ALASKA WORKERS' COMPENSATION BOARD

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

BRUCE J. BROWN, Employee, Claimant, v. ASRC ENERGY SERVICES, Employer, and ARCTIC SLOPE REGIONAL CORP., Insurer, Defendants.	)	INTERLOCUTORY DECISION AND ORDER AWCB Case No. 200820295 AWCB Decision No. 14-0129 Filed with AWCB Anchorage, Alaska on September 24, 2014

Bruce J. Brown's December 20, 2010 claim, as amended June 1, 2011, was heard on August 19, 2014 in Anchorage, Alaska, a date selected on March 25, 2014. Non-attorney representative Claire L. Keene appeared and represented Bruce J. Brown (Employee). Attorney Robert J. Bredesen appeared and represented ASRC Energy Services and Arctic Slope Regional Corp. (collectively, Employer). Witnesses were Claire L. Keene and Lindsey Brown for Employee, and Brent T. Burton, M.D., and Lynn Palazzotto for Employer.

As a preliminary matter, the hearing panel considered Employee's July 25, 2013 petition to strike medical summaries from May 30, 2013, June 11, 2013, and June 19, 2013. After deliberation, the panel issued an oral order denying the petition, and proceeded to hear the merits issues raised in Employee's amended claim. On August 26, 2014, the board notified the parties it intended to take official notice of some or all of twelve facts contained in a document it had prepared entitled, *Quotations from the Centers for Disease Control and Prevention Website.* The record

closed on September 4, 2014, after the parties had a reasonable opportunity to present evidence or authority to refute the officially noticed facts.

ISSUES

In preparation for the hearing, the board designee discovered a July 25, 2013 petition, filed by a former non-attorney representative for Employee, to strike medical records attached to summaries dated May 30, 2013, June 11, 2013 and June 19, 2013 as "immaterial, impertinent or scandalous matter." Employer answered on August 2, 2013, deeming the petition spurious, but the dispute was never resolved. At an emergency prehearing on August 15, 2014, the parties stipulated to argue this dispute as a preliminary issue at the August 19, 2014 hearing. Employee had not read the petition, medical records, or Employer's answer prior to hearing, and a recess was taken to enable him to do so.

Employee and his current non-attorney representative first narrowed the issue to contend treating physician Dr. Gonzalo Fraser's records from May 30, 2006 to June 27, 2007 should be stricken as irrelevant to the work injury, and possibly obtained without Employee's permission. After expressing some confusion, Employee later agreed he had signed broad medical releases and Employer had properly obtained the records; Ms. Keene contended Dr. Fraser's records were not relevant, but also stated she didn't see their inclusion as a "big problem."

Employer contended it legally obtained Dr. Fraser's records via a board-authorized subpoena. Employer further contended they were relevant because they documented prescriptions for narcotic painkillers, and Employer's Medical Evaluation (EME) physician Dr. Brent T. Burton opined Employee's histories of intravenous drug abuse, chronic pain complaints and drug-seeking behavior were among the substantial causes for the work injury.

After deliberation, Dr. Fraser's records were found relevant and Employee's petition to strike was orally denied. After being reassured he would be able to address the issue of drug use in his testimony, Employee said, "that's what my point was" and thanked the panel, thereby effectively resolving the dispute.

1) ***Was the oral order denying Employee's July 25, 2013 petition to strike medical records filed May 30, 2013, June 11, 2013 and June 19, 2013 proper?***

Employee contended his pneumonia and sepsis may have been caused by, or the result of, an infectious disease contracted on the worksite. If so, Employee's illness, medical treatment and resulting disabilities would be compensable under the Alaska Workers' Compensation Act (Act).

Employer contended the substantial cause of Employee's injury and resulting disabilities was a history of drug use that weakened his immune system. Employer contended no medical evidence establishes exposure to a pathogen at work caused Employee's pneumonia and sepsis.

2) ***Did Employee's disability or need for medical treatment arise out of and in the course of his employment with Employer and, if so, to what benefits is he entitled?***

In the course of deliberating the merits of this case, the hearing panel noted both gaps in the medical record and its own lack of understanding of the medical evidence. In order to best ascertain the rights of the parties, the panel therefore decided to (1) take official notice of medical facts from a source whose accuracy cannot reasonably be questioned; and (2) order an Second Independent Medical Evaluation (SIME) records review.

On August 26, 2014, the hearing panel notified the parties it intended to take official notice of "some or all" of twelve facts regarding influenza, contained in a document entitled, *Quotations from the Centers for Disease Control and Prevention Website*. The hearing record was held open through September 4, 2014, to give the parties reasonable opportunity to present evidence or authority to refute the officially noticed facts.

In its Limited Objection to the Board's Invocation of Administrative Notice, Employer contended the board was not authorized to use Centers for Disease Control and Prevention (CDC) information to independently derive specific medical conclusions or to decide the merits of a medical case, without testimony by an expert to explain the officially noticed material. Employer contended the

website information is admissible hearsay if it is used to supplement and explain the EME opinion, but it may not be used to reach conclusions contrary to the EME physician's "ultimate opinions."

Employee did not present evidence or authority to refute the officially noticed facts. It is therefore assumed he did not oppose their inclusion in the record.

The SIME issue was not discussed at hearing. However, because Employee expressed his interest in obtaining one at a prehearing conference on April 23, 2014, it is assumed he would have no objection to a board-ordered SIME.

Employer contended a SIME records review under AS 23.30.110(g) was the proper means to investigate medical matters and obtain more information with which to evaluate the EME opinions.

3) ***Was the decision to take official notice of facts from the Centers for Disease Control and Prevention proper?***
4) ***Should an SIME be ordered?***

FINDINGS OF FACT

The following facts and factual conclusions are either undisputed or established by a preponderance of the evidence:

1) On December 25, 2008, Employee experienced breathing problems while working as a mechanic for Employer at the Northstar Island drilling platform. Employee, in upper respiratory distress, was medivaced to Anchorage for treatment. Upon arrival at Providence Alaska Medical Center (Providence), Employee was coughing up blood and was intubated and placed on life support. (Report of Occupational Injury or Illness, undated.)

2) Employer did not accept Employee's condition as compensable. A factual and procedural case history is recorded in:

a) *Brown v. Arctic Slope Regional Corp.*, AWCB Decision No. 12-0048 (March 8, 2012) (*Brown I*), denying Employer's petition to dismiss for failure to cooperate with discovery, and ordering Employee to sign releases and participate in a deposition;

b) *Brown v. Arctic Slope Regional Corp.*, AWCB Decision No. 13-0062 (May 30, 2013) (*Brown II*), granting Employer's petition to strike Employee's request to cross-examine the authors of medical records, and admitting the disputed July 5, 2012 medical summary and attached medical documents, dated December 25, 2008 through January 21, 2009, as business records;

c) *Brown v. Arctic Slope Regional Corp.*, AWCAC Order (August 26, 2013) denying Employee's petition for review of *Brown II*; and

d) *Brown v. Arctic Slope Regional Corp.*, AWCB Decision No. 13-105 (August 29, 2013) (*Brown III*), granting Employee's petition to change venue from Fairbanks to Anchorage.

This factual recitation incorporates the relevant findings of all the above and addresses only the issues currently in dispute.

3) On June 26, 2006, treating family physician R. Lynn Carlson, M.D., saw Employee, who had recently been exposed to pneumonia and was interested in obtaining antibiotics. Dr. Carlson assessed bronchitis and prescribed Zithromax. (Carlson progress note, June 26, 2008.)

4) On August 28, 2008, Employee saw Dr. Carlson, who suspected pneumonia and wrote a letter excusing Employee from work for the next week. (Carlson progress note and letter, August 28, 2008.)

5) On August 28, 2008, Employee's chest was x-rayed. Radiologist Harold Cable, M.D., noted "a rounded area of radiodensity in the supradiaphragmatic region" that "may represent rounded pneumonia or rounded atelectasis." (Cable radiology report, September 15, 2008.)

6) On August 29, 2008, Dr. Carlson prescribed a course of Zithromax. (Carlson progress note, August 29, 2008.)

