WEST VIRGINIA

SECRETARY OF STATE

KEN HECHLER

ADMINISTRATIVE LAW DIVISION

Form #5

FILED

SEP 13 10 04 AM '94

OFFICE OF WEST VIRGINIA SECRETARY OF STATE

NOTICE OF AGENCY ADOPTION OF A PROCEDURAL OR INTERPRETIVE RULE OR A LEGISLATIVE RULE EXEMPT FROM LEGISLATIVE REVIEW

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

CITE AUTHORITY: §21A-2-6(2); 21A-3-7(b) & -7(c); 23-1-1; 23-1-13, 23-1-15

RULE TYPE: PROCEDURAL _____ INTERPRETIVE _____

EXEMPT LEGISLATIVE RULE X
CITE STATUTE(s) GRANTING EXEMPTION FROM LEGISLATIVE REVIEW

§21A-3-7(c)

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 ADOPTED: 16

TITLE OF RULE BEING ADOPTED: Guidelines for Permanent Impairment Evaluations, Evidence, and Ratings

THE ABOVE RULE IS HEREBY ADOPTED AND FILED WITH THE SECRETARY OF STATE. THE EFFECTIVE DATE OF THIS RULE IS February 1, 1995

John H. Kozak

Authorized Signature
John H. Kozak, Director
Legal Services Division

17.30

Bureau of Employment Programs
Legal Services Division
Post Office Box 3922
Charleston, West Virginia 25339-3922

Gaston Caperton
Governor
Andrew N. Richardson
Commissioner

M E M O R A N D U M

TO: The Honorable Ken Hechler
Secretary of State

FROM: John H. Kozak
Director, Legal Services Division

DATE: September 13, 1994

RE: Filing of Exempt Legislative Rule

Attached hereto, please find a copy of the legislative rule titled "Guidelines for Permanent Impairment Evaluations, Evidence, and Ratings" and a completed copy of your form #5. This rule is exempt from legislative review, West Virginia Code, §21A-3-7(c).

Also attached hereto you will find copies of all the written comments that were received from the public regarding this rule. A hearing was not held on this rule; hence, there were no oral comments received and there is no attendance sheet. The rule as filed today contains the changes that the Compensation Programs Performance Council made to the original draft in response to the comments. A memorandum responding to the comments is also attached. It reviews the comments that were made and states the Council's responses to them and the reasons for the changes that were made to the original draft.

Also enclosed herewith, please find a computer diskette containing the rule. It is encoded in Display Write 4 Version 2 and is named A:\Series 16.

Thank you for your assistance in this matter.

w/ Attachments

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

SERIES 16
Guidelines for Permanent Impairment 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.

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. Pursuant to enrolled committee substitute for house bill 4030, regular session, 1994, the department of commerce, labor and environmental resources was abolished. Pursuant to that same bill and to executive order no. 5-94 by the governor, the commissioner of the bureau of employment programs is empowered to promulgate rules and regulations without the consent or approval of a departmental secretary.

1.3. Filing Date. --September 13, 1994

1.4. Effective Date. -- February 1, 1995.

1.5. The effective date of these rules has been set at February 1, 1995, for two reasons. First, the council is of the opinion that the six (6) month period will afford the medical community and the other participants in the workers' compensation system sufficient time to become familiar with the "Guides to the Evaluation of Permanent Impairment," (4th ed. 1993). A training and education period was requested in a number of the comments received on the rule. Second, the council intends to develop the additional standards necessary for the determination of requests for permanent disability beyond physical impairment. A number of the comments received for these rules recommended that these rules not be implemented without the other standards.

§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 impairment . 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. "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.

3.3. "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.

3.4. "Permanent impairment" means an impairment that is related to a compensable injury "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.

4.1. 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. If in any

particular claim, the examiner is of the opinion that the Guides or the section 6 substitutes cannot be appropriately applied or that an impairment guide established by a recognized medical speciality group may be more appropriately applied, then the examiner's report must document and explain the basis for that opinion. Deviations from the requirements of the Guides or the section 6 substitutes shall not be the basis for excluding evidence from consideration. Rather, in any such instance such deviations shall be considered in determining the weight that will be given to that evidence. An example of an acceptable recognized medical speciality group's own guides is the "Orthopaedic Surgeons Manual in Evaluating Permanent Physical Impairment."

4.2. These rules are not applicable to any permanent impairment rating examination performed prior to the effective date of these rules. Accordingly, the rules are not applicable to any reports or opinions based upon those examinations, in whole or in part, which are submitted either before or after the effective date of these rules.

4.3. These rules are not applicable to examinations and opinions provided to the commissioner by a claimant's treating physician pursuant to West Virginia Code, §23-4-7a(c)(1).

§23-16-5. Evidentiary Requirements.

5.1. The evidentiary weight to be given to a report will be influenced by how well it demonstrates that the evaluation and examination that it memorializes were 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.

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).

5.1.4. To the extent that factors other than the compensable injury may be affecting the claimant's impairment, the opinion stated in the report must, to the extent medically possible, determine the contribution of those other impairments whether resulting from an occupational or a nonoccupational injury, disease, or any other cause, whether or not disabling.

5.2. 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 or by annually filing an appropriate document with the commissioner. 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 affect the evidentiary weight given to the opinion and findings in the reports offered by that opinion giver. Those individuals who are conducting examinations and providing reports and opinions for injuries within their field of practice or specialty and who have been trained in the use of the Guides shall be deemed an expert for the purposes of these rules. Additional qualifications such as board certification or eligibility to become board certified shall go to the weight to be afforded the report and opinion. Acceptable training must be accomplished by attendance at a training event or accomplished in a manner which is sanctioned for continuing medical education credit purposes. On an individual-by-individual basis, consideration will be given to other persons who do not meet the above stated criteria.

5.3. 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 until such standards are promulgated as a rule of their own. It is expressly noted that Chapter 4, "The Nervous System," is not excluded and shall be used when applicable.

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 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. A later submission or supplement to the report which demonstrates compliance with these rules shall serve to permit such payment.

§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.

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?: _____

_____

_____

_____

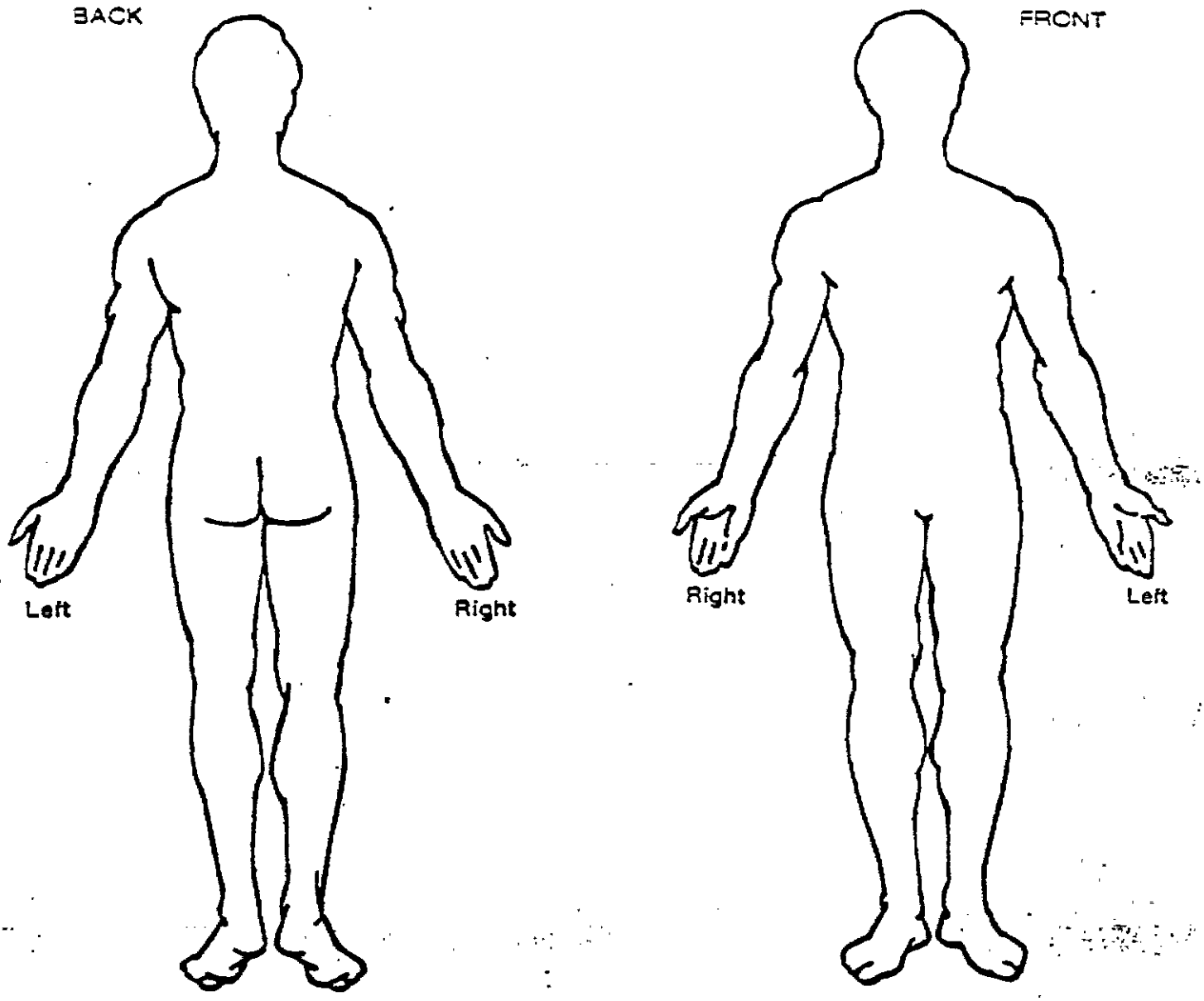
_____

_____

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

Re-Exams

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

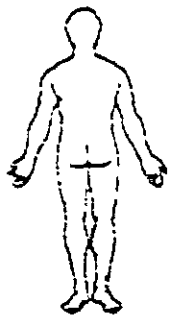
– (worse) ○ (same) + (improvement) ✓ (normal, negative or resolved)

#__ __ __ __

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

te of This Exam: _____

L R



Mark Any Asymmetries On Figure to the Right.

INSPECTION (standing and/or seated)

		YES	NO	A	B	C	Notes:
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 _____			☐	☐	☐	

PALPATION (standing, seated, or prone)

		Left Yes	Left No	Right Yes	Right No	A	B	C	Notes:
2.1	Paraspinal muscle tenderness	☐	☐	☐	☐	☐	☐	☐	
2.2	Paraspinal muscle spasm	☐	☐	☐	☐	☐	☐	☐	
2.3	Sacroiliac joint tenderness	☐	☐	☐	☐	☐	☐	☐	

		Yes	No					
2.4	Vertebral tenderness/restriction	☐	☐	☐ L1	☐ L2	☐ L3	☐ L4	☐ L5
2.5	Coccyx tenderness (external palpation)	☐	☐					

GAIT

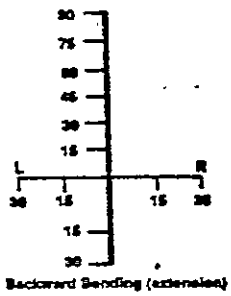
					A	B	C	Notes:
3.1	Limp	☐ Yes	☐ No	☐ Left ☐ Right	☐	☐	☐	
3.2	Other observations _____				☐	☐	☐	

SQUAT

				A	B	C	Notes:
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	☐	☐	☐	

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

Forward Bending (flexion)



Backward Bending (extension)

X = Pain ☐ = Restriction ✓ = WNL

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

Inclinometer ☐ Yes ☐ No

Comments: _____

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

		Yes	No	Left	Right		A	B	C	Notes:
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 _____	☐	☐	☐	

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

		Left Normal	Left Diminished	Left Absent	Right Normal	Right Diminished	Right Absent	A	B	C	Notes:
7.1	L3 sensory	☐	☐	☐	☐	☐	☐	☐	☐	☐	
7.2	L4 sensory	☐	☐	☐	☐	☐	☐	☐	☐	☐	
7.3	L5 sensory	☐	☐	☐	☐	☐	☐	☐	☐	☐	
7.4	S1 sensory	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Name: ______________________________ SS# ____ ___ ______

8. STRAIGHT LEG RAISING (Sitting)
(Measure knee extension)

8.1 Left ______° Pain: ☐ Yes ☐ No Location of Pain: ☐ Back ☐ Same Leg ☐ Contralateral back/leg

8.2 Right ______° Pain: ☐ Yes ☐ No Location of Pain: ☐ Back ☐ Same Leg ☐ Contralateral back/leg

9. REFLEXES (seated) (+2 normal)

Patellar 9.1 Left ☐ 0 ☐ +1 ☐ +2 ☐ +3 ☐ clonus

9.2 Right ☐ 0 ☐ +1 ☐ +2 ☐ +3 ☐ clonus

Achilles 9.3 Left ☐ 0 ☐ +1 ☐ +2 ☐ +3 ☐ clonus

9.4 Right ☐ 0 ☐ +1 ☐ +2 ☐ +3 ☐ clonus

10. HIP AND SACROILIAC TESTS

10.1 Hip test pain ☐ Yes ☐ No
(See Patrick's or other textbook hip joint test)

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)

11. STRAIGHT LEG RAISING (Supine)

11.1 Left ______° Pain: ☐ Yes ☐ No Location of Pain: ☐ Back ☐ Same Leg ☐ Contralateral hip/leg

11.2 Right ______° Pain: ☐ Yes ☐ No Location of Pain: ☐ Back ☐ Same Leg ☐ Contralateral hip/leg

12. PEDIS PULSES

12.1 Left Posterior tibialis ______ Dorsalis Pedis ______

12.2 Right Posterior tibialis ______ Dorsalis Pedis ______

13. MUSCLE WASTING MEASUREMENT

13.1 Left Thigh ______ Right Thigh ______ ______ cm above tibial tubercle

13.2 Left Calf ______ Right Calf ______ ______ cm below tibial tubercle

14. LEG LENGTH EXAM DONE? ☐ Yes ☐ No

14.1 Short ☐ Left ☐ Right ☐ Even ☐ Supine ☐ Standing

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

SENSORY EXAMINATION: RESPONSE TO PINPRICK

		SCORE	
15.1	No deficit or deficit well localized to dermatome(s)	0	☐
	Deficit related to dermatome(s) but some inconsistency	1	☐
	Nondermatomal or very inconsistent deficit	2	☐
	Blatantly impossible (i.e., split down midline of entire body with positive tuning fork test)	3	☐
15.2	AMOUNT OF BODY INVOLVED		
	< 15%	0	☐
	15 - 35%	1	☐
	36 - 60%	2	☐
	> 60%	3	☐

MOTOR EXAMINATIONS:

		SCORE	
15.3	No deficit or deficit well localized to myotome(s)	0	☐
	Deficit related to myotome(s) but some inconsistency	1	☐
	Nonmyotomal or very inconsistent weakness, exhibits cogwheeling or giving away, weakness is coachable	2	☐
	Blatantly impossible, significant weakness which disappears when distracted	3	☐
15.4	AMOUNT OF BODY INVOLVED		
	< 15%	0	☐
	15 - 35%	1	☐
	36 - 60%	2	☐
	> 60%	3	☐

Re-Exams

− (worse) O (same) + (improvement)
✓ (normal, negative or resolved)

	A	B	C	
8.1	☐	☐	☐	______
8.2	☐	☐	☐	______
9.1	☐	☐	☐	______
9.2	☐	☐	☐	______
9.3	☐	☐	☐	______
9.4	☐	☐	☐	______
10.1	☐	☐	☐	______
10.2	☐	☐	☐	______
11.1	☐	☐	☐	______
11.2	☐	☐	☐	______
12.1	☐	☐	☐	______
12.2	☐	☐	☐	______
13.1	☐	☐	☐	______
13.2	☐	☐	☐	______
14.1	☐	☐	☐	______

		A	B	C
15.1	0	☐	☐	☐
	1	☐	☐	☐
	2	☐	☐	☐
	3	☐	☐	☐
15.2	0	☐	☐	☐
	1	☐	☐	☐
	2	☐	☐	☐
	3	☐	☐	☐
15.3	0	☐	☐	☐
	1	☐	☐	☐
	2	☐	☐	☐
	3	☐	☐	☐
15.4	0	☐	☐	☐
	1	☐	☐	☐
	2	☐	☐	☐
	3	☐	☐	☐

Name: _____ SS# ___ __ ____

TENDERNESS:

			Re-Exams A	B	C
15.5 No tenderness or tenderness clearly localized to discrete, anatomically sensible structure	0	☐	15.5 0 ☐	☐	☐
Tenderness not well localized, some inconsistency	1	☐	1 ☐	☐	☐
Diffuse or very inconsistent tenderness, multiple anatomic structures involved (skin, muscle, bone, etc.)	2	☐	2 ☐	☐	☐
Blatantly impossible, significant tenderness of multiple anatomic structures (skin, muscle, bone, etc.) which disappears when distracted	3	☐	3 ☐	☐	☐

15.6 AMOUNT OF BODY INVOLVED

< 15%	0	☐	15.6 0 ☐	☐	☐
15 - 35%	1	☐	1 ☐	☐	☐
36 - 60%	2	☐	2 ☐	☐	☐
> 60%	3	☐	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	☐	15.7 0 ☐	☐	☐
Difference 20 - 45°	1	☐	1 ☐	☐	☐
Difference > 45°	2	☐	2 ☐	☐	☐
No pain seated, but strongly positive SLR when supine at less than 45°	3	☐	3 ☐	☐	☐
TOTAL SCORE			TOTAL		

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: _____

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,

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)

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,

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 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.

Rev. 6-94

WORKERS' COMPENSATION DIVISION

LOW BACK EXAMINATION

USE BLACK INK — *To Be Completed by the Physician* — *Page 1*

Patient Name: _____ Physician: _____

SSN: ___-___-_____ HT. _____ Address: _____

Date of Injury: __/__/__ WT. _____

Date of Birth: __/__/__ Pulse _____ Phone: _____

Claim Number _____ BP _____ FEIN: _____

Date of Exam: __/__/__ Resp. _____

PLEASE CHECK ONE:

☐ CONSULTATION ☐ IMPAIRMENT RATING ☐ INDEPENDENT EXAMINATION ☐ 120-DAY EXAMINATION ☐ COMPREHENSIVE EXAMINATION

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 (Asymmetry)	❑	❑	
1.5 Lumbar hypolordosis	❑	❑	
1.6 Lumbar hyperlordosis	❑	❑	

Other observations _____

2. PALPATION (standing, seated, or prone)

	YES	NO	
2.1 Vertebral tenderness/ restriction	❑	❑	❑ L1 ❑ L2 ❑ L3 ❑ L4 ❑ L5
2.2 Coccyx tenderness (external palpation)	❑	❑	
2.3 Sacral base & pelvis level (Standing)	❑	❑	

	LEFT		RIGHT		
	YES	NO	YES	NO	
2.4 Paraspinal muscle tenderness	❑	❑	❑	❑	
2.5 Paraspinal muscle spasm	❑	❑	❑	❑	
2.6 Sacroiliac joint tenderness	❑	❑	❑	❑	

3. GAIT

3.1 Limp ❑ Yes ❑ No ❑ Left ❑ Right Explain: _____

3.2 Assistive devices (cane, brace, prosthesis) _____

3.3 Other observations _____

4. SQUAT

4.1 Squats fully and rises without difficulty ❑ Yes ❑ No

Comments _____

5. RANGE OF MOTION (standing)

		WNL	PAIN	RESTRICTION
5.1 Forward bending (Flexion)	____°	❑	❑	❑
5.2 Backward bending (Extension)	____°	❑	❑	❑
5.3 Left side bending	____°	❑	❑	❑
5.4 Right side bending	____°	❑	❑	❑
5.5 Right Rotation (torso)	____°	❑	❑	❑
5.6 Left Rotation (torso)	____°	❑	❑	❑

5.7 Comments _____

5.8 Inclinometer ❑ Yes ❑ No

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

	NORMAL	ABNORMAL	GRADE (OUT OF 5) LEFT	RIGHT
6.1 Hip flexion	❑	❑		
6.2 Hip Extension	❑	❑		
6.3 Hip Abduction	❑	❑		
6.4 Knee extension	❑	❑		
6.5 Knee flexion	❑	❑		
6.6 Ankle dorsiflexion	❑	❑		
6.7 Ankle Planter flexion	❑	❑		
6.8 Great toe extension	❑	❑		
6.9 Heel toe walk	❑	❑		
6.0 Toe walk	❑	❑		

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

	LEFT			RIGHT		
	Normal	Diminished	Absent	Normal	Diminished	Absent
7.1 L3 sensory	❑	❑	❑	❑	❑	❑
7.2 L4 sensory	❑	❑	❑	❑	❑	❑
7.3 L5 sensory	❑	❑	❑	❑	❑	❑
7.4 S1 sensory	❑	❑	❑	❑	❑	❑

7.5 Comments _____

8. REFLEXES (seated) (+2 normal)

Patellar	9.1 Left	❑ 0	❑ +1	❑ +2	❑ +3	❑ clonus
	9.2 Right	❑ 0	❑ +1	❑ +2	❑ +3	❑ clonus
Achilles	9.3 Left	❑ 0	❑ +1	❑ +2	❑ +3	❑ clonus
	9.4 Right	❑ 0	❑ +1	❑ +2	❑ +3	❑ clonus

Other _____

9. STRAIGHT LEG RAISING (sitting)
(Measure knee extension)
8.1 Left _____° Pain: ❑ Yes ❑ No Location of Pain: ❑ Back ❑ Same Leg ❑ Contralateral back/leg
8.2 Right _____° Pain: ❑ Yes ❑ No Location of Pain: ❑ Back ❑ Same Leg ❑ Contralateral back/leg

10. HIP AND SACROILIAC TEST
10.1 Hip test pain ❑ Yes ❑ No ❑ Left ❑ Right
(See Instructional manual) _____

10.2 Sacroiliac test pain ❑ Yes ❑ No ❑ Left ❑ Right
(See Instructional manual) _____

11. STRAIGHT LEG RAISING (supine)
11.1 Left _____° Pain: ❑ Yes ❑ No Location of Pain: ❑ Back ❑ Same Leg ❑ Contralateral back/leg
11.2 Right _____° Pain: ❑ Yes ❑ No Location of Pain: ❑ Back ❑ Same Leg ❑ Contralateral back/leg

12. PEDIS PULSES

	NORMAL	ABNORMAL
12.1 Popliteal _____	❑	❑
12.2 Posterior tibial _____	❑	❑

12.3 Other observations (Clubbing, Cyanosis) _____

13. MUSCLE WASTING MEASUREMENT
13.1 Left Thigh _____ Right Thigh _____ _____ cm above tibial tubercle
13.2 Left Calf _____ Right Calf _____ _____ cm below tibial tubercle

