

**STATE OF CONNECTICUT
WORKERS' COMPENSATION COMMISSION**



**Professional Guide for Attorneys,
Physicians, and Other Health
Care Practitioners
Guidelines for Cooperation**

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Changes Effective July 7, 2025

Pursuant to Memorandum 2025-02

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&

APPENDIX II WORKERS' COMPENSATION SUMMARY OF FEE SCHEDULE page 31

Effective July 7, 2025, Subsection D of Section VI is retitled from "Failure to Attend Examination" to "Late Cancellations/ Failure to Attend Examinations" and the Subsection now reads as follows:

Where a claimant cancels a scheduled Commission Medical Examination (CME) **less than two business days prior to the date of the examination**, the Commission recommends that the physician's office limits the cancellation fee to **\$300.00**. There shall be no cancellation fee assessed for CMEs cancelled more than two business days prior to the exam. Where a claimant fails to attend a Commission Medical Examination and does not call or otherwise alert the physician's office prior to the appointment time, the Commission recommends that the physician's office limit the no show fee to **\$450.00**.

In either situation, when determining responsibility for the payment of the late cancellation or no-show fee, the parties and the administrative law judge should implement a fault-based approach that takes into account the circumstances surrounding the claimant's failure to attend the examination.

Workers' Compensation Commission
Professional Guide for Attorneys, Physicians, and Other Health Care Practitioners
Guidelines for Cooperation

I. INTRODUCTION: PURPOSE OF THESE GUIDELINES

A. Overview of the Workers' Compensation Adjudicative System

1. An Administrative Remedy

Connecticut's Workers' Compensation Act was enacted in 1913 to address the significant societal problem of workplace injuries. The Workers' Compensation Commission was created to afford a prompt, equitable remedy to injured workers. In return, employers were given virtual immunity from civil suit for injuries sustained in the workplace. Thus, responsibility for adjudication of disputes that arose from injuries at work was taken away from the court system and assigned to an administrative tribunal, i.e., the Workers' Compensation Commission.

Administrative Law Judges preside over hearings, both informal and formal. An Informal Hearing is truly "informal" where the parties meet in a room at a conference table before an Administrative Law Judge to try to resolve disputes through informal discussion and agreement.

If disputes cannot be resolved informally, a Formal Hearing is held before an Administrative Law Judge. A Formal Hearing is analogous to a civil trial: the parties are represented by legal counsel, many of whom focus their practice on workers' compensation litigation; witnesses testify; documents are introduced into evidence; and a stenographic record of the proceedings is kept. Notwithstanding such formalities, evidentiary and procedural rules are generally relaxed. After all evidence is presented, the Administrative Law Judge makes a decision. This decision must be rendered within 120 days after the record closes.

2. Medical and Legal Professions: Their Place within the Workers' Compensation System

The process for resolution of disputes that arise from injuries at work is established by law. Although attorneys are important to the effective functioning of the adjudicative aspect of the workers' compensation system, the system is designed to function without legal involvement in every case, or at every stage in any given case. Physicians are central to the operation of the workers' compensation system. The remedy that the Workers' Compensation Act is designed to extend translates essentially into indemnity for lost wages and, no less important, prompt and effective medical treatment. At the heart of the workers' compensation scheme is the employer's legal responsibility to provide reasonable or necessary, and curative medical treatment for workplace injuries, which is where physicians come into play.

The role that physicians play is pivotal. Indeed, a claim may not even fall within the jurisdiction of the Workers' Compensation Commission without an opinion, based upon reasonable medical probability,

that work activity contributed substantially to an injury or a disease. At the same time, the growth of the workers' compensation system and the complex evolution of workers' compensation law have served to increase the involvement of the legal profession—intensifying the need for both professions to cooperate with each other.

If the workers' compensation system is to provide resolutions of disputed issues on a timetable significantly more expedient than that of a civil case in Superior Court, it is essential that all participants of the system adopt a cooperative and open manner of working with each other. It is recognized that both attorneys and physicians will oftentimes not receive financial remuneration commensurate with the services rendered. The workers' compensation system is designed to effect a speedy resolution of disputed matters to allow an injured employee to receive the treatment necessary for him/her to return to work as soon as physically able. This should be the overriding concern and objective of all attorneys and physicians involved in the system. If the remuneration does not meet the expectations of attorney or physician participants, then that individual should consider refraining from participation in the workers' compensation system.

B. Interaction of Physicians and Attorneys within the Workers' Compensation System

While many cases evolve smoothly, many do not. Disputes frequently arise over such issues as the link between injury and work activity, disability status, extent of a permanent injury, the interplay of the recent injury with a previous injury or pre-existing condition, and so forth. These are the types of questions that doctors must address as they are the most qualified to answer them.

Thus, there must necessarily be considerable interaction between doctors and attorneys as both professions carry out their responsibilities within the workers' compensation system. While the roles of both professions are markedly different, i.e., the physician is a healer and the attorney is an advocate, both professions must cooperate to implement the goals and purposes of the workers' compensation system, subject to strictures imposed by law and ethics. These guidelines address various situations where attorneys and physicians interact within the operation of the workers' compensation system with a view toward facilitating cooperation between the professions.

Most of these interactions consist of efforts on the part of one profession to obtain information from the other. Attorneys must, to meet their professional responsibilities to their clients, look to physicians for answers to questions. Attorneys pursue information through telephone calls, letters, meetings, and depositions. These guidelines are meant to address these interactions and, by answering questions and clarifying duties and responsibilities in advance, avert obstacles that would impede the cooperation between members of both professions.

C. In General: The Physician as Expert

1. Reasonable Medical Probability

As mentioned above, attorneys need physicians to answer questions and these answers are expressed as opinions. Physicians are considered qualified to render expert opinions within the scope of their

expertise. Physicians must be mindful of whether their opinions are—or are not—based upon reasonable medical probability. For physicians’ opinions to carry any weight before the Administrative Law Judge, those opinions must be based upon reasonable medical probability. Opinions which are expressed in terms of what is “possible” are regarded as speculative and carry little if any weight.

Physicians, in light of their training, might gravitate toward quantifying reasonable medical probability in rigorous scientific terms. This would be the correct approach for the laboratory, but not for the hearing room. While the requisite scientific quantum of proof might be expressed as a very high percentage, the legal criterion of reasonable medical probability is quantified as merely greater than fifty percent (50%) or “more likely than not”.

2. “A” Substantial Contributing Factor

Physicians are also frequently asked to render opinions on causation. Physicians must appreciate certain distinctions in answering these questions. One such distinction is whether work activity amounted to a substantial contributing factor to a medical problem, as opposed to simply a contributing factor that is less than substantial. An injury is compensable if work activity was a substantial contributing factor in causing it. Causation may be multi-factored; work activity need only be a substantial contributing factor, among other possible substantial contributing factors, to establish a compensable injury. The outcome of a case often pivots on the presence or absence of the tiny article “a” in the context of an opinion on causation.

3. Caveats for the Physician as Expert

a. Limits to Scope of Expertise

The law generally considers physicians to be experts. While physicians are uniquely capable of imparting specialized knowledge, at the same time they must be alert to their limitations as experts. The opinions that physicians offer must be tailored to their medical training and experience. For example, a physician is qualified and often expected to offer an opinion on work status, e.g., whether a patient is totally or partially disabled. However, the Administrative Law Judge may also consider the opinion of a vocational rehabilitation specialist in regard to a claimant’s work capacity.

b. Legal Consequences Begin Where Medical Opinions Leave Off

Physicians should recognize that it is the role of the Administrative Law Judge to assign legal consequences to medical opinions. Again, while an orthopedist might characterize a patient as totally disabled on the basis of diagnostic studies, subjective complaints, and objective physical findings, the Administrative Law Judge decides whether medical evidence is persuasive enough to warrant the legal determination of total disability. Ultimately, the Administrative Law Judge weighs the evidence, expert and otherwise, and makes a decision on the basis of the evidence that is more persuasive.

D. What the Workers’ Compensation Commission Expects from Physicians (Beyond Quality Care)

The Workers’ Compensation Commission expects physicians to exercise objective, independent medical judgment in providing quality medical treatment to injured workers. It perceives no conflict

between the standards that the medical community is sworn to meet and the Commission's mandate to assure prompt and effective medical treatment to injured workers.

While the Commission possesses the legal authority to establish a process by which physicians who seek to treat injured workers must apply in advance for approval, it has never chosen to exercise this authority. It has never required, for example, specialized training or board certification. Instead, it has consistently maintained the policy that all licensed physicians in the state of Connecticut are eligible to treat injured workers. This evinces the Commission's respect for the Connecticut medical community. It constitutes a vote of confidence on the part of the Commission in the ability of the Connecticut medical community to protect the interests of injured workers under the statutory scheme.