7) On September 5, 2008, Employee saw Dr. Carlson for a pneumonia follow-up. Dr. Carlson diagnosed a cough and recent pneumonia, and wrote a letter excusing Employee from work missed "this week and next." (Carlson progress note and letter, September 5, 2008.)

8) On September 23, 2008, Employee saw Dr. Carlson, who noted resolved pneumonia and approved Employee to return to work. (Carlson progress note, September 23, 2008.)

9) On September 25, 2008, Employee's supervisor sent him to see PA-C Leanne Buck, Northstar Island's onsite medical provider, to be "checked out" to determine whether he was ready to resume work after a "six-week course" of pneumonia. The clinic note indicates Employee worked the previous night without problems and had no complaints, though he felt he

needed some time to regain his strength. PA-C Buck's assessment was resolving pneumonia; acute, situational insomnia; and smoking cessation. Employee was advised to continue treatment as needed and return to the clinic if his symptoms persisted. (Buck clinic note, September 25, 2008.)

10) On October 23, 2008, Employee was interviewed by ACT AES Safety Specialist Robert J. Olsen, who opined on ASRC Energy Services letterhead, "I have concluded from the conversation with Bruce that there aren't any issues with drugs or alcohol that would be areas of concern. Bruce seems like a dedicated and caring individual that truly likes his job and working for ASRC. He is well liked by our client BP and should be allowed to continue working in his present capacity." (Olson memo, October 23, 2008.)

11) On November 4, 2008 PA-C Buck gave Employee an influenza shot and a "fit test" in which Employee passed all components. (Buck clinic note, November 4, 2008.)

12) On November 6, 2008, PA-C Buck reviewed test results from Employee's fasting blood sample, collected November 4, 2008. PA-C Buck wrote on the report the medical shorthand for influenza with Pneumocystis carinii pneumonia, but the record includes no evidence she treated Employee for either. (Quest Diagnostics report, November 6, 2008.)

13) On November 7, 2008, treating internist Dr. Patrick Brady, M.D., wrote:

> I have been treating Bruce for liver, kidney and immune system function. To monitor his progress, we have been taking blood and urine samples. At the beginning, it was twice a month for blood and urine. Due to his improvement, this testing has been tapered off and now Bruce is only required to take a blood sample every three months. The purpose of these blood and urine samples is to monitor the progress of his kidney and liver functions and his immune system. (Brady narrative report, November 7, 2008.)

14) On December 16, 2008, Employee was seen by treating general practitioner Joan Itano, ANP, for chronic degenerative disc disease. ANP Itano prescribed Oxycodone every six hours, and Xanax and Flexeril twice daily. She noted Employee would be returning to the North Slope for two weeks starting the next day. (Itano progress report, December 16, 2008.)

15) At the current hearing Employee testified he was not sick when he arrived at Northstar Island on December 17, 2008. (Brown.)

16) Employee testified that in the weeks before the disputed illness, he had not noticed anything wrong with his health. When asked, "Do you remember having any sort of signs leading up to this incident that there was – you know, even looking back now, something was wrong for a day

or two or a week before the incident happened?," Employee responded, "No." (Employee deposition, pp. 35-36, May 3, 2012.)

17) On December 22, 2008, Employee saw PA-C Buck and reported a sudden onset of sore throat and fever. PA-C Buck noted Employee had a significant history of respiratory illness, including a two-month course of pneumonia, and a negative lab test for influenza, though the specifics of this test are not noted. (Buck clinic note, December 22, 2008.)

18) Shortly after midnight on December 25, 2008, Employee was found somnolent in the TV room on Northstar Island. Employee complained of fever, fatigue, and increased breathing difficulty over the last day. PA-C Buck noted "rapid breathing, hot, lethargic" and assessed "fever [secondary] to pneumonia? respiratory illness." PA-C Buck contacted LifeMed Alaska, LLC, whose chart notes indicate the chief complaint was respiratory distress, with a sore throat of 3-days duration, and a history of hepatitis C, pneumonia and smoking. A critical care team transported Employee first to the Deadhorse clinic, and then to Providence. (Buck clinic note, December 25, 2008 (mistakenly dated February 24, 2008); LifeMed Alaska chart notes, December 25, 2008.)

19) On December 25, 2008, Providence emergency medicine specialist Anson Cheng, M.D., noted Employee "seemed to have some difficulty answering questions given his respiratory distress." An "influenza A swab was positive." Dr. Cheng's clinical impression was pneumonia, respiratory failure, influenza A, and hypotension. (Cheng emergency admit report, December 25, 2008.)

20) Providence's Abstract Summary Form for Employee indicates internist Javid Kamali, M.D., admitted Employee on December 25, 2008, with a diagnosis of pneumonia, organism unspecified, and a principal diagnosis of septicemia unspecified. Secondary diagnoses included influenza with pneumonia, methicillin susceptible pneumonia due to Staphylococcus aureus, and pneumonia due to E. coli. (Providence Abstract Summary Form, January 23, 2009.)

21) On December 25, 2008, Dr. Kamali issued an admission history, based on information obtained from the emergency room, paperwork, and Employee's daughter, Lindsey Brown. Dr. Kamali wrote, "[r]eportedly, the patient has been complaining of sore throat and fever over the last couple of days" and he was admitted for respiratory failure and septic shock. Dr. Kamali noted Ms. Brown "ha[d] not been involved in his medical issues very much" but stated her father had been "sick over the last couple of months with multiple upper respiratory infection[s]" and

"has had a 'weak immune system'." Dr. Kamali noted Employee was positive for influenza A. Dr. Kamali concluded Employee was in critical condition, with "multi-organ failure including cardiac, respiratory and renal at minimum" and the prognosis was poor. (Kamali admission history and physical examination, December 25, 2008.)

22) On December 27, 2008, Employee was evaluated by internist and infectious disease specialist Paul L. Steer, M.D., whose impressions included "probable influenza" and "major bacterial bronchopneumonia with right upper lobe dense consolidation and patchy other infiltrates – questionable pulmonary aspiration, questionable Staph aureus superinfection." Dr. Steer recommended continued treatment with Tamiflu "for now":

> Although the reported influenza A circulating in The Lower 48 States this year is said to be 50% resistant to Tamiflu, we do not have anything else to offer and thus the empiric treatment that you are doing seems appropriate. There is a possibility this was a false-positive nasal smear that was obtained in the emergency room, but in either case would treat. (Steer consult report, December 27, 2008.)

23) In the morning of December 28, 2008, Employee was evaluated by internist and critical care specialist Ryan McGhan, M.D., who noted he had discussed the case with Dr. Steer. Dr. McGhan assessed influenza and multi-organ system failure, including respiratory failure secondary to acute respiratory distress syndrome (ARDS), and reiterated Employee was critically ill. (McGhan progress report, December 28 a.m., 2008.)

24) In the afternoon of December 28, 2008, Dr. McGhan's assessment was severe pneumonia and influenza, including respiratory failure secondary to pneumonia and ARDS. Dr. McGhan's plan included continuing antibiotics for influenza, MSSA (methicillin-sensitive Staphylococcus aureus) and E. coli. (McGhan progress report, December 28 p.m., 2008.)

25) On December 30, 2008, Dr. McGhan's assessment was influenza and severe sepsis, again including respiratory failure secondary to pneumonia and ARDS. (McGhan progress report, December 30, 2008.)

26) On December 30, 2008, pathologist Sharon M. Tobias, M.D., reported that cells collected in a December 26, 2008 bronchoalveolar lavage were negative for Pneumocystis carinii. (Tobias cytology report, December 30, 2008.)

27) On January 15, 2009, Dr. McGhan prepared an "interim summary" in which the diagnoses included right upper lobe pneumonia and influenza. Dr. McGhan noted the microbiology on December 25, 2008 revealed influenza, E. coli and MSSA. Dr. McGhan stated Employee's

influenza was treated with Tamiflu and had resolved. Dr. McGhan opined Employee's pneumonia was "likely a post influenza bacterial pneumonia" that was positive for E. coli and MSSA. Dr. McGhan noted Employee experienced "marked delirium" and was receiving Haldol around the clock. (McGhan interim summary, January 15, 2009.)

