ALASKA WORKERS' COMPENSATION BOARD

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

FELICIA CROCKETT, Employee, Claimant, v. STATE OF ALASKA, Self-insured Employer, Defendant.	)	INTERLOCUTORY DECISION AND ORDER AWCB Case No. 201507018 AWCB Decision No. 24-0037 Filed with AWCB Anchorage, Alaska on June 24, 2024

Felicia Crockett's (Employee) August 12 and August 16, 2019 petitions for a second independent medical evaluation (SIME) were heard on May 29, 2024, in Anchorage, Alaska, a date selected on April 11, 2024. The designee on April 11, 2024, set a hearing on his own motion, which gave rise to this hearing. Non-attorney Employee appeared, represented herself and testified. Assistant Atty. Gen. Daniel Moxley appeared and represented the State of Alaska (Employer). All participants attended by Zoom. The record closed at the hearing's conclusion on May 29, 2024.

ISSUE

Employee in her petitions initially contended there were medical disputes between her attending physicians and Employer's medical evaluator (EME). She later doubted the need for an SIME.

Employer did not initially recognize that Employee's petitions requested an SIME. However, it later declined to stipulate to an SIME and the matter was set for a hearing.

Shall the panel order an SIME on its own motion?

FINDINGS OF FACT

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

1) On or about January 15, 2005, Teresa Neeno, MD, with Allergy, Asthma & Immunology Center of Alaska (AAIC) saw Employee for the first time. Employee weighed 276 pounds. She told the examiner, "Asthma has put me in and out of the hospital my whole life. The Dr. said that I wasn't supposed to live past 5." Her pulmonary tests showed "mild to moderate obstruction" pre-bronchodilator. Employee responded well to the bronchodilator. Her pre- and post-dilator "lung ages" where "71" and "42," respectively. (Neeno report, November 16, 2005).

2) On November 16, 2005, Employee was again on prednisone for her asthma. She was "chronically ill" with a significant cough:

> [Employee] is a 20-year-old female who has had problems with asthma essentially all her life. She has been on numerous courses of prednisone. Recently, she has been on prednisone a couple of weeks out of every month for the past four months or so. This week, she is [sic] required her nebulizer several times per day although the last three days she has not required it. She wakes "all the time" with respiratory difficulties. She has been hospitalized numerous times. She cannot recall if she has been in the ICU [intensive care unit]. . . . She reports woodstove smoke, tobacco smoke, strong odors, fumes, cold air, and exercise will increase respiratory difficulties. She reports frequent "small attacks" where she cannot breathe in all the way. She reports if she uses her inhaler, it would usually work within 30 seconds. Now, it is taking about a minute to work. Sometimes cats will cause nose and eye symptoms. Dogs have caused urticaria. Upper respiratory tract infections nearly always go to her chest. She has had four sinus infections this past year, pneumonia once. . . . She has been reported to wake gasping. She has had rhinitis. She has had a rash on her arms all her life. When she plays with the dog, she will have hives. . . .
> . . . .
>
> CURRENT MEDICATIONS
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> Albuterol using once an hour, sometimes she uses a spacer, prednisone since Monday, Combivent every 3-4 hours, Advair 250/50 one inhalation twice daily, and antibiotic, Singulair and Clarinex none for 1-2 weeks, and over-the-counter cold medications.

The relevant diagnosis was, "Persistent asthma with significant overuse of bronchodilators." Employee had "moderate" pre-dilator obstruction and "borderline" post-dilator obstruction. (Neeno report, November 16, 2005).

3) On December 5, 2005, Employee had uncontrolled "moderate" asthma probably contributed to by seasonal and perennial allergies with a "76" lung age. (Neeno report, December 5, 2005).

4) On July 7, 2006, Employee had a Xolair shot for her asthma. (AAIC report, July 7, 2006).

5) On August 16, 2006, Employee had "severe" airway obstruction and pre- and post-dilator "lung ages" of 84 and 80, respectively. (Neeno report, August 16, 2006).

6) On October 11, 2006, Employee weighed 308 pounds, her asthma was "good," and she had "PND" [paroxysmal nocturnal dyspnea -- a feeling she could not breathe] for two weeks. (AAIC report, October 11, 2006).

7) On November 16, 2006, Employee had "mild" airway obstruction and a "64" lung age. (AAIC report, October 11, 2006).

8) On June 14, 2007, Employee's pulmonary tests disclosed "borderline" airway obstruction with a "lung age" of "51"; she was 21 years old. (Pulmonary Function Report, June 14, 2007).

9) On September 25, 2007, Employee went to the emergency room (ER) for chest congestion and gave a history including "reactive airway disease," asthma, and vocal cord "dystoriation." She had never smoked. (Alaska Regional Hospital records, September 25, 2007).

10) On February 7, 2008, Employee reported being at the gym for only 10 minutes and she "couldn't breathe." The previous evening, she walked briefly and had "trouble catching breath." Employee said she went to California in October 2007, had to go to the ER for her asthma, and took prednisone. She weighed 311 pounds. Employee's pulmonary test results showed "moderate airway obstruction." Her "lung age" was "82" years; she was 22 years old. (Pulmonary Function Report, February 7, 2008).

11) On July 22, 2008, Employee's doctor completed a form for her to obtain asthma medication:

> 22 yr old woman with severe persistent asthma. Poor perceiver with FEV1 67% despite maximal therapy. . . . She has intense mood swings while on oral steroids -- thus avoiding them is imperative. . . . (Statement of Medical Necessity, July 22, 2008).

12) On September 2, 2008, Employee's provider at AAIC recorded:

> [Employee] is a 22-year-old female with a significant history of uncontrolled asthma, diagnosed during childhood. She had trialed several medication protocols to improve management of her breathing. In December 2005 she was initially diagnosed with vocal cord dysfunction (VCD) and seasonal and perennial allergic rental conjunctivitis (with allergy to grasses, trees, cat, dog, and dust mite).

> Previously poorly managed allergies contributed to her declining respiratory function. [Employee] reported using her rescue inhaler 1-2 times weekly, sometimes more. This summer she began Xolair treatment, and lung function and allergy management improved significantly. Despite this improvement she continued to present with episodic events of shortness of breath that were not consistently responsive to asthma medications. Onset of shortness of breath had become increasingly worse with certain exertion-based activities. For example, her breathing was typically worse when hiking, but yet she experienced no symptoms of shortness of breath while swimming. . . . (AAIC report, September 2, 2008).

13) From October 27, 2008, through October 15, 2014, Employee's AAIC records contain dozens of phone messages, phone contacts, appointments and prescriptions for her consistently, and frequently, exacerbated asthma and allergies, too numerous to list in detail here. (AAI records, October 27, 2008, through October 15, 2014).

14) On August 8, 2009, Employee went to the ER complaining of "asthma and cough." The prior evening, she reported frequent awakening secondary to shortness of breath. The diagnosis was "asthma exacerbation." (Providence Hospital records, August 8, 2009).

15) On October 13, 2009, Employee's pulmonary tests showed "moderate obstruction." (Pulmonary Function test, October 13, 2009).

16) On July 19, 2010, Employee reported typical asthma, vocal cord dysfunction, dermatitis, upper respiratory infection and allergies. (AAIC records, July 19, 2010).

17) On August 1, 2010, Employee, then age 24, reported that her first asthma episode occurred 22 years earlier when she was two years old. On this date her Body Mass Index (BMI) was approximately 56, which is "morbidly obese." (AAIC records, August 1, 2010).

18) On August 29, 2010, Employee went to the ER for an acute and persistent asthma exacerbation for the previous three to four weeks. The diagnosis was, "Acute and persistent asthma exacerbation." (Providence Hospital records, August 29, 2010).

19) On March 21, 2011, Employee's pulmonary tests showed "moderate airway obstruction." (Spirometry Report, March 21, 2011).

20) On August 8, 2012, Janelle Dupuis, PA-C, with AAIC completed a Family Medical Leave Act (FMLA) form to excuse Employee from work with a previous employer. She stated, "It is possible that asthma may flare causing an absence from work." PA-C Dupuis opined that these absences could happen "1-2" times every 12 months and could last from "1-5" days per episode:

> [Employee] is diagnosed with moderate to severe persistent asthma. She is on high dose inhaled steroids, and albuterol as needed. She continues to have frequent asthma exacerbations that make it difficult to perform any duties due to respiratory distress. She has severe allergies as well. I recommend she be able to run a HEPA filter at her desk at work to help control her allergy symptoms & asthma. (FMLA form, August 8, 2012).

21) On August 8, 2012, Employee also went to the ER for a "medication reaction" after seeing her physician earlier that day "for a headache." On this visit, she weighed 380 pounds. (Providence Hospital records, August 8, 2012).

22) On September 18, 2012, Employee's pulmonary function tests showed, "Moderately severe obstruction, with low vital capacity. Post bronchodilator test not improved." (Spirometry report, September 18, 2012).

23) By October 12, 2012, Employee was continuing with regular follow-ups with her providers to address her asthma and vocal cord dysfunction as she had done for years. Her physician classified her asthma pattern as "severe persistent." (AAIC records, October 12, 2012).

24) On October 12, 2012, Employee sought assistance from a dietitian. On this date she weighed 414 pounds. (Sherryl G. Meek, RD, report, October 12, 2012).

25) On August 15, 2013, Employee went to the ER for asthma. She reported having been hospitalized at age 19 and intubated. The diagnosis on this date was an "acute asthma exacerbation." (Providence Hospital records, August 15, 2013).

26) On August 25, 2013, Employee returned to the ER, citing asthma. Causation was smoke from a barbecue. She weighed 425 pounds. (Providence Hospital records, August 25, 2013).

27) On September 25, 2013, Robert Thornquist, MD, completed paperwork from a private insurer for Employee to obtain short-term disability benefits resulting from her asthma. (Medical Request Form, September 23, 2013).

28) On October 29, 2013, Dr. Neeno completed an FMLA form for Employee:

> Asthma can be well-controlled. If she's having an asthma flare, she may not be able to perform her job. Her asthma has been quite labile and she has recovered slowly. (FMLA form, October 29, 2013).

29) On April 28, 2014, Employee had an ER visit for asthma. She said she had a myocardial infarction at age 12. Employee was now using her EpiPen [emergency epinephrine injection device] "regularly." She weighed 385 pounds. (Providence Hospital records, April 28, 2014).

30) On December 27, 2014, Employee went to the ER for asthma. She had difficulty speaking and used her cell phone to communicate. The records disclosed no "unusual exposures" causing her shortness of breath and asthma exacerbation. On discharge, the diagnosis was, "Acute dyspnea (Probably secondary to vocal cord dysfunction)." On this date, Employee's self-reported weight was 400 pounds. She was to start a new job with the state in two days and "should have insurance" then. (Alaska Regional Hospital records, December 27, 2014).

31) On December 29, 2014, Employer hired Employee who began work for it that day as a Child Support Specialist I. (Employer Report of Occupational Injury or Illness to Division of Workers' Compensation, May 4, 2015).

32) Beginning March 4, 2015, Dr. Thornquist began prescribing Diazepam [a sedative normally used to treat anxiety] for Employee. (Thornquist prescription, April 13, 2015).

