The Independent Medical Examination (IME) Handbook

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IME DEFINITION / CHARACTERISTICS

An Independent Medical Examination (IME) is "a usually one-time evaluation performed by an independent medical examiner who is not treating the patient or claimant, to answer questions posed by the party requesting the IME".[1] It is a specialized evaluation best performed by a physician who should have special training and experience in assessing issues unique to an IME. Although IME reports share some similarities with conventional medical reports, the IME is distinctly different.[2]

This handbook provides an orientation to performing IMEs and developing a successful IME practice. The IME has three major characteristics:

- "**I**" stands for Independent or Impartial.
- "**M**" stands for Medical.
- "**E**" stands for Examination or Evaluation.

Independent: While the IME may have a clinical bias on how certain issues are assessed, opinions should be consistent and impartial regardless of the referral source and based on scientific evidence based medicine (EBM).

Medical: An IME includes the essential elements of a medical assessment including a history, usually but not always a physical examination, and review of relevant records and applicable diagnostic studies followed by clinical impressions or diagnoses and then by recommendations. The IME typically also discusses, depending on the request from the referral source, disability (definition is jurisdiction dependent) based on activity of daily living deficits; and claims issues which can include causation, apportionment, impairment, work ability, appropriateness and costs of medical care and/or future needs.

Examination: An independent medical evaluation involves an examination by a health care professional at the request of a third party (or rarely by the individual examinee - usually for another opinion or to document status of an existing condition) in which the examiner will not be providing care. The physician is not involved in the medical care of the examinee (there is no physician/patient relationship or privilege with some exceptions – please see liability issues below) and provides medical opinions on issues associated with the case.

The report is not necessarily to facilitate the well-being of the examinee. Impartiality, objectivity, and an understanding of medicolegal issues are required. Unlike a medical consultation report, the IME report is not confidential and is likely to be read by many stakeholders in the claim; it should be easily read and understood by non-medical personnel. Standards for independent medical evaluations have been published.[3]

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INDEPENDENT MEDICAL EVALUATION (IME) VERSUS MEDICAL CONSULTATION

While an independent medical evaluation has some similarities to a comprehensive medical consultation, there are significant differences.

Medicine and law have different approaches. The practice of law is based on the advocacy system and is contentious and argumentative in nature by design. It is a system that allows different and conflicting points of view to be heard with resolution achieved by way of a jury, judge or through arbitration. The practice of medicine is focused on diagnosing and treating patients to the best of the physician's ability to help them regain and maintain good health.

Physicians providing either a one-time consultation or ongoing medical care are accustomed to having their advice sought and followed by a usually grateful patient. Whereas in the legal system, physicians can expect to have their opinions challenged vigorously and in detail by skilled opposing attorneys. In some cases, physicians may have their credentials and ability to testify as an expert questioned in a harsh and demeaning manner. While the attack may seem personal, in fact it is only a method used by attorneys to discredit physicians' testimony to either have it thrown out or its value minimized. A skilled attorney will ask questions that are often difficult to answer and physicians may find that the opportunity for explanation may be limited. Lastly, physicians typically require that an issue have a 95% probability of being true before accepting validity; legal systems usually require only that an issue be more likely than not (>50%).

TREATING PHYSICIAN VERSUS INDEPENDENT MEDICAL EVALUATION

The treating physician, who has a doctor-patient relationship with the claimant, may have a different perspective than the independent medical evaluator. The treating physician has a patient-advocate role (as is appropriate) and may have little desire or experience to comment on claims issues, such as causation, apportionment, disability, impairment and work ability. The treating physician, as the patient's advocate, may be unable to assess these issues in an independent manner.[4] it is noted that the treating physician should be advocating for what the patient needs (active rehabilitation and return to work) and not necessarily what they want (rest, medications and time off work).

The evaluating physician must assess subjective reports in relationship to the objective evidence of tissue damage or organ pathology; this is necessary to assess the extent to which the claimant is impaired or disabled from functional activities of daily living.

The treating physician may be uncomfortable providing opinions that will negatively impact benefits to the patient. With an IME, conflict and distrust may develop between claimants and both defense IME physicians and claims examiners handling their claim. Patients may feel their problems are being discounted while IME physicians and claims representatives may express doubt and skepticism about their complaints.

The treating physician's role is one of being a patient advocate. Thus, the treating physician often has a different perspective than the IME physician.

IME physicians will have their biases based on their experiences and belief systems. In most jurisdictions IMEs are more often requested by defense counsel, representing the insured. Since treating physicians are patient advocates, their opinions are often more favorable to the patient; furthermore, reports issued by treating physicians are typically less costly than an IME and plaintiff attorneys may refer to certain treating physicians. In some venues, the physician may be utilized by both sides jointly; in the California workers' compensation system, this is referred to as the "agreed" medical examiner (AME).

When the physician provides treatment, the doctor-patient relationship is one of trust. The physician is acting as an agent for the patient. When performing an IME, the physician is performing a service for the referral source. In 1992, Sullivan and Loeser recommended that treating physicians refuse to do disability evaluations since adverse consequences may ensue for the patient who has disability benefits terminated. [5]

IME REFERRAL SOURCES

IMEs are an integral part of case management and are utilized widely by insurers and attorneys in a variety of arenas, including automobile casualty, workers' compensation, personal injury, medical malpractice and long-term disability. The term Civil or 3rd Party litigation is sometimes used to designate nonworkers' compensation cases such as automobile casualty and personal injury.

It is important to understand that each of these systems/jurisdictions is unique with different definitions of disability while having different requirements for reporting.

Workers' compensation systems are no fault, but litigation issues often center around causation, the extent and duration of medical care needs, the length of temporary disability, the extent and cost of permanent impairment and/or disability, and issues of apportionment to non-industrial causation. An insurance carrier or third-party administrator (TPA) typically handles claims. Some employers are partially or fully self-insured.

Civil or 3rd Party litigation, including malpractice cases, involve primarily the cause and extent of injuries and the level of associated disability, activity of daily living deficits, loss of work capacity and future medical care costs. Once a lawsuit is filed, the defendant is generally allowed one IME. In these cases, the defendant is counting on the IME to be unusually thorough as the case may hinge on the examination findings and report conclusions.

Short- and long-term disability cases range from private disability policies to Social Security benefits for persons expected to be totally disabled for at least 12 months to individuals who have purchased or been provided by their employer private disability insurance policies. These cases focus on work ability with the definition of disability contract specific.

