# ALASKA WORKERS' COMPENSATION BOARD

**P.O. Box 115512** **Juneau, Alaska 99811-5512**

| | |
|---|---|
| JANA L. WRIGHT,<br><br>Employee,<br>Claimant,<br><br>v.<br><br>STATE OF ALASKA,<br><br>Self-Insured Employer,<br>Defendants. | FINAL DECISION AND ORDER<br><br>AWCB Case No. 201604175<br><br>AWCB Decision No. 19-0020<br><br>Filed with AWCB Juneau, Alaska<br>On February 20, 2019 |

Jana L. Wright's (Employee) September 12, 2016 claim was heard on January 22, 2019 in Juneau, Alaska, a date selected on November 27, 2018. A June 20, 2018 affidavit of readiness for hearing gave rise to this hearing. Employee appeared telephonically, represented herself and testified. Attorney Adam Franklin appeared and represented State of Alaska (Employer). Witnesses included Brian Baehr and Kitty Angerman, who testified telephonically for Employee. Employee sought an order keeping the record open to submit additional medical records. An oral order sustained Employer's objection to this request. The record closed at the hearing's conclusion on January 22, 2019. This decision examines the oral order and addresses Employee's claim on its merits.

## ISSUES

Employee requested the hearing record be left open so she could submit additional medical evidence. Employee contended she continued to seek medical care for her work injury before and after the date the hearing evidence record closed. Employee contended Employer failed to

file the medical evidence and the Alaska Workers' Compensation Division (division) failed to obtain the medical evidence.

Employer opposed admission of additional medical evidence. Employer contended Employee was informed about the hearing evidence deadline and the process for submitting medical records. Employer contends acceptance of additional medical evidence would be prejudicial to Employer. Employer contends Employee failed to provide good cause for her failure to file additional medical evidence. At hearing, an oral order issued denying Employee's request to leave the record open.

1) **Was the oral order denying Employee's request to leave the hearing record open to file additional medical records correct?**

As a preliminary issue, the parties stipulated the issue for hearing is whether Employee's work for Employer is the substantial cause of her disability and need for medical treatment. Employee contends she developed reactive airway disease after exposure to chemicals while working for Employer. She contends her work for Employer is the substantial cause of her disability and need for medical treatment. Employee seeks an award of permanent total disability (PTD) and medical benefits.

Employer contends Employee's work with Employer is not the substantial cause of her disability and need for medical treatment. Employer contends the weight of the evidence does not support finding Employee's work for Employer was the substantial cause of her reactive airway disease. Employer contends Employee's non-work related preexisting asthma is the substantial cause of her disability and need for medical treatment. Employer requests an order denying Employee any additional benefits.

2) **Is Employee's work for Employer the substantial cause of her disability and need for medical treatment?**

## FINDINGS OF FACT

A preponderance of the evidences establishes the following facts and factual conclusions:

1) On August 17, 2015, Employee reported coughing, wheezing and malaise for the prior three days. An examination revealed a prolonged respiratory phase with faint wheeze. Employee was diagnosed with tobacco abuse disorder and asthmatic bronchitis. She was encouraged to stop smoking and prescribed a Z-pack and albuterol inhaler. (Paul Weinberg, MD, Medical Report, August 17, 2015).

2) On November 30, 2015, Employee complained of a moderate productive cough lasting four weeks and gradually worsening. She is a smoker and has a sick family member. Lying down and exertion aggravated her symptoms, which included dyspnea, post-nasal drainage, rhinorrhea, sinus pressure, sore throat and wheezing. A physical examination revealed mild wheezing. Employee was diagnosed with acute bronchitis and was prescribed Zithromax, prednisone and albuterol. (Denise McPherson, ARNP, Medical Report, November 30, 2015).

3) On December 8, 2015, Employee described a nonproductive cough for one month and reported dyspnea. Employee completed antibiotics and felt better but still had a lingering cough. She used the albuterol inhaler when she went for a walk and it helped. A physical exam revealed mild wheezing. After an albuterol nebulizer treatment, her wheeze cleared. Employee was prescribed Flovent. (Denise McPherson, ARNP, Medical Report, December 8, 2015).

4) On February 5, 2016, Employee described a productive cough lasting five days and reported chills, cough, dyspnea, fatigue, fever, nasal congestion, night sweats, rhinorrhea, sinus pressure, sore throat and wheezing. An examination of her respiratory system revealed cough and mild wheezing. Employee was diagnosed with acute bronchitis and prescribed Augmentin. She was excused from work on February 5 and 6, 2015. (Denise McPherson, ARNP, Medical Report, February 5, 2016).

5) On March 14, 2016, Employee reported trouble breathing and a non-productive cough aggravated by chemicals while working for Employer on the M/V Kennecott as a cashier. (Employee First Report of Occupational Injury or Illness, March 14, 2016).

6) On March 14, 2016, Employee visited the emergency room at Ketchikan General Hospital for a dry cough starting three days ago. Employee reported trouble breathing. She was diagnosed with a viral infection and instructed, "No strenuous activity. Rest. Return to work when better. ([W]ear a mask at work)." Employee was prescribed an albuterol inhaler, Robitussin AC, and Tessalon perles. (Emergency Room Medical Report, March 14, 2016).

7) On March 16, 2016, Employee followed up with Donna Paul, ARNP, for ongoing chest congestion and cough. Employee reported mild intermittent episodes of shortness of breath worse at night and a persistent cough beginning three months ago. ARNP Paul assessed asthma exacerbation, cough and smoking history greater than 30 pack years. ARNP Paul noted:

> Unfortunately patient presents with an extended history of cough. 11/30 she was seen by acute care and treated for bronchitis with prednisone and Z-Pak. She was instructed to return to the clinic in 10 days if not improved. She did return to the clinic at that time for persistent cough but again saw the acute care provider and not her PCP. She was given an inhaled steroid and was told to follow up with her PCP in 2 weeks if she was still having an issue. Patient reports that she will use the albuterol but that she is not using the inhaled steroid because it is "scary" – chest x-ray at that time was negative. Patient had thought that she had improved but was seen again in acute care 2/5/2016 with a flare of her bronchitis and a secondary ear infection which was treated with albuterol and Augmentin. She returned to work on the ferry and found herself becoming more and more [short of breath] - especially at night. She had a roommate with a humidifier and it got a lot worse when she moved to another room. She left the boat that morning on 3/14/2016 and was seen in the ER in [Ketchikan]. Normal EKG and chest x-ray - she was instructed to follow through with her PCP and was given 2 forms of cough suppressant. She needs a work excuse today. . . . The good news is that patient has stopped smoking about 1 week ago because of this cough.

Employee's physical examination revealed wheezing. She was treated with nebulized albuterol. Employee was prescribed prednisone and albuterol. (Paul Chart Note, March 16, 2016).

8) On March 21, 2016, Employee followed up with Lynn E. Prysunka, MD, for respiratory issues. Employee reported ongoing cough, wheezing, shortness of breath and right ear pain. Dr. Prysunka diagnosed mild intermittent asthma beginning months ago, aggravated by airborne chemicals and respiratory infections and noted Employee's family history of brittle severe asthma. She stated Employee "did not really have symptoms of this until a viral infection last fall. Recently Employee's job on the ferry exposed her to fumes while cleaning. Her symptoms have improved now but she continues to feel short of breath and wheezy with moderate activity." Employee used both nebulized and metered doses of albuterol. Employee's examination was fairly normal. Dr. Prysunka took Employee off work for another week and scheduled reevaluation on March 28, 2016. (Prysunka Chart Note, March 21, 2016).

9) On March 28, 2016, Dr. Prysunka assessed chemical pneumonitis or acute asthmatic reaction caused by exposure to fumes at work, because Employee's symptoms started after exposures to chemicals while cleaning the ferry she worked on last October and November. Employee's

milder cough and dyspnea improved but upon returning to work she was exposed to chemicals which caused a rebound in symptoms in March with increased severity. Employee's examination revealed expiratory wheezes and a non-productive cough. A pulmonary function test indicated obstructive ventilatory defect. Initially, Dr. Prysunka thought Employee's symptoms were due to an asthma exacerbation. In retrospect, Dr. Prysunka noted Employee's only other asthma-like symptoms occurred in October when she was initially exposed to chemicals at work. Dr. Prysunka continued Employee on albuterol and Flovent. She did not release Employee to work. Employee requested referral to a specialist. (Prysunka Chart Note, March 28, 2016).

10) On April 11, 2016, Employee visited Dr. Prysunka for a work release examination. Employee reported a continuing cough, fatigue and shortness of breath after exposure to chemicals at work. Employee felt she was still not up to her full functional capacity and could not perform her work duties. Dr. Prysunka referred Employee to a pulmonologist in May and did not release her to work. (Prysunka Chart Note, April 11, 2016).

11) On April 21, 2016, Employer denied all benefits contending Employee's claim is medically complex and she failed to produce medical evidence linking her medical condition and need for treatment to her employment. (Controversion Notice, April 21, 2016).

