



# Independent Medical Evaluations

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## The Why's and What's

*And who really cares?*

Thomas Freedland, D.C.

8196 SW Hall Blvd

Suite 306

Beaverton, Oregon 97008

(503) 684-1273

TFreedland@AOL.com



# Documentation Bloopers

- › The patient was in his usual state of good health until his airplane ran out of gas and crashed.
- › The patient has a brother and sister who are normal.
- › She also complains of pain in her right ankle. She says she is not sexually active.
- › The patient has been depressed ever since she began seeing me in 2003.
- › The patient was breathing heavily with no signs of respiration.
- › He was advised to force fluids through his interpreter

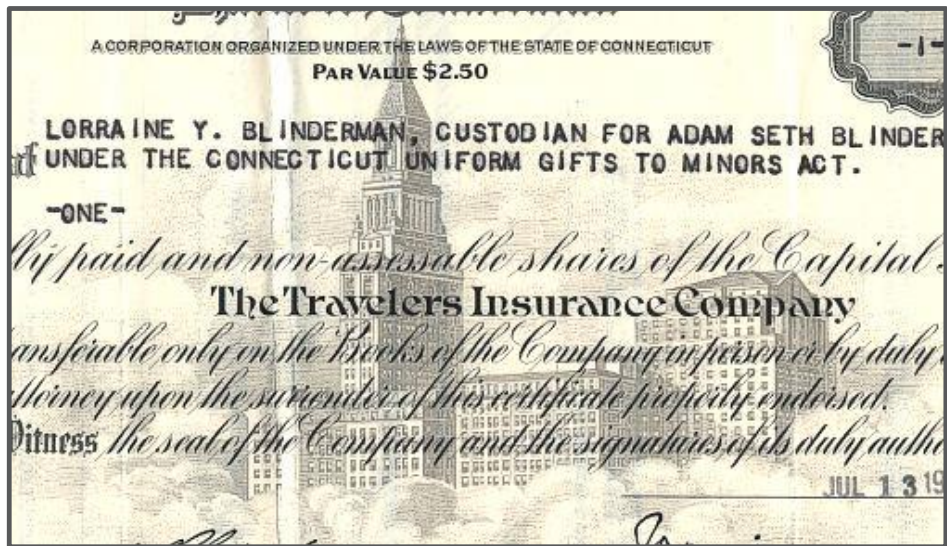
# First Recorded Automobile Crash

- › May 30, 1896 – Henry Wells collided with a bicyclist in New York City.



# First Auto Policy

- › In 1897 the first auto policy was issued by the Travelers Insurance Company.
- › The policy was a liability-only policy
- › The premium was \$11.25, and provided coverage amounts between \$5000 and \$10,000



# Workers' Compensation



Traced back to 2050 BC in  
City-State of Ur

**2050 BC**

Code of Hammurabi

**1750 BC**

Prussia

**1871**

US Congress passed the Employees'  
Liability Acts

**1906 & 1908**



## Definition – Independent Medical Evaluation (IME)

- › An impartial, evidence-based evaluation by a doctor who is not involved in the patient's care.
- › Examinee is usually referred by a third party.
- › Includes medical history, physical examination, and review of medical records & diagnostic studies.



# Objective

- › Based on observable phenomena
- › Undistorted by emotion or personal bias
- › Independent of the perceiving individual
- › Without distortion of personal feelings, insertion of fictional matter, or interpretation





## And...

although they may be independent of the observer, they are not necessarily independent of the patient.  
Which of these examination findings are truly objective?

- › ROMs
- › Gait
- › Imaging findings
- › Pain on Palpation
- › Spasm/splinting/hypertonicity
- › Posture
- › Joint function
- › Orthopedic/provocative tests
- › DTRs
- › Mensuration
- › Blood tests
- › Muscle strength
- › Sensation



## Assumption:

- › In the vast majority of patients with musculoskeletal complaints, we assume the patient is presenting credibly
- › Is this assumption valid?



# Gordon Waddell, CBE, DSc, MD, FRCS, Orthopedic Surgeon

- › "Medical management of the individual patient always has been, always should be, and indeed can only safely be based on the clinical history and physical findings.
- › "This assumes that the information obtained from the interview and examination provides a reliable measure of abnormality, distinguishes normal from abnormal, and permits valid interpretation.
- › "In routine clinical assessment of backache all of these assumptions may be questioned."



