

Health Policy

## Independent Medical Examinations: Facts and Fallacies

Paul Ky, DO, Haroon Hameed, MD, and Paul J. Christo, MD

From: Johns Hopkins University School of Medicine, Department of Anesthesiology and Critical Care Medicine, Division of Pain Medicine; and Department of Physical Medicine and Rehabilitation, Baltimore, MD.

Dr. Ky is with the Department of Anesthesiology and Critical Care Medicine, Division of Pain Medicine, The Johns Hopkins University School of Medicine, Baltimore, MD. Dr. Hameed is with the Department of Physical Medicine and Rehabilitation, The Johns Hopkins University School of Medicine, Baltimore, MD. Dr. Christo is Pain Fellowship Director, The Johns Hopkins University School of Medicine, Department of Anesthesiology & Critical Care Medicine, Pain Treatment Center, Division of Pain Medicine, Baltimore, MD.

Address correspondence:  
Johns Hopkins Hospital Division  
of Pain Medicine  
550 N. Broadway, Suite 301  
Baltimore, MD 21205  
E-mail: pchristo@jhmi.edu

Disclaimer: There was no external funding in the preparation of this manuscript.  
Conflict of interest: None.

Manuscript received: 03/17/2009  
Revised manuscript received: 04/27/2009  
Accepted for publication: 05/18/2009

Free full manuscript:  
[www.painphysicianjournal.com](http://www.painphysicianjournal.com)

**Background:** Independent Medical Examinations (IMEs) have protected the rights of workers in the United States since the first laws protecting employees were established in the early 1900s. There have been many social advancements and a great collective struggle over the last 100 years that have ultimately lead to justice for the injured or disabled worker.

**Objective:** We describe the origins of the IME as well as the evolution of both medical and social processes that have provided the legal framework for the correct practice of IMEs. This article will summarize the current medical principles, legal process, and social controversy embodying the modern IME.

**Discussion:** Medical professionals must adhere to the same principles of impartial and ethical conduct that they uphold in general patient care when dealing with IMEs. Although previously controversial, it is now clear following successful litigation of many physician examiners that at least a 'limited doctor-patient relationship' is created during an IME.

**Limitations:** The limitations of this manuscript include a paucity of the literature, lack of IME updates, and certain conflicts with guidelines by various organizations.

**Conclusion:** IMEs represent a valuable mechanism for determining alleged impairment and/or disability. In the current economic environment of declining reimbursement to physicians, IMEs exist outside the scope of traditional payment methods and offer competitive compensation.

**Key words:** Independent Medical Examination, disability, impairment, worker's compensation, injured worker, disabled worker, doctor-patient relationship

**Pain Physician 2009; 12:811-818**

In the United States, the history of social advocacy in favor of the injured or deceased worker from causes naturally or proximally related to their work began in the late 1800s and early 1900s in a period known as the Progressive era (1). This was a period of increasing social concern for the welfare of the labor force and the rights of the lower classes, minorities, and women (1). The first laws protecting the rights of the worker by regulations for workplace

safety and compensation for injury were enacted by individual states.

Worker's compensation is a no fault system designed to protect workers who become hurt on the job or contract an illness as a result of their job, and usually entitles the worker to medical care, the payment of a percentage of wages, and certain benefits (2). The first worker's compensation law was passed in Maryland in 1902, followed by the enactment of

the first federal regulations in 1908 (3). Famous activists of this era include William Jennings Bryan, Henry Ford, Andrew Carnegie, John D. Rockefeller Jr., Theodore Roosevelt, and Franklin Delano Roosevelt (4). During the early 1900s, a national momentum with a somewhat socialist ideology led to the development of several protective labor laws including the Federal Employers Liability Act (FELA) in 1908, which protected railway workers from negligence by railway owners, operators, and fellow workers; the United States Revenue Act of 1913, which created the Federal Income Tax by way of the sixteenth amendment; the right to vote for women by way of the nineteenth amendment in 1920; the Merchant Marine act of 1920 which protected seafarers in similar fashion to railway workers; and many other legal provisions that supported the general and working public (4-6).

