The Approach to the Orthopaedic IME: What the Science Says

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Key Components of High-Quality IME Reports

In some cases, the referral source may need the physician only to review the provided records and answer questions without conducting a full IME of the claimant. Depending upon the type and nature of the request from the referral source, such as in record review and opinion-only cases, an actual claimant interview, history taking, and physical examination may not be required. However, such data are critical and can be obtained from the record in those instances. While the specific contents of the physician's report may vary depending on the nature of the case, five main content areas are common to all high-quality IME and expert reports:

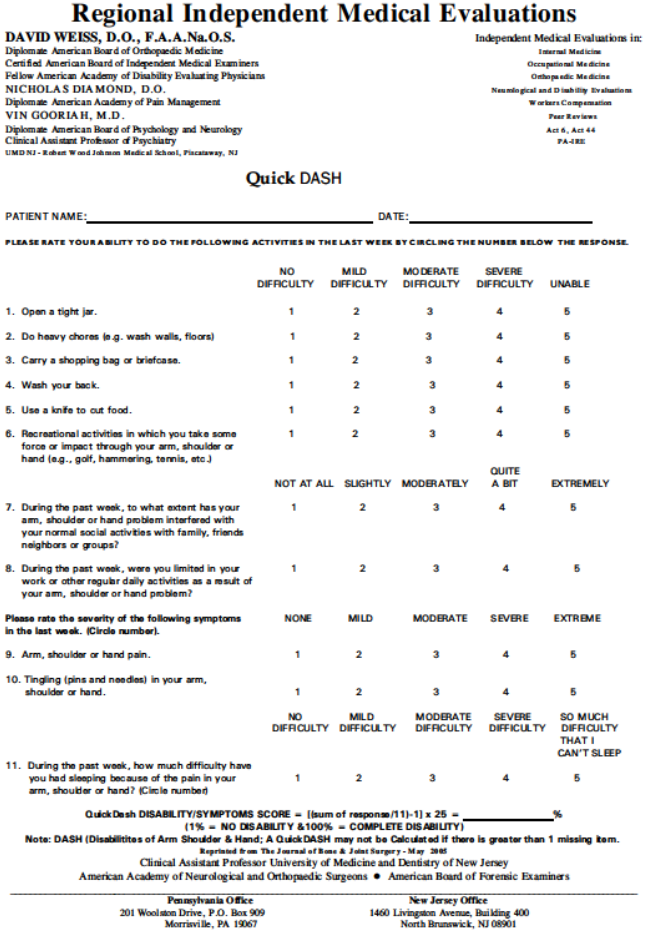
1. History of presenting injury or illness
2. Current chief complaints (including their effect on activities of daily living [ADLs})
3. Physical examination findings
4. Record review excerpts (including imaging studies and lab data)
5. Discussion and conclusion

Practice Pearls

Obtaining a comprehensive longitudinal history of the presenting injury or illness, including mechanism of injury, treatment rendered to date, outcomes, and compliance, is the first critical step in writing a high-quality IME report. The examiner should do the following:

- In acute injury claims, obtain the exact mechanism of injury directly from the claimant by inquiring into all the related details, such as the body parts affected and the onset and chronology of symptoms involved in the claimant's view of causation.
- In occupational disease or musculoskeletal disorders (repetitive trauma) claims, obtain a detailed history of all the various job tasks that are alleged to have caused the disease or injury.
- In claims of occupational musculoskeletal disorders without acute injury, focus on the frequency of various tasks that require repetition, lifting, bending, and postural variables.
- In claims of toxicological injuries or illness, include a review of chemicals used, particularly the names of the specific chemicals, and the onset and chronology of symptoms.
- Document treatment outcomes – both negative and positive – and any pending treatment
- Document any significant inconsistencies between the claimant's history and the records provided.
- Document the claimant's current work status or plans to return to work

PROMIS Functional Assessment (Patient Reported Outcomes Measurement Information System)



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Independent Medical Evaluations in:
Internal Medicine
Occupational Medicine
Orthopaedic Medicine
Neurological and Disability Evaluations
Workers Compensation
Peer Reviews
Act 6, Act 44
PA-IRE

