California Orthopaedic Association

Template

Medical-Legal Report -Workers' Compensation

This document is presented as a template of the required elements of an orthopaedic QME/AME report. It is provided as an example only and not intended to imply this is the only format that can be used when preparing a Medical-Legal report. The numbers in the left-hand margin refer to the DWC's 26-point checklist for Medical-Legal reports to help ensure the completeness of the report.

(Put on QME's/AME's Letterhead)

4,5 (Date of Evaluation)

Department of Industrial Relations
Division of Worker's Compensation
Disability Evaluation Unit
(Address)

RE: (Name of Patient)

Birthdate
Exam Date
Injury Date
Carrier
Adjuster
Interpreter (name and certificate number)

Carrier Claim #
WCAB Claim #
Social Security Number (if no claim number available)
Patient's Attorney
Defense Attorney
Employer
Occupation at time of injury
Current occupation

SUBSTANTIATION

This report is billed at the ML _____ level because:

ABSTRACT

The following lists findings detailed elsewhere in the report.

List relevant diagnoses

MMI/P & S: (Date)
R_x Cause: (Industrial/Non-Industrial)
PD Appor: (Yes/No)
PD/Imprmt: (Work restrictions or Percentage of Whole Person impairment
RTW: (Date)
Cont R_x: (Yes/No)
Voc Rehab: (Yes/No)

8 **PRESENT HISTORY (AS OBTAINED FROM THE PATIENT)**

HISTORY OF THIS INJURY

PREVIOUS INJURIES – ALL TYPES (e.g., WC/AUTO/SLIP AND FALL/SPORTS, ETC.)

PRIOR WORKERS' COMPENSATION CLAIMS

OTHER PREVIOUS COMPLAINTS

10 **CURRENT COMPLAINTS**

PAST PERSONAL HISTORY

FAMILY AND SOCIAL HISTORY

EDUCATION

EMPLOYMENT HISTORY

11 **PAST MEDICAL HISTORY**

9 **INJURY JOB DESCRIPTION/JOB DUTIES**

13 **REVIEW of RECORDS/LISTING of MATERIAL REVIEWED**

12 **PHYSICAL EXAMINATION (RELEVANT TO THIS CLAIM)**

COMPARATIVE MEASUREMENTS

REGIONAL EXAMINATION

IMAGING, LAB, AND OTHER DIAGNOSTIC STUDIES

DIAGNOSTIC FINDINGS

14 **DIAGNOSES**

CONCLUSIONS

16 **STATUS**

PERMANENT & STATIONARY
SUBJECTIVE AND OBJECTIVE RESIDUALS (P&S PRIOR TO 1/1/05)
or
MAXIMUM MEDICAL IMPROVEMENT (MMI)
WHOLE PERSON IMPAIRMENT (MMI AFTER 1/1/05)

17 PERMANENT DISABILITY APPORTIONMENT/CAUSATION

WORK CAUSED/WORK CONTRIBUTED

15 **DISABILITY/IMPAIRMENT**

SUBJECTIVE and OBJECTIVE FACTORS
(if evaluating under the Schedule of Rating Permanent Disabilities –old system)

OR
WHOLE PERSON IMPAIRMENT (LIST TABLES AND CALCULATIONS)
(if evaluating under the AMA Guides 5th Edition)

Include in either report, work restrictions and an estimate of reduction of pre-injury capacity.

RETURN TO WORK – WITH OR WITHOUT RESTRICTIONS

19 **RECOMMENDED MEDICAL CARE – PRESENT AND FUTURE**
(CONSISTENT WITH DWC-ADOPTED TREATMENT GUIDELINES)

18 **MEDICAL DETERMINATION OF ELIGIBILITY FOR VOCATIONAL REHABILITATION – IF P&S PRIOR TO 1/1/04**

21 **CONTESTED ISSUES – IF KNOWN & REASONS FOR OPINIONS**

20 **APPORTIONMENT OF DISABILITY, IF ANY**

RESEARCH
(List bibliography of articles)

23 **ASSISTANTS**
NAMES AND QUALIFICATIONS OF THOSE ASSISTING WITH REPORT

25/24 **AFFIDAVIT OF COMPLIANCE WITH LABOR CODE § 139.3 AND 4628**

Sample Language
(Required DWC Language is in italics)

6 **Option 1**

After a review of the history as obtained directly from the patient and the voluminous records that have been submitted, my physical examination and the x-rays available, it is my opinion that the above-captioned patient has the following industrially related orthopaedic conditions: (List diagnoses – make sure they are consistent throughout the report.)

Please note, obtaining a history directly from the patient (with the assistance of an interpreter, if needed), reviewing and summarizing all records (if any), performing the entire physical examination and all measurements, reviewing x-rays (if any), and the preparation and dictation of this entire report were entirely and solely performed personally by the undersigned. The only exceptions were the measuring of vital signs and transcription of my personally dictated findings onto an office work sheet which were done by (office manager), who has been my office manager and back office assistant for 20 years and has been instructed and monitored in these activities by me. The time spent in connection with this evaluation was in compliance with any available guidelines.

