



Stories From the Front:

IE (IME) Excesses and How to Counter Them

By John Haberstroh, DC, and Kevin Mulhern, DC

Abstract

In two prior papers, “Properly Documenting a File and Forensic Examination of IME Doctors” and “Qualifications and Paradigms for the Independent Examiner,” we first explained how field practitioners can better document case files to withstand challenges, including those made by Independent Examiners (IEs, a.k.a. IMEs, ICE, DME, QME), and addressed forensically examining the IE, as well. The second paper sought to establish reasonable standards and protocols to which IEs should be held. It is thought that, in this way, the examiner’s credibility can be established, to say nothing of actuating fair and accurate examinations. Still, despite nationwide protest and outrage among practicing doctors and angry patients, the reality is that in a vast majority of jurisdictions in the U.S., any doctor can become an IE merely by making application with an insurance company or intermediary; for most states, there are simply no standards or guidelines to organize this process. We have always spoken out against this. The previous two papers represent two of the few published works on this subject.

This paper will demonstrate the excesses some IEs go to in cutting claims. While we hasten to add that this is not an indictment against all Independent Examiners, these are stories that need to be told because they shed light on what is becoming alarmingly commonplace in health care: IEs who ignore patients, ignore factual medical realities, and ignore sworn testimony, downgrading real injuries under the fiction of being “independent.” When called to task, the IE has only to say, “That’s my opinion,” without threat of lawsuit, discipline, or any form of sanction. We consider such scenarios a moral outrage and an injustice to patients who suffer as the result of biased “independent” examinations. Many IEs do “reviews” and “independent examinations” full time and do not actually treat patients anymore. Although business is booming, it’s the patients who lose out.

Key Words: IE, Independent Contractor, interrogatory

This article is approved by the following for continuing education credit:

(ACFEI) The American College of Forensic Examiners International provides this continuing education credit for Diplomates.

(CMI) The American College of Forensic Examiners International provides this continuing education credit for Certified Medical Investigators.

(ACCME) The American College of Forensic Examiners International is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME). The American College of Forensic Examiners International designates this educational activity for a maximum of 1 hour AMA PRA Category 1 Credits TM. Physicians should only claim credit commensurate with the extent of their participation in the activity.

After studying this article, participants should be better able to do the following:

1. Quickly understand the immense gravity of an IE performed on a patient, client, or friend and better prepare the patient for the encounter.
2. Formulate a forensic plan to adjudicate either the IEs and/or the report submitted.
3. Identify the legal aspects and remedies available to combat the more egregious fraud perpetrated by the IEs in the name of “cost containment.”

This paper will demonstrate true stories of IE excess. It will move forward to suggest strategies, both clinical and legal, to deal with these excesses. As always, the main thrust of this essay, like its two predecessors, is to bring a realization of a major problem to the forefront of forensic analysis and public awareness and to offer reasonable counter-measures to address the problem.

PART I—“But Doctor, I really do have these problems. My pain is real!”

**This article again is written by chiropractors. As such, it slants somewhat towards chiropractic practices. Interestingly, our first story coincidentally involves a chiropractor “victim.”*

Joan Hangarter was a successful chiropractor in California. She was building a busy practice. She

owned a nice home in Marin County, and she had two small children. One day in 1997, she was attempting a difficult lumbar adjustment on a large male patient and felt a burning, ripping pain in her right forearm. The pain seemed to radiate up to her neck. Like most people, she thought a little rest would clear it right up. How wrong she was. The pain got worse. Months later, after numerous attempts to treat the pain with physical therapy, chiropractic care, medical intervention, and numerous tests including MRIs, she was diagnosed with a permanent disability and was told she would no longer be able to practice (Bourhis, 2005). **She had cervical disc disease and lateral epicondylitis. It wasn’t elaborated on in the book, but I gather she had at least one frank disc herniation in her lower cervical spine.*

Years before, Joan had bought a disability plan that was supposed to cover her in the event she

couldn't work again. Although Joan was deeply saddened by the medical condition, she was glad she had disability coverage. Following an investigation by Paul Revere Insurance, she was deemed disabled, and disability payments followed. This allowed her to maintain her home, pay the bills, and with some frugal budget pinching, maintain her basic lifestyle. All was well until Paul Revere was swallowed up by its chief rival, Provident. Suddenly, her benefits stopped. Shortly thereafter, her life spiraled out of control. She couldn't work. She sold her practice to a young chiropractor who couldn't afford to make payments to her, her car was repossessed, she and her children were eventually thrown out of her house, and she finally wound up on welfare and food stamps (Bourhis, 2005). Disability insurance is about peace of mind. It doesn't replace a car or house, but it makes up for one's inability to work. Barring a medical examination that speaks to the contrary, a person in Joan's position, one with a viable policy and a legitimate claim, should have the peace of mind he or she was paying for.

