



STATE OF WASHINGTON
DEPARTMENT OF LABOR AND INDUSTRIES
PO Box 44322 • Olympia Washington 98504-4322

IME Examiner Renewal Application

Thank you for your continued interest in providing services to our workers. Attached you will find the Independent Medical Examiner (IME) Renewal Application. *IME providers must renew every three years or when required by the department.* This application is for IME examiners who are currently approved to conduct IMEs.

Examiners: please submit the following documents:

- Application (1 page).
- Signed and dated attestation (with explanations if applicable).
- Provider Agreement (2 pages).
- Current Certificate of successful completion of the *Medical Examiner's Handbook* test.
- Current copy of your curriculum vitae.
- Documentation of required Continuing Medical Education (CME) hours since your last renewal if applicable

Please note: Incomplete applications will be returned and electronic signatures cannot be accepted. The *Medical Examiners Handbook* test must be completed within six months of received date.

You will receive notification of your renewal approval status by mail.

Additional information:

- IME and impairment rating information can be found on our website Lni.wa.gov/IMEs.
- State Fund Worker Compensation IME billing and payment questions, contact Provider Hotline at 800-848-0811.
- State Fund and Self-Insured Medical Aid Rules and Fee Schedule at: www.Lni.wa.gov/ClaimsIns/Providers/Billing/default.asp.
- Crime Victims IME billing and payment questions, contact Crime Victims at 800-762-3716.
- Crime Victims Compensation Fee Schedule at: www.Lni.wa.gov/ClaimsIns/CrimeVictims/ProvResources/
- A list of all approved IME examiners and firms can be found online at "[Find a Medical Examiner.](#)"
- For questions about the IME application process, call 360-902-5131.
- Mail or fax completed applications to:

Department of Labor and Industries
Provider Quality and Compliance
PO Box 44322
Olympia WA 98504-4322
Fax: 360-902-4249

Mail or fax completed applications to:
 Department of Labor and Industries
 Provider Quality and Compliance
 PO Box 44322
 Olympia WA 98504-4322
 Fax: 360-902-4249



IME Examiner Renewal Application

A. Practitioner Information

1. Provider's Name (Last, First, Middle Initial)		2. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		3. Date of Birth		
4. Type of license <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> DC <input type="checkbox"/> DDS/DMD <input type="checkbox"/> DPM			5. Professional license number			
6. Practice specialty/subspecialty			7. DEA number			
8. Provider's mailing address						
Street address			City	State	Zip Code	
9. Provider's phone number			10. Provider's email address			
11. Individual NPI Number						
12. Foreign Language(s) you speak fluently :						

B. Practice and Continuing Education Information

1. Do you currently provide patient related services (excluding IME's)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate how many hours – select only ONE reporting method below: Per week _____ Hours Per Month _____ Hours If Per Year _____ Hours If no, list the date you retired from direct patient care: _____					
2. Name of Practice, Affiliation or Clinic:					
3. Effective Date at primary practice location					
4. Contact Name			Contact Phone number		
5. Practice Website					
6. Additional practice location listed on CV? <input type="checkbox"/> Yes <input type="checkbox"/> No					
7. Include Contact information for additional practice:					
8. Are you currently active duty military? <input type="checkbox"/> Yes <input type="checkbox"/> No					
9. Do you have approval to conduct IMEs and testify from your Commanding Officer? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please attach a copy of the approval.					
10. Do you currently provide a minimum of 768 hours of patient related services per year? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, you must submit documentation showing you have fulfilled the requirements for your respective state licensure since your last renewal per WAC 296-23-317(3). Submit documentation of CE hours indicating the name of course, date and hours earned.					

Labor and Industries IME Attestation Questions – to be completed by the practitioner

Please answer all of the following questions. If your answer to any of the following questions is “Yes,” provide details as specified on the attached Professional Liability Action Page. **If you attach additional sheets, sign and date each sheet.**

