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WORKERS' COMPENSATION COMMENTARY

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ADMISSIBILITY OF MEDICAL REPORTS

By: John C. Martin, Esq.

Remember the good old days, before the workers' compensation system became "reformed" and "simpler"? Well, there were a few features of the old days that proved not to be so good and were susceptible to abuse by a greedy few. Certainly, that had to be stopped but in the process, our ham-handed legislature, distrustful of consulting practitioners while reforming the system have developed a procedural nightmare which also produces a strange alchemy.

Under this system, reports that under some circumstances would be admissible are made inadmissible in other circumstances based upon the content of the report itself. The report may not necessarily be inadmissible in every case, much depends on the date of injury. The system assigns a special status to certain reports which then may be stripped from those reports based upon the reports of subsequent physicians. The law also provides for an arduous entry into an elite status called "QME" and then degrades the status of those reports by establishing a presumption of correctness for reports prepared by the treating doctor who perhaps could never qualify as a QME.

Workers' compensation professionals deal with this scenario every day but we all know the puzzled expression we would face when trying to explain this system to someone involved in any other branch of law. The only term that I think could describe this process is a term which Warren Hanna used to describe the application of apportionment in California law: "Thaumaturgic Hermeneutics", defined as a strained and wondrous mystical process. Indeed it is that! (Incidently, many years ago I had the privilege of knowing and speaking with Mr. Hanna on multiple occasions. He was probably the last attorney to whom the legislature actually listened. I think if he were alive today, the system would not be in the procedural mess that it is and I am sure that he is veritably spinning in his grave seeing what is happening.)

The purpose of this newsletter is to identify some of the problems associated with the entry of medical reports into evidence so that our clients may more effectively prepare cases which are likely to go into litigation and will understand the reason for the acquisition or re-characterization of medical reports which are sometimes needed. In order to view the situation more clearly, I will set forth three examples of typical situations confronted by claims handlers and discuss the potential consequences.

1. Let us take a very typical situation faced by a claims handler. An employee reports pain in the back claiming a slip and fall injury in the parking lot at work. The employee is sent to the industrial clinic and begins receiving physical therapy. The investigation discloses no facts which would allow the employer to deny the claim. Three weeks into the therapy, the claims handler arranges for the employee to be seen by Dr. Ortho for an orthopedic consultation. The doctor sends a report indicating that the treatment appears to be effective and recommends that he continue on with the treatment as well as taking the medication prescribed at the clinic.

Three months later, the employee is sent back to Dr. Ortho who declares his condition permanent and stationary without any residual disability. The employee at that point obtains counsel, who writes a letter proposing the use of an agreed medical examiner and when that is refused, goes ahead and schedules a QME with a doctor of his choosing. On receipt of that report, which specifics factors of permanent disability and recommends additional treatment, applicant's attorney makes a demand for same and on being refused, files a Declaration of Readiness to Proceed. The file is then sent to defense counsel with a note, "We want to rely on the treating doctor's presumption, please answer and appear on our behalf."

What is wrong with this picture? From the applicant's perspective, nothing. From the defense perspective, if that file has been sent only a week or so before the MSC, the defendant might well consider waiving a white flag and retiring from the battlefield because under those circumstances the report of Dr. Ortho would be inadmissible, the treating doctor had issued no final comprehensive report because Dr. Ortho had already covered the ground and the only admissible

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report would be the QME submitted by the applicant.

Despite the fact that the defendant had an absolute right to have the applicant examined by Dr. Ortho, pursuant to Labor Code §4050 that does not mean that the report is necessarily admissible or probative. Such a report is frequently necessary to conduct a medical investigation as to what is going on in the case so that the defendant might get their bearings but is not a report on which they can rely before the Board. Sections 4061 and 4062 are very specific in indicating that the treating doctor's report is admissible but Dr. Ortho was not a treating doctor, he had rendered no treatment whatsoever, he was merely an evaluating physician. The fact that he commented favorable upon the treatment being received by the applicant did not establish him as a treating doctor. He cannot be a QME either because the only manner in which a QME can be appointed under those sections with a compensable injury is through the performance of the AME/QME dance.

What should the claims handler have done? Well, the referral was made to Dr. Ortho within the 30 day post-injury during which the employer has medical control. The claims handler should have sent a letter designating Dr. Ortho as the treating physician and asking the doctor to evaluate the treatment being received, provide a comprehensive report and render such treatment as appears warranted either by himself or through another agency. Dr. Ortho and his staff should then be instructed that when an applicant appears for such a medical evaluation, if the doctor agrees that the individual should be continuing to receive medication, it would be appropriate for the doctor to prescribe same to him. Even the providing of an over-the-counter analgesic to the applicant by that physician would constitute treatment. The doctor could write a prescription for continued therapy even though therapy is still being rendered by the other agency and indicate that the individual can continue on with the therapy at the clinic under the prescription of the new treating doctor. In this fashion, Dr. Ortho becomes, indeed, a treating doctor. His reports become admissible and, if the applicant should choose an QME, Dr. Ortho's report will carry with it the presumption of correctness.