12) On April 26, 2016, Employer withdrew its April 21, 2016 controversion notice "as further medical evidence has been received to attach the presumption of compensability." (Withdrawal Notice, April 26, 2016).

13) On May 4, 2016, Employee followed up with Dr. Prysunka for breathing difficulties. Since her last visit, Employee travel to New Mexico and at elevation with dry heat she was worse. Employee's oxygen level went down to 91 percent and her family purchased oxygen for her. After she returned home, Employee tried to exercise but felt worse. Employee ran out Flovent and her symptoms got worse. Employee was prescribed Solu-Medrol and Singular and her Flovent dosage was increased. She was not released to work. (Prysunka Chart Note, May 4, 2016).

14) On May 6, 2016, Employee visited Anthony Gerbino, MD, for a pulmonary consultation for persistent cough, dyspnea and wheezing. Dr. Gerbino noted Employee had a thirty-pack-year smoking history. Employee reported a history of occasional bronchitis with "perhaps 1 episode of productive cough responding to antibiotic treatment every three years." Employee developed

a productive cough in October that was somewhat prolonged despite antibiotics. During the same time, she used cleaning chemicals on the ferry where she works. She improved but in March "had a very predominate cough, chest congestion without ability to produce sputum, a sense of gurgling in her chest and wheezing, as well as significant shortness of breath." Employee had been cleaning with routine household disinfectants for a number of days in small confined living quarters with bathrooms. Employee's brother and daughter have asthma. Her physical examination revealed mild, subtle expiratory wheezing more easily heard with deep breaths and a few gurgling sounds and crackles at her left base lung. Dr. Gerbino diagnosed an exacerbation of either asthma or COPD since March. He noted, "[I]is difficult to say whether she has asthma, COPD or a combination of the two. Her [diffusion capacity of the lung] argues in favor of asthma. I do not see emphysema on her CT scan. These would support a diagnosis of asthma with recurrent exacerbation further exacerbated by exposures at work." He recommended Employee take prednisone in addition to her inhaled corticosteroid while traveling to Durango, Colorado and follow up in a year for the nodule revealed in her CT scan. (Gerbino Medical Report, May 6, 2016).

15) On May 9, 2016, Employee saw Thomas Solenberger, MD, and asked whether she should continue taking prednisone because she had quite a bit of shaking. Employee was diagnosed with reactive airway disease, either asthma or COPD, by Dr. Gerbino. If Employee was having a significant reaction to the prednisone, she should stop taking it. (Solengerger Medical Report, May 9, 2016).

16) On May 25, 2016, Employee followed up with Dr. Prysunka for asthma due to inhalation of fumes. Employee's wheezing and shortness of breath have significantly improved and she is no longer on oral steroids. Employee was taking Zyrtec in the morning. Employee had a scratchy throat, anterior neck discomfort and ear pain consistent with viral pharyngitis. Dr. Prysunka also noted Employee could have allergies. (Prysunka Chart Note, May 25, 2016).

17) On June 9, 2016, Emil Bardana, MD, MACP, an allergist and immunologist, examined Employee for an Employer's Medical Evaluation (EME) and reviewed Employee's medical records. Employee identified five cleaners she used at work out of 17 Material Safety Data Sheets (MSDS) provided by Employer: Swisher Clear Disinfectant/Sanitizer, Ultra Degreaser/Detergent, Ultra Citrus Neutral Multi-Purpose Cleaner, Swisher Ultra-No-Rinse Sanitizer and Ultra Pot/Pan Detergent. Dr. Bardana diagnosed adult-onset, non-allergic, non-

occupational, moderately severe bronchial asthma precipitated by acute respiratory infections, probably viral, and probable mild to moderate chronic bronchitis associated with chronic tobacco smoking. He opined Employee's employment is not the substantial cause of her need for medical treatment or disability. After reviewing 18 cleaning products with Employee and the industrial hygiene data, Dr. Bardana stated the medical evidence does not support the exposures to cleaning chemicals at work as a likely contributor to Employee's ongoing asthma. He opined the substantial cause of Employee's need for treatment and disability are the recurrent respiratory infections Employee developed and her smoking history. (Bardana EME Report, June 9, 2016).

18) On June 17, 2016, Employer denied all benefits based upon Dr. Emil Bardana's EME report. (Controversion Notice, June 17, 2016).

19) Employer paid TTD starting March 15, 2016 through June 17, 2016. (SROI, June 24, 2016).

20) On June 15, 2016, Dr. Prysunka referred Employee to physical therapy for pulmonary rehabilitation. Employee had been out of work for three months for the work related injury and was slowly improving. However, Employee did not feel she had the exercise tolerance required to return to work. Employee's Flovent prescription dosage was increased until her symptoms settled down. (Prysunka Chart Note, June 15, 2016).

21) On July 7, 2016, Employee reported slow improvement in asthma symptoms "that seem to have been triggered by exposure to fumes at her place of employment" to Dr. Prysunka. Dr. Prysunka encouraged Employee to quit smoking again and recommended she continue taking Singulair regularly and Flovent as directed and use albuterol for breakthrough symptoms. Employee had questions about applying for permanent disability. Dr. Prysunka suspected Employee was not a candidate because Employee could be employed in a job without exposure to fumes or without physical exertion and she has not been out of work for a year. (Prysunka Chart Note, July 7, 2016).

22) On July 22, 2016, Employee was still having difficulty with increased dyspnea with any exertion and sometimes when she woke up during the night. Employee stopped taking Singulair because it was possibly causing increased bleeding. She had a minor trauma with development of a large hematoma. (Prysunka Chart Note, July 22, 2016).

23) On August 5, 2016, Employee visited Dr. Prysunka for an unfit/fit for duty examination. Employee reported her chronic moderate asthma symptoms are fairly controlled but she still had difficulty with bending over or walking up an incline. Dr. Prysunka stated Employee would be

fit for duty on August 8, 2016 but was limited to no work around cleaning products. (Prysunka Unfit/Fit for Duty Form, August 5, 2016).

24) On August 8, 2016, Dr. Prysunka authored a letter stating, "[Employee] suffered a series of asthma attacks over the course of the last 12 months. The trigger for these attacks appears to be related to fumes she was exposed to at her place of employment. There is no indication that her asthma is triggered by viruses." (Prysunka Letter, August 8, 2016).

25) On September 7, 2016, Employee followed up with Dr. Prysynka requesting a work release. Employee has been able to tolerate moderate physical activity with minimal use of her inhaler in the last several months. Dr. Prysunka stated Employee is physically capable of returning to work but must avoid cleaning chemical fumes because they are a significant trigger. (Prysunka Chart Note, September 7, 2016).

26) On September 12, 2016, Employee filed her claim seeking permanent total disability (PTD). (Claim for Workers' Compensation Benefits, September 12, 2016).

27) On October 27, 2016, Employee and Employer attended a prehearing conference to discuss Employee's September 12, 2016 claim. The board designee informed the parties medical records must be filed and served with a medical summary form. The board designee included a copy of a medical summary form with the prehearing conference summary for Employee. (Prehearing Conference October 27, 2016).

28) On October 27, 2016, Employer deposed Dr. Prysunka. Dr. Prysunka is licensed to practice medicine in Alaska and she has the Canadian equivalent of a family medicine board certificate. (Prysunka Deposition Transcript, October 27, 2016 at P. 7-8). Employee has been her patient for about 20 years. (*Id*. at P. 12). Dr. Prysunka did not know what chemical cleaners Employee was exposed to at work. (*Id*. at 28). She also did not have expertise on individual products Employee used at work to know what they might do in individual patients. (*Id*. at 36). Dr. Prysunka disagreed with Dr. Bardana's report stating,

> I think that [Employee]'s presentation for asthma, having known [Employee] for 20 years, I have never seen her present with symptoms as clearly as that, because she hasn't that last -- from May on.
>
> And her length of symptoms certainly suggests significant bronchospasm and inflammation of her bronchial tubes, despite the sort of typical treatment for asthma that went on for quite some time. She also saw a pulmonologist who also felt that exposure at her place of employment likely was a factor.

> And to go back and figure out what the initial trigger was as providers for treating people with asthma is less important than treating the asthma. But I had nothing to indicate that there was definitely a viral syndrome versus exposure.
>
> And she was giving me -- is giving me a clear history that her symptoms started after her job description changed briefly and she was required to use the cleaning products at her place of employment. (*Id*. at 34-35).

Dr. Prysunka released Employee to full-time work with the only restriction being avoiding exposure to the chemicals that caused the exacerbation of her asthma. (*Id*. at 38). When asked whether exposure to chemicals caused Employee's asthma or whether the chemical exposure caused a trigger of underlying asthma, Dr. Prysunka stated,

> I have never seen her show signs of wheeziness and shortness of breath anywhere close to what was her representation in March of or the spring of this year. These symptoms were significantly worse. And so given that there is at least over a decade of history of repeated physician/patient encounters, I guess I can feel fairly confident saying that, if this is not a completely new diagnosis, the degree of which her bronchospasm and asthma symptoms worsened with occupational exposure appears to be significant. (P. 39-40).

