

# Understanding independent medical assessments – a multi-jurisdictional analysis

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**June 3 2013**

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## **Introduction and literature review**

Independent medical assessments (MA) are a key part of compensation systems. Their purpose is to provide expert advice on injured workers' (IW) eligibility for cover and entitlements. Independent MAs are valuable in determining the level of disability and/or impairment sustained by an injured worker (Ky, Hameed, & Christo, 2009). A stated goal of IME is the evidence-based, objective measurement of disability (Clifton, 2006).

Questions investigated through IMEs may relate to any or all of four areas: medical diagnosis, the work-relatedness of the diagnosis/injury, the likely extent and duration of disability and treatment matters (Lax, Manetti, & Klein, 2004). The report generated by the MA should reflect a fair and thorough evaluation. The examiner should not be afraid to request supplemental documentation if required (Ky et al., 2009). Those performing the assessment should have an understanding of the sensitivity and specificity of any tests or manoeuvres which they use during the examination to assess dysfunction or impairment (Ky et al., 2009). An impairment assessor must have a strong clinical background, but also an understanding of the biomedical, mental, emotional and vocational aspects related to injury and illness (Manchikanti, 2000).

Independent MAs are sometimes used as a counter-balance to the role of physician as "advocate" for the patient. The goal of the assessment is to derive an unbiased opinion free from all influences outside the actual facts gathered in the examination (Lax et al., 2004). Critics of the independent MA process, however, argue that although the examiner is independent of the patient, they are subject to a conflict of interest by way of the financial connection to the requesting party (Lax et al., 2004). Some argue that while WCBs may give the impression that assessments are requested because of a lack of medical information or a conflict of opinion, in reality, most are requested with a view to stopping financial benefits, to reduce the specified level of impairment or to stop or disallow treatment (Manchikanti, 2000). This can result in distrust and apprehension among IWs who are sent to MAs.

Murphy reports that there is a dislike of independent MA amongst some medical specialists as well (Murphy, 2012). Some specialists are uncomfortable interacting with the legal system and going to court (Murphy, 2012). The time commitment involved in reviewing records prior to the appointment, the actual contact time with the patient and then the time involved in writing up the report, which can be lengthy and require multiple revisions, can also be a disincentive to conducting MAs (Murphy, 2012).

While "traditional" MAs can provide valuable information, some researchers have argued that worker's compensation systems should move towards assessments that account for the psychosocial impact and the individual's subjective experience of injury; this is particularly relevant for chronic musculoskeletal conditions (Clifton, 2006; Feuerstein, 1991).

It is important to note that the literature on independent MAs is limited and we were only able to identify articles based on research in the USA.

## **Purpose**

ACC requested an environmental scan to determine how other compensation bodies use medical assessments including their processes and policy, procurement models and quality assurance.

The purpose of this study was to determine how other compensation bodies use medical assessments including their processes and policy, procurement models and quality assurance.

## **Methods**

The study involved a review of publically available information on MA in Canadian and Australian/NZ jurisdictions and interviews with senior policy makers in workers' compensation boards (WCB) or insurers underwriting those boards. This report focuses on the interview data.

A number of jurisdictions in Australia, Canada, New Zealand and one from the USA were selected based on where we could find publically available information on the MA process, where the Institute for Safety, Compensation and Recovery Research (ISCRR) had contacts or where individual researchers had some organizational contacts.

ISCRR emailed their contacts a study information letter, requesting a telephone interview with an individual in a senior policy or health service role who could speak to the process of MA in that jurisdiction. The initial person contacted was either in a position to do the interview him or herself or provided the names of another person in the organization.

Where ISCRR or the research team had no contacts, the researchers sent an information letter to a generic WCB email address and the letter was then forwarded to the relevant person/unit.

All participants were provided information about the study, given the opportunity to ask questions and then signed a consent form. The study protocol was reviewed and approved by the Monash University Human Ethics Board.

Due to scheduling difficulties, a WCB in North America was contacted but did not participate. One WCB in Australia was contacted several times but did not respond to requests for an interview. Two participants were interviewed in one Australian jurisdiction.

