What to expect from an IME Examiner

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Principles and Processes

- Referral Screening Process
- Orientation of the patient
- Take a thorough history
- Get background understanding (Physics) of accident in question
- Examination
- Documentation and record review
- Request of additional records or information
- Prepare a thorough report
- Determine if there are conflicts of Interest
- What if you have to testify?

General Principles

- Treating physician vs. IME physician
- Subjective history is not fact
- With injury history, get records of initial treatment (ambulance, ER, etc).
- If delayed recovery, evaluate disincentives for recovery
- RTW often is less related to physical pathology and more work issues

SHIPYARD WORKERS INJURY RATES

- The Rate Of Injury In Shipyard Workers Is Twice as High as That of Construction Workers
- Bureau of Labor Statistics data show that in 2005, the injury and illness rate for the shipyard industry was 10.9 per 100 employees compared to an injury and illness rate of 4.6 per 100 employees for all private industry. In 2005, 31 percent of injuries and illnesses that resulted in days away from work for shipyard employees involved musculoskeletal disorders; thus prompting OSHA To release 2007 Draft Ergo Guidelines For Shipyard Industry
  - Laws have been put into place as a protection: The Longshore & Harbor Workers Compensation Act & The Jones Act have been placed into action as well as State Workers Compensation Acts

What is in an exam?

- Examinations recommended by all specialty boards generally require assessing the degree of musculoskeletal and functional impairment and also include social and emotional impairment rating scales
- Examiners must also carefully consider patient motivations and perceived gains associated with IMEs. For example, poor job satisfaction may lead some patients to view the IME as a means of securing financial stability without returning to work
- Examiners should inquire about the familial medical history—Hx needs to be detailed

Consensus Statements

- The AMA encourages physicians everywhere to advise their patients to return to work at the earliest date compatible with health and safety and recognizes that physicians can, through their care facilitate patients return to work –American Academy of Orthopaedic Surgeons. AAOS Position Statement: Early Return to Work Programs. www.aaos.org/wordhtml/papers/position/1150.htm. Accessed May 21, 2004
- The Australian Faculty of Occupational Medicine conference report concluded that compensable injuries have a worse prognosis than the same injury would if it were not compensable. This was felt to be due to a complex interaction of factors. In short they concluded Unemployment to be a risk factor for poor health.—The Royal Australasian College of Physicians. Compensable Injuries and Health Outcomes. www.racp.edu.au/afom/compensable/index.htm. Accessed May 21, 2004.
- A review from Canada of 46 original articles concluded unemployment as having a strong positive association with adverse outcomes. –Jin RI, Shah CP, Svoboda TJ. The impact of unemployment on health: a review of the evidence. CMAJ. 1995;153:529-540.

How to Think About Work Ability and Work Restrictions: Risk, Capacity, and Tolerance

- In: *A Physician's Guide to Return to Work,* Ed. By Talmage, JB and Melhorn, JM. AMA Press, 2005

Risk

- Risk refers to the chance of harm to the patient, or to the general public, if the patient engages in specific work activities.
  - Examples are that the DOT medical certification processes require examining physicians to disqualify individuals with uncontrolled seizure disorders working as aircraft pilots and as commercial motor vehicle drivers. When patients should not attempt certain work activities because of known risk, this is clearly a basis for physician-imposed "work restrictions".
- Work Restrictions: This is something the patient can do but should not do as opposed to Work Limitation, which is defined as "capacity" something the patient is unable to do physically.

Work Restrictions and Work Limitations

- Work restrictions—on a medical certification form the term refers to what a patient *Should Not Do* on the basis of risk of harm.
  - This does not apply to symptoms as these are not harm so “work restrictions” would not be appropriate in such cases.
- Work limitations—refers to the things a patient lacks ability to do.
  - This can not be applied to activities the patient dislikes performing.

Capacity

- Capacity refers to the concepts such as strength, flexibility, and endurance
- Many times physicians have no objective way to decide whether the patient does or does not have the current ability to do a task.—When this arises it is appropriate to order an FCE (Functional Capacity Evaluation)
- FCE's tell the physician whether or not on the day of testing patient was willing to demonstrate the current ability to do a job or a job task.
  - It does not always measure total capacity however, it reflects tolerance for symptoms.

