MLAC Workers' Compensation
Management-Labor Advisory Committee

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Independent Medical Examination Report

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Background

Independent medical examinations (IMEs) are directed by an insurer or self-insured employer for the purpose of processing a workers' compensation claim under ORS 656.325(1). This type of exam has been allowed since the workers' compensation law was enacted in 1914. Under current law, the insurer is allowed three IMEs per opening of a claim without obtaining permission from the director of the Department of Consumer and Business Services (DCBS). The insurer pays for the exam, including reimbursement for travel and related expenses to the worker. The worker must attend the exam unless he or she provides a good cause reason. The worker may object to the location of the exam by contacting the Workers' Compensation Division.

There have been frequent policy discussions about IMEs in the past 15 years. In 2001, several issues were raised during discussions about Senate Bill 485 and reform. The early versions of the bill included provisions for certification of IME physicians and a selection process involving the department. The final version of the bill did not include those items, but the bill created the related worker-requested medical examination process.

In 2004, DCBS conducted a study on independent medical examinations at the request of the Management-Labor Advisory Committee (MLAC). After reviewing the department's study, MLAC recommended Senate Bill 311 to the 2005 Legislature. Among many changes, the bill required DCBS to develop a certification process, training requirements, and educational materials for independent medical examination providers. Only certified providers were allowed to conduct exams. The bill and associated rules also allowed a worker to dispute the location of the exam. The department also instituted an ongoing survey about the exam process for workers. The bill took effect July 1, 2006.

Recently, two 2015 legislative proposals (Senate Bill 701 and House Bill 2581) proposed changes to the IME process. The bill proponents expressed concerns about bias of IME providers and that examinations are not truly independent. Senate Bill 701 proposed that DCBS select the provider. House Bill 2581 proposed that insurers be allowed one IME and introduced the concept of a random external file review from a provider selected by DCBS. Neither bill moved forward. However, MLAC agreed to review IME issues in the 2015 and 2016 interim and to provide recommendations to the Legislature.

MLAC established a subcommittee to review available data, information, and processes related to IMEs. The following sections summarize the information received by the subcommittee.

IME data and process review

Most IMEs are conducted after the insurer has made its initial determination about the claim. Between 65 percent and 85 percent of IMEs are conducted more than 60 days after the employer learned of the claim.

Independent medical examinations by insurer type

	2011	*2012*	*2013*	*2014*	*2015*
SAIF Corp.	4,709	4,934	5,321	5,810	6,064
Private	636	667	867	668	703
Self-Insured	496	908	1,310	2,025	1,484
Total	5,842	6,509	7,499	8,503	8,251
Accepted disabling claims (all insurer types)	18,693	18,643	18,633	19,742	19,572

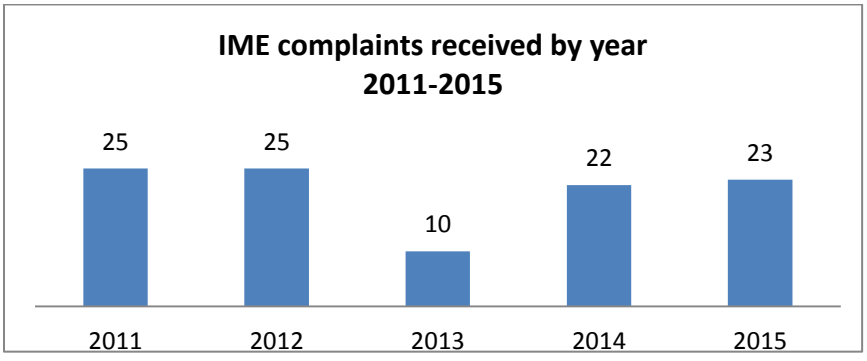
Note: The counts of IME are based on the date of service. If a worker attends more than one appointment within a 72-hour period, it is counted as one examination [OAR 436-010-0265(1)(a)]. Disabling claim counts are based on the date reported to DCBS as disabling.

