Sensory Impairments, Including Hearing, Meniere’s Disease and Speech Disorders

8:00 a.m.-9:00 a.m.

Presented By

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THE SPECIAL SENSES LISTINGS AT 2.07 AND 2.09

TOPICS

I. Listing at 2.07, Disturbance of labyrinthine-vestibular function including Meniere’s Disease, vertigo, balance disturbance, tinnitus, and hearing loss

A. Anatomy of the Head, Ear, and Brain and definitions

B. Review of the Listing and how to establish the MDI and prove disability

1. Evaluation and Management of Meniere’s Disease from American Speech-Language and Hearing Association

2. Medical examinations, tests, and treatment (caloric and audiograms) and use of the National Dizzy and Balance Center

3. Meniere’s Disease 2.07 Listings Residual Functional Capacity Questionnaire

C. Tinnitus

D. Hyperacusis

II. Listing at 2.09, Loss of Speech and SSR 82-57

A. Stuttering, articulation issues, vocal cord dysfunction, and speech tics

B. Is “stage whispering” a disability?

   Beauvoir v. Chater, 104 F.3d 1432 (2d Cir. 1997)

C. Consideration of psychiatric or psychological factors and need for evaluation
Definitions:

**anvil** - (also called the incus) a tiny bone that passes vibrations from the hammer to the stirrup.

**cochlea** - a spiral-shaped, fluid-filled inner ear structure; it is lined with cilia (tiny hairs) that move when vibrated and cause a nerve impulse to form.

**eardrum** - (also called the tympanic membrane) a thin membrane that vibrates when sound waves reach it.

**Eustachian tube** - a tube that connects the middle ear to the back of the nose; it equalizes the pressure between the middle ear and the air outside. When you "pop" your ears as you change altitude (going up a mountain or in an airplane), you are equalizing the air pressure in your middle ear.

**hammer** - (also called the malleus) a tiny bone that passes vibrations from the eardrum to the anvil.

**nerves** - these carry electro-chemical signals from the inner ear (the cochlea) to the brain.

**outer ear canal** - the tube through which sound travels to the eardrum.

**pinna** - (also called the auricle) the visible part of the outer ear. It collects sound and directs it into the outer ear canal.

**semicircular canals** - three loops of fluid-filled tubes that are attached to the cochlea in the inner ear. They help us maintain our sense of balance.

**stirrup** - (also called the stapes) a tiny, U-shaped bone that passes vibrations from the stirrup to the cochlea. This is the smallest bone in the human body (it is 0.25 to 0.33 cm long).
4. How do we evaluate your word recognition ability if you are not fluent in English?

If you are not fluent in English, you should have word recognition testing using an appropriate word list for the language in which you are most fluent. The person conducting the test should be fluent in the language used for the test. If there is no appropriate word list or no person who is fluent in the language and qualified to perform the test, it may not be possible to measure your word recognition ability. If your word recognition ability cannot be measured, your hearing loss cannot meet 2.108 or 2.118. Instead, we will consider the facts of your case to determine whether you have difficulty understanding words in the language in which you are most fluent, and if so, whether that degree of difficulty medically equals 2.108 or 2.118. For example, we will consider how you interact with family members, interpreters, and other persons who speak the language in which you are most fluent.

C. How do we evaluate vertigo associated with disturbances of labyrinthine-vestibular function, including Ménière's disease?

1. Vertigo associated with disturbances of labyrinthine-vestibular function, including Ménière's disease. These disturbances of balance are characterized by a hallucination of motion or a loss of position sense and a sensation of dizziness which may be constant or may occur in paroxysmal attacks. Nausea, vomiting, ataxia, and incapacitation are frequently observed, particularly during the acute attack. It is important to differentiate the report of rotary vertigo from that of "dizziness" which is described as light-headedness, unsteadiness, confusion, or syncope.

2. Ménière's disease is characterized by paroxysmal attacks of vertigo, tinnitus, and fluctuating hearing loss. Remissions are unpredictable and irregular, but may be long-lasting; hence, the severity of impairment is best determined after prolonged observation and serial reexaminations.

3. The diagnosis of a vestibular disorder requires a comprehensive neuro-otolaryngologic examination with a detailed description of the
vertiginous episodes, including notation of frequency, severity, and duration of the attacks. Pure tone and speech audiometry with the appropriate special examinations, such as Bekesy audiometry, are necessary. Vestibular function is accessed by positional and caloric testing, preferably by electronystagmography. When polytomograms, contrast radiography, or other special tests have been performed, copies of the reports of these tests should be obtained in addition to appropriate medically acceptable imaging reports of the skull and temporal bone. Medically acceptable imaging includes, but is not limited to, x-ray imaging, computerized axial tomography (CAT scan) or magnetic resonance imaging (MRI), with or without contrast material, myelography, and radiocnuclear bone scans. "Appropriate" means that the technique used is the proper one to support the evaluation and diagnosis of the impairment.

D. Loss of speech.

In evaluating the loss of speech, the ability to produce speech by any means includes the use of mechanical or electronic devices that improve voice or articulation. Impairments of speech may also be evaluated under the body system for the underlying disorder, such as neurological disorders, 11.00ff.

E. How Do We Evaluate Impairments That Do Not Meet One Of The Special Senses And Speech Listings?

1. These listings are only examples of common special senses and speech disorders that we consider severe enough to prevent an individual from doing any gainful activity. If your impairment(s) does not meet the criteria of any of these listings, we must also consider whether you have an impairment(s) that satisfies the criteria of a listing in another body system.

2. If you have a medically determinable impairment(s) that does not meet a listing, we will determine whether the impairment(s) medically equals a listing. (See §§404.1526 and 416.926.) If you have an impairment(s) that does not meet or medically equal a listing, you may or may not have the residual functional capacity to engage in
substantial gainful activity. Therefore, we proceed to the fourth, and if necessary, the fifth steps of the sequential evaluation process in §§404.1520 and 416.920. When we decide whether you continue to be disabled, we use the rules in §§404.1594, 416.994, or 416.994a, as appropriate.

2.01 **Category of Impairments, Special Senses and Speech**

2.02 **Loss of Central Visual Acuity.** Remaining vision in the better eye after best correction is 20/200 or less.

2.03 **Contraction of the visual field in the better eye, with:**

A. The widest diameter subtending an angle around the point of fixation no greater than 20 degrees;

OR

B. An MD of 22 decibels or greater, determined by automated static threshold perimetry that measures the central 30 degrees of the visual field (see 2.00A6d).

