

AMA Guides®

NEWSLETTER



*Updates, authoritative guidance, practical information,
and rationales for proper use of AMA Guides*

September/October 2017

**For subscription information
click here.**

IN THIS ISSUE

Independent Medical Evaluation Best Practices 3

Q&A: Rating Upper Extremity Motion Loss, Comparison to the Opposite Side 19



AMA Guides Newsletter Advisory Board

EDITOR

Christopher R. Brigham, MD, MMS
Hilton Head, South Carolina

ASSOCIATE EDITOR

James B. Talmage, MD
Cookeville, Tennessee

ADVISORY BOARD

Gunnar B.J. Andersson, MD, PhD
Chicago, Illinois

Robert J. Barth, PhD
Chattanooga, Tennessee

Charles N. Brooks, MD
Bellevue, Washington

Stephen L. Demeter, MD, MPH
Las Vegas, Nevada

Lorne K. Drenfeld MD, FRCP(C)
Kahului, Hawaii

Dwight K. Dowda, MB BS, MPH
Sydney, Australia

Lee H. Ensalada, MD, MPH
Tucson, Arizona

Marjorie Eskay-Auerbach, MD, JD
Tucson, Arizona

Steven Feinberg, MD
Palo Alto, California

LuAnn Haley, JD
Tucson, Arizona

Richard T. Katz, MD
St. Louis, Missouri

Les Kertay, PhD
Chattanooga, Tennessee

J. Mark Melhorn, MD
Wichita, Kansas

Kathryn L. Mueller, MD, MPH
Denver, Colorado

Mohammed I. Ranavaya, MD, JD, MS
Huntington, West Virginia

Robert D. Rondinelli, MD, PhD
Des Moines, Iowa

E. Randolph Soo Hoo, MD, MPH
Tucson, Arizona

David B. Torrey, JD
Pittsburgh, Pennsylvania

AMA Staff

Nancy Baker
*Manager, Editorial Development
and Production*

Mary Ann Albanese
Production Specialist

Vanessa Prieto
Marketing Manager

Calendar of Events

11/2/2017	AAOS Improving Your IME Report	Las Vegas, NV	AAOS
11/3-11/5/2017	19th Annual AOS Worker's Compensation and Musculoskeletal Injuries	Las Vegas, NV	AAOS
1/10-1/13/2018	Medicolegal Institute and Annual Scientific Sessions	Orlando, FL	IAIME
4/13-4/18/2018	AMA Guides 6th Ed Training & IME Skills Workshops	Johannesburg, SA	ABIME

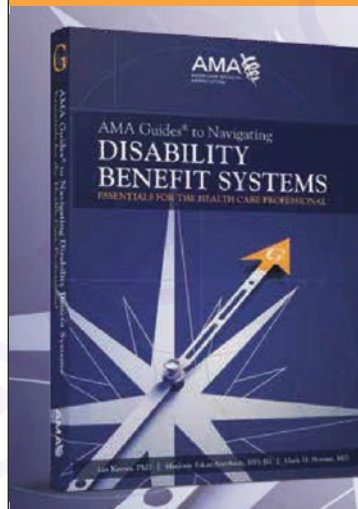
For further information about training, contact:

AMA	American Medical Association (www.amastore.com)	800-621-8335
IAIME	International Academy of Independent Medical Evaluators (www.iaime.org)	312-663-1171
ABIME	American Board of Independent Medical Examiners (www.abime.org)	304-733-0095
AAOS	American Academy of Orthopaedics Surgeons (www.aaos.org)	847-823-7186

Future Articles

- Neuropathic Pain
- Lumbar Disk Herniation
- Central Nervous System Impairment
- Medicolegal Issues for IMEs

AMA GUIDES® TO NAVIGATING DISABILITY BENEFIT SYSTEMS: ESSENTIALS FOR THE HEALTH CARE PROFESSIONAL



Explore basic principles and practices that lead to the best outcomes for patients at early stages of an encounter with worklessness. The health care professional, who usually has the first encounter with the patient, has the best opportunity to help patients change course.

Written for front-line health care professionals who do not have specialized training in evaluating patients with respect to work capacity, this book will help navigate unfamiliar disability systems with greater ease.

Softbound, 7" x 10", 192 pages

Item #: OP539015

ISBN: 978-1-602202-374-5 Price: \$60

AMA MEMBER PRICE: \$45

Order Information

1 year (6 issues)

AMA members \$150

Nonmembers \$200

2 years (12 issues)

AMA members \$240

Nonmembers \$320

Back Issues

AMA members \$19.95

Nonmembers \$29.95

Phone Orders: Call (800) 621-8335

© 2017 American Medical Association.
No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without the prior written permission of the publisher.

BP60-NG0340961

BP60-NG0340962

Cover Photo: Wildpixel/Thinkstock/Getty photos

The contents of this publication represent the views of the author[s] and should not be construed to be the views or policy of the AMA, or of the institution with which the author[s] may be affiliated, unless this is clearly specified. Information contained in this publication does not constitute legal advice and should not be substituted for independent advice of an attorney.

Independent Medical Evaluation Best Practices

Christopher Brigham, MD, Lorne K. Drenfeld, MD, Steven Feinberg, MD, MPH, Les Kertay, PhD, and James B. Talmage, MD

An independent medical evaluation (IME) is “a usually one-time evaluation performed by an independent medical examiner who is not treating the patient or claimant, to answer questions posed by the party requesting the IME” (6th ed, 612). Standards are “a required or agreed level of quality or attainment” and “are used as measure, norm or model in comparative evaluations.”¹ Adherence to best practice standards is essential to achieving excellence. Standards may change over time; and this article updates work published in 2000, 2002, and 2005 in the *AMA Guides Newsletter*.^{2,3,4}

The tangible result of an IME is the report. An IME report may contain more elements than an impairment evaluation, as explained in the Sixth Edition, Section 2.7, Preparing Reports (6th ed, 28-29) and the Fifth Edition, Section 2.6, Preparing Reports (5th ed, 21-22). Assessing impairment and disability in the pain patient, one of the most common IME scenarios, is particularly challenging.⁵ High-quality IME reports that are based on thorough and accurate evaluations, are valuable and assist with appropriate case and litigation management and closure. However, obtaining an excellent IME is difficult for many clients.⁶

IME Standards

IME standards are essential to the evaluating physician and all other stakeholders including the examinees, treating providers, benefit payers, employers, fact finders, and/or attorneys. These standards include the following:

- Definition of IME and principles,
- Examiner qualifications,
- Evaluation methodology (preevaluation, evaluation, and post-evaluation),
- Report structure, and
- Quality assurance.

There is variability in the needs of an IME based on the jurisdiction and the specifics of the case; therefore, these are recommended guidelines and not necessarily absolutes for all evaluations.

Definitions and Principles

An IME is a unique and specialized evaluation that is performed by a physician who preferably has special training and experience in the IME field. Although IMEs are similar in some ways to conventional medical evaluations, there are also distinct differences.

An IME is:

I: Independent (Impartial). The physician (evaluator) must arrive at his or her own diagnosis and opinion, independent of the referral source, remuneration, or

others' opinions. We all have personal biases that are based on our experiences and knowledge. For example, in assessing causation, a physician may base conclusions on the facts and current science and another physician may base conclusions solely on a temporal sequence (ie, “since event Y followed event X, event Y must have been caused by event X”). These differing approaches may be perceived as more favorable to certain stakeholders but may not necessarily represent a bias in favor of those stakeholders. Physicians who are biased for the defense or the plaintiff are not impartial.

The examiner cannot have been or be involved in the examinee's (valuee's, patient's, claimant's, or plaintiff's) care in the past, present, or future. No physician-patient relationship is created by these evaluations.

M: Medical. An IME involves the essential elements of a medical assessment, including history, examination, and review of relevant records and diagnostic studies. If the examinee is not directly seen and hence no interview or physical examination is performed, the term “independent medical (record or file) review” may be used. Although most evaluations are performed by medical (allopathic or osteopathic) physicians, in some circumstances, they may be performed by a psychologist, neuropsychologist, oral surgeon or other dentist, chiropractor, naturopath, podiatrist, or physical or occupational therapist. Those evaluations share many of the same features outlined herein, but there may also be specialty-specific considerations that are outside the scope of this article.

E: Evaluation (Examination). The purpose of an IME is to evaluate issues relevant to the claim and answer the referring client's questions.

Impartiality, objectivity, and an understanding of both clinical and medicolegal issues are required. In many jurisdictions, the IME report may be considered part of a requesting attorney's work product, and access to the report may initially be restricted to the requesting source. However, if legal issues remain unresolved, the report is usually made available to all parties in the dispute under court rules of discovery. It is then likely to be read by many stakeholders in the claim and should be easily understood by nonmedical personnel.

Research on the reliability of medical evaluations of disability for work is limited and indicates high variation in judgments among assessing professionals. Standardizing the evaluation process could improve reliability; therefore, structured best practice approaches are needed.⁷

Arenas

An IME is an integral part of case and litigation management and is used widely, both in the United States and internationally, by insurers, claims administrators, employers, and attorneys in a variety of arenas. These include automobile casualty, workers' compensation, personal injury, medical malpractice, and long-term disability, as illustrated in Figure 1.

