Chapter 5. Medical Records and Evidence
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Paralegal Practice Tips

Well-qualified paralegals who are responsible for obtaining and reviewing medical records in workers' compensation practices should:

- Know the relevant state statutes, case law and/or state agency rules regarding obtaining and disclosure of medical records, as well as contact with medical providers.
- Know how frequently contacted medical providers accept medical record requests.
- Keep medical record release forms or authorizations for frequently contacted medical providers in a form file (paper or digital image).
- Obtain an itemized billing statement from each medical provider to compare with the medical records and verify that no records are missing.
- Have a working knowledge of basic medical abbreviations used by many medical providers.
- Prepare a medical record summary for each client.
- Know where to look up CPT and ICD-9 diagnosis and billing codes.
- Contact medical providers regarding the injured worker's unpaid medical expenses.
- Prepare a medical expense summary when medical expenses have been paid by group health insurance, Medicare or Medicaid, or the injured worker.
- Know if state statutes and/or state agency rules prohibit medical providers from dunning or pursuing collection actions against patients who have workers' compensation claims pending.
- Know if the state agency requires that an itemized statement of medical expenses be attached to any clincher or settlement agreement submitted for approval.

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5.1 Obtaining Medical Records

Paralegals for both plaintiffs' and defense firms play a key role in the management of workers' compensation cases by obtaining, organizing and summarizing medical records. They are not only responsible for gathering all medical records related to the work injury or illness, but
also for gathering prior and unrelated records for discovery and litigation purposes. They are responsible for organizing and locating the records as needed during the course of the firm's representation. They need to know how to obtain records, when to disclose records, how to read and understand the records, and how to organize the records for easy and quick access by the firm.

5.1(1) Ethical Considerations

Paralegals should be familiar with the applicable state statutes, case law and state agency rules regarding who can obtain medical records and under what circumstances. They should also be familiar with HIPAA requirements when contacting medical providers. The injured worker can obtain his or her own medical records or sign a HIPAA compliant medical authorization allowing the plaintiff's firm to obtain the medical records and communicate with medical providers. The employer and its representatives, such as the carrier/administrator or defense attorney, may also obtain medical records and communicate with medical providers, if the injured worker has signed a HIPAA compliant medical authorization allowing them to do so, or if the workers' compensation act allows employers access to medical records even without an authorization. Once an injured worker retains the plaintiff's firm to represent the worker in a workers' compensation case, the firm should state in correspondence to medical providers that the firm's medical authorization revokes all previous authorizations signed by the worker.

In cases where an injured worker has not signed a HIPAA compliant authorization allowing the employer or its representatives to obtain medical records, they may still be able to do so if permitted by state statute, case law and/or state agency rules. They may be limited in the scope of their request for information, be required to use specific language and/or state agency forms, and/or have to copy the injured worker or the worker's attorney on all requests as well as the information obtained. State statutes, case law and/or state agency rules may also require the injured worker or the worker's attorney to copy the employer and its representatives on all information obtained. One of a paralegal's case management tasks may be to make sure that all parties are properly and timely copied when medical records are received.

5.1(2) Contacting Medical Providers

There are a variety of different ways to request medical records. The method of the request may vary, depending on the medical provider's preferred method of contact. If the firm does not already have a form medical request, a paralegal can help create a form. Some medical providers will only accept releases signed within certain time frames, such as within 90 days or 6 months of the request, or on a date after (not before) the medical services were rendered. In those cases, paralegals should know the time frames accepted by frequently used medical providers.

1Usually the firm prefers to obtain medical records directly from the medical provider for evidentiary reasons, including verifying directly with the provider that the chart is complete. However, the injured worker may already have his or her own records, or in a situation where the plaintiff's firm has agreed to review a case with a statute of limitations immediately pending, the firm may allow the injured worker to personally make arrangements with the providers to pick up the records to save time.
Some medical providers, particularly hospitals, require that all medical requests be sent via the United States Postal Service and contain either an original release or the provider’s original form release signed by the patient. However, rising overhead costs, including postage and paper, may make other methods more attractive if medical providers will accept them. Many medical providers will accept a medical request via facsimile with a copy of a HIPAA compliant medical release attached. Faxing the request may reduce the turnaround time to receive the records and can be very helpful if the request is urgent. Some firms are using online medical record retrieval companies and download the medical records as image files, instead of receiving paper files.

5.1(3) Organizing Medical Records

Organizing medical records in client files is crucial. Everyone in the firm who accesses the files should be able to find specific medical records easily and quickly. There is nothing more frustrating than being unable to find a medical record while the opposing party is holding on the phone, while trying to assemble exhibits to request emergency relief for the client, or while preparing for a hearing or mediated settlement conference. While there is more than one way to organize medical records, the firm should agree on consistent method which will be used on all of its files.

One method is to organize the medical records by medical provider. This is helpful because the copy of the medical provider’s chart stays together and contains a copy of all the records the firm received from that provider. Some firms may file each medical provider’s records chronologically, with the initial date of service appearing first and the most recent date of service appearing last. Other firms may file the records in reverse chronological order, with the most recent date of service on top. However, medical records may be Bates-stamped or numbered for use as pleading, deposition, hearing and/or brief exhibits, and may be cited by page number. Medical records organized chronologically are easier to cite when drafting a history of events because the services occur in a natural order, like events in a time line. Court documents may be more challenging to draft if the records are organized “backwards,” or even worse, in no particular order at all.

Another method of organizing records is to arrange them chronologically, regardless of provider. This method makes it harder to review the treatment by one provider, but easier to follow the injured worker’s overall course of treatment. Sometimes doctors reviewing other medical providers’ records prefer to review documents that have been organized in this manner.

Injured workers’ medical records should be indexed so they may be quickly located by anyone in the firm. The index may include the name of the medical provider, the dates of service in the records and the page numbers, if any. A medical record index may also be used as a cover sheet for medical exhibits at a state agency hearing. See Form 5.3, Sample Medical Records Index.

5.1(4) Verifying Complete Set of Medical Records

There is a simple rule (applicable not just to workers’ compensation cases but to any kind
of case where paralegals have to gather medical records and expenses, such as personal injury or medical malpractice cases) for assembling a complete set of medical records:

Every medical record should be matched to a date of service on an itemized billing statement from the medical provider, and every date of service on an itemized billing statement should be matched to a medical record, with a corresponding date of service.

Even if the carrier/administrator has accepted the claim and paid all of the medical expenses to date, a paralegal should still request an itemized billing statement from each medical provider and compare the dates on the medical records to the dates of service on the bill, to make sure that no records are missing. Paralegals can also use the carrier/administrator’s printout of medical benefits paid to make sure there are medical records for all dates of service on the printout. Paralegals should carefully review all other available documentation of medical treatment, such as rehabilitation reports and group health insurance benefit statements, paying close attention to all dates of service referenced to ensure that all necessary medical records have been requested. Paralegals can also contact their firms’ clients with questions about medical treatment.

