WEST VIRGINIA
SECRETARY OF STATE
KEN HECHLER
ADMINISTRATIVE LAW DIVISION

Form #2

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APR 14 12 14 PM '94

OFFICE OF WEST VIRGINIA SECRETARY OF STATE

NOTICE OF A COMMENT PERIOD ON A PROPOSED RULE

AGENCY: Workers' Compensation Division Bureau of Employment Programs TITLE NUMBER: 85

RULE TYPE: Legislative* ; CITE AUTHORITY WV Code, §21A-2-6(2); 21A-3-7(b);& 7(c); 23-1-1; 23-1-13; & 23-1-15

AMENDMENT TO AN EXISTING RULE: YES___ NO X

IF YES, SERIES NUMBER OF RULE BEING AMENDED: _____

TITLE OF RULE BEING AMENDED: _____

IF NO, SERIES NUMBER OF NEW RULE BEING PROPOSED: 16

TITLE OF RULE BEING PROPOSED: Guidelines for permanent impairment and disability evaluations, evidence, and ratings

*Per W.Va. Code, §21A-3-7(c), these rules are not subject to Legislative review.

IN LIEU OF A PUBLIC HEARING, A COMMENT PERIOD HAS BEEN ESTABLISHED DURING WHICH ANY INTERESTED PERSON MAY SEND COMMENTS CONCERNING THESE PROPOSED RULES. THIS COMMENT PERIOD WILL END ON May 16, 1994 AT 5:00 p.m.

ONLY WRITTEN COMMENTS WILL BE ACCEPTED AND ARE TO BE MAILED TO THE FOLLOWING ADDRESS.

John H. Kozak
Director, Legal Services Division
Post Office Box 3922
Charleston, WV 25339-3922

THE ISSUES TO BE HEARD SHALL BE LIMITED TO THIS PROPOSED RULE.

Andrew N. Richardson
Commissioner

ATTACH A **BRIEF** SUMMARY OF YOUR PROPOSAL

12.90

DEPARTMENT OF COMMERCE, LABOR & ENVIRONMENTAL RESOURCES
OFFICE OF THE SECRETARY
State Capitol, Room M-146
Charleston, West Virginia 25305-0310
Telephone: (304) 558-0400
Fax No.: (304) 558-4983

GASTON CAPERTON
Governor

JOHN M. RANSON
Cabinet Secretary

April 14, 1994

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OFFICE OF WEST VIRGINIA SECRETARY OF STATE

Mr. Andrew F. Richardson
Commissioner
Bureau of Employment Programs
Building 4, Room 610
Charleston, West Virginia 25305-0112

Re: Proposed Exempt Legislative Rule, Title 85, Series 16, Guidelines for Permanent Impairment and Disability Evaluation, Evidence, and Ratings

Dear Mr. Richardson:

Pursuant to West Virginia Code Section 5F-2-2(a)(12), I hereby consent to the proposal of the rule specified above.

You may attach a copy of this letter to your filing with the Secretary of State as evidence of my consent.

Sincerely yours,

John M. Ranson

John M. Ranson
Cabinet Secretary

JMR/ss
T:\WC85-16.RUL

APPENDIX B

FISCAL NOTE FOR PROPOSED RULES

Rule Title: Guidelines for Permanent Impairment and Disability Evaluations, Evidence, and Ratings

Type of Rule: X **Legislative** ____ **Interpretive** ____ **Procedural**

Agency Workers' Compensation Division, Bureau of Employment Programs

Address Post Office Box 3922

Charleston, WV 25339-3922

1. Effect of Proposed Rule

	ANNUAL		FISCAL YEAR		
	INCREASE	DECREASE	CURRENT	NEXT	THEREAFTER
ESTIMATED TOTAL COST	$	$	$	$	$
PERSONAL SERVICES					
CURRENT EXPENSE					
REPAIRS & ALTERNATIONS					
EQUIPMENT					
OTHER					

2. Explanation of above estimates:

The rule will not affect the Division's administrative budget. The costs of evaluations and reports are borne as part of claims costs. It is expected that the costs of evaluations and reports will increase in the range of $100 to $300 depending upon the complexity of the claim. This will be an increase of some $1 million to $3 million yearly.

3. Objectives of these rules:

To bring regularity and standardization to impairment and disability ratings process. To ensure that reports that are submitted are reliable and credible evidence and that opinions have a demonstrable factual basis and rationale. This will remove abuse from the ratings process.

Rule Title: Guidelines for Permanent Impairment and Disability Evaluations, Evidence, and Ratings

4. Explanation of Overall Economic Impact of Proposed Rule.

A. Economic Impact on State Government.

The Workers' Compensation Fund has a discounted deficit of $1.9 billion as of July 1, 1993. This rule will assist in ensuring that the Fund's resources are appropriately expended.

B. Economic Impact on Political Subdivisions; Specific Industries; Specific groups of Citizens.

There will be an increase in costs for obtaining thorough and correct examinations and reports. Health care providers and others will have to increase the time expended on evaluations and reports.

C. Economic Impact on Citizens/Public at Large.

The guidelines will reduce costs to the Workers' Compensation system by removing abusive evaluations and opinions. This will ensure that injured workers will be accurately and appropriately compensated.

Date: April 13, 1994

Signature of Agency Head or Authorized Reprensentative

Andrew N. Richardson

Andrew N. Richardson
Commissioner

SUMMARY OF PROPOSED LEGISLATIVE RULE

Guidelines for Permanent Impairment and Disability Evaluations, Evidence, and Ratings

TITLE 85, SERIES 16

This proposed legislative rule establishes the requirements and procedures to be followed by the Workers' Compensation Division, parties to claims pending before the division, health care providers, vocational professionals, and others involved in the process of evaluating injured workers and then reporting opinions of the degree of impairment or disability that the injured worker has suffered as a result of his or her compensable injury or disease.

In 1990, the Legislature created the Health Care Advisory Panel for the purpose of advising the Commissioner on a number of health care related issues. One such issue was the establishment of protocols and procedures for the evaluation of claimants. The Health Care Advisory Panel has recommended to the Commissioner that the "Guides to the Evaluation of Permanent Impairment," (4th ed. 1993), (hereinafter referred to as "Guides") as published by the American Medical Association be generally adopted for the purpose of performing evaluations and obtaining medical opinions on the degree of impairment a claimant has suffered.

Exceptions to the use of the Guides are also provided for in the following areas. The Health Care Advisory Panel has previously formulated recommendations in three areas which have been adopted by the Commissioner. In the area of noise induced hearing loss claims, a separate set of regulations has been adopted. In the area of psychiatric and emotional injuries, a separate protocol and procedure has been established. That protocol and procedure is incorporated into this rule. In the area of back examinations, in addition to the requirements of the Guides, a previously adopted back examination form has been incorporated into this rule. The rule also exempts claims for occupational pneumoconiosis from the Guides as that area has been adequately addressed through the procedures of the Occupational Pneumonoconiosis Board.

The rule requires that all impairment evaluations be conducted in accordance with the Guides or the incorporated standards. The report must demonstrate that the examination was so performed and the factual results of the examination of the claimant must be set forth in the report. Any degree or percentage of impairment that is offered by way of an opinion must have its factual basis set forth in the report and the opinion must itself have been formulated and calculated in accordance with the standards. Failure to meet these requirements will result in the rejection of the report and opinion as not being credible or reliable evidence.

The rule requires that the professional conducting the evaluation, giving the report, and making the opinion must be qualified and competent in the necessary fields of expertise. These qualifications must be shown by way of a resume or curriculum vitae that is to be attached to the report.

The distinction between impairment ratings and disability ratings is stated. The rule requires that disability ratings be provided only by professionals qualified to do so and that the qualifications be shown.

The rule also sets forth criteria for the payment by the division for the performing of evaluations and the furnishing of opinions.

TITLE 85
LEGISLATIVE RULES
BUREAU OF EMPLOYMENT PROGRAMS
WORKERS' COMPENSATION DIVISION

SERIES 16
Guidelines for Permanent Impairment and Disability Evaluations, Evidence, and Ratings

§85-16-1. General.

1.1. Scope. -- This rule implements the provisions of West Virginia Code, §23-4-3b(b), §23-4-7a(h), and §23-4-8, regarding the procedures, forms, evidence, and standards for impairment ratings of claimants for workers' compensation benefits. In the event that an opinion is offered on the degree of disability suffered by a claimant, then that opinion must also meet the requirements of this rule.

1.2. Authority. -- West Virginia Code, §21A-2-6(2); §21A-3-7(b) & -7(c); §23-1-1; §23-1-13, and §23-1-15. Pursuant to West Virginia Code, §21A-3-7(c), rules adopted by the compensation programs performance council and the commissioner are not subject to legislative approval as would otherwise be required under West Virginia Code, §29A-3-1 et seq. Public notice requirements of that chapter and article, however, must be followed. This rule has received the approval of the Secretary of the Department of Commerce, Labor and Environmental Resources.

1.3. Filing Date. --

1.4. Effective Date. --

§85-16-2. Purpose of rule.

The purpose of this rule is to implement the provisions of West Virginia Code, §23-4-3b(b), §23-4-7a(h), and §23-4-8, which relate to the development of standards for the rating of permanent impairments suffered by claimants as a proximate result of their compensable injuries or diseases. The standards adopted by this rule have been approved by the health care advisory panel and recommended to the compensation programs performance council for its adoption. This rule does not apply to the additional factors, beyond impairment, that determine the degree of disability suffered by a claimant. The rule is applicable to all ratings for permanent partial impairment or disability and for permanent total impairment or disability. The rule is applicable to evidence submitted by any party to a claim and to evidence gathered by the division.

§85-16-3. Definitions.

As used in this legislative rule, the following terms have the stated meanings unless the context of a specific use clearly indicates another meaning is intended.

3.1. "Commissioner" means the Commissioner of the Bureau of Employment Programs pursuant to West Virginia Code, §21A-2-1, and West Virginia Code, §23-1-1, and any deputies designated pursuant to West Virginia Code, §21A-2-12 & -13.

3.2. "Disability" means "an alteration of an individual's capacity to meet personal, social, or occupational demands, or statutory or regulatory requirements, because of an impairment. Disability refers to an activity or task the individual cannot accomplish. A disability arises out of the interaction between impairment and external requirements, especially those of a person's occupation. Disability may be thought of as the gap between what a person can do and what the person needs or wants to do." Guides, at page 1/2 (emphasis in the original; footnote omitted).

3.3. "Division" means the Workers' Compensation Division within the Bureau of Employment Programs as provided for by West Virginia Code, §21A-1-4, and West Virginia Code, §23-1-1 et seq.

3.4. "Guides" means the "Guides to the Evaluation of Permanent Impairment," (4th ed. 1993), as published by the American Medical Association or such later edition as may have then been published.

3.5. "Permanent impairment" means an impairment "that has become static or stabilized during a period of time sufficient to allow optimal tissue repair, and one that is unlikely to change in spite of further medical or surgical therapy." Guides at page 1/1. An "impairment" is defined as "an alteration of an individual's health status" and is "assessed by medical means and is a medical issue. An impairment is a deviation from normal in a body part or organ system and its functioning." Id.

§85-16-4. Adoption of Standards.

Except as provided for in section 6 of this rule, on and after the effective date of this rule all evaluations, examinations, reports, and opinions with regard to the degree of permanent impairment which a claimant has suffered shall be conducted and composed in accordance with the "Guides to the Evaluation of Permanent Impairment," (4th ed. 1993), as published by the American Medical Association or such later edition as may have then been published. If in any particular claim, the examiner is of the opinion that the Guides or the section 6 substitutes cannot be appropriately applied, then the examiner's report must thoroughly document and explain the basis for that opinion.

§23-16-5. Evidentiary Requirements.

5.1. In order to be found to be credible and reliable for evidentiary purposes during the course of a workers' compensation claim for benefits at any level of review thereof, a report must demonstrate that the evaluation and examination that it memorializes was conducted in accordance with the Guides and that the opinion with regard to the degree of permanent impairment suffered by a claimant was arrived at and composed in accordance with the requirements of the Guides.

5.1.1. The report must state the factual findings of all tests, evaluations, and examinations that were conducted and must state the manner in which they were conducted so as to clearly indicate their performance in keeping with the requirements of the Guides. For any evaluation and examination of a compensable back injury, the back examination form previously adopted by the health care advisory panel must be completed and submitted with the narrative report. A copy of the current edition of the back examination form is attached hereto and is incorporated herein as if fully set forth. A report and opinion submitted regarding the degree of permanent impairment as a result of a back injury without a completed back examination form shall be disregarded as not reliable and not credible.

5.1.2. The opinion stated in the report as to the degree of permanent impairment must reflect the process of calculation as stated in the Guides so as to demonstrate how the degree of permanent impairment was arrived at and calculated.

5.1.3. As stated in the Guides, at page 1/5, section 1.5: "The physician performing an impairment evaluation must provide more than a number or percentage. The physician should provide as comprehensive a medical picture of the patient as possible, using the Report of Medical Evaluation form (p.11) as an outline. If this is done, the person receiving the evaluation will be able to determine how the medical information fits with the nonmedical information and will have the basis for an improved understanding of how the impairment may affect the patient's employability and daily activities." (Insertion in the original).

5.2. The report must separate the degree of permanent impairment found from the degree of disability, if any, stated in the report. The basis for the opinion on the degree of disability suffered by a claimant must be shown and explained in detail in order to be credible and reliable for evidentiary purposes.

5.3. The qualifications of the expert giving the opinion on the degree of permanent impairment must be shown by way of an attachment to the report in each and every instance. The

attachment may be in the form of a resume or curriculum vitae and must be sufficient to qualify the opinion giver as an expert in the field of impairment determination. Failure to so qualify the opinion giver shall result in a finding that the opinion and findings in the reports offered by that opinion giver are not reliable and not credible.