Waddell G, Main CJ et al, *BMJ*, 1982. 284:1519-23



## Reasons to Seek an IME

- › To Ensure good management and treatment of the injured party
- › Best Outcomes
- › Return to Work
- › Needless Disability
- › Second Opinion
- › Avoid/Identify symptom magnification and malingering



## File Review vs. IME

- › A File Review looks at the clinical documentation and whether it supports the treatment rendered.
- › A course of care can be suggested.
- › It cannot determine disability since there is no exam.
- › It cannot determine resolution unless the attending doctor closes case.
- › It cannot assess future needs unless it is described in the records.
- › Conclusions are limited to what information is provided.

# File review red flags

## Overtreatment / Inappropriate treatment

- › Patient treated but not evaluated on initial visit.
- › Patient evaluated on first visit but told to return for “report of findings” before treatment can begin.
- › Diagnosis of “severe” injury inconsistent with relatively mild examination findings.
- › Daily treatment > 1 week.
- › Patient requires daily treatment but not on Saturdays, Sundays, or holidays.



# File review red flags

## Overtreatment / Inappropriate Treatment

- › No treatment plan.
- › Treatment plan does not give anticipated recovery date or return to work date.
- › Sporadic treatment.
- › Unexplained gaps in treatment, especially when inconsistent with treatment plan.
- › No instruction in posture and body mechanics.
- › No exercise instruction or exercise instruction begins late in course of care.



# File review red flags

## Overtreatment / Inappropriate Treatment

- › No progression from passive to active therapy.
- › No reports of clinically significant improvement within 3-4 weeks of initial treatment.
- › Focus on pain relief to the exclusion of functional progress.



# File review red flags

## Inappropriate billing / coding

- › Use of higher-level E&M codes\*, e.g., 99204, 99205, 99214, 99215, with little or no documentation of key components.
- › Use of high level CMT codes (98942 - 5 spinal regions or 98943 - extraspinal adjustment) with little or no supporting documentation or establishment of medical necessity and no related diagnosis.
- › Minor note: CPT code 99201 has been eliminated from the AMA. That may not automatically change an establish fee schedule for WC.





# File review red flags

## Inappropriate billing / coding

- › X-rays of areas not included in diagnosis or areas not injured and/or no imaging report.
- › Charges for technical and professional x-ray components when x-rays were read by consulting radiologist.
- › Repeat x-ray examinations without clinical justification.
- › Charges for computerized strength and ROM testing.



# File review red flags

## Inappropriate billing/coding

- › Ordering specialty diagnostic testing, especially at outset of care, e.g., EMG, NCVs, video fluoroscopy, spinal ultrasound.
- › Surface EMG (sEMG) and thermographic studies.
- › Charges for numerous dispensary items (DMEs) in first few days of care: cervical pillows, lumbar belts, cervical collars, ice packs, vitamins, traction devices, etc., especially absent documented medical necessity.
- › Inadequate/illegible chart records. Documentation does not comply with “dead doctor rule.”

