California Orthopaedic Association
Medical-Legal Report Template

In an effort to: 1) improve the ratability of Medical-Legal reports;
2) to help parties find information in your report; and
3) to ensure that you have addressed all the required elements,
While the Division of Workers' Compensation (DWC) is not mandating the use of this template for your Medical-Legal reports, COA strongly recommends that you prepare your Report in this order and with these topic headings.

Put on your Letterhead

(Date of Report)

(List Names & Address/Fax/Email of Report Recipients)

Identifying Information Injured Worker *(Consider identifying the IW via a photo or other ID)*

RE: *(Name of Injured Worker)*
DOB: *(Date of birth of Injured Worker)*
DOI: *(Date of Injury(s))*
EMP: *(Name of Employer)*
Claim#: *(List Claim Number(s))*
WCAB#: *(List WCAB Number(s))*
DOE: *(List Date of Evaluation)*

Dear (List Report Recipients):

Advocacy/Cover Letters

Acknowledge and note advocacy/cover letters received (date of letter and date received and issues you were asked to address. If no letter was received, also note this in your report.

Location of Evaluation

List location/street address evaluation performed.

Include a statement that you informed the injured worker of their rights contained in CA Code of Regulations §40. Disclosure Requirements: QME panel shall advise an injured worker prior to or at the time of the actual evaluation that he or she is entitled to ask the evaluator and the evaluator shall promptly answer questions about any matter concerning the evaluation process in which the QME and the injured worker are involved and that the injured worker may discontinue the evaluation based on good cause. See https://www.dir.ca.gov/t8/40.html

Evaluator Status

Identify your status: ☐ *QME* ☐ *AME* ☐ *PTP* ☐ *Other*
☐ *"Regular" (IME) WCAB Judge ordered Exam*

Individuals who Assisted in Preparation of Medical-Legal Report or Examination of Patient.

List anyone who helped (excluding interpreter or transcriber) in the preparation of the medical legal report or examination of the injured worker (including records summarizer individual/company).

List type of Medical-Legal Report – Comprehensive Medical-Legal Evaluation, Supplemental Medical-Legal Evaluation, or Follow-up Medical-Legal Evaluation and Medical-Legal Code billed.

Face-to-Face Time with Injured Worker

List face-to-face time. MSK evaluations are required to spend a minimum of 20 minutes.

Use of an Interpreter – Modifier 93

If an interpreter is needed during the evaluation, add Modifier -93. Modifier -93 requires that the QME/AME include in their report "a description of the circumstances and the increased time required for the examination as a result" of using an interpreter. Without this statement, payors refuse to pay the additional 10%.

Add the below language to your report to meet this requirement:

> *"This examination was conducted with the assistance of interpreter _____, certification number _____. The use of an interpreter increased the amount of time needed to complete a comprehensive examination in excess of 20 minutes. This report qualifies for a 10% augmentation pursuant to Title 8 California Code of Regulations 9795 modifier 93."*

Number of Pages of Records Received/Reviewed

List # of pages, date records (medical and other records) were received, and who sent the records. Records must be accompanied by a declaration from the party sending the records and an attestation stating the number of records sent signed under penalty of perjury. If no records were received or records were received without an attestation/declaration, note that the evaluation was performed without the benefit of records. Do not review the records without the declaration/attestation as you likely won't get paid for review of the records. If the attestation is incorrect and lists the wrong number of pages sent, contact the party who sent the records to get a corrected attestation/declaration before reviewing the records, otherwise you likely won't get paid for the additional pages.

State whether there were missing records of potential importance.

Several clarifications regarding records:

1. Regulation § 35(i) indicates the physician's course of action if the records have not been received 10 days after the date of the evaluation.