FIGURE 1. Independent Medical Evaluation Areas

<ul style="list-style-type: none"> • Automobile casualty • Personal injury (civil litigation) • Workers' compensation <ul style="list-style-type: none"> ○ State <ul style="list-style-type: none"> ▪ Example: California: Agreed Medical Evaluation and Qualified Medical Evaluation ○ Federal–Office of Workers Compensation Program <ul style="list-style-type: none"> ▪ Federal Employee's Compensation ▪ Energy Employees' Occupational Injury Compensation ▪ Longshore and Harbor Workers' Compensation ▪ Division of Coal Mine Workers' Compensation • Disability <ul style="list-style-type: none"> ○ Long term ○ Short term ○ Social Security ○ Retirement disability • Railroad • Medical malpractice
--

The arena is determined by the contractual or regulatory context of the subject case and by jurisdiction, for example, state or provincial, or federal. The context determines specific standards for the evaluation, the types of issues addressed, and the report. For example, causation is often important in workers' compensation, personal injury, and automobile casualty cases but is typically irrelevant in a long-term disability claim. Because of the variability in arenas and the specific requirements of each case, it is impossible to define all requirements of a specific IME report.

IME vs Traditional Clinical Evaluation

An IME has many features in common with a conventional medical evaluation, including taking a history, performing a physical examination, obtaining or reviewing relevant diagnostic studies, and making a diagnosis. However, an IME report differs from conventional medical chart notes and consultation reports in several important ways, as illustrated in Table 1.

TABLE 1. Independent Medical Evaluation vs Conventional Medical Report

ASPECTS (USUAL)	INDEPENDENT MEDICAL EVALUATION	TRADITIONAL CLINICAL EVALUATION
Goal	Case management and evaluation	Clinical care
Physician	Independent	Treating or consulting
Visits, prior or future, with physician	No	Yes, possible
Physician–patient Relationship	No (or limited)	Yes
Visits	One	Multiple possible
Reader	Claims professionals, attorneys, fact finder	Health care providers
History	Comprehensive	Focused on chief complaints
Record review	Detailed	Limited, if at all
Physical examination	Detailed, with documentation of negative, positive and non-physiologic findings; when applicable, compliant with <i>AMA Guides</i> standards	Focused on complaints and diagnoses
Issues	Multiple potential	Clinical assessment, evaluation and treatment
Report	Detailed, written	Concise, often electronic record
Testimony probability	High (depending on arena)	Low

The purpose of an IME is to clarify issues associated with a claim, generally by answering questions submitted by the referral source. By contrast, a conventional medical report is produced by the treating physician, with the primary goals of diagnosis and treatment. The IME is performed by an independent evaluator who has no clinical relationship with the examinee, and its purpose is determined by the arena and specific case requirements. A physician who performs an IME should have no relationship with the examinee apart from the evaluation. Specifically, the examiner should not treat or offer to treat the examinee, have provided treatment in the past, or do so in the future. Ideally, the examiner should not have a close relationship with any of the examinee's health care providers.

The treating physician has a patient advocate role (as is appropriate) and may have little desire or experience to comment on claims issues such as causation, apportionment, disability, impairment, and work ability. As the patient's advocate, the treating physician may be unable to assess these issues without bias.⁸

In an IME there is usually only one opportunity for a history and physical examination. Therefore, the IME needs to include a complete and objective description of the examinee's condition at that time, in the context of prior health, physical and vocational capabilities, and social functioning. In contrast, the treating physician's opinions are typically based on multiple, shorter encounters over time.

The history in an IME is more comprehensive than the conventional history obtained by a treating or consulting physician. It usually includes a detailed history of the mechanism of injury or contributors to an illness, such as type and extent of occupational exposure, types and results of evaluation and treatment rendered since, plus past medical, occupational, and psychosocial histories. The examiner also reviews health care and perhaps administrative records and is usually provided a more complete set of these records than is available to the treating physician. Treating physicians may not have access to any prior medical records and are therefore dependent on the historical information provided by the patient, which frequently contains inaccuracies.

The IME physical examination is a one-time examination. The purpose is to objectively document the examinee's clinical status, confirm the diagnosis, and evaluate the individual's functional status, including documentation of positive, negative, and nonphysiologic findings. According to accepted protocols, specific measurements may be used to provide the basis for impairment ratings. If the jurisdiction uses the *AMA Guides*, these measurements must comply with the standards provided in the applicable edition and section. By contrast, the purpose of a physical examination by a treating or consulting physician is to diagnosis, treat, and/or document the clinical course over time.

There are often several, sometimes multiple, issues to be addressed in an IME; whereas the evaluation by a treating or consulting physician usually ends with diagnoses and treatment recommendations. The IME report often answers specific questions posed by the referring source.

Referring sources for IMEs include insurers, employers, attorneys, and others involved in case management. Since the individuals who read these reports are usually not in the medical field, the language must be understandable to a lay reader. This means the examiner should avoid or define eponyms and abbreviations. IME reports must be well organized, clear, and precisely written.

Depending on the arena and jurisdiction, IME physicians will likely need to defend their opinions in deposition or testimony.

Examiners must understand concepts and terminology that are encountered with IMEs but typically not in clinical care.⁹ Section 2.5, Concepts Important to the Independent Medical Examiner (6th ed, 25–27), provides useful insights, including legal vs medical possibility and probability, causation and apportionment analysis, maximum medical improvement, permanency, and cultural differences. The IME report must include specific terminology that is appropriate for the applicable jurisdiction.¹⁰ For example, while

the *AMA Guides* refers to maximum medical improvement, synonymous phrases including “fixed and stable,” “maximum cure,” “medically stable,” “permanent and stationary,” and “stable and ratable” are used in various jurisdictions. In summary, IMEs and the reports thereof are distinct from conventional medical evaluations and records in how they are requested, performed, reported, and used.

No or Limited Physician–Patient Relationship

With a physician–patient relationship, the physician is legally obligated to act in the best interests of his or her patient and is held to a standard of medical care defined by the accepted standards of practice. In such a fiduciary relationship, mutual trust and confidence are essential. In most jurisdictions, performance of an IME does not result in a physician–patient relationship. However, in some states there are assertions that a limited relationship exists, and there is a duty to avoid harm.¹¹ In the evaluator–examinee relationship, challenging and controversial issues may arise, including the duty of care, disclosure of important medical findings, and the right of the examinee to access the report.^{12, 13, 14}

The *AMA Principles of Medical Ethics* states in Section 1.2.6, Work-Related and Independent Medical Examinations, that¹⁵

Physicians who are employed by businesses or insurance companies, or who provide medical examinations within their realm of specialty as independent contractors, to assess individuals' health or disability face a conflict of duties. They have responsibilities both to the patient and to the employer or third party. Such industry-employed physicians or independent medical examiners establish limited patient-physician relationships. Their relationships with patients are confined to the isolated examination; they do not monitor patients' health over time, treat them, or carry out many other duties fulfilled by physicians in the traditional fiduciary role.

In keeping with their core obligations as medical professionals, physicians who practice as industry employed physicians or independent medical examiners should:

- (a) Disclose the nature of the relationship with the employer or third party and that the physician is acting as an agent of the employer or third party before gathering health information from the patient.
- (b) Explain that the physician's role in this context is to assess the patient's health or disability independently and objectively. The physician should further explain the differences between this practice and the traditional fiduciary role of a physician.

(c) Protect patients' personal health information in keeping with professional standards of confidentiality.

(d) Inform the patient about important incidental findings the physician discovers during the examination. When appropriate, the physician should suggest the patient seek care from a qualified physician.

Examiner Qualifications

Required qualifications for an IME provider vary by arena, jurisdiction, and issues. A summary is provided in Figure 2.

FIGURE 2. Examiner Qualifications

- Professional licensure: full and unrestricted
- Physicians board-certified by a specialty board recognized by the American Board of Medical Specialties
- Special credentials in performing IMEs and, as applicable, impairment rating
- Report-writing skills
- Deposition and testimony skills
- No adverse history of events that would compromise the ability to perform an IME

Abbreviation: IME, independent medical evaluation.

The requirements to perform an impairment rating may differ from requirements to perform an IME that focuses on other issues.

The Sixth Edition states, in Section 2.3a, Who Performs Impairment Ratings?, that

Impairment evaluation requires medical knowledge; therefore, mostly doctors who are qualified in allopathic or osteopathic medicine or chiropractic medicine use the *Guides* to evaluate permanent impairment. For the purpose of determining impairment, the appropriate health regulatory agency in a given jurisdiction is the best-suited authority to determine the definition of doctor in regard to who uses the *Guides* to rate impairment in that jurisdiction. (6th ed, 24)

2-1, Fundamental Principles of the *Guides*, explains in that

Rule 6. Impairment evaluation requires medical knowledge. Physicians duly recognized by an appropriate jurisdiction should perform such assessments within their applicable scope of practice and field of expertise.