OR

C. A visual field efficiency of 20 percent or less, determined by kinetic perimetry (see 2.00A7c).

2.04 **Loss of visual efficiency, or visual impairment, in the better eye:**

A. A visual efficiency percentage of 20 or less after best correction (see 2.00A7d).

OR

B. A visual impairment value of 1.00 or greater after best correction (see 2.00A8d).

2.07 **Disturbance of labyrinthine-vestibular function** (Including Ménière's disease), characterized by a history of frequent attacks of
balance disturbance, tinnitus, and progressive loss of hearing. With both A and B:

A. Disturbed function of vestibular labyrinth demonstrated by caloric or other vestibular tests; and

B. Hearing loss established by audiometry.

2.09 Loss of speech due to any cause, with inability to produce by any means speech that can be heard, understood, or sustained.

2.10 Hearing loss not treated with cochlear implantation.

A. An average air conduction hearing threshold of 90 decibels or greater in the better ear and an average bone conduction hearing threshold of 60 decibels or greater in the better ear (see 2.00B2c).

OR

B. A word recognition score of 40 percent or less in the better ear determined using a standardized list of phonetically balanced monosyllabic words (see 2.00B2e).

2.11 Hearing loss treated with cochlear implantation.

A. Consider under a disability for 1 year after initial implantation.

OR

B. If more than 1 year after initial implantation, a word recognition score of 60 percent or less determined using the HINT (see 2.00B3b).
Evaluation and Management of Ménière's Disease

Ménière's disease is a chronic illness that is characterized by symptoms of episodic vertigo, aural fullness, tinnitus, and fluctuating sensorineural hearing loss. There are approximately 615,000 cases of Ménière's disease in the United States (National Institute on Deafness and Other Communication Disorders, 2008). The diagnosis is most common in adults during their 4th or 5th decade of life and has a slight female preponderance. There also appears to be a strong genetic component (Sajjadi & Paparella, 2008). Ménière's has been studied since 1861, when Prosper Ménière first described a condition with the symptoms as listed. Although there is still much to be understood about the underlying physiological mechanisms that cause Ménière's disease, research has shown that a majority of patients receive benefit either from a change in lifestyle or from medical or surgical intervention.

Pathophysiology

The pathophysiology of Ménière's disease is not clearly understood. It was previously thought that Ménière's was closely correlated with endolymphatic hydrops, a condition in which endolymph builds up due to an obstruction in the endolymphatic sac. Hormones such as saccin and glycoproteins are produced in excess, which may relieve the blockage and cause vertigo due to the sudden release of endolymph across the sac (Sajjadi & Paparella, 2008). However, histological studies of temporal bones have shown the presence of endolymphatic hydrops in patients without symptoms associated with Ménière's disease (McCall et al., 2009), raising the question of why some people with hydrops are symptomatic while others are not. Other possible origins of the disease are perisaccular fibrosis, atrophy of the endolymphatic sac and loss of epithelial integrity, hypoplasia of the vestibular aqueduct, and narrowing of the lumen of the endolymphatic duct (Sajjadi & Paparella, 2008). McCall and colleagues (2009) examined the vestibular end organs of patients with intractable Ménière's that were obtained during labyrinthectomy. They noted that the specimens showed "variable degrees of neuroepithelial degeneration including conversion of the sensory epithelium to a monolayer, [basement membrane] thickening, cellular vacuolization, absence of hair cell stereocilia, and increased intercellular stromal spaces" (McCall et al., 2009, p. 10). Further research is needed to replicate this study and obtain more information regarding the pathophysiological processes underlying Ménière's disease.

Symptoms

Ménière's disease is characterized primarily by its accompanying symptoms, which include tinnitus, hearing loss, aural fullness, and vertigo. The tinnitus is typically described as a "roaring" sound that becomes louder
prior to the onset of vertigo. Hearing loss typically follows the configuration of low-frequency sensorineural hearing loss and commonly fluctuates. Many patients describe a sensation of aural fullness or pressure prior to the onset of vertigo, which may be accompanied by tinnitus. Episodes of vertigo typically last at least 20 minutes and may persist for up to several hours.

In 1995, the American Academy of Otolaryngology-Head and Neck Surgery established the following criteria for diagnosis of Ménière's disease (p. 182):

**Certain Ménière's disease**
- Definite Meniere's disease, plus histopathological confirmation

**Definite Ménière's disease**
- Two or more definitive spontaneous episodes of vertigo 20 minutes or longer
- Audiometrically documented hearing loss on at least one occasion
- Tinnitus or aural fullness in the treated ear
- Other causes excluded

**Probable Ménière's disease**
- One definitive episode of vertigo
- Audiometrically documented hearing loss on at least one occasion
- Tinnitus or aural fullness in the treated ear
- Other causes excluded

**Possible Ménière's disease**
- Episodic vertigo of the Ménière's type without documented hearing loss, or
- Sensorineural hearing loss, fluctuating or fixed, with dysequilibrium but without definitive episodes
- Other causes excluded


These criteria illustrate the importance of integrating case history and the patient's report of symptoms with objective test measures to reach a diagnosis of Ménière's disease.
Evaluation
Evaluation of patients with Ménière's symptoms is very important in determining a diagnosis. Before the patient is seen by an otolaryngologist, the physician may request a variety of clinical tests. The case history is critical. It is especially important to determine the onset of symptoms and to describe the frequency and duration of vertiginous episodes as well as identify any accompanying ear complaints. A comprehensive audiologic evaluation should be completed, including pure-tone air and bone conduction thresholds at standard audiometric frequencies, word recognition scores, and immittance testing. Audiometric thresholds should be closely monitored to document any fluctuations in hearing sensitivity. Formal vestibular testing should be done to assess the integrity of the vestibular system and may include dynamic posturography, rotary chair, and videonystagmography evaluations. Electrophysiological evaluations such as electrocochleography and vestibular evoked myogenic potentials may be completed as well. Finally, the patient will be seen by an otolaryngologist to determine a diagnosis and discuss treatment options.

Treatment Options
Much research has been done to determine the efficacy of treatment options for patients with Ménière's disease. These treatment options range from changes in lifestyle to ablative surgery. A fairly high correlation of seasonal allergies exists in patients diagnosed with Ménière's disease, and studies have shown a significant decrease in vertigo symptoms for these patients after implementing allergy-avoidance behaviors and/or starting immunotherapy for allergies. Other lifestyle changes, such as limiting caffeine, chocolate, alcohol, and salt, have been effective in reducing vertigo attacks. Patients diagnosed with Ménière's disease are typically counseled to adopt a low-salt diet (1,500-2,000 mg per day), and some are also started on a diuretic.

If changes in lifestyle are not sufficient for the suppression of vertigo attacks, other treatments are considered. The Meniette device is a minimally invasive form of therapy in which pressure pulses are delivered to the ear through a small device following placement of a tympanostomy tube in the tympanic membrane. These pressure changes are thought to help stimulate the flow of endolymph, which can result in a reduction of vertigo symptoms. Studies have shown that up to 67% of patients report an improvement in symptoms at 2 years, while longer term studies have shown a success rate of up to 58% (Dornhofer & King, 2008). The primary drawback to use of the Meniette device from the patients' perspective is the cost; third-party payers do not cover the device at this time.

