

Submission of Final Research Report

Independent Medical Examinations, a tool of the Rehabilitation Process

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ABSTRACT

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Independent Medical Examinations, a tool of the Rehabilitation Process

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A CONVENIENCE SAMPLE OF INSURANCE ADJUSTERS WAS INTERVIEWED. A NONEXPERIMENTAL SURVEY DESIGN WAS USED IN THIS STUDY. THE OBJECTIVE OF THIS STUDY INCLUDED: THE REVIEW OF LITERATURE RELATING TO THE USE OF INDEPENDENT MEDICAL EXAMINATIONS AND INTERVIEWING INSURANCE ADJUSTERS REGARDING CRITERIA THAT PRECEDES THE REQUEST FOR THE PERFORMANCE OF, THE PURPOSE OF AND USE OF INDEPENDENT MEDICAL EXAMINATIONS. THIS STUDY WAS CONDUCTED TO GAIN INSIGHT INTO VARIOUS CRITERIA THAT ARE USED REGARDING THE USE OF INDEPENDENT MEDICAL EXAMINATIONS. THIS INSIGHT MAY ASSIST IN COST CONTAINMENT, MEDICAL MANAGEMENT, AND AS WELL AS

DECREASING THE NUMBER OF UNNECESSARY INDEPENDENT MEDICAL EXAMINATIONS BEING PERFORMED.

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Chapter 1

Introduction

In the private sector of rehabilitation, the insurance adjuster coordinates the process of returning an injured employee back into the work world. The process starts when an employee is injured on the job. This individual then enters into the medical system where he/she will receive treatment for the injury. This injury can be of the physical or psychological nature. There is a first report of injury filed by the employer and is sent to the insurance company that is handling the worker's compensation claims. The company also assigns an adjuster to the claim who is the main coordinator of the employee process. This coordination involves the medical treatment, wage reimbursement, and the return to the work world (Boynton, 1996).

The process of returning an injured worker back to the work world uses many tools. These tools may involve a rehabilitation specialist who assists the injured with the employment and medical aspects of the rehabilitation. The employer must provide a place back in the work force. Conversely, the medical professionals provide diagnosis and treatment to the worker. The part of the medical team that has the greatest responsibility is the primary care provider of the worker. This person is in full charge of the medical treatment which begins the time of diagnosis of the injury, progresses to referral for treatment of the injury, provides restrictions for the worker, if needed, and at completion of the cycle, deems the worker at Maximal Medical Improvement (Harmon Swihart, 1994).

This process of returning an individual back to the work world happens at different rates. Issues such as severity of the injury and ability of the rehabilitation team to work together toward the proper treatment of the worker and his/her condition are important factors in the smoothness of this transition. The primary physician is responsible for the direction of care. How the physician directs this process is also crucial to the case. Guidelines for this process are provided within the Hippocratic oath.

The Medical Hippocratic oath is the code of ethics that physicians are to follow. Such a code of ethics clearly leaves room for second opinion from another physician if either the patient or primary physician requests such an opinion. In the medical profession, this second opinion can also be known as an Independent Medical Examination (hereafter referred to as an IME).

My interest in the IME started when I was involved in a series of auto accidents. The auto insurance companies requested I have an IME. Because of my nine years in the Physical Therapy profession, I had an extensive knowledge of my injury and was very prepared for this examination. Upon completion, I requested a copy of the report that the doctor issued to the insurance company; I was horrified at the errors that were in the report. Before my injuries, I coached gymnastics, golfed, downhill skied, and ran 3-5 days per week. My report stated, however, that I was currently participating in all these activities, including running 3-5 miles per time. This experience made me question the entire process of an Independent Medical Examination and the

ethics of the physician, lawyers and insurance companies involved in this process.

I had been precise in the answers that I had given them; after all, I was a trained medical professional. What would have happened to an individual who was not as knowledgeable about the medical reasons for each question and the implications of the answers? The physicians had indicated my post injury physical condition was above the norm of the general population; therefore, the insurance companies concluded that their parities were less liable. As I sat with the three attorneys, it became increasingly clear that they felt I had nothing wrong with me. As a result, my experience with the physicians, lawyers, and insurance companies lead to the question of necessity for the IME process.