During this period, 12 different state worker's compensation funds were concurrently established such as the giant State Compensation Insurance Fund (SCIF) of California in 1913 and the American College of Occupational and Environmental Medicine (ACOEM) in 1915. The ACOEM was founded by a group of surgeons who were interested in protecting the health of workers in the country. For instance, the members of ACOEM identified factors that were responsible for injury to workers, educated the public about these potential dangers, and advocated both socially and legally in favor of the worker. It seems natural, therefore that the modern Independent Medical Evaluation (IME) found its roots during this time of support for the employee, and its significance grew in proportion to the rights afforded to the worker.

Despite this early national push to secure worker's protection and compensation, the rights granted to the general labor force were widely considered to be inadequate until the passing of the Occupational Safety and Health Act of 1970 (3). Although many universities and hospitals in the early 1900s described specific hazards in the workplace and reported on occupational health, this work alone was not sufficient to assist workers in obtaining adequate compensation; that is, workers were still required to litigate their claims through the courts (3,7-10). In the last 40 years, the cause of the injured worker and all disabled persons has been supported by most industrialized nations and governing bodies. For example, regulations now exist in many countries for worker's compensation claims, and laws enforce access to public buildings, restrooms, and other facilities for all disabled persons (11-13).

## **SCOPE OF INDEPENDENT MEDICAL EXAMINATIONS**

IMEs are conducted by medical practitioners such as physicians, dentists, or chiropractors who make formal assessments within their own specialty regarding the health of a patient, document any injuries or illnesses, and then explain the natural or proximal relationship of the injury or illness to the patient's work or workplace (14). For worker's compensation, the term "causality" often refers to a greater than 50% chance that the injury or illness is related to their work or workplace, while considering any pre-existing injury and and/or diseases. The scope of the IME also extends to disability evaluations and examinations of victims of violent crime (14,15). For the purpose of this review, we will focus on IMEs conducted by physicians.

### **Guidelines and Controversy**

There are many different standards to which the examiner must adhere when completing an IME. The most prominent of which are federal regulations set forth by the Social Security Administration, local state laws, and the American Medical Association's (AMA) Guidelines to the Evaluation of Permanent Impairment. There are also guidelines set forth by many American colleges and boards of medical specialties including the American College of Surgeons, American Society of Interventional Pain Physicians (16-20), and quite significantly the American College of Occupational and Environmental Medicine (21). In addition to many nationally created guidelines, the examiner may also consult the World Health Organizations Disability Assessment Schedules I and II, which provide an excellent simple and unified approach to the disabled patient (22).

The guidelines established by the American Medical Association must be used in accordance with legal requirements in most states when performing a disability exam in the United States (23). Examinations recommended by all specialty boards generally require assessing the degree of musculoskeletal and functional impairment and also include social and emotional impairment rating scales (15). Yet, the extent to which the social and emotional scales are actually useful is highly controversial, especially those related to the ACOEM and AMA (24).

It is widely believed that there has been undue influence of personal and corporate interests in the language of the guidelines related to IMEs (24). Corporate sponsorship of research by pharmaceutical

companies and medical device manufacturers vis a vis the occupational medicine guidelines inherently raises concerns about potential conflicts of interest (24). For example, it has been reported that many members of the ACOEM guideline committee have significant relationships to industry, lack practical expertise in the subjects about which they write specific guidelines, and serve on the committee for the purpose of financial gain (24). Furthermore, this has been a particular problem associated with the ACOEM guidelines because these documents are primarily purchased by corporations, insurance companies, and state agencies while less easily accessible to physicians (24).

Importantly, the examiner must lawfully adhere to responsible record keeping policies which include maintaining medical records for a minimum of five years from the time of examination (14). This is particularly important for IMEs given the inherent legal ramifications for the patient, liability to the employer, and the current litigious environment in which physicians practice.

