

Standards for Independent Medical Examinations

(AIMEHI Note: This article was published by the AMA, American Medical Association, in “The Guides Newsletter” November/December 2005 edition. The AMA published version has some comments relevant only to the 5th edition of the guides which are not included here.)

Preface:

Until now there have been no official standards that define a high quality Independent Medical Examination (IME). A committee of experienced IME physicians propose the following suggested standards for Independent Medical Examination reports.

The committee consisted of;

Chet Nierenberg, M. D.(Chairman, Principal Contributor and Editor)

Principal Contributors:

Chris Brigham, M.D., Lorne K. Dierenfeld, M.D., Clarissa Burkert, M.D.

Contributors and reviewers:

Mohammed Ranavaya, M.D., William Shaw, M.D., Henry Roth, M.D., Allan Colledge, M.D., Jack Richman, M.D., Charles Brooks, M.D., James Talmadge ,M.D., Frank Jones, M, D., J Mark Melhorn, M.D., Steve Babitsky, J.D.

The value of a high quality IME cannot be overstated. A high quality IME will aid all parties by providing:

- Proper and efficient case management
- Understanding of multiple interrelated case details
- Feedback to Treating Physicians
- Closure and accurate disposition in impairment cases
- Guidance to adversarial parties when issues are disputed
- The benefit of an independent physician’s medical opinions

These standards are written to assist the Examiner as well as the reader of the report. The Standards include:

- ◆ Definition of IME and key concepts
- ◆ Comments on ideal qualifications of the Examiner
- ◆ Discussion of methodology and procedures
- ◆ What happens at the time of the Physical Examination

- ◆ A suggested generalized report format
- ◆ Suggestions for Quality Assurance

Because of variability of the requirements in individual IME cases, it is impossible to define exactly what should be in every report; therefore The Standards should be viewed as guidelines rather than absolutes.

Section 1: Definitions and Principles

An Independent Medical Examination (IME) is a unique and specialized examination and report, ideally performed by a medical physician with special training and experience in the field of Independent Medical Examinations. Although IME's share some similarities with conventional medical reports, the IME is distinctly different. The need for a high quality IME cannot be overstated.

The IME has three key characteristics:

- *Independent*
- *Medical*
- *Examination*

The Examiner is *Independent*, and must arrive at his/her own diagnosis and opinions, independently of the referring source, remuneration, other's opinions, or personal bias. The Examiner is a medical professional, who is not involved in the claimant's care.

IME's are *Medical* evaluations. They involve the essential elements of a medical assessment, including history, *Examination*, and review of relevant records and applicable diagnostic studies. Usually, but not always, a physical examination is performed. If there is no physical exam component, sometimes the term Independent Medical (Record) Review is used.

The term Independent Medical Examination, or IME, is widely used. In some jurisdictions, it will be called by a different name. However, the principles that define a quality IME still apply.

The concept of *arena* as it applies to IME's is important. The arena is determined by the context of the subject case. Common subject areas are automobile casualty, personal injury, workers' compensation and long term disabilities. The arena is further determined by jurisdiction. For example, one arena would be automobile casualty cases in a specific state. Another arena would be an impairment rating resulting from a worker's compensation maritime case under Federal jurisdiction. The possibilities are numerous. However, the concept is important, because it will largely determine what is required in any specific report. The requirements of the report may also be determined by the specific case. For example, causation might be important in one case, but in another case causation may be irrelevant, and apportionment may be a key area.

Because of the variability in arenas and the specific requirements of each case, it is impossible to define all the requirements of a quality IME report. However, many similarities exist in all IME reports. A suggested general structure for most reports is found in detail in Section 5 of this document.

