- ▲ Review and summarize prior medical records;
- ▲ Compose and draft the conclusions of the report.

Writing The Medical-Legal Report

The required elements of a medical-legal report are listed in the box on page 103. Although there is no required format, you will probably want to develop one that prompts you to include all of the required information.

Medical-legal reports are prepared in the context of workers' compensation law, which has its own logic and definitions. It is *essential* that your report use the terminology and standards of the workers' compensation system. Chapters 2 and 3, and the glossary of this manual includes explanations of many of the key terms.

The law does not require that the report be written in any particular style, but you should keep in mind that the main audience for the report is nonmedical. The applicant, claims administrators, disability raters, attorneys, and workers' compensation judges are relying on your opinion to make decisions that may drastically affect the applicant's life. Your report should be clear, concise, reasoned, internally consistent and objective.

The physician who signs the report must be the only person who examines the injured employee or who participates in the non-clerical preparation of the report. Nurses are permitted to perform those functions that are routinely performed by a nurse, such as taking blood pressure. The Industrial Medical Council requires that examinations by Qualified Medical Evaluators for unrepresented injured workers be conducted only at the office location noted on the Selected Qualified Medical Evaluator Panel Form. ***Examinations may not be performed at another location.***

The Industrial Medical Council has adopted protocols for the methods of measuring certain disabilities. At the date of publication, these evaluation protocols cover the measurement of low back, cervical spine, psychiatric, pulmonary, cardiac, and immunologic disabilities. Physicians evaluating these areas *must* follow these guidelines, which are available free from the IMC or can be downloaded at **www.dir.ca.gov.** Under Lab. Code section 4628, failure to follow the specific evaluation protocol may make the report inadmissable before the WCAB.

The following sections describe the types of information your report should include:

The IMC has enacted the following forensic protocols to be used by Qualified Medical Evaluators in writing a medical-legal report:

Psychiatric (IMC Rule 43)
Pulmonary (IMC Rule 44)
Cardiac (IMC Rule 45)
Neuromusculoskeletal (IMC Rule 46)
Immunologic (IMC Rule 47)

These protocols must be followed in all QME evaluations and set forth the areas which must be addressed or considered in conducting an examination and composing your conclusions.

IDENTIFYING INFORMATION

The heading of the report should provide the information necessary to identify the report, including: the date of the report, the name of the applicant, the date of injury, the claim number, and the WCAB number, when possible.

OPENING STATEMENT

This section should provide information on the context of the report and the performance of the examination. You are required to provide the date, place and, duration of the exam. There are specific minimum time requirements for the "face to face time" spent by the physician with the injured worker. This time includes the time in which the evaluator takes the history, performs the physical, or discusses the worker's medical condition with the worker. Face to face time does not include time spent in performance of diagnostic or laboratory tests (such as blood tests or x-rays) or time spent on records review or report writing.

Face to Face Time

Face to face time does not include time spent in the parking lot, waiting room, or time spent filling out pre-evaluation history forms.

- IMC Rule 49(b).

Face To Face Time Requirements

All QME Evaluations are required to include the amount of time spent face to face with the injured worker in their report. (8 Cal. Code Regs. § 49 - § 49.9)

Examination Type	Minimum Required Minutes
Neuromusculoskeletal	20
Cardiovascular	30
Pulmonary	30
Psychiatric	60
All others	30

SOURCES OF INFORMATION

This section should contain a list of all the medical records that were reviewed in preparation of this report. You must also record any nonmedical information and its source, that was received from either party and reviewed in preparing your report or in formulating your opinion. You should list the names of anyone other than the patient who was interviewed or with whom the case was discussed.

HISTORY OF THE PRESENT INJURY OR ILLNESS

The report must include a comprehensive and factual account of the industrial exposure, the applicant's complaints, and the treatment the applicant has received. The nature of the claim will determine how extensive this history must be. Injuries resulting from cumulative trauma or occupational illnesses will require a detailed explanation of the applicant's job duties, the conditions of the injurious exposures, including the approximate time spent on the tasks in question, and the temporal relationship between the exposure and the symptoms. Your discussion should include any occupational exposures, including those from previous jobs, that may have contributed to the condition. You should describe the onset or progression of symptoms experienced by the injured worker, including the time frame in which these occurred.