We interviewed one individual from an insurer in the USA but have included limited information based on that interview since the process of MA in that jurisdiction had just gone through a major legislative overhaul and was heavily influenced by the private health care system.

A total of 14 in-depth, semi structured interviews were conducted. Table one provides information about participants. Interviews lasted between 45 minutes and 1 hour and were conducted over the telephone. Interviewers prepared for the interviews by reviewing any information about the MA process that was publically available on the WCB website. Interviewers (Allen & Kosny) asked participants about the process of MA in their WCB jurisdiction. The questions focused on the purpose of MAs, the process of procurement, reporting and quality assurance.

Interviews were recorded and transcribed. We used the interview questions and emergent findings as the basis for the creation of research codes. In qualitative research, a code is a word or short phrase that symbolically assigns a summative, significant, essence-capturing attribute to a section of data. Each interview transcript was carefully reviewed and coded. Analytic notes were written based

on the data. Key similarities and differences were examined in the MA process across jurisdictions and novel practices were identified.

**Table 1. Participant information**

<b>Role</b>	<b>Time in Role</b>	<b>WCB or insurer</b>	<b>North America or Australia/NZ</b>
1. Director of Health Care Services	6 years	WCB	North America
2. Senior Clinician/Senior Medical Advisor	4 years	WCB/Insurer	Australia/NZ
3. Manager of Health Care Services	6 years	WCB	North America
4. Chief Medical Officer/Director of Clinical Services	5 years	WCB	North America
5. Chief Nursing Officer/Director of Professional Practices	5 years	WCB	North America
6. Physician Advisor, Integrated Disability Management/Chief Occupational Health	19 years	Insurer	North America
7. Senior Coordinator, Medical Assessment Tribunal	3 years	Insurer	Australia/NZ
8. Workers' Compensation Manager	6 months	Insurer	Australia/NZ
9. Manager, Vocational and Pain Services	3 Years	WCB	Australia/NZ
10. Assistant Director	12 years	WCB	Australia/NZ
11. Relationship manager, Medical and Hospital	1 year	WCB	Australia/NZ
12. Physician Manager	6 years	WCB	North America
13. Manager, Legislation and Scheme Information	2 years	WCB	Australia/NZ
14. Manager, Independent Medical Exams	2 years	WCB	Australia/NZ

*Important methodological considerations*

The term independent medical assessment has different meanings in different jurisdictions. For example, sometimes the term “panel” refers to a group of people who gather in one room and complete a MA while other times being on a “panel” means that a health care professional is on a roster and available to conduct MAs. Various terms also mean different things depending on the local context. For example, “client” in one jurisdiction refers to the injured worker, while in another jurisdiction it refers to an employer. There are many different terms describing someone who has responsibility for claim management (adjudicator, claim owner, claim manager etc.) While different

jurisdictions employ different terminology, we have tried to be consistent with the terms we use to facilitate clearer reporting. Below is a list of commonly used terms and abbreviation in the report.

Terms: MA=Medical assessment HCP= health care provider IW=Injured worker RTW= return to work CM=Claim manager WCB=Workers' compensation board MC=Medical consultant

Our interviews also revealed that many WCBs have multiple MA mechanisms – external independent medical exams, internal claim file reviews done by medical consultants, panels for when a case has escalated. This made it difficult for participants to answer certain questions. We asked participants, for example, how many MAs were done per year, however, for some, this information was difficult to provide. When asked about the outcome of MAs (do they result in RTW, for example), this was also virtually impossible for participants to answer given the range of circumstances and MA pathways. Those having a permanent impairment assessment, for example, would likely have very different “outcomes” than those whose file had gone through a claim file review. In some circumstances, participants only had in-depth knowledge about one type of MA done by their WCB. Other times, participants had greater knowledge of policy related to MA rather than actual practice since the MA process was managed by private insurers. Ideally, in each case where a WCB and insurer had some partial responsibility or oversight of the MA process, we would have liked to interview both parties but timelines did not permit us to do so. It is important to note that the interview findings are based on what participants were able to describe to us and this was limited by their own knowledge and how much time they had for the interview.

