ALASKA WORKERS' COMPENSATION BOARD

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

JASON F. WRIGHT, Employee, Claimant, v. SALTWATER, INC., Employer, and LM INSURANCE CORPORATION, Insurer, Defendants.	INTERLOCUTORY DECISION AND ORDER AWCB Case No. 201603220 AWCB Decision No. 18-0067 Filed with AWCB Anchorage, Alaska on July 9, 2018

Saltwater, Inc. and LM Insurance Corporation's (Employer) March 12, 2018 petition to strike non-medical second independent medical evaluation (SIME) records and for SIME physician specialty selection was heard in Anchorage, Alaska, on June 21, 2018, a date selected on May 15, 2018. Jason Wright (Employee) appeared telephonically and represented himself. Attorney Martha Tansik appeared and represented Employer. The record remained open to receive Employee's records list to which his "reference" numbers on his SIME supplemental records correspond. The record closed on July 5, 2018.

ISSUES

Employer opposes portions of evidence Employee filed for submission to and review by the SIME physician and contends they should be stricken from the SIME binder. Employer contends non-medical records, duplicate medical records already in the SIME binders, altered medical records

with marginalia, photos of imaging studies, and Employee's opinions regarding his appointment with Employer's medical examiner (EME) should be stricken.

Upon learning more about the SIME process and relevant records, Employee did not dispute some records he submitted were duplicates or that original imaging studies will be better depictions than the photos he took of the images. Employee contended Employer's training manual should be included in the SIME records because it accurately describes his job, which is unique and that it will be impracticable to fully describe his job and work environment at the SIME appointment. Employee contends the Observer Manual describes on-the-job hazards and the protocol he is required to follow when a hazard is encountered. Employee contends his work history documents show he was cleared for work and rebut the EME's assertions his "issues" stem from past health concerns originating at Employee's birth.

1. **What records, if any, should be stricken from the SIME binders?**

Employee contends the medical specialty required is the specialty from which he received his initial treatment, a cardio-thoracic surgeon.

Employer contends the medical specialty required is a pulmonologist. Employer contends a pulmonologist has the greatest knowledge base about Employee's underlying condition's pathology and the ability to determine what Employee's lung condition was and what caused the condition.

2. **What physician specialty should be selected to perform the SIME?**

FINDINGS OF FACT

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

1) On March 1, 2016, Employer reported Employee was performing his job duties, "fainted due to pneumonia" and broke a rib on February 10, 2016. (First Report of Injury, March 1, 2016.)

2) On March 14, 2016, Employer controverted all benefits. It asserted:

> Employee has failed to attach the presumption of compensability to his claim. Employee has not provided medical opinion that his work for Employer is the substantial cause of his pneumonia or resulting rib fracture, pneumothorax and related conditions. Employee already had a respiratory infection for which he had been prescribed antibiotics before starting the work assignment for the employer. Employee's claim involves a highly complex or technical medical condition as to which an expert medical opinion is necessary. AS 23.30.120; *Burgess Constr. Co. v. Smallwood*; 623 P.2d 312 (Alaska 1981).

(Controversion, March 14, 2016.)

3) On May 5, 2016, Employee filed a workers' compensation claim. He described how his illness and injury occurred:

