DOCTOR'S CROSSING
CARPE DIEM PODCAST
BY HEATHER FORK, MD, MCC

TRANSCRIPT

EPISODE 164 IMEs - A Side Gig For a Variety of Specialities

With guest Dr. Steven Borzak

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SB: "Most of us have trouble with wide open space. We apply for programs and there's a choice of programs, and we rank them in order for college and medical school and residency and fellowship. Imagining what you can do with your life and your career is pretty hard when we've been on the rails for so long and now the rails stop."

Welcome to The Doctor's Crossing Carpe Diem podcast. If you're questioning your career in medicine, you've come to the right place. I'm Heather Fork, a former dermatologist and founder of The Doctor's Crossing. As a master certified coach, I've helped hundreds of physicians find greater happiness in their career, whether in medicine, a nonclinical job, or something else. I started this podcast to help you discover the career path that's best for you and give you some resources and encouragement to make it happen. You don't need to get stuck at the white coat crossroads. So, pull up a chair, my friend, and let's carpe that diem.

Hi there and welcome back to the Doctor's Crossing Carpe Diem podcast. You're listening to episode number 164. Today we're talking about IMEs - Independent Medical Examinations where the physician performs an evaluation on a patient who is seeking disability or workers' comp benefits or insurance coverage to answer specific questions about their impairment.

One of my physician friends had to go and have an IME done recently. She had unfortunately developed a serious reaction to an eye medication and her compromised vision was making it impossible for her to safely practice her specialty.

As part of the process of applying for disability benefits, she was instructed to have an examination by an ophthalmologist selected by her disability carrier. As part of the requirement, this physician needed to be someone who had not seen her before and was not in any way involved in her care, hence the term independent medical exam.

Today we have a wonderful guest who is very well versed in IMEs. Joining us is Dr. Steven Borzak, a cardiologist with over 20 years of experience in clinical practice, as well as IMEs, disability, files reviews, and expert witness work. He is also involved in teaching in clinical research. Dr. Borzak is going to help us have a better understanding of the nature of the IMEs. What the necessary qualifications are, steps to get started, compensation, and more. We'll also be addressing concerns around whether or not your specialty is a good fit, testifying, and whether or not you need to be clinically active. Without further ado, it is my distinct honor and pleasure to welcome Dr. Steven Borzak to the podcast. Hi Steven. Great to have you here.

SB: Hi Heather. Thank you so much. It's a pleasure to be your guest today.

HF: Well, thank you. And it was really neat to discover on LinkedIn that we both went to Oberlin.

SB: Yes, indeed. Many years ago. At least many years for me. Not so many for you.

HF: Many, many years for me too. I came right after you. All right, I'd love it if we could start with just a brief description from you of what IMEs are.

SB: I stands for Independent and medical examination is what we do every day. What it involves the physician to do is really to change roles. Although we're trained as doctors and most of what we do is take care of patients, we're not in a doctor-patient relationship and that's the most important thing.

I usually start my IME exams by reminding the claimant she's not a patient, she's a claimant because she's making a claim against insurance, against workers' comp or in some other way. That I'm not there to provide any medical advice or offer any type of clinical care, but rather to make an independent determination of the extent of impairment.

The insurance company or whoever requests or compels an individual to undergo the IME usually has very specific questions to make a determination about what sorts of benefits might be available or applicable.

HF: That's a great description and we're going to be diving into a lot of the details about IMEs. I would love it if you could share with the listeners how you started doing them.

SB: I'm not sure I can retrace my steps back, but I began a side panel of nonclinical work in the very beginning. Somebody sent me a file to review someone who was admitted to the hospital after an auto accident and got a workup for chest pain and two insurance companies were fighting over it. The auto carrier said it was a pre-existing medical condition and the medical insurance company said, “Oh, it has to do with the accident” and they needed someone to settle the dispute.

That sort of led into different branches of these nonclinical experiences, which you've done a beautiful job of elucidating in your various podcasts and your training and consultation programs.

