CUMULATIVE PUBLIC COMMENTS
OCTOBER 8TH – NOVEMBER 12TH

Public Comments Received October 28th via email:

I was informed that the WCA is soliciting feedback on a proposed rule change to allow for a "limited IME." As an IME provider, I feel that limiting the scope of some IMEs would be helpful. After reviewing the proposed changes, I have the following comments.

A primary concern when considering a limited Independent Medical Examination (IME) is that the IME provider needs to be given a stated causally related diagnosis. In my experience, IME requests consistently seek an expert opinion on causation, and the need for reasonable and necessary care will depend on the accepted causally related diagnosis.

I recommend clarifying that the purpose of a limited IME is to address a specific dispute between the parties regarding the reasonableness and necessity of medical care prescribed by an authorized healthcare provider (HCP) for a specified causally related diagnosis. This addition would ensure that the IME report directly addresses both parties' needs for clarity on medical treatment within the scope of the disputed treatment.

Thank you for giving me the opportunity to provide comments on the proposed rule change. Please do not hesitate to reach out to me for further clarification if needed.

Chris Patton, DO.
New Mexico Orthopedic Associates.

Public Comments Received October 28th via email:

I am in favor of limited IMEs for specific purposes that must be spelled out beforehand from a specific list of options.

Would the billing be "By Report"?

Bill Ritchie
William Ritchie, M.D., MBA, FAAOS

Public Comments Received October 28th via email:

I have reviewed the proposal.
I do not have any objections.

William H. Brady, MD

Public Comments Received October 28th via email:

Seems reasonable. A record review should be sufficient in most cases for this determination. A "limited IME" only in cases that are still under dispute.

Leon D. Zeitzer MD

Public Comments Received October 29th via email:

I do not really understand why the designation of "limited IME" is needed. When I do an IME, I answer the specific questions posed by the parties contained in the formal IME letter sent to me by the parties. Therefore, if there's a question about treatment, I will address that issue. I do not address any other matters if it is not asked in the letter. I believe this is standard practice for the completion of all IMEs.

Barrie W. Ross, MD

Ross Rehabilitation, PC

Public Comments Received October 28th via email:

A limited IME is difficult because to do a thorough job, one must review all the medical records from prior treatment and illness to make an informed decision to answer the questions being asked.

There is not a way to abridge this process or to provide a 'limited IME' in my opinion.

I think this is going to put the injured worker at a disadvantage and the recommendations will neither be informed nor accurate.

Deana Mercer, MD

Public Comments Received November 9th via email:

To Whom It May Concern:

I understand the WCA is looking for public input regarding changes to NMAC 11.4.4.13.S.(2), which would allow parties to seek a "limited" IME for the purpose of identifying reasonable and medically necessary treatments as ordered by the healthcare provider (HCP).

Allowing parties to obtain a limited IME to address the above critical issue would be, in my opinion, helpful. I suspect that disputes do not usually involve treatments that are clearly appropriate and related to the work injury in question (WIQ), but rather to treatments ordered by the HCP that do not appear to be reasonable and medically necessary. Having a second opinion in this setting could result in better outcomes with some caveats noted below.

I have been treating injured workers in New Mexico for 30 years. I have also been involved in the IME process for most of that time. The cases I tend to evaluate are years past their injury date and expected time of recovery. These cases tend to have extensive testing, multiple treatments, repeated invasive procedures, and even unnecessary surgeries. Despite these extensive treatments, the injured worker (IW) is often not improved, and many do not return to work (there are many reasons for this failure to progress, which will not be addressed here). It is not unusual for the healthcare providers involved in a case to treat conditions that are not causally related to the WIQ. If not causally related, then treatments for those conditions are not reasonable or medically necessary as it relates to the WIQ.

The root cause of the above issue boils down to the fact that most providers across the nation and in the state of NM are not trained in applying evidenced based medicine (EBM) to scientifically (forensically) determine if a complaint, condition, or diagnosis is causally related to the WIQ. The same issue applies to recommending medical treatments. Many of the cases I have reviewed that involve inappropriate treatments are due to HCP, specialist, or IME evaluators listing complaints, conditions, or diagnoses and making treatment recommendations based on their medical opinion and experience without applying EBM. Allowing limited IME providers to base their recommendations on expert opinions only is inconsistent with the scientific literature and the AMA Guides to the Evaluation of Permanent Impairment, 6th Edition (see chapter 1, section 1.5 and Table 1-2; chapter 2, section 2.6, the Standards of Legal Admissibility), as well as the AMA Guides to the Evaluation of Disease and Injury Causation, 3rd Edition. If EBM is not utilized, then many varied diagnoses and treatments are given from as many different providers who are involved in the case. This is confusing to all parties including the injured worker. This issue is written about in medical literature. Therefore, allowing a limited IME to address reasonable and appropriate treatment can only be as good as the EBM and treatment guidelines applied by the limited IME provider.

As I understand that in the proposed new rule, the limited IME provider will only be allowed to comment on the conditions, complaints, and diagnoses identified by the HCP and not causation. I often see appropriate treatment being given for an accurate diagnosis, but the diagnosis is not causally related to the WIQ. What happens when this occurs in the limited IME setting? The limited IME provider may be asked to render an opinion based on the diagnosis already given by the HCP who did not scientifically determine causation. I fear

that the same poor outcomes will continue as we see today if EBM is not applied to the diagnosis by the HCP or to the treatment recommendations made by the limited IME provider, since the diagnosis given by the HCP is *assumed* to be causally related (which happens often). What happens if the limited IME evaluator does not agree with the diagnosis given by the HCP because it is not causally related? Can the limited IME evaluator comment on that problem? The WCA must recommend that the HCP and the limited IME provider apply EBM to diagnosis (ses) and treatments being addressed. This is the standard in our country, and are the same recommendations being applied to regular IMEs currently* being performed. I realize this is a big ask which may not be implemented with these proposed rules, but perhaps it can be in the future. Fortunately, there are EBM guidelines that are available like the ODG or MD guidelines which offer guidance on appropriate treatments. There are also causation analysis steps that can be taken to better ensure that a diagnosis given is causally related to the WIQ.