Perhaps the purpose and function of an IME does not correlate between the medical ethics that hold the physician/patient relationship in the highest regard and the insurance companies use of these results.

Independent Medical Examination or IME

Currently an Independent Medical Examination is a special type of second opinion. It is a formal medical examination that is performed by a board-certified physician of the same specialty in which the patient is currently receiving treatment (Boynton, 1996). A second opinion is requested for many reasons: gaining a diagnosis (for this doctor may be a specialist) or confirming or disputing a previously given diagnosis; confirming or disputing a treatment plan; confirming or disputing physical restrictions; confirming or disputing the need for surgery; and/or releasing the employee to full or light duty or determining permanency.

Regardless of the reason for the IME, the physician must not have any prior knowledge of the patient and must receive all the past medical records, test results, test reports, and films regarding the patient's questioned medical condition. These records must be in the office of the examining physician at least 48 hours prior to the examination. The adjuster and others involved develop a list of questions designed to address specific issues, this list accompanies the medical reports. The examining physician takes the client through a physical examination, generates a report, and sends it to the insurance company for review. Based on this report, the adjuster makes crucial decisions.

These decisions could be to continue benefits as usual, to discontinue benefits, to go forward with advanced treatment such as surgery, to apply for social security benefits, or to pay a settlement or permanency award. These decisions are very crucial to the client and the future of the file. Results of the IME influence the direction that the adjuster is to take on this file. In my IME experience, however, the physician's report was incorrect. Such errors and their impact require investigation.

Statement of the problem

Does the IME actually serve its purpose and function as an examination tool? The purpose of the examination is to clearly present the factual status of the injured patient/client. The functional use of the IME within the insurance process should be ethical, honest and serve the patient/client above all.

Investigation of various companies will disclose the IME and the actual purpose

of the IME use. Therefore, what is the purpose of the performance and the use an Independent Medical Examination?

Chapter 2

A review of the literature

With the questioning of the purpose of the performance and the use of an Independent Medical Examination, a literature review was necessary. This review was completed first in a general search of Independent Medical Examinations (IMEs), then refined to specific areas relating to this topic. These areas were directly related to ethics, reliability, and cost relations within workers' compensation.

Ethics

An independent medical examination must by definition be independent and without bias. Ethics-related based literature questions how the physician can be totally unbiased. However, Boynton (1996) states that it is, "generally acceptable for a physician to be biased toward the insurance carrier to the extent that it appreciates the importance of returning an injured worker to work." A reference is also made to the loyalty felt toward the insurer or attorney who has requested and is *paying* for the service (Kraus, 1997). Even though the Hippocratic oath requires physicians to always consider the best interests of the patients, somehow the IME sways physicians toward the interest of the insurance company. Nevertheless, bias is a result of experiences and perspective and difficult to avoid. It is the responsibility of the physician to prevent these biases from distorting the evaluation of the case; moreover, sound medical judgment may be compromised if a physician is overly biased (Boynton, 1996).

These physicians need to take both the bias that they have and the objective and subjective information that they are provided and process it. They can then answer the question that lead to the initiation of the IME, for there is a significant need for quality IMEs to be done by qualified physicians. Ethics must be a priority.

Ethics of the adjuster and the insurance companies are rarely discussed in the literature. Only one reference is made to the trend of reducing medical utilization for limiting diagnostic testing and specialty physician visits (Kraus,1997). It is the place of the adjuster to decide if a patient should be provided these services. Referrals for services are done by medical professionals. In the state of Iowa, refusal to attend an examination set by the insurance company, will waive the right to any compensation (Swihart, 1994). If it then is a question of the financial factor ruling over the proper care of the patient, this is an ethical dilemma that the medical profession and patients must address.

Reliability

The accuracy of the actual report is one of the most crucial elements of an ethical IME approach. The client may accurately present the physical aspects, adequate and objective testing data may be presented, and the physician may do a thorough and lengthy examination of the case; however, if the report is filled with errors or falsely presented facts, the report is not reliable. Unfortunately, as in my case, this does happen.