5.4. In order to give an opinion on the degree of disability, if any, suffered by a claimant for workers' compensation benefits, the opinion giver must demonstrate his or her expertise in the field of disability determination as opposed to impairment rating. As noted in section 3.2, impairment is a medical issue while disability is a personal, social, and occupational issue. The expertise of the opinion giver must be demonstrated in an attachment to the report and may be in the form of a resume or curriculum vitae and must be sufficient to qualify the opinion giver as an expert in the field of disability determination. Failure to so qualify the opinion giver shall result in a finding that the opinion and findings in the reports offered by that opinion giver are not reliable and not credible.

5.5. As impairment is a medical issue, the opinion giver on the degree of permanent impairment must demonstrate his or her expertise in the pertinent medical field or fields. As disability is not a medical issue, the opinion giver must demonstrate expertise in fields pertinent to a claimant's personal, social, or occupational demands, or applicable statutory or regulatory requirements. "If the physician is well acquainted with the patient's activities and needs, he or she may also express an opinion about the presence or absence of a disability or handicap." Guides, at page 1/2. In order to do so, however, the evidentiary basis for the physician's knowledge must be thoroughly demonstrated.

5.6. In any claim for occupational pneumoconiosis benefits (section 6.1), for noise induced hearing loss (subsection 6.2), or for mental and emotional loss (subsection 6.3), the application of these evidentiary requirements of this section 5 shall be based upon the guidelines referred to in subsections 6.1, 6.2, and 6.3 in lieu of the Guides. All of the other requirements of section 5 shall be accordingly applied.

§23-16-6. Exceptions to the Guides.

The following portions of the Guides or their successor provisions shall not be used in the determination of the degree of permanent impairment that has been suffered by a claimant for workers' compensation benefits.

6.1. In claims for occupational pneumoconiosis benefits, the provisions of Chapter 5, "The Respiratory System," are exempted from this rule. The provisions of the statute related

to occupational pneumoconiosis, rules adopted in accordance with the statute, and policies and procedures adopted by the occupational pneumoconiosis board adequately and separately control the determination of the degree of permanent impairment suffered by such a claimant.

6.2. In claims for noise induced hearing loss, the provisions of section 9.1, Chapter 9, "Ear, Nose, Throat, and Related Structures," are exempted from this rule. The legislative rule styled "Protocols and Procedures for Performing Medical Evaluations in Noise-Induced Hearing Loss Claims," 85 CSR 13 (1993), were previously promulgated for such claims.

6.3. In claims for mental and emotional loss, the provisions of Chapter 14, "Mental and Behavioral Disorders," are exempted from this rule. Separate standards for such claims have been developed by the health care advisory panel and are attached hereto and incorporated herein as if fully set forth.

6.4. In those claims affected by the provisions of West Virginia Code, §23-4-6(f), the minimum degree of disability stated there shall be applied in lieu of any lesser finding based upon any degree of permanent impairment which may have been determined in accordance with the Guides.

6.5. In those claims affected by the provisions of West Virginia Code, §23-4-6(m), the conclusive presumption of total disability stated there shall be applied in lieu of any lesser finding based upon any degree of permanent impairment which may have been determined in accordance with the Guides.

§85-16-7. Payment for evaluations.

The division shall not make payment to any impairment or disability examiner whose reports, opinions, examinations, or evaluations are not conducted, performed, and composed in accordance with this rule. In the event payment was made prior to a determination that the report, opinion, examination, or evaluation was not conducted, performed, or composed in accordance with this rule, then the amount so paid shall be recovered from the examiner either by way of a direct repayment to the division or by way of an offset against any future sums that may be owed by the division to the examiner for any services rendered for or to the division or for or to a claimant.

§85-16-8. Severability

If any provision of this rule or the application thereof to any entity or circumstance shall be held invalid, such invalidity shall not effect the provisions or the applications of this rule which can be given affect without the invalid

provisions or application and to this end the provisions of this rule are declared to be severable.

TITLE 85

LEGISLATIVE RULES

BUREAU OF EMPLOYMENT PROGRAMS

DIVISION OF WORKERS' COMPENSATION

SERIES 16

Guidelines for Permanent Impairment and Disability Evaluations, Evidence, and Ratings

INDEX

USE BLACK INK

Patient History Form -- Back Pain

Name: _____ D.O.B. _____

Date of Onset: _____ SS# ___ ___ ____

I. History

Present History

1. How did the pain occur?

2. Where is the location of the pain?

3. Have you had this type of pain before? ☐ Yes ☐ No
When? _____

4.1 What is the name of your employer?

4.2 What is the type of business of that company?

5.1 What was your job title when pain began?

5.2 What was your usual job?

5.3 What job were you performing when pain began?

6. Who is your immediate supervisor?
Name: _____
Phone #: _____

7. Have you discussed your pain with your supervisor? ☐ Yes ☐ No

8. Is there modified or alternative work at your job? ☐ Yes ☐ No ☐ Don't Know

9. Your pain is worse in your:

☐ Head	☐ Left Leg	☐ Right Arm
☐ Neck	☐ Left Hip	☐ Left Arm
☐ Shoulder	☐ Right Leg	☐ All of These
☐ Back	☐ Right Hip	☐ None of these

10. Your pain is:

	Better	Worse	No Different
When you urinate or move your bowels	☐	☐	☐
When coughing or sneezing	☐	☐	☐
When you wake up in the morning	☐	☐	☐
In the middle of the night	☐	☐	☐
Mid-day	☐	☐	☐
Evening	☐	☐	☐
Lying	☐	☐	☐
Sitting	☐	☐	☐
Driving	☐	☐	☐
Bending	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐
Change of position	☐	☐	☐

11. Have you been treated for this pain before now? ☐ Yes ☐ No

12. What has helped this pain the most? _____

13. What has not helped or made this pain worse? _____

14.1 Do you get pain at the tip of your tailbone? ☐ Yes ☐ No

14.2 Does your whole leg ever become painful? ☐ Yes ☐ No

14.3 Does your whole leg ever go numb? ☐ Yes ☐ No

14.4 Does your whole leg ever give way? ☐ Yes ☐ No

14.5 In the past year, have you had any spells with very little pain? ☐ Yes ☐ No

14.6 Have you had any intolerance to your treatment or reactions to treatment?
☐ Yes ☐ No

14.7 Have you had an emergency room visit to the hospital with back trouble?
☐ Yes ☐ No

Past History

15. Have you ever had a spine X-ray, CT scan, MRI or myelogram?
X-ray ☐ Yes ☐ No MRI ☐ Yes ☐ No
CT scan ☐ Yes ☐ No Myelogram ☐ Yes ☐ No
Which/When? _____

16. Have you ever been hospitalized for neck, arm, back or leg pain?
☐ Yes ☐ No When? _____

17. What other medical problems do you have?
☐ Heart, blood pressure, or circulation problems
☐ Diabetes ☐ Gout
☐ Arthritis ☐ Cancer
☐ Other _____

18. Have you been hospitalized for any of these problems in Number 17?
☐ Yes ☐ No Which/When _____

19. What medicines are you now taking, including over-the-counter?

20. Do you have a family doctor? ☐ Yes ☐ No
Name: _____
Phone #: _____

21. Allergies to food, medicine, or other? ☐ Yes ☐ No
List: _____

22. Do you smoke, rub, or chew tobacco? ☐ Yes ☐ No

23.1 Do you drink beer, wine, or liquor? ☐ Yes ☐ No How Much? _____

23.2 Ever have an alcohol problem? ☐ Yes ☐ No

24. Do you drink coffee or tea or caffeine drinks? ☐ Yes ☐ No
How much per 24 hours? _____

25. How much formal education do you have?
☐ College or higher
☐ Vocational Training
☐ High School Diploma or GED
☐ Grade Completed _____

26. Do you have other family members with serious back or neck problems?
☐ Yes ☐ No
Are they disabled? ☐ Yes ☐ No

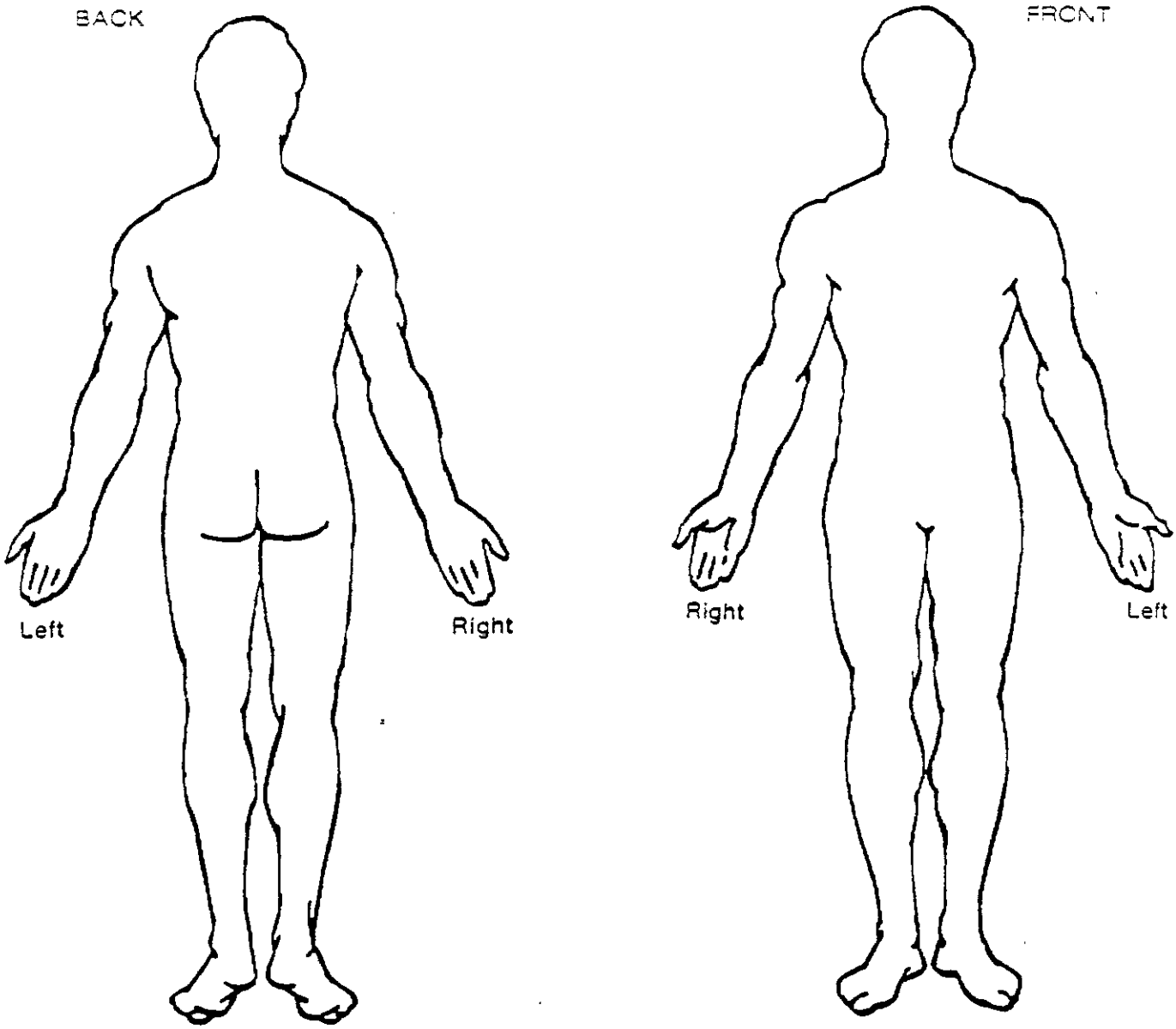
27. Any additional comments?: _____

INSTRUCTIONS

Where is your pain? How does it feel? Draw your pain using the following key. Do not indicate areas of pain which are not related to your present injury or condition. Draw in your face.

KEY

/ / / Stabbing	X X X Burning	000 Pins and Needles	▲▲▲ Aching, Throbbing	= = = Numbness	• • • Other



Signature _____ Date _____

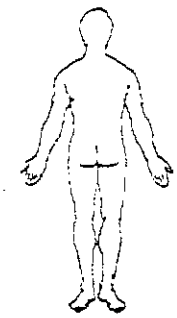
Back Examination

SS# ___ ___ ____

Name: _____ D.O.B. _____ Ht. _____ Wt. _____

Date of This Exam: _____

L R



Mark Any Asymmetries On Figure to the Right.