Steroid therapy has also been utilized for treatment of symptoms associated with Ménière's disease, especially in patients with a sudden decrease in hearing. It is a nonablative form of treatment that does not require surgery. Steroids can be given orally or via intratympanic (IT) injection. A review of the literature in 2004 concluded that the strongest evidence of improvement was seen in patients with sudden, idiopathic hearing loss, while evidence of improvement in patients with Ménière's disease is weakly correlated (Doyle et al., http://www.asha.org/aud/articles/menieres-disease-eval-management/ 4/11/2014
A study completed by Boleas-Aguirre, Lin, Della Santina, Minor, and Carey (2008) reported a 91% success rate in Ménière's patients after 2 years following IT dexamethasone. Of the patients followed for longer than 2 years, 70% did not require any further treatment. It is important to consider other autoimmune inner ear disorders if a patient responds favorably to the steroid treatment.

Some patients elect to undergo endolympathic sac decompression surgery, which has a high preservation rate for hearing and balance function. In this procedure, a Silastic sheet is inserted into the lumen of the endolympathic sac. Efficacy of this surgery is fairly controversial. Some studies report improvement in vertigo symptoms, while others note no difference between the surgical and placebo groups (Sajjadi & Paparella, 2008).

If treatments aimed at restoring normal function of the inner ear are not successful, ablative forms of treatment are considered. One of these forms is IT gentamicin injection, in which gentamicin is injected directly into the middle ear space. This form of treatment has been found to successfully treat vertigo attacks in many patients, but potential secondary effects include disequilibrium and sensorineural hearing loss, and these must be explained to the patient.

Surgical options for patients with intractable Ménière's are vestibular nerve section or labyrinthectomy. Vestibular nerve section has been performed in cases where hearing preservation is desired. However, this form of surgery has become less popular since the widespread introduction of IT gentamicin.

Labyrinthectomy is more desirable in patients who already have a substantial degree of hearing loss (Gacek & Gacek, 1996). Ablative procedures are generally effective in alleviating the disabling attack of vertigo, and patients typically recover quite well due to the principles of central compensation following a stable unilateral vestibular system weakness.

Although Ménière's disease affects a substantial number of people in the United States, control of vertigo attacks can often be achieved through a variety of lifestyle changes coupled with other medical or surgical interventions. The proper diagnosis of Ménière's depends on an accurate case history, completion of auditory and vestibular testing measures, and a thorough medical evaluation. A majority of patients benefit from dietary changes or minimally invasive medical treatments and procedures, while those who do not may explore options such as IT gentamicin, vestibular nerve section, and labyrinthectomy. Vestibular rehabilitation can be useful in patients who are no longer experiencing acute attacks of spontaneous vertigo but who may be left with symptoms of disequilibrium or unsteadiness. While much is known about the symptoms and treatments associated with Ménière's disease, the underlying pathophysiology of the disorder is poorly understood. Further research is necessary to obtain a better understanding of the disease process, which will likely increase treatment efficacy.
References


About the Authors

**Crystal VanDerHeyden** is an audiologist at the University of Michigan Health System in Ann Arbor, Michigan. Her clinical interests focus on the area of diagnostic testing, including vestibular assessments.
auditory evoked potentials, and comprehensive pediatric and adult audiolologic evaluations. She is actively involved with the training and mentorship of audiology graduate students and is a member of the 2010 Michigan Audiology Coalition conference planning committee.

Jaynee A. Handelsman is Assistant Director of the Vestibular Testing Center in the Department of Otolaryngology Head and Neck Surgery in the University of Michigan Health System. Her clinical, teaching, and research areas of focus include the assessment and management of patients with dizziness and balance disorders, as well as the impact of potentially ototoxic medications on auditory and vestibular system function. Dr. Handelsman is ASHA Vice President for Audiology Practice (2010-2012) and an ASHA Fellow.

Coding and Reimbursement Resources on the ASHA Website

Coding for Reimbursement

ICD-9-CM Diagnosis Codes related to Meniere's Disease:

386.0 Meniere's disease
   Endolymphatic hydrops
   Lermoyez's syndrome
   Meniere's syndrome or vertigo

386.00 Meniere's disease, unspecified Meniere's disease (active)

386.01 Active Meniere's disease, cochleovestibular

386.02 Active Meniere's disease, cochlear

386.03 Active Meniere's disease, vestibular

386.04 Inactive Meniere's disease, Meniere's disease in remission

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INITIAL PATIENT EVALUATION

DATE: 08/03/2010

DEMOGRAPHIC INFORMATION:

PATIENT: 
DOB: 
AGE: 35
GENDER: Male
PROVIDER: 

REFERRAL:

is being seen today at the request of

CHIEF COMPLAINT / PURPOSE OF VISIT:

presents today with a chief complaint of:

- Dizziness
- Imbalance
- Lightheadedness
- Unsteadiness
- Vertigo (spinning)
- Falling
- Blacking out or fainting
- Nausea/vomiting

HISTORY OF PRESENT ILLNESS:

Nature of the Problem

recalls his problem started July 11, 2010 following no related event, with the onset of symptoms occurring gradually. The condition is currently variable with the severity of symptoms ranging from 2 at the best times to 10 at the worst times on a scale of 0 to 10 (with 10 being the worst). rates the average severity of his symptoms a 10 on a scale of 1 to 10 (with 10 being the worst). reports that his dizziness/imbalance comes and goes in spells and attacks. He reports his dizziness/imbalance is affected by different body positions including: rolling his body to the left or right, going from lying to sitting positions, looking up or head back positions, turning head left or right and bending over or head down positions. He reported that limited head movement, rest, and meclizine makes the dizziness/imbalance better, and moving his head, riding or driving in a car, large crowds or busy environments and quick movements makes the problem worse. Walking in the dark is not difficult for him, and walking on uneven surfaces, such as lawn, is not difficult. When the dizziness/imbalance occurs, he needs support to prevent falling. said he has fallen 3 times due to his dizziness/imbalance problem, and has had 10 or more near falls, and he tends to fall in all directions. He reports no history of migraines.

Ear Related Symptoms

reports having hearing problems that started over the past two years in both ears, and currently does not wear any hearing aides. He reported having noise in both ears, describes the noise as a ringing, it's variable in volume/ intensity. He reported having pain, fullness, or pressure in both ears.

Associated Symptoms While Dizzy/Imbalanced

When dizzy/imbalance, he experiences lightheadedness or floating sensations. Experiences objects or surroundings spinning and turning around him. Experiences a sensation that he is turning or spinning while objects remain stationary around him. Does experience some nausea or vomiting. No tingling of the hands, feet or lips.
National Dizzy & Balance Center - Medical Department

INITIAL PATIENT EVALUATION

Patient: [redacted]

DATE: [redacted]

Prior Relevant Medical Evaluations and Treatment
[redacted] has seen his primary care physician and an ENT regarding his condition prior to coming to NDBC.