28) On January 21, 2009, Employee was transferred to St. Elias Specialty Hospital, where he was evaluated by family practitioner Robert D. Church, M.D., who certified he met the "severity of illness and intensity of service criteria" for admission to long-term acute care. (Providence Abstract Summary Form, January 23, 2009; Church history and physical, downloaded January 24, 2009.)

29) On January 26, 2009, Hospitalist Joseph Lestina, M.D., completed a Certification of Health Care Provider form in which he opined Employee was currently unable to perform work of any kind, due to respiratory failure and sepsis, generalized weakness, and altered mental status, all of which were resolving. (Lestina certification, January 26, 2009.)

30) On January 30, 2009, while still in St. Elias Specialty Hospital, Employee was presented with an ASRC Energy Services form, asking him to describe in his own words what happened, what he saw, and what in his opinion caused the accident. Employee wrote, "Got sick. Had medevac. I don't feel it's work related. Because I got sick at home previssly [sic]. (before)." When asked at his deposition on May 3, 2012, if he "actually recall[ed] writing" the statement, Employee responded, "Vaguely. You know, it was a pretty hazy time." At hearing Employee testified at the time he wrote this statement he was still coming off a drug-induced coma and things were pretty hazy. (Employee written statement, January 30, 2009; Employee deposition, p. 43, May 3, 2012; Brown.)

31) Employee was discharged from St. Elias on January 31, 2009. Discharge diagnoses included necrotizing pneumonia and altered mental status. (Discharge summary, January 31, 2009.)

32) On February 3, 2009, Dr. Carlson referred Employee to physical therapy, noting diagnoses of "[r]ecent severe pneumonia, sepsis, severer [sic] ongoing weakness, influenza, [low back pain], [l]eg pain, [arthritis]." (Carlson patient orders, February 3, 2009.)

33) On March 31, 2009, Employee saw Dr. Carlson, who noted Employee stated he felt ready to return to work. "At work the main concern is his susceptibility to contract colds." Dr. Carlson wrote "OK for work, no restrictions." (Carlson progress note, March 31, 2009.)

34) On April 27, 2009, Dr. Carlson noted Employee needed a letter releasing him to work. Dr. Carlson stated he believed he has written such a letter on April 22, 2009, but that the clinic computer lost the record of it. Dr. Carlson wrote another letter certifying he had released Employee to work as of April 22, 2009. (Carlson progress notes and letter, April 27, 2009.)

35) On February 13, 2010, Employee presented at Central Peninsula Hospital with a cough productive of green and yellow sputum, and complaining of fever, shortness of breath, and sore throat. He was assessed with acute bronchitis and hemoptysis, prescribed Zithromax, and provided with an albuterol inhaler, and an Aerochamber. (Hospital emergency room note, February 13, 2010.)

36) On January 5, 2011, Employee filed a workers' compensation claim seeking temporary total disability (TTD) benefits from December 25, 2008 through "about April 09," permanent partial impairment (PPI) benefits, medical costs, transportation costs, compensation rate adjustment, penalty, interest, a finding of unfair or frivolous controversion, and attorney's fees and costs. Employee described the illness as:

> 2 or 3 days prior to being medevaced out of the North Slope, I hadn't been feeling well because of a stomach ache & saw the P.A. I was treated with an antibiotic for a sore throat & fever. I woke up the 24th and wasn't feeling well but went to work. After a few hours I laid down in the T.V. Room and ended up passing out. I was medevaced to Providence Med. Center on 12-25-08.

Employee listed the injured body parts as "[l]ungs, bloodstream, basically the whole body," and described the nature of his illness as "I was admitted to the Providence Emergency Room for E. Coli and Influenza A and ended up in respiratory failure and septic shock. From the E.R. I was transferred to the I.C.U. and was in a coma for approximately 3-4 weeks." (Claim, December 20, 2010.)

37) On January 26, 2011, Employer filed a controversion of TTD from 12/25/08-4/30/09, PPI, medical and transportation costs, compensation rate adjustment, penalties, interest, unfair or frivolous controversion, and attorney's fees and costs, based on a lack of medical evidence linking Employee's illness to his work for Employer. (Answer and controversion, January 25, 2011).

38) At a prehearing conference on June 1, 2011, Employee "generally described the nature of his claim: he got [E. coli] poisoning at work and had to be resuscitated. [Employee] can't return to work, has problems breathing, and has suffered weight loss, a loss of motor skills and memory

loss." The parties stipulated to amend Employee's December 20, 2010 claim, rendering the TTD claim open-ended, rather than ending "about April 09." (Prehearing conference summary, June 1, 2011.)

39) On June 17, 2011, Employer filed a controversion of benefits sought in Employee's June 1, 2011 amended claim. (Controversion, June 15, 2011.)

40) At a May 3, 2012 deposition, Employee described his cognitive impairment since the accident:

> **Q: Do you have any reason to believe that your ability to understand and respond to questions is in any way impaired today?**
> A: Just the normal – you know, from my accident.
> **Q: Okay. And what is the normal? Can you describe it?**
> A: Well, sometimes I don't understand things, you know. When I woke up in the hospital after, you know, I don't know how long – anyway, they told me I had ADD or whatever, which I never had that. And I just don't. . .

At hearing Employee testified he had suffered a brain injury and could not "remember stuff" after the work injury. (Employee deposition, pp. 3-4, May 3, 2012; Brown.)

41) On July 16, 2012, Michael L. McLaughlin of Professional Paralegals entered his appearance on behalf of Employee. (Division database.)

42) On November 27, 2012, Dr. Brent T. Burton, M.D., M.P.H., who identified his specialty as occupational and environmental toxicology, issued an EME report based on records review. Dr. Burton opined:

> In addition to [Employee's] recently diagnosed necrotizing pneumonia, the medical records document multiple and significant underlying medical conditions, which include the following:
>
> - History of intravenous drug abuse, including heroin and, possibly, cocaine. Hepatitis C secondary to intravenous drug abuse.
> - Indeterminate smoking history with reported periods of cessation and resumption.
> - History of chronic pain complaints and drug-seeking behavior.
> - History of GERD [gastroesophageal reflux disease].
> - History of hypercholesterolemia.
> - History of shoulder dislocation followed by chronic pain complaints.
> - History of reported alcohol abuse.
>
> [Employee's] most significant risk factors for the development of pneumonia include his intravenous drug abuse, smoking history, and GERD.
> (EME report, p. 15, November 27, 2012.)

43) Dr. Burton opined Employee developed severe pneumonia due to infection with E. coli and MSSA, organisms "ubiquitous in the environment" and "colonized on the skin and within the gastrointestinal tract." Dr. Burton opined Employee "developed infection with these organisms and the subsequent necrotizing pneumonia in the absence of any identifiable workplace factor. Whether at work, at home, or in any other conceivable environment, he would have developed the same illness." (*Id.*, pp. 15-16.)

44) Dr. Burton noted "medical records indicate the proposed role of influenza A as an etiologic agent in the production of his pneumonia." However, Dr. Burton opined

> there are no data to support this hypothesis as a work-related exposure. Though it is possible that a severe case of influenza A may precipitate the development of a complicated pneumonia, the invocation of such a theory is unnecessary to explain the onset and clinical course of [Employee's] pneumonia. . . . There was never any clinical indication that he actually had influenza A. Moreover, the incubation time required to develop influenza and the development and progression of clinical illness would place the time of exposure prior to his shift on the North Slope.

Dr. Burton opined Employee "has a significant history of multiple factors that place him at risk for developing respiratory infections, including the acute necrotizing pneumonia encountered during December 2008," and concluded "[t]here are no workplace activities that have been identified, nor any environment at the workplace, that resulted in exposures to infectious agents that may have produced his pneumonia." (*Id.*, pp. 16-17.)

45) On February 4, 2013, Employee met with treating physician Dr. Carlson to review recent bloodwork. Dr. Carlson noted:

> [Patient] has never been able to discover what actually happened to cause [the December 25, 2008 illness]. . . . Others are claiming that this is not work-related, and that it could have happened anywhere. . . . The key point of the case is whether or not he got strep while on the slope. [Patient] is exposed to sick people on the slope all the time.