Brighman, Babitsky (1986) refer to the increased efficiency and accuracy of the IME report if completed immediately following the evaluation of the patient's narrative history, physical examination and treatment records. The professional literature does make recommendations regarding physician reliability. Kraus (1997) recommends the physician dictate the patient's narrative history in the presence of the patient prior to the physical examination. This procedure would allow the patient to confront the physician regarding any misunderstood information the physician has interpreted. The patient may also provide additional information or explanations as needed at this time. A level of respect between the patient and physician could develop and even increase their cooperation during the physical examination itself (Kraus, 1997).

In addition, Kraus (1997) also recommends the physician should suggest the patient acquire a copy of the report from the referring source. Upon receiving the report copy, the patient can review the report for errors and inaccuracies. Written reports are classified as legally "discoverable," which means that all parties to the case have the legal right to obtain a copy of it (Brigham, Babitsky, 1986). This legal aspect allows the individual to obtain a copy of the report, to review it, and to recognize its content.

The literature also mentions patient reliability. Brigham and Babitsky (1996) state that the physician must take into consideration the medical information and nonmedical issues that are of concern to the client. A patient's behavior during the initial contact with the physician may not correlate with the physician's objective findings regarding this patient. For example, a reliable

patient's injury or disability would correlate with the physician's finds. An unreliable injury or disability would not.

Obviously, the physician and the patient must both be reliable. A good Independent Medical Examination requires a physician's commitment of time and effort; thus, the physician can perform a reliable evaluation and draw conclusions based on factual information and examination findings. Because the physician must provide an unbiased and thorough assessment, the physician must be responsible to patient and to the referring source (Kraus, 1997). It is also the responsibility of the physician to assure that the report addresses the issues and/or answer the questions which gave rise to the request for an IME (Brigham, Babitsky, 1986).

Cost Containment

Reliability extends further into the cost containment issue, as well. Cost of the workers' compensation claims have more than tripled over the past ten years (Perry, 1994); hence, any insurance company demands cost containment. The articles regarding worker compensation and cost containment mainly focus on injury prevention (Perry, 1994, Church, 1995, Myers, 2000, Walker, 1993). Injury prevention would clearly eliminate the need for cost containment; however, injuries do occur. When injuries do occur, the insurance company's main issue is to manage costs of medical expenses and wage replacement.

Gill (1999) discusses the adjusters are used "late in the claim when certain cost levels are reached or when problems arise." Gill also discusses the immediate involvement of the medical personnel, adjuster, and, the employer.

These two factors are important both in the attitude of the client and the direction, development, and cost effectiveness of the medical treatment plan. An IME may also be used as a tool to identify cases that are apt to incur a high cost (Earman, Andersson, 1996). This may enable an adjuster to be aware of possible upcoming testing and surgical interventions.

Numerous techniques seem to positively affect cost containment. Walker (1993) reports that a discount of 10% to 15% for the direction and use of the same medical care provider can be negotiated. This repeat use of a clinical practice may also result in quicker appointments. Similarly, the use of Managed Care also has been responsible for a 10%-40% reduction of the medical costs of the worker's compensation claims ("Managed Care Cuts Workers' Compensation Costs", 1996). Another way to affect cost containment is to have the employer identify light duty jobs available for the employee. Getting the employee back to work decreases the cost of the claim (Myers, 2000). If the employee experiences proper initial diagnosis, proper treatment, and employer's support, there will be less resistance to return to light duty work. Upon the file review of an employee that has failed to return to work within 90 days of the injury, some adjusters automatically schedule an IME (Boynton, 1996). As a result, the insurance company can lose any cost containment effect.

On the other hand, if the employee does not experience a smooth process, he/she will potentially seek legal intervention. Legal intervention may not be the most reliable or most ethical path. For example, there are times when an IME physician finds nothing to support ongoing disability. This may be due to

the successful previous treatment or possibly the patient's unreliability. A reliable and ethical patient should not need legal intervention; a reliable and ethical physician would not precipitate legal intervention. If the patient is ethical and reliable, all of the medical issues are supported; consequently, there would be no need for cost containment. An unreliable patient and/or an unreliable and unethical physician cause insurance companies to discontinue benefits. This does result in cost containment.