Under administrative rule, insurers must provide the worker's attending physician a copy of all IME reports. The rules do not require that the insurer ask for a specific response from the attending physician.

Some parties have said that because IME reports are written for insurers, they tend to favor the insurer's position. Currently, there is no factual review of the quality of IME reports. IMEs are one of many medical opinions, including the opinion of the worker's attending physician, that is used by an insurer to evaluate a claim. If there is a dispute regarding a worker's claim, an administrative law judge would weigh the persuasiveness of the medical opinions.

Complaints about IMEs

DCBS receives complaints about IMEs by phone, mail, and email. A summary of total complaints received in recent years is below.



The department was unable to verify more than half of the complaints, mostly because there was insufficient evidence to substantiate one or more topics of the complaint. Between 2011 and

2015, 26 IME providers were given education or information to provide compliance with rules, to change behavior, or to improve customer service. One IME provider was issued a formal letter of warning.

Worker survey

Under current rules, insurers must provide workers specific information with their IME appointment letter. Part of that information includes a link to an online survey (www.wcdimesurvey.info) to provide feedback or if they have a complaint about the IME provider. Any worker who does not have access to the Internet can call the department for help. The current survey was developed after the 2003 legislation affecting the IME process. In 2011, the department switched from paper surveys to an online format. The survey asks questions about distance traveled, number of IMEs, and about the satisfaction with the provider and process. The department receives a small number of surveys per year.

IME location disputes

Under ORS 656.325(1)(c)(A), a worker may dispute the location of the IME within six days of the date the insurer mails the notice of the examination. The director reviews the disputes for the reasonableness of the location. The determination by the director is not appealable.

IME location disputes

Year	Total	Location approved by director	Location not approved by director	Dismissed (IME canceled or rescheduled)	Withdrawn by worker
2011	357	75	24	196	62
2012	338	83	20	179	56
2013	332	83	15	143	91
2014	312	67	12	137	96
2015	323	39	15	195	74

IME provider list and training

The department must keep a list of providers authorized to perform independent medical examinations and worker-requested medical examinations.

To be on the list, a provider must do all of the following:

- Hold a current license and be in good standing with the professional regulatory board that issued the license
- Attend a director-approved training on IMEs or review IME training materials approved by the director
- Complete the online application form
- Agree to abide by the standards of professional conduct that either the relevant medical licensing board has adopted or the standards published in OAR 436-010 (Appendix C)
- Agree to abide by the Oregon workers' compensation laws and rules

To become an authorized IME provider, the provider must review training materials provided or approved by the department, such as the "Guide to Providing Independent Medical Exams." The

IME provider completes an online application that the department reviews for completeness. The department verifies the provider is in good standing with the professional regulatory board that issued his or her license. By signing the application, the provider agrees to abide by the standards of professional conduct that either the relevant medical licensing board has adopted or the IME standards established by rule. The division's standards were adopted in 2004 and have not been reviewed since that time. The provider training materials were last updated in 2011.

There are currently 754 authorized IME providers. Between 2011 and 2015, the department added 285 new providers and removed 119. The main reasons for removal were due to death, retirement, or license expiration (59 providers), at the physician's request (35), or a licensing board restriction (17). During the application process, the provider may self-select a specialty and sub-specialty. Many providers select multiple specialties.

Worker-requested medical examinations

ORS 656.325(1)(e) allows a worker a specific examination called a worker-requested medical examination (WRME) when:

1) The worker has a timely hearing request on a denied claim;
2) The denial is based on at least one IME; and
3) The worker's attending physician does not concur with the IME report.

A worker or his or her attorney must request the WRME. The director determines the worker's eligibility by establishing if the worker meets the three statutory criteria and issues either an approval order (including physician selection) or a denial order.

A provider on the DCBS list of authorized IME providers must conduct the WRME.