## **Principles and Process of Conducting IMEs**

### ***1. Referral screening and contracts with third-party payers***

The examiner should develop a referral screening process that judges the appropriateness of the consultation and the time frame for completion, and specifically excludes submission of a rough draft to the third party for their review. After accepting the assignment, the examiner should craft a contract outlining the policies and fee structure of the consultation (25).

### ***2. Orientation of the claimant (patient)***

Before beginning the exam, the examiner should allay any claimant fears and state the nature and sequence of the IME. The examiner should indicate that the physician-patient relationship is not confidential, and confirm the limited scope of disclosure of any medical findings to the patient (25).

### ***3. Thorough history taking: family, past medical, military, education, and incarceration histories, and immediate and post injury care***

IME examiners should consider the circumstances of the examinee's personal life, social and occupational obligations, the nature of the examinee's injuries and the effects of the injuries on the individual, and conduct a full medical history that focuses on direct

or indirect effects on the claimant's current condition (25). Examiners must also carefully consider patient motivations and perceived gains associated with IMEs. For example, poor job satisfaction may lead some patients to view the IME as a means of securing financial stability without returning to work (26). Some examiners even recommend asking patients what they "think their case is worth" in a straightforward manner, to gauge how much they feel they may stand to benefit from their claim (25). Further, the examiner may need to inquire about the health of immediate relatives in order to screen for major familial illness. Some patients may feign their own illness in order to gain worker's compensation benefits for the purpose of caring for a loved one. Furthermore, because of serious illness in close family members, other patients may create or exaggerate their own illness so they can care for someone close to them. Inquiring about parents or siblings with chronic illnesses may also be useful in order to ascertain a familial pattern of disease (25). It is important for the examiner to ask about drug abuse, physical and sexual abuse, and psychiatric disorders since these conditions may contribute significantly to the patient's symptomatology (27,28). In fact, physical and sexual abuse may occur in as many as 61% of patients with chronic pain (27). Moreover, a history of sexual abuse alone exists in as many as 90% of women with somatoform disorders (29).

### ***4. Understanding physics and biomechanics***

The examiner should become familiar with the physics surrounding common injuries, especially motor vehicle accidents. For instance, one may need to keep in mind the low probability of tissue damage from low speed collisions that generate little force. Today, front and rear bumpers and crumple zones on automobiles are designed to decrease the force of impact during collisions. At the same time, airbags can be life saving at high speeds, but may cause harm in low speed collisions (25).

### ***5. Examination***

For pain physicians, this should most often include a thorough musculoskeletal and neurological examination, and should be performed in sufficient detail to permit an impairment rating according to the AMA or alternative organizational set of IME guidelines. It is important to be familiar with the degree of sensitivity and specificity of certain tests and maneuvers that are used to assess joint or neurological dysfunction (25).

### **6. Documentation and surveillance data review**

One must review all available medical records, including relevant data from past caregivers and request additional opinions and tests when necessary. For example, if the examinee claims to have developed chronic fatigue syndrome following an accident, it may be prudent to consult a sleep expert. This consultant may consider a sleep test for the purpose of determining a remediable source of the symptoms that are unrelated to the injury, like sleep apnea (25).

### **7. Requesting additional information**

Other important aspects of the IME include a review of all supportive documentation and a request for additional information deemed relevant by the examiner from either the referring party or the examinee. Supplemental information may include copies of a driver's license, driving records, criminal records, and past medical records that all may provide clues to the patient's past habits, illnesses, and legitimacy of their claimed injuries. This due diligence enables the examiner to fully investigate the patient's behavioral patterns prior to and following injury, and aids in uncovering potential ulterior motives for influencing the outcome of the examination (25).