We have not identified any jurisdiction by name in the report. Participants were interviewed with the understanding that they had anonymity. Because of the small number of participants interviewed we felt that identifying the WCB by name might in some cases lead to the identification of the participant.

## **Findings**

### **General overview**

In North American and Australian jurisdictions, the first MA typically takes place with the treating HCP (or at a hospital, depending on the severity of injury). Participants reported that in a vast majority of cases a worker will only see a treating HCP in the course of a claim and never go for any other MA. Subsequent MAs are carried out by a number of parties employed by WCBs (or insurers) to assess liability to the WCB, causation of injury, level of disability, failure to return to work (RTW) and so on. The number of MAs conducted varies widely by the size of the jurisdiction, the number of claims that come to that WCB and the WCB's reliance on MAs as part of the claims management process. Appendix B provides information about the MA process, including the number and types of assessments undertaken each year (where available).

Workers' compensation boards tend to use multiple MA approaches. The approaches vary depending on the circumstances and issue under consideration. Workers' compensation boards tend to favour one approach and use the others in special circumstances. For example, while many of the WCBs list medical panels or tribunals as a MA mechanism on their websites, in several cases study participants reported these were used only in extremely rare circumstances due to their cost and administrative complexity.

While the approaches to MA were varied we found that they could be categorized according to the following type of approaches:

*Internal:* Medical assessments are almost exclusively carried out “in-house”. Health care professionals based at the WCB provide assessment services as needed.

*External:* Medical assessment is carried out outside of the WCB. Health care professionals in the community are paid to carry out a variety of evaluations. The health care professional may have an on-going (contractual) relationship with the WCB or may be contacted on an ad-hoc basis. Some WCBs use private medical-legal clinics that provide assessment services.

*Collaborative:* Medical assessment is a collaborative process that includes a number of health care professionals from a variety of specialties (as needed). The IWs’ treating HCP is asked to participate through a process of information sharing and discussion. There is an on-going conversation with health care professionals conducting the assessment, the treating HCP and the IW about the process and its outcomes.

*Individualistic:* Medical assessment is carried out with little contact with external parties. Typically the process only involves one health care professional who is not the treating HCP. Assessment is based on an exam, the information available in the claim file, or the information provided to the assessing health care professional by the CM. If more than one assessor is involved, there is little or no contact between them.

*In-person assessment:* The IW attends the MA and is examined by the health care professional. Typically the health care professional is sent the claim file or information that has been summarized by the case manager. In some cases the IW has the opportunity to discuss their injury/situation with the assessing health care professional.

*Paper based review:* The IW is not seen or examined in person. The claim file is reviewed or the health care professional provides information on the basis of questions posed by the claims manager (CM). The IW is not necessarily informed that this process is taking place.

It is important to note that these categories are not necessarily mutually exclusive. For example, external MAs can be collaborative or individualistic in nature.

While all of the jurisdictions included in the study engaged in some types of MA, participants from a number of the North American jurisdictions noted that their WCBs were moving away from conducting independent MAs, where workers were sent to short, one-on-one assessments by specialists outside of the WCB. While most boards were still using such a model for permanent impairment assessments, some boards had moved to a “whole person” model of MA when the reason for the assessment was claim complexity, slow recovery or failure to return to work as expected. In such cases the assessment was carried out by multidisciplinary teams made up of physicians, occupational therapists, physiotherapists, orthopaedic specialists, psychologists and so on. As needed, the worker was evaluated by one or several members of the team who then provided a detailed report providing direction for treatment, return-to-work, further assessment, etc.