Regulation 35 (i)

In the event that a party fails to provide to the evaluator any relevant medical record which the evaluator deems necessary to perform a comprehensive medical-legal evaluation, the evaluator may contact the treating physician or other health care provider, to obtain such record(s). If the party fails to provide relevant medical records within 10 days after the date of the evaluation, and the evaluator is unable to obtain the records, the evaluator shall complete and serve the report to comply with the statutory time frames under section 38 of Title 8 of the California Code of Regulations. The evaluator shall note in the report that the records were not received within the required time period. Upon request by a party, or the Appeals Board, the evaluator shall complete a supplemental evaluation when the relevant medical records are received. For a supplemental report the evaluator need not conduct an additional physical examination of the employee if the evaluator believes a review of the additional records is sufficient.

The following language for your Medical-Legal report is suggested if records were not received within 10 days following the evaluation:

> "Records were received but not reviewed. Per CA Code of Reg § 35(i) since the records were not received within 10 days after the evaluation, if you want me to review the records, please send a

request for a supplemental report. (If records were received with no Declaration, add – Please also send the required Declaration which includes the number of pages of records sent.)"

2. *A summary of the records from one of the parties/attorneys cannot be relied upon by the QME. A QME cannot comply with relevant portions of the Labor Code and the California Code of Regulations by reviewing only a summary of records in preparing the medical-legal report. Pursuant to the provisions of Labor Code § 4628(a)(2) and regulation § 41(c)(2), the physician must* ***actually review all available records*** *as part of the medical-legal evaluation and/or the preparation of the medical-legal report.*

List other individuals present during the evaluation

- *Family, friend, other*
- *Interpreter/Transcriber (list Name, language, and License #)*
- *Nurse Case Manager – with agreement of injured worker*

Information on Injured Worker

- *Age; marital status, handedness, gender. job title*
- *Employer: Start date & stop date (if applicable):*
  Current work status: ☐ off work ☐ working modified (describe) ☐ working full duty
- *List/describe any concurrent or subsequent employment dates (including employer, hours per week and job duties)*
- *Include employment history – for at least the last 10 years*

Job description

Include job description as described by the patient and any received from defendant – note differences.

History of Injury

Describe injury as related by injured worker and contrast with advocacy letters and/or medical records.

Pertinent Records Summary

Summarize:

- *History of relevant/pertinent pre-existing injuries/illnesses.*
- *History of industrial injury you are being asked to evaluate per medical records contrasted with patient's recollection.*
- *History of subsequent medical care from the subject industrial injury and other pertinent history.*

Current Treatment & Names of Treaters

List current treatment and names of treating health care professionals.

Personal and Social History

- *Social Situation*
- *Place of Birth*
- *Childhood: normal or dysfunctional (note any history of adverse childhood experiences (ACEs))*
- *Significant other condition*
- *Children*
- *Living situation/arrangement/accessibility*
- *Education (note if illiterate):*

- *Military service*
- *Recreation (prior to injury and current)*
- *Habits:*
  - *Caffeine:*
  - *Alcohol:*
  - *Tobacco:*
  - *Marijuana:*
- *Incarceration history*
- *Illicit substance use (current & past)*
- *Income (previous)*
- *Current Source of income: (family members, Workers' Compensation, pension, Long-Term Disability, State Disability, Social Security, etc.)*

Past Medical History

- *Diseases*
- *Illnesses*
- *Surgeries*
- *Present Medications – current and past medications – both prescription and over-the-counter (vitamins, supplements, herbals, THC, etc.) including dosage and number taken per day, efficacy, and any side effects of past and current medications.*
- *Allergies*
- *Psychiatric*
- *Injuries (including childhood, adult, military, etc.)*
- *Previous Accidents (include auto)*
- *Hospitalizations*

Family Medical History:

Medical including any alcoholism, substance abuse, major injuries, disability, chronic pain issues, etc.