Participation of physicians in the workers' compensation system is voluntary. The physician is not obligated to act as an authorized treating physician or as a respondent's examiner under the Workers' Compensation Act. However, in doing so, the physician is essentially exercising a privilege that carries with it both benefits and responsibilities.

One obvious benefit is compensation. Physicians are compensated for their services to injured workers under fee protocols that the Workers' Compensation Commission is obligated to establish. The Commission, mindful of its paramount interest in quality medical care for injured workers, seeks not only to assure fair and adequate compensation to physicians for their services, but also to foster the medical community's perception that the Commission is sensitive to this issue. To this end, the Commission engages in an active, continuing process of evaluation and reevaluation of the issue of compensation for physicians for treatment and other services. It encourages physicians to express their concerns and it weighs their comments carefully.

By the same token, the Commission also expects the medical community to acknowledge reasonable burdens and restraints that are imposed upon it as part of the responsibility of treating injured workers in the state of Connecticut. It recognizes that some physicians may choose simply not to treat an injured worker; that is their prerogative. However, where physicians do choose to treat injured workers, they are expected to accept what the Commission has determined, after careful consideration, to be fair and reasonable remuneration for services rendered.

The Commission recognizes that reasonable minds can differ over what constitutes fair and adequate compensation for services, especially where such services demand a commitment of time to medical and legal interactions. However, compensation for this commitment of time must be balanced against the injured workers' ability to pay. It must be remembered that an injured worker's out-of-pocket expenses are not reimbursed as they might be in a civil action. In addition, the injured worker may be required to advance these costs at a time when they are out of work due to their injury and are receiving benefits that are substantially less than what their regular employment pays weekly.

II. CRITERIA THAT DELINEATE THE PHYSICIAN'S RESPONSIBILITIES WITHIN THE WORKERS' COMPENSATION SYSTEM

A. Reasonable, Necessary, and Curative Treatment

In general, employers are legally obligated to provide medical treatment for injured workers, to be administered by a physician selected by the injured worker. More specifically, the employer is legally obligated to provide “reasonable” or “necessary” and “curative” medical treatment that is related to the compensable injury. These legal obligations that the employer bears serve essentially to define the scope and limits of medical services that physicians may provide, and be compensated for providing, within the workers’ compensation system. The terms “reasonable” and “necessary” are part of the workers’ compensation statute, while the term “curative” has been made part of the statute through court cases.

What exactly constitutes “reasonable”, “necessary” or “curative” care, and whether such care is causally related to the compensable injury, is a subject upon which many disputes can arise in good faith. Such terms are not susceptible to precise, unyielding definition. They must be applied flexibly, on a case-by-case basis, because no two cases are alike, either medically or legally. They incorporate both objective and subjective elements. The fact that, for example, a patient suffers from marked muscle spasm makes it easier for an orthopedic surgeon to conclude what is indicated by way of additional treatment. But the fact that a patient is experiencing significant—if subjective—pain does not automatically render the reasonableness or necessity of treatment recommendations suspect.

B. Acute Treatment Phase

The Workers’ Compensation Commission assumes that physicians are exercising their independent clinical judgment in the best interests of the patient and that the best interests of the patient coincide with the workers’ compensation system’s goal of returning an injured worker to productivity and restoring that worker to health as quickly and reasonably as possible. The Commission encourages the extension of a relatively free hand to physicians in management of a case during what might be called its acute phase, a very flexible concept that generally means a medically reasonable interval after the date of injury. During the acute phase in the evolution of a case the exercise of clinical judgment should not be unduly impeded by requirements to obtain authorization for treatment recommendations, as will be discussed in greater detail below.

C. Implications of Maximum Medical Improvement

The point of maximum medical improvement on the chronological continuum of treatment is invariably the focus of attention. In general, maximum medical improvement has been reached when the curative effect of treatment has plateaued. Disputes are less likely to arise about “reasonable” or “necessary” medical care where the goal of maximum medical improvement is in sight. Disputes are more likely to arise about the “curative” effect of proposed treatment, even if such treatment is objectively “reasonable” or “necessary” once maximum medical improvement has been reached. Thus, the criteria of “reasonable,”

“necessary,” and “curative” care, not to mention causal connection of that care to the original compensable injury, must be applied in the context of the patient’s evolving clinical status on a case-by-case basis.

As far as “related” care is concerned, disputes over causal connection generally emerge as a direct function of the passage of time beyond the date of maximum medical improvement, e.g., where a patient might seek renewed treatment for a back sprain that ostensibly resolved, with little or no permanency, five years before.

The fact that a patient has reached maximum medical improvement, however, does not extinguish the role of the treating physician. If the patient’s accepted workers’ compensation claim remains open (the case has not been resolved by way of a full and final stipulation), then that patient is entitled to periodic return visits to the treating physician. The employer, insurer, or its representative should inform the physician about the significance of maximum medical improvement as it relates to the authorization for further treatment. Once maximum medical improvement has been achieved, a general rule of thumb would be that an injured employee may periodically (usually not to exceed one visit per year) consult with the authorized treating physician to determine if any significant changes have occurred. This should be considered a routine visit and should be billed by the physician accordingly. If the physician determines additional treatment is necessary, the permission of the insurance company should first be obtained. If a dispute arises, a hearing should be requested before the Commission, which is prepared to resolve such disputes.

The Appendix to these guidelines contains examples that serve to illustrate the interplay between the criteria described above on a clinical continuum whose focal point is maximum medical improvement. These examples illustrate an approach toward issues of authorization for treatment that the Workers’ Compensation Commission would encourage.

D. Cessation of Treatment

1. Settlement of the Case

Physicians must be sensitive to the fact that authorization to treat can be extinguished under various circumstances. One such circumstance would be settlement of the case. Here the patient’s attorney should step in to inform the treating physician in writing of the significance of settlement to the physician, i.e., that the employer and/or its insurer would no longer be responsible for treatment-related expenses.

2. Maximum Medical Improvement

Another such circumstance would occur, as discussed above, when the patient has reached maximum medical improvement. At that point, the workers’ compensation insurer, or its representative, should inform the treating physician in writing of the significance of this, e.g., possible reluctance to authorize further treatment.

E. Related Issues

1. Form 43 Disclaimer

The Commission’s Form 43 serves two purposes. First, it is used by the respondent to put the

claimant and the Workers' Compensation Commission on notice of the reasons for denial of compensability of a claim. As the employer, insurer, or its representative serves the Form 43 on the claimant, they shall at the same time send a copy of the notice to the attending physician.

Second, the Form 43 disclaimer is used to facilitate payment for treatment through group medical insurance where the respondents are legitimately contesting liability or, more particularly, an operation or other treatment that is being recommended. Under such circumstances, the workers' compensation statute imposes initial liability upon the group medical insurer. The group medical insurer may perfect a lien to protect its interests in the event that treatment is later determined to be compensable at which time, the workers' compensation insurer may have to reimburse the group medical insurer. Thus, a Form 43 can afford a claimant/patient a first bite at the apple of medical treatment, pending resolution of issues that prevent, at least initially, workers' compensation insurance coverage.

2. Interaction of Physicians and Attorneys to Advance the Treatment Process

The nature of the workers' compensation system requires that physicians provide prompt and complete reports to enable employers, insurers, and their representatives to act quickly in determining whether to authorize treatment. The Workers' Compensation Commission is very sensitive to the fact that the remedial purpose of the law is frustrated by delay that arises from disputes over treatment recommendations. Physicians and the legal representatives of both patients and respondents should cooperate to forestall delay and the frustration, expense, and loss of productivity that delays bring.

The Commission strongly encourages physicians to transmit treatment recommendations in writing and respond promptly and completely to inquiries about whether recommendations are medically reasonable or necessary, curative, and related substantially to the compensable injury. Attorneys, for the same reason, are encouraged to act not merely as passive conduits of information, but to promote prompt and informed decisions on the part of their clients.

III. MEDICAL REPORTS: THE IMPORTANCE OF DOCUMENTATION

A. What is a Physician Expected to Generate by Way of Medical Reports under Present Guidelines?

1. Original Report Followed by Progress Reports

A treating physician is expected to generate, with reasonable promptness, an original report of injury. Thereafter, the physician is expected to generate subsequent progress reports, with reasonable promptness, after office visits or other medical developments. Reports must be sent to both the patient and the insurer, or representatives of either party, in the same manner and at the same time.