A PROFESSIONAL SANCTIONS

1.	<i>In the interval since your last application</i> , have you been, or are you now in the process of being denied, revoked, terminated, suspended, restricted, reduced, limited, sanctioned, placed on probation, monitored, or not renewed for any of the following? Or have you voluntarily or involuntarily relinquished, withdrawn, or failed to proceed with an application for any of the following in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct?	
a.	License to practice any profession in any jurisdiction	<input type="checkbox"/> Yes <input type="checkbox"/> No
b.	Other professional registration or certification in any jurisdiction	<input type="checkbox"/> Yes <input type="checkbox"/> No
c.	Specialty or subspecialty board certification	<input type="checkbox"/> Yes <input type="checkbox"/> No
d.	Membership on any hospital medical staff	<input type="checkbox"/> Yes <input type="checkbox"/> No
e.	Clinical privileges at any facility, including hospitals, ambulatory surgical centers, skilled nursing facilities, etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No
f.	Medicare, Medicaid, FDA, NIH (Office of Human Research Protection), governmental, national, or international regulatory agency or any public program	<input type="checkbox"/> Yes <input type="checkbox"/> No
g.	Professional society membership or fellowship	<input type="checkbox"/> Yes <input type="checkbox"/> No
h.	Participation/member in an HMO, PPO, IPA, PHO, or other entity	<input type="checkbox"/> Yes <input type="checkbox"/> No
i.	Academic appointment	<input type="checkbox"/> Yes <input type="checkbox"/> No
j.	Authority to prescribe controlled substances (DEA or other authority)	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	<i>In the interval since your last application</i> , have you been subject to review, challenges, and/or disciplinary action, formal or informal, by an ethics committee, licensing board, medical disciplinary board, professional association or education/training institution?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	<i>In the interval since your last application</i> , have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	<i>In the interval since your last application</i> , have you been the subject of any reports to a state, federal, national data bank, or state licensing or disciplinary entity?	<input type="checkbox"/> Yes <input type="checkbox"/> No

B CRIMINAL HISTORY

1.	<i>In the interval since your last application</i> , have you been charged with a criminal violation (felony or misdemeanor) resulting in either a plea bargain, conviction on the original or lesser charge, or payment of a fine, suspended sentence, community service or other obligation?	
a.	Do you have notice of any such anticipated charges?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b.	Are you currently under governmental investigation?	<input type="checkbox"/> Yes <input type="checkbox"/> No

C AFFIRMATION OF ABILITIES

1.	Do you presently use any drugs illegally?	
2.	Do you have, or have you had in the last five years, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or will affect your current ability to practice with or without reasonable accommodation? If reasonable accommodation is required, specify the accommodation required. If the answer to this question is yes, please identify and describe any rehabilitation program in which you are or were enrolled which assures your ability to adhere to prevailing standards or professional performance.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Are you unable to perform any of the service/clinical privileges required by the applicable participating practitioner agreement, with or without reasonable accommodations, according to the accepted standards of professional performance?	<input type="checkbox"/> Yes <input type="checkbox"/> No

D LITIGATION AND MALPRACTICE COVERAGE HISTORY

1.	<i>In the interval since your last application</i> , have allegations or claims of professional negligence been made against you at any time, whether or not you were individually named in the claim or lawsuit?	
2.	<i>In the interval since your last application</i> , have you or an insurance carrier ever paid any money on your behalf to settle/resolve a professional malpractice claim (not necessarily a lawsuit) and/or to satisfy a judgment (court-ordered damage award) in a professional lawsuit?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Are there any such claims being asserted against you now?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	<i>In the interval since your last application</i> , have you ever been denied professional liability coverage or has your coverage ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

I warrant that all the statements made in this form and on any attached informational sheets are complete, accurate, and current. I understand that any material misstatements in, or omissions from, this statement constitute cause for denial of application or cause for administrative action.

Print Applicant's Name

Applicant's Signature (no electronic signatures)

Date

Practitioner Name (Print or Type)

Please list any past or current professional liability claim(s) or lawsuit(s), in which allegations of professional negligence were made against you, whether or not you were individually named in the claim or lawsuit. Please do not include patient names or other HIPAA protected PHI. Photocopy this page as needed and submit a separate page for EACH claim/event. A legible signed practitioner narrative that addresses all of the following details is an acceptable alternative.

Date of Incident:

Clinical Details of the incident, with preceding events:

Your role and specific responsibility in the incident:

Subsequent events, including patients outcome

Date suit of claim was filed:

Name of Insurance Carrier that handled the claim:

Address of above carrier City State Zip Code

Your status in the legal action Primary Defendant Co-Defendant Other

Current status of suit or other action:

Date of settlement, judgment or dismissal:

If case was settle out of court, or with a judgement, settlement amount attributed to you? \$

Print Practitioner Name

Practitioner Signature (No Electronic Signature)

Date

IME Provider Agreement

The Industrial Insurance Program is authorized by Washington State law, [Title 51 Revised Code of Washington \(RCW\)](#), and is administered by the Department of Labor and Industries. IME services are provided according to [Title 51 RCW](#), [Washington Administrative Code \(WAC\) Chapter 296-23](#), and policies by the department, including medical coverage decisions.