Tolerance

- Tolerance is a psychophysiologic concept
  - The patient may have an ability to do a certain task (no work limitation), but not the ability to do it comfortably. Thus tolerance is not scientifically measurable or verifiable. Tolerance is frequently less than either capacity or current ability.
  - Tolerance is a dependant on the rewards available for doing the activity it is not scientifically measurable. Physicians will never all agree on the on questions of tolerance.

Precautions and Risks Cont’d

- Americans with Disabilities Act of 1990 permits the employer to deny tentatively offered employment only if, on the basis of objective findings, the work activities of the “essential job functions” pose a substantial risk of significant harm to self or others that is imminent.
- Substantial harm means an objectively verifiable worsening in the patient-examinee’s condition , and not merely an increase in previously present symptoms like pain or fatigue. This US law says that individuals may choose to work despite pain or fatigue.
- Spine surgeons placed permanent lifting and other restrictions on patients who had good results after a first-operation lumbar diskectomy. Recently studies have shown that those with good results can return quickly to full work with no increase in the incidence of disk re-rupture.

No Objective Pathology

- How should a physician respond to symptoms that are out of proportion to the physical examination and test results—most physicians agree that working despite symptoms poses no major risk.
  - Example: A patient with no objective findings that complains of intolerable pain while attempting to raise a postage stamp raises an issue of tolerance and not an issue of risk or current ability.
  - At times physicians (perhaps inappropriately) place restrictions on patients with conditions such as Fibromyalgia solely on the basis of tolerance.

IME MODLES

- Biomedical Model-used to determine disability this is a severe objective impairment involving all medical facts. (used by almost all Western societies)
- Biopsychosocial Model-much better at explaining and dealing with disability in problematic cases.

No right answer to the wrong questions

- As long as we continue to use the Western Society Model we will be forced to answer using Biomedical Model to determine disability .
- Physicians will never be able to agree on what activity a given patient with less than dramatic objective pathology should be able to tolerate in terms of symptoms like pain and fatigue; it is best that physicians not pretend there is a medical answer to this question.

When it is in the patients best interest to remain at work tell them

You do not appear to meet the SSA's criteria for total disability. Thus, in our society, there is some job you are expected to be able to do. Because there is no medical evidence that you are at high risk of significant harm by working, I can not certify that you qualify as disabled for this job. There is no basis for work restrictions based on risk. I understand that you have pain, fatigue, etc but you posses the ability to do many things despite your pain. Whether the rewards of working are sufficient for you to choose to remain at work, or whether the pain you feel is sufficient for you to choose a different type of work, or not work at all is a question for YOU to answer YOURSELF. I can record on this form what you feel to be your current activity tolerances however, they will not be listed as "work restrictions" or as "work limitations". Your tolerances are not scientific, and they may change in the future.

How to Evaluate Work Ability

- Is there significant risk of substantial harm with work activity (not merely an increase in subjective symptoms)? If "yes" on the basis of sound science or a major consensus document, certify that work *restrictions are appropriate on the basis of risk.* If "no", consider current ability.

- Is the patient actually able to physically do the task in question (not considering symptoms, but ability)" If "no", state the reason as a limitation ("lacks shoulder range of motion to reach overhead machine controls")

- If the patient has the ability to do the work task, at acceptable risk and, wants to do the job, certify that he or she is medically able.

- If the patient has the ability to do the work task, at acceptable risk, and does not like doing the job based on tolerance for symptoms like pain and fatigue, is there severe objective pathology present that makes physician agreement on work "problems" based on tolerance likely? If yes, certify that work "problems" are present "on the basis of believable symptoms and severe objective pathology," but certify that the patient may work despite the symptoms if he or she wishes. (note that there will usually not be a line or a box on the work ability form for "work problems" but there frequently is a line for "comments.") If "no" and the objective pathology is only mild or moderate, certify that the patient may work at the job in question, but that he or she describes symptoms at a certain level of work activity. This scenario represents a "medically unanswerable question," and should be labeled as such by physicians. The decision whether or not to work despite symptoms is ultimately the patient's, and not the physician's.

