IME Best Practices for Quality Evaluation

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Excellent IME Report

- Reflective of thoughtful quality evaluation.
- Provides reliable data obtained from document review, history, exam and studies.
- Questions asked by the client are answered with supporting data.
- Professional appearance and organized.

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For an IME, what are best practices?

- Goal is to define an efficient process resulting in a quality work product in a timely manner.
- Each step should reflect best practices and use appropriate technologies.

1.Pre-evaluation
2.Evaluation
3.Post-evaluation


Independent Medical Evaluation Best Practices

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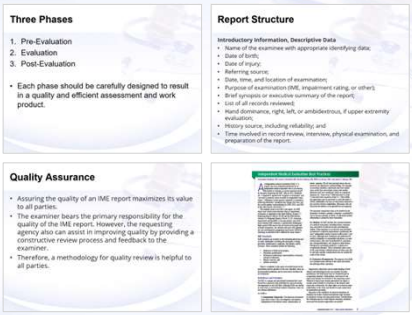
Three Phases
1. Pre-Evaluation
2. Evaluation
3. Post-Evaluation
• Each phase should be carefully designed to result in a quality and efficient assessment and work product.

Report Structure
Introductory Information, Descriptive Data
• Name of the 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 the 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.

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Three Phases

1. Pre-Evaluation
2. Evaluation
3. Post-Evaluation

- Each phase should be carefully designed to result in a quality and efficient assessment and work product.

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Pre-Evaluation

- Referral process
  - IME Company or broker
  - Direct: online, mail, phone
- Records
  - Electronic (.pdf) vs. paper
- Record organization and review
  - Internal or external (offshore)
- Preparation of clinical chronology and/or summary
- Prepare report template

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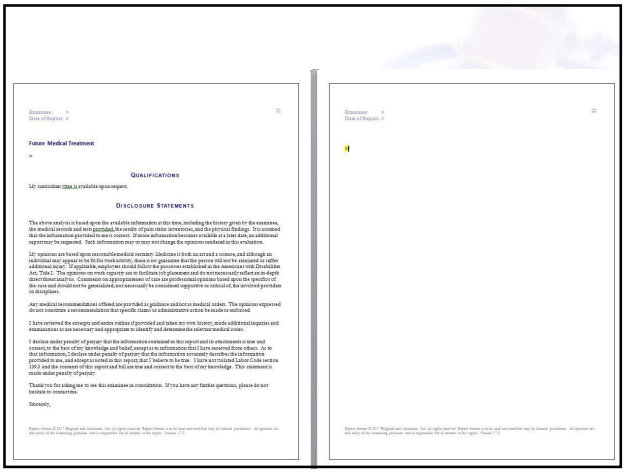

Examinee: >
Date of Report: >

Future Medical Treatment

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QUALIFICATIONS

My curriculum vitae is available upon request.

DISCLOSURE STATEMENTS

The above analysis is based upon 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 at a later date, an additional report may be requested. Such information may or may not change the opinions rendered in this evaluation.

My opinions are based upon reasonable medical certainty. Medicine is both an art and a science, and although an individual may appear to be fit for work activity, there is no guarantee that the person will not be reinjured or suffer additional injury. If applicable, employers should follow the processes established in the American with Disabilities Act, Title I. The opinions on work capacity are to facilitate job placement and do not necessarily reflect an in-depth direct threat analysis. Comments on appropriateness of case are professional opinions based upon 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 a recommendation that specific claims or administrative actions be made or enforced.

I have reviewed the excerpts and entire exhibits if provided and taken my own history, made additional inquiries and examinations as are necessary and appropriate to identify and determine the relevant medical issues.

I declare under penalty of perjury that the information contained in this report and its attachments is true and correct to the best of my knowledge and belief, except as to information that I have received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted in this report, that I believe to be true. I have not violated Labor Code section 139.3 and the contents of this report and bill are true and correct to the best of my knowledge. This statement is made under penalty of perjury.

Thank you for asking me to see this examinee in consultation. If you have any further questions, please do not hesitate to contact me.

Sincerely,

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Evaluation

- Examinee is greeted and the identity of the examinee is verified.
- Evaluation process is explained to the examinee, and written informed consent is obtained.
- Questionnaires and/or applicable inventories are completed, paper or online.
- Staff members may interview examinees prior to a physician.
- Physician reviews any radiographs or diagnostic studies.