> I was assigned by Saltwater, Inc. to cover the Unisea plant as an NMFS Alaska Groundfish Observer. I worked 12+ hour shifts from midnight to noon seven days a week. I worked, ate, and slept at the Unisea plant that employed up to 1700 workers (many of which were sick and ill as well). I caught an illness early on in February at the plant. After a few days, the illness got worse. I tried to attend to the illness myself as best I could. The illness got worse. I started coughing and had pains on my left side I thought were a pulled muscle after a few days. On 02/10.2016, I had coughing spasm that broke a rib in the office (not known at the time, but felt something collapse / give in same broken rib area after coughing spell). I went to the clinic the following day at work after some worsening symptoms (see 02/11/2016 symptoms sheet) over the next 24 hours developed that concerned me. The doctor at the clinic (Dr. Douglas Nicholson) agreed he thought I pulled muscle and gave me some medicine to help me sleep and muscle relaxers (indicative of pulled muscle diagnosis, not anything that would show up on x-ray, etc.). I did not feel too bad during this clinic visit as my pain was not present as it had been over the previous hours after the injury. I took notes as I felt rubbing and movement and sometimes intense pain in the area occasionally, mostly tolerable pain with general over-the-counter pain medication. . . . The doctor stated it would take time to heal. I have an unrestricted work release Dr. Douglas Nicholson and attached medical paperwork from the 02/11/2016 visit.

(Workers' Compensation Claim, April 29, 2016.)

4) Employee attached an injury summary to his claim, which states, in part:

> . . . .
> I worked on shift from midnight to noon. It was a cold, wet, tiring, and miserable shift. . . . During my normal shift, I was outside and exposed to weather most of time while monitoring for salmon on average over 6 hours for each 12 hour shift. I split the time with the vessel observers as required by work, though always pretty much monitored more than half of the offload time. The plant cannot offload pollock without myself or the vessel observer monitoring the offload. There is a lot effected (financially obviously) if I am unable to work including plant, owners,

> quotas, vessel workers, processors, etc. I was required to be available 24/7 as the lead observer to address issues at the plant. . . . My injury/reaction that was a result of my illness (coughing spasms that broke rib) occurred in the office on two occasions while on shift working in the office area of Unisea, Inc.
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> I started to get sick around the first two days of February. I tried to take care of the illness with what I had in my possession (over the counter and prescription items). In response to the controversion notice that I had a previous illness. I had no ill effects from being sick with a persistent cold from late December into January. I went to a clinic on January 12th, 2016 to ask for opinion on being able to work for contract starting on 01/16/2016. They took down some symptoms in Family and Urgent Care clinic notes about the visit (some were similar to symptoms encountered later, but the illness was not the same and I did not have the broken rib and will swear in court I was better before getting sick again). I take daily notes as required by NMFS. I have to write any health issues in these notes. I have only one note on 01/19/2016 in notes saying I'm feeling better (referring to sickness I went to Family and Urgent care clinic for) and another a few days later about an allergic reaction to something on my waist area (red color). I have no other notes on my Illness until February 5th when I stated I had been sick for a couple of days (start of February) and the previous day's shift I had off, I think I was running a fever, etc. The preexisting illness is therefore not relevant to the injury or I was unable to get better due to my work environment. I was cleared to go to work by Family and Urgent care in Vancouver, WA . . . . There are 1700 people employed at Unisea, Inc. in Dutch Harbor. I am housed in their bunkhouses next to the processing plant. There are supposedly 80 different nationalities, each with their own diseases, etc. that can cause illness. There was an epidemic of sickness going around at the plant in late January and early February and I would think over a 100 or more went to the clinic in Dutch Harbor to help with their Illness. I eat at the company's galley, work, and sleep on Unisea plant's property. I was only not at Unisea for brief trips to the grocery store. My work is my life when I work as a groundfish observer/marine biologist etc.

(Memorandum to Alaska Workers' Compensation Board, RE: Injury summary for Jason Wright in response to Controversion Notice, undated, attached to claim, April 29, 2016.)

5) On April 12, 2016, Dr. Febinger summarized Employee's medical history leading up to his broken rib and hemopneumothorax. Employee first felt ill in Dutch Harbor on February 4, 2016, and was seen for a cough and left flank pain in a clinic on February 10, 2016. He was released to work with a muscle strain diagnosis. On February 19, 2016, Employee had severe pain with syncope, was taken to the clinic, hemopneumothorax was diagnosed and a chest tube was placed to drain 1600 milliliters of fluid. Employee was air lifted to Anchorage and Kenton Stephens, M.D., performed a VATS evacuation of retained hemothorax and stabilized Employee's fractured

left ninth rib. Employee spent 10 days in the hospital, returned to Vancouver, Washington on March 3, 2016, and began treating with Dr. Febinger. (Chart Note, Dr. Febinger, April 12, 2016.)