When asked when Employee was medially stable, Dr. Pyrsunka stated,

> On 9-7-16, I said that she was physically capable of returning to work and at that point she was no longer wheezing but still had a mild cough and dyspnea by self report.
>
> Her lung sounds were normal. So it was 9-7-16.
>
> On 8-5, so a month before that, she reported the symptoms of cough, wheeze and shortness of breath. Her lung sounds were normal, but she was still expressing symptoms and had started to tolerate some more physical activities.
>
> So in terms of stability, I think she was continuing to improve between 8-5 and 9-7. So if you look at pure medical stability, I would say she continued to slowly improve over that time. I think she's stable now. In terms of ability to do physical labor, I think that occurred earlier. (*Id*. at 41-42).

When asked whether she could say to a reasonable degree of medical probability that an exposure at work is the substantial cause of any disability or need for treatment Employee has at this time, Dr. Prysunka responded, "I'd say it's possible. It's possible at this time." (*Id*. at 42).

29) On December 8, 2016, Employee reported an ongoing cough for the last two to three weeks and receiving a diagnosis of pneumonia in the emergency room. She was treated with Zithromax

and one IM injection of Solu-Medrol. Employee did not feel much better, had a loose sounding cough, diffuse expiratory and inspiratory wheezes with some crackles. Her x-ray revealed a probable right middle lobe pneumonia. Employee was prescribed ipratropium to use along with the albuterol every four hours and prednisone. She was excused from work until her follow up appointment. (Prysunka Chart Note, December 8, 2016).

30) On December 15, 2016, Employee followed up with Dr. Prysunka to check her lung condition. Employee treated successfully with antibiotics and the x-ray findings went away. She continued to be diffusely wheezy. Dr. Prysunka recommended continuing prednisone because Employee continued to show signs of fairly significant bronchospasm. She also recommended Employee avoid exercising, especially in cold air while her asthma is flared. (Prysunka Chart Note, December 15, 2016).

31) On December 21, 2016, Employee visited Dr. Prysunka for a large bruise on her abdomen secondary to prednisone use. Employee was no longer wheezy to auscultation but she still had a persistent cough and discolored greenish brown sputum. Initial x-ray findings suggested right middle lobe pneumonia. Dr. Prysunka prescribed Augmentin for ten days. (Prysunka Chart Note, December 21, 2016).

32) On December 22, 2016, Employer and Employee attended a prehearing conference. Total temporary disability (TTD) was added as a benefit sought by Employee. (Prehearing Conference Summary, December 22, 2016).

33) On December 28, 2016, Employee followed up with Dr. Prysunka for asthma. Employee tapered off her prednisone and was feeling quite well for a couple days and then caught another upper respiratory infection and again had a cough. Dr. Prysunka recommended she increase her albuterol to every four hours while away and continue on Flovent. (Prysunka Chart Note, December 28, 2016).

34) On January 12, 2016, Employee saw Dr. Prysunka for a chronic cough that developed within the last week. Employee had a wet sounding, paroxysmal cough, crackles in her left base and mild diffuse wheeziness. She could not tolerate albuterol 2.5 milligram nebulizers. Dr. Prysunka recommended she use 1.25 milligrams of albuterol per dose. She also ordered an x-ray of Employee's chest. (Prysunka Chart Note, January 12, 2015).

35) On January 16, 2017, Employee visited Dustin McLemore, MD, a pulmonologist, who stated:

> This is a 56-year-old who comes to establish care for inhalational injury induced asthma.
>
> According to the records and she developed asthma symptoms in March 2016 following heavy exposure to cleaning solutions while detailing the state rooms of an Alaska Marine Highway ferry. The patient works on the Alaska Marine Highway system as a cashier and occasionally cook, and in the spring of this year was assisting the crew in detailing state rooms when she was exposed to high concentrations of unspecified cleaning chemicals. Immediately after that she developed shortness of breath, wheezing, and decreased exercise tolerance. She's been treated through the last year for pneumonia at least once, and several times with steroids per her report. She is currently on Flovent 220 µg twice daily and albuterol by nebulizer or inhaler every 4 hours pretty much around the clock. [She's] doing a little bit better now but couldn't breathe at all initially in March and has had difficulty with minor activities ever since then. She's had at least 4 courses of prednisone throughout the course of this year, and was tried on Singulair, but stopped it due to some bruising lumps which appeared on her abdomen and legs, and resolved after she stopped it. She's also been tried on ipratropium, which she was unable to tolerate.
>
> She does not smoke, and there is no smoke in her home. She does have a wood stove inside the house. She denies any history of asthma or asthmatic breathing up until this year in her life. . . .

Under "Impression and Plan," Dr. McLemore stated:

> Asthma v. Reactive airway dysfunction syndrome (RADS). Her history of exposure to cleaning chemicals followed by an acute onset of asthma is clinically very compatible with RADS. I explained to her that the natural history of this disease is often months to years prior to resolution and that in some cases it does not resolve. The cornerstones of therapy are inhaled corticosteroids and albuterol rescue inhalers, just as in ordinary asthma. I explained that she may require short courses of prednisone with flares but the goal is to use adequate controller medications to prevent systemic corticosteroids as much as possible. She will likely remain sensitive to fumes or vapors for the rest of her life and is at higher risk to have flares of her asthma. She will need to maintain fastidious avoidance of triggers and remain compliant with her inhalers.

Under "Histories," Dr. McLemore noted Employee currently denied tobacco use and on December 14, 2014, Employee smoked less than a pack of cigarettes every day. He diagnosed moderate airflow obstruction with a significant bronchodilator response, compatible with reactive airway disease. Dr. McLemore recommended Employee use Dulera twice per day and albuterol as needed and avoid any smoke, fumes or cleaning products. (McLemore Chart Note, January 16, 2017).

36) On February 2, 2017, Employee sought treatment for an upper respiratory infection and to obtain an unfit for duty release. Employee was wheezy and has a nonproductive cough upon examination. Employee stated she needs a work release today as she is scheduled to return to work on the ferry and she cannot work with wheezing and decreased exercise tolerance. Employee was prescribed prednisone. (Cindy Rosenberger, ARNP, Chart Note, February 2, 2017).

37) On February 10, 2017, Employee followed up with Dr. Prysunka after her visit with Dr. McLemore. Dr. Prysunka diagnosed moderate and persistent reactive airways dysfunction syndrome with acute exacerbation triggered by exposure to fumes in the workplace. Employee recently saw Dr. McLemore and he felt her history is consistent with RADS and he switched her from Flovent to Dulera and advised her to avoid further exposure to fumes. Employee briefly returned to work at the end of January and "once more she had an exacerbation of her reactive airways syndrome." Employee was seen by another provider and was found to be acutely wheezy and short of breath. She was prescribed prednisone and is feeling improved. Dr. Prysunka stated Employee is not released to return to her job as further exposure to fumes could exacerbate her symptoms. (Prysunka Chart Note, February 10, 2017).

38) On February 14, 2017, Employee underwent a transthoracic echocardiogram. It revealed an atrial septal defect. (Echocardiogram Report, February 14, 2017).

39) On February 17, 2017, Employee saw Dr. Prysunka about the echocardiogram. Dr. Prysunka referred Employee to Gordon Kritzer, MD, for repair of the moderate atrial septal defect and noted her initial x-ray was for Employee's reactive airway dysfunction syndrome. (Prysunka Medical Report, February 17, 2017; Prysunka Referral Letter, February 17, 2017).

40) On March 13, 2017, Employee reported dyspnea, cough and wheeze beginning four weeks ago. The initial trigger was likely a viral upper respiratory infection with persistent reactive airway symptoms. She also has postnasal drip, itchy eyes and nose suggesting a contributory allergic component. Employee was prescribed Flonase to use daily. (M. Jane Moore MD, Medical Report, March 13, 2017).

41) On April 17, 2017, Employee followed up regarding lab tests. Employee was assessed with a cough secondary to a virus exacerbating her reactive airways dysfunction syndrome. Employee had an echocardiogram in February which revealed an atrial septal defect. However, she must

wait until her ankle fracture healed for surgery to fix the atrial septal defect. (Prysunka Progress Report, April 17, 2017).

42) On April 28, 2017, Employee reported she was seen in the emergency room two days ago with an acute exacerbation of asthma. She was treated with DuoNeb and Solu-Medrol IV and started on prednisone. Dr. Prysunka recommended Employee stay on the prednisone. (Prysunka Progress Report, April 28, 2017).

43) On May 2, 2017, Employee followed up with Dr. McLemore. Dr. McLemore diagnosed reactive airway disease that was not well controlled. He noted:

> The patient was last seen in January 2017, and was diagnosed with reactive airway disease secondary to possible chemical exposure from cleaning solutions. She was discontinued on Dulera, albuterol and since that time has had at least one extreme exacerbation last week requiring a dose of IV steroids as well as multiple nebulized treatments for shortness of breath. She is currently completing [oral] steroids from her last exacerbation, and is concerned about ongoing steroid use, especially in light that she will need [atrial septal defect] repair in the future.