5.2 Reviewing and Summarizing Medical Records

Simultaneously reviewing and summarizing injured workers’ medical records is well worth the time and effort. Reading and summarizing each record upon receipt may seem time-consuming at first, but is actually more efficient in the long run. No one can memorize all of the medical records for multiple plaintiffs, and without some kind of reference or index, it can be difficult to find medical records later, even if the attorney and/or paralegal read them thoroughly upon receipt. Preparing a medical summary for each plaintiff is an excellent way to show the chronological history of treatment and also to have immediate access to medical information, especially when the firm has a high volume of cases to manage. See Form 5.5 and 5.6, Sample Medical Record Summaries

A medical summary can be used to:

- **Evaluate claims and defenses.** A careful chronological summary of the injured worker’s medical records, with the facts regarding the occurrence of the injury or onset of the illness included, can help identify any causation problems and reporting inconsistencies by the worker. For example, the worker may have told the employer that he hurt his back lifting heavy equipment at work when his medical records show that he told his doctors that he hurt his back moving furniture at home.

- **Calculate statutes of limitations and avoid missing other actionable injury claims** which may be reported in the medical records, but not by the injured worker to the plaintiff’s firm. Some injured workers are poor historians. During an intake, they may provide incorrect dates of injury or even forget they had more than one date of injury at work, especially if they have had a lot of medical treatment in the past few years. In those
cases, a medical summary is crucial to identify all dates of injury referenced in the medical records and help the plaintiff’s firm determine what injuries, if any, should be filed as workers’ compensation claims.

- **Reference while talking to the client about medical issues.** A paralegal or attorney can quickly access the summary from a desktop computer, review the most recent entries and intelligently discuss the injured worker’s medical issues, without having to leave the desk to find the hard file and then hunt through the medical records for the most recent date of treatment. The medical summary can even be updated while the client (adjuster or injured worker) is on the telephone, by asking if the injured worker has had treatment since the last date on the summary and entering the dates and providers in the summary, with a reminder to request the records. If the client has the dates for upcoming appointments, they can be added to the summary, with a note and/or tickler that the records need to be requested at the appropriate time.

- **Review medical providers’ itemized billing statements** and compare them to the medical summary to verify whether the dates of service listed on the bill are for medical conditions related to the work injury.

- **Reference when drafting correspondence, discovery responses, requests for medical relief or any other document** which discusses the worker’s medical treatment. Text from the summary can be quickly copied and pasted into the document, without having to locate pages in a bulky medical records file.

- **Use to prepare for and during a mediation, deposition or hearing.** A chronological summary of the worker’s medical history provides a quick reference when medical information is needed on short notice.

### 5.2(1) Medical Summary Format

Paralegals can prepare medical summaries using the firm’s available word processing or spreadsheet software. A case management software program can be used if it has features to enter medical data and show a chronological history of medical treatment. Whatever method the firm chooses, the main purpose of a medical summary is to provide a chronological overview of key medical issues and to answer frequently asked questions such as:

- What medical treatment has the injured worker received to date?
- What are the injured worker’s most recent restrictions?
- What medications were last prescribed for the injured worker?
- When is the last time the injured worker saw a doctor?
- What is the injured worker’s current treatment plan?
- Has the injured worker reached maximum medical improvement (MMI)?
- Has the doctor provided impairment ratings?

One clear and easy way to summarize medical records is to use the same medical reporting format that most medical providers use to organize information in their charts or records: **Subjective, Objective, Assessment and Plan** or “SOAP.” Medical records organized in the “SOAP” format contain the following information:

<table>
<thead>
<tr>
<th>S = “Subjective”</th>
<th>The patient’s self-reported complaints and history regarding the cause of injury, body parts affected, extent of pain, limitations on daily or work activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>O = “Objective”</td>
<td>The doctor’s clinical or physical exam findings, including but not limited to, visible injuries, tenderness upon palpation, ranges of motion, reflexes, muscle spasms, and diagnostic test results.</td>
</tr>
<tr>
<td>A = “Assessment”</td>
<td>The doctor’s diagnosis or differential diagnoses if there is more than one possible cause of the injury or illness, medical findings and causation if applicable</td>
</tr>
<tr>
<td>P = “Plan”</td>
<td>The doctor’s recommended course of treatment including conservative non surgical measures, surgery, physical therapy, prescriptions, functional capacity evaluation (FCE), injections, diagnostic studies, work restrictions, whether the patient has reached maximum medical improvement (MMI), and permanent impairment ratings, if any.</td>
</tr>
</tbody>
</table>

The purpose of preparing a medical summary is not to have a document containing a retyped or verbatim version of the medical records in their entirety, but to provide a chronological overview of key medical issues related to the work-related injury or illness. A successful medical summary will highlight and emphasize typical medical issues in workers’ compensation cases, such as:

- Causation of the injury or illness reported by the patient
- Diagnosis (or differential diagnoses if there are multiple possibilities for the cause of the injury or illness)
- Treatment plan, including recommended diagnostic reports, referrals and prescriptions
- Likelihood of recovery or “prognosis” (good, fair or poor)
- Permanent impairment or ratings of body members, if any
- Maximum Medical Improvement (“MMI”)
- Future medical needs, if any

Paralegals should keep medical summaries continuously updated, as additional information regarding the worker’s medical status becomes available. Paralegals can use the following sources of information to identify and insert the names of medical providers, dates of service, the type of services, and/or the treatment plan:

- Medical records
- Medical bills
- Client history and updates, including telephone calls, medical provider receipts and disability statements
- Rehabilitation consultant updates, including phone calls, correspondence and reports
- Carrier/administrator claim file, including printout of medical benefits paid
- Explanation of Benefit (EOB) statements from the worker’s group health insurance provider

Paralegals should carefully review all available documentation of medical treatment to ensure that medical summaries are complete and accurate. Medical records may reference treatment by other medical providers. Progress reports or updates from rehabilitation consultants generally discuss medical providers, dates of service and kinds of treatment. Itemized billing statements identify the medical provider, the dates of service and the type of treatment. If the firm does not already have the medical records for treatment referenced and identified in other documents, a paralegal can summarize as much information as is available from the document, such as entering dates of service or the names of providers, and then request the records.