6) On April 15, 2016, Dennis Febinger, M.D., stated Employee's work environment was a major contributor to his worsening illness and eventual poor outcome. Dr. Febinger considered Employee was working in close quarters with personnel from many countries and stated this increased his exposure to diseases and working long shifts, without time off, in a cold environment, exposed to the elements of the strenuous workload, compromise Employee's immune system "making it more difficult to recover from an illness." Dr. Febinger noted, on January 12, 2016, Employee was cleared for work to commence January 17, 2016 despite Employee feeling ill in late December 2015. In early February, Employee "still felt ill and feverish." On February 10, 2016, Employee had a severe coughing spell associated with rib pain, for which he was seen in another clinic on February 11, 2016, and diagnosed with a muscle spasm, treated with muscle relaxants and pain medications and returned to full duty work without restrictions. Dr. Febinger concluded Employee had probably fractured his rib but the diagnosis was not made and "continuing his strenuous work schedule from 11 to 19 February, probably with a fractured left rib, was a major factor in the eventual outcome of the lung tear, hemorrhage and subsequent events." (Letter To Whom It May Concern, Dr. Febinger, April 15, 2016.)

7) On April 22, 2016, Rita Williams, NP, noted Employee's symptoms had improved rapidly since his last visit. She noted Employee's job requires him to work, or at least be available, 24 hours a day for months at a time; there are no other employees to cover for him if he needs time off; and the entire plant is dependent on results related to work for which Employee is responsible; Employee works in a cold, damp environment in close quarters with other employees, many from other countries. NP Williams concluded Employee's work increased his risk for exposure to infectious diseases and, especially, respiratory diseases. "This working environment likely contributed to the onset and worsening of his respiratory illness." Employee was expected to return to work on May 23, 2016. (Chart Note, NP Williams, April 22, 2016.)

8) On December 15, 2016, Employee filed an affidavit of readiness for hearing (ARH) on his claim's merits. (Affidavit of Readiness for Hearing, December 12, 2016.)

9) On December 18, 2016, Ravinder Pal Singh Sergill, M.D., a pulmonologist, conducted an Employer's Medical Examination (EME) and diagnosed: (1) reactive airway disease/asthma, unrelated to and not substantially caused by Employee's work for Employer; (2) left rib fracture

with hemopneumothorax as part of coughing, unrelated to and not substantially caused by his employment with Employer. Dr. Sergill said Employee has allergic tendencies, including hay fever, and had gotten bronchitis prior to February 2016, which was bad enough that Employee needed oral steroids in the month of January 2016, and had been on an inhaler. Dr. Shergill concluded, "This all points toward him having reactive airway disease/evolving asthma. He keeps having recurrent infections. That is something we do see in these patients." Employee's coughing episode "possibly was part of his reactive airway disease, and that possibly caused a muscle tear or may have partially contributed to the partial fracture of the ninth rib." Dr. Shergill did not think there was significant bleeding at the time because "if that fracture had been at the time and led to significant bleeding, he should have had near syncope at the time." Dr. Shergill said, on February 11, 2106, "clinically" Employee was "not that symptomatic except local pain, and that is something we do see with cough and torn ligaments or muscles associated with the cough." Dr. Shergill thinks what occurred on February 19, 2016, "was a sudden event" because "if he was bleeding all this time, and his hemoglobin is 11.9-gram percent on arrival to the medical facility, he should not be that symptomatic." The fact Employee had near syncope told Dr. Shergill Employee "had a sudden event where he bled at the time, he lost intravascular volume which contributed to his syncope/near syncope." Dr. Shergill said, "Either it was related to some coughing episode preceding it or he was bronchospastic" that suddenly caused Employee's intrathoracic pressure to go up, "which leads to ruptured rib at the time, which, in fact, I believe injured his lung." Dr. Shergill suspected a sharp rib edge "at the time" caused Employee's pneumothorax and also caused him to bleed." Dr. Shergill thought if Employee has been bleeding "all along" starting on February 11, 2016, his blood would have clotted, but instead 1.6 liters of blood were removed when the chest tube was placed. Therefore, Dr. Shergill thinks the bleeding "exactly happened on the 19th of February 2016." Dr. Shergill said, "He was appropriately addressed with surgical intervention. All the clot was removed, his lung healed, and he continued to improve." When asked if he concurred that Employee's upper respiratory tract infection in January/February 2016 did not arise out of and in the course of his employment with Employer, but rather preexisted his work contract, Dr. Shergill responded there is no correlation between what happened at work and the problems Employee had in late 2015, and early 2016. Dr. Shergill opined Employee's work with Employer was not the substantial cause of "any of the conditions" he diagnosed, including coughing, rib fracture, or need for hospitalization. Dr. Shergill attributed