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Evaluation by Physician

- Physician interviews examinee and may dictate the history in the presence of examinee.
- Physician examines examinee with a staff member in attendance, documenting negative, physical, and nonphysiologic findings.
- Physician concludes evaluation and provides a satisfaction survey to the examinee.

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Physical Examination

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, e.g., chaperone, translator, or other participants;
- Appearance, grooming, and nutrition;
- Observations about the examinee's effect, attitude, cooperation, and mental status;
- Objective observations of behavior or statements that the examiner believes relevant to reliability and/or credibility of the examinee;

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Physical Examination

Most physical examination sections include documentation on the following:

- 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.

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Post-evaluation

- Phone contact with the client, as appropriate
- Report development
- Dictation (within 24 hours)
- Report completion with quality assurance (sent within 5 working days)
- Enclosures (potential) with the report: Invoice, W-9, Fee and Payment Policy, CV, articles
- Post report f/u with client

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Report Structure

Introductory Information, Descriptive Data

- Name of the 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 the report.

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History

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

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Record Review

- Record review should be thorough, complete, and accurate.
- Data sources should be identified, e.g., the provider's name and date of service.
- Verbatim quotes should be used when possible to avoid the possible change of meaning when paraphrasing.
- Intellectual honesty when summarizing records and recording history is essential. Both should be recorded completely and without an 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.

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Record Review

- 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 organizations are acceptable if they present the history in a clear and nonprejudicial 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.

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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;

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Current Interview (Oral History)

- Chronologic clinical course, including
  - providers involved,
  - diagnostic studies,
  - treatments and responses, 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;

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Current Interview (Oral History)

- 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;

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Current Interview (Oral History)

- Occupational history, including
  - any time off work due to the subject's injury or illness.
  - Job duties relevant to current injury, with the 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;

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Current Interview (Oral History)

- 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
  - diet

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Physical Examination

- Document findings in a clear, organized manner.
- Consider using tables to document the range of motion.
- 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).

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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.

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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.

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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 correlating 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 findings 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) should be stated.
  - If the information necessary to render well-informed or complete opinions is missing, state this.

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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.
- 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]
  - 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 Guidelines[28] published by the Work Loss Data Institute

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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 and are not meant to constitute a physician-patient relationship. That additional testing and/or treatment must be ordered or done by the attending physician.

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Prognosis

- 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.

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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 a 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.

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Causation and Apportionment

- 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.

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Causation and Apportionment

- 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.

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Causation and Apportionment

- Causality requires a 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.

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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.

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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.

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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 citations of the relevant page numbers, table numbers, and methodology.
- Absolute precision in utilizing the appropriate rating guide is essential.

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Work Ability and Functional Status

- Work ability is defined by consideration of the following 3 factors: risk, capacity, and tolerance.[30]
- The IME physician needs to assess each factor when discussing workability 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."

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Work Ability and Functional Status

- **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).

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Work Ability and Functional Status

- **Tolerance** is a psycho-physiological 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 do an activity for the rewards available (typically rate of pay; nonmonetary rewards from work, such as recognition or sense of accomplishment; or social interaction).

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Answers to Specific Questions

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

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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.

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Disclosures and Signature - Example

- 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 the 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.

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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.

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Quality Assurance

- 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?

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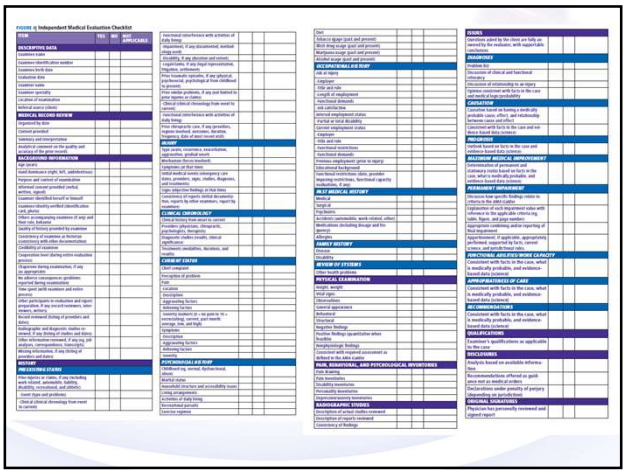