Prior Diagnostic Testing
[redacted] has undergone the following studies relevant to this condition: MRI of the Brain performed at [redacted] Hospital in July 2010. Hearing test performed at [redacted] Clinic in July 2010.

PAST MEDICAL HISTORY:
Serious Injuries/Illnesses: [redacted] denies history any serious injury/illness relevant to his condition.
Surgeries: History is positive for the following procedures: Neck fusion C5-C6 in 2000, Neck fusion C6-C7 in 2008.
Serious hospitalizations: See above.

CURRENT MEDICATIONS:
A complete list of [redacted] medications is filed in his medical record.

ALLERGIES:
Medications: [redacted] reported no medication allergies.
Non-medications: [redacted] reported a history of seasonal allergies.

SELF AND FAMILY MEDICAL HISTORY:
He reports a personal medical history of arthritis. He reports a family medical history of arthritis, cataracts, Type II diabetes, fibromyalgia, high blood pressure, high cholesterol, osteoporosis and thyroid disease.

SOCIAL HISTORY:
Marital/Children Status: [redacted] reports being married.
Current Living Situation: He currently lives in a house with his spouse and children.
Exercise/Activity/Hobbies: He has increased activity, due to: Dizziness, imbalance, fear of falling, neck pain and headaches, and vomiting.
Smoking: He is an ex-smoker.
Alcohol use: He does not consume alcohol.
Caffeine use: He consumes 1 caffeinated beverages per day.
Recreational drug use: [redacted] reported no use of recreational drugs, no history of chemical dependence or addiction.

REVIEW OF SYSTEMS:
Of the systems reviewed, these systems were positive: Excess thirst or hunger, Fatigue, Fevers/chills/sweats, Fluid retention, General weakness, Allergies/hay fever, Blurred vision, Ear pain, Headaches, Hearing problems, Nasal congestion, Ringing in ears, Sinus infections (chronic), Lightheaded on arising quickly, Poor circulation, Confusion, Coordination problems, Insomnia, Memory loss, Stress, Tremor, Walking difficulty or disorder, Heartburn/reflux/ulcers, Nausea/vomiting and Aching muscles, Back pain/disc disease, Foot pain/problems, Joint pain/stiffness, Leg cramps/spasms, Neck pain/stiffness.

PHYSICAL EXAM
Constitutional:
General Examination and Appearance:

is a 35 year old casually dressed and groomed young man. general health can be described as well developed, well nourished, not in acute distress.

Head, Eyes, Ears, Nose, Throat, and Neck Examination:
HEAD: Normocephalic and no lesions noted. EYES: Conjunctiva, and eye lids were normal. Non-icteric sclera. PERRLA. No spontaneous or gaze-evoked nystagmus. Normal smooth pursuit and saccadic tracking ability. NECK: ____________neck has decreased range of motion.

Respiratory:
Lungs clear to auscultation and no rales, rhonchi, or wheezes were heard.

Cardiovascular:
Regular sinus rhythm observed.

Neurological:
Cranial nerves 2-12 grossly intact. Sensation and vibration proprioception normal. Strength and tone normal. General motor control is normal. Fine motor control is normal. Gait is normal. Tandem walk is normal. Romberg and sharpened Romberg were performed and were normal.

Dizziness Handicap Index (DHI):
Dizziness Handicap Inventory (DHI) resulted in an initial score of 78. The identical questionnaire will be re-administered at the completion of his rehabilitation program if treatment is at an NDBC facility.

EXPLANATION: The Dizziness Handicap Inventory (DHI) is a nationally used self-reported questionnaire designed to be a valid measure of a person's perceived disability as it pertains to their dizziness/balance problem. The DHI is a score from 0 to 100 points, with 00 being the worst. Recent research has shown that a score greater than 50 points correlates with a higher risk of falling.

IMPRESSIONS / REPORT / PLAN OF CARE:

Impression:
____________is a 35-year-old man who is seen today for symptoms of dizziness, imbalance, lightheadedness, unsteadiness, vertigo and falling. Apparently, he had BPPV. He was supposed to go back for a follow up visit in September. He came to our clinic instead. Past medical history includes a car accident, which caused a neck injury. He had neck fusion at 5-6 for herniation of the disk twice. For five years he was not able to go back to his work. Eventually, he started working as a security officer. What he describes sounds like sudden drop attacks. He has been off work for the past three to four weeks. He had an MRI scan of head, which was negative. He also describes symptoms of oscillopsia. He lives with his family. He is not working at the present time.

Physical examination shows a well developed, casually dressed and groomed young man who is in mild distress. Extraocular movements are full without any spontaneous or gaze evoked nystagmus. It is quite striking as to how much neck stiffness he has. There is significant guarding of any movement although he does have full range of motion of rotation. Cranial nerves appear to be grossly intact. He has normal sensation, strength, coordination and motor control. His gait is normal. He is able to tandem walk. He does not sway on Romberg with or without vision. Supine head right and head left positions did not trigger any symptoms of vertigo. Deep tendon reflexes were normal.

The etiology of his symptoms is not very clear. The positional vertigo started a month ago, and is recurrent, which might suggest BPPV. However, he has been tested for BPPV at ____________office. He may have cervicogenic dizziness. The blacking out episode and sudden drop attacks are not suggestive of vestibular pathology.
I am going to go ahead and recommend a physical therapy evaluation, including BPPV testing. If BPPV is negative, we will go ahead and schedule him for full VENG. This was thoroughly explained to him.

Preliminary Diagnoses:
- 780.4 Dizziness & giddiness
- 388.11 BPPV
- 781.2 Gait abnormality (NEURO)
- 723.1 Neck pain NOS
- 310.2 Post Concussive Syndrome

Plan of care:
2. Proceed with Physical Therapy Evaluation and Computerized Dynamic Posturography (CDP) testing.
3. Following above evaluations, follow-up with MD for Report of Findings visit to discuss Mr. Hoernemann's results and continued treatment plan.

It was a pleasure seeing your patient. I appreciate the opportunity to assist you in his evaluation. We will keep you informed of your patients progress in our program. Please feel free to call us if you have any questions or concerns.

SIGNED BY:
THIS DOCUMENT HAS BEEN ELECTRONICALLY SIGNED.

DATE SIGNED: 08/03/2010

CC:
DEMOGRAPHIC INFORMATION:
CLINIC ID: COON RAPIDS, MN (763) 786-6900
DOB: [redacted] AGE: 35
GENDER: male

REFERRAL:
[redacted] is being seen today for a Balance Testing Lab Evaluation at the request of [redacted].