Rule 8. The evaluating physician must use knowledge, skill, and ability generally accepted by the medical scientific community when evaluating an individual, to arrive at the correct impairment rating according to the *Guides*. (6th ed, 20)

The Fifth Edition specifies in Section 2.2, Who Performs Impairment Evaluation, that impairment evaluations are performed by a licensed physician that

A state may restrict the type of practitioner allowed to perform an impairment evaluation, and some require additional state certification and other criteria, such as a minimum number of hours of practice, before the physician is approved as an impairment evaluator. (5th ed, 18)

Several factors need to be considered in determining who is the most appropriate person to perform an IME. The weight given to these factors is also dependent on the case. For example, if the issue is whether a patient should have a specific surgical procedure, it would be appropriate to have the person examined by a physician who has significant clinical experience in treating that condition. If the issue is a complex impairment rating, it would be most appropriate to involve someone who is highly skilled in use of the *AMA Guides*.

Professional Licensure

If the examination is medical in nature, it should be performed by an allopathic or osteopathic physician with a full and unrestricted license to practice medicine. There should be no current adverse actions that would impede on professional licensure status, eg, probation, monitoring, restrictions, and/or sanctions. Depending on the arena and jurisdiction, licensure in the state where the examinee is seen and/or the principal jurisdiction of the case may be required.

In some cases, other practitioners such as a psychologist, chiropractor, or dentist may produce a report and examination. However, if the examiner is not a medical doctor or a doctor of osteopathy, the report should be clearly labeled with this information (eg, “independent psychological examination,” “independent chiropractic examination,” “independent dental examination”). Less commonly, other health care providers such as podiatrists, naturopaths, or physical therapists and sometimes other professionals, eg, life care planners and vocational rehabilitation specialists, are asked to perform an independent evaluation.

Professional Qualifications and Certification

IME physicians should have qualifications in both of the following:

- Medical knowledge and/or training in the specific area or areas pertinent to the subject case and
- Experience, training, and additional credentials in performing independent medical examination per se.

Experience and qualifications in only 1 of these 2 areas are insufficient for producing a quality report.

Physicians must perform assessments within their applicable scope of practice and field of expertise. The

scope may be narrow, eg, a complex visual problem would be most appropriately evaluated by an ophthalmologist. However, if the clinical problem is a musculoskeletal injury, the physician might be an orthopedic surgeon, physiatrist, neurologist, occupational medicine physician, pain medicine physician, or other practitioner with experience and training in the evaluation and management of musculoskeletal injuries. It is usually not necessary that the examiner be of the same specialty as the treating physician for the problem principally addressed in the IME if the examiner possesses skill, experience, and knowledge in the appropriate medical area. The examiner should consider if the case is out of his or her area of expertise before agreeing to do the examination.

Medical evaluators should be board certified in one of the boards associated with the American Board of Medical Specialties or a board recognized as equivalent in a specific jurisdiction.

Clinical skills are important but not the only skills needed to perform a high-quality IME. Examiners must also demonstrate the ability to perform a quality IME. IME skills are acquired by training and experience. Examiners can obtain a special credential issued by a nationally recognized IME association, eg, the American Board of Independent Medical Examiners or the International Association of Independent Medical Evaluators. If the physician is performing impairment assessments, it is best to be able to demonstrate competency in the use of the *AMA Guides*. Training and certification programs, both live and Web-based, are listed in Figure 3, and recommended readings are listed at the end of this article.

FIGURE 3. Independent Medical Evaluation Training and Certification

Physicians who perform IMEs should consider participating in IME training activities and/or obtaining certification offered by:

- American Academy of Orthopaedic Surgeons (www.aaos.org)
- American Board of Independent Medical Examiners (www.abime.org)
- International Academy of Independent Medical Evaluators (www.iaime.org)

Training on practical aspects of performing IMEs is also provided by:

- SEAK (www.seak.com)

Information about Web-based training on performing IMEs is available at www.imetools.com and impairment at www.impairment.com.

Abbreviation: IME, independent medical evaluation.

IME physicians may not necessarily need to be involved in active clinical care; however, this requirement varies by arena and jurisdiction. If the issues are primarily guidance on clinical care, the physician must have strong clinical skills and be familiar with current evidence-based medicine. Special credentials are desirable but not necessary for an individual who performs IMEs.

Following is a list of potential examiners in order of what may be most desirable to least desirable:

1. Specialist or generalist with expertise and familiarity with the most current medical evidence in the medical area in question; demonstration of previous experience in producing excellent reports; and a special credential;
2. Specialist or generalist with medical expertise in the medical area in question; demonstration of previous experience in producing excellent reports; and training and education in performing IMEs;
3. Specialist in area of problem (“same specialty”); no special credential; and
4. Generalist or not “same specialist” with relevant medical knowledge of the area in question; no special credential.

Those in the first category would appear to be more likely to produce a high-quality IME report. However, no studies have been performed that demonstrate that a physician with a special credential produces a higher-quality report than another physician experienced in performing IMEs who does not have that credential.

Report Writing Skills

Specific skills in IME report writing are also required, including principles and style. Because the report will be read by many and become part of a permanent record, it must be clearly written, logical, understandable, and organized. A well-written report should reflect the quality of the evaluation.

Testimony Skills

If required, the skilled evaluator must be able to support written opinions and conclusions in deposition or testimony, which may be required as the case progresses. The expert should have a general understanding of the legal system, including the nature of discovery and discovery depositions, and be skilled as an expert witness, eg, being truthful and responding directly (and typically briefly) to questions asked.

Federal rules of evidence require the expert witness to list all publications authored in the previous 10 years, all other cases during the previous 4 years in which the witness testified as an expert at trial or by deposition, and a

statement of the compensation to be paid for the study and testimony in the case.¹⁶

Standards of Conduct

In addition to the qualifications listed above, it is imperative that the examiner demonstrate the highest possible standards of ethics, objectivity, and impartiality. Personal bias, prejudice, slanting, or partiality are not tolerated. Indications of bias may disqualify the evaluator.

Additional Requirements

The IME physician should not have any contractual relationships with the stakeholders that would reflect conflict of interest and/or interfere with the ability to be independent and unbiased.

Clients who request an evaluation, whether as the direct referral source or an independent medical evaluation company or broker, may also require the following from the potential independent examiner:

- ❑ Malpractice claims history, which includes a review of any past significant malpractice claims, particularly any substantiated claims that involved criminal fraud, sexual misconduct, or gross negligence. These, if present, generally are not acceptable.
- ❑ Malpractice insurance and/or errors and omissions insurance.
- ❑ Disclosure of whether the physician has been convicted of or plead guilty to any violation of any laws relating to the use, manufacturing, distribution, or dispensing of controlled substances or has a personal history of drug addiction and/or treatment for drug or alcohol abuse.
- ❑ Disclosure of convictions or guilty pleas to any criminal offense, misdemeanor (other than minor traffic violations), or felony.
- ❑ Disclosure of being excluded, suspended, or barred from participating in federal or federally assisted programs, eg, Medicare and Medicaid.

In certain cases, clients may perform an expert witness background search, either as a screen or comprehensive analysis, to assess testimonial history, challenge history (based on rules of evidence regarding the admissibility of expert, ie, Daubert and/or Frye standards), and obtain other critical information. These searches are performed by trained attorneys who use large legal research databases, including semiprivate and proprietary databases. Expert witnesses must be aware that testimonial history, transcripts of depositions and testimony, challenge history, disciplinary actions, and other extensive data are permanent and accessible online.

Evaluation Methodology

It is the responsibility of the client who requests the IME to define the scope of the report, ie, the specific issues to be addressed. The examiner must define an evaluation process that will result in a quality report that addresses these issues. The process varies depending on the setting, eg, it is different if a physician sees an examinee directly upon referral from the client vs sees the person while working with an IME company or broker who serves as an interface between the physician and the ultimate client.

Simply, the process is “data in” and “data out.” *Data in* is information specific to the case (obtained from history, medical records, other documents, physical examination, and diagnostic studies) and information used to assess that data (evidence-based medicine, other current science, applicable guidelines). Depending on the arena, jurisdiction, and scope, different data may be required. The data must be correctly analyzed. Data out is the report. It is essential that accurate and appropriate data are used since the quality of the output (the report) is determined by the quality of the input. The computer science and mathematics concept of “GIGO” (garbage in, garbage out) is equally applicable to performing IMEs; flawed or nonsense input data provides nonsensical output. The evaluator must know what data to obtain, how to obtain and analyze the data, and how to produce the report. Successful examiners use best practice approaches that enhance the quality and efficiency of their work.

Preevaluation

Request

The request for services usually is in the form of a cover letter, but requests also can be made via phone, form, or online. It is imperative that the referral specify the requirements relevant to the individual case, including case information (name, date of injury, and context) and specific questions and issues. If this information is not available, the examiner should contact the referring source prior to proceeding with the evaluation.

Appointment and Notification

Upon receiving a request, an appointment is made. The examiner needs to schedule appropriate time for the evaluation, including adequate time to complete needed questionnaires and inventories and conduct the interview and physical examination. The evaluation should be in an appropriate setting (professional office). Since the examinee must be notified, typically IMEs are not scheduled sooner than 2 to 3 weeks in advance of the evaluation. However, with some examiners, scheduling an appointment may take months. The client (requesting source or agency), whether it is a direct referral or via an IME company, is responsible for the appointment notification, which is sent either directly to the examinee or to his/her attorney.