The IME has many features in common with a conventional medical examination, including obtaining a history, performing a physical examination and making a diagnosis. However, IME reports *differ* from medical consultations and conventional medical reports in several important ways:

- The conventional medical report is produced by the treating physician, with the primary goal being determination of treatment. The IME is performed by an Independent Reviewer, with the purpose being determined by the arena and specific case requirements.
- The history in an IME is more comprehensive than the conventional history obtained by a treating physician. An IME history usually includes a comprehensive review of prior medical records, occupational and socioeconomic history, in addition to the usual subjective history of present illness. Records available for review to the IME examiner are usually more complete than those available to the treating physician.
- A physical examination by a treating physician is performed primarily for purposes of determining diagnosis and documenting the clinical course over time. The IME physical examination is a one-time examination for the purpose of objective documentation of the examinee's status. Specific measurements according to accepted protocols may be used to provide the basis for impairment ratings.
- In an IME examination, there is usually only a one-time opportunity for examination. Therefore, the IME needs to provide a complete, comprehensive, and objective description of the examinee's condition at that time, in the context of prior health, physical and vocational capabilities, and social functioning. In contrast, the treating physician's evaluations are based on multiple, shorter encounters over the course of time.
- Unlike the medical consultation that ends only with treatment recommendations, the IME is broader in scope. Often, the IME will answer specific questions posed by the referring source. Referring sources include insurers, attorneys, and others involved in the management of workers' compensation, personal injury, disability cases, and other similar issues.
- The conventional medical report utilizes complex medical terminology. However, the reader of an IME may not have extensive medical background. Therefore, the Independent Medical Examiner should craft the report such that key issues are understandable to the lay reader.

- The conventional medical report does not usually employ precision in utilizing non- medical IME terminology. Terms such as aggravation, causation, impairment and disability have multiple meanings. The IME report must accurately use all terms as they apply to each specific arena.

The following table illustrates some of the common similarities and differences between various types of medical reports. It is for illustrative purposes only and is not comprehensive:

Similarities and Differences by type of Report				
Features of Report	Worker's Comp IME	Motor Vehicle Injury or Personal injury IME	Long Term Disability IME	Conventional Medical Report
Level of History Detail	Comprehensive involving subjective and written record review	Comprehensive involving subjective and written record review	Comprehensive involving subjective and written record review	Usually brief and relevant to Chief Complaint Usually Subjective only
Physical Exam	Directed toward Objective documentation, Usually utilizes protocol for impairment rating	Directed toward Objective documentation, sometimes utilizes protocol for impairment rating	Directed toward Objective documentation, rarely utilizes protocol for impairment rating	Directed toward Diagnosis rarely utilizes protocol for impairment rating
Diagnosis	Always	Always	Always	Always
Causation	Often	Often	Rarely	Rarely
Prognosis	Often	Often	Often	Often
MMI (Maximum medical Improvement)	Usually	Often	Often	Rarely
Impairment Rating	Usually	Sometimes	No	No
Functional ability	Often	Often	Often	Rarely
Prior Care appropriate?	Sometimes	Often	Sometimes	Rarely
Apportionment	Sometimes	Sometimes	Rarely	Rarely
Future Care Recommendation	Often	Often	Sometimes	Always
Specific Questions answered from Requesting Agency	Often	Usually	Usually	No
Who does them?	Independent Examiner	Independent Examiner	Independent Examiner	Treating Physician
Terminology	Use of specific terms defined by Guidelines; Opinions	Use of specific terms defined by Guidelines; Opinions	Specific terms defined by disability contract	Complex Medical Terminology not using Guidelines definitions

	explained in Lay terms	explained in Lay terms		
--	------------------------	------------------------	--	--

In summary, Independent Medical Examinations are distinct from conventional medical reports in terms of how they are used, how they are requested and performed, the issues addressed, and how they are reported. Because an IME report may be an important source of evidence in hearings and other legal proceedings, it must be clearly and precisely written.

The skill set required to perform an excellent IME requires specific training that is not provided in the standard medical curriculum. The recommended qualifications of the Independent Medical Examiner are further discussed in Section 2.