The history for a specific injury should describe the activity that immediately preceded the accident and how the accident occurred. Wherever possible, you should provide relevant details, such as the approximate weights of objects, the worker's position while

Common Medical-Legal Deficiencies

The most frequent types of problems we have with medical-legal reports are untimeliness, failure to use appropriate terminology, incomplete medical evaluations, and internal inconsistencies in the reports.

The physician has to realize that we don't have the patient standing in front of us. All we have is their report. Since we have to do our best to rate all reports, the physician community has to produce reports that (1) reflect reality and (2) are ratable. There's just no other way to put it.

—DEU Disability Evaluator

Writing For An Audience

Board Rule 10606 sets out what should be included in a medical report. However, it doesn't tell you why that is needed . . . It's because non-medical personnel, such as claims examiners and workers' compensation judges need all that information to properly do their job. A workers' compensation judge's determination based on a medical report that is just a string of unsubstantiated conclusions is no better than judicial dart-throwing. . . For the medical report to be usable it should clearly explain why the medical conclusions are reached in a way that someone who is not a medical expert can understand. Then, the claims examiner, or ultimately a workers' compensation judge, can use that information in making his or her determination.*

—Honorable Alan Eskenazi, Workers' Compensation Judge, San Francisco

** see Appendix C*

performing the task that resulted in injury, the height of a fall, or the names of chemicals to which the worker was exposed. If the worker or employee provides material safety data sheets (MSDS) or other exposure documentation, you should attach them to the report. Include any information about conduct that might indicate that the employer has been seriously or willfully negligent.

The report should describe what happened after the injury. For example, was the applicant transported by ambulance to a hospital, or did the applicant continue working that day and seek treatment later. This section should also summarize the current and past treatment.

If there is more than one injury, the report should clearly describe each injury and the subsequent treatment, or changes in treatment, if treatment was on-going at the time of the second injury.

Workers' Compensation Judge Pamela Foust[2] explains that the purpose of the history section is to provide

> ". . .sufficient information regarding the nature of the injury and the patient's relevant physical or emotional condition before, after, and during the alleged injurious exposure to understand what the applicant is claiming happened to him and why. . . A skilled attorney will know what questions to ask to present his client's story in the best light at trial. Likewise, a skilled forensic doctor who believes there is merit to an applicant's case from a medical standpoint will be able to elicit information and report the facts in such a manner that the reader will understand the basis for applicant's claim."

In some cases, the physician may have an assistant make an initial outline of the patient's history or take excerpts from prior medical records, to prepare the physician for personally taking a thorough history and summarizing the records. However, the physician must review the excerpts and outline with the patient and make any necessary additional inquiries. For psychiatric evaluations, under the IMC Psychiatric protocols, ***only*** the physician may take the patient's history. The physician can assign other trained and qualified individuals to perform diagnostic tests. The name, qualifications, and role of any and all persons involved in making outlines or excerpts, in performing diagnostic tests, or in drafting the report, must be disclosed in the report (see p. 110).

PRESENT COMPLAINTS

This section should explain in detail the patient's current complaints. You should attempt to relate the frequency, duration, and

intensity of the complaints to specific activities and note temporal patterns, such as stiffness in the morning, or pain that increases throughout the day. Pain that interferes with activity is a "ratable" disability in workers' compensation, so it is important that the report give a clear understanding of the extent of any limitations.

Before the examination, the injured worker or representative should have received copies of all materials to be reviewed by the physician, from the employer or insurance carrier. For disability evaluations, the employee should also receive an Employee's Permanent Disability Questionnaire (DEU Form 100). The QME should review this form and discuss any conflicting or missing information with the worker. If the worker does not have this form, the QME should have the worker fill one out at the time of the appointment. The QME should also receive a Request for Summary Rating Determination (DEU Form 101) from the party requesting the disability evaluation. The request form contains the address of the Disability Evaluations Unit office to which the completed medical evaluation, together with DEU Forms 100 and 101, must be sent. The Disability Evaluation Unit will not complete a disability rating unless the two completed forms are submitted with the medical evaluation report.

You should be accurate in repeating the applicant's version of physical limitations. Distinguish between activities that the applicant avoids as compared to activities that the applicant finds impossible to do. Overstating the applicant's claimed limitations may cause the applicant to be discredited, while understating those limitations may limit access to treatment or other benefits.