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THE UNBIASED IME

There has been much criticism in the medical literature (and on the Internet) about the quality of independent medical examinations (IMEs) basically suggesting that they are not "independent" or "neutral" and suggesting that they are often biased.

Many physicians are known for being "defense" or "plaintiff" oriented/directed. There are physicians though that do both plaintiff and defense IMEs.

The quality IME physician does not pander to the referral source. In fact, the smart referral source recognizes the importance of an honest and truly independent opinion. Whether it is the plaintiff or defense attorney, the IME physician who provides erroneous or seriously flawed opinions, may either be discredited by the opposing attorney during trial and/or is not believable to the jury. Further, providing information that is erroneous or not credible, may be very costly with an unfavorable settlement/award.

The approaches and perspectives of evaluators may be perceived as more favorable to defense or plaintiff. For example, in assessing causation, if an evaluator uses a rigorous scientific approach, this is more likely to be perceived as favorable to defense counsel than another evaluator who opines that certain events caused or aggravated a condition based on a temporal relationship. In a similar way, physicians who provide more weight to objective findings, use evidence-based medicine as the basis for their opinions versus personal opinions, assess permanent impairment more strictly following applicable guidelines, are less likely to restrict patients from working, and are more conservative on treatments, may be perceived as defense oriented; however, the physician may be totally unbiased, yet have opinions that are typically found more acceptable to defense counsel.

Some IME referrers sometime select the doctor knowing the examiner will make opinions that will benefit their position. While that may be the case, highly biased IMEs undermine the integrity of the process.

POTENTIAL PITFALLS

The referral source will often ask whether the potential IME physician has any possible conflicts of interest. It is important to make sure that the claimant has never been seen in the IME's office previously for any reason; the referral source should be notified of any involvement with other physicians or attorneys in the case.

An IME should not be performed on a former or active patient but you can choose to write a report and testify as an ongoing or former treater. In the alternative, you can make a full disclosure and have a signed agreement with the patient and his or her attorney to proceed with an evaluation; however, it will not be a true IME.

Stay within your area of expertise. No good comes out of providing opinions outside the scope of your training and expertise. For instance, it is perfectly legitimate to state that while the non-radiologist IME physician can review imaging studies, that he or she defers to a radiologist. A non-surgeon such as a physiatrist or neurologist may have an opinion about surgery but defer on the specifics regarding back surgery to a spine surgeon.

Do not be pressured by the referral source to change or modify a report to meet the "needs" of the client.

Physicians who come up with outlandish or ridiculous opinions will not be respected by the judge or jury.

It is critically important to have the referral source make it very clear what areas of opinions are being requested; for example, if causation is not at issue, there is no need to address it.

IME REPORT QUALITY ISSUES

While the quality of the physician's testimony at a deposition, arbitration or trial may be critical; the initial written report is typically most important. This report is relied upon in any settlement negotiation and often becomes part of the evidence. The well-written and defensible report must be valid, defensible and readable.

A well-written report will assist the IME physician during deposition cross examination and may even discourage the opposing attorney from going to trial; thus, the report itself may lead to early case settlement or resolution. The physician will be judged by the quality of the written report. A poorly written report reflects negatively on the IME physician and may damage the underlying case. A well-written report enhances the reputation of the IME physician and leads to further referrals.

A quality IME report is responsive to the specific questions asked by the referral source. The report should be understandable by non-medical individuals. In some contexts, a verbal report is provided prior to submission of a written report thus giving the referrer the opportunity to further direct specific questions or concerns or to even defer on receiving a written report. The physician should always maintain integrity but should remember that there is no traditional doctor-patient relationship and the payer is the client.

Whether the referral source is an insurance carrier, defense or plaintiff attorney, they are much better off with an honest opinion before wading further into the subject case.

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IME REPORT WRITING TECHNIQUE

Some IME third party intermediaries ask the IME physician to answer specific questions and "fill in the blanks." For the most part, IME physicians will use their own system of report writing.

Evaluation reports should be without spelling errors and should be grammatically correct. The report structure should include appropriate formatting with headings and categories. Bold lettering, italics, underlining, numbering and bullet points can be used for clarity and emphasis. All material and records reviewed should be listed. Paragraphs should be kept relatively short and separate ideas should be put in distinct categories. Unnecessary repetition should be avoided. Use unambiguous language that can be easily understood by the referral source. When reporting, superfluous information should be left out. The claimant as well as past treating and evaluating physicians should not be disparaged. List the time spent with the claimant face-to-face, reviewing the records and preparing the report. The report should contain all opinions to be expressed at a hearing or trial.

IME PRE-EVALUATION ISSUES

Prior to examining the claimant, the physician's office will receive a IME request by the referral source. A chart is established which will contain all notes, emails and written correspondence. Telephone calls and meetings can be documented but the referring attorney may purposely not be committing comments in writing so the IME should be sensitive to what is documented in the medical record.

It is important to provide documentation regarding charges and usually a curriculum vitae will be requested. Some physicians insist on a pre-payment advance prior to reviewing records, providing an examination report or attending a deposition, arbitration or trial. Charges should include costs for late cancellations, records review, the actual examination, report writing, research, meeting time with the referral source, deposition, arbitration and trial testimony time. It is important to identify who will be notifying the examinee of the appointment date and time.

It is appropriate to review records in advance to assure that all historical items are reviewed with the examinee. Many physicians will prepare the medical record summary in advance and prepare a template for their report. This is very important particularly for defense examinations where the IME physician will only one chance to examine the claimant. There may be issues found in the medical records that need to be addressed.

INTERACTIONS WITH THE EXAMINEE

If the evaluation is being accomplished at the request of the examinee's attorney, there is an implied understanding that the physician is serving in that individual's best interest. When examining for the defense (the "other side"), it is not uncommon to find an examinee who is, at a minimum, suspicious and maybe even hostile.

For a defense IME, there may be limitations set ahead of time by the plaintiff attorney on what questions can be asked and what body parts can be examined. These issues should be discussed with the referring defense attorney prior to the examination.

Depending on the jurisdiction, the claimant's attorney or representative and sometimes even a court reporter or videographer may attend the evaluation. This may or may not be permissible, depending on the setting/jurisdiction. Any other individual attending the appointment should remain silent and not provide information except for significant others if they are specifically asked to provide information. If the plaintiff attorney is present, that individual may limit the claimant from answering certain questions. The claimant may request to tape record the examination, however whether this is permissible is dependent on the jurisdiction.