everything to reactive airway disease and stated, "He had an infectious process before that perpetuated that possibly led to a tear in the ninth rib on the left side. I think that subsequently broke fully and tore into the lung around the 19th of February 2016, and subsequent hospitalization ensued." Dr. Shergill also opined Employee received "adequate great care" at the Iliuliuk Clinic in February 2016. Employee was medically stable and able to perform medium to heavy level work by the third week of April 2016, with no restrictions. Treatment recommended by Dr. Shergill included Employee's "reactive airway disease be addressed in a pulmonary clinic and he "stay ahead of his allergy testing and stay ahead of his allergies." Dr. Shergill suggested Employee has undiagnosed sleep apnea that needs to be addressed. Dr. Shergill does "not believe the event of February 10, 2016, is the substantial cause of [Employee's] need for these recommendations." (EME Report, Dr. Shergill, December 18, 2017.)

10) On January 16, 2017, in reliance upon Dr. Shergill's report, all benefits were controverted. Employer stated, "No physician with knowledge of all pertinent facts has opined that Employee's employment is the substantial cause of his claim disability or need for medical treatment." (Controversion Notice, January 16, 2017.)

11) On January 8, 2018, Lisa Rinker, M.D., followed up with Employee and provided the following opinion:

> Jason had a severe respiratory infection and was diagnosed in early February. This infection likely resulted from his interactions with roughly 1700 plant workers and/or his rigorous schedule at work.
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> He worked a rough schedule in cold weather and miserable conditions as required by his job duties for the 12 hour (often more) shift from midnight to noon. Working in such conditions for seven days a week limited his ability to recovery from a respiratory infection, and likely made it worse. He had a severe coughing spell in the office that broke his rib on 2/10/2016. This coughing was caused likely from his inability to recover from illness effectively, but also could have been reaction to his environment at the plant (chemicals, smells, fish meal in air). The plant was dependent on him being there and able to work his shift, as there are no sick days offered him at this position.
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> Jason went to the local clinic the following day after having severe pain from coughing incident. The clinic told him he had a pulled muscle and prescribed muscle relaxers and a note that he could return to work unrestricted.
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> During the following days he performed his normal work duties, the broken rib caused additional damage that led to him passing out in the office on 2/19/2016.

> He recovered in the work office and again went to the local clinic. He was med-evac'd out that same day from Dutch Harbor to Alaska Regional Hospital as a result of bleeding into his lung. He had 1600 ml blood found in his lung that was caused by a puncture by the fractured rib.
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> The Alaska Regional Hospital report states that his reason for the visit was hemopneumothorax. His lung collapsed and filled with blood. The collapse was due to puncture by a fractured rib.
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> All of these diagnoses are consistent with the work illness/injury described above and the complications from work after the illness and injury occurred. Had he been able to take time off work after his initial diagnosis 2/10/2016 he may never had incurred the life threatening injury. He did require extensive recovery time to 5/12/2016 while under care of trauma surgeon Dr. Febinger at PeaceHealth. He was unable to work during that entire spring because of the severe injury to his ribs and lung.