2. Approved Forms

a. Forms in General

In addition to an original report, followed by progress notes, physicians are expected to fill out forms that have been approved by the Workers' Compensation Commission. These forms address, for

example, an employee's work status or the extent of permanent injury to a body part once a patient has reached maximum medical improvement. These forms are relatively simple and the need to prepare them does not arise in every case. Such forms must be prepared and submitted upon request, at no charge. These reports are required to insure the injured employee can return to work quickly and safely when he/she has a capacity to work and the employer has a position that meets that capacity. The Commission's goal is to get people back to work as quickly as physically able and this report is the key document.

b. Forms in Particular: Form 36 and Form 42

Physicians would typically see these forms: Form 36 and Form 42.

The Form 36 titled "Notice of Intention to Reduce or Discontinue Payments" focuses on the work status of the patient, that is, whether the patient is totally or partially disabled, and if partially disabled, what restrictions on work activity apply.

The Form 42, titled "Physician's Permanent Impairment Evaluation" is used when a patient has reached maximum medical improvement (MMI). A physician notes the date of maximum medical improvement and assesses permanency to a body part. The Form 42 should be submitted with the office note that records findings upon which the rating is based.

3. Points for the Physician to Consider in Assigning Ratings

a. Percentage Rating for "Specific" Loss of Function of Body Part

After a patient reaches maximum medical improvement from an injury, and if there are permanent sequelae from the injury, then the patient is entitled to compensation for loss of use of the function of the injured organ or body part. This is called compensation for "specific" loss or, more frequently, compensation for "permanent partial disability."

Connecticut's workers' compensation statute identifies the organs and body parts for which loss of use of function would entitle an injured worker to "specific" compensation. These are "scheduled" losses. The statutory schedule is not all-inclusive anatomically; any physician would recognize some omissions, e.g., the intestines. Those organs and body parts that are scheduled are assigned a value that is expressed in weeks with the permanency rating expressed as a percentage. Thus, if the back is assigned a maximum of 374 weeks, ten percent (10%) loss of back function would equate to 37.4 weeks of benefits.

b. Criteria upon which to Base Ratings

The Commission encourages physicians, in formulating ratings, to rely upon such established criteria that have stood the test of time as the American Medical Association Guides to the Evaluation of Permanent Impairment. However, where these or any other guidelines conflict with the workers' compensation statute, the statute prevails, and ratings must be tailored accordingly. The statute does not, for example, recognize "whole person" ratings, as do the AMA Guides.

Furthermore, anatomical terms and definitions that are common currency to physicians must yield to statutory definitions where conflicts arise. Physicians often refer, for example, to the "upper

extremity” or “lower extremity.” The statute does not recognize the “extremity.” The arm, for example, is rated where permanent injury is located at or above the elbow, and it encompasses the shoulder. The hand is rated where permanent injury is located at or above the wrist, and it encompasses the forearm, up to but not including the elbow. Thus, elbow and shoulder injuries are “arm” injuries for the purpose of ratings, while wrist and forearm injuries are “hand” injuries for the purpose of ratings. Similarly, the “foot” begins at the ankle and extends to, but does not include the knee. The “leg” begins at the knee and encompasses the hip.

“Whole person” and “extremity” ratings are not legally cognizable in Connecticut. They create confusion and often mean extra effort on the part of both physicians and attorneys to translate “upper extremity” ratings into hand and/or arm ratings or “lower extremity” ratings into foot and/or leg ratings. “Whole person” ratings have to be reduced to a rating that is consistent with such scheduled body parts as the back, neck, and so forth.

B. What Should Medical Reports Contain by Way of Information?

1. “SOAP” Format for Office Notes – and Then Some

The information that the physician is expected to impart does not vary all that much from the standard SOAP (“subjective—objective—assessment—plan”) format that physicians employ in office notes and consultation reports: subjective/history, objective/findings, assessment/diagnosis, and plan/treatment recommendations.

More specifically, though, the physician should take a complete and accurate history and, upon formulation of any diagnosis, state whether or not it is likely that work activity, as described by the patient, contributed substantially/significantly to the cause of that diagnosis. Physicians should be prepared to revisit the issue of causation, as treatment progresses, to remove doubt that treatment remains related to injury from work activity.

2. Patient’s Work Status

The patient’s work status is a continuing concern in workers’ compensation litigation. The physician should comment on work status whenever the patient is examined and note findings upon which the work status opinion is based. Any limitations should be delineated.

3. Obligation to Report Significant Clinical Developments, e.g., Maximum Medical Improvement

The physician has the obligation, as treatment evolves, to advise the employer or the workers’ compensation insurer of significant clinical developments as they occur. The physician should indicate in writing, for example, when an injured employee has recovered to the point where he or she has a work capacity, and, if so, what restrictions on work activity are being imposed. Another such significant development would occur when, as discussed above, a patient has reached maximum medical improvement; a related development would be assessment of permanency, if any, at that time.

4. Referrals

A physician may wish to refer a patient to another physician for an evaluation. For example, a neurosurgeon may wish to refer a patient to a neurologist for electrodiagnostic studies. An orthopedist may wish to refer a patient to a specialist to rule out a rheumatological disorder. A physician who wishes to refer a patient to a specialist should state the basis for the referral and its link to the compensable injury or condition. See page 19 (Second Opinion/Consultation Examiner) for interplay between the terms “referrals” and “second opinions”.

5. Special Reports

While a physician bears an affirmative responsibility to generate reports and, concomitantly, apprise the insurer of such significant developments as described by the examples above, the physician has no affirmative obligation to prepare a report, whether for the workers’ compensation insurer or the patient, which addresses medical/legal issues that arguably lie beyond the scope of those reporting requirements. Sometimes, however, a physician is called upon to prepare a more detailed report that might address such an issue as, for example, the interplay, if any, between the injury for which the physician is currently treating the patient and the sequelae from previous injury to the same body part. Such a report would have to be affirmatively requested by either the patient’s attorney or the insurer’s attorney, and the party whose attorney requested the report is responsible for payment, as discussed in greater detail below.

6. Timeliness of Medical Reports

Any and all reports, whether progress notes or more detailed narrative responses to particular inquiries should be prepared with reasonable promptness. As far as office/progress notes and work status reports are concerned, one might expect passage of no more than a week between examination of the patient and dissemination of the office note.

As far as a special report is concerned, what constitutes reasonable promptness is more likely to depend upon the circumstances of the case. A key consideration is the relative importance of the issue that is addressed. If, for example, a physician is asked for an opinion on surgery, where that issue is of immediate concern and about to be the subject of discussion at an Informal Hearing, the physician should give this priority. Obviously, it is incumbent upon attorneys to give physicians a full and fair opportunity to respond reasonably to inquiries. They should not expect physicians to succumb at the last minute to pressure that they themselves have created. Should any problem arise that impedes the preparation of a report, the physician should promptly bring this to the attention of the individual who requested the report. Again, the professions must cooperate to see to it that the flow of information is not impeded.

C. Who, if Anyone, Pays for Medical Reports?

1. Reports Provided Without Charge

Problems and questions arise from the commitment of time that the Workers’ Compensation Commission expects physicians to make beyond the time that they spend in treating patients—and who bears

the cost of that extra effort. Typically, these problems and questions arise in the context of documents that a physician is expected to generate in workers' compensation cases. **The physician may not charge for an original report, subsequent progress/office notes, or for preparation of approved forms.** The law requires that such reports and forms be completed without additional charge. The approved workers' compensation fee schedule takes this commitment of time into consideration.

2. Charges for Special Reports

The Workers' Compensation Commission became concerned over the incidence of discord over charges for special reports; instances were brought to the attention of the Commission of charges that were obviously and grossly disproportionate to the effort expended. As a result, the Commission decided to regulate that a treating physician may charge up to \$200 for a special report. In this regard, the Commission, in allowing a flat rate, contemplates that cases where extra time is warranted will be balanced by cases where minimal time is warranted for the preparation of a special report.

Notwithstanding the above, under unusual circumstances an additional charge may be allowed, at the discretion of the Administrative Law Judge, where voluminous additional records must be reviewed, for example, as part of preparation of a special report. To seek an additional report fee over \$200, the physician should provide to the respective Administrative Law Judge and the requesting party, a copy of the report and an explanation of the report fee including time and expense involved in completion; whereupon, the Administrative Law Judge will respond to the parties, in writing, about the fee determination. Subsequently, and if necessary, this matter may be subject to a hearing.

In the alternative, if prior to the preparation of the report, the physician reasonably determines that the special report involves unusual circumstances necessitating a charge over \$200, then the physician may request, in writing, and the Administrative Law Judge may grant advance authorization for an additional charge.