14. LEG LENGTH EXAM
14.1 Symmetrical ❑ Yes ❑ No ❑ Not Tested
14.2 Shorter ❑ Left ❑ Right ❑ Even ❑ Supine ❑ Standing
Difference of _____cm Right _____cm Left _____cm
❑ Supine: measure from anterior superior iliac spine to medial/lateral malleolus. ❑ Standing: measure from greater trochanter to floor

Workers' Compensation Division

USE BLACK INK

Patient History - Back Pain

Patient Name: _____
SSN: ___ ___ - ___ ___ - ___ ___ ___ ___
Date of Injury: ___/___/___
Date of Birth: ___/___/___
Claim Number _____
Date of Exam: ___/___/___

Physician: _____
Address: _____
_____
Phone: _____
FEIN: ___ ___ - ___ ___ ___ ___ ___ ___ ___

PLEASE CHECK ONE:

❑ IMPAIRMENT RATING ❑ 120-DAY EXAMINATION
❑ CONSULTATION ❑ INDEPENDENT EXAMINATION ❑ COMPREHENSIVE EXAMINATION

Present History (to be completed by the patient)

1. What are your problems? _____

2. How did the problem occur? _____

3. Where is the location of the problem/pain?

4. Have you had this type of complaint before? ❑ Yes ❑ No
When?/ Where?

4.1 How did that complaint occur?

4.2 What is the name of your employer?

4.3 What is the type of business of that company?

5.1 What was your job title when problem began?

5.2 What was your usual job? (Job Tasks)

Describe your job tasks. _____

5.3 What job were you performing when problem began?

6. Who is your immediate supervisor?

Name Phone Number

7. Have you discussed your problem 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 problem/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 complaint before now? ❑ Yes ❑ No

12. What has helped this complaint the most? _____

13. What has not helped or made this complaint 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 spell with very little pain?	❑ Yes	❑ No
14.6 Have you had any intolerance to your treatment or reaction to treatment?	❑ Yes	❑ No
14.7 Have you had an emergency room visit to the hospital with back trouble?	❑ Yes	❑ No

Past History

Claim Number _____

15. Have you ever had a spine X-ray, CT scan, MRI or myelogram?
    X-ray ❑ Yes ❑ No
    When/Where/Results_____
    MRI ❑ Yes ❑ No
    When/Where/Results_____
    CT scan ❑ Yes ❑ No
    When/Where/Results_____
    Myelogram ❑ Yes ❑ No
    When/Where/Results_____
    Other_____
16. Have you ever been hospitalized for neck, arm, back or leg complaints/pain? ❑ Yes ❑ No
    When/Where_____
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 the above problems? ❑ 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 No:_____
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: _____

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 ///

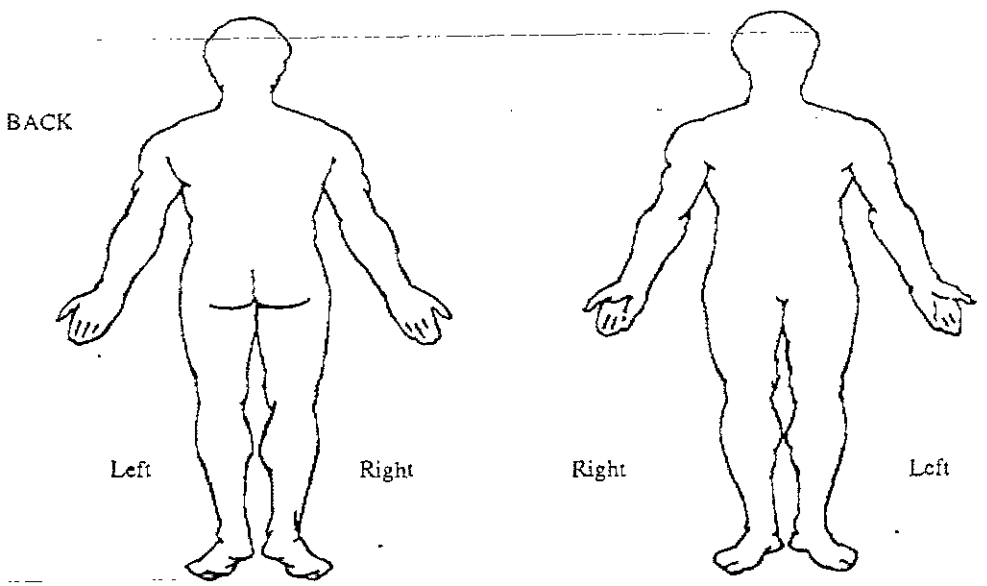
Burning XXX

Pins and Needles OOO

Aching, Throbbing ^^^

Numbness = = =

Other . . .



Signature of person completing form _____ Date _____

If signature is not of patient, then state relationship to patient _____

15. CLINICAL IMPRESSION OF SOMATIC AMPLIFICATION

SCORE

SENSORY EXAMINATION: RESPONSE TO PINPRICK

15.1 No deficit or deficit well localized to dermatome(s) 0 ☐
Deficit related to dermatome(s) but some inconsistency 1 ☐
Nondermatomal or very inconsistent deficit 2 ☐
Blatantly impossible (i.e., split down midline of entire body with positive tuning fork test) 3 ☐

15.2 AMOUNT OF BODY INVOLVED

<15% 0 ☐
15 - 35% 1 ☐
36 - 60% 2 ☐
> 60% 3 ☐

MOTOR EXAMINATIONS

15.3 No deficit or deficit well localized to myotome(s) 0 ☐
Deficit related to myotome(s) but some inconsistency 1 ☐
Nonmyotomal or very inconsistent weakness, exhibits cogwheeling or giving away, weakness is coachable 2 ☐
Blatantly impossible, significant weakness which disappears when distracted 3 ☐

15.4 AMOUNT OF BODY INVOLVED

<15% 0 ☐
15 - 35% 1 ☐
36 - 60% 2 ☐
>60% 3 ☐

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 ☐

DIFFERENTIAL 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

Claim Number _____

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

Findings (Attach report if available): _____

Patient Position During X-ray ☐ Recumbent ☐ Weight Bearing

18. CLINICAL DIAGNOSIS

(Please indicate appropriate IC-9 code(s) and give verbal description. 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)

POSTERIOR JOINTS
- ☐ Facet syndrome (724.8)
- ☐ Lumbar subluxation or lumbar segmental dysfunction (739.4)

DISC
- ☐ Lumbar disc displacement (without radiculopathy) (722.10)
- ☐ Lumbar disc displacement (with radiculopathy) (722.73)

SACROILIAC
- ☐ Sacroiliitis (720.2)
- ☐ Sacroiliac subluxation or sacroiliac segmental dysfunction (739.4)

☐ OTHER: _____

19. OTHER TESTS PERFORMED AND FINDINGS: _____

20. TREATMENT PLAN, REFERRALS, RECOMMENDATIONS: _____

21. AUTHORIZATION(S) REQUESTED FOR: _____

Bureau of Employment Programs
Legal Services Division
Post Office Box 3922
Charleston, West Virginia 25339-3922

Gaston Caperton
Governor
Andrew N. Richardson
Commissioner

RESPONSE TO COMMENTS

85 CSR 16

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

The following is a synopsis of the comments received on these proposed rules and the agency's responses to them

1). The rules should not be implemented until corresponding rules on disability determination are promulgated.

Issuance of this rule will heighten the attention paid to the historically ignored difference between impairment and disability. The Supreme Court of Appeals, in the context of permanent total disability, has defined the disability component of an award as being based upon three elements: first, the impairment of earning capacity; second, the effect of possible impairment on the claimant's efficiency at work; and, third, impairment to the normal pursuit of everyday living. Neither the Court nor the Legislature has defined or quantified these elements for application purposes. Presumably, these same elements or some variation of them are applicable in the context of permanent partial disability.

It would be better to have both the disability and the impairment portions of the system in place together. It may well be possible to adopt a system of measurements for the three elements stated above.

2). A file of approved evaluators should be maintained by the division rather than requiring submissions of resumes and curriculum vitae with each report.

This idea is acceptable and the rule modified accordingly.

3). The rule should set the fees the division will pay for impairment ratings examinations and report writing.

It was not contemplated that the rule would undertake this function. The current rate is for a payment of $75 per quarter hour expended on the actual examination. The division's fee schedule currently sets the amount that will be paid.

4). One comment suggested that the evaluator be asked "how does the impairment affect function?" This question, it is

suggested, will bring into the analysis a knowledge of functional capabilities and the need for accommodations.

This item is really a matter of preparation of the form the referral letter will take upon being drafted. Impairment of function is a necessary component of a functional capacities examination. Whether this information is obtained at the time of the impairment rating or when and if a functional capacities examination is performed is simply a procedural matter.

5). Dr. Ralph Smith wants the rule to be clear that psychiatrists can use chapter 4 of the Guides regarding the nervous system.

This suggestion is acceptable (and was intended). The appropriate change was made.

6). The rules "inappropriately limit the consideration of medical and professional evidence."

Comments suggest that use of the Guides be more flexible and the weight of the opinions based upon examinations that differ from those prescribed by the Guides be varied depending upon the explanations given for those differences. The rules contain the statement in section 4 that deviations from the Guides is permitted as long as the reasons for the deviations are documented and explained. Based upon other comments, this statement was made more prominent and its application to the entirety of series 16 was made more pronounced.

7). The Health Care Advisory Panel should be asked whether the Guides have been accepted by the medical community as the best choice based upon full professional scrutiny and peer review. The Guides have previously been criticized for a lack of independent testing for both validity and reliability.

The Health Care Advisory Panel (HCAP) did discuss the acceptability of the Guides during their deliberations. It was concluded that the Guides were the product of the medical community itself. Criticism of the scientific basis for the rules has continued throughout the history of the Guides and no version - present or future - will be immune from such attacks. However, no other general source of standards is available and many states have adopted the Guides well recognizing that there are times they must be deviated from. The response to comment 6 made the exception provision of the rules more pronounced. Doing so addresses this concern as well.

8). The division must develop a plan to educate and inform the evaluators of the requirements of the Guides.

This is readily agreed to and has been the subject of planning by HCAP for sometime. It is expected that a seminar or seminars will be provided in late summer to early fall. This necessarily entails that the rule not be made effective until after this training is offered.

9). The rules should not be retroactively applied to evaluations done before the effective date of the rules.

The suggestion is accepted as not doing so would impose unreasonable burdens on the claimants, the employers, and the division itself.

10). There is a great need for flexibility for when the Guides cannot be strictly applied.

As discussed above in comment 6, provision for such deviations has been made.

11). One comment suggests that there is a need to emphasize that the impairment rating that is to be determined must be confined to the compensable injury itself.

This comment is readily accepted. It is a statement of current law, West Virginia Code, §23-4-9b.

12). One comment suggests that a separate rule be developed for disability determination for permanent total disability requests. Hence, this rule should only address impairment.

The agency agrees that the references to disability should be removed from this rule as leaving them there does tend to confuse the purpose of this rule. It is also agreed that a separate rule is needed for determining disability.

13). Protocols for vocational evaluations and reports should be developed and should be tied to the rehabilitation rules.

This aspect of disability determination should not be addressed in this impairment rating rule. A separate disability determination rule should address this point.

14). The rules should more clearly state how its evidentiary provisions apply to the Office of Judges and to the Appeals Board.

This issue was addressed in the responses to comment 6 and to comment 9 and appropriate changes were made.

15). Do these rules conflict with section 7a(c)(1) regarding the authority of a treating physician to recommend a disability rating of up to 15%?

The draft's section 5.5 was intended to address this point; but, it does not do so explicitly. The rules have been amended to note that the requirements of section 7a(c)(1) remain in place. Hence, if a treating physician suggest a PPD rating of 15% or less prior to the closure of the claim for TTD benefits, then that amount is to be entered without further evaluations.

16). The Guides are more restrictive than statutory provisions. Reference is made to the fact that section 6(f) provides for a greater PPD rating than would the Guides for the loss of the great toe. The comment goes on to question how the partial loss of the great toe would be handled.

The rules note that the statutory PPD amounts must be complied with and override the provisions of the Guides. With reference to partial losses, section 6(j) of the statute suggests that the ratings provided by 6(f) are to be used as guides but are not limited by the percentages stated there. The Guides can be used to make an impairment rating for partial losses and the disability portion of the PPD rating can accommodate any remaining issues.

17). One comment suggests that IMEs need to provide greater instructions to claimants on the completion of the pain diagrams that are part of the back forms and other forms in the Guides.

This is a valid point as the claimants need to be completing the diagrams correctly. It can be addressed in the training discussed above in response to comment 8.

18). The term "qualified evaluator" should be defined by HCAP.

Definitions being developed by HCAP for use under the rehabilitation rules and will be applicable here. Hence, once those definitions are completed, they can be incorporated here.

19). The Self Insured Employers Association comments against the definition of disability used in the rules as being the difference between what the claimant can do and what the claimant may want to do.

The references to disability have been removed from these rules and this issue no longer matters.

20). A comment suggests that the rules prescribe the degrees of impairment for various injuries.

This is not possible. Other than for the provisions of section 6(f) and 6(m) dealing with the loss of specific portions of the body, other injuries are generally a matter of infinite individual degrees.

21). A comment suggests the use of specifically used terms of art such as "reasoned medical judgement" and "documented and reasoned".

The suggested terms are the ones that attorneys and some physicians are more used to. As such there is some clarity in their use and this suggestion was incorporated.

22). A comment suggests that a resume or curriculum vitae only be attached to a report if the claim is in litigation.

This comment ignores the value of evidentiary decisions at the Commissioner's level. While it is agreed above that a file of approved providers can be maintained, the requirements for qualified evaluators must be applied at all levels of review and not just in litigation.

23). A comment suggests that the same weight be given to all evaluators on the question of disability and that the treating physician should not hold a special ranking.

The statute at section 7(a) discussed above does give the treating doctor the prerogative to recommend a PPD rating of up to 15% which must be generally accepted by the division. However, the Guides recognize that local community physicians do learn over their careers what the requirements are for performing jobs in that local community. This plus their familiarity with their patients does place them in a unique position to evaluate the disability of the patient and to state an opinion. However, that opinion must be accompanied by a demonstration of the provider's familiarity and knowledge and this is stated in the rules.

24). A comment objects to the use of the term "handicap" in section 5.5.

The reference to disability has been removed from the rules and this issue has been eliminated.

25. A comment wants the provisions of the series 1 rules relating to OP evaluations set forth in these rules.

Reference to the series 1 rules can readily be made without having to encumber the series 16 rules with duplicative language. If accepted, then the provisions of the hearing loss rules, series 13, would be equally necessary for duplication here.

26). A comment asks if HCAP's psychiatric standards have been set forth for comment. It is suggested that the 1993 amendment clarifying that mental-mental claims are not compensable be explicitly included. Another comment criticizes the standards at

great length and raises a number of pertinent points to the use of the standards.

These standards have not been the subject of specific public comment. HCAP is revising the standards and they will be made available for public comment as were the hearing loss rules. All of the comments received on these rules have been made available to the HCAP members and the comments will be considered by them. In the meantime, the standards that are in place were developed by a committee of psychiatrists and psychologists from around the state and was made up of both "employer" and "claimant" oriented individuals. As a consensus document, the standards do have validity but can be improved.

27). A comment suggests that the Guides should not be used and that the experience of local doctors is more important in setting PPD awards.

The comment does not take into account the great variety of recommendations that are made on the same or similar injuries. One purpose of the use of the Guides is to increase the predictability of awards and to make them more consistent from case to case. In addition, the peculiar place of the local treating doctor is given deference in section 7a with regard to the 15% rule. These rules incorporate that feature of the statute.

28). A comment suggests that anyone should be permitted to testify on both impairment and disability. Evaluation of the weight and merit of the testimony can be made based upon the qualifications of the evaluators.

In other areas of the law, the qualifications of an expert must be determined before the witness is allowed to testify on an opinion. Doing so avoids encumbering the record with worthless "evidence" and wasting the time of the fact finders. A more conservative use of the system's resources can be had if only qualified testimony and reports are permitted in the first place.

29). A comment suggests that the use of the back examination form and the other forms provided by the Guides will be too expensive. It is suggested that narrative reports are sufficient.

The back examination form in particular was developed to provide the division with a consistent picture of a claimant's improvement or deterioration. By requiring similar tests and consistent reporting of results from one examination to another, a comparison between past reports and present reports as well as an evaluation of the credibility of conflicting reports can be made. These comparisons are difficult to impossible when reliance is made solely on narrative reports. It was this difficulty which led to the development of the forms in the first instance.

Further, the forms reflect a consensus of medical opinion on what tests and results are needed to properly evaluate a claimant. A form ensures that these tests are performed and the results recorded.

30). A comment suggests that the provision of the rules stating that circumstances where payment will not be made to an IME is "outrageous".

The provision, section 7, simply notes that if the examination and report are not what the division thought it was getting for its money, then it will not be paid for. If appropriate supplement or amendment is made to a deficient examination or report, then payment can be made.

31). It is suggested that the number of different evaluations that will be needed per claimant will increase which will cause the cost of rating a claimant to increase.

This increase - as well as an increase in costs per report - was contemplated. Too often, claimants are evaluated in a piecemeal fashion with various evaluations occurring at different times rather than in a coordinated manner. It is believed that the actual number of evaluations will not increase. Rather, they will be done at once rather than stretched over various times of a claim's life.

32). It is suggested that the number of physicians who will be willing to treat claimants and willing to do ratings will be diminished.

Every time the division contemplates a change in past practice, this objection is made by health care providers or by others. A couple of statements to this effect are made in comments from providers. Policy determinations cannot be made by giving great weight to these types of objections. They simply lead to a continuance of the status quo.

The need for more IMEs is readily recognized. The division must address methods by which examinations can be performed in the numbers needed and in a prompt manner.

It must also be recognized that the Guides were developed by physicians and not by state bureaucrats. The Guides reflect what a significant portion of the medical community has decided is necessary to conduct a proper rating.

33). One physician comments that the Guides are too generous in the amounts that would be awarded. He prefers his own system which results in lesser recommendations. He also indicates that he will not make recommendations for PPD awards if he is forced to use the Guides.

The comment does not take into account that the use of the Guides is to provide uniformity and consistency from one evaluator to another. What is desired is a reasonable recommendation from the evaluator, not one which is necessarily low. Equally strident arguments can be made by physicians whose standard methods result in greater amounts than the Guides would predict.

34). A comment asks the question whether the previously adopted rules on hearing loss evaluations will be affected by these rules.

The rules note in section 6.2 that the previously adopted series 13 rule is to be used instead of the chapter on hearing loss provided by the Guides.

35). A comment from a physician suggests that the rules are too demanding in terms of documentation and justifications requirements.

Again, it is noted that the Guides were developed by physicians for physicians' use in these ratings. Also, where a physician wishes to deviate from the Guides in a particular case, it is necessary to receive an explanation of that necessity. Simply accepting the physician's statement that deviation was necessary without requiring an explanation leaves the decision maker with no basis for accepting or rejecting that statement. This is particularly troublesome when there are other reports in the record which were conducted in accordance with the Guides and the decision maker must decide which report to accept.

36). A comment requests that the exact qualifications needed to be considered an expert be provided.

A request has been made to the HCAP to develop such criteria.

37). A comment suggests that on some occasions, especially in the orthopedic areas, the use of a professional group's manual may be more appropriate.

It was intended that the flexibility in the rules would permit this option. A greater specification of that flexibility has been made.

38). A comment suggests that the Guides rely too heavily upon range of motions figures which are, in turn, too heavily influenced by non-objective items such as age and overall physical condition unrelated to the injury.

The comment does not suggest another method for use in making these determinations. The Guides do allow for taking these other factors into account. Moreover, age and other conditions do enter into the determination when the issue is permanent total disability.

39). A comment suggests that West Virginia law requires that pain, even if objective reasons for it are lacking, must be taken into account in arriving at an impairment award.

Chapter 15 of the new edition of the Guides attempts to take into account the presence of pain in making an impairment rating. This differs from earlier versions of the Guides. The Guides note that pain is a highly subjective matter. As a result, the method by which the Guides attempts to rate pain is also largely subjective. However, pain is now taken into account.

40). A comment suggests that an organ-system by organ-system development of standards peculiar to West Virginia should be made as has been done for hearing loss, psychiatric injury, OP claims, and other areas should be done in lieu of adoption of the Guides.

This approach was originally taken by the HCAP. However, when the Guides were changed from the third edition to the fourth, the HCAP reviewed them and, with the exceptions noted, concluded that their independent work would only duplicate what was accomplished in the fourth edition.

41). A comment suggests that all medical information must be provided to the examiner and that it is often difficult to sort out the effects of earlier injuries and diseases from the compensable injury.

An examiner must be given access to all medical information pertinent to the ratings decision. However, sorting out the affects of earlier injuries and diseases will remain a difficult task that often results in a judgment call by the examiner. The agency does not know of any way presently available to assist in this problem. Its presence must simply be recognized and dealt with as best a humanly possible. It must also be noted that this problem is not unique to the adoption of the Guides.

WEST VIRGINIA UNIVERSITY
SCHOOL OF MEDICINE

April 18, 1994

John H. Kozak
Director, Legal Services Division
P O Box 3922
Charleston WV 25339-3922

Ref: Guidelines for permanent impairment and disability evaluations, evidence, and ratings.

Dear Mr. Kozak:

I would offer the following comments concerning the above referenced proposed rule.

Allow professional conducting evaluations to maintain current resume and/or curriculum vitae on file with the Commissioner in lieu of attaching a copy of same to each evaluation. This would decrease paper volumes handled, and potentially decrease costs for evaluations.

The proposed rule references that it "sets forth criteria for the payment by the division for the performing of evaluations and the furnishing of opinions". After reading the proposed rule, I find that this remains less than adequately defined. Set fees per unit time should be carefully outlined and attached to the rule. This allows for equity in reimbursement and may minimize confusion.

Concerning item 5.5 - I strongly believe that it is in the best interest of the injured/ill worker being evaluated, and the State of West Virginia to request opinion per evaluating professional as to how the impairment affects function. When possible, evaluations should be obtained from professionals knowledgeable in rendering opinion on functional capabilities and the need for accommodation. The ultimate goal is restoring productivity, not simply to award impairment.

Thank you for the opportunity to comment.