Worker Requested Medical Exam Requests

Year	Total	Approved by director	Denied by director	Withdrawn by worker	Incomplete request (dismissed)	Unrepresented workers
2011	113	72	21	17	3	0
2012	121	79	16	25	1	2
2013	142	111	11	10	10	7
2014	113	95	7	4	7	5
2015	139	112	14	10	3	3

Because a WRME is part of an appeal of a denied claim, the subcommittee was concerned about the share of workers not represented by an attorney. In the WRME process, few workers are unrepresented. Generally, worker representation rates have been steady for the past 12 years, and workers typically have an attorney for 87 percent to 88 percent of hearings, 90 percent to 93 percent of board review cases, and 84 percent to 87 percent of claim disposition agreements.

As part of the conversation about WRMEs, the subcommittee wanted to know about denied claims and how frequently they are appealed. DCBS has information about disabling claims. The table below shows the number and percent of originally denied disabling claims and the share appealed by insurer type. Data reflects the date entered into the department's system, regardless of the date of injury.

Denied disabling claims and appeal rate

	SAIF Corporation		Private insurers		Self-insured		All insurers	
	#	%	#	%	#	%	#	%
2011	736	45.40	395	45.88	269	42.63	1,400	44.97
2012	622	42.52	333	45.68	232	41.73	1,187	43.20
2013	670	46.05	318	45.82	230	42.99	1,218	45.38
2014	742	42.28	311	40.23	230	38.59	1,283	41.07
2015	722	38.53	297	38.47	203	39.26	1,222	38.63

Stakeholder input

The subcommittee held three round-table style meetings to solicit public input about problems and opportunities for improvement (see Appendix A).

Stakeholders noted that it is difficult to quantify "bias" – real or perceived. The low number of complaints from workers about IME process was cited as an indication that the IME system is working relatively well. However, others said that filing a complaint offers little tangible benefit, especially as a complaint is unlikely to change the fate of the claim. The department's worker survey and complaint process are not set up to capture the subtleties of provider bias.

The concerns raised about IMEs fell in two areas. The first is the exam itself and the interaction between the worker and provider. The second is the resulting report from the IME provider to the insurer. Both areas are hard to quantify. The nature of the exam – a provider examining a worker in a private medical situation – creates a "he said/she said" situation and it is difficult to determine bias based on subjective responses without an observer or third-party account. There is not currently a neutral analysis of the quality of resulting IME reports. Sometimes it could be that a difference in the medical opinions is interpreted as bias.

Regarding one of the legislative proposals to reduce the number of IMEs, several stakeholders stated that the statute allows three IMEs to balance the worker's ability to make three choices for an attending physician, who acts as the gatekeeper for the claim. The subcommittee was unable to locate legislative history that supported this statement.

There were several comments about setting expectations for workers and providers about the IME itself. The claim process can be complex, and there may be misunderstandings of the process leading to negative perceptions. There was general agreement that more information and education would be beneficial for all parties.

One stakeholder group representing workers made a specific request to change the WRME process. Under the law, DCBS makes the selection of the physician for the worker from an IME provider list. Some cited concerns that the provider list favors insurers (who are the primary users of the list). Proponents requested that workers be able to select their own provider, giving them more choice and reducing the perceived bias having someone choose for them.

The same group also requested that the criteria to obtain a WRME be expanded to grant an exam when the worker's attending physician does not completely agree with the IME report. Under the current interpretation of the law, the lack of comment from a worker's attending physician on an IME report is not enough to qualify for a WRME. Only a clear disagreement from the attending physician about IME allows a WRME. There was much discussion about the reasons why an attending physician might not respond to a report.

The subcommittee consulted the Medical Advisory Committee (MAC) about the reasons an attending physician might not respond or comment on a report. The MAC indicated that many reports are sent without a request for comment and that most providers will not respond unless directly asked. Other reasons included the provider wanting to discuss the exam with the worker, the complexity of cases that involve an IME, and inconsistent communications from various insurers.