If the software used to prepare the medical summary has a word or text search/find feature, the feature can be used to quickly find medical records by locating key words in the summary, such as “MRI,” “tendinitis” or a certain treating doctor’s surname, “Jones.” For example, a paralegal may need to request copies of the injured worker’s MRI scans for the last ten years. Instead of reading and reviewing voluminous pages of records trying to find all of the MRI reports, the search/find feature can be used to locate all of the times the word “MRI” appears throughout the medical summary in a few seconds. The paralegal can use the identified dates and providers of MRIs from the medical summary to locate the corresponding medical records in the chronologically organized file.
5.2(2) Prior and Unrelated Medical Treatment

While reviewing and summarizing medical documentation as it becomes available, paralegals should also pay close attention to references to prior and/or unrelated medical treatment and procedures. At initial evaluations in a new doctor’s office and/or histories and physicals (H&P) for surgeries, most medical providers request the patient’s medical background via interview, intake forms and/or patient questionnaires. Paralegals should include information regarding prior medical treatment at the beginning of the medical summary. Unrelated medical treatment should be included in the summary on the dates of treatment. However, unless the prior and/or unrelated medical treatment is relevant to the current case, it does not have to be summarized in as much detail as related medical records. This information may be used to:

- Respond to interrogatories regarding prior and/or unrelated medical treatment.
- Determine if the injured worker has unrelated medical conditions which need to be factored into a determination of the worker’s life expectancy for settlement purposes.
- Determine if there are other possible causes of the worker’s current condition that are not covered under the workers’ compensation claim.
- List unrelated and/or pre-existing medical conditions when asking Medicare to approve a Workers’ Compensation Medicare Set-aside Arrangement (WCMSA).
- Prepare the worker to testify at a hearing or deposition.
- Prepare to cross-examine the worker at a hearing or deposition.
- Provide to a treating doctor or other medical expert who has been asked to give a medical opinion.

5.2(3) Deciphering Medical Abbreviations, Terms and Codes

If the firm specializes in injury cases and has experienced staff, they will be familiar with basic medical abbreviations used frequently by medical providers. Some firms may even have a current or former licensed nurse on staff whose main responsibility is to review medical records. **Paralegals who review medical records should have a working knowledge of at least the basic abbreviations** or the “shorthand” used by many medical providers to record their handwritten notes. *See Appendix A: List of Frequently Used Medical Abbreviations.* If everyone who will use the summary knows basic medical abbreviations, then the abbreviations can be used to save time while summarizing the records. If the medical summary will be used by individuals who are not familiar with basic medical abbreviations, the full word or phrase should be used instead of an abbreviation.

The definition of medical terms can be included in a medical summary for quick reference. There are numerous online sources to look up medical abbreviations and definitions (see below). However, sometimes a medical provider may use nonstandard abbreviations (or
have his or her own shorthand which only his or her staff can decipher). If an abbreviation (or handwriting) cannot be deciphered from the context of the medical record, the medical provider can be contacted directly for clarification. Occasionally, the firm may ask a doctor to dictate his handwritten notes into a typed record in order for them to be legible.

Paralegals frequently have to review medical billing statements from providers and medical expense printouts from group health insurance carriers, workers' compensation carrier/administrators, or Medicare and Medicaid. In many cases the only information regarding the diagnosis on a treatment date is a medical billing code, such as a CPT or ICD-9 code. Current Procedural Technology or “CPT” billing codes are used by medical providers to classify medical, surgical and diagnostic procedures and are maintained and copyrighted by the American Medical Association (AMA). International Classification of Diseases or “ICD-9” diagnosis codes are used by medical providers to describe diseases, conditions and related issues, and are published by the World Health Organization. CPT codes are used to identify and document the services or treatment for the diagnosis indicated by the ICD-9 codes. Paralegals do not need to become medical billing/coding experts or specialists, but they do need to know how to look up CPT and ICD-9 codes to decipher medical bills or medical expense summaries. Sometimes simply googling “CPT” or “ICD” plus the code number in question will provide a quick answer.

Prior to the availability of the Internet, researching medical terms, definitions and codes was much more challenging and time-consuming for paralegals working in practices that specialized in injury cases, such as workers’ compensation, personal injury and medical malpractice. Paralegals had to rely on expensive medical dictionaries and textbooks, and sometimes even go to medical libraries in person to locate medical textbooks or articles. Now the majority of this information is available on the Internet, via free, fee-based or subscription-based websites. Information that may previously have taken hours to locate can now be found in seconds. Sometimes simply googling a medical abbreviation, term, code or procedure can result in an instant definition or explanation. There are also many online sources which provide access to medical information. Some of the free websites include (but are not limited to):

- **AMA CPT Code/Relative Value Search**, https://catalog.ama-assn.org/Catalog/cpt/cpt_search.jsp (CPT codes and Medicare’s relative value payment for a code)
- **MedicineNet**, http://www.medterms.com/script/main/hp.asp (Medical dictionary)
- **MediLexicon**, http://www.medilexicon.com/ (Medical abbreviations, definitions, ICD-9 codes)
5.3 Identifying Key Medical Issues

Workers’ compensation paralegals may spend significant time reviewing voluminous medical records, especially for seriously injured workers or cases with complex medical issues. Much of the information contained in a standard medical report is required by medical providers to diagnose and treat the medical condition, but not necessarily helpful to evaluate injured workers’ claims to workers’ compensation benefits. While reviewing and summarizing medical records, paralegals should be aware of key medical issues that may directly affect injured workers’ entitlement to workers’ compensation benefits as follows:

5.3(1) Causation

Causation is the basis of a workers’ compensation case. Injured workers are entitled to workers’ compensation benefits only if the injury or illness occurred during the course of their employment or because of their job duties. Paralegals must pay close attention to what an injured worker reported to all medical providers regarding the illness or injury, such as:

- How was the worker injured?
- Was the worker injured at work or elsewhere?
- Did the worker have more than one injury?
- Are the worker’s reports of injury consistent or inconsistent?
- Did the worker tell one provider one story and another provider a different story?
- Did the worker report no injury at all?

These are important questions for paralegals to answer while reviewing and summarizing medical records.

Medical providers generally record the patient’s account of the injury or “history” at the beginning of their reports, in the “complaint” or “subjective” part of the records. The patient’s history may be reported in more than one place in the medical chart, including the office notes, patient questionnaire and/or nurses’ notes. A paralegal should check to see how the injury is reported in all of the documents in the medical chart, not just the first page or the beginning. Key records can be flagged or highlighted for the supervising attorney’s review, especially if the injured worker’s report of injury in the medical records is inconsistent with the history given to the attorney or the employer and its representatives.

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2However, these details may be important to document relevant issues in third party personal injury or medical malpractice cases, such as pain and suffering or medical provider violations of the standard of care.
5.3(2) Pre-existing Conditions

If an injured worker has pre-existing conditions, such as osteoarthritis, bulging discs or prior surgeries or injuries to a relevant body member, this does not mean that the worker is not entitled to workers’ compensation benefits, if the affected body part or member is injured or re-injured during the course of employment. A worker may be entitled to workers’ compensation benefits if an injury occurred at work, and a non disabling pre-existing condition is exacerbated, aggravated or becomes disabling due to the work injury. However, pre-existing injuries or conditions, especially to the same body part involved in the workers’ compensation case, might cause the carrier/administrator to prolong its initial investigation to determine liability. The carrier/administrator may want to review prior medical records as part of its investigation. The carrier/administrator might even deny the claim (with or without justification) on the basis that the injured worker had a pre-existing medical condition.