2. Let us take another example: The employee while driving to work is rear-ended by a vehicle when he was slowing down approximately 100 yards before he would be making a right turn into the parking lot of the employer. Neck and back injuries are claimed. The employee also claims headaches and dizziness from having struck his head inside of the vehicle. A claim is submitted and within the 90 day time limit, the claim is denied since the accident was sustained during a commute to work; therefore, the "going and coming" rule applies according to the claims handler. The employee seeks treatment from a local clinic and before the claim has been denied, he is sent for a medical evaluation by his attorney to an orthopedist and neurologist. Upon denial of the claim, the employer has the individual evaluated by a orthopedist and neurologist and a Declaration of Readiness to Proceed is filed at that time. The issues raised are those of temporary disability, injury AOE/COE, need for medical treatment and liability for self-procured medical treatment.

When the matter is set for hearing, which reports will be accepted into evidence? Well, Labor Code §4060 specifies that if a report based upon a medical examination which takes place prior to the filing of a claim and prior to the time the claim is denied, or becomes presumptively compensable under §5403, it is inadmissible. Note, that the term "and" is used rather than the term "or" so a question remains whether such a report might be admissible because the filing of the claim had been made even though the evaluation took place before the denial or the presumption applied. This section is generally being interpreted as prohibiting the entry of reports under circumstances such as those described and under that interpretation the reports would not be admissible.

If the reports were admissible, would the defendant have to pay for the cost of the evaluations? What if one of the doctors was rendering medical treatment? The section clearly specifies that if a doctor is treating the individual, even if the claim is denied, that report is admissible but what of two reports in two medical specialties?

A literal interpretation of the code section would indicate that the employer would be responsible for payment for only one comprehensive medical evaluation and the other would be at the expense of the applicant. That would not affect, however, the admissibility of the report if, otherwise, the report was admissible. In fact, Labor Code §4061 and §4062 also specify that the defendant shall not be liable for more than one comprehensive medical report. The WCAB appears to be leaning toward allowing the cost of medical/legal evaluations in different medical specialties independently and a recent panel decision confirms that tendency. I am referring to the case of *Gubbins v. Metropolitan Insurance (1997) 62 CCC 946*. This only a panel decision and therefore not legally binding but does give an indication as to what the Appeals Board is thinking

3. Let us take a third scenario now: An individual with an admitted injury is receiving medical treatment from the employer clinic. The condition is declared permanent and stationary with the need for further medical treatment consisting of the provision of medication. At that point, the employee retains counsel and the following day selects a treating doctor based upon the advice of his attorney. That doctor then continues to render medical treatment to the applicant and ultimately prepares a report specifying a

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greater degree of permanent disability. The defendant indicates that they are going to rely upon the report of the original treating doctor. The applicant claims that the status of treating doctor has now been conferred on his choice of treating physician and the issue goes to the WCAB. What is the result? Well, Labor Code §4061.5 says "The treating physician is the physician primarily responsible for managing the care of the injured worker or the physician designated by that treating physician" it does refer to "more than one treating physician" but the section clearly assumes that those other physicians are working under the auspices of the primary care giver and reporting to that individual in other medical specialties, not a situation where there is both a defense and an applicant's treating doctor.

The label "treating doctor" under the scenario that we have outlined probably fits the applicant's selection as long as the "former" treating physician indicated that there is an ongoing need for treatment.

Obviously, this can lead to some very unfair results so what can a defendant do about this? The doctors at the medical clinics who are rendering treatment to injured workers should know the consequences of the language that they place in their reports. When a physician releases an employee and indicates that the only treatment required is to take non-prescription analgesic medication as necessary, that doctor should know that such a recommendation is a recommendation of further medical care, perhaps, however, the doctor does not really believe that the individual is actively in need of medical care but only needs to take an aspirin if they get an occasional slight pain. In those cases, the doctor should be cautioned against making such remarks and told that if they do not believe that an individual will have more than the level of pain that will be relieved by an occasional aspirin that that individual is, in effect, placed in the same status as any other member of society who will take an aspirin when they have an ache or pain but, in effect, medical care is really not required to further relieve from the effects of the injury. If the doctor is comfortable with this, substantial money may be saved. This is something to be addressed on a case by case basis but even if in one case in ten, a treating doctor is convinced that that is a reasonable position to take, it will save a substantial amount of money over time.

Until the workers' compensation rules approach a degree of reasonableness a high degree of sophistication will be demanded of claims professionals. The only and best general advice we can offer is for claims handlers to ask questions when not sure and move swiftly on the opening of a claim.

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