Dr. Carlson referred Employee to infectious disease specialist Robert Bundtzen, M.D. for a consultation. The referral was accompanied by a letter stating:

> This is to certify that [Employee] was healthy when he went to work on the Slope 12/17/2008. Five days later on 12/22/2008 he developed a sore throat and subsequently developed sepsis, probably from the same organism.

> It would take a consultation from Infectious Disease to decide the likelihood of his upper respiratory infection being caught from somebody on the slope versus from someone before 12/17/2008 when he was not on the Slope.
>
> If it is significantly more likely that he contracted the infection after arriving to his work site, then depending on established criteria about 'work related' versus not, this may be considered a work related illness.

(Carlson office visit notes, referral and letter, February 4-5, 2013.)

46) On February 7, 2013, Employee had an office consultation with infectious disease specialist Robert Bundtzen, M.D., who noted:

> "Sepsis" 2008, December
> Influenza A [positive]
> Pneumonia [right upper lobe] + [right middle lobe] / ARDS
> Spu + MSSA + E. coli

Dr. Bundtzen's one-page record of the visit noted a diagnosis of "influenza pneumonia [with] secondary bacterial pneumonia, necrotizing – MSSA." He stated he had a long discussion with Employee and "girlfriends" about influenza and secondary bacterial pneumonia. Dr. Bundtzen concluded, "He could have acquired influenza on the slope." (Bundtzen narrative report, emphasis original, February 7, 2013.)

47) On February 13, 2013, Employer filed a Request for Cross-Examination of Dr. Carlson's February 5, 2013 medical report to "test the author as to recollection, knowledge, perception, actions and opinions." (Request for Cross-Examination, February 13, 2013.)

48) At an April 4, 2013 deposition, Dr. Brady, Employee's treating internist, testified he first saw Employee on July 26, 2007, at which time Employee was being treated for back pain and chronic pain management. Based on medical records, Dr. Brady testified he last saw Employee on October 20, 2008. Dr. Brady testified he did not recall Employee's having a history of respiratory illness, nor did he see that reflected in the clinic notes. (Brady deposition, pp. 8, 20, 30; April 4, 2013.)

49) At an April 23, 2013 deposition, treating general practitioner Joan Itano-Merrick, ANP, who worked in the same clinic as Dr. Brady, testified she treated Employee from April 24, 2008 through December 16, 2008. Reviewing Employee's clinic notes, ANP Itano-Merrick testified her role was "mostly just refilling his pain medications for his chronic back pain." When asked, "Would you say that during the entire period that you were interacting with [Employee], that he

was generally in good health?" she replied "Yes." ANP Itano-Merrick then added, "[a]side from his back pain. . . [w]hich seemed to be his biggest problem," and she also noted a history of hepatitis C. (Itano-Merrick deposition, pp. 4, 5, 12, 17, April 23, 2013.)

50) On July 25, 2013, Mr. McLaughlin petitioned to strike medical summaries dated May 30, 2013, June 11, 2013 and June 19, 2013 as "immaterial, impertinent, or scandalous." The June 11, 2013 medical summary includes medical records from family practitioner Gonzalo Fraser, M.D., for office visits from May 30, 2006 through June 27, 2007, for prescription medication for back and neck pain. (Petition, July 25, 2013; Fraser records, May 30, 2006 through June 27, 2007.)

51) On August 2, 2013, Employer requested Employee's July 25, 2013 petition to strike be denied as a spurious document seeking to exclude medical records but offering "no coherent rationale for their exclusion." (Answer, August 2, 2013.)

52) On October 28, 2013, Employee terminated Mr. McLaughlin as non-attorney representative and replaced him with Darrel W. Vandergriff of Vandergriff Legal Aid Service. (Notice of Termination of Representation, October 28, 2013.)

53) On December 2, 2013, Mr. McLaughlin petitioned to withdraw as Employee's non-attorney representative. (Petition, December 2, 2013.)

54) On January 21, 2014, Dr. Burton reviewed medical summaries filed since his November 27, 2014 EME report and concluded they did not alter his prior conclusions.

55) At a February 2, 2014 prehearing Employee stated he was no longer being represented by Mr. Vandergriff. (Prehearing conference summary, February 2, 2014.)

56) At a prehearing conference on March 25, 2014, a hearing was scheduled for August 19, 2014 on the issues of Employee's December 20, 2010 claim as amended on June 1, 2011: TTD (12/25/2008 – continuing), PPI (when rated), medical costs, transportation costs, compensation rate adjustment, penalty, interest, unfair or frivolous controversion, and attorney's fees & costs. (Prehearing conference summary, March 25, 2014.)

57) At a prehearing conference on April 23, 2014, Employee expressed interest in obtaining an SIME. He was advised to contact a Workers' Compensation Technician if he decided to petition for one. (Prehearing conference summary, April 23, 2014.)

58) On June 10, 2014, Claire L. Keene, Employee's girlfriend, entered her appearance as his non-attorney representative. (Notice of Appearance, June 9, 2014.)

59) At hearing on August 19, 2014, Employee testified he had been reluctant to file a workers' compensation claim, fearing he would never be employed in the oil patch again if he did so. (Brown.)

60) Employee testified he had used both prescription and illegal drugs in the past, including marijuana, cocaine and heroin, but he did not believe they weakened his immune system. "I don't know what happened to me at work, but drug abuse had nothing to do with it." (*Id.*)

61) At hearing Employee's daughter, Lindsey Brown, testified that when contacted by Providence on December 25, 2008, she had told the doctor her father had a history of drug use, but he had recovered and had been clean and sober for years. She further testified she hadn't lived with him for several years, but kept in touch with him. (Lindsey Brown.)

62) At hearing Lynn Palazzatto, Arctic Slope Regional Corporation's HSET (health, safety and environment) Loss Prevention Manager, testified there was no influenza epidemic on Northstar Island at or near the injury date. She stated she investigated the matter after Employee's claim because of the remote site doctrine, and would know if a flu outbreak occurred. Noting the tight quarters on Northstar Island, Ms. Keene asked if Ms. Palazzatto would have knowledge of every onsite illness; Ms. Palazzatto responded she found out about illnesses when a report of injury was filed. (Palazzatto.)

63) At hearing Dr. Burton opined Employee had a history of respiratory infections, including a bout of pneumonia treated with antibiotics in August and September, 2008. Dr. Burton testified when pneumonia is undertreated or treated with the wrong antibiotics, new organisms resistant to antibiotics can flourish and lead to a very serious form of pneumonia. Dr. Burton opined Employee's December 28, 2008 pneumonia was a superinfection, "an infection on top of an existing infection." (Burton.)

64) Employer's hearing evidence included a letter from Akeela Inc. Panel member Stacy Allen disclosed her daughter had worked at Akeela, during a period post-dating the letter, and Ms. Allen was therefore familiar with Akeela's operating procedures. Both Employee and Employer's counsel stated they had no problem with Ms. Allen's participation in the hearing. (Allen; Brown; Bredesen.)

65) On August 22, 2014, the board notified the parties that due to the hearing's late ending time and the subsequent unavailability of a panel member, deliberations were not concluded and no decision was made as to whether the record was closed. (Letter, August 22, 2014.)

66) On August 26, 2014, the board notified the parties it intended to "take official notice of some or all of the twelve facts contained in the attached document, *Quotations from the Centers for Disease Control and Prevention Website*." The parties were also noticed that the record from the August 19, 2014 hearing would be held open through September 4, 2014, in order to give them reasonable opportunity to present evidence or authority to refute the officially noticed facts.