5.3(3) Disability or Work Restrictions

The carrier/administrator will not pay indemnity or disability benefits without evidence or documentation from the treating doctor that the injured worker cannot perform his or her job, with or without restrictions, or cannot work at all, due to the work injury or illness. The employer should require and the injured worker should request a disability statement or “work note” at each medical visit, including to hospital emergency rooms. The note should state whether the patient cannot work at all due to the injury, can work with restrictions, or can return to work with no restrictions. If the injured worker does not have disability statements or work notes, then a paralegal can review the medical records to see if the doctor addressed the injured worker’s ability to work. If the doctor does not discuss work restrictions in the office notes, the paralegal may have to send the doctor a written request for an opinion regarding the injured worker’s current ability to work or ability to work during a certain time period.

5.3(4) Permanent Injury

An injured worker may be entitled to compensation for permanent injury or impairment to specific body members as a result of the work injury or illness. Often, when an injured worker is released by the treating doctor as having reached maximum medical improvement (MMI), the doctor will assign a percentage of permanent injury to each injured body member, such as a leg or the back, or the whole body. A paralegal should review the medical records carefully to see if any opinions regarding permanent injury or impairment are stated. If the doctor has discharged the injured worker but not addressed the permanent impairment or ratings (if any), the firm may have to send the doctor a written request for an opinion on the percentage of permanent injury or impairment to the injured body part. Paralegals should know if the state agency has its own guidelines or forms for reporting or documenting permanent impairment. If so, the required forms and guidelines can be sent to the treating doctor to complete.

5.3(5) Future Medical Needs

The employer and the injured worker need to know what future medical needs the worker may have over the course of the worker’s anticipated lifetime because of the work injury or
illness, including (but not limited to): office visits, physical therapy, surgeries, durable medical equipment (DME) and/or prescriptions. This information is used to evaluate the injured worker’s entitlement to future medical benefits over the worker’s anticipated lifetime and to estimate the cost of future medical services. If an injured worker has the option of resolving the case for a lump sum of money and wants to pursue it, future medical needs need to be estimated and valued. Workers’ compensation practitioners should be able to:

- Discuss the estimated value of these benefits with the client and get settlement authorization.
- Discuss future medical costs with the opposing party in informal settlement discussions.
- Prepare a settlement letter with realistic estimates and values for future medical costs.
- Present a realistic summary of future medical costs at mediation.
- Possibly submit an estimate of the worker’s future medical needs to Medicare if the injured worker’s case requires a Workers’ Compensation Medicare Set-aside Arrangement (WCMSA).

Paralegals should carefully review medical records to see if treating doctors address injured workers’ future medical needs in reports and/or in correspondence to the parties. If not, requests for written opinions regarding future medical needs can be sent to treating doctors. Paralegals should know if the state agency has its own guidelines or forms for reporting or documenting future medical treatment. If so, the required forms and guidelines can be sent to the treating doctor to complete.

5.4 Medical Research

Paralegals can perform medical research for a variety of reasons, including to:

- Educate the firm about the nature of the injury and/or illness.
- Educate the firm about symptoms, treatment and prognosis of the injury and/or illness.
- Educate the firm regarding the general causes of the injury and/or illness.
- Educate the firm about medical terms, tests and procedures.
- Obtain copies of medical and scholarly research articles.
- Locate experts in the subject medical specialty.
- Obtain basic illustrations and diagrams of standard injuries and/or conditions.
One of the best ways to start a medical research project is to google the key terms, such as "carpal tunnel syndrome." A Google search of a medical term will generally provide an overview of the subject matter and provide online sources or links to pursue for more specific information.

There are many online sources for medical research, some free and some subscription-based. Some of the frequently used online sources for medical research include (but are not limited to):

- **eMedicine Emergency Medicine Medical Reference**, http://www.emedicine.com/emerg/
- **Medscape**, http://www.medscape.com/home
- **Physicians Desk Reference**, http://www.pdr.net

Some firms may hire medical consultants and experts, such as doctors or legal nurse consultants, to perform medical research. However, this is a costly option due the high hourly fees requested by most medical consultants and experts.

### 5.5 Medical Provider Contact

Paralegals should be familiar with the relevant HIPAA requirements, ethical rules, state statutes and state agency rules regarding medical provider contact. **They should not contact medical providers directly unless instructed to do so by a supervising attorney.** Attorneys should review and approve all correspondence to medical providers, including facsimiles and E-mails, because these documents may be discoverable depending on the circumstances and applicable state statutes and rules.

When directed to do so by supervising attorneys, paralegals may need to contact medical providers to:

- Request copies of medical records and/or the chart in its entirety.
- Request copies of disability statements.
Request copies of prescriptions for medications and durable medical equipment.

Request copies of correspondence.

Request that the treating doctor complete a medical necessity letter or provide other documentation for the carrier/administrator to authorize medical treatment. See Form 5.7, Sample Request for Medical Necessity Letter to Doctor.

Request that the treating doctor answer written questions regarding whether the injured worker can return to work, with or without restrictions, or perform specific jobs.

Request that the treating doctor assign or clarify a permanent impairment rating.

Request that the treating doctor provide an estimate of future medical treatment and expenses.

Complete the state agency’s required medical information forms.

The firm should have its own forms and required state agency forms for routine requests, such as requesting medical records or obtaining a rating. More complex requests, such as whether the injured worker needs home attendant services or is mentally competent to handle his or her affairs, may require a paralegal to draft specialized documents, including affidavits. The supervising attorney should review and approve all documents before they are sent to medical providers.

5.5(1) Obtaining Written Opinions from Doctors

Sometimes the parties’ attorneys will want written opinions about specific medical issues from treating doctors. Written medical opinions by treating doctors are usually requested for the following kinds of issues in typical workers’ compensation cases:

- Did the work injury as reported by the worker cause or significantly contribute to the injury or condition?

- Did the work injury as reported by the worker aggravate a pre-existing condition?

- Is the condition for which the worker is being treated unrelated to the reported work injury or illness?

- Can the worker perform a specific job, with or without restrictions?

- What are the worker’s permanent restrictions?

- Is the worker permanently and totally disabled from earning wages?
What is the percentage of permanent impairment (or rating) due to the work injury?

What medical treatment will the worker need in the future?

Paralegals should be familiar with the relevant HIPAA requirements, ethical rules, state statutes and state agency rules regarding any kind of communication with medical providers. The kinds of communications allowed may be different for the injured worker’s representatives as opposed to the employer and its representatives. The law may require all the parties to copy each other on any written communication to medical providers as well as on any information received from the medical provider in response to the request. The law may limit written contact by the employer or its representatives to specific issues and/or questions. The law may even specify that the employer’s representatives only use specific questions and/or state agency forms or questionnaires to obtain information.