HISTORY

This section should summarize important medical events or conditions that may have bearing on the applicant's injury, the social history, review of systems, and any other relevant medical information. The applicant should be questioned about any pre-existing injuries or conditions in the affected part of the body. This section should also report other conditions or disabilities that may affect the degree of disability this injury has caused. For example, an applicant who had previously lost the use of his right leg will suffer greater disability from an injury to his left hip than a previously unimpaired person. Workers' compensation recognizes certain combinations of impairments as total disabilities, even though either impairment by itself is not considered totally disabling. You should also include any relevant occupational history in this section.

In preparing this section, you should consider information from medical records that has been provided for this examination. You need not quote extensively from the records, but you should note any important points, especially any pre-existing conditions or treatments. You should discuss with the applicant any discrepancies between the records and information supplied by the applicant and note inconsistencies in your report. Occasionally, your discussion with the patient may reveal the existence of other medical records that you wish to review. ***When the patient is unrepresented,*** the regulations governing QME and AME examinations limit information that is provided to the evaluating physician and limit communications with any party other than the patient. You are not allowed to communicate with either party outside of the evaluation exam, except in writing, and any written communication must be served on the opposing party within 20 days (except for requests for releasing medical records). See Chapter 7, p. 121, for more information on *ex parte communication.*

Required Elements of a Medical-Legal Report

- Summary form (for QME and AME)
- DEU Form 100 is included (unrepresented QME only, report must contain comments about the form)
- DEU Form 101 is included
- Date and location of the exam
- Statement that the physician actually performed the examination
- Time spent face to face with the injured worker
- Listing of material reviewed or relied upon to prepare the report
- History of the present injury or illness
- Present complaints
- Medical history including injuries, conditions and residuals
- Findings of the examination, including laboratory or diagnostic test results
- Diagnosis
- Factors of disability: subjective, objective, work restrictions, estimate of loss of pre-injury capacity
- Opinion on whether permanent and stationary
- Cause of the disability (work caused/work contributed)
- Treatment currently needed
- Future medical treatment where reasonably, medically probable
- Vocational Rehabilitation
- Apportionment of disability, if any
- Reasons for opinions
- Disclose the name and qualifications of anyone who assisted in report
- Mandatory declaration in its entirety
- Statement concerning that physician did not violate LC 139.3
- Original signature of physician with the date signed and county noted

FINDINGS OF THE EXAMINATION

This section should include both your findings on the clinical examination and the results of diagnostic tests that you administer. The IMC has adopted guidelines for the evaluation of psychiatric and certain physical disabilities. (IMC Psychiatric Protocols (Appendix C)).

Try to present your findings as simply and directly as you can. Findings should be described in accordance with IMC guidelines mentioned above. The physical examination should follow the guidelines presented in *Evaluation of Industrial Disability by Packard Thurber* for any disability that is not covered by IMC guidelines. You should not use the *American Medical Association Guide to the Evaluation of Permanent Impairment* as it outlines different measurement techniques than those used in California.

Describe the purpose of clinical tests rather than referring to the test only by name. Remember, the main function of this report is to enable people who are not physicians to evaluate the case in the workers' compensation system.

If you have performed or reviewed any diagnostic tests, such as x-rays or EMG, you should summarize the findings in this section.

DIAGNOSIS

This section should give a specific diagnosis for each and every condition you are evaluating. If you cannot make a specific diagnosis, you should state an impression or indicate the differential diagnosis.

CAUSE OF THE DISABILITY

This section addresses the relationship between the conditions you found on examination and the injury or occupational exposure. In some situations, this section can be quite brief. For example, "the employee's fracture resulted from the fall he sustained on January 23, 1990." More detailed discussion is required in cumulative trauma cases, occupational illnesses, stress claims, or in cases where additional body parts or systems have become affected since the original injury. You should explain how different exposures or tasks contributed to the condition. If you are discussing symptoms that developed secondary to the original injury, explain how or why they developed. For example, you might state that the applicant developed low back pain due to the altered gait that was caused by his knee injury.[3]

You should be as direct and definite in this section as possible. Avoid the use of terms such as "possibly" or "maybe," because they have no definition in the system. See Chapter 2, pp. 22-26 for further discussion of causation.

It isn't necessary for work activities to be the entire cause of the injury. Work can be a contributing or aggravating cause. If there is permanent disability, and you have described an injury as an aggravation to an existing condition, you should be prepared to address that issue in the apportionment section of the report. (Psychiatric injuries are held to a different standard of causation. (See box on p. 32 "Percentage of Causation in Psychiatric Injuries.") For information on apportionment see Chapter 3.