Quick DASH

PATIENT NAME:_____ DATE:_____

PLEASE RATE YOUR ABILITY TO DO THE FOLLOWING ACTIVITIES IN THE LAST WEEK BY CIRCLING THE NUMBER BELOW THE RESPONSE.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight jar.	1	2	3	4	5
2. Do heavy chores (e.g. wash walls, floors)	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back.	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.)	1	2	3	4	5
	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends neighbors or groups?	1	2	3	4	5
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5
Please rate the severity of the following symptoms in the last week. (Circle number).	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? (Circle number)	1	2	3	4	5

QuickDash DISABILITY/SYMPTOMS SCORE = [(sum of response/11)-1] x 25 = _____%
(1% = NO DISABILITY & 100% = COMPLETE DISABILITY)
Note: DASH (Disabilities of Arm Shoulder & Hand; A QuickDASH may not be Calculated if there is greater than 1 missing item.

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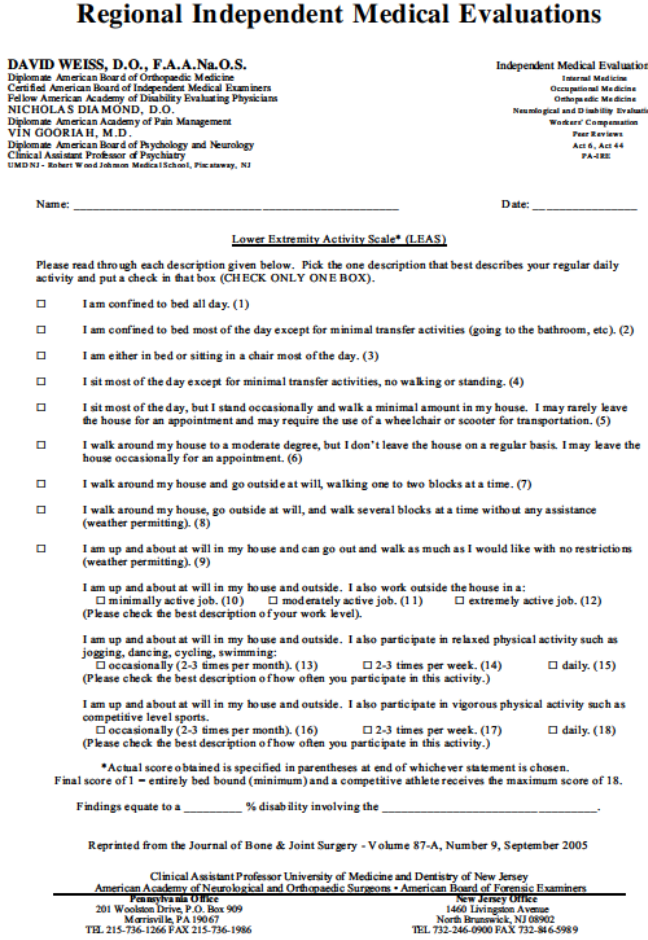

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Name: _____ Date: _____

Lower Extremity Activity Scale* (LEAS)

Please read through each description given below. Pick the one description that best describes your regular daily activity and put a check in that box (CHECK ONLY ONE BOX).

☐ I am confined to bed all day. (1)

☐ I am confined to bed most of the day except for minimal transfer activities (going to the bathroom, etc). (2)

☐ I am either in bed or sitting in a chair most of the day. (3)

☐ I sit most of the day except for minimal transfer activities, no walking or standing. (4)

☐ I sit most of the day, but I stand occasionally and walk a minimal amount in my house. I may rarely leave the house for an appointment and may require the use of a wheelchair or scooter for transportation. (5)

☐ I walk around my house to a moderate degree, but I don't leave the house on a regular basis. I may leave the house occasionally for an appointment. (6)

☐ I walk around my house and go outside at will, walking one to two blocks at a time. (7)

☐ I walk around my house, go outside at will, and walk several blocks at a time without any assistance (weather permitting). (8)

☐ I am up and about at will in my house and can go out and walk as much as I would like with no restrictions (weather permitting). (9)

I am up and about at will in my house and outside. I also work outside the house in a:
☐ minimally active job. (10) ☐ moderately active job. (11) ☐ extremely active job. (12)
(Please check the best description of your work level).