He recommended Employee continue with Dulera 200/5 two puffs twice per day, continue albuterol as needed, and begin Atrovent four times a day as needed. Dr. McLemore stated there is no further indication for chronic steroids and "it does appear she is improving slowly from when I first saw her. I would expect if her wheezing and [shortness of breath] are truly from RADS that it will eventually resolve with avoidance of triggers or further chemical fume exposure." (McLemore, Chart Note, May 2, 2017).

44) On May 24, 2017, Employee's atrial septal defect was surgically corrected. (Kritzer Operative Report, May 24, 2017).

45) On June 2, 2017, Dr. Prysunka noted fumes and smoke may be the main triggers for Employee's asthma. She would prefer to avoid prednisone or other systemic corticosteroids while Employee heals from heart surgery. Dr. Prysunka recommended Employee use her albuterol and Atrovent every six hours and avoid exposures to smoke and fumes. (Prysunka Progress Report, June 2, 2017).

46) On June 14, 2017, Employee reported her exercise intolerance is increasingly poor after her heart repair and she was using her albuterol nebulizer every three hours. Employee was concerned she was reacting to nickel used in her cardiac repair. (Prysunka Medical Report, June 14, 2017).

47) On July 13, 2017, Employee reported recurrence of her breathing symptoms when she lies down at night and recurrent exercise intolerance. She used her nebulizer every three hours and felt like it give her some relief. (Prysunka Medical Report, July 13, 2017).

48) On September 11, 2017, Employee continued to have intermittent problems with exertional dyspnea and exhaustion after her heart repair. Employee reported she is feeling better and her shortness of breath and fatigue with exertion is markedly better than before her heart repair. (Kritzer Medical Report, September 11, 2017).

49) On March 8, 2018, Daniel M. Raybin, MD, FACP, a specialist in pulmonary diseases and internal medicine, examined Employee for an SIME and reviewed her medical records. He also reviewed the MSDS sheets for 17 cleaners, including the five Employee identified to Dr. Bardana as cleaners she recalled using. Dr. Raybin listed Employee's preexisting asthma, cigarette smoking, repeated viral infections, and exposure to cleaning chemicals as causes of Employee's disability or need for treatment. He opined Employee's exposure to chemicals combined with her preexisting asthma to cause temporary disability and need for medical treatment but it was not the substantial cause. Employee does not have RADS which occurs after exposure to a high concentration of an irritant. Employee had previous respiratory complaints, she worked with cleaning chemicals for a few months, the symptoms onset did not occur within 24 hours of a single specific exposure, and she was not exposed to fumes with irritant properties present in very high concentrations. Employee's history is also not typical for RADS because corticosteroids are not helpful for RADS but are effective in treating asthma exacerbations and Employee's asthma exacerbations respond to corticosteroids. Repeated viral infections during the fall-winter 2015-2016 are the substantial cause of the flare up of Employee's asthma, which previously had been mild and intermittent. Employee's exposure to cleaning chemicals was a relatively small additional contributing factor. Dr. Raybin noted exposure to chemicals may have worsened her preexisting asthma but did not cause it. The substantial cause of Employee's disability and need for treatment in March 2016 and presently is her repeated viral infections during the fall and winter 2015-2016. Employee became medically stable by June 2016, and the substantial cause of her current disability is her preexisting asthma. (Raybin SIME Report, March 8, 2018).

50) On May 29, 2018, Edward B. Holmes, MD, a specialist in occupational medicine and toxicology, completed a records-review SIME report. He also reviewed the MSDS sheets for 19

cleaners, including the five Employee identified to Dr. Bardana as cleaners she recalled using. He considered all of the causes of Employee's disability or need for medical treatment, including (1) "preexisting asthma not caused by work related exposures;" (2) "[r]epeated episodes of acute and chronic bronchitis; viral and smoking related;" and (3) "[c]ongenital atrial septal defect (ASD) with symptomatic shunting, right ventricular and atrial enlargement, and increased pulmonary arterial pressures; improved with ASD repair. Not caused by work related exposures." Dr. Holmes opined the employment exposures are not the substantial cause of Employee's disability and need for medical treatment. Rather, the substantial cause of Employee's disability and need for treatment is smoking, repeated viral illnesses, and her genetic pre-disposition or family history. He stated, "Although an irritant chemical may have temporarily exacerbated her preexisting underlying lung disease, there is no evidence that it altered the need for treatment or resulted in disability" and "At the most, the irritant exposures may possibly have caused a temporary change only." Dr. Holmes opined Employee "is not and has not been disabled due to the work injury." Employee was medically stable on March 21, 2016 or about one week after the work exposure and her ongoing treatment is not related to the work exposure. Dr. Holmes recommended she avoid exposure to dust, smoke, gases, odors, mists, aerosols, fumes, vapors and other particulates. However, Employee's limitations are due to her asthma condition and not her work exposure. After reviewing the MSDS for 19 products, Dr. Holmes stated:

> The threshold level of exposure generally required to produce an asthma attack in a susceptible individual or similar complaints will vary by chemical, inhaled concentration, and susceptibility of the individual. Although some of these chemicals do have [threshold limit values] TLVs and/or [permissible exposure limits] PELs, these are not permissible concentration maximums specific only to respiratory toxicity. Respirable concentrations even below the TVL and/or PEL could cause asthma exacerbation in an individual who already has asthma (such as in this case), for many if not most of the chemicals listed above. However, it must be noted that a temporary exacerbation of a pre-existing asthma condition (reactive airways) is not the same thing as causation of a new, de novo asthma condition that never existed before. Generally, for these chemicals, as a group, to cause a de novo asthma like illness such as RADS (reactive airways dysfunction syndrome which would have somewhat similar symptoms to asthma), a massive inhalation event would have been required. These types of events are usually unmistakable, massive spills, accidental type inhalations, or other misuse of the products resulting in acute severe new symptoms often with knock-down and a requirement for emergency evacuation and immediate medical intervention. (No

> such massive exposure was documented in this file). (Holmes SIME, May 29, 2018).

51) On June 20, 2018, Employer requested a hearing on Employee's September 12, 2016 claim. (ARH, June 20, 2018).

52) On June 26, 2018, at a prehearing conference scheduled to discuss the SIME reports, Employee contended a hearing is not appropriate because she needs additional time for discovery. Employee stated she had doctor appointment scheduled on July 9 and 13, 2018, and she expected to discuss the SIME reports with her physicians. The board designee informed Employee she can amend her claim to add a request for medical costs. Employee stated her medical costs have been covered by Medicaid and SEARHC. The board designee noted the date of the prehearing conference was unique because it was scheduled before Employer filed its ARH and took place during the time period Employee had to oppose Employer's ARH in writing. The parties agreed to a July 17, 2018 prehearing conference to set a hearing. (Prehearing Conference Summary, June 26, 2018).

53) On July 13, 2018, a division technician spoke with Employee and Employee stated Employer agreed to move the July 17, 2018 prehearing conference to the end of August. (Phone Call, ICERS Event Entry, July 13, 2018).

54) On July 13, 2018, Employer filed a letter stating it did not oppose rescheduling the July 17, 2018 prehearing conference but did not agree to a delay in setting a hearing date. (Letter, July 13, 2018).

55) On, August 28, 2018, the parties agreed to schedule an oral hearing on Employee's September 12, 2016 claim. The parties agreed witness lists must be filed with the board and served upon all parties by October 9, 2018. The board designee set October 3, 2018 as the hearing evidence deadline and informed the parties medical documents must be filed and served with a medical summary form. Medical documents already filed and served on all parties with a medical summary form do not need to be re-filed and re-served. The board designee included a copy of a medical summary form with the prehearing conference summary for Employee. (Prehearing Conference Summary, August 28, 2018; Prehearing Conference Summary Served Event, August 28, 2018).

56) On October 16, 2018, Employee filed a hearing brief:

> My entire life I have been an extremely active outdoors person, hiking, camping, hunting, chopping firewood, etc. I enjoy and rely on that kind of lifestyle. In March 2016, I developed a cough. I didn't feel sick but began to have difficulties breathing. I noticed it more when bending to pick things up or clean under things. I had been treated a couple times before this with antibiotics for cough even though I didn't feel sick. It was thought I had bronchitis. The antibiotics didn't work. The cough became severe pretty quickly. It was when I started to really have a hard time breathing that I decided to get off the boat and see a doctor. Once again I was put on something to control my coughing. When I came back to Wrangell and went to the clinic, I was told not to take the cough controller (tessalon), for I needed to cough this up.
>
> After seeing a pulmonologist in Anchorage, it was decided I had reactive airway disease. . . .
>
> I have three children that live in Durango[,] Colorado, (elevation 6,000 ft plus). I also have four grsnd children [sp] there. It's difficult to go there and visit because the elevation affects my breathing. I've been there twice since this happened it and it was difficult on me, my children, and grandchildren because my abilities were severely limited.
> . . . .
>
> I am asking to be compensated as I believe my injury to lungs was caused and exacerbated from working in enclosed spaces without proper ventilation. . . . (Employee Hearing Brief, October 16, 2018).