### **8. Preparing the report**

In preparing the report, it is important to list the diagnoses followed by a discussion of the claim's credibility in which the examiner distinguishes between the possibility or less than a 50% chance from probability of the event's occurrence, or greater than a 50% chance of work or incident related causality (25). Subsequently, the examiner should provide opinions about the apportionment of resources, future medical care, and work restrictions related to the claim. Many examiners also include opinions on maximum medical improvement (MMI) (25). The report should be internally self-sufficient and complete; that is, the examiner should formulate conclusions based on the data contained in the report, thereby minimizing the need for follow-up depositions. The report should clearly state the responses to relevant questions and focus on the available facts of the claim so the reader can unambiguously understand the content. Furthermore, it may be prudent to add a signature on any page with text to avoid substitution or alteration of pages within the report (25).

### **9. Giving testimony in court**

When providing depositions, it is important to remain impartial (25). The examiner must demonstrate thorough and current knowledge, listen to every question carefully, and answer completely without allowing counsel to interrupt (25). It is also critical to remain composed and not permit the cross examiner to incite anger or dismiss the testimony as subjective or based on inferior sources (25). Finally, an examiner should speak slowly and calmly, explain all technical terms, and furnish references when appropriate (25).

## **IMPLICATIONS TO MEDICINE**

### **Medicolegal Considerations**

Currently, there is debate over the development of a doctor-patient relationship during IMEs (30). However, consensus opinion suggests that a "limited doctor-patient" relationship does indeed occur during an IME (30) and that the physician is further responsible for disclosing any medical findings that could affect the patient's health so that the patient can seek medical care elsewhere (30). This element of medical disclosure makes the medical examiner most vulnerable to litigation (31). In fact, several successful lawsuits have been litigated against physicians who have failed to comply with this requirement when the outcome led to patient injury or death (30,30-32). In order to mitigate against the risk of litigation, the examiner should inform the patient that the scope of the examination is limited, the IME cannot substitute for a standard physician examination and additional care should be sought with his/her primary care physician if necessary (30).

Before conducting an IME, physicians should ask patients to review and sign standard Release of Information Agreements in accordance with the Health Insurance Portability and Accountability Act (HIPPA). This avoids any breach of confidentiality laws when reporting the findings of the IME to the requesting parties (25,28,33).

### **Conflict of Interest**

An important prelude to the IME includes disclosures of any socioeconomic conflict of interest that may benefit the physician directly or indirectly by means of benefits to friends, family, or colleagues (25). For instance, a previous physician-patient relationship with the claimant would be unacceptable in the context of an IME (25).

### **Patient Coaching**

There are currently a number of organizations and websites that provide information to patients on methods of maximizing the appearance of injury and even feigning a workplace injury (25,34). For instance, these resources provide in depth coaching on the process of IMEs, the nature and presentation of common injuries, and preparatory skills for answering questions. Patient coaching may have evolved from previous worker's compensation denials that resulted from poor physician evaluation. Such denials lead to the creation of guidelines for the portrayal of "iron clad" clinical presentations of injuries that would more likely succeed in rendering a worker's compensation claim (34). Unfortunately, these resources may invite claimants to exaggerate or fake injuries in a manner that is difficult for the physician to detect (25,34).

## **IMPLICATIONS FOR PAIN MANAGEMENT**

---

### **Prognostic Implications**

There are many factors that are of prognostic significance in determining the level of permanent disability after injury, especially with respect to pain. For instance, psychological factors represent a dominant factor in influencing the likelihood of disability; specifically, self-efficacy or one's confidence in performing an activity and in overcoming barriers to performing that activity appears to negatively correlate with the likelihood of disability (35). Contrariwise, an increase in self-efficacy correlates with reduced disability due to lowered levels of anxiety and a tendency toward greater initiative (35). Alternatively, fear avoidance correlates with increased disability, but appears to be a less statistically important correlate for worse outcome related to functional capacity and return to work (36). It is essential for the examiner to consider kinesiophobia or the irrational fear of movement, low self esteem, and depression when assessing pain because these factors may predict a worsening of long-term function (36,37).