1. INSPECTION (standing and/or seated)

		YES	NO
1.1	Patient stands unassisted	☐	☐
1.2	Scoliosis	☐	☐
1.3	Iliac crest level	☐	☐
1.4	Antalgic lean (posture)	☐	☐
1.5	Lumbar hyperlordosis	☐	☐
1.6	Lumbar hypolordosis	☐	☐
1.7	Other observations _____		

2. PALPATION (standing, seated, or prone)

		Left Yes	Left No	Right Yes	Right No	Yes	No	
2.1	Paraspinal muscle tenderness	☐	☐	☐	☐			
2.2	Paraspinal muscle spasm	☐	☐	☐	☐			
2.3	Sacroiliac joint tenderness	☐	☐	☐	☐			
2.4	Vertebral tenderness/restriction			☐ L1	☐ L2	☐ L3	☐ L4	☐ L5
2.5	Coccyx tenderness (external palpation)			☐	☐			

3. GAIT

3.1 Limp ☐ Yes ☐ No ☐ Left ☐ Right

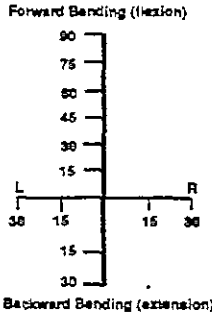
3.2 Other observations _____

4. SQUAT

4.1 Squats fully and rises without difficulty ☐ Yes ☐ No

4.2 If No, how much is performed adequately ☐ 1/4 ☐ 1/2 ☐ 3/4

5. RANGE OF MOTION (standing) – Mark Diagram and Complete 5.1 through 5.4



X = Pain ☐ = Restriction ✓ = WNL

			WNL	PAIN	RESTRICTION
5.1	Forward bending (Flexion)	____°	☐	☐	☐
5.2	Backward bending (Extension)	____°	☐	☐	☐
5.3	Left side bending	____°	☐	☐	☐
5.4	Right side bending	____°	☐	☐	☐

Inclinometer ☐ Yes ☐ No

Comments: _____

6. MOTOR STRENGTH (standing, walking, seated, or supine)

		Yes	No	Left	Right	
6.1	Hip flexion weakness	☐	☐	☐	☐	If Yes, grade _____
6.2	Knee extension weakness	☐	☐	☐	☐	If Yes, grade _____
6.3	Ankle dorsiflexion weakness	☐	☐	☐	☐	If Yes, grade _____
6.4	Great toe extension weakness	☐	☐	☐	☐	If Yes, grade _____
6.5	Knee flexion weakness	☐	☐	☐	☐	If Yes, grade _____
6.6	Ankle eversion weakness	☐	☐	☐	☐	If Yes, grade _____
6.7	Ankle plantar flexion weakness	☐	☐	☐	☐	If Yes, grade _____

7. SENSORY (pinwheel or pin prick) (seated or supine)

		Left Normal	Left Diminished	Left Absent	Right Normal	Right Diminished	Right Absent
7.1	L3 sensory	☐	☐	☐	☐	☐	☐
7.2	L4 sensory	☐	☐	☐	☐	☐	☐
7.3	L5 sensory	☐	☐	☐	☐	☐	☐
7.4	S1 sensory	☐	☐	☐	☐	☐	☐

Re-Exams

		Date	Initials
A.	1st re-exam	_____	____
B.	2nd re-exam	_____	____
C.	3rd re-exam	_____	____

– (worse) ○ (same) + (improvement) ✓ (normal, negative or resolved)

	A	B	C	Notes:
1.1	☐	☐	☐	_____
1.2	☐	☐	☐	_____
1.3	☐	☐	☐	_____
1.4	☐	☐	☐	_____
1.5	☐	☐	☐	_____
1.6	☐	☐	☐	_____
1.7	☐	☐	☐	_____
2.1	☐	☐	☐	_____
2.2	☐	☐	☐	_____
2.3	☐	☐	☐	_____
2.4	☐	☐	☐	_____
2.5	☐	☐	☐	_____
3.1	☐	☐	☐	_____
3.2	☐	☐	☐	_____
4.1	☐	☐	☐	_____
4.2	☐	☐	☐	_____
5.1	☐	☐	☐	_____
5.2	☐	☐	☐	_____
5.3	☐	☐	☐	_____
5.4	☐	☐	☐	_____
6.1	☐	☐	☐	_____
6.2	☐	☐	☐	_____
6.3	☐	☐	☐	_____
6.4	☐	☐	☐	_____
6.5	☐	☐	☐	_____
6.6	☐	☐	☐	_____
6.7	☐	☐	☐	_____
7.1	☐	☐	☐	_____
7.2	☐	☐	☐	_____
7.3	☐	☐	☐	_____
7.4	☐	☐	☐	_____

Name: _____ SS# ___ __ ____

Re-Exams

– (worse) ○ (same) + (improvement) ✓ (normal, negative or resolved)

		A	B	C	
8. **STRAIGHT LEG RAISING** (Sitting) (Measure knee extension)					
8.1 Left _____° Pain: ☐ Yes ☐ No Location of Pain: ☐ Back ☐ Same Leg ☐ Contralateral back/leg	8.1	☐	☐	☐	_____
8.2 Right _____° Pain: ☐ Yes ☐ No Location of Pain: ☐ Back ☐ Same Leg ☐ Contralateral back/leg	8.2	☐	☐	☐	_____
9. **REFLEXES** (seated) (÷2 normal)					
Patellar 9.1 Left ☐ 0 ☐ +1 ☐ +2 ☐ +3 ☐ clonus	9.1	☐	☐	☐	_____
9.2 Right ☐ 0 ☐ +1 ☐ +2 ☐ +3 ☐ clonus	9.2	☐	☐	☐	_____
Achilles 9.3 Left ☐ 0 ☐ +1 ☐ +2 ☐ +3 ☐ clonus	9.3	☐	☐	☐	_____
9.4 Right ☐ 0 ☐ +1 ☐ +2 ☐ +3 ☐ clonus	9.4	☐	☐	☐	_____
10. **HIP AND SACROILIAC TESTS**					
10.1 Hip test pain ☐ Yes ☐ No (See Patrick's or other textbook hip joint test)	10.1	☐	☐	☐	_____
10.2 Sacroiliac test pain ☐ Yes ☐ No ☐ Left ☐ Right (Use Gaenslen's, Hibb's, Goldthwait's, Iliac compression, Patrick's or other textbook sacroiliac test)	10.2	☐	☐	☐	_____
11. **STRAIGHT LEG RAISING** (Supine)					
11.1 Left _____° Pain: ☐ Yes ☐ No Location of Pain: ☐ Back ☐ Same Leg ☐ Contralateral hip/leg	11.1	☐	☐	☐	_____
11.2 Right _____° Pain: ☐ Yes ☐ No Location of Pain: ☐ Back ☐ Same Leg ☐ Contralateral hip/leg	11.2	☐	☐	☐	_____
12. **PEDIS PULSES**					
12.1 Left Posterior tibialis _____ Dorsalis Pedis _____	12.1	☐	☐	☐	_____
12.2 Right Posterior tibialis _____ Dorsalis Pedis _____	12.2	☐	☐	☐	_____
13. **MUSCLE WASTING MEASUREMENT**					
13.1 Left Thigh _____ Right Thigh _____ _____ cm above tibial tubercle	13.1	☐	☐	☐	_____
13.2 Left Calf _____ Right Calf _____ _____ cm below tibial tubercle	13.2	☐	☐	☐	_____
14. **LEG LENGTH EXAM DONE?** ☐ Yes ☐ No					
14.1 Short ☐ Left ☐ Right ☐ Even ☐ Supine ☐ Standing	14.1	☐	☐	☐	_____
Difference of _____ cm (Supine: measure from anterior superior iliac spine to lateral malleolus) (Standing: measure from greater trochanter to floor)					

15. **CLINICAL IMPRESSION OF SOMATIC AMPLIFICATION**	SCORE			A	B	C
SENSORY EXAMINATION: RESPONSE TO PINPRICK						
15.1 No deficit or deficit well localized to dermatome(s)	0	☐	15.1	0 ☐	☐	☐
Deficit related to dermatome(s) but some inconsistency	1	☐		1 ☐	☐	☐
Nondermatomal or very inconsistent deficit	2	☐		2 ☐	☐	☐
Blatantly impossible (i.e., split down midline of entire body with positive tuning fork test)	3	☐		3 ☐	☐	☐
15.2 AMOUNT OF BODY INVOLVED						
< 15%	0	☐	15.2	0 ☐	☐	☐
15 - 35%	1	☐		1 ☐	☐	☐
36 - 60%	2	☐		2 ☐	☐	☐
> 60%	3	☐		3 ☐	☐	☐
MOTOR EXAMINATIONS:						
15.3 No deficit or deficit well localized to myotome(s)	0	☐	15.3	0 ☐	☐	☐
Deficit related to myotome(s) but some inconsistency	1	☐		1 ☐	☐	☐
Nonmyotomal or very inconsistent weakness, exhibits cogwheeling or giving away, weakness is coachable	2	☐		2 ☐	☐	☐
Blatantly impossible, significant weakness which disappears when distracted	3	☐		3 ☐	☐	☐
15.4 AMOUNT OF BODY INVOLVED						
< 15%	0	☐	15.4	0 ☐	☐	☐
15 - 35%	1	☐		1 ☐	☐	☐
36 - 60%	2	☐		2 ☐	☐	☐
> 60%	3	☐		3 ☐	☐	☐

Name: _____ SS# ___ ___ ____

TENDERNESS:

15.5 No tenderness or tenderness clearly localized to discrete, anatomically sensible structure — 0 ☐

Tenderness not well localized, some inconsistency — 1 ☐

Diffuse or very inconsistent tenderness, multiple anatomic structures involved (skin, muscle, bone, etc.) — 2 ☐

Blatantly impossible, significant tenderness of multiple anatomic structures (skin, muscle, bone, etc.) which disappears when distracted — 3 ☐

15.6 AMOUNT OF BODY INVOLVED

< 15% — 0 ☐

15 - 35% — 1 ☐

36 - 60% — 2 ☐

> 60% — 3 ☐

DISTRACTED STRAIGHT LEG RAISING (SLR):

15.7 The difference between SLR tests performed in the supine and sitting positions (the patient is distracted in the sitting position by examining the bottom of his/her feet). *Example:* supine SLR positive at 10°, seated SLR positive at 50°, difference = 40°.

Difference < 20° — 0 ☐

Difference 20 - 45° — 1 ☐

Difference > 45° — 2 ☐

No pain seated, but strongly positive SLR when supine at less than 45° — 3 ☐

TOTAL SCORE _____

16. **COMMENTS:** _____

17. **RADIOGRAPHIC EXAM** ☐ Yes ☐ No Date _____ Type (Plain, CT, MRI) _____

Findings (Attach report if available): _____

Patient Position During X-ray ☐ Recumbent ☐ Weight Bearing

18. **CLINICAL DIAGNOSIS**

(Generic diagnoses are printed for your convenience; you may substitute other diagnoses.)
(If appropriate, multiple diagnoses can be designated.)

SOFT TISSUE

☐ Lumbar sprain/strain (847.2)

☐ Lumbosacral sprain/strain (846.0)

☐ Sacroiliac sprain/strain (846.9)

☐ Thoracic sprain/strain (847.1)

POSTERIOR JOINTS

☐ Facet syndrome (724.8)

☐ Lumbar subluxation or lumbar segmental dysfunction (circle one) (739.3)

DISC

☐ Lumbar disc displacement (without radiculopathy) (722.10)

☐ Lumbar disc displacement (with radiculopathy) (722.73)

SACROILIAC

☐ Sacroiliitis (720.2)

☐ Sacroiliac subluxation or sacroiliac dysfunction (circle one) (739.4)

☐ **OTHER:** _____

19. **OTHER TESTS PERFORMED AND FINDINGS:** _____

Re-Exams

		A	B	C
15.5	0	☐	☐	☐
	1	☐	☐	☐
	2	☐	☐	☐
	3	☐	☐	☐
15.6	0	☐	☐	☐
	1	☐	☐	☐
	2	☐	☐	☐
	3	☐	☐	☐
15.7	0	☐	☐	☐
	1	☐	☐	☐
	2	☐	☐	☐
	3	☐	☐	☐
TOTAL				

20. **TREATMENT PLAN, REFERRALS, RECOMMENDATIONS:**

21. **AUTHORIZATION(S) REQUESTED FOR:**

22. **EXAMINER INFORMATION:** (Physician's Name, Address and Telephone Number)

PHYSICIAN'S SIGNATURE/DATE

Re-Exams

A. PHYSICIAN'S SIGNATURE/DATE

B.

C.

DIVISION OF WORKERS' COMPENSATION PSYCHIATRIC EXAMINATION GUIDELINE OUTLINE

THIS DICTATION AIDE IS TO BE USED WHEN COMPLETING YOUR NARRATIVE REPORT. CONSULT EXPANDED PSYCHIATRIC EXAMINATION GUIDELINE FOR DETAILS. THIS FORM MAY BE PHOTOCOPIED AND USED TO TAKE NOTES ON FRONT AND BACK.

I. Identifying Data

Claimant Name: _____
Date _____
Social Security Number _____
Claim Number _____
Date of Injury: _____
Date of Birth: _____ Age _____ Sex _____
Employment Status: (working, unemployed, retired) _____
Job Title & Occupation (current): _____
Job Title & Occupation (when injured): _____
Employer Name & Location: _____
Marital Status: (S M W D Sep) _____
Parental Status: _____
Ethnic Origin: _____
Date of Examination _____

II. Consent

III. Chief Complaint

IV. History of the Present Illness

A. Describe in detail the claimant's job on which he was injured.

B. A detailed history of the accident or injury must be obtained.

C. Describe the treatment claimant received for all physical problems.

D. Present Condition and Complaints

1. Catalog all physical and mental symptoms and conditions.

2. Date of onset of each symptom, its chronology, intensity, frequency, fluctuation.

3. Describe any somatic complaints

4. Describe any changes in sleep, dreams, appetite, weight, energy, interest, libido, sexual activity, mood, concentration, memory, thinking, behavior.

5. Claimant's perception of his/her present mental and physical states.

E. Describe how psychiatric symptoms relate to work capability.

F. If not working due to symptoms, explain why.

G. Have there been any attempts to return to work? Describe.

H. Explore prior work injuries to same area of body as above.

I. Catalog all previous psychiatric evaluations.

J. Current psychiatric treatment, if any, when it began, for what?

K. Past psychiatric history & hospitalizations & outpatient Rx.

L. Describe any current medical conditions or problems.

M. List all medications currently being prescribed or used including OTC.

N. Describe contacts with rehabilitation agencies & results.

V. **Personal History**

A. Use and abuse of alcohol, street drugs, tobacco, caffeine;

B. Misuse of Prescription Drugs.

C. Source of income (Job, Workers' Compensation Fund TTD, % award, Social Security.)

D. Living arrangements; with whom, where (rural, city, town).

E. Mode of transportation (driving?).

F. Activities of Daily Living:

1. Postures, travel, hand function, ambulation, personal hygiene, lifting?, bathroom, feeding, dressing; Duration of sitting, standing, walking, riding.

2. What are claimant's routine activities, daily responsibilities?

3. How much daily time is up and about versus lying down?

4. How much of a typical day or week is devoted to health care?

G. Describe any pending litigation.

H. Patient's life circumstances at the time of injury, pre-morbid.

1. Hobbies, trips, shopping, sex, community activities, clubs, groups, recreation, sports, relaxation, leisure activities

2. Socialization (with: relatives, friends, civic, fraternal)

I. How illness has affected life activities and personal relations.

1. Restrictions or changes of items in #H.

2. Current typical personal, household and family activities.

VI. **Review of Systems: General, neurological, organ system review**

VII. **Past Medical History**

A. Hospitalization(s) including date(s), diagnosis & duration.

B. Significant Childhood Illnesses & Pre-natal history, if pertinent.

C. Long standing medical conditions, handicaps or disabilities.

D. Work-related Accidents, Injuries, periods of disability, outcome.

E. Non-work-related Accidents, Injuries, periods of disability,

F. Other illnesses requiring a physician's attention.

G. Head Injury? Period of unconsciousness? Amnesia? seizures?

H. Significant Toxic Metal or Chemical Exposure? (Ever overcome by fumes or gases?)

I. History of being assaulted, robbed or raped?

VIII. Developmental History and History of Family of Origin

A. National heritage, place of birth, where raised, by whom?

B. Family History of Mental Illness, suicide, alcohol or drug abuse

C. Quality of home life in childhood; harmony, sharing, love, versus strife, trauma, parental divorce, deprivation, neglect, child abuse (physical/sexual/emotional.)