33) On March 15, 2015, Employee, who had now been working for Employer at the Child Support Services Division since December 29, 2014, reported to the ER and said she had severe shortness of breath; the hospital admitted her. On March 17, 2015, a hospital physician completed a FMLA form for Employee and stated, "Asthma exacerbation due to environmental exposure (unclear trigger)." She was to avoid environmental allergen triggers. Employee, communicating with hospital staff by texting her friend who showed the texts to providers, said:

> A 29-year-old female presents to the emergency department, "asthma attack." The patient is speaking in one word sentences, though she does not appear to be in severe respiratory distress, but is unable to give much history. Her companion later shows up and helps with that. She sees Dr. Neeno. She has used an EpiPen today. She is texting with her friend who is here during the interview and showing the texts to help elaborate. She does use inhalers. She does appear to have a history of asthma. She has no fever or chills. She relates that she thinks that her current exacerbation symptoms are related to diesel fumes that she has inhaled at work. She denies any other new symptoms, any other new stressors. . . .

While hospitalized, Employee improved somewhat and then elaborated on her recent, month-long exposure history:

> This is a 29-year-old female with a past medical history significant for asthma, obstructive sleep apnea using CPAP, vocal cord dysfunction, and numerous environmental allergies, who reports that she has been needing to escalate her asthma care over the past month because of exposures that she has encountered on the job. She is in a training program for the Child Support Department and is in an office that is next door to a building that is being renovated. There are significant

> amount [sic] of apparently diesel fumes that she is exposed to on a Monday through Friday basis. She said this has been happening for the past month. She says she has 2 more months of training to go, but she cannot lose her job. She said that she has been escalating her care for her breathing because she is feeling short of breath, tight, and wheezy. . . . She said she'd de-escalate her care on the weekends. . . .
>
> She says she does have vocal cord dysfunction. She has been seen by speech therapist in the past and knows how to do her exercises. However, she has been losing ground because of this exacerbation of her presumed asthma secondary to presumed environmental exposures.
> . . . .
>
> She has prednisone [a corticosteroid] at home which she started 20 mg a day for the past month because of this exacerbation.
>
> She was seen in the emergency room at Alaska Regional December 2014 for a flare-up of her asthma.
> . . . .
>
> She does have seasonal allergies and environmental allergies to "everything." She says lactose seems to make things worse. She is trying to eliminate certain foods that might trigger her flare ups. She says red meat seems to flare her breathing problems.
> . . . .
>
> ASSESSMENT: This is a 29-year-old female with a history of vocal cord dysfunction by history, asthma by history, and she has been having increasing work of [sic] breathing and hypoxia. She believes it is related to environmental exposures at work, which may be the case. It sounds as if on the weekends, she usually gets better, although she deescalates her nebulizer regimen and her Valium regimen. She has been taking very large doses of DuoNebs [aerosolized bronchodilator] in addition to self-medicating with prednisone, and she has been taking Valium to counteract the tremulousness she feels from all her DuoNeb treatments. . . . (Michael Mraz, MD, report, March 15, 2015).

Another physician who also examined Employee while she was hospitalized wrote:

> ASSESSMENT AND PLAN:
> . . . .
>
> 4. Multiple environmental allergies. This is likely the inciting event to her asthma exacerbation. She works in a local office where they are doing a reconstruction. (Terry Lester, MD, report, March 16, 2015).

On March 17, 2015, Dr. Lester stated, "Given the fact that she is returning to an environment that likely has allergens that have exacerbated her asthma, I support her request for FMLA, with my approval through 03/30/2015."

> IMPRESSION:
> . . . .
>
> 1. . . . I suspect environmental allergy related to her work environment. . . .
> . . . .
>
> 4. Multiple environmental allergies. This was likely the inciting event for asthma exacerbation. I have discussed that she needs to contact her human resources department for further options. The patient will not be able to return to work until further evaluation by pulmonary and allergy. This was likely viral or environmental allergy in the ecology. (Lester report, March 17, 2015).
> . . . .
>
> ASSESSMENT AND PLAN:
> . . . .
>
> 1. Acute hypercapnic and hypoxic respiratory failure/asthma exacerbation/hypoxia/leukocytosis. . . . This is suspected to be environmental allergy possibly in her work environment. . . . She may need further environmental modifications at her work to prevent exacerbations. . . .
> . . . .
>
> 4. Multiple environmental allergies likely inciting her asthma exacerbation. She works in a local office where they are doing a reconstruction work. I have instructed her to talk to her human resources person for potential alternate location for work at this time until construction ended. . . . (Lester report, March 17, 2015).

A specialist also examined Employee:

> IMPRESSION:
> . . . .
>
> I discussed this with her in detail, but I feel that her vocal cord dysfunction is not playing a role with the current issues of shortness of breath. . . . (Jerome List, MD, report April 13, 2015).

34) On March 19, 2015, the hospital discharged Employee and Dr. Lester excused her from work until March 30, 2015. (Lester note, March 19, 2015).

35) On March 25, 2015, Employee's spirometry report disclosed "mild restriction." She was taking oral steroids. (Spirometry Report, March 25, 2015).

36) On March 26, 2015, Employee saw her regular asthma physician:

> Asthma: Seen in ER last weekend for asthma exacerbation, for which she was then hospitalized for 2 days. . . . Prior to this she has been really well controlled other than in October after she developed bronchitis and was treated with oral steroids. Symptom [sic] are only associated with being at work due to fumes coming into the building. . . . There is construction going on next door. Many diesel trucks are parking in front of the vent and causing the air quality to deteriorate. [Employee] notes that several people have been treated for respiratory symptoms, the building has been evacuated, the police have been called, a security guard was hired to keep trucks from parking there but this is not very effective, many co-workers are complaining, they are angry and several formal complaints have been made. . . . (AAIC report, March 26, 2015).

37) On March 31, 2015, Dr. Thornquist completed an Americans with Disabilities Act (ADA) accommodation form for Employee. He stated "asthma" was Employee's disability, which was both "long-term or permanent," and, "Intermittent. Exacerbated by temporary fumes at work." She would have difficulty performing all functions of her job. The physician further stated, "During exacerbation, triggered by exhaust fumes at work. Reduced work hours as needed." She, "Cannot work during exacerbation." (Robert Thornquist, MD, report, March 31, 2015).

38) On March 31, 2015, Dr. Neeno at AAIC said Employee had "lifelong" asthma and could not work "until work environment can be stabilized." Her persistent asthma had been "exacerbated by construction near workplace." (Certification of Health Care Provider, March 31, 2015).

39) On April 1, 2015, Gregory Gerboth, MD, examined Employee and removed her from work because of her asthma until April 15, 2015. He too completed an ADA accommodation form and said her asthma was permanent. Dr. Gerboth stated, "Asthma is exacerbated by exposure to: exhaust fumes, dust, smoke & strong odors/smells. Patient reports those exposures have occurred in her work environment." He added, "Patient not able to work in an environment where above exposures occur as that results in an exacerbation of her asthma." Dr. Gerboth stated, "If work environment can be structured such that the above exposures are eliminated then there would be no restrictions. Otherwise, [illegible] cannot work at all." (Gerboth record, April 1, 2015).

40) On May 4, 2015, Dr. Neeno released Employee to return to work with no restrictions. (Neeno note, May 4, 2015).

41) On May 13, 2015, Employer's adjuster wrote Dr. Gerboth, provided its understanding of Alaska law regarding causation, and asked several questions based on that understanding:

> The Alaska Workers' Compensation Board may be called upon to determine whether any aspect of [Employee's] employment with the State of Alaska was the "***substantial cause***" for ***her*** current condition and disability. The Workers' Compensation Act requires that a determination of "***substantial cause***" must be made relative to the contribution of different causes. All causes of the disability or need for medical treatment must first be identified. The ***substantial cause*** must then be determined relative to the contribution of the different causes.
>
> **Alaska Law requires that employment be -- *more than any other cause* -- the substantial cause of the employee's disability or need for medical treatment. Conversely, the employment cannot be the substantial cause if something else is more of a cause.**
> . . . .
>
> Work activities or conditions can be a cause of a condition but only if such activities or conditions are "***the substantial cause***" will they be deemed a legal cause of the condition (emphasis in original).
>
> With this in mind, please state whether [Employee's] work activities or condition on March 29, 2015 [continue] to be "the substantial cause" of respiratory/pulmonary/lungs condition(s) and the need for continuing treatment.

Dr. Gerboth said the work activities or conditions continued to be the substantial cause:

> I did not see [Employee] until after she was discharged from the hospital so I can only base my opinion on historical data provided by the patient. She has asthma which was generally well controlled & did not limit her activity. Only after being in the work environment where she was exposed to strong fumes/exhaust did she have increasing respiratory problems. (Gerboth response, May 19, 2015).

42) On October 9, 2015, Ty Vincent, MD, saw Employee for immunotherapy:

> . . . She is reacting notably less to foods and most inhalants, but still reacts to dust and possibly some chemicals. Her chemical reactions are better than they were before, for sure. Her asthma has been much better with using the doses regularly; she is doing quite a bit worse now having gone nearly three months. She had lost 30# since starting with us in March; but then she gained it all back last month because she was given steroids for a month due to a persistent cough (that was after diesel exhaust exposure at work). She is off the steroids now. (Vincent report, October 9, 2015).

43) On December 18, 2015, pulmonologist Lawrence Klock, MD, saw Employee for an EME. Employee described embarking on a new job as a Child Support Specialist and going through training. She stated that at training, diesel fumes and construction dust entered her area from an adjacent building under reconstruction. Dr. Klock reviewed her medical records and performed an evaluation. He concluded, in relevant part:

> 1. Severe asthma, lifelong, with acute exacerbation and hospitalization in March 2015. At that time, the examinee was acutely ill with respiratory failure and "status asthmaticus." It is my opinion that the diagnosis of asthma was a long-standing and pre-existing condition, but there was an exacerbation of March 2015 secondary to occupational exposure to unknown environmental irritants and alleged automobile exhaust fumes. The examinee is still slowly recovering from this hospitalization.

He added that "the substantial cause" of Employee's acute respiratory failure in March 2015 was "occupationally related environmental irritants." Dr. Klock said Employee had not yet fully recovered and had not returned to her "baseline" asthma status. In his opinion, Employee did not need additional diagnostic studies. Dr. Klock agreed with Employee's treating physicians' recommended treatment, and would change nothing. Employee's asthma was not medically stable, and he could not predict when she would be, but hoped it would occur in six months. Dr. Klock did not expect any permanent impairment resulting from the work exposure. Employee should work in a clean environment without particulate matter, respiratory irritants or noxious fumes or odors. After she improved, Employee should be able to perform her duties as a Child Support Specialist. (Klock report, December 18, 2015).

44) On January 3, 2016, Employee went to the ER for "asthma exacerbation." Her physicians suspected a "viral" infection that exacerbated her asthma. Employee said she had been on "daily steroids for past 6 months since being in a car accident." She took steroids "for inflammation" and not necessarily for asthma. (Alaska Regional Hospital records, January 3, 2016).

45) On February 10, 2016, Dr. Gerboth saw Employee for an asthma reaction to cat dander. She stated her office was moving, which was kicking up dust, and she requested a "letter for work," which he said he would provide. (Gerboth report, February 10, 2016).

46) On March 9, 2016, Employee told Dr. Gerboth that she had lost her job "due to her respiratory status limiting her ability to work." (Gerboth report, March 9, 2016).

47) On March 27, 2016, Employee went to the ER for an asthma exacerbation likely caused by a viral infection. (Alaska Regional Hospital records, March 27, 2016).

48) On June 10, 2016, Employee went to the ER again for an acute asthma exacerbation. (Alaska Regional Hospital records, June 10, 2016).

49) On July 21, 2016, Employee went to the ER for an asthma attack caused by suspected pneumonia and contributed to by smoke from a fire in South Anchorage. (Alaska Regional Hospital records, July 21, 2016).