Pending Claims/Lawsuits

Present/Current Symptoms/Complaints

- *Both by specific body part and overall including radiation of symptoms with spatial characteristics, duration periodicity, and intensity/severity.*
- *Functional: Interference/Changes in Activities of Daily Living (ADLs) & work ability.*
- *Pain: Character and quality; provocative/aggravating or palliative/alleviating factors*
- *Daily Routine (including change from preinjury): Exercise, outdoor activities, recreation, household chores, etc.*
- *Bowel/Bladder/Sexual functioning*
- *Mental & Emotional: Changes in cognition/concentration and/or emotional state (depression, anxiety, etc.)*

Review of Systems:

Physical Examination (performed using AMA Guides 5th protocols) (Female exam should include the presence of a same gender assistant.) Exam should only include body parts requested. If there

is a body part/condition that is part of the industrial injury that is beyond your typical scope of practice, such problems should be addressed by a QME/AME in the appropriate specialty.

Patient descriptors: pleasant & cooperative; good or poor historian, etc.

- *General observations: Appearance and constitution; adaptive aids (braces, cane, wheelchair, etc.)*
- *Pain behavior/observations of physical functioning (note nonphysiologically findings)*
- *Orthopaedic Examination -appropriate to evaluation. (ROM, girths, deformity, joint laxity/stability, tenderness, alignment, etc.)*
  Lumbosacral Spine/Lower Extremity in case of loss of limb or short leg or atrophy
  Cervical Spine/Upper Extremity in case of loss of limb or short leg or atrophy
  Lower Extremities – including measurements
  Upper Extremities – including measurements
- *Neck*
- *Provocative tests*
- *Neurologic*
  - *Assessment of level of consciousness and mental status, thought processes and content, speech, and communication/language*
  - *Cranial nerves*
  - *Strength*
  - *Sensation*
  - *Sphincter tone and superficial reflexes – limited to people who may have Cauda Equina Syndrome and should not be performed on routine neurological exams.*
  - *Deep tendon reflexes (DTR) including pathologic reflexes*
  - *Coordination*

List of Records/Information Received/Reviewed/Relied upon

Include date of medical record, a description of the record, including review of x-rays.

Discussion/Causation

- *Diagnoses/Impression/Assessment*
  Objecting Findings
  Does the diagnosis appear consistent with examination and medical history?
- *Diagnostic and laboratory testing results related to this evaluation*
- *Document any Medical or Other Research performed with explanation and references*
- *Should also address any specific (beyond the standard) questions raised by either party.*
- *Report should meet the threshold of* ***Substantial Medical Evidence****. (See definition of Substantial Medical Evidence included at the end of this document.)*
  You must explain the how and the why of your conclusions
- *Causation of Injury - remember, injury occurring in the course of employment (COE) is deferred to the trier of fact whereas injury arising out of employment (AOE) is a physician decision. Include a discussion of subjective and objective factors of disability.*

  Note: If medical records and employee description differ, while contemporaneous records are assumed to be more accurate (per Evidence Code), determination must be

two-fold:

- Based on employee history; and,
- Based on record information (absent actual film of the incident).

Disability Status/Work Restrictions/Limitations:

Provide an opinion as to the nature, extent, and duration of disability and work limitations (if any) - explain rationale for opinion.

☐ Can work regular duty ☐ Cannot work regular duty (explain rationale for opinion)

Impairment Rating

The impairment rating should be determined using the AMA Guides to the Evaluation of Permanent Impairment - 5th Edition unless the Almaraz-Guzman comparative rating is more applicable.

You must discuss and give your rationale as to why you selected one or the other option.

Apportionment = causation of disability Labor Code Sections 4663 and 4664

For a discussion of important case law and when and how to apply the case, refer to the "Discussion of Important Terms/Concepts" at the end of this document.

- Using the AMA Guides to the Evaluation of Permanent Impairment - 5th Edition *(with clear documentation of the process used to derive the rating)*
- *Standard Approach and*
- *Almaraz Guzman Analysis*
  Put both the standard approach rating and an analysis under Almaraz-Guzman in your report.
- *Statement that the most accurate impairment rating has been provided.*
- *Address adding versus combining with the CVC Table.*
  If Psyche injury, percent of total causation resulting from actual events at work
  Rolda analysis in the causation for psych/stress injuries.
  Statement that all the opinions/conclusions within are based on a reasonable medical probability.

