Unraveling The Mystery of Medical Records

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"All that may come to my knowledge in the exercise of my profession or outside of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and never reveal."

—The Oath Of Hippocrates, as quoted in *Rush Limbaugh v. State of Florida*, Case No. 4D03-4973, D. Ct of Appeal, 4th District, Brief of Amicus Curiae, available at www.aapsonline.org/judicial/aapsamicus.pdf.

EVERY TIME a person receives medical treatment, a record is made of that visit. The record should chronicle the patient's complaints, the physician's observations, and treatment outcomes. *Medical Records and Health Information Technicians,* U.S. Department of Labor, Bureau of Labor Statistics. It would, therefore, appear that counsel should have an easy time in retrieving and analyzing a plaintiff's medical records. Nothing could be further from the truth.

The American Medical Association's Code of Ethics mandates that information disclosed to a physician during the doctor-patient relationship is "confidential to the utmost degree." The purpose of this rule is to allow the patient to

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make a complete and frank disclosure of information, confident in the knowledge that the health care provider will protect the confidential nature of the information. This professional requirement has also been turned into law by federal and state statutes that prohibit the disclosure of confidential patient information unless very specific conditions have been satisfied. This is especially true since the enactment of the Health Insurance Portability and Accountability Act ("HIPAA") Pub. L. No. 104-191, 110 Stat. 1936 (1996), and its Privacy Rule (Standards for Privacy of Individually Identifiable Health Information), 45 C.F.R. Parts 160 and 164, which took effect on April 14, 2003. Patients have now gained unprecedented safeguards concerning the disclosure of their medical information.

Once the claimant's medical records have been obtained, counsel is confronted with a second obstacle: trying to make sense out of what has been recorded. The records may not be arranged in a uniform fashion, abbreviations abound, handwritten comments are often illegible, and procedures will be listed by diagnostic codes.

As one may remember from law school, understanding court opinions required a little time. Medical records present the same challenge. Armed with practice and a medical dictionary, however, attorneys will discover that making sense out of the medical records follows a learning curve that can be mastered. This article will offer suggestions on how to make the medical record retrieval process easier and will offer tips on how to understand those documents.

THE NEED TO OBTAIN THE MEDICAL RECORDS • It is important to obtain a claimant's medical records to ascertain the nature of the injury, to document or refute the alleged medical problem, and to establish a value for the claim.

From The Plaintiff's Perspective

Counsel for the plaintiff must obtain the medical records to investigate the merits of the claim and to properly document the injury. The records are also important so that counsel may learn about adverse health issues, such as prior claims or pre-existing medical problems that may play a role in the current complaints. In this regard, counsel for the claimant has a much easier task in retrieving the records since the client is not adverse and a properly worded and executed medical authorization should suffice.

The Authorization

The one or two paragraph medical authorization signed by the client is no longer the magic wand in obtaining the records. The authorization must now comply with the HIPAA requirements as set forth in 42 U.S.C. §1301 et seq. For more information on HIPAA, *see* www.hhs.gov/ocr/hipaa.

To expedite the receipt of medical records or to reduce the chances of encountering problems, counsel should check with the health care provider to ascertain if a specific form is required. For example, some hospitals are very demanding about the contents of the medical authorization and will not release the records unless specific language is used. Also, certain records enjoy an additional layer of protection. These include the disclosure of drug and psychiatric information, which require a specific authorization that satisfies the appropriate legislation on these issues. For instance, records dealing with substance abuse are protected by 42 C.F.R. pt. 2, Confidentiality of Alcohol and Drug Abuse Patient Records and section 543 of the Public Health Service Act.

Many states also have their own statutory schemes for obtaining medical records. These are subservient to the federal laws but may impose additional patient safeguards. For example, Pennsylvania has its own statute on the

production of medical records that is set forth in 42 Pa. Cons. Stat. Ann. §6155(b):

"(1) A patient or his designee, including his attorney, shall have the right of access to his medical charts and records and to obtain photocopies of the same, without the use of a subpoena duces tecum, for his own use. A health care provider or facility shall not charge a patient or his designee, including his attorney, a fee in excess of the amounts set forth in section 6152(a)(2)(i) (relating to subpoena of records)."

The Defense Perspective

Defense counsel has different reasons for wanting to obtain the medical records of a claimant. Although a client can provide defense counsel with a description of the accident or events on which the claim is based, the client can rarely supply accurate or detailed information about the plaintiff's health. At a minimum, however, counsel should ask the defendant to describe the claimant's medical condition at an accident scene, find out if the plaintiff was walking around, and ascertain if the claimant admitted that he or she was not injured.