3. Photocopying Charges

a. Physicians may not pass along the expense of photocopying reports and forms that they must generate without charge, including all copies provided under the original request to each employee/attorney, employer/attorney, and insurance carrier. In the event, however, a party requests *additional* copies of documents or even the entire chart, that party must reimburse the physician from whom the records have been requested. In such a case, the Workers' Compensation Commission recommends reimbursement at the statutory rate, currently **no more than sixty-five (65) cents per page including research fees, handling fees or related costs, and the cost of first class postage**, pursuant to C.G.S. §20-7c(c) [Public Act 08-184, Sec. 32, effective October 1, 2008].

In the event that an entire chart is requested and that chart is voluminous, the Commission recognizes that the physician's office should not be burdened with the photocopying responsibility. It recommends that the chart be forwarded to a professional photocopier with the cost of photocopying to be borne by the party requesting the information.

b. Hospitals are also restricted from passing along the expense of photocopying reports and forms upon first request, but may thereafter, charge **no more than sixty-five (65) cents per page including research fees, handling fees or related costs, and the cost of first class postage**, pursuant to C.G.S. §19a-490b.

D. Open Disclosure of Medical Documents

The Workers' Compensation Commission expects disclosure of special reports to all parties. In fact, it expects reasonably prompt reciprocal disclosure of all medical information, in a broad sense, whether special reports, mundane office notes, or otherwise, on the part of legal representatives of the parties, upon request of one side to any other. The Commission considers it unethical on the part of professionals, whether medical or legal, to withhold, "bury," or even knowingly destroy medical documents that are relevant to a pending case. Just as attorneys should not selectively disclose relative medical documents, physicians should not selectively disclose chart documents that have been appropriately requested. In summary, the Commission endorses a policy of open, reciprocal disclosure of all relevant medical documents.

E. Retention of Patients Medical Records

The Commission also recommends that medical professionals retain patients' records for 15 years rather than the seven-year period prescribed by § 19a-14-42 of the Connecticut State Regulations, given that workers' compensation cases often remain open over long periods of time.

IV. ATTORNEY MEETINGS WITH PHYSICIANS

A. Ex Parte Meeting between Patient's Attorney and Treating Physician

The patient's attorney may meet ex parte—that is, in the absence of respondents' counsel—with the treating physician. In fact, in many instances the patient's attorney is virtually obligated to meet with the treating physician, as part of an effort to develop a compensable claim. The patient's attorney would also be expected to meet with the treating physician where, for example, the attorney wishes to prepare the physician for a deposition or testimony at trial. Under such circumstances ex parte meetings are acceptable. Where the respondents' attorney wishes to meet with a treating physician, however, different concerns are presented that require different approaches.

B. Ex Parte Meeting between Respondent's Attorney and Treating Physician—Disfavored

The Workers' Compensation Commission is necessarily concerned about ex parte communications. Communication between respondents' counsel and the treating physician where such communication would involve unilateral disclosure or discussion of material information—for example, videotaped surveillance of a patient that purports to militate against the treating physician's opinion that the patient is totally disabled from all work activity—should be avoided. If respondents' counsel seeks to reveal such information to a treating physician, the attorney should inform the patient's counsel in advance.

The Commission prohibits efforts on the part of attorneys for either side unilaterally to influence the thinking or opinions of physicians on significant issues where, as a result, one party may gain through

surprise a legal advantage over another. The Commission does not, however, disfavor inquiries that relate to the physician's obligation to provide progress notes, forms, etc. Respondents' counsel, for example, may request the physician to fill out a form and inquire thereafter about the status of such a form. The patient or the patient's representative must be sent a copy of any written communication to the treating physician.

The Commission also recognizes that respondents' counsel in many cases wishes to communicate with the treating physician on the issue of "apportionment," that is, the extent to which one insurer might be in a position to limit its legal liability for a repetitive strain/trauma injury by implicating previous employers on a continuum of such injurious work activity. Such an inquiry does not typically implicate the litigation interests of the patient, as would the disclosure of surveillance as described above. Nevertheless, even in such cases, the patient's counsel must be apprised of any such inquiry in advance.

C. Ex Parte Meeting Between Respondent's Attorney and Physician

Where a physician has performed an **Employer/Respondent's Exam**, that is, examined a claimant at the behest of the respondents, respondents' counsel is free to meet ex parte with the examining physician. But inasmuch as the examining physician is an expert who has been retained by the respondents, claimant's counsel should not communicate ex parte with that physician; communication with that physician should be coordinated through respondents' counsel.

D. Commission Medical Examiners: Ex Parte Meetings and Correspondence

The Administrative Law Judge has authority to order his/her own medical examination; this will be discussed in greater detail herein. Here, too, different concerns are implicated as far as communication with that physician is concerned. Where a physician has examined a claimant at the request of the Administrative Law Judge, attorneys for neither party are allowed to communicate ex parte with that physician. Should the need arise for the attorney for either party to communicate with the Commission Medical Examiner, any inquiries or requests for information should be directed in writing to the Administrative Law Judge, with counsel to any other party copied in.

In this regard, should any physician selected to perform a Commission Medical Examination require additional information or otherwise have questions, that physician should direct inquiries in writing to the Administrative Law Judge, with copies to counsel for all parties.

V. PHYSICIAN AS A WITNESS

A. Depositions

1. What is a Deposition?

A deposition is an official proceeding, authorized by law, whereby a person testifies under oath, outside of court, before a court stenographer in the presence of attorneys representing the parties. In the case of a physician, a deposition is an official proceeding that usually takes place in that physician's office. The physician will invariably be requested to produce the complete chart, together with any films of diagnostic studies, at that deposition. While a physician may be asked numerous detailed questions, he/she often

testifies directly from the contents of the chart. The physician may be required to release documents and films to the court stenographer, who will then diligently duplicate and return them to the physician.

2. *What are the Circumstances of a Deposition?*

a. *Who Schedules a Deposition?*

The attorney who wishes to take the physician's deposition will arrange, in advance, for the scheduling of that deposition. The attorney will typically reserve time in advance to prepare the physician for the deposition. The attorney will go over with the physician the scope of the anticipated direct examination of the physician. The attorney will have questions for the physician, the answers to which that attorney wants to know in advance of the deposition. The attorney will in all likelihood apprise the physician of the nature of questions that another attorney or attorneys might ask on cross-examination.

As a matter of professional courtesy, depositions should begin at their scheduled time. If the prospect of a delayed start arises, either the physician or the attorney should inform the other promptly and the attorney must inform other attorneys who would be attending. All those who are participating should be fully prepared so that the deposition proceeds as efficiently as possible.

b. *What Happens at a Deposition?*

Testimony at a deposition is sworn testimony. Physicians must be thoroughly prepared to answer questions completely and accurately. The attorney who has noticed the deposition asks "open" questions by way of what is called direct examination. Such questions often call for more informative as opposed to terse responses. Physicians are invariably asked, for example, at the beginning of a deposition, to describe their medical training, qualifications, etc. They will be asked questions about the history that they took of the patient, the treatment that they rendered, and so forth.

Upon completion of direct examination the physician is subject to cross-examination. The attorney for the other party is entitled to ask what are called "leading" questions, i.e., questions that typically require yes or no answers and no more than that. Attorneys feel that they have wide latitude on cross-examination and physicians can expect to be rigorously questioned at a deposition. Attorneys are expected to conduct questioning in a professional way and to refrain from badgering, harassing, or intimidating the physician.

Upon conclusion of the deposition the physician has the right to read and sign the transcript. This constitutes an opportunity to correct errors in transcription, but not to alter or extend testimony. The reading and signing of the transcript may be waived.

c. *Significance of Deposition Testimony*

A deposition is sworn testimony given under penalty of perjury. Transcripts of depositions become part of the evidentiary record of a Formal Hearing. The Administrative Law Judge reads them very carefully and gives great weight to sworn testimony. The sworn deposition testimony of physicians is often dispositive of critical issues in a worker's compensation case.

3. What May a Physician Charge for a Deposition and Who Pays the Fee?

The party who notices the deposition is responsible for paying the physician's fee. The Workers' Compensation Commission allows the following charges in connection with deposition testimony:

a. Any physician rendering services under the workers' compensation system may charge up to \$500 per hour for a deposition. The physician is guaranteed a minimum of \$500 for the first hour even if the deposition lasts less than 60 minutes. All preparation time and travel is in addition to the initial 60-minute period and shall be billed pro rata at the rate of \$500 per hour.

b. Where the party that noticed the deposition cancels the deposition three (3) business days prior to its scheduled date, **NO CANCELLATION FEE IS TO BE ASSESSED.** Otherwise, a cancellation fee may be assessed by the Administrative Law Judge upon request of a party alleging a financial loss due to the cancellation.