A number of participants also noted that by engaging a medical team “in house” (at the WCB) they were decreasing their need for independent MAs in the community that were difficult to arrange

and manage. These boards tended to have a staged approach to MA. The first source of MA was the treating HCP. If advice or additional information was needed, the CM would consult an in-house health care professional. If the information provided was insufficient or contentious, the health care professional would see the IW for an exam or the IW would be referred for a MA in the community, by a specialist, for example. Medical panel reviews tended to be reviews of “last resort” in the jurisdictions that had them. Participants generally felt that an internal team of medical assessors was a great resource for CMs. For example, close proximity between CM and health care professionals allowed for “teachable moments” where, through regular interactions, health care professionals could educate CMs on various medical management issues and where health care professionals developed a nuanced understanding of the compensation system. Further, internal medical consultants often liaised with treating HCPs, for example, to gather information or discuss treatment options. It was also felt that having in house medical consultants led to more timely reporting and allowed for tighter controls around quality assurance.

Below we provide some more in-depth information about the purpose and process of MAs. We also describe different models of reporting, quality assessment and client perception of the process.

#### *Why are medical assessments undertaken?*

There were 4 main reasons why MAs were undertaken by the WCBs surveyed.

*Failure to progress:* Participants uniformly reported that a key reason for sending an IW for a MA was that the claim was not progressing as expected. This could mean that recovery was delayed for unknown reasons, the IW was not returning to work and/or certain types of treatment were not helping with recovery. Many participants noted that claims with a mental health component often resulted in MAs.

*Permanent impairment:* All WCBs engaged in MA to determine permanent impairment after maximum medical recovery had been reached and the condition had stabilised. Injured workers were examined by medical assessors and were assigned a disability rating that corresponded to a compensation payment.

*Medical disputes:* When two HCPs gave conflicting medical opinions or recommended radically different treatment options, IWs were often sent for a MA. In some jurisdictions, a course of treatment was regularly reviewed, however, typically this was done internally by reviewing the claim file. Additionally, an internal review might be conducted by an in house medical consultant if it were deemed that the primary treating HCP had recommended a treatment approach considered to be an experimental or emerging type of therapy.

*Determining liability and cutting payments:* Participants from some jurisdictions indicated that the primary aim of MAs was to determine liability for the cost of the injury or make a decision about decreasing (or ceasing) payments to the worker. In jurisdictions where workers were permitted to sue for damages for work-related injuries, MAs were used as a form of evidence in court cases.

Participants also cited other reasons for MA in their jurisdictions. These included reviews of IW surveillance footage, seeking to determine fitness for work, for the purposes of RTW planning and vocational rehabilitation, to assess treatment recommendations or simply to get a “fresh” medical opinion from a new HCP.

### *Who requests medical assessments?*

While a review of publically available information on MAs in many jurisdictions indicated that a number of parties could request a MA, in most instances, the CM drove the process. This was the case for paper based reviews where a CM could ask an internal medical consultant (MC) to review part of a claim file and the input from other external MAs. The exception to this was in jurisdictions where IWs could access common law. Participants from such jurisdictions reported that workers and worker representatives also sought MAs to use as evidence in court cases.

### *Who carries out medical assessments?*

As we note in the methods section, the term “medical assessment” is very broad and can involve paper based reviews, multidisciplinary team assessments, and traditional independent medical examinations where a worker is sent for an evaluation by a specialist in the community. Who carries out the MA thus depends on the purpose of the assessment, the type of assessment being done and the injury of the worker. Typically the speciality of the health care professional who carries out a MA corresponds to the worker’s injury. For example, a psychiatrist would be asked to provide a MA for an IW with a mental health claim. Who carries out the assessment also in part depends on the purpose of the assessment. For example, multidisciplinary teams seemed to be used when the assessment was done to aid recovery and return to work. The worker was involved in the process and input was invited from the employer (about RTW options), the treating HCP and other professionals such as occupational therapists and physiotherapists. In contrast, a MA conducted to determine the level of permanent impairment typically only included one health care professional and the worker’s input in the process was limited. In several jurisdictions the assessor was not even permitted to discuss the results of the assessment with the worker, rather these were sent directly to the CM.