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Questions and Answers

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Independent Medical Evaluation Best Practices

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

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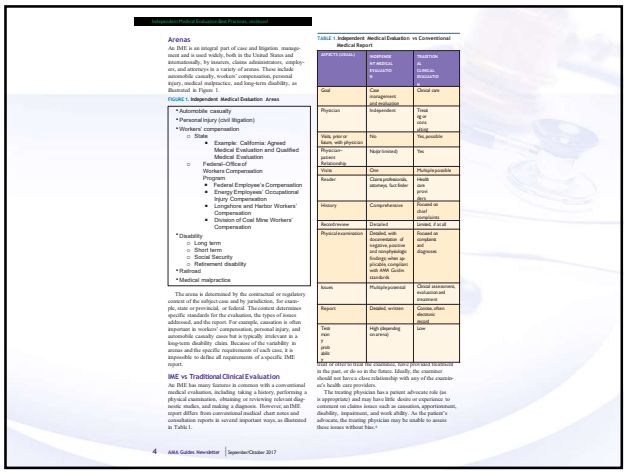

Arenas

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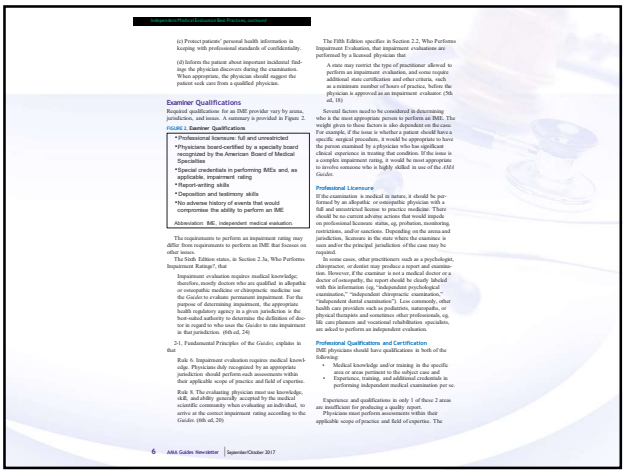

(c) Protect patients' personal health information in keeping with professional standards of confidentiality.

(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: stains, 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

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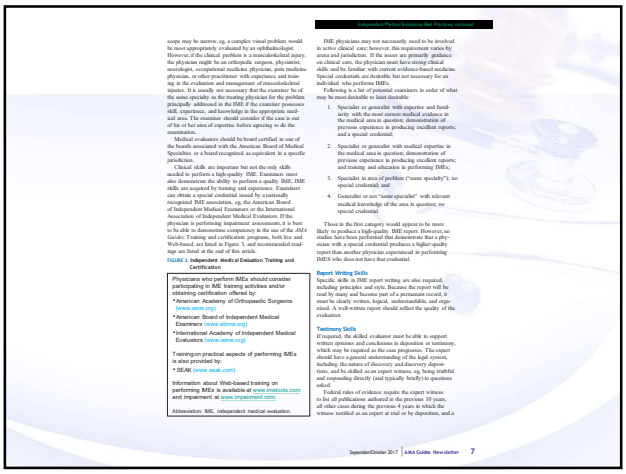

scope may be narrow, eg, a complex visual problem would be most appropriately evaluated by an ophthalmologist. However, if the clinical problem is a musculoskeletal injury, the physician might be an orthopedic surgeon, physiatrist, neurologist, occupational medicine physician, pain medicine physician, 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 an 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 readers 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

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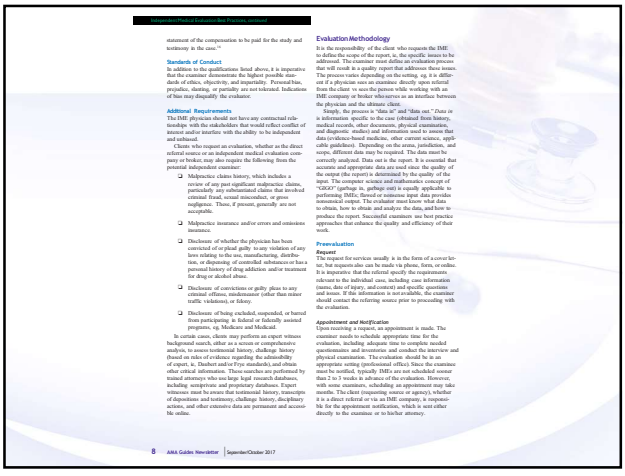

statement of the compensation to be paid for the study and testimony in the case.[10]

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, chatting, 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 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. Those, 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, manufacture, 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.