I am up and about at will in my house and outside. I also participate in relaxed physical activity such as jogging, dancing, cycling, swimming:
☐ occasionally (2-3 times per month). (13) ☐ 2-3 times per week. (14) ☐ daily. (15)
(Please check the best description of how often you participate in this activity.)

I am up and about at will in my house and outside. I also participate in vigorous physical activity such as competitive level sports.
☐ occasionally (2-3 times per month). (16) ☐ 2-3 times per week. (17) ☐ daily. (18)
(Please check the best description of how often you participate in this activity.)

*Actual score obtained is specified in parentheses at end of whichever statement is chosen.
Final score of 1 = entirely bed bound (minimum) and a competitive athlete receives the maximum score of 18.

Findings equate to a _____ % disability involving the _____.

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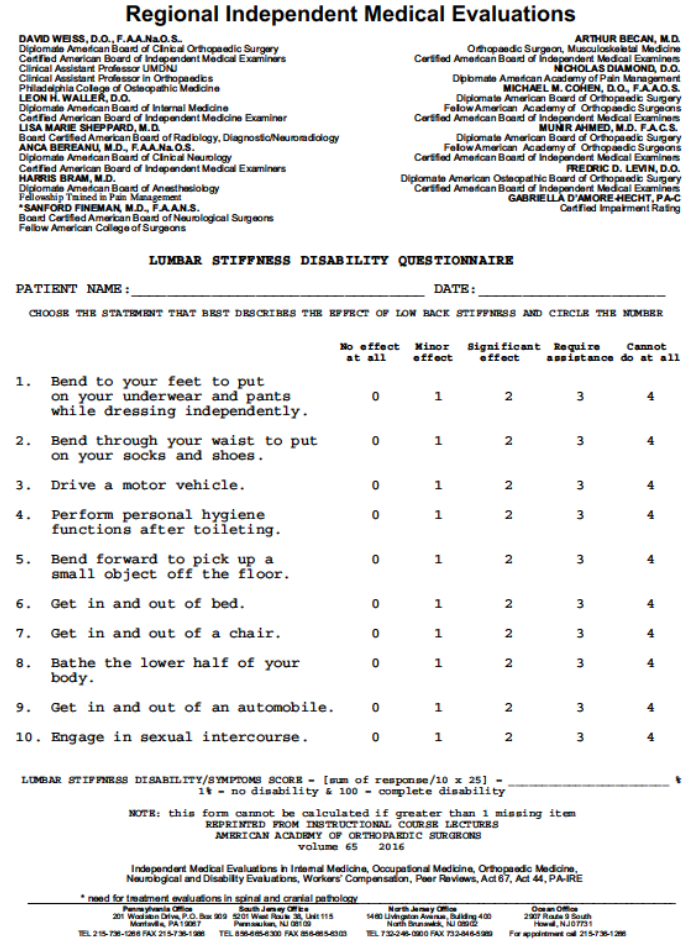

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Certified Impairment Rating

LUMBAR STIFFNESS DISABILITY QUESTIONNAIRE

PATIENT NAME:_____ DATE:_____

CHOOSE THE STATEMENT THAT BEST DESCRIBES THE EFFECT OF LOW BACK STIFFNESS AND CIRCLE THE NUMBER

	No effect at all	Minor effect	Significant effect	Require assistance	Cannot do at all
1. Bend to your feet to put on your underwear and pants while dressing independently.	0	1	2	3	4
2. Bend through your waist to put on your socks and shoes.	0	1	2	3	4
3. Drive a motor vehicle.	0	1	2	3	4
4. Perform personal hygiene functions after toileting.	0	1	2	3	4
5. Bend forward to pick up a small object off the floor.	0	1	2	3	4
6. Get in and out of bed.	0	1	2	3	4
7. Get in and out of a chair.	0	1	2	3	4
8. Bathe the lower half of your body.	0	1	2	3	4
9. Get in and out of an automobile.	0	1	2	3	4
10. Engage in sexual intercourse.	0	1	2	3	4

LUMBAR STIFFNESS DISABILITY/SYMPTOMS SCORE = [sum of response/10 x 25] = _____ %
1% = no disability & 100 = complete disability

NOTE: this form cannot be calculated if greater than 1 missing item
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Independent Medical Evaluations in Internal Medicine, Occupational Medicine, Orthopaedic Medicine, Neurological and Disability Evaluations, Workers' Compensation, Peer Reviews, Act 67, Act 44, PA-IRE