CHIEF COMPLAINT / PURPOSE OF VISIT:
[redacted] returns today for his Balance Lab Evaluation after his Initial Medical Evaluation with [redacted] on 08/03/2010, and an initial chief complaint of:
- Dizziness
- Imbalance
- Lightheadedness
- Unsteadiness
- Vertigo (spinning)
- Falling
- Blacking out or fainting
- Nausea/vomiting

SUMMARY OF ELECTROPHYSIOLOGIC STUDIES:

I. AUDIOMETRIC EVALUATION RESULTS
Audiometry:

Tympanometry / Acoustic Reflexes:

II. VIDEONYSTAGMOGRAPHY RESULTS
Oculomotor Testing:
Gaze:
Spontaneous:
Saccades:
Optokinetics:

Pendular tracking:
PT testing was performed at .30Hz and the results were NORMAL. PT was within normal limits with well defined waveforms and normal gain.
PT testing was performed at .50Hz and the results were NORMAL. PT was within normal limits with well defined waveforms and normal gain.
PT testing was performed at .70Hz and the results were NORMAL. PT was within normal limits with well defined waveforms and normal gain.
Pendular tracking: PT testing was performed at .30Hz and the results were NORMAL. PT was within normal limits with well defined waveforms and normal gain. PT testing was performed at .50Hz and the results were NORMAL. PT was within normal limits with well defined waveforms and normal gain. PT testing was performed at .70Hz and the results were NORMAL. PT was within normal limits with well defined waveforms and normal gain.

High Frequency Headshake:
ABNORMAL - Right beating nystagmus was provoked with mention of dizziness post stimulus with horizontal headshakes. Vertical headshakes show reduced or reversed nystagmus post stimulus.

Fistula Testing:
NOT PERFORMED.

Hyperventilation Nystagmus:
NORMAL - Neither nystagmus nor mention of symptoms was noted over the course of 60 seconds of testing at one breath/second.

Hallpike Head Positioning Testing:
NORMAL - NOT RECORDED. The right and left Hallpike was negative.

Body Positional Testing:
ABNORMAL - Not Recorded - Weak intermittent upbeats in head left.

Caloric Testing:
NORMAL - Bithermal air caloric were symmetrical. Non-significant left weakness of: 8 percent. Non-significant right beating directional preponderance of 14 percent (22-25% and 26-30% respectively are generally considered significant by meta analysis).

III. ROTATIONAL CHAIR TESTING RESULTS
Sinusoidal Harmonic Acceleration (SHA):
NOT PERFORMED.

Trapezoidal Step Velocity (TSV):
NOT PERFORMED.

IV. EVOKED POTENTIAL TESTING RESULTS
Vestibular Evoked Myogenic Potential (VEMP):
NORMAL - Repeatable waveforms showed comparable and expected latencies and amplitudes, bilaterally. Results suggest normal function of the saccule and inferior vestibular nerve tract bilaterally.

Auditory Brainstem Response (ABR):
NOT PERFORMED.

V. AUDIOLOGY IMPRESSIONS:
1. The patient reported taking Meclazine yesterday morning.
2. Equivocal OPK testing at 40 deg/sec is not highly diagnostic in isolation.
3. Right beating nystagmus noted post stimulus high frequency headshake may suggest a high frequency, typically peripheral, vestibular deficit.
4. Intermittent upbeating nystagmus in positionals may suggest a central sign.
5. will follow up with additional testing.
6. Pendular tracking and VEMP testing was normal or unremarkable.
7. will follow up with a ROF for consideration of VBRT.
SUMMARY OF PHYSICAL THERAPY EVALUATION (I-V):

I. SUBJECTIVE FINDINGS
In 1995 he has a MVA causing him to have to have 2 neck fusions. 6 years ago he had an episode like the present one (this resolved with Meclizine and antibiotics). 3 years ago he had a similar episode for 4-5 days. 6 months ago he had another episode about 1.5 weeks. Currently, 3 weeks ago, this started again and is still bothering him, with the onset of symptoms occurring suddenly. Mr. Hoernemann describes his symptoms as dizziness, vertigo, lightheadedness, woosiness, nausea, vomiting, HA's and imbalance. Mr. Hoernemann describes how nauseous constantly, major HA's, sensitivity to light, dizzy spells, quick movements will cause him to want to vomit. His conditions ranges in intensity from 2 at the best times to 10 at the worst times on a scale of 0 to 10 (with 10 being the worst). Mr. Hoernemann has functional deficits that include: He is unable to work or do much of anything and needs to take 4 Meclizine/day to not vomit. He is not comfortable driving, shopping. The following positional changes increase his symptoms: sit to supine, rolling left, rolling right, supine to sitting, sitting to standing, bending over, looking up, head turning and gaze. He reported pressure or fullness in the right and left ears, pain in the right and left ear, tinnitus in the right and left, hearing loss in the right and left ear and he notes that these symptoms increase in intensity when their dizziness/imbalance increases. He has constant imbalance and no history of falling. Mr. Hoernemann reported having pain in his neck and back.

II. OBJECTIVE FINDINGS
Gait Analysis:
Preferred walking speed is 4 ft/s which is within age norms. The following gait abnormalities were noted: mild path deviation noted when horiz head movements added to ambulation, mild path deviation noted when vert head movements added to ambulation and imbalance in dim lit conditions.

Positional Testing for BPPV:
The Modified Vertebral Artery Test was administered and the results were normal bilaterally. Dix-Hallpikes and Positional testing were negative for Benign Paroxysmal Positional Vertigo (BPPV).

Dynamic Visual Acuity Testing:
NORMAL - (less than or equal to a 2 line difference).

Balance Tests:
Functional gait assessment (FGA) score = 25 out of 30 points. Mr. Hoernemann is at no specific risk of falling per this test.

III. COMPUTERIZED DYNAMIC POSTUROGRAPHY (CDP) RESULTS
Sensory Organization Test (SOT):
The test was not performed.

Modified Sensory Organization Test with Headshake (ModSOT):
The test was not performed.

Motor Control Test (MCT):
The test was not performed.

Adaptation Test (AT):
The test was not performed.
National Dizzy & Balance Center - Medical Department
REPOR OF FINDINGS VISIT

Modified Clinical Test of Sensory Integration in Balance (mCTSIB):
1. [Redacted] demonstrates decreased use of vestibular cues in postural stability and balance.
2. [Redacted] demonstrates LAB falls on 1 trials on condition 4.

TOTAL COMPOSITE SCORE = 1
OVERALL mCTSIB RESULT = ABNORMAL

IV. ASSESSMENT / SUMMARY:
Assessment/Summary:
[Redacted] is a 35 year old male who presents with a 3 week history of dizziness, imbalance, light sensitivity, nausea. He has had 3 similar episodes in the past which have not lasted this long. Etiology is unclear at this point, but may be central or peripheral based on FGA and mCTSIB. If vestibular etiology is apparent with VNG testing pt would benefit from skilled PT intervention to reduce his sx and for pt to return to a more full and active lifestyle. If VNG is normal pt should be referred back to his primary care physician for further evaluation.