### **Comprehensive Training**

Similar to other professional medical work, it is desirable to obtain comprehensive training in this highly specialized area. This avoids loss of respect from clients, business associates, and colleagues; excessive legal scrutiny of the examiner's practice; and loss of billable practice time (e.g, income) while defending against angry attorneys, colleagues, or patients. Inter-

ested examiners can consider attending pain-focused training programs through the American Board of Independent Medical Examiners, and the American Academy of Disability Evaluating Physicians. Both organizations offer continuing medical education programs and certification.

### **Current Environment**

Physicians currently face a decline in Medicare reimbursement for their services (35). This is in contrast to yearly increases in Medicare expenditures for other sectors in health care including payments to managed care organizations, hospitals, and pharmaceutical companies (38). Since reimbursement for interventional pain management services has been reduced disproportionately, performing IMEs may be an attractive method of replacing this lost income (38).

Currently, low back pain affects an estimated 80% of adults at some point in their lives and accounts for a significant portion of lost workplace productivity (39). According to some estimates, the total annual direct and indirect cost related to disability from back pain and its associated lost productivity and related legal costs may exceed \$100 billion per year (41). This cost rises to \$120 billion per year when all chronic pain conditions are considered along with back pain (40,41).

Pain physicians are in high demand as IME evaluators compared to other physicians because pain is a frequent reason for patient referral and pain treatment for work related disability is incorporated into the legal aspects of the IME process (14,15). Typical payments for IMEs range from \$300 to \$600 per hour and sometimes physicians can secure greater compensation based on more extensive specialization, greater experience with IMEs, and greater number of years in clinical practice (29,42).

## **DISCUSSION**

---

Many advances in the United States legal system have contributed to the development of a system of protection for injured workers (1,3-6). Current legislation in the form of OSHA and the Americans with Disabilities Act provides the worker with a right to a safe and accessible workplace, as well as the the right to legal recourse if injury occurs or rights are violated (11-13).

Most of the 50 states accept the AMA's Guidelines to the Evaluation of Permanent Impairment as a legal standard by which to determine disability. Although several other references for impairment determination

exist, many evaluators recommend a familiarity with the AMA document prior to initiating IMEs and especially before performing disability evaluations since it is considered a legal standard in most states (25). A physician may obtain certification to perform IMEs by studying the American Medical Association's Guidelines to the Evaluation of Permanent Impairment, and then successfully completing a course and examination administered by the American Board of Independent Medical Examiners or the American Academy of Disability Evaluating Physicians. A certification may make an insurance company or attorney more likely to request an IME from a particular physician, although there is no legal requirement for a certification in order to complete an IME. Before conducting an IME, the examiner must qualify as an expert in the field of medicine in question (e.g. psychiatry, pain medicine, radiology) and the report must be guided by the impartial and ethical standards expected by all medical professionals.

A physician engaged in conducting IMEs should be familiar with the intricacies of the patient's personal life including pertinent family and financial conditions that may influence the subject of their examination. For example, the examiner must understand the relationship between illnesses and physical, emotional, or financial difficulties that may coexist in the patient's family or close friends. A patient's past sexual and familial history may also play an important role in influencing the manifestation of certain illnesses or disorders, like depression, diabetes, substance abuse, or fibromyalgia (25). This especially relates to a family history of mental disorder and the link between physical or sexual abuse with a greater risk of somatization disorder (27,28).

Since patient awareness of IME procedure and policies has heightened and the financial gain is so high for the individual under examination, it is natural that examinees have created educational resources to optimize their "presentation" during exams. Physicians should therefore be mindful of current tactics such as exaggerating or malingering that can increase the likelihood for disability determination.

Physicians should dispel any notion that an IME is free of medical liability. Further, physicians must conform to standard record keeping and disclosure when involved with IME-associated activities. For instance, a policy of retaining medical records for 5 years (30) is advisable and disclosure of any previously unknown medical findings should be shared with the patient as well as documented (30).