Records and Documents

The client should provide the records and documents at least 2 weeks in advance of the evaluation. It is important to review records before performing an evaluation. *AMA Guides* Section 2.7a, Clinical Evaluation (6th ed, 28), explains that reviewing the records before performing an evaluation enable the examiner to, among other things, do the following:

- ❑ Clarify or at least document inconsistencies, if any, between the history provided by the patient and the history contained in the medical records;
- ❑ Reconcile inconsistencies, if any, between the patient's history during the examination and other previous medical records. It is necessary to clarify historical inconsistencies because several issues, including causation, are primarily determined by the history; and
- ❑ Focus on the portions of the history pertinent to the impairment rating.

Records may be provided as paper copies or in digital format. Historically, examiners have received paper documents; however, today most clients have documents in a digital format (usually .pdf) and simply print them for the examiner. There are advantages to using digital records, including being easy to manage, store, organize, share, and view (especially with use of multiple monitors). Digital documents can be converted to text documents using optical character recognition (OCR). This permits copying and pasting content to reports, searching for key words, and preparing automated indexes. It is essential that the records be secured, including password protection and encryption, as appropriate. If paper records are provided, they can be scanned to create .pdf documents.

Often, records provided to the examiner are poorly organized, and most examiners prefer to read records in chronological order. This may be done internally or externally (if digital records are provided); an evaluator may consider use of vendors who can sort, organize, and remove duplicate documents. If a document management firm is used, it is important to assess security and infrastructure, US registration, disaster and business recovery, experience, size, turnaround time, and pricing. Services range from indexing records (ie, organizing and providing .pdf records in chronological order), preparing a chronological listing of the documents (in MS Word), and listing records by source to preparing detailed medical chronologies and summaries (typically performed by a nurse or physician). Examiners may prepare their own medical chronology and summary; others may have their office staff perform this task. Regardless of the approach, the examining physician must personally read all records and documents provided and assume full responsibility for the report's content. If someone else prepares the chronology, the examining physician must ensure that the content provided is accurate

and inclusive. It is important to document in the report any outside services or individuals involved in the report generation.

The conventional method for reviewing written records has been for the reviewer to manually read the written records, dictate a summary, and have the summary transcribed. However, unless done carefully, inaccuracies or paraphrasing may change the meaning of the original records. One electronic method that can be used to avoid this is to perform OCR of the records, organized by date, and insert the appropriate text verbatim into the IME report. Indenting and using a different font for direct quotes helps the reader identify a verbatim quote vs the examiner's summary.

Forms and Templates

Most evaluators use forms and templates to ensure uniformity and a quality, efficient evaluation. Forms include engagement letters, examinee notification letters with instructions (if the examiner is notifying the examinee or to be provided via the client), consent forms, questionnaires, inventories, checklists, and satisfaction surveys.

The use of report templates has become an integral and necessary part of IME evaluations and report writing. Templates provide an organizational structure for the report and may ensure that the examiner does not omit critical information. Prior to the evaluation, some examiners customize an applicable template that includes the medical chronology (based on the record review) and use this to facilitate performance of the IME. Appropriate use of technological tools can help to ensure quality, uniformity, completeness, accuracy, and efficiency; therefore, rationale use of new technology is encouraged.

Evaluation

The evaluation process must be thoughtful and thorough. Dignity and respect for all involved is essential, particularly for the examinee who may be apprehensive about the IME and unsure about the role of the evaluator.

Specific standards for impairment evaluations are provided in the Sixth Edition in Section 2.7a, Clinical Evaluation (6th ed, 28), and in the Fifth Edition in Section 2.7a, Clinical Evaluation (5th ed, 21-22). Principles of assessment are provided at the beginning of each chapter, focusing on the assessment of organ system or regional impairment.

Informed Consent

Before beginning the examination, it is imperative that the physician explain to the examinee the purpose of the examination, who is requesting the examination, and where the report will be sent. The examiner must explain that there is no physician-patient relationship involved, the evaluation is not a comprehensive medical evaluation, the examinee must advise the examiner immediately if any problems are encountered during the evaluation, and a report will be

provided to the requesting client. Unless jurisdictionally not permitted, written informed consent should be obtained before proceeding with the examination.

Questionnaires and Inventories

Many physicians use questionnaires, inventories, and pain drawings; however, these may not be allowed in all jurisdictions or may be specifically excluded by the examinee's attorney. Questionnaires may be used to obtain a complete history, including of the subject injury or illness, preexisting status, clinical course, past medical history, review of systems, family history, personal and social history, and occupational history. Inventories assist in understanding activities of daily living and behavioral, psychological, and disability factors. Along with the Sixth Edition, use of a Pain Disability Questionnaire (PDQ), *QuickDASH* (for upper extremity problems), and the American Academy of Orthopaedic Surgery's lower limb questionnaire (for lower extremity problems) is recommended. If a pain drawing is used, it should be attached or included in the report.

Ground Rules

Ground rules about who may participate in the evaluation and recording must be explained. The requesting agency also should be informed of these ground rules in writing and in advance, and they should forward them to the examinee. In certain jurisdictions, there may be additional judicial rules or statutes regarding audio or videotaping and who may attend the examination.

Participants

Physicians should use their own customary procedures when taking the history and performing the physical examination. Typically, the only people who are present during the examination are the examinee, the examiner, and, as needed, a chaperone of the appropriate gender. Provisions must be made for appropriate draping as required for modesty.

Among those generally excluded from the examination are family members, legal representatives, other health care professionals, and other representatives of the examinee. There are exceptions to this rule, such as when a translator is needed (only professional translators should be used) or the jurisdiction stipulates or allows the examinee to have a representative present. In some cases, an immediate family member, such as husband, wife, sister, or brother, may be appropriate. It should be clearly explained that if other people are present, they should not contribute to the history (or interfere with the evaluation) in any way.

Recording

The use of any recording devices, audio and/or video, by the examinee typically is prohibited; however, this may vary dependent on the type of examination and the jurisdiction. At times, a court order requires recording of the examination.

History

The physician performs the interview; however, others may obtain a preliminary history. The physician asks questions and documents the examinee's responses. The examiner should be thoughtful and curious in understanding the history and the examinee's perspective, rather than being limited by preconceived biases. Whenever possible, the exact words used by the examinee should be quoted. The history must be thorough and systematic and should use neutral and professional language. The use of pejorative terms and editorializing when documenting subjective complaints and other portions of the history are inappropriate.

The premise that examinee reports are accurate has repeatedly failed scientific testing.¹⁷ Studies have demonstrated that in addition to exaggerating their preexisting health status, claimants tend to minimize their current health status, ie, they tend to report that they are better than they were prior to an injury and to overreport symptoms and functional difficulties after the injury. Some examinees are "coached" prior to their evaluation by their attorney. The IME physician should be aware of this potential symptom bias when taking the examinee's history. Examiners should always base their opinions on their physical examinations and clinical assessments.

In obtaining the history and analyzing a case, the IME physician must understand the critical importance of psychosocial issues and/or comorbid psychiatric conditions. Scientific knowledge clearly indicates that psychological and social factors commonly play a more significant role than the direct/primary physical effects of the condition in the development of chronic pain; therefore, the evaluator must consider these factors. Subjective complaints are reinforced by the context of litigation, and scientific findings have indicated that eligibility for compensation is a risk factor for chronic pain claims.¹⁸ Adverse childhood experiences (ACEs)¹⁹ and personality disorders have also been identified as significant risk factors for aggravated symptoms and delayed recovery.^{20, 21, 22, 23}

Physical Examination

The physical examination commences as soon as the evaluator sees the examinee, including observations of pain behaviors, movements, and consistency.

Most physical examination sections include documentation on the following:

- General appearance, behavior;
- Formal and informal observations of the examinee, description of correlation or lack of correlation with other physical findings;
- Who was present, eg, chaperone, translator, or other participants;
- Appearance, grooming, and nutrition;

- ❑ Observations about examinee’s affect, attitude, cooperation, and mental status;
- ❑ Objective observations of behavior or statements that the examiner believes relevant to reliability and/or credibility of the examinee;
- ❑ Pain behavior and/or reported comfort or discomfort levels;
- ❑ Use of assistive devices or braces;
- ❑ Vital signs and/or weight, as appropriate; and
- ❑ Detailed clinical examination findings, including all pertinent positive, negative, and nonorganic findings.

Observations must be thoroughly and consistently documented.

If an impairment rating is being performed, the physical findings must be documented in a manner that is consistent with the requirements of the applicable edition of the AMA Guides or other impairment rating guide used in the jurisdiction. Findings must be documented in a manner that allows the reader to easily make comparisons between appropriate tables and figures listed in the applicable impairment guide. Measurements should be documented as carefully as possible but should not be presented in a manner that suggests a level of precision that is not possible to obtain in clinical physical examination (eg, joint motion cannot be reliably measured to single degrees and should be mathematically rounded off). The examiner also should refer to normal variability of measurements and consistency.

