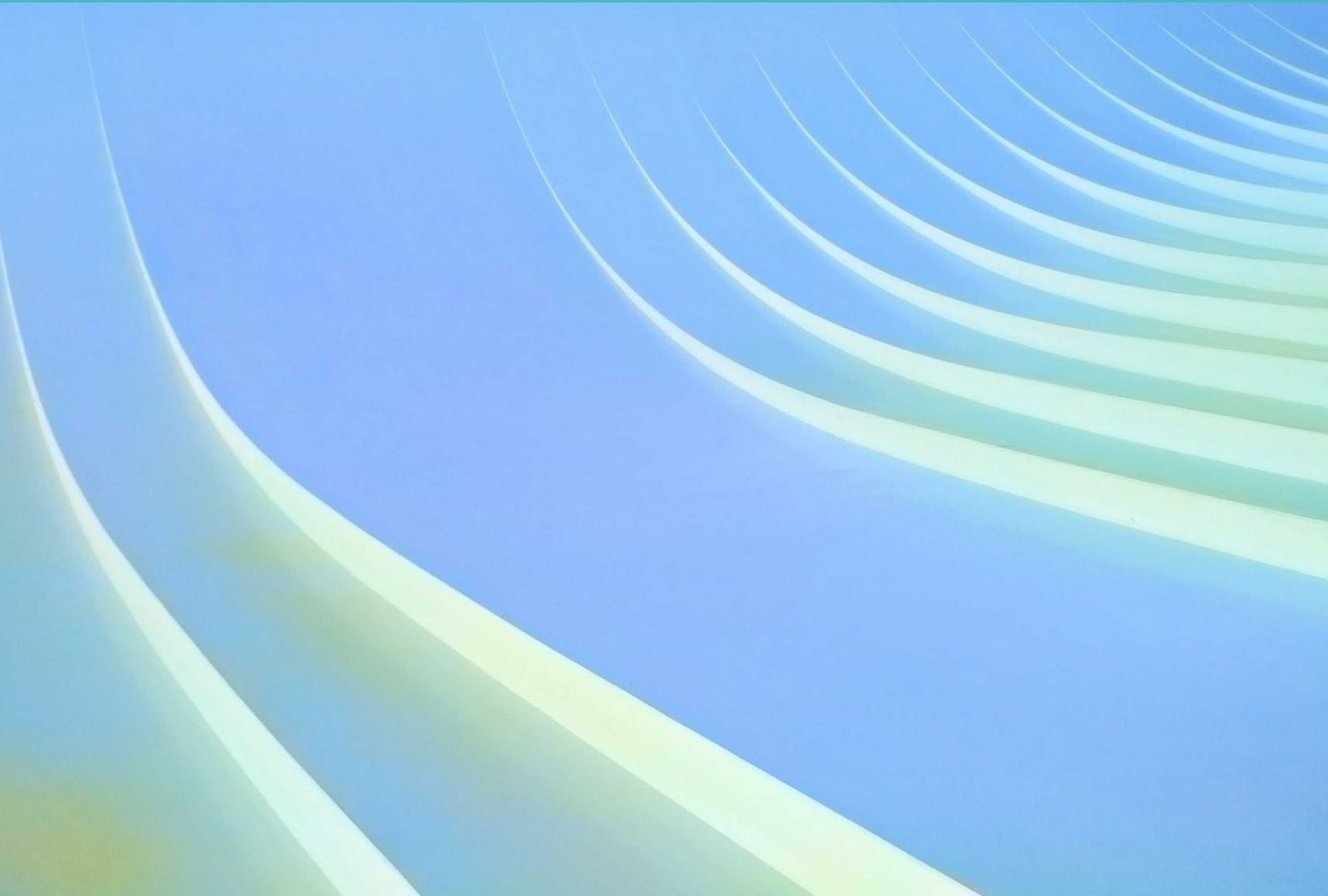

Uses and abuses of records reviews

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REOH

Why get a records review

- Need a rapid answer on a simple question
  - Is a treatment recommendation endorsed by U & T Guidelines?
  - Is further treatment necessary?
  - Impairment rating when no PE needed
    - *Hearing loss*
    - *Lung injury*
    - *COVID-19*
- Injured worker is no longer in MT

Limitations of a records review

- No history obtained from injured worker
- Can’t ask questions concerning past injuries/medical problems
- Hard to address exacerbation/aggravation if info isn’t in the records
- Medical record quality varies and this matters
  - Medical specialty matters
  - Knowledge of medical condition matters

Limitations of a records review

- Often cannot address
  - Work restrictions
  - RTW
  - Job analyses
  - MMI

Impairment ratings

Contrary to popular belief, only a limited number of impairment ratings can be done by records review

Possible records review impairment ratings

- Hearing loss relies solely on audiogram
- Lung injury relies solely on pulmonary function tests, VO_2 max test, medication usage

Most impairment ratings rely on history taking (for functional history adjustment) and physical exam (for physical examination adjustment)

Low quality medical records

- History of present illness
    - No description of injury, only statement that body part is painful/dysfunctional and injured worker’s statement that work is cause
    - Wrong description of injury
    - Wrong body part
    - No description of job duties beyond ‘repetitive’ (cycle time <30 s important in occ dz claims)
    - No images of workstation, vehicle crashes, or surveillance videos
    - No FROI
    - No TOI job description or other completed JAs

- History of present illness
  - EMR repopulates history from visit to visit without reflecting current status (cut and paste records)
  - No editing after using voice activated software (work salad)
  - No records pre-dating the current conditions

Low quality medical records

- Physical exam
  - No weight or height (knee pain and 5’6” 150# vs 5’6” 350#)
  - Poor description physical exam (shoulder tender (which shoulder, where tender?)
  - Everything except injured body part examined (HEENT, lungs heart, abd)

Low quality medical records

- Physical exam
  - Tests inappropriately applied (Waddell’s tests on neck)
  - Tests incorrectly interpreted (SLR positive for back pain)
  - Symptoms described without doing physical exam (this info should be in HPI)

Low quality medical records

- Diagnostics
  - No diagnostics in records or never done
  - Diagnostics inappropriately interpreted (disc bulge interpreted by treating as disc herniation)
  - No diagnostics to exclude other sources of current complaints (thyroid function and diabetes in carpal tunnel syndrome)
  - **Find out if the RR provider would like images or not

The letter

I like to see the questions a records review is supposed to answer before agreeing to do the review; sometimes the questions can’t be answered without an in-person (or telephonic) encounter

The letter

Should include the accepted condition since this isn’t always obvious in the records

Should include the specific issues to address (aggravation, MMI, restrictions, treatment, etc.)

Should not include questions about a physical examination

Don’t ask about cost of care, this is outside an IME doc’s “sandbox”

Administrative details

Ask first! If you are in doubt about whether a file review is the best choice – ask!

- Run the record set *and letter* by the physician (They don't have a crystal ball)

Modifications

- Additional diagnostics
- Is a telephonic history

Many providers work without staff, the tidier your records and letter, the better result (for example, duplicates, bills, HCFAs, chronologically organized…)

- Some of this you have no control over (quality of treating records)

Ask how they prefer the records – digital vs paper