Issuance of a provider number does not guarantee that all services billed by a provider will be paid by the department. Payments will be made according to the department Medical Aid Rules and Fee Schedule as updated annually and according to department policy. The department will only reimburse for covered services, provided to injured workers by approved providers.

I (the IME provider), _____

(print or type name)

agree to and accept all the terms of this agreement and to follow all applicable federal and Washington State statutes, rules, and policies. I will provide independent, objective and timely medical opinions for all IMEs I conduct. I understand that it is the expectation of the department that all workers will be treated with dignity and respect. I understand that my performance will be measured by the quality of my examination and report, and not by whether my recommendations are perceived as favorable or unfavorable to the parties involved. I understand that the approval of my re-application does not guarantee that I will receive any IME referrals from the department.

The provider agrees:

1. To meet and maintain all applicable state and/or federal licensing or certification requirements to assure the department of the provider's qualifications to perform services for injured workers.
2. To comply with Washington State Law [Title 51 RCW](#), Washington Administrative Code (WAC), including but not limited to [Chapter 296-23](#) and policies adopted by the department, including fee schedules and medical coverage decisions. The provider who treats or provides a service to an injured or ill worker who is covered under the department's jurisdiction, accepts the requirements for [Title 51 RCW](#), and the WACs, including but not limited to Chapter [296-20](#), [296-21](#), [296-23](#), and [296-23A](#), and policies adopted by the department, including fee schedules and medical coverage decisions.
3. To be reasonably available to testify at the Board of Industrial Insurance Appeals (Board) or by deposition. Reasonably available to all parties means cooperating in the timely scheduling of the pre-testimony conference and testimony.
 - a. Doctor testimony is preferred to be taken in person and may be required by an Industrial Appeals Judge. Examiners who travel to conduct exams in Washington must be willing and able to return to testify if called to do so.
4. To accept the department or self-insured employer's payment as sole and complete remuneration for services provided to the worker as required by Washington State law. The provider agrees not to bill a worker for:
 - a. Services covered by the industrial insurance program which are related to the industrial injury or occupational disease;
 - b. The difference between the billed and paid charges.

In the event a provider believes additional funds are due, the provider may submit a Provider's Request for Adjustment Form to the department for consideration in accordance with the instructions contained on the Remittance Advice.

5. To return promptly to the department or self-insurer any excess monies received as payment from the department or self-insurer in error or in excess of the amount properly due under the applicable rules and policies. The department may audit the provider's records to determine compliance with the rules and regulations of the department as provided by Washington State law.
6. To maintain documentation and records for a minimum of five (5) years to support the services provided and levels of services billed. The provider agrees that these records and supportive materials will be made available to the department upon request as provided by Washington State law.
7. To notify the department immediately of any change to information in the application or provider status (e.g. any new actions against your professional license, federal tax identification number, ownership, incorporation, address, etc.). Any change in ownership or federal tax ID will require a new IME provider account application.
8. To provide quality care that is respectful, equitable and responsive to diverse cultural health beliefs, practices, preferred languages, and communication needs in accordance with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in health and health care.

A provider will be held to all the terms of this agreement even though a third party may be involved in billing claims to the department.

The department reserves the right to deny, revoke, suspend, or condition an IME provider's authorization to provide IME services to injured workers.

Agreement to Code of Ethics

I further agree:

1. To learn and adhere to the standards of ethical conduct as listed in [RCW 42.52.140](#) (Gifts) and [RCW 42.52.150](#) (Limitations of Gifts).
2. To not offer any gift, gratuity, or favor to any department employee to include food and other refreshments.
3. To not seek to unduly influence the actions or decisions of the department employees.
4. To report any incidence of unethical conduct or abuse of position by a department employee to the Manager of Provider Quality and Compliance, Health Services Analysis, Department of Labor and Industries.
5. To accept that a failure to meet these standards of ethical conduct could result in adverse administrative action by the department and/or criminal actions per [RCW 51.48.280](#) and [Title 9A.68](#).

By signing, I accept the terms of this agreement and attest that this application and all attachments are accurate and true to the best of my knowledge.

Print Applicant's Name

Applicant's Signature (no electronic signature)

Date