Prudent physicians include a comprehensive disclaimer at the end of any report that reduces any liability of harm, states that the best possible conclusion was determined at the time the report was prepared and after considering the available information, and indicates that any new information that may surface in the future may affect the outcome of the report accordingly (25). Although certifications are not mandated by any disability evaluation board, all physicians should educate themselves on proper legal IME terminology that must be used in order to protect themselves from future litigation (43).

Costs of occupational injuries in the United States have been estimated to exceed \$170 billion per year, and these costs are escalating (41). Accordingly, the assessment of injuries afforded by the IME will likely continue in an effort to offset the costs of frivolous claims and litigation. The pain medicine physician can offer a unique perspective on the evaluation of a subset of patients who frequently report pain as a prime complaint.

## **SUMMARY**

IME reports should always reflect a fair and thorough evaluation, and physicians should never hesitate to request supplemental documentation when necessary. A physician evaluator should apply IME guidelines for patient examination, consider influences of employers on the ACOEM guidelines, and ultimately produce an independent assessment of injury causality while reducing physician liability with appropriate legal language (24,25). The IME physician should further realize that compelling social and financial incentives may lead patients to malingering; therefore, he/she should be familiar with common strategies for deception acquired through workshops and fraudulent organizations. Examiners can educate themselves by consulting websites and referencing texts written on the topic of IME (34).

IMEs must be performed while upholding traditional standards of medical ethics and codes of conduct (30). Evaluators must remember that they have entered into a "limited-doctor patient relationship" and may be held accountable for not disclosing significant medical findings to the patient (28). Although some physician contracts limit the degree of patient disclosure, it is prudent to extend every physician-patient privilege to the claimant (28). Moreover, physicians should carefully screen their contracts to avoid such limitations on patient disclosure. IMEs represent

a service that pain physicians are uniquely trained to provide to organizations, employers, and insurers in an impartial manner; they may even serve as a means of supplemental income in light of declining managed care reimbursement (25,38).

### CONCLUSION:

IMEs represent a valuable mechanism for determining alleged impairment and/or disability. In the

current economic environment of declining reimbursement to physicians, IMEs exist outside the scope of traditional payment methods and offer competitive compensation.

### ACKNOWLEDGMENTS

The authors would like to thank the editorial board of *Pain Physician* journal for their constructive comments and guidance in improving this manuscript.

