



Medical Records Analysis

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The analysis of medical-legal issues posed in any case can be complicated, requiring some close reading and “detective work” to both locate medical records and then interpret the medical history contained in those records. Each case is fact-specific and must be analyzed in conjunction with the prevailing statutory and case law involving standard of proof of medical causation, compensability issues and jurisdictional issues. Those topics are beyond the scope of this article, but the information that can be developed with aggressive medical record acquisition and analysis applies equally to management of all types of claims.

Medical records can loosely be broken down into two categories:

1. Hospital Records
2. Medical Records from personal or treating physicians

The way in which these categories of records are requested will impact the time span and amount of information received. For example, a Subpoena Duces Tecum for all records of a particular entity should produce more records than a limited release signed by the claimant but restricted to a certain time frame (date of injury-to-present) and body part (e.g. “shoulder”) However, when requesting medical records relating to a specific area of injury, don’t overlook the importance of broadening the request to include the region of the body surrounding the injury. This is best illustrated by the “shoulder” injury and request for treatment records regarding the “shoulder.” Sometimes, cervical injury can mimic shoulder injury or cause referred pain, and from a claims management and medical diagnostic perspective, this information can become critical. Whenever possible or in case of doubt, a certified copy of all medical records is preferable to a partial record. The copying of which may be left to the interpretation and discretion of a medical records custodian.

In any case, the claimant's prior medical history and treatment records can be just as important as medical records generated as a result of the claim being litigated. The further away you get from the date of the injury that gave rise to the claim, medical records serve as an important source of information about medical treatment received contemporaneous with and subsequent to the injury that gave rise to the claim.

Medical Records Generated Prior to the Date of the Claim

Some key pieces of information to look for in analyzing medical records generated prior to the date of injury that gave rise to the claim include:

- Treatment to the same body part or region of the body that was injured in the claim;
- Chronicity, or the time frame in which prior treatment was sought and received in relation to the claim;
- Referrals to specialists for treatment to the same body part or region of the body that was injured in the claim;
- Referrals for diagnostic radiologic tests on the same part of the body or region of the body that was injured in the claim; and
- Medical conditions, illnesses or disease processes that may impact symptom presentation, differential diagnosis and treatment recommendations for the injury that is the subject of the claim.

Often, the only way to discover information about prior medical history and treatment is via deposition. However, a good medical history by the authorized treating physician can also give rise to some of this information.

Medical Records Generated Contemporaneous With the Date of the Claim

One of the hallmarks of Missouri Workers' Compensation law is that the employer has the right to direct and control medical treatment for an injured worker. Medical treatment specifically not authorized is not the responsibility of the employer.

What if the claimant seeks medical treatment with his own physicians concurrent with medical treatment authorized by the insurer?

What if the history in those medical records is at odds with the description of the injury contained in the authorized treatment physician's records?

What if the history in those medical records contains a subsequent intervening event causing injury to the same body part or region of the body that is the subject of the claim?

What if the claimant's medical condition is made worse by this unauthorized and undisclosed medical treatment?

If there is any reason to believe that claimant is receiving unauthorized medical care outside the scope of workers' compensation that may possibly impact the management of the workers' compensation claim, a deposition of the claimant would certainly be in order to further develop this information and track down healthcare providers' records.

Medical Records Generated After the Date of the Claim

The more time that passes from the date of the injury, the greater the possibility for other medical conditions or intervening events to interfere with or blur the medical causal relationship between the injury claimed and the treatment received. Often, a deposition of the claimant is the best way to quickly identify subsequent treatment providers. Again, some key pieces of information to look for when analyzing medical records generated after the date of the claim are:

- New injury or aggravating factor superimposed on the same body part or region of the body injured in the claim;
- Whether this new injury or aggravating factor is work-related or non-work-related;
- Newly developed or newly diagnosed medical conditions that may impact symptom presentation, differential diagnosis, treatment response or treatment recommendations for the work-related injury; and
- Factors that may contraindicate or complicate medical treatment procedures, such as newly developed or discovered medical conditions or psychiatric conditions.

Medical Record Categories in General

Earlier in this piece, medical records were loosely grouped into two categories:

- Hospital Records
- Medical Records from personal or treating physicians

A few brief notes and some analysis about each of these record categories are warranted here.