But the specific line of work for independent medical evaluation I find interesting, because it's sort of a different twist. It involves a different skill set, although still falls within the framework of general expertise, which we're trained in and are experienced in, but allows us to make an assessment and really try and be independent of whoever's paying the bill.

We should understand that I means independent, and so we're not here to make a case for the insurance company or to always side with the claimant either. It's really to make an assessment, an honest assessment, about what sorts of impairment are there.

Impairment is an important word because that's what the examiner is really seeking to determine. We're not here to decide, is the individual disabled or not. That's a determination that's made by the insurance company. Just like if your car is involved in an accident, you know that there's damage, but whether the car is declared a total loss or not is up to the insurance company. They may elect to repair it or they may elect to give you the value of the car. Whether it's a totaled car or not, is their determination not the repair shop's determination. Likewise, the examiner will make an assessment using whatever objective and medical skills that we have in our clinical skillset to determine what sorts of impairment are supported.

Sometimes we're also asked to make an assessment about what sorts of restrictions or limitations might be applicable in an individual's workplace. And that's another part of the independent medical evaluation.

For example, someone who's had open heart surgery will certainly be impaired for any work for a certain period of time, but then they'll have another set of restrictions and limitations until their sternum heels. They may be able to return to work in sedentary capacity after four weeks and more limited capacity at eight weeks, and then perhaps at 12 weeks to return to full capacity depending on what their job description is. There is an aspect of vocational medicine that sometimes applies to IMEs as well.

HF: There's a lot in here to tease apart, but one of the things that came to my mind when you were speaking is as physicians, we often worry when we're getting between two opposing factions that somehow we're going to not be able to use our integrity and our ethics and that there might be pressure to go with whoever's paying our bill or go to one side or the other. Can you speak to that situation and that concern when you're doing IMEs?

SB: It's gratifying that in this industry, I've really never felt pressure by whoever hires me to side in one way or in another way, that they really do seek an independent evaluation. And as long you, as the examiner, can support your opinion with logic and with objective findings and with a reasonable interpretation of the medical records in the file, then that's what they're really seeking.

One should be aware, however, because there's often money on the line, there's usually litigation. And by the time it gets to an independent medical evaluation, there are usually lawyers on both sides. One should be prepared if one wants to embark in this direction to be expecting depositions and having to deal with lawyers. Sometimes even lawyers will accompany the claimant into the exam room, which is allowed under state law, at least in Florida where I practice and probably in other places.

One, with the idea that their work will be scrutinized, that the report that one writes will be read carefully and that one will be deposed and expected to explain and defend their opinions.

HF: Now that's something I'm glad you brought out, Steven, because physicians are often comfortable looking in a chart and writing a report and giving their opinion that way, but it actually becomes a whole nother thing when you're talking about potentially going to court or giving a deposition. How often when you're doing an IME, does it end up requiring a deposition or going to court?

SB: I think it really depends on the subset of the work that you do. Most of the time, if it's for disability insurance, there might be a deposition, but almost never a court appearance. Most of the time, at least in Florida workers' comp, which is a fair part of Miami business in Florida, workers' comp is heard by judges of compensation claims. It's an administrative law judge and there's no jury. This type of litigation does not involve the juries and one's not entitled to a jury trial. All of the evidence that comes from both the report as well as the deposition is given to the judge. That judge reads the case and then makes a decision. There's no court appearance, but there is a deposition.

Doctors in general hate lawyers. Nobody likes being deposed, especially if they're the object of scrutiny. But if you were not being accused of wrongdoing as in a med mal case, God forbid. Being deposed, in my opinion, it's not so hard to become comfortable with as long as you stick to the questions. Answer the questions, not overstate and try hard not to get rattled because there are little ways that the lawyers can have sometimes to throw you off kilter a little bit.

It's important to recognize that no matter how smart the lawyer is, we know 10 times, if not 100 times more about the subject and about the condition and about the disease than they do, no matter how well read they are. As long as we are honest and consistent and stick with what we know and even sometimes admit when we're wrong, depositions go smoothly after a little bit of practice.

