Analyzing Medical Evidence: Understanding and Using Medical Reports

Toni Smith and Andre Stephens
Dallas and New York District Management Advisors
Why Analyze Medical Evidence?

• To obtain a broader and deeper understanding of each case

• To identify opportunities for moving case forward via job offers, returns to work, closures, etc.

• To note what is missing in the medical evidence and develop it at the agency or OWCP level

• To facilitate communication between ICPA and OWCP or with medical providers
Choice of Physicians

• Under the Federal Employees’ Compensation Act (FECA), employee is entitled to select physician who is to provide treatment. Provider must meet the FECA definition of “physician” and must not have been excluded from payment.

• Physicians employed by or under contract to EA may examine employee at EA’s facility in accordance with Office of Personnel Management’s regulations. However, employee’s choice of physician must be honored, and treatment by employee’s physician must not be delayed for purpose of obtaining an EA-directed medical examination.
Definitions of Medical Providers

Who is a “physician” or proper medical provider?

- **Physician**’ includes surgeons, podiatrists, dentists, clinical psychologists (Ph.D.), psychiatrists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by State law.

- **Chiropractors** are included only to the extent that their reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct an existing subluxation as demonstrated by X-rays.

- In **psychiatric cases**, medical opinion must come from a Doctor of Medicine in Psychiatry or a Ph.D. in Psychology, not from a counselor with only an M.A. degree.
Non-Physician Practitioners

- **Psychologist – PhD**
  - Non-MD evaluates and treats mental disorders; cannot prescribe medications
- **Physical Therapist**
  - Provides treatment, exercise instruction (FYI if doctor rating code is Certified Physical Medicine (CPMR), he can treat and bill for both medical and physical therapy treatment)
- **Masters in Social Work (MSW)**
  - Provides counseling services
- **Licensed Clinical Social Worker (LCSW)**
  - Provides counseling services
- **Licensed Professional Counselor (LPC)**
  - Provides counseling services
- **NOTE:** LPC, MSW, LCSW cannot write prescriptions
Non-Physician Practitioners (cont’d)

• Nurse Practitioner
  • Registered Nurse with additional formal training, licensed state to provide primary care. In most states, must work under direction of licensed physician. In some states, approval to provide direct care and midwife without physician supervision.

• Physician’s Assistant
  • Licensed by states to provide primary care. Must do so under the direct supervision of a licensed physician (Physician must sign off on all medical reports).
Fitness for Duty Examinations

• A report from such a physician should receive due consideration; however, since the agency directed the examination, reliance upon the findings for case action must be tempered.

• If the findings or conclusions differ materially from those of the AP, the CE may consider further development; but the reports cannot be used as the basis for a formal reduction or termination of benefits.

• Also, under the FECA procedures, such a report may not be used to create a conflict in medical evidence that requires resolution under 5 U.S.C. 8123(a).
Components of a Medical Report

- Reason for examination or referral
- History of injury (may also include family and social history)
- Current complaints
- Review of previous medical records
- Findings on examination
- Findings from lab work, diagnostic procedures, psychological testing
Components of a Medical Report

- Diagnoses (expressed also with ICD-10 codes)

- Detailed discussion and conclusion with medical rationale linking objective findings in case with physician’s medical opinion

- Physician’s responses to specific questions from OWCP or employing agency

**RED FLAG:** Not all medical reports may contain all the above components but key reports of record should. Other reports will contain some of the more key components.
Importance of Factual Evidence

Sound medical reports with probative weight will have a history containing:

- Adequate factual and medical background on the claimant and injury
- Accurate facts about the accident or exposure and the accepted employment conditions
- Clearly identified cause (“mechanism”) of injury or exposure

Deficiencies in the above diminish probative value of medical evidence and may invalidate conclusions.
RED FLAG: Agency should indicate to Attending Physician (AP) or OWCP whenever history of injury is invalid due to incomplete or deficient factual evidence.