6 Face to Face Time with Patient = _____hours (History and Physical Examination)

Record Review Time = _____ hours (Sorting, Reading, Summarizing)

Report Preparation Time = _____hours (Dictation and Proof Reading)

Total Hours _____

24 *I declare under penalty of perjury that there has not been a violation of Labor Code Section 139.3, that the contents of the report are true and correct to the best of my knowledge, and any statements concerning any bill for services are true and correct to the best of my knowledge.*

I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true.

26 _____ _____

(Name of QME/AME) (Specialty/Board Certification) Date Signed in the County of (name of county)

Option 2

Pursuant to the above code, I certify the following:
The initial history was recorded by the patient on an intake history form and reviewed for accuracy by my medical staff. I then went over the history in detail with the patient. If an interpreter was used, it is so noted on the first page of the report. If any portion of the findings was recorded by my medical staff, it is herein so noted with the name of that staff member: (NONE). If so, I then reviewed these findings and supplemented them in detail with my own examination of the patient. Otherwise, I performed the entire examination. I personally reviewed and annotated the available medical records for the amount of time allowed within this report category. The report was then transcribed from my dictation by a professional medical transcriptionist. I reviewed, formatted printed and approved the final draft.

The examination was performed on the date and at the location described in the "Substantiation" section on the first page of this report. The dictation and reviews are done at home, and occasionally at my office. I actually performed the evaluation. The evaluation performed and the time spent performing it, was in compliance with the guidelines established by the Division of Workers' Compensation pursuant to paragraph (5) of subdivision (j) of Section 139.2 or Section 5307.6 of the California Labor Code. I have not violated Section 139.2 of this Code. In the case of a supplemental report, I personally performed the cognitive services necessary to produce the report. In the unlikely event that there was any variance from these guidelines, it has been explained, in detail, within the body of this report.

Sources of Facts: History as related by the patient; Review of available records; Review of available diagnostic studies; Examination of the patient.

Reasons for Opinions: Patient obtained history; Orthopaedic examination; Available imaging findings; Review of available medical records; Consistency of complaints and findings; Patient authenticity; Medical experience of the examiner.

This report is for Medical-Legal assessment only, and is not to be construed as a complete physical examination for general health purposes. Only those symptoms which I believe to have been involved in the injury, or might relate to the injury, have been assessed in detail. *I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true. I further so declare that I have not violated the provisions of California Labor Code Section 139.3 with regard to the evaluation of this patient or the preparation of this report.* The opinions herein stated are my own. I have attempted to address all the issues which normally arise in the course of a medicolegal evaluation pursuant to the Labor Code, and consistent with the time allowed in this report classification. I have the qualifications listed after my name beneath the signature (a curriculum vitae can be provided upon request). **More than 90% of my total practice time is annually devoted to medical treatment.** No amount has been charged in excess of the professional services and the reasonable costs of diagnostic testing, clerical and overhead expenses necessary to produce the report. I also verify under penalty of perjury that the total time (in 15 minute increments) that I spent on the following activities is true and correct:

a. Face to face time with patient:	____	**hours**
b. Record review (including my records and reports):	____	**hours**
c. Report preparation (including draft review and revision):	____	**hours**
d. Other relevant activities:		
Orthopaedic Research	____	**hours**
TOTAL HOURS	____	**hours**

_____ _____

(Name of QME/AME) (Specialty/Board Certification) Date Signed in the County of (name of county)

DWC QME/AME Report Checklist

1. Summary form (for AME and QME)

2. DEU form 100 is included (unrepresented QME)

3. DEU form 101 is included (with comments for unrepresented worker)

4. Date of examination

5. Location of examination

6. Statement that the physician actually performed the examination

7. Time spent fact to face with the injured worker

8. History of the present injury or illness

9. Job duties

10. Present complaints

11. Prior medical history, including injuries, conditions and residuals

12. Findings of the exam, including laboratory or diagnostic test results

13. Listing of material reviewed or relied upon to prepare the report

14. Diagnosis

15. Factors of disability: subjective, objective, work restrictions and estimate of loss of pre-injury capacity

16. Opinion of whether permanent and stationary

17. Cause of the disability (work caused/work contributed)

18. Medical determination of eligibility for vocational rehabilitation

19. Treatment indicated, including continued and future treatment

20. Apportionment of disability, if any

21. Reasons for opinions

22. If psychiatric problem, determination of percent of total disability from work

23. Disclose the name and qualifications of anyone who assisted with the report

24. Mandatory declaration in its entirety:

"I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true."

25. Statement about LC §139.3 (proprietary interest, etc.)

26. Original signature of the physician, date of signature and county where it was signed.