Institute of Occupational and Environmental Health
3313 Health Sciences South PO Box 9190 Morgantown WV 26506-9190 Telephone 304 293-3693 FAX 304 293-2629
Equal Opportunity / Affirmative Action Institution

Sincerely,

Janie R. Vale, M.D.
Clinical Director
IOEH

cc: Andrew N. Richardson, Commissioner
Alan M. Ducatman, M.D., Director IOEH
Patricia Treharne, HCAP, 2000 Kanawha Ave SE, Charleston WV 25304

JRV/nh

CHARLESTON PSYCHIATRIC GROUP, INC
CPG

BEP-LEGAL DIVISION
94 MAY 12 AM 8:42

2008 Kanawha Boulevard, East, Charleston, WV 25311-2204 (304) 344-0349

May 5, 1994

John H. Kozak, Director
Legal Services Division
P.O. Box 3922
Charleston, WV 25339-3922

Re: Proposed Title #85 Series 16 "Guidelines for Permanent Impairment and Disability Evaluations, Evidence, and Ratings"

Dear Mr. Kozak:

I am writing regarding Title #85, Series 16, and have some comments. First of all, the psychiatric Sub-Panel of the Health Care Advisory Panel developed standards for impairment ratings for psychiatric and emotional injuries for Workers' Compensation claimants. As you know, the Health Care Advisory Panel has adopted the Guides To The Evaluation of Permanent Impairment by the American Medical Association, latest edition, except for the psychiatric and the hearing loss impairment ratings. However, the psychiatric sub-panel was strictly looking at what is now in the AMA Guides, 4th Edition, Chapter 14 "Mental and Behavioral Disorders" section. I wanted to make sure that psychiatrists could continue to utilize Chapter 4, The Nervous System of the Guides To The Evaluation of Permanent Impairment, which is excellent in its description of brain problems. Psychiatrists, neurologists, or neurosurgeons, who are evaluating brain injured or brain diseased patients for impairment ratings, should use Chapter 4 of the AMA Guides To The Evaluation of Permanent Impairment.

Second of all, it is my suggestion that the Workers' Compensation Division develop a credentialling process for Independent Medical Examiners and to maintain a periodically updated folder of credentialling information regarding each examiner that performs such examinations as an examiner for the Division. This would be in lieu of "a resume or curriculum vitae that is to be attached to the report". Attaching a resume or curriculum vitae to each report would prove extremely cumbersome for the Division, and clog up the microfiche and computers with needless paperwork for examiners performing these examinations on a frequent basis. The rule should be amended to make examiners not credentialled by Workers' Compensation to provide such curricula vitae.

Sincerely,

Ralph S. Smith, Jr., M.D.
Psychiatrist

RSS/cld

Workers' Compensation Office of Judges
Post Office Box 2233
Charleston, West Virginia 25328-2233

May 16, 1994

Andrew N. Richardson, Chairman
Workers' Compensation Performance Council
112 California Avenue
Charleston, West Virginia 25305

Re: Comment on Proposed Guidelines for Permanent Impairment and Disability Evaluations, Evidence, and Ratings

Dear Chairman Richardson:

Please accept for filing my comments in regard to the above mentioned proposed regulations. In the strongest possible terms, I urge the Council not to adopt these regulations in their present form.

Following are the major points which I believe fatally flaw the proposal:

- The proposed regulations completely abolish the manner in which permanent partial disability evaluations are currently made, and the rules and assumptions by which permanent partial disability awards are currently determined and made.
- Having abolished the current rules and assumptions, the proposed rules do not establish any pathway or mechanism to go from impairment to disability.
- To my knowledge, no study exists which illustrates the impact these new regulations will have on claimants, employers, the Workers' Compensation Fund, the Office of Judges, Workers' Compensation Appeal Board, or the Workers' Compensation Bar.

Re: Comment on Proposed Guidelines for Permanent Impairment and Disability Evaluations, Evidence, and Ratings

- It is my belief the Workers' Compensation Fund does not have employees in sufficient numbers or that possess the necessary skills to undertake true disability evaluations. Moreover, Fund management has indicated that it will take more than a year to put in place the numbers of employees with the skills necessary to perform such evaluations.

- Because the proposed rules provide no guidance on how to determine disability, it is certain that the rate of protests to Commissioner's Orders will substantially increase, thus, further increasing the workload of the Office of Judges.

- The proposed regulations inappropriately limit the consideration of medical and professional evidence.

- The proposed regulations are a piecemeal approach to dealing with Workers' Compensation issues concerning benefits.

These comments are made in my capacity as Chief Administrative Law Judge of the Workers' Compensation Office of Judges. These rules provide no guidance to the Fund, the Office of Judges, or the Appeal Board as to how to review the required expert reports and determine a percentage of disability. If these proposed regulations are to be considered by the Performance Council at the July 14, 1994 meeting, I request an opportunity to personally address the Council regarding this issue.

Your consideration of these comments and my request is appreciated.

Very truly yours,

Robert J. Smith
Chief Administrative Law Judge

RJS:cm

cc: Performance Council Members

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May 16, 1994

BEP-LEGAL DIVISION
94 MAY 18 AM 10: 14

The Honorable Andrew N. Richardson
Workers' Compensation Fund
Post Office Box 3151
Charleston, West Virginia 25322

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

Dear Commissioner:

We have reviewed your proposed Legislative Rule, Title 85, Series 16. Thank you for the opportunity to file the following remarks:

POSITIVE COMMENTS:

1) We appreciate your goal of bringing a greater degree of consistency to the rating of medical impairment related to compensable injuries. The rule will take a major step toward that goal.

2) We appreciate your choosing nationally recognized medical standards to use as consistent guidelines. Too often, West Virginia is on the fringe: the exception to regularly accepted standards.

3) We appreciate that your proposed rule is clear and concise. Complicated and lengthy regulations can lead to confusion and additional litigation.

CONSTRUCTIVE SUGGESTIONS:

1) We have reviewed the *Guides to the Evaluation of Permanent Impairment* (4th ed. 1993), and often rely upon them in litigating workers' compensation claims. However, we do not presume to substitute our opinion on your choice of the *Guides* for that of qualified medical experts. We recommend that careful inquiry be made of the Health Care Advisory Panel to determine whether the *Guides* have been fully scrutinized and have shown upon peer review to have been generally accepted by

the medical community as the best choice for purposes of the proposed rule. It is our understanding that the fourth edition of the *Guides*, as well as the earlier editions, have been criticized for a lack of independent testing of both validity and reliability, particularly in the orthopedic area. Since these guidelines will dramatically affect the system, the most valid set of medical standards should be chosen.

2) Once standard procedures are adopted, confusion will result that will prejudice both employers and employees unless the medical community has been properly informed and given ample opportunity to adapt their office and examination procedures. Thus, we recommend that you adopt a plan to properly educate and inform appropriate vendors before the rule becomes effective. Also, we assume the rule will be effective for evaluations performed after the effective date so that current opinions or reports in pending litigation based upon earlier examinations will not be stricken from the record.

3) It appears clear from the rule that you recognize certain claims will not properly fit procedures outlined in the *Guides*. The workers' compensation system was designed to benefit people -- claimants and employers -- not a process. For example, a person with congenital deformities may score differently on certain testing. To the extent that language in certain parts of the rule seemed to require an inflexible application of the rule to all claims, we have suggested language that recognizes the need for guidelines, but permits appropriate exceptions that must be clearly defined.

4) Evaluating the qualifications of persons giving expert opinions is critical. Though it may be easier to require evaluators' resumes to be attached to each report so as to properly outline qualifications, we have suggested that evaluators who are regular vendors in the system be permitted to file current resumes annually. If the process for indexing those resumes is administratively difficult, the system suggested in the rule is a fair substitute. However, in a paper intensive process, we offer this suggestion to save paper and cost.

AREAS OF DISAGREEMENT:

1) Nowhere does the rule recognize that the only medical impairment relevant to an evaluator's opinion is that resulting from a compensable injury. A fifty-year-old claimant who no longer has the range of motion to touch his toes, though medically impaired, should not receive workers' compensation benefits if that impairment relates to age, lack of proper exercise, nonwork-related injuries or causes other than an injury on the job. We have suggested language that recognizes the

purpose for the system: to justly compensate for injuries received in the course of and resulting from employment.

2) The comprehensive guidelines published by the American Medical Association relate to the evaluation of permanent impairment. Though disability is referenced, the *Guides* do not contain an in-depth analysis of the inquiry necessary to determine an individual's disability that may result from that impairment. The definition of disability contained in paragraph 3.2 of the proposed rule illustrates clearly that disability includes the analysis of an individual's capabilities, background, education, aptitudes, job description, motivation, and other factors that require investigation and information beyond a medical examination. Therefore, we suggest limiting the application of this rule to impairment ratings, upon which workers' compensation benefits are granted in most cases, and that for permanent total disability claims or other claims where there is a unique relationship between the effects of impairment and an individual's job, a separate rule be adopted for disability determinations.

A rule related to disability determinations should only be effective after protocols are adopted related to vocational evaluations, which currently use widely inconsistent testing procedures, and should outline information which must be reviewed to render an opinion on disability. The disability rule should also properly reference and incorporate the concepts outlined in the vocational rehabilitation regulations recently adopted by the Compensation Programs Performance Council.

In addition to these general comments, we have redlined a copy of your proposed rule with our specific suggestions for language changes. Thank you for considering our comments.

Very truly yours,

BOWLES RICE MCDAVID GRAFF & LOVE

Sarah E. Smith

SES/cjw
Enclosure

244908

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 as general guidelines 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, or state with specificity why use of the standards would be inappropriate based upon the facts of the individual claim. 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 current resume or

curriculum vitae that is to be attached to the report or filed annually with the Workers' Compensation Fund and available to the parties upon request.

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, nor does the rule apply to medical records or other information relevant to an investigation of the claimant's medical history. 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~~2. "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~~3. "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~~4. "Permanent impairment" related to a compensable injury 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 the loss or abnormality of psychological or anatomical structure and function that results in "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 which relies upon the Guides 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).

5.1.4. To the extent that factors other than the compensable injury may be affecting impairment, the opinion stated in the report must determine the contribution of those other factors, including but not limited to age, weight, congenital deformities, preexisting conditions or diseases, general physical conditioning, and prior injuries.

~~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.~~

5.32. 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, or by annually filing an appropriate document with the commissioner. 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. The party producing a report from an expert whose resume or curriculum vitae is on file at the Fund rather than attached to the report must produce a copy of the document to any party upon request. 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~~3. 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.

JACKSON & KELLY

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May 16, 1994

340-1301
WRITER'S DIRECT DIAL NO.

Mr. John H. Kozak, Director
Legal Services Division
Workers' Compensation Division
601 Morris Street
Charleston, West Virginia 25301

RE: Proposed Legislative Rule: Guidelines for Permanent Impairment and Disability Evaluations, Evidence and Ratings

Dear Mr. Kozak:

Please find enclosed herewith brief comments prepared as a result of review of the proposed rule noted above.

My kindest regards.

Very truly yours,

TIMOTHY E. HUFFMAN

TEH:tsn

COMMENTS TO THE PROPOSED LEGISLATIVE RULE, TITLE 85, SERIES 16 "GUIDELINES FOR PERMANENT IMPAIRMENT AND DISABILITY EVALUATIONS, EVIDENCE AND RATINGS"

Section 85-16-2 and Section 85-16-5(5.1)

Pursuant to Section 85-16-2, the rule is applicable "to evidence submitted by any party to a claim" as well as to the evaluations sought by the Workers' Compensation Division. Additionally, Section 5.1 of Code Section 85-16-5 provides that for any report to be deemed credible and reliable, such report must conform to these rules and apparently applies to any report prepared for "evidentiary purposes during the course of a workers' compensation claim for benefits at any level of review". Both these sections purport to apply the rule requirements to reports which are submitted by either party in a litigated claim before the Office of Judges. If that is the intention of the rule, the same needs to be clearly stated and some guidance must be given with regard to the use of nonconforming reports previously submitted into litigation in claims where a final order has not yet been entered.

General Comments

While the overall purpose of this rule is to bring conformity to the quality of evidence being considered by the Workers' Compensation Division and apparently to the evidence being submitted by the parties to a claim, some consideration must be given to the present requirement of West Virginia Code §23-4-7a(c)(1). Pursuant to that particular code provision, if an authorized treating physician recommends a permanent partial disability award of 15% or less, the Commissioner is required to enter an award based upon such a recommendation. Specific provision should be made in the proposed rule to deal with such situations to insure that such awards are based upon "credible and reliable evidence".

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94 MAY 18 AM 10:33
BEP-LEGAL DIVISION

May 16, 1994

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

Re: Comments to Guidelines for Permanent Impairment and Disability Evaluations, Evidence, and Ratings

Dear Mr. Kozak:

The first and most critical comment I have concerning the new proposed rule is that it is supposed to be Guidelines for Permanent Impairment and Disability Evaluations and it does not address the additional factors, beyond impairment, that determine the degree of disability suffered by a claimant. This rule is therefore confusing and restrictive. It's avowed purpose is to give guidance but the most difficult determinations are how the impairment and the "additional factors" interact and effect ones ability to work. The Commissioner and performance council should address this tough issue instead of leaving parties to guess at what is to be done and by whom. There are times when equal impairment will result in different disabilities for different individuals. An example would be that a 15% impairment to the lumbosacral spine might equate to a lesser disability to a college professor than it would to a gas station attendant. Without this issue being addressed this rule is virtually worthless except to watch the fund rubber stamp doctors impairment ratings.

Given this rule, parties will be left with trying this and trying that. This will breed litigation. Already exorbitant legal expenses will increase for employers and claimants in many cases will get more than they deserve. Others will be left wondering what type of evidence they need and what type expert through which to present it to get there just rating. Dealing with this problem in that fashion will result in inconsistent application of the law.

I perceive a problem with the adoption of the AMA Guide to impairment rating by this rule. One cannot adopt a regulation more restrictive than the underlying substantive statutes. The AMA Guide is in many instances more restrictive than our

substantive statutes. An example is the AMA Guide 4th Edition for the loss of a great toe indicates a 5% impairment is appropriate when our code awards a 10% permanent partial disability. This is only one example as there are many more instances where the AMA Guide would mandate a lower award than our statutes. Such a change can only be made by the legislature. A more difficult problem would exist when for example an individual would lose one-half of a great toe.

The second problem with the total consumption of the Guide is that it is merely a guide. It should be used as such and not be adopted as black letter law.

Sub-section 5.1.3 sets forth the importance of a thorough consideration of the medical information along with the non-medical information. However, as previously noted these rules fail to give guidance on what type of expert would be acceptable to address this issue. The rule further fails to state how the fund will deal with this information.

It has been my experience that a lot of claimants asked to deal with the pain diagram section of the Back Examination form are confused by it. The examiners should be instructed to insure that the examinee understands what they are being asked to do.

Sincerely,

James M. Robinson

JMR/lfs

WEST VIRGINIA SELF-INSURERS ASSOCIATION'S COMMENTS TO THE GUIDELINES FOR PERMANENT IMPAIRMENT AND DISABILITY EVALUATIONS, EVIDENCE, AND RATINGS

§ 85-16-3 Definitions

Throughout the proposed Guidelines, references are made to the "qualifications" and the "expertise" of the opinion giver. The Association believes that the definition of a "qualified evaluator" should be set forth in this section, to go along with the definitions of other pertinent terms used in this rule. Furthermore, the Association is of the opinion that the Health Care Advisory Panel should adopt guidelines to be used in certifying an opinion-giver as one who is qualified to evaluate. Finally, the Association advocates that one who makes a recommendation for a permanent impairment rating must fall within the definition of a qualified evaluator, as opposed to being merely a treating physician.

The Association believes that the definition of disability, under Paragraph 3.2 of this section is problematic. By asserting that disability may be thought of as the gap between what a person can do and what the person need or wants to do, this proposed guideline opens the door for many people who simply do not have a disability to be deemed "disabled." For example, it is not uncommon for a person to want to perform a particular activity or task, but simply cannot for a number of reasons, besides impairment. Consequently, the Association recommends that the definition of disability as set forth in Paragraph 3.2 would be sound without the assertion of this so-called gap distinguishing what a person can do from what he or she may want to do.

§ 85-16-4 Adoption of Standards

The Association is pleased with the requirement of utilization of the American Medical Association's Guides to the Evaluation of Permanent Impairment (AMA Guides) in medical evaluations to determine the degree of permanent impairment which a claimant has suffered. The

Association also agrees that an examiner must be required to document his or her reasons for not following the Guides should he or she choose not to do so. We would merely suggest that the rule itself be consistent with the concept of scheduled injuries, such as those set forth in W. Va. Code § 23-4-6(f). For example, the rule could set forth degrees of impairment which would correspond to various injuries, where such degrees reflect the allocations of impairment set forth in the AMA Guides.

§ 85-16-5 Evidentiary Requirements

Under Paragraph 5.2, the proposed rule requires that the opinion on the degree of disability suffered by a claimant "must be shown and explained in detail." The Association believes that the terms "shown and explained in detail" are rather vague. Rather, this section should be couched in a more recognizable term of art which has been accepted by courts and other administrative bodies, such as "documented and reasoned," or "reasoned medical judgment."

With respect to Paragraph 5.3 under this section, which requires the qualifications of the expert to be attached to his or her report, the Association suggests that this rule should clearly spell out that the requirement only applies to evaluations performed as part of a litigated claim. Furthermore, perhaps the Workers' Compensation Division could keep an updated "master list" of experts who are presumptively qualified so that in the event a clerical error would result in a failure to attach a curriculum vitae, then the report will still be deemed reliable.

Under Paragraphs 5.4 and 5.5, the Association recommends that these provisions should be drafted more clearly so as to ensure that the Regulations will allow all evaluators, including those who perform evaluations at the request of employers, to give an opinion on disability, which will have the same weight as any opinion given by an evaluator who performs an evaluation at the request of the Commissioner or the claimant's treating physician. Specific reference is made to the statement in Paragraph 5.5 regarding how well a physician may be

acquainted with a claimant's activities and needs. Under the proposed rule, such a physician may also express an opinion about the presence or absence of a disability. The Association submits that this is rather one-sided, in favor of claimants. Rather, this rule should be drafted to permit equal weight to be given to the opinions of all evaluators.

Furthermore, the use of the word handicapped in this rule is also problematic. We believe that, standing alone, this term lends itself to a connotation of permanent impairment. If it remains in the rule, then the definition which accompanies it in the AMA Guides should also be included, which sets forth the view of federal law in determining whether a person is handicapped.

§ 85-16-6 Exceptions to the Guides

Under Paragraph 6.1 of this section, the provisions of C.S.R. § 85-1-20, including the Table for Impairment of Pulmonary Function, should be set forth so as to provide a complete guideline for evaluating pulmonary impairment.

With respect to mental and behavioral disorders, as set forth in Paragraph 6.3, it is not clear as to whether or not the standards developed by the Health Care Advisory Panel have ever been sent out for public comment, or if they are already in place and are being utilized. Furthermore, the Association suggests that this provision should be clarified to reflect the 1993 legislation which repealed the compensability of the so-called "mental-mental" claim. In other words, the provision should be written so as to provide guidance to evaluators that, in order to be compensable, a mental disorder must be accompanied by a physical injury.

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May 16, 1994

John H. Kozak, Director
Legal Services Division
Bureau of Employment Programs
Post Office Box 3922
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Dear Mr. Kozak:

Please find enclosed herewith my comments regarding policy statement for the handling of requests for permanent partial disability awards, and comments directed towards the proposed legislative rule for the guidelines for permanent impairment and disability evaluations, evidence, and ratings.

I would like the opportunity to appear before the appropriate authority to further express my comments orally regarding the proposed policy statement and rule.

Sincerely yours,

Thomas P. Maroney

TPM/clg

Enclosures

94 MAY 16 PM 3:54
BEP-LEGAL DIVISION

COMMENTS OF THOMAS P. MARONEY REGARDING GUIDELINES FOR PERMANENT IMPAIRMENT AND DISABILITY EVALUATIONS, EVIDENCE, AND RATINGS

§85-16-1

1.2. Authority. -- The undersigned has not seen the letter of approval of the Secretary of the Department of Commerce, Labor and Environmental Resources, but would like to see the Secretary's comments in order to express thoughts concerning the Secretary's communication regarding this matter.

§85-16-2; §85-16-3; §85-16-4

The undersigned is totally opposed to the use of the "Guides to the Evaluation of Permanent Impairment" (4th ed. 1993), as published by the American Medical Association for the use of establishing impairment and disability of injured workers. The preface to this book indicates to the users that they are merely guidelines, and are not to be regarded as totally authoritative in nature. Often, treating or examining physicians in West Virginia are more aware of the impairment and disability definitions as applied to the real work setting, and, therefore, are in a better position to express opinions as to disability and impairment from their own practical experiences, as opposed to those set forth by the "Guides."

§85-16-5

5.1-5.6. The West Virginia Workers' Compensation Fund is the initiating party to determine the degree of disability that an injured worker has as a result of an industrial accident, disease, or occupational pneumoconiosis. The Fund should secure from physicians prior to the referral, the curriculum vitae or other necessary background information of a physician and have it on file. In most instances, all physicians in West Virginia have agreed to become treating physicians under the Workers' Compensation Medical Provider Program. At the time that the physician becomes a provider, his or her qualifications should be placed on file with the Fund. Only in those instances where the Fund does not have prior knowledge of the physicians background should it be necessary to secure a curriculum vitae or resume.

Opinions expressed by physicians, psychologists, physical therapists, and vocational rehabilitation or guidance workers should be allowed as to on both impairment and disability. The issue here is not whether or not the person should be allowed to express an opinion, but the weight should be

attached to each depending upon his or her experiences and qualifications in the fields of medicine, vocational rehabilitation and training, physical impairment from physical evaluation performances, and psychological and/or psychiatric involvement and overlay.

The use of the forms attached to be completed by the physician and/or provider will not accomplish what needs to be done in the evaluation of permanent disabilities. These requirements will increase the cost to claimants, the Fund and employers. The current system of being provided a narrative report by physicians in West Virginia has time and time again proved to be effective in the administration of the West Virginia Workers' Compensation Fund.

These proposed regulations are attempts to create a standard such as is found within the Occupational Pneumoconiosis Rules and Regulations. However, medical evaluations for traumatic and/or psychiatric injuries to the person cannot be categorized as those breathing impairments which are found in occupational pneumoconiosis cases.

The increased cost to all parties utilizing these methods violates the spirit of the West Virginia Workers' Compensation Laws under these proposed regulations.

§85-16-7

For the Fund to refer a person to any disability or impairment examiner for an examination, report, and opinion, and, then not pay for the same, is totally outrageous.

Respectfully submitted,

Thomas P. Maroney

FOLWELL CHIROPRACTIC CLINIC

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BEP-LEGAL DIVISION
94 MAY 20 PM 12: 15

Attention: John H. Kozak
Bureau of Employment Programs
Legal Services Division
Post Office Box 3822
Charleston, West Virginia 25339-3922

May 17, 1994

RE: Impairment Recommendations for the State of West Virginia Workers' Compensation

Dear Mr. Kozak:

There exists a need for uniform rating as established by the "Guides", when evaluating musculoskeletal disorders for impairment. I would like to make a few recommendations in regards to this procedure which may better serve the Bureau and its administration.