Paralegals should be aware that any written correspondence to medical providers becomes a part of the patient or injured worker’s medical chart and may be discoverable or disclosed to the other parties. All correspondence to medical providers should be drafted carefully and under an attorney’s supervision because of the legal issues involved, including the knowledge that it may be seen by all parties. See Form 5.8 - Sample Letter to Doctor re: Causation Opinion.

5.5(2) Providing Documents to Doctors to Review

In order to obtain an opinion from a doctor, the firm may need to provide copies of documents for the doctor’s review, especially medical records from other medical providers. A doctor will have access to his or her own chart, but may not have a complete set of the injured worker’s medical records to review. If an opinion regarding prior or pre-existing medical conditions is needed from a doctor, he or she will need a copy of the injured worker’s medical records prior to the injury. Paralegals should not provide any medical records to a doctor unless requested to do so by a supervising attorney. Any documents provided to a doctor, including but not limited to, other medical providers’ records, accident reports, deposition testimony and job descriptions, may be discoverable by or disclosed to the other parties. Therefore, all documents submitted to a doctor for review should be selected carefully and reviewed by a supervising attorney prior to being sent to the doctor.

All documentation provided by the firm to a treating doctor should be organized to make the doctor’s review of the records as easy as possible. Most doctors charge a significant hourly fee for their time spent reviewing medical records and writing a report with their opinion. A well-organized set of medical records could save the firm and the client time and money. If a doctor requests that certain records be organized in a specific format, then the firm should comply with the request. If a specific format is not requested, then a copy of the medical records may be organized in chronological order and numbered. Page numbering makes it easier for everyone to literally be “on the same page” when discussing issues with doctors over the telephone, in-person, or at depositions. The firm should retain a copy of any documentation provided to doctors, including cover letters.
5.6 Handling Unpaid Medical Expenses

In cases where the carrier/administrator has denied all or part of a claim, the injured worker may have unpaid or unreimbursed medical expenses. In denied cases where the injured worker needed emergent or immediate medical treatment and was covered by the employer’s or spouse’s group health insurance, all or a portion of the medical expenses may have been paid. However, the group health insurance carrier may have a subrogation lien in the amount of the medical expenses it paid against any recovery of medical benefits in the workers’ compensation case.

5.6(1) Requesting Itemized Billing Statements

In denied cases, or accepted cases where the carrier/administrator has refused to pay all or some of the medical expenses, an itemized billing statement must be requested from the medical providers. Even if the injured worker provides bills received at home, the firm should still request a complete itemized statement to verify that no expenses have been omitted. An itemized billing statement should contain the following information:

- The name and contact information for the medical provider;
- The dates of each service;
- The types of service rendered (by description or medical code);
- The amount of the charges for each service;
- Any payments on the account and source of each payment (workers’ compensation carrier, group health insurance carrier, Medicare, Medicaid, patient self-pay or other);
- Any “adjustments” or amounts subtracted by the medical provider; and
- The unpaid balance on the account, if any.

Paralegals may also request a printout of medical expenses paid by the workers’ compensation carrier or group health insurance carrier to compare with the medical providers’ itemized billing statements.

5.6(2) Contacting Medical Billing or Collection Departments

Paralegals working for plaintiffs’ firms should ask clients to provide the firm with all medical bills and/or collection notices received for medical expenses related to the work injury or illness. Paralegals should carefully review all medical bills and/or collection notices and verify that the medical expenses are related to the work injury or illness. If the medical expenses appear to be related to the work injury or illness, and the injured worker is unable to pay the bills pending resolution of the workers’ compensation case, a paralegal should contact the medical providers via telephone and letter, and ask that the provider voluntarily hold the accounts until
the case is resolved. Calling and writing the medical provider’s patient billing department ensures that the paralegal has both talked to the appropriate person about the account and that the medical provider also has received written notice of the pending workers’ compensation claim.

Paralegals should know if state statutes and/or state agency rules prohibit medical providers from dunning or pursuing collection actions against patients who have workers’ compensation hearings pending on the state agency hearing docket. If medical providers are prohibited by law from pursuing collections against injured workers pending a state agency hearing, the plaintiff’s firm should send a letter to the medical provider and/or its collection agent, notifying them of the case status and citing the relevant statute or rule.

5.6(3) Summarizing Medical Expenses

A summary of medical expenses should be prepared in the following situations:

- The injured worker has a claim for unpaid and/or unreimbursed medical expenses.
- Medical providers have an alleged lien or subrogation interest for unpaid medical expenses.
- A group health insurance carrier, Medicare or Medicaid has a claim or subrogation lien for medical expenses paid as a result of the work injury or illness.
- The state agency requires that a summary of medical expenses be filed.

At minimum, the medical expense summary should show:

- The medical provider;
- The dates of each service;
- The amount of the charges for each date of service;
- The amount of payments for each date of service and who made the payments (the carrier/administrator, group health insurance, Medicare, Medicaid, patient self-pay or other);
- Any adjustments made by the medical provider; and
- The amount which remains unpaid or unreimbursed.

See Form 5.4, Sample Summary of Medical Expenses. A medical expense summary may be used to document the amount of unpaid or unreimbursed medical expenses at mediation, voluntary settlement or upon receipt of a state agency order directing defendants to pay the expenses. Paralegals should know if the state agency requires that an itemized statement of medical
expenses be attached to any clincher or settlement agreement submitted for approval.

5.7 Preparing for Medical Depositions

The most important task a paralegal can perform to help an attorney prepare for a medical deposition is to verify that the firm has a complete set of medical records, including the chart in its entirety from the doctor to be deposed. The deposed doctor’s chart is usually the main exhibit to the doctor’s deposition. Most medical providers do not provide every sheet of paper in the patient chart in response to a medical request from a law firm. They will generally provide only their own facility’s office notes and refuse to disclose records in the chart from other medical providers. Well in advance of the deposition, a paralegal should review the medical provider’s chart to see if it appears to be complete.

A complete patient chart from a doctor’s office may contain the following documents:

- Office Notes
- Diagnostic reports, including laboratory results and films
- Registration/intake form
- Patient questionnaires
- Nurses’ notes
- Prescription logs
- Correspondence and/or facsimiles to other providers
- Referral sheets
- Disability or work notes

A paralegal for the plaintiff’s firm should verify with the treating doctor’s office that the chart is complete, either by:

- Reviewing the chart page by page with a medical records clerk over the telephone;
- If the chart is small, faxing a copy to the medical records clerk to review and verify it is complete or supply missing records; or
- Scheduling an appointment to go to the office and review the chart in person.