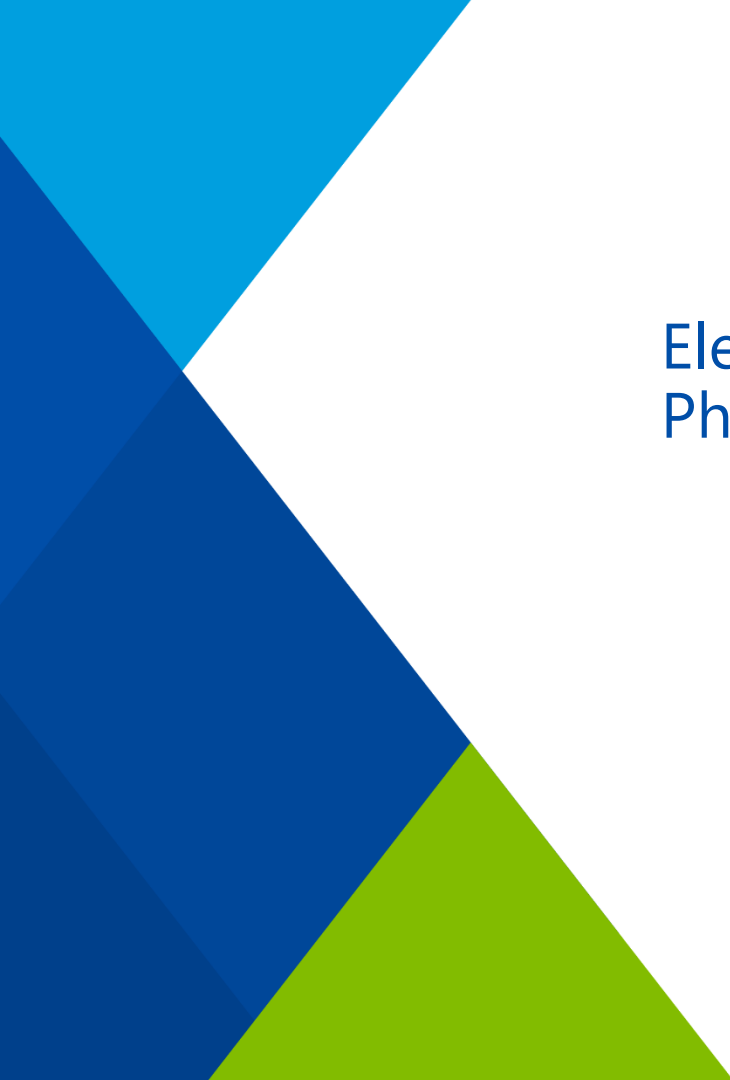


# File review red flags

## Inappropriate billing / coding

- › Notes do not document services on bills.
- › Unjustifiably frequent re-examinations.
- › Infrequent or no re-examinations.
- › Billing for multiple modalities on each visit (along with CMT charges).
- › Billing E&M code at every visit in addition to therapy codes
- › Billing for duplicative therapies at same visit.
- › Unnecessary services: billing for treatment of conditions not associated with compensable injury.





# Elements of the Physical Examination

# Observation

- › Evaluation begins when doctor first sees examinee.
- › Ends only when examinee leaves doctor's sight.
- › Observations outside of "formal examination."
- › Gait, heel/toe walk, squat and rise.
- › Posture & notations of scars, tattoos, other prominent features.



# Palpation

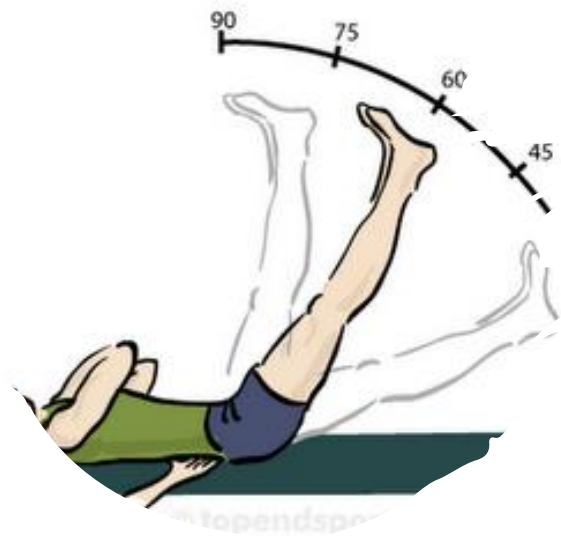
- › “Direct examination”
- › Palpatory quality of soft tissues
- › Palpatory tenderness / pain (not “palpable pain”)
- › Grading of muscle splinting, palpatory pain
- › Examinee’s responses to palpation: wincing, guarding, withdrawal, histrionics
- › Motion palpation, joint play assessment, other functional articular findings





## Ranges of Motion

- › Measured, not extrapolated from observation
- › Dual inclinometers are preferred methods for spine ROMs
- › Separate measurements for cervical, thoracic, and lumbar
- › Standard ROM values in AMA Guides to the Evaluation of Permanent Impairment (4th and 5th Editions; not used in the newer 6th Edition)
- › Extremity joints measured if claimed to be injured or otherwise indicated
- › Record to precise degree, not to nearest 5° or 10°