57) On October 23, 2018, at hearing, Employee's request for a hearing continuance was orally granted. (Record).

58) On October 24, 2018, notice of a November 27, 2018 hearing was served on Employer and Employee. (Hearing Notice Served, November 28, 2018).

59) On November 6, 2018, *Jana L. Wright v. State of Alaska*, AWCB Decision No. 18-0117 (*Wright I*) issued. It held the oral order continuing the October 23, 2018 hearing was correct because Dr. McLemore was unavailable to testify. Employee was advised it is her responsibility to notify her witnesses of the hearing's date and time so they can arrange their schedules to be available to testify. (*Wright I*).

60) On November 13, 2018, Employee contacted the division and stated Employer has not filed any of her medical records in a long time and asked for the most recent dates of her medical records. A worker's compensation technician informed Employee the most recent medical report in the file was dated September 11, 2017, other than the SIME reports. The technician discussed the process for filing and serving medical records with a medical summary form with

Employee and emailed Employee a medical summary form. (ICERS Phone Call Entry, November 13, 2018; Email, November 13, 2018).

61) On November 26, 2018, Employee contacted the division and left a voicemail stating her son was in the intensive care unit. A division technician called her back and informed Employee she could request a hearing continuance. (ICERS Phone Call Entry, November 26, 2018).

62) On November 27, 2018, at hearing, the parties agreed to a hearing continuance and to reschedule the hearing on January 22, 2019. Employee did not request an extension of the hearing evidence deadline. (Record).

63) On November 28, 2018, notice of a January 22, 2019 hearing was served on Employer and Employee. (Hearing Notice Served, November 28, 2018).

64) As a preliminary issue, the parties stipulated the issue for hearing is whether Employee's work for Employer is the substantial cause of her disability and need for medical treatment. (Record).

65) Employee testified she initially thought she had bronchitis but it would not go away and it turned out to be reactive airway disease. Employee got off the ship and sought medical care because she could not breathe after cleaning with chemicals while working for Employer. Employee's reactive airway disease is better now but she still experiences shortness of breath. Employee believes the reactive airway disease aggravated her congenital atrial septal defect it never presented until she was in her 50s and after she was diagnosed with reactive airway disease. The prednisone prescribed for her reactive airway disease weakened her bones and caused her broken leg. Employee used to hunt and fish, cut her own wood and hike mountains; but she cannot do those activities anymore. Employee has a hard time walking up hills and stairs. Employee's reactive airway disease turned into chronic adult asthma. While working on the ferry in the winter time, the chief steward placed her in another job cleaning. The chief steward was supposed to ensure she wore gloves and a face mask but often did not do so. Employee emptied out bottles of chemicals that should not have been in spray bottles. Certain cleaners should not be sprayed because of the fumes. Employee would tell the chief steward to get rid of those bottles of chemicals. (Employee).

66) Brian Baehr testified Employee is his mother. He has lived in Durango, Colorado since 2001 and he owns a tavern. Prior to 2001, Mr. Baehr lived with Employee. Employee was an active mother, she would hike, mow the lawn, and weed. Mr. Baehr observed drastic changes in

Employee's physical abilities. Since the work injury, Employee cannot do the chores she did before and she has become very sedentary. Employee visited him three times since he moved to Durango and he tries to visit his mother every 12 – 18 months. Employee told him about her work injury and the difficulties she has breathing. When Employee visits Durango she cannot shop or hang out because the altitude difference of 6,000 feet above sea level affects her breathing. (Mr. Baehr).

67) Kitty Angerman testified Employee is her neighbor. She observed Employee chopping firewood and stacking it for Ms. Angerman. Employee was a hard worker and she provided excellent firewood. She also observed Employee working in her yard in the spring, it always looked really nice. However, Ms. Angerman has not observed Employee working in her yard for the last three years. (Ms. Angerman).

68) Employee testified she continuously went to medical appointments for her work injury, at least on a monthly basis. Employee would like letters from Drs. Prysunka and Dr. McLemore to be considered but does not know the date of the letters. Employee would also like the MSDS for the cleaners she identified in the record to be considered. Dr. McLemore's letter included a statement about Employee's ability to work indoors. Employee does not know the date of the last medical record filed. Employee believed all of the medical records were filed by the hearing evidence deadline. Employee received medical treatment after the SIMEs and since the hearing evidence deadline. Employee believed all of her medical records prior to the hearing evidence deadline should have been filed because she signed releases authorizing Employer to obtain her medical records. Employee believed all of the medical evidence had been filed and now she does not know what medical evidence has been filed. Employee's son passed away last month and she has been dealing with his death. Employee requested the division obtain all of her medical records and consider them when making a determination on her claim. Employee requested the record remain open to allow her to file and serve additional medical evidence. (Employee).

69) Employee contended it was Employer's responsibility to obtain and file all medical evidence and Employer failed to do so. Employee contended the Division should obtain her medical records on her behalf. (Employee's hearing arguments).

70) Employee contended her witnesses' testimony proves her use of cleaners at work caused her disability and need for medical treatment. (*Id.*).

71) Employer objected to Employee's request to keep the record open to file additional medical evidence. Employer contended it would be prejudiced if Employee was allowed to file additional medical evidence this late in the proceedings. Employer contended it has no idea what information or opinions are contained in the medical evidence Employee is seeking to file. Employer refused to waive its right to cross-examine the author of any additional medical evidence should Employee be permitted to file additional medical reports. (Employer's hearing arguments).

72) The proof of service for the medical summaries Employer filed and served on Employee indicates it was served on Employee by certified mail, return receipt requested. (Medical Summary Proof of Service, September 20, 2016; Medical Summary Proof of Service, April 7, 2017; Medical Summary Proof of Service, April 12, 2017; Medical Summary Proof of Service, August 21, 2017; Medical Summary Proof of Service, October 5, 2017; Medical Summary Proof of Service, April 27, 2018; Medical Summary Proof of Service, June 26, 2018).

## PRINCIPLES OF LAW

**AS 23.30.001. Intent of the legislature and construction of chapter.** It is the intent of the legislature that

(1) this chapter be interpreted so as to ensure the quick, efficient, fair, and predictable delivery of indemnity and medical benefits to injured workers at a reasonable cost to the employers who are subject to the provisions of this chapter;

(2) workers' compensation cases shall be decided on their merits except where otherwise provided by statute;

(3) this chapter may not be construed by the courts in favor of a party;

(4) hearings in workers' compensation cases shall be impartial and fair to all parties and that all parties shall be afforded due process and an opportunity to be heard and for their arguments and evidence to be fairly considered.

**AS 23.30.005. Alaska Workers' Compensation Board**. . . .

. . . .

(h) . . . Process and procedure under this chapter shall be as summary and simple as possible. . . .

The board may base its decision not only on direct testimony, medical findings, and other tangible evidence, but also on the board's "experience, judgment, observations, unique or peculiar facts of the case, and inferences drawn from all of the above." *Fairbanks North Star Borough v. Rogers & Babler*, 747 P.2d 528, 533-34 (Alaska 1987).

> **AS 23.30.010. Coverage.**
> (a) Except as provided in (b) of this section, compensation or benefits are payable under this chapter for disability or death or the need for medical treatment of an employee if the disability or death of the employee or the employee's need for medical treatment arose out of and in the course of the employment. To establish a presumption under AS 23.30.120(a)(1) that the disability or death or the need for medical treatment arose out of and in the course of the employment, the employee must establish a causal link between the employment and the disability or death or the need for medical treatment. A presumption may be rebutted by a demonstration of substantial evidence that the death or disability or the need for medical treatment did not arise out of and in the course of the employment. When determining whether or not the death or disability or need for medical treatment arose out of and in the course of the employment, the board must evaluate the relative contribution of different causes of the disability or death or the need for medical treatment. Compensation or benefits under this chapter are payable for the disability or death or the need for medical treatment if, in relation to other causes, the employment is the substantial cause of the disability or death or need for medical treatment.

> **AS 23.30.095. Medical treatments, services, and examinations.**
> (a) The employer shall furnish medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus for the period which the nature of the injury or the process of recovery requires, not exceeding two years from and after the date of injury to the employee. However, if the condition requiring the treatment, apparatus, or medicine is a latent one, the two-year period runs from the time the employee has knowledge of the nature of the employee's disability and its relationship to the employment and after disablement. It shall be additionally provided that, if continued treatment or care or both beyond the two-year period is indicated, the injured employee has the right of review by the board. The board may authorize continued treatment or care or both as the process of recovery may require.
> . . . .

> **AS 23.30.120. Presumptions.**
> (a) In a proceeding for the enforcement of a claim for compensation under this chapter it is presumed, in the absence of substantial evidence to the contrary, that
>
> (1) the claim comes within the provisions of this chapter . . . .

Under AS 23.30.120(a), benefits sought by an injured worker are presumed to be compensable, and the burden of producing evidence is placed on the employer. *Sokolowski v. Best Western Golden Lion Hotel*, 813 P.2d 286, 292 (Alaska 1991). The Alaska Supreme Court held the presumption of compensability applies to any claim for compensation under the Act. *Meek v. Unocal Corp*., 914 P.2d 1276, 1279 (Alaska 1996). An employee is entitled to the presumption of compensability as to each evidentiary question. *Sokolowski* at 292.