It is important in any scenario to carefully explain your role including the fact that the evaluation is not meant to be a comprehensive medical evaluation covering all possible problems and that no doctor-patient relationship is implied. Risk is reduced by having the examinee signed an informed consent form. There is usually no confidentiality. Typically, the physician's opinions and any recommendations are not discussed with the examinee unless specifically requested by the referral source.

The examinee is told to not perform any maneuver that her or she feels will be harmful to them. Adequate gown coverage is important and a chaperone, from the physician's staff, is recommended. In some jurisdictions, for a defense IME, the claimant may have the right and choose to have another party present during the physical examination portion of the evaluation. Request a picture ID such as a driver's license to make sure you are examining the correct individual.

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IME AND REPORT WRITING

INTRODUCTION

Physicians are aware of the usual details covered in a standard history and physical examination. The IME report goes into much greater detail in certain areas, as compared to a medical consultation; other factors contribute to the issues of perceived pain and disability.

The examinee's preinjury status is carefully detailed. It is very important to determine if there was any condition, impairment or disability predating the injury. The history of the injury, subsequent events and medical care up to the present time are carefully ascertained.

Any inconsistency between the individual's report and information found in the medical record is noted. It is important to remember that individuals often have selective memories and, sometimes, what they remember is not accurate. The premise that examinee reports are accurate has repeatedly failed scientific testing.[6] Studies have demonstrated that in addition to exaggerating preexisting health status, claimants tend to minimize their current health status, i.e., they tend to report they were better than they were prior to an injury and after the injury over report symptoms and functional difficulties.

Sadly, some examinees are "coached" prior to their evaluation by their attorney. The IME physician should be aware of this potential symptom bias when taking the examinee's history. Careful preparation with the medical records beforehand can be invaluable in detecting this bias.

The medical record is of critical importance; however, it is possible that the health care professional left something out or misunderstood the examinee. Therefore, just because something is not reported in the medical record does not mean that it did not happen. An evaluator considers all these factors. The IME physician is neither a magician nor fortune teller, but must assess all the information available and provide a medically reasonable explanation, to a reasonable degree of medical probability (more likely than not).

IDENTIFYING INFORMATION

The report starts with identifying information of the name of examinee, claim or identifying numbers, date of injury, date of the evaluation and/or report, and the name of the examinee. For workers' compensation cases, the employer's name is often listed.

Any other parties present for the examination should be listed (attorney or the representative, interpreter or other participant).

PURPOSE OF THE EXAMINATION

The report is addressed directly to the referral source. The first report paragraph typically notes the purpose of the exam and any other specific questions asked or reasons for the evaluation. You may add a paragraph noting that the report is based upon the personal interview and examination of the examinee, combined with review of available medical records and radiographs and other submitted

information. A list of all records reviewed is either listed in the body of the report or attached as an addendum. Typically, a summary of the content of each document is provided.

You may choose to ask to see examinee's picture identification such as a driver's license. You should identify if the examinee was accompanied by an interpreter or any other person (significant other, friend, relative, lawyer, nurse, court reporter, videographer, etc.) and whether the examinee tape recorded the examination. Document that the examinee was informed the purposes of the examination and that there was no doctor-patient relationship and that the examinee should not perform any maneuvers that the individual would consider harmful or injurious. Some IME physicians ask for a baseline pain level before the exam and then ask what the pain level is at the termination of the exam; mainly to document that that the IME did not cause any injury during the exam. This information also helps if the examinee alleges that symptoms were worse the next day due to the exam.

EXAMINEE INTRODUCTION

The next paragraph lists the examinee's age, handedness, and marital status. In the workers' compensation arena, the employer, years on the job, and current work status can be listed.

PERTINENT HISTORY

For most evaluations, there is a point in time when problems surfaced, either due to a specific injury or illness or on an alleged cumulative trauma basis; this date should be identified. The reported mechanism of injury and associated problems and care must be thoroughly documented.

Document pre-existing status, i.e. whether prior to some identified point in time the examinee described being in good health without ongoing disability or the examinee had a pre-injury (or illness) history of pertinence. Also describe any relevant prior history of injuries or illness (this might include auto accidents, illnesses, prior work or other injuries, surgeries, etc.).

The clinical course is described in detail, including subsequent symptoms, health care provider visits, diagnostic testing and treatment (including medications prescribed and surgeries). You should assess whether the history is consistent with the records; if it is not, you should attempt to clarify inconsistencies with the examinee and document them.

CURRENT SYMPTOMS

Current symptoms are carefully documented. The examinee is given the opportunity to detail all symptoms and complaints, including any interference with activities of daily living or perceptions of loss of pre-injury capacity. Document body parts involved including location and radiation of symptoms and referral patterns along with spatial characteristics, duration periodicity, and intensity/severity.

Pain complaints are commonly associated with disability and the character of the pain (i.e., continuous, non-fluctuating; continuous fluctuating; episodic; paroxysmal, etc.). A description of the quality of the pain (e.g., burning; freezing; sharp; pins and needles; aching; dull; hot; cold; numbing; and electrical.) A Pain Drawing or other questionnaires (Pain Disability Index, Oswestry Function Test, McGill Pain Questionnaire, Etc.) can be useful.

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Additional descriptors should be listed (tingling; numbness; weakness; swelling; color change; temperature change; sweating; skin or hair growth changes. etc.).

Provocative or aggravating factors that worsen the pain and palliative factors that alleviate the symptoms should be detailed.

- Provocative or aggravating factors can include sitting; rising from sitting; standing; walking; stair climbing; lying on side, back or stomach; kneeling, bending or squatting; lifting and carrying; reaching, grasping, gripping, holding and manipulation; pushing or pulling; driving, coughing or sneezing; running; sleeping; sexual activity; Valsalva-type maneuvers; physical activity including exercise; and other activities of daily living.
- Palliative or alleviating factors or treatments can include rest; passive modalities (heat, ice, TENS, acupuncture, massage, manipulation, trigger point injections, etc.); medications; procedures and other treatments; active activities (physical therapy, yoga, tai chi, stretching and exercise, etc.); and mind–body treatments (biofeedback, cognitive behavioral therapy, meditation, etc.).