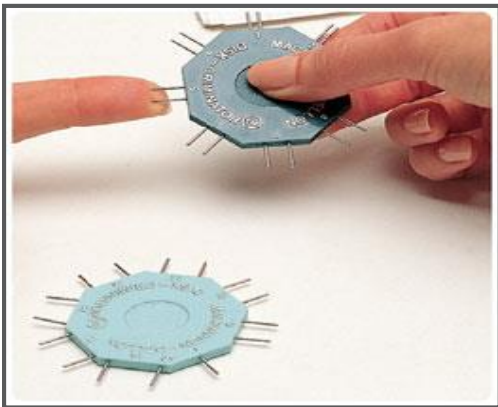
## Orthopedic tests

- › AKA provocative tests
- › Avoid eponyms whenever possible
- › "Cross-leg test" = Patrick or Patrick/FABER



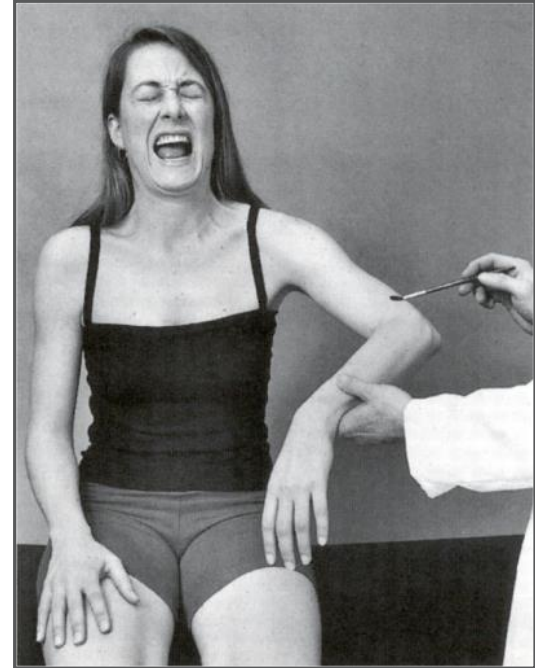
# Neurologic tests

- › Cranial nerves, cerebellar functions (if indicated)
- › Upper extremity neuro eval performed if neck injury
- › Lower extremity neuro eval performed if low back injury
- › DTRs, muscle strength, sensation, mensuration
- › Additional tests: grip and pinch strength, two-point discrimination ( $\leq 5$  mm)



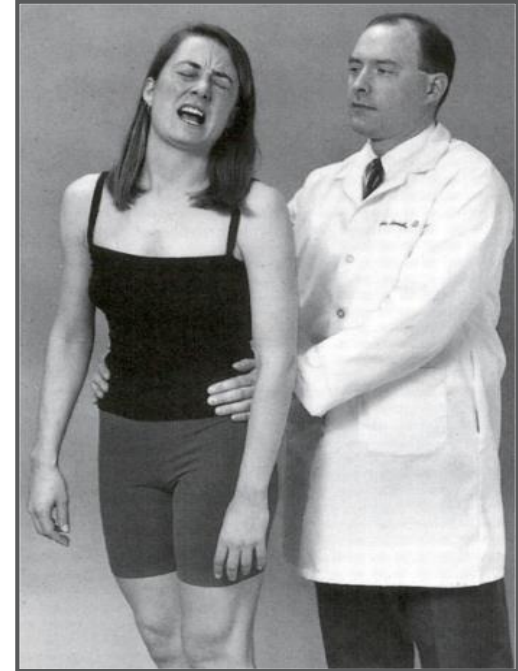
## 5 “Waddel signs” = 8 tests

1. Tenderness: superficial, nonanatomic
2. Simulation: axial loading, en bloc rotation
3. Distraction: seated SLR (not axial distraction)
4. Regional signs: nonanatomic weakness & sensation
5. Overreaction