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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 the 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.

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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), Quick-DASH (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 recording 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 orders 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.

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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 report. 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 ensure that the content provided is accurate, complete, and assumes full responsibility for the report's contents. 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 the 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 examinee 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 evaluation 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

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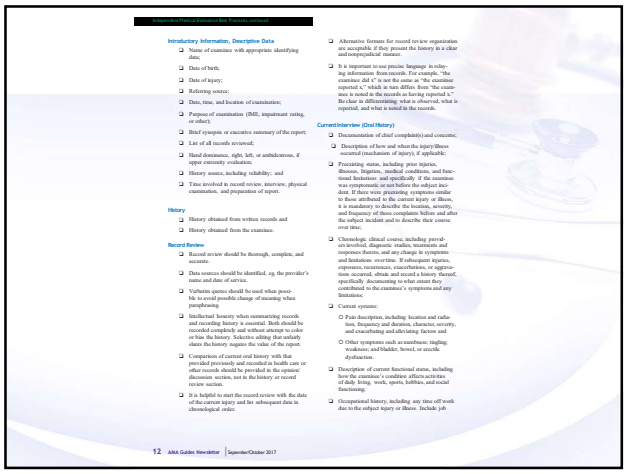

Independent Medical Evaluation Best Practices, continued

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

- Records and 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 nonprejudicial 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 overtime. 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

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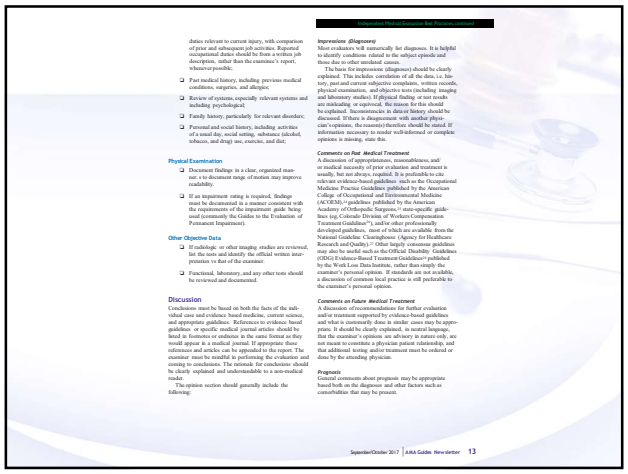

Independent Medical Evaluation Best Practices, continued

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 ve 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:

Impairions (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),[1] guidelines published by the American Academy of Orthopedic Surgeons,[2] state-specific guidelines (eg, Colorado Division of Workers Compensation Treatment Guidelines[3]), and/or other professionally developed guidelines, most of which are available from the National Guideline Clearinghouse (Agency for Healthcare Research and Quality).[4–7] Other largely consensus guidelines may also be useful such as the Official Disability Guidelines (ODG) Evidence-Based Treatment Guidelines[8] 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.

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Independent Medical Evaluation Best Practices, continued

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.[9]

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 (eg, My 3 % is 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.[10] 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. This, 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).

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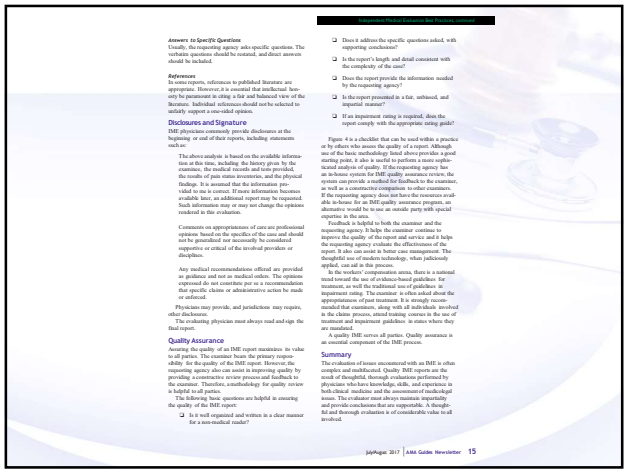

Independent Medical Evaluation Best Practices, continued

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 nor are 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 set 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 consistency 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 standards methodology, 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 as 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.

