Quality Review Tips!

QR Tips October 5, 2022

Medical History vs Medical Analysis- What is the difference?

Medical History:

The Medical History section is intended to be where you provide pertinent details and tell the 'story' on which to build the foundation for your Analysis and Conclusions.

- Discuss relevant documents from all providers, noting symptoms, clinical exam findings (or lack of), treatment, as well as any imaging, labs or diagnostic testing performed to evaluate the claimant's function and/or the impairing condition within the time frame of the review.
- Be clear and concise in your history so the reader can follow your rationale. It is not necessary to retell verbatim each visit nor include every detail in each visit. Keep your audience in mind (often this is a non-clinical claim reviewer).
- Not all records provided may be relevant to your specialty. Records outside the time period in question can be summarized briefly; focus on events/findings that are pertinent to the time period in question.
- The information that is documented in the Medical History section will be what is used to support your opinion that is provided in the Medical Analysis section of the report.

Medical Analysis:

This section pulls together the findings (detailed in the History) with a medically reasonable evaluation of these as relates to the claimant's sustainable functional capacity for the time period in question.

- The Medical Analysis is your opinion regarding the claimant's level of function, clearly stated and with rationale based in the documentation provided for review. Opinions should be provided within the scope of your own specialty; comment on conditions outside the scope of your specialty can/should be deferred.
- Factors include consistencies or inconsistencies, evidence that is present or lacking, self-reported (subjective) data as well as clinical (objective) findings, consideration of the AP opinion and your agreement or disagreement. In the circumstance of lack of data to support impairment, it is helpful to the Carrier to explain what you would expect to see in support of impairment. For example, 'if impairment were supported it would be expected the claimant would have been referred for a higher level of care such as IOP or PHP'…. 'Evidence of xyz (abnormal findings) is absent in the records provided for review…' 'I looked for and could not find evidence of non-healing fracture to indicate …'

- When addressing multiple conditions, discussion of each condition can be summarized individually, (particularly helpful when addressing numerous co-morbidities), or as a whole; you must however pull together the impact of conditions in their totality on the claimant's function.

******Insurers (aka the "Carrier") are legally required to provide an explanation to the claimant (and legal representation if applicable) a claim that is denied on a medical basis. Often this is done quoting a consultant's opinion and/or full report. Thus, it is key to clearly state your opinion, based in the facts of the provided records.***

Look for our next tip in the upcoming weeks.

We hope this has been helpful and we welcome your feedback and questions.

Thank you,
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