D. Parents; age, occupation, mental and physical health status.

E. Siblings; age, occupation, mental and physical health status.

F. Determine the quality of intimate life relationships in the family.

G. Childhood emotional or behavioral indicators?

IX. Social History

A. Education

1. Age at entry, type of school
2. Problems starting school (school phobia, anxiety)
3. Specify highest grade achieved; current pursuit of study.
4. Grade point average in school?
5. Any learning problems, special education?
6. Any grades (years) repeated?
7. Attendance, drop out? (why?)
8. Extracurricular, sports, music, clubs
9. Awards, honors
10. Skills developed (can read, write, calculate?)
11. Behavioral difficulties? (discipline problem, hookey, fighting, suspended)

B. Peer relations - quality & quantity now & pre-morbid at school

C. Legal History - legal problems, arrests, convictions, jail

D. Financial History - financial resources, difficulties, bankruptcy

E. Religious - type of church, level of involvement

F. Military Service

1. Dates of Service, branch, rank, special training, duty title.

2. Ever rejected from military service, disciplinary problems.

3. Awards, honors, citations.

4. Any medical, physical, mental or behavioral problems while in.

5. Type of discharge, diagnosis if medical discharge, disability.

G. Marital and Current Family History

1. List each marriage with date married separated or divorced

2. List all children and their ages, health status, adjustment

3. Current spouse's age, health status and occupation.

4. Current and pre-morbid marital adjustments of sex, power,

5. Quality of marital or significant relationship - Any spousal physical, mental, or sexual abuse?

6. Quality of parenting, sense of family obligations.

X. Occupational History

A. List all jobs held with job title, duties, and performance.

B. List any periods of unemployment or underemployment.

C. Career trajectory - normal progression, steady or spotty.

D. Attitudes toward work; attendance, advancement, raises,

E. Job stresses (racial or sexual harassment, hassles)

F. Job skills - marketable current skills, transferable skills

G. Job conflicts; relations with authority, peers, fired,demoted.

H. Ambitions, vocational plans, current job and feelings.

I. Claimant's perception of his work performance prior to injury.

XI. MENTAL STATUS

A. General Description: Height _____ Weight _____ Handedness _____

1. Arrival & Punctuality

a) How patient arrived at the examination (alone; accompanied)

b) On time, early, late; missed and rescheduled

2. Appearance: Posture, demeanor, nutritional status, build, size, clothes, grooming/hygiene, signs of anxiety

3. Level of Consciousness: alert, hypervigilant, clouded, confused

4. General Behavior: appropriate, compulsions, odd, irrelevant

5. Psychomotor Activity: Gait, posture, (erect, relaxed, tense),

B. Attitude toward self/examiner/situation:

1. Self aggrandizement/depreciation/loathing/grandiosity

2. Rapport/eye contact/ability to relate (empathy, emotional distance)

3. Interpersonal relations - candor, openness; defensive, guarded

4. Insight (Degree of awareness and understanding that he is ill) None, Slight or Fair, Moderate, Good to Excellent

5. Attitudes toward body (disfigurement reactions?)

6. Attitudes toward the future (plans, work, disability, retirement)

7. Attitude toward family, significant others

8. Motivation - symptom relief, rehab, money, revenge

9. Reliability: Veracity, dissimulation, minimizing, exaggeration

C. Voice & Speech Characteristics: Relevant, coherent; pressure, speed

D. Language Skills: read, write, speak, spell, comprehension,

E. Mood, Feelings and Affect:

1. Mood (a pervasive and sustained emotion); depth, intensity, duration

2. Affect (the feeling tone attached to the thought): Amount, Range, Mobility, Appropriateness, Communicability

F. Cognition:

1. Orientation - Time, Place, Person, Situation

2. Attention and Concentration - Attention, Concentration, Distractibility

3. Perception & disturbances
Hallucinations and illusions, Depersonalization and derealization

4. Thought processes and Associations - Stream of thought, Productivity, Organization and Continuity of thought, Language impairments and Distortions

5. Content of thought
Themes and Preoccupations, Violence potential

6. Thought disturbances (contact with reality)
Delusions, Ideas of reference and ideas of influence

7. Abstract thinking - Disturbances in concept formation

8. General Fund of Information (Common Sense Knowledge Base)

9. Calculating Ability - add, subtract, multiply and divide

10. Intellectual Functioning - estimated IQ range

11. Memory - Impairment, efforts made to cope with impairment Remote memory, Recent past memory, Recent memory, Immediate retention and recall, Effect of

defect on patient

12. Special Cognitive Exams in suspected Organicity: Cortical Sensations, Frontal Lobe tests, Constructional ability, Apraxia determination, Agnosia determination

G. Impulse control: How well is patient able to control strong emotions?

H. Conscience and Values: level of development

I. Judgment: appropriate or inappropriate in social relations, Social judgment, Test judgment in contrived situations

XII. Other Tests Given or Ordered by Examiner

Physical Examination, Laboratory Data, Medical Imaging, Additional Interviews, Psychological Testing

XIII. Review of Medical and Other Records

A. Summarize pertinent data to be used in conclusions

B. Review records from a variety of sources:

XIV. Diagnosis Axis I through V

Describe any complications accompanied by the diagnosis Partial Remission, Full Remission, Recovered, Residual State. Include severity ratings of the disorders (Mild, Moderate, Severe)

XV. Assessment, Conclusions, Opinions, and Report Preparation

Thorough, complete, yet succinct, clearly written and logical. Report must contain the evidence on which the conclusions and opinions were based. There should be a separation of observations and historical facts from opinion by the psychiatrist. Explain your reasoning and the facts backing up your opinions. Don't just offer opinions or conclusions without explanation. Answer all questions posed by the referral source.

A. Does the claimant have (a) mental disorder(s)?

B. Give your opinion on the cause of the disorders found.

1. Caused by injury, trauma, or stress at work; injury, trauma or stress unrelated to work.

2. Aggravated by injury or injury contributes to prolongation or intensity.

3. Consider causation by examining various known factors.

C. Is claimant temporarily and totally disabled?

D. Has the claimant reached maximum degree of medical improvement?

E. Does the claimant have any permanent psychiatric impairment?

1. If yes, explain the impact of the psychiatric condition(s) on work efficiency and normal pursuit of everyday life activities.

2. If yes, what is the percentage impairment from each condition?

3. What is the combined total whole man psychiatric impairment?

4. Explain what percentage is due to work-related causes and what percentage is due to non-work-related causes. : Exaggeration and minimization factors, "coaching"

5. Allocate the percentage attributable to each injury

6. Is the impairment from any cause expected to be progressive?

7. Does the psychiatric condition itself permanently preclude gainful employment in the old job or other similar job or one claimant has performed in past?

8. Don't rate if no psychiatric treatment due to refusal.

9. Don't rate if treatment was incompetent or inadequate

10. Don't rate if malingering is suspected or confirmed.

XVI. Recommendations

A. Further examinations, consultations or re-examinations required.

B. Psychiatric Treatment and rehabilitation recommendations

XVII. Comments

XVIII. Signature Block with degree

I. Identifying Data

Claimant Name: _____
Date _____
Social Security Number _____
Claim Number _____
Date of Injury: _____
Date of Birth: _____ Age _____ Sex _____
Employment Status: (working, unemployed, retired _____
Job Title & Occupation (current): _____
Job Title & Occupation (when injured): _____
Employer Name & Location: _____
Marital Status: (S M W D Sep) _____
Parental Status: _____
Ethnic Origin: _____
Date of Examination _____

II. Consent

Explain to claimant the nature and purpose of the examination: that the examiner is a psychiatrist; that the examination is for the West Virginia's Division of Workers' Compensation; who referred the claimant (Commissioner, claimant or defense attorney); the lack of confidentiality in the exam with no "off the record" comments; that a written report will be issued to the referring party and that the case may come to litigation; at which time the examiner may have to testify about the case; that the examiner will not be treating the claimant and will not be referring the claimant directly for any treatment; and that the examiner will provide no conclusive opinion or recommend treatment by others directly to the claimant; that no physician-patient relationship will be established.

III. Chief Complaint

What bothers the claimant the most at this point in time in his/her own words?

IV. History of the Present Illness

Chronological background and development of the symptoms or behavioral changes culminating in the present state. Focus on change that occurred in the claimant and to see if that change was a result of any work-related event. Have symptoms developed because of work or would they have occurred anyway?

A. Describe in detail the claimant's job on which he was injured or became ill, his or her work role and function, hours or shifts worked, tasks performed, how well the claimant performed the job and how he or she liked the job, how claimant got along with coworkers, supervisors, subordinates (did he/she get along with anyone on the job?), special areas of satisfaction and dissatisfaction on the job. Any other simultaneous job (moonlighting).

B. A detailed history of the accident or injury must be obtained, with an emphasis on the person's thoughts and feelings and reactions to the injury. Both structured and unstructured time during the interview should be provided. Inquire about the claimant's mental and physical state just prior to the injury. Was he or she under medical care then? Provide a detailed history of the injury process. Include what the claimant was doing at work, stress factors, safety measures, how the injury took place, what parts of the body were injured, what immediate treatment was rendered and when. Obtain a full description of the event or events to which the claimant attributes the onset of the injury or illness.

C. Describe the treatment claimant received for all physical problems, including outpatient, hospitalizations and operations. Explore patient's reaction to the treatment process, surgery, and recovery. Did claimant feel his or her complaints were accepted, rejected or dismissed?

D. Present Condition and Complaints - preferably in patient's own words. If that is not possible, indicate who supplied the information. Include:

1. Catalog all physical and mental symptoms and conditions of which claimant is complaining at present. Determine which of these are attributed by the claimant to work-related causes and which to other causes.

2. Date of onset of each symptom, its chronology, progression, regression, duration, ameliorating, precipitating and aggravating factors and current status, including intensity (minimal, slight, moderate, marked), frequency (intermittent <25% of time, occasional 25% to 50%, frequent 50 to 75% and constant 75%+), and fluctuation. Did symptoms develop suddenly or gradually over time? When did symptoms become stable, if applicable.

3. Describe any somatic complaints, and relationship, if any between physical and psychic symptoms.

4. Describe any changes in sleep, dreams, appetite,

weight, energy, general interest level, libido, sexual activity (present and past function, arousal and satisfaction), mood/spirits, concentration, memory, thinking and behavior.

5. Claimant's perception of his/her present mental and physical states (getting better, getting worse, staying the same). List all sources of stress currently operating in claimant's life and why.

E. Describe how psychiatric symptoms relate to work capability.

F. If not working due to symptoms;

1. Under what circumstances did the claimant cease working.

2. How do symptoms and problems prevent return to work.

3. Why does the claimant feel incapable of working.

G. Have there been any attempts to return to work? Describe. What were the circumstances? What was the outcome? What work plans does claimant have? Under what circumstances would claimant work?

H. Explore prior work injuries to same area of body as above.

I. Catalog all previous psychiatric evaluations.

J. Current psychiatric treatment, if any, when it began, for what reason, what does it consist of, who does it, and its effects on:

1. Symptoms

2. Claimant's ability to return to work

K. Past psychiatric history & hospitalizations & outpatient treatments, as well as dates, diagnosis & duration, and effectiveness. Include marital and family counseling, and visits with any mental health professional.

L. Describe any current medical conditions or problems.

M. List all medications currently being prescribed or used including OTC, dosage, how they are taken, and any side effects. Describe those taken during the 24 hours before the examination and especially the day of the exam.

N. Describe contacts with rehabilitation agencies & results. What specific efforts has the claimant made to better his/her condition?

V. Personal History

A. Use and abuse of alcohol, street drugs, tobacco, caffeine; amount, frequency, effects. History of unexplained falls, Emergency Room visits for contusions and bruises.

B. Misuse of Prescription Drugs – excessive use, non-compliance

C. Source of income (Job, Workers' Compensation Fund temporary total disability or percentage award, savings, spouse, long term disability policy, investments, Social Security, other passive income). Total current income and income prior to the injury. Any financial problems?

D. Living arrangements; with whom, where (rural, city, town), type of domicile (apartment, house, trailer).

E. Mode of transportation (driving?).

F. Activities of Daily Living:

1. Postures, travel, hand function, ambulation, personal hygiene, bathroom, feeding, dressing, attention to personal appearance? Note capacity to lift, and duration of walking, standing, sitting and riding.

2. What are claimant's routine activities, daily responsibilities?

3. How much daily time is up and about versus lying down?

4. How much of a typical day or week is devoted to health care?

G. Describe any pending litigation.

H. Patient's life circumstances at the time of injury, pre-morbid functioning in terms of temperament, mood, activities, interests.

1. Hobbies, trips, shopping, sex, community activities, work, clubs, groups, church, sports, recreation, relaxation, leisure.

2. Socialization (with: relatives, friends, civic,

fraternal, community or professional organizations)

I. How illness has affected life activities and personal relations.

1. Restrictions or changes of items in #H

2. Current typical personal, household and family activities (exercise, cooking, cleaning, shopping, parenting, household management, finances, yard & garden work, maintenance work around the house). Level of satisfaction from activities.