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Independent Medical Evaluation Best Practices, continued

FIGURE 4. Independent Medical Evaluation: Checklist

Item	Yes	No	Not applicable
DESCRIPTIVE DATA			
Examinee name			
Examinee identification number			
Examinee birth date			
Evaluation date			
Examinee career			
Examinee specialty			
Location of examination			
Referral source (clinic)			
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			
Quality of history provided by examinee			
Consistency of examinee on interview (consistency with other documentation)			
Credibility of examinee			
Cooperation level during entire evaluation process			
Need for an interpreter, if any, and how provided			
No adverse consequences (problems reported during examination)			
Time spent (with examinee and outside examinee)			
Other participants in evaluation and report preparation, if any (named reviewers, later viewers, writers)			
Record reviewed (listing of providers and dates)			
Laboratory and diagnostic studies reviewed, if any (listing of studies and dates)			
Other information reviewed, if any (eg, job analysis, correspondence, depositions)			
Missing information, if any (listing of providers and dates)			
HISTORY			
PRESENTING STATUS			
Prior injuries or claims, if any (dates, body parts affected, outcomes, treatment, disability, impairment, litigation)			
Current injury or illness (dates, body parts and problems)			
Clinical (clinical chronology, from current injury or illness to present)			
Functional (interference with activities of daily living)			
Impairment, if any (documented, method [chap used])			
Disability, if any (duration and extent) (applicable, if any) (legal representation, litigation, settlement)			
Prior treatable episodes, if any (physical, psychiatric, psychological [from childhood to present])			
Prior similar problems, if any (not limited to the subject body part)			
Clinical (clinical chronology, from onset to current)			
Functional (interference with activities of daily living)			
Prior chiropractic care, if any (providers, regions treated, dates, duration, and frequency, date of most recent visit)			
INJURY			
Type (break, laceration, sprain/strain, aggravation, exacerbation)			
Mechanism (direct/indirect)			
Symptoms (at first time)			
Initial medical events (emergency room [date, providers, signs, studies, diagnoses, and treatments])			
Signs (objective findings at that time)			
Persistence of signs (duration)			
Resolution of signs (duration, current, report by examinee)			
EXAMINATION FINDINGS			
Clinical history from onset to current			
Providers (physicians, chiropractic, psychologists, therapists)			
Frequency (visits/ month, clinical significance)			
Treatments (modalities, durations, and results)			
CURRENT STATUS			
Chief complaint			
Description of problems			
Pain			
Location			
Descriptors			
Aggravating factors			
Relieving factors			
Severity (current) [0 = no pain to 10 = excruciating], current, past [average, low, and high]			
Symptoms			
Location			
Descriptors			
Aggravating factors			
Relieving factors			
Severity			
PSYCHOSOCIAL HISTORY			
Childhood (eg, moves, dysfunction, abuse)			
Education			
Household structure and assembly issues			
Employment history			
Military history			
Recreational pursuits			
Review regimen			

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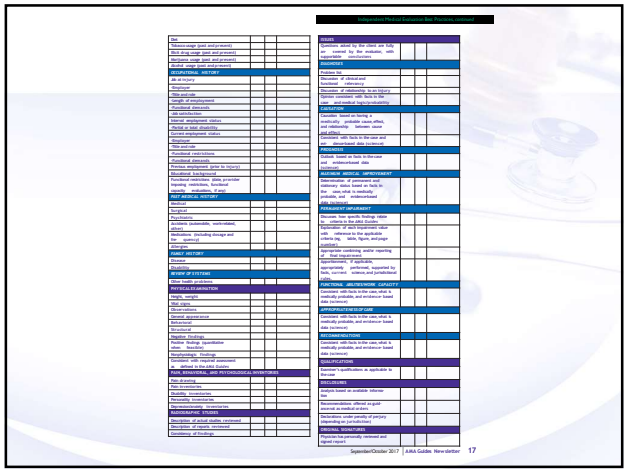