Vocational Rehabilitation / Educational Voucher

If Permanent & Stationary (P&S), complete Physician's Return-to-Work and Voucher Report

☐ MMI/P&S **(list date)** and/or ☐ TD (Temporary Disability – **list dates of TD)**

- *Explain the rationale for opinion particularly if it disagrees with the PTP or other evaluators.*
- *List a rationale specific P&S date.*
- *List specific dates/periods of temporary disability.*

Future Medical Care and Treatment:

☐ Yes ☐ No (with recommendations)

Summarize recommended future medical treatment and whether the injured worker has reached Maximum Medical Improvement (MMI). Was there a finding of permanent disability?

Closing Required Affidavits and Disclosures

Statement that the physician did not violate Labor Code § 139.3 (self-referral)
https://law.justia.com/codes/california/2011/lab/division-1/110-139.6/139.3/

Sample language:

Please be informed that I personally obtained from the patient the history of injury, conducted

the examination, reviewed the provided medical records and prepared and dictated this report.

In accordance with Labor Code 4628, I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to thebest of my knowledge and belief, except as to information I have indicated I have 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 have not violated Labor Code Section 139.3, and the contents of this report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

This report has been transcribed, edited and printed by (name of transcriptionist) and was thoroughly read prior to my signature.

Date of Report:
City and County Where Report Was Signed:
Signature of physician
Proof of Service
Cc: copies to appropriate parties

Where to you send your reports? (California Code of Regulations 36)
For represented workers, complete DWC Form 122 and send to the injured worker and their attorney and the claims administrator or if none, the employer and the defense attorney if known.

For unrepresented workers, complete DWC Form 111 and send to the injured worker, the claims administrator or if none, the employer, and the local DWC Disability Evaluation Unit (DEU) office.

Discussion of Important Terms/Concepts

Permanent & Stationary (P&S) / Maximal Medical Improvement (MMI)
"Permanent and stationary status" is the point when the employee has reached maximal medical improvement, meaning his or her condition is well stabilized, and unlikely to change substantially in the next year with or without medical treatment. See https://www.dir.ca.gov/t8/9785.html

Permanent and stationary means the same thing as maximum medical improvement.

Reaching permanent and stationary status suggests that a condition has stabilized (or even resolved/cured) and there will probably not be major improvement with ongoing medical care. In many cases, a future medical award will be included to cover ongoing treatment. There may be fluctuations in symptoms and also flareups deserving increased medical attention. If the condition and disability worsen over time, within 5 years of the P&S date, the injured worker may file for New & Further Disability which would lead to reconsideration regarding the disability and the impairment by the medical legal evaluator.

Substantial Medical Evidence
The analysis of what constitutes substantial medical evidence has a sequential analysis and is best described in Part II.E. of the California Workers' Compensation Appeals Board (WCAB) en banc decision Escobedo v. Marshalls [(2005) 70 Cal. Comp. Cases 604, 620-621]: https://law.justia.com/cases/california/workers-compensation-appeals-board/2005/gro-0029816.html

1. [I]n order to constitute substantial evidence, a medical opinion must be predicated on reasonable medical probability (> 50% i.e., more likely than not).
2. [A] medical opinion is not substantial evidence if it is based on facts no longer germane, on inadequate medical histories or examinations, on incorrect legal theories, or on surmise, speculation, conjecture, or guess.

3. [A] medical report is not substantial evidence unless it sets forth the reasoning behind the physician's opinion, not merely his or her conclusions.
4. [A] medical opinion must be framed in terms of reasonable medical probability, it must not be speculative, it must be based on pertinent facts and on an adequate examination and history, and it must set forth reasoning in support of its conclusions.