The professional literature presents reasons cost containment becomes more important reliability and ethics in IME use. In a study quoted by Earman, Andersson, Leavitt and McNeill (1996) of 157 patients with work-related spine injuries, variables account for 48% of the cost variance: "Surgery accounted for 19.9%, psychological disturbance accounted for 10.5%, litigation accounted for 9.1%, the measure of motor strength and radiographs accounted for 8.4%." The aspect of litigation was present in 72% of the cases. This one aspect incurred an average of \$28,000 greater cost of care. In the 111 cases not involving surgery, the cost of care incurred by an injured worker with a lawyer was \$23,666 greater. Thus, legal participation increased total charges by \$1,703.952. If lawyers involved in nonsurgical cases were reduced by 20%, savings of \$340,804 would occur. The adjusters would then be able to manage care without the legal implications added to the case. Of the total number of cases discussed, 26% had a psychological dimension. 88% of those cases had the litigation component. The psychological aspect of an injury that is initially totally physical is one that greatly concerns the medical profession today. If the physician

diagnosis the psychological component and if the adjuster would accept this component as a viable aspect of the patients condition, more claims would not a delayed resolution. Furthermore, such a diagnosis and acceptance would enhance the chances of recovery, decrease the utilization of medical services, and possibly decrease the use of legal services.

Even though the professional literature thoroughly covers the cost containment issue of an IME, more must appear regarding reliability and, most importantly ethics. No amount of cost containment or statistics can compensate for unreliability and lack of ethics. A legitimate patient with a legitimate injury or disability has the right to obtain a reliable and ethical physician IME and proper insurance coverage.

Chapter 3

Methodology

Subjects

Insurance adjusters are the source for an investigation of IME use. Therefore, a survey was distributed to adjusters within insurance companies. These companies work with different types of claims, such as workers' compensation, automobile accidents and long-term disability due to any reason.

The companies that were initially contacted for this survey each were considered to be representative of private insurance based rehabilitation companies that provide services in workers' compensation and long term disability with exception to adjuster working with property and automobile claims. The adjusters that were initially contacted were found to be part of a database of the private insurance based rehabilitation company.

First, a letter of consent describing the purposes of the study and the adjuster's role (see appendix) was faxed to the adjuster. The survey was not conducted without a signed consent form. Twenty-five consent forms were distributed with twenty responding and completing the survey.

Procedure

The adjusters that participated in this survey were contacted by telephone. They were informed of the initial need for consent. Upon the return of the signed consent, the adjusters were again contacted by telephone and the survey was

completed. The adjusters varied with type of insurance companies, years of experience, and location of the company. There was also a goal of reaching different companies to learn about their different philosophies.

Methods

Data Collection

The method of data collection was a structured phone interview (see appendix B). A database was compiled of which adjusters had been asked who completed the survey. Also, the database identifies which companies and their specialties in order to achieve a wide variety of types of rehabilitation providers with the sample.

The gathered information was confidential and was destroyed upon completion of the data collection. If the participant requested a copy of the results, it was distributed upon completion of the project.

Data Analysis

Surveys was be gathered, and the multiple-choice answers was be tabulated. The information that was provided by the adjusters beyond the multiple-choice answers (i.e. qualitative responses to open-ended questions) was written on the survey form and compiled for review.

Limitations

The limiting factor of this study and the completion of more surveys was the willingness of the adjusters to complete the consent form and take the time to complete the survey. The essence of the job of an adjuster is determined by the amount of work that they are able to complete on the phone in a day. For some of the adjusters to take the time to complete the telephone survey was not feasible. Consideration of mailing this survey to adjusters was made. In consideration of the amount of paperwork that is compiled, it was deemed more feasible to complete the survey through the use of the telephone. Future research could utilize a larger sample to further reveal the use of and purpose of the IMEs.

Summary

Consent forms were faxed to 25 adjusters between 11/10/2000 and 12/08/2000. Twenty consents were returned, and subsequent surveys were conducted. The interviews were conducted on the telephone at a time the adjuster indicated.

Chapter 4

Results

IN SEARCH OF THE PURPOSE

While in search of the purpose of the performance and use of an Independent Medical Examination, twenty adjuster surveys were completed. In the completion of this survey, 19 of the 20 performed IMEs. From that point on, the answers to the questions varied, even though the types of claims they were working were similar.