Reviewing the chart in person is the best way for a plaintiff’s attorney to verify that it is complete, but that may not be feasible in some cases or practices. If an injured worker is
receiving ongoing care, records for recent treatment may not have been filed at the time the chart was copied for the firm. If possible, a paralegal for the plaintiff's firm should schedule a meeting at the doctor's office at least thirty minutes prior to the deposition for the attorney and/or paralegal to review the chart in its entirety.

In many cases, it is also important that the doctor to be deposed, whether he is the treating doctor or a hired expert, has a complete set of numbered medical records from every medical provider who has treated the injured worker. The paralegal assembling the medical records should work with her supervising attorney to verify which records the attorney wants the doctor to review prior to his deposition.
Form 5.1 - Sample Medical Request Letter to Doctor's Office

[Provider Address]

Re: [Patient name] [Patient date of birth] [Date of injury or illness onset]

To Whom It May Concern:

This firm represents the above-referenced patient in a workers’ compensation case.

Please send me a copy of the patient’s chart in its entirety, including but not limited to, office notes, nurses’ notes, diagnostic reports and correspondence to and from your office.

In addition, please send me an itemized billing statement for all services rendered to the above-referenced patient.

I am enclosing a medical authorization signed by the patient, allowing you to release information to this firm. If you have any questions or if you need additional information, please do not hesitate to contact me.

Thank you for your attention to this request.

[signature line]

Enclosure as stated
cc: [Client] [Adjuster or opposing counsel if required by statute or rule]
Form 5.2 - Sample Medical Request Letter to Hospital

[Hospital Medical Correspondence Address]

Re: [Patient name]  
[Patient date of birth]  
[Date of injury or illness onset]

To Whom It May Concern:

This firm represents the above-referenced patient in a workers’ compensation case.

Please send me a copy of the following documents only from patient’s chart:

Admission chart(s)  
Emergency room record(s)  
Diagnostic report(s)  
History and physical(s)  
Consultant report(s)  
Operative notes(s)  
Discharge report(s)

In addition, please send me an itemized billing statement for all services rendered to the above-referenced patient.

I am enclosing a medical authorization signed by the patient, allowing you to release information to this firm. If you have any questions or if you need additional information, please do not hesitate to contact me.

Thank you for your attention to this request.

[signature line]

Enclosure as stated
cc: [Client]  
[Adjuster or opposing counsel if required by statute or rule]
### Medical Records Index of Joe Smith

<table>
<thead>
<tr>
<th>Tab</th>
<th>Medical Provider</th>
<th>Dates of Service</th>
<th>Page Number(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>County Ambulance</td>
<td>01/15/2007</td>
<td>1 - 3</td>
</tr>
<tr>
<td>2</td>
<td>State Hospital</td>
<td>01/15 - 01/24/2007; 02/23/2007</td>
<td>4 - 15</td>
</tr>
<tr>
<td>3</td>
<td>City Orthopaedics</td>
<td>01/30/2007 - present</td>
<td>16 - 35</td>
</tr>
<tr>
<td>4</td>
<td>City Radiology</td>
<td>02/15/2007</td>
<td>36 - 37</td>
</tr>
</tbody>
</table>
## Form 5.4 - Sample Summary of Medical Expenses

[Insert case caption]

<table>
<thead>
<tr>
<th>Exhibit</th>
<th>Medical Expenses</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Provider/Date(s) of Service</th>
<th>Charge</th>
<th>WC Paid</th>
<th>Group Health Ins</th>
<th>Adjustment</th>
<th>Self Pay</th>
<th>Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>County Ambulance</strong> 01/15/2007</td>
<td>$365.00</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>$365.00</td>
</tr>
<tr>
<td><strong>State Hospital</strong> 01/15 - 01/24/2007</td>
<td>$9,450.00</td>
<td>0</td>
<td>$4,500.00</td>
<td>$3,800.00</td>
<td>$1,000.00</td>
<td>$150.00</td>
</tr>
<tr>
<td>02/23/2007</td>
<td>$1,200.00</td>
<td>0</td>
<td>$620.00</td>
<td>$380.00</td>
<td>$165.00</td>
<td>$35.00</td>
</tr>
<tr>
<td><strong>City Orthopaedics</strong> 01/16/2007</td>
<td>$3,600.00</td>
<td>0</td>
<td>$1,900.00</td>
<td>$750.00</td>
<td>$250.00</td>
<td>$700.00</td>
</tr>
<tr>
<td><strong>City Radiology</strong> 01/15/2007</td>
<td>$70.00</td>
<td>0</td>
<td>$40.00</td>
<td>$30.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$14,685.00</td>
<td>0</td>
<td>$7,060.00</td>
<td>$4,960.00</td>
<td>$1,415.00</td>
<td>$1,250.00</td>
</tr>
</tbody>
</table>
### FORM 5.5 - Sample Medical Record Summary

**Medical Summary of Sally Smith**  
**DOI: 11/01/2005**

<table>
<thead>
<tr>
<th>Date</th>
<th>Provider</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>06/01/2004</td>
<td>County Family Practice</td>
<td><strong>A: Muscle soreness, strain s/p MVA</strong></td>
</tr>
</tbody>
</table>
| 06/03/2004 | City Hospital                   | **Cervical MRI**  
**A: Spondylosis at C4-5 level with prominent osteophytic formation resulting in narrowing of canal and foramina. Tiny central disc protrusion at C3-4 not likely to be of any significance.** |
| 01/29/2005 | County Family Practice          | **A: Neck Strain...very small likelihood of any impingement...**           |
| 12/01/2005 | **DOI [Denied] - pulling a piece of foil out of machine which was turned off...then raised her arm & had immediate pain in R shoulder & elbow**  
**Supervisor's First Report of Injury:** Reported to Johnny White, supervisor...EE hurt her arm while removing a core from the unit bobbin...core was hard to remove and as a result, she hurt her arm. |