50) On July 25, 2016, Employee went to the ER for shortness of breath and wheezing for the prior three days. She told providers she had been exposed to exhaust fumes, after which she started seeing Dr. Gerboth. The diagnosis was "asthma exacerbation" apparently caused by smoke from local fires. (Providence Hospital records, July 25, 2016).

51) On September 4, 2016, Employee went to the ER for shortness of breath caused by using a fire extinguisher in her home. (Providence Hospital records, September 4, 2016).

52) On September 5, 2016, she returned to the ER stating she had a small fire in her home and there was still smoke and fire extinguisher powder in the air, which triggered her symptoms. (Providence Hospital records, September 5, 2016).

53) On September 12, 2016, Employee returned to the ER again for asthma treatment and, while there, mentioned suicidal ideation. (Providence Hospital records, September 12, 2016).

54) On September 23, 2016, Employee told Dr. Thornquist she had a history of welding "(used to be a welder)." (Thornquist report, September 23, 2016).

55) On September 24, 2016, Employee had another ER visit for asthma. (Providence Hospital records, September 24, 2016).

56) On October 13, 2016, Dr. Vincent approved a medical marijuana permit for Employee to use edible cannabis, which she had tried and had "dramatic success" with her breathing. (Vincent report, October 13, 2016).

57) From October 28, 2016 through October 31, 2016, Employee was hospitalized to treat shortness of breath and increased wheezing. The diagnosis was "acute exacerbation." The examining physician consulted with Employee's "lung doctor" and they both believed her vocal cord dysfunction and her weight likely play a large role in her ongoing anxiety and in "perpetuating this." (Providence Hospital records, October 28, 2016).

58) On November 23, 2016, Employee visited the ER again for breathing issues attributed to cold weather. (Providence Hospital records, November 23, 2016).

59) On December 12, 2016, Employee went to the ER again for a "suspected allergic reaction" after "taking medications." She had suffered from a head cold two weeks earlier. Employee had been using her EpiPen with minimal relief. Physicians at the ER advised her to stop taking antibiotics, which they thought may be causing her symptoms. Employee wondered if her symptoms could be from her "anxiety." (Providence Hospital records, December 12, 2016).

60) On February 14, 2017, Employee told Dr. Gerboth:

> . . . She states she is doing pretty well with respect to her asthma, although she states she was on the Kenai Peninsula in early February and got sick there and actually went to the emergency room where she was given steroids to take for one week. She has completed those up now and feels as though her breathing is better. . . . (Gerboth report, February 14, 2017).

61) On March 14, 2017, Employee went to Restoration Wellness, LLC, in Wasilla, Alaska, "to establish for medical care." Her immediate concerns were asthma and weight loss:

> [Employee] has had an ongoing struggle with asthma after an exhaust exposure at her place of employment. Overall she has been doing better, but she was seen recently in the ER for exacerbation. . . .

The examiner assessed secondary hypothyroidism, vocal cord disorder, and severe, persistent asthma with an acute exacerbation. (Lydia Peterson, ANP, report, March 14, 2017).

62) On March 24, 2017, Dr. Klock examined Employee again for an EME. He reviewed 1.5 inches of Employee's medical records, which included records since Dr. Klock last examined her in December 2015. He did not have Dr. Vincent's records. After examining Employee, Dr. Klock diagnosed (1) asthma with an acute exacerbation in March 2015 secondary to the occupational exposure at work; (2) morbid obesity, unrelated to the work injury; (3) chronic allergic rhinitis and allergies, unrelated; (4) obstructive sleep apnea, unrelated; (5) vocal cord dysfunction, unrelated; (6) chronic anxiety and depression, unrelated; (7) migraine headaches, unrelated; and (8) Hashimoto's thyroiditis, unrelated. She currently weighed 432 pounds. He added:

> I can see no significant changes, improvement, or signs of stabilization since I last evaluated this examinee in December 2015. It is difficult to state that she has reached any type of "medical stability" because she has required markedly

> fluctuating dosages of corticosteroids, and has received frequent emergency care for asthma.
>
> On two occasions during the past year, flare-ups of her asthma appeared to have been caused by ambient smoke inhalation. . . .
>
> As noted above, I cannot identify any significant period of time where this examinee's medical condition could be described as being stable and improved since the original industrial exposure of March 15, 2015. Her medical course over the past two years has been one of almost continual asthma, with "ups and downs," including slight improvement followed by relapse. She does appear to have corticosteroid-dependent asthma.
>
> As pointed out in the narrative above, this examinee has had moderate asthma since childhood. But prior to the industrial exposure, she had been fully employed, and appeared to have had manageable symptoms.

After reviewing the adjuster's questions, Dr. Klock stated he had no changes to his December 18, 2015 causation opinions. "This examinee has not returned to her pre-injury baseline status." He recommended her pulmonologist perform pulmonary function studies to evaluate her ongoing asthma objectively. Dr. Klock had no recommendations regarding physical therapy, exercise or chiropractic treatments. "She continues to be on an optimal medical program and I would recommend that this be continued." Dr. Klock further stated:

> It is my opinion, that at this time, this examinee's condition does not rise to the threshold of the definition of "medical stability." Over the past two years since the industrial injury, there does not appear to have been any significant time period between 30 to 45 days in which the examinee has been medically stable. There has been fluctuating symptoms along with multiple changes in medications requiring ongoing medical treatment.
> . . . .
>
> During my previous independent medical evaluation, I did not anticipate any permanent impairment. At this time, this cannot be stated with any degree of certainty. I do not believe that permanent impairment can be considered at this time due to the fluctuating nature of the examinee's condition and the lack of medical stability.
> . . . .
>
> This examinee continues to have the same restrictions as before, including working in a relatively clean environment without airborne particulates, respiratory irritants, or noxious fumes and orders.
> . . . .

> Based upon her past two-year history, it does not appear that this examinee could return to her pre-injury employment as described above.
> . . . .
>
> I am not able to predict, determine, or estimate an approximate time when she would be able to return to work.
> . . . .
>
> I believe this examinee could return to gainful employment under the category of sedentary work. (March 24, 2017).

63) On March 27, 2017, Employee visited the ER again for an "acute worsening" of her asthma. She was sitting at home on her couch and was not sure what caused her symptoms. (Providence Hospital records, March 27, 2017).

64) On April 18, 2017, Dr. Gerboth wrote:

> I have been following the patient, [Employee], for 2 years now for problems with severe asthma. Her symptoms initially resulted in her being hospitalized. She has been hospitalized 1 or 2 times since that time for treatment of this.
>
> Her most recent pulmonary function studies were done on April 18, 2017, and revealed that while her lung function has improved slightly compared to studies that were done back in 2015, they still demonstrate significant pulmonary limitations on her activity and ability to do any kind of work that involves any kind of stress.
>
> Because of this, in my opinion, she should be considered temporarily 100% disabled from any job that does not allow her to be sedentary all the time and can be assured that she will not be exposed to any of these agents to which she is quite sensitive. . . .

Dr. Gerboth stated he had written the above letter to facilitate "getting her some type of benefits." (Gerboth letter, April 18, 2017).

65) On April 20, 2017, Dr. Gerboth gave Employee a pulmonary function test. He compared this to her 2015 test and noted "there have [sic] been significant improvement [in spirometric values] since that time." Dr. Gerboth opined that Employee had a "moderate obstructive ventilatory impairment" with good bronchodilator response and "evidence of air trapping." Diffusing capacity was "moderately impaired." (Gerboth letter, April 20, 2017).

66) In apparent response to Dr. Gerboth's April 20, 2017 letter, the adjuster wrote to him seeking his opinion on various topics. He responded:

> Listing causes of the patient's conditions. The patient has problems with asthma that were present at the time I initially saw her as a new patient on April 1, 2015. She had been hospitalized at Alaska Regional Hospital prior to me initially seeing her for a severe asthma exacerbation that required several days of inpatient care. The patient reports that prior to that hospitalization she never really had any significant problems with asthma. She would just have to take an occasional albuterol inhaler very rarely. She says that she would be able to be very active, reporting that she would go on hikes in the mountains surrounding Anchorage and did so without any problems or restrictions. Since my visits with her, the patient has been very limited in her ability to exert herself. She has been admitted to the hospital multiple times and has been seen in my office many times as well.
>
> The patient has no other activities that might have resulted in exacerbation of her asthma. She does not smoke cigarettes. She is not exposed to any fumes or vapors with obvious habits. As mentioned, her only other pulmonary problem is that of obstructive sleep apnea, which also was present prior to me initially seeing her. Historically, it would appear as if the patient's occupational [sic] that occurred that led to her hospitalization in early 2015 resulted in exacerbation of her underlying asthma, although not having seen her before then I cannot say that definitively.
>
> . . . Historically, without having seen the patient before her initial hospitalization, I would say that the patient's exposure that occurred in the work environment that led to her initial hospitalization was the substantial cause of the marked deterioration of her respiratory status. . . .
>
> The patient does have difficulty with significant obesity. When I had first seen the patient, she weighed 407 pounds. She had gotten up to as high as 455 pounds. When she was last seen, she was approximately 435 pounds. Her obesity is no doubt contributing to some of her difficulty with activity. However, she was fairly obese prior to her problems with asthma, so this does not appear to have been a substantive cause in her deterioration of her pulmonary status.
>
> In response to your question, "When did [Employee's] work related disability begin?" I had seen the patient for the first time after hospital discharge where she was cared for by another provider on March 25th 2015, and she was already unable to work at that time. Since that time, over 2 years ago, she has not been able to return to work for more than a very short period of time. As whenever she does, respiratory symptoms deteriorate necessitating either being absent from work, or frequently going to the emergency room and being admitted to the hospital. Therefore [Employee] has been completely unable to work ever since I first saw her on March 25th 2015. I have no personal encounters with her prior to that time so I cannot comment on her ability to work prior to my first encounter with her. (Gerboth letter, May 10, 2017).

67) On July 4, 2017, ER physician Tiffany Peterson, MD, saw Employee who suspected her asthma symptoms may relate to "a 'panic attack' in combination with her asthma exacerbation."

She was on steroids three weeks earlier after an asthma exacerbation while visiting Homer, Alaska. Dr. Peterson diagnosed "asthma exacerbation." (Providence Hospital records, July 4, 2017).

68) On August 29, 2017, Employee returned to the ER, with "shortness of breath" since the prior evening. (Providence Hospital records, August 29, 2017).

69) On September 14, 2017, Employee went to the ER for an asthma exacerbation. (Providence Hospital records, September 14, 2017).

70) On September 28, 2017, Dr. Gerboth wrote to Employee stating he felt "it necessary to inform" her that he was "withdrawing from further professional attendance of [her] medical care." His letter did not give a reason. (Gerboth letter, September 28, 2017).

71) On October 9, 2017, Employee went to the ER for asthma and "difficulty breathing":

> [Employee] is a 32 y.o. morbidly obese female with history of anxiety, asthma and Hashimoto's disease who presents to the ED [emergency department] dyspnea. Patient has been seen every 2 weeks in the past month here in the ED for concerns of dyspnea. She was last seen here in the ED on 9/14/17 for concerns of dyspnea. Patient states that every time she tries to wean down on her prednisone, her dyspnea seems to worsen. She is followed by Dr. Gerboth the pulmonologist. She went down from 15 mg of prednisone daily to 10 mg just 2 days ago and since then her dyspnea has increased. She has been using her DuoNeb and albuterol nebulizer treatments every 45 minutes at home in the past day. Earlier this evening, she noted some swelling of her hands and thought that she may have experienced an allergic reaction. She took some Benadryl which has helped the swelling. . . .