67) The *Quotations from the Centers for Disease Control and Prevention Website* document read as follows (emphases in original):

> **1) The Flu Is Contagious**
> Most healthy adults may be able to infect other people beginning 1 day **before** symptoms develop and up to 5 to 7 days **after** becoming sick. Children may pass the virus for longer than 7 days. Symptoms start 1 to 4 days after the virus enters the body. **That means that you may be able to pass on the flu to someone else before you know you are sick, as well as while you are sick**. Some people can be infected with the flu virus but have no symptoms. During this time, those persons may still spread the virus to others. http://www.cdc.gov/flu/about/disease/spread.htm
>
> **2) How soon will I get sick if I am exposed to the flu?**
> The time from when a person is exposed to flu virus to when symptoms begin is about 1 to 4 days, with an average of about 2 days. http://www.cdc.gov/flu/about/qa/disease.htm
>
> **3) Influenza Symptoms**
> Influenza (also known as the flu) is a contagious respiratory illness caused by flu viruses. It can cause mild to severe illness, and at times can lead to death. The flu is different from a cold. The flu usually comes on suddenly. People who have the flu often feel some or all of these symptoms:
> - Fever* or feeling feverish/chills
> - Cough
> - Sore throat
> - Runny or stuffy nose
> - Muscle or body aches
> - Headaches
> - Fatigue (tiredness)
> - Some people may have vomiting and diarrhea, though this is more common in children than adults.
>
> * *It's important to note that not everyone with flu will have a fever.* http://www.cdc.gov/flu/about/disease/symptoms.htm

4) Flu Severity

Flu is unpredictable and how severe it is can vary widely from one season to the next depending on many things, including:

- what flu viruses are spreading,
- how much flu vaccine is available,
- when vaccine is available,
- how many people get vaccinated, and
- how well the flu vaccine is matched to flu viruses that are causing illness.

http://www.cdc.gov/flu/about/disease/symptoms.htm

5) Flu Complications

Most people who get influenza will recover in a few days to less than two weeks, but some people will develop complications (such as pneumonia) as a result of the flu, some of which can be life-threatening and result in death. Pneumonia, bronchitis, sinus and ear infections are examples of complications from flu. The flu can make chronic health problems worse. For example, people with asthma may experience asthma attacks while they have the flu, and people with chronic congestive heart failure may experience worsening of this condition that is triggered by the flu.

http://www.cdc.gov/flu/about/disease/symptoms.htm

6) People at High Risk of Developing Flu–Related Complications

Most people who get the flu will have mild illness, will not need medical care or antiviral drugs, and will recover in less than two weeks. Some people, however, are more likely to get flu complications that result in being hospitalized and occasionally result in death. Pneumonia, bronchitis, sinus infections and ear infections are examples of flu-related complications. The flu also can make chronic health problems worse. For example, people with asthma may experience asthma attacks while they have the flu, and people with chronic congestive heart failure may experience a worsening of this condition that is triggered by the flu. The list below includes the groups of people more likely to get flu-related complications if they get sick from influenza. . . .

People who have medical conditions including:

. . .

Liver disorders

. . .

Weakened immune system due to disease or medication (such as people with HIV or AIDS, or cancer, or those on chronic steroids)

. . . http://www.cdc.gov/flu/about/disease/high_risk.htm

7) What kinds of flu tests are there?

A number of flu tests are available to detect influenza viruses. The most common are called “rapid influenza diagnostic tests.” These tests can provide results in 30 minutes or less. Unfortunately, the ability of these tests to detect the flu can vary greatly. Therefore, you could still have the flu, even though your rapid test result is negative. In addition to rapid tests, there are several more accurate and

sensitive flu tests available that must be performed in specialized laboratories, such as those found in hospitals or state public health laboratories. All of these tests require that a health care provider swipe the inside of your nose or the back of your throat with a swab and then send the swab for testing. These tests do not require a blood sample. http://www.cdc.gov/flu/about/qa/testing.htm

8) How well can rapid tests detect the flu?
During an influenza outbreak, a positive rapid flu test is likely to indicate influenza infection. However, rapid tests vary in their ability to detect flu viruses, depending on the type of rapid test used, and on the type of flu viruses circulating. Also, rapid tests appear to be better at detecting flu in children than adults. This variation in ability to detect viruses can result in some people who are infected with the flu having a negative rapid test result. (This situation is called a false negative test result.) Despite a negative rapid test result, your health care provider may diagnose you with flu based on your symptoms and their clinical judgment. http://www.cdc.gov/flu/about/qa/testing.htm

9) Will my health care provider test me for flu if I have flu-like symptoms?
Not necessarily. Most people with flu symptoms do not require testing because the test results usually do not change how you are treated. http://www.cdc.gov/flu/about/qa/testing.htm

10) What about people who get a seasonal flu vaccine and still get sick with flu-like symptoms?
There are several reasons why someone might get a flu-like illness, even after they have been vaccinated against flu.

1. One reason is that some people can become ill from other respiratory viruses besides flu such as rhinoviruses, which are associated with the common cold, cause symptoms similar to flu, and also spread and cause illness during the flu season. The flu vaccine only protects against influenza viruses, not other viruses.
2. Another explanation is that it is possible to be exposed to influenza viruses, which cause the flu, shortly before getting vaccinated or during the two-week period after vaccination that it takes the body to develop immune protection. This exposure may result in a person becoming ill with flu before protection from the vaccine takes effect.
3. A third reason why some people may experience flu like symptoms despite getting vaccinated is that they may have been exposed to a flu virus that is very different from the viruses the vaccine is designed to protect against. The ability of a flu vaccine to protect a person depends largely on the similarity or "match" between the viruses selected to make the vaccine and those spreading and causing illness. There are many different flu viruses that spread and cause illness among people. For more information, see Influenza (Flu) Viruses.
4. The final explanation for experiencing flu-like symptoms after vaccination is that unfortunately, the flu vaccine doesn't always provide adequate

> protection against the flu. This is more likely to occur among people that have weakened immune systems or people age 65 and older. http://www.cdc.gov/flu/about/qa/misconceptions.htm
>
> **11) How many people get sick or die from the flu every year?**
> Flu seasons vary in severity. It is estimated that between 5% to 20% of U.S. residents get the flu, and it is estimated that more than 200,000 people are hospitalized on average for flu-related complications each year. Over a period of 30 years, between 1976 and 2006, estimates of flu-associated deaths in the United States range from a low of about 3,000 to a high of about 49,000 people. http://www.cdc.gov/flu/about/qa/disease.htm
>
> **12) When is the flu season in the United States?**
> In the United States, flu season occurs in the fall and winter. The peak of flu season has occurred anywhere from late November through March. The overall health impact (e.g., infections, hospitalizations, and deaths) of a flu season varies from year to year. CDC monitors circulating flu viruses and their related disease activity and provides influenza reports (called "FluView") each week from October through May. See Weekly U.S. Influenza Summary Update. http://www.cdc.gov/flu/about/qa/disease.htm

68) On September 3, 2014, Employer filed a Limited Objection to the Board's Invocation of Administrative Notice, which stated Employer

> is concerned about the relatively novel manner in which administrative notice is being used, given other means of medical investigation which are expressly written into the Act. [Employer] is also concerned about the possibility that the Board may use the website information to independently derive specific medical conclusions, to decide the merits of a medical case, without testimony by an expert to explain the treatise material. If that is the case here, then [Employer] objects. (Limited Objection to the Board's Invocation of Administrative Notice, September 3, 2014.)

69) Employer's Limited Objection contended:

> In the event the Board has any doubts about Dr. Burton's testimony and wants more information with which to evaluate his opinions, an AS 23.30.110(g) records review provides the proper means of doing so. It is the general mechanism which the Legislature empowered the Board with in order to investigate medical matters, and a records review by a Board toxicologist would be far more appropriate than resorting to the internet, then trying to form specialized medical opinions well-beyond [sic] the expertise of a Board panel. (*Id.*)

70) The Limited Objection also contended the Centers for Disease Control and Prevention (CDC) information was hearsay and therefore, "if the CDC information will be used to supplement and

explain Dr. Burton's testimony, then the Board may do so. The Board may not use the CDC information to reach conclusions contrary to Dr. Burton's ultimate opinions (footnote omitted)." (*Id.*)

71) Employer's Limited Objection was accompanied by a letter from Dr. Burton, who stated review of the CDC patient information did not prompt any alteration of his prior conclusions. (Burton letter, September 3, 2014.)

PRINCIPLES OF LAW

> **AS 23.30.001. Intent of the legislature and construction of chapter**. It is the intent of the legislature that
> 1) this chapter be interpreted . . . to ensure the quick, efficient, fair, and predictable delivery of indemnity and medical benefits to injured workers at a reasonable cost to . . . employers. . .
> . . .
> 4) hearings in workers' compensation cases shall be impartial and fair to all parties . . .