B. Formal Hearings

1. What is a Formal Hearing?

In the event that disputes cannot be resolved informally, they must be resolved by way of formal litigation. As discussed above, the Formal Hearing is analogous to a civil trial over which a judge presides in that the parties introduce evidence and a stenographic record is made of the proceedings. The claimant and other witnesses testify before the Trial Administrative Law Judge. Medical reports are typically introduced into evidence, as are the transcripts of depositions. The Trial Administrative Law Judge then decides the issues on the basis of the trial record.

2. What are the Circumstances of a Formal Hearing?

a. Who Calls a Physician to Testify?

In most cases, a physician is not called upon to testify because the physician's reports and/or the transcript of a deposition have been introduced into evidence. However, there are cases where the attorney for either the patient or the insurer wishes to have a physician testify in person before the Trial Administrative Law Judge. Sometimes the Trial Administrative Law Judge wants to hear live testimony from a physician. An attorney or even the Trial Administrative Law Judge may subpoena the physician to attend a Formal Hearing. Although this is uncommon, when necessary, the attorney who seeks to have the physician testify should arrange scheduling.

b. Location and Timing of Testimony

Both the Workers' Compensation Commission and the attorneys who practice before it are mindful of the amount of time that the professional responsibilities of a physician consume. Attorneys must do their best to apprise the physician as far in advance as reasonably possible of the attorney's intention to have the physician testify at a Formal Hearing. It must be made known to the physician where and when the Formal Hearing is scheduled to take place. The Commission and the attorneys try their best to see to it that a physician who is scheduled to testify will testify as promptly as possible on the scheduled date and time.

Attorneys are encouraged to inform the Commission well in advance of their intention to have a physician testify to facilitate this.

3. *What May a Physician Charge for Attendance at a Formal Hearing and Who Pays the Fee?*

The party who calls the physician as a witness is responsible for paying the physician's fee. If the Trial Administrative Law Judge calls the physician as a witness, then the Administrative Law Judge will see to it that responsibility for payment will be assigned and that the physician is compensated. The Administrative Law Judge allows the following charges in connection with testimony at a Formal Hearing:

a. An Employee's Treating Physician may charge up to \$550 per hour for testimony at a Formal Hearing. The Employee's Treating Physician is guaranteed a minimum of \$550 for the first hour even if the testimony lasts less than 60 minutes. All preparation and travel time is in addition to the initial 60-minute period and shall be billed pro rata at the rate of \$550 per hour.

b. An Employer/Respondent's Examiner may charge up to \$650 per hour for testimony at a Formal Hearing. The Employer/Respondent's Examiner is guaranteed a minimum of \$650 for the first hour even if the testimony lasts less than 60 minutes. All preparation and travel time is in addition to the initial 60-minute period and shall be billed pro rata at the rate of \$650 per hour.

4. *What are the Roles of the Attorney as Advocate and the Physician as a Witness before the Workers' Compensation Commission?*

a. *Attorney as Advocate*

Both physicians and attorneys come before the Workers' Compensation Commission as highly respected professionals who carry out significant responsibilities under the Act.

Attorneys who appear before the Commission are expected to meet standards of conduct that are commensurate with the high standing of their profession. Attorneys should never question physicians in a discourteous or antagonistic way. While it is proper for attorneys to cross-examine physicians on such issues as their qualifications, the accuracy and completeness of their records, and so forth, such questioning should at all times be conducted in a civil and restrained manner. No witness, whether physician or otherwise, should be questioned in a personally demeaning way. Should an attorney exceed the bounds of propriety in questioning a witness, the attorney who called that witness would object. More importantly, the Administrative Law Judge may intervene. The Administrative Law Judge will not hesitate to maintain proper decorum in the hearing room.

b. *Physician as a Witness – What the Workers' Compensation Commission Expects*

Similarly, the Workers' Compensation Commission expects physicians who come before it to meet standards that are commensurate with the high standing of their profession.

Physicians should testify objectively; physicians should not sacrifice objectivity to advance the litigation interests of any party to workers' compensation proceedings. The parties already have advocates in the form of their attorneys.

The Administrative Law Judge pays particular attention to the live testimony of a physician. In fact, the Commission encourages live testimony from physicians because that affords the Administrative Law Judge an opportunity to ask questions. Both attorneys and physicians should expect the Administrative Law Judge to ask questions on his/her own initiative. In listening to a physician's testimony and by asking questions, the Administrative Law Judge is weighing the credibility of the physician just as the Administrative Law Judge would weigh the credibility of any other witness. Thus, physicians should testify dispassionately, commensurate with their standing as scientifically trained professionals.

VI. PHYSICIAN AS EXAMINER

A. Physicians Participating in the Workers' Compensation System

Over the course of time, the Workers' Compensation Commission has identified the services provided by physicians largely depending on who retained them to perform their services. *Example:* the physician retained by the employer/respondent has become known as the "independent" medical examiner, which all will agree is a misnomer when any physician is retained by one party in the context of litigation. However, the "independent" medical examiner is no more presumptively biased than the injured worker's treating physician is presumptively neutral. In recognizing that injured workers who are not well versed in the system continually become confused by the utilization of these terms, the Commission is taking this opportunity to more appropriately name and define the physicians who typically perform services within the system. These changes are made to more accurately reflect the role that each physician performs.

1. **Employee's Attending Physician (previously "Treater")** is the licensed medical professional who is authorized to be the treating physician for the injured employee.

2. **Employer/Respondent's Examiner (previously "IME")** is the licensed medical professional retained by the employer or its designated representative to examine the injured employee and provide information and/or opinions requested by the employer or its representative.

3. **Commission Medical Examiner** is the licensed medical professional selected by an Administrative Law Judge to address questions or issues as requested by the Administrative Law Judge.

4. **One-Time Medical Evaluation** is an office visit/examination for which payment by the respondent is guaranteed, but with the understanding that further treatment, referrals, or outside testing will require approval by the respondent or administrative law judge. One-time evaluations are typically requested when the patient has not yet seen a physician (or has not yet seen a specialist), or when circumstances suggest a possible need to reinstate treatment after a hiatus.

a. **Initial One-Time Evaluation** – This is simply an *initial office visit* between the patient and physician. As with any other initial office visit, the physician is expected to generate a routine office note (SOAP or other standard format) reciting his/her understanding of the patient's history and symptoms, findings on examination, and recommendations for further diagnostics or treatment if warranted. In the note,

the physician should also comment on the patient's disability status or work restrictions (if applicable) and, if asked, give a preliminary opinion on causation, based upon the history and information available at the exam.

The one-time evaluation is not a respondent's examination or a Commission Medical Examination, and the physician is *not* expected to review outside records beyond what they would typically request or review for any new patient.

b. Subsequent One-Time Evaluation. In the case of existing patients, who are already a patient of the physician's practice, the one-time evaluation rate may be charged if the physician has not seen the patient for more than one year.

The physician should send a copy of the office note, disability slip (if applicable) and bill to the respondent payer. A copy of the office note and disability slip (if applicable) is to be provided to the claimant (or his/her representative, if known). The office note should clearly note that the exam is a one-time evaluation.

Reimbursement for one-time evaluations will be pursuant to the *Official Connecticut Practitioner Fee Schedule* rate for a Level 4 new patient consultation (CPT code 99244). An office visit that is authorized as a one-time evaluation may not be down coded by the payer. If in-office x-rays are required, they may be billed in addition to the office visit fee. Should either party require additional information from the physician after the one-time evaluation exam, any additional reports issued will be payable at the special report rate (\$200).

5. A *Second Opinion* occurs when a patient is referred to a physician so the physician may render a medical opinion. Such opinions may include questions as to the confirmation of a diagnosis, work capacity, and treatment recommendations, including whether surgery is warranted or what type of surgery should be undertaken. The physician should be informed specifically by the requesting party what information is being sought.

This examination may occur as the result of either a request by a treating physician or a request by the claimant. Typically, the second opinion is requested by the claimant and the respondent has agreed to both authorize and pay for the examination or has been ordered to do so by an administrative law judge.

Regardless of how the examination is arranged, **the second opinion is not a respondent's examination or a Commission Medical Examination. The physician is *not* expected to review outside records beyond what the physician would typically request or review for any second opinion referral between physicians. If questions are addressed to the physician by a respondent that broach legal questions – e.g., opinions on causation or apportionment – then this enters the realm of a respondent's examination and is not a referral for a second opinion.**

The physician should send a copy of the report and bill to the respondent. A copy of the report should also be sent to the claimant (or his/her representative, if known) and to the referring physician if applicable. The report should clearly note that the exam was a second opinion.

