr. Zimmerman found that Dr. Mongiardo's May 2005 report was not in accordance with the Office requirements.

On October 20, 2005 appellant requested reconsideration on the basis of an October 18, 2005 report from Dr. Mongiardo who stated that, under the A.M.A., *Guides*, appellant's May 4, 2005 audiograms showed right ear hearing impairment of 60 percent, left ear impairment of 30 percent and binaural hearing impairment of 35 percent.

On March 8, 2006 the Office medical adviser, Dr. Zimmerman, found that Dr. Mongiardo's October 18, 2006 report, which was not accompanied by an audiogram report, had no impact on schedule award for noise-induced hearing loss, as the noise exposure ceased in January 2003.

By decision dated March 17, 2006, the Office denied modification of its September 28, 2005 decision on the grounds that the Office medical adviser found the new medical evidence to be insufficient.

On April 26, 2006 appellant requested reconsideration of the Office's decision. On March 28, 2006 Dr. Guindi stated that he was treating appellant for hearing loss, right worse than left. He reported that appellant's tympanic membranes were intact and clear, that his speech threshold was 60 decibels on the right and 25 decibels on the left, and that his speech recognition was 92 percent on the right and 88 percent on the left. Dr. Guindi found 11 percent whole person impairment and recommended a hearing aid. The audiologist found that appellant had moderate to profound hearing loss in his right ear and normal to profound loss in his left ear.

On May 10, 2006 Dr. Zimmerman found that the March 28, 2006 audiometric assessment was not in conformance with the Office's protocols for hearing loss schedule awards. He also found that Dr. Guindi's report did not explain how appellant's current hearing condition was related to his employment exposure. For these reasons, Dr. Zimmerman found that the new evidence did not allow a revision of appellant's schedule award.

By decision dated June 23, 2006, the Office denied modification of the March 17, 2006 decision. The Office found that Dr. Guindi's reports provided no reasoned medical opinion, failed to address the effect of appellant's nonemployment-related disease on his hearing loss and did not provide an impairment rating consistent with the A.M.A., *Guides* (fifth edition).

On November 27, 2006 appellant requested reconsideration of the Office's decision and submitted the August 2, 2006 report of Dr. Mongiardo. He also contended that there was no medical evidence that diabetes could have an effect on his hearing loss, as suggested by Dr. Kavanagh. In the August 2, 2006 hearing evaluation report, the audiologist stated that appellant had continuing bilateral sensorineural hearing loss with Type A tympanograms and speech responses comparable with his hearing loss and audiograms. Dr. Mongiardo stated that the hearing loss was due to noise exposure and provided impairment ratings of 26.2 percent for the right ear, 24.4 percent for the left ear and 24.7 percent binaurally.

On December 20, 2006 the Office medical adviser, Dr. Zimmerman, found that the August 2, 2006 audiogram was not sufficient to revise the schedule award because it was not submitted along with a report of the type required by the Office.

By decision dated January 29, 2007, the Office denied modification of its June 23, 2006 decision. The Office found that Dr. Zimmerman had concluded that Dr. Mongiardo's August 2, 2006 report and audiogram did not meet the Office's requirements for evaluation of a hearing loss claim.

LEGAL PRECEDENT

The Board has long held that, if a claimant's employment-related hearing loss worsens in the future, the claimant may apply for an additional schedule award for any increased permanent impairment.[3]

In order to establish an employment-related hearing loss, the Board requires that the employee undergo both audiometric and otologic examination; that the audiometric testing precede the otologic examination; that the audiometric testing be performed by an appropriately certified audiologist; that the otologic examination be performed by an otolaryngologist certified or eligible for certification by the American Academy of Otolaryngology; that the audiometric and otologic examination be performed by different individuals as a method of evaluating the reliability of the findings; that all audiological equipment authorized for testing meet the calibration protocol contained in the accreditation manual of the American Speech and Hearing Association; that the audiometric test results included both bone conduction and pure-tone air conduction thresholds, speech reception thresholds and monaural discrimination scores; and that the otolaryngologist report must include: date and hour of examination, date and hour of the employee's last exposure to loud noise, a rationalized medical opinion regarding the relation of

[3] *Roberts E. Cullison*, 55 ECAB 570 (2004).

the hearing loss to the employment-related noise exposure and a statement of the reliability of the tests.[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 Hz, 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 1.5 to arrive at the percentage of monaural 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 loss.[9] The Board has concurred in the Office's adoption of this standard for evaluating hearing loss.