A three-step analysis is used to determine the compensability of a worker's claim. At the first step, the claimant need only adduce "some" "minimal" relevant evidence establishing a "preliminary link" between the injury claimed and employment. *McGahuey v. Whitestone Logging, Inc.,* 262 P.3d 613, 620 (Alaska 2011). The evidence necessary to attach the presumption of compensability varies depending on the claim. In claims based on highly technical medical considerations, medical evidence is often necessary to make that connection. *Burgess Construction Co. v. Smallwood*, 623 P.2d 312, 316 (Alaska 1981). In less complex cases, lay evidence may be sufficiently probative to establish causation. *VECO, Inc. v. Wolfer*, 693 P.2d 865, 871 (Alaska 1985). Witness credibility is not weighed at this step in the analysis. *Resler v. Universal Services Inc.*, 778 P.2d 1146, 1148-49 (Alaska 1989).

At the second step, once the preliminary link is established, the employer has the burden to overcome the presumption with substantial evidence. *Wien Air Alaska v. Kramer*, 807 P.2d 471, 473-74 (Alaska 1991) (quoting *Smallwood* at 316). To rebut the presumption, an employer must present substantial evidence that either (1) something other than work was the substantial cause of the disability or need for medical treatment or (2) that work could not have caused the disability or need for medical treatment. *Huit v. Ashwater Burns, Inc.*, 372 P.3d 904 (Alaska 2016). "Substantial evidence" is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. *Tolbert v. Alascom, Inc*., 973 P.2d 603, 611-12 (Alaska 1999). At the second step of the analysis, the employer's evidence is viewed in isolation, without regard to the claimant's evidence. Issues of credibility and evidentiary weight are deferred until after a determination whether the employer has produced a sufficient quantum of evidence to rebut the presumption. *Norcon, Inc. v. Alaska Workers' Comp. Bd.*, 880 P.2d 1051, 1054 (Alaska 1994).

If the presumption is raised but not rebutted, the claimant prevails and need not produce further evidence. *Williams v. State*, 938 P.2d 1065, 1075 (Alaska 1997). If the employer successfully rebuts the presumption, it drops out, and the employee must prove all elements of his case by a preponderance of the evidence. *Louisiana Pacific Corp. v. Koons*, 816 P.2d 1379, 1381. At this last step of the analysis, evidence is weighed and credibility considered. To prevail, the claimant must "induce a belief" in the minds of the fact finders the facts being asserted are probably true. *Saxton v. Harris*, 395 P.2d 71, 72 (Alaska 1964). The presumption does not apply if there is no factual dispute. *Rockney v. Boslough Construction Co.*, 115 P.3d 1240 (Alaska 2005).

Where an Employee has a pre-existing condition, "[b]oth the work injury and the pre-existing condition must be evaluated, and the relative relationship of both must be weighed, before determining if the need for ongoing medical treatment is the result of the aggravation by the work injury of the underlying condition." *ARCTEC Alaska v. Traugott*, AWCAC Decision No. 249 (June 6, 2018). The claimed work event must be examined in relation to previous work events and the underlying condition. Even if an event hastened the need for treatment, it does not necessarily make the event the substantial cause of the need for treatment. *Alaska Interstate Construction, LLC v. Morrison et al.*, AWCAC Decision No. 243 (January 25, 2018). Further, even if "but for" the work event an employee may not have needed additional treatment, "all causes must be weighed against each other before work can be found to be the substantial cause of the ongoing disability." *ARTEC*, at 16. Although an employer takes an employee as the employer finds the employee, where such an employee has a pre-existing condition which may make the employee more susceptible to a work injury, the work injury must still be the substantial cause for any need for medical treatment under AS 23.20.010(a). *ARTEC*, at 14. There can only be one substantial cause. *Morrison*, at 8. Employment cannot be 'the substantial cause' if something else is more of a cause. *Morrison*, at 10.

The timing of the onset of pain relative to an injury may be evidence of causation, but as the Alaska Supreme Court reiterated in *Rivera v. Wal-Mart Stores, Inc.*, 247 P.3d 957 (Alaska 2011), continuing pain following a work injury does not invariably lead to the conclusion that the work injury caused the pain.

> **AS 23.30.122**. **Credibility of witnesses**. The board has the sole power to determine the credibility of a witness. A finding by the board concerning the weight to be accorded a witness's testimony, including medical testimony and reports, is conclusive even if the evidence is conflicting or susceptible to contrary conclusions. . . .

The board's finding of credibility "is binding for any review of the Board's factual findings." *Smith v. CSK Auto, Inc.*, 204 P.3d 1001, 1008 (Alaska 2009). When doctors' opinions disagree, the board determines which has greater credibility. *Moore v. Afognak Native Corp.*, AWCAC Decision. No. 087 at 11 (August 25, 2008).

> **AS 23.30.130. Modification of awards.** (a) Upon its own initiative, or upon the application of any party in interest on the ground of a change in conditions, including, for the purposes of AS 23.30.175, a change in residence, or because of a mistake in its determination of a fact, the board may, before one year after the date of the last payment of compensation benefits under AS 23.30.180, 23.30.185, 23.30.190, 23.30.200, or 23.30.215, whether or not a compensation order has been issued, or before one year after the rejection of a claim, review a compensation case under the procedure prescribed in respect of claims in AS 23.30.110. Under AS 23.30.110 the board may issue a new compensation order which terminates, continues, reinstates, increases, or decreases the compensation, or award compensation.
> . . . .

> **AS 23.30.135. Procedure before the board.** In making an investigation or inquiry or conducting a hearing, the board is not bound by common law or statutory rules of evidence or by technical or formal rules of procedure, except as provided by this chapter. The board may make its investigation or inquiry or conduct its hearing in the manner by which it may best ascertain the rights of the parties. . . .

> **AS 23.30.180. Permanent total disability.** (a) In case of total disability adjudged to be permanent 80 percent of the injured employee's spendable weekly wages shall be paid to the employee during the continuance of the total disability. . . .

> **AS 23.30.185. Compensation for temporary total disability.** In case of disability total in character but temporary in quality, 80 percent of the injured employee's spendable weekly wages shall be paid to the employee during the continuance of the disability. Temporary total disability benefits may not be paid for any period of disability occurring after the date of medical stability.

**8 AAC 45.060. Service.**

. . . .

(b) Service by mail is complete at the time of deposit in the mail if mailed with sufficient postage and properly addressed to the party at the party's last known address. If a right may be exercised or an act is to be done, three days must be added to the prescribed period when a document is served by mail.

. . . .

**8 AAC 45.063. Computation of time.** (a) In computing any time period prescribed by the Act or this chapter, the day of the act, event, or default after which the designated period of time begins to run is not to be included. The last day of the period is included, unless it is a Saturday, Sunday or a legal holiday, in which case the period runs until the end of the next day which is neither a Saturday, Sunday nor a holiday.

(b) Upon petition by a party and for good cause, the board will, in its discretion, extend any time period prescribed by this chapter.

**8 AAC 45.070. Hearings.**

. . . .

(j) If the hearing is not completed on the scheduled hearing date and the board determines that good cause exists to continue the hearing for further evidence, legal memoranda, or oral arguments, the board will set a date for the completion of the hearing.

**8 AAC 45.120. Evidence.**

. . . .

(b) All proceedings must afford every party a reasonable opportunity for a fair hearing.

(c) Each party has the following rights at hearing:

(1) to call and examine witnesses;

(2) to introduce exhibits;

(3) to cross-examine opposing witnesses on any matter relevant to the issues even though the matter was not covered in the direct examination;

(4) to impeach any witness regardless of which party first called the witness to testify; and

(5) to rebut contrary evidence.

**8 AAC 45.150. Rehearings and modification of board orders.** (a) The board will, in its discretion, grant a rehearing to consider modification of an award only upon the grounds stated in AS 23.30.130.

(b) A party may request a rehearing or modification of a board order by filing a petition for a rehearing or modification and serving the petition on all parties in accordance with 8 AAC 45.060.

(c) A petition for a rehearing or modification based upon change of conditions must set out specifically and in detail the history of the claim from the date of the injury to the date of filing of the petition and the nature of the change of conditions. The petition must be accompanied by all relevant medical reports, signed by the preparing physicians, and must include a summary of the effects which a finding of the alleged change of conditions would have upon the existing board order or award.

(d) A petition for a rehearing or modification based on an alleged mistake of fact by the board must set out specifically and in detail

(1) the facts upon which the original award was based;

(2) the facts alleged to be erroneous, the evidence in support of the allegations of mistake, and, if a party has newly discovered evidence, an affidavit from the party or the party's representative stating the reason why, with due diligence, the newly discovered evidence supporting the allegation could not have been discovered and produced at the time of the hearing; and

(3) the effect that a finding of the alleged mistake would have upon the existing board order or award.

