



Detailed Information For Our Providers Regarding Joining The CompreMed Network

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CompreMed Canada Inc. offers the only national, "Preferred Provider Network" organization of its kind in Canada. Our medical provider network began within teaching hospital centers, but has expanded to include Canadian cities coast to coast and includes many of this country's finest medical practitioners and facilities.

We provide Independent Medical Examination (IME) and Diagnostic Imaging Services to large insurance companies, health care companies and national public and private organizations. By quality assuring and credentialing our providers, we maintain our accountability to clients and foster an industry reputation for excellent customer service, high standards and integrity. This reputation has resulted in rapid growth for CompreMed along with new and significant revenue streams for our providers.

A physician-founded organization, CompreMed maintains a physician perspective in its priorities and direction. It reserves an appropriate independence and distance from Insurers and claimants. Insurers in need of definitive, arms-length opinions, value the objectivity of CompreMed's service.

CompreMed is committed to maintaining the highest ethical and professional standards as it finds and accesses legitimate markets for its health care professionals. We are always interested in working with reputable medical providers with high standards of integrity and professionalism. Such individuals, who also possess an orientation toward service, and the ability to communicate effectively, have the potential to become valued providers in the CompreMed network.

CompreMed offers a complete range of administrative services to providers. For assistance in managing all your third-party service needs, from booking to billing, dictation and report preparation, contact CompreMed, toll free at: 1-888-777-2500.

Requirements For CompreMed Providers

Physicians must hold a valid medical license with the appropriate Provincial College of Physicians and Surgeons and must be in good standing with that college

Other Professionals (OT / PT, etc) must be a members in good standing of their professional college

Have in place, current CMPA coverage. We require verification of malpractice insurance coverage.

Medical Specialists must be in good standing with the Royal College of Physicians and Surgeons of Canada with valid FRCP(C) or FRCS(C) designation in the specialty in which they are performing the service.

In addition:

The provider should be an acknowledged expert in his/her field and should be committed to high standards of service. He/she must be able to perform examinations in a timely fashion, providing complete, concise reports, which attempt to clearly answer all questions asked. The provider should be committed to integrity and objectivity, and must be above reproach in this regard. Finally, our providers must be compassionate to and considerate of, each claimant.

1. What is an Independent Medical Examination (IME)?

The IME is an independent medical assessment designed to diagnose the nature of the medical impairment. The IME can be a complex assessment which seeks to determine the presence of objective medical or psychiatric impairment. Prognosis is usually estimated and a treatment plan is generally required to optimize the outcome.

Note: For the examination to be independent, the provider must not have treated the claimant in the past, and must refrain from providing any form of treatment at the time of the examination.

2. Once the IME is completed, is it O.K. to treat the claimant?

After an IME, the examiner **should not** agree to treat the claimant, as such treatment would change the provider's role to one where they must act on behalf of the claimant in the traditional doctor/patient relationship, and would therefore no longer be considered by the Insurer to be independent. In rare emergency situations, for example, a suicidal claimant, an exception may be made.

3. What is an Independent Medical Consultation (IMC)?

The IMC is an independent assessment, which usually occurs very early in the disability management process, often within one month of disability. It is designed to diagnose the injury or illness and formulate optimal treatment strategies to facilitate the claimant's return to work at the earliest and safest possible date. As such, the IMC is not adversarial in nature. It requires the joint cooperation of the Insurer, claimant, IMC physician and the claimant's own family physician. This new procedure reflects an industry trend toward a more cooperative approach to the management of disability. Insurers request that, if at all possible, the IMC provider takes an active roll in initiating treatment of the claimant in order to effect the best outcome. **In contrast to the IME, treatment administered by the IMC provider is authorized and encouraged by the Insurer.** Treatment does, however, depend upon the consent of the claimant, claimant's physician and the physician performing the IMC. If follow-up care of the claimant is undertaken by the IMC provider, such care is normally funded through the claimant's provincial health care plan.

4. What kind of support or training does CompreMed offer to providers?

CompreMed gives physicians the tools necessary to perform first rate IMEs. With CompreMed information manuals, peer support and administrative assistance, even physicians with little or no IME experience, can accomplish them effectively from the start. We certify our providers over time, based on peer review and industry evaluations of each service completed on our behalf. A performance and information database is maintained on every one of our providers, giving each physician a unique opportunity to establish and maintain his or her own professional reputation of excellence.