Reimbursement for a second opinion will be pursuant to the *Official Connecticut Practitioner Fee Schedule* rate for a Level 4 new patient consultation (CPT code 99244). An office visit that is authorized or ordered as a second opinion **may not** be down coded by the payer. Should either party require additional information from the physician after the second opinion exam, any additional reports that are issued will be payable at the special report rate (\$200).

B. Employer/Respondent’s Examiner (previously “IME”)

The Workers’ Compensation Commission allows a physician to charge **up to \$850** for an Employer/Respondent’s examination, which cost is borne by the Respondent. The Commission has decided to approve a flat fee because, as in the case of special reports, while some cases entail an extra commitment of time, such cases will be balanced by those where the commitment of time is relatively small. To seek additional compensation, the physician should provide to the respective Administrative Law Judge and the respondents, a copy of the report and an explanation of the report fee including time and expense involved in completion. The Administrative Law Judge will respond to the parties in writing about the fee determination. Subsequently, and if necessary, this matter may be subject to a hearing. In the alternative, if prior to conducting the examination, the physician reasonably determines that the examination involves unusual circumstances necessitating a charge over \$850, then the physician may request, in writing, and the Administrative Law Judge may grant advance authorization for an additional charge.

Any physician who performs an Employer/Respondent’s examination must send a copy of the report of the examination directly to the claimant or the claimant’s representative. Similarly, a claimant who has had him/herself examined by an “independent” physician should send a copy of the report to the respondents or their legal representative.

C. Commission Medical Examination

1. Circumstances of a Commission Medical Examination

An Administrative Law Judge has the statutory authority to order a Commission Medical Examination. *Example:* There is a confirmed medical diagnosis and a significant disparity between the permanency rating of a treating physician and that of a respondent’s examiner, and the parties are unable to reach a compromise. The Commission Medical Examiner is selected on the premise that this physician is free of any bias or interest, thus enabling the physician to exercise independent medical judgment.

Either party may request that the deposition of a Commission Medical Examiner be taken. However, both sides should be aware that the administrative law judge would only consider testimony related to the issues that the examiner was directed to address by the administrative law judge who ordered the examination.

2. Limitations on Parties' Access to the Commission Medical Examiner

The Commission Medical Examiner is insulated from ex parte communications. The scheduling of examinations is handled by the respective district offices. The parties are obligated to see to it that all medical records are submitted to the district offices in advance for transmission to the Commission Medical Examiner. Should the need to communicate with the Commission Medical Examiner arise, the parties should discuss this between themselves in advance and obtain the consent of the administrative law judge to approach the Commission Medical Examiner; the district offices will coordinate this. A physician who has been selected to perform a Commission Medical Examination and who has inquiries, e.g., a request for access to diagnostic films, should direct such inquiries to the district office.

3. Cost of a Commission Medical Examination

The Workers' Compensation Commission **allows a Commission Medical Examiner to charge up to \$900 for a Commission Medical Examination.** Here, too, the Commission allows a flat fee because it contemplates that the more difficult cases, involving an extra commitment of time, will be balanced by the easier cases, where the chart is thin and/or the examination less comprehensive.

The physician who performs a Commission Medical Examination may request of the Administrative Law Judge additional compensation under unusual circumstances, e.g., review of a truly voluminous chart and/or numerous films from diagnostic studies. To seek additional compensation, the physician should provide to the respective administrative law judge and respondents a copy of the report and an explanation of the report fee including time and expense involved in completion. The Administrative Law Judge will respond to the parties in writing about the fee determination. Subsequently, this matter may be the subject of a hearing, if necessary. In the alternative if, prior to conducting the examination, the physician reasonably determines that the examination involves unusual circumstances necessitating a charge over \$900, then the physician may request in writing, and the administrative law judge may grant advance authorization for an additional charge.

The physician who performs a Commission Medical Examination must send a copy of the report to the Administrative Law Judge who ordered the examination, to the patient or his representative, and to the respondents or their representative. **The cost of a Commission Medical Examination is borne by the respondent.**

D. Late Cancellations/ Failure to Attend Examinations

Where a claimant cancels a scheduled Commission Medical Examination (CME) **less than two business days prior to the date of the examination**, the Commission recommends that the physician's office limits the cancellation fee to **\$300.00**. There shall be no cancellation fee assessed for CMEs cancelled more than two business days prior to the exam. Where a claimant fails to attend a Commission Medical Examination and does not call or otherwise alert the physician's office prior to the appointment time, the Commission recommends that the physician's office limit the no show fee to **\$450.00**.

In either situation, when determining responsibility for the payment of the late cancellation or no-show fee, the parties and the administrative law judge should implement a fault-based approach that takes into account the circumstances surrounding the claimant's failure to attend the examination.

VII. RELATED ISSUES

A. Subpoenas

An attorney may issue a subpoena to compel the attendance of a witness or the production of documents (or both) at a deposition or a Formal Hearing. The Administrative Law Judge, as well, has authority to issue a subpoena. A subpoena is served on a witness by a marshal or an indifferent person. If necessary, the authority of the judicial system may be invoked to enforce that subpoena. The judicial system has the authority to sanction anyone who defies a subpoena.

While it is common for medical records and in particular, hospital records to be subpoenaed to a "records" deposition or a formal proceeding, it *is* uncommon for a physician to be subpoenaed at all. Invariably attorneys coordinate with physicians to schedule depositions or appearances at formal proceedings; access to medical records is generally obtained by way of a medical authorization without the need for a subpoena.

A physician who refuses to testify may be subject to removal from the list of approved physicians. A physician, who is unwilling to testify, whether at a Formal Hearing or even at a deposition, may simply elect not to treat injured workers.

B. Medical Authorizations

Respondents do not need a medical authorization for access to an original report of injury or subsequent progress notes for a given injury. As discussed above, the physician is under an affirmative obligation to supply such records. A medical authorization would be required where, for example, an attorney requests treatment records in connection with a previous injury.

It is not unusual for respondents' counsel to seek a medical authorization to obtain additional records. The Workers' Compensation Commission is concerned about inquiries that are intrusive or seek records that have only an attenuated link to the issues in the case. Requests for additional medical records must be tailored to bear a reasonable relation to the issues in the case. For example, access to ob-gyn records might be unreasonable where the injured body part is the shoulder, but might be reasonable where claimant underwent a series of hernia procedures in the aftermath of caesarean deliveries and subsequently claims that repetitive work activity was responsible for the most recent procedure.

C. Role of Rehabilitation Nurses/Nurse Case Managers

Rehabilitation nurses and nurse case managers employed by the employer/respondent have, in general, played an important role in seeing to it that an injured worker receives appropriate medical treatment and returns to productivity as quickly as reasonably possible. These healthcare professionals must be sensitive, however, to the potential for a conflict of interest. There are many cases where disputes arise between the

claimant and the insurer and the positions of the parties become adversarial. The rehabilitation nurse or nurse case manager must be sensitive to this at all times and refrain from engaging in any activity that could create a conflict of interest or otherwise leave him/her vulnerable to accusations of partisanship. The extent to which the rehabilitation nurse and nurse case manager may become actively involved in the medical treatment of a claimant, e.g., physical presence of the rehabilitation nurse at a physician's examination of the claimant, lies within the discretion of the claimant and the treating physician after consultation with each other. The patient has the right to limit or reject the involvement of a rehabilitation nurse or nurse case manager. Where disputes arise, the Administrative Law Judge shall make the final decision.

D. Role of Physician Assistants and Advanced Practice Registered Nurses

Physician Assistants (PA) have the ability to perform workers' compensation examinations under the direction of a physician **at seventy percent (70%) of the fee schedule rate**. Physician Assistants **may not** see patients on **more than two consecutive visits** and **may not** assign the permanency rating at the final visit. The supervising physician is required to review all paperwork prepared by a PA.

Advanced Practice Registered Nurses (APRN) have the ability to perform workers' compensation examinations and other procedures without the supervision, direction and co-signature of a physician contingent upon compliance with all requirements set forth in C.G.S. Section 20-87a. The APRN will be reimbursed **at the lesser of seventy percent (70%) of the fee schedule allowable or billed charges**.

E. Pre-Payment for Reports, Meetings, Depositions and Formal Hearings: Disallowed

Physicians are barred by state law from requiring advance payment for reports or testimony, including examinations which are preliminary to such reports or testimony. See Sections 31-280-1(a)(6) of the Administrative Regulations of Connecticut State Agencies.