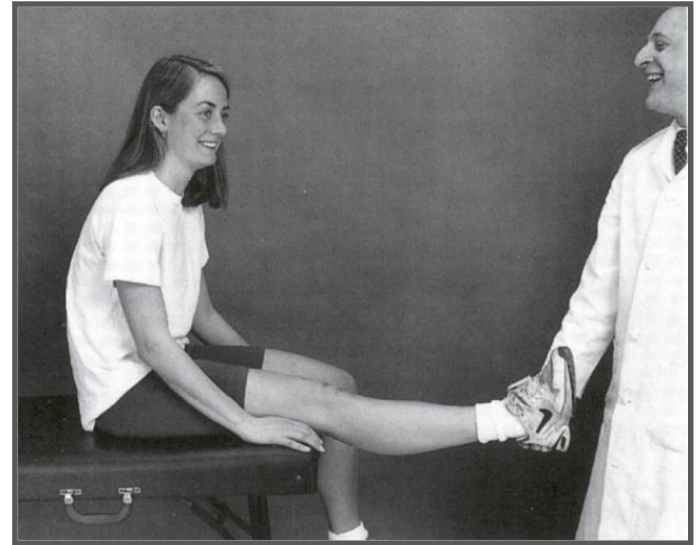
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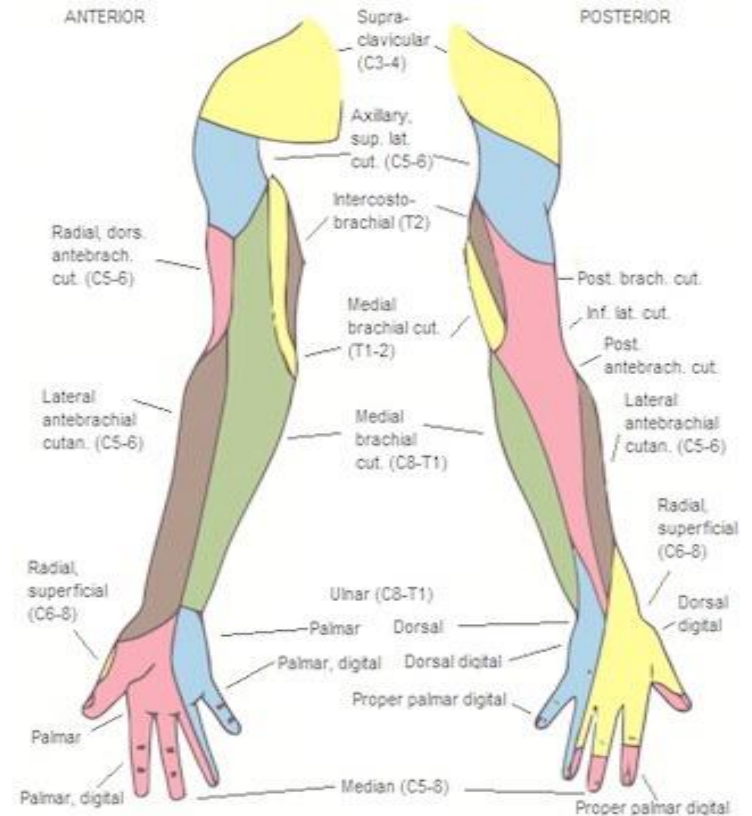
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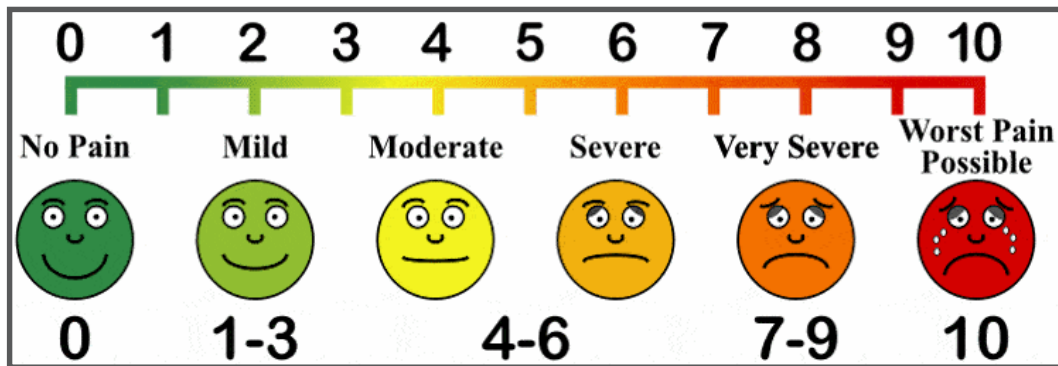
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## 5 "Waddel signs" = 8 tests

Over – focused / Overreaction??





## 5 “Waddel signs” = 8 tests

- › Presence of  $\geq 3$  signs suggests nonorganic LBP.
- › Does not rule out organic problem, but examination findings may not be reliable.