Counsel for the defense should not rely on the medical specials submitted to the insurance carrier by the claimant or plaintiff's counsel. There is no mandate that these records be complete and plaintiff's counsel may disclose only favorable information.

Discovery Areas

Once the case is in suit, the defense should always issue formal discovery and obtain answers under oath. Unless court rules mandate the use specific interrogatories, the defense should always include a series of questions that focus on the claimant's general health, including:

- Visits to doctors within the 12 months before the date of loss;
- The name and address of the family doctor;
- Health insurance information such as the name of the carrier and policy number;
- The name of the claimant's pharmacy and its location;
- The name and policy number of the automobile insurance or workers' compensation carrier that has paid the medical expenses;
- Whether the claimant has received benefits from a disability policy.

Answers to these questions will provide the defense with a good start in learning more about the claimant's health and relationship of the claimed injuries to the accident, even if the plaintiff is not honest or is evasive in disclosing prior health issues.

Family Doctor's Records

By obtaining the records of the entities disclosed in response to these basic questions, the defense will obtain a blueprint of the claimant's health. The family doctor is the person most often seen when a health issue arises, especially in a non-litigation setting. These records may contain treatment about the claimed problem which pre-existed the incident. The documents may also shed light on another medical reason for the claimed injury. For instance, a diabetic neuropathy may cause numbness in an extremity instead of a herniated disk claimed to be the cause. Pain in the back may be related to Lyme Disease instead of a car accident. These records will also contain the reports of prior diagnostic tests and visits to medical specialists.

Pharmacy Records

The pharmacy will provide a computerized listing of medication and prescribing doctors. With a little detective work, one can easily ascertain the nature of the medication and the medical specialty of the prescribing doctor. For instance, a patient who has filled a prescription

for Darvocet, Vicodin, or Percoset within a few months before the accident is having significant pain somewhere in the body. Motrin, Vioxx, or Celebrex, will provide a clue that the individual is suffering from some type of inflammatory process such as a sprain or strain from a prior accident. If counsel is unsure of a specific drug, the *Physician's Desk Reference* ("PDR") is a quick and easy reference tool for learning the nature of a particular drug. The medication can also be searched online at: www.pdrhealth.com/drug_info/index.html. A medical directory such as Dorland's can provide a physician's medical specialty. Counsel may learn that the patient has had prior visits to an orthopedic surgeon or neurologist. This information can also be researched online at: www.dorlandhealth.com or by initiating a Google search by typing in the name of the medication.

Health Insurance Records

Most people do not like to pay for medical treatment especially when the premiums for health insurance are so high. By retrieving the claimant's health insurance records, defense counsel will obtain a computer listing of health care providers, dates of treatment, and diagnostic codes. Most carriers require bills to be submitted by use of diagnostic code numbers that have been established by the International Classification of Diseases. These codes were developed by the World Health Organization and may be found on the internet at www.eicd.com/EICDMain.htm. A variety of sources also publish the information in book form including the American Medical Association.

Obtaining the medical records from the automobile insurance or workers' compensation carrier in a third-party action is useful since these documents may contain reports of medical audits or independent medical examinations. These records may also contain statements by the parties and potential witnesses, as well as photographs of the vehicles.

The Records To Obtain When Investigating A Claim

Counsel should always obtain the full medical records of the claimant and not just isolated pages such as a hospital discharge summary. One never knows what information may be gleaned from even the most seemingly innocent record.

Defense counsel should not limit a request to treatment records after the accident date. In fact, the medical authorization or subpoena should not contain an incident date. If the health care provider decides to issue only the medical records that follow the date of loss, or merely to provide the accident records, the defense should persist in efforts to obtain all of the records—even if it means issuing a new subpoena, taking the deposition of the records custodian, or filing a motion to compel production.

If a sufficient period of time has elapsed since the initial records were produced, consider serving a new subpoena to obtain updated information. Plaintiff's counsel may find a medical complication that the client has inadvertently failed to mention which may increase the value of the claim. The defense may find a new accident, an improvement in the claimant's medical condition, or a different medical cause for the problem.

PHYSICIAN OFFICE NOTES • Physician office notes do not follow a uniform format but typically contain certain standard types of information, including:

- An initial patient questionnaire;
- Progress notes;
- Correspondence from third parties;
- Notes of diagnostic procedures;
- Miscellaneous records.