- Note that medical evidence is always contingent on factual evidence: *time, place, manner*

- ICPA, therefore, always plays key role in establishing factual evidence in a case.
Objective Medical Findings

Extensive objective findings are not always required in every report but should be expected in:

• Complex cases at critical points in their management

• Detailed medical examinations: Permanent & Stationary (P&S) reports, second opinions, independent medical examiner/ referee reports, etc.

• Medical conflict cases
Objective Medical Findings (cont’d)

• Objective medical evidence is required to make an informed employment decision (Which may be separation from employment if claimant unable to physically perform his job after being out more than 1 year)

• The agency may monitor a claimant's medical progress and duty station by obtaining periodic medical reports. See 20 CFR 10.506 (See attached for sample letter and CA-17)

• The employee has the burden to provide prima facie evidence to establish the initial claim of work related injury and disability.

  – A note on cases involving reemployment: With such claims, which have been accepted as having an injury sustained during federal employment, and resulted in a period of total disability with continued medical restrictions, the burden of proof shifts to OWCP.
  – There is no prima facie evidence accepted to establish the employee’s ability to work. OWCP must establish by weight of medical evidence the injured employee’s current work tolerance level. Medical evidence must be conclusive and not speculative.

• The employees’ over all physical and mental condition must be considered (“whole person”). Conditions developed after the injury, conditions that pre-existed, and the injury itself must be taken into consideration.
Objective Medical Findings (cont.)

Extensive objective findings are not always required in every report but should be expected:

• When issues of etiology with questions on causal relationship to work factors are raised

• When issues of residuals still linked to original injury are developed

• When extent of disability goes beyond what is normally expected (medical matrix)
Objective Medical Findings (cont.)

The most reliable objective findings include:

• Physical findings: physician’s visual inspection, palpation, manipulation of body, temperature, pulse, respiration, blood pressure, range of motion (*), essentially any finding not under claimant control, thereby “objective”

• Lab work: blood tests, urine tests, tissue samples, etc., when done by licensed personnel

• Diagnostic procedures: radiographs (x-rays), MRI, EMG, psychological/personality testing*

**RED FLAG:** Lab work and diagnostic procedures should include, when appropriate, the interpretation of the physician or technical specialist.

*Currently, its objectivity is still debated.
Semi-Objective Medical Findings

Tests requiring cooperation by the claimant, rendering the claimant partially in control, are second-best medical findings:

• Visual, hearing, pulmonary/breathing tests

• Range of motion (ROM) or any test requiring physical motion by the claimant (e.g., vs. automatic knee jerk when struck)

• Psychological exams/tests (still debated)

• Medical providers should detect, identify, and report extent of claimant’s performance on exam: that is, poor effort, lack of participation, and even possible obstruction

**RED FLAG:** When any of above occurs, agency should request further development by OWCP before any final actions are taken on claim.
Subjective Complaints

Complaints alleged by claimant but without independent confirmation by medical specialist or technician are considered “subjective complaints”.

- Examples include: pain (most common), coldness (but not to the touch), odd sensations, heaviness, “pins and needles”, inability to move, etc.

- May not be used exclusively to reach a medical conclusion regarding causal relationship, residuals, return to work vs. disability, or work capacity/restrictions.
Subjective Complaints (cont.)

• When medical evidence consists mostly or solely of subjective complaints, lack of objective findings should be raised with Attending Physician and/or OWCP.

• Words are important. Words such as: “can”, “could”, “more likely”, “in my medical opinion”, are not sufficient to establish causal relationship. The physician must express his/her opinion in terms of direct or proximate relationship. The physician must explain how the injury produced the change in the body. The physician needs to explain the mechanical process. (see J.S. and Postal Service July 28, 2014; Docket 13-2022.)

• RED FLAG: Further development is required and no final decisions should be taken on case.