The Sixth Edition, in Section 2.7a, Clinical Evaluation (6th ed, 28), provides the following guidance:

The physical examination should be performed in a manner and setting that facilitates the effective communication between the patient and the examiner, thereby decreasing anxiety and increasing concentration and effort. If the examiner believes the patient may be giving an inconsistent effort during the physical examination, the patient should be encouraged to give a full effort. For extremity impairment evaluations, findings should be documented bilaterally; if the contralateral extremity is uninjured, this may serve as the baseline for defining “normal” for the impaired extremity. The results of specific measurements must be reproducible to be valid. Review of all available diagnostic studies and laboratory data is critical in this step.

It is also appropriate to measure passive range of motion. This cannot be used to establish impairment; however, it may be useful if active motion appears nonphysiologically inhibited.

Although no physician–patient relationship exists in the IME process, if a not previously documented

health-threatening condition is discovered during the examination, the examiner should bring this information to the examinee’s attention, instruct him or her to seek appropriate medical care, and document accordingly.

Diagnostic Studies

Available diagnostic studies should be reviewed, and the evaluator should limit analysis to those areas where the evaluator is competent.

Concluding the Visit

At the end of the visit, the examinee should be asked if he or she wishes to make any additions or corrections to information provided and recorded previously. Depending on the jurisdiction, the examinee is not provided any medical opinions or the results of the IME. It is reasonable to have the examinee complete a satisfaction survey, but this may not be allowed or wise depending on the nature of the case and the jurisdiction. Where permitted, this information can be used for quality improvement and risk management.

Post-Evaluation

The report should be completed as soon as possible after the evaluation; a reasonable timeframe is within 5 to 10 working days. Report delays make case management more difficult and reduce the value of the report. There are situations in which the referral source may not want a written report until they have communicated verbally with the examiner.

The report must be complete, well organized, and professional in appearance. In preparing the report, the author may include standardized discussions; however, these should be specific to the issues related to the case. The examiner needs to ensure, via proofreading and editing, that the document is correct in content, grammar, and style. If speech recognition software is used, it is important to review the report with an eye to misinterpretations of the spoken word. The IME report may be used in court or in other adjudication situations, so it should be written with that mind. It should be clearly written as free from errors as possible, and the opinions should be medically defensible.

The IME is a confidential document. The report should be released only to the requesting agency, unless mandated by judicial authority or other circumstances.

Report Structure

The actual structure of the written report varies from examiner to examiner. It also depends on the arena or context, jurisdiction, and type of examination. Guidance on preparing impairment assessment reports is provided in the Sixth Edition in Section 2.7, Preparing Reports (6th ed, 28), and in the Fifth Edition, Section 2.6, Preparing Reports (5th ed, 21–22). Principles of Assessment are provided at the beginning of each chapter, focusing on the assessment of organ system or regional impairment.

The following is a general outline of the topics that should be covered in a thorough report.

Introductory Information, Descriptive Data

- ❑ Name of examinee with appropriate identifying data;
- ❑ Date of birth;
- ❑ Date of injury;
- ❑ Referring source;
- ❑ Date, time, and location of examination;
- ❑ Purpose of examination (IME, impairment rating, or other);
- ❑ Brief synopsis or executive summary of the report;
- ❑ List of all records reviewed;
- ❑ Hand dominance, right, left, or ambidextrous, if upper extremity evaluation;
- ❑ History source, including reliability; and
- ❑ Time involved in record review, interview, physical examination, and preparation of report.

History

- ❑ History obtained from written records and
- ❑ History obtained from the examinee.

Record Review

- ❑ Record review should be thorough, complete, and accurate.
- ❑ Data sources should be identified, eg, the provider's name and date of service.
- ❑ Verbatim quotes should be used when possible to avoid possible change of meaning when paraphrasing.
- ❑ Intellectual honesty when summarizing records and recording history is essential. Both should be recorded completely and without attempt to color or bias the history. Selective editing that unfairly slants the history negates the value of the report.
- ❑ Comparison of current oral history with that provided previously and recorded in health care or other records should be provided in the opinion/discussion section, not in the history or record review section.
- ❑ It is helpful to start the record review with the date of the current injury and list subsequent data in chronological order.

- ❑ Alternative formats for record review organization are acceptable if they present the history in a clear and nonjudicial manner.
- ❑ It is important to use precise language in relaying information from records. For example, "the examinee did x" is not the same as "the examinee reported x," which in turn differs from "the examinee is noted in the records as having reported x." Be clear in differentiating what is observed, what is reported, and what is noted in the records.

Current Interview (Oral History)

- ❑ Documentation of chief complaint(s) and concerns;
- ❑ Description of how and when the injury/illness occurred (mechanism of injury), if applicable;
- ❑ Preexisting status, including prior injuries, illnesses, litigation, medical conditions, and functional limitations and specifically if the examinee was symptomatic or not before the subject incident. If there were preexisting symptoms similar to those attributed to the current injury or illness, it is mandatory to describe the location, severity, and frequency of those complaints before and after the subject incident and to describe their course over time;
- ❑ Chronologic clinical course, including providers involved, diagnostic studies, treatments and responses thereto, and any change in symptoms and limitations over time. If subsequent injuries, exposures, recurrences, exacerbations, or aggravations occurred, obtain and record a history thereof, specifically documenting to what extent they contributed to the examinee's symptoms and any limitations;
- ❑ Current systems:
 - Pain description, including location and radiation, frequency and duration, character, severity, and exacerbating and alleviating factors and
 - Other symptoms such as numbness; tingling; weakness; and bladder, bowel, or erectile dysfunction.
- ❑ Description of current functional status, including how the examinee's condition affects activities of daily living, work, sports, hobbies, and social functioning;
- ❑ Occupational history, including any time off work due to the subject injury or illness. Include job

duties relevant to current injury, with comparison of prior and subsequent job activities. Reported occupational duties should be from a written job description, rather than the examinee's report, whenever possible;

- ❑ Past medical history, including previous medical conditions, surgeries, and allergies;
- ❑ Review of systems, especially relevant systems and including psychological;
- ❑ Family history, particularly for relevant disorders;
- ❑ Personal and social history, including activities of a usual day, social setting, substance (alcohol, tobacco, and drug) use, exercise, and diet;

Physical Examination

- ❑ Document findings in a clear, organized manner. s to document range of motion may improve readability.
- ❑ If an impairment rating is required, findings must be documented in a manner consistent with the requirements of the impairment guide being used (commonly the Guides to the Evaluation of Permanent Impairment).

Other Objective Data

- ❑ If radiologic or other imaging studies are reviewed, list the tests and identify the official written interpretation vs that of the examiner.
- ❑ Functional, laboratory, and any other tests should be reviewed and documented.

Discussion

Conclusions must be based on both the facts of the individual case and evidence based medicine, current science, and appropriate guidelines. References to evidence based guidelines or specific medical journal articles should be listed in footnotes or endnotes in the same format as they would appear in a medical journal. If appropriate these references and articles can be appended to the report. The examiner must be mindful in performing the evaluation and coming to conclusions. The rationale for conclusions should be clearly explained and understandable to a non-medical reader.

The opinion section should generally include the following:

Impressions (Diagnoses)

Most evaluators will numerically list diagnoses. It is helpful to identify conditions related to the subject episode and those due to other unrelated causes.

The basis for impressions (diagnoses) should be clearly explained. This includes correlation of all the data, i.e. history, past and current subjective complaints, written records, physical examination, and objective tests (including imaging and laboratory studies). If physical finding or test results are misleading or equivocal, the reason for this should be explained. Inconsistencies in data or history should be discussed. If there is disagreement with another physician's opinions, the reason(s) therefore should be stated. If information necessary to render well-informed or complete opinions is missing, state this.

Comments on Past Medical Treatment

A discussion of appropriateness, reasonableness, and/or medical necessity of prior evaluation and treatment is usually, but not always, required. It is preferable to cite relevant evidence-based guidelines such as the Occupational Medicine Practice Guidelines published by the American College of Occupational and Environmental Medicine (ACOEM),²⁴ guidelines published by the American Academy of Orthopedic Surgeons,²⁵ state-specific guidelines (eg, Colorado Division of Workers Compensation Treatment Guidelines²⁶), and/or other professionally developed guidelines, most of which are available from the National Guideline Clearinghouse (Agency for Healthcare Research and Quality).²⁷ Other largely consensus guidelines may also be useful such as the Official Disability Guidelines (ODG) Evidence-Based Treatment Guidelines²⁸ published by the Work Loss Data Institute, rather than simply the examiner's personal opinion. If standards are not available, a discussion of common local practice is still preferable to the examiner's personal opinion.

Comments on Future Medical Treatment

A discussion of recommendations for further evaluation and/or treatment supported by evidence-based guidelines and what is customarily done in similar cases may be appropriate. It should be clearly explained, in neutral language, that the examiner's opinions are advisory in nature only, are not meant to constitute a physician patient relationship, and that additional testing and/or treatment must be ordered or done by the attending physician.