Patient Treatment Diagnosis:
(781.2) Gait Abnormalities due to Possible central or peripheral vestibular deficits

V. PROGNOSIS / PLAN OF CARE:
Short Term Goals: Goals will be set if pt returns for PT
Long Term Outcomes: Goal will be set if pt returns for PT.

Intervention (Treatment may include):
- Neuromuscular Re-Education: VRT (Vestibular Rehabilitation Therapy).
- Therapeutic Exercise: Stretching UB and Neck.
- Patient education.
- Retest mCTSIB and functional assessments to track progress.
- To be determined after: VNG testing.

Frequency / Duration: To be determined if pt returns for PT.

[Redacted] has participated in the development of this plan of care and agrees with the goals, interventions and frequency/duration.

OVERALL IMPRESSION / REPORT / PLAN OF CARE:
Impression:
He has not returned to work yet. He continues to get episodic vertigo. He will be seeing [Redacted] for a follow up visit.

Neurology testing showed a right beating nystagmus post stimulus high frequency headshake, which may indicate a high frequency peripheral vestibular deficit. Intermittent upbeatting nystagmus in positionals and OPK may indicate a central sign; however, he had taken medicine before the testing, which might have affected it. The caloric testing was normal and evoked potential testing was normal.

Physical therapy evaluation showed that the modified clinical test of sensory integration and balance was abnormal, indicating imbalance that may be central. FGA balance score was 25/30, which indicates no risk of falling. From the testing, it is not very clear if there is any vestibular etiology, either central or peripheral. His dizziness handicap index is 78, which is a quite high showing possible anxiety. Also, history of blacking out episodes and sudden drop attacks is not consistent with a vestibular etiology.
At this point, I am encouraging him to keep up with his follow up visits for possible Menerie's. He certainly has significant spinal pathology, and ongoing cervical pain, that might trigger imbalance. Since there is mild suggestion of peripheral weakness, I am offering a short course of vestibular rehab therapy about once a week for four weeks to learn balance exercises to build compensation. He had normal findings on dynamic visual acuity testing; it did not indicate oscillosia. No further therapy was recommended. Ongoing cervical therapy is recommended.

Diagnoses:

386.10 Peripheral vertigo, unspecified
780.4 Dizziness & giddiness
386.03 Ménière’s Disease (active)
781.2 Gait abnormality (NEURO)
723.1 Neck pain NOS
300.00 Anxiety NOS

Plan of care:
A trial of vestibular rehab therapy once a week for four weeks to learn a home exercise program. Continue follow-up visits with *نة* for possible early Ménière’s although testing is not consistent with it. Continue the exercises for cervical spondylosis status post neck fusion with some deficits.

It was a pleasure seeing your patient. I appreciate the opportunity to assist you in his evaluation. We will keep you informed of your patient's progress in our program. Please feel free to call us if you have any questions or concerns.

SIGNED BY: Sunanda Apte-Kakade, M.D.
THIS DOCUMENT HAS BEEN ELECTRONICALLY SIGNED.

DATE SIGNED: 08/12/2010
To:

Re: 

Please answer the following questions based on your examinations, medical history, clinical findings, and duration of the patient’s limitations arising from his medical condition:

1. When did you begin to treat this patient? ________________________________

2. Does your patient have Meniere’s Disease or Disturbance of Labyrinthine-Vestibular Function? 
   _____ Yes  _____ No  Date you confirmed the diagnosis__________________

3. Please identify your patient’s clinical signs and symptoms of Meniere’s Disease as set out by the 
   Academy of Otolaryngology or AAO HNS Criteria for Meniere’s Disease Diagnosis attached:
   a) _____ two spontaneous episodes of vertigo, each lasting 20 minutes or longer
   b) _____ hearing loss verified by a hearing test on at least one occasion
   c) _____ tinnitus or aural fullness
   d) _____ exclusion of other known causes of these sensory problems

4. Attached please find and review the SSA Listings at 2.07 and state whether in your medical opinion your patient would meet or equal the criteria at 2.07 for Meniere’s Disease. If yes, please state the reasons for your medical opinion including a description of the vertiginous episodes, frequency, severity, duration of the episodes; the audiometric studies, and vestibular function assessments including the ENG or VNS or other studies/tests results to describe your patient’s balance difficulties:

   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________

   1
5. Has your patient responded effectively to any medications?  ____Yes  ____No  
If “no” please describe the reactions to his medications:  
__________________________________________________________________________________________
List the medications you have prescribed:  
__________________________________________________________________________________________
__________________________________________________________________________________________
   
6. What other treatment/therapies have you recommended?  ____Physical therapy  ____Occupational  
   ____Vestibular therapy  ____Cognitive behavioral therapy  ____Vision Therapy  
   
7. Has your patient been compliant with her treatment?  ____Yes  ____No  
   
8. Is your patient a malingerer?  ____Yes  ____No  
   
9. Do emotional factors contribute to the severity of your patient’s symptoms and functional limitations?  
   ____Yes  ____No  
   If “yes”, please describe the factors:  
__________________________________________________________________________________________
   
10. Have the signs and symptoms of your patient’s Meniere’s Disease lasted or expected to last at least twelve months?  
   ____Yes  ____No  

11. What surgeries and dates have you performed?  
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

12. Does your patient have a severe impairment in his focus or concentration serious enough to cause a substantial reduction in his ability to perform occupational, social, and educational activities?  
   ____Yes  ____No
13. To what degree can your patient tolerate work stress
   
   ____ Incapable of even "low stress" jobs?
   ____ Capable of low stress jobs?
   ____ Moderate stress is okay?
   ____ Capable of high stress work?
   
   Please explain the reasons for your conclusion:
   
   ____________________________________________________________
   
14. Are your patient's impairments likely to produce "good days" and "bad days"?
   ____ Yes  ____ No
   
   If yes, please estimate, on the average, how often your patient is likely to be absent from work as a result of the impairments or treatment:

   ____ Never  ____ About three times a month
   ____ About once a month  ____ About four times a month
   ____ About twice a month  ____ More than four times a month

15. What is the earliest date that the description of symptoms and limitations in this questionnaire apply to your patient?
   