The current intensity of the pain is described on a 10-point scale, where "0" represents no pain and "10" represents the worst pain imaginable. Stanford Five[7]:

1. **Cause:** What tissue abnormalities the examinee believes to be the cause of the current problem.

2. **Meaning:** The presence of any sinister beliefs related to the pain, in terms of tissue damage, that precludes activity.

3. **Impact:** What impact does the primary problem have on the examinee's life including interferences with vocational, social, recreational activities and in general, the quality of life.

4. **Goals:** What the examinee expects to achieve with further treatment.

5. **Treatment:** What the examinee believes needs to be done now and in the future to help resolve the problem.

Scientific knowledge clearly indicates that psychological and social factors commonly play a more significant role than the direct/primary physical effects of the condition in the development of chronic pain; therefore, the evaluator must consider these factors. Subjective complaints are reinforced by the context of litigation and scientific findings have indicated that eligibility for compensation is a factor for chronic pain claims.[8] Adverse childhood experiences (ACEs)[9] and personality disorders have also been identified as a significant risk factor.[10] [11] [12] [13] In addition to the prominence that has been scientifically established for personality disorders as risk factors for the development of chronic pain, other forms of mental illness have also been established as risk factors.[14]

The presence of any examinee reported emotional (anxiety, depression, etc.) or cognitive dysfunction (memory, concentration, etc.) should be noted. Additional relevant information may be obtained from significant others.

FUNCTIONAL HISTORY

Obtain information regarding activities of daily living (ADLs - feeding, grooming, bathing, dressing, and toileting) and instrumental ADLs (IADLs - complex skills needed to function independently, i.e., using the telephone, doing laundry, preparing meals, care of others, managing finances, shopping, taking medication, managing transportation, etc.). IADLs overlap with questions concerning any changes in cognition, concentration and memory.

If work capacity is an issue, it is also important to assess more complex issues such as pacing (speed of activity); Repetition (repetitive activities); time (prolonged activity); and positioning (static or awkward posturing).

Also obtain a description of the examinee's daily routine (exercise, outdoor activities, recreation, household chores, etc.) and changes from pre-injury status.

Any use of adaptive equipment such as braces, canes, wheelchairs, etc., should be noted.

CURRENT & PAST MEDICATIONS

Obtain a list of past and current medications. It is useful to request that the examinee bring all current medications to the examination. The examiner should assess medication effectiveness, side-effects and any evidence of misuse or abuse.

REVIEW OF SYSTEMS

Consider constitutional, head and neck, cardiovascular, respiratory, genitourinary, gastrointestinal, neurological, psychiatric and musculoskeletal symptoms in the review.

PAST MEDICAL AND SURGICAL HISTORY

Note relevant injuries and illnesses including accidents (auto and other) and include a review of all past significant or similar medical diagnoses, treatments, allergies, previous hospitalizations, and surgical procedures plus any history of psychiatric disorders / treatments / hospitalizations. Note potentially significant other medical problems such as diabetes, cardiovascular or pulmonary disease, hypertension, arthritis, gout, etc.

FAMILY HISTORY

Document relevant family history issues especially any alcoholism, substance abuse, major injuries, disability, pain, etc. Disability, illness or death in the family may affect how the individual responds to his or her own medical problems. A family history of certain diseases may explain symptoms in the examinee that have not previously been well explained.

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PERSONAL HISTORY

Information in this section can be of critical importance and areas of concern include the following.

- Childhood, i.e., was the examinee's childhood normal, dysfunctional, or abusive (sexual/verbal/physical/neglect)?
- Education, i.e., years of formal education; military service and any legal history (litigation or incarceration).
- Significant other and/or spouse, i.e., does the examinee have a significant other or has he or she ever been married, how many times and for how long? Was there any associated abuse history? Is this significant other and/or spouse working or disabled?
- Children, i.e., if there are children, what ages and how many?
- Current living situation, i.e., who is the examinee living with? Is there an apartment or house? Is it accessible (number of steps, adaptive equipment, etc.)?
- Illicit substance use or abuse? If positive, provide previous and current usage level.
- Tobacco, caffeine and alcohol usage.
- Current income source, if any (family members, workers' compensation, pension, Long Term Disability, State disability, Social Security, etc.)
- Work history: The occupational history should include not only the names of previous employers, job titles, types and physical intensity of previous jobs, but also continuity and length of previous positions. Attitudes about work (work "ethic" and work attitude) can be of considerable importance.

RECORDS REVIEWED

A listing of all materials and records reviewed should be listed and relevant information summarized. For imaging studies, it should be noted whether the actual studies were reviewed or just the reports.

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PHYSICAL EXAMINATION

The physical examination is similar to a medical consultation; but it is important to document negative, positive and non-organic findings.

If you are performing an AMA *Guides* impairment evaluation, perform the assessment according to specific examination requirements in the relevant edition and section of the AMA *Guides to the Evaluation of Permanent Impairment.*

When giving testimony, an opposing attorney can make the IME physician feel quite uncomfortable when parts of the examination are not documented. A template or checklist of anticipated examinations or parts of examinations used during the examination can be helpful to minimize this issue.

The examination integrates information obtained from physical findings to support or refute diagnoses suggested during the history taking. The examination may uncover physical findings not readily apparent from the history or even known to the examinee.

The physical examination is not limited to, but is directed to the concerned body parts and when a change or abnormality is identified, the appropriate regional examination is expanded. The examination includes documentation of:

- General observation of the examinee.
    - Appearance and constitutional can include body habitus (nutrition: over-, under- or average-weight), grooming (appropriateness of dress and general cleanliness), odor (tobacco, alcohol, body odor, etc.), body markings (tattoos, piercing, etc.) and other observances (i.e. dirt stained and calloused hands, etc.).
    - Adaptive aids are noted such as braces/splints, walking aids/wheelchair and including whether such are appropriate or inappropriate to the diagnosis and whether they're utilized appropriately or are more suggestive of pain behavior.
    - Behavior includes such issues as cooperation and attentiveness, along with any pain behaviors or unusual activities. The individual's sitting and standing tolerance are noted and all measurements recorded. Non-physiologic findings (Waddell's signs, symptom magnification, chronic pain behavior such as moaning, groaning and misuse of assistive devices, etc.) are also noted.