CompreMed Canada's mission is to provide the highest quality medical evaluations and service to our clients. We use specific mechanisms and operating principles to accomplish our mission. CompreMed seeks, as service providers, those whose skill, experience, professional qualifications and credentials exceed the ordinary, and who demonstrate their integrity and professional character. We enlist and utilize the services of, only the best providers who continue to meet our comprehensive credentialing standards. CompreMed's standards are maintained through rigorous service evaluations, which include peer review.

CompreMed operates on the principle that both our clients and their customers are best served when each CompreMed provider functions according to their best objective medical judgment, unhindered by any conflicting influences. CompreMed's unique value is derived from ensuring the independent examination process provides prompt, complete, and concise answers to all referral questions in accordance with our guidelines. If, after peer review, it is felt a report does not adequately meet these objectives, changes may be suggested to the provider in writing. Suggested changes normally deal with the format, clarity, consistency and completeness of a report, and do not attempt to influence the fundamental content or medical opinions. While the provider remains independent of CompreMed, and is under no obligation to make any suggested changes, no report is released to a third party until any outstanding issues have been reviewed with the provider, and the provider's wishes regarding changes have been verified.

CompreMed encourages routine, written evaluations of our service by our clients. We seek continuous improvement by identifying and correcting any problems, which may arise.

CompreMed Canada is committed to respect and abide by the Federal and Provincial regulations that govern third party eligibility for health care services.

These Operating Principles form the ethical foundation with which we establish and maintain our reputation of excellence, in our delivery of third-party health care services.

How To Become A Provider In the CompreMed Network

If you meet all of the provider criteria required by CompreMed, and you wish to be considered as a potential provider in the CompreMed network, simply call our toll free number, **1-888-777-2500**, and express your interest to one of our Customer Service Representatives. A Provider Enlistment package will be mailed to you for your review and consideration.

Basic Approach to the IME

Prior to the Examination: Prior to the interview, the provider should review all available information about the claimant, including past history and diagnostic tests. CompreMed will send this information to the provider in advance of the IME. Based on the information gathered, a summary should be made which clearly defines any overt problems, as well as the implied covert problems (i.e. hidden agendas). The provider looks for missing, but relevant information that is required, before he sees the patient, and looks to see if there are incomplete aspects of the claimant's record.

History and Physical Examination: After reviewing all available information, the provider performs the examination, including history and physical. Throughout the interview, the provider attempts to determine if the claimant's stated concerns agree with his/her clinical perception of the claimant's actual concerns. The provider attempts to unmask hidden agendas and tries to understand the claimant's expectations regarding his or her illness. As this report is performed on behalf of the Insurer, care must be taken to avoid discussing the provider's findings and opinions with the claimant, especially as they relate to functional ability or disability.

Analysis of Findings: Once the examination is complete, the provider reviews his/her gathered information, and compares it with the information available from outside sources. If there are any conflicts and dissimilarities between these information sources, he/she will attempt to determine why. Similarities should also be assessed and analyzed.

Problem List and Treatment Recommendations: A final problem list is then generated, and a treatment plan is usually formulated for each problem. Care must be taken to outline treatment recommendations that are practical, specific and reasonable. Some Insurers do not require or want treatment recommendations in the report, as the report is needed to quantify disability for claims adjudication purposes rather than to outline strategies for further treatment. The need for treatment recommendations will be detailed on the report format and question sheet provided with each CompreMed referral.

Please note: Unless the provider is performing an IMC, the provider should never treat the claimant. As soon as treatment is provided, a doctor/patient relationship exists, and the independence of the examination is voided. Most Insurers will not accept the report in this situation.

CompreMed Recommendations

The IME/IMC provider must obtain a signed **Claimant Authorization Form** prior to the examination. This form is included in the IME/IMC referral information package you Receive from CompreMed. As you are acting on behalf of a third party and not on behalf of the claimant, it is important that you obtain consent from the claimant to act in this special capacity. For your protection, it is strongly recommended that you obtain a signed authorization from the claimant, to release the report to CompreMed and the Insurer.

(Cont...)

The **Procedural Consent (Claimant Authorization) Form** has been provided for your convenience. It covers third party consent, as well as authorization to release the report to CompreMed Canada Inc. and the Insurer. *Although CompreMed makes every effort to assist you in obtaining the needed consents, the ultimate responsibility for this rests with you, the medical provider.*

The provider should not release the report or discuss the report with the claimant unless a serious medical concern has been identified.