• Psychiatric claims: They consist mostly of subjective complaints, so consider broader view of claimant’s total situation, work environment and accommodation, claimant’s accuracy and consistency upon examination, and also evolving factual evidence.
Medical Rationale

After objective findings and subjective complaints are determined, report is in posture for its medical rationale:

• “Rationale” is a detailed, medical discussion explaining how the medical opinion was reached.

• Not all medical opinions require rationale: e.g., simple traumatic injuries with prompt medical exam by physician.
Medical Rationale (cont.)

Some examples of when medical rationale is needed:

• When causal relationship is not obvious

• When there are intervening, non-industrial causes (pre-existing or post-injury)

• When disability lasts longer than normally expected (protracted return to work)
Good vs. Poor Medical Rationale

When determining quality of the rationale presented, consider “weight of medical evidence”:

• **Definition**: Weight of the evidence refers to the **quality** of evidence, not the quantity.

• Poor rationale is characterized by being speculative, tentative or conjectural: “might be”, “could be”, “may be”, with equivocal or uncertain phrasing.

• Poor rationale has little probative value (“diminished weight”) for decisions in case.
• Good medical rationale presents primarily objective findings to demonstrate basis for ultimate medical opinion.

• Firm medical rationale, therefore, uses physical exams, lab tests, diagnostic procedure, etc., and perhaps even medical quotes from respected reference sources.
Probative Value

Sound medical rationale carries the most “probative value”:

• **Definition**: Probative value is the value given to a particular fact or contention

• Probative value is essentially the thoroughness and reliability of the medical evidence

• Present when conclusions ("medical opinion") are drawn from complete, accurate, and consistent history of injury considering both factual and medical aspects.

• When the conclusion is well-rationalized or well-reasoned: high probative value ("weight of medical")

• Diminished probative value: when only conclusive statements appear but no rationale
• Greater probative value when provider is specialist in the field, or Board-certified in the field, or Board-certified Professor at a medical school, or widely recognized expert author in field

• Greater probative value when physician has actually examined the claimant with complete exam, not just claimant’s file

• Greater probative value when final medical opinion is consistent with exam findings and tests results

**RED FLAG:** One-time exams may have greater probative value than routine exams by Attending Physician when specialist reviews Statement of Accepted Facts (SOAF), all medical records and conducts thorough exam
Speculative Evidence

Probative value is diminished when medical conclusion and its rationale are speculative or equivocal:

• Language is couched throughout in “could”, “may”, “might”

• Discussion in the rationale is unclear, ambiguous, or vague

• There is scant, positively expressed, “firm” medical opinion

• **RED FLAG:** Terms like “probably” and “most likely” express “reasonable medical certainty” to avoid “absolute scientific certainty”, therefore these are still acceptable in medical reporting.

• Even with “reasonable medical certainty” opinions, physicians may be asked to explain basis for any doubt they may have, especially with work-related disability.
Identifying Good Medical Evidence

To determine whether a report is firm medical evidence with a good degree of probative value, consider:

- History is complete and factual evidence is correct regarding injury, exposure and work factors.

- There are sufficient objective findings to warrant the rationalized conclusion.

- Subjective complaints do not drive the discussion, the rationale, or the final medical opinion.

- Final medical opinion is based on well-reasoned discussion of all factual and medical evidence.
Identifying Good Medical Evidence (cont.)

• Language is not speculative, equivocal, unclear, vague, or conjectural.

• Opinion rendered is within reasonable medical certainty, not necessarily absolute scientific certainty.

• Writer of report is physician with proper credentials, perhaps even additional qualifications.

• Evidence is based on actual exam of claimant, is not cursory but thorough and complete.
Requesting Medical Reports

• The second opinion report must meet the same standard as any other medical report. The second opinion physician will be instructed to perform an examination. This will include authorization for any non-invasive test and if requested, a functional capacity evaluation. OWCP will evaluate the quality of the report and determine if the opinion carries the weight of medical evidence. If the weight of medical evidence is with the second opinion, these work tolerance limitations will be forwarded to EA asking if a position can be modified and offered for the employee’s reemployment.