The board may base its decision not only on direct testimony and other tangible evidence, but also on the board's "experience, judgment, observations, unique or peculiar facts of the case, and inferences drawn from all of the above." *Fairbanks North Star Borough v. Rogers & Babler*, 747 P.2d 528, 533-34 (Alaska 1987). An adjudicative body must base its decision on the law, whether cited by a party or not. *Barlow v. Thompson*, 221 P.3d 998 (Alaska 2009).

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

> causes, the employment is the substantial cause of the disability or death or need for medical treatment.

In *City and Borough of Juneau v. Olsen*, AWCAC Decision No. 11-0185 (August 21, 2013), the commission explained the application of "the substantial cause" in cases where a work injury "aggravates or accelerates" or "combines" with a preexisting condition. When an employee asserts a work injury caused the aggravation or acceleration of a preexisting condition, the board must evaluate the relative contribution of both the preexisting condition and the work injury. To establish causation, the employee must show the work injury played a greater role in the disability or need for medical treatment than did the preexisting injury. *Olsen, 17-18.* When an employee asserts his disability or need for medical treatment arose as a result of a combination of his work injury and a preexisting condition, the employee must establish two additional facts to prevail, first, that the disability or need for treatment would not have happened "but for" the work injury, and second that reasonable persons would regard the work injury as the substantial cause of the disability or need for medical treatment. *Olsen, 18-19.*

> **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. .
> . .
> . . .

Subsection AS 23.30.110(g) has long been considered procedural in nature, not substantive, for the reasons outlined in *Deal v. Municipality of Anchorage*, AWCB Decision No. 97-0165 (July 23, 1997) at 3; *see also Harvey v. Cook Inlet Pipe Line Co.*, AWCB Decision No. 98-0076 (March 26, 1998) at 4. Wide discretion exists under AS 23.30.110(g) to consider any evidence available when deciding whether to order an SIME to assist in investigating and deciding medical issues in contested claims, to best protect the rights of all parties. *See, e.g., Hanson v. Municipality of Anchorage*, AWCB Decision No. 10-0175 (October 29, 2010) at 18; *Young v. Brown Jug, Inc.*, AWCB Decision No. 02-0223 (October 28, 2002) at 3; AS 23.30.135(a); AS 23.30.155(h).

The Alaska Workers' Compensation Appeals Commission (Commission) in *Bah v. Trident Seafoods Corp.,* AWCAC Decision No. 073 (February 27, 2008) at 5 addressed the board's authority to order an SIME. Referring to § 110(g), the Commission stated "the board has discretion to order an SIME when there is a significant gap in the medical or scientific evidence and an opinion by an independent medical examiner or other scientific examination will help the board in resolving the issue before it. . . ." In denying Mr. Bah's request for a board-ordered SIME, the Commission noted: "Ordering an SIME is not proper if it serves no purpose to the board by advancing its understanding of the medical evidence or by filling in gaps in the medical evidence, where that gap in the evidence, or lack of understanding of the medical evidence, prevents the board from ascertaining the rights of the parties in the dispute before the board." *Id.* at 5.

Bah further noted "the purpose of ordering an SIME . . . is to assist the board…" *Id.* Citing *Olafson v. State, Dep't of Trans. & Pub. Facilities,* AWCAC Decision No. 061 (October 25, 2007) at 23, *Bah* reiterated the SIME physician is the *board's expert,* not the employee's or employer's expert. *Id.*, emphasis in original.

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

Under AS 23.30.120, benefits sought by an injured worker are presumed to be compensable, and the burden of producing evidence is placed on the employer. *Sokolowski v. Best Western Golden Lion Hotel*, 813 P.2d 286, 292 (Alaska 1991). The Alaska Supreme Court held the presumption of compensability applies to any claim for compensation under the Act. *Meek v. Unocal Corp.*, 914 P.2d 1276, 1279 (Alaska 1996); *Carter* at 665. An employee is entitled to the presumption of compensability as to each evidentiary question. *Sokolowski* at 292.

A three-step analysis is used to determine the compensability of a worker's claim. At the first step, the claimant need only adduce "some" "minimal" relevant evidence establishing a "preliminary link" between the injury claimed and employment. *McGahuey v. Whitestone Logging, Inc.*, 262 P.3d 613, 620 (Alaska 2011); *Smith v. Univ. of Alaska, Fairbanks,* 172 P.3d 782, 788 (Alaska

2007); *Cheeks v. Wismer & Becker/G.S. Atkinson, J.V.*, 742 P.2d 239, 244 (Alaska 1987). The evidence necessary to attach the presumption of compensability varies depending on the claim. In claims based on highly technical medical considerations, medical evidence is often necessary to make that connection. *Burgess Construction Co. v. Smallwood*, 623 P.2d 312, 316 (Alaska 1981). In less complex cases, lay evidence may be sufficiently probative to establish causation. *VECO, Inc. v. Wolfer*, 693 P.2d 865, 871 (Alaska 1985). Witness credibility is not weighed at this step in the analysis. *Resler v. Universal Services Inc.*, 778 P.2d 1146, 1148-49 (Alaska 1989).

At the second step, once the preliminary link is established, the employer has the burden to overcome the presumption with substantial evidence. *Kramer* at 473-74, quoting *Smallwood* at 316. If the employer can present substantial evidence demonstrating that "a cause other than employment played a greater role in causing the [need for medical treatment], etc., the presumption is rebutted." *Runstrom v. Alaska Native Medical Center*, AWCAC Decision No. 150 (Mar. 25, 2011) at 7. "Substantial evidence" is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. *Tolbert v. Alascom, Inc.*, 973 P.2d 603, 611-612 (Alaska 1999). At the second step of the analysis, the employer's evidence is viewed in isolation, without regard to the claimant's evidence. Issues of credibility and evidentiary weight are deferred until after a determination whether the employer has produced a sufficient quantum of evidence to rebut the presumption. *Norcon, Inc. v. Alaska Workers' Comp. Bd.*, 880 P.2d 1051, 1054 (Alaska 1994); *Wolfer* at 869-870.

If the presumption is raised but not rebutted, the claimant prevails and need not produce further evidence. *Williams v. State*, 938 P.2d 1065, 1075 (Alaska 1997). If the employer successfully rebuts the presumption, it drops out, and the employee must prove all elements of his case by a preponderance of the evidence. *Louisiana Pacific Corp. v. Koons*, 816 P.2d 1379, 1381. At this last step of the analysis, evidence is weighed and credibility considered. To prevail, the claimant must "induce a belief" in the minds of the fact finders the facts being asserted are probably true. *Saxton v. Harris*, 395 P.2d 71, 72 (Alaska 1964).

A fundamental principle in workers' compensation law is the "eggshell skull doctrine," which states an employer must take an employee "as he finds him." *Fox v. Alascom, Inc.*, 718 P.2d 977, 982

(Alaska 1986), citing *S.LW, v. Alaska Workmen's Compensation Board*, 490 P.2d 42, 44 (Alaska 1971); *Wilson v. Erickson, All* P.2d 998, 1000 (Alaska 1970). A pre-existing condition does not disqualify a claim if the employment aggravated, accelerated or combined with the pre-existing condition to produce the disability or need for medical treatment for which compensation is sought. *DeYonge v. NANA/Marriott*, 1 P.3d 90, 96 (Alaska 2000); *Peek v. SKW/Clinton*, 855 P.2d 415, 416 (Alaska 1993).

> **AS 23.30.135. Procedure before the board.**
> (a) In making an investigation or inquiry or conducting a hearing the board is not bound by common law or statutory rules of evidence or by technical or formal rules of procedure, except as provided by this chapter. The board may make its investigation or inquiry or conduct its hearing in the manner by which it may best ascertain the rights of the parties. . . .
>
> **AS 23.30.155. Payment of compensation.**
> . . .
> (h) The board may upon its own initiative at any time in a case . . . where right to compensation is controverted . . . make the investigations, cause the medical examinations to be made, or hold the hearings, and take the further action which it considers will properly protect the rights of all parties.
>
> **AS 23.30.395. Definitions.**
> In this chapter,
> . . .
> (2) "arising out of and in the course of employment" includes employer-required or supplied travel to and from a remote job site; activities performed at the direction or under the control of the employer; and employer-sanctioned activities at employer-provided facilities; but excludes . . . activities of a personal nature away from employer-provided facilities;
> . . .