I am currently taking a program through the Chiropractic profession known as a "Diplomate program". Different areas of study exist, i.e., orthopedic, neurology, radiology and internal medicine. Each program consists of 360 hours (except neurology with 300 hours) post graduate training, of which impairment rating is provided with 36 separate hours through the orthopedic program. I have completed better than 2/3's of the orthopedic and neurology programs to date. Completion of the impairment rating section was made last summer. I am currently updating my training to include modifications made with the 4th ed. of the Guides.

As an IME for local attorneys and the state of West Virginia I am capable of properly performing and completing an impairment rating as set forth through the *Guides*. In my opinion, it is very important to have a broad based training in neuromusculoskeletal disorders such as orthopedics and neurology in order to better evaluate.

This acts as a top rate filtering system in making recommendations for further treatment courses and when to deem a condition permanent which has become static or well stabilized with or without medical (chiropractic) treatment, or that is not likely to remit despite medical treatment.

I have been totally shocked when asked to perform a second IME for a patient when I am told, and I mean often, that the first investigator did virtually nothing. I question how the "back examination form" might have been completed.

With a properly prepared impairment comes an explanation of limitations which better explains to the proper authorities what limiting loss or absence of capacity an individual has when meeting personal, social, or occupational demands. Since disability is assessed by non-medical means (employability) a greater relationship is developed between vocational rehabilitation at both state and federal levels. Perhaps even the employer can better place this individual to meet what limitations developed as a result of the impairment when an explanation is made by the ME.

I am currently working with a group who performs the mathematical computations set forth through the AMA's Guide when calculating the total whole body percentages by way of combining. When I complete an examination, and it is determined that a significant impairment exists to interfer with this person's acts of daily living and employability, I complete a questionnaire and forward to Kaplan Software Group. This takes very little time, a faxed copy is sent and then received back usually within 3-7 days.

Some evaluations are considered compound injuries in which a pre-existing injury was noted prior to the injury in question. This again requires skillful knowledge in evaluation. A complete history of both injuries is taken. A more broad based examination must be performed in order to better differeniate between what exists as previous overlay of a pre existing injury and what is considered as further damage or simple aggravations of said injury.

There is no way of physically separating out these injuries when evaluating them, however a division of the percentage can and should be made according to the differences in history and perhaps examination previously sought. This whole process points outs uniformity but, depends more so on greater skill of evaluators who strive to maintain up to date methods of evaluation and observation.

The current process by which a person is evaluated is fairly consistent. The methodology by which the Bureau requests input is proper and necessary. However, additional screening of independent examiners on training should be sought before permitting access to such a valuable part of the Workers' Compensation system.

If I can be of any further assistance to you or your staff with this matter, please don't hesitate to contact my office. I have previously traveled to Charleston to discuss impairment issues and would be glad to do so in the future.

Sincerely concerned,

Byron R. Fatwell, D.C.
Doctor of Chiropractic

Bureau of Employment Programs
Workers' Compensation Division
601 Morris Street
Charleston, West Virginia 25301-1416

Gaston Caperton, Governor
Andrew N. Richardson, Commissioner

Workers' Compensation Division
601 Morris Street
Charleston, West Virginia 25301

Attention: Sam Bays

TO: OUR VALUED INDEPENDENT MEDICAL EXAMINERS & PROVIDERS

FROM: Claims Management Redesign Committee and
HCAP (Health Care Advisory Panel)

DATE: May 3, 1994

A major overhaul of the West Virginia Workers' Compensation Division is in progress. In fact, the changes will be dramatic.

As many of you now know, we are entering into a new era in our approach to case management. The 4th Edition (most current) of the AMA Guidelines for Rating Impairment has been adopted as our preference for use by the independent examiner. The Health Care Advisory Panel is also developing clearer guidelines in regards to the appropriate treatment of injured workers with workers' compensation claims.

Continuing with a positive outlook to the many changes, we are also addressing in greater detail the independent medical examination process. **Our goal is to increase the effectiveness and timeliness of the reports and to provide coverage for these examinations in areas of the state where a shortage of examiners now exists.** With that in mind, we recognize that you and your staff are a valuable source from which we gain insight and have developed a questionnaire on the reverse side of this memorandum for your input. Your earnest and timely response is of great importance to us. Also, feel free to elaborate on issues that are not identified on the form. Your comments and those of your staff will receive our attention. It would be most appreciated if you could respond within the next 10 - 15 days.

Please fold this letter so that our address (see above) will appear in the window of the envelope provided. Thank you.

Belinda S. Morton
Attorney at Law

106 Maple Street
P.O. Box 636
Fayetteville, WV 25840-0636
(304) 574-3000

May 1994

BEP-LEGAL DIVISION
94 MAY 17 AM 10:51

John H. Kozak, Director
Legal Services Division
P. O. Box 3922
Charleston, WV 25339-3922

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

Dear Director Kozak:

I have reviewed the proposed rules regarding the above-captioned matter, and, although I agree that a definite standardization of the impairment and disability ratings process needs to be implemented, there appears to me that some of the provisions seem to be extreme and ambiguous in nature.

In reviewing the proposed rules, the major goals appear to be the reduction of costs to the Workers' Compensation system, while providing more thorough, comprehensive, accurate and fair evaluations for claimants. It is estimated that implementation of these rules will increase Workers' Compensation expenditures from one to three million dollars yearly. However, based on the proposed guidelines, I would think that Compensation's expenditures will be much greater than is estimated because claimants will need to be referred out to various experts in order to comply with the proposed standards. For example, while a medical doctor may be qualified to evaluate a claimant for his physical "impairment", he would not customarily be qualified to evaluate a claimant as to the degree of "disability" from which he might suffer. As such another evaluation would have to be performed by a qualified psychologist because the disability issue is a personal, social and occupational one. Further, it appears that claimants may also be required to undergo "FCE and EMG" studies in order to comply with the proposed standards. This means that each claimant may be required to undergo at least three separate evaluations, not to mention a psychiatric evaluation, if a claimant has been diagnosed as having such an impairment as a direct and proximate result of his occupational injury.

Further, it is my judgment that the proposed rules will greatly eliminate and/or limit the number of physicians who will be willing and/or qualified to treat and/or evaluate claimants. Although not specifically addressed in the rules, it appears that, not only will the Fund's evaluators need to be experts in their fields, but also the claimants will need to secure the services of experts who are qualified in their certain areas of expertise before their findings and recommendations will be considered or given any credence, whatsoever. I have been a "workers' compensation attorney" for many years, and, unfortunately, it

has been my experience that experts such as this will only examine claimants if they have been referred to them by their attending physician. At present, claimants experience problems in obtaining physicians because said physicians are extremely hesitant to accept individuals as workers' compensation patients. The major reasons given by said physicians for their hesitancy are (1) the Fund's refusal to pay them and/or the dilatory manner in which they are paid and (2) they find it very exasperating to have wait to find out whether or not the Fund is going to either authorize or deny treatment and/or diagnostic testing that they feel is necessary. Now, combining their present attitudes with the stringency of the proposed rules, it is my judgment that, as above stated, it will greatly limit the number of physicians that will be willing to treat claimants.

Furthermore, the proposed rules will greatly limit a claimant's ability to effectively litigate his/her claim if he/she so desires. As I am sure you know, the majority of workers' compensation claimants have very minimal and/or limited incomes, which makes it extremely difficult for them to come up with the necessary funds to have independent evaluations performed. At present, the majority of physicians charge fees from somewhere in the neighborhood of $400.00 to $500.00. However, if these rules are enacted, I have no doubt in my mind that their fees will almost double. As such, it appears to me that the only parties who will be benefiting from the proposed rules will be the Fund and the employer because they have much greater resources at their disposal than does the claimant. This means that claimants will be compelled to acquiesce to the Fund's evaluators' recommendations and/or the employers' evaluators' recommendations, inasmuch as they will not be able to bear the financial burden of procuring their own independent evaluations.

As above stated, I do agree that a definite standardization of the impairment and disability ratings process needs to be implemented. However, I also believe that, as the Workers' Compensation Fund was designed in aid and support of the injured worker, further consideration should be given to their plight.

Sincerely,

BELINDA S. MORTON, ESQUIRE

BSM/llr
cc: Linda Rice, Chairperson
Workers' Compensation State Bar Committee

JAMES D. WEINSTEIN, M.D.
Neurological Surgery

300 Davisson Run Road
Suite 301
Clarksburg, WV 26301

304-624-6601
FAX: 304-624-4728

May 18, 1994

John H. Kozak
Bureau of Employment Programs
PO Box 3922
Charleston, WV 25339-3922

Dear Mr. Kozak,

I am in receipt of recent memorandum which I presume gives me the option to respond to it. Apparently legislation is coming along in hopes of developing guidlines for impairment rating, disability evaluation, etc. First of all, the question of impairment based on the AMA guidelines is, in my opinion, a major error. These guidelines are grossly exaggerated in terms of what a reasonable impairment should be. For example, if a patient has a lumbar strain and sprain syndrome, which is a typical diagnosis, and no objective pathology on diagnostic studies, specifically MRI or myelogram/CAT scan, the patient if they never get better, which occurs, it would be entitled a 5% impairment rating for that area of the body. Multiple areas of strain and sprain might increase this to 7% but 5% could represent impairment for multiple areas. A patient who has an objective pathology, such as osteoarthritis, or spondololysis, might be than entitled to 10% impairment of the whole person. On table 53 we have patients with a grade 1 or 2 spondololysis entitled to 20% impairment plus additional impairment due to other effects. There is also impairments based on inability to bend. Try dealing with patients who are obese or uncoporative; it doesn't happen. Does that mean that their entitled to a 30 or 40% impairment? In summary I am quite comfortable with the reasonable impairment classification that I have developed myself, this is roughly in line with what Dr. Bob Wilson recommends because many times we see patients together. I would be glad to outline this impairment rating in detail.

The other major factor which should be considered is that the interval of time should be abbreviated for patients who are getting temporary total disability. This is costing the system a fortune. I can't tell you how many patients have simple strain and sprain syndromes that don't get the situation resolved in two or three months which would be correct in my opinion. First of all the HCX Corporation frequently refuses testing so a diagnosis can't be made and the patients remain on TTD. Than when a diagnosis is finally made (ie. strain and sprain syndrome) they continue with this indefinitely in some cases perhaps years. Most of us when we sprain an ankle we're back to work in two weeks. Some of these people go on permanent disability

JAMES D. WEINSTEIN, M.D.
Neurological Surgery

300 Davisson Run Road
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for a sprain after years of temporary total disability. I think there is a lot of room for improvement and I have in the past offered my services but to no avail. Perhaps this letter will stimulate an interest.

Yours sincerely,

James D. Weinstein, M.D.

JDW/jkw

P.S. If I must use the AMA guidelines consider that I will turn in my evalutor badge and will no longer offer commentary about my patients in that regard either.

Bureau of Employment Programs
Legal Services Division
Post Office Box 3922
Charleston, West Virginia 25339-3922

Gaston Caperton, Governor
John Ranson, Cabinet Secretary,
Commerce, Labor and Environmental Resources
Andrew N. Richardson, Commissioner,
Employment Programs

M E M O R A N D U M

TO: To Workers' Compensation Practitioners

FROM: John H. Kozak
Director, Legal Services Division

DATE: May 11, 1994

RE: Proposed Legislative Rule: Guidelines for Permanent Impairment and Disability Evaluations, Evidence, and Ratings; Title 85, Series 16.

The Compensation Programs Performance Council has issued the above noted proposed rule for public comment prefatory to the Council's adoption of a permanent rule. The comment period has been extended until July 5, 1994, in response to a number of requests for additional time to submit responses. The rule is not in effect at this time as an emergency rule.

The purpose of the rule is to bring uniformity of methodology to the performance of examinations for impairment ratings, composition of reports, and opinions on the degree of impairment which a workers' compensation claimant has suffered. The rule incorporates three items by reference: first, the previously adopted back examination form; second, the previously adopted psychiatric standards; and third, the "Guides to the Evaluation of Permanent Impairment," (4th ed. 1993), as published by the American Medical Association. The Commissioner's Health Care Advisory Panel has recommended the adoption of these three standards for impairment rating. Please note that the rule is not applicable to examinations and reports related to treatment issues or to the extension of temporary total disability benefits.

Further, the rule notes the distinction between impairment and disability as defined in the Guides and the law and incorporates that distinction into the ratings process.

Copies of the proposed rule may be obtained from the Office of the Secretary of State, State Capitol Building, Charleston, WV 25305, or by calling (304) 558-6000. Your review and comments are invited. The comment period has been extended to July 5, 1994, until 5:00 p.m. Only written comments are being accepted. There will not be a public hearing on the rule. Comments should be sent to my attention at the address noted in the letterhead.

William C Morgan, Jr., M.D.
Otology
Diseases & Surgery of the Ear

Janet S. Strohl
Administrator

WILLIAM C MORGAN, JR., M.D., INC.

May 20, 1994

Mr. John Kozak
Director, Legal Services Division
P.O. Box 3022
Charleston, WV 25339-3922

Dear Mr. Kozak:

I have noted your memo of 05/11/94, and I wonder how it can fit into the hearing evaluations. We have worked on the guides for West Virginia on a number of occasions, as you well know, and they do not coincide with the AMA Guides to Evaluation of Permanent Impairment.

I would assume that we continue to do it as we have in the past, but it would be a great thing if we were to adhere to the guides.

You have been very kind to us in the past with respect to our problems in hearing evaluations, and I would like for you to know that I am very appreciative.

Sincerely yours,

WCMorgan

William C Morgan, Jr., M.D.

WCM/rcb

ST. FRANCIS MEDICAL PLAZA • 331 LAIDLEY STREET, SUITE 602 • CHARLESTON, WV 25301 • 304-345-7100

SCOTT ORTHOPEDIC CENTER
Incorporated
Orthopedic Surgery & Rehabilitation

FRANCIS A. SCOTT, M.D.
(1929-1974)
THOMAS F. SCOTT, M.D.
COLIN M. CRAYTHORNE, M.D.
ROBERT W. LOWE, M.D.
JOHN O. MULLEN, M.D.

EARL J. FOSTER, M.D.
KYLE R. HEGG, M.D.
DANIEL E. CARR, M.D.
JACK R. STEEL, M.D.
SCOTT A. RILEY, M.D.

May 26, 1994

John H. Kozack
Box 3922
Charleston, WV 25339-3922

Dear Mr. Kozack:

Someone in your division asked that I review the proposed changes and guidelines for permanent impairment and disability evaluations. Accordingly I obtained at my own expense a copy of the proposed rule, and have reviewed Title 85, Series 16, omitting the psychiatric and pneumoconiosis guideline outline.

It is my observation the examiner would need the wisdom of Solomon and the equanimity of St. Francis.

I have been an orthopedic examiner for the Commissioner for the past 30 odd years. I don't think this experience would permit me to be of much assistance to you under the new proposed guidelines.

I know that throughout most of my professional life, there have been attempts to codify and make disability impairment evaluations more objective and quantifiable. I would think this attempt is the most recent effort. I am sorry that I can't express more enthusiasm for Rule 16, but feel that it would add chaos rather than order. I for one do not have the wisdom or the patience to be able to document and justify a sincere and meaningful opinion under these rules.

Section 85-16-17 referable to payment tends to add insult to injury.

I am well aware that the committee has probably labored long and hard to produce Rule 16. I cannot endorse it. If you have any specific questions, do not hesitate to contact me.

Sincerely,

Thomas F. Scott, M.D.

TFS/mas

2828 FIRST AVENUE, SUITE 400 • P. O. BOX 3127
HUNTINGTON, WEST VIRGINIA 25702
TELEPHONE (304) 525-6905
FAX (304) 525-9643

2000 CARTER AVENUE
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3 WOODLAND PLACE • U.S. 23 SOUTH
PAINTSVILLE, KENTUCKY 41240
TELEPHONE (606) 789-8442

Wayne-Oakland Medical Centers, Inc.

ADMINISTRATIVE OFFICES
DRUMMER BUILDING
SUITE 200
2075 WEST BIG BEAVER ROAD
TROY, MICHIGAN 48084-3439

BRUCE F. SANDERSON
PRESIDENT

JANICE L. GERHOLD
ADMINISTRATOR

ADMINISTRATION AND
CENTRAL BOOKING
LOCAL 810-643-9640
TOLL FREE USA & CANADA 800-338-8543
FAX NUMBER 810-643-9007

94 JUN -3 PM 3:35 P-LEGAL DIVISION

FAX TRANSMITTAL

DATE 6-3 19 94

TO: John H. Kozak

Director, Legal Services Division

WE ARE TRANSMITTING 3 PAGES INCLUDING THIS COVER. YOU MAY RESPOND TO OUR FAX NUMBER (810) 643-9007.

BY: Kim Jeffery

NOTES: Please read Following. Please Fax your reply to us!

Attention: Bruce F. Sanderson / Kim
Wayne-Oakland Medical Centers, Inc.

Fax #: (810) 643-9007

REGARDING: Title #: 85; Series #16 "Guidelines"

SOCIAL SECURITY #: -NA-

CLAIM NUMBER: -NA-

Wayne-Oakland Medical Centers, Inc.

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FAX NUMBER 810-643-9007

May 31, 1994

JOHN H. KOZAK
DIRECTOR, LEGAL SERVICES DIVISION
POST OFFICE BOX 3922
CHARLESTON, WEST VIRGINIA 25339-3922

RE: WORKERS' COMPENSATION DIVISION BUREAU OF EMPLOYMENT PROGRAMS PROPOSED RULE, TITLE NUMBER 85, CITED AUTHORITY WV CODE; 21A-2-6(2); 21A-3-7(B) AND 7(C); 23-1-1; 23-1-13; AND 23-1-15, NEW RULING PROPOSED 16. TITLE OF RULE BEING PROPOSED GUIDELINES FOR PERMANENT IMPAIRMENT AND DISABILITY EVALUATION, EVIDENCE AND RATINGS.

Dear Mr. Kozak:

This letter is in regards to the above proposal on your docket. We are not writing for any further proposals to be made or deleted but do have some questions and concerns regarding the proposal if said proposal passes.

In brief, we schedule Independent Medical Evaluations for the State of West Virginia's Workers' Compensation Fund. These examination are scheduled both within and out of state. Our out of state doctors must rely on the outlines that we forward them to produce the proper report. Sometimes, however, the doctors do not get the information all in one report and an addendum must be received to complete the case.

We have read all the bulletins and proposals and have been able to accommodate West Virginia in retrieving all their required criteria with our exams. In reading the above Rule that is being proposed we have a few questions and hope that you could please take the time to answer this for us.

1. IN YOUR RULES PAGES 3 AND 4 OF 85 CSR 16, HEADING 23-16-5 EVIDENTIARY REQUIREMENTS, SUBHEADINGS 5.3 AND 5.4 IT IS PRESENTED THAT THE DOCTOR'S CREDENTIALS MUST ACCOMPANY EACH AND EVERY REPORT AND THAT WITHIN EITHER THE RESUME OR THE CURRICULUM VITAE IT MUST SHOW THAT THE INDEPENDENT PHYSICIAN IS BOTH AN EXPERT IN THE FIELD OF IMPAIRMENT DETERMINATION AS WELL AS IN THE FIELD OF DISABILITY DETERMINATION. ALL THE DOCTOR'S THAT WE DO USE ARE BOARD CERTIFIED IN THEIR RESPECTIVE FIELDS, HOWEVER WHAT WOULD BE YOUR EXACT CRITERIA IN ACCEPTING A DOCTOR AS AN EXPERT? PLEASE FORWARD US A LIST OF GUIDELINES THAT YOU WILL BE FOLLOWING IN THIS RESPECT AS EACH DOCTOR AND EACH CURRICULUM VITAE WILL BE DIFFERENT RANGING FROM SCHOOLS, INTERNSHIPS, RESIDENCIES AS WELL AS FINAL PRACTICE AND ASSOCIATIONS, FELLOWSHIPS AS WELL AS BOARDS AND PUBLICATIONS. WE FEEL THAT THE CREDENTIAL'S OF OUR DOCTOR'S WOULD MEET OR EVEN EXCEED YOUR EXPECTATIONS BUT FEEL THAT WE SHOULD HAVE THE CRITERIA TO GO BY IN REGARDS TO WHAT FELLOWSHIPS, BOARDS ETC... THAT YOU DEEM ARE ACCEPTABLE.

OUR CONCERN ON THIS IS IF WE DO SCHEDULE WITH A DOCTOR WHO GIVES A PROPER REPORT COVERING ALL ASPECTS OF THE STATE OF WEST VIRGINIA'S WORKERS' COMPENSATION CRITERIA AND THE CV DOES NOT HOLD THE INFORMATION THAT YOU ARE SEEKING, PAYMENT FOR THIS EXAMINATION WOULD BE TERMINATED ON BEHALF OF THE STATE.

2. IN REGARDS TO YOUR RULE 85 CSR 16 PAGE 5 HEADING 85-16-7 PAYMENT FOR SERVICES IT IS INTERPRETED TO US AS THE FOLLOWING:

ANY EXAMINATION THAT IS DONE FOR THE STATE OF WEST VIRGINIA'S WORKERS' COMPENSATION THAT IS NOT CONDUCTED, PERFORMED, AND COMPOSED IN ACCORDANCE WITH THIS RULE SHALL NOT BE PAID. RE-PAYMENT TO THE STATE OF WEST VIRGINIA SHALL BE EXTRACTED IN ONE OF TWO WAYS; EITHER DIRECT RE-PAYMENT REMITTED TO WEST VIRGINIA OR BY WAY OF OFFSET AGAINST ANY FUTURE SUMS THAT MAY BE OWED BY THE DIVISION TO THE FACILITY AND/OR DOCTOR.

OUR QUESTIONS AND CONCERNS REGARDING THIS RULING ARE AS FOLLOWS:

IF A REPORT CAN BE CORRECTED WITH AN ADDENDUM, IF THE CRITERIA ARE NOT MET IN THE ORIGINAL REPORT, WOULD THIS THEN BE ACCEPTABLE FOR PAYMENT? ANY FURTHER INFORMATION THAT IS NOT GIVEN IN A REPORT THAT COULD BE GIVEN IN AN ADDENDUM WOULD COMPLETE THE CRITERIA AND ALL THE INFORMATION COULD BE SENT TOGETHER.

ALSO, IF WE RELEASE A REPORT THAT WE FEEL UPON REVIEW COMPLETES THE CRITERIA IN ACCORDANCE WITH THE STATE OF WEST VIRGINIA'S RULINGS AND THE STATE FEELS THAT MORE INFORMATION IS NEEDED, WOULD WE BE ALLOWED TO GET THE ADDENDUM FROM THE DOCTOR TO RIGHT THE CASE FOR THE STATE AND STILL RECEIVE PAYMENT ON THE EXAMINEE'S EVALUATION?

I would like to take this opportunity to thank you for your time in answering these questions for us. We are more than happy to be scheduling these examinations for the State of West Virginia and only hope to be sure that the reports go out in their proper form complete with all criteria answered.

