

The Independent Medical Evaluation Begins with You

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Independent Medical (or Psychological) Evaluations should be an opportunity for an examiner to form an unbiased opinion on an injured worker's status, review the past care, recommend future treatment, and clarify diagnoses. An IME can be a powerful resource when care is at a standstill, or conversely, when a case is approaching mediation or resolution. Efficient scheduling and arrangement, in conjunction with comprehensive assessment and clear communication, is the ideal to which we strive.

Because IMEs are important, they are sometimes scheduled on a contentious battleground. The opportunity for a misstep begins when the examination is first scheduled.

Why Schedule an IME?

Defense attorneys generally schedule IMEs because their client (employer or insurer) is unhappy with

- the current course or length of care
- failure to reach MMI and consequent delay in return to work, often perceived as malingering
- excessive diagnostic studies and duplicative treatment
- physician recommendations for surgery or psychological care
- current psychological care, prompting a second opinion

Mistakes

The first error is asking the wrong person to arrange the appointment. Rarely do partners personally schedule an IME, although they often formulate the referral questions and have direct communication with the employer or insurer. An associate, paralegal, or insurance adjuster is tasked with scheduling. All are more than competent to manage this referral if they are fully informed.

1. The responses to the following questions are telltale signs that the scheduler is not well informed.

“Why is this appointment being scheduled?” or “Is this person already receiving psychological care (i.e., true IME) or has the exam been requested by the treating physician?”

- A. I really don't know; they just asked me to schedule it
- B. It's not my case, I'm just scheduling it for (insert busy person's name here)
- C. All they want is three dates right now. We are going with the doctor who
 - a. can see the patient right after two weeks' notice has been given
 - b. has an office closest to the worker's residence
 - c. charges the least amount of money (because we do not differentiate between quality and cost)
 - d.

“Has the patient’s attorney been informed that you are scheduling this exam?”

- A. He’ll know about it just as soon as we fax him
- B. We have the right to this examination and the attorney cannot interfere with it
- C. I’m sure he must know this is coming.

2. The scheduler needs the following information at hand:

- A. Specific reason for the referral even if a detailed letter from the attorney is to follow
- B. Demographic information including
 - a. Patient’s address, phone number, social security number, date of injury, and birth date
 - b. The insurance company name and address, the adjuster and contact information, and the WC claim number (not the firm's case number and not the State’s claim number)
 - c. The employer's name (address not necessary unless they are self-insured)
 - d. The opposing attorney’s address and phone number
- C. The nature of the injury and name of the ATP, or authorized treating physician
- D. Firm knowledge of who is sending the medical records

3. The all-important medical records

Delegate this critical step to one person who ensures the records arrive before the patient does.

Last minute emailing or faxing of forgotten medical records is unprofessional and a burden to the clinician. And, because it is last minute, it cannot be complete. Not only is the record incomplete, but the examiner must then print those records.

Why are *medical* records so important in a *psychological* IME? The injured worker has a concept of their condition, and past and present care. The accuracy of this conception must be weighed against the objective medical records. Patients never completely understand their injury and treatment, the opinions of their providers, why certain diagnostic procedures or surgeries have been denied, or what to expect in terms of recovery. Additionally, the description of the injury may change over time, and the initial report of injury and assessment is often the truest.

Medical records should include

- Initial consultations, whether by a treating physician or from a second opinion
- Watershed events – surgery, a change in provider, a physical therapy discharge note, or FCE
- The last year of ongoing medical care from all providers including drug screens

Past psychological records may reveal little more than frequency of visits. But the patient’s perception of psychological care, the benefit accrued, and the goals of treatment, are extremely important. If that information is not clear to the patient, then psychological care has been ineffective.

4. Choosing the data to share

Most IME referrals come with a letter, and some letters include a chronology of past care. A summary of past medical care is a handy reference for lengthy records, but it is only a starting point, and sometimes, a selective one. If done properly, a chronology outlines all the medical information, but in practice, this summary may exclude data that does not support the referrer's position.