The diagnosis was, "severe persistent asthma with acute exacerbation." Employee told Susan Hayner, MD, that since being involved in a "motor vehicle accident" in March 2015, "she has been on oral prednisone for the most part." She believed her recent asthma exacerbation was related to tapering prednisone. Her asthma "since childhood," was "poorly controlled" particularly in the spring and fall. Employee had recently cared for her friend's dog and thought she may be allergic to it. She also had her own dog to which she thought she may be allergic. The hospital admitted her and discharged her the next day. (Providence Hospital records, October 9-10, 2017).

72) On October 19, 2017, Employee returned to the ER because she had "shortness of breath." She said Dr. Gerboth had recently "fired her," because he told her to go to the ER after an asthma exacerbation, but she did not. Employee said this was a mistake as she was hospitalized at the time. She was tearful about her asthma. (Providence Hospital records, October 19, 2017).

73) On October 25, 2017, Employee saw providers at Restoration Wellness, LLC. On this date she weighed 460 pounds. (Restoration Wellness, LLC report, October 25, 2017).

74) On October 30, 2017, Employee saw ER physicians for fatigue related to her asthma:

> She reports that all of her symptoms started when she had a prolonged exposure to diesel fumes in 2015, she reports asthma exacerbation and that has left her disabled, she reports that she has a disability hearing coming up November 17. She reports [that] currently all of her medical visits are covered by Worker's [sic] Compensation. . . .

Employee weighed 463 pounds. She appeared anxious and endorsed "steroid induced suicidality." Employee declined to see a counselor because she already saw "one once-a-week." Differential diagnoses included steroid induced psychosis; steroid induced weight gain; secondary adrenal dysfunction related to steroids; depression; malingering; anxiety; electrolyte disturbance; pleuritis or pleurisy; acute coronary syndrome; pneumonia; and bronchitis. After reviewing lab and other test results, Jamie Butler, MD, stated, "Patient's report of symptoms is out of proportion to my exam findings." Dr. Butler's final impression was "steroid-dependent asthma." (Providence Hospital records, October 30, 2017).

75) On November 1, 2017, Employee returned to the ER, with back and abdominal pain. The physician noted Employee had been seen six times in the ER since July 4, 2017, all for asthma. The diagnosis was a left kidney stone. (Providence Hospital records, November 1, 2017).

76) On November 3, 2017, Employee had another ER visit for her back and flank pain. (Providence Hospital records, November 3, 2017).

77) On November 4, 2017, Employee had another ER visit for her back and flank pain. (Providence Hospital records, November 4, 2017).

78) On November 22, 2017, Employee went to an ER for an asthma attack with back and chest pain. (Mad River Community Hospital records, November 22, 2017).

79) On November 30, 2017, Employee went to an ER for an out-of-state asthma attack. She related her issues back to her 2015 exposure to diesel fumes. (Banner Lassen Medical Center records, November 30, 2017).

80) By December 15, 2017, Employee had returned home, and went to the ER for shortness of breath. She stated that while in California she developed "extreme anxiety" and shortness of breath. Upon her return to Anchorage, she continued with "symptoms of stress and shortness of

breath." On this date she awoke with worsening shortness of breath. The diagnosis was, "other form of dyspnea" and "anxiety." (Providence Hospital records, December 15, 2017).

81) On December 27, 2017, Employee on referral from Beth Baker, MD, sought treatment with Denali Asthma & Pulmonary Clinic, where David Kingston, PA-C, saw her. She referred to her 2015 work exposure to diesel fumes. Employee now weighed 462 pounds. Pulmonary function tests showed "moderate airways obstruction" with "not significant" response to bronchodilator. (Kingston records, December 27, 2017).

82) On January 22, 2018, PA-C Kingston responded to the adjuster's letter and stated Employee had not been not released to work after his recent examination because of "uncontrolled asthma." Her diagnoses included "severe persistent asthma (uncontrolled)"; morbid obesity; and obstructive sleep apnea. PA-C Kingston recommended "investigation into new injectable therapy for asthma." (Kingston record, January 22, 2018).

83) On January 26, 2018, Employee underwent Cortrosyn infusion. (Providence Infusion Center, January 22, 2018).

84) On February 2, 2018, Patrick Nolan, DO, said that Employee had a good response to her infusion which was a good prognostic sign for getting her off long-term steroids, "if that is going to be possible." (Nolan report, February 2, 2018).

85) In early 2018, Employee underwent therapy for vocal cord dysfunction. She did not reference her work injury with Employer as playing a role in this condition. (Providence Hospital records, February 5, 2018, through April 5, 2018).

86) On February 12, 2018, PA-C Kingston said Employee would be traveling to Seattle, Washington soon. She suffered from severe persistent asthma, vocal cord dysfunction and obstructive sleep apnea, was morbidly obese, and needed accommodation to first-class seating because she would not "fit safely" in coach seats. (Kingston letter, February 12, 2018).

87) On February 23, 2018, Dr. Klock saw Employee for his third EME. He reviewed 3.5 inches of new medical records and examined her. Dr. Klock referred to specific medical records including Dr. Peterson's July 4, 2017 ER report, and noted, "It does not appear that there have been any hospitalizations during the past year." Employee told him that in 2017 she went two months without taking any prednisone, "which is the first time this has occurred for some time." Currently, Employee had been off prednisone for 37 days. She was using Pulmicort in her nebulizer and felt "this has made a considerable improvement in her ability not to take oral prednisone." Employee

lived alone, drove infrequently and rarely went shopping. Her friends assisted her in helping with errands. She told Dr. Klock she was "admitted several times" to the hospital and at one time was hospitalized for four to five days, but he could not find these in his records. Trial injections with Xolair made no significant improvement and were discontinued. He added:

> As I have noted in my previous report, prior to the alleged exposure event in 2015, [Employee] had worked for the Cook Inlet Tribal Council for several years, and did a considerable amount of traveling to remote village sites, and had minimal difficulty with her asthma, although she did have some ongoing symptoms.
>
> I have previously reviewed her past records, but I was provided today with "pre-injury records."

Dr. Klock then summarized pre-injury records beginning in 2010. He paid particular attention to an October 9, 2012 report from AAIC. Dr. Klock noted these records continued through 2013 and Employee was seen on a twice-yearly basis at that clinic. He also noted Employee's ER visit to Alaska Regional Hospital on December 27, 2014. Dr. Klock diagnosed life-long asthma, with acute exacerbation and hospitalization in March 2015 following occupational urgent exposure, nasal allergies and rhinitis, vocal cord dysfunction, chronic anxiety and depression, morbid obesity, hypothyroidism and cholecystectomy. In his opinion, only the acute exacerbation in 2015 was work-related. Dr. Klock found "definite objective improvement" in Employee's asthma since the last time he saw her. He noted that in 2011, Employee's FEV1 was 2.73 liters (77 percent), in May 2015, it was 1.2 liters (35 percent of predicted), and in April 2017, it was 2.29 liters (67 percent). In responding to questions:

> As I have noted previously, the industrial injury or exposure of March 15, 2015, resulted in acute exacerbation of a chronic underlying asthmatic condition, and this was the substantial cause of the aggravation. . . .
> . . . .
>
> It is my opinion at this time, that this work injury of March 15, 2015, caused a temporary aggravation of a pre-existing condition. At this time, it is my opinion, based upon objective pulmonary function studies, that the examinee has returned to a pre-injury status. This is based on objective assessment of pulmonary function findings as I have discussed above.
> . . . .

> Since asthma is a fluctuating disease, it is very difficult to put forth any timeframe or duration. It is now medically stable with regard to her March 15, 2015 industrial exposure.
> . . . .
>
> The exacerbation was the substantial cause of this examinee's asthmatic aggravation, and subsequent treatment. It was during the calendar year 2017, that the symptoms improved, resolved, and she returned to baseline status.
> . . . .
>
> This examinee will require unrelated chronic asthma treatment, just as she had in the pre-injury status which I have documented above.
> . . . .
>
> This examinee will require daily asthma treatment and periodic visits to her pulmonary physician. However, this is unrelated to her industrial injury/exposure.
> . . . .
>
> It is my opinion that there is no permanent impairment as a result of the March 15, 2015 industrial injury. Currently pulmonary function studies have returned to the pre-injury status, indicating no permanent decline or impairment of her pulmonary function studies including spirometry.
>
> Therefore, her chronic permanent asthmatic state is based upon a pre-existing condition, and there is no specific impairment related to the industrial injury.
> . . . .
>
> There are no specific restrictions with regard to the industrial injury. Obviously, ongoing asthma care is required.

Dr. Klock subsequently received more medical records from 2017 and 2018 and reviewed those in an addendum portion to his report. He stated these additional records did not change his opinions from his main report. (Klock report, February 23, 2018).

88) On April 10, 2018, Employer denied Employee's right to all temporary total and temporary partial disability benefits, permanent partial impairment benefits, and medical treatment after February 23, 2018, based on Dr. Klock's report. (Controversion Notice, April 10, 2018).

89) On May 7, 2018, Employee returned for follow-up at "DAP Anchorage" and stated her asthma had stabilized over two weeks. She was on Medicare and Medicaid because her workers' compensation benefits had "been revoked." Employee said her stabilization came from using Fasenra; she had been off prednisone for four months. (DAP records, May 7, 2018).

90) On June 8, 2018, Employee had another Fasenra injection. She denied wheezing or shortness of breath. (DAP records, June 8, 2018).

91) On July 16, 2018, Employee went to the ER for shortness of breath. She reported having been off prednisone for the previous six months "and has felt her breathing improve." However, she had an exacerbation. (Providence Hospital records, July 16, 2018).

92) On September 20, 2018, Employee returned to DAP and stated she was doing well and had "no concerns today." (DAP records, September 20, 2018).

93) On November 6, 2018, Employee returned to DAP, was still doing well and had no concerns. (DAP records, November 6, 2018).

94) On January 16, 2019, Employee reported having had no hospitalizations for asthma for one year. She was "stable subjectively." (DAP records, January 16, 2019).

95) On February 15, 2019, in a form dated November 21, 2018, Employee claimed temporary total disability (TTD), permanent total disability (PTD), and permanent partial impairment (PPI) benefits. She did not request medical care or related transportation expenses, but stated:

> Exacerbation of asthma that led to total disability. Exposed repeatedly to diesel fumes while training in the Child Support Office. Lung took a significant loss in function which led to ample medications, hospitalization and loss of function.
>
> This injury cost me my ability to work, continue my education and basic functionability [sic]. Can't breathe, can't move. The medication used to keep me alive has significantly damaged my body. I spend most of my time in physical therapy, doctors apts [appointments], hospitalizations, emergency visits and need help with daily functioning.

On her claim's flip-side, Employee further explained:

> . . . I am appealing my case closure. I believe my case was closed prematurely. When I went to my IME apt. [appointment] [t]he IME doctor did not have significant medical information to determine the case closure. I have discovered that there are significant time delays between providers/hospitals to send medical and billing information and to workmen's [sic] compensations [sic]. Sometimes the bills don't arrive to the workmen's [sic] compensation workers for six months. In my case some records never arrived to the IME doctor. I was sent to collections on several emergency doctors [sic] bills that were not paid. The hospital ended up forgiving the debts. These bills that ended up in collections never ended up with the IME doctor and possible [sic] before my workmen's [sic] compensation workers. Considering the significant lack of information, I would like my workmen's compensation case to be reinstated.