### *Recruitment and training*

The recruitment and training of those conducting MAs varied widely by jurisdiction. Some jurisdictions recruited assessors by word-of-mouth, asking existing MCs to approach colleagues who might be interested in conducting assessments. Recruitment was also driven by demand. If a WCB needed certain types of assessors (e.g. occupational physicians or rheumatologists) they would actively recruit those health care professionals by emailing an invitation for expressions of interest to known specialists practicing within the region. Others used a tendering process where individuals or teams (who would conduct multidisciplinary assessments, for example), replied to a request for proposals. Their application was then evaluated according to medical merit and cost. In some instances applicants were asked to do a presentation to the WCB as part of the application process. Those selected signed a multi-year contract with the WCB. Other WCBs recruited professionals at medical conferences or by contacting clinics directly and recruiting individuals to be part of a roster of health care professionals who could be asked to do reviews in their speciality area. A few Australian jurisdictions indicated their WCB used medico-legal firms for MAs. In such cases the firms had a roster of health care professionals on hand to conduct assessments. In those instances, the firms were responsible for ensuring that the health care professionals working for them had appropriate training and qualifications. Some WCBs did not sign agreements or contracts with medical assessors but rather paid on a per service basis. These assessors did not necessarily have any sustained relationship with the WCB.

There was agreement that recruitment was sometimes challenging. Workers' compensation boards wished to attract experienced health care professionals in relevant disciplines (orthopaedic surgeons, psychiatrists, occupational physicians, etc) that were available to conduct assessments. Those involved in permanent impairment assessments had to know how to do whole person impairment calculations. In a number of jurisdictions, WCBs required assessors to have training and certification by the American Board of Independent Medical Evaluation. Specific training related to workers' compensation and the medical assessment process was also provided by some WCBs. Some WCBs said that they had success recruiting retired or semi-retired health care professionals to carry out assessments but this was sometimes met with complaints from IWs and their representatives that the board was employing assessors who were no longer in clinical practice and potentially out of touch with the latest medical knowledge. Employing health care professionals who were in active practice was desirable but expensive and difficult due to their time constraints.

Participants described a number of ways that WCBs tried to attract and retain health care professionals for MAs. These included financial incentives (paying for the assessors' time and not by report, paying higher fees) and opportunities for continuing medical education. Another challenge was recruiting assessors in rural areas of a state or province. Some WCBs regularly flew health care professionals to remote regions to conduct assessments or alternatively flew IWs to urban areas where there were larger numbers of assessors. Both scenarios were costly. In a number of jurisdictions, WCBs kept a roster of health care professionals available to do assessments but since it was up to the individual health care professional whether she or he accepted to do a review, some assessors did many more assessments than others. A number of participants worried that this could lead to bias (or perceptions of bias) since the majority of reviews were being conducted by a handful of health care professionals, many of whom had developed close relationships with the board.

One Australian jurisdiction had an interesting medical assessor appointment process. Health care professionals submitted applications to become a medical assessor with the WCB and the application was reviewed by a panel which included members from the community (as well as the WCB). The process was repeated every three years to ensure that health care professionals on the roster were still interested, available and that their reviews met certain quality standards.

### *Payment*

Payment for MAs varied widely by jurisdiction. Those assessors who worked in-house (doing file reviews, for example) essentially were salaried employees of the WCBs and spent a number of days at the WCB offices per month or week (depending on the arrangement). For external assessments, some jurisdictions paid health care professionals per report completed. Rates were set by the WCB based on the type of report. Others were paid for time spent per assessment/report. The rationale for this approach was that both assessments and reports varied in complexity and length depending on the questions posed and the nature of the injury. One Australian jurisdiction did not have a formal payment structure – a medical professional submitted an invoice for an amount determined by that health care professional. Two North American jurisdictions with a formal payment structure per report also had a built-in incentive for timely reporting. The WCBs paid a premium for reports submitted by a given deadline and if a report was submitted late the health care professional received a lower payment for the report.