The group surveyed handled a variety of types of claims. Of the 20 completed; 85% (n=17) Worker's Compensation; 10% (n=2) Long term Disability; 5% (n=1) Auto; 5% (n=1) accidental, health and occupational health, and 5% (n=1) general liability and property. Two of the adjusters were working with a combination of claims. The individuals that were working in the area of workers' compensation only handled workers' compensation.

Table 1: Type of Claims handled by insurance adjusters surveyed.

Type of claims handled by adjuster	Number of adjuster per 20 surveyed
Workers' Compensation	16
Long-term disability	1
Workers' Compensation and Long-term Disability	1
Auto/ accidental health and occupational health	1
General liability and Property	1

During questioning, 95% (n=19) stated that they requested an IME. The only adjuster that did not request IMEs, works with claims related to general liability, property, and some automobile. The medical implications related to general liability and property are limited. The type of automobile claims was generally related to theft. If the adjuster responded to no use of the IME, the survey was completed.

26% (n=5) of the companies stated they had guidelines stipulate the use of an IME. Four different companies made up this sampling. Of the 5 adjusters in question, 4 of them stated that the guidelines addressed case file expense management, time from date of injury, a surgical intervention request, present restrictions, and any lack of forward progress of the file. One adjuster's guidelines address only the surgical intervention request, present restrictions, and the lack of forward progress of the file.

74% (n=14) of the adjusters decide if and when an IME is to be performed. The issues that prompt this request in 55% of the adjusters are case file expense management, time from date of injury, surgical intervention request, present restrictions, and lack of forward progress of the file. One adjuster only addresses time from date of injury and lack of forward progress of the file as the issues. Another stated the surgical intervention request, present restrictions, and lack of forward progress of the file were the important issues. Still another stated that time from date of injury, the surgical intervention request, present restrictions, and the lack of forward progress of the file were the issues. The lack

of progress of the file is a deciding issue in requesting an IME for 100% of the adjuster' responding.

Of the 19 adjusters responding, only 1 stated that he/she request the same IME physicians to do all or most of the IMEs. Of the adjusters that request different IME physicians, they indicated some IME physicians are better then others, and it was clarified that there is a need to use the physicians that are most knowledgeable with the type of injury being addressed.

Cost of IMEs varied among the adjusters. 1 quoted an average of \$600-1100, 2 adjusters at \$700-1000 and another at \$800. 68% (n=13) averaged range was \$1000-1200 and it increased \$1200-1500 in 11% (n=2). The price difference of the services was dependent on the regional location. The mid-western region averaged \$1000-1500.

Table 2: Cost of an Independent Medical Examination.

Estimated cost of an IME given by insurance adjuster	Number of adjusters
\$600-1100	1
\$700-1000	2
\$800	1
\$1000-1200	13
\$1200-1500	2

* These answers are of the 19 of 20 adjusters that performed IMEs.

Upon the completion of the IME, 21% (n=4) of the reports support the primary doctor's diagnosis. Conversely, 37% (n=7) contradict the primary

physician's diagnosis. 16% (n=3) stated that the results were divided evenly; 11% (n=2) were divided, 75% support and 25% contradict, 5% (n=1) mixed; 5% (n=1) the medical opinion doesn't contradict and depends on the physician's experience and understanding of claim issues; and in 5% (n=1) the primary physician is contradicted and IME was used to gain referral for an MRI to assist in the forward progress of the claim.

In 21% (n=4) the general outcomes of the IME supported the primary physician's diagnosis and the treatment plan continued. Conversely, in 58% (n=11) the primary physician's diagnosis is contradicted, and the treatment plan changed. 21% (n=4) reported other options: the results are varying or the results may address settlement and treatment issues or changes in the treatment plan. Still another result has outcomes that are 50% supporting and 50% contradicting the primary physician's opinion.

If the report contradicts the primary physician, the implications to the claims were: the treatment plan care are denied; all benefits are denied; restrictions are change, and the EMPLOYEE is required to return to work; and the wage benefit is stopped. One adjuster also added the option that the treatment plan may continue, but there is a change in restrictions. One company is obligated to use the results of the IME to make the final decisions on the claim.