- Initial functional observations that include observation of functional maneuvers such rising from seated position, using hands/arms to complete forms, head turning, gait, quality of handshake, interactions with office staff. These observations are used to cross reference the functional history and either invalidate or verify findings when similar maneuvers are used during the exam.

- Patient descriptors, i.e., whether the examinee is a good, poor or fair historian and, when appropriate, descriptions, e.g., pleasant and cooperative (versus unpleasant and uncooperative), angry or hostile and/or garrulous or loquacious.

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- Pain behavior, i.e., verbal (sighing, moaning, groaning) and non-verbal (grimacing, guarding, splinting, clutching, bizarre gait).

Other physical examination findings, dependent on the context of the evaluation, may include:

- Head, eyes, and ears - General appearance, deformities, assistive devices (e.g., hearing aids, glasses), and visual/auditory acuity.
- Mouth, throat, and nose - General appearance, general dental condition, and patency of airway.
- Neck - General appearance, vascular distension, auscultation for bruits, and active range of motion (AROM) and passive range of motion (PROM), lymph nodes.
- Cardiovascular - Auscultation of the heart, examination of peripheral pulses, inspection of vascular refilling, varicosities, swelling, and edema.
- Respiratory & Chest - General appearance of the chest, breasts for masses or tenderness, auscultation of lungs and upper airways, observation of breathing pattern, and examination for peripheral clubbing or cyanosis.
- Gastrointestinal/genitourinary - Inspection of abdomen and pelvis, auscultation of bowels, palpation of abdominal organs, and rectal examination.
- Genitourinary – directed as appropriate.
- Integumentary - Inspection and palpation of skin and subcutaneous tissues for color, mottling, sweating, temperature changes, atrophy, tattoos, lesions, scars, rashes, ulcers, and surgical incisions.
- Musculoskeletal – Inspection, percussion and palpation of joints, bones, and muscles/tendons noting any deformity, effusion, misalignment, laxity, crepitation, masses or tenderness; assessment of AROM and PROM and stability of joints; inspection of muscle mass; spinal alignment and symmetry; and assessment of muscle strength and tone.
- Provocative tests – Maneuvers for thoracic outlet syndrome, Phalen's and Tinel's for carpal tunnel, foraminal compression for cervical radiculopathy, straight leg raising for sciatica, etc.
- Neurologic - Assessment of level of consciousness (alert, lethargic, stuporous, comatose) and mental status (e.g., orientation, memory, attention and concentration, thought processes and content, speech and communication /language and naming, fund of knowledge, insights into current condition), and assessment of cranial nerves. The neurologic examination also includes assessment of (1) sensation to pinprick, two point discrimination (in selected cases) sensibility (light touch), vibration, and proprioception, (2) assessment of sphincter tone and superficial reflexes (e.g., bulbocavernosus, abdominal, cremasteric, etc., as appropriate), (3) assessment of deep tendon reflexes (DTR) in the upper and lower extremities, including pathologic reflexes (e.g., Babinski, Hoffman, palmomental, etc.), (4) assessment of coordination (e.g., finger/nose,

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heel/shin, rapid alternating movements, fine finger dexterity), and tandem gait, and (5) functional mobility including gait and station.

- Non-physiologic behaviors are assessed such as Waddell signs (e.g., superficial skin tenderness, stimulation of back pain by axial loading or trunk rotation, differences in straight leg raising response between supine and sitting positions, regional non-anatomic weakness or numbness, and overreaction/disproportionate pain responses).

ASSESSMENT

Based on the findings from the history, review of medical records and other documents, physical examination and clinical studies, the evaluator responds to the specific questions asked by the client.

The evaluation physician cannot base opinions solely on only the basis of "education, training and experience." Rather, the evaluator must provide a clear description of why a conclusion has been reached, including reference to the facts and current science and best practices.

Opinions are stated clearly and explicitly using terminology such as “based on a reasonable degree of medical probability.” This means “more likely than not”, i.e., that there is a probability greater than 50%. All opinions should be supported with a detailed explanation to justify those opinions.

Credibility issues should be discussed and explained. Do you believe the examinee is malingering (lying) or you find evidence of symptom magnification/exaggeration related to her chronic pain syndrome?

CASE SUMMARY

Provide a succinct summary of the history and physical examination followed by opinions (when requested) on the specific issues requested by the client.

CLINICAL IMPRESSION

List the diagnostic categories and/or the differential diagnoses. Typically, this is done as a numbered list. Also, include the basis for your impression – findings in medical records, labs, imaging, current exam findings, etc.

CLINICAL ANALYSIS

It is essential to provide a clinical discussion of the problems in a manner that is clearly understood by a non-medical reader. Your opinions must be supported by the facts in the case and evidence-based medicine. As appropriate, provide specific references to the medical literature.

CAUSATION AND APPORTIONMENT

Causation and apportionment are often critical issues. The evaluator must determine whether the problem, impairment and/or disability was preexisting or was caused by an event or occurrence. There may be multiple factors, including occupational and non-occupational, that contribute to the

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development of a clinical problem. Causation must be based on the facts and current science. Legal standards for causation may differ from medical standards and may vary by jurisdiction.

Many clinicians focus on aspects of clinical care for their patients, i.e., what is appropriate evaluation and treatment, and may not be formally trained in causation analysis or epidemiology, nor may they be familiar with the most current science. IME physicians must understand the current science and the process of determining whether a condition is injury-related. In the AMA *Guides* series of publications, the *Guides to the Evaluation of Disease and Injury Causation* provides guidance on the process of causation and apportionment analysis.[15] This publication provides guidance on understanding work-relatedness, methodology, causality examination, and provides chapters dealing with specific regions.

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 the condition (e.g., impairment).
- The event could cause the condition.
- The event caused or medically contributed to the condition within medical probability.

It appears that some physicians opine that certain injurious events caused or aggravated a condition based on a temporal relationship, without a scientific basis to support these conclusions, and these opinions are accepted by fact finders without further analysis. This results in faulty decisions on these cases and a failure of the examinee to understand the true nature of the condition.