You should consider all work exposures in determining causation in cumulative trauma or occupational illness cases. However, you must identify the last year that the employee had the hazardous exposure, because the law limits liability to the applicant's employers during that year (Lab. Code § 5500.5).

If conflicting accounts of how the injury happened affect your opinion regarding causation, then you should state your opinion conditionally in each of the possible scenarios. It is not your job to determine which history is correct. However, if your medical evaluation corroborates or is not compatible with one of the histories that has been provided, you should note that in your report.

California law, Labor Code section 3212, contains *rebuttable presumptions* regarding causation for certain injuries in certain occupations (see Chapter 2). In evaluating those injuries, you should give your opinion in support of causation or provide your opinion and evidence to rebut the presumption.

Psychiatric evaluations have one additional requirement. These reports must contain a determination whether work factors were the predominant cause (at least 51%) of the injury.

OPINION ON PERMANENT AND STATIONARY STATUS

In this section you should state whether or not you have determined the patient's condition to be permanent and stationary, along with the reasons for this determination. If the condition is not permanent and stationary, you should indicate what additional treatment is needed, and if possible, estimate when the patient should be reevaluated. Discussion of disability factors, Qualified Injured Worker status, future medical needs, and apportionment may not be possible until the patient's condition has become permanent and stationary.

FACTORS OF DISABILITY

This section should describe any permanent disability that you believe will result, or has resulted from, the injury. (See Chapter 3, p. 36 for a complete discussion of permanent disability.) It is very important that you be thorough and specific in this section, because it will be a basis for the DEU rating. For each body part being evaluated or systems, you should give an opinion on the:

- ▲ Subjective Factors
- ▲ Objective Factors
- ▲ Work Restrictions
- ▲ Estimate of limitations or loss of pre-injury capacity.

Your opinion in this section should relate to the information you provided in the findings section of your report. Based on the patient's subjective complaints and on your examination, you should describe any subjective disability. For example, limitations due to pain should be identified by a description of the activity that produces the disability, the duration of the disability, the activities that are precluded by the disability, those that can be performed with the disability, and the means necessary for relief. (See box, p. 44, for further discussion on describing subjective disability.)

If your physical examination revealed a restricted range of motion, in this section you should describe the resulting range of motion. You should describe any loss of a body part, disfigurement, atrophy, or measurable loss of function, including range of motion or strength, as well as any device or prosthesis that should be used. (See Chapter 3, pp. 41-49, for further discussion on describing permanent disability.)

This section should also describe any work restrictions that you determine should be placed on the worker, regardless of whether they are specifically relevant to the applicant's current job. Work restrictions can be actual or preventive (prophylactic). Actual work restrictions are those that the employee cannot perform, either because the employee is physically prevented from doing so, such as being unable to bear weight on an injured ankle, or because the activity causes severe pain. Preventive work restrictions are appropriate to:

- Avoid or prevent undue pain,
- Avoid causing an increase in symptoms that would lead to a period of temporary disability,
- Avoid causing increased permanent disability,
- Prevent exacerbations that would increase the need for medical care.

Review Chapter 3, pp. 44-46, for further discussion of how to write work restrictions.

Once you have clearly defined the actual work restrictions, you should also ***separately*** describe, to the best of your ability, the worker's loss of pre-injury capacity. You should describe what the worker could do before the injury, as compared to what the worker can do after the injury. Based on that description, estimate the percentage of loss of capacity. (See Chapter 3, pp. 46-47, for more information on how to estimate loss of pre-injury capacity.)

APPORTIONMENT OF DISABILITY

This section should describe the degree to which any permanent disability is due to pre-existing conditions or underlying disease. Apportionment is a legal concept and applies only to permanent disability. It is never applied to medical treatment, temporary disability, vocational rehabilitation, or death benefits. Apportionment can only be based on disability. It is not correct to base apportionment on personal risk factors, asymptomatic disease, or pathology. You are being asked to determine the portion of the disability that would have existed without the current injury. (See Chapter 3, pp. 50-58 for discussion of apportionment.)