Please send your typewritten response back to us at:

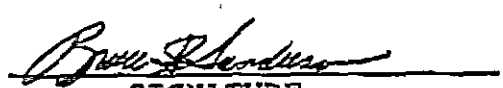
WAYNE-OAKLAND MEDICAL CENTERS, INC.
DRUMMER BUILDING
SUITE 300
2075 WEST BIG BEAVER ROAD
TROY, MICHIGAN 48084

FAX: (810)643-9007

I look forward to hearing from you in regards to this information.

Respectfully,

Bruce F. Sanderson
President


SIGNATURE

Raleigh Psychiatric Services, Inc.

P.O. Box 1025
Beckley, West Virginia 25802
Phone 252-8409
Fax 252-0022

M. KHALID HASAN, M.D., F.A.P.A.
M.R.C. Psych. (UK), F.R.C.P. (C)
Diplomate, American Board of Psychiatry & Neurology
Fellow, American Psychiatric Association
Diplomate, Geriatric Psychiatry
Diplomate, Addiction Psychiatry

John H. Johnson, Jr., M.S.W., B.C.D.
Licensed Social Worker

Dreama G. Baker, M.A.
Licensed Psychologist

Roger P. Mooney, M.A., Ed. D., N.C.C., L.P.C.
Licensed Psychologist

Linda K. Mills, M.S.W.
Licensed Social Worker

Debra R. Mooney, M.S.N., R.N., C.S.
Certified Family Nurse Practitioner

TELECOPIER COVER LETTER

Fax Number: (304) 252-0022
Office Number: (304) 252-8409

Date: 06/16/94

Please deliver the following page(s) to:

NAME: John H. Kozak, Director, Legal Services Division

FROM: D. G. Baker

COMMENTS: _____

We are transmitting 2 page(s) excluding this cover letter.

If you do not receive all of the page(s), please contact our office number as soon as possible.

June 16, 1993
John H. Kazak
Director, Legal Services Division
POB 3922
Charleston, WV 25339-3922
FAX: 558-1377

Dear Mr. Kozak:

Thanks to your office for sending the requested Notice of Comment Period on a Proposed Rule; specifically, the Proposed Legislative Rule on the Guidelines for permanent impairment and disability evaluations, evidence, and ratings. [PER WEST VIRGINIA CODE 21A-3-7(C), THESE RULES NOT SUBJECT TO LEGISALTIVE REVIEW].

I think your proposed guidelines are fine.

As you are aware, these evaluations unsually involve the evaluations and reports of a psychiatrist/psychologist team.

I am writing to apprise you a situation that is certainly not new, but which the psychologists with whom I have spoken have found to be disheartening. I doubt that it is really your domain and further doubt that it is an issue you can address.

When individuals are referred for evaluation of psychological functioning and tests are administered, including some sort of validity scale (to assess for malingering or for "fake good" or "fake bad" attitudes), the psychologists administer, score, and interpret these tests. This is their job.

However, psychologists usually are also the ones who take a detailed history of the claimants' medical and psychiatric histories, job history, deatils about the injury under present consideration, legal and substance abuse history, family interactions and daily activities, etc.

When psychiatrists see the claimants, they spend very little time with the individual, and then they dictate their psychiatric reports lifting the psychologists' obtained history - verbatum. Some psychiatrists have never once obtained a history, which is vital to getting a perspective on the claimant's situation and ability to relate and subtle personality characteristics. They ask a few cursory questions, knowing they will lift the psychologist's history report.

One psychiatrist in Beckley relies totally on his psychologist, Crystal, to take the history - and also to dictate his psychiatric report. She makes every effort to make the reports sound like two reports. She has commented that she would someday love for an attorney doing a deposition to ask who really did the report! However, this has never happened.

Now that medical records are supplied on microfilm, at this clinic at least, the psychiatrist never reviews the film. As the psychologist, I review all film and take notes of the pertinent data found therein. This is time consuming and not essential to my own report. I simply report the history I obtained (and so does the psychiatrist, reading directly from the history), along with psychometric test data.

Your thought probably is that we psychologists should balk about this stuff and tell the psychiatrist to do his / her own work. However, there is a subtle sort of intimidation involved when the psychiatrist signs the psychologists' paychecks. It is difficult to refuse directives, given the circumstances under which most of us work.

Do you think there is any way to require psychiatrists to do their own honest work and not plagiarize the psychologists' work in writing Compensation reports?

Thank you!

Sincerely,

Dreama G. Baker
Licensed Clinical Psychologist

Orthopaedic Surgery, Inc.
Wheeling, West Virginia 26003

Sam Vukelich, M.D.
Derek H. Andreini, M.D.
J.P. Griffith, Jr., M.D.

302 Professional Center IV
Medical Park
(304) 242-6373
FAX (304) 242-6374

June 21, 1994

Bureau of Employment Programs
Attention: John H. Kozak
Legal Services Division
P.O. Box 3922
Charleston, W.Va. 25339-3922

Dear Mr. Kozak:

I am replying in response to your recent letter regarding "proposed legislative rule." I have been doing Workers Compensation evaluations for 35 years and certainly changes in the program over the years have been good and acceptable. The green sheet for low back problems was an excellent measure.

I do, however, take exception to the directive that all evaluations must be based exclusively on the American Medical Association "Guides," 4th Edition '93. Although I use this text primarily in about 85 to 90% of my evaluations, there are some instances in which the Academy of Orthopaedic Surgeons Manual in Evaluating Permanent Physical Impairment is more helpful and precise.

Also in my opinion range of motion figures so much emphasized in the AMA are not very reliable because they are influenced by the claimants' age, stature, physique, cooperation, and especially motivation. This is very true when no objective findings are present which would tend to limit these motions.

I was present in January at the W.V. Orthopaedic Society Meeting in Charleston when this matter was discussed, and I assure you the vote for the AMA Guides was definitely not unanimous when a show of hands was effected. It was about 65-70% for the Guides, and I know Dr. Tom Scott from Huntington sided with me at that time as well as several other orthopaedists.

Personally I believe the evaluating physician for the Commissioner should be permitted in some selected cases to use the Academy Manual in order to attain a percentage of permanent impairment.

Finally I did appreciate very much Mr. John Farley's nice letter to me on his retirement early this year. He was a hard worker and sincere gentleman. If you have occasion to see him, please

give him my regards.

Sincerely,

John P. Griffith, Jr., M.D.

JPG:le

COLLEGE OF LAW
WEST VIRGINIA UNIVERSITY

June 24, 1994

John H. Kozak
Director, Legal Services Division
Bureau of Employment Programs
P.O. Box 3922
Charleston, WV 25339-3922

Re: Comments on Proposed Legislative Rule: Guidelines for Permanent Impairment and Disability Evaluations, Evidence, and Ratings

Dear Mr. Kozak:

I understand that the comment period on the proposed Guidelines for Permanent Impairment has been extended until July 5. After reviewing the proposed rule, I feel that it is essential that some important concerns be addressed.

Before indicating some of the shortcomings of the proposal, I would like to note that I understand the need to develop consistency among physical examinations and impairment ratings. I assume that it is this need which underlies this proposal. I also applaud the recognition in this proposal (long overdue, I believe) of the need to separate impairment ratings from disability determinations; the Supreme Court of Appeals has always been clear that these concepts need to be better defined and separated. The WCF has not, in the past, addressed this issue; it is one of the areas in which I have always felt that I failed as Commissioner.

Despite the evident need to achieve both this separation and increased objectivity in medical examinations, the rule which has been proposed simply fails to achieve the appropriate balance. Briefly, I think the problems lie in the following areas:

First, the adoption of the AMA Guides poses serious problems for the appropriate ratings of impairments. I am not personally familiar with the 4th edition. Prior editions, however, were clearly developed <u>as guides</u> to assist in the evaluation of impairments; this is not, however, an objective system. As one commentator noted with regard with the 3rd edition:

> [T]he <u>Guides</u> is not the objective, medical evaluative system that it purports to be and that has been so appealing to legislators and other decisionmakers. Instead, like any impairment rating scheme, it rests in large part on important and difficult normative

judgments . . . [1]

For example, the Guides (at least the 3rd edition) "does not consider chronic pain for purposes of an impairment . . ." This is "neither a consensus view nor a purely medical decision."[2] A decision to ignore chronic pain in making impairment determinations in West Virginia is contrary to former practice and law. The 3rd edition also demonstrated a significant amount of gender bias in proposing the benchmark activities of daily life (ADL). In fact, the choice of and approach to these benchmark activities represents significant subjective choice which may not be appropriate in all instances. If impairment ratings are based upon an assessment of ADL, then a serious discussion must be undertaken regarding the appropriate activities to be used as a benchmark for a rural, industrial/mining workforce.

This proposed rule makes the basic assumption that the Guides can be applied rigidly, without adaptation, to West Virginia workers' compensation claims; this is simply fallacious. It is for this very reason that, when we have attempted to develop appropriate standards and evaluative techniques for particular organ systems (e.g., hearing loss, lung disease, psychological claims, even back evaluations) we have, in every case, deviated from the AMA Guides. An organ-system by organ-system assessment of the evaluative approach and the rating scheme in the AMA Guides is essential to achieve appropriate ratings which comply with judicial precedent in West Virginia.

Second, the proposal is excessively rigid in its requirements regarding who can perform evaluations. A couple of important points in this regard:

- §5.3 requires that any opinion regarding degree of impairment be offered by "an expert in the field of impairment determination." There is no guidance as to the qualifications for this expertise. This raises four related problems: the definition of this expertise is too vague to provide adequate guidance to physicians, attorneys or their clients; it is (as a result) an invitation to extensive, expensive, and time-consuming litigation; it creates a serious problem of the geographical accessibility of appropriate evaluating physicians for many claimants; it

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[1] Ellen Smith Pryor, Flawed Promises: A Critical Evaluation of the American Medical Association's Guides to the Evaluation of Permanent Impairment, 103 HARV.LAW REV. 964, 965 (1990).

[2] Id. at 969.

inappropriately bars treating physicians from participation in the impairment rating process.

• With regard to this last point, few treating physicians are familiar with the AMA Guides -- or could qualify as having the necessary expertise. But it is entirely appropriate for a family practitioner or general internist to be the regular treating physician for a claimant who has been made ill or has been injured at work. The rigid requirements of the proposal make it even less likely that workers will receive the appropriate continuity of care from their primary care physicians; they will, instead, be encouraged to see specialists, at least for the purpose of evaluations, and the evaluations by their primary care physicians will be disregarded. This means that the physician most familiar with the claimant is excluded from the rating process and it means that the current delay in obtaining evaluations will become even worse. Are you contemplating that in claims involving less than 15% ppd, the claimant would have to seek an evaluation from a physician with sufficient "expertise"? If so, delays and costs will unquestionably increase. Moreover, such a requirement appears to violate the clear legislative and judicial direction in W.Va. Code §23-4-7a(c) and Dalton v. Spieler, 401 S.E.2d 216 (W.Va. 1990)[3] (holding that the treating physician's recommendation regarding ppd must be accepted when it is less than 15%). I would strongly

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[3] I always have regretted the caption to this case. As you know, I personally attempted (but failed) to convince others at the Fund that we were required to accept treating physician ratings below 15% and I also failed to convince many treating physicians that providing these ratings would be in the best interest of their patients as well as themselves. How ironic that the issue would be settled in a mandamus action against me! It is important to remember the relevant syllabus point here:

> 3. Pursuant to W.Va.Code, 23-4-7a(c)(1), as amended, when an authorized treating physician recommends a permanent partial disability award of fifteen percent or less, and such recommendation is based upon an examination performed prior to the closing of a claimant's temporary total disability benefits, then the workers' compensation commissioner has a mandatory duty to enter an award of permanent partial disability benefits based upon the recommendation of the authorized treating physician.

The proposed rule fails to follow this requirement.

suggest, at a minimum, that allowance must be made in the rule for consideration of evaluations by regular treating physicians even if they do not fully comply with the requirements of the rule; I would not limit this to ratings under 15%, however.

Third, the proposal totally fails to provide for the process by which the "impairment" rating is to be converted into a "disability" rating. This is an insuperable problem and is made worse by the failure of the rule (§5.4) to provide any guidance regarding what constitutes adequate expertise for a physician to offer an opinion regarding the extent of a claimant's disability. With regard to this last problem, all of my comments in the second point, above, are applicable. In fact, I simply do not think that this rule can be promulgated in the absence of a companion rule which elucidates the disability rating process. Moreover, I think that the problem can only be cured by issuing a new draft, again for public comment, which includes a full description of the disability rating process together with the impairment rating procedure. A failure to proceed in this way will result in serious problems: the opinions of physicians regarding disability will (under this proposal) be ignored; impairment ratings, which in many cases fail to reflect the full extent of disability, are likely to be translated directly into awards; the rate of protest and litigation will increase, not decrease; and ultimately the rule itself will be subject to successful legal challenge.

Fourth, a corollary of the preceding point: I have significant concern about who is going to do the conversion to disability ratings. Is it intended that vocational experts will be required in every ppd case? If so, the cost and delay -- and the levels of litigation -- will all increase substantially. If not, then will in-house claims people be adequately trained to collect and review the necessary data to make this conversion? Will either of these approaches be in place when this proposed rule goes into effect? If not, then you will have created another administrative nightmare. And, again, the legal requirement and the administrative need to allow efficient issuance of small ppd awards will be destroyed.

Again, I understand the underlying concerns which led to the issuance of this proposal. I am concerned that the Performance Council is not adequately familiar with the AMA Guides to understand the full implication of the proposal. I hope that the Commissioner and the Council will continue to try to achieve the laudable goals of more administrative efficiency, more consistency in medical evaluations, and increased examination of the level of disability -- not simply impairment -- in claims. I think this proposal needs some work or it will fail to meet these

goals.

Sincerely,

Emily A. Spieler
Professor

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Fellow American Academy
Disability Evaluating Physicians

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June 24, 1994

Bureau of Employment Programs
ATTN: John H. Kozak
Director, Legal Services Division
Post Office Box 3922
Charleston, WV 25339-3922

Dear Sir:

I have reviewed the Proposed Legislative Rule: Guidelines for Permanent Impairment and Disability Evaluations, 4th edition by the Workers' Compensation Fund for the evaluations of claimants injured at work for the rating of disability and of the impairment that could result from an industrial accident.

I agree that this is a good measure that Workers' Compensation has taken to standardize the method of doing the evaluations and to avoid discrepancies in the results of these evaluations, as we see at the present time.

The IME will have to familiarize him or herself with the use of these Guides. It will require sometime to study and get acquainted with the proposed method. One cannot learn the use of the Guides from night to day. As a matter of fact, there are special courses or lectures offered by professional institutions to show the proper use of the Guides. The American Academy of Disability Evaluating Physicians has programmed one of these courses to take place in Charleston next September 3rd and 4th at the Marriott Charleston, as you are probably aware. There are also videos and audiotapes available for this purpose.

I do not know the time that Workers' Compensation will take to put the Proposed Rule into effect. It will require sometime for many of the professionals dedicated to the practice of their specialties to study the proper use of the Guides and its interpretation; as I have read some of the chapters of the Guide, there is still room for misinterpretations.

It would be up to the Workers' Compensation Medical Division or its representatiave, as Wayne-Oakland Medical Centers, Inc. to submit all the medical information regarding the claimant to be examined at the time the evaluation is requested. This is a situation in which we are confronted at the present time, as I have noticed in the course of doing evaluations I have been requested to do, that in many cases lack sufficient information related to the case on the instant claim or in past claims that I am asked to evaluate also. Many of these

letters of request contain several calims, some of them related to old injuries occurring years ago; other times, there is overlapping of claims related to the same part of the body to be evaluated, more commonly, low back injuries; thus, under these circumstances, it is not an easy task to allocate ratings for permanent impairments of old claims and at times it is just guess work, which I know is not the right thing. It would be necessary for this situation to be made clear when we are requested to do the evaluation.

Hopefully, Workers' Compensation will inform us on time of the decision to take regarding this Proposed Rule.

Yours very truly,

Jorge de la Piedra, M. D.
Diplomate of the American Board of
Professional Disability Consultants

JP:mc

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ATTORNEY AT LAW

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BECKLEY, WEST VIRGINIA 25802

Andy
John Knight
Dr. Tatum

June 27, 1994

Performance Council
c/o Andrew N. Richardson, Commissioner
Workers' Compensation Fund
P.O. Box 3151
Charleston, WV 25332

Re: Guidelines for permanent impairment and disability evaluations, evidence, and ratings

Dear Sir:

The hereinafter comment relates to proposed rule Title 85, Series 16 and specifically with reference to the Performance Council's reliance on the American Medical Association's guidelines for impairment ratings, 4th edition.

I would like to call your attention to the fact that since there is a definite distinction between the terms "impairment" and "disability" there should never be strict reliance on the AMA guidelines. To do so fails to recognize that we are evaluating injured people, not inanimate objects. Disability is a much broader term and should always apply to impairment ratings. This is a great deficiency in the AMA guidelines.

Also, of great importance is the fact that strict reliance upon the AMA guidelines for evaluating impairment and total disability will substantially increase litigation in an already overburdened adversarial system. Please note also that the AMA guides 4th edition has many pages of errata sheets clearly indicating its fallibility as well as the fact that the AMA is clearly working on a 5th edition. The AMA obviously never intended the guidelines to be "the last word" on impairment.

Finally, if a medical examiner is to be totally bound by the AMA guidelines the clinical judgment would be barred, and such is not acceptable in the workers' compensation system. Since we are evaluating injured individuals, the medical evaluator's professional judgment should always be allowed and seen as an important faculty.

Thank you for giving me the opportunity to comment on the proposed rule, and please give this matter sincere consideration before implementation.

Yours very truly,

Rodney A. Skeens

Rodney A. Skeens

RAS:ag:d

Clifford H. Carlson, M.D.

Disability Evaluation and Management
Industrial and Medical Rehabilitation

249 New Hope Road
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Princeton, WV 24740
(304) 425-7790

6/28/94

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

Dear Mr. Kozak:

I do agree with the importance of standardizing impairment/disability evaluations in West Virginia to the National Standard as set forth in the Guides to the Evaluation of Permanent Impairment, 4th Edition, published by the American Medical Association.

It is also important that this be done in a manner resulting in a smooth transition. This would require appropriate time and education for physicians performing these evaluations. As you may know; a course for this will be given in Charleston on September 4 and 5 by the Academy of Disability Evaluating Physicians. I will be attending as will many other physicians.

One must also remember that any system/book is only a framework. We are taught by the Academy to follow principals; not only specific rules. There are many conditions/situations which cause true impairment but may not be specifically cited in tables in the Guides. Here the physician's education, training and experience are the appropriate guide for an impairment reccomendation. These may not be disregarded in the evaluation process.

The state of Kentucky has been standardized to the 3rd Edition of the Guides for some time. They request, "If you feel that the AMA does **not** adequately assess the medical impairment of the Claimant, please express a whole body impairment that you think is appropriate for this patient. Please explain how you arrived at this percentage:_____ % whole body.

Thank you for your consideration.

Sincerely yours,

Clifford H. Carlson, M.D.

Clifford H. Carlson, M.D.

Diplomate, American Board of
Physical Medicine and Rehabilitation

Fellow, American Academy of
Disability Evaluating Physicians

Clifford H. Carlson, M.D.

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6/28/94

558-1377

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

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Thank you for your consideration.

Sincerely yours,

Clifford H. Carlson, M.D.

P.S.

94 JUL -5 PM 3:14
BEP-LEGAL DIVISION

7/5/94 - Note I spoke to AADEP and course is ~~tentatively~~ tentatively rescheduled for sometime in November, '94. Date not yet set. CC

Diplomate, American Board of
Physical Medicine and Rehabilitation

Fellow, American Academy of
Disability Evaluating Physicians

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FACSIMILE TRANSMITTAL SHEET

DATE: June 29, 1994 TIME: _____

Total pages sent, including front cover: 2

FROM: Rodney A. Skeens

TO: John H. Kozak, Director, Legal Services Division, WCF FAX #558-1377

REMARKS - MESSAGE:

Comment to proposed Rule 16 "Guidelines for permanent impairment and disability evaluations, evidence, and ratings

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June 27, 1994

Performance Council
c/o Andrew N. Richardson, Commissioner
Workers' Compensation Fund
P.O. Box 3151
Charleston, WV 25332

Re: Guidelines for permanent impairment and disability evaluations, evidence, and ratings

Dear Sir:

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Thank you for giving me the opportunity to comment on the proposed rule, and please give this matter sincere consideration before implementation.

Yours very truly,

Rodney A. Skeens

Rodney A. Skeens

RAS:ag:d

Wayne-Oakland Medical Centers, Inc.

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BRUCE F. SANDERSON
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BEP-LEGAL DIVISION
94 JUN 29 PM 3:52

FAX TRANSMITTAL

DATE 6-29 19 94

TO: John Kozak

Bureau of Employment Programs
Legal Services Division

WE ARE TRANSMITTING 2 *PAGES INCLUDING THIS COVER. YOU MAY RESPOND TO OUR FAX NUMBER (810) 643-9007.*

BY: Kim Jeffery

NOTES: Please submitt Response by Fax: (810)643-9007 OR
Send to: Wayne-Oakland Medical Centers, INC.
Drummer Building
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Troy, Michigan 48084-3439

REGARDING: Proposed Emparment Ratings Rules

SOCIAL SECURITY #: — —

CLAIM NUMBER:

Wayne-Oakland Medical Centers, Inc.

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June 29, 1994

JOHN KOZAK
DIRECTOR
BUREAU OF EMPLOYMENT PROGRAMS
LEGAL SERVICES DIVISION
P.O. BOX 3922
CHARLESTON, WEST VIRGINIA 25339-3922

RE: PROPOSED IMPAIRMENT RATINGS RULES

Dear Mr. Kozak:

I would like to take this opportunity to thank you for your response to our letter of May 31, 1994 regarding the Professional Criteria and Billing information, this was very helpful.

There is one area that I would like to ask for clarification in regards to your response to us dated June 6, 1994, stemming from the credentials that would qualify a physician to dO the Workmans' Compensation Evaluations:

IN YOUR LETTER YOU STATED: "WITH REGARDS TO CREDENTIALS, BOARD CERTIFICATION WOULD BE SUFFICIENT TO QUALIFY THE EXAMINER AS AN EXPERT IF HE OR SHE IS PERFORMING A TASK WITHIN HIS OR HER SPECIALTY".