HF: I think that's a really good point that you brought up about how yes, if we are doing a deposition, it's really not about us, it's about whatever statement or opinion we've given based on our assessment of this claim. And that's an entirely different ballgame than when someone is really questioning our treatment and our care.

SB: Yes, although it is true that both sides can't be right. It's not our job to decide. It's our job to make an assessment, and often the cases settle. The lawyers decide on a compromise and they reach a settlement or not. But that's the choice of the parties. We

didn't cause the illness, we didn't cause the injury, we didn't cause the accident. We're just here to help make an honest assessment, bringing our medical expertise and skill to the situation and to the questions asked.

HF: I know a lot of physicians want to feel like they're well prepared for whatever it is they're doing. We went to medical school to learn how to become physicians. However, some of the things you mentioned such as impairment ratings and assessing how someone can return to work, how does a physician who is doing this work learn about making these kinds of assessments that we're not really trained to do in medical school?

SB: Yeah, it's a different skill set. It's a different world, so to speak. There's a whole world of insurance out there. When I started to develop this area for myself, one of the things that helped me was I joined LinkedIn and got, I forget what it's called, the advanced package.

HF: Oh, Premium?

SB: The Premium. Exactly. Yeah, the premium. I joined some of the groups in insurance companies and track down people and just tried to read through LinkedIn what the world was like. Went to companies, looked at their webpages. I took a SEAK course, which was very helpful. For a time I put my name and had an ad in the SEAK book, which I no longer do because it's expensive and business does seem to find me now, at least as much as I can handle.

And colleagues that are in the field are very helpful as well. I had a patient who is a workers comp lawyer who helped guide me a bit and steer me into becoming an expert medical advisor for the judge of compensation claims in Florida, which is a super IME in the workers' comp field.

Not everyone who does IMEs has to be involved in workers' comp. There's often an overlap, again, depending on the specialty. Gynecology probably has very little to do with workers' comp. There's not many on the job injuries there, but ortho, PM&R, psychiatry, those are very big in workers' comp fields. In fact, probably most practicing orthopedists do participate in workers' comp and are involved in sometimes set aside a half a day every couple of weeks or month just for depositions to deal with workers' comp legalities.

HF: Yeah, that's definitely something I wanted to touch upon is which specialties are most common for doing this work, and then what other specialties might be able to make a go even if they wouldn't be the top busiest IME physician?

SB: I think that there's probably a role for most of the specialties, though obviously some are busier than others. The busier specialties tend to have more providers. So, it's not a foregone conclusion that there's no work out there if you're a gynecologist or ENT. For example, who would think that cardiology would have a lot of IME work? But there is, and it's a fraction of what ortho and on the job injuries are, but it's there nonetheless. So it's just a question of finding the provider, the company, the insurance company, the lawyer, whomever that may need the services of an expert who's providing items.

HF: Do you have some steps that you would recommend to a physician who's looking into getting started? What they might do?

SB: Again, I think the SEAK course is an excellent place to start. SEAK. They have a web page and they have a bunch of different divisions based on the different types of nonclinical careers like file review, independent medical evaluation, expert witness work and so on. There is some overlap and there are a lot of people who do all of the above, but at least as far as starting on IMEs, that's an excellent place to start because it gives you an overview and a perspective of the industry, how it's set up, who are the key players, and

there are a lot of resources for companies to begin contacting so that you can become credentialed and potentially get work referred.

They also give you a sense of what the report is like and introduce you to some of the terms that are important like, what's the difference between impairment and disability, and how to think about some of these concepts. They're not super complicated compared to a medical specialty. It's a fraction of the knowledge that's required for practicing in a specialty, but it is new and different and something that we have to acquire.

HF: I have attended SEAK for 10 years as a speaker, as a mentor, as an attendee initially, and they do offer really high quality training. And so, I've never taken their IME training, but I imagine that it's very good. I think that's an excellent place to start. Now, there is board certification, is that correct for IMEs?