<table>
<thead>
<tr>
<th>Date</th>
<th>Provider</th>
<th>Treatment</th>
</tr>
</thead>
</table>
| 11/01/2005 | Plant Doctor                    | **RN**  
S: EE presented c/o pain to R elbow that extends up into R shoulder. Increased pain noted with extension & abduction of R shoulder. Unable to fully elevate R arm above shoulder height without increased pain. Will not attempt to extend R elbow states “I can’t do that”....EE states “I was trying to take off an empty core and it was harder than usual to get off.” “When I tried again to take it off the machine, I felt a pain in my R arm.”...  
**O:** Visual inspection of R elbow/shoulder show no sign of swelling/deformity.  
**P:** EE unable to finish her work shift b/c of pain. Given Advil... use ice pack to help control pain...call in a.m. if any further problems & for evaluation by dr since she states she is unable to complete shift. |
| 11/02/2005 | City Orthopaedic Center         | **William Bones MD**  
S:...47 yo pleasant female...presents today w/R elbow & shoulder pain. While at work on 12/01/2005...pulling a piece of foil out of machine which was turned off...then raised her arm and had immediate pain in R shoulder & elbow...pain isolated in lateral aspect of shoulder...  
**A:** 1. R shoulder strain, possible rotator cuff tear 2. R medial epicondyle strain of elbow  
**P:**...injected subacromial space w/Lidocaine/Marcaine/Kenalog...obtained excellent relief of shoulder sx...had improved strength as well...Rx for Mobic...QQW 3 wks...undergo PT...f/u after shoulder MRI... |
| 12/07/2005 | City Radiology                  | **R Shoulder MRI (Bones MD)**  
**A:** Supraspinatus and infraspinatus tendinopathy with deep bursal sided tearing of supraspinatus and infraspinatus tendons. Acromioclavicular degenerative disease. Subscapularis tendinopathy. |
<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
<th>Doctor</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/17/2006</td>
<td>City Orthopaedic Center</td>
<td>William Bones MD</td>
<td>S: R-hand dominant...she was taking a roll off a machine when it caused her shoulder to twist and felt a pop in the shoulder...has had pretty much pain since that time...able to function in repetitive activities above her shoulder level with no problem prior to injury...&lt;br&gt;A: R shoulder partial thickness rotator cuff tear secondary to OTJ injury as well as acromioclavicular joint arthritis&lt;br&gt;P: I discussed with pt that she has almost all of her rotator cuff torn from injury at work...she would benefit greatly from an arthroscopic evaluation of her joint as well as arthroscopic subacromial decompression of any open rotator cuff repair and open disk clavicle excision...unable to work 01/17 - 01/22, able to work 01/23 light work duties...</td>
</tr>
<tr>
<td>02/27/2006</td>
<td>City Orthopaedic Center/City Outpatient Surgical Center</td>
<td>SURGERY - William Bones MD</td>
<td>A: R shoulder rotator cuff tear as well as acromioclavicular joint arthritis, as well as torn biceps tendon&lt;br&gt;P: R shoulder arthroscopy with extensive intraarticular debridement of torn biceps. Arthroscopic biceps tenotomy and smoothing of superior labrum. Arthroscopic subacromial decompression and CA ligament release. Open disk clavicle excision, mini open rotator cuff repair, and mini open biceps tenodesis in bicipital groove.</td>
</tr>
<tr>
<td>03/07/2006</td>
<td>City Orthopaedic Center</td>
<td>William Bones MD</td>
<td>S: recheck R shoulder, 8 days s/p rotator cuff repair, biceps tenodesis and distal clavicle resection...doing fairly well...taking Robaxin &amp; Percocet for pain control...&lt;br&gt;A: 8 days s/p R shoulder arthroscopy, doing well&lt;br&gt;P: con’t PT...denied any need for pain Rx....f/u 4 wks...OOW 4 weeks</td>
</tr>
<tr>
<td>07/26/2006</td>
<td>City Orthopaedic Center</td>
<td>William Bones MD</td>
<td>S: recheck R shoulder...21 wk s/p rotator cuff tear &amp; arthroscopy...some con’t weakness...has been OOW since surgery...discharged from formal PT...not taking any pain Rx...very happy with progress thus far...would like to RTW.&lt;br&gt;O: R shoulder shows anterior incision...forward flexion up to 140 deg. External rotation to 45 deg. Internal rotation to L2. Neurovascularly intact...strength in internal/external rotators 5/5 bilaterally..&lt;br&gt;A: 21 wks S/p R shoulder rotator cuff repair, arthroscopy, doing very well.&lt;br&gt;P: recommend RTW full duties...to ease back into activities, esp. lifting and overhead activities...denies need for any pain Rx...15% PPD RUE...return prn.</td>
</tr>
</tbody>
</table>

July 31, 2006 - RTW Full Duties
## Form 5.6 - Sample Medical Record Summary

### Medical Summary of Joe Smith
**DOI: 01/24/2007**

<table>
<thead>
<tr>
<th>Date</th>
<th>Provider</th>
<th>Doctor</th>
<th>Subjective (Complaints)</th>
<th>Objective (Exam) &amp; Diagnostic</th>
<th>Assessment (Dx)</th>
<th>Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/15/2006</td>
<td>USA Family Care</td>
<td>Shelton, Jim</td>
<td>Injured low back moving Christmas tree... still working... having trouble sleeping due to back pain...</td>
<td>...tenderness to palpation at L4-5... normal ROM</td>
<td>Lumbar strain</td>
<td>Rx = 1BU 800 mg qd; alternate ice/heat; RTW no restrictions</td>
</tr>
</tbody>
</table>

**DOI: 01/24/2007 [Accepted Claim]**

Per Dr. Martin 03/06/2007... lying on back on ground using legs to push up wing carrier of tractor trailer which collapsed despite use of pneumatic support... had some lower back pain at that time but about 2 days later had significant increase of back pain and pain down LLE.