• If the second opinion does not carry the weight but is adequate to establish a conflict of medical opinion with the treating physician, OWCP will set up a referee examination. EA must not contact the physician, and all reports must be evaluated by OWCP before any action is taken to reemploy the injured worker.

• If OWCP determines the referee examination meets the stipulated requirements and the physician’s opinion carries the weight of the evidence, then EA must use these work tolerance limitations in designing a modified job for the employee.
Analyzing Medical Evidence: Case Study # 1

Dr. Cornwall has indicated that your claimant Tom’s torn cartilage in his knee is due to a work-related fall. You know that 10 days earlier Tom had developed knee pain after playing basketball off the job.

1. What do you look for in the report to establish that this is an industrial injury?

2. What does the physician need to do?

3. How do you develop this case with Dr. Cornwall?

4. What will persuade you that this was an industrial injury?
Dr. Easton states that your claimant Melinda has a back strain causally related to a work injury that occurred 9 years ago. Dr. Easton cites no physical findings to support his conclusion. He explains that Melinda’s injury is causally related to the past injury because prior to the incident Melinda had had no complaints of back pain. Dr. Easton then adds that since the injury Melinda has continued to complain of back pain. The physician writes nothing else in his report.

1. What is missing from this medical report?

2. Is this a well-rationalized medical opinion? Explain.

3. What needs development from you with Dr. Easton?

4. What would have convinced you that this was an industrial injury
Analyzing Medical Evidence: Case Study # 3

Your employee Sung was referred to a second opinion. You have just received a copy of the secop and you already had a copy of Sung’s AP report. The Office has taken no action since the secop was received. Both reports are from Board-certified orthopedists. Both physicians provide well-rationalized reports based on an accurate medical and factual background. However, they differ in their medical opinions around Sung’s disability. Both physicians examined the claimant but only the secop performed current diagnostic testing and referred Sung to a functional capacity evaluation (FCE). Based on the overall comparison of the reports they may be similar in many aspects but they are not of equal weight.

1. Which physician’s report has the greater probative value?

2. What can you say about objective findings in this case?

3. What about conclusions regarding disability?

4. What is your next step with the OWCP?
Analyzing Medical Evidence: Case Study # 4

Your employee Gwen has been on total disability compensation for a long time. Recently, her compensation has been denied on the basis of a report from a second opinion specialist. In her Decision the claims examiner noted the specialist was Board-certified in the appropriate field, performed a full and complete exam, reviewed the current SOAF, and provided a rationalized opinion. Gwen’s longtime physician then wrote a very supportive rebuttal report on continuing disability. Dr. Mendoza is a general medicine doctor who has seen Gwen many times over the years and has always stated that her total disability has continued. Dr. Mendoza has not explained herself further because she asserts the record speaks for itself given the length of treatment and her knowledge of Gwen.

1. Do you think the CE’s Decision stands on solid legal ground?

2. Does the Attending Physician make a compelling case?

3. What is left for you to do on this case regarding medical evidence?
References

DOL Office of Workers’ Compensation Programs, Procedure Manual, Part 2, 0810-5, Content of a Medical Report

Ibid., 0810-06, Weighing Medical Evidence

Donney T. Drennon-Gala, 56 ECAB 469 (2005), on incomplete history and probative value

Floyd Stilley, Docket No. 02-2016 (19 FEB 2003), causal relationship and incomplete history

Lee R. Newberry, 34 ECAB 1294, 1299 (1983), physician’s qualification and probative value

American Osteopathic Association, in OWCP Procedure Manual, Part 3-0500-7, Board certification programs

Glenn P. Buckmann, Docket No. 96-356 (5 DEC 1997), cursory vs. complete examinations

James P. Roberts, 31 ECAB 1010 (1980), and R.C., 58 ECAB 238 (2006), IME referrals and weight of medical