VI. Review of Systems

Neurological symptoms – seizures, headaches, problems with sensory, motor, coordination, special sense.
General symptoms; organ system review

VII. Past Medical History

A. Hospitalization(s) including date(s), diagnosis & duration.

B. Significant Childhood Illnesses & Pre-natal history, if pertinent.

C. Long standing medical conditions, handicaps or disabilities.

D. Work-related Accidents, Injuries, periods of disability, outcome.

E. Non-work-related Accidents, Injuries, periods of disability outcome.

F. Other illnesses requiring a physician's attention.

G. Head Injury? Period of unconsciousness? Amnesia? seizures?

H. Significant Toxic Metal or Chemical Exposure? (Ever overcome by fumes or gases?)

I. History of being assaulted, robbed or raped?

VIII. Developmental History and History of Family of Origin

A. National heritage, place of birth, where raised, by whom?

B. Family History of Mental Illness, suicide, alcohol or drug

abuse, physical or mental disability

C. Quality of home life in childhood; harmony, sharing, love, easy, mutuality, stability versus conflict, trauma, strife, moves, family upheavals, disrupted relationships, early loss of significant figure, parental divorce, home loss, desertion, substance abuse, promiscuity, legal or financial problems, poverty, child labor, neglect, deprivation, child abuse (physical or sexual) or exploitation.

D. Parents; age, occupation, mental and physical health status or cause of death & age, current relationship with claimant. Parental marriage intact during formative years or age of claimant when divorce occurred.

E. Siblings; age occupation, mental and physical health status or cause of death & age, current relationship with claimant. Birth rank of claimant.

F. Determine the quality of intimate life relationships beginning with the family of origin. Attitudes and feelings about family members, quality of current relationships.

G. Childhood emotional or behavioral indicators? (enuresis, thumb sucking, sleepwalking, temper tantrums, hyperactivity, attention span problems, fears, anxiety, tics, habits, aggressiveness,antisocial or conduct problems, being a loner, shyness).

IX. Social History

A. Education

1. Age at entry, type of school (public, private, parochial, alternative or "special")

2. Problems starting school (school phobia, anxiety)

3. Specify highest grade achieved; current pursuit of study (if applicable), special training, certification or licenses. Vocational or technical training.

4. Grade point average in school?

5. Any learning problems, special education?

6. Any grades (years) repeated?

7. Attendance, drop out? (why?)

8. Extracurricular, sports, music, clubs

9. Awards, honors

10. Skills developed (can read, write, calculate?)

11. Behavioral difficulties? (discipline problem, hookey, fighting, referral to counselor or principal, suspended or expelled).

B. Peer relations – quality & quantity now & pre-morbid at school, work, neighborhood. Friendships in childhood, adolescence and adulthood.

C. Legal History – legal problems, arrests, convictions, periods of incarceration, litigation, Driving Under the Influence, previous workers compensation claims

D. Financial History – financial resources, difficulties, bankruptcy

E. Religious – type of church, level of involvement

F. Military Service

1. Dates of Service, branch, rank, special training, duty title, where stationed, combat?

2. Ever rejected from military service, disciplinary problems; court martial, nonjudicial punishment (article 15 or Captain's Mast), reduction in rank (busted).

3. Awards, honors, citations.

4. Any medical, physical, mental or behavioral problems while in Service, ever treated at a Veterans Hospital?

5. Type of discharge, diagnosis if medical discharge, any military connected disability awards and if so the percentage.

G. Marital and Current Family History

1. List each marriage with date or age married separated or divorced (why?) or widowed

2. List all children and their ages, health status, adjustment in school, neighborhood and home; any legal or drug problem.

3. Current spouse's age, health status and

occupation.

4. Current and pre-morbid marital adjustments of sex, power, sharing, duties, finances, household, work, in-laws, roles.

5. Quality of marital or significant relationship: characterized by sharing, collaborative, compatible, smooth versus separations, strife, problems, role conflicts. – Any spousal physical, mental, or sexual abuse?

6. Quality of parenting, sense of family obligations. Paying child support?

X. Occupational History

A. List all jobs held with job title, duties, and performance in each, length of each, and why left.

B. List any periods of unemployment or underemployment & explanations.

C. Career trajectory – normal progression, steady or rapid advancement or frequent job changes, early peak and decline, spotty employment, fragmented progress, discontinuity

D. Attitudes toward work; attendance, advancement, raises, and promotions, transfers.

E. Job stresses (racial or sexual harassment, hassles)

F. Job skills – marketable current skills, transferable skills

G. Job conflicts; relations with authority, peers and subordinates, ever demoted or fired.

H. Ambitions, vocational plans, current job and feelings about it.

I. Claimant's perception of his/her work performance prior to injury and subsequently.

XI. MENTAL STATUS

Sum total of the examiner's observations and impressions derived from the complete examination process plus specific cognitive tests.

A. General Description

1. Arrival & Punctuality

   a) How patient arrived at the examination (alone; accompanied – Friend, Family, Other, drove self, public transportation, brought by other)

   b) On time, early, late; missed and rescheduled

2. Appearance: Posture, demeanor, nutritional status, build, state of health, appeal
   Size – Height _____ Weight _____
   Handedness _____ Clothes – seasonable, neat, drab, soiled, decorative
   Grooming/Hygiene – clean, good, dirty (body, hands, nails), needs shave, needs bath
   Signs of anxiety, shifts in level of anxiety

3. Level of Consciousness: alert, hypervigilant, clouded, confused, lethargic

4. General Behavior: appropriate, compulsions, odd, irrelevant, embarrassing, impulsive;
   Response to the lengthy examination process – how claimant responds to fatigue, stress of exam.

5. Psychomotor Activity: Gait, posture, (erect, relaxed, tense), mannerisms, facies, tics, gestures, twitches, stereotypes, echopraxia, clumsy, agile, limp, rigid, retarded, hyperactive, hand wringing, picking, agitated, combative.

B. Attitude toward self/examiner/situation:

1. Self aggrandizement/depreciation/ loathing/grandiosity

2. Rapport/eye contact/ability to relate (empathy, emotional distance)
   Cooperative, attentive, interested, frank, seductive, defensive, hostile, playful, ingratiating, evasive, guarded, paranoid

3. Interpersonal relations – candor, openness, disclosure versus defensiveness, guarded, resistive, suspicious; Basic attitudes.

4. Insight (Degree of awareness and understanding the patient has that he/she is ill)

   a) None – complete denial of mental illness,

doesn't see self as sick or troubled.

b) Slight or fair – awareness of being sick and needing help, sees some aspect of the problem, but with an outside locus of control (blames it on others, on external factors, or organic factors.)

c) Moderate – recognizes self as ill, troubled and to some degree his or her part in it, awareness that illness is due to something unknown in himself or herself.

d) Good to excellent – recognizes self as ill, his or her own contribution to it and the recognition of need for assistance.

5. Attitudes toward body (disfigurement reactions?)

6. Attitudes toward the future (plans, work, disability, retirement)

7. Attitude toward family, significant others

8. Motivation – symptom relief, rehab, monetary compensation, revenge, dependency gratification, retirement

9. Reliability: Estimate of examiner's impression of patient's veracity or ability to report his situation accurately, any dissimulation, minimizing, exaggeration, malingering. Varies from: truthful, reliable, partly reliable, unreliable, lies, distorts, fabricates, vague, skirts the issues, confuses, smoke screen effect.

C. Voice & Speech Characteristics:
Relevant, coherent, intensity, pitch, ease, spontaneity, productivity, pressure, fluency, melody, retardation, rapid, slow, hesitant, emotional, monotonous, loud, whispered, slurred, mumbled, stuttering, echolalia, manner, reaction time, vocabulary.

D. Language Skills: read, write, speak, spell, comprehension, naming, word finding

E. Mood, Feelings and Affect:

1. Mood (a pervasive and sustained emotion that colors the person's perception of the world): How does the patient say he feels; depth, intensity, duration and fluctuations of mood –

eurythmic or neutral, calm, angry, anxious, depressed, despairing, irritable, anxious, terrified, angry, expansive, euphoric, empty, guilty, fearful, disgust, awed, futile, self-contemptuous, anhedonic.

2. Affect (the feeling tone attached to the thought):
Amount of Affective expression
Range (broad, constricted or shallow, fixated, blunted or flat)
Mobility (restricted, not smooth, sudden & inexplicable, hyperability)
Appropriateness (incongruity with facies, posture, gestures, speech or thought content, the culture, the setting of the exam)
Examples if emotional expression is not appropriate:
Communicability (empathy)
Difficulty in initiating, sustaining, or terminating an emotional response.

F. Cognition:

1. Orientation

a) Time – Does patient identify the date correctly, can he/she approximate date, time of day, does patient behave as though he/she is oriented to the present?

b) Place: Does patient know where he/she is.

c) Person: Does patient know who the examiner is; does he/she know the roles or names of the persons with whom he is in contact.

d) Situation: Does the patient understand what is going on around him/her?

2. Attention and Concentration

a) Attention – (focusing, maintaining, shifting); inattentive, hyperalert, selective attention.

b) Concentration – digit span forward & backward, serial seven subtraction

c) Distractibility

3. Perception & disturbances

a) Hallucinations and illusions: Does patient hear voices or see visions; content, sensory system involved, circumstances of the occurrence; hypnogogic or hypnopompic hallucinations.

b) Depersonalization and derealization: Extreme feelings of detachment from one's self or the environment.

4. Thought processes and Associations – Stream of Thought
Use Quotations from patient

a) Productivity: Excesses or overabundance of ideas, deficiencies or paucity of ideas, rapid thinking, slow thinking, hesitant thinking; does patient speak spontaneously or only when questions are asked.

b) Organization and Continuity of thought: Do patient's replies really answer questions; are they goal directed and relevant or irrelevant; are there loose associations; is there a lack of cause-and-effect relationships in the patient's explanations; are statements illogical, tangential, circumstantial, rambling, evasive, preservative, thought blocking (for a sample, ask claimant to detail how he got to the office)

c) Language impairments and Distortions: Impairments that reflect disordered mentation, such as incoherent or incomprehensible speech (word salad), clang association, neologisms.

5. Content of thought

a) Themes and Preoccupations – about the illness/injury, environmental problems; obsessions, plans, intentions, hypochondriacal symptoms.

b) Violence potential toward self, others, property recurrent ideas about suicide, homicide (toward whom) specify intensity, means, method and plan specific antisocial urges

6. Thought disturbances (contact with reality)

   a) Delusions: Content of any delusional system, as to its validity, how it affects his life; somatic delusions - isolated or associated with pervasive suspiciousness; mood-congruent delusions-in keeping with a depressed or elated mood; mood in-congruent delusions-not in keeping with the patient's mood; bizarre delusions, such as thoughts of being controlled by external forces or thoughts being broadcast out loud.

   b) Ideas of reference and ideas of influence: How ideas began, their content, and the meaning the patient attributes to them.

7. Abstract thinking: Disturbances in concept formation; manner in which the patient conceptualizes or handles his ideas; similarities, differences, absurdities, meanings of simple proverbs such as: "A rolling stone gathers no moss"; answers may be concrete (giving specific examples to illustrate the meaning) or overly abstract (giving generalized explanation); appropriateness of answers should be noted.

8. General Fund of Information (Common Sense Knowledge Base)
   Current political figures (President, Vice President, Governor), temperature water freezes, metal attracted to a
   magnet, time of day ones shadow is shortest, number of weeks in a year.

9. Calculating Ability - add, subtract, multiply and divide single and double digits, written complex arithmetic, making simple and complex change.

10. Intellectual Functioning: Estimation based on patient's level of formal and self-education, vocabulary, calculation, general knowledge, questions that have some relevance to the patient's educational and cultural background, and whether he/she is capable of functioning at the level of his/her basic endowment.
    Clinical screening instruments such as Rapid Approximate IQ Test

11. Memory: Impairment, efforts made to cope with impairment denial, confabulation,

D. Additional Interviews (with family, employer, coworker, other) An interview with a family member can be quite helpful. Claimants are frequently accompanied by the spouse. The family member can confirm or refute the presence of symptoms complained of and describe other symptoms not mentioned and provide helpful background information.

An interview with a job supervisor or coworker can also help put the whole story in perspective. The person's behavior prior to the injury is extremely important and by getting information from family members and supervisors, the built-in bias of each can be counterbalanced.

E. Psychological Testing (may include separate report) Psychological testing should be a part of every initial workup of a claimant to provide a comprehensive view of his mental, intellectual, emotional and personality functioning. Obtain neuropsychological testing in cases of head trauma, brain injury from toxins, chemicals, COPD

(Consult separate West Virginia Division of Workers' Compensation Psychiatric Evaluation Guidelines)

XIII. Review of Medical and Other Records

A. Summarize pertinent data to be used in conclusions; note overview of issues, contradictions between records, questions raised by the records and assess credibility of various data. Review for evidence of either frank psychiatric symptoms or evidence of mental symptoms, problems, "overlay", or problems noted by examining or treating physicians. Look for evidence of discrepancy between the claimant's level of pain complaints and dysfunction and the objective medical findings. Such discrepancies can alert the psychiatric examiner to consider either abnormal illness behavior, psychiatric condition or malingering as operative to explain the symptoms.

B. Review records from a variety of sources:

1. Examinations and treatments pertaining to the work-incurred illness or injury including hospital narrative summaries.

2. Pertinent medical contacts, examinations and treatments prior to the work-related event.

3. School, military, and prior employment and personnel records as available

4. Records of legal involvement; civil, administrative and criminal as available.

5. Reports of investigations and statements from employers, coworkers, and subordinates, and former ones as appropriate.

6. All past psychiatric and psychological examinations and treatment summaries.

7. Depositions taken of the claimant, treating and examining physicians, coworkers and employers involved in the claim or who were involved with the claimant in earlier legal actions.

8. Rehabilitation reports

XIV. Diagnosis

Axis I:
Axis II:
Axis III:
Axis IV:
Axis V:

Describe any complications accompanied by the diagnosis, any: Partial Remission (expectation that the person will fully recover or have a complete remission) or Full Remission (no longer any symptoms or signs of the disorder but need for continued evaluation or prophylactic treatment), or Recovered (No Mental Illness), or Residual State (little expectation of a complete remission or recovery in the next few years).

Include severity ratings of the disorders as follows:

Mild – Few, if any, symptoms in excess of those required to make the diagnosis AND symptoms result in only minor impairment in occupational functioning or in usual social activities or relationships with others.