In 1965, the English statistician Sir Austin Bradford Hill proposed a set of nine criteria to provide epidemiologic evidence of a causal relationship between a presumed cause and an observed effect or simply an association. This causation analysis checklist is sometimes referred to as the Bradford Hill criteria.[16]

The list of the criteria is as follows:

1. Strength (effect size): A small association does not mean that there is not a causal effect, though the larger the association, the more likely that it is causal.
2. Consistency (reproducibility): Consistent findings observed by different persons in different places with different samples strengthens the likelihood of an effect.
3. Specificity: Causation is likely if there is a very specific population at a specific site and disease with no other likely explanation. The more specific an association between a factor and an effect is, the bigger the probability of a causal relationship.
4. Temporality: The effect has to occur after the cause (and if there is an expected delay between the cause and expected effect, then the effect must occur after that delay).
5. Biological gradient: Greater exposure should generally lead to greater incidence of the effect. However, in some cases, the mere presence of the factor can trigger the effect. In other cases, an inverse proportion is observed: greater exposure leads to lower incidence.
6. Plausibility: A plausible mechanism between cause and effect is helpful (but Hill noted that knowledge of the mechanism is limited by current knowledge).

7. Coherence: Coherence between epidemiological and laboratory findings increases the likelihood of an effect. However, Hill noted that "... lack of such [laboratory] evidence cannot nullify the epidemiological effect on associations".
8. Experiment: "Occasionally it is possible to appeal to experimental evidence".
9. Analogy: The effect of similar factors may be considered.

The evaluator must be able to distinguish between an aggravation and an exacerbation. An aggravation results from an event or injury causing a permanent worsening, hastening or deterioration of a pre-existing 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. It is important to understand the use of appropriate terminology in the jurisdiction/context in which you are working.

Medical apportionment is an estimate of the extent to which two or more probable factors caused an injury or disease. When apportioning responsibility for an injury or disease, one must first consider all potential causes and then determined whether each is probable or possible. A compensable injury or disease may exacerbate or aggravate a pre-existing condition, but may also be temporarily or partly worsened by subsequent trauma or exposure. Many illnesses are multifactorial in etiology. Physicians must be aware of the current medical literature to determine the causes for a condition, including occupational and non-occupational causes and the significance of these causes.

It is also important to recognize that the definition of apportionment depends on the jurisdiction.

PROGNOSIS

Determine prognosis based on the clinical problems and probable future clinical course.

MAXIMUM MEDICAL IMPROVEMENT (MMI)

The evaluator assesses whether a condition has stabilized and is unlikely to change (improve or worsen) substantially in the next year, with or without treatment. Synonyms include: fixed and stable, permanent and stationary and stable and ratable.

IMPAIRMENT

Impairment evaluation is the acquisition, recording, assessment and reporting of medical evidence using a standard method such as that described in the AMA *Guides to the Evaluation of Permanent Impairment.* The appropriate Edition of the *Guides* should be used, based on the jurisdiction. The evaluation and reporting must comply with the standards provided in the *Guides.*

WORK ABILITY

Work ability is defined by consideration by of three factors: risk, capacity and tolerance.[17] The IME physician needs to assess each of these factors in opining on work ability. Risk refers to the chance of harm to the examinee, co-workers, or to the public, if the examinee engages in specific work activities. Substantial harm means an objectively worsening in the examinee's condition, and not merely an increase in previously present symptoms, like pain or fatigue. Capacity refers to concepts such as

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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. Tolerance is a psychopathologic 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 limits the ability to do task(s) in question. Tolerance is dependent on the rewards available for during the activity in question.

APPROPRIATENESS OF MEDICAL CARE

When requested, the appropriateness of medical care should be evaluated using evidence-based medicine and recognized practice guidelines, such as the American College of Occupational and Environmental Medicine Practice Guidelines and/or Official Disability Guidelines - Treatment Guidelines.

RECOMMENDATIONS

The client may request recommendations on further medical care and/or steps to facilitate recovery. Some IME physicians may provide cost estimates but typically a separate Life Care Planner works with the IME on future medical care costs.

DISCLOSURES

IME physicians commonly provide disclosures at the end of their reports, such as:

> 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 later, 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 probability. 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 Americans 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 care 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 action be made or enforced.
>
> I have reviewed the excerpts and entire outline 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.

Certain jurisdictions may require other disclosures.

IME QUALITY ASSURANCE

The quality of the IME report is of paramount importance to the subject case but also with respect to future referrals. The following are list of questions to ask about regarding quality issues.

- Is the IME report well-organized and written such that he can be well understood by the nonmedical reader?
- Are there specific asked questions and information needed answered and the opinions provided supportable?
- Is the report fair, unbiased and impartial?

The IME Checklist provided in the Appendix may be used to assess the quality of the evaluation and report.

FUNCTIONAL CAPACITY EVALUATION

The IME may be asked to address the examinee's functional ability or work capacity. The opinion is based on a review of medical records, the historical and physical examination, test results and the examinee's functional capacity. The evaluation is made difficult when the individual demonstrates pain behaviors and a suboptimal effort on examination and testing.

The report should include the number of hours to be worked per day, sitting, standing and walking tolerance, as well as lifting and carrying capabilities. For the upper extremities, the ability to perform forceful and repetitive activities should be discussed. Other factors to be considered are reaching, pushing, pulling, grasping or gripping, bending, crouching, squatting, climbing, balancing, working on uneven terrain and working at heights. For difficult cases, a formal functional capacity evaluation (FCE) may be helpful.

A formal Physical or Functional Capacity Evaluation (FCE) is a systematic process of assessing an individual's physical capacities and functional abilities. Testing, lasting one-half day to several days, is usually carried out by a physical or occupational therapist with special training and expertise in this area.

The job specific FCE matches human performance levels to the demands of a specific job or work activity or occupation. The general FCE establishes the physical level of work an individual can perform. The FCE is useful in determining job placement, job accommodation, or return to work after injury or illness. An FCE can provide objective information regarding functional work ability in the determination of occupational disability status.

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The FCE is a tool that can be used to make objective and reliable assessments of the individual's condition. Its precise data format provides information that can be used in various contexts. The FCE may be used 1) To determine the individual's ability to safely return to work full time or on modified duty; 2) To determine if work restrictions, job modifications, or reasonable accommodations are necessary to prevent further injury; 3) To determine the extent to which impairments exist, or the degree of physical disability for compensation purposes; and 4) To predict the potential ability to perform work following acute rehabilitation or a work-hardening/work-conditioning program.

A Physical or Functional Capacity Evaluation (FCE) provides additional information beyond what can be determined by the physician directed disability evaluation but the FCE does have its limitations as well. The functional capacity of the examinee who does not provide a full effort cannot be accurately assessed. Further, while providing a greater depth of testing than the physician physical examination, the FCE can only measure capacity in a controlled environment over a short period of time and does not necessarily equate with full time, real world, everyday life and job tasks.