Substantial medical evidence means "more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." Richardson v. Perales, 402 U.S. 389, 401 (1971). https://supreme.justia.com/cases/federal/us/402/389/

The physician's medical opinion must set forth the **how** and **why** and the facts and reasoning (not just his or her conclusions/opinions) that justify the opinion.

Key Elements of an expert's opinion that ensure that it rises to the level of substantial evidence:

1. Expert's testimony or opinion must involve matters beyond common experience.
2. Expert's opinion must be based on assumptions of fact supported by the evidence.
3. The assumptions of fact must be the type that are reasonably relied upon by other experts.
4. The controlling factors relied upon by the expert cannot be based on conjecture or speculation.
5. The expert must display a familiarity with the appropriate legal theory to be applied to the facts of the case.
6. The expert must relate the reasoning by which they progress from their material to their conclusion. This would be the how and why.

Causation of (Industrial) Injury
An injured worker has the burden of proof to show by a preponderance of the evidence that an injury is work related. Work activities need not be the sole cause of the injury or even the primary cause. Except in psychiatric cases, it is sufficient that the employment contributed to the injury to a significant degree.
The question of whether an injury is work related is divided into two parts (Labor Code § 3600):

- Did the injury "arise out of employment" (AOE)?
- Did the injury "occur in the course of employment" (COE)?

Because the physician provides direct evidence on whether and how the activities of work led to the current injury, the physician answers the question of whether the injury arose out of employment (AOE).

The question of whether an injury occurred in the course of employment is not a medical question because it involves the circumstances of the accident or exposure. If COE is in dispute, a workers' compensation judge will decide the issue based on evidence offered by the employee, the employer, or other witnesses and on legal precedents.

Apportionment
Apportionment in California is about parceling out all the industrial and nonindustrial **contributing-causal factors** of the injured worker's permanent disability once the injured worker is at maximal medical improvement (MMI) / permanent and stationary (P&S).
Apportionment is based on California Labor Code Section 4663 and 4664.

When considering apportionment, the following are three critical portions or provisions of Labor Code Section 4663: https://california.public.law/codes/ca_lab_code_section_4663

a) Apportionment of permanent disability shall be based on causation.

b) A physician who prepares a report addressing the issue of permanent disability due to a claimed industrial injury shall in that report address the issue of causation of the permanent disability.

c) In order for a physician's report to be considered complete on the issue of permanent disability, the report shall include an apportionment determination. A physician shall make an apportionment determination by finding what approximate percentage of the permanent disability that was caused by the direct result of injury arising out of and occurring in the course of employment and what approximate percent- age of the permanent disability was caused by other factors both before and subsequent to the industrial injury, including prior industrial injuries… .

California Labor Code 4664 https://california.public.law/codes/ca_lab_code_section_4664 states the following:

In Escobedo (2005) 70 CCC 604, the WCAB basically provided an analytical roadmap as to the construction and application of the apportionment statutes.

A physician preparing a medicolegal report is tasked in part to determine apportionment of the disability arising from the specific and/or cumulative industrial injury(ies) in question but also to prior or subsequent injuries or illnesses and nonindustrial contributing-causal factors that are the contributing cause of the disability. Those nonindustrial contributing-causal factors may include asymptomatic conditions or underlying pathology that may or may not have been known or causing symptoms or disability prior to or at the time of the industrial injury. The key inquiry for the reporting physician is to determine whether any underlying pathology or previously asymptomatic conditions are contributing-causal factor(s) of the applicant's current permanent disability.

In essence, the purpose of apportionment is to limit the employer's liability to the percentage of actual permanent disability caused by the current industrial injury(ies), not to determine what the level of permanent disability would have been absent the nonindustrial cause.

It is not enough to know the etiology or cause of a particular underlying nonindustrial pathology (congenital, developmental, genetic, heredity, etc.), or asymptomatic condition, but rather what approximate percentage the extent or severity of the pathology or disease process itself (confirmed by diagnostic studies and supported by substantial evidence) is a present contributing-causal factor of the injured worker's permanent disability at the time of MMI status for each and every body part or condition at issue.

