Toward making IMEs independent: Balancing the source of work

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It has been said many times that “money is what makes the world go around”. The article “Toward making ‘IMEs’ Independent” (pages 9-10) certainly reinforces this phenomenon in the insurance context, highlighting the economic forces at work in independent medical examinations (IMEs).

The independence of medical examiners in an insurance context is important because of the power wielded by examiners to recommend that insurance benefits be allowed or terminated. This adjudicative responsibility operates in the context of a significant inequality in ‘bargaining power’ among insurers, who enjoy very large economic resources, and insureds, who by definition suffer disabilities that in many instances render them economically vulnerable.

Given the change in public satisfaction between the previous system and the new system described in the article, there is little room to doubt the economic pressures that experts may find themselves under if their livelihood rests on conducting IMEs for insurers.

Various systems have been devised to redress this inherent economic imbalance and achieve some degree of fairness in disputed insurance claims.

As a lawyer, I must admit to a certain bias in favour of the traditional tort system, which offers an effective method of granting aggrieved parties redress for biased IMEs by subjecting the IME provider’s opinion to open scrutiny. In a trial setting, the IME opinion is tested against an array of witnesses who can testify to postaccident changes in the claimant, as well as the expert opinions of the claimant’s treating physicians and any IME examiners retained by the

claimant. The determination of the claimant’s rights is made by the court and binds the insurer. While being criticized as expensive, the strength of the tort system is its strong tradition of judicial independence and an impressive body of jurisprudence in the field of insurance law that recognizes – and seeks to redress – the inequalities between insurers and claimants.

In no-fault systems, recourse to the courts is often highly circumscribed or completely eliminated, and administrative processes usually replace the courts. The ability of these bodies to adjudicate disputed claims with fairness and impartiality is highly variable, depending on such factors as the association between the decision-making body and the insurers, and the strength of the insurers’ political lobby to influence the format and operation of the administrative systems. (Where the body that holds the purse strings is also responsible for adjudicating claims, there is inevitably a serious conflict of interest favouring insurers.) Once again, the presence of well-funded corporations on one side and individual claimants on the other creates a dynamic of imbalance. Thus, the economic vulnerability of insurance claimants often carries political consequences as well.

In rare but notable instances (such as in Colorado), members of the public have formed a collectivity, which has successfully lobbied for greater fairness in the system.

The new program in Colorado attempts to introduce fairness at the first level of adjudication, the IME.

Interestingly, the primary method of accountability within the new system is financial. However, the new pro-

gram goes a long way toward equalizing the previous economic inequalities, by making it most profitable for providers to maintain neutrality, with those providers who are most acceptable to both parties (ie, those who are best at finding the middle ground) being rewarded with the most work.

I make two observations pertaining to the new system – one on fairness and the other on funding.

First, the high confirmation rate may reflect a phenomenon of ‘rubber stamping’ the treating provider’s recommendations. In this context, it is important to note that a doctor/patient relationship exists only between the claimant and his or her treating physician, not between the claimant and the IME examiner. Given that the foundation of the doctor/patient relationship is the physician’s legal duty to act in the patient’s best interest on medical issues, the high rate of

endorsement of the treating provider’s recommendations is comforting.

Second, there is a surprisingly high percentage (60%) of IME examiners who recommend additional treatment. One would hazard to guess that the significance of this is directly related to the ‘same specialty’ requirement. For treating IME experts, there may well be an ‘I’ll scratch your back if you scratch mine’ dimension to the IMEs. It is not surprising (although not necessarily appropriate) that insurers have sought to have psychiatrists and orthopedic specialists review the treatment recommendations of those specialties who most stand to profit from insurance-funded medical treatment.

Overall, however, it is encouraging to learn of a system that recognizes the financial interests of the respective parties and equalizes them in a practical and economical fashion.

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