Moderate – Symptoms or functional impairment between "mild" and "severe"

Severe – Several symptoms in excess of those required to make the diagnosis AND symptoms markedly interfere with occupational functioning or with usual social activities or relationships with others.

XV. Assessment, Conclusions, Opinions, and Report Preparation

The psychiatric examination report to the West Virginia Division of Workers' Compensation should be thorough,

catastrophic reaction, circumstantiality used to conceal deficits; whether the process of registration, retention, or recollection of material is involved.

a) Remote memory: Childhood data, important events known to have occurred when the patient was younger or free of illnesses, personal matters, neutral material.

b) Recent past memory: The past few months

c) Recent memory: The past few days, what did patient do yesterday, the day before; what did he/she have for breakfast, lunch, dinner (confirm with outside sources)

d) Immediate retention and recall - ability to repeat 4 linguistically dissimilar words after 5 & 10 minutes

e) Effect of defect on patient. Mechanisms patient has developed to cope with his/her defect such as confabulation or perseveration.

12. Special Cognitive Exams in suspected Organicity:

a) Cortical Sensations - Visual and Tactile double simultaneous stimulation, traced figures, stereognosis, atopognosis

b) Frontal Lobe tests - gait and posture reflex, paratonic rigidity or gegenhalten, grasp reflex, tonic foot response, sucking reflex, rooting reflex, palmomental reflex, motor impersistence, perseverations, visual pattern completion test, alternating motor patterns (Fist-palm-side test, fist-ring test, reciprocal coordination test)

c) Constructional ability - reproduction drawings, drawings to command, dressing apraxia.

d) Apraxia determination - limb-kinetic, ideomotor, buccofacial, whole body

e) Agnosia determination - objects, right-left,

visual, prosopagnosis, color anomia & agnosia, geographic disorientation

G. Impulse control: How well is patient able to control strong emotions (emotional continence); hostile, aggressive, sexual and amorous impulses; delay gratification and defer pleasure; tolerate stress and frustration, fear and anxiety.

H. Conscience and Values: level of development from primitive fear of punishment or selfish need to more altruistic concerns. Affirmative, flexible, reasonable, modulated, tolerant versus overstrict, punitive, bribed, defective, partial, inconsistent, prejudiced, bigoted, opinionated, power mad, overly competitive.

I. Judgment: appropriate or inappropriate in social relations, social principles, action and behavior, family relations, sexual relations, legal matters, financial matters, plans for the future.

1. Social judgment: Subtle behavioral manifestations that are harmful to the patient and contrary to acceptable behavior in the culture; does the patient understand the likely outcome of his/her behavior and is he/she influenced by this understanding; examples of impairment.

2. Test judgment in contrived situations: Patient's prediction of what he/she would do in imaginary situations; for instance, what he would do if they found a stamped, addressed letter in the street.

XII. Other Tests Given or Ordered by Examiner

A. Physical Examination

A limited physical examination is often revealing especially in terms of noting the area of injury, limitation of movement, scars or deformities that result and general physiological functioning. Blood pressure and pulse can be taken to not only assist in determining the physical status but to see the person's physiological responses and document anxiety reactions.

B. Laboratory Data

C. Medical Imaging (x-rays, MRI, CT)

complete, yet succinct, clearly written and logical in exposition. Pay attention to good organization, clarity, relevance and reasoning in your opinion. The basis of your opinions must be explicit and the report must contain the evidence on which the conclusions and opinions were based. All reasoning processes should be outlined to explain exactly how the particular conclusions were reached -

Do not leave out any missing links. Opinions must be couched in terms of "reasonable medical certainty" or "reasonable medical probability". Avoid terms such as "possibility", or other speculative or conjectural terms. Do not issue an opinion unless you feel conviction for it.

There should be a separation of observations and historical facts from opinion by the psychiatrist. Conclusions and opinions are needed. A report of opinion only, however, ("This claimant has Major Depression that was caused by his low back injury and it makes him permanently and totally disabled") is of no value to the reviewing medical claim disability specialists, attorneys and judges. Explain how the various parameters in the WVDWC Psychiatric Committee Impairment Rating Guide are affected by the psychiatric disorder.

Explain your reasoning and the facts backing up your opinions. Don't just offer opinions or conclusions without explanation. Answer all questions posed by the referral source. Note that in disputed claims, judges rely most on opinions in which the opinions conform most closely to the factual evidence in the record. The judge relies most on the psychiatrist who is most believable and logical, who presents the most thorough and persuasive reasoning, with integration of psychiatric knowledge with the clinical facts. Do not provide a lengthy report full of voluminous details giving the impression of thoroughness without the necessary adequately documented connecting logic.

Provide opinions on the genuineness, cause, severity, duration and extent of the psychiatric condition and impairment.

A. Does the claimant have (a) mental disorder(s)? Describe duration and patterns of mental disorders found. Why was the particular Axis I diagnosis made (what were the symptoms and signs that were found)?

B. Give your opinion on the cause of the disorders found and specifically any relation to work or injury.

    1. Caused by injury, trauma, or stress at work; injury, trauma or stress unrelated to work,

preexisting personality structure, or natural progression of a pre-existing disorder. If solely related to an injury, show a causal connection by time, and absence of other stressors. If multiple causation, trace each stressor.

2. Aggravated by injury or injury contributes to prolongation or intensity.

3. Consider causation by examining:

   a) What is the natural course of the disorder?

   b) What has been the course of the claimant's life up to the time in which he/she sustained the injury?

   c) Did the industrial stress or injury event contribute substantially to the formation of the mental disorder. Did the work situation play an active or positive role in causing the condition or were other non-industrial events the precipitating causes.

   d) Is the psychiatric disorder that has come to light after the industrial injury or stress all or in part the result of the industrial event or was there a preexisting disorder that was discovered by the industrial event rather than created by it (convenient focus).

   e) How would the claimant have been faring but for the injury or work-related event?

   f) What is the degree of susceptibility of the person in question to the type of stress involved (preexisting personality dysfunction, low IQ, learning disability, organic brain syndrome, genetics)

   g) Is the psychiatric diagnosis one usually seen after injury or work-related stress? (see protocol)

   h) Does the type of impairment involved tend to be caused by the disease/injury involved in the case?

   i) Note that termination of employment for

economic or any other reason, and unemployment and its attended stresses leading to a psychiatric disorder or impairment are not considered work-related psychiatric problems and hence not compensable.

C. Is claimant temporarily and totally disabled (unable to work due to psychiatric symptoms) at the time of the examination? (and therefore eligible for up to 208 weeks of benefits)

1. If yes, is the temporary disability due to effects of the compensable current injury or illness?

2. What is the anticipated period of continued disability?

3. Has the claimant reached maximum degree of medical psychiatric improvement, or stabilized at a level of functioning? Is he or she likely to improve, stay the same, or deteriorate? Explain the medical/psychiatric basis for any conclusion that the psychiatric condition has or has not become stabilized. If stabilized, it means that active treatment is not likely to cause improvement or that only maintenance treatment is needed, and that treatment is not likely to improve employability.

4. Does the claimant have any permanent whole man psychiatric impairment?

   a) If yes, explain the impact of the psychiatric condition(s) on work efficiency and normal pursuit of everyday life activities.

   b) Explain the medical/psychiatric basis for any conclusions that claimant is, or is not likely to:

      (1) Suffer sudden or subtle incapacitation as a result of the psychiatric condition.

      (2) Suffer injury or harm or further medical impairment by engaging in activities of daily living or any other activity necessary to meet personal, social and

occupational demands.

(3) Need restrictions or accommodations with respect to daily activities or any other activities that are required to meet personal, social and occupational demands. If needed, discuss their therapeutic or risk-avoiding value.

D. If yes, what is the percentage of whole man impairment from each psychiatric condition identified? What factors lead to the impairment rating rendered? How is the examiner judging the impairment? The Axis I Clinical Syndrome is the only diagnosis that would lead to a work-related impairment rating, after the condition has stabilized and the person has had significant attempts at psychiatric treatment. The Axis II diagnoses, which could include mental retardation, learning disability or personality disorders, would not be related to the injury or worsened by it. However, they are very likely to predispose the person to having a psychiatric clinical Axis I disorder post-trauma.

E. What is the combined total whole man psychiatric impairment?

F. Explain what percentage is due to work-related causes and what percentage is due to non-work-related causes.

1. Consider exaggeration and minimization factors

2. Consider the power of external influences, "coaching" by others (refusal to answer certain lines of questioning, low self-disclosure, bringing a tape-recorder, over-rehearsed phrases, etc.)

3. Consider level of communication, cooperativeness, resistance, hostility, guardedness and suspiciousness

G. Allocate the percentage attributable to each injury, if appropriate.

H. Is the impairment from any cause expected to be progressive?

I. Does the psychiatric condition itself permanently preclude gainful employment in the old job or other similar job or one claimant has performed in past?

J. If claimant has a psychiatric disorder caused by the injury, yet has never been treated for it, some attempt at treatment is usually warranted. If the claimant refuses non-intrusive, standard psychiatric care for a treatable condition likely to improve, then an impairment rating is not justified.

K. If treatment that has been rendered was incompetent or inadequate, no rating is to be done.

L. Do not rate if malingering is suspected or confirmed.

XVI. Recommendations

A. Further examinations, consultations or re-examinations required.

B. Psychiatric Treatment and rehabilitation recommendations

1. To relieve symptoms from the psychiatric condition

2. To restore normal functioning.

3. To enable claimant to return to work.

4. Type of psychiatric therapy recommended:

   a) Outpatient care versus hospitalization

   b) Medication

   c) Psychotherapy; individual, couple, family, group

5. Special Care – physical therapy, occupational therapy, pain center

6. Length of treatment needed, frequency and intensity

7. Prognosis of case with treatment;

   a) Claimant likely to get better (symptom relief and functional improvement expected from treatment) and will likely, probably, possibly or unlikely return to work.

   b) Remain the same (treatment to prevent deterioration; full or partial symptom relief only, without functional improvement expected)

c) Deteriorate (treatment to provide partial relief of symptoms for a deteriorating condition)

8. Any need for Vocational Assessment or Rehabilitation? If vocational rehabilitation is recommended, what effect would the psychiatric condition or medications used have on the rehabilitation process.

XVII. Comments

XVIII. Signature Block with degree

PSYCHOLOGICAL EXAMINATION GUIDELINES
DIVISION OF WORKERS' COMPENSATION

I. Purpose:

The purpose of the psychological assessment is to obtain a current view of the claimant's emotional and cognitive functioning, interpersonal relation- ships, and approach to tasks. Symptoms and behaviors must be sampled through interview techniques, checklists, and standardized psychological measurements. Long term personality traits and dysfunctions should be identified. Inferences should be made regarding motivation and dissimulation (faking). It is assumed that psychological assessments are comprehensive and not limited to the presentation of psychometric data. Even when part of an interdisciplinary team, the psychologist retains responsibility for recommending additional evaluations and interventions by other health care professionals as deemed necessary.

II. Guidelines:

The following are guidelines for psychologists to use when performing psychological evaluations for the Division of Workers' Compensation. It is assumed that all psychologists providing services for the Division of Worker's Compensation adhere to all relevant standards for practice as set forth by the American Psychological Association (Ethical Principles, Standards for Providers of Psychological Services, and Specialty Guidelines).

III. Initial Evaluation:

A: Intelligence Testing:

During the initial evaluation, a standard intelligence Test, such as the Wechsler Adult Intelligence Scale-Revised, should be administered. An intelligence screen should not be used during the initial evaluation. Behavioral observations of an individual in a structured testing environment is as important as the claimant's level of intellectual functioning. Therefore, such clinical observations should be provided. Also, all subtest scores as well as Verbal, Performance, and Full Scale IQ scores should be reported. This allows comparison of test results from one administration to another over time.

B: **Achievement Testing:**

Achievement testing, such as the Wide Range Achievement Test-Revised or the Peabody Individual Achievement Test, should be administered during the initial evaluation. Such tests are used to demonstrate that the claimant has the requisite reading skills to understand and reliably respond to objective measures of personality. They are also used to help determine whether the claimant might have a diagnosis of Learning Disability, for rehabilitation purposes.

C: **Personality Assessment:**

The type of personality instrument(s) to be used depends upon the claimant's intellectual capacities and reading level. Taped versions are acceptable when a claimant has an appropriate intellectual level but limited reading abilities. At a minimum, personality assessment should include tests that address not only acute and chronic symptoms of emotional disorders, but also longstanding personality characteristics. A measure of dissimulation should be included in the evaluation, unless clinically contraindicated. For example, low intellectual functioning may preclude the administration of tests which provide a measure of dissimulation (eg., MMPI). Personality assessment may include objective/projective personality measures, symptom checklists, and other instruments that meet accepted professional standards. Psychologists should also report a summary of raw data from objective personality testing. For example, a copy of the MMPI profile sheet or Welsh Code can be extremely helpful when other psychologists are comparing test results over time.

D: **Neuropsychological Screen:**

If a clinician wishes to address the issue of presence or absence of organic dysfunction in a claimant, then a neuropsychological screen is in order. If a screening is determined to be necessary, evaluate at a minimum, the following: attention and concentration, memory, judgment, language skills, and visual/spatial abilities.

E: **Comprehensive Neuropsychological Evaluations:**

When sufficient information is indicated by the results of a neuropsychological screen or by the claimant's history, a comprehensive neuropsychological evaluation consisting of accepted evaluation procedures should be used by a psychologist qualified and trained in neuropsychology. A psychologist qualified to interpret neuropsychological evaluations should document at least 500 hours of intensive training in administration and

interpretation supervised by a qualified neuropsychologist.

Current national standards for such supervising neuropsychologists suggest either intensive graduate course work and practica in assessment of brain function and extensive clinical supervision of such clinical activities, or a graduate degree in psychology and two years of full-time post-graduate supervised training in neuropsychology in a program specifically designed for such training.

F: Integrations of Findings:

A detailed report integrating all the data from observations, test responses and their interpretation, results of previous assessments and any other relevant data such as school records, rehabilitation reports, and medical findings should be prepared. Address any inconsistencies noted between behavioral observations and test responses or previous assessments.