You should address the issue of apportionment if you have described pre-existing conditions or underlying disease, or if you have indicated in your causation section that the injury is an aggravation of an existing condition or previous injury. Explain the portions of your findings that affect your opinion on apportionment. The existence of underlying disease or pre-existing injury does not automatically justify apportionment to those factors, but the issue should be addressed.

The chief method to apportion permanent disability is to use the "subtraction method." (See Chapter 3, p. 51)

MEDICAL TREATMENT INDICATED

Labor Code section 4600 provides that an injured worker is entitled to treatment reasonably required to cure or relieve the effects of the injury.

Thus, this section should include your recommendations for current and future treatment. If the patient is currently receiving treatment, indicate whether the treatment is necessary to either improve or prevent deterioration of the current condition. Refer to both subjective and objective factors (see Chapter 3, pp. 42-44). If you believe that additional treatment is indicated to achieve maximum improvement, you should explain the type of treatment indicated, the reasons for the treatment, and the possible benefits of the treatment. The way you phrase this need for treatment and the definitions used are critical to the injured worker receiving proper benefits for the work injury.

PROVIDING FOR FUTURE MEDICAL TREATMENT

A worker may still require further medical treatment after the worker's condition is permanent and stationary and workers may receive awards which include future medical care if the treatment is needed:

- ▲ To maintain the worker's optimum condition;
- ▲ To relieve or cure the effects of the injury;
- ▲ To relieve the effects of exacerbations or recurrences that are reasonably expected from the worker's condition.

Treating and evaluating physicians should carefully consider and calculate the need for future medical treatment and include as much detail on this as possible in their reports, without including finite numbers and dollar amounts. When medically appropriate, future medical treatment must be awarded by the WCAB. The physician is in the best position to estimate what the needs might be (see box p. 110). This estimate should include check-ups, anti-inflammatory or pain medication, splints, future surgery, future hospitalization, and any other necessary medical care. The WCAB will not be bound by estimates of an injured workers' medical needs in a P&S report. The WCAB will look at the reports of the treating physician, and possibly a QME, at the time medical care is requested by the injured worker.

REASONS FOR THE OPINION

For each opinion, you must provide a clear description of why you have reached that opinion. You should also provide explanations for any unusual findings. This should be done throughout the report, in the appropriate sections. Avoid meaningless summaries such as "My opinion is based upon the patient's history, the examination findings, and the available medical records." A medical-legal report that does not contain the reasoning behind the medical opinions reached is worthless in the workers' compensation system.

The Report Should Be Internally Consistent

I can handle it when the report's findings are inconsistent as long as the physician tells me why. If the work restrictions don't logically match what you've said in your findings, you need to explain why . . . to give your reasoning. Otherwise the rater has no possible idea of what may be going on with that worker. Without the explanation the rater is basically left to guess, which may well not be to the benefit of the worker.

— disability rater

The Rushing Decision Defines Forms of Treatment

*"Section 9785 uses the terms continuing treatment and further treatment; not future treatment. The terms are not interchangeable. Continuing means constant, needing no renewal: lasting, enduring. (Webster's Third New Internat. Dict. (16th ed. 1971) p. 493.) "Further" indicates "going or extending beyond what exists." (*Id. *at p. 924.) The terms "continuing" and "further" denote treatment protocol that is ongoing, uninterrupted and unceasing. By contrast, future is "existing or occurring at a later time." (Id. at p. 926.) Hence, "future" medical care suggests medical attention which would be required at a later date."*

-Tenet/Centinela Hospital Medical Center v. WCAB (Rushing) 80 Cal. App. 4th 1041; 65 C.C.C. 477

Excerpts from Inadequate Reports

Many medical-legal reports do not provide the information necessary for raters or judges to make decisions about worker's cases. Following are several excerpts of inadequate medical-legal reports, with accompanying comments on how the report should be changed.

WORK PRECLUSIONS:
I would preclude any heavy lifting or prolonged repetitive activities with her right upper extremity and any gripping with her right hand.

Comment:
These work restrictions are too vague. Work restrictions should be more specific to the actual precluded tasks and limits. (i.e. keyboarding) % loss of pre-injury capacity for lifting or gripping activities.

DEGREE OF DISABILITY:
The left foot complaints preclude him from prolonged weightbearing activities and limit him to semi-sedentary work. However, this does not affect such things as stooping or bending or lifting capability, and the raters should take this into account when considering his overall working capacity. The left knee and low back complaints appear to represent minimal hindrance to his activity and would not add significantly to his disability level.