(e) A bare allegation of change of conditions or mistake of fact without specification of details sufficient to permit the board to identify the facts challenged will not support a request for a rehearing or a modification.

(f) In reviewing a petition for a rehearing or modification the board will give due consideration to any argument and evidence presented in the petition. The board, in its discretion, will decide whether to examine previously submitted evidence.

**8 AAC 45.195. Waiver of procedures.** A procedural requirement in this chapter may be waived or modified by order of the board if manifest injustice to a party

> would result from a strict application of the regulation. However, a waiver may not be employed merely to excuse a party from failing to comply with the requirements of law or to permit a party to disregard the requirements of law.

The Alaska Supreme Court has held that courts hold *pro se* litigants to a lesser standard than attorneys. *Dougan v. Aurora Electric, Inc.*, 50 P.3d 789, 795 (2002). A judge must inform a *pro se* litigant "of the proper procedure for the action he or she is obviously attempting to accomplish." *Id* (citation omitted). Specifically, a judge must notify a *pro se* litigant of defects in his or her brief and give the party an opportunity to remedy those defects. (*Id*.).

The Alaska Supreme Court has held the board owes a duty to every claimant to fully advise him of "all the real facts" bearing upon his right to compensation and instruct him on how to pursue that right under law. *Richard v. Fireman's Fund Ins. Co.*, 384 P.2d 445, 449 (Alaska 1963). In *Bohlmann v. Alaska Construction & Engineering*, 205 P.2d 316 (Alaska 2009), the Court held the board's failure to correct an employer's erroneous assertion to a self-represented claimant that his claim was already time-barred rendered the claimant's ARH timely. Applying *Richard*, *Bohlmann* stated the board has a specific duty to inform a self-represented claimant how to preserve his claim.

In *Israelson v. Alaska Marine Trucking*, LLC, AWCAC Decision No. 226 (May 27, 2016), the Alaska Workers' Compensation Appeals Commission concluded 8 AAC 45.063(b) rather than 8 AAC 45.195 governs the board's exercise of discretion with respect to extensions of time established by regulation. *Id*. at 8. When considering whether the circumstances warranted an extension of time to file an affidavit of attorney's fees, the Commission considered: (1) whether the delay in filing was minimal; (2) whether the late affidavit was otherwise compliant with the regulation controlling filing of affidavit of attorney's fees; (3) whether the affidavit was delivered to opposing counsel on the date of filing; (4) whether there was prejudice to a party; (5) whether there was a pattern of failure to meet deadlines by the claimant or his counsel; and (6) whether the fee awarded is reasonable compensation as compared with the fee claimed. *Id.* at 10-11.

## ANALYSIS

**1) Was the oral order denying Employee's request to leave the hearing record open to file additional medical records correct?**

Employee testified she continuously went to medical appointments for her work injury. Employee wanted letters from Dr. Prysunka and Dr. McLemore to be considered. Employee requested the record remain open to allow her to file and serve additional medical evidence. Employer objected to Employee's request. Employer contended Employee failed to provide good cause for her failure to file and medical records by the hearing evidence deadline. Employer contended it would be prejudiced if Employee was allowed to file additional medical evidence. An oral order issued denying Employee's request.

Employee cannot recall the date of the records from Drs. Prysunka's and McLemore's records that she would like to be considered. An August 8, 2016 letter from Dr. Prysunka is in the record, as are medical reports from Dr. McLemore from January 16, 2017 and May 2, 2017. The medical record is extensive and includes medical opinions from Employee's treating physicians, Drs. Prysunka and McLemore, the SIME physicians and the EME physician. Many are Dr. Prysunka's records for treatment of Employee's continuing breath problems, consistent with Employee's testimony she continuously sought treatment. Upon review of the medical record and Employee's testimony she believed all of the medical records were filed by the hearing evidence deadline, it is unclear which medical evidence Employee is contending is missing from the medical record.

Employee contended Employer had the responsibility to file all medical evidence and failed to do so. She contended the division should obtain all of her medical records on her behalf. The division does not obtain medical evidence on behalf of parties. Both Employer and Employee have the responsibility to file and serve all medical reports under their control or in their possession. AS 23.30.095(h). While Employee is unrepresented and held to a lesser standard, she is still required to file medical evidence and her *pro se* status does not excuse failing to file medical evidence. *Dougan*. Employee was properly instructed how to file and serve medical evidence during the October 27, 2016 and August 28, 2018 prehearing conferences. *Dougan*; *Richard*; *Bohlmann*. Employee was also properly informed on August 28, 2018 of the October

3, 2018 hearing evidence deadline, 20 days before the October 23, 2018 hearing, which is the hearing evidence filing deadline under 8 AAC 45.054(c)(4) and 8 AAC 45.120(f). *Id*. Employee stated she was unfamiliar with her responsibility to file evidence by the hearing evidence deadline. Employee is not credible. AS 23.30.122.

Employee's delay in filing medical evidence is not minimal. *Israelson*. During the June 26, 2018 prehearing conference, Employee discussed filing additional medical evidence because she had upcoming medical appointments in July. The next prehearing conference on August 28, 2018 set the hearing evidence filing deadline. The prehearing order established medical evidence was to be filed by the October 3, 2018 hearing evidence deadline. Employee had 56 days from the prehearing conference until the deadline to file her evidence and she failed to file any medical evidence. Employee did not request an extension of the hearing evidence deadline to file medical evidence at the October 23, 2018 hearing where Employee's request for a hearing continuance was granted because her witness was unavailable. Nor did she request an extension of the hearing evidence deadline at the November 27, 2018 hearing where the parties agreed to a hearing continuance.

On November 13, 2018, Employee contacted a workers' compensation technician by telephone to inquire about what medical evidence has been filed by Employer. Employee was informed the last medical records filed on a medical summary were the SIME reports and the September 11, 2017 Kritzer medical report and she was instructed how to file medical evidence again. Employer filed all of the medical summaries and served them on Employee by certified mail, return receipt requested. Employee stated she did not know which medical records were filed; this contradicts her other statement she believed all of the medical records were filed by the hearing evidence deadline. Employee is not credible. AS 23.30.122. As of the January 22, 2019 hearing, 70 days passed after Employee spoke with a workers' compensation technician on November 13, 2018 and Employee failed to file any medical evidence. Employee had adequate time to prepare for hearing and file and serve evidence and did not exercise due diligence in filing and serving evidence. Employee provided no reason why additional medical evidence, if it exists, could not have been obtained and filed earlier. Good cause does not exist to continue the hearing for additional evidence. 8 AAC 45.070(j). The hearing evidence deadline may not be

waived merely to excuse Employee from failing to comply with the hearing evidence deadline or to permit her to disregard the hearing evidence deadline. 8 AAC 45.195. There is insufficient cause to waive the hearing evidence deadline or to extend the hearing evidence deadline. 8 AAC 45.063(b); 8 AAC 45.195.

Hearings in workers' compensation cases shall be impartial and fair to all parties. AS 23.30.001(4). Parties must also be afforded due process and a reasonable opportunity to be heard and for their arguments and evidence to be fairly considered. AS 23.30.001(4); 8 AAC 45.120(b). Employee was provided a reasonable opportunity to present evidence. Employer's due process right to know the opposing evidence, to present contrary evidence, and to cross-examine witnesses must also be considered. 8 AAC 45.120(c). Employer was not included in Employee's November 13, 2018 contact with the workers' compensation technician and had no notice Employee inquired about the medical record. Employee never filed the medical evidence, Employer has had no opportunity to review the medical evidence and to consider whether it would present contrary evidence or request cross-examination of the author of the medical evidence. Allowing Employee to file additional medical evidence she failed to file at all after she was provided a reasonable opportunity to present evidence and without providing any reason for the failure will prejudice Employer and deny it due process. *Israelson*.

It would be contrary to the legislative's intent requiring quick efficient fair and predictable delivery of benefits to Employee, if she is entitled to them, at a reasonable cost to Employer to allow Employee to file additional medical evidence. AS 23.30.001(1). A determination on the compensability of Employee's claim has already been postponed twice resulting in a 91 day delay (October 23, 2018 thru January 22, 2019 = 91 days). Employer did not waive its right to cross-examine the author of any medical report Employee sought to file. Because Employee failed to file the additional medical evidence, the medical records could not be reviewed to determine whether the medical reports were admissible under a hearsay exception. If the record remained open to allow Employee to file additional medical evidence, Employer would have to be provided the opportunity to review it, to present contrary evidence and to request cross-examination of the author of the medical evidence under 8 AAC 45.052, further delaying a determination on the compensability of Employee's claim. Process and procedure shall be as

summary and simple as possible. AS 23.30.005(h). It would be disruptive to the orderly presentation and consideration of relevant evidence to permit Employee to file additional medical evidence, if it exists, in this circumstance. AS 23.30.005(h); AS 23.30.135(a). The oral order denying Employee's request to leave the hearing record open to file and serve additional medical evidence was correct.