IV: Reevaluations:

The examining psychologist should attempt to determine whether the claimant's level of intellectual functioning has previously been assessed.
The same test battery for intellectual functioning (eg., WAIS-R) should not be administered to a given claimant more than once in a six month period, unless otherwise justified. An example would be when the clinician judges that the previous intellectual assessment was of questionable validity due to other identifiable factors, such as severe depression, psychosis, or the influence of drugs or alcohol. The report of the intellectual results should address the potential effects of previous administrations of the same test upon the observed outcome of the current assessment. For instance, the literature suggests there is a learning effect for taking Standardized intellectual tests which can increase the measured level of intellectual functioning.

I. Principles of Law, or Regulation as Applicable to DWC Psychiatric Examinations, Impairment Ratings, Treatment and Rehabilitation

Confidentiality does not exist in any Doctor-Claimant treatment relationship due to the potential for or actuality of litigation.
Claimants or even potential claimants should be told by their treating or evaluating psychiatrist that no confidentiality exists and that anything brought up in the sessions could be put in a report or testified about in a hearing.

II. Professional Standards for Examiners

Examiners for the WVDWC are expected to adhere to professional standards of competent practice established by the State Licensing Boards, National Certifying Organizations and Professional Associations, and to Codes of professional, ethical, and legal conduct promulgated by these organizations. They must also follow rules and regulations of the WVDWC and applicable WV law. Clinical assessment procedures and measures utilized in forming an expert opinion must be generally accepted in the expert's scientific community. In forming his expert opinion, the examiner must use the standard of "Reasonable Medical Probability", meaning that the presence of the disorder, and the causation of the disorder by a work injury, disease or stress is "more likely than not."

III. General Principles

A psychiatric examiner should be an objective evaluator who has no conflict of interest and no prejudgment regarding the claimant's condition or the presence or absence of impairment. The examiner should not be a treating psychiatrist and vice versa.

A. Bias in an examiner is an inherent risk while performing these examinations and self-scrutiny is required to prevent or minimize it. Bias costs the WVDWC a lot of money because it leads to litigation, obstructs efficient care and fair settlement or compromise. One biased report begets another from

the other side, thus increasing litigation and prolonging recovery. Splitting the difference between the two biased reports does not lead to an accurate assessment or equitable resolution of the problem.

There is a tendency to identify with the referring sources who may subtly pressure for a favorable opinion or only selectively supply needed information (medical records, employment records, previous injuries, evaluations etc.). The examiner may develop a philosophical identification with workers or employers due to his or her own background, development and experiences. The examiner may assume in his or her mind the role of the trier of fact or dispenser of justice. Sibling rivalry or other competitive motivations may skew the examiner as he or she attempts to "outdo" another psychiatrist involved in the case. The examiner may become paralyzed with indecision or need for appearing unbiased such that no definite opinion is rendered. Favorable or unfavorable personal opinions about the claimant may enter the picture due to knowing the claimant or someone associated with the claimant.

Pro-Plaintiff evaluation biases:

1. Inadequate exam - lack of tracing of symptoms, no exploring of pre-existing conditions or non-work stresses.

2. Very pessimistic vocational prognosis early in a case which hasn't been treated or without scientific foundation or supportive evidence, proper diagnostic studies or a clear description of the factors that are causing the claimant's level of impairment.

3. Mixing of roles - both treating and evaluating the claimant.

4. Inappropriate legal advocacy.

5. Diagnoses that go beyond the capacity of the diagnostic tests that have been performed or without objective mental status or psychological test data to support them.

6. Sweeping statements as to disability from employment without a vocational expert assessment and no careful consideration of

limited duty possibilities, transferable vocational skills, job analysis, or even the potential impact of treatment.

7. "Pseudo-validating" a claim by the treating physician by means of "case building", whereby the physician provides a frequency and intensity of treatment not otherwise within the reasonable community standards for quality, cost-effective care.

8. Use of numerous medical eponyms and jargon that are not explained in the text of the report and that are not obvious to the reader.

9. Use of esoteric or pedantic terminology to ensure that the practitioner will be called upon for testimony, thus increasing his or her reimbursement for each case.

10. Use of conclusory terms and statements based on the unclear named tests that place controversial or nonspecific categorical terms in a high profile, using a false premise giving rise to a faulty conclusion.

Pro-Defense Evaluation Biases:

1. Routine discounting of the findings and opinions of even the most conscientious treating physicians.

2. The finding of No Basis to otherwise well-defined permanent impairment ratings.

3. Routine recommendations against treatment, contrary to the opinions of the primary treating physician and/or a consultant.

4. The examination does not lead to the same findings described by the treating physician, consultants, or other impartial observers.

5. Unsubstantiated generalizations and psychiatric judgments about a claimant and his or her motivation for involvement in the case.

6. Claimants perceive the examiner as cold, harsh, unpleasant, hostile, or biased manner in questioning.

7. A brief or cursory examination is often reported.

8. Routine overgeneralization of the conclusions of other doctors by further minimizing subtle positive or borderline findings.

9. Discounting objective findings that cannot be ignored.

10. Commenting skeptically or negatively on the competence and opinions of the treating physician.

11. Dodging specific issues or being vague about certain critical findings or treatment recommendations while surrounding these discussions with negative comments.
(adapted from Grudem)

B. Norms of recovery.
Recognize that recovery from psychiatric conditions usually leads to maximum degree of recovery in 6 months, except for brain damage or toxic exposures which can take 2 years or more.
Stabilization with static status of condition usually can be attained within three months.

C. Payment of Temporary Total Disability (TTD) for psychiatric cases.
Psychiatric impairment alone usually does not warrant payment of TTD. Exceptions would be for significant brain damage, psychosis, or severe depression requiring hospitalization.
The latter two frequently recover sufficiently to take them out of the TTD category within months.

IV. Definitions:

Work Injury-Related Psychiatric Disorders – Those psychiatric disorders caused by or aggravated by a work injury, disease or stress condition.

Causation, Legal Standard – "The fact of being the cause of something produced or of happening. The act by which

an effect is produced."
(That which produces or is the cause of a psychiatric condition and/or impairment)

Aggravation, Legal Standard – "The result of an act, action, or circumstance that intensifies or makes worse a medical condition; an unfavorable progression of the claimant's medical condition."

Apportionment – "The act of allocating, usually in terms of a percentage, between various causes, injuries or diseases."

Psychiatric Impairment – The loss of, loss of use of, or derangement of mental, emotional or brain functioning.

Disability – An administrative finding of the limiting loss or absence of the capacity of the individual to meet personal, social, or occupational demands, or to meet statutory or regulatory requirements.

Permanent Psychiatric Impairment – Impairment that is static or well stabilized with or without psychiatric treatment, or that is not likely to remit despite psychiatric treatment of the impairing condition.

Permanent Partial Psychiatric Impairment – Impairment that is assigned a percentage of impairment rating from the AMA "Guides To The Evaluation of Permanent Impairment."

Temporary Total Disability, Psychiatric – A psychiatric condition that in and of itself, or in combination with a physical condition, makes the claimant unable to function in the work setting.

Maximum Medical Improvement, Psychiatric (Stabilized Psychiatric Condition) – A disorder is stable when, after a period of time particular to that disorder, no further improvement is likely with or without treatment. This ranges from six months for functional disorders to two years for brain injury cases.

V. Conditions Likely And Unlikely to Be Related To Trauma or Work

The Following Classes of Disorders are frequently Diagnosed post-trauma:

A. Organic Mental Disorders

Organic Mental Disorders associated with Axis III

physical disorders
Delirium, Dementia, Organic Delusional Disorder, Organic Hallucinosis, Organic Mood Disorder, Organic Anxiety Disorder, Organic Personality Disorder, Organic Mental Disorder NOS

B. Mood Disorders

Depressive Disorders
Major Depression (single episode, recurrent)
Dysthymia Depressive Disorder NOS

C. Anxiety Disorders

Panic Disorder (with or without Agoraphobia)
Agoraphobia without Panic
Simple Phobia
Post-Traumatic Stress Disorder
Generalized Anxiety Disorder
Anxiety Disorder NOS

D. Somatoform Disorders

Conversion Disorder (Hysterical Neurosis)
Somatoform Pain Disorder
Undifferentiated Somatoform Disorder
Somatoform Disorder NOS

E. Adjustment Disorder (note: reaction has lasted no more than 6 months in most cases except when there is a chronic physical condition acting as a stressor)

with Anxious or Depressed Mood, Disturbance of Conduct, Mixed disturbance of Emotions and Conduct, Mixed Emotional Features, Physical Complaints, Withdrawal, Work or Academic Inhibition, NOS

F. Psychological Factors Affecting Physical Condition

G. Psychotic Disorders Not Otherwise Classified
Brief Reactive Psychosis

The Following Classes of Disorders are by definition developmental in etiology and/or are defects in structure or function and do not occur post-trauma. In the committee's opinion they are not caused by industrial injuries, diseases or stresses nor are they worsened or aggravated by them.

A. Disorders Usually First Evident in Infancy, Childhood or Adolescence:

Developmental Disorders
Mental Retardation
Pervasive Developmental Disorders (autism)
Specific Developmental Disorders (developmental arithmetic, expressive writing and reading disorders; developmenal articulation, expressive language and receptive language disorders; developmental coordination disorder)
Disruptive Behavior Disorders (Attention Deficit Hyperactivity, Conduct and Oppositional Defiant Disorders)
Anxiety Disorders of Childhood or Adolescence (separation anxiety, avoidant, and overanxious disorders)
Eating Disorders (anorexia Nervosa, Bulimia nervosa, pica, rumination disorders)
Gender Identity Disorders (Gender identity, transsexualism)
Tic Disorders (Tourette's, Chronic motor or vocal tic disorders)
Elimination Disorders (functional encopresis, enuresis)
Speech Disorders (cluttering, stuttering)
Other Disorders of Infancy, Childhood or Adolescence (elective mutism; identity, reactive attachment, stereotypy/habit and undifferentiated attention-deficit disorders)

B. Sexual Disorders

Paraphilias
Exhibitionism, Fetishism, Frotteurism, Pedophilia, Masochism, Sadism, Transvestic Fetishism, Voyeurism, Paraphilia NOS
(telephone scatologia, necrophilia, partialism, zoophilia, coprophilia, klismaphilia, urophilia)

C. Personality Disorders

Paranoid, Schizoid, Schizotypal, Antisocial, Borderline, Histrionic, Narcissistic, Avoidant, Dependent, Obsessive Compulsive, Passive Aggressive, NOS, Sadistic, Self-Defeating

The Following Classes of Disorders are rarely diagnosed post-trauma and in the committee's opinion are usually not caused or worsened by industrial injuries, diseases or stresses.

A. Organic Mental Disorders

Dementias Arising in the Senium and Presenium
Primary degenerative dementia of Alzheimer type, senile or presenile
Multi-infarct dementia
Senile and Presenile dementias NOS
Psychoactive Substance-Induced Organic Mental Disorders
Alcohol (intoxication, idiosyncratic intoxication, uncomplicated alcohol withdrawal, withdrawal delirium, hallucinosis , amnestic disorder, dementia associated with alcoholism)
Amphetamine (intoxication, withdrawal, delirium, delusional disorder)
Caffeine (intoxication)
Cannabis (intoxication, delusional disorder)
Cocaine (intoxication, withdrawal, delirium, delusional disorder)
\+ Hallucinogen (hallucinosis; delusional, mood, or post hallucinogen perception disorders)
\+ Inhalant (intoxication)
Nicotine (withdrawal)
* Opioid (intoxication, withdrawal)
Phencyclidine (PCP) (intoxication, delirium; delusional mood or organic mental disorders)
* Sedative, Hypnotic or Anxiolytic (intoxication, withdrawal, withdrawal delirium, amnestic disorder)
* Other or unspecified psychoactive substance (intoxication, withdrawal, delirium, dementia, hallucinosis; delusional, mood, anxiety, personality, or organic mental disorders)

B. Psychoactive Substance Use Disorders

Alcohol (dependence, abuse)
Amphetamine (dependence, abuse)
Cannabis (dependence, abuse)
Cocaine (dependence, abuse)
Hallucinogen (dependence, abuse)
Inhalant (dependence, abuse)
Nicotine (dependence)
* Opioid (dependence, abuse)
Phencyclidine (PCP) (dependence, abuse)
* Sedative, Hypnotic or Anxiolytic (dependence, abuse)
Polysubstance dependence
Psychoactive Substance dependence or abuse NOS

C. Schizophrenia (catatonic, disorganized, paranoid, undifferentiated, residual)

D. Delusional (Paranoid) Disorder (erotomanic,

grandiose, jealous, persecutory, somatic, unspecified)

E. Psychotic Disorders Not Elsewhere Classified

Schizophreniform Disorders
Schizoaffective Disorder
Induced (shared) psychotic Disorder
Psychotic Disorder NOS

F. Mood Disorders

Bipolar Disorders (Mixed, Manic, Depressed)
Cyclothymia
Bipolar Disorder NOS

G. Anxiety Disorders

Social Phobia
Obsessive Compulsive Disorder

H. Somatoform Disorders

Body Dysmorphic Disorder
Somatization Disorder

I. Dissociative Disorders

Multiple Personality Disorder
Psychogenic Fugue

J. Sexual Disorders

Sexual Dysfunctions (unless caused by a physical disorder caused by a work injury, or psychogenic only secondary to work stress, disease or injury). Not compensable if lifelong or acquired through other than compensable means.
Hypoactive sexual desire, sexual aversion disorder, sexual arousal disorders (female arousal, male erectile), Orgasm disorders (inhibited female or male orgasm, premature ejaculation), sexual pain disorders (dyspareunia,vaginismus), sexual dysfunction NOS
Sexual Disorder NOS

K. Sleep Disorders - unless there is an organic factor related to the compensable injury.

Dyssomnias; Insomnia, Hypersomnia, Sleep-Wake Schedule Disorder
Parasomnias; Dream Anxiety Disorder, Sleep Terror

Disorder, Sleepwalking Disorder, Parasomnia NOS

L. Factitious Disorders; With Physical Symptoms, Psychological Symptoms, or NOS

M. Impulse Control Disorders Not Elsewhere Classified

Intermittent Explosive Disorder
Kleptomania
Pathological Gambling
Pyromania
Trichotillomania
Impulse Control Disorder NOS

N. V Codes for Conditions Not Attributable to a Mental Disorder That are a Focus of Attention or Treatment

Academic Problem
Adult Antisocial Behavior
Borderline Intellectual Functioning
Childhood or Adolescent Antisocial Behavior
Malingering
Marital Problem
Parent-Child Problem
Other Interpersonal Problem
Other Specified Family Circumstances
Phase of Life or Other Life Circumstances Problem
Uncomplicated Bereavement

O. Late Luteal Phase Dysphoric Disorder

\+ = compensable if an industrial agent exposure occurs at worksite
* = compensable if iatrogenic via treatment for compensable injury

VI. Psychiatric Evaluations, and Reports:

Consult the accompanying WV DWC Psychiatric Standards Committee Examination Guide.