(Letter To Whom It May Concern written by Dr. Rinker, January 8, 2018.)

12) On January 18, 2018, the parties stipulated to an SIME and agreed to work around Employee's schedule in preparing for the SIME. The parties were notified to list medical disputes on the SIME form but those disputes were subject to review by a designee, at the time of processing, and based upon the designee's records review additional disputes may be included and the parties' listed disputes may be excluded. Parties were provided the board's standard questions. (Prehearing Conference Summary, January 18, 2018.)

13) On January 22, 2018, Employer requested to cross examine Lisa Rinker, M.D., to ascertain the basis and rationale of her opinions. (Request for Cross-Examination, January 22, 2018.)

14) On March 2, 2018, Employee filed two compact discs, which contained documents and information he wished to include in the SIME binder. Disc two contained a CT scan from Open Advanced MRI. (Employee's SIME Disc 1 and Disc 2, March 7, 2018.)

15) On March 13, 2018, Employer requested an order striking all non-medical records and altered records from the SIME binders and for an order barring Employee from bringing any additional materials to the SIME. (Petition, March 12, 2018.)

16) On June 4, 2018, the parties filed the SIME form, which identifies disputes regarding causation, compensability, treatment, functional capacity, and medical stability. (SIME Form, June 4, 2018.)

17) Employer stipulated the CT scan on Employee's disc two is a relevant medical record. The images on the disc Employee provided cannot be accessed; however, Employer stipulated it will

obtain the record from Open Advance MRI for which Employee has signed a release. Employee stipulated the records he filed that are his contentions, non-medical records, and duplicate medical records need not be included in the SIME binders; however, he did not stipulate to exclusion of Employer's Observer Sampling Manual, his assignment and history, and occupational health assessments. (Record.)

18) Employee contended the 2018 Observer Manual, which is 556 pages long, should be included in the SIME binder because it documents all hazards he encounters at each assignment and his official duties. His assignment history documents his work assignments as an observer for Employer and other companies during his career. Employee contends because Dr. Shergill's opinion denies work was the substantial cause of his disability and need for medical treatment, proof of his exposure to "unsafe health conditions" that could have caused his cough should be assessed by the SIME physician. Finally, Employee contends the occupational health assessment form, completed annually when working for Employer, should be included in the SIME binder because it documents his work environment and that he was cleared for work. (Record.)

PRINCIPLES OF LAW

> **AS 23.30.001. Intent of the legislature and construction of this chapter.** It is the intent of the legislature that
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> > 1) This chapter be interpreted so as to ensure the quick, efficient, fair, and predictable delivery of indemnity and medical benefits to injured workers at a reasonable cost to the employers who are subject to the provisions of this chapter;

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). Liberal and wide-ranging discovery is favored. *Schwab v. Hooper Elec.*, AWCB Decision No. 87-0322 at 4, n.2 (Dec. 11, 1987) (citing *United Services Automobile Ass'n v. Werley*, 526 P.2d 28, 31 (Alaska 1974).

Under the Act, coverage is established by work connection, and the test of work connection is, if accidental injury is connected with any of incidents of one's employment, then the injury both would "arise out of" and be "in the course of" employment. The "arising out of" and the "in the

course of" tests should not be kept in separate compartments but should be merged into a single concept of "work connection." *Northern Corp. v. Saari*, 409 P.2d 845 (Alaska 1966).