IT HAS COME TO OUR ATTENTION IN ENGAGING DOCTOR'S IN THE STATE OF WEST VIRGINIA THAT A NUMBER OF PHYSICIAN'S THAT PERFORM WORKMANS' COMPENSATION EXAMINATIONS FOR THE STATE OF WEST VIRGINIA ARE ONLY BOARD ELIGIBLE AND HAVE DONE THE EXAMS FOR A NUMBER OF YEARS. WOULD THESE PARTICULAR BOARD ELIGIBLE PHYSICIANS BE CONSIDERED "QUALIFIED" WITH THE APPROPRIATE "CREDENTIALS" THAT WOULD SUFFICE TO FULFILL THE REQUIREMENTS IF THIS BILL DOES PASS?

I do appreciate you taking the time to submit a comment back to me regarding this information so that we at Wayne-Oakland Medical Centers, Inc. can service the State of West Virginia with the highest standards and performance as possible.

Sincerely,

Bruce F. Sanderson
President

BFS/kkj

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July 1, 1994

Mr. John H. Kozak, Director
Legal Services
Bureau of Employment Programs
Workers' Compensation Fund
P. O. Box 3922
Charleston, WV 25301-3922

Re: Comments on Proposed 85 CSR 16

Dear Mr. Kozak:

I have reviewed the proposed regulations setout in 85 CSR 16 and offer the following comments:

Apparently the purpose of these regulations is to eliminate some of the physicians who are not properly qualified to perform evaluations from the system. In other words, it appears as though the intended purpose of these regulations is to prohibit the gynecologist from performing orthopedic examinations.

While I believe that is a noble purpose and is proper, our law firm does not regularly request opinions from physicians operating outside of their specialty. One physician I do not use, who shall remain nameless, practices in Chapmanville, West Virginia, and not only performs orthopedic examinations, pulmonary function testing, but also tests for and prescribes hearing aids. I think practices such as these need to be stopped. However, I believe that the scope of proposed regulations 85 CSR 16 is too broad and reaches into other areas.

I think the Commissioner essentially needs to set up standards for qualifying experts rather than relying on Rule 5.3. I have seen many inconsistant decisions coming from the Office of Judges. I can see situations appearing in the future where the Office of Judges will find experts to be qualified in one case, but not qualified in another.

Also concerning qualifications of experts, I have spoken with the staff of one of the Commissioner's favorite physicians for evaluating permanent total disability cases. I have been informed that these rules do not apply to that physician and the Commissioner considered him to be qualified and does not have to attach a resume to each report. Apparently a double standard

for all of the Commissioner's experts is beginning to evolve even before the adoption of these proposed rules.

Similarly under Rule 5.1.1 wherein the report must state that the examinations were performed in accordance with the Guides. This represents another problem. You will find that the physicians are going to perform the examinations the way they have in the past and that they will **not** be changing their techniques to conform to the standards of the Guides. A statement showing compliance will become another piece of the broiler plate language in each report. I am aware that the majority of the physicians do not perform three trials of each motion. My clients have informed me that some physicians do not even perform an orthopedic examination but simply observe the claimants in the examining room. They have told me that they see no instruments, such as inclinmeters or other devices used to measure angles as required by the Guides. The only physician that I am aware of that currently performs three trials of each range of motion is Dr. Clifford Carlson of Princeton. I am aware of this because my clients constantly complain about Dr. Carlson's evaluations.

If a question comes up as to the technique used, it becomes the claimant's word against the physician. As I have found in the past, the ALJ's will find that the claimant had made "self serving statements" verses the physician who has "no reason to lie". The claimant is going through the system one time seeking one award, yet the physician may be performing $30,000 worth of examinations per month for the Commissioner. It really makes you wonder as to who is telling the truth.

I have had a rather unique opportunity to observe one of the Commissioner's regular evaluators examining a claimant. This expert who regularly testified that he follows the AMA Guides 4th Edition only performed one trial of each motion. He did have a goniometer in his hand but did not move it as noted in the Guides. When he performed motions other than lumbar range of motions, he did not use a goniometer and simply "eyeballed" the angles. I will probably be taking his testimony in this case in the future and I can tell you right now that he is going to testify that he did follow the 4th Edition of the Guides and that he did make three measurements of each range of motion.

I can assure you that all physicians will indicate that they did follow the Guides and make three trials. They realize that the other end of this is that they will not get paid if they don't.

I believe this will create another explosion of litigation to discredit the experts and have their reports removed from the record. With the current backlog at both the Fund and Office of Judges, no additional increases are needed at this time.

I can spend the next hundred pages explaining why the strict adoption of impairment verses disability is not a good idea. It is already well set out in case law that a physician finds impairment and the Commissioner finds disability. I seriously doubt that it would be possible to have the people working at the Fund change the way they have done things for years. For

example, when a claimant is granted twenty (20) weeks of benefits for the x-ray diagnosis of occupational pneumoconiosis, which is clearly set out in the Code as having no impairment, that award is offset against the OP Board's recommendation of impairment. Very few people involved in the Workers' Compensation system, including many lawyers who have practiced many years, can adequately explain the differences between impairment and disability. I think if this disability section is added to the regulations, it will also open up a new area of litigation placing economic experts into the system. Consider the following example.

A thirty-year old coal miner suffers an initial back injury for which he is granted a 5% disability award. A few years later, at age thirty-five, he suffers a second back injury which requires three lumbar surgical procedures. Based upon the AMA Guides he may only have a 10% impairment. However because of the surgery, in practical terms he is unable to obtain a job in the mining industry. He has now lost twenty-five years of future employment at a present day salary of $50,000 per year. While the impairment in this case may be an additional 5%, the loss of earnings and therefore more properly disability as can be shown by economist will be $1,250,000. That is without taking into the consideration of the effect this disability has on the 148 hours per week that he does not work. We could take the easy way out and grant him a total disability award, but at best it would compensate him $25,000 per year, which over the next twenty-five years would only be $625,000. There is a significant discrepancy in this case between the actual disability the claimant has suffered and the benefits that he is able to receive from the Fund.

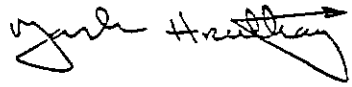
Suppose that this person was able to perform other work, but only makes $20,000 per year performing it. He would still come out behind receiving $25,000 per year from the Fund. So even if there was a wage supplement benefit created in the future to compensate a worker for the difference between his old wages and his current wages, it would probably still not be a fair trade.

I think that the purpose of 85 CSR 16 is noble. However, I think in its execution, it opens up many tunnels which do not have a light in the end of them.

I appreciate having this opportunity to comment upon these proposed rules.

Sincerely,

WILSON & HRUTKAY LAW OFFICES, L.C.



By: Mark Hrutkay

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SUSAN KIPP McLAUGHLIN
ROGER D. CURRY
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LOCATION:
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1 July 1994

Workers' Compensation
Attn: John Kozak, Esq.
Director, Legal Services Division
P O Box 3922
Charleston, WV 25339-3922

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

Dear Mr. Kozak:

We respectfully take issue with several provisions of the above cited proposed rule.

The concept of using the Guides is expected and, if they are not applied mechanistically, is basically fair. However, numerous provisions of the proposed rule mandate the Commssioner and ALJ's to ignore reliable doctor opinions for picayune technical reasons and, as a practical matter, stack the deck against Claimants.

These portions of the rule relating to doctor's reports are premised on two inaccurate propositions, (1) that doctors will willingly cooperate with (or have the time to cooperate with) very technical requirements for the preparation of reports and (2) that claimants are on the same economic footing with employers in hiring doctors to do detailed reports. We all have called Workers' Compensation a "doctor driven" system. Provisions of the proposed rule suggest that we no longer trust doctors.

Also, several provisions of the psych rules are repugnant and probably unconstitutional.

We have the following specific comments.

1 - Phase in: To the extent that the proposed rule is not revised, it needs a phase-in period. Particularly, is the mandatory credibility/reliability standard for doctors' reports as contained in various sections to apply to claims now in litigation? If so,

does it apply to doctor's/expert's reports generated before the proposed rule takes effect? Claimants and employers alike put substantial money into doctor's and VE reports. It would be fundamentally unfair to disregard or diminish reports prepared according to then-existing standards.

2 - Technicality and credibility:

a - Several provisions mandate that reliable reports be ignored for technical reasons:

(1) §5.1 requires that a report comports fully with the Guides "in order to be found credible and reliable." Here is a potential slippery slope - What language does the doctor need to use, other than a simple statement that the Guides have been adhered to?

(2) §5.1.1 requires a report with the results of all tests. That is unnecessary. Doctors, particularly orthopedists, look for numerous signs & symptoms in examinations which, because of these doctors' training and experience, don't have to take too long. Why should it be necessary for a doctor to say, for example, that specific test A was positive at x°, but that specific tests B, C, D, etc., were negative, rather than just reporting the positive finding and reporting that all other tests were negative or within normal limits. Requiring a doctor to report all that he/she does not see means either that (1) the doctor will spend more time writing a report than doing the exam or (2) that the doctor's computer will contain boilerplate that while being faithfully regurgitated with every report, will add not one thing to reports that was not there before.

(3) §5.1.1 requires that a doctor in a back claim[1] use the back examination form. This guarantees that a lot of good doctors will no longer do examinations. The doctors to whom we vastly prefer to refer clients for exams are those with practices that actually see and treat patients, many of whom the form will put over the edge. There are fewer and fewer doctors in Northern West Virginia who are willing to examine and rate Claimants for Claimants.[2] Obviously, if the Fund requires the back form, we will try to get doctors to use it. But, unlike injured workers, doctors are relatively financially independent enough to ignore requests they really don't like, and the time will certainly come soon when some good doctors will not do the form.

(4) §5.4 requires an expert to "demonstrate his or her

---

[1]I don't know what the proportion is of back injury claims generally with the Fund, but in our practice, it's a good 50%.

[2]That may also be the case with employers and the Fund itself. Several well-qualified doctors have retired in recent years.

expertise in the field of disability" or be found not credible. Where we are dealing with vocational experts, this makes sense. But this would appear to result in ignoring well-qualified doctors from giving disability opinions. Where the Claimant is a 55 year old career construction laborer with a back injury that scores 35% under the guides, who has an 8th grade education, the doctor should be permitted to add to his/her opinion the obvious conclusion that this individual is permanently and totally disabled.

(5) §5.5 is similar, requiring the doctor, etc., to demonstrate knowledge of a claimants personal, social or occupational demands. In ALJ hearings now, ALJ's will (properly) not permit either counsel to dwell on what an underground coal miner has to do exertionally and otherwise, because we all know about what those requirements are! Judges tell juries in the tort and criminal systems "not to leave your experience and common sense outside the courtroom." Surely, we can trust doctors and ALJ's with the same latitude.

b - Other provisions give the decision-maker an artificial standard by which to disregard reliable reports -

(1) §85-6-14 requires that where the Guides cannot be applied, the examiner "thoroughly document" why. The "thoroughly" is either redundant or gives a (non-doctor) decision maker the ability to declare that what a doctor has done is not "thorough" enough.

(2) §5.2 requires that an opinion of disability be explained in detail in order to be found credible. How much detail is enough? That is not discernable from the rule.

3 - <u>Confidentiality of psychological reports/records</u> - In addition to the general confidentiality of the statute, the rule should specifically require that psychiatric/psychological records be maintained strictly confidential by parties and counsel. Even where improper matters are not addressed, psych reports and records contain deeply personal and potentially embarassing information. Such reports and records should not be maintained by employers in personnel files, and should not be available to agents or officers of employers who are not directly charged with defending or dealing with workers' comp claims. Otherwise, some Claimants will feel coerced by the circumstances into concealing genuine psychological distress.

4 - <u>Portions of the psych standards are discriminatory, elitist, and illogical</u>.

a - The psychiatric & psychological examination outlines:

(1) § IX - C, D, and E - Psychiatrists/psychologists must ask about legal problems, arrests, convictions, jail, financial

resources, difficulties, bankruptcy, type of church attended and level of involvement. What does any of the above have to do with disability? Why is the state entitled to ask such nosey questions? At what point does the information requested (particularly arrests and church) cross the constitutional boundary? Since benefits are predicated on opinions based in part on these answers, I believe that the line is crossed by asking the questions.

(2) §V, page 11, Psych exam outline - What is relevant about a Claimant's use of tobacco, or caffeine? Without at least the latter, activity in offices of counsel for both Claimants and Employers would come to a creaking halt.

b - Appendix B: Of particular repugnance are some provisions of Appendix B, page 52, on malingering. The official imprimatur of the State and of the Fund is placed upon notions that benefits should be denied for malingering where a claimant has "a history of spotty employment and drifting." On the other hand, one is less likely to malinger who has been ". . . a responsible, honest adequate member of society . . ." The malingerer may "retain the capacity for recreation, such as enjoyment of theater, television, or card games." "The malingerer may have a history of previously incapactiating injuries and extensive absences from employment." "The malingerer may have been a marginal member of society for many years." The malingerer may even have "[a] past history of lying and/or arrests." The effects of doctors (and employers) seizing on some of these would lead to an outrageous result -

(1) "A history of spotty employment and drifting." - West Virginia has the highest or nearly the highest unemployment rate in the nation, and our county, Marion, has nearly the highest unemployment rate in West Virginia. Some people here go from job to job, and lay-off to lay-off, when they would dearly love to work a steady job for a steady employer for years and years to come, like the Japanese are supposedly able to do. Whoever is responsible for less-than-full employment in West Virginia, it surely isn't the worker who is trying to keep body and soul together in a crummy economy.

(2) "A responsible, honest adequate member of society . . ." - Who's that? Someone who has been fortunate enough to have a job for a while? Someone who goes to church? Someone who votes regularly? Various provisions of the Constitutions seek to avoid state-sponsored value judgment of individuality. This notion (like all of the rest discussed here) offend these grievously.

(3) May "retain the capacity for recreation, such as enjoyment of theater, television, or card games." - What does the drafter of this appendix think Claimants who really can't work do during the day? The ability to watch TV from a recliner does not translate into the ability to return to any sort of work, no matter how sedentary. Indeed, in their evaluations, VE's often question Claimants closely on how long they watch TV, whether they have to move around much while watching, and whether a Claimant can

concentrate on a 1/2 hour or 1 hour TV story and follow the plot. Ability to watch TV in a normal sitting position for long periods of time may indicate the possibility of a residual functional capacity to do sedentary work. But just the act of watching indicates nothing. Playing 15 minutes of rummy with one's spouse or family likewise does not translate into anything vaguely resembling malingering. Adoption of this section means that when a Claimant answers honestly that he/she watches TV, a mean-spirited doctor will diagnose malingering. Granted, playing football with the kids spells malingering, and those Claimants should be out of the system. But TV? This reminds me of H. L. Mencken's definition of a Puritan - Someone who fears that somebody else isn't totally miserable all of the time.

(4) "The malingerer may have a history of previously incapactiating injuries and extensive absences from employment." - Poorer folks work in manual jobs which have a greater incidence of injury. In some of those occupations, employers' safety conciousness isn't the best. (In the better paid industrial jobs, e.g., coal miner, power lineman, the employers are so intense about safety that catastrophic injuries are relatively rare. In Joe's Garage kinds of employment, that's not the case.) These workers may be injured more than once. Under the proposed rule, this means that they may be faking. That is a rather absurd <u>non sequitur</u>.

(5) "The malingerer may have been <u>a marginal member of society</u> for many years." - This is blatant, unconstitutional elitist trash. Who on God's cool green earth is a "marginal member of society." The decision-making refered to in this part of the proposed rule, as in the rest of Compensation law, is by people who have been to medical or law school. So, maybe the easy answer to the question who is marginal is that it's not people like us.

(6) May "[a] past history of lying and/<u>or arrests</u>." - This, too, is a little blatant. Here, the author hasn't even talked about <u>convictions</u>, merely arrests is enough to cast a shadow on an allegedly injured person. What's next? Forfeiture of assets and corruption of blood?

It may be hard to believe, I really have tried to tone down the rhetoric here. As you can see, much of the proposed rule has tickled my ire buttons. I hasten to add to you personally, Mr. Kozak, that I know that you're the messenger. My dealings with you have always been most pleasant, and I have the greatest respect for you. It is some parts of the rule which has (necessarily) gone out under your signature with which I take issue, and nothing I say here is intended to have the slightest personal cast.

With kindest regards, I remain,

Yours respectfully,

Roger D. Curry

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July 5, 1994

John H. Kozak, Director
Legal Services Division
Bureau of Employment Programs
Workers' Compensation Division
P.O. Box 3922
Charleston, WV 25339-3922

Re: Proposed Legislative Rule:
Guidelines for Permanent Impairment
and Disability Evaluations,
Evidence, and Ratings

Dear Mr. Kozak:

First, I want to thank you for extending the comment period on the Proposed Legislative Rule: Guidelines for Permanent Impairment and Disability Evaluations, Evidence, and Ratings, until July 5, 1994. Hopefully, this will allow a broader spectrum of opinion to be submitted to the Compensation Programs Performance Council.

The proposed Guidelines appear to be motivated by a desire to achieve standardization of the evaluation process. I don't disagree with that goal per se. However, I fear that putting so much emphasis on standardization ultimately may detract from the accuracy of the evaluation process, and may also lead to instances of unfairness, particularly to claimants.

By way of illustration, let me give you an example of how a process of standardization can be incompatible with accuracy. Last Friday I represented a claimant in a federal black lung hearing (I am taking this example from a compensation system other than the West Virginia Workers' Compensation system). One of the issues at the hearing was whether this claimant, who had worked in and about coal mines for over 40 years, had developed pneumoconiosis. The employer presented, as an expert witness, Dr. N. LeRoy Lapp, to testify about the results of the x-rays. As I'm sure you know, Dr. Lapp is a Professor of Medicine in the Pulmonary Department at West Virginia University, and is one of the leading experts in the country on black lung. In my

experience, Dr. Lapp is a very honest witness. In his testimony, Dr. Lapp utilized the standardized system of the International Labor Organization for the interpretation of chest radiographs for pneumoconiosis. He examined a series of films on this particular claimant, and noted the existence of four or five rounded opacities in the right upper zone of the lungs. Dr. Lapp testified that rounded opacities are consistent with pneumoconiosis, and that pneumoconiosis appears first in the right upper zone of the lungs. However, he interpreted this man's chest films as negative for pneumoconiosis because they did not meet the profusion criteria of the standardized ILO system. Dr. Lapp acknowledged that this claimant may well, in fact, have contracted pneumoconiosis, and the opacities he observed may well be lesions of pneumoconiosis. His opinion was not that pneumoconiosis did not exist, but rather that he could not make a diagnosis of it based on the standardized system for the classification of x-rays.

Likewise, I am concerned that the "Guidelines for Permanent Impairment and Disability Evaluations, Evidence, and Ratings" is too oriented toward the standardization of opinions, to the detriment of accuracy and fairness in determining a particular claimant's extent of impairment and disability.

Evidentiary Requirements of Opinions Regarding Impairment

Section 85-16-5.1 of the proposed Guidelines requires that medical opinions as to impairment must reflect strict accordance with the AMA Guides to the Evaluation of Permanent Impairment, 4th Ed. (hereinafter "AMA Guides"), or else the report will not be found "credible and reliable". The same evidentiary standard is expressed in Section 85-16-4. I am very concerned about the strictness of this evidentiary rule, for several reasons.

I think that this rule will make it extremely difficult in many instances for claimants to obtain useable reports from their treating physicians, particularly physicians practicing in small rural communities. The treating physician may be the person best equipped to render a fair and accurate assessment of a claimant's impairment. However, the opinion of the treating physician will be rejected as not "credible and reliable" unless the physician has fulfilled every technical criteria of the AMA Guides. With many physicians, this is not a practical expectation.

I am also concerned that the effect of the rule will be to lead decision makers in the Commissioner's office and the Office of Judges to give added weight to the opinions of those physicians whose opinions jump through all the hoops of the technical requirements of the AMA Guides. In operating under this system, employers will potentially have an advantage over claimants in two respects. If the employer has counsel but the claimant is unrepresented, the claimant will not know to advise the physicians he obtains reports from as to the proper evidentiary foundation which is necessary to render the report credible and reliable. Secondly, employers generally spend more money than claimants in obtaining medical reports, and this money will partly be invested in making sure that the reports comply (or appear to comply) with the requirements of the AMA Guides.

To remedy these problems, I think that the language in Sections 85-16-5.1 and 18-16-4 should be made less stringent. These sections should state that substantial compliance with the standards of the AMA Guides is recommended, although it is not required.

If the AMA Guides are to become a benchmark for the West Virginia Workers' Compensation system, I think that the Fund has an obligation to notify all physicians in the State that this is happening. Moreover, the Fund should offer physicians training in the use of the AMA Guides. Hopefully, there will be many physicians who will take advantage of such training so that they can render service to their patients who are subject to the Workers' Compensation system.

Definition of Disability

I am disturbed by the definition of "disability" contained in Section 85-16-3.2. This definition was taken directly from the 4th Edition of the AMA Guides. While the AMA Guides might be a very good source for the definition of impairment, I don't think that it is authoritative as to the definition of disability. While "impairment" is a medical concept, "disability" is a legal concept whose definition should be taken from legal sources rather than medical sources.

The definition contained in Section 85-16-3.2 is couched solely in functional terms. While this is part of a suitable definition of disability, it should not be taken as the whole definition.

A more complete view of disability is contained in the "Division of Workers' Compensation Psychiatric Examination Guideline Outline" attached to the proposed Guidelines for Permanent Impairment and Disability Evaluations, Evidence, and Ratings, at page 44. In this section, it is recognized that disability includes the impairment of the employee's earning capacity, the effect of the impairment on the claimant's efficiency at work, and the effect of the impairment on the claimant's normal pursuit of everyday living. I believe that these three considerations need to be built into the definition of disability in Section 85-16-3.2

The problem with the definition of disability contained in the AMA Guides is shown by the following sentence from page 1/4 of the AMA Guides: "Under the Workers' Compensation laws, disability, whether temporary or permanent, is equivalent to economic loss for which the individual is to be compensated". That statement is not correct (or at least not complete) when applied to the West Virginia Workers' Compensation system. As page 44 of the Psychiatric Guidelines illustrates, the West Virginia Workers' Compensation system of disability evaluation includes impairment of a claimant's normal pursuit of everyday living.

Basically, the problem is that the definition of disability contained in the AMA Guides is too narrow. We should not be taking it wholesale and incorporating it into the West Virginia Guidelines for Permanent Impairment and Disability Evaluations, Evidence, and Ratings.

<u>Reliance on Disability "Experts"</u>

I urge you and the Performance Council to delete Section 85-16-5.4. This section is predicated on the idea that there exists (or could exist) a class of professionals who are qualified to give opinions as to the extent of an individual's disability. I have grave doubts that such professionals exist, and I fear that the creation of a place for them in the West Virginia Workers' Compensation system will lead to the creation of a class of charlatans and whores.