Recommendations

MLAC also held three more subcommittee meetings to review input and discuss recommendations. The committee acknowledges the frustrations of some workers about the IME process and that there are occasions it does not go smoothly. Based on public input and review of existing data, the subcommittee did not identify any major issues with the current IME system that merit a statutory change.

The subcommittee agreed, however, that the current process could be improved. In particular, there should be more focus on improving worker and provider interactions and the collection of worker feedback about their IME experience.

After reviewing the subcommittee recommendations, the full MLAC voted on Jan. 17, 2017, to accept the subcommittee report and the following recommendations.

The first area of recommendations is a request that the department undertake a thorough review of existing rules and requirements in the following areas:

1. **Rule review**: The department should review and seek comments on the administrative rules relating to IME provider certification, ethics standards, and training requirements.
2. **Notice requirements**: The department should determine whether to specify standardized language for transmittal of IME reports to attending physicians, including a description of how the worker may be affected if the provider does not respond.
3. **Worker survey**: The department should review the current worker IME survey and update questions to gather more meaningful data about worker and provider interactions.
4. **Provider training**: The department should update IME provider training in consultation with affected stakeholders.

In the related worker-requested medical examination (WRME) process, the committee identified possible statutory improvements. The WRME directly affects workers and their ability to request another medical opinion if their claim is denied based on an IME. A small number of these exams are requested each year, in part because the statute has strict criteria. The requirement that the worker's attending physician specifically not concur with the IME report was identified as a particularly stringent requirement. Also, although the exam is for the worker, the worker does

not select the provider for the exam (the director makes that decision). This contributes to the perception that the WRME may be biased.

To that end, MLAC also recommends the following law changes:

1) **Expand access to WRME.** Modify the third criteria to obtain a worker-requested medical examination (WRME). Allow a WRME if the attending physician sends written objections or provides no response to the IME report within 30 calendar days from the date of the insurer's denial.
2) **Provide worker more choice.** After determining whether the criteria for a WRME were met, the director will provide the worker a list of up to three appropriate health care providers to conduct the exam. The worker may select any provider on the list. Maintain the current administrative rule requirement that the exam be scheduled within 14 days of the notice the worker is eligible for the exam.

Appendix A
Round table discussion participants
Jan. 15, 2016; May 5, 2016; and July 6, 2016 meetings

Stakeholders

Representative **Phil Barnhart**
Chad Kosieracki, Special Districts Association of Oregon
Gina Wescott, Special Districts Association of Oregon
Mary MacDuffee, Integrity Medical
Mike Van Leuven, Integrity Medical
Jaye Fraser, SAIF Corporation
Dan Schmelling, SAIF Corporation
David Barenberg, SAIF Corporation
Jessica Smith, Medical Consultants Network
Adam Coberley, IMEA
Hasina Squires, IMEA
Dan Farrington, IMEA
Sue Quinones, City of Portland
Keith Semple, Oregon Trial Lawyers Association
Colin Hackett, CRH law/Oregon Trial Lawyers Association
Linh Vu, City of Portland
Lana Butterfield, American Family Insurance
Jennifer Flood, Ombudsman for Injured Workers
Betsy Earls, Associated Oregon Industries
Sheri Sundstrom, Hoffman Construction
Tracy Hughes, Objective Medical Assessments Corporation

MLAC members

Aida Aranda, Oregon and Southern Idaho Labor-Employers Trust
Guy Boileau, Louisiana-Pacific Corporation
Tammy Bowers, May Trucking
Jim Denham, ATI
Lynn McNamara, CityCounty Insurance
Ben Stange, Polk County Fire District No.1
Diana Winther, IBEW Local 48
Kimberly Wood, Perlo Construction

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Lori Graham, Workers' Compensation Division
Cara Filsinger, Workers' Compensation Division