There are certain impermissible, invalid, and potentially unlawful nonindustrial contributing-causal factors of permanent disability that should not be used to establish nonindustrial apportionment. These impermissible and potentially unlawful factors would include, but are not necessarily limited to, age alone and gender alone.

While it is impermissible to apportion solely to age or gender specifically, the physician can apportion to degenerative changes (assuming they are a contributing-causal factor of the permanent disability).

The physician is not to apportion to a condition or a risk factor (e.g., diabetes, degenerative disease, or a genetic condition) just because it exists, but only if the physician can articulate that the

underlying condition or pathology is an actual contributing-causal factor of the applicant's permanent disability.

How do we then decide to apportion in a way that is not speculative and meets the standard of substantial medical evidence? How do we decide with any particular injured worker that something else other than work is contributing to the disability? The answer is that each physician must provide his or her best opinion based on reasonable medical probability and defend that opinion using substantial medical evidence.

Questions or issues for every evaluating physician to consider:

- What is the nature of the injury?
- What are the person's job duties?
- What factors activities outside of the work injury or exposure may be a contributing-causal factor of the resultant permanent disability at the time of the MMI evaluation?
- What prior and subsequent injuries has the applicant sustained, both on an industrial and nonindustrial basis?

In summary, apportionment refers to parceling out all the contributing-causal factors both industrial and nonindustrial of the resultant permanent disability. This would he follow-up Simply put, what approximate percentage of the permanent disability was caused by the work injury or industrial exposure, and what approximate percentage was caused by other nonindustrial contributing-causal factors. Those contributing-causal factors, whatever they might be, may not have been known or even labor disabling previously, but if they are contributing-causal factors of the permanent disability, apportionment is required.

Adding versus Combining Using the CVC Table
The CVC Table applies as a default in accordance with the 2005 Permanent Disability Rating Schedule and the AMA Guides in Chapter 1 on pages 9-10. To opine otherwise, the physician must clearly explain/describe why the application of the CVC is not accurate and why adding impairment ratings is.

Definitions:

- **OVERLAP:** Combined effect (ADL loss) of the body parts less than the sum of their separate effects.

- **SYNERGY:** Combined effect (ADL loss) of the body parts greater than the sum of their separate effects.

There are two Methods to rebut the CVC (i.e., add rather than combine). That opinion MUST provide a rationale and meet the threshold of substantial medical evidence.

1. There are multiple impairments that have no overlap on ADLs. This is not about body parts (psyche v heart v. spine) but about ADLs! There does NOT have to be synergy to meet this threshold.

2. There are overlapping ADLs which are synergistic, and the separate impairments have an amplifying effect (see Kite[1] and La Count[2]).

[1] Athens Administrators v. WCAB (Kite) (2013) 78 Cal. Comp. Cases 213 (writ denied).

[2] Los Angeles Metropolitan Transportation Authority v. WCAB (La Count) (2015) 80 Cal. Comp. Cases 470 (writ denied).

With all that said, case law has evolved since Kite, it is currently more about accuracy: Does the WPI correlate with the disability (ADL deficits)? Have you provided the most accurate impairment rating?

REFERENCES & EDUCATIONAL INFORMATION

1. **State of California Department of Industrial Relations Division of Workers' Compensation *Physician's Guide to Medical Practice in the California Workers' Compensation System* Fourth Edition, 2016 https://www.dir.ca.gov/dwc/medicalunit/toc.pdf**

2. **QME Competency Examination Information Booklet https://www.dir.ca.gov/dwc/medicalunit/QMEInformationBooklet.pdf**

3. **DWC Physician Education: Qualified Medical Evaluators (QME) https://www.dir.ca.gov/dwc/CaliforniaDWCCME.htm**

4. **Apportionment: Case Law Outline Focusing On Evolving Themes, Trends, And Problem Areas , Raymond F. Correio, January, 2020 http://pbw-law.com/resources/educational-materials.html**