### *Reports*

In most jurisdictions reports were based on questions posed by the CM (or the party requesting the assessment). For example, a CM sent a series of questions to the assessor along with accompanying information about the claim. The documentation was reviewed and an examination undertaken. Once complete, a report was written by the assessor addressing the questions posed. A number of jurisdictions had recommended templates that prompted the assessor to address various domains. These included information on the mechanisms of injury, signs and symptoms, range of motion, previous medical conditions, work history and treatment recommendations. Where contracts existed between health care professionals conducting assessments and a WCB, these sometimes specified the format of reports. Reports for permanent injury assessments were required to include a score or determination indicating level of impairment. Multidisciplinary team assessment reports tended to be more comprehensive and detailed. Each member of the assessment team provided information based on their expertise and examination.

Reports were always sent to the CM who used them in the course of adjudication and claim management. In each jurisdiction, IWs could also access reports. In most jurisdictions, treating HCPs also received the report, or were given access to the report. Sometimes it was the treating HCP's responsibility to share the findings of the report with the IWs, particularly if they resulted in a decision that was likely to upset the workers (for example, a cessation of benefits).

#### *Quality assurance*

Participants wanted assessments done that were timely, comprehensive, decisive, medically justifiable and clearly written. However, there was great variation in how WCBs ensured that MAs and reports produced as part of the assessment process were of high quality. While some jurisdictions had a quality assurance team or unit at their WCB, medical assessments often fell outside of its scope. In some jurisdictions there was no formal review process and feedback mechanism to medical assessors at all. If the reporting was delayed or incomplete the WCB simply "talked with its feet" and did not go back to that assessor. Some boards asked for supplementary reports when information was missing but this resulted in additional cost and delays. Participants from WCBs that had contracts with individual health care professionals reported that contracts often contained reporting guidelines. Workers' compensation boards that used internal MCs often had a supervisor or director who had some oversight over the MA process. This individual would informally provide feedback to assessors or carry out some systematic assessment of reports (for example, every month review a selection of reports from assessors, then provide them with feedback).

One of the jurisdictions in Australia had a very rigorous process of quality assurance. The WCB had developed a quality assurance program that used peer reviewers from the same speciality as the assessor to review a selection of de-identified reports. These reports were examined by two reviewers and given a score. If the score was lower than a predetermined level, the health care professional who wrote the report was contacted and given feedback on how to improve reporting. If the quality of the report was particularly poor, a senior clinician provided feedback in person. Three months later, three reports written by that same health care professional were reviewed to make sure that she or he had adopted the feedback provided. Reports were normally reviewed every three years, however, for health care professionals who had a poor rating on an initial review, a subsequent review took place three or twelve months later.

It is important to note that typically, quality assurance assessments almost always has to do with making sure the reporting was complete, timely and answered the questions posed. There seems little done to assess the quality of medical opinion provided. This however, was something that the Australian jurisdiction discussed above was planning.

### *Client perception*

While we did not interview any IWs who had gone through MAs, we did ask participants whether they had any information about how clients perceived the process (from satisfaction surveys or informal feedback, for example). Generally it was felt that clients did not like the MA process. They did not understand what was being done and why. Some participants gave anecdotal accounts of IWs who did not feel that a one-off, brief appointment (typically an hour or less) with a specialist who had never seen them before, provided sufficient time for the assessor to fully understand the nature or complexity of their injury. Clients typically did not have a choice in which health care professional they saw for an assessment (although some participants said that if the IW objected to an assessor they would try to find someone else). We were told that IWs also felt that a MA was the first step toward cutting benefits and that the medical assessors were working with the WCB to achieve this goal. With permanent impairment assessments, it was not clear to clients how a certain disability percentage was reached and on what basis. A number of participants reported that they had received complaints that an assessor was rude, curt or that the clinical examination caused the IW considerable pain. In some jurisdictions, IWs were not prepared in any way for assessments, nor did they receive any direct feedback from assessors. Sometimes, we were told, clients had misconceptions about the sort of “pay out” they would receive after an assessment was completed which could result in anger and disappointment.

One Australian jurisdiction was very proactive in preparing IWs for MAs. Each IW who was going to have an assessment was contacted by a CM and the process was explained to them (how many people would be in the room, what would happen, etc.) This jurisdiction had a video that workers could watch describing the process in detail.