### REFERENCES

1. "Progressivism." The Columbia Encyclopedia (6th). (2007). Columbia University Press. [www.bartleby.com/65/pr/progrsvsm.html](http://www.bartleby.com/65/pr/progrsvsm.html) last accessed April 17th, 2009.
2. *West's Encyclopedia of American Law*, 2nd edition Lehman I, Phelps J, Cengage G (Eds). West Group Publishing 1998, 2005. eNotes.com. 2006. last accessed Apr 14, 2009 [www.enotes.com/wests-law-encyclopedia/workers-compensation](http://www.enotes.com/wests-law-encyclopedia/workers-compensation).
3. Aldrich M. *Safety First: Technology, Labor and Business in the Building of Work Safety, 1870-1939*. Johns Hopkins University Press, Baltimore, MD, 1997, pp. 93-121.
4. Glad PW. Progressives and the business culture of the 1920s. *The Journal of American History* 1966; 53:75-89.
5. Bailey TA, Kennedy DM, Cohen L. , *The American Pageant*, 11th ed. Houghton Mifflin, Boston, MA, 1998, pp. 709-710.
6. History of Workers' Compensation in the U.S. by Price Fishback, University of Arizona. <http://eh.net/encyclopedia/article/fishback.workers.compensation>. Last accessed April 17, 2009.
7. Hounshell D. *From the American System to Mass Production, 1800-1932: The Development of Manufacturing Technology in the United States*. Johns Hopkins University Press, Baltimore, MD, 1984, pp. 317-322.
8. Hayhurst ER. The prevalence of occupational factors in disease and suggestions for their elimination: Results of a study conducted at the Central Free Dispensary (Rush Medical College) and Cook County Hospital, Chicago. *Am J Public Health* (N Y). 1915; 5:538-550.
9. McCord CP, Friedlander A. An occupational syndrome among workers in zinc. *Am J Public Health* 1926; 16:274-280.
10. Draper WF. Voluntary health insurance on the national scene; The United Mine Workers Health Program. *Am J Public Health Nations Health* 1950; 40:595-601.
11. Disability Social History Project. [www.disabilityhistory.org/](http://www.disabilityhistory.org/) last accessed August 19, 2009.
12. ENABLE. [www.un.org/disabilities/](http://www.un.org/disabilities/) last accessed August 19, 2009.
13. Americans with Disabilities Act of 1990. [www.ada.gov/pubs/adastatuteo8.pdf](http://www.ada.gov/pubs/adastatuteo8.pdf)
14. Medical Examiners Handbook. Washington State Dept of Labor and Industries. <http://www.lni.wa.gov/FormPub/Detail.asp?DocID=1668> last accessed August 19, 2009.
15. Attending Doctor's Handbook. Washington State Dept of Labor and Industries <http://www.lni.wa.gov/FormPub/Detail.asp?DocID=1669> last accessed August 19, 2009.
16. Manchikanti L, Boswell MV, Singh V, Benyamin RM, Fellows B, Abdi S, Buenaventura RM, Conn A, Datta S, Derby R, Falco FJ, Erhart S, Diwan S, Hayek SM, Helm S, Parr AT, Schultz DM, Smith HS, Wolfer LR, Hirsch JA. Comprehensive evidence-based guidelines for interventional techniques in the management of chronic spinal pain. *Pain Physician* 2009; 12:699-802.
17. Trescot AM, Helm S, Hansen H, Benjamin R, Adlaka R, Patel S, Manchikanti L. Opioids in the management of chronic non-cancer pain: An update of American Society of Interventional Pain Physicians' (ASIPP) Guidelines. *Pain Physician* 2008; 11:S5-S62.
18. Trescot AT, Boswell MV, Alturi SL, Hansen HC, Deer TR, Abdi S, Jasper JF, Singh V, Jordan AE, Johnson BW, Cicala RS, Dunbar EE, Helm S, Varley KG, Suchdev PK, Swicegood JR, Calodney AK, Ogoke BA, Minore WS, Manchikanti L. Opioid guidelines in the management of chronic non-cancer pain. *Pain Physician* 2006; 9:1-40.
19. Boswell MV, Shah RV, Everett CR, Sehgal N, McKenzie-Brown AM, Abdi S, Bowman RC, Deer TR, Datta S, Colson JD, Spillane WF, Smith HS, Lucas-Levin LF, Burton AW, Chopra P, Staats PS, Wasserman RA, Manchikanti L. Interventional techniques in the management of chronic spinal pain: Evidence-based practice guidelines. *Pain Physician* 2005; 8:1-47.
20. Manchikanti L, Staats PS, Singh V, Schultz DM, Vilims BD, Jasper JF, Kloth DS, Trescot AM, Hansen HC, Falasca TD, Racz GB, Deer T, Burton AW, Helm S, Lou L, Bakhit CE, Dunbar EE, Atluri SL, Calodney AK, Hassenbusch S, Feller CA. Evidence-based practice guidelines for interventional techniques in the management of chronic spinal pain. *Pain Physician* 2003; 6:3-80.
21. Manchikanti L, Singh V, Kloth DS, Slipman CW, Jasper JF, Trescot AM, Varley KG, Atluri SL, Giron C, Curran MJ, Rivera JJ, Baha A, Bakhit CE, Reuter M. Interventional techniques in the management of chronic pain: Part 2.o. *Pain Physician* 2001; 4:24-96.
22. World Health Organization Disability Assessment Schedule II (WHODAS II) [www.who.int/icidh/whodas/index.html](http://www.who.int/icidh/whodas/index.html)
23. *Guides to the Evaluation of Permanent Impairment, Sixth Edition*. American Medical Association. 2007.
24. Manchikanti L, Singh V, Derby R, Helm S 2nd, Trescot AM, Staats PS, Prager JP, Hirsch JA. Review of occupational medicine practice guidelines for interventional pain management and potential implications. *Pain Physician* 2008; 11:271-289.
25. Ameis A, Zasler ND. The independent medical examination. *Phys Med Rehabil Clin N Am* 2002; 13:259-286.