> From my understanding my pulmonary functions test was used to determine a base-line of my pre-injury status. The pulmonary function test in the past three years have been within less than 24 hours of being on ample bronchial dilators [sic] medications. One medication specifically is Prednisone. When I took the pulmonary function test prior 2015 [I] had little to no bronchial dilators [sic] medication(s). For the most part I was not on Prednisone. It took significant amounts of medication over a three-year period to get data that is consistent to my pre-injury baseline. I have to take [an] injection that I will be on for the rest of my life. I can't function at work, college and even basic daily living activities being heavily medicated. In addition, the extreme weight gain from these medications and injury.
> . . . .
>
> How did the injury happen?
>
> • My understanding is the air intake system for the building is/was in the alley. Diesel fumes were coming into the building through the air intake system in the alley from construction that was being done on another building. Also, because the building is under a parking garaged [sic] during the cold months the diesel fumes come in from the parking garage. The building was evacuated a few times. Other people suffered.
>
> From my understanding my pulmonary doctors are not sure that I will ever be able to work again. Once my pulmonary functions are restored without all the additional medications there is still the damage that has been done to my body by the medications.
> . . . .
>
> . . . Because my case was closed it is harder to get the medical help I need. It is delaying my possible wellness. I need both the finical [sic] and medical support back. Since the medical has been dropped I haven't been able to get all the recommended medical treatments. For example, I was supposed to go through pulmonary rehabilitation and Medicare and Medicaid will only cover so much. I stopped going to speech therapy appointments because my medical coverage was cut with no warning. Getting the medical reinstated alone is a significant piece. I also need the finical [sic]. According to my doctors and even social security [sic] disability I cannot work because of my injury. I can't even clean my own house. I must get help. If I don't get the medical re-instated there is a medication that I am on that I may not receive here soon. Medicare and Medicaid don't pay for it. My doctors have been amazing at getting sample [sic] of the medication since my medical through workmen's compensation was terminated. . . . (Claim for Workers' Compensation Benefits, November 21, 2018).

96) On March 7, 2019, DAP providers diagnosed Employee with severe, persistent asthma, well-controlled on Fasenra. (DAP records, March 7, 2019).

97) On July 31, 2019, Employee's asthma remained controlled. (DAP records, July 31, 2019).

98) On August 12 and August 16, 2019, Employee petitioned for an SIME. (Petitions, August 12 and August 16, 2019).

99) On September 1, 2019, Employee went to the ER for shortness of breath. She was no longer on Fasenra and had returned to prednisone. The assessment was severe persistent asthma with acute exacerbation. (Providence Hospital records, September 1, 2019).

100) On September 5, 2019, DAP suggested Employee try Nucala for her asthma. She continued her Nucala injections at DAP. There was no causation opinion offered in any DAP reports. (DAP records, September 5, 2019).

101) On January 16, 2020, Employee felt especially tired but said she had a daughter "with whom she needs to keep up," but she lacked energy. (DAP reports, January 16, 2020).

102) On April 9, 2020, Employee mentioned her March 2015 work exposure with Employer to her medical provider and felt her issues were still related to that exposure. However, there is no causation opinion in these reports from any physician. (DAP reports, April 9, 2020).

103) In January and February 2021, Employee was hospitalized on numerous occasions for issues related to an ectopic pregnancy. During these early months in 2021, Employee's medical records do not include visits to the ER for her asthma or other asthma-related medical care. (Providence Hospital records, January and February 2021; agency file).

104) On February 24, 2021, Employee told a counselor "my lungs are doing better." (Human Relations Center report, February 24, 2021).

105) On March 31, 2021, Employee told her counselor that she lost a year and one-half after "Workman's Comp." stopped her healthcare; she "has asthma more severe now" in her view. (Human Relations Center report, March 31, 2021).

106) On April 14, 2021, Employee told her counselor it was "really rough with allergies, Epi-pens." She said "records" were slow to get to "Workman's Comp." Employee stated she had been almost two years without "good care/good meds" after "Workers Comp" shut off her medical benefits. (Human Relations Center report, April 14, 2021).

107) On June 18, 2021, Glen Williams, PhD, completed a physician's report form for Employee. The report does not include a case number or injury date. It states the "condition" is work-related from "substance inhalation at worksite." The form refers to an attachment with Dr. Williams'

diagnoses, which include Cushing's Syndrome, and depression and anxiety due to Cushing's syndrome. The provider's handwriting is difficult to read, but the form states in part:

> Tx [treatment] is EOW [every other week] (Psychological). Mode is CBT [cognitive behavioral therapy] and relational therapies. Due to inhaled substance and stress and steroid tx [treatment] Cushing's Syndrome has resulted. Difficult to predict flareups and level of deterioration. The condition is affecting the endocrine system and production of cortisol.
>
> Tx [treatment] is supportive, increasing coping strategies, increase positive self-talk, use resources effectively, cope with emotional upset, encourage self-care, establish realistic goals.
> . . . .
>
> Cushing's Syndrome is listed as an Endocrine Disease on the National Institute of Diabetes and Digestive and Kidney Disease (niddk.nih.gov). (Physician's Report, June 8, 2021).

108) On July 14, 2021, Konrad Kaltenborn, MD, referred Employee to the infusion center for a "Cortrosyn stimulation test." (Kaltenborn report, July 14, 2021).

109) On July 28, 2021, Employee began infusion therapy for "adrenal insufficiency," later referred to as "adrenocortical insufficiency," and then for "eosinophilic asthma." These infusions continued. (Providence Hospital records, July 28, 2021; September 27, 2021; May 17, 2022; September 7, 2022; November 2, 2022; December 28, 2022; February 22, 2023; April 25, 2023, for "mild persistent asthma, uncomplicated"; and May 30, 2023; July 28, 2023; September 22, 2023; and November 25, 2023, for asthma).

110) On February 16, 2022, Dr. Williams wrote to the Social Security Administration:

> I have seen [Employee] therapeutically since 1/15/20. [Employee] presented with depressive and anxious symptoms. She has Cushing's Syndrome (E24.9) due to steroid treatment from industrial exposure to diesel fumes at a previous job (2015).
> . . . .
>
> She recently (Dec. 2021 and Jan. 2022) tried to work at a job which she was qualified for and enjoyed. She was only able to work there briefly due to her body's stress symptoms. She had asked for several adjustments to her work area due to her disability. These weren't provided. Due to the effects of working early mornings, long hours, and stress she started on steroids again to help her lungs. . . . (Williams letter, February 16, 2022).

111) On April 5, 2022, Timothy Murray, MD, saw Employee to establish care for her asthma. The history Employee gave for this visit states:

> 36 y. o. female with history of asthma has been referred to establish care in this clinic. Patient has longstanding asthma since childhood[;] however after an inhalation injury occurring in the workplace in 2015 she has had marked worsened asthma requiring much more aggressive therapy. She was initially started on Nucala with modest benefits and then switched to Fasenra which she has been on for the last 3 years. On Fasenra and her usual inhalers she has had exceptional control for asthma. In the previous 5 years she was in the emergency room 2 [sic] many times to count and on near continuous prednisone. After being on Fasenra for the last 3 years she has required prednisone only once in association with Covid infection. Her last Fasenra injection was in January and she was due in March and is missing her dose. She has had worsening breathing as a result and is [sic] started using her EpiPen at home twice in the last week.
>
> Patient describes shortness of breath, chest tightness, inability to take a full breath and chest congestion. She states this is [sic] all slowly increased since she has missed her Fasenra dose. Patient's breathing has deteriorated to the point where she has started using her EpiPen autoinjectors twice in the last week.
> . . . .
>
> Patient has started a new job [in] the last 3 months where she can work from home.
> . . . .
>
> Occupational Exposure: Previous diesel exhaust inhalation injury that has worsened her asthma. Episode occurred in 2015.
>
> Environmental Exposures: None.
>
> Animal Exposures: Poodle.
> . . . .
>
> Steroids: Prednisone in Dec 2021-2022 (associated with Covid infection)

Employee listed past medical diagnoses; they did not include Cushing's Syndrome. Dr. Murray did not note Employee had any distress, wheezing, congestion or other respiratory sounds. She was not coughing. He also reviewed diagnostic imaging from January 2021, which found Employee had advancing cardiomegaly [enlarged heart], "now moderate in severity." Dr. Murray reviewed Employee's pulmonary function tests from 2015 and 2017 and noted "there has been improvement" over that time. He diagnosed (1) eosinophilic asthma/severe persistent asthma, (2) shortness of breath, (3) [report skipped "3" and mislabeled it "4"], cardiomegaly, (4) decrease

diffusion capacity, (5) obstructive sleep apnea, and (6) history of COVID-19. Dr. Murray recommended an updated pulmonary function test, getting Employee back on Fasenra and future radiographic and allergy testing. He did not offer a causation opinion. Employee weighed 467 pounds on this visit. (Murray report, April 5, 2022).

112) On June 17, 2022, Employee had a pulmonary function test as a preoperative assessment for bariatric [weight loss] surgery. She advised the examiner that she took Combivent one hour before testing because she could not do the test without it and "has never done pulmonary function testing without" taking her inhalers. Employee had switched from oral prednisone use approximately three weeks before this testing. Dr. Gerboth interpreted the test results and found Employee's lung volumes "do not support the diagnosis of restrictive lung disease." He suspected that the "impaired restriction" seen in her spirometry was likely related to her obesity. Employee's diffusing capacity was normal. (Providence Hospital records, June 17, 2022).

113) On July 6, 2022, Sean Lee, MD, bariatric surgeon, saw Employee for a preoperative physical for her expected gastrectomy. Her pulmonologist advised Dr. Lee that she was "sufficiently low risk" to proceed with bariatric surgery. With diet and exercise, Employee had lost five pounds in the prior six months. (Lee report, July 6, 2022).

114) On July 11, 2022, Dr. Thornquist examined Employee by Zoom. She was expecting bariatric surgery on July 14, 2022. "Patient for the most part states her asthma is stable." However, near the end of her Fasenra dosing, she was having "increasing awareness of symptoms." Employee "is allergic to dogs based on allergy test and has a poodle at home." Dr. Thornquist's report repeats the history given previously. (Thornquist report, July 11, 2022).

115) On July 11, 2022, Dr. Murray reviewed Employee's June 17, 2022 pulmonary function test and noted "significant improvement." (Murray report, July 11, 2022).

116) On July 14, 2022, Employee was diagnosed with, among other things, "Morbid (severe) obesity due to excess calories." The medical history taken prior to surgery did not include Cushing's Syndrome. On this date, Employee underwent a laparoscopic sleeve gastrectomy. Her physician opined that her "significant comorbid illnesses" including "moderate" asthma, and were "as a result of [her] refractory morbid obesity." (Providence Hospital records, July 14, 2022).

117) On December 1, 2022, Dr. Gerboth saw Employee and explained that he had seen her in the past but in good conscience did not continue to be her pulmonary provider "due to her inappropriate use of EpiPens." He now saw Employee because her pulmonary physician had

retired, and she needed medication refills. Following her bariatric surgery, Employee now weighed 437 pounds. The history Dr. Gerboth obtained from her still did not include Cushing's Syndrome. He refilled her medications and referred her to the allergy clinic, making it clear he did not want to become her pulmonary provider. (Gerboth report, December 1, 2022).