While the FCE therapist evaluator is skilled in interpreting test results, it is the physician who must put together the medical history, the physical findings and the FCE results to come to a conclusion as well as assessing the validity of the findings. It is wise to remember that an FCE determines what a person is willing to do, not necessarily what a person is capable of doing.

A similar test of capability, based on cardiopulmonary conditions and overall fitness is called a cardiopulmonary exercise stress test. It measures not only cardiac and pulmonary capabilities and reserves, but it measures a person’s overall fitness and endurance.

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POST IME ISSUES

IME reports should be completed and sent with appropriate billing to the referral source in a timely manner. The examinee and the treating physician are not provided copies of the report unless requested by the referral source although this is uncommon. Depending upon the situation, the referral source may be contacted to discuss opinions or recommendations. In some cases, a written report may not be required or desired at that time. This is particularly true when the opinion generated is not deemed to be in the best interest of the referral source's case.

POST CASE CLOSURE

It is helpful to request feedback from the referral source regarding your case involvement. Any the remaining charges should be submitted and a thank you note for being included as an expert witness is recommended. Always asked at the end of the case if it is okay to proceed with safely discarding submitted medical records.

FEE AND PAYMENT POLICIES

The IME physician should have written Fee and Payment Policies that are provided prior to the evaluation. For example:

> My hourly charges are $$$/hour for chart review and report preparation and $$$ an hour for meeting time and patient examination. For depositions, I charge $$$ for the first hour and $$$ for each quarter hour thereafter. For time away from the office for trial testimony, I charge $$$ per half day and additional charges for travel time or for work over normal working hours. I require a $$$ advance payment to begin working on a case (any unused funds will be returned). My tax ID # is XX-XXXXXX. Any additional charges will be submitted as generated. I do not work on a lien basis.
>
> Please also understand and agree that all services must be prepaid including planned trial testimony. There will be a charge submitted for cancellation of appointments, depositions and trial testimony for time that cannot be otherwise scheduled or for cancellations within 10 working days of the scheduled time.
>
> Please do not hesitate to contact me if I can be of further assistance.

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TESTIMONY: DEFENDING YOUR IME REPORT

The evaluator should be prepared to be deposed, and to attend an arbitration hearing or trial. Depositions are usually requested by the opposing counsel to gauge the potential effectiveness of the physician as a witness. Should the case go forward to arbitration or trial, the effectiveness of the physician goes beyond medical knowledge, but also involves the IME's presentation and demeanor in front of a judge and/or jury.

Credibility is always increased through the observer's perception of the physician's honesty and integrity. It is always best to be honest and not appear to be trying to "help" the case of the referral source. Any potential negative information or opinions should have been discussed previously with the referring attorney or claims person as to how to deal with it in the least damaging manner. While honesty and integrity are essential, there is no need to volunteer information that might be damaging to your referral source. It is ultimately the job of the IME physician to be an expert witness, not to "make" the case for the referral source. It is never appropriate to demean or demonize the claimant, treating physicians or the opposing IME.

The opposing counsel's tactics during cross examination can be upsetting to the IME physician. Keeping a cool head and presenting a relaxed but professional demeanor is critical.

It is critical for the IME physician to keep within his or her area of expertise. Only the specific question should be answered directly and truthfully and without embellishment or straying into other unasked areas.

It is important to clarify with the referral source/attorney exactly what areas the IME physician has been asked to address. For instance, even though you may have an opinion, do not address causation if the scope of your work is strictly limited to the extent of disability and the ongoing in future medical care needs. Remember, the attorney/referral source can object and/or ask questions on cross examination.

We cannot emphasize enough that the IME physician should focus on answering the questions and not be perceived as an advocate or trying to "help" the case. For example, if there is a piece of information that is negative for the case, either own that information or explain why it is not relevant or wrong.

IME LIABILITY ISSUES

The claimant may not be pleased with the evaluator's opinions. Medical malpractice lawsuits against physicians who conduct independent medical evaluations have become more common.

Despite the absence of a traditional physician-patient relationship, physicians who conduct IMEs still have various legal duties to the examinee, although this issue is in flux and ever changing.[18] Some view that the IME is associated with a limited physician-patient relationship.

Examinees generally can sue IME physicians for negligently causing physical injury during the examination, failing to take reasonable steps to disclose significant or life-threatening medical findings to the patient, and disclosing confidential medical information to third parties without authorization, but they generally *cannot* successfully sue for inaccurate or missed diagnoses.

Therefore, physicians should have well defined processes to reduce their risk and assure they have appropriate liability insurance coverage. Some medical malpractice policies may provide this coverage; however, often it is appropriate to obtain insurance that specifically covers the associated risks.

MARKETING

The best approach to marketing is to provide an excellent report and quality service. This will result in more referrals from your client and likely positive information about the work you perform will be shared by others. You may also generate awareness of your services through speaking and networking.

Provide the referral source a curriculum vitae which is accurate, complete and is professional in appearance. Per Federal Rules of Civil Procedure, you must list all publications you have authored during the past 10 years.

Physicians may also perform work for IME companies who will market their services.

Marketing approaches also include being visible via speaking and attending meetings where potential clients are likely to be present, providing internal education for organizations (e.g., for claims adjusters in their office), and listing your services in directories and/or with online search organizations.

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TRAINING AND CERTIFICATION

IME TRAINING AND CERTIFICATION

Physicians performing IMEs should consider participating in IME training activities and obtaining certification offered by:

- 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.

IME RESOURCES AND MENTORING

Resources, such as templates, questionnaires, and forms are available at www.imetools.com; online training, mentoring and consulting services are also provided.

LINKS

Useful links are provided at http://impairment.com/links.html

SUMMARY

The evaluation of issues encountered with an independent medical evaluation (IME) are often complex and multifaceted. These evaluations are performed at the request of a third party in which no medical care is provided by the evaluator to the examinee. The evaluation results in a report that must reflect a thorough evaluation, answer the specific issues requested by the client, and be easily understandable by non-medical individuals. These evaluations are part of the legal or advocacy system that may be contentious and argumentative. The skilled independent medical examiner must always maintain impartiality and provide conclusions that are supportable. A thoughtful and thorough evaluation is of considerable value to all involved.