Understand that insurance companies don't make big money on the premiums they collect. The big money that floats most, if not all, of these companies is in the investments the insurance company makes. They earn interest and capital gains on investments in stocks, bonds, and real estate. The 1980s were the decade of double-digit interest rates and returns on investments. The first blow to the insurance industry was in the 1980s when the structure for depreciation on real estate investments changed, which precipitated the savings and loan crisis that then spilled over into the banking and insurance industry. This is when a number of "performing loans" became non-performing loans, and foreclosures and bankruptcies tripled. The second blow came when health-care insurance carriers cut reimbursements to doctors and dentists, and claims by these professionals nearly put the long-term disability carriers like UNUM out of business. The third blow arrived in the 1990s with the bust of the dot-com boom. The investments weren't bringing in nearly the revenue they had been, and claims were still pouring in from policyholders. Provident alone had to post a \$430 million loss in 1993 out of its reserve fund to cover incoming claims. Provident hired a new CEO by the name of J. Harold Chandler. He had an MBA and no experience in the insurance world. However, he did know how to operate a calculator. What would follow was shocking.

Shortly after Chandler's arrival, Provident hired Ralph Mohney to take over Provident's claims department. Mohney's background was that of a tax accountant. He, too, had not handled a single insurance claim. But, like Chandler,



Mohney did know numbers. The end result of this corporate shake up: the thrust of the company became finding ways to refuse claims. Since interest rates on investments had dropped precipitously and couldn't be changed, the company altered its bottom line by denying claims. Joan Hangarter was one person caught up in this seismic paradigm shift.

Oddly, Joan had already had an independent examination with a Paul Revere doctor who had initially authorized disability payments. But Paul Revere, Inc. no longer existed. Provident bought Paul Revere, Inc. in 1997, and the deal was hailed as being worth more than \$1 billion. Provident was now going to conform to Chandler's vision. In March of 1999, Provident demanded a new independent examination by a doctor they approved of. This was a handpicked orthopedist named Aubrey Swartz. Joan brought in her MRIs, treatment notes from all the other

“ Understand that insurance companies don't make big money on the premiums they collect. The big money that floats most, if not all, of these companies is in the investments the insurance company makes.”



“ Sadly, this is not an isolated case. Big companies do pay many claims, but paying some claims is a part of their defense.”

doctors, and most importantly, herself, for the “independent” examination. Dr. Swartz didn’t say a word throughout the “exam,” and Joan left assuming his findings would be consistent with the other examinations. A few weeks after the “independent” examination, a claims representative named Ken Seaman arrived at her door. He told Joan that upon reviewing Dr. Swartz’s report, it was clear to Provident that Joan had no disability and could perform her chiropractic duties with no hindrance. Joan next received her official termination letter from an adjuster named Joseph Sullivan informing her she was not entitled to any aspect of her benefits, and they were, indeed, terminated immediately. The decision had been reached using a number of factors, but primarily on the IE doctor’s report (Bourhis, 2005).

Joan sued UnumProvident. She used Ray Bourhis, Esq. as legal council out of San Francisco. During pre-trial depositions, and later in actual trial testimony, it became clear that another medical specialist had been enlisted to cut claims. Joseph Sullivan often referred case files to the UnumProvident in-house medical specialist Dr. John Bianchi. It was Dr. Bianchi who read Dr. Swartz’s report and opted to recommend to