Section 2: The Examiner

Exactly who qualifies to perform an Independent Medical Examination will vary by jurisdiction. If the examination is medical in nature, it can be called “Independent Medical Examination,” and it should be performed by an M.D. or D.O. physician with a full and unrestricted license to practice medicine in the principal jurisdiction of the case. The physician standard is dictated by *the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition*, Chapter 2, pg. 18. In some cases, other practitioners, such as a psychologist or a chiropractor may produce a report and examination, but if it is not an M.D. or D.O. physician, it should be clearly labeled (e.g., “Independent Psychological Examination,” “Independent Chiropractic Examination,” “Independent Dental Examination,” etc.)

The author of the report must have qualifications in two areas:

- Medical knowledge and/or training in the specific area or areas pertinent to the subject case.
- Experience, training, and preferably additional credentials in the area of Independent Medical Examination *per se*.

Experience and qualifications in only one of the two areas above, are not sufficient for producing a quality report. To produce a quality IME, two distinct skill sets are required. For example, if the primary area of concern is a musculoskeletal injury, the Examiner might be an orthopedic surgeon, physiatrist, neurologist or general practitioner with experience and training in treating musculoskeletal injuries. However, treatment skills alone are not sufficient to produce a quality IME. A separate skill set is also needed. These IME skills are acquired by specialized training, experience and the certification process.

It is recommended that examiners have a special credential issued by a recognized disability or independent medical examiners national association. This is hereafter referred to as “special credential.”

It is not necessary that the Examiner be “same specialty” for the problem principally addressed in the Independent Medical Examinations, as long as the Examiner possesses skill, experience, and knowledge in the appropriate medical area.

It may not be possible in every instance to have the ideal Examiner perform the examination. The following is a list of categories of potential Examiners in order of most desirable to least desirable:

1. Specialist or generalist with medical expertise in the medical area in question, demonstration of previous experience in producing excellent reports, and special credential.
2. Specialist or generalist with medical expertise in the medical area in question, demonstration of previous experience in producing excellent reports, and training and education in performing IME's.
3. Specialist in area of problem (“same specialty”), without special credential.
4. Generalist or not “same specialist” with relevant medical knowledge of the area in question without special credential.

Those in the first categories are more likely to produce a high quality IME report.

In addition, the Examiner must also possess specific skills in the art of IME report writing. Because the report will be read by many, and becomes part of a permanent record, the report must be clearly written.

It is strongly recommended that authors of IME's understand the principles and style required in formal IME report writing. It is recommended that they take a formal course on report writing, such as a Writing Workshop, which specifically addresses IME report requirements. Such a workshop will help the author present material in a logical, understandable and organized fashion.

In addition to the qualifications above, it is imperative that the Examiner demonstrate the *highest* possible standards of ethics, objectivity and impartiality. Personal bias, prejudice, slanting or partiality cannot be tolerated. Indications of bias disqualify the Independent Medical Examination as a useful document.

A well-written report should reflect the dedication, skill and professionalism of the Examiner.

Section 3: Service, Process and Methodology

The IME report is generated in response to a requesting agency. It is the requesting agency's responsibility to define the scope of the report. For example, what specific issues need to be addressed? In some cases, an Impairment rating may be requested, but issues of causation and apportionment are not needed. Conversely, apportionment and causation may be the primary issues in other cases.

The request for services will usually be in the form of a cover letter, but requests can also be made via phone or direct Internet requisition. In order for the Examiner to produce a high quality report, he or she needs to know the specific requirements relevant to the individual case. If the Examiner is unable to obtain specific instructions regarding requirements, then the Examiner should use his/her own best judgement concerning content. If an Examiner feels certain information is crucial to understanding the case, then he or she may include it even if not specifically asked about it.

If the requirements are known and documents have been provided, the Examiner should have a procedure for timely scheduling of the examination and generation of the report. Prompt turnaround time helps to assure accuracy. Report delays make case management more difficult and reduce the value of the report.