Prognosis

General comments about prognosis may be appropriate based both on the diagnoses and other factors such as comorbidities that may be present.

Causation and Apportionment.

Causation and apportionment are often critical issues. The evaluator may be asked to determine if the problem, whether a symptom, finding, impairment, and/or disability was preexisting, caused or worsened by the subject injury or illness, and/or worsened by a subsequent occurrence. If there was worsening of a preexisting condition it is often necessary to determine if the worsening was temporary (an exacerbation) or permanent (an aggravation). Multiple factors, including occupational and non-occupational, may contribute to the development of a clinical problem. Legal standards for causation may differ from medical standards and vary by jurisdiction. Causation analysis must be based on the facts and current science and fully explained in the report.

The *AMA Guides to the Evaluation of Disease and Injury Causation* provides guidance on causation and apportionment analysis including understanding work-relatedness, methodology, and causality examination and includes chapters that deal with specific body regions.²⁹

Causality requires determination that each of the following has occurred to a reasonable degree of medical certainty:

- A causal event took place.
- The patient experiencing the event has a condition (injury or illness).
- The event could cause the condition.
- The event caused or medically contributed to the condition within medical probability.

The evaluator must be able to distinguish between an aggravation and exacerbation. Some jurisdictions use these as two distinct terms, with definitions consistent with the Glossary of the *AMA Guides*, while others use these terms interchangeably. An aggravation occurs when an event or injury causes permanent worsening, hastening, or deterioration of a preexisting condition. An exacerbation is a temporary increase in the symptomatology of a pre-existing condition; in some jurisdictions, this is referred to as a temporary aggravation. To avoid potential confusion, the IME report should define and use exacerbation and aggravation as in the *AMA Guides*, even if the jurisdiction treats these terms as synonyms, or explain, in the report, exactly what is meant (ie, Mr. X had a temporary worsening of his pre-existing condition, which returned to his baseline status in 4 months).

Apportionment

Medical apportionment is an estimate of the extent to which 2 or more probable factors caused an injury or disease. The reasoning for apportionment must be carefully explained. A list of all factors considered by the examiner when addressing the apportionment issue should be

documented. The actual methodology for apportionment varies widely, depending on jurisdiction and arena. In some jurisdictions apportionment does not occur legally, and thus this section may not be present in some reports.

Maximum Medical Improvement

If appropriate, a comment on maximum medical improvement and when this occurred should be made. As mentioned, synonyms specific to certain jurisdictions include fixed and stable, permanent and stationary, and stable and ratable.

Impairment

If impairment is rated, the explanation must be exact with specific reference to objectively measurable criteria. Findings should be correlated accurately with the appropriate rating guide, including citation of the relevant page numbers, table numbers, and methodology. Absolute precision in utilizing the appropriate rating guide is essential. With the *AMA Guides*, it is essential to follow the procedures defined in the Sixth Edition in Chapter 1, Conceptual Foundations and Philosophy and in Chapter 2, Practical Applications; in the Fifth Edition in Chapter 1, Philosophy, Purpose, and Appropriate Use of the Guides and in Chapter 2, Practical Application of the Guides, and the applicable chapters.

Work Ability and Functional Status

Work ability is defined by consideration by of the following 3 factors: risk, capacity, and tolerance.³⁰ The IME physician needs to assess each factor when discussing work ability and explain the rationale in the report. Risk refers to the chance of harm to the examinee, co-workers, or the public if the examinee engages in specific work activities. Substantial harm means objective worsening of the examinee's condition, not merely an increase in previously present symptoms such as pain or fatigue. Thus, risk addresses what the examinee can do but should not do because of risk, commonly described as "restrictions." Capacity refers to concepts such as strength, flexibility, and endurance. These are measurable with a fair degree of scientific precision. Current capacity may increase with exercise or the passage of time. Capacity addresses what the examinee can and is not objectively capable of doing (e.g. cannot reach the overhead control button for a press due to limited shoulder motion). Tolerance is a psychophysiological concept that refers to the ability to tolerate sustained work or activity at a given level. Symptoms such as pain and/or fatigue are what limit the ability to do the task(s) in question. Tolerance is dependent on the rewards available for doing the activity in question. Tolerance is the basis for the examinee to choose if he or she will doing an activity for the rewards available (typically rate of pay; nonmonetary rewards from work, such as recognition or sense of accomplishment; or social interaction).

Answers to Specific Questions

Usually, the requesting agency asks specific questions. The verbatim questions should be restated, and direct answers should be included.

References

In some reports, references to published literature are appropriate. However, it is essential that intellectual honesty be paramount in citing a fair and balanced view of the literature. Individual references should not be selected to unfairly support a one-sided opinion.

Disclosures and Signature

IME physicians commonly provide disclosures at the beginning or end of their reports, including statements such as:

The above analysis is based on the available information at this time, including the history given by the examinee, the medical records and tests provided, the results of pain status inventories, and the physical findings. It is assumed that the information provided to me is correct. If more information becomes available later, an additional report may be requested. Such information may or may not change the opinions rendered in this evaluation.

Comments on appropriateness of care are professional opinions based on the specifics of the case and should not be generalized nor necessarily be considered supportive or critical of the involved providers or disciplines.

Any medical recommendations offered are provided as guidance and not as medical orders. The opinions expressed do not constitute per se a recommendation that specific claims or administrative action be made or enforced.

Physicians may provide, and jurisdictions may require, other disclosures.

The evaluating physician must always read and sign the final report.

Quality Assurance

Assuring the quality of an IME report maximizes its value to all parties. The examiner bears the primary responsibility for the quality of the IME report. However, the requesting agency also can assist in improving quality by providing a constructive review process and feedback to the examiner. Therefore, a methodology for quality review is helpful to all parties.

The following basic questions are helpful in ensuring the quality of the IME report:

- Is it well organized and written in a clear manner for a non-medical reader?
- Does it address the specific questions asked, with supporting conclusions?
- Is the report's length and detail consistent with the complexity of the case?
- Does the report provide the information needed by the requesting agency?
- Is the report presented in a fair, unbiased, and impartial manner?
- If an impairment rating is required, does the report comply with the appropriate rating guide?

Figure 4 is a checklist that can be used within a practice or by others who assess the quality of a report. Although use of the basic methodology listed above provides a good starting point, it also is useful to perform a more sophisticated analysis of quality. If the requesting agency has an in-house system for IME quality assurance review, the system can provide a method for feedback to the examiner, as well as a constructive comparison to other examiners. If the requesting agency does not have the resources available in-house for an IME quality assurance program, an alternative would be to use an outside party with special expertise in the area.

Feedback is helpful to both the examiner and the requesting agency. It helps the examiner continue to improve the quality of the report and service and it helps the requesting agency evaluate the effectiveness of the report. It also can assist in better case management. The thoughtful use of modern technology, when judiciously applied, can aid in this process.

In the workers' compensation arena, there is a national trend toward the use of evidence-based guidelines for treatment, as well the traditional use of guidelines in impairment rating. The examiner is often asked about the appropriateness of past treatment. It is strongly recommended that examiners, along with all individuals involved in the claims process, attend training courses in the use of treatment and impairment guidelines in states where they are mandated.

A quality IME serves all parties. Quality assurance is an essential component of the IME process.

Summary

The evaluation of issues encountered with an IME is often complex and multifaceted. Quality IME reports are the result of thoughtful, thorough evaluations performed by physicians who have knowledge, skills, and experience in both clinical medicine and the assessment of medicolegal issues. The evaluator must always maintain impartiality and provide conclusions that are supportable. A thoughtful and thorough evaluation is of considerable value to all involved.

FIGURE 4. Independent Medical Evaluation Checklist

ITEM	YES	NO	NOT APPLICABLE
DESCRIPTIVE DATA			
Examinee name			
Examinee identification number			
Examinee birth date			
Evaluation date			
Examiner name			
Examiner specialty			
Location of examination			
Referral source (client)			
MEDICAL RECORD REVIEW			
Organized by date			
Content provided			
Summary and interpretation			
Analytical comment on the quality and accuracy of the prior records			
BACKGROUND INFORMATION			
Age (years)			
Hand dominance (right, left, ambidextrous)			
Purpose and context of examination			
Informed consent provided (verbal, written, signed)			
Examiner identified herself or himself			
Examinee identity verified (identification card, photo)			
Others accompanying examinee (if any) and their role, behavior			
Quality of history provided by examinee			
Consistency of examinee as historian (consistency with other documentation)			
Credibility of examinee			
Cooperation level (during entire evaluation process)			
Chaperone during examination, if any (as appropriate)			
No adverse consequences (problems reported during examination)			
Time spent (with examinee and entire process)			
Other participants in evaluation and report preparation, if any (record reviewers, interviewers, writers)			
Record reviewed (listing of providers and dates)			
Radiographic and diagnostic studies reviewed, if any (listing of studies and dates)			
Other information reviewed, if any (eg, job analyses, correspondence, transcripts)			
Missing information, if any (listing of providers and dates)			
HISTORY			
PREEXISTING STATUS			
Prior injuries or claims, if any (including work related, automobile, liability, disability, recreational, and athletic)			
-Event (type and problems)			
-Clinical (clinical chronology from event to current)			