   ____________________________________________________________
   
Remarks:
   
   ____________________________________________________________
   
   ____________________________________________________________

Signature ___________________________  Date __________________

Print name ___________________________  Address __________________

Board certified medical specialty(ies)
   
   ____________________________________________________________
   
   ____________________________________________________________
   
   ____________________________________________________________
   
3
2.07 Disturbance of Labyrinthine Vestibular Function (Including Meniere's disease), characterized by a history of frequent attacks of balance disturbance, tinnitus, and progressive loss of hearing. With both A and B:

A. Disturbed function of vestibular labyrinth demonstrated by caloric or other vestibular tests; and

B. Hearing loss established by audiometry.
Disability Insurance

(PPS-76)

SSR 82-57

SSR 82-57: TITLES II AND XVI: LOSS OF SPEECH

PURPOSE: To state the policy and describe the necessary elements for the evaluation of organic loss of speech when determining disability under titles II and XVI of the Social Security Act.

CITATIONS (AUTHORITY): Sections 223(d), 216(i), and 1614(a) of the Social Security Act, as amended; Regulations No. 4, Subpart P, section 404.1525, and Appendix 1, Part A, sections 2.00.B.3, 2.09 and 11.00-11.19; and Regulations No. 16, Subpart I, section 416.925.

INTRODUCTION: Regardless of the cause of organic loss of speech, disability occurs when the individual is unable, by any means, to produce speech which can be heard, understood, and sustained. This policy statement explains in detail how loss of speech is to be evaluated. Functional loss of speech is addressed in sections 2.00.B.3 and 2.09 of the Listing of Impairments. Neurological disorders resulting in loss of speech are evaluated under sections 11.00-11.19. (Note: Medical criteria for evaluating impairments for children under age 18 are generally contained in Part B of the Listing. When a particular impairment is not included in the "childhood listings," it should be evaluated under Part A of the Listing).

POLICY STATEMENT: Ordinarily, when an individual's impairment prevents effective speech, the loss of function is sufficiently severe so that an allowance under Listing 2.09 is justified on the basis of medical considerations alone, unless such a finding is rebutted by work activity. To speak effectively, an individual must be able to produce speech that can be heard, understood, and sustained well enough to permit useful communication in social and vocational settings. These criteria are applicable to the production of speech whether by natural function of the voice mechanism or by the use of a prosthetic device.

Three attributes of speech pertinent to the evaluation of speech proficiency are: (1) audibility -- the ability to speak at a level sufficient to be heard; (2) intelligibility -- the ability to articulate
and to link the phonetic units of speech with sufficient accuracy to be understood; and (3) functional efficiency -- the ability to produce and sustain a serviceably fast rate of speech output over a useful period of time. When at least one of these attributes is missing, overall speech function is not considered effective.

When a refined assessment of speech proficiency is necessary, it should be made by an otolaryngologist or a speech therapist whose evaluation should be based both on personally listening to the claimant's speech and on a history of the claimant's performance in everyday living. The findings should be sufficient to provide the reviewer with a clear picture of the individual's speech capacity. Such an analysis covering the attributes of speech discussed above would include a detailed description of the following points:

1. The intensity of speech (audibility) -- the conditions under which the individual can and cannot be heard (e.g., in quiet surroundings, noisy places, a moving automobile); the maximum distance at which individuals can be heard; whether their voices tend to become inaudible, and if so, after how long;
2. The ability to articulate (intelligibility) -- the frequency of any difficulties with pronunciation, the extent to which the individual is asked to repeat, how well he or she is understood by strangers unaccustomed to hearing esophageal speech; and
3. The rate of speech and the degree of ease with which the individual's speech flows (functional efficiency) -- how long he or she is able to sustain consecutive speech; the number of words spoken without interruption or hesitancy; whether he or she appears fatigued, and if so, after how long.

If medical considerations alone are not determinative of the issue of disability for a title II worker or childhood disability claimant or for a title XVI claimant age 18 or older, consider the individual's vocational factors (age, education, training and work experience) as these factors relate to the ability to perform past relevant work or any other work.

**EFFECTIVE DATE:** The policy explained herein was effective on August 20, 1980, the date the regulations covering the basic policy in the subject area were effective (45 FR 55566).

**CROSS-REFERENCE:** Program Operations Manual System, section DI 2202.
United States Court of Appeals, Second Circuit.

104 F.3d 1432 (2d Cir. 1997)

Argued October 24, 1996

Decided January 21, 1997

BEAUVOIR V. CHATER

GARY BEAUVOIR, PLAINITFF-APPELLANT, V. SHIRLEY S. CHATER, COMMISSIONER OF SOCIAL SECURITY ADMINISTRATION, DEFENDANT-APPELLEE.

NOS. 96-6082, 342.

UNITED STATES COURT OF APPEALS, SECOND CIRCUIT.

ARGUED OCTOBER 24, 1996.

DECIDED JANUARY 21, 1997.
Stanley F. Meltzer, Meltzer, Fishman, Madigan Campbell, New York City, for Plaintiff-Appellant.


APPEAL FROM A JUDGMENT IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF NEW YORK (REENA RAGGI, JUDGE) UPHOLDING THE DENIAL OF DISABILITY BENEFITS FOR SPEECH IMPAIRMENT BEYOND SEPTEMBER 30, 1990.

WE AFFIRM.
Before: OAKES, VAN GRAAFEILAND, and WINTER, Circuit Judges.
WINTER, Circuit Judge:

Gary Beauvoir appeals from Judge Raggi's decision upholding the Social Security Administration's denial of disability insurance benefits to Beauvoir beyond September 30, 1990. Beauvoir asserts that he continues to suffer from an inability to speak that constitutes a listed impairment under 20 C.F.R. Section(s) 404, Subpart P, App. 1, Listing 2.09 ("Listing 2.09"). We hold that Beauvoir’s ability to speak in a sustained whisper is not within Listing 2.09’s description of an "organic loss of speech."

Beauvoir applied for disability benefits under the Social Security Act, 42 U.S.C. § 423, on March 31, 1991, claiming that he had been unable to work since a car accident on October 26, 1986, due to fractures of his ankle and hip and damage to his trachea that caused a significant impairment of his ability to speak. After a hearing on June 14, 1993, at which Beauvoir appeared with his attorney and testified in a soft whisper, Administrative Law Judge Harold Rosenbaum ("ALJ") determined that the relevant period of disability was from the date of the accident to September 30, 1990. In rendering his decision, the ALJ relied on medical reports and other evidence that surgery on Beauvoir's vocal cord in 1987 followed by speech therapy had improved his ability to speak. The ALJ also relied on his own assessment of Beauvoir’s ability to speak as demonstrated during the hearing. With regard to Beauvoir’s other injuries, the ALJ relied on reports and testimony by Beauvoir that the injuries to his hip and ankle had healed by March 1990. The ALJ concluded that by the end of September 1990, Beauvoir was physically able to return to his prior work as a liquor store manager — although by this time appellant had become a full-time accounting student — and that Beauvoir was therefore not entitled to further disability payments.