RECOMMENDED READING

1. Babitsky S, Mangraviti JJ, Melhorn JM. Writing and Defending Your IME Report: The Comprehensive Guides. Falmouth, MA: SEAK; 2004. (ISBN-13: 978-1892904249)

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9. Rondinelli RD, Guides to the Evaluation of Permanent Impairment, Sixth Edition. Chicago: American Medical Association; 2008 (ISBN1-57947-888-9) Also the Edition, pertinent to your jurisdiction.

10. Rondinelli RD, Katz RT. Impairment Rating and Disability Evaluation. Philadelphia, Pa: WB Saunders; 2000 (ISBN 0-7216-7772-X).

11. Talmage JB, Melhorn JM, Hyman MH. Guides to the Evaluation of Work Ability and Return to Work, Second Edition. Chicago: American Medical Association; 2011 (ISBN#: 978-1-60359-530-8)

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IME CHECKLIST

Item	Compliance			
	Yes	±	No	N/A
Descriptive Data				
Examinee name				
Examinee identification number				
Examinee birth date				
Evaluation date				
Examiner name				
Examiner specialty				
Location of examination				
Referral source (client)				
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, behavior				
Quality of history provided by examinee				
Consistency of examinee as historian (consistency with other documentation)				
Credibility of examinee				
Cooperation level (during entire evaluation process)				
Chaperone during examination, if any (as appropriate)				
No adverse consequences (problems reported during examination)				

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	Yes	±	No	N/A
Time spent (with examinee and entire process)				
Other participants in evaluation and report preparation, if any (record reviewers, interviewers, writers)				
Record reviewed (listing of providers and dates)				
Radiographic and diagnostic studies reviewed, if any (listing of studies and dates)				
Other information reviewed, if any (job analyses, correspondence, transcripts, etc.)				
Missing information, if any (listing of providers and dates)				
HISTORY				
Pre-Existing Status				
Prior injuries or claims, if any (including work related, automobile, liability, disability, recreational, and athletic)				
-Event (type and problems)				
-Clinical (clinical chronology from event to current)				
-Functional (interference with activities of daily living)				
-Impairment, if any (documented, methodology used)				
-Disability, if any (duration and extent)				
-Legal/Claims, if any (legal representation, litigation, settlement)				
Prior traumatic episodes, if any (physical, psychosocial, psychological from childhood to present)				
Prior similar problems, if any (not limited to prior injuries or claims)				
-Clinical (clinical chronology from event to current)				
-Functional (interference with activities of daily living)				
Prior chiropractic care, if any (providers, regions involved, outcomes, duration, frequency, date of most recent visit)				
Injury				
Type (acute, recurrence, exacerbation, aggravation, gradual onset)				
Mechanism (forces involved)				
Symptoms (at that time)				
Initial medical events (emergency care dates, providers, signs, studies, diagnoses, and treatments)				
Signs (objective findings at that time)				
Consistency of reports (initial documentation, reports by other examiners, report by examinee)				
Clinical chronology				
Clinical history from onset to current				

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	Yes	±	No	N/A
Providers (physicians, chiropractic, psychologists, therapists)				
Diagnostic studies (results, clinical significance)				
Treatments (modalities, durations and results)				
Current status				
Chief complaint				
Perception of problem				
Pain				
-Location				
-Description				
-Aggravating factors				
-Relieving factors				
-Severity (numeric [0=no pain to 10=excruciating], current, past month: average, low, and high)				
Symptoms				
-Description				
-Aggravating factors				
-Relieving factors				
-Severity				
Psychosocial history				
Marital status				
Household structure				
Living arrangements				
Activities of daily living				
Recreational pursuits				
Exercise regimen				
Diet				
Tobacco usage				
Drug usage				
Alcohol usage				
Occupational history				
Job at injury				
-Employer				
-Title and role				
-Length of employment				
-Functional demands				

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	Yes	±	No	N/A
-Job satisfaction				
Interval employment status				
-Partial or total disability				
Current employment status				
-Employer				
-Title and role				
-Functional restrictions				
-Functional demands				
Previous employment (prior to injury)				
Educational background				
Functional restrictions (date, provider imposing restrictions, functional capacity evaluations, if any)				
Past medical history				
Medical				
Surgical				
Medications				
Allergies				
Family history				
Disease				
Disability				
Review of Systems				
Other health problems				
PHYSICAL EXAMINATION				
Height, Weight				
Vital signs				
Observations				
General appearance				
Behavioral				
Structural				
Negative findings				
Positive findings (quantitative when feasible)				
Nonphysiologic findings				
Consistent with required assessment as defined in the *Guides*				

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	Yes	±	No	N/A
PAIN, BEHAVIORAL, AND PSYCHOLOGICAL INVENTORIES				
Pain drawing				
Pain inventories				
Disability inventories				
Personality inventories				
Depression/anxiety inventories				
RADIOGRAPHIC STUDIES				
Description of studies reviewed				
Consistency of findings				
ISSUES				
Questions asked by the client are fully answered by the evaluator, with supportable conclusions				
Diagnoses				
Problem list				
Discussion of clinical and functional relevancy				
Discussion of relationship to an injury				
Opinion consistent with facts in the case and medical logic				
Causation				
Causation based on having a medically probable cause, effect, and relationship between cause and effect				
Consistent with facts in the case and evidence based data (science)				
Prognosis				
Outlook based on facts in the case and evidence based data (science)				
Maximum medical improvement				
Determination of permanent and stationary based on facts in the case and evidence-based data (science)				
Permanent impairment				
Discusses how specific findings relate to criteria in the *Guides*				
Explanation of each impairment value with reference to the applicable criteria (eg, Table, Figure and page number)				
Appropriate combining and/or reporting of final impairment				
Apportionment, if applicable, appropriately performed, supported by facts, current science and jurisdictional rules.				

	Yes	±	No	N/A
Functional Abilities/Work Capacity				
Consistent with facts in the case and evidence- based data (science)				
Appropriateness of care				
Consistent with facts in the case and evidence- based data (science)				
Recommendations				
Consistent with facts in the case and evidence- based data (science)				
Qualifications				
Examiner's qualifications as applicable to the case				
Disclosures				
Analysis based on available information				
Recommendations offered as guidance not as medical orders				
Declarations under penalty of perjury				
Original Signatures				
Physician has personally reviewed and signed report				

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