-Functional (interference with activities of daily living)			
-Impairment, if any (documented, methodology used)			
-Disability, if any (duration and extent)			
-Legal/claims, if any (legal representation, litigation, settlement)			
Prior traumatic episodes, if any (physical, psychosocial, psychological from childhood to present)			
Prior similar problems, if any (not limited to prior injuries or claims)			
-Clinical (clinical chronology from event to current)			
-Functional (interference with activities of daily living)			
Prior chiropractic care, if any (providers, regions involved, outcomes, duration, frequency, date of most recent visit)			
INJURY			
Type (acute, recurrence, exacerbation, aggravation, gradual onset)			
Mechanism (forces involved)			
Symptoms (at that time)			
Initial medical events (emergency care dates, providers, signs, studies, diagnoses, and treatments)			
Signs (objective findings at that time)			
Consistency of reports (initial documentation, reports by other examiners, report by examinee)			
CLINICAL CHRONOLOGY			
Clinical history from onset to current			
Providers (physicians, chiropractic, psychologists, therapists)			
Diagnostic studies (results, clinical significance)			
Treatments (modalities, durations, and results)			
CURRENT STATUS			
Chief complaint			
Perception of problem			
Pain			
-Location			
-Description			
-Aggravating factors			
-Relieving factors			
-Severity (numeric [0 = no pain to 10 = excruciating], current, past month: average, low, and high)			
Symptoms			
-Description			
-Aggravating factors			
-Relieving factors			
-Severity			
PSYCHOSOCIAL HISTORY			
Childhood (eg, normal, dysfunctional, abuse)			
Marital status			
Household structure and accessibility issues			
Living arrangements			
Activities of daily living			
Recreational pursuits			
Exercise regimen			

Diet			
Tobacco usage (past and present)			
Illicit drug usage (past and present)			
Marijuana usage (past and present)			
Alcohol usage (past and present)			
OCCUPATIONAL HISTORY			
Job at injury			
-Employer			
-Title and role			
-Length of employment			
-Functional demands			
-Job satisfaction			
Interval employment status			
-Partial or total disability			
Current employment status			
-Employer			
-Title and role			
-Functional restrictions			
-Functional demands			
Previous employment (prior to injury)			
Educational background			
Functional restrictions (date, provider imposing restrictions, functional capacity evaluations, if any)			
PAST MEDICAL HISTORY			
Medical			
Surgical			
Psychiatric			
Accidents (automobile, work-related, other)			
Medications (including dosage and frequency)			
Allergies			
FAMILY HISTORY			
Disease			
Disability			
REVIEW OF SYSTEMS			
Other health problems			
PHYSICAL EXAMINATION			
Height, weight			
Vital signs			
Observations			
General appearance			
Behavioral			
Structural			
Negative findings			
Positive findings (quantitative when feasible)			
Nonphysiologic findings			
Consistent with required assessment as defined in the <i>AMA Guides</i>			
PAIN, BEHAVIORAL, AND PSYCHOLOGICAL INVENTORIES			
Pain drawing			
Pain inventories			
Disability inventories			
Personality inventories			
Depression/anxiety inventories			
RADIOGRAPHIC STUDIES			
Description of actual studies reviewed			
Description of reports reviewed			
Consistency of findings			

ISSUES			
Questions asked by the client are fully answered by the evaluator, with supportable conclusions			
DIAGNOSES			
Problem list			
Discussion of clinical and functional relevancy			
Discussion of relationship to an injury			
Opinion consistent with facts in the case and medical logic/probability			
CAUSATION			
Causation based on having a medically probable cause, effect, and relationship between cause and effect			
Consistent with facts in the case and evidence-based data (science)			
PROGNOSIS			
Outlook based on facts in the case and evidence-based data (science)			
MAXIMUM MEDICAL IMPROVEMENT			
Determination of permanent and stationary status based on facts in the case, what is medically probable, and evidence-based data (science)			
PERMANENT IMPAIRMENT			
Discusses how specific findings relate to criteria in the <i>AMA Guides</i>			
Explanation of each impairment value with reference to the applicable criteria (eg, table, figure, and page number)			
Appropriate combining and/or reporting of final impairment			
Apportionment, if applicable, appropriately performed, supported by facts, current science, and jurisdictional rules.			
FUNCTIONAL ABILITIES/WORK CAPACITY			
Consistent with facts in the case, what is medically probable, and evidence-based data (science)			
APPROPRIATENESS OF CARE			
Consistent with facts in the case, what is medically probable, and evidence-based data (science)			
RECOMMENDATIONS			
Consistent with facts in the case, what is medically probable, and evidence-based data (science)			
QUALIFICATIONS			
Examiner's qualifications as applicable to the case			
DISCLOSURES			
Analysis based on available information			
Recommendations offered as guidance not as medical orders			
Declarations under penalty of perjury (depending on jurisdiction)			
ORIGINAL SIGNATURES			
Physician has personally reviewed and signed report			

Recommended Readings

AMA Guides Publications

- Brigham CR, ed. *AMA Guides Newsletter*. Bi-monthly.
- Kertay L, Eskay-Auerbach M, Hyman M. *AMA Guides to Navigating Disability Benefit Systems*. Chicago: American Medical Association; 2016.
- Melhorn M, Talmage JB, Ackerman WE, Hyman NH. *Guides to the Evaluation of Disease and Injury Causation*, 2nd ed. Chicago: American Medical Association.
- Rondinelli RD. *Guides to the Evaluation of Permanent Impairment*, 6th ed. Chicago: American Medical Association; 2008. Also the Edition pertinent to your jurisdiction.
- Talmage JB, Melhorn JM, Hyman MH. *AMA Guides to the Evaluation of Work Ability and Return to Work*, 2nd ed. American Medical Association: Chicago; 2011.

Other Recommended Publications

- Babitsky S, Mangraviti JJ, Melhorn JM. *Writing and Defending Your IME Report: The Comprehensive Guides*. Falmouth, MA: SEAK; 2004.
- Brigham CR, Mangraviti J, Babitsky S. *Independent Medical Evaluation Report: A Step by Step Guide with Models*. Falmouth, MA: SEAK; 1997.
- Demeter SL, Andersson GBJ. *Disability Evaluation*, 2nd ed. Chicago: American Medical Association; 2003.
- Gerhardt J, Cocchiarella L, Lea R. *Practical Guide to Range of Motion Assessment*. Chicago: American Medical Association; 2002.
- Mayer TG, Gatchel RJ, Polatin PB, eds. *Occupational Musculoskeletal Disorders: Function, Outcomes & Evidence*. Philadelphia, PA: Lippincott, Williams & Wilkins; 2001.
- Rondinelli RD, Katz RT. *Impairment Rating and Disability Evaluation*. Philadelphia, PA: WB Saunders; 2000.