Sullivan that Joan Hangarter’s benefits be terminated. His findings were completely contrary to all the gathered medical evidence in Joan’s case. Sullivan also admitted that UnumProvident solicited doctors through an intermediary company (Brokerage Firm) called Genex, Inc. The initial strategy was to insinuate that Aubrey Swartz was totally “independent.” It came to light during cross-examination that UnumProvident actually *owned* Genex, Inc. Thus, the “independent” doctors that “independently” examined patients were, in effect, working for the main insurance company. Records indicated Dr. Bianchi had never met Joan Hangarter, much less examined her. Upon further testimony at trial, Dr. Bianchi referred to himself as an “independent contractor.” He performed “claims reviews” for UnumProvident as follows: A couple of times per week he would come to work and face a stack of files and attendant medical reports. He also had a page of written questions to answer on each file posed by the adjuster. He was paid extremely well for his “opinions” and he provided written answers on each file he was given. He never spoke to the patients, nor did he speak to the IE doctors who did the “independent examinations.” He reviewed records. Interestingly, Bianchi admitted

that UnumProvident normally did not provide information on the “usual and customary” duties of the people he was evaluating. In this case, he was ignorant of exactly what chiropractors did and how they performed their services. How could someone that had no idea what people actually did for a living make an informed assessment about the claimant’s ability to return to normal duties? He reviewed the report of hired gun Dr. Aubrey Swartz and made an uninformed decision that negatively affected Joan’s life.

Joan Hangarter eventually won her suit against the insurance company, which predictably appealed the decision immediately. The appeal added another year to her case, but in the end, Joan was awarded more than \$7 million (Bourhis, 2005).

Sadly, this is not an isolated case. Big companies do pay many claims, but paying some claims is a part of their defense. While they pay many of the day-to-day medical claims that come in, they save the most money on the denial of long-term disability claims. The mechanism of these denials is built and supported entirely around the “opinions” of IME (IE) doctors and “independent contractors” that may be far from independent. They save even more money on denials of personal injury and workers’ compensation claims. The denials are again based on the opinions of “independent medical examinations.”

The authors have observed IME (IEs) reports and their validity since the early 1980s, primarily in the personal injury (PI) arena. We recognize that some IMEs perform their work fairly and reasonably. In our opinion, the workers’ compensation system has similar problems. We foresee that these abuses will spread into the routine major medical/health insurance system, which may further limit care. As we see it, the current abuses and failures in the IME system must be taken to task and cleaned up for the benefit of the public.

**Note: The authors are in no way trying to suggest that it’s only the medical orthopedists who cause all the problems. Our next two stories involve chiropractor IEs. As stated in our previous essay, with the average everyday claim review/IE, at least here in Massachusetts, the medical orthopedists have been refreshingly fair, generally speaking, compared to chiropractor IEs.*

PART II—“Ask me no questions, I’ll tell you no lies.”

In late 2004, Jerry Blackwood, a Doctor of Chiropractic practicing in Boston, contacted this author to review and, if possible, rebut a rather strenuous report rendered by one of the better-known chiropractic IEs in Massachusetts. We’ll

call the IE doctor Dr. D. In short, we found this to be one of the most preposterous “reports” ever written by anyone. The IE report is allegedly supported by available critical literature. This appears to be an attempt to add scientific validity to the report and thus render it more “legitimate.” A closer look at this report shows that of the 12 pages included therein, more than eight pages are references. The first two pages of the report are more or less a table of contents, leaving about two pages of actual report writing. In those two pages, the IE manages to debunk literally everything in the entire chiropractic canon. According to this chiropractic IE, literally everything that chiropractors do (and for that matter, have ever done) is unsubstantiated and clinically irrelevant; thus, most, if not all, treatment should not be reimbursed.

The rebuttal, written by me, dissects and forensically examines the literature and, more importantly, the doctor. In our previous essays, the authors have spoken about obtaining the CV of IE doctors. In an early draft of our first article, we mentioned a bogus CV that we had obtained. This was the actual case and the CV we have referred to. My forensic rebuttal explains the dishonesty and exaggerations in this CV. Some of you may be thinking, “Why not inform the Chiropractic Board of Registration and have them discipline this doctor?” The Board heard about the CV and did nothing. It seems most of the Board members are IE doctors or “insurance consultants” also. Final outcome: Dr. Blackwood was paid in full on his case, based entirely on my forensic examination of the IE doctor and his report (Haberstroh Rebuttal, 2004).