It is difficult enough for physicians to rate degrees of impairment. The determination of disability is an even more subjective exercise. Certainly, the Workers' Compensation system should be able to include room for vocational experts, who can make assessments of the effect of a particular claimants

impairment on his or her vocational prospects. The system could also utilize economists to testify about reduced wages as a result of reduced vocational prospects. But, I don't think it is possible to have "expert testimony" on that portion of disability evaluation which deals with the impairment of the claimant's normal pursuit of everyday living. This is the kind of thing that juries routinely consider in civil cases. The fact finder is the lay jury, and experts are of no assistance.

In addition to the futility of the idea of "expertise in the field of disability determinations", I think that this is something which is open to vast amounts of abuse. Because it is so subjective, anyone can say virtually anything. I would not trust the opinion of an "expert" in the "field of disability determination" no matter how long his or her trail of paper credentials. His or her opinion would, in my view, be worth considerably less than that of an average juror who hears both sides of an issue in a courtroom.

Moreover, we must recognize that "expertise in the field of disability determination" has no relevance to society except in a Workers' Compensation system. Unlike physicians or physical therapists or people in the field of vocational rehabilitation, these so-called "experts" do not contribute anything toward the treatment or rehabilitation of an injured worker. Since their sole function is in the determination of disability, they exist only to render opinions. Assuming that such people have the natural human desire for money, they will offer these opinions generally to the side which will pay them the most. The more they get paid, the fancier and more impressive-looking the opinion.

Since employers can pay more (generally speaking) than claimants for opinions, claimants are at a disadvantage when the Workers' Compensation system creates a class of professionals with "expertise in the field of disability determination".

Although the determination of disability necessarily is subjective, it can be done. Juries do it every day. Likewise, people in the Commissioner's office can do it and Administrative Law Judges can do it. In my view, they will get no credible assistance from so called professionals who claim an "expertise in the field of disability determination".

Thank you for your consideration of these comments.

Sincerely,

Robert F. Cohen Jr.

RFC/slb

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Thank you for your consideration of these comments.

Sincerely,

Robert F Cohen

Robert F. Cohen Jr.

RFC/slb

Rev. 6-94

WORKERS' COMPENSATION DIVISION

LOW BACK EXAMINATION

USE BLACK INK — *To Be Completed by the Physician* —

Patient Name: _____ **Physician:** _____

SSN: ___-___-____ HT. _____ **Address:** _____

Date of Injury: __/__/__ WT. _____ _____

Date of Birth: __/__/__ Pulse _____ **Phone:** _____

Claim Number _____ BP _____ **FEIN:** _____

Date of Exam: __/__/__ Resp. _____

PLEASE CHECK ONE:

☐ CONSULTATION ☐ IMPAIRMENT RATING ☐ INDEPENDENT EXAMINATION ☐ 120-DAY EXAMINATION ☐ COMPREHENSIVE EXAMINATION

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 (Asymmetry)	❑	❑	_____
1.5 Lumbar hypolordosis	❑	❑	_____
1.6 Lumbar hyperlordosis	❑	❑	

Other observations _____

2. PALPATION (standing, seated, or prone)

	YES	NO	
2.1 Vertebral tenderness/ restriction	❑	❑	❑ L1 ❑ L2 ❑ L3 ❑ L4 ❑ L5
2.2 Coccyx tenderness (external palpation)	❑	❑	_____
2.3 Sacral base & pelvis level (Standing)	❑	❑	_____

	LEFT		RIGHT		
	YES	NO	YES	NO	
2.4 Paraspinal muscle tenderness	❑	❑	❑	❑	_____
2.5 Paraspinal muscle spasm	❑	❑	❑	❑	_____
2.6 Sacroiliac joint tenderness	❑	❑	❑	❑	_____

3. GAIT

3.1 Limp ❑ Yes ❑ No ❑ Left ❑ Right Explain: _____

3.2 Assistive devices (cane, brace, prosthesis) _____

3.3 Other observations _____

4. SQUAT

4.1 Squats fully and rises without difficulty ❑ Yes ❑ No

Comments _____

5. RANGE OF MOTION (standing)

		WNL	PAIN	RESTRICTION
5.1 Forward bending (Flexion)	_____°	❑	❑	❑
5.2 Backward bending (Extension)	_____°	❑	❑	❑
5.3 Left side bending	_____°	❑	❑	❑
5.4 Right side bending	_____°	❑	❑	❑
5.5 Right Rotation (torso)	_____°	❑	❑	❑
5.6 Left Rotation (torso)	_____°	❑	❑	❑

5.7 Comments _____

5.8 Inclinometer ❑ Yes ❑ No

Claim Number _____

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

	NORMAL	ABNORMAL	GRADE (OUT OF 5) LEFT	RIGHT
6.1 Hip flexion	❑	❑		
6.2 Hip Extension	❑	❑		
6.3 Hip Abduction	❑	❑		
6.4 Knee extension	❑	❑		
6.5 Knee flexion	❑	❑		
6.6 Ankle dorsiflexion	❑	❑		
6.7 Ankle Planter flexion	❑	❑		
6.8 Great toe extension	❑	❑		
6.9 Heel toe walk	❑	❑		
6.0 Toe walk	❑	❑		

7. SENSORY (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	❑	❑	❑	❑	❑	❑

7.5 Comments _____

8. REFLEXES (seated) (+2 normal)

Patellar	9.1 Left	❑ 0	❑ +1	❑ +2	❑ +3	❑ clonus
	9.2 Right	❑ 0	❑ +1	❑ +2	❑ +3	❑ clonus
Achilles	9.3 Left	❑ 0	❑ +1	❑ +2	❑ +3	❑ clonus
	9.4 Right	❑ 0	❑ +1	❑ +2	❑ +3	❑ clonus

Other _____

9. STRAIGHT LEG RAISING (sitting)
(Measure knee extension)

8.1 Left _____° Pain: ❑ Yes ❑ No Location of Pain: ❑ Back ❑ Same Leg ❑ Contralateral back/leg
8.2 Right _____° Pain: ❑ Yes ❑ No Location of Pain: ❑ Back ❑ Same Leg ❑ Contralateral back/leg

10. HIP AND SACROILIAC TEST

10.1 Hip test pain ❑ Yes ❑ No ❑ Left ❑ Right
(See Instructional manual) _____

10.2 Sacroiliac test pain ❑ Yes ❑ No ❑ Left ❑ Right
(See Instructional manual) _____

11. STRAIGHT LEG RAISING (supine)

11.1 Left _____° Pain: ❑ Yes ❑ No Location of Pain: ❑ Back ❑ Same Leg ❑ Contralateral back/leg
11.2 Right _____° Pain: ❑ Yes ❑ No Location of Pain: ❑ Back ❑ Same Leg ❑ Contralateral back/leg

12. PEDIS PULSES

	NORMAL	ABNORMAL
12.1 Popliteal _____	❑	❑
12.2 Posterior tibial _____	❑	❑

12.3 Other observations (Clubbing, Cyanosis) _____

13. MUSCLE WASTING MEASUREMENT

13.1 Left Thigh _____ Right Thigh _____ _____ cm above tibial tubercle
13.2 Left Calf _____ Right Calf _____ _____ cm below tibial tubercle

14. LEG LENGTH EXAM

14.1 Symmetrical ❑ Yes ❑ No ❑ Not Tested
14.2 Shorter ❑ Left ❑ Right ❑ Even ❑ Supine ❑ Standing
Difference of _____cm Right _____cm Left _____cm

❑ Supine: measure from anterior superior iliac spine to medial/lateral malleolus. ❑ Standing: measure from greater trochanter to floor

Workers' Compensation Division

USE BLACK INK

Patient History - Back Pain

Patient Name: _____
SSN: ___ ___ - ___ ___ - ___ ___ ___ ___
Date of Injury: ___/___/___
Date of Birth: ___/___/___
Claim Number _____
Date of Exam: ___/___/___

Physician: _____
Address: _____
_____
Phone: _____
FEIN: ___ ___ ___ ___ ___ ___ ___ ___ ___

PLEASE CHECK ONE:

❑ IMPAIRMENT RATING ❑ 120-DAY EXAMINATION
❑ CONSULTATION ❑ INDEPENDENT EXAMINATION ❑ COMPREHENSIVE EXAMINATION

Present History (to be completed by the patient)

1. What are your problems? _____

2. How did the problem occur? _____

3. Where is the location of the problem/pain?

4. Have you had this type of complaint before? ❑ Yes ❑ No
When?/ Where?

4.1 How did that complaint occur?

4.2 What is the name of your employer?

4.3 What is the type of business of that company?

5.1 What was your job title when problem began?

5.2 What was your usual job? (Job Tasks)

Describe your job tasks. _____

5.3 What job were you performing when problem began?

6. Who is your immediate supervisor?

Name Phone Number

7. Have you discussed your problem 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 problem/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 complaint before now? ❑ Yes ❑ No

12. What has helped this complaint the most? _____

13. What has not helped or made this complaint 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 spell with very little pain?	❑ Yes	❑ No
14.6 Have you had any intolerance to your treatment or reaction 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
When/Where/Results_____
MRI ❑ Yes ❑ No
When/Where/Results_____
CT scan ❑ Yes ❑ No
When/Where/Results_____
Myelogram ❑ Yes ❑ No
When/Where/Results_____
Other_____

16. Have you ever been hospitalized for neck, arm, back or leg complaints/pain? ❑ Yes ❑ No
When/Where_____

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 the above problems?
❑ Yes ❑ No
Which/When_____

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

Claim Number _ _ _ _ _ _ _ _ _ _

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

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: _____

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 ///

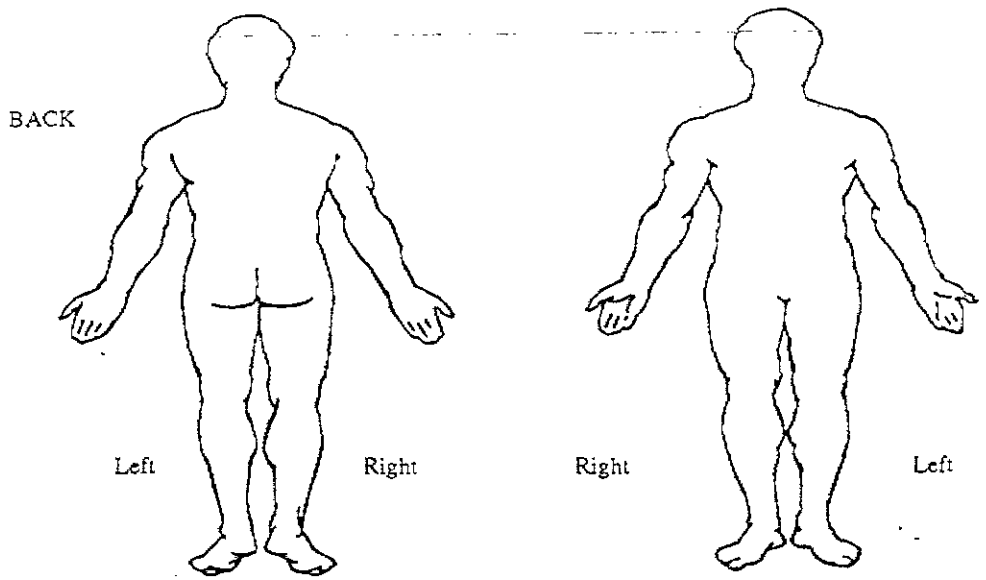
Burning XXX

Pins OOO and Needles

Aching, ^^^ Throbbing

Numbness = = =

Other . . .



Signature of person completing form _____ Date _____

If signature is not of patient, then state relationship to patient _____

15. CLINICAL IMPRESSION OF SOMATIC AMPLIFICATION

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

_____

_____

_____

Claim Number _____

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

Findings (Attach report if available): _____

Patient Position During X-ray ☐ Recumbent ☐ Weight Bearing

18. CLINICAL DIAGNOSIS

(Please indicate appropriate IC-9 code(s) and give verbal description. 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)

POSTERIOR JOINTS
- ☐ Facet syndrome (724.8)
- ☐ Lumbar subluxation or lumbar segmental dysfunction (739.4)

DISC
- ☐ Lumbar disc displacement (without radiculopathy) (722.10)
- ☐ Lumbar disc displacement (with radiculopathy) (722.73)

SACROILIAC
- ☐ Sacroiliitis (720.2)
- ☐ Sacroiliac subluxation or sacroiliac segmental dysfunction (739.4)

☐ OTHER: _____

19. OTHER TESTS PERFORMED AND FINDINGS: _____

20. TREATMENT PLAN, REFERRALS, RECOMMENDATIONS: _____

21. AUTHORIZATION(S) REQUESTED FOR: _____

Rev. 6-94

WORKERS' COMPENSATION DIVISION
LOW BACK EXAMINATION

USE BLACK INK — *To Be Completed by the Physician* —

Patient Name: _____ Physician: _____

SSN: ___ ___ - ___ - ___ ___ ___ ___ HT. _____ Address: _____

Date of Injury: ___/___/___ WT. _____ _____

Date of Birth: ___/___/___ Pulse _____ Phone: _____

Claim Number _____ BP _____ FEIN: _____

Date of Exam: ___/___/___ Resp. _____

PLEASE CHECK ONE:

☐ CONSULTATION ☐ IMPAIRMENT RATING ☐ INDEPENDENT EXAMINATION ☐ 120-DAY EXAMINATION ☐ COMPREHENSIVE EXAMINATION

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 (Asymmetry)	❑	❑	_____
1.5 Lumbar hypolordosis	❑	❑	_____
1.6 Lumbar hyperlordosis	❑	❑	

Other observations _____

2. PALPATION (standing, seated, or prone)

	YES	NO	
2.1 Vertebral tenderness/ restriction	❑	❑	❑ L1 ❑ L2 ❑ L3 ❑ L4 ❑ L5
2.2 Coccyx tenderness (external palpation)	❑	❑	_____
2.3 Sacral base & pelvis level (Standing)	❑	❑	_____

	LEFT		RIGHT		
	YES	NO	YES	NO	
2.4 Paraspinal muscle tenderness	❑	❑	❑	❑	_____
2.5 Paraspinal muscle spasm	❑	❑	❑	❑	_____
2.6 Sacroiliac joint tenderness	❑	❑	❑	❑	_____

3. GAIT

3.1 Limp ❑ Yes ❑ No ❑ Left ❑ Right Explain: _____

3.2 Assistive devices (cane, brace, prosthesis) _____

3.3 Other observations _____

4. SQUAT

4.1 Squats fully and rises without difficulty ❑ Yes ❑ No

Comments _____

5. RANGE OF MOTION (standing)

		WNL	PAIN	RESTRICTION
5.1 Forward bending (Flexion)	_____°	❑	❑	❑
5.2 Backward bending (Extension)	_____°	❑	❑	❑
5.3 Left side bending	_____°	❑	❑	❑
5.4 Right side bending	_____°	❑	❑	❑
5.5 Right Rotation (torso)	_____°	❑	❑	❑
5.6 Left Rotation (torso)	_____°	❑	❑	❑

5.7 Comments _____

5.8 Inclinometer ❑ Yes ❑ No

Claim Number _____

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

	NORMAL	ABNORMAL	GRADE (OUT OF 5) LEFT	RIGHT
6.1 Hip flexion	❑	❑	____	____
6.2 Hip Extension	❑	❑	____	____
6.3 Hip Abduction	❑	❑	____	____
6.4 Knee extension	❑	❑	____	____
6.5 Knee flexion	❑	❑	____	____
6.6 Ankle dorsiflexion	❑	❑	____	____
6.7 Ankle Planter flexion	❑	❑	____	____
6.8 Great toe extension	❑	❑	____	____
6.9 Heel toe walk	❑	❑	____	____
6.0 Toe walk	❑	❑	____	____

7. SENSORY (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	❑	❑	❑	❑	❑	❑

7.5 Comments _____

8. REFLEXES (seated) (+2 normal)

Patellar	9.1 Left	❑ 0	❑ +1	❑ +2	❑ +3	❑ clonus
	9.2 Right	❑ 0	❑ +1	❑ +2	❑ +3	❑ clonus
Achilles	9.3 Left	❑ 0	❑ +1	❑ +2	❑ +3	❑ clonus
	9.4 Right	❑ 0	❑ +1	❑ +2	❑ +3	❑ clonus

Other _____

9. STRAIGHT LEG RAISING (sitting)
(Measure knee extension)

8.1 Left _____° Pain: ❑ Yes ❑ No Location of Pain: ❑ Back ❑ Same Leg ❑ Contralateral back/leg
8.2 Right _____° Pain: ❑ Yes ❑ No Location of Pain: ❑ Back ❑ Same Leg ❑ Contralateral back/leg

10. HIP AND SACROILIAC TEST

10.1 Hip test pain ❑ Yes ❑ No ❑ Left ❑ Right
(See Instructional manual) _____

10.2 Sacroiliac test pain ❑ Yes ❑ No ❑ Left ❑ Right
(See Instructional manual) _____

11. STRAIGHT LEG RAISING (supine)

11.1 Left _____° Pain: ❑ Yes ❑ No Location of Pain: ❑ Back ❑ Same Leg ❑ Contralateral back/leg
11.2 Right _____° Pain: ❑ Yes ❑ No Location of Pain: ❑ Back ❑ Same Leg ❑ Contralateral back/leg

12. PEDIS PULSES

	NORMAL	ABNORMAL
12.1 Popliteal _____	❑	❑
12.2 Posterior tibial _____	❑	❑

12.3 Other observations (Clubbing, Cyanosis) _____

13. MUSCLE WASTING MEASUREMENT

13.1 Left Thigh _____ Right Thigh _____ _____ cm above tibial tubercle
13.2 Left Calf _____ Right Calf _____ _____ cm below tibial tubercle

14. LEG LENGTH EXAM

14.1 Symmetrical ❑ Yes ❑ No ❑ Not Tested
14.2 Shorter ❑ Left ❑ Right ❑ Even ❑ Supine ❑ Standing
Difference of _____cm Right _____cm Left _____cm

❑ Supine: measure from anterior superior iliac spine to medial/lateral malleolus. ❑ Standing: measure from greater trochanter to floor

Workers' Compensation Division

USE BLACK INK

Patient History - Back Pain

Patient Name: _____
SSN: ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Date of Injury: ___/___/___
Date of Birth: ___/___/___
Claim Number _____
Date of Exam: ___/___/___

Physician: _____
Address: _____
_____
Phone: _____
FEIN: ___ ___ ___ ___ ___ ___ ___ ___ ___

PLEASE CHECK ONE:

❑ IMPAIRMENT RATING ❑ 120-DAY EXAMINATION
❑ CONSULTATION ❑ INDEPENDENT EXAMINATION ❑ COMPREHENSIVE EXAMINATION

Present History (to be completed by the patient)

1. What are your problems? _____

2. How did the problem occur? _____

3. Where is the location of the problem/pain?

4. Have you had this type of complaint before? ❑ Yes ❑ No
When?/ Where?

4.1 How did that complaint occur?

4.2 What is the name of your employer?

4.3 What is the type of business of that company?

5.1 What was your job title when problem began?

5.2 What was your usual job? (Job Tasks)

Describe your job tasks. _____

5.3 What job were you performing when problem began?

6. Who is your immediate supervisor?

Name Phone Number

7. Have you discussed your problem 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 problem/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 complaint before now? ❑ Yes ❑ No

12. What has helped this complaint the most? _____

13. What has not helped or made this complaint 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 spell with very little pain?	❑ Yes	❑ No
14.6 Have you had any intolerance to your treatment or reaction to treatment?	❑ Yes	❑ No
14.7 Have you had an emergency room visit to the hospital with back trouble?	❑ Yes	❑ No

Past History

Claim Number _____

15. Have you ever had a spine X-ray, CT scan, MRI or myelogram?
    X-ray ❑ Yes ❑ No
    When/Where/Results_____
    MRI ❑ Yes ❑ No
    When/Where/Results_____
    CT scan ❑ Yes ❑ No
    When/Where/Results_____
    Myelogram ❑ Yes ❑ No
    When/Where/Results_____
    Other _____
16. Have you ever been hospitalized for neck, arm, back or leg complaints/pain? ❑ Yes ❑ No
    When/Where_____
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 the above problems?
    ❑ 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 No:_____
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: _____

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 ///

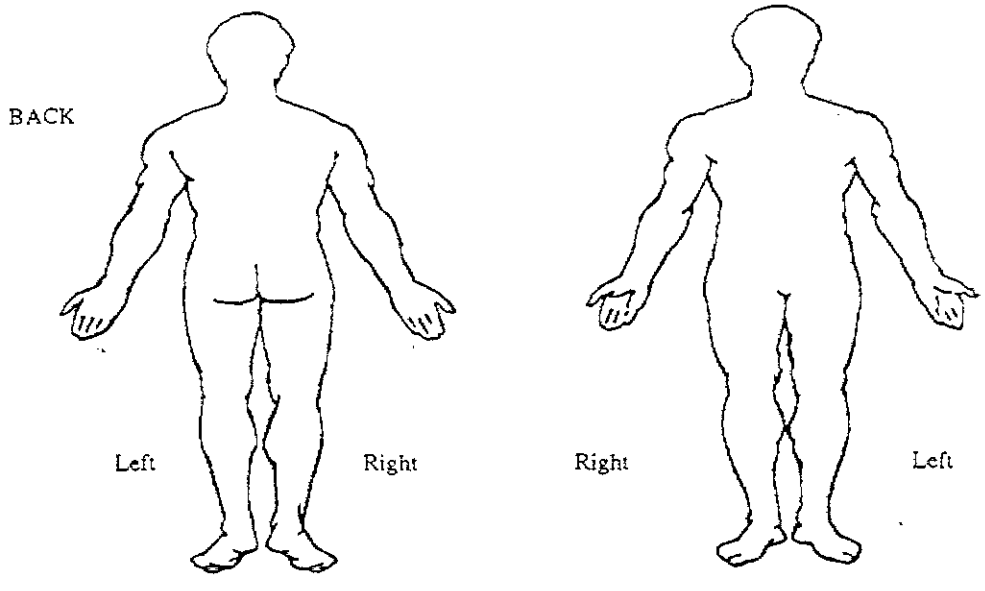
Burning XXX

Pins OOO and Needles

Aching, ^^^ Throbbing

Numbness = = =

Other . . .



