

What I've Learned Performing IMEs and What CEOs Should Know

By Craig Westin, M.D.

I've learned a lot performing IMEs. For those not familiar, an Independent Medical Examination (IME) is an exam of an injured worker by a physician specialist familiar with the body part injured. The purpose is to determine the extent of the work related injury, and the nature and duration of treatment required to treat it. The employer (or its insurance company) is entitled to obtain an IME under Section 12 of the Illinois Workers Compensation Act. An IME is considered "independent" because the doctor agrees not to treat the injured worker or establish a doctor-patient relationship. The employer pays for the exam and may request a particular IME doctor, if desired.

IMEs are done by specialists familiar with the IME process and objectives and with expertise in treating the area of the body injured. The doctor agrees not to solicit the claimant as a patient, and not to share his opinion with the claimant the day of the exam. The IME physician is paid a standard, pre-arranged fee that does NOT depend on the opinions in the report.

We all have first impressions when we meet people. We all have our personal opinions and attitudes. Whether I am IME or treating physician, I need to always be mindful of my preconceived opinions (or biases). I learned when doing IMEs to take

special care to remain objective, especially because there is only a single encounter and no ongoing doctor-patient relationship. We don't "get to know" IME examinees. I occasionally see IME reports from other doctors that appear biased one way or another. An honest, objective assessment by the doctor produces the best IME. We must call things as we see them, based on the evidence available at the visit.

I learned early how carefully IMEs are scrutinized. I thought my first few were pretty good: thoughtful, careful and complete. When several clarifications and corrections were requested on my first report, it reminded me of college essays ripped apart by tough professors. With IMEs, the "professors" are IME vendors and combative attorneys. No one gets an "A" at the top of an IME report, but I still learn from the experience.

Practicing medicine requires us to learn from treating our patients. IMEs are a unique opportunity to learn from other doctors treating the same problems I treat. I can review the initial evaluation and diagnosis, imaging, surgery, therapy and any complications. I then get a chance to question and examine the patient to assess patient satisfaction and clinical outcome. I gain additional medical experience



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without the worry and time of patient care. I compare my techniques and results with other surgeons. I may have a particular approach or sequence for an operation. Other surgeons may have a novel or even a rarely used older surgical technique that works well too. I see the good, the bad and the ugly. IMEs helped me improve my office and medical records, and I've picked up or at least tried a few surgical "pearls" along the way. I enjoy reviewing cases with efficient diagnosis and testing, clear treatment plans, well planned surgical cases and effective rehab.

With few exceptions, my colleagues are good doctors that perform reasonable and effective treatments. Most are interested in returning their patients to employment as soon as possible. Overall I'm proud of my colleagues and the care they give.

CEOs should know that most orthopedic surgeons realize the best outcome for everyone (employers, patients and physicians) is to have our patients return to work as soon as it is safe, full time at their

regular jobs.

However, after doing IMEs for several years, I've seen a few providers that are not as effective. Here are three patterns of concern that CEOs should know about.

1. The treating doctor schedules an elective operation before appropriate tests are completed. This amounts to: "My patient needs an operation, I'll find out which one later". Once a patient has surgery, it is not clear if non-surgical measures would have worked.

Surgery is usually one of the treatment options. Accurate test are needed to make an accurate treatment plan.

2. Frequent and prolonged "rehab therapy" before and usually after surgery, sometimes for 3 to 6 months without objective measurements of patient progress such as joint motion, strength and abilities such as lifting. Treatment notes from these providers are usually identical cut-and-paste documents three times per week for months

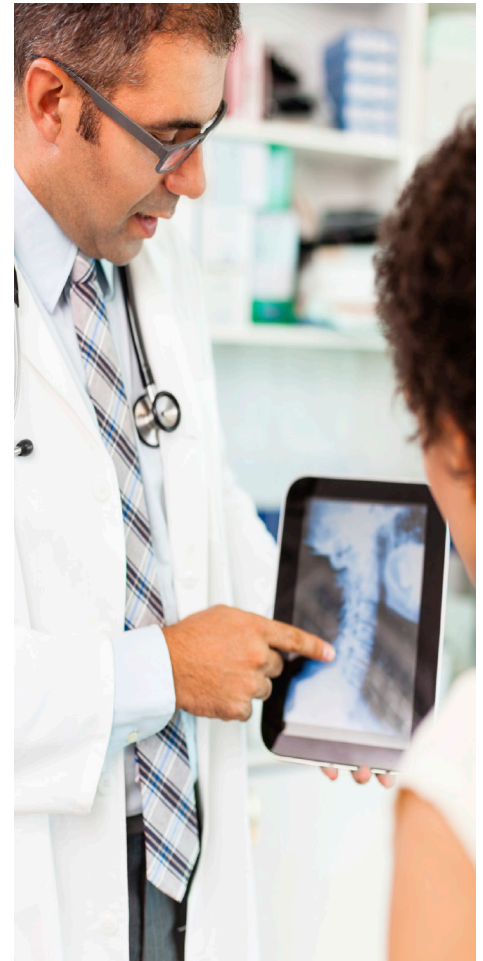
CEOs should also know about utilization review. This is a process where a non-examining doctor employed by the insurance company (often out of state) denies further physical therapy treatment once a patient has finished an "average" number of

visits. It mystifies me how a UR denial can arbitrarily halt the significant and documented improvement of one patient after 24 visits, while other patients are treated endlessly, by providers who are often not physical therapists.

3. In-office drug dispensing by treating providers. The pattern is the same: 3-4 drugs are given at every visit to every patient. The office notes for these visits contain identical paragraphs every visit justifying each drug. Patients receiving excessive medications think the doctors are "generous". I recently performed an IME on a claimant with drug costs totaling over \$20,000 for a few months of routine, generic drugs. It is a conflict of interest for a treating physician to benefit financially from dispensing drugs.

Treating injured workers is an important and expensive endeavor. I have learned how IMEs can help the patient, the employer and the physician make the process more fair, efficient and hopefully cost effective.

CEOs should remember that physicians are taxpayers and consumers too. A more efficient workers' compensation system is in all our mutual best interest.



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