Hospital Records

This category of medical records will include the following:

- Emergency Department Records and Nurses' Notes or Triage Notes
- Admissions
- Admitting History
- Discharge Summary
- Operative Notes
- Consulting Physician Reports
- Pathology Reports
- Laboratory Test Reports
- Diagnostic Radiology Reports
- Reports from Ancillary Services Departments such as Occupational Therapy, Physical Therapy

Generally, hospital records will contain a more complete history. The Face Sheet, or the portion of the record that indicates the patient's name, date of birth, insurance information, etc., is a key place to start. Generally, the Face Sheet will indicate the date of prior admission or treatment at that same facility, so a quick check for the date of last admission is the best clue that there may be more records yet to be discovered.

The Face Sheet is also a good source of information about a person's referring physician or personal care physician, whose records may become necessary to the analysis of the case.

In general, Hospital Records contain a specific outline of what information is contained within a patient's history. This isn't so much a "rigid structure," but more of a general guideline that covers many relevant areas of medical inquiry. In most cases, the "History" contains the following sub-categories:

- **Chief Complaint:** Problem or reason for the visit; duration of the problem; patient information such as age, sex, marital status, previous hospital admissions, occupation; and other complaints or secondary issues, fears or concerns that caused the patient to seek care.
- **Present Problem:** Includes sequence of events patient experienced; state of health just prior to the presenting problem; description of the first symptom such as time and date of onset, location, movement, trauma; if symptoms are intermittent, description of the typical attack, duration, inciting or exacerbating factors; limitation imposed by

illness/event; review of current and recent medications, dosage of prescriptions, non-prescription medicines; and review of the particular body part or system where the medical problem manifests itself.

- **Past Medical History:** General health and strength; childhood illness history; major adult illness history; immunization history; surgeries; serious injuries; medications; allergies; and emotional status (includes mood disorders or psychiatric treatment).
- **Family History:** Relatives with similar illness; immediate family history such as ethnicity, health, cause of death and age at death; disease history; spouse and children; and hereditary disease history.
- **Personal and Social History:** Personal, social, educational, marital, cultural status; habits involving nutrition, diet, exercise, tobacco, alcohol, illicit drugs; self-examination history; sexual history; home conditions; occupation; environment; military service; and religious preference.
- **Review of Symptoms:** General constitutional symptoms; diet; skin, hair and nails; musculoskeletal; head and neck; endocrine; chest and lungs; heart and blood vessels; hematologic; lymph; and gastrointestinal, genitourinary, neurologic and psychiatric.

Medical Records from Personal or Treating Physicians

These records may or may not contain extensive documentation such as that found in Hospital Records, but there are a few things to watch out for when analyzing these types of records. Don't hesitate to ask for clarification or supplementation if it appears the record is incomplete.

First, the method by which medical records are requested will affect the materials received and the time frame of the records. Incomplete medical records are like reading a history book by starting in the middle or the end. You can't get the big picture without starting from the beginning. Some "red flags" for incomplete medical records:

- Do the records begin abruptly in time without reference to the onset of treatment or first visit/new patient?
- Does the record begin with the words, "This is an established patient..." or "Patient is seen in follow-up?"
- Do the records contain a "New Patient Questionnaire" or "Medical History Update"?
- Do the records mention referrals to other physicians for consultation or specialized treatment that may impact management of the claimed injury?
- Do the records indicate that the patient is being referred to that physician by another physician?

- Do the records contain letters from one physician to another regarding his or her consult on this patient?
- Are there references in the records to appointments made for diagnostic testing? If so, do the records contain the results of those tests or indicate whether the tests have been completed and interpreted?
- Do the medical records end abruptly in time, perhaps in the middle of the diagnostic process, without explanation?

It is also important to note that due to HIPAA concerns and restrictions on the release of medical information, some physicians will not allow their staff to secondarily release records of other physicians in their possession – so a separate release may need to be generated for the patient’s signature to authorize secondary release of one physician’s records by another.

Look carefully at the history and notations made by physicians in their records regarding cause of symptoms, nature of symptoms, date of onset, cause of onset of symptoms or injury and past medical and treatment history. Check this information against the facts of your case to determine:

- Need for additional discovery of medical records that may impact the defense of your claim;
- If the history contained in the medical records is contradictory to the alleged facts of the case regarding date of injury, cause of injury, onset of symptoms and complaints; and
- If the medical records lead to discovery of additional information regarding a subsequent intervening injury or non-work-related event, or a prior or subsequent medical condition that may impact on the defense of your claim.

In the end, the practice of medicine – and medical record analysis – is both an art and a science. Follow the clues logically and creatively for the best results.

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