<table>
<thead>
<tr>
<th>Date</th>
<th>State Hospital</th>
<th>ER</th>
<th>...Back pain since lifting at work 1/24... Pain to L hip to calf this a.m. increased with moving leg.</th>
<th>...walks with limp... muscle spasms... tenderness to palpation lower back... L SLR positive...</th>
<th>Musculoskeletal hip pain</th>
<th>IV Morphine/Phenergan; f/u PCP tomorrow as scheduled; Rx: Darvocet; OOW thur 01/29/2007.</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/29/2007</td>
<td>Small City Urgent Care</td>
<td>Fant, Louise</td>
<td>...had another episode at home over weekend... bent over to tie shoes at home &amp; had sharp pain in L sciatic notch associated with nausea...</td>
<td>L sciatic notch minimally tender... SLR positive 45 deg L...</td>
<td>L sciatica</td>
<td>Sterapred dose pack; if no progress in 5 days, recommend lumbar MRI &amp; orthopaedic referral. Since he is truck driver &amp; on pain medication/muscle relaxers, unable to drive at this point.</td>
</tr>
<tr>
<td>02/02/2007</td>
<td>Small City Urgent Care</td>
<td>Fant, Louise</td>
<td>...doing minimally better...</td>
<td>...quite a bit of sx to L side with some radicular numbness down LLE... sore over L S1 &amp; sciatic notch... positive SLR 45 deg... reflex absent L Achilles</td>
<td></td>
<td>Injection Marcaine/Depo-Medrol; Lyrica samples; Lumbar MRI ASAP; no driving 1 wk.</td>
</tr>
<tr>
<td>02/08/2007</td>
<td>City Radiology</td>
<td>Lumbar MRI</td>
<td>Lumbar MRI</td>
<td>Lumbar MRI</td>
<td>...disc extrusion centrally with extruded fragment extending inferiorly along L side at L5-S1...</td>
<td>Minimal response with Prednisone shot but try one more time; Flexeril; recommend orthopaedic back surgeon; PT with disc syndrome in mind; can't not driving</td>
</tr>
<tr>
<td>Date</td>
<td>Facility</td>
<td>Provider</td>
<td>Notes</td>
<td>Notes</td>
<td></td>
<td></td>
</tr>
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<td>------------</td>
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<td>-----------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>03/05/2007</td>
<td>State Neurosurgery</td>
<td>Martin, George</td>
<td>…bulk of pain in L hip &amp; L leg…feels better lying down w/ hip flexed...[no] difficulty sitting...difficulty standing in one spot for any length of time...can walk w/o much difficulty...no increase in pain w/ cough or sneeze...no incontinence...2 rounds of Medrol dose-packs &amp; muscle relaxants [gave] temporary relief...has had no PT, epidural blocks or bracing...</td>
<td>I think this pt has L S1 radiculopathy due to extruded, L L5-S1 HNP due to work injury. …given extreme large size of disk, I do not think PT likely to help...epidural blocks would give temporary relief...L L5-S1 lumbar disectomy best chance of getting back to work in near term...</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 03/15/2007 | Big City Memorial  | Martin, George  | Surgery                                                                                                                                  | Left L5-S1 herniated nucleus pulposus with L S1 radiculopathy                                                                                                                                      | Surgery  
1. L L5 decompressive laminectomy  
2. L L5-S1 medial 1/3 facetectomy  
3. L S1 decompressive laminectomy |
| 03/23/2007 | State Neurosurgery | Martin, George  | …1 wk s/p L L5-S1 disectomy…overall a pretty significant improvement of leg pain...some L leg numbness & some hamstring tightness...                                                                  | Doing well s/p left L5-S1 lumbar disectomy                                                                                                                                                    | …OOW completely until he completes PT and has FCE unless light duty available; removed staples; flu after PT. |
| 03/27/2007 - 05/18/2007 | Therapy Assoc. | PT             |                                                                                                                                                                                                      | PT - 15 visits  
Moist Heat & interferential electrical stimulation preceding stretching & strengthening exercises for trunk musculature/lower extremities...progress to work conditioning as tolerated.                                                                                                                                                        |
| 05/21/2007 | Therapy Assoc.     | FCE             | Physical Demand Characteristic  
VERY HEAVY                                                                                                                                  | FCE  
Physical Demand Characteristic  
VERY HEAVY...no functional limitations...can perform all essential duties & meet all physical demand requirements of job without any identifiable work restrictions.                                                                                                                                                  |
| 05/23/2007 | State Neurosurgery | Martin, George  | …has had dramatic resolution of sx...working incredibly hard in PT/work hardening...some occasional residual L hip pain...overall feeling very well...very pleased with outcome of surgery...                                                                  | Doing well s/p L L5-S1 lumbar disectomy...has mild L S1 reflex findings only.                                                                                                                                                                                                                                                                                  | Released from active followup. MMI. May work at previous job without restriction at very heavy physical demand level...15% PPD lumbar spine. |
Form 5.7 - Sample Request for Medical Necessity Letter to Doctor

[insert medical provider address]

Request for Medical Necessity Letter

Re: Patient: Sally Smith
DOB: [insert worker's date of birth]
MRN: [insert the provider's medical record number for the worker]

Dear Dr. [insert name]:

As you may know, this firm represents Ms. Smith in regard to her claim for workers’ compensation benefits arising out of a May 1, 2005 back injury which occurred during the course of her employment as a registered nurse for City Hospital. Per her treating physician, Dr. Robert Jones, her diagnosis is “multi-level disc disease with significant 4-5 degenerative disc disease with annular tear and radiculitis in the L5 distribution.”

City Hospital recently authorized an initial pain management evaluation by you on May 9, 2007. I am attaching a copy of your office note for your quick reference. See attached note. You made several treatment recommendations, including a prescription for Ultram, a sacroiliac (SI) joint injection under fluoroscopy and a follow-up visit following the injection. City Hospital has not yet authorized the injection or the follow-up visit, but has asked me to contact you and get your written opinion regarding the following issues:

Is the SI joint injection under fluoroscopy part of medical treatment reasonably required to effect a cure, give relief and lessen Ms. Smith’s pain and current disability arising out of the original compensable back injury she sustained on May 1, 2005? □ Yes □ No

If “no”, have you recommended the SI joint injection to treat a medical condition unrelated to Ms. Smith’s compensable back injury of May 1, 2005? □ Yes □ No

Additional Comments, if any: ___________________________________________
_____________________________________________________________________
_____________________________________________________________________

[insert doctor’s name]
Date: __________________________
Thank you for your attention to this request for additional information. You should already have a medical authorization on file allowing you to release medical information to this firm. If you have any questions or need additional information, please do not hesitate to contact me or my legal assistant, [insert name].

With kind regards, I am

[Signature Line]

Attachment as stated
cc: Client
    Adjuster
Form 5.8 - Sample Letter to Doctor re: Causation Opinion

[insert medical provider address]

Re: Patient: Sally Smith  
DOB: [insert worker’s date of birth]  
MRN: [insert the provider’s medical record number for the worker]

Dear Dr. [insert name]:

This firm represents Ms. Smith in a claim for workers’ compensation benefits. As you may know, the risk carrier is declining to pay medical or indemnity benefits to Ms. Smith for her shoulder injury.

Ms. Smith has worked for [insert defendant-employer name] for approximately 10 years. On December 1, 2005, during the course of her employment as a machine operator for [insert defendant-employer name], Ms. Smith tried to remove the core off a 364 machine to replace the foil. She had difficulty removing it. The core did not come off easily like it normally did; Ms. Smith did not know pins had been placed on the machine to hold the core down. Ms. Smith was pulling and twisting hard on the core in an effort to remove it and felt a pulling sensation in her right arm and shoulder with the immediate onset of pain.

Assuming this is an accurate description of her work injury and that Ms. Smith did not have a prior history of right shoulder problems, I would appreciate your written opinion regarding her right shoulder condition as follows:

1. Diagnosis/diagnoses: ____________________________

2. In your opinion, did the workplace incident, as described by the patient, more likely than not (please check the one that, in your opinion, best applies):

    _____ Have/has no relation to the current injury or condition;
    _____ Cause or significantly contribute to the injury or condition;
    _____ Aggravate, accelerate, or activate a pre-existing condition; or
    _____ Combine with other non-work related factors to bring about the current injury or condition.

3. Other medical conditions that are affected/exacerbated by the injury or condition:

4. Reasonable and necessary treatment/treatment plan (to include: labs, medications,
diagnostic images, tests, studies, referrals, physical therapy, surgery, etc.): 

Additional Comments, if any: 

[insert doctor’s name]
Date: ______________________

You should have a medical authorization on file allowing you to release this information to us.

Please call me if you have any questions regarding this request. Thank you very much for your attention to this matter.

With kind regards, I am

[Signature Line]

Attachment as stated
cc: Client
    Adjuster