118) On January 23, 2023, Employee visited the ER for shortness of breath, cough and chills:

> [Employee] is a 37 y .o. female with a history of sleeve gastrectomy, vocal cord disease, asthma, anxiety who presents with shortness of breath. She reports she has really not felt well for the entire winter, since November. She has been having shortness of breath, cough, and cold symptoms. December 28 symptoms got worse and she was seen at urgent care shortly after that and diagnosed with pneumonia. She was treated with prednisone and amoxicillin. She was starting to feel better until 6 days ago when her symptoms got worse again. She was seen in urgent care and diagnosed with COVID-19. She has had persistent shortness of breath and cough. She has not had fevers but has had chills and sweats. . . .

Employee's weight was now 421 pounds. Her respiratory symptoms were attributed to COVID-19. (Providence Hospital records, January 23, 2023).

119) On February 22, 2023, Employee returned to AAIC on Dr. Gerboth's referral. Laura Moore, MD, saw her to establish care for allergies. Employee told Dr. Moore that her allergy and respiratory symptoms were "lifelong." Among other things, Employee reported:

> . . . She previously had oral steroids twice a year prior to 2015 when she had a workman's [sic] compensation injury (exposure to diesel fuel going into her building), she's required oral steroids more often. Patient has been hospitalized once in the last year, but reports numerous hospitalizations in the past, not in the ICU [intensive care unit] since she was younger. . . . She feels she's been diagnosed with pneumonia every few years. . . . She reports daily asthma symptoms, to include shortness of breath on inhalation and exultation. . . .
> . . . .
>
> Assessment & Plan
>
> POORLY CONTROLLED SEVERE PERSISTENT ASTHMA WITHOUT COMPLICATION. . . .
>
> Impression: Patient reports a lifelong history of asthma, worse since 2015 after reported ongoing exposure to diesel exhaust in the parking lot of her place of work. She was previously followed by Dr. Neeno in our office prior to 2015, at which time she was reported as requiring 4-6+ doses of steroids annually for at least the

> prior 10 years. . . . Despite her [various medications], she reports oral steroids 4-5 times a year, and hospitalization at least once a year. . . .

A spirometry report on this date showed "persistent moderate obstruction," and "persistent mild obstruction," presumably after bronchodilation. (Moore records, February 22, 2023).

120) From February 22, 2023, through November 25, 2023, Employee had regular Fasenra infusions. (Providence Infusion Center, February 23, 2023, through November 25, 2023).

121) On September 29, 2023, *Crockett v. State of Alaska*, AWCB Dec. No. 23-0054 (September 29, 2023) (*Crockett III*) found that Employee on August 11, and again on August 16, 2019, had petitioned for an SIME. *Crockett III* stated the deadline by which she had to request a hearing on her claim was May 2, 2025. It directed the parties to attend a prehearing conference "immediately" to discuss Employee's lingering requests for an SIME. *Crockett III* explained the need for Employee to produce medical evidence showing a medical dispute between one or more of her attending physicians and Dr. Klock's third opinion, to justify her SIME requests. Lastly, *Crockett III* stated that if the parties were not able to stipulate to an SIME, "the designee is directed to set the matter on for an SIME hearing, promptly." (*Crockett III*).

122) On December 2, 2023, Employee went to the ER for chest pain. "States that she has not needed to be on steroids since this summer." The examining physician provided no "unifying diagnosis." (Providence Hospital records, December 2, 2023).

123) On March 8, 2024, Daniel Urbach, MD, internal medicine specialist, saw Employee for another EME. She provided Dr. Urbach the following relevant history, summarized for brevity:

- "In the past, exacerbations were usually just in the spring or fall."
- She started a new job with Employer in 2015 and was exposed to diesel fumes, "apparently more or less continuous for three months and at the end of three months," her lungs "gave out" and she was hospitalized.
- "She tells me if she gets a cold, her lungs 'lose their capacity.'"
- "She says she was on prednisone more or less chronically following her 2015 exposure until starting Fasenra and this caused a lot of problems."
- "She does get night-time symptoms."

Employee also completed an intake form, which gave Dr. Urbach a written history:

> In 2015 I was exposed to diesel fumes over the course of three months or so. They came into the building through the air intake system. I was new to the job. I waited years to get that job. So I kept doing treatments but my body gave out. I ended up hospitalized [and] asked to resign so when I got better I could get my job back. I ended up on SSDI [Social Security Disability Insurance] for six years. Lost almost everything in the process. I am working at this time. However, FMLA is the only thing keeping my job in place. I miss too much work. I work from home mostly. So it makes it worse that FMLA is saving my job for now. My boss wants me to resign. I'm trying to get my life back. My lungs are not there yet. My doctors say they may never be what they were. I want to fix it.

Dr. Urbach listed hundreds of pages of Employee's medical records beginning in 2005, including numerous Pulmonary Function Reports. However, he did not summarize or comment on most documents; he just listed them. At this appointment, Employee weighed 398 pounds. On examination, she was breathing "comfortably." Dr. Urbach responded to Employer's questions and diagnosed (1) severe persistent asthma with eosinophilia, (2) severe obesity with a 55.5 BMI, and (3) sleep apnea, vocal cord dysfunction, anxiety when on prednisone, back pain, kidney and ureter disorder, gallbladder disease, kidney stones and migraines, all based on history. He added, in response to a question about "the substantial cause":

> Prior to the exposure, Ms. Crockett had moderate persistent asthma with occasional exacerbations requiring oral steroids. Examples of objective evidence of this are pulmonary function testing showing FEV1/FVC percent predicted ranging between 70 and 89.9 percent prior to the exposure. Following the exposure, she was admitted to hospital with a severe exacerbation of asthma. Illustrative of this is the frequency of prednisone "bursts" over the years prior to exposure. In 2009 she required one prednisone burst, in 2010 she required one burst, in 2012 she required none, in 2013 she required three, in 2014 she required one, in 2015 she required three, and following March 15, 2015, she required continuous prednisone. Beginning in 2018, she was on a monoclonal antibody called Fasenra on which she was able to stay off prednisone. However, for reasons of insurance coverage, this was stopped in 2019 and that year she required three prednisone bursts. Following this, she required monoclonal antibodies (so-called "biologics") in order to stay off prednisone. When she was forced to stop biologics for reasons of insurance coverage, she immediately required bursts of prednisone. As an illustration on April 5, 2022, her provider states the following: "After being on Fasenra for the last three years, she has required prednisone only once in association with COVID infection."
>
> Regarding substantial cause, it is well established that volatile organic compounds, ambient particulate matter, and elemental carbon exacerbate asthma in susceptible individuals. Diesel exhaust contains carbon particles, also called "black carbon,"

> and numerous organic compounds. Examples of these chemicals include polycyclic aromatic hydrocarbons, benzene, formaldehyde, and others. It also contains gaseous pollutants including volatile organic compounds and oxides of nitrogen. These are categorized as low-molecular-weight sensitizers. Quoting from the AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition, page 91 "more than 50 percent of workers with occupational asthma fail to recover completely, even after two or more years since the last exposure and complete avoidance of the workplace." Following her exposure on 3/15/15, she required ongoing oral steroid (prednisone) in order to maintain adequate lung function, something that had never been the case before exposure. This is good evidence that the substantial cause of her severe asthma is the work exposure, which caused her asthma to "light up" and worsen, likely on a permanent basis.

Dr. Urbach stated the following were not substantially caused by the work injury and therefore any treatment for these conditions would not be work-related:

> Severe obesity, while exacerbated by prednisone, was present prior to her 3/15/15 exposure, as documented for example on 5/11/11 at the Alaska Sleep Clinic, where her BMI was 53.4. Therefore, the question is not applicable to severe obesity.
>
> This question is not applicable to sleep apnea, vocal cord dysfunction, anxiety, back pain, disorder of kidney and ureter, gallbladder disease, kidney stones, migraines.

As for additional medical treatment:

> The exposure is the substantial cause of the worsening of her asthma as described above. Additional medical treatment is necessary.

The additional medical treatment should include:

> For her severe asthma she requires targeted type 2 biologics, namely monoclonal antibodies against type 2 proinflammatory mediators. Choices include but are not limited to dupilumab, mepolizumab, reslizumab, and benralizumab [Fasenra]. Frequency and dose will depend on the biologic chosen.

As for medical stability:

> As of the day of evaluation, she is not medically stable with respect to the condition substantially caused by the March 15, 2015 exposure.
> . . . .
>
> She is not medically stable as to the severe asthma substantially caused by the March 15, 2015 exposure. She has just started a new biologic as described above. It takes several weeks for a biologic to become fully effective. At that point,

> assuming there are no advances in available medical treatment, I expect her to be stable, as long as she is able to continue the biologic or one of its cogeners.

As for permanent partial impairment, and notwithstanding the fact Dr. Urbach said Employee is not yet medically stable:

> Her rating, according to the permanent impairment rating table 5-5 on page 90 of the AMA Guides to the Evaluation of Permanent Impairment, Sixth Edition, is currently class 2. Please note that the classes conflict somewhat based on how they are defined. The above definition I am using is based on FEV1. The impairment can also be based on medications used to maintain stability. Unfortunately, biologics are not included in the table using medications, and therefore I could not calculate her rating based on medications.

Dr. Urbach opined that Employee was not, at any time between March 15, 2015, and March 8, 2024, partially or fully able to perform her job, Child Support Specialist I, because of her severe persistent asthma. Dr. Urbach stated, "She was fully unable to do the job because she was unable to maintain stability of her asthma when exposed to any respiratory illness which might have been transmitted to her by a child." She could perform jobs from her home, "which do not include the presence of others who may transmit respiratory infections or other asthma triggers to her." In his opinion, she "will be permanently unable to perform" her Child Support Specialist job. Dr. Urbach opinion set forth in his report assume "the materials are true and correct." He did not diagnose Employee with occupational asthma. (Urbach report, March 8, 2024).

124) On May 28, 2024, Employee filed and served various documents by email. Included with the email were photographs of documents apparently taken with her cell phone camera. The documents, including a Medical Summary form, are too small to read clearly, and when enlarged, are impossible to read because they become pixelated. More readable documents include, an undated "Staff FMLA request for Employee. Under, "Please check reason for leave of absence," Employee checked, "Own serious health condition (not work-related)." The "Work-incurred injury" box is not checked. Employee requested leave "as needed," and signed the form but did not date it. Presumably related to the FMLA Leave Request form, is a "FMLA Medical Certification" form for Employee. On it, she requests leave from March 18, 2024, until March 18, 2025. The portion reserved for the healthcare provider on the form states she has a "Chronic serious health condition," that began in 2015. It was "to be determined" when she could return to work, and she needs an intermittent leave schedule because:

> Patient has severe persistent asthma that flares with variety of triggers including poor air quality, viral infections, and spontaneous requiring intermittent leave to resolve recurrent asthma flares.

PA-C Kingston, with a specialty in allergy, asthma and immunology, signed the medical certification form on March 18, 2024. He stated Employee could perform her job description if her asthma was not flared. These documents were prepared for Nine Star Education & Employment Services, Employee's new employer. Also included from an October 1, 2020 examination, is a "Brain View" Neural Functional Response Test from Denali Healthcare Specialists, LLC. Associated documents include colorful brain avatars, and what may be actual brain images and charts, all unfamiliar to this panel. They include electroencephalogram (EEG), electrocardiogram (ECG) Evoked Potentials, a Neural Functional Response Test and a Behavioral Motor Test results, and various colorful "Headmaps" and other charts and graphs, including BMI measurements. The report states Employee's BMI was 50, which is in the "extremely obese" category. This lengthy document, though providing narrative in some sections, does not appear to provide diagnoses or causation opinions and is not something familiar to, and easily understood by, this lay panel. (Employee email, May 28, 2024, with attachments; observations).