The report needs to be legible, complete and organized. The Examiner needs to assure, via proofreading or editing, that the document is correct in content, grammar, and style.

The IME report may be used in Court or in other adjudication situations and the IME report should be written with that mind. It should be clearly written and the opinions medically defensible.

The IME is a confidential document. The report should be released only to the requesting agency, unless mandated by judicial authority or other circumstances. Informed written consent should be obtained prior to the examination.

Although no doctor/patient relationship exists in the IME process, if a health-threatening condition is discovered during the examination, the Examiner should bring this information to the examinee's attention, instruct them to seek appropriate medical care, and so document.

To assure uniformity of procedures, the use of pre-defined forms is encouraged. These would include forms such as engagement letters, examinee notification letters with instructions and examination procedures, consent forms, pre-exam questionnaires, satisfaction surveys, etc.

Methodology

The Independent Medical Examiner will use a variety of tools, including physical, written and electronic tools for producing the report. The use of electronic and computer tools has become an integral and necessary part of IME report writing. There is criticism of some IME reports that use fill-in-the-blank type computer generated forms. A thoughtless use of this method does not produce a high quality report. However, appropriate use of electronic and computer tools is virtually essential in producing a high quality IME report. The proper use of computer technology adds value to the IME report, rather than subtracts from it. These tools can help to assure uniformity, completeness, accuracy and reproducibility.

For example, the conventional method for reviewing written records is for the reviewer to manually read the written records, edit them, dictate them, and then have them transcribed. However, unless done very carefully, there are many opportunities for inaccuracies or paraphrasing, which may change the intent of the original records. An electronic method is to optically scan the records, electronically organize by date and insert the appropriate text verbatim into the IME report. If done properly and with care, the electronic means are more efficient, more accurate, and more objective. Thus, the use of electronic and computer methodology as it continues to evolve, can be an extremely positive force for efficiency, objectivity and accuracy. The use of new technology is to be encouraged.

With electronic methods, it is possible to include a wide variety of supplementary data directly into IME Reports, which might include pictures, medical references, diagrams, pain or other inventories.

Whatever system the Examiner employs, it must produce consistently accurate, objective, and complete reports.

Section 4: The Physical Examination

When meeting the examinee for the physical examination, the Examiner will document subjective complaints of the examinee on the day of examination, as well as documenting objective clinical findings. Sometimes ancillary data, such as imaging studies, are also directly reviewed. Documentation of the physical examination and history should be systematic, thorough and relevant to the body systems in question. Findings need not be limited to a single body portion, if other findings or subjective symptoms are relevant to the questions that are being evaluated.

Before beginning the examination, it is imperative that the Examiner explains to the examinee the purpose of the examination, who is requesting the examination, and where the report will be sent. The Examiner must explain that there is no doctor/patient relationship involved, that his/her opinions are advisory in nature only, and that he/she will not be providing treatment for the examinee.

The Examiner should use his/her own customary procedures when taking the history and performing the physical examination. However, certain ground rules are universal.

Generally, the only people present during the examination are the examinee and the Examiner. In addition, a chaperone of the appropriate sex may be present when conducting the physical examination itself, and, in some cases, during the history portion. The examinee must be treated with dignity and respect, and provisions be made for appropriate draping, as required for modesty.

Those generally excluded from the examination are family members, legal representatives, other health care professionals or other representatives of the examinee. There are exceptions to this rule, such as when a translator is needed. In some cases, an immediate family member, such as husband/wife, sister/brother may be

appropriate. It should be clearly explained that if other people are present, they should not contribute to the history or the physical examination in any way.

The use of any recording devices by the examinee is prohibited.

These ground rules must be explained at the time of the examination. The requesting agency should also be informed of these ground rules in writing in advance, and they should forward them to the examinee. In certain jurisdictions, there may be additional judicial ground rules.