* need for treatment evaluations in spinal and cranial pathology

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Guidelines of Conduct of the American Board of Independent Medical Examiners

Physicians should:

1. Be honest in all communication;
2. Respect the rights of the examinees and other participants, and treat these individuals with dignity and respect;
3. At the medical examination:
    a. Introduce himself/herself to the examinee as the examining physician;
    b. Advise the examinee they are seeing him/her for an independent medical examination, and the information provided will be used in the assessment and presented in a report;
    c. Provide the examinee with the name of the party requesting the examination, if requested;
    d. Advise the examinee that no treating physician-patient relationship will be established;
    e. Explain the examination procedure;
    f. Provide adequate draping and privacy if the examinee needs to remove clothing for the examination;
    g. Refrain from derogatory comments; and
    h. Close the examination by telling the examinee that the examination is over and ask if there is further information the examinee would like to add.
4. Reach conclusions that are based on facts and sound medical knowledge and which the independent medical examiner has adequate qualifications to address;
5. Be prepared to address conflict in a professional and constructive manner;
6. Never accept a fee for services which are dependent upon writing a report favorable to the referral service; and
7. Maintain confidentiality consistent with the applicable legal jurisdiction.

AGGRAVATION

Guides 5th: "A factor (physical, chemical, biological, or medical condition) that **adversely alters the course or progression** of the medical impairment" (page 599)

Guides 6th: "Permanent worsening of a pre-existing condition. A physical, chemical, biological or other factors results in an increase in **symptoms, signs, and/or impairment** that never returns to baseline, or what it would have been except for the aggravation (the level pre-determined by the natural history of the antecedent injury of illness" (page 610).

Does Trauma Aggravate Degenerative Joint/Disc Disease (Arthritis)?

Did the traumatic event

- 5th: have a real adverse effect or altered the course or progression of the pre-existing degenerative joint and disc disease?

- 6th: results in an increase the degenerative joint and disc disease symptoms, signs, and/or impairment that never returned to baseline?

Apportioning Evaluation and Treatment

When a compensable injury or exposure causes a new condition, there is no apportionment of subsequent evaluation and treatment. Generally, apportionment is not warranted when a preexisting asymptomatic and untreated condition is rendered symptomatic and now requires evaluation and treatment. The same is usually true with respect to a preexisting symptomatic but untreated condition. If not for worsening as a result of the compensable injury or exposure, the person would not have needed evaluation and treatment – or at least not when he or she did.

AMA Guides to the Evaluation of Disease and Injury Causation, Second Edition, page 143

Example of the Science

Opposite Lower Limb Causation:

Review of the medical literature reveals no generally accepted studies that support such a causal relationship, nor is there any reasonable scientific logic therefore. In fact, the literature available, most notably an editorial, “Can Favouring One Leg Damage the Other?,” by Ian Harrington, MD, refutes the reported cause and effect relationship.

In 2005, Harrington provided a discussion paper titled “Symptoms in the Opposite or Uninjured Leg,” prepared for the Workplace Safety and Insurance Appeals Tribunal in the Province of Ontario, which concluded:

> There is no clear evidence to suggest that an injury to one lower extremity would have any significant impact on the opposite uninjured limb unless the injury resulted in major muscle or nerve damage causing partial or complete paralysis of the damaged leg, and/or shortening of the injured lower extremity resulting in a limb length discrepancy of more than 4 or 5 centimeters so that the individual’s gait pattern has been altered to the extent that clinically there is an obvious lurching type gait (a significant limp). In order for this type of gait to have impact on the opposite or uninjured leg, it is likely that the abnormal gait or limp would need to be present over an extended period of time – years. A temporary abnormality in gait, eg, a limp over a relatively short period of time of weeks or months is unlikely to have any effect on the opposite leg. The use of a cast, cane, and crutches is also unlikely to have any major impact on the stress borne by the uninjured limb. Increased body weight (obesity) does, however, have a detrimental effect on both lower extremities and magnifies all of the previously described risk factors.

AMA Guides to the Evaluation of Disease and Injury Causation, Second Edition, page 771

Disclosure Statement

The author declares that he has no known competing financial interests or personal relationship that could have appeared to influence the work reported in this presentation.