Under the "remote site doctrine," everyday activities that are normally considered non-work-related are deemed a part of a remote site employee's job for workers' compensation purposes because the requirement of living at the remote site limits the employee's activity choices. *Doyon Universal Services v. Allen*, 999 P.2d. 764, 769 (Alaska 2000).

> Because of the unique situation that remote worksites present, we have adopted a particularly expansive view of "work-connectedness," which we have articulated in the now-familiar "remote site" doctrine. The crux of this doctrine is that everyday activities that are normally considered non-work-related are deemed a part of a remote site employee's job for workers' compensation purposes because

> the requirement of living at the remote site limits the employee's activity choices . . . . [B]ecause a worker at a remote site is required, as a condition of employment, to eat, sleep and socialize on the work premises, activities normally divorced from his work become part of the working conditions to which the worker is subjected… *Id.* at 768-69 (footnotes omitted.)

> **2 AAC 64.300. Official notice.**
> (a) If a fact may be judicially noticed by the courts of the state, an administrative law judge may take official notice of that fact by informing the parties of, and referring in the administrative hearing record to, the fact that the administrative law judge intends to officially notice. The administrative law judge, on the request of a party, will give the party a reasonable opportunity to present evidence or authority to refute the officially noticed facts.

The State of Alaska Department of Law's *Hearing Officer's Manual*, Fifth Edition (August 2002), at Chapter 8, p. 58, is instructive on official notice:

> It is important to provide notice to the parties and provide an opportunity to rebut the 'noticed' facts. The hearing officer should attempt to provide written notice before the hearing or oral notice during the hearing of the facts to be officially noticed. Otherwise, written notification, allowing each party sufficient time to object, may be accomplished after the hearing and before the closing of the record.

> **8 AAC 45.120. Evidence**.
> . . .
> (e) Technical rules relating to evidence and witnesses do not apply in board proceedings, except as provided in this chapter. Any relevant evidence is admissible if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any common law or statutory rule which might make improper the admission of such evidence over objection in civil actions. . . .

Granus v. Fell, AWCB Decision No. 99-0016 (January 20, 1999), provided guidance in determining relevancy:

> Parties may obtain discovery regarding any matter, not privileged which is relevant to the subject matter involved in the pending action. . . . To be admissible at hearing, evidence must be 'relevant.' However, we find a party seeking to discover information need only show the information appears reasonably calculated to lead to the discovery of evidence admissible at hearing. *Smart v. Aleutian Constructors*, AWCB Decision No. 98-0289 (November 23, 1998).

> **Alaska Evid. R. 201. Judicial Notice of Fact**
> **(a) Scope of Rule.** This rule governs only judicial notice of facts. Judicial notice of a fact as used in this rule means a court's on-the-record declaration of the existence of a fact normally decided by the trier of fact, without requiring proof of that fact.
>
> **(b) General Rule.** A judicially noticed fact must be one not subject to reasonable dispute in that it is either (1) generally known within this state or (2) capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned.
>
> **(c) When Discretionary.** A court may take judicial notice as specified in subdivision (b), whether requested or not.

ANALYSIS

1) ***Was the oral order denying Employee's July 25, 2013 petition to strike medical records filed May 30, 2013, June 11, 2013 and June 19, 2013 proper?***

The July 25, 2013 petition was filed by a non-attorney representative since terminated by Employee. At the beginning of the hearing, Employee had not read the petition, medical records or Employer's answer. After he and his current non-attorney representative had a chance to review the documents, Employee narrowed the dispute to contend treating physician Dr. Gonzalo Fraser's records from May 30, 2006 to June 27, 2007 should be stricken as irrelevant to the work injury, and perhaps illegally obtained. Employee later changed his mind, agreeing Employer had properly obtained Dr. Fraser's records, and Ms. Keene contended the records were not relevant, but she didn't regard their inclusion as a "big problem." After the oral order to deny the petition, it became clear Employee's objection stemmed from his disagreement with the records' content. After being reassured he would be allowed to address the topic of his drug use in testimony, Employee said, "that's what my point was" and thanked the panel. The issue of the disputed petition was thereby rendered moot.

In the alternative, Dr. Fraser's documentation of Employee's prescription drug use relates directly to Employer's defense, since Dr. Burton opined a history of drug abuse was one of the three most significant factors in the development of Employee's pneumonia. Morevoer, the issue of drug use appears elsewhere in the evidence. Dr. Fraser's records are clearly admissible

as "the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs." 8 AAC 45.120(e); *Granus*. The oral order denying Employee's July 25, 2013 petition to strike medical records was proper.

2) ***Did Employee's disability or need for medical treatment arise out of and in the course of his employment with Employer and, if so, to what benefits is he entitled?***

The causation of Employee's pneumonia is a factual issue subject to the presumption analysis. *Sokolowski.* Under the remote site doctrine, Employee's everyday activities on Northstar Island are deemed part of his job for workers' compensation purposes, because he was confined to the worksite and had no option to live elsewhere. Therefore, if at any time on the Slope (i.e. not just during his work shift) Employee contracted influenza or any other illness leading to pneumonia and subsequent complications, he would have a compensable medical condition and disability. *Allen.*

Also relevant to the presumption analysis here is the "eggshell skull doctrine," under which an employer takes an employee as he finds him. If, at a merits hearing, Employee is found to have had a pre-existing pathology, such as a weakened immune system, that made him predisposed to contracting pneumonia, his injury would still be compensable if he contracted the pneumonia, or an infectious agent leading to it, on the Slope. *Fox; DeYonge; Olsen.* On the other hand, if the pre-existing pathology itself is ultimately found to be the substantial cause of the pneumonia, then Employer would prevail. AS 23.30.010(a).

At the first step of the analysis, a preliminary link between Employee's injury and employment was established by at least three medical opinions: (1) Dr. McGhan's January 15, 2009 interim hospital summary, which stated Employee's pneumonia was "likely a post influenza bacterial pneumonia"; (2) Dr. Carlson's February 4, 2013 certification Employee was healthy when he went to the Slope on December 17, 2008, but five days later "developed a sore throat and subsequently developed sepsis, probably from the same organism"; and (3) Dr. Bundtzen's February 7, 2013 record of "influenza pneumonia [with] secondary bacterial pneumonia,

necrotizing – MSSA," and conclusion Employee "could have acquired influenza on the slope." The presumption of compensability therefore attached. *McGahuey; Smith; Cheeks; Smallwood.*

Although EME physician Dr. Burton acknowledged "medical records indicate the proposed role of influenza A as an etiologic agent in the production of [Employee's] pneumonia," he also opined there was no data to support this hypothesis as a work-related exposure. Instead, Dr. Burton opined Employee had underlying risk factors for the development of pneumonia, including intravenous drug use, smoking and GERD, and his severe pneumonia in December, 2008 was a superinfection resulting from his unresolved bout with pneumonia in August and September, 2008. Viewed in isolation, Dr. Burton's testimony constitutes substantial evidence that a cause other than employment played a greater role in causing Employee's injury and disability. The presumption of compensability was thereby rebutted. *Runstrom; Tolbert; Norcon.*

At the third step of the presumption analysis, the hearing panel was hampered by both gaps in the medical evidence and its own lack of understanding of the evidence produced. EME Dr. Burton opined there was no data to support the hypothesis Employee's illness resulted from exposure to influenza at work. On the other hand, ANP Itano-Merrick and Dr. Carlson independently corroborated Employee's testimony he was healthy when he returned to Northstar Island on December 17, 2008. Five days later, on December 22, 2008, Employee reported a sudden onset of sore throat and fever to PA-C Buck. Less than three full days after that, in critical condition, Employee was airlifted to Providence, where influenza A was among his diagnoses. Employee was treated with Tamiflu, but the issue of whether Employee's pneumonia was a flu complication was not clearly addressed in the hospital records. As a practical matter the issue was irrelevant to the Providence team; they were concerned with saving Employee's life, not with a legal determination whether influenza acquired at the workplace was the substantial cause of his life-threatening condition. AS 23.30.010(a).