26. van der Giezen AM, Bouter LM, Nijhuis FJ. Prediction of return-to-work of low back pain patients sicklisted for 3-4 months. *Pain* 2000; 87:285-294.
27. Bailey BE, Freedendfeld RN, Kiser RS, Gatchel RJ. Lifetime physical and sexual abuse in chronic pain patients: Psychosocial correlates and treatment outcomes. *Disabil Rehabil* 2003; 25:331-342.
28. Council on Ethical and Judicial Affairs, American Medical Association, Code of Medical Ethics: Current Opinions, Opinion 10.03, Patient-Physician Relationship in the Context of Work-Related and Independent Medical Examinations.
29. Rodin G, de Groot J, Spivak H. Trauma, dissociation, and somatization. In: Bremner JD, Marmar CR (eds). *Trauma, Memory, and Dissociation*. American Psychiatric Press, Inc., Washington, D.C., 1998, pp. 161-179.
30. Baum K. Independent medical examinations: An expanding source of physician liability. *Ann Intern Med* 2005; 21:974-978.
31. Grant D. Independent medical examinations and the fuzzy politics of disclosure. *Can Med Assoc J* 1997; 156:73-75.
32. Stanley v. McCarver, 92 P.3d 849 (Ariz. 2004).
33. Health Insurance Portability and Accountability Act, Pub. L. No. 104-191.
34. Horwitz JE, McCaffrey RJ. A review of internet sites regarding independent medical examinations: Implications for clinical neuropsychological practitioners. *Appl Neuropsychol* 2006; 13:175-179.
35. Denison E, Asenlöf P, Lindberg P. Self-efficacy, fear avoidance, and pain intensity as predictors of disability in subacute and chronic musculoskeletal pain patients in primary health care. *Pain* 2004; 111:245-252.
36. Gheldof EL, Vinck J, Van den Bussche E, Vlaeyen JW, Hidding A, Crombez G. Pain and pain-related fear are associated with functional and social disability in an occupational setting: Evidence of mediation by pain-related fear. *Eur J Pain* 2006; 10:513-525.
37. Crombez G, Vlaeyen JW, Heuts PH, Lysens R. Pain-related fear is more disabling than pain itself: Evidence on the role of pain-related fear in chronic back pain disability. *Pain* 1999; 80:329-339.
38. Manchikanti L, Giordano J. Physician payment 2008 for interventionalists: Current state of health care policy. *Pain Physician* 2007; 10:607-626.
49. Manchikanti L. Transforaminal lumbar epidural steroid injections. *Pain Physician* 2000; 3:374-398.
40. Manchikanti L. Impairment evaluation in pain management: Physician or attorney in white coat? *Pain Physician* 2000; 3:201-217.
41. Leigh JP, Markowitz S, Fahs M, Shin C, Landrigan PJ. Occupational injury and illness in the United States. Estimates of costs, morbidity, and mortality. *Arch Intern Med* 1997; 157:1557-1568.
42. Unjust Treatment: 'Independent' Medical Examinations & Workers Compensation in New York State. A Special Report prepared in 1998 by the New York State AFL-CIO and the New York Committee for Occupational Safety and Health. [www.nycosh.org/workers\\_comp/IME\\_Report1.html#anchor287778](http://www.nycosh.org/workers_comp/IME_Report1.html#anchor287778)
43. Brodsky SL. Testifying in court: Guidelines and maxims for the expert witness. American Psychological Association; Washington, DC: 1991.