MEDICAL RECORDS REVIEW PROCESS

Chronological Narrative Summaries

Workers' Compensation QME/AME/IME | Personal Injury

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Applies to	All QME/AME/IME and personal injury case files handled by Narralex Solutions

1. Purpose

This document explains how I review medical records and produce chronological narrative summaries for medical-legal clients. It exists so that every file is handled the same way: accurately, confidentially, and on time. Every file is reviewed and written by me personally.

2. Scope

This process covers all workers' compensation (QME/AME/IME) and personal injury files I handle for US-based medical-legal clients, from intake through final delivery.

3. Tools and Systems

- **Secure file transfer:** the encrypted channel agreed with each client under our Business Associate Agreement (BAA).
- **Work computer:** encrypted and used only by me.
- **Case log:** my own tracker of case ID, client, deadline, page counts, and status. It holds no clinical details.
- **Email:** scheduling, questions, and delivery notices. Summaries are delivered through the secure method agreed with the client.

4. Workflow

Step 1: Intake

- Confirm a signed BAA is in place before opening any records.
- Confirm receipt of the files and check the total page count.
- Confirm the case type, appointment date, and delivery deadline.
- Check for unreadable pages, missing sections, or records that appear to belong to another patient. If I find any, I tell the client before starting.
- Add the case to my log with status "In Progress."

Step 2: Cover Letter First

Before reviewing any records, I read the cover letter in the file. It identifies:

- **Requesting party:** the attorney, insurance carrier, or other party requesting the evaluation.
- **Evaluation purpose:** what the physician is being asked to address, such as causation, apportionment, impairment rating, future medical care, or specific body parts.
- **Focus areas:** any records, time periods, or providers the requesting party has highlighted.

This step keeps the summary purposeful. It addresses what the physician and requesting parties need, not just a mechanical chronology.

Step 3: Records Review and Summary Writing

I review all records in chronological order and write one entry per report, using this format:

- **Entry format:** [Date of Service], [Name of Report] by [Provider]. Date of Injury. History of Present Illness/Injury. Subjective Complaints. Objective Findings. Past Medical History. Current Medications. Diagnostic Tests (date, exam, findings). Diagnoses. Treatment Plan/Recommendations. Work Status.
- **QME/AME/IME reports:** additionally, Causation, Apportionment, Impairment Rating, Disability Status, Subjective and Objective Factors of Disability, and Future Medical Care. These are always attributed to the author of the report, never stated as my own conclusions.
- **Personal injury cases:** the same format with more detailed narrative, particularly in History of Present Illness/Injury, Subjective Complaints, and Objective Findings, because these summaries are used in litigation.
- **Field inclusion:** only fields present in the source report are included. I do not add placeholders or "N/A."
- **Objective findings:** abnormal findings only, unless a normal finding is clinically significant to the case.

Step 4: Duplicate Records

- I note duplicate pages as I encounter them and summarize only the first instance.
- At the end of the review I subtract duplicate pages from the gross page count to get the net pages reviewed.
- The "Pages Reviewed" field in the header shows net pages only, for example "312 pages (excluding duplicates)."

Step 5: Quality Control

Before delivery, I check each summary against the source records:

- **Patient identity:** every record belongs to the correct patient. Records from other patients are flagged and excluded.
- **Header accuracy:** patient name, date of birth, date of injury, body parts, and pages reviewed.
- **Dates, ages, and intervals:** cross-checked against the records, including patient age at each visit and time between visits.

- **Attribution:** causation, apportionment, and impairment findings are credited to the report that made them.
- **Field completeness:** no report entry skipped and every applicable field populated.
- **Proofreading:** grammar, spelling, and consistent formatting.

Step 6: File Naming and Delivery

- **File name:** [Patient Last Name, First Name] – [Doctor Last Name] – [Date of Appointment]. Example: Martinez, John – Nguyen – 03-10-2026.
- **File format:** Microsoft Word (.docx). PDF on request.
- **Delivery:** sent directly to the client contact through the secure method agreed in the BAA, with confirmation of receipt requested.
- **Case log:** status updated to "Delivered."

5. Turnaround

- **Standard:** 48 hours from receipt of complete records, for files up to 150 pages.
- **Larger files:** turnaround is confirmed with the client at intake, before work begins.
- **Rush requests:** available by arrangement, subject to my current caseload.
- **Capacity:** I accept a limited number of new cases each week so that deadlines stay safe.
- **Delays:** if I cannot meet an agreed deadline, I tell the client immediately rather than at the deadline.

6. HIPAA and Confidentiality

All medical records and completed summaries contain Protected Health Information (PHI) and are handled under HIPAA and the BAA with each client.

- I access records only through the secure channels agreed with the client.
- Records are handled only by me. I do not use subcontractors without the client’s prior written consent.
- Records and summaries are stored only on my encrypted, password-protected work computer and are never placed on personal cloud accounts or messaging apps.
- I do not discuss case details over unsecured channels.
- I use records and summaries only for the client’s case. Client work is never used as a sample, and my portfolio samples are fictional.
- Records are returned or securely destroyed as set out in the BAA.
- I report any suspected breach or unauthorized access to the client promptly, within the timeline in the BAA.

— End of Process Document —