F. Exception for Psychiatrists, Psychologists, Neuropsychologists, and Neuropsychiatrists

Due to the particular nature of these fields, there are some exceptions to Commission rules, regulations and guidelines granted to providers in these disciplines. Please note the following:

1. Most Commission rules and regulations, including deposition fees and formal hearing testimony fees, **do apply**
2. Fees as listed in the Official Connecticut Practitioner Fee Schedule, which encompasses most office visit/treatment fees, **do apply** unless there is a contract indicating otherwise
3. Fees for Commission Medical Exams and Employer/Respondent Exams **DO NOT** apply. The provider may charge a maximum of \$2500 for these types of exams without prior approval. Any fee above \$2500 for a CME must be approved by the ALJ **prior** to the exam taking place. In the case of an RME, the provider may request the higher fee from the respondent. If the provider and respondent cannot agree on a fee, the respondent may choose another provider or request a hearing with an ALJ to determine a reasonable fee.

WORKERS' COMPENSATION GLOSSARY

Acute treatment phase: Treatment which occurs immediately after an injury for a period of time that is medically reasonable (generally not to exceed three (3) months).

Aggravation of a pre-existing disease or condition: Apportionment (see below) based upon aggravation of a pre-existing disease or condition refers only to occupational disease (see below). Where there is no pre-existing impairment due to an occupational disease, the employer, as in the law of tort, takes the victim as it finds him/her and pays the entire resulting disability.

Apportionment: If a claimant suffers from an occupational disease or repetitive trauma injury that occurred over a time continuum, the Administrative Law Judge may apportion liability among different employers on that continuum and order the employers or their insurers to reimburse pro rata the employer found initially liable; it is usually the most recent employer on the continuum who administers the claim. Physicians are needed to “apportion” responsibility between and among various employers and/or insurers; this is usually done by way of percentage allocations. It is not unusual for physicians, especially orthopedic surgeons and neurosurgeons, to be asked to review medical records and even a patient’s deposition testimony to render an opinion on “apportionment.”

Approved list of physicians: Sec. 31-280-1 of the Regulations of Connecticut State Agencies; provides the list of Approved Practicing Physicians, Surgeons, Podiatrist, Optometrist, and Dentists from which an injured worker shall choose for examination and treatment. This list includes all practitioners who hold a current and valid license in their field in the State of Connecticut who meet the following standards:

1. Continuation of a current and valid license in the State without revocation, suspension or limitation of such license in any way;
2. Possession of a valid Federal Drug Enforcement Administration registration certificate in the case of practitioners whose license permits them to prescribe controlled drugs;
3. Compliance with the Medicare Antikickback Regulations promulgated by the United States Department of Health and Human Services;
4. Possession of admitting/active staff privileges at a general hospital accredited by the Joint Commission on Accreditation of Hospitals, if such privileges are required in order to provide satisfactory professional services within the practitioner’s area of practice;
5. Compliance with the administrative obligation of attending physicians and other practitioners under Section 31-279-9 of the Regulations of Connecticut State Agencies;
6. Forbearance from requiring in advance a payment for providing an opinion or report either written or oral, or for presenting testimony as a witness at a hearing or a deposition;

7. Completion of training, approved by the Chairperson of the Workers' Compensation Commission, which course shall include a session describing the general responsibilities and obligation of physicians under the provisions of Chapter 568, along with training in the recognition and reporting of certain occupational and other diseases under Section 31-40a and 19a-110 of the Connecticut General Statutes and;

8. Forbearance from referring workers' compensation patients for physical therapy or diagnostic testing to a facility in which such practitioner has an ownership or an investment interest other than an ownership of investment securities purchased by the practitioner in terms available to the general public which are publicly traded.

Authorized physician:

not within a preferred provider organization (PPO): Where there is no preferred provider organization, the claimant may select his/her own physician within the State of Connecticut list of approved physicians (see above) without prior approval of an Administrative Law Judge. Once a doctor is selected, the Administrative Law Judge may authorize a change in physician, even without a hearing. An injured worker cannot unilaterally change physicians if the authorized physician wishes to continue treatment without prior approval of the Administrative Law Judge. A valid referral to a physician is needed to qualify the new physician as an authorized treating physician. An Administrative Law Judge does have the power to retroactively authorize a physician.

within a preferred provider organization (PPO): When an employer has an approved managed medical care plan, the injured worker must select a doctor from within that plan. Any referrals or change of physician must be made within the medical care plan membership.

Causally related to employment: Very broadly, an injury is compensable if it arises out of and in the course of employment. This is a factual determination; the Administrative Law Judge makes it. In so doing, the Administrative Law Judge weighs all medical opinions, uncontradicted or not, in reaching a decision.

Claimant: An individual who asserts eligibility for workers' compensation benefits.

Commission medical examination: The Administrative Law Judge has the discretion to order the claimant to undergo a further medical examination by a licensed medical professional of the administrative law judge's choice. This examination is normally ordered when there is conflict in the medical reports between the Employee's Attending Physician and the Employer/Respondent's Examiner, or if an Administrative Law Judge requires further information to make a decision. The insurer or employer bears the cost of this examination.

Curative: Curative (or remedial) care is care that seeks to repair the damage to health caused by the job, even if not enough health is restored to enable the employee to return to work. Treatment that is designed to keep the employee working or return him or her to work is curative. Such treatment might be held compensable even if the patient had long since reached maximum medical improvement. A claimant might, for example, seek payment for a weight loss program. The Administrative Law Judge might find, after hearing the evidence, that while further weight loss might benefit the claimant, the program would be palliative and thus not compensable.

Employee's attending physician: The licensed medical professional who is authorized to be the treating physician for the injured employee.

Employer/respondent's examiner: The licensed medical professional who is retained by the employer or its designated representative to examine the injured employee and provide information and/or opinions requested by the employer or its representative.

Ex parte (communication): Generally, in civil litigation a party engages in ex parte communication where it applies to an administrative law judge for recourse or remedy in the absence of the other party. In workers' compensation litigation, a party who calls or writes the Administrative Law Judge about the merits of a case, in the absence of the other party, engages in ex parte communication. The term is given a more specific application in workers' compensation litigation in that it is used to describe one party's communications with a treating physician in the absence of knowledge on the part of the other party.

Employer/respondent's examination: The Employers/Respondents have the right to have the claimant examined by a physician of their choice. The claimant must submit to such an examination, to be paid for by the respondents, subject to reasonable constraints on distance traveled, etc. The claimant has a right to have his or her own physician present during such an examination with the cost to be borne by the claimant.

Injury: There must be a work-related "injury" for a claim to fall within the jurisdiction of the Workers' Compensation Commission. There are three categories of "injury" under workers' compensation law: an accidental injury that can be definitely located as to time or place of occurrence; repetitive use/strain/trauma injury; and occupational disease.

accidental injury: Such injuries, also characterized as the result of a "discrete" incident of trauma, are typically orthopedic injuries, e.g., broken bone from a fall or blunt trauma. Such injuries are typically easy to identify through objective evidence of trauma.

repetitive use/strain/trauma injury: Such injuries are typically the result of cumulative wear and tear from work activity over a span of time. These, too, are typically orthopedic injuries, with the classic example being carpal tunnel syndrome. But a disease process might also be a cognizable “injury” in this category where, for example, cumulative exposure to irritants at work culminates in the development of asthma.

occupational disease: Occupational disease constitutes an “injury” if the disease is peculiar to the occupation in which the employee was engaged or due to causes in excess of the ordinary hazards of employment. A classic example of this is the incidence of “black lung disease” among coal miners. A more recent example, from Connecticut, is a case where a dental hygienist was found to have compensable hepatitis as a result of exposure to patients with the disease; her occupation was determined to have created a risk in excess of ordinary employment.

Maximum medical improvement: The point on the continuum of medical treatment where the curative effect of such treatment plateaus. Maximum medical improvement has been reached when a physician determines that the patient is healed to the fullest extent expected. At this time the physician determines whether there is any permanent partial impairment (see below) to any body part or parts, and the degree of such physical impairment. This rating is expressed as a percentage.

Palliative: Treatment that provides transient relief of symptomatology without advancing the healing process; not curative.

Participating workers’ compensation physicians are comprised of the following:

commission medical examiner: this is the licensed medical professional selected by an Administrative Law Judge to address questions or issues as requested by the Administrative Law Judge.

employee’s attending physician or treating physician: this is the licensed medical professional who is authorized to be the treating physician for the injured employee.

employer/respondent’s examiner: this is the licensed medical professional who is retained by the employer or its designated representative to examine the injured employee and provide information and/or opinions requested by the employer or its representative.

second opinion/consultation examiner: this is the licensed medical professional to whom a referral is made for purposes of rendering medical opinions only.