Another strange case involves a different chiropractic IE doctor (Dr. M.) who was involved in a report with the other author of this article. In his report, Dr. M. stated, “*As anyone knows, the chiropractic subluxation* has not yet been determined to be a clinical entity that is either reproducible or detectable amongst practitioners with any degree of consistency or reliability . . . None of my opinions as stated in my . . . report have changed in this matter . . . under the pains and penalties of perjury.*” How odd then, that this same chiropractor, who is an IME and an insurance consultant, had a website that discussed subluxations in numerous areas. Furthermore, this same Dr. M. does not remember that we as chiropractic physicians, Doctors of Chiropractic, or chiropractors are licensed in Massachusetts and maintain that the term subluxation does exist. The term subluxation is actually cited on the Massachusetts Board website. Notwithstanding, this individual is certain this is not a clinical entity. (**Subluxation* is a term used to describe vertebrae slightly out of place.) Dr. Mulhern rebutted this IE vigorously with a favorable outcome. So, what can be done

Definitions of Key Words

1) IE: Independent Examiner or Independent Exam. A simple abbreviation of the more commonly used “IME” (IE, a.k.a. ICE, IME, DME, QME, etc.) contraction. A patient is, actually, physically examined by an examiner. The examiner is called an IE.

2) Paper Review: A review of a case file, not the actual patient. In this event, the review is still conducted by an IE. He or she may also be called a Peer Reviewer. The terms IE and Peer Reviewer are interchangeable here.

3) Forensic Exam: An examination that may ultimately lead to a discovery of detail in a legal setting.

4) Outcome Measures: These are generally questionnaires that are periodically handed to patients by the treating physician. They ask specific questions about how patient are feeling and their ability to perform activities of daily living (ADLs) throughout their treatment. The doctor, after the fact, tabulates the “values” of the answers via a point system not available to patients. These responses are considered to be valid indicators as to how a patient feels in an ongoing format that is suggestive of the efficacy of the treatment protocol the doctor is using. *Oswestry* is probably the oldest and most well known of these. However, one of the better measures of outcome is the actual return to work. Another is the reduced use of scripted meds. Both of these issues are quantifiable, and both save money for the insurance company.

5) Independent Contractor: Refers to another level of IEs that often review reports submitted by IEs and render a second opinion on a medical case on behalf of an insurance company.

6) Adjustment: This is the word used by chiropractors to describe the manual manipulation they perform on someone’s spine or extremities. “I gave Ms. Jones an *adjustment* to the neck today.”

7) Interrogatories: A set of questions that one party sends to another party during a lawsuit. Typically, both parties send interrogatories to the principles on either side. The answers are in affidavit form. They have to be honest and truthful in lieu of the responding individual committing perjury.

8) Brokerage Firms: The term “brokerage firm” in the insurance arena denotes a separate company that employs doctors and a support staff usually comprised of former insurance company employees. Thus, the strategy here is to make all parties (patients, unsuspecting attorneys, treating doctors, and judges) believe that the firm and its doctors are separate entities from the insurance companies. One key benefit was to coin the word “independent” for their contractors, even though these firms are at arm’s length from the insurance companies.

Claim Concepts



1) Playing the Float: This is a banking and insurance company term for using other people's money to earn interest. By withholding payments as long as possible, the insurance company has more money available to earn interest. Even though the insurance company knows it has to pay the claim, by using stalling techniques, it may hold the money for a longer period of time. As an example, if the company holds the money for 3 years earning 12% a year on the money, and inflation is 4% a year compounded over 3 years, the company has earned 50% on the money it withheld, paying, in actuality, only 50 cents on the dollar that it owes.

2) Setting Reserves: This is an insurance company term that involves the estimated cost of settling a claim. When a claim comes into the insurance company, an adjuster looks at the type of injury and claim, and based on actuarial tables, "sets a reserve." This reserve is a pre-paid expense, according to GAAP (Generally Accepted Accounting Principles). Now, here is the important part: If the insurance company can settle the claim for less than the reserve, the difference comes to the income side of the ledger statement and drops to the bottom line as profit. As an example, if a claim for reflex sympathetic dystrophy (RSD) is received, most insurance actuarial tables have the reserve listed as \$1 million. However, with proper diagnosis, it turns out 71% of RSD cases are really nerve entrapments that can be treated for \$50,000 (Hendler, 2002). If the RSD case turns out to be nerve entrapment and is properly treated, the insurance company can then move \$950,000 (\$1 million minus \$50,000) to the income side of the

about all of this?