125) On May 29, 2024, the parties appeared for a hearing on Employee's petition for an SIME. Employee agreed that she had been receiving Employer's medical summaries with attached records over the years. When asked if she had reviewed those documents and found any medical disputes, she said yes, she had reviewed the records, but did not clearly state whether she identified any attending physicians' records that disagreed with Dr. Klock's most recently expressed opinions from his third examination. Employee focused on Dr. Klock's second EME opinion, which supported her case, and also relied on Dr. Urbach's March 2024 report and stated she was not sure she needed or wanted an SIME; she leaned toward it "not being necessary." (Record).

126) At hearing, Employee explained how her injury occurred and said she "did not really understand how sick [she] was," at the time, so she just kept trying to work until she no longer could. She cannot wait "for this case to end" preferably "sooner than later." Employee is not sure why March 15, 2015, the administrative injury date assigned to her case, was significant. She was no longer on Fasenra, but had been on a new medication for the prior three months. The only issue Dr. Urbach's report did not address was what happened to "her mind." She knows she is "capable of something." Employee said, thanks to Dr. Urbach's report, she now understood she wrongly

attributed her weight gain to her prednisone use. She now works for Nine Star and has worked there for a little over two years. (Record).

127) She said that the evening prior to the hearing, Employee emailed materials to the Division and copied Moxley. Attached were medical records from a physician who passed away, which Employee has had in her possession since approximately 2020. (Record).

128) Employer contends Employee withdrew her petition for an SIME at hearing and no longer wants one. It did not have a "strong opinion" whether the Board should order an SIME on its own motion. However, were the Board to do so, Employer had a strong opinion as to the specialty. In Employer's view, any SIME should be conducted by a pulmonary specialist; Employee agreed that if ordered, any SIME should be conducted by a pulmonary specialist. Employer also requested that the Board "update" the AS 23.30.110(c) deadline for Employee to request a hearing, which currently sits at May 2, 2025, pursuant to *Crockett III*. (Record).

129) At hearing, the designated chair answered many questions Employee had about her case. He instructed her how to file and serve medical records and medical summaries. The chair suggested she re-file the medical records she filed the night before the hearing. He also recommended she obtain a "Notice of Award" letter from Social Security (which she should have already received upon obtaining these benefits) showing the date upon which she began receiving Social Security disability benefits. The chair directed her to obtain a conditional payment lien itemization from Medicare and Medicaid so if her case settled or went to hearing on its merits, any liens held by those entities could be considered. Lastly, the chair pointed out to Employee that she had not claimed medical benefits and related transportation expenses and told her to amend her existing claim to include those if she was seeking them, which seemed to be the case. He advised Employee that she could amend her existing claim at the next prehearing conference. (Record).

130) SIMEs often require more than one specialty and can take months to arrange, resulting in considerable cost and delay. The more medical records sent to an SIME physician, the more costly the evaluation becomes. (Experience; observations).

PRINCIPLES OF LAW

AS 23.30.001. Legislative intent. It is the intent of the legislature that

> (1) this chapter be interpreted . . . to ensure . . . quick, efficient, fair, and predictable delivery of indemnity and medical benefits to injured workers at a reasonable cost to the employers. . . .

The Board may base its decision not only on direct testimony and other tangible evidence, but also on its "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 23.30.095. Medical treatments, services, and examinations**. . . .
>
> (k) In the event of a medical dispute regarding . . . causation, medical stability . . . degree of impairment, functional capacity, the amount and efficacy of the continuance of or necessity of treatment, or compensability between the employee's attending physician and the employer's independent medical evaluation, the board may require that a second independent medical evaluation be conducted by a physician or physicians selected by the board from a list established and maintained by the board. . . .

The Alaska Workers' Compensation Appeals Commission in *Bah v. Trident Seafoods Corp.,* AWCAC Dec. No. 073 (February 27, 2008) addressed the Board's authority to order an SIME. *Bah* stated in *dicta*, that before ordering an SIME it is necessary to find the medical dispute is significant or relevant to a pending claim or petition. *Bah* said when deciding whether to order an SIME, the Board considers three criteria, though the statute does not require it:

> 1) Is there a medical dispute between Employee's physician and an EME?
> 2) Is the dispute significant? and
> 3) Will an SIME physician's opinion assist the board in resolving the disputes? (*Id*.).

Dwight v. Humana Hospital Alaska, 876 P.2d 1114, 1119-20 (Alaska 1994), addressed former §095(k). That version was similar to the current law but stated that if there was a medical dispute between the employee's attending physician and an EME, an SIME "shall be conducted." On appeal, the injured worker said the Board erred in dismissing her claim and finding she had waived her right to an SIME, because there was a medical dispute, and the Board was thus "required" to order an SIME. Alternatively, she argued the Board was required to "inform her" of her right to an SIME, but did not. Two of *Dwight*'s three holdings are still relevant: (1) in every case the Board is required to give the parties notice of their right to request and obtain an SIME in the event of a medical dispute; and (2) where there is a medical dispute, the Board on its own can order an SIME. The legislature

amended §095(k) post-*Dwight*, removed the "shall" requirement and replaced it with "may," as set forth above. Therefore, under the current statute, the Board "may" order an SIME, or it may not.

> **AS 23.30.110. Procedure on claims**. . . .
>
> (g) An injured employee claiming or entitled to compensation shall submit to the physical examination by a duly qualified physician which the board may require.

Under AS 23.30.110(g) the Board may order an SIME when there is a significant "gap" in the medical evidence or a lack of understanding of the medical or scientific evidence prevents the Board from ascertaining the rights of the parties and an opinion would help. *Bah*.

> **AS 23.30.135. Procedure before the board**. (a) . . . 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. . . .

The American Medical Association, *Guides to the Evaluation of Permanent Impairment*, Sixth Edition, pp. 87-91 (*Guides*), referenced by EME physician Dr. Urbach, state in part:

> **CHAPTER 5**
>
> **THE PULMONARY SYSTEM**
> . . . .
>
> **5.6 Asthma and Other Hyperreactive Airway Diseases**
> . . . .
>
> **5.6b Evaluation of Impairment and Disability**
> . . . .
>
> **Assess Work-Related Asthma**
>
> Although different categories of asthma can be described, they all share an underlying commonality of airway hyperresponsiveness. There are 3 recognized variants of asthma in the workplace: occupational, work-aggravated, and irritant-induced. Occupational asthma represents a special subset of asthma subjects. Occupational asthma is defined as a reversible airflow limitation caused by a specific agent in the workplace. Occupational asthma has now surpassed pneumoconiosis as the most commonly reported occupational lung disease linked to a particular occupational or environmental agent. In addition, besides directly causing occupational asthma de novo, work exposures can also acutely exacerbate a pre-existing underlying asthmatic condition, which typically returns to baseline status with removal from exposure. Such events are recognized as work-aggravated

> asthma. Although potentially very dangerous, this exacerbation is temporary. Irritant -induced asthma, known as RADS (reactive airways dysfunction syndrome), may result from a single massive high-level exposure to a highly irritating gas, mist, or vapor.
>
> A variety of sensitizers (allergens) or irritants can cause occupational asthma. Sensitizers are classified as either high molecular weight or low molecular weight. High-molecular-weight of plant origin include animal dander or grain dust. Such agents are of similar molecular weight to the common antigens associated with exacerbation of asthma outside of the workplace. Low-molecular-weight sensitizers, typically organic or inorganic chemicals, include diisocyanates. These agents are often peculiar to the workplace. Low-molecular weight sensitizers generally require a latency period for the development of immunologic responsiveness. This latency period may last from a few months to several years after first exposure.
>
> There is substantial evidence to show that the best prognosis is obtained through early diagnosis and prompt removal from further exposure as soon as possible after the diagnosis. Yet, not all workers leave the workplace after receiving a diagnosis of occupational asthma. In sensitized workers who remain in the workplace, asthma typically persists, with the potential for severe and even life-threatening exacerbations of asthma upon reexposure. Workers who leave the workplace may improve, yet improvement is not always predictable. More than 50% of workers with occupational asthma fail to recover completely, even after 2 or more years since the last exposure and complete avoidance of the workplace. In those workers in whom asthma persists, a physician needs to monitor the worker's course of asthmatic symptoms.
>
> For individuals with occupational asthma that occurs de novo in the workplace -- those with work-aggravated asthma and in those with asthma after an acute inhalation injury (RADS) -- the issues of employability in certain jobs and job accommodation are separate issues from an impairment rating. Follow-up studies of occupational asthma cases document that recovery is gradual, but most people with asthma related to the workplace have a plateau in their symptoms and lung function about 2 years after removal from exposure to putative agents. It is prudent that final recommendations for permanent impairment in occupational asthma cases be made at least 2 years after the initial diagnosis and removal from exposure. . . .

ANALYSIS

Shall the panel order an SIME on its own motion?

The SIME provision, AS 23.30.095(k), states a prerequisite to an SIME: there must be a "medical dispute" regarding one or more enumerated issues, "between the employee's attending physician and the employer's independent medical evaluation. . . ." In other words, an attending physician

must disagree with the EME's opinion on one or more specified points. The issues on which physicians could disagree include: "causation, medical stability, ability to enter a reemployment plan, degree of impairment, functional capacity, the amount and efficacy of the continuance of or necessity of treatment, or compensability." Without a medical dispute, or at least a gap in medical evidence, there can be no SIME ordered as there would be no need for one. *Bah*. This case is in a peculiar procedural posture, because Employee originally requested an SIME and then at hearing suggested one was no longer needed. Nonetheless, to best ascertain the parties' respective rights in this regard, this decision will review the facts and law to determine if Employee's two SIME petitions should be granted, or in the alternative, if the panel should order an SIME on its own motion, which now appears to be the real issue. AS 23.30.135(a).

Bah said when deciding whether to order an SIME, the factfinders consider three criteria:

1) Is there a medical dispute between Employee's physician and an EME?
2) Is the dispute significant? and
3) Will an SIME physician's opinion assist the board in resolving the disputes? (*Id*.).

These considerations will be addressed in order:

(1) Is there a medical dispute between Employee's physician and an EME?

The short answer to this question is, yes. Nearly five years ago, Employee twice requested an SIME. Various oversights described in detail in *Crockett III*, but not relevant here, resulted in her requests languishing until now. Dr. Klock's third EME report provided opinions upon which Employer controverted her rights to continued benefits. That report prompted Employee's claim and her requests for an SIME. *Crockett III* directed Employee to be prepared to provide, at hearing, medical records showing a medical dispute between her attending physician and Dr. Klock, to support her SIME request. At hearing, Employee did not specifically refer to any records showing medical disputes between her physicians and Dr. Klock in his third EME report. She contended that, based on Dr. Urbach's recent EME report, Employee did not think an SIME was necessary. She was anxious to get this case resolved "sooner than later." Employer said it had "no strong feelings" about the panel ordering an SIME on its own motion. Both parties agreed that if an SIME were ordered, a pulmonary specialist should be chosen to perform it.