Comment:
These work restrictions are too vague, and internally inconsistent. If a patient is precluded from weight-bearing activities, this would likely affect lifting capability.

FUTURE MEDICAL TREATMENT:
As was stated previously, based on present findings on examination, there is no clinical indication to warrant any further diagnostic studies or active treatment, other than on a simple supportive and symptomatic basis. It is felt, however, that, based on symptoms over this period of time of some six years, and with the pathology as noted from the previous arthroscopic procedures performed, medical care should be afforded to him in the future with any settlement in the event that his symptoms do progress or become intolerable where he would need a more active treatment program, including the possibility of further surgery.

Comment:
Future medical care needs to be much more specific. What kind of treatment? How frequent? What kind of surgery?

Excerpts From Inadequate Reports, cont'd

DISCUSSION:
The patient sustained a serious injury on January 17, 1992. It is very likely that he has had subclinical psoriatic arthritis for a long time prior to the injury. It is very possible for the psoriatic arthritis to precipitate as a result of trauma.

In consideration of the patient's overall medical condition, it is reasonable to assume that the patient has reached the permanent and stationery status. The objective factors and the patient's disability rating are very minimal, perhaps less than 5 percent of the right upper extremity. The subjective complaint plays a significant role in the range of about 10 percent of the right upper extremity. However, there is a contributing factor which is his psoriatic arthritis and history of his gout. I would estimate that 20 percent of his disability is contributed by the underlying medical problem, and 80 percent by the injury itself.

Comment:
It is not correct to apportion to an underlying condition unless the physician can demonstrate that the symptoms would have occurred regardless of the industrial injury. The physician has not done so in this report.

The End Result of Inadequate Reports: Rejection and Delay

EVALUATION OF QME REPORT

Physician Name: Dr. Smith

This QME report could not be used for disability rating because:

✓ Report failed to provide adequate information on factors of disability.

___ Report failed to address necessary legal issues.

___ Report was internally inconsistent.

___ Other:

Comment:

Dr. Smith indicates decreased range of motion of wrist, but does not provide measurements. Says there are symptoms on use, but doesn't describe what these symptoms are. Report is unratable necessitating writing to the QME.

Calculating Future Medical Costs

A 45 year-old worker has an episode of back pain resulting from a disc problem. It is not a surgical problem at this time. The physician writes the following in the medical-legal report under *"Need for Future Medical Care."*

I estimate that this patient will need the following care:

- Two to three office visits per year to evaluate progression of the back problem;
- Physical therapy for periodic recurrence of the problem (approximately six sessions per year);
- Four tablets per day of anti-inflammatory medication, on-going;
- It is possible the problem may progress to the point at which the patient may need an L5-S1 laminectomy and discectomy, to be determined by treating and consulting physicians.

DISCLOSURE OF OTHER INDIVIDUALS INVOLVED

Your report must disclose the name, qualifications, and roles of other individuals who participated in the evaluation by performing such tasks as:

- ▲ Taking and outlining the medical history.
- ▲ Reviewing and summarizing medical records.
- ▲ Administering diagnostic studies.
- ▲ Drafting or editing any part of the report.

The name of the transcriptionist is not required. Violation of this provision can result in your suspension or termination as a Qualified Medical Evaluator. (Lab. Code § 139.3, 8 Cal. Code Regs. § 4628).

MANDATORY DECLARATION

Since all reports, whether comprehensive medical-legal, supplemental, or follow-up reports are submitted to the WCAB and may be used in evidence, the following declaration in its entirety must be included in every medical-legal report:

> "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."

SIGNATURE

The report must be signed by the physician who prepared the report, under penalty of perjury (Lab. Code § 4628(j)). If you sign the report, you must have examined the applicant, taken the applicant's history or reviewed with the applicant an outline of the history, reviewed the medical records, and composed and drafted the conclusions of the report. Include the date and county where the declaration was signed.

DISCLOSURE OF ANY SIGNIFICANT BENEFICIAL INTEREST

Your report must disclose any proprietary interest or co-ownership you have in any laboratory, pharmacy, clinic, or health care facility you used in the evaluation. QME's and AME's are

generally prohibited from most self-referrals, with some exceptions (Lab. Code § 139.31). Your report must contain the statement that you have not violated Labor Code section 139.3 in that you have not made an illegal referral(s). Failure to include this statement however, is not necessarily fatal and may be cured by a later amendment (*Leyba v. LSI Logic Corp.* (1995) 23 CWCR 230). See Chapter 7, for more information on prohibited self-referrals. Violation of this section can result in your suspension or termination as a QME.