First, the everyday treating doctors (like your authors), regardless of discipline, need to meticulously document each and every case file. We've said this before, but it bears repeating. Second opinions are often helpful, but as we saw with Joan Hangarter's case, several second opinions were ignored, and it took a lengthy lawsuit to bring justice to her cause. Nevertheless, in a particularly involved case, a second opinion is not only a good idea but nearly always indicated. With an extremely detailed and well-authored first day report, detailed treatment notes, use of outcome measures (**Oswestry Disability Index, SF36, SIP—this is becoming a highly important aspect of all practices at this point and should be done by all practitioners*), occasional re-examinations to check progress or lack thereof, advanced imaging where indicated, and the possible inclusion of a second opinion and/or secondary treatment, the clinical case picture becomes more solid, harder to attack, and easier to defend, especially if the case goes to court. If an independent examination is scheduled and your patient does go, as the authors suggested in the first two papers, there is a checklist of things to do to level the playing field (Haberstroh et al., 2005; Haberstroh et al., 2006).

A. Inform patients what is in store for them when they go to an insurance exam. Most patients seem to think that it is a friendly part of the process. The fact is, the IE is there to determine whether or not continued care is indicated. If the IE is more of a "hired gun" type of doctor, this encounter could lead to abridged care. The patient should be admonished to go to it but to understand it is not a "friendly" exam. The patient should be carefully instructed by the treating doctor to not attempt to exaggerate his or her condition in any way, but to just be truthful about the situation.

B. If at all possible, bring a witness to the IE. The witness can verify what went on, take notes, and most importantly, make a forensic timeline as to when the exam started, how much of it was talking, how much was actual examination, and when it ended. The witness can provide another opinion as to what happened at the exam (or should we say, what didn't happen).

C. Have patients fill out a sworn affidavit after they return to you from the IE. In that sworn affidavit they should, among other inventories, describe the timeline of the exam. We urge that the witness, if there was one, fill out the affidavit as well. Too

many people like Joan Hangarter simply trust the IE and think things will be okay. Not necessarily, we say.

D. The treating doctor should also examine the patient the same day as the IE. He or she can render a report as to what his/her findings were that may or may not be consistent with the IE "findings."

Second, the field doctors are urged to refute any IME report they feel is in error. Explain what symptoms supported the clinical treatment regime, describe the outcome measures used, highlight and summarize re-examinations, and make available second opinions and/or imaging/testing, if applicable. One of the best ways to attack biased IME (IE) reports is to cite your own collection of literature and articles from peer-reviewed medical journals supporting your own treatment regime and/or debunking the opinions offered by the IME. Be advised: This technique works both ways as we saw with Dr. D. A classic IME fall-back position is to say, "Well, in my opinion . . ." We now know with the advent of the Daubert Criteria, this kind of ad hoc opinion won't stand up well in court. Again, outcome studies are crucial for the practicing doctor of any discipline to document care, progress, and to substantiate

ledger and report \$950,000 in additional profit. On the other hand, if a “whiplash” claim comes in, and the typical reserve is \$12,000, but later it turns out to be a C5–6 herniated disc that requires an anterior cervical fusion, which costs \$60,000, the insurance company has “under-reserved” the case, by \$48,000. If this occurs multiple times, the insurance commissioner in the state where the insurance company is licensed can fine the company for being under-reserved. If there is a consistent pattern of “under-reserving” cases, the insurance commissioner can declare the company insolvent and revoke its license to operate. Setting the proper reserve is the single most important concept in the insurance industry.

3) Bad Faith: This refers to an intentional failure to honor contractual obligations, such as paying on a claim that the company is obliged to pay. If convicted of “bad faith” activity, the insurance company must pay triple damages. For example: A \$60,000 claim is filed to pay for an operation following an accident, but the insurance company denies the operation is related to an accident. If it is proved in court that the operation was accident related, then the company has to pay \$180,000.