Understanding that doctors may be deposed or cross-examined at a hearing, and their opinions may change, the panel reviewed thousands of Employee's medical records to find any medical disputes. AS 23.30.135(a); *Rogers & Babler*. On March 15, 2015, emergency room physicians stated in respect to causation for Employee's asthma exacerbation, "I suspect environmental allergy related to her work environment. . . ." and, "Multiple environmental allergies. This is likely the inciting event to her asthma exacerbation. She works in a local office where they are doing a reconstruction." On March 31, 2015, Dr. Thornquist stated, "During exacerbation, triggered by exhaust fumes at work. Reduced work hours as needed." On the same date, Dr. Neeno commented on Employee's asthma stating it was "exacerbated by construction near workplace." On May 15, 2015, Dr. Gerboth stated the work activities or conditions continued to be the substantial cause of her asthma exacerbation. Nearly two years later on April 20, 2017, Dr. Gerboth said:

> . . . Historically, without having seen the patient before her initial hospitalization, I would say that the patient's exposure that occurred in the work environment that led to her initial hospitalization was the substantial cause of the marked deterioration of her respiratory status. . . .

EME Dr. Klock agreed with these opinions in his first two EME reports. To this point, there are no medical disputes between Employee's attending physicians and EME Dr. Klock. Thereafter, Employee had many opportunities to give her work-exposure history to numerous physicians, and they dutifully recorded it in the "history" portion of their records. However, most did not offer causation opinions -- they just repeated Employee's account. Based on the uncontradicted medical opinions cited above, Employer paid Employee's disability and medical benefits.

The agreement among physicians changed on February 28, 2018, when Dr. Klock saw Employee for his third EME, nearly three years post-exposure. Having reviewed pre-injury medical records that he did not have before, and reexamining Employee, Dr. Klock stated:

> It is my opinion at this time, that this work injury of March 15, 2015, caused a temporary aggravation of a pre-existing condition. At this time, it is my opinion, based upon objective pulmonary function studies, that the examinee has returned to a pre-injury status. This is based on objective assessment of pulmonary function findings as I have discussed above.

Dr. Klock also gave associated opinions and alternate causes for any continuing disability and need for treatment, and medical stability, permanent impairment, and ability to work. His February 28, 2018 report signaled the beginning of the possibility of a medical dispute, should there be an attending physician's opinion that differed from his. The panel of course found medical records before February 28, 2018, that disagreed with Dr. Klock, as cited above, but could find none in Employee's agency file after February 28, 2018, with one notable, possible exception.

On June 18, 2021, clinical psychologist Dr. Williams diagnosed Cushing's Syndrome that he said was, "Due to inhaled substance and stress and steroid tx [treatment] Cushing's Syndrome has resulted." On February 16, 2022, Dr. Williams added, "She has Cushing's Syndrome (E24.9) due to steroid treatment from industrial exposure to diesel fumes at a previous job (2015)." No other physician diagnosed Employee with Cushing's Syndrome, and no EME physician ever commented on it. Thus, although Dr. Williams' raised a new issue, his report did not create a medical dispute between him and Dr. Klock, the only EME physician who had seen Employee at that time, because Dr. Klock never commented about Cushing's Syndrome.

On March 8, 2024, EME Dr. Urbach disagreed with EME Dr. Klock's February 28, 2018 report and attributed all Employee's asthma-related disability and need for medical treatment to her work March 15, 2015 exposure with Employer. This clearly created a medical dispute between two EME physicians, but such dispute does not create a need for an SIME. The medical dispute must be between an attending physician and an EME. AS 23.30.095(k).

Medical records from 2015 through Dr. Gerboth's April 20, 2017 report, disagree with Dr. Klock's February 28, 2018 report. No attending physician provided a medical opinion since February 28, 2018, contradicting Dr. Klock's most recently expressed opinions. Nevertheless, the differences between Dr. Gerboth's 2017 opinion and Dr. Klock's 2018 report create a medical dispute between an attending physician and an EME. AS 23.30.095(k); *Dwight*; *Bah*.

(2) Is the dispute significant?

The answer to this question is, yes and no. In 2017, Dr. Gerboth said Employee's work injury with Employer continued to be the substantial cause of her need for treatment. In 2018, Dr. Klock

said it was not. These are diametrically opposed opinions, and depending upon which if either opinion the factfinders ultimately accept at a merits hearing as correct, one of them may affect Employee's rights to lifelong benefits under the Act. Employee said her asthma medications are extremely expensive. She takes them regularly. Employee claims temporary and permanent total disability benefits. She is relatively young, and were she to succeed on her claims, Employer could be required to provide her with lifelong expensive medications and total disability benefits. Thus, the continuing asthma "causation" dispute between Drs. Gerboth and Klock, while relatively "old" at this point, is "significant" because significant benefits are at stake. *Bah*.

Dr. Williams' Cushing's Syndrome opinion could support an SIME based on an evidence "gap," or a condition with which the panel is unfamiliar. AS 23.30.110(g). But it does not create a dispute under §095(k) because no EME commented on it. Likewise, it does not create a "significant" issue either because no other physician offered that diagnosis. His opinion stands alone. Employee has never listed Cushing's Syndrome as one of her conditions when she gave her medical history and diagnoses to her providers. It appears she does not consider Dr. Williams' Cushing's Syndrome diagnosis work-related or a significant issue either.

(3) Will an SIME physician's opinion assist the factfinders in resolving the disputes?

The answer to this question is more complicated and nuanced. Employee's agency file contains over 3,000 pages of medical records. There is a plethora of expert medical opinions both from treating doctors and EME physicians. The panel has plenty of medical evidence from which to choose, and direction from the *Guides*. Moreover, Employee made it clear she wanted this case resolved "sooner than later." At hearing, though she stopped short from withdrawing her petitions, Employee said she did not think an SIME was necessary given Dr. Urbach's recent report.

Employer had no strong feelings about this panel ordering an SIME. It is well known that SIMEs are expensive, and the more records there are, the longer it takes for the SIME physician or physicians to review them. This increases the SIME cost to Employer. An SIME often delays case resolution by at least months. *Rogers & Babler*. Another opinion will probably not assist the factfinders at this point. Therefore, given the ample expert medical evidence already in the agency file, Employee's stated belief that an SIME is no longer necessary and her desire to resolve this

matter quickly, and Employer's ambivalence on the SIME issue, this decision will deny Employee's August 12 and August 16, 2019 petitions for an SIME, and will not order an SIME on its own motion. *Dwight*. This decision comports with the legislature's expressed intent that these cases ensure "quick, efficient, fair, and predictable delivery of indemnity and medical benefits" to Employee, if she is entitled to them, at a "reasonable cost" to Employer. AS 23.30.001(1).

As this decision will not order an SIME, Employee may be ready for a hearing on her claim's merits. If she is ready, Employee is encouraged to obtain, and file and serve on Employer, an Affidavit of Readiness for Hearing. This form is available on the Division's website under the "Forms" menu. Employee must pay particular attention to the instructions on the form, which is an affidavit. Thus, it must be signed before a Notary Public. If she has any questions about how to complete the form, Employee is directed to contact a Division Workers' Compensation Technician, at 907-269-4980. Once Employee files her Affidavit of Readiness for Hearing form, the Division will schedule a prehearing conference at which time a hearing can be scheduled. Employee is reminded that she should **orally amend her claim at the next prehearing conference to add medical costs and related transportation expenses** as issues for hearing. Employee's considerations *before* she files her Affidavit of Readiness for Hearing and asks the Division to schedule a hearing on her claim's merits include:

- She has a right to obtain an attorney. Attorneys will not charge her attorney fees and any attorney fee awarded will be paid by Employer in the event she prevails at hearing. If she does not prevail at hearing, her attorney does not get paid.
- The burden to file with the Division and serve on Moxley evidence for the hearing to support the benefits she claims, rests on Employee.
- For example, if Employee requests TTD benefits, she should provide in advance of the hearing the dates for which she claims these benefits. She cannot receive TTD benefits if she was working for Employer or for someone else post-injury. She needs to provide medical evidence supporting her inability to work during periods for which she seeks TTT benefits.
- If Employee claims PTD benefits, she must provide medical and probably vocational expert evidence or testimony showing why she is incapable of working at any regular, consistently

available employment given her education, age, experience, and her physical limitations brought about by her work injury with Employer.

- If Employee wants Employer to pay, or reimburse others, for her work-related medical bills, she must provide itemizations from the medical providers, or from Medicare or Medicaid, showing the bills that remain unpaid, or that should be reimbursed to third-party payers such as Medicare or Medicaid.
- If Employee wants Employer to reimburse her for past medical-related transportation expenses, she must provide an itemized "transportation log" showing travel dates and mileage to and from her various medical appointments for work-related medical treatment.
- If Employee wants PPI benefits from Employer, she must provide evidence of a PPI rating done in accordance with the *Guides*, done after she becomes medically stable as defined in the Act. If Employee's believes she is not yet medically stable, she should withdraw that issue from hearing as it would not yet be "ripe."
- Any and all evidence upon which Employee intends to rely at a merits hearing must be filed with the Division and served on Moxley by no later than 20 days before the scheduled hearing date. This does not mean Employee must or even should wait until 20 days before the hearing; it signifies the latest date upon which the evidence may be filed so that a panel may rely upon it at hearing. She should obtain her evidence immediately and file and serve it as soon as she gets it. Employee is reminded to serve any documents she files with the Division on Moxley, contemporaneous with filing it, or the evidence may not be relied upon at a hearing.
- Lastly, she must ask for a hearing to be scheduled by filing her Affidavit of Readiness for Hearing by no later than **May 2, 2025**, or her claims may be denied under the applicable statute of limitations. Employee should review *Crockett III* for more information.

At hearing, Employer asked the panel to "update" the deadline for Employee to file her Affidavit of Readiness for Hearing, but provided no specific reason why the date should change. Given there no reason to do so, and since this decision does not order an SIME, Employee's deadline date for filing her Affidavit of Readiness for Hearing remains **May 2, 2025**.

For future reference, Employee is directed to email medical summaries to the Division at the Division's email address and include the medical summaries and related medical records **as a PDF**

attachment to her email and simultaneously email a copy to Moxley. The emailed medical summary and records Employee sent to the Division the night before hearing were photographs and were not readable. She is also directed to file on medical summaries and serve on Moxley any medical records relevant to her case **within five days after receiving the records**. Employee testified that she had at least one of the records she filed the night before the hearing, since 2020. **She should not re-file duplicate documents that Employer has already filed**.

CONCLUSION OF LAW

The panel shall not order an SIME on its own motion.

ORDER

1) Employee's August 12 and August 16, 2019 petitions for an SIME are denied.
2) The panel will not order an SIME on its own motion.

Dated in Anchorage, Alaska on June 24, 2024.

ALASKA WORKERS' COMPENSATION BOARD

/s/
William Soule, Designated Chair

/s/
Randy Beltz, Member

/s/
Bronson Frye, Member

PETITION FOR REVIEW

A party may seek review of an interlocutory or other non-final Board decision and order by filing a petition for review with the Alaska Workers' Compensation Appeals Commission. Unless a petition for reconsideration of a Board decision or order is timely filed with the board under AS 44.62.540, a petition for review must be filed with the commission within 15 days after service of the board's decision and order. If a petition for reconsideration is timely filed with the board, a petition for review must be filed within 15 days after the board serves the reconsideration decision, or within 15 days from date the petition for reconsideration is considered denied absent Board action, whichever is earlier.

RECONSIDERATION

A party may ask the board to reconsider this decision by filing a petition for reconsideration under AS 44.62.540 and in accordance 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 accordance 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 Interlocutory Decision and Order in the matter of Felicia Crockett, employee / claimant v. State of Alaska, self-insured employer / defendant; Case No. 201507018; dated and filed in the Alaska Workers' Compensation Board's office in Anchorage, Alaska, and served on the parties by certified U.S. Mail, postage prepaid, on June 24, 2024.

/s/
Rochelle Comer, Office Assistant II