After the IME, the provider should not agree to treat the claimant, as treatment would void the independence of the provider, and render the assessment to be of no value to the Insurer. Administering treatment changes the provider's role to one where the physician must act on behalf of the claimant, and is therefore no longer considered by the Insurer to be independent. In rare emergency situations (e.g., a suicidal patient), an exception may be made.

The provider should show the claimant normal courtesy, and explain the nature of, and reason for, components of the examination which could cause discomfort or pain.

The provider should consult the Provincial College of Physicians and Surgeons, or Provincial Insurance Commission for the most up to date information as needed. CompreMed is unable to provide legal advice, nor can we guarantee up to date information on specific Provincial Insurance regulations.

Performance Requirements

In order that we may provide the valuable service that we do to the clients we serve, we have developed some performance targets with respect to service delivery. We assess ourselves and every provider on each report to ensure that they meet the following:

Appointment within two weeks of request

Final written report completed and faxed within 7 business days of the examination

Original report also forwarded to CompreMed by mail within 10 business days of examination

Report format corresponds to Insurer's outline with all Insurer questions addressed.

Significant differences may exist in report requirements between insurance companies. It is essential that all questions asked by the Insurer be answered as completely as possible. A format guideline, detailing specific content requirements and questions to be addressed in your report, will be supplied by CompreMed with each referral. It is important your report answer these specific questions and correspond to the format requested.

Content Of Reports

State the claimant's name, date of examination, Insurer or client requesting the examination, policy number and CompreMed's Referral ID number. The report header should be addressed to the Insurer or client requesting the service, *not to CompreMed.*

Begin with a brief statement of your qualifications.

List any relevant material you have reviewed (such as X-rays and medical history) for the record. Comment on pertinent aspects of this material.

Clear, concise reports are very popular with claims management professionals. It is helpful to use underlined headings in your report for easy reference and reading.

Use the term "claimant" rather than "patient" to describe the subject of the examination. Although this is a minor point, the term "patient" implies a doctor/patient relationship and less independence.

It is essential that a critical approach be taken. Do not take what is said at face value, but compare it to what is observed clinically and what is contained in the medical records provided. State any discrepancies observed and provide your opinion as to what you think they might mean.

Avoid unsupported or sweeping statements in the report. If you conclude there is significant impairment, you must be able to support this conclusion in your observed clinical findings at examination. A claimant may describe significant disability or impairment in the medical history. If your observations at examination are not in agreement with these claims, please take care to note such observations in your report.

As stated above, a comprehensive content outline for each IME/IMC report is provided by CompreMed with every referral. It contains the questions to be addressed in the evaluation. **These questions should be answered in a summary at the end of the report even if they are addressed in the body of the report.** It is very important that you tailor your report format to this outline. Answering each question asked, in sequence, also helps to ensure the report has met the requirements.

IME/IMC Report and Billing Process

Service request and documentation are sent to you

You obtain consent, (signed "Claimant Authorization Form"), and perform the service.

The report is prepared in your office or dictated on the CompreMed toll-free dictation line within 48 hours of the service (see dictation instructions).

If you use CompreMed's dictation line, CompreMed will type your report and fax back your first raw draft, usually within 24 hours.

CompreMed Peer Medical Evaluator will peer review and evaluate your final draft. The Medical Evaluator may request in writing, that you provide additional clarification or Information.

The report is signed and faxed back to CompreMed, along with the completed billing form, if no further corrections are required.

If you prepared the report in your own office, it should be signed and promptly Forwarded to CompreMed by mail or courier.

Payment for Services will be sent within 45-60 days of receipt by fax of the final signed report. The report must be accompanied by a completed CompreMed provider billing form.

IME/IMC Fee Guidelines

Fees may vary between specialty areas, as well as geographically. CompreMed will request you quote a maximum anticipated fee up front, to enable the Insurer to do a cost benefit analysis for the service.

Cancellation Fees

If the appointment is not cancelled, but the claimant fails to attend, a cancellation fee of \$100.00 may be charged. If this fee is not satisfactory to you, please advise CompreMed of your cancellation policy, prior to the service date in order that we may advise the Insurer of same.