Signature of person completing form _____ Date _____

If signature is not of patient, then state relationship to patient _____

15. CLINICAL IMPRESSION OF SOMATIC AMPLIFICATION

SCORE

SENSORY EXAMINATION: RESPONSE TO PINPRICK

15.1 No deficit or deficit well localized to dermatome(s) 0 ☐
Deficit related to dermatome(s) but some inconsistency 1 ☐
Nondermatomal or very inconsistent deficit 2 ☐
Blatantly impossible (i.e., split down midline of entire body with positive tuning fork test) 3 ☐

15.2 AMOUNT OF BODY INVOLVED

<15% 0 ☐
15 - 35% 1 ☐
36 - 60% 2 ☐
> 60% 3 ☐

MOTOR EXAMINATIONS

15.3 No deficit or deficit well localized to myotome(s) 0 ☐
Deficit related to myotome(s) but some inconsistency 1 ☐
Nonmyotomal or very inconsistent weakness, exhibits cogwheeling or giving away, weakness is coachable 2 ☐
Blatantly impossible, significant weakness which disappears when distracted 3 ☐

15.4 AMOUNT OF BODY INVOLVED

<15% 0 ☐
15 - 35% 1 ☐
36 - 60% 2 ☐
>60% 3 ☐

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 ☐

DIFFERENTIAL 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

Claim Number _____

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

Findings (Attach report if available): _____

Patient Position During X-ray ☐ Recumbent ☐ Weight Bearing

18. CLINICAL DIAGNOSIS

(Please indicate appropriate IC-9 code(s) and give verbal description. 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)

POSTERIOR JOINTS
- ☐ Facet syndrome (724.8)
- ☐ Lumbar subluxation or lumbar segmental dysfunction (739.4)

DISC
- ☐ Lumbar disc displacement (without radiculopathy) (722.10)
- ☐ Lumbar disc displacement (with radiculopathy) (722.73)

SACROILIAC
- ☐ Sacroiliitis (720.2)
- ☐ Sacroiliac subluxation or sacroiliac segmental dysfunction (739.4)

☐ OTHER: _____

19. OTHER TESTS PERFORMED AND FINDINGS: _____

20. TREATMENT PLAN, REFERRALS, RECOMMENDATIONS: _____

21. AUTHORIZATION(S) REQUESTED FOR: _____

Rev. 6-94

WORKERS' COMPENSATION DIVISION

LOW BACK EXAMINATION

USE BLACK INK — *To Be Completed by the Physician* —

Patient Name: _____ **Physician:** _____

SSN: ___-___-___ HT. _____ **Address:** _____

Date of Injury: __/__/__ WT. _____ _____

Date of Birth: __/__/__ Pulse _____ **Phone:** _____

Claim Number _____ BP _____ **FEIN:** _____

Date of Exam: __/__/__ Resp. _____

PLEASE CHECK ONE:

☐ CONSULTATION ☐ IMPAIRMENT RATING ☐ INDEPENDENT EXAMINATION ☐ 120-DAY EXAMINATION ☐ COMPREHENSIVE EXAMINATION

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 (Asymmetry)	☐	☐	
1.5 Lumbar hypolordosis	☐	☐	
1.6 Lumbar hyperlordosis	☐	☐	

Other observations _____

2. PALPATION (standing, seated, or prone)

	YES	NO	
2.1 Vertebral tenderness/ restriction	☐	☐	☐ L1 ☐ L2 ☐ L3 ☐ L4 ☐ L5
2.2 Coccyx tenderness (external palpation)	☐	☐	
2.3 Sacral base & pelvis level (Standing)	☐	☐	

	LEFT		RIGHT		
	YES	NO	YES	NO	
2.4 Paraspinal muscle tenderness	☐	☐	☐	☐	
2.5 Paraspinal muscle spasm	☐	☐	☐	☐	
2.6 Sacroiliac joint tenderness	☐	☐	☐	☐	

3. GAIT

3.1 Limp ☐ Yes ☐ No ☐ Left ☐ Right Explain: _____

3.2 Assistive devices (cane, brace, prosthesis) _____

3.3 Other observations _____

4. SQUAT

4.1 Squats fully and rises without difficulty ☐ Yes ☐ No

Comments _____

5. RANGE OF MOTION (standing)

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

5.7 Comments _____

5.8 Inclinometer ☐ Yes ☐ No

Claim Number _____

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

	NORMAL	ABNORMAL	GRADE (OUT OF 5) LEFT	RIGHT
6.1 Hip flexion	☐	☐	____	____
6.2 Hip Extension	☐	☐	____	____
6.3 Hip Abduction	☐	☐	____	____
6.4 Knee extension	☐	☐	____	____
6.5 Knee flexion	☐	☐	____	____
6.6 Ankle dorsiflexion	☐	☐	____	____
6.7 Ankle Planter flexion	☐	☐	____	____
6.8 Great toe extension	☐	☐	____	____
6.9 Heel toe walk	☐	☐	____	____
6.0 Toe walk	☐	☐	____	____

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

	LEFT			RIGHT		
	Normal	Diminished	Absent	Normal	Diminished	Absent
7.1 L3 sensory	☐	☐	☐	☐	☐	☐
7.2 L4 sensory	☐	☐	☐	☐	☐	☐
7.3 L5 sensory	☐	☐	☐	☐	☐	☐
7.4 S1 sensory	☐	☐	☐	☐	☐	☐

7.5 Comments _____

8. REFLEXES (seated) (+2 normal)

Patellar	9.1 Left	☐ 0	☐ +1	☐ +2	☐ +3	☐ clonus
	9.2 Right	☐ 0	☐ +1	☐ +2	☐ +3	☐ clonus
Achilles	9.3 Left	☐ 0	☐ +1	☐ +2	☐ +3	☐ clonus
	9.4 Right	☐ 0	☐ +1	☐ +2	☐ +3	☐ clonus

Other _____

9. STRAIGHT LEG RAISING (sitting)
(Measure knee extension)

8.1 Left _____° Pain: ☐ Yes ☐ No Location of Pain: ☐ Back ☐ Same Leg ☐ Contralateral back/leg
8.2 Right _____° Pain: ☐ Yes ☐ No Location of Pain: ☐ Back ☐ Same Leg ☐ Contralateral back/leg

10. HIP AND SACROILIAC TEST

10.1 Hip test pain ☐ Yes ☐ No ☐ Left ☐ Right
(See Instructional manual) _____

10.2 Sacroiliac test pain ☐ Yes ☐ No ☐ Left ☐ Right
(See Instructional manual) _____

11. STRAIGHT LEG RAISING (supine)

11.1 Left _____° Pain: ☐ Yes ☐ No Location of Pain: ☐ Back ☐ Same Leg ☐ Contralateral back/leg
11.2 Right _____° Pain: ☐ Yes ☐ No Location of Pain: ☐ Back ☐ Same Leg ☐ Contralateral back/leg

12. PEDIS PULSES

		NORMAL	ABNORMAL
12.1 Popliteal	_____	☐	☐
12.2 Posterior tibial	_____	☐	☐

12.3 Other observations (Clubbing, Cyanosis) _____

13. MUSCLE WASTING MEASUREMENT

13.1 Left Thigh _____ Right Thigh _____ _____ cm above tibial tubercle
13.2 Left Calf _____ Right Calf _____ _____ cm below tibial tubercle

14. LEG LENGTH EXAM

14.1 Symmetrical ☐ Yes ☐ No ☐ Not Tested
14.2 Shorter ☐ Left ☐ Right ☐ Even ☐ Supine ☐ Standing
Difference of _____ cm Right _____ cm Left _____ cm

☐ Supine: measure from anterior superior iliac spine to medial/lateral malleolus. ☐ Standing: measure from greater trochanter to floor

Workers' Compensation Division

USE BLACK INK

Patient History - Back Pain

Patient Name: _____
SSN: ___ ___ - ___ - ___
Date of Injury: ___/___/___
Date of Birth: ___/___/___
Claim Number _____
Date of Exam: ___/___/___

Physician: _____
Address: _____
_____
Phone: _____
FEIN: ___ ___ - ___ ___ ___ ___

PLEASE CHECK ONE:

❑ IMPAIRMENT RATING ❑ 120-DAY EXAMINATION
❑ CONSULTATION ❑ INDEPENDENT EXAMINATION ❑ COMPREHENSIVE EXAMINATION

Present History (to be completed by the patient)

1. What are your problems? _____

2. How did the problem occur? _____

3. Where is the location of the problem/pain?

4. Have you had this type of complaint before? ❑ Yes ❑ No
When?/ Where?

4.1 How did that complaint occur?

4.2 What is the name of your employer?

4.3 What is the type of business of that company?

5.1 What was your job title when problem began?

5.2 What was your usual job? (Job Tasks)

Describe your job tasks. _____

5.3 What job were you performing when problem began?

6. Who is your immediate supervisor?

Name Phone Number

7. Have you discussed your problem 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 problem/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 complaint before now? ❑ Yes ❑ No

12. What has helped this complaint the most? _____

13. What has not helped or made this complaint 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 spell with very little pain?	❑ Yes	❑ No
14.6 Have you had any intolerance to your treatment or reaction 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
When/Where/Results_____
MRI ❑ Yes ❑ No
When/Where/Results_____
CT scan ❑ Yes ❑ No
When/Where/Results_____
Myelogram ❑ Yes ❑ No
When/Where/Results_____
Other_____

16. Have you ever been hospitalized for neck, arm, back or leg complaints/pain? ❑ Yes ❑ No
When/Where_____

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 the above problems?
❑ Yes ❑ No
Which/When_____

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

Claim Number _ _ _ _ _ _ _ _ _ _

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

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: _____

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 ///

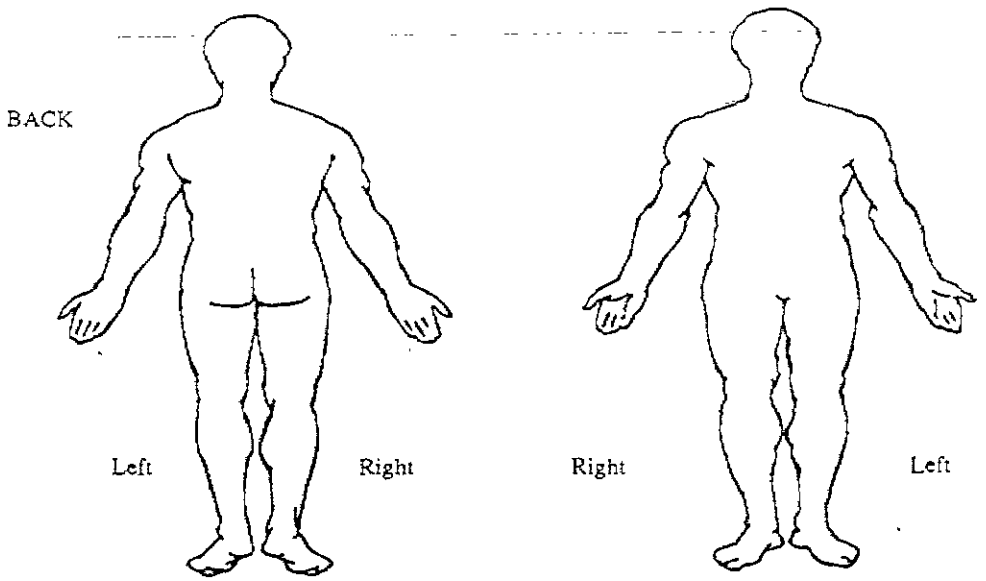
Burning X X X

Pins OOO and Needles

Aching, ^ ^ ^ Throbbing

Numbness = = =

Other . . .



Signature of person completing form _____ Date _____

If signature is not of patient, then state relationship to patient _____

15. CLINICAL IMPRESSION OF SOMATIC AMPLIFICATION

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

_____

_____

_____

Claim Number _____

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

Findings (Attach report if available): _____

Patient Position During X-ray ☐ Recumbent ☐ Weight Bearing

18. CLINICAL DIAGNOSIS

(Please indicate appropriate IC-9 code(s) and give verbal description. 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)

POSTERIOR JOINTS
- ☐ Facet syndrome (724.8)
- ☐ Lumbar subluxation or lumbar segmental dysfunction (739.4)

DISC
- ☐ Lumbar disc displacement (without radiculopathy) (722.10)
- ☐ Lumbar disc displacement (with radiculopathy) (722.73)

SACROILIAC
- ☐ Sacroiliitis (720.2)
- ☐ Sacroiliac subluxation or sacroiliac segmental dysfunction (739.4)

☐ OTHER: _____

19. OTHER TESTS PERFORMED AND FINDINGS: _____

20. TREATMENT PLAN, REFERRALS, RECOMMENDATIONS: _____

21. AUTHORIZATION(S) REQUESTED FOR: _____

Rev. 6-94

WORKERS' COMPENSATION DIVISION

LOW BACK EXAMINATION

USE BLACK INK — *To Be Completed by the Physician* — *Page 1*

Patient Name: _____
SSN: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ HT. _____
Date of Injury: ___/___/___ WT. _____
Date of Birth: ___/___/___ Pulse _____
Claim Number _____ BP _____
Date of Exam: ___/___/___ Resp. _____

Physician: _____
Address: _____
_____
Phone: _____
FEIN: _____

PLEASE CHECK ONE:

☐ CONSULTATION ☐ IMPAIRMENT RATING ☐ INDEPENDENT EXAMINATION ☐ 120-DAY EXAMINATION ☐ COMPREHENSIVE EXAMINATION

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 (Asymmetry)	❑	❑	_____
1.5 Lumbar hypolordosis	❑	❑	_____
1.6 Lumbar hyperlordosis	❑	❑	

Other observations _____

2. PALPATION (standing, seated, or prone)

	YES	NO	
2.1 Vertebral tenderness/ restriction	❑	❑	❑ L1 ❑ L2 ❑ L3 ❑ L4 ❑ L5
2.2 Coccyx tenderness (external palpation)	❑	❑	_____
2.3 Sacral base & pelvis level (Standing)	❑	❑	_____

	LEFT		RIGHT		
	YES	NO	YES	NO	
2.4 Paraspinal muscle tenderness	❑	❑	❑	❑	_____
2.5 Paraspinal muscle spasm	❑	❑	❑	❑	_____
2.6 Sacroiliac joint tenderness	❑	❑	❑	❑	_____

3. GAIT

3.1 Limp ❑ Yes ❑ No ❑ Left ❑ Right Explain: _____
3.2 Assistive devices (cane, brace, prosthesis) _____
3.3 Other observations _____

4. SQUAT

4.1 Squats fully and rises without difficulty ❑ Yes ❑ No
Comments _____

5. RANGE OF MOTION (standing)

		WNL	PAIN	RESTRICTION
5.1 Forward bending (Flexion)	_____°	❑	❑	❑
5.2 Backward bending (Extension)	_____°	❑	❑	❑
5.3 Left side bending	_____°	❑	❑	❑
5.4 Right side bending	_____°	❑	❑	❑
5.5 Right Rotation (torso)	_____°	❑	❑	❑
5.6 Left Rotation (torso)	_____°	❑	❑	❑

5.7 Comments _____
5.8 Inclinometer ❑ Yes ❑ No

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

	NORMAL	ABNORMAL	GRADE (OUT OF 5) LEFT	RIGHT
6.1 Hip flexion	❑	❑	____	____
6.2 Hip Extension	❑	❑	____	____
6.3 Hip Abduction	❑	❑	____	____
6.4 Knee extension	❑	❑	____	____
6.5 Knee flexion	❑	❑	____	____
6.6 Ankle dorsiflexion	❑	❑	____	____
6.7 Ankle Planter flexion	❑	❑	____	____
6.8 Great toe extension	❑	❑	____	____
6.9 Heel toe walk	❑	❑	____	____
6.0 Toe walk	❑	❑	____	____

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

	LEFT			RIGHT		
	Normal	Diminished	Absent	Normal	Diminished	Absent
7.1 L3 sensory	❑	❑	❑	❑	❑	❑
7.2 L4 sensory	❑	❑	❑	❑	❑	❑
7.3 L5 sensory	❑	❑	❑	❑	❑	❑
7.4 S1 sensory	❑	❑	❑	❑	❑	❑

7.5 Comments _____

8. REFLEXES (seated) (+2 normal)

Patellar	9.1 Left	❑ 0	❑ +1	❑ +2	❑ +3	❑ clonus
	9.2 Right	❑ 0	❑ +1	❑ +2	❑ +3	❑ clonus
Achilles	9.3 Left	❑ 0	❑ +1	❑ +2	❑ +3	❑ clonus
	9.4 Right	❑ 0	❑ +1	❑ +2	❑ +3	❑ clonus

Other _____

9. STRAIGHT LEG RAISING (sitting)
(Measure knee extension)
8.1 Left _____° Pain: ❑ Yes ❑ No Location of Pain: ❑ Back ❑ Same Leg ❑ Contralateral back/leg
8.2 Right _____° Pain: ❑ Yes ❑ No Location of Pain: ❑ Back ❑ Same Leg ❑ Contralateral back/leg

10. HIP AND SACROILIAC TEST
10.1 Hip test pain ❑ Yes ❑ No ❑ Left ❑ Right
(See Instructional manual) _____

10.2 Sacroiliac test pain ❑ Yes ❑ No ❑ Left ❑ Right
(See Instructional manual) _____

11. STRAIGHT LEG RAISING (supine)
11.1 Left _____° Pain: ❑ Yes ❑ No Location of Pain: ❑ Back ❑ Same Leg ❑ Contralateral back/leg
11.2 Right _____° Pain: ❑ Yes ❑ No Location of Pain: ❑ Back ❑ Same Leg ❑ Contralateral back/leg

12. PEDIS PULSES

	NORMAL	ABNORMAL
12.1 Popliteal _____	❑	❑
12.2 Posterior tibial _____	❑	❑

12.3 Other observations (Clubbing, Cyanosis) _____

13. MUSCLE WASTING MEASUREMENT
13.1 Left Thigh _____ Right Thigh _____ _____ cm above tibial tubercle
13.2 Left Calf _____ Right Calf _____ _____ cm below tibial tubercle

14. LEG LENGTH EXAM
14.1 Symmetrical ❑ Yes ❑ No ❑ Not Tested
14.2 Shorter ❑ Left ❑ Right ❑ Even ❑ Supine ❑ Standing
Difference of _____cm Right _____cm Left _____cm
❑ Supine: measure from anterior superior iliac spine to medial/lateral malleolus. ❑ Standing: measure from greater trochanter to floor

Workers' Compensation Division

USE BLACK INK

Patient History - Back Pain

Patient Name: _____
SSN: ___ - ___ - ___
Date of Injury: ___/___/___
Date of Birth: ___/___/___
Claim Number _____
Date of Exam: ___/___/___

Physician: _____
Address: _____
_____
Phone: _____
FEIN: _____

PLEASE CHECK ONE:

❑ IMPAIRMENT RATING ❑ 120-DAY EXAMINATION
❑ CONSULTATION ❑ INDEPENDENT EXAMINATION ❑ COMPREHENSIVE EXAMINATION

Present History (to be completed by the patient)

1. What are your problems? _____

2. How did the problem occur? _____

3. Where is the location of the problem/pain?

4. Have you had this type of complaint before? ❑ Yes ❑ No
When?/ Where?

4.1 How did that complaint occur?

4.2 What is the name of your employer?

4.3 What is the type of business of that company?

5.1 What was your job title when problem began?

5.2 What was your usual job? (Job Tasks)

Describe your job tasks. _____

5.3 What job were you performing when problem began?

6. Who is your immediate supervisor?

Name Phone Number

7. Have you discussed your problem 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 problem/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 complaint before now? ❑ Yes ❑ No

12. What has helped this complaint the most? _____

13. What has not helped or made this complaint 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 spell with very little pain?	❑ Yes	❑ No
14.6 Have you had any intolerance to your treatment or reaction to treatment?	❑ Yes	❑ No
14.7 Have you had an emergency room visit to the hospital with back trouble?	❑ Yes	❑ No

Past History

Claim Number _____

15. Have you ever had a spine X-ray, CT scan, MRI or myelogram?
    X-ray ❑ Yes ❑ No
    When/Where/Results_____
    MRI ❑ Yes ❑ No
    When/Where/Results_____
    CT scan ❑ Yes ❑ No
    When/Where/Results_____
    Myelogram ❑ Yes ❑ No
    When/Where/Results_____
    Other_____
16. Have you ever been hospitalized for neck, arm, back or leg complaints/pain? ❑ Yes ❑ No
    When/Where_____
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 the above problems?
    ❑ 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 No:_____
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: _____

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 ///

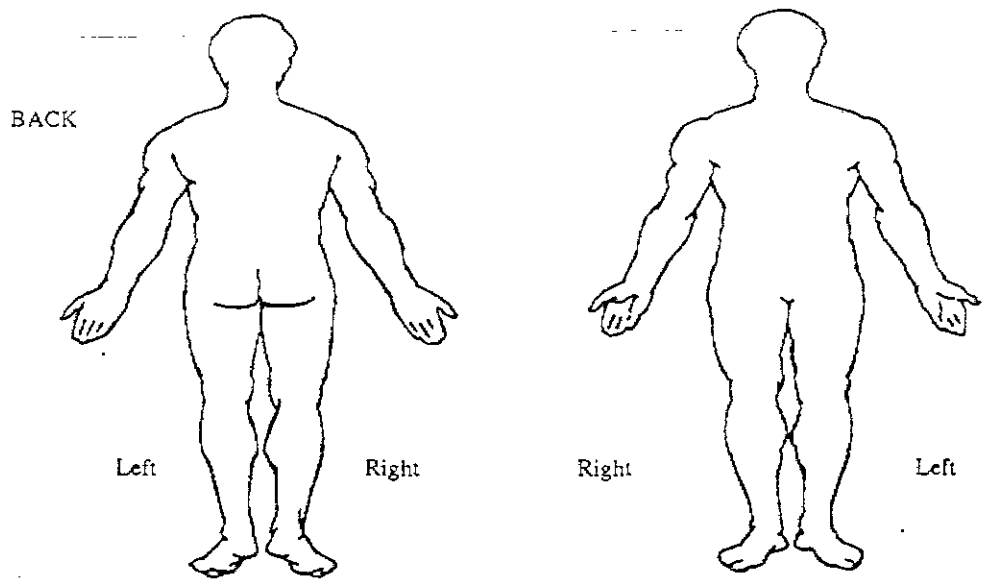
Burning XXX

Pins and Needles OOO

Aching, Throbbing ^^^

Numbness = = =

Other . . .



Signature of person completing form _____ Date _____

If signature is not of patient, then state relationship to patient _____

15. CLINICAL IMPRESSION OF SOMATIC AMPLIFICATION

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

Claim Number _____

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

Findings (Attach report if available): _____

Patient Position During X-ray ☐ Recumbent ☐ Weight Bearing

18. CLINICAL DIAGNOSIS

(Please indicate appropriate IC-9 code(s) and give verbal description. 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)

POSTERIOR JOINTS

- ☐ Facet syndrome (724.8)
- ☐ Lumbar subluxation or lumbar segmental dysfunction (739.4)

DISC

- ☐ Lumbar disc displacement (without radiculopathy) (722.10)
- ☐ Lumbar disc displacement (with radiculopathy) (722.73)

SACROILIAC

- ☐ Sacroiliitis (720.2)
- ☐ Sacroiliac subluxation or sacroiliac segmental dysfunction (739.4)

☐ OTHER: _____

19. OTHER TESTS PERFORMED AND FINDINGS: _____

20. TREATMENT PLAN, REFERRALS, RECOMMENDATIONS: _____

21. AUTHORIZATION(S) REQUESTED FOR: _____