In the subjective portion (sometimes referred to as the “Current Interview”), the Examiner will ask questions and document the examinee’s responses. As with the physical findings, the subjective history must be thorough and systematic. When documenting both subjective and objective findings, the Examiner should use neutral and professional language. The use of pejorative terms or editorializing when documenting the subjective or objective complaints is unacceptable, and negates the value of the IME. The only appropriate place in the report for the Examiner to voice his/her own professional opinions is in the opinion section, and they should be clearly labeled as such. Opinions must not be mixed in with the subjective or physical examination section.

Most physical examination sections will include documentation on the following:

- General appearance, behavior.
- Formal and informal observations of the examinee, describing correlation or lack of correlation with other physical findings.
- Who was present; e.g. chaperone, translator, other participants.
- Appearance, grooming and nutrition.
- Observations about examinee’s affect, attitude, cooperation, and mental status.
- Objective observations of behavior or statements which the Examiner believes relevant to reliability and/or credibility of the examinee.
- Pain behavior and/or comfort or discomfort levels.
- Use of assistive devices or braces.
- Vital signs and/or weight as appropriate.
- Detailed clinical examination findings, including all pertinent positive and pertinent negative findings. Include non-physiologic findings if appropriate.

It cannot be emphasized strongly enough, that objective observations need to be documented in a thorough and consistent manner. If an Impairment Rating is being performed, the physical findings must be documented in a manner consistent with the requirements of the Impairment Rating Guide used in the applicable jurisdiction. This will most often be the Current edition of the *Guides to the Evaluation of Permanent Impairment*, published by the American Medical Association. Findings must be documented in a manner that allows the reader to easily make comparisons between appropriate tables and figures listed in the applicable Impairment Guide. Measurements should be documented as carefully as possible, but should not be presented in a manner that suggests a level of precision that is not possible to obtain in clinical

physical examination. The Examiner should also make reference to normal variability of measurements and consistency. These topics are addressed in detail in the *Guides to the Evaluation of Permanent Impairment*.

Although physical findings must be precisely and objectively recorded, it is also appropriate to report objectively observable signs indicating a non-physiologic process. An example of this type of observation would be the signs of Waddell. The physical examination section is not the place in the report to point out inconsistencies in history provided by the claimant and information contained in the records. The encounter should be objectively described in the physical examination section. In subsequent sections of the report, when opinions by the Examiner are made, consistencies or inconsistencies can be pointed out.

The clinical skills of the evaluating physician are critical to performing and documenting a complete, thorough and appropriate examination.

Section 5: Structure Of The Report

The actual structure of the written Report will vary from examiner to examiner. It will also depend on the arena or context of the examination, such as what jurisdiction or type of examination. Therefore, it is not possible to describe the ideal format for every IME report. However, the following is a general outline of the topics that should be covered in a thorough report:

Introductory information, descriptive data:

- Name of Claimant with appropriate identifying data.
- Date of injury.
- Referring source.
- Date, time and location of examination.
- Purpose of examination (IME, PPD, impairment rating or other).
- Brief synopsis or executive summary of the report.
- List of all records reviewed.
- Hand dominance, right, left or ambidextrous, if upper extremity evaluation.

History

- History is usually recorded in two separate sections; one for history obtained from written records (also referred to as Record Review), and one obtained from subjective oral history (also referred to as Current Interview).
- Source of data needs to be carefully identified (e.g. claimant, interpreter, family member, records, or other).

Record Review:

- Record review should be thorough, complete, and accurate.

- Source of data should be carefully identified, including provider by name, and identification of encounter date (date of service). All treatments and outcomes should be clearly documented.
- Editorial comments should be avoided, except when necessary to explain unclear data. Editorial comments must be clearly identified as such.
- Verbatim citations should be used when possible, avoid paraphrasing which may change meaning.
- Intellectual honesty when editing records is essential. History should be recounted objectively without attempt to color or bias the history. Selective editing that unfairly slants the history negates the value of the report.
- Correlation of subjective oral history and written history from record review should be done in the opinion section, not in record review section.
- It is helpful to start the record review with date of the current injury and list subsequent data in chronological order.
- Past medical history record review (prior to the subject incident) should be listed in a different subsection than the record review for the current injury. All clinical encounters, diagnostic tests, and outcomes relevant to the current condition should be listed.
- Alternative formats for record review organization are acceptable, if they present the history in a clear and non-prejudicial manner.