ANALYSIS

The Office has accepted that appellant sustained four percent impairment in his left ear caused by his federal employment. The issue to resolve is whether appellant has met his burden of proof to establish that he has a greater hearing loss causally related to his federal employment.

On July 30, 2004 Dr. Kavanagh, a Board-certified otolaryngologist, provided narrative and audiometric reports that met all the criteria set by the Office. He reported that appellant had a history of high blood pressure, heart disease, and diabetes and that he had air and fluid levels behind the right eardrum. Dr. Kavanagh reported that appellant's speech to reception threshold had increased from 5 to 35 decibels in the left ear and 5 to 50 decibels in the right ear, though 15 to 20 decibels of the right-sided loss was related to inner ear fluid. He stated that appellant's audiometric tests revealed sensorineural hearing loss that was severe in the high frequencies and mild in the low frequencies, but he also noted that the right ear loss had a significant conductive component. Dr. Kavanagh opined that appellant's hearing loss had progressed significantly since 2001. He found that appellant had extensive progression of the inner ear portion of his hearing loss, which strongly suggested that noise was not the cause of the hearing loss. Dr. Kavanagh stated that, once noise exposure stops, hearing loss due to that noise progresses in the same manner as presbycusis. He opined that the probable etiology of appellant's increased hearing loss was small vessel disease secondary to heart disease and diabetes. Dr. Kavanagh noted that the conductive hearing loss in the right ear also indicated pathology besides noise-induced hearing loss. In light of there findings, he opined that appellant's hearing loss was not

[4] *Raymond H. VanNett*, 44 ECAB 480, 482-83 (1993). *See also* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Requirements for Medical Reports*, Chapter 3.600.8(a) (September 1995).

[5] A.M.A., *Guides* 250 (5th ed. 2001).

[6] *Id*.

[7] *Id.*

[8] *Id.*

[9] *Id.*

due to occupational exposure. The Board finds that Dr. Kavanagh's opinion carries the weight of the medical opinion evidence and that he resolved the issue of whether appellant's increased hearing loss was employment related.

After the Office denied his claim based on Dr. Kavanagh's medical opinion, appellant submitted several reports from Dr. Guindi, Dr. Little and Dr. Mongiardo, all of whom are Board-certified otolaryngologists. Though these physicians diagnosed varying degrees of hearing loss and opined that it was related to employment noise exposure, none of their opinions were sufficient to establish appellant's claim because they lacked medical rationale. The Board has held that a mere conclusion without medical rationale, explaining how and why the physician believes that a claimant's accepted exposure resulted in the diagnosed condition, is not sufficient to meet the claimant's burden of proof. The medical evidence must include rationale that explains how the physician reached the conclusion he or she is supporting.[10] The Board also finds that the audiometric reports appellant submitted were not in conformity with the requirements set by the Office. For example, the most recent audiogram, supplied by Dr. Mongiardo, lacked the identity and certification of the audiologist, the equipment calibration certification and bone conduction results.

The Board finds that appellant has not presented medical evidence that meets all of the requirements set by the Office, as outlined above. Therefore, the Board finds that appellant has not met his burden of establishing that his increased impairment is the result of his federal employment.

CONCLUSION

The Board finds that appellant has not established that he has greater than four percent hearing loss in his left ear causally related to factors of his federal employment.

[10] *Beverly A. Spencer*, 55 ECAB 501 (2004).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated January 29, 2007 is affirmed.

Issued: November 13, 2007
Washington, DC

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

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

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