**2) Is Employee's work for Employer the substantial cause of her disability and need for medical treatment, and if so, is Employee entitled to disability and medical benefits?**

Employer and Employee do not dispute Employee used cleaning chemicals while working for Employer. The issue for hearing is whether Employee's work for Employer is the substantial cause of her disability and need for medical treatment. The presumption of compensability applies to this issue. AS 23.30.095(a); AS 23.30.180; AS 23.30.185; AS 23.30.120(a); *Meek*; *Sokolowski*. Without regard to conflicting evidence and without considering credibility, Employee raised the presumption her work for Employer is the substantial cause of her disability and need for medical treatment through Dr. Prysunka's August 8, 2016 opinion that Employee's exposure to chemicals at work triggered her asthma attacks and Dr. McLemore's May 2, 2017 opinion that Employee has reactive airway disease secondary to chemical exposure at work. AS 23.30.010(a); *McGahuey*; *Smallwood*; *Resler*.

Because Employee raised the presumption of compensability, Employer was required to rebut it with substantial evidence that either something other than work was the substantial cause of her disability and need for medical treatment or that work could not have caused the disability or need for medical treatment. *Kramer*; *Huit*; *Tolbert*. Credibility is not considered; nor is the evidence weighed against competing evidence. *Norcon*. Employer rebutted the presumption through Dr. Bardana's opinion the substantial cause of Employee's disability and need for treatment are recurrent respiratory infections and her smoking history.

Employee is required to prove her work for Employer is the substantial cause of her disability and need for medical treatment by a preponderance of the evidence because Employer successfully rebutted the presumption. *Koons*. Evidence is weighed and credibility considered.

There are several potential causes of Employee's disability and need for treatment including Employee's use of cleaning chemicals while working for Employer, repeated viral infections, Employee's smoking history, preexisting asthma, a genetic predisposition to asthma and Employee's atrial septal defect. The physicians in the record disagreed as to the substantial cause of Employee's disability and need for medical treatment. When physicians disagree, the credibility of the physician's opinions must be considered. *Moore*. As stated previously, Dr. Prysunka opined Employee's exposure to chemicals at work triggered her asthma attacks and Dr. McLemore opined Employee has reactive airway disease secondary to chemical exposure at work. Dr. Raybin, a pulmonologist, opined the substantial cause of Employee's disability and need for treatment in March 2016 and currently is her repeated viral infections during the fall and winter 2015-2016. Dr. Holmes, an occupational medicine and toxicology specialist, opined the substantial cause of Employee's disability and need for treatment is smoking, repeated viral illnesses, genetic pre-disposition and congenital factors.

Dr. Prysunka's opinion is given less weight than Drs. Holmes' and Raybin's opinions because she lacks training in occupational medicine and toxicology and pulmonology. AS 23.30.122. Furthermore, Dr. Prysunka did not review the MSDS on cleaners Employee may have used at work and did not have the expertise to predict how the chemicals in the cleaners may affect someone using them. Dr. Prysunka relied on Employee's history that her symptoms started after using cleaners at work and Dr. McLemore's opinion Employee has reactive airway disease secondary to chemical exposure at work.

Drs. Holmes' and Raybin's opinions are given more weight than Dr. McLemore's opinion because Drs. Holmes and Raybin reviewed Employee's medical record and the MSDS sheets for cleaners Employee may have used at work. AS 23.30.122. Like Dr. Prysunka, Dr. McLemore relied on Employee's explanation of her medical history, including Employee's denial of any history of asthma or asthmatic breathing "until this year in her life" as stated in his January 16, 2017 medical report. However, Dr. Weinberg diagnosed Employee previously with asthmatic bronchitis on August 17, 2015. Furthermore, Drs. Holmes and Raybin considered all of the relative contributions of the different causes of Employee's disability and need for medical

treatment. *Traugott*. Dr. McLemore's medical reports did not include or consider Employee's smoking history. Nor did he consider Employee's family history of asthma as documented in Dr. Gerbino's May 6, 2016 medical report.

Dr. Gerbino a pulmonologist, diagnosed asthma with recurrent exacerbation, further exacerbated by exposures at work. His opinion also relied on Employee's explanation of her medical record, including Employee's report of a history of occasional bronchitis with "perhaps 1 episode of productive cough responding to antibiotic treatment every three years." Employee medical records prove Employee had three episodes of coughing in 2015 and another in 2016 before reporting exposures to cleaning chemicals at work aggravated her cough on March 14, 2016. Dr. Weinberg's August 17, 2015 asthmatic bronchitis diagnosis was also not provided to Dr. Gerbino. Therefore, Dr. Gerbino's opinion is given less weight than Drs. Holmes' and Raybin's.

Employee testified she got off the ferry because she could not breathe after cleaning with chemicals while working for Employer and she reported a non-productive cough aggravated by chemicals. Employee also contended her witness testimony proves her breathing difficulties, cough and shortness of breath worsened after cleaning with chemicals at work. However, the fact that her cough or shortness of breath may have worsened after using cleaners at work does not invariably lead to the conclusion that the use of cleaners at work caused Employee's disability and need for medical treatment. *Rivera*. Both Drs. Raybin and Holmes opined Employee's exposure to cleaning chemicals at work is not the substantial cause of disability and need for medical treatment after reviewing the MSDS for at least 17 cleaners. Dr. Raybin noted exposure to chemicals in cleaners at work may have worsened her preexisting asthma but it was a relatively small additional contributing factor. Instead he opined Employee's repeated viral infections during the fall and winter of 2015-2016 were the substantial cause of her disability and need for medical treatment. Dr. Holmes stated there is no evidence a chemical irritant altered the need for treatment or resulted in disability. Both noted there is no evidence Employee's exposure to cleaning chemicals at work was significant enough to cause RADS. Because Dr. Raybin physically examined Employee, his opinions are given the most weight. In comparison to all other causes, Employee's repeated viral infections and preexisting asthma are the substantial cause of Employee's disability and need for medical treatment. Employee is not

entitled to disability and medical benefits. Employee failed to prove by a preponderance of the evidence her work for Employer is the substantial factor in her disability and need for medical treatment. Employee's claim for benefits will be denied.

Pursuant to *Richard* and *Bohlman*, Employee is advised if she obtains information showing this decision made a mistake in determination of fact and decides to seek modification, Employee has one year to do so. In other words, Employee has until February 24, 2020 to seek modification of this decision by filing a petition and evidence, including medical records supporting her belief an error was made. AS 23.30.130; 8 AAC 45.060(b); 8 AAC 45.063(a); 8 AAC 45.150.

## CONCLUSIONS OF LAW

1) The oral order denying Employee's request to leave the hearing record open to receive additional medical evidence was correct.
2) Employee's work for Employer is not the substantial cause of her disability and need for medical treatment.

## ORDER

1) Employee's September 12, 2016 claim is denied.

Dated in Juneau, Alaska on February 20, 2019.

ALASKA WORKERS' COMPENSATION BOARD

/s/
Kathryn Setzer, Designated Chair

/s/
Charles Collins, Member

/s/
Bradley Austin, Member

## APPEAL PROCEDURES

This compensation order is a final decision. It becomes effective when filed in the office of the board unless proceedings to appeal it are instituted. Effective November 7, 2005 proceedings to appeal must be instituted in the Alaska Workers' Compensation Appeals Commission within 30 days of the filing of this decision and be brought by a party in interest against the boards and all other parties to the proceedings before the board. If a request for reconsideration of this final decision is timely filed with the board, any proceedings to appeal must be instituted within 30 days after the reconsideration decision is mailed to the parties or within 30 days after the date the reconsideration request is considered denied due to the absence of any action on the reconsideration request, whichever is earlier. AS 23.30.127.

An appeal may be initiated by filing with the office of the Appeals Commission: 1) a signed notice of appeal specifying the board order appealed from and 2) a statement of the grounds upon which the appeal is taken. A cross-appeal may be initiated by filing with the office of the Appeals Commission a signed notice of cross-appeal within 30 days after the board decision is filed or within 15 days after service of a notice of appeal, whichever is later. The notice of cross-appeal shall specify the board order appealed from and the ground upon which the cross-appeal is taken. AS 23.30.128.

## RECONSIDERATION

A party may ask the board to reconsider this decision by filing a petition for reconsideration under AS 44.62.540 and in accord with 8 AAC 45.050. The petition requesting reconsideration must be filed with the board within 15 days after delivery or mailing of this decision.

## MODIFICATION

Within one year after the rejection of a claim, or within one year after the last payment of benefits under AS 23.30.180, 23.30.185, 23.30.190, 23.30.200, or 23.30.215, a party may ask the board to modify this decision under AS 23.30.130 by filing a petition in accord with 8 AAC 45.150 and 8 AAC 45.050.

## CERTIFICATION

I hereby certify the foregoing is a full, true and correct copy of the Final Decision and Order in the matter of JANA L. WRIGHT, employee / claimant v. STATE OF ALASKA, employer; STATE OF ALASKA, insurer / defendants; Case No. 201604175; dated and filed in the Alaska Workers' Compensation Board's office in Juneau, Alaska, and served on the parties by First-Class U.S. Mail, postage prepaid, on February 20, 2019.

/s/
Dani Byers, Technician