Legal Note:

Daubert Criteria: *Daubert v. Merrell Dow Pharmaceuticals* (1993) was first filed in the Southern District Court of California in 1989. Eventually, it wound up in front of the Supreme Court of the United States, who decided that the more modern “Federal Rules of Evidence”

criteria comprised the proper standard to which scientific evidence and testimony must comply. Rule 702 of the “Federal Rules of Evidence” governs evidentiary issues such as expert testimony, and, furthermore, affirms what is minimally necessary in order for a judge to fulfill what has become essentially a gatekeeper role when screening and filtering scientific evidence trying to be entered in court. Thus, according to the court’s ruling on the Rules of Evidence (including Rule 702), the standard is such that (1) it intends a grounding in the scientific method, (2) “knowledge” means a set of facts or ideas accepted as true on “good” grounds, and (3) the scientific data/testimony may be tested by applying several more rigorous criteria than heretofore appreciated in the federal system. Therefore, concerning the testimony of an IE who says merely, “In my opinion...”: this testimony is inadmissible in a federal court (Rast, 2006).

References

Hendler, N. (2002, October). Differential diagnosis of complex regional pain syndrome, Type I (RSD). *The Pan Arab Journal of Neurosurgery*, 6(2).

Rast, P. (2006). The Daubert decision: Accident reconstruction considerations. *The Forensic Examiner*, 15(4), 37–41.

the choices a doctor makes in treatment inventories. Do a forensic examination of the IE doctor. In Joan Hangarter’s case, it was found that Dr. Swartz was not a practicing doctor, but only engaged in examinations for the insurance company. Dr. Bianchi also did not practice, nor did he perform examinations. Both doctors worked for the brokerage firm Genex, owned by UnumProvident, which is a conflict of interest. Dr. Bianchi merely looked at files, and made relatively quick decisions on lifetime disability issues without meeting the patients. These details matter. Find out who is paying the IME; you may uncover the real motivation behind a denial of benefits (Bourhis, 2005).

Third, many of the IE’s opinions will remain “unchanged” no matter what you are able to substantiate or how compelling the clinical case. If Daubert arguments don’t work in paper rebuttals, the patient or doctor should consider contacting a lawyer to seek reimbursement for services rendered. If a lawsuit is filed, the insurance company will be notified of the suit. If the lawsuit is big enough (larger than small claims), a set of interrogatories are sent out to the principles at the insurance company, the plaintiff, and the doctor. This is where meticulous care and well-documented

case notes become crucial for the plaintiff. As the lawsuit progresses, depositions may ensue. Depositions, although they appear “informal,” should be approached as seriously as an actual trial. They are legally binding sessions with the plaintiff’s and defendant’s attorneys present and a court stenographer. The court stenographer will record everything that is asked and answered during the deposition. Depositions are known for being “fishing trips.” The latitude in questioning is vast and often the questioning lawyer(s) will keep pressing on a variety of issues to see what they can “catch” to weaken the deponent. After the deposition, the court reporter will create a written record of everything that was said. This transcript will be given to the deponent to read. The deponent may make corrections to the transcript at this point if they are needed. Once corrections are made, the witness signs the transcript. Make certain the deposing attorney understands you want a copy and your signature on the transcript. Both the original and corrected version will be available to be used as evidence in future court actions (Israel, 2001). Occasionally, a settlement may be offered by the defendant. In Joan Hangarter’s case, UnumProvident continually offered \$500,000 to settle the case to

make her go away (Bourhis, 2005). She held out for more on the strength of the forensic medical data in her case and what Attorney Bourhis had uncovered via interrogatories and trial testimony. It was a good thing that she did. All cases are different and a settlement offer, if it comes, can sometimes be satisfying to all concerned. An offer like that should be carefully considered.

If the case goes to trial, remember one main point: You must convince the jury of your cause and your issues. Jurists are people like you and me. They are affected by seemingly little things, like whether or not an expert witness smiled at them. When jurors were interviewed about which expert witness impressed them the most during the O.J. Simpson trial, they responded that they liked Dr. Henry Lee because he smiled at them as he approached and left the witness stand (Bugliosi, 1996). At some point the treating doctor/forensic examiner will be called to testify. You will be able to refer to your notes, so do so, and be confident of your case. Few experts have ever testified where a few points didn’t have to be conceded here and there during cross-examination. Speak the truth; if you can’t remember something, say you don’t remember. Stay away from terms like “never” and “always,” and do