The WCA can provide one-page worksheets/tools to help the HCP, the limited IME provider, and the regular IME provider to arrive at the correct and causally related diagnosis such that appropriate and EBM treatment guidelines can be applied to ensure a positive outcome for the IW. This, in turn, curtails costly and inappropriate treatments which can prolong recovery and result in unnecessary disability (which is associated with a shortened lifespan) as written about in scientific literature.

It is my opinion that NM can improve the outcome of the IW if EBM is utilized. I recommend that the limited IME be undertaken earlier rather than later (perhaps about 6 weeks from the day of injury) when a patient/claimant is not progressing as expected, has new complaints or expanding pain that is non-physiologic, or new diagnoses added on that are not causally related to the WIQ. There are many risk factors and prognostic indicators written about in the medical literature that can help identify the patient or claimant at risk for delayed and failed recovery and unnecessary disability.

In addition, I also understand that section 11.4.4.13, under S (2), states that "…Unless otherwise ordered, relevant medical records *not more than one year* prior to the claimed date of accident may be sent to the limited IME provider…" I ask the WCA to reconsider this proposed rule change. In my practice, it is common to find significant information in past medical records that could affect the claim. Past records (often over a year prior to the WIQ) can reveal medical histories not disclosed by the patient/claimant or known in real-time medical records that may be or are pertinent to the current diagnosis. This information can help determine causation, aggravation or exacerbation and affect treatment recommendations. Therefore, I recommend sending the limited IME provider past medical records from more than a year prior to the claimed date of injury.

I thank you in advance.

Eva C. Pacheco, MD, FAAPMR, FIAIME, CMLE

Public Comments Received November 11th via email:

Greetings:

Desert States Physical Therapy Network, Ltd appreciates the opportunity to make comment on the proposed rule Part 7, Section 11.4.7.9, letter D, number (3)

"Failure to contest in accordance with the criteria for contesting bills and an appropriate explanation of benefits or make good faith payment within 30 days of receipt of a bill for reasonable and necessary services shall result in an interest rate of ten percent of the unpaid HCP fee schedule or $25.00, whichever is greater, to be paid at the same time as any delinquent amounts. "

Desert States Physical Therapy Network, Ltd, stands in full support of this proposed language. Healthcare providers have increasing difficulties with several payers/carriers /bill review companies and timely payment or denial of claims. Sometimes hours are spent in an effort to rectify the "issue" with the claim only to be told it will be corrected and paid in 30-45 days. We believe this language will start to help the situation.

Desert States also believes additional future language should have more severe consequences for the most egregious payers/carriers and the Medical Cost Containment Bureau should be given more enforcement protocols to help make them more effective.

Thank you.

Amy C. Dixon, Executive Director

Public Comments Received November 11th via email:

Good afternoon,

PAX believes this rule change would be a positive step forward. By focusing IMEs on validating and supporting the treating provider's recommendations as warranted, we can significantly enhance physician availability and expedite appointment scheduling. This streamlined process reduces administrative burdens and unnecessary delays, ensuring that injured workers have better access to timely and appropriate care. Additionally, this approach promotes cost containment by minimizing redundant evaluations and associated expenses.

Thank you.
Stacy Snow, Operations Manager
PAX Resource Consulting

Public Comments Received November 12th via email:

Dear Sir or Madame,

I would like to comment on the proposed changes to Rule 11.4.7.13. I understand the proposed changes are in response to the difficulty and hesitancy of doctors being willing to testify in workers' compensation claims. While I believe that the increase should help with these issues, I believe the timing of it is not correct. The issue from my perspective is that the statutory discovery advance given to workers is not increasing as well. Under the current statute and rules a worker has the ability to take two, possibly three, one-hour doctors' depositions, if necessary, plus an employer representative deposition while staying within the current discovery advance. Under the proposed rule change, with no change to the discovery advance, a worker would be limited to one one-hour doctors' deposition plus an employer representative deposition.

This puts injured workers in a worse position as they will no longer have the same ability to take depositions in their case as the previously had.

Again, I do believe that an increase will help with issues of the willingness of doctors to testify, but it should not be done while it would harm an injured worker's ability to litigate their claim. I understand that an increase to the discovery advance in our statutes is going to be proposed in the next legislative session. This rule change should either occur simultaneously with, or after a commiserate increase to the discovery advance has occurred. Kindest regards.

Rodney Dunn
Attorney at Law

Public Comments Received November 13th via email:

To whom it may concern,

My name is Paul Saiz, MD and I am an Orthopedic Spine Surgeon. I did review the proposed changes re: limited IME's.

I would like to suggest one change.

See S 1

S. Independent Medical Examinations

(1) An IME may address any medical issue in dispute between the parties, including the causal relationship to the accident. At the judge's discretion, relevant medical records from up to 10 years prior to the claimed date of accident may be provided to the IME provider.

suggest " all relevant medical records available prior to the claimed date of accident may be provided to the IME provider."

Thank You

Paul Saiz