> **AS 23.30.005. Alaska Workers' Compensation Board.**
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> (h) The department shall adopt rules . . . and shall adopt regulations to carry out the provisions of this chapter. . . . Process and procedure under this chapter shall be as summary and simple as possible. . . .
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> **AS 23.30.095. Medical treatments, services, and examinations.**
> . . . .
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> (k) In the event of a medical dispute regarding determinations of causation . . . 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 cost of an examination and medical report shall be paid by the employer. The report of an independent medical examiner shall be furnished to the board and to the parties within 14 days after the examination is concluded.
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> **AS 23.30.110. Procedure on claims.**
> . . . .
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> (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. The place or places shall be reasonably convenient for the employee. . . .

The Alaska Workers' Compensation Appeals Commission (commission) in *Bah v. Trident Seafoods Corp.*, AWCAC Decision No. 073 (February 27, 2008), addressed the board's authority to order an SIME under AS 23.30.095(k) and AS 23.30.110(g). With respect to AS 23.30.095(k), and referring to its decision in *Smith v. Anchorage School District*, AWCAC Decision No. 073 (February 27, 2008), the commission affirmed a SIME's purpose is to assist the board in resolving a significant medical dispute. "[T]he SIME physician is the board's expert." *Bah*, at 5, citing *Olafson v. State, Dep't of Trans. & Pub. Facilities*, AWCAC Dec. No. 061, at 23 (Oct. 25, 2007).

> **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. Declarations of a deceased employee concerning the injury in respect to which the investigation or inquiry is being made or the hearing conducted shall be received in evidence and are, if corroborated by other evidence, sufficient to establish the injury.
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> **AS 23.30.155. Payment of compensation.**
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> (h) The board may upon its own initiative at any time in a case in which payments are being made with or without an award, where right to compensation is controverted, or where payments of compensation have been increased, reduced, terminated, changed, or suspended, upon receipt of notice from a person entitled to compensation, or from the employer, that the right to compensation is controverted, or that payments of compensation have been increased, reduced, terminated, changed, or suspended, 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.

Considering the broad procedural discretion granted in AS 23.30.135(a) and AS 23.30.155(h), wide discretion exists under AS 23.30.110(g) to consider any evidence available when deciding whether to order an SIME or other medical examination and to determine evidence other than medical records an SIME physician should review to assist in investigating and deciding medical issues in contested claims, to best protect the parties' rights. *See, e.g.*, *Young v. Brown Jug, Inc.*, AWCB Decision No. 02-0223 (October 28, 2002); *Gurnett v. Millennium Hotel Anchorage,* AWCB Decision No. 07-0003 (January 4, 2007); *Perry v. Mappa, Inc*., AWCB Decision No. 13-0016 (February 22, 2013).

> **8 AAC 45.092. Selection of an independent medical examiner**. (a) The board will maintain a list of physicians' names for second independent medical evaluations. The names will be listed in categories based on the physician's designation of his or her specialty or particular type of practice and the geographic location of the physician's practice. . . .
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> (h) If the board requires an evaluation under AS 23.30.095(k), the board will, in its discretion, direct

> (1) a party to make two copies of all medical records, including medical providers' depositions, regarding the employee in the party's possession, put the copies in chronological order by date of treatment with the initial report on top and the most recent report at the end, number the copies consecutively, and put the copies in two separate binders;
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> (2) the party making the copies to serve the two binders of medical records upon the opposing party together with an affidavit verifying that the binders contain copies of all the medical reports relating to the employee in the party's possession;
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> (3) the party served with the binders to review the copies of the medical records to determine if the binders contain copies of all the employee's medical records in that party's possession. The party served with the binders must file the two binders with the board within 10 days of receipt and, if the binders are
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> > (A) complete, the party served with the binders must file the two sets of binders upon the board together with an affidavit verifying that the binders contain copies of all the employee's medical records in the party's possession; or
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> > (B) incomplete, the party served with the binders must file the two binders upon the board together with two supplemental binders with copies of the medical records in that party's possession that were missing from the binders and an affidavit verifying that the binders contain copies of all medical records in the party's possession. The copies of the medical records in the supplemental binders must be placed in chronological order by date of treatment and numbered consecutively. The party must also serve the party who prepared the first set of binders with a copy of the supplemental binder together with an affidavit verifying that the binder is identical to the supplemental binders filed with the board;
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> (4) the party, who receives additional medical records after the two binders have been prepared and filed with the board, to make three copies of the additional medical records, put the copies in three separate binders in chronological order by date of treatment, and number the copies consecutively. The party must file two of the additional binders with the board within seven days after receiving the medical records. The party must serve one of the additional binders on the opposing party, together with an affidavit stating the binder is identical to the binders filed with the board, within seven days after receiving the medical records.