Appellant's request for review by the Social Security Administration's Appeals Council was rejected in June 1994. Beauvoir then filed the instant action seeking review of the Social Security Administration's decision under 42 U.S.C. Section(s) 405(g). After examining the record and listening to a recording of the hearing before the ALJ, Magistrate Judge Mann recommended that the ALJ's decision be affirmed. Beauvoir v. Shalala, 94-CV-3757 (RR) (E.D.N.Y. Sept. 1, 1995). District Court Judge Raggi, after considering the record and also listening to the recording of the hearing, adopted Magistrate Mann's report and recommendation.

The Social Security Act defines "disability" in relevant part as the "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months." 42 U.S.C. § 423(d)(1)(A). Administrative regulations prescribe the analytic framework for evaluating claims of disability. The Social Security Administration ("SSA") first considers whether the claimant is currently engaged in substantial gainful employment. If not, the SSA next considers whether the claimant has a "severe impairment" that significantly limits the ability to do basic work activities. If the claimant does suffer such an impairment, then the SSA determines whether the claimant has an impairment listed in Appendix 1 of the regulations, 20 C.F.R. Section(s) 404, Subpart P (such as Listing 2.09). If the claimant meets the descriptions of one of the listed impairments, then the SSA presumes the claimant to be disabled without considering the claimant's actual ability to perform substantial gainful activity, 20 C.F.R. 404.1520(d), 416.920(d); see also Berry v. Schweiker, 675 F.2d 484, 487 (1982). The sole question before us is whether Beauvoir's limited ability to speak is a "listed" impairment.

Our review of the Social Security Administration's "final decision denying a SSI disability benefits claim is not de novo; it is limited to inquiring into whether the Secretary's conclusions are supported by substantial evidence in the record as a whole or are based on an erroneous legal standard.” Cruz v. Sullivan, 912 F.2d 8, 11 (2d Cir. 1990) (citation omitted). The question here is somewhat unusual in that the ALJ based his decision in part on his personal observation and hearing of Beauvoir's testimony, and the magistrate and district judges listened to the tape of that hearing. We also have the tape before us.

1.

Effective March 31, 1995, the functions of the Secretary of Health and Human Services in social security cases was transferred to the Commissioner of the Social Security Administration. Accordingly, Shirley S. Chater, Commissioner of Social Security, was substituted as the defendant in the instant case. However, the Secretary of Health and Human Services is referred to in the relevant caselaw, as well as in the Report and Recommendation filed by Magistrate Judge Mann in the instant case. At the time of the ALJ's
decision in the instant case and the denial of review by the Appeals Council, the Social Security Administration was under the control of the Secretary of Health and Human Services.

The issue in the instant matter concerns Listing 2.09. Listing 2.09 states the qualifying disability condition as:

Organic loss of speech due to any cause with inability to produce by any means speech which can be heard, understood, and sustained.

20 C.F.R. Section(s) 404, Subpart P, App. 1, Listing 2.09. Social Security Ruling 82-57 ("Ruling 82-57") further defines the disability condition of Listing 2.09:

Three attributes of speech pertinent to the evaluation of speech proficiency [under Listing 2.09] are: (1) audibility — the ability to speak at a level sufficient to be heard; (2) intelligibility — the ability to articulate and to link the phonetic units of speech with sufficient accuracy to be understood; and (3) functional efficiency — the ability to produce and sustain a serviceable fast rate of speech output over a useful period of time. When at least one of these attributes is missing, overall speech function is not considered effective.

Medical reports, the ALJ, Judge Mann, Judge Raggi, and even on occasion Beauvoir's own counsel have characterized appellant as being able to speak in an understandable whisper. Dr. J.B. Jasmin, a medical consultant who evaluated Beauvoir in 1992 on behalf of the SSA, stated in his report: "Speaks in a whisper, but can be heard and understood." The ALJ who conducted an hour-long hearing consisting of appellant's testimony, observed in his opinion that Beauvoir was able to communicate by speaking "very low, as in a whisper." The ALJ commented to Beauvoir's counsel, "You and I have learned at this hearing he can be understood, right?" Beauvoir's counsel responded, "Yes."

Magistrate Judge Mann listened to a tape recording of the hearing and reached the same conclusion as the ALJ. She was "able to understand nearly all of plaintiff's [Beauvoir's] testimony, including the portions designated as inaudible on the transcript." Beauvoir, 94-CV-3757, at 11. Judge Raggi, adopting Judge Mann's report "in all respects," wrote: "The Court has also listened to the tape recording of the ALJ hearing in this case. . . . [Beauvoir] is able to make himself heard and understood over a sustained period. The tape recording demonstrates this."

Although appellant asserts on appeal that his speech at the ALJ hearing constituted "scant intermittent monosyllabic grunts," Appellant's Br. at 18, another section of his brief concedes that his condition allows him to speak in a "stage whisper." Id. at 21. Moreover, as noted above, Beauvoir's attorney acknowledged during the ALJ hearing that his client was able to be understood by the judge during that hearing.

Finally, we agree that the recording of the hearing before the ALJ supports the conclusion of the three other judges, namely, that while Beauvoir's speaking ability is impaired, he is able to speak in a soft, yet sustainable and understandable whisper. We therefore conclude that their factual findings are not clearly erroneous.

We now turn to whether the ALJ's decision was based on an "erroneous legal standard," Cruz, 912 F.2d at 11, that is, whether appellant's inability to converse in more than a stage whisper meets the requirements of Listing 2.09 and Ruling 82-57 regarding audibility, intelligibility, and functional efficiency. Appellant relies on Gresh v. Shalala, No. 93-129J, 1994 WL 485828 (W.D. Pa. June 16, 1994) (memorandum order), in which the court reversed an ALJ's denial of benefits under Listing 2.09 where the record "clearly documents that plaintiff's speech is nothing more than a whisper." Id. at *3. However, in Gresh the claimant had problems both in sustaining speech and in making herself understood. She would speak an occasional word in a normal tone and then become inaudible afterwards. Her ability to speak was thus "variable." Id. at *2. Most significantly, Gresh was unable "to testify in a manner which was capable of being recorded." Id. at *3. At Gresh's administrative hearing, Gresh's sister attempted to relay answers to the ALJ, but at one point there was a break in the testimony due to a communication problem. Id.

In the instant case, there was medical evidence that Beauvoir was able to communicate orally, albeit in a whisper. He was able "to speak at a level sufficient to be heard." Ruling 82-57, by the ALJ, and his speech at the hearing was successfully recorded. He was, therefore, heard and understood, fulfilling the audibility and intelligibility prongs of Ruling 82-57. Moreover, Beauvoir maintained his stage whisper throughout the hour-long ALJ hearing. He was thus
able to sustain speech. This ability satisfies the functional efficiency prong, "the ability to produce and sustain a serviceably fast rate of speech output over a useful period of time." Ruling 82-57.

We therefore affirm.