Subjective Current Interview (Oral History)

- Documentation of Chief Complaint(s) should include characteristics of symptoms and chronology.
- Pain should be described, including location, frequency, radiation, duration, and factors that aggravate or alleviate symptoms.
- Standardized pain or behavioral inventories and pain diagrams are sometimes used.
- Describe associated symptoms, such as weakness or neurologic complaints.
- Describe how and when the injury/ illness occurred: (Mechanism of injury).
- If symptoms have changed over time, describe initial symptoms and their course.
- Describe subjective, symptomatic response to treatment.
- If pre-incident symptoms are similar to those related to the current incident, document symptomatic status over time. It is mandatory to describe the symptoms *before* and *after* the subject incident.
- If the examinee was asymptomatic before the subject incident, so state.
- If subsequent injuries or episodes have occurred, document them and correlate to the symptoms from the subject incident.
- Describe current functional status, including how the examinee's condition affects activities of daily living, work activities, sports, hobbies and social functioning.
- Document occupational history and time off work, if appropriate. Include Job duties relevant to current injury, with comparison of prior and subsequent job activities.
- Describe relevant past medical history (subjective), including previous relevant injuries or conditions.

- Document other conditions or injuries requiring medical treatment, if relevant.
- Include personal, family, and social history when relevant.
- In Review of Systems, document all other relevant data, including appropriate psychological symptoms (especially symptoms of chronic pain or depression).

Physical Examination:

- Document who was present at the examination.
- It cannot be emphasized enough that findings need to be documented thoroughly. If an impairment rating is required, findings must be documented in a manner consistent with the requirements of the impairment guide being utilized (commonly the *Guides to the Evaluation of Permanent Impairment*).
- Use of tables in documenting range of motion is preferable when impairment ratings are performed.
- More aspects of the physical examination are described in Section 4.

Other Objective Data:

- If radiologic or other imaging tests are reviewed, list the tests and clearly identify official written interpretation vs. Examiner's opinions of tests reviewed.
- Functional tests, if applicable, should be documented.
- Review of ancillary tests and other miscellaneous material when relevant.

Opinion Section:

- **It is mandatory that all opinions must have facts and reasoning supporting them. The opinion section should generally include the following:**

A list of Impressions (diagnoses):

- It is helpful to clearly identify impressions (diagnoses) related to the subject episode and differentiate those due to other unrelated causes.

Discussion of Diagnoses:

- The basis for impressions (diagnoses) should be clearly explained. It should include correlation of subjective complaints, written records, physical examination and objective tests (including imaging and laboratory studies). If tests or findings are misleading or equivocal, the reasons for this should be explained. If there are any inconsistencies in data or history, this is the place to note them and discuss them. An assessment of the examinee's credibility is appropriate. A discussion of related diagnoses may be appropriate. Explanation of the subject condition or diagnoses is sometimes appropriate for the education of the reader. If there is disagreement with another examiner's opinions, the basis for disagreement should be clearly stated, along with the reasons for disagreement. If information necessary to form complete opinions is absent or missing, this should be stated.

Comments on Past Medical Treatment:

- A discussion of appropriateness, reasonableness and medical necessity is usually, but not always, required. It is preferable to cite national or local standards, rather than the Examiner's personal opinion. If standards are not available, a discussion of common local practice is preferable to the Examiner's personal opinion.

MMI (Maximum Medical Improvement):

- If appropriate, comment on maximum medical improvement (MMI) and when this occurred.