100% (n=19) of the adjusters using IMEs found them beneficial to their work. Following are explanations of the benefits derived from the findings:

*The IME gives another opinion to see where the claim in going and to help decrease the malingering.

*The IME assists in the determining of the future time period of payments in a disability claim. IMEs assist in the verification of the medical condition from the primary physician.

*The IME is a second opinion of the restrictions and the need for surgical intervention.

*The IME provides an independent look at the medical management of the case.

*The IME validates the decisions to the auditor and claimant on the decisions that are made on the file. They are a wonderful tool to use.

*The IMEs save money. They keep on track for the treatment plan and add insight o issues that are not seen by the treating physician and the adjuster. They assist as a tool to be able to make decisions and support for closing a file.

*The IME provides a treatment plan to assist the primary doctor and the treatment direction.

*The IME is used at a six-month period of a file that incurs lost time. They are beneficial in litigation. It is a piece or part when looking at an issue. It provides something as support for a position. IMEs get matters moving. IMEs create an issue to force an employee to take a stand. IMEs aid in the conclusion of a file, with possible settlement or closure of the file.

* IME are used so the adjuster can suspend benefits and used as a tool to return the employee to work. They can be used to gain objective findings from the doctor and to increase the doctors ability to gain objective information and to get them to move forward and return the employee to work.

* It is beneficial to have an IME done. It assists in the opinions, plan, restrictions, and maximal medical improvement of the client. It allows me to do my job and not be performing work in a vacuum and have a second opinion.

*The IME is a tool I use to complete what needs to be done.

*The IME answers causal questions and enables a back-up of a denial and providing objective information for litigation.

In summary 24 of 25 adjusters had IMEs performed. All felt they were beneficial.

Chapter 5

Conclusion

The literatures review and survey information both support and negate many issues regarding IME use. The first of the issues is unbiased and reliable reports. The bias is fostered by the financial gains from the fees charged for IME performance. Support of high incidence of the IMEs is shown with the 95% usage by insurance adjusters surveyed. The survey also supported the large financial gains that the physician receives upon completion of this service. Only ethical principals of physicians can produce reliable reports. The survey also fosters positive use of the IME through examination of issues that have been overlooked by the primary physician.

Both the literature and the survey support the need of cost containment. Reliability extends further into the cost containment issue, as well. Cost of the workers' compensation claims have more than tripled over the past ten years (Perry, 1994); hence, any insurance company demands cost containment. The literature regarding worker compensation and cost containment mainly focus on injury prevention (Perry, 1994, Church, 1995, Myers, 2000, Walker, 1993). Injury prevention would clearly eliminate the need for cost containment; however, injuries do occur. When injuries do occur, the insurance company's main issue is to manage costs of medical expenses and wage replacement.

Gill (1999) discusses the adjusters are used "late in the claim when certain cost levels are reached or when problems arise." Gill also discusses the immediate involvement of the medical personnel, adjuster, and the employer.

These two factors are important both in the attitude of the client and the direction, development, and cost effectiveness of the medical treatment plan. An IME may also be used as a tool to identify cases that are apt to incur a high cost (Earman, Andersson, 1996). This may enable an adjuster to be aware of possible upcoming testing and surgical interventions.

The verbal comments of the adjuster that stated, "IMEs save money, they provide objective information and validation when making decisions, forcing employees to return to work and to close files" supports continuing use, as well.

As in the literature, the survey referred to legal implications. Increased cost when legal intervention is involved was cited and the survey discussed needs for objective and supportive documentation for purpose of litigation. Clearly the negative financial implications of legal intervention needs to be addressed.

Even though the Hippocratic oath requires physicians to always consider the best interests of the patients, somehow the IME sways physicians toward the interest of the insurance company. Nevertheless, bias is a result of experiences and perspective and difficult to avoid. It is the responsibility of the physician to prevent these biases from distorting the evaluation of the case; moreover, sound medical judgment may be compromised if a physician is overly biased (Boynton, 1996). The issue of physician bias towards the insurance company again arises but is contradicted by the results that IME reports contradict the primary physician only 37% of the time. The adjuster is not guaranteed the biased result. The survey presents that the IME is that of a tool in the processing of the medical aspect of a claim. This tool may be used to identify claims that need a second

opinion regarding current diagnosis, treatment plan, and restrictions. The use of an IME for these reasons may increase awareness and expose new needs of the file.