References

1. Oxford Dictionary, <https://en.oxforddictionaries.com/definition/standard>. Accessed Sept. 29, 2017.
2. Brigham CR, Ensalada LH. Perfecting the IME process. *Guides Newsletter*. September–October 2000 and March–April 2001.
3. Brigham CR. Independent medical evaluation report standards. *Guides Newsletter*. September–October 2002.
4. Nierenberg C, Brigham CR, Drenfeld LK, Burket C. Standards for independent medical examinations. *Guides Newsletter*. November–December 2005.
5. Feinberg SD, Brigham CR, Ensalada L. Assessing impairment and disability in the pain patient. *Guides Newsletter*. January–February 2016.
6. Christian J, Siktberg D, Brigham CR, Brooks CN. Independent medical evaluations: the client perspective. *Guides Newsletter*. July–August 2002.
7. Barth J, de Boer W, Busse J, et al. Inter-rater agreement in evaluation of disability: systematic review of reproducibility studies. *BMJ*. 2017;356:j14. <http://www.bmj.com/content/356/bmj.j14>.
8. Barth RJ, Brigham CR. Who is in the better position to evaluate, the treating physician or an independent examiner? *Guides Newsletter*. September–October 2005.
9. Lukcsó D, Green-McKenzie J. What are some terms commonly encountered by the physician expert witness? *J Occup Environ Med*. 2010; 52(1):109–110.
10. Somford MP, Nieuwe RA, Sierevelt I, et al. The reliability of orthopaedic eponymous terms. *J Bone Joint Surg Am*. 2017; 99:e70(1–6).
11. <https://www.independentmedicalexamtraining.com/potential-liability-physician-conducting-ime-independent-medical-examination/>. Accessed Oct. 1, 2017.
12. Ebrahim S, Sava H, Kunz R, Busse JW. Ethics and legalities associated with independent medical evaluations. *Can Med Assoc J*. 2014, 186(4):248–249. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3940566/pdf/1860248.pdf>.
13. Baum K. Independent medical examinations: an expanding source of physician liability. *Ann Intern Med*. 2005; 142:974–8.
14. Shane JA. Physician–patient relationships may blur during independent medical examinations. *Orthopedics Today*. 2009; 29:24.
15. <https://www.ama-assn.org/sites/default/files/media-browser/code-of-medical-ethics-chapter-1.pdf>. Accessed Oct. 2, 2017.
16. Federal Rules of Civil Procedure, Title V. Disclosures and Discovery, Rule 26. Duty to Disclose, General Provisions Governing Discovery. https://www.law.cornell.edu/rules/frcp/rule_26. Accessed Oct. 1, 2017.
17. Barth RJ. Examinee-reported history is not a credible basis for clinical or administrative decision making. *Guides Newsletter*. September–October 2009.
18. Barth RJ. Chronic pain: fundamental scientific considerations, specifically for legal claims. *Guides Newsletter*. January–February 2013.
19. <https://www.cdc.gov/violenceprevention/acestudy/index.html>. Accessed Oct. 1, 2017.
20. Dersh J. Prevalence of psychiatric disorders in patients with chronic disabling occupational spinal disorders. *Spine*. 2006; 31(10):1156–1162.
21. Monti DA, Herring CL, Schwartzman RJ, Marchese M. Personality assessment of patients with complex regional pain syndrome type I. *Clin J Pain*. 1998; 14:295–302.
22. Fishbain DA, Goldberg M, Meagher BR, Steele R, Rosomoff H. Male and female chronic pain patients categorized by DSM-III psychiatric diagnostic criteria. *Pain*. 1986; 26(2):181–197.
23. Gatchel RJ, Garofalo JP, Ellis E, Holt C. Major psychological disorders in acute and chronic TMD: an initial examination. *J Am Dent Assoc*. 1996; 127(9):1365–1370, 1372, 1374.
24. <https://www.acoem.org/PracticeGuidelines.aspx>. Accessed Oct. 6, 2017.
25. <https://www.aaos.org/guidelines/?ssopc=1>. Accessed Oct. 6, 2017.
26. <https://www.colorado.gov/pacific/cdle/medical-treatment-guidelines>. Accessed Oct. 6, 2017.
27. <https://www.guideline.gov/>. Accessed Oct. 6, 2017.
28. <http://www.worklossdata.com/treatment-guidelines.html>. Accessed Oct. 6, 2017.
29. Melhorn JM, Talmage JB, Ackerman WE, Hyman MH. *AMA Guides to the Evaluation of Disease and Injury Causation*, 2nd ed. Chicago: American Medical Association; 2014.
30. Talmage JB, Melhorn JM, Hyman MH. *AMA Guides to the Evaluation of Work Ability and Return to Work*. Chicago: American Medical Association; 2011.

Rating Upper Extremity Motion Loss, Comparison to the Opposite Side

James B. Talmage, MD, J. Mark Melhorn, MD, and Christopher R. Brigham, MD

QUESTION: Using the *AMA Guides*, Sixth Edition, how would I rate impairment for motion loss of upper extremity joints when there is also diminished range of motion on the opposite, uninjured side.

A right wrist injury resulted in decreased flexion of 30 degrees vs 50 degrees of the left wrist and decreased extension, also 30 degrees vs 50 degrees on left. Radial and ulnar deviation are normal and equal for both wrists.

In the Sixth Edition, Section 15.7a, Clinical Measurements of Motion, it states that "if the opposite extremity is neither involved nor previously injured, it must be used to define normal for that individual; any losses should be made in comparison to the opposite normal extremity" (page 461).

How should I rate impairment for the right wrist using the opposite, uninjured wrist as normal?

ANSWER: The *AMA Guides*, Sixth Edition, does not provide specific instruction on how to do this, but the Fifth Edition does. In the Fifth Edition, it states that "if a contralateral 'normal' joint has a less than average mobility, the impairment value(s) corresponding to the uninvolved joint can serve as a baseline and are subtracted from the calculated impairment for the involved joint. The rationale for this decision should be explained in the report" (5th ed, 453).

In jurisdictions that use the Fifth Edition, this is easy. Using Table 16-28, Pie Chart of Upper Extremity Motion Due to Lack of Flexion and Extension of Wrist Joint (5th ed, 467), the injured right wrist with 30 degrees of flexion has 5% upper extremity impairment (UEI), with an additional 5% UEI for the extension of 30 degrees. The uninjured left wrist with 50 degrees of flexion has 2% UEI, while the extension of 50

degrees would be an additional 2% UEI. With radial and ulnar deviation being normal in both wrists and with the unstated assumption that pronation and supination are also normal in each wrist/forearm, the total right wrist impairment is 10% UEI, or 6% whole person impairment (WPI); while the total left wrist impairment is 4% UEI, or 2% WPI.

Per instruction IX (5th ed, 512), when both upper extremities are involved, the impairments of each are combined at the whole person level. This implies that the subtraction should also occur at the whole person level. Thus, 6% WPI for the right wrist minus 2% WPI for the left equals a final right wrist impairment of 4% WPI. In jurisdictions that require extremity, not whole person, impairment ratings for injuries or illnesses that involve the limbs, the calculation would be 10% UEI for the right wrist minus 4% UEI for the left, which equals 6% UEI.

In jurisdictions that use the Sixth Edition, apportionment of impairment is more difficult. In Table 15-32, Wrist Range of Motion (6th ed, 473), both 30 and 50 degrees of flexion fall in the Mild or Grade Modifier 1 column and both have the same 3% UEI rating. Similarly, both 30 degrees and 50 degrees of extension have the same 3% UEI rating. The total impairment would be 3% plus 3% equals 6% UEI or 4% WPI, for both right and left wrists. Subtracting the left wrist rating from the right would result in a net right wrist impairment of 0%. However, this rating does not make sense for a wrist that was injured and now has decreased motion. The rationale for including a range of measurements within the same impairment percentage in the Sixth Edition is that variables such as body weight, blood pressure, and range of motion are not the same every day of the year. Additionally, different

examiners may use different techniques when they measure joint motions, so the reliability and reproducibility thereof is only fair. The Sixth Edition has only 4 categories of severity for motion loss in the tables (mild, moderate, severe, and ankylosis), as opposed to 10-degree increments in the Fifth Edition (or 5 degrees in the case of radial and ulnar deviation), making it far more likely that 2 examiners will obtain and report the same motion-derived impairment percentage. The increased likelihood of interrater reliability should decrease controversy, minimize delays in claim resolution, and reduce the administrative costs associated with disputes regarding differing ratings from "dueling doctors."

Hypothetically, if motions of the injured right wrist were worse, with only 20 degrees each of flexion and extension, the right wrist would have 7 plus 7 equals 14% UEI, or 8% WPI, per Table 15-32. Subtracting the 4% WPI for the left wrist would yield a final rating of 4% WPI for the right wrist. This makes more sense than the net 0% rating.

Another option is to rate the wrist injury by diagnosis, which is the preferred method in the Sixth Edition. Depending on the diagnosis and grade modifiers, the final rating may be more or less than the Fifth Edition rating of 4% WPI.

If the diagnosis is not listed in the Sixth Edition, a third option would be to follow the instruction provided in Section 2.5e, Maximum Medical Improvement (6th ed, 26). This instruction states that "in certain instances, the treatment of an illness may result in apparent total remission of the person's signs and symptoms. However, if the examiner concludes that with such permanent treatment based on

(CONTINUED ON PAGE 20)

AMA Plaza

330 N. Wabash Ave., Suite 39300
Chicago, IL 60611-5885

If you perform independent medical evaluations (IMEs) and/or review IME reports (as attorney, claims professional, or fact finder), you will benefit from subscribing to the *AMA Guides Newsletter*. Bimonthly you are provided with essential updates, authoritative guidance, practical information, and rationales for proper use of *AMA Guides* in assessing impairment, causation, work ability, and other important case issues.

For subscription information click [here](#).

(CONTINUED FROM PAGE 19)

objective findings, the patient has actually not regained his or her previous function, and if the *Guides* has not provided specific criteria to rate such impairment, the physician may choose to increase the impairment estimate by a small percentage (eg, 1%–3%). Such a discretionary impairment is provided only once and is not to be duplicative of impairment provided for BOTC [burden of treatment compliance].” One might argue that this instruction is not entirely applicable. Treatment in this case did not result in “total remission of the person’s signs” as the patient still had limited wrist flexion and extension. Presumably the wrist injury, unlike

diabetes mellitus, eg, does not require permanent treatment. Additionally, since active range of motion (that used for impairment rating in the *AMA Guides*) depends on patient effort, it is objective only to the extent motion is demonstrated. Generally, an examiner does not know whether with decreased pain, further effort, or other change the patient could have achieved greater motion. Finally, in this case one is attempting to derive a rating de novo, not increase a rating that underrepresents the patient’s true impairment.

However, assuming the wrist motion losses were reproducible on repeat measurements and consistent

with other objective evidence of wrist pathology, it would be reasonable to conclude that “based on objective findings” the patient has “not regained his or her previous function” and use the approach on page 26 (6th ed). Since the Fifth Edition rating for this injury would be 4% WPI, it would be appropriate to select the 3% WPI from the range of 1%–3% permitted.

Regardless of the approach to impairment rating that is used, the rationale for doing so and the methodology must be explained in the report, thereby increasing the likelihood that the rating will be accepted.