VII. WV DWC Psychiatric Standards Committee Impairment Rating Guide

This section reviews the problems with attempts at determining the amount of psychiatric impairment using existing national guidelines and presents a proposed method for the WV DWC Psychiatric Examiners to use.

The doctor is not authorized to fix the amount of disability. That is the responsibility and duty of the commissioner. (WV Code 23-4-6 IV B.)

In determining disability, the commissioner must give consideration to (WV Code 23-4-6 IV B.):

1. The impairment of the employee's earning capacity

2. The effect of possible impairment of his efficiency at work

3. The impairment to the normal pursuit of everyday living

The doctor does not have the education, training or experience to assist the commissioner in addressing the effect of the psychiatric condition on the the claimant's earning capacity. By giving a a percentage of medical or psychiatric impairment, however, the psychiatrist assists the commissioner in his task of assigning disability by showing the effect of the psychiatric disorder on the claimant's efficiency at work and his or her normal pursuit of everyday living.

No easy, efficient or workable rating system for psychiatric impairment to meet the WV law is in existence. What is available will be examined.

A. The AMA Guides To the Evaluation of Permanent Impairment, 3rd edition 1988 are geared mainly for Social Security claimants. They include four areas of functioning believed important to examiners for Social Security;

1. Activities of Daily Living

2. Social Functioning

3. Concentration, persistence and pace

4. Deterioration or Decompensation in work or work-like settings due to repeated failure to adapt to stressful circumstances.

"Activities of Daily Living" is defined by the AMA Guides to Evaluation of Permanent Impairment, 3rd edition, 1988, as: "activities such as self care and personal hygiene, communication, ambulation, attaining all normal living postures, travel, non-specialized hand activities, sexual function, sleep, and social and recreational activities." The appendix further explains:

	ACTIVITY	EXAMPLE
	Self care & Personal hygiene	Urinating, defecating, brushing teeth, combing hair, bathing, dressing oneself, eating
	Communication	Writing, typing, seeing, hearing, speaking
	Normal Living postures	Sitting, lying down, standing
	Ambulation	Walking, climbing stairs
*	Travel	Driving, riding, flying
	Nonspecialized hand activities	Grasping, lifting, tactile discrimination
*	Sexual function function	Having normal sexual and participating in usual sexual activity
*	Sleep	Restful nocturnal sleep pattern
*	Social and recreational activities	Ability to participate in group activities

Those activities preceded by "*" have significance for claimants having psychiatric disorders. Note that impairment in any of these areas is likely to be a combination of physical as well as mental symptoms. To use this system to rate impairment, one would have to somehow tease out the mental/emotional component.

Social Functioning, as defined by the AMA Guides, refers to an individual's capacity to interact appropriately and communicate effectively with other individuals. It includes the ability to get along with others, such as family members, friends, neighbors, grocery clerks, landlords, or bus drivers. Impaired social functioning may be demonstrated by a history of altercations, evictions, firings, fear of strangers, avoidance of interpersonal relationships, social isolation, etc. Strengths in social functioning may be documented by an individual's ability to initiate social contacts with others, communicate clearly with others, interact and actively participate in group activities, etc. Cooperative behaviors, consideration for others, awareness of other's feelings, and social maturity also need to be considered. Social functioning

in work situations may involve interactions with the public, responding appropriately to persons in authority, such as supervisors, or cooperative behaviors involving coworkers.

Concentration, persistence and pace are defined by the AMA Guides as referring to the ability to sustain focused attention sufficiently long to permit the timely completion of tasks commonly found in work settings. In activities of daily living, concentration may be reflected in terms of ability to complete tasks in everyday household routines. Deficiencies in concentration, persistence and pace are best observed in work or work-like settings. They caution that mental status examinations and psychological tests should NOT be used alone to accurately describe concentration and sustained ability to adequately perform work-like tasks. They suggest strongly the use of "work-evaluation programs" to assess this functional impairment.

Deterioration or decompensation in work or work-like settings refers to the individual's repeated failure to adapt to stressful circumstances. He or she may either withdraw from the situation or experience exacerbation of signs and symptoms of the mental disorder (decompensate) with accompanying difficulties in maintaining activities of daily living, social relationships, and/or maintaining concentration, persistence or pace. They speak of even the person having a deterioration of adaptive behaviors, whatever they are. They list stresses common to the worksite to include decisions, attendance, schedules, completing tasks, interactions with supervisors and peers.

Thus, out of the four major areas under consideration by the AMA Guides, two of them cannot be accurately determined by a clinical examination, but rather must be assessed by having the person in a "work-evaluation program" that simulates work.

In addition to the above four areas of prime consideration, the examiner is cautioned to stir in "special considerations" such as the effects of structured settings, effects of medication,
effects of rehabilitation, pain, motivation, and to note "controversial impairment categories", such as character disorders and substance abuse. These four areas of functioning then are to be evaluated using a guide that simply lists:

class 1 = no impairment

class 2 = mild impairment (impairment levels compatible with most useful function)

class 3 = moderate impairment (impairment levels compatible with some but not all useful function)

class 4 = marked impairment (impairment levels significantly impede useful function)

class 5 = extreme impairment (impairment levels preclude useful function)

The Guides do not say how to combine one's ratings in these four areas into a global class nor do they include an ordinal scale to convert the classes into percentages of impairment. In fact, they specifically caution that to attempt to do so is wrong –
"Translating these guidelines for rating individual impairment on ordinal scales into a method for assigning permanent impairments, as if the ratings were made on precisely measured interval scales, is not recommended." They further state that in the event a percentage rating is required, "It is important to remember that such judgments are based on clinical impression rather than on empirical evidence." They go on to define 100% impairment as a coma.

When one considers that clinically, a psychiatrist, even with the assistance of psychological testing, can only evaluate accurately two of the four areas considered by the Guides to be important, and that no real "system" of evaluation that translates into a percentage impairment is explained once these four areas are assessed, one has to conclude that the AMA Guides are essentially worthless for our purposes.

B. The level of impairment relating to efficiency at work could be determined using the California Workers' Compensation 8 work functions, which are as follows:

Work Function

1. Ability to comprehend and follow instructions.
   Consider ability to: maintain attention and concentration for necessary periods; understand written or oral instructions; do work requiring set limits, tolerances or standards.

2. Ability to perform simple and repetitive tasks.
   Consider ability to: ask simple questions or request assistance; perform activities of a routine nature; remember locations and work procedures.

3. Ability to maintain a work pace appropriate to a given workload.
   Consider ability to: perform activities within a schedule, maintain regular attendance and be punctual; complete a normal work day and/or work week and perform at a consistent pace.

4. Ability to perform complex or varied tasks.
   Consider ability to: synthesize, coordinate and analyze data; perform jobs requiring precise attainment of set limits, tolerances, or standards.

5. Ability to relate to other people beyond giving and receiving instructions. Consider ability to: get along with co-workers or peers; perform work activities requiring negotiating with, explaining, or persuading; respond appropriately to criticism.

6. Ability to influence people.
   Consider ability to: convince or direct others; understand the meaning of words and to use them appropriately and effectively; interact appropriately with people.

7. Ability to make generalizations, evaluations or decisions without immediate supervision.
   Consider ability to: recognize potential hazards and follow appropriate precautions; understand and remember detailed instructions; make independent decisions or judgements based on appropriate information; set realistic goals or make plans independent of others.

8. Ability to accept and carry out responsibility for direction, control, and planning.
   Consider ability to: set realistic goals or make plans independently of others; negotiate with, instruct or supervise people; respond appropriately to changes in the work condition.

However, this schema would not cover the need for an assessment of "the normal pursuit of everyday living" impairment. The "normal pursuit of everyday living" impairment could possibly be gauged using four of Kennedy's DSM-II-R Axis V subscales; Psychological Impairment, Social Skills, and ADL-Occupational Skills (see copies). How one would use these California scales for work and the Kennedy scales together to come up with a percentage impairment globally is not evident.

C. The following impairment rating schema was approved by the Committee as an attempt to provide something useful and helpful. It is a system of global impairment ratings based partly on the AMA Guides to The Evaluation of Permanent Impairment and with impairment figures representative of the examiner's ratings on the committee.

"Functioning" is defined in this schema to represent a global concept to include all aspects of work efficiency, and social and other skills necessary for the "normal pursuit of everyday living."

Levels of Impairment:	Percentage Range
1. **Slight** (detectable impairment in functioning)	0 – 5
2. **Mild** (noticeable impairment in functioning)	6 – 15
3. **Moderate** (marked impairment in functioning)	16 – 30
4. **Severe** (unable to perform function)	31 – 50
5. **Extreme** (from required assistance for ADL up to a need for institutionalization)	51 – 85

Appendix A Psychiatric Impairment Probability

A case likely to result in a significant psychiatric impairment rating has the following characteristics:

1. The case is chronic and stabilized. The claimant's condition is no longer recovering or deteriorating.

2. There was a significant work-related psychosocial stressor that precipitated the psychiatric condition. This means usually that there has been a significant bodily injury or disease, or significant fright or near miss or overwhelming traumatic experience in the work place which precipitated the emotional or mental symptoms.

3. There is the absence of any significant other non-work-related psychosocial stressor such as divorce, death of a close relative, an off-the-job accident, or a non-injury related serious medical condition which would explain the formation of the mental symptoms.

4. There is independent medical documentation regarding the presence of these mental symptoms close temporally (months) to the accident and tracing their development to the present time.

5. There has been substantial evidence of appropriate evaluation and treatment of the claimant's mental disorder by a psychiatrist, psychologist or other mental health professional. However, all medical psychiatric conditions require diagnosis, treatment planning, implementation and monitoring by a psychiatrist.

6. There is accompanying non-medical documentation of the person's good functioning prior to the injury in the form of good attendance records at work, absence of a lot of personnel problems such as being fired, work absences and troubles with supervisors.

7. There is evidence that the person has made at least an average attempt at rehabilitation and there is no evidence of malingering or overwhelming smothering and dependency reinforcing behaviors on the part of the family or significant others in the claimant's life.

8. The presence of significant symptoms reported by the patient and his family and physician of mental symptoms that interfere significantly in the person's personal, social, occupational or familial functioning. This is evidenced by reports that the claimant is no longer able to pursue his usual hobbies and pastimes, has a shrinking of personal contacts with limited socialization, lessening of capacities at work, difficulties with sleep, appetite, energy, sex drive, and mood, and difficulty in

interacting with others because of irritability or withdrawal.

9. Confirming evidence from the mental status examination, observations made during the interview, reports from other staff in the office and the results of psychological tests which substantiate the presence of a typical psychiatric disorder following trauma, and residual signs of impairment (difficulty with control of mood, shortened attention span, pain above and beyond what would be expected on the basis of physical findings, decrease in intellectual capacity as judged by previous testing or by previous level of education and vocabulary or vocational attainment or military service, and the absence of a pre-existing psychiatric disorder or character pathology that would explain the current symptoms).

Appendix B Malingering

A special word on malingering is needed. Philip Resnick, Cleveland Forensic Psychiatrist has written that the following items should increase the clinician's suspicions that a claimant is malingering after a traumatic incident:

1. The malingerer may assert an inability to work, but retain the capacity for recreation, such as enjoyment of theater, television, or card games.

2. The malingerer may have a history of spotty employment and drifting. A person who has always been a responsible, honest, adequate member of society is less likely to feign illness.

3. The malingerer may seem evasive during the interview and be unwilling to make definite statements about returning to work, financial gain, or other expectations.

4. The malingerer may be sullen, ill-at-ease, suspicious, uncooperative, or resentful. (also vague, reacts with anger and hostility to close questioning and is cautious about self-incriminating responses)

5. The malingerer may try to avoid examination, unless it is required to receive some financial benefit.

6. The malingerer may decline to cooperate in recommended diagnostic or therapeutic procedures (and, it might be added, in any rehabilitative measures).

7. The malingerer may have a history of previously incapacitating injuries and extensive absences from employment.

8. The malingerer's personality is more likely to be greedy, dishonest, unpleasant, or demanding.

9. The malingerer may have been a marginal member of society for many years.

10. The malingerer may depict himself or herself and prior functioning in extremely complimentary terms.

11. The malingerer may pursue a claim tenaciously, although he alleges that he is depressed or incapacitated by symptoms of Post Traumatic Stress Disorder.

12. The malingerer may refuse employment which could be handled in spite of some disability.

London (1988) called attention to the following factors as being alerting examples in Workers' Compensation cases:

1. Symptoms that do not fit any particular diagnostic category.

2. Physical symptoms, including pain, that have no explainable organic basis.

3. A claimant who is extremely hostile, confusing, or intimidating in the interview.

4. A past history of lying and/or arrests.

5. A conveniently patchy or hazy memory.

6. A history of avoiding physical examinations or failing to follow medical advice.

7. History of avoiding psychological testing or psychiatric interviews.

8. Withholding of information concerning past illnesses, injuries, litigation, and periods of disability.

The malingerer tends to give "approximate" answers to mental status items, such as saying it is "April" when the month is May. Have a high index of suspicion for Malingering in any claimant with an Antisocial Personality Disorder. Psychological testing results are typical in many cases, with "faking bad" indicators high on standardized tests. Richard Roger's 1988 Book on Malingering is particularly useful.