Comments on Future Medical Treatment:

- A discussion of what is customarily done in similar cases may be appropriate. It should be clearly explained, in neutral language, that the opinions are advisory in nature only, and are not meant to constitute a doctor/patient relationship. It should be stated that actual treatment or orders for additional testing must be done by the attending physician. Often the need for future interventions, such as surgery, is commented on.

Causation:

- Reasoning for the opinions on causation must be carefully explained.
- Factors may include mechanism of injury, correlation of past and current medical history, activities of daily living, work and social history. Any factors that are considered should be clearly specified.

Apportionment:

- The reasoning for apportionment must be carefully explained. A list of all factors considered by the Examiner when addressing the apportionment issue should be documented. The actual methodology for apportionment will vary widely, depending on jurisdiction and arena.

Impairment:

- If impairment is rated, the explanation must be exact, with specific reference to objectively measurable criteria. Findings should be correlated accurately with the appropriate rating guide, including citation of the relevant page numbers, table numbers and methodology. Absolute precision in utilizing the appropriate rating guide is essential.

Disability/Functional Status:

- An estimate of functional abilities is sometimes made. However, detailed comments on functional capacity abilities are beyond the scope of most IME's. Work Restrictions are the province of the attending physician.
- Comments on disability are sometimes appropriate. However, it should be explained that disability is not strictly a medical determination. It is often helpful to discuss the differences between impairment and disability as it applies to the specific case. Sometimes, it is useful to distinguish between functional deficits as they relate to work and other types of disability.

Prognosis:

- General comments about prognosis may be appropriate.

Answers to Specific Questions:

- Usually the requesting agency will ask specific questions. The verbatim questions and direct answers should be included.

References:

- In some reports, references to published literature are appropriate. However, it is essential that intellectual honesty be paramount in citing a fair and balanced view of the literature. Individual references should not be selected so as to unfairly support a one-sided opinion.

Section 6: IME Quality Assurance

Assuring the quality of an IME report will maximize the value to all parties. The Examiner bears the primary responsibility for the quality of the IME Report. However, the requesting agency can also assist in improving quality by means of a constructive review process and feedback to the Examiner. Therefore, a methodology for quality review is helpful to all parties.

The following are basic questions to ask that are helpful in assuring the quality of the IME Report:

- Is it well organized, and written so as to be clear to a non-medical reader?
- Does it address the specific questions asked, with supportable conclusions?
- Is the report's length and detail consistent with the complexity of the case?
- Does the IME report provide the information needed by the requesting agency?
- Is the report presented in a fair, unbiased and impartial manner?
- If an impairment rating is required, does the report comply with the appropriate rating guide? (e.g., *AMA Guides to the Evaluation of Permanent Impairment*, Fifth Edition, Section 2.6, "Preparing Reports.")

- Does the report contain the elements described in Sections 4 and 5 of this document? It is helpful to use the content of these chapters as a checklist.

Although use of the basic methodology listed above provides a good starting point, it is also useful to perform a more sophisticated analysis of quality. If the requesting agency has an in-house system for IME Quality Assurance review, there are a number of advantages. In addition to assuring quality, it can provide a method for feedback to the Examiner, as well as a constructive comparison to other examiners. If the requesting agency does not have the resources available in-house for an IME quality assurance program, then an alternative is to use an outside party with special expertise in the area.

Feedback is helpful to both the Examiner and the requesting agency. It helps the Examiner continue to improve his/ her own quality of report and service. It helps the requesting agency evaluate the effectiveness of the report, and can assist in better case management. The thoughtful use of modern computer technology, when judiciously applied, can aid in this process.

In the Worker's Compensation arena, there is a national trend toward the new use of guidelines for treatment as well the traditional use of guidelines in impairment rating. The Examiner will often be asked about the appropriateness of past treatment. It is strongly recommended that Examiners, as well as all those involved in the claims process, attend training courses in the use of treatment and impairment guidelines in those states where they are mandated.

A quality IME serves all parties. Quality assurance is an essential component of the IME process.