As defined in *Mitchell v. United Parcel Service,* AWCB Decision No. 15-0040 (April 9, 2015), citing *Wilson v. Eastside Carpet Co.*, AWCB Decision No. 09-0029 (February 10, 2009), "medical records" for SIME purposes are "records maintained in the regular course of business by a

physician or other medical provider" which "the medical provider has prepared," or which have "been generated at the direction of the physician or other medical provider, for the purpose of providing medical diagnosis or treatment on behalf of the patient." *Wilson*, at 5, specifically stated, "while requiring the inclusion of 'all medical records, including medical providers' depositions' in the SIME binder, 8 AAC 45.092(h) does not prohibit the inclusion of 'non-medical' records."

> **8 AAC 45.120. Evidence**.
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> (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. Hearsay evidence may be used for the purpose of supplementing or explaining any direct evidence, but it is not sufficient in itself to support a finding of fact unless it would be admissible over objection in civil actions. The rules of privilege apply to the same extent as in civil actions. Irrelevant or unduly repetitious evidence may be excluded on those grounds. Irrelevant or repetitious evidence may be excluded on those grounds.

ANALYSIS

1. What records, if any, should be stricken from the SIME binders?

Alaska workers' compensation statutes and case law strongly favor development of an inclusive medical record to be considered when deciding a claim's merits. *Schwab*. Investigation and inquiry is permitted in the manner that will enable the parties' rights to be best ascertained when there is a dispute. AS 23.30.135(a); AS 23.30.155(h). All medical records, including medical providers' depositions must be included in SIME binders. 8 AAC 45.092. This requirement does not bar inclusion of additional documents if an SIME physician's review will assist in ascertaining parties' rights. AS 23.30.001; *Wilson*; *Gurnett*.

Employee coughed very hard and broke a rib, which punctured his lung causing a hemopneumothorax. This occurred while Employee was at work for Employer. Coverage for a work-related injury is established by a work connection; in Employee's case, was his cough connected with any incident of his employment. *Saari*. The underlying question that must be

answered is the cause of Employee's cough. Dr. Shergill opined there is no connection between Employee's employment with Employer and his cough. Dr. Shergill attributes Employee's cough to reactive airway disease and asthma, pre-existing Employee's work incident. Employee's physicians, attribute Employee's cough to his work environment and inability to take time from work to recover from a respiratory infection they believe he contracted at work.

The parties stipulated to inclusion or removal of all records Employee submitted except three. Non-medical records Employee compiled for inclusion in the SIME binder to which there continues to be a dispute are the 2018 Observer Manual, Employee's assignment history, and a blank occupational health assessment form. These are all non-medical records. *Wilson, Mitchell*.

The 2018 Observer Manual is 556 pages long and describes Employee's duties and the work environment he encountered during his work for Employer. This same environment and the hazards to which Employee is exposed, as well as his duties are more succinctly described in the blank occupational health assessment form. While the SIME binder will contain completed occupation health assessment forms, they contain additional information, which detracts from the paragraph regarding what an individual employed as an Observer can expect to encounter during a three to four month contract. *Rogers & Babler*. This case's facts are unique and to determine the source of Employee's cough, providing the SIME physician with evidence regarding Employee's environment, access to health care, and work duties in a clean, clear and concise format will enable the parties' rights to be best ascertained. AS 23.30.110; *Bah*. The lengthy 2018 Observer Manual provides irrelevant information in addition to information also contained in the occupational health assessment form. The 2018 Observer Manual will not be included in the SIME binder. 8 AAC 45.120(e). A clean, blank occupational health assessment form, in addition to those completed showing Employee's fitness for duty, shall all be included in the SIME binder. AS 23.30.135(a); AS 23.30.155(h); *Wilson*; *Gurnett*; *Perry*.