Contradiction of the primary physician according to the survey and literature resulted in the adjuster possibly returning the employee to work, to decrease or eliminate further treatment, or to assist the primary physician in the treatment plan.

Both the survey and literature review discusses the direction of the repeated use of physicians. The literature sees the use of the same medical provider as a means of cost containment, but the survey does not support the use of specific doctors for IMEs.

This survey was unable to broach the issue of the reliability of the IME reports. The example given within the introduction clearly demonstrates the need for further investigation into this issue. However, the literature does give suggestions on how to increase the efficiency and accuracy of the report, but does provide any investigation of this issue.

The IME must be considered a tool of the rehabilitation process. Its performance should not be viewed immediately as a negative or detrimental. The factors that need to be examined are the presentation of the IME to the client, accurate and thorough presentation of the medical history, records, and reports, and, most importantly, an accurate and objective IME examination and report. An adjuster's use of this tool solely depends on the report the IME physician generates. The reporting process is the area that needs scrutiny.

In the defense of the IME performer, the first step that has to occur is the presentation of questions that thoroughly address the IME issues. The next step is further development of a certification for physicians. This certification would entail the specialization in the area of IME performance. This would assure knowledge of the laws regarding workers' rights and provide basic outlines of areas to be addressed through examinations and guidelines for the generation of the report. A commission regulating proper practice skills would be formed to improve the quality report being produced and thereby increasing the reliability of the tool to be presented to adjusters. Improving the reliability and validity of the tools used will assure quality work in the rehabilitation process.

In conclusion, the expectation of this research and the results demonstrated by the research were quite disparate. Certainly, more research must be done.

References

Boynton, B (1996). Analyzing IME Reports for Workers Compensation Cases, National Medical-Legal Journal, 7(4), p.1-7.

Brigham, C.R; Babitsky S. (1986). Independent Medical Evaluations and Impairment Ratings, Occupational Medicine, 13(2), p 325-43.

Church Jr., Frederic C.; Goldstein, M (1995). Containing Workers' Compensation Claims, CPA Journal, 65(4), p66, 2p.

Earman, W. A.; Andersson, Gunnar B.; Leavitt, Frank; McNeill, Thomas W.; et al (1996). Factors influencing the cost of chronic low back injuries: An analysis of data from independent medical examinations, Journal of Occupational Rehabilitation, 6(1), p. 5-16.

Gill, M (1999). Cutting Workers' Comp Cost, American City & County, 114(12), p10, 1p,1c.

Harmon Swihart, L, (1994). The independent Medical Examination of injured Workers, National Medical-Legal Journal, 5(2), p. 1-6.

Kraus, J., (1997). The Independent Medical Examination and the Functional Capacity Evaluation, Occupational Medicine, 12(3), p 525-56.

Managed Care Cuts Workers' Compensation Costs. (1996). In Best's Review/Property-Casualty Insurance Edition, 96(10), p65, 1/9p)

Mangan, D, (1997). Got disability insurance? Just try collecting on it, Medical Economics, 74(12), p68.

Myers, S, (2000). Rising Costs Beginning to Overtake Benefits of Reform. Kansas City Business Journal,18(31), p18, 1/2p, 1bw.

Perry, P.M. (1994). 12 Ways to Cut Workers' Comp Costs, HR Focus, 71(10), p12, 2p, 1 chart.

Walker, K.L. (1993). Controlling Workers' Comp Costs. Business West, 10(7),p44, 1/2p.

Appendix A

This form is to be faxed to Participants prior to the telephone survey

I understand that my participation in this study is strictly voluntary and I may discontinue my participation at any time without any prejudice. I understand that the purpose of this study is to investigate the use of Independent Medical Examinations. I further understand that any information about me that is collected during this study will be held in the strictest confidence and will not be part of my permanent record. I understand that at the conclusion of this study all records, which identify individual participants, will be destroyed.