SB: There's a lot of companies out there who are seeking to credential you. The highest and most important board certification is your specialty board certification, which hopefully everybody has, that is much more valuable and is a much higher level than any other type of IME certification that you can get. I've never really considered that, it seems like an expense and at best it may be perhaps a source of referral. But it's a cash cow for the providers in my opinion.

HF: Okay. You don't really recommend that someone has to go and do that and spend that money?

SB: I don't. There is a book called The AMA Guide for Permanent Impairment. This is something that the AMA publishes, it's now in the sixth edition after having undergone a number of revisions even in the sixth edition. And there are companies who will provide training for you in this book. Again, it's not something I paid for myself, but it might be a worthwhile thing if your client who's hired you to do an IME expects you to provide an

impairment rating that comes from the AMA guide. It takes a little bit of getting used to how to think about it and how the guide works. I think it's possible to acquire that skill without spending a couple thousand dollars for training, but you do have to understand how it works.

HF: Thank you for sharing that, Steven. I know as physicians we often like having a training program for learning something specific and getting additional certifications. Sometimes these are very helpful and sometimes they're really not worth the money as you mentioned.

One of my clients who is an occupational medicine physician did take the training courses through the ABIME and became certified, and she said these were very helpful for her. I think it's a good thing that there are options and folks can figure out what will work best for them.

I just wanted to go back and highlight what you said earlier that IME work is open to most specialties, although some will be more in demand. The most common specialties I've ever mentioned are occupational medicine, as in this client I mentioned, orthopedic surgery, neurosurgery, neurology, psychiatry, pain management and psychiatry. But as you stated, if you are in a less in-demand specialties such as cardiology, there's less competition and potentially plenty of work. Now, I wanted to ask you, what do you enjoy the most about doing IMEs?

SB: I like a few things. One is that it's a different twist, but still within my specialty and my field of expertise. I like that at least the part of it, which is not the face-to-face exam, the report generation and the records review, that it's something I can do on my own time and offline. And it's a compliment on an hourly basis these days, especially with more looming Medicare cuts. It probably pays better on an hour for hour basis, though it's not something I would ever spend my whole time on. It's not an alternative to a clinical career, but more of a supplement to it.

HF: Would you recommend that a physician who's doing IME stay clinically active?

SB: I think it's important, and in fact, most expect you to have at least a part-time clinical practice so that it's probably not a great retirement gig. If many of the companies find out that you no longer are clinically active, then it might be a problem. You have to have an active clinical license to practice medicine, and I think it's important to retain a board certification as well. So, some sort of a clinical career, even part-time I think is important.

HF: And how soon do you think someone could start doing this out of residency?

SB: It probably makes sense to take a couple of years just to kind of get used to what you're doing. As we know, the first year or two out when you're done with training and there's no one standing behind you who you can call professor or teacher, you're on your own. It's a very rich learning environment when you have to figure it out yourself and help is available but much harder to find than during a training program. After a couple years, I think it is fine, although some people wait longer than that before they undertake it.

HF: And what do you find challenging about doing IMEs?

SB: I've gotten used to it now, and so the challenges sometimes relate to having too many cases at once or having a very large file of records that I have to go through. The biggest frustration used to be handwritten records. Yeah, we remember those. It's been a while. Now, Epic was a big challenge for me. I was never trained in Epic. Where I practiced does not have Epic, but when I get Epic medical records, it took a while to figure out how it was structured and how to find the two or three lines of meaningful text in a 20 page note. So, that was a big challenge, but I got used to that.

HF: Some IMEs are done completely from the chart and some are done when you're actually examining the patient.

SB: Yes, that's right. Sometimes just a paper IME review is requested and sometimes there's a full company clinical exam.

HF: Is there a case that you would like to share of how you felt that your assessment was helpful or maybe a particular memorable case?