Similarly, Dr. Burton opined Employee's pneumonia and sepsis were etiologically the result solely of pre-existing conditions, and would have occurred no matter where Employee happened to be from December 17-25, 2008. On the other hand, Employee's physicians rendered no

opinions as to the role, if any, his medical history and pre-existing conditions played in his December, 2008 illness.

The brief records from Employee's February, 2013 office visits with Dr. Carlson and Dr. Bundtzen are the only medical evidence addressing the issue of how Employee got sick in December, 2008, and they are minimal and inconclusive. The record includes no medical evidence from a physician who evaluated both Employee's medical history and Dr. Burton's EME opinions.

Due to these evidentiary gaps, the panel was unable to decide the key legal issue of what caused Employee to become deathly ill in December, 2008. Specifically, the panel was unable to determine if:

1. Employee's pneumonia was community-acquired, resulting from exposure to influenza A on the worksite;
2. Employee was an "eggshell skull" claimant who was exposed to a pathogen at work that aggravated, accelerated or combined with his pre-existing conditions to result in his near-fatal illness; or
3. Employee's pre-existing conditions were, more than any other factor, the substantial cause of his disability and need for medical treatment. AS 223.30.010(a); *Fox; DeYonge; Olsen*.

The hearing panel therefore decided it needed more medical evidence before rendering a decision regarding the compensability of Employee's claim. In order to be fair and impartial to all parties, the presumption analysis was halted at the third step, and decisions were made to take official notice of general facts regarding influenza published by the Centers for Disease Control and Prevention, and to order an SIME records review. AS 23.30.001(4); AS 23.30.135(a); AS 23.30.155(h); 2 AAC 64.300(a); Alaska Evid. R. 201(a), (b), (c); AS 23.30.110(g).

3) ***Was the decision to take official notice of facts from the Centers for Disease Control and Prevention proper?***
4) ***Should an SIME be ordered?***

Alaska Evidence Rule 201 (a), (b), and (c) authorizes taking official notice of facts not subject to reasonable dispute because they are capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned. Here the noticed facts were taken from the website of the United States Centers for Disease Control and Prevention, an authoritative government source, and included information about influenza's contagious nature, incubation period, symptoms, severity, and complications, as well as available diagnostic tools, the efficacy of flu vaccinations, and flu seasons. This information was directly relevant to the issues in dispute here, and was noticed not for diagnostic reasons or to decide the merits of the case, but rather to supplement and explain the direct evidence in the medical records and testimony. The guidelines of 2 AAC 64.300(a) and the Department of Law's current *Hearing Officer's Manual* were followed, and nothing was done that would constitute an objectionable action according to Employer's Limited Objection to the Board's Invocation of Administrative Notice. The decision to take official notice of facts from the Centers for Disease Control and Prevention was proper.

An SIME may be ordered when there is a significant gap in the medical evidence or a lack of understanding of the medical evidence, and the opinion of an independent medical examiner will help ascertain the parties' rights. AS 23.30.110(g); *Bah*. Subsection AS 23.30.110(g) is procedural in nature, not substantive, and AS 23.30.135(a) and AS 23.30.155(h) confer broad procedural discretion to make investigations, including ordering medical examinations, in the manner that best ascertains and protects the rights of all parties. *Deal; Harvey.* Any available evidence may be considered when deciding whether to order an SIME to assist in investigating and deciding medical issues in contested claims. *Hanson; Young.*

This is a highly complex medical case, involving a large number of physicians, diagnoses and treatments. As discussed above, the hearing panel's deliberations were thwarted at the third step of the presumption analysis both by gaps in the medical evidence and its own lack of understanding of the evidence produced. Employee expressed his desire to have an SIME at a prehearing conference summary on April 23, 2014, and Employer's counsel specifically recommended a board-ordered SIME "in the event the Board has any doubts about Dr. Burton's

testimony and wants more information with which to evaluate his opinions." An SIME records review with internist and pulmonary disease specialist Daniel M. Raybin, M.D., will be ordered under AS 23.30.110(g), subject to the board's designee's conflict of interest inquiry.

Employer will be ordered to provide a transcript of the August 19, 2014 hearing for inclusion in the SIME binders, along with a copy of this Decision and Order. The *Quotations from the Centers for Disease Control and Prevention Website* document, and all depositions, medical records and medical opinions expressed in any format, including letters, are also to be included. In addition to the standard questions posed by the board designee, the following questions will be posed to the SIME physician:

1. Was exposure to an infectious agent, including but not limited to influenza A, on Northstar Island the substantial cause of Employee's disability and need for medical treatment on December 25, 2008?
2. Did Employee have pre-existing conditions that constituted the substantial cause of his disability and need for medical treatment on December 25, 2008, regardless of whether Employee worked on Northstar Island?
3. Did Employee have pre-existing conditions that, when aggravated, accelerated or combined with exposure to an infectious agent on Northstar Island, produced his disability and need for medical treatment on December 25, 2008?
4. Did Employee suffer any brain injury or cognitive impairment as a result of his December, 2008 pneumonia and complications? If so, what was the nature of this injury or impairment and has it resolved? If so, when?

CONCLUSIONS OF LAW

1) The oral order denying Employee's July 25, 2013 petition to strike medical records filed May 30, 2013, June 11, 2013 and June 19, 2013 was proper.

2) The issue of whether Employee's disability or need for medical treatment arose out of and in the course of his employment with Employer is not ripe.

3) The decision to take official notice of facts from the Centers for Disease Control and Prevention was proper.

4) An SIME will be ordered.

ORDER

1) Workers' Compensation Officer Susan Reishus-O'Brien is directed to schedule an SIME records review with internist and pulmonary disease specialist Dr. Daniel M. Raybin, subject to his availability and the lack of any potential conflict of interest.

2) A prehearing conference to address deadlines and instructions for compilation of the SIME binders is scheduled for October 10, 2014, at 10:30 a.m. with Workers' Compensation Officer Harvey Pullen.

3) Employer is ordered to provide a transcript of the August 19, 2014 hearing for inclusion in the SIME binders, along with a copy of this Decision and Order. The *Quotations from the Centers for Disease Control and Prevention Website* document, and all depositions, medical records and medical opinions expressed in any format, including letters, are also to be included.

4) In addition to the standard questions posed by the board designee, the following questions will be posed to the SIME physician:

1. Was exposure to an infectious agent, including but not limited to influenza A, on Northstar Island the substantial cause of Employee's disability and need for medical treatment on December 25, 2008?
2. Did Employee have pre-existing conditions that constituted the substantial cause of his disability and need for medical treatment on December 25, 2008, regardless of whether Employee worked on Northstar Island?
3. Did Employee have pre-existing conditions that, when aggravated, accelerated or combined with exposure to an infectious agent on Northstar Island, produced his disability and need for medical treatment on December 25, 2008?
4. Did Employee suffer any brain injury or cognitive impairment as a result of his December, 2008 pneumonia and complications? If so, what was the nature of this injury or impairment and has it resolved? If so, when?

5) Jurisdiction over the employee's claim is retained, pending receipt of the SIME report.

6) Upon receipt of the SIME report, if either party chooses to proceed to hearing, it is ordered to request a prehearing conference with Hearing Officer Margaret Scott.

Dated in Anchorage, Alaska on September 24, 2014.

ALASKA WORKERS' COMPENSATION BOARD

Margaret Scott, Designated Chair

Michael O'Connor, Member

Stacy Allen, Member

PETITION FOR REVIEW

A party may seek review of an interlocutory of 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 BRUCE J BROWN, employee / claimant; v. ASRC ENERGY SERVICES, employer; ARCTIC SLOPE REGIONAL CORP., insurer / defendants; Case No. 200820295; dated and filed in the Alaska Workers' Compensation Board's office in Anchorage, Alaska, and served on the parties on September 24, 2014.

Pamela Murray, Office Assistant