Dictation of the Report

The report may be dictated in your own office, or dictated for a nominal fee of \$45.00 on the toll free, CompreMed Central Dictation System, accessed from your office telephone. Using CompreMed's dictation service facilitates quality reports and rapid report turnaround. (Please refer to the dictation instructions for information on using this system).

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The report is dictated in draft form. CompreMed proofreads the draft report to detect ambiguities, and to ensure it is complete and answers all the Insurer's questions. It is also proofread for grammatical and spelling errors.

The edited report, along with your unedited draft report (if the two reports differ significantly), are faxed back to you for correction. Your corrected draft is faxed back to CompreMed and your corrections are incorporated.

Finally, the report is peer reviewed and evaluated by a CompreMed Peer Medical Evaluator. The Medical Evaluator may request in writing, that you provide additional clarification or information. In some circumstances, they may suggest that changes be made to the report. These recommended changes are governed by our "Operating Principles", and may be accepted or rejected at your sole discretion.

The final report, when you are satisfied, is signed by you and faxed back to CompreMed, while the original is sent from CompreMed to you by mail, to be signed and forwarded again to CompreMed.

CompreMed Toll Free Dictation Service Instructions

1. Dial toll free **1-888-538-2502**
2. Key in ID number **22** and press # key, if you receive message "*ID in use, call back later*", call back using ID number **11** and press # key.
3. Activate recording by starting your dictation at the sound of the constant tones.
4. Begin your confidential dictation by providing:
 - Your name & professional credentials
 - Office address
 - Claimant's name
 - Claimant's date of birth
 - Insurance company and claim #

Please make sure to spell proper names and drug names
5. Dictation commands: *see diagram at right*
6. When finished: Press the * # keys and hang up

Please be advised that CompreMed charges the provider a \$50.00 flat fee for each report dictated.

STOP 1 <small>*1 to slow down</small>	RECORD 2	PLAY 3 <small>*3 to speed up</small>
DELETE 4 <small>*4 - undo delete</small>	INSERT 5	FORWARD 6 <small>*66 - skip to end</small>
REWIND 7 <small>*7 - normal speed</small>	PRIORITY 8 <small>*8 - main menu</small>	SUMMARY MARK 9 <small>*9 to find mark</small>
*	0 <small>*0 - intercom</small>	END # <small>*# to hang up</small>

For further assistance, please call CompreMed toll free at **1-888-777-2500**.

Medical Disability

Disability, in the context of the IME and IMC, is difficult to quantify and define. In general terms, each claimant's insurance contract contains a working definition of the term "disability". If an assessment of a claimant's disability is requested for the report, a specific definition of disability will be provided. Frequently, life and disability insurers will request the provider **not** attempt to determine the level of disability. Rather, the provider will be asked to assess the level of medical impairment. Medical impairment is only one factor in the determination of a claimant's disability and eligibility to receive insurance benefits. The final determination is made under the terms of the claimant's insurance coverage.

Auto Insurers, in contrast, are more likely to request you *do* estimate the level of disability. For a given level of measurable medical impairment, individual claimants vary significantly in the amount of disability they may claim. Factors such as individual motivation, availability of support, and psychological outlook will modify and impact the level of disability observed and claimed. For example, in the case of amputation of the leg, a medical impairment is clearly present. Individuals with similar amputations will vary considerably in what disability they demonstrate as a result of the amputation.

Medical Impairment

In contrast to disability, impairment represents a measurable, documented, physical, cognitive or psychiatric abnormality that limits function. An objective evaluation of medical impairment can be used to determine the level of disability. **It is best to use the term impairment (rather than disability) to describe measurable abnormalities seen on examination.**

Occupation

In most life and disability insurance policies, the definitions of "disability" and "any occupation" are detailed in the claimant's insurance contract. For this reason, it is important to provide objective information that will enable the Insurer to understand the restrictions and capabilities of the claimant in relation to the workplace and home. Unless requested to do so, it is best to avoid the use of terms and definitions related to occupation (i.e., "any occupation" in your report) as such terms are detailed in the claimant's insurance contract. Providing a clear understanding of the claimant's functional capacity and limitations will enable the Insurer to apply the definitions of occupation in the contract to the claimant. Some Insurers will request your evaluation of what occupation a claimant could reasonably be expected to carry out, based on your assessment. Again, it is very important to respond to the specific questions and formats outlined in the information sent to you with each referral, which outline the specific requirements of the Insurer requesting the procedure in this regard.