An example of a declaration listing the above information can be found in Appendix C.[4]

Required Forms

Several forms must be attached to the medical-legal report. For QME and AME reports, the reporting physician must include a copy of the summary form (Form 111) that is found in Appendix D. If the injured worker is unrepresented, DEU Form 100 and 101 must also be included, and the report must contain comments about DEU Form 100. If the injured worker is represented, only DEU Form 101 must be included, but no comment about it is required nor are you required to complete the Summary Form.

Timeliness

The timely submission of reports is mandated by law. For injuries between January 1, 1991 and December 31, 1993 the report must be prepared and submitted within 45 days after the evaluator has seen the employee or otherwise commenced the evaluation procedure. For injuries on or after January 1, 1994, the report must be submitted within 30 days. Forty five day extensions (for injuries between 1/1/91 and 12/31/93) and 30 day extensions (for injuries on or after 1/1/94) shall be approved only when the evaluator has not received test results or a consulting physician's evaluation in time to meet the initial deadline. In this instance, the evaluator must notify the employee and the employer/insurer/claims administrator no later than five days before the end of the initial 30 or 45-day period that an extension is needed. A copy of this notice must be sent to the Executive Medical Director at the Industrial Medical Council. If the extension requires more than an additional 30 or 45-day period, approval must be granted by the Executive Medical Director. A copy of the QME and AME Time Frame Extension Request form is in Appendix D.

Payment for the Report

The employer must pay for medical-legal expenses within 60 days after receiving the written billing and report, unless the employer contests the reasonableness or necessity for incurring the expense. When the payment is not made as required, the "unreasonably unpaid" amount can be increased by 10 percent. The employer is also liable for 7 percent interest per annum retroactive to the date the bill was received (Lab. Code § 4622). (For information on filing lien claims see

What Can Physicians Do If They Have A Dispute Over Payment Of Medical Legal Bills?

- Make sure you are performing a valid medical-legal evaluation (see Lab. Code § 4621 and 8 Cal. Code Regs.§ 9793). For example, for claims accepted by the employer, the report will be inadmissible if performed during the first 60 days after the notice of claim has been filed. If you perform an exam before then, you are asking for a fee dispute.
- Do not perform unnecessary diagnostic tests or x-rays. If tests are necessary, offer a specific reason for them when requesting approval from the claim adjustor. If unusual or expensive testing is required, or if you think it is medically necessary to repeat tests performed in the recent past, notify the insurer in advance. Be able to provide a sound medical justification for doing the testing.
- Follow the medical-legal fee schedule honestly. This should resolve many problems before they start. The employer is required to pay all reasonable charges within 60 days. Under the fee schedule, this means that the employer should pay a minimum of $500 for a standard uncomplicated medical-legal report (ML 102). Even if the payor disputes a charge above this level, the basic medical-legal fee must be paid within 60 days.
- If the dispute over the validity or the amount of payment cannot be resolved, the provider must file a lien and litigate the matter before the Appeals Board.

Chapter 8.) Medical-legal reports must be billed in accordance with the medical-legal fee schedule (Appendix C). You can reduce delays and facilitate speedy payment by including supporting information in your report as to how you achieved the level billed (i.e., hours present or elements included).

End Notes

1 8 California Code of Regulations section 9793 and description by Honorable Pamela Foust, Workers' Compensation Judge, *"Handling Medical-Legal Issues: An Analysis and Proposal,"* Conference of California Workers' Compensation Judges, Los Angeles (1992).

2 Honorable Pamela Foust, Workers' Compensation Judge, *"Handling Medical-Legal Issues: An Analysis and Proposal,"* Conference of California Workers' Compensation Judges, Los Angeles (1992) p. 32.

3 Honorable Pamela Foust, Workers' Compensation Judge, *"Handling Medical-Legal Issues: An Analysis and Proposal,"* Conference of California Workers' Compensation Judges, Los Angeles (1992) p. 39.

4 Honorable David O'Brien, Workers' Compensation Judge (ret), Work. Comp. Claims & Benefits, 10th Ed. (1996), p. 300.