- $$$ should not be the motive for accepting a consult
  - Judge the appropriateness of a consult “Is it your area of expertise?”—if on the witness stand could you defend your involvement in the case
  - Best practices for physician-payer involve your declaring a time frame for completion of review excluding-record review and rough draft of report.
  - Fee structure should be clarified before you begin consultation.—avoid ruining relationships with potential client by being forthright

Claimant Orientation

- Let them know upfront there is no physician-patient confidentiality
- Claimant should understand you will have no treating physician-patient relationship
- Explain to the Claimant what the exam consists of including the sequence of events

Taking a Thorough History

- Why is more than a history of the work-related events necessary?
  - Psychological aspects
  - Motivation for claims
  - How much of the complaint is related to past medical history
  - Relevancy of claim vs. history

Documentation & Record Review

- Is the claim of injury possible
  - Consider the physics
  - Did the claimant’s injuries match the claim?
  - Review office notes, imaging study reports, medication reports etc.—take notes as you go along
    - Is there supporting evidence based medical studies that uphold possibility of claimant’s injury?
    - What are the guidelines for treatment or disability regarding the claim?

Record Review

- Don’t just settle for the notes supplied
  - Should you read of studies/notes that were not provided you, request them!
  - You can not have too much information to complete a well founded report
  - The issues in question will determine which records are needed

Evaluating Malingering in Contested Injury or Illness

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Malingering

- The gross volitional exaggeration or fabrication of symptoms/dysfunction for the purpose of obtaining substantial material gain or avoiding or escaping formal duty or responsibility.

Malingering

- Incidence very variable from 1% (Keiser, 1968) to > 50% (Miller and Cartlidge, 1972)
- Amer Bd of Clin. Neuropsychology (Mittenberg et al. 2002) respondants noted probable malingering in 29% of personal injury cases presented, 30% of disability cases, 19 % of criminal cases, and 8% of medical cases.

Malingering-2

- Incidence of suspected malingering in the mild head injury population was 39%
- Binder et al(1993) reported the incidence of suspected malingering to be 27% in a population of patients with mild head injury.
- Rogers(1992) found 20-60% of the patients with mild head injury and financial incentives had improbably poor performances.

Malingering-3

- Youngjohn(1991)-Malingering as high as 47% in a WC group.
- It is often difficult to distinguish between “true” malingering and interference from other extraneous factors that can lead to sub-optimal performance…Moreover, it is very difficult to establish a threshold at which exaggeration or response bias reaches the proportion of malingering.

Guidelines for Malingering

- 1.Improbably poor performance on 2 or > neuropsychological measures
- 2.Total disability in a major social role
- 3.contradiction between collateral sources
- 4.claims of remote memory loss

Griffenstein et al (1994)

Categories of Malingering-1

1. Fabrication- a patient with no impairment or symptoms fraudulently responds that he/she does
2. Exaggeration-a patient with symptoms or impairment caused by the injury represents them to be worse than they are

Miller(2001)

Categories of Malingering-2

- 3.Extension- patient with symptoms or impairment from an injury falsely reports that they have continued unabated when in fact they have significantly improved or resolved
- 4.Misattribution-patient with symptoms or impairment that may have preceded or post-dated the accident and are unrelated to it fraudulently attributes them to the injury

Suspicion of Malingering

- “Although the threshold for suspicion of malingering should be low on all settings, the threshold for its diagnosis should be high, particularly in view of potential judicial impact in forensic cases”

Gerson(2002)

Importance of claimant's credibility

- Considering that the base rate of malingering or significant symptom distortion appears to be somewhere between 20% and 40% in litigating and benefit-seeking claimants and the fact that chronic pain, PTSD, psychiatric disorders, and neuropsychological disorders are predominantly self-report syndromes, determining the credibility of the examinee is a paramount issue