SB: One case that I remember was unusual, maybe it's not the best case to relate to your listeners because it's kind of atypical. But I was approached by a lawyer representing a woman who was involved in divorce proceedings, and her ex-husband claimed that he had medical issues which prevented him from working and which therefore prevented him from paying alimony. They were able to compel him to have an independent medical evaluation by a cardiologist, that would be me, to make a determination as to the extent of his impairment.

And that was the one time that I actually wound up in court. Interestingly, he represented himself, so he didn't do a very good job of examining this witness, but that was a very odd and unusual manifestation of IME in a divorce court. I have never been in a divorce court before.

HF: Oh, very interesting. I'm guessing that he is paying alimony, he ended up having to pay alimony.

SB: I found that he was not impaired and that his claims were not well founded and that there was nothing that would prevent him from working. His work was largely sedentary. He was an insurance agent, had a branch of a large insurance company. So I don't know the outcome of the case.

HF: Oh, I see. Well, interesting. Now, when you think about this work, do you have any way to gauge how often people who do IMEs also serve as an expert witness in addition to their IME work?

SB: That's a good question. I don't really know. Expert witness work, as you know of course, can span many areas not just med mal and not just in disability and independent medical evaluation, sometimes product liability and other things. But once you speak to lawyers, and if lawyers like the way you talk to them, if lawyers value the way that you can express your opinion and handle yourself in a deposition, then that tends to lead to referrals. The boundaries between IME and med mal and expert witness work sometimes blur when they talk to their friends. I think it's probably pretty common that people who do one will be willing to undertake the other because a lot of the skills are similar.

HF: What you say really resonates with me because so often when I speak with a physician who is doing expert witness work or considering it, they maybe had to give a deposition or were even in a med mal trial and the lawyer has given them great feedback saying, "You would be excellent at this. If you ever want to do more work, here's my number."

SB: Yeah, I think so. And word does spread. Sometimes I've gotten work within the same firm, but in different divisions. I did a case and then got a case referred by one of his partners who's in the disability section or department.

HF: Excellent. I have a couple more questions I want to ask you, including about the compensation, but before that, I'm going to take a quick break to share a pertinent resource.

Hello, my dear listeners. I wanted to let you know about an upcoming opportunity to learn about being an expert witness. On Wednesday, January 17th at 7:00 PM Eastern Standard Time, I will be hosting a free webinar with Dr. Gretchen Green, where she will be talking about what this work is like to help you assess if it would be a good fit for you.

Dr. Green will also be sharing some details about her Virtual Expert Witness School, which will be starting at the beginning of February. To get more information about this

free webinar and to save your seat, simply click the link in the show notes or go to doctorscrossingprograms.com/webinar. I hope to see you there.

All right, now we're back here with our wonderful guest, Dr. Steven Borzak. I wanted to ask you, Steven, if someone is thinking about, "I wonder if this might be a good fit for me" and specialty aside, how might someone start to think about maybe their personality, what they like to do, how they like to use their mind to help them get an idea of if they should pursue this or not?

SB: Well, a lot of it is chair work, sitting in the chair and reviewing records and writing reports. You can dictate reports also either through your own dictation service or some of the companies have a dictation service for you, but you have to be comfortable with that aspect. And many people really are fleeing from records as quickly as they can. I understand that, and this is kind of running in the opposite direction towards more charting and file review. But that's a part of it.

And the other part is understanding that the doctor-patient relationship is completely altered here and that it's not a doctor-patient relationship. You have to be cognizant of the fact that you're stepping out, and that a person who's compelled by their insurance company to come see you is not going to love you. They may be courteous and you should be courteous to them, but they're not your friend and they're not there to give you great reviews. You're there to accomplish a job, which is to make an assessment, which may or may not be in their financial best interest. But sometimes it can be contentious, and as I mentioned, lawyers are often involved. If that's a scary prospect or an unpleasant prospect that one doesn't want to engage with, then there are other forms of nonclinical careers that can be found on your wonderful webpage.