## Other nonorganic signs

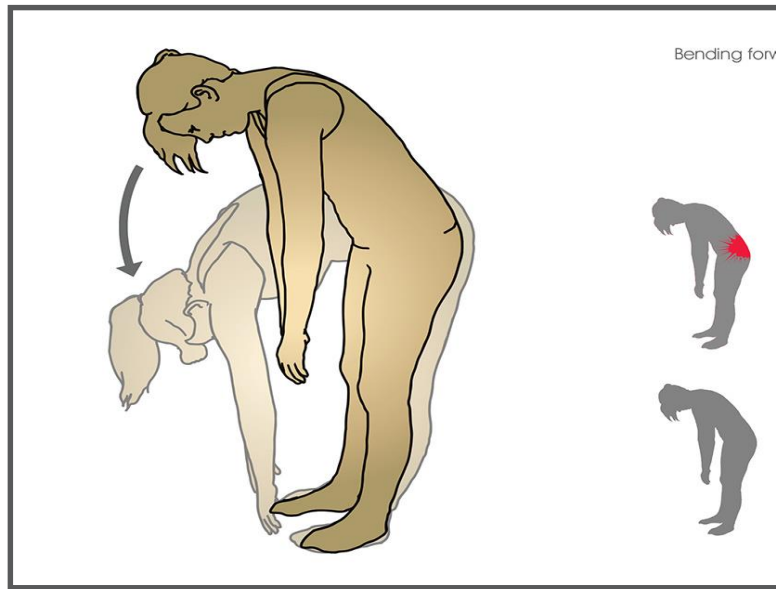
### › Marxer's and "pre-Marxer's"



Blom A et al. A new sign of inappropriate lower back pain.  
*Annals of the Royal College of Surgeons of England*, 84:(5). 2002: 343-343

## Other nonorganic signs

### > Measured vs. observed ROMs



Blom A et al. A new sign of inappropriate lower back pain.  
*Annals of the Royal College of Surgeons of England*, 84:(5). 2002: 343-343

## Other nonorganic signs

### > Gait



## Other nonorganic signs

- › Squat compared to sit/stand



## Other nonorganic signs

### > Heel tap test



**NOT MALINGERING TESTS**

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## Claims of IME physician bias

- › WC Survey of IMEs
- › “Data” reported claim of bias in the system
- › 53% of IME physicians stated they believed bias was perceived within the IME process.
- › Treating doctors and patients asked if there was bias.

# Claims of IME physician bias

It is claimed...

- › Most IME doctors find nothing wrong with the patient
- › The IME doctor's opinions are not objectively substantiated
- › The purpose of an IME is to cut off treatment
- › Insurance companies only use docs who are pro-insurance and anti-patient
- › The IME doc knows which side the bread is buttered







# Claims of IME physician bias

- › The treating doctor's income is directly related to the amount, type, and frequency of treatment
- › The more serious the injury appears to be...
  - The greater the amount, frequency, and length of treatment
  - The more money the doctor will receive

AND

- › The higher the degree of permanent impairment
  - The more the claim is worth
  - The bigger the settlement
  - The more prodigious the attorney's fee



# Documentation Bloopers

- › 19-year-old vehicle involved in a female accident
- › “I follow him for his paranoia”
- › He had a left-toe amputation one month ago. He also had a left-knee amputation last year.
- › The lab test indicated abnormal lover function.
- › Patient has two teenage children but no other abnormalities.



# Documentation Bloopers

- › Rectal examination revealed a normal-size thyroid.
- › Occasional constant infrequent headaches
- › She was the belted driver in the back seat.
- › Past medical history is significant for a basal cell carcinoma on her head which was removed recently.
- › The patient has no previous history of suicides.
- › He has been monitoring his blood pressure. Does not drink. Does not use much soap.



# Documentation Bloopers

- › Bleeding began in the rectal area and continued all the way to Los Angeles.
- › Exam of genitalia was completely negative except for the right foot.
- › Since the patient stopped smoking, his smell is beginning to return.
- › The patient lives at home with his mother, father, and pet turtle who is presently enrolled in day care three times a week.
- › On the second day the knee was better, and on the third day it disappeared completely.



# Questions?