It was reported to us that clients who went through a multidisciplinary MA had very positive feedback about the process. As one participant described it, IWs sent to that board’s multidisciplinary program were seen by a number of specialists and offered opportunities to “tell their story”. Clients felt listened to and that the WCB was taking the time to really understand their situation. The report was shared and discussed with the worker, treating HCP and CM. Our study participant reported that evaluations of the program were overwhelmingly positive. Similarly, it seemed that in jurisdictions where MAs resulted in accelerated access to certain services (surgery, for example) or specialists, evaluations of the process tended to be positive.

### **Discussion**

The MA process varies widely among jurisdictions and many individual WCBs have multiple processes that take place simultaneously or sequentially if the matter has escalated. Each approach has its merits and drawbacks. For example, in house medical consultants may be readily accessible to CMs but because they are hired by and housed at the WCB, their impartiality may be challenged by IWs. The use of external firms to manage the MA process may relieve WCBs of administrative burden but may also lead to limited control over the quality of assessments. It seems likely that the

suitability of approaches varies depending on the purpose of the MAs. So, for example, if the purpose of the assessment is to help an IW recover and RTW then a multidisciplinary assessment is likely a good approach. This approach however is probably not practical if the aim of the MA is to assess the level of functional impairment.

It is important to consider the social, health care and legislative context within which assessments take place. For example, in Canada, New Zealand and a number of Australian jurisdictions, IWs do not have access to common law as part of the workers' compensation process. Jurisdictions with common law provisions allow injured workers to sue the employer for the costs of the injury they have sustained if it can be proven that it arose from the employer's negligence. Schemes may have a pure no-fault model (e.g. the ACC in New Zealand), a pure common law model, or a hybrid of the two models. Most jurisdictions in Australia (except South Australia and Northern Territory) apply a hybrid model with at least some degree of access to common law pathways. Damages available through common law may be either capped or unlimited and may include both economic and non-economic loss (pain and suffering), depending on the jurisdiction. There is often a minimum level of whole person impairment required (typically 15-20%) before an injured worker can commence proceedings under common law (Safe Work Australia, 2012). It seems to us that the process of MAs is more adversarial and less collaborative if the purpose of the MA is to provide evidence that could be used in a court of law. Further, Canada has a public health care system and waiting lists for certain surgeries (or consultations with certain HCPs) can be long. Those IWs going through workers' compensation can sometimes "jump the queue" and receive services faster. In these jurisdictions access to speciality services and faster surgery can be desirable to workers and they may see the MA process in a more positive light.

We were perplexed by why some jurisdictions identified major difficulties finding and retaining medical assessors, while in others there seemed to be plenty on hand and the WCB could impose certain selection criteria related to training, availability and specialty. When there are numerous individuals interested in doing MAs, quality control can also be easier because if a medical assessor is not open to receiving feedback then he or she can be replaced by someone who is more amenable. It is possible that some WCBs have developed systems to make the MA process less administratively burdensome for assessors. We also suspect that in some jurisdictions there are simply more health care professionals to choose from. For example, it is unlikely that geographically isolated communities have many orthopaedic surgeons or rheumatologists. Further, some jurisdictions may offer greater benefits to an assessor (higher pay or continuing education opportunities) that will attract them to this sort of work. One participant identified the pay rate for assessors in his jurisdiction to be "woeful" and reported being aware of specialists who prefer to travel interstate to jurisdictions where the pay for conducting an assessment could be up to 100% better.

During the study we identified a number of practices which we feel may improve various aspects of the MA process. These are listed below.

#### *Best practices*

*Internal medical consultants* – There may be some benefit in having a number of MC located "in house" at the WCB or insurer. Not every matter needs to be sent out for medical review. It seems that sometimes a CM simply needs to have a brief consultation with someone who has medical

expertise. While likely not appropriate for all types of MAs, in-house MC can help educate CMs to make well informed judgements on health-related matters.