HF: Thank you for your kind words and your kind words earlier too. That's an excellent description. I think that's very helpful advice. Now lastly, I wanted to talk about compensation. I'm sure there's a range, and it varies with specialty, but are you able to

give us a little bit of guidance about that?

SB: Yeah, it really is a little bit all over the place. One can have a fee schedule and that is usually asked for before an agreement is made to retain you as an expert. There's different ways of doing it. There's a case rate, there's an hourly rate. And sometimes, for instance, the state of Florida imposes a fee schedule on depositions for workers' comp, which is $200 an hour. Most of the work in IME is more than that. But generally around $400 an hour is a rough metric of what one can expect to get. Sometimes starting low to get the work and then once you feel comfortable with it and recognize your value as an examiner and others recognize your value, then the fee can go up. That's what I did. I started low and then raised my fee once I felt comfortable and once I felt like I wasn't going to chase away clients.

HF: Do you think that LinkedIn is a good source for finding work and letting people know that you do this kind of work?

SB: I think so. I've had contacts approach me and I've had cases referred to me through LinkedIn. Not a huge number, but some. It really all depends on how you set up and how you target your LinkedIn. I created my LinkedIn page specifically for the disability and file review aspect of my business because people don't look for their doctors on LinkedIn. They look for doctors from other sources. LinkedIn I thought would be useful for this side hustle rather than for my primary practice. I used it more as a tool to learn and to understand the industry rather than a source of referrals. But part of it is because I'm not really a social media person. I don't post, I'm not on Facebook. LinkedIn is pretty much the extent of all of my social media interactions.

So, I really don't know how to use social media as a tool to get business. Younger, or more literate social media types, would probably have a much better way of attracting business to themselves. I'm kind of a dinosaur in that regard and don't really have a

social media presence, but that probably is a very good way if you know how to do it, to get work.

HF: Absolutely. You've done very well for yourself and LinkedIn is a good resource. They keep coming up with new ways that we can use it to our benefit. For example, you can even create your own newsletter now like a blog on LinkedIn. I think it will just continue to be a good resource.

Lastly I wanted to ask you since you have been in practice for a good number of years, you do some different nonclinical activities. Do you have any advice for the physician who is burned out and a lot of the physicians, unfortunately, are very young these days to think about their career trajectory and how to navigate these challenging waters?

SB: Well, I think you're a much better teacher and advice giver than I am in this area. I'm pretty traditional in the sense of still wanting to maintain a clinical practice, still wanting to go to the hospital, at least as a cardiologist. I feel that we belong there. Our patients expect to see us there.

Most of us have trouble with wide open space. We apply for programs and there's a choice of programs and we rank them in order and we try and get into the best program we can. And that holds true for college and medical school and residency and fellowship. But then once that's it, it's all open and there's no more forks in the road. It's just a huge field. Imagining what you can do with your life and your career is pretty hard when we've been on the rails for so long and now the rails stop.

I think that's what you're trying to do, is to help people imagine what choices are out there, what the shape of choices can be, what combination of things might make for a worthwhile and interesting career.

HF: Well, I love your answer and I love all the metaphors that you use because it's so striking. You're absolutely right. We have guardrails on, we have left, right, left, right. These choices are limited and defined. And then you're right, once we get out there, it is open space and that can be very unsettling.

But thanks to you and my other wonderful guests who come on this podcast, physicians now can actually see in concrete terms what someone is actually doing out there to help their career be more satisfying, help it be more sustainable, and have options. I really appreciate all that you've shared on this podcast and for taking the time to come here and speak with me.

SB: It's my pleasure. Thank you so much for hosting me.

HF: Thank you, Steven. I'm wishing you all the best.

SB: Thank you.

HF: Thank you, my dear listeners. I appreciate you being here and I'd love it if you share this podcast with anyone you think could benefit from this episode or any of the other ones. We want to keep spreading the word and helping those physicians out there who are looking for a way to diversify their options. As always, don't forget to carpe that diem and I'll see you in the next episode. Bye for now.

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Podcast details

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