Employee's assignment history is calendars, which do not reveal information specific to Employee. *Rogers & Babler*. Completed occupational health assessment forms for all the years Employee has worked for Employer, contain evidence Employee's contracts average three to four months. An SIME physician will be able to extrapolate the time Employee was exposed to the

environment on commercial fishing vessels and fish processing plants based upon the occupational health assessment forms. Employee's assignment calendars will not be included in the SIME binders. AS 23.30.135(a); AS 23.30.155(h).

Employee is free to file both the 2018 Observer Manual and his assignment calendars as hearing evidence. AS 23.30.120.

2. What SIME physician specialty should be selected to perform the SIME?

Employee contends a cardio-thoracic surgeon will be familiar with his need for surgery, the overall healing process and whether Employee will experience future complications from the surgery he had to treat his hemopneumothorax. Employer contends the relevant specialty to perform the SIME is a pulmonologist. It is not necessary to determine, nor does a dispute exist regarding what type treatment was reasonable and necessary to treat his hemopneumothorax. Rather, the dispute concerns what caused Employee's cough, which caused his rib to break, which led to his hemopneumothorax, and what part, if any, his work environment, work duties, work schedule and lack of routine medical care played in his cough's development. Although a cardio-thoracic surgeon can respond to these questions, a pulmonologist has the greatest experience and expertise to analyze a respiratory condition and the cause of Employee's cough.

The SIME list contains one pulmonologist, Daniel Raybin, M.D. Dr. Raybin also has an internal medicine specialty. He will be selected to conduct the SIME. AS 23.30.095(k).

CONCLUSIONS OF LAW

1. The 2018 Observer Manual and assignment history records will be stricken from the SIME binder.
2. Pulmonologist Daniel Raybin, M.D., shall perform the SIME.

ORDER

1. Employer's petition is granted in part and denied in part.
2. Employer shall obtain the CT scan performed at Open Advanced MRI, which is contained on Employee's inaccessible disc two, and the image shall be submitted for the SIME physician's review.
3. Employer shall obtain actual and authenticated copies of all imaging studies, including colored, detailed images, and the images shall be submitted for the SIME's review.
4. A blank occupational health assessment form will be submitted for the SIME physician's review.
5. All Employee's completed occupational health assessment forms will be submitted for the SIME physician's review. If they are not currently a part of the SIME binder submissions, Employer must provide them for inclusion in the records submitted for the SIME physician's review.
6. The 2018 Observer Manual and Employee's assignment history calendars will not be submitted for the SIME physician's review.
7. Employee is directed to contact a technician or workers' compensation officer and inquire about his duties under the Act to provide Employer an opportunity to cross-examine Dr. Rinker.

Dated in Anchorage, Alaska on July 9, 2018.

ALASKA WORKERS' COMPENSATION BOARD

/s/
Janel Wright, Designated Chair

/s/
Pamela Cline, Member

/s/
Linda Murphy, Member

PETITION FOR REVIEW

A party may seek review of an interlocutory 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 JASON F. WRIGHT, employee / respondent; v. SALTWATER, INC., employer; LM INSURANCE CORPORATION, insurer / petitioners; Case No. 201603220; dated and filed in the Alaska Workers' Compensation Board's office in Anchorage, Alaska, and served on the parties by First-Class U.S. Mail, postage prepaid, on July 9, 2018.

/s/
Charlotte Corriveau, Office Assistant