Permanent partial impairment: Residual loss of use or function to an organ or body part after maximum medical improvement has been reached.

Reasonable or necessary medical care: Care which is curative or remedial. The Administrative Law Judge determines whether medical care is reasonable or necessary, including whether it is palliative or curative. The Administrative Law Judge also determines whether medical care is causally related to a compensable injury.

Respondent: This is the designation that is given to an employer or insurer (or both) as parties to workers' compensation litigation. A party respondent is analogous to a party defendant, just as a claimant is analogous to a plaintiff in civil litigation.

Second opinion/consultation examiner: This is the licensed medical professional to whom a referral is made for purposes of rendering medical opinions only. As an example, this professional may be asked questions confirming a diagnosis or a treatment plan for an injured employee. (If questions addressed to this professional broach legal areas, e.g., opinions on causation, apportionment, etc., then this examination enters the realm of an Employer/Respondent's examination and is not a referral for a second opinion).

Temporary disability:

total: Where an individual has no work capacity whatsoever as a result of a compensable injury or disease. That is, an individual can perform neither usual work, nor any other occupation. The Administrative Law judge is ultimately responsible for determining whether a patient is temporarily totally (or partially) disabled. While the physician bases opinions on work status on medical criteria, the Administrative Law Judge considers such additional criteria as the patient's age; level of education; training; physical ability; transferable skills; and other criteria in combination with medically imposed physical restrictions.

partial: Where an individual cannot return to regular work as a result of a compensable injury or disease, but otherwise has a work capacity. The physician is qualified to determine, on the basis of medical criteria, restrictions that would allow the patient to obtain alternative work.

APPENDIX I – CLINICAL EXAMPLES

The following examples serve to demonstrate the approach that the Workers' Compensation Commission would encourage where authorization for medical treatment is concerned:

1. If a worker suffers a low back strain/sprain from an incident of heavy lifting that has led to the onset of lower extremity pain, numbness, and tingling, radiating into the great toe, the treating physician might recommend, during what is obviously an acute treatment phase, an MRI or other diagnostic study. Such a study would arguably be routine and obviously reasonable under the clinical circumstances, and it should be promptly authorized.

2. An orthopedist, who is treating a patient for compressive symptomatology in the upper extremity where the working diagnosis is ulnar neuropathy, might want a neurosurgical consultation to rule out a cervical etiology for the symptom complex. Ordinarily this would be a routine and obviously reasonable referral during the acute clinical phase, and it should be authorized promptly.

3. Where a patient with a lower lumbar injury complains of urinary incontinence, the treating physician might refer that patient to a urologist. While that referral might ostensibly bear no significant causal relation to a low back injury, if its purpose is to rule out a cauda equina lesion, it would likely be considered causally related for diagnostic purposes and thus compensable medical treatment. But if the urologist concluded that the problem was not neurogenic, but attributable to prostatism, then it is likely that authorization for further treatment would be reasonably questioned.

4. While epidural steroid injections, after a patient has reached maximum medical improvement, might be palliative in that they no longer facilitate healing per se, but provide only transient relief, the Workers' Compensation Commission might consider them "curative" and thus compensable where they have facilitated a return to work and promote a continuing ability to work. This example serves to illustrate the flexibility with which the criteria described above are applied and how the application of these criteria varies on a case-by-case basis.

5. A neurosurgeon who is treating a patient for a compensable cervical injury might recommend a podiatric evaluation where that patient is complaining of concomitant bilateral foot pain. A podiatrist recommends inserts for plantar fasciitis. This does constitute reasonable and necessary medical treatment, but such treatment, or even the podiatric referral, would reasonably be questioned on the basis of causal connection, even if the referral were made ostensibly for diagnostic purposes.

APPENDIX II – WORKERS’ COMPENSATION SUMMARY OF FEE SCHEDULE

Commission Medical Examination: (page 21)

The Workers’ Compensation Commission allows a Commission Medical Examiner to charge **up to \$900** for a Commission Medical Examination, which cost is borne by the respondent.

Depositions: (page 16)

Any physician rendering services under the Workers’ Compensation Act may charge **up to \$500 per hour** for a deposition. The physician is guaranteed a minimum of \$500 for the first hour even if the deposition lasts less than 60 minutes. All preparation time and travel is in addition to the initial 60-minute period and shall be billed pro rata at the rate of \$500 per hour.

Employer/Respondents’ Examination: (page 20)

The Workers’ Compensation Commission allows a physician to charge **up to \$850** for an Employer/Respondents’ examination, which cost is borne by the respondent.

Formal Hearings: (page 17)

An **Employee’s Treating Physician** may charge **up to \$550 per hour** for testimony at a Formal Hearing. The Employee’s Treating Physician is guaranteed a minimum of \$550 for the first hour even if the testimony lasts less than 60 minutes. All preparation and travel time is in addition to the initial 60-minute period and shall be billed pro rata at the rate of \$550 per hour.

An **Employer/Respondent’s Examiner** may charge **up to \$650 per hour** for testimony at a Formal Hearing. The Employer/ Respondent’s Examiner is guaranteed a minimum of \$650 for the first hour even if the testimony lasts less than 60 minutes. All preparation and travel time is in addition to the initial 60-minute period and shall be billed pro rata at the rate of \$650 per hour.

Forms: (page 12)

A physician is expected to fill out forms that are approved by the Workers’ Compensation Commission, which address work status or extent of permanent injury to a body part once maximum medical improvement has been reached. The need for such reports does not arise in every case, but they must be prepared and submitted upon request, at **no charge**.

Meetings with Physicians: (pages 13-14)

A physician may charge **\$250 per hour** for a meeting with counsel. The physician is guaranteed a minimum of \$250 for the first hour even if the meeting lasts less than 60 minutes. All preparation time and conference time is in addition to the initial 60-minute period and shall be billed pro rata at the rate of \$250 per hour.

When a party (not the physician) cancels a meeting with a physician within 24 hours of its scheduled time, the physician is entitled to be paid a cancellation fee equivalent to the charge for an extended consultation under the Connecticut Practitioner Fee Schedule, which incorporates by reference the CPT schedule of the American Medical Association, by the party responsible for cancellation of the meeting.

Late Cancellations/ No Show Fees: (page 21-22)

Where a claimant cancels a scheduled Commission Medical Examination (CME) **less than two business days prior to the date of the examination**, the Commission recommends that the physician's office limits the cancellation fee to **\$300**. Where a claimant fails to attend a Commission Medical Examination and does not call or otherwise alert the physician's office prior to the appointment time, the Commission recommends that the physician's office limit the no show fee to **\$450**.

One-Time Evaluation: (pages 18-19)

The Workers' Compensation Commission allows physicians to bill CPT code 99244. Physicians will be reimbursed at the rate listed in the *Official Connecticut Practitioner Fee Schedule*.

Original Report, Subsequent Progress/Office Notes and Preparation of Approved Forms: (page 12)

A physician **may not charge** for an original report, subsequent progress/office notes, or for the preparation of approved forms. The approved workers' compensation fee schedule takes this commitment of time into consideration.

Photocopying Charges: (page 12-13)

Physicians may not charge photocopying fees for reports/forms that they must generate without charge, but if a party requests *additional* copies of documents or an entire chart, the Workers' Compensation Commission permits reimbursement at the statutory rate, currently **65 cents per page**.

Hospitals may not charge photocopying fees for reports/forms that they must generate without charge, but if a party requests *additional* copies of documents or an entire chart, the Workers' Compensation Commission permits reimbursement at the statutory rate, currently **65 cents per page**.

Pre-Payment for Reports, Meetings, Depositions and Formal Hearing Testimony: (page 23)

Physicians are barred by statute from requiring advance payment for reports or testimony including examinations which are preliminary to such reports or testimony. See Sections 31-280-1(a)(6) of the Regulations of Connecticut State Agencies.

Second Opinion: (pages 19-20)

The Workers' Compensation Commission allows physicians to bill CPT code 99244. Physicians will be reimbursed at the rate listed in the *Official Connecticut Practitioner Fee Schedule*.

Special Reports: (page 12)

A physician may charge **up to \$200 for a special report**. However, under unusual circumstances an additional charge may be allowed at the Administrative Law Judge's discretion, where voluminous additional records must be reviewed as part of the preparation of a special report. Sometimes a physician is called upon to prepare a more detailed report, e.g., the interplay, if any, between the current injury the physician is treating and the sequelae from previous injury to the same body part. The party whose attorney requested the special report is responsible for payment.