*Incentives for medical assessors* – Well-trained health care professionals currently in clinical practice need incentives to perform MAs. We have already described some incentives used by WCBs – higher payments for assessments and opportunities for professional development. We also feel that making the process less administratively burdensome would make MAs more attractive to some health care professionals. There are organizations in Australia, like E-reports (<https://www.ereports.com.au/content/>) that manage the MA process both for insurers and medical specialists. Their service allows specialists to upload their availability onto a calendar and then a CM can choose a health care professional by availability, geographic area and speciality. Claims managers can view a health care professional's curriculum vitae on line and health care professionals can manage bookings according to their availability. Documents for review are uploaded and stored electronically on a secure server and there is a transcription service included in the fee. The company has consultation rooms in various locations but health care professionals can also conduct assessments at their own clinical practice. Clients are sent a reminder prior to their appointment to help improve attendance rates. These sorts of supports may be desirable to health care professionals who have an interest in providing medical opinion and assessment but who are deterred by the administrative burden of the process.

*Quality assurance* – When there is a greater pool of qualified health care professionals available for MAs it will be easier for WCBs to impose tighter quality controls on the process. We saw that in some boards this was already possible. A systematic review of the quality of reports would permit WCBs to give feedback to assessors whose reports are unclear, lacking in detail or late. Payment structures that reward timely reporting (and penalise late reporting) are also worth considering.

*Tapping various sources of information* – In cases where MAs are done because a worker is not recovering as expected, is having trouble returning to work or there is a conflict of medical opinion, the MA process can be improved by tapping various sources for information about the problem at hand. This should include information from the treating HCP and the worker him or herself. The purpose of this sort of assessment is not simply to pass judgement (on the level of medical impairment, for example) but rather to “solve the puzzle” of why recovery has stalled or RTW has not been possible. In such cases, understanding can be enhanced by including parties who may have additional insight into the problem (such as allied health professionals beyond the primary treating practitioner).

*Public input* – There may be ways in which the public, including HCPs, IWs and employers can have input into the MA process. Community panels can be set up, for example, to evaluate applications from those wishing to be on a MA roster. Feedback from a range of community stakeholders on the appointment process would make it more balanced and transparent.

*Preparing workers* – Injured workers would benefit from having some preparation prior to MAs. Since there are so many different types of assessments (sometimes even within one WCB), workers should know clearly the purpose of the assessment, what to expect (the sort of exam, whether it will be with one person or a panel), what sort of information they may be asked to provide and so on. It should also be made clear to the IW that a therapeutic relationship with the assessor does not exist in the same way it would between the IW and their primary treating HCP. Thus it may not be

possible or appropriate for the assessor to provide medical advice or treatment. Prior to permanent impairment assessments, workers should be given a realistic impression of the likely outcome of the assessment. It would be useful to provide IWs with a simple flow chart that explains the various steps of the process, approximate time lines and who to turn to if they have questions. This would make the process of MA more transparent and understandable to IWs.

*Incentives for IWs* – While injured workers are typically compelled by legislation or policy to undergo a MA if their CM deems it necessary, the process would likely be less adversarial if workers felt they were getting some benefit from the assessment. It is possible that in jurisdictions where MA leads to receiving enhanced services or accessing earlier treatment, the process is viewed in less derisive ways. If nothing else, efforts should be made to make the process less onerous for workers. We were told that in some jurisdictions IWs were expected to travel substantial distances for an assessment. This may be particularly difficult if an injury has compromised mobility or a worker is experiencing mental health problems. In such instances, WCBs should consider new consultation technologies such as tele-health that may decrease the need for extensive travel.

<http://www.medicareaustralia.gov.au/provider/incentives/telehealth/information-for-health-professionals.jsp>

#### **Future research directions**

- Many participants noted anecdotally that IWs do not like MAs. It would be important to understand how IWs perceive different types of MAs processes and what, from their perspective, could improve their experiences (if they are negative).
- Further research should examine how those performing MAs view their role and how their work with IWs and the WCB can be enhanced.
- The examination of forms, templates and guidelines used for various MAs would yield important information about the sorts of reports that are expected from health care professionals in various jurisdictions.
- New models of providing MAs should be explored. For example, how can new technologies and information management systems make the process less burdensome while helping to maintain assessor impartiality?

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