Signature of Participant_____ Date:_____

Note: Questions of concerns about participation about participation in the research should be addressed first to the researcher or research advisor and second to Dr. Ted Knous, Chair, UW-Stout Institutional Review Board for the Protection of Human Subjects in research, 11HH, UW-Stout, Menomonie, WI 54751, phone (715) 232-1126.

Please fax this consent form upon completion to:

Attention: Wendy Parks – 651-631-1215.

Thank you,

Wendy

Appendix B

Survey

INTERVIEWER INSTRUCTIONS: PLEASE READ THESE INSTRUCTIONS AND THE PROTOCOL CAREFULLY BEFORE BEGINNING THE INTERVIEW.

---INTERVIEWER INSTRUCTIONS HAVE BEEN CAPITALIZED AND SHOULD **NOT** BE READ ALOUD.

---INSTRUCTIONS TO THE SUBJECT APPEAR IN LOWER CASE LETTER.

YOU ARE TO FOLLOW THE PROTOCOL EXACTLY AS IT APPEARS. DO NOT DEVIATE FROM IT, I.E., DO NOT ENGAGE THE SUBJECT IN CONVERSATION AND DO NOT RECORD DATA OTHER THAN THAT WHICH IS REQUESTED BY THE QUESTIONS.

---IF THE SUBJECT REQUESTS ADDITIONAL INSTURCTIONS, REPEAT THE QUESTION **ONCE**.

---IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT YOUR CHIEF INVESTIGATOR.

Introduction: Hello, My name is _____. The purpose of this interview is to obtain some general information about the use of Independent Medical Examinations. The survey was constructed as a means to gather information from the individuals who request their use. There are 10 questions. The 1st questions are laid out asking what type of claims you work with and to establish if you have IMEs perform and progress through the purpose of their use.

At this time I want to confirm that you received, signed and returned the consent form that I faxed to you. Yes___ No___

1. What types of claims do you regularly work? READ ALOUD ALL THE CHOICES AND CHECK AS APPROPRIATE.
 - a. Worker's Compensation
 - b. Long term Disability
 - c. Auto
 - d. Other _____

2. DO you request for IMEs to be performed?
 - a. Yes
 - b. No

IF THE ANSWER IS B, STOP SURVEY HERE AND PROGRESS TO THE CONCLUSION

3. Does your company have guidelines that stipulate when an IME is to be performed?
- Yes
 - No

IF YES TO QUESTION 3 MOVE TO QUESTION #4

IF NO TO QUESTION 3 MOVE TO QUESTION #5

TO THE INTERVIEWEE:

For the next question answer yes to all that apply.

4. Do these guidelines address:
- case file expense management
 - Time from date of injury (13 weeks)
 - Surgical intervention request
 - Present restrictions
 - Lack of forward progress of the file
 - All the above
 - Other_____
5. If within your company you are the individual that decides to have an IME performed, what issues prompt you to request an IME?
- Case file expense management
 - Time from date of injury (13 weeks)
 - Surgical intervention request
 - Present restrictions
 - Lack of forward progress of the file
 - All the above
 - Other_____
6. Do you request the same IME physicians to do all or most of your work?
- Yes
 - No
7. What is the average cost of an IME?
- \$1000-1200
 - \$1200-1500
 - \$1500-1800
 - Other_____

8. Do the IME reports generally;
- Support the primary doctor's diagnosis
 - Contradict primary doctor's diagnosis
 - Other_____
9. What are the general out comes of the IME
- the primary doctor's diagnosis is supported and treatment plan continues
 - the primary doctor's diagnosis is contradicted and the treatment plan changes
 - Other_____

IF ANSWER IS A OR C: GO TO QUESTION 10.

IF ANSWER IF B: GO TO QUESTION 11.

10. If the report contradicts the primary doctor...
- the treatment plan care are denied
 - all benefits are denied
 - restrictions are change and the EMPLOYEE is required to return to work and the wage benefit is stopped.
 - Other_____
11. Do you find IMEs beneficial to your work?
- Yes
 - No
 - Other_____

12. Are there any other comments you would like to make regarding IMEs?_____
-
-

CONCLUSION:

Thank you for participating with this survey.