Independent Medical Evaluation Best Practices, continued

Item	Yes	No	Not applicable
Narrative (past and present)			
Work drug usage (past and present)			
Alcohol usage (past and present)			
Tobacco usage (past and present)			
OCCUPATIONAL HISTORY			
Job at injury			
Tasks			
Time at employment			
Positional demands			
Job satisfaction			
Interval employment status			
Partial or total disability			
Current employment status			
Employer			
Title and role			
Functional restrictions			
Positional demands			
Previous employment (prior to injury)			
Vocational background			
Functional restrictions (date, provider who imposed, and duration)			
Capacity evaluations, if any			
PAST MEDICAL HISTORY			
Medical			
Surgical			
Psychiatric			
Accidents (automobile, work-related, other)			
Medications (including dosage and duration)			
Allergies			
FAMILY HISTORY			
Disease			
Disability			
REVIEW OF SYSTEMS			
Other health problems			
PHYSICAL EXAMINATION			
Height, weight			
Vital signs			
Chest wall/ore			
Cervical spine/motion			
Behavioral			
Structural			
Positive findings			
Positive findings (quantitative when feasible)			
Nonphysiologic findings			
Consistent with impaired awareness			
Consistent with symptom magnification			
RELEVANT LABORATORY AND PSYCHOLOGICAL INVESTIGATION			
Skin drawing			
Pain inventories			
Disability inventories			
Personality inventories			
Neuropsychologic inventories			
RADIOGRAPHIC STUDIES			
Description of actual studies reviewed			
Description of reports reviewed			
Consistency of findings			

Item	Yes	No	Not applicable
ISSUES			
Questions asked by the client are fully or content by the evaluator, with supportable conclusions			
DIAGNOSES			
Problem list			
Description of clinical and functional relevancy			
Discussion of relationship to an injury			
Opinion consistent with facts in the case and medical logic/probability			
CAUSATION			
Opinion based on having a medically probable cause-effect, and relationship between cause and effect			
Consistent with facts in the case and medically probable and evidence-based			
PROGNOSIS			
Outlook based on facts in the case and evidence-based data			
Discussed			
MAXIMUM MEDICAL IMPROVEMENT			
Determination of permanent and stationary status, or lack thereof, in the case, what is medically probable, and evidence-based data discussed			
PERMANENT IMPAIRMENT			
Discusses how specific findings relate to criteria in the AMA Guides			
Appropriate rating method applied, with reference to the applicable criteria (eg, table, figure, and page number)			
Appropriate combining and/or reporting of impairments			
Determination, 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 discussed			
APPROPRIATE/NEED FOR CARE			
Consistent with facts in the case, what is medically probable, and evidence-based data discussed			
RECOMMENDATIONS			
Consistent with facts in the case, what is medically probable, and evidence-based data discussed			
QUALIFICATIONS			
Examiner's qualifications as applicable in the case			
DISCLOSURES			
Analysis based on available information			
Recommendations offered as guidance/ not as medical orders			
Declarations under penalty of perjury (if required by jurisdiction)			
FINAL MEASURES			
Physician has personally reviewed and signed report			

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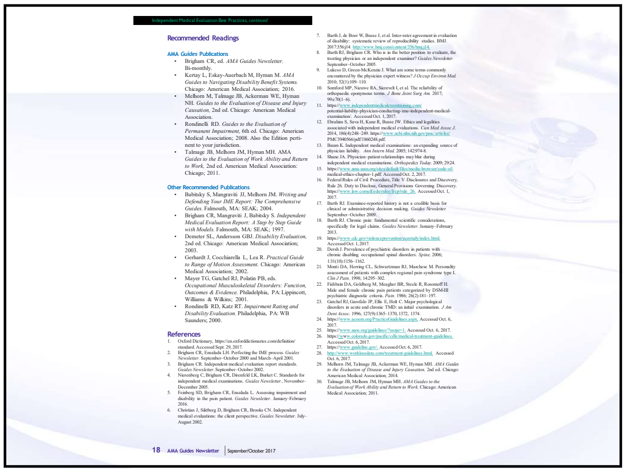

Independent Medical Evaluation Best Practices, *continued*

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.

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Questions and Answers

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