About the Authors

John J. Haberströh, DC: Private practitioner-Somerville/Boston, Massachusetts, U S A , Diplomate of the American Board of Chiropractic Neurology, Diplomate of the American Chiropractic Academy of Neurology, Fellow of the American College of Forensic Examiners Institute, Certified Medical Investigator-Level 5, Certified Forensic Consultant, Certified: Spinal Trauma/Sports Physician/Rehab. Methods and IME/Peer Reviewing. You may access his website at www.boston-spineclinics.com



Kevin Mulhern, DC, FICC, is a private practitioner in Waltham/Boston, Massachusetts.



not speak in a condescending manner. Later, upon re-direct, your lawyer will be able to rehabilitate you on whatever points may have arisen that clouded an issue. Just make sure everything is as clear as possible to the jury as you explain the case file. If the jury understands your case, the chances are good that you and your patient will prevail when the jury returns a verdict.

In smaller court actions, such as small claims court, there is a court magistrate who will hear both sides of an issue in an anteroom somewhere in the courthouse. While expedient, magistrates may not be educated in your field of work. Again, it is crucial to get your points across and make the case as clear as humanly possible. There are no exceptions to a well-documented case file. For the treating doctor, this should include an extensive and detailed case history, all relevant orthopedic/neurological findings (where applicable), a differential DX, final DX, treatment plan, consent to treat form, and prognosis.

Conclusion

As it stands, the general public is unaware of the occasionally contemptuous, fraudulent nature of some IEs. Even an educated, intelligent, practicing doctor like Joan Hangarter went to her IE blithely unaware of the agenda-driven nature of the faux exam and its harmful conclusions. All people, treating doctors and their patients, need to be aware of what may go on in the IME (IE) arena and prepare for the worst. If a reasonable examination is conducted with reasonable conclusions, so be it. If not, precautions need to be taken. As stated, having a witness who can corroborate what happened at the IME (IE) and a signed IME affidavit are good strategies. There is no Federal protection from this behavior, either. According to the *McCarran-Ferguson Act* of 1945, the Federal government is prevented from enact-

ing any consumer protection laws with regard to insurance companies. State regulations, or lack thereof, are largely handled by the appointed or elected Insurance Commissioner. The *McCarran-Ferguson Act* does not itself regulate insurance, nor does it mandate that states regulate insurance. However, it does empower Congress to pass laws in the future that will have the effect of regulating the "business of insurance." However, Federal acts that do not expressly claim to regulate the "business of insurance" will not trump state laws and regulations that do (U.S. CODE, Title 15). Everyone benefits from being educated to the realities of the insurance industry. If all else fails, then a lawsuit may be the only final option.

References

- Bourhis, R. (2005). *Insult to injury: Insurance, fraud and the big business of bad faith*. Berrett-Koehler Publishers, Inc.
- Bugliosi, V. (1996). *Outrage: The five reasons O.J. Simpson got away with murder*. Island Books (through Dell Publishers).
- Dr. D. (2003, October). IME Report on patient RH.
- Dr. D. (2003, October). CV.
- Haberströh, J. (2004, May). Rebuttal of Dr. D. IME Report on patient RH.
- Haberströh, J., & Mulhern, K. (2005). Properly documenting a file and forensic examination of IME doctors. *The Forensic Examiner*, 14(4), 26–39.
- Haberströh, J., & Mulhern, K. (2006). Qualifications and paradigms for the independent examiner. *The Forensic Examiner*, 15(3), 24–32.
- Hendler, N. (2002, October). Differential diagnosis of complex regional pain syndrome, Type I (RSD). *The Pan Arab Journal of Neurosurgery*, 6(2).
- Israel, S.M. (2001). 130 Rules for Every Deponent. *Litigation*, 27(4), 46.
- Rast, P. (2006). The Daubert decision: Accident reconstruction considerations. *The Forensic Examiner*, 15(4), 37–41.
- Spitzer, E. (2004, October 14). Investigation reveals widespread corruption in insurance industry. Office of the New York State Attorney General. Press Release.
- U.S. CODE, Title 15, Ch. 20, Sec. 101

Earn CE Credit

To earn CE credit, complete the exam for this article on page 80 or complete the exam online at www.acfei.com (select "Online CE").