The referral source is usually frustrated at the inability to control the care that has led to this IME. S/he may feel that the facts clearly support the insurer's position, and wants to ensure that these facts do not go unnoticed. Allow your examiner to find this information from the medical records.

5. Requesting an addendum based upon withheld data

If damaging data is withheld in the hopes that it will not be needed (or discovered by opposing counsel), the ensuing report lacks credibility. Further, the clinician has been manipulated. Withholding data until after a report has been issued does nothing for provider relations, to put it politely.

"This guy's neighbor reports that he is selling all of his oxy on the corner." (Produce the clean drug screen but do not ask a clinician to rely upon third party hearsay.)

"We have him under surveillance and want to send the Good Doctor a DVD of his activity." Do not rely on the examining psychologist to watch a surveillance video of what is believed to be physical malingering.

- The voyeuristic nature of surveillance videos makes most practitioners uncomfortable.
- The before and after circumstances of this video is unknown
- On two occasions in this office, the video was of the wrong person
- The evidence rarely pertains to the psychological aspect of a claim

Defense attorneys often present evidence of activities that are inconsistent with the patient's reported condition, and ask the psychologist if the patient is malingering. This is a question for the physician who treats the *medical* condition. If a patient grossly exaggerates their emotional distress, invalidates formal testing with inconsistent responding, and fakes a seizure in the office, those behaviors fall within the purview of *psychological* malingering.

6. Challenging the findings of an IME examiner

Presumably, you have selected a provider whose opinion you respect. You may not agree with that opinion, or fear it weakens your client's position, and this may be a simple misunderstanding that calls for clarification. But ignoring or challenging IME recommendations is counterproductive to the goal of an objective evaluation.

An example:

The patient is referred for a psychological evaluation to determine need for care. The surgeon may have requested this consultation and the claimant attorney is amenable to the referral. The patient is now in chronic pain, resulting in marital stress, poor parenting ability, financial strain, and a general decline in the quality of life. This patient is depressed.

Because a psychological evaluation is incomplete without a thorough background of work, medical, family, and developmental history, this information is included in the report, along with objective diagnostic assessment, clinical interview, and review of medical records. The result is DSM-based diagnostic impressions and recommendations for care.

What could go wrong?

- The employer/insurer ignores recommendations for care, believing the depression is unrelated to the injury. Consequently, a disorder that might have responded well to timely intervention is likely to worsen
- The recommendations are under consideration because they seem reasonable, but no one follows through to schedule ongoing care, perhaps hoping for settlement
- The recommendation for care is denied because “Did you know this injured worker has other problems in her life? Did you know there are family and financial problems not directly related to our injury?” (The only reason *you* know is because this information was elicited during the exam.)
- Return for care is authorized with the caveat that “none of this other stuff in her life is work-related so please confine your care to the actual injury” (Easier said than done because injuries never occur in a vacuum, and everyone has problems.)

Writing a follow up letter in legalese

A follow-up letter asks that the diagnosis of depression be qualified and quantified so that all may “understand” the findings (i.e., “please rethink your diagnosis”). These are not good questions:

- *“Is her depression directly related to the injury?”* (If the report failed to answer this question, it is not a complete report.)
- *“Do you not agree that...”* (Any positive response to this leading question appears biased.)
- *“Did the depression arise naturally and unavoidably out of the course of employment?”* (This is a confusing technical question; the injury arose out of and in the course of employment, and the depression arose from the injury.)

- *“Is this depression a simple and expected response to injury that anyone might experience, or is it a Major Depression?”* (“Major” is not synonymous with “more severe”; the word simply means that certain criteria have been met, usually changes in appetite, sleep, and energy. Major Depression is an acute condition that usually responds well to *timely* and appropriate care.
- *“What does the Doctor think/recommend...”* about findings that were painstakingly outlined in the report. This gives the distinct impression that the report was not read closely.
- *“Will you provide the care you recommended?”* – Asked many months later when ordered by the ALJ. At this point, the original recommendations may no longer be relevant or effective.

The takeaway is this: IME examinations and reports are only as accurate as the information provided and only useful if the recommendations are respected. Despite what may appear obvious to the parties involved, the IME opinion should never be a foregone conclusion.