WEST VIRGINIA
SECRETARY OF STATE
KEN HECHLER
ADMINISTRATIVE LAW DIVISION

Form #1

Do Not Mark In this Box

MAR 1 2 31 PM '95

OFFICE OF ADMINISTRATIVE LAW
SECRETARY OF STATE

NOTICE OF PUBLIC HEARING ON A PROPOSED RULE

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

RULE TYPE: Exempt Legislative ; CITE AUTHORITY §21A-2-6(1),-6(2) 7 -6(14); §21A-2-19; §21A-3-7(b) &-7(c)& §23-1-1; §23-1-15 & §23-4-1f

AMENDMENT TO AN EXISTING RULE: YES___ NO X

IF YES, SERIES NUMBER OF RULE BEING AMENDED: _____

TITLE OF RULE BEING AMENDED: _____

IF NO, SERIES NUMBER OF NEW RULE BEING PROPOSED: 22

TITLE OF RULE BEING PROPOSED: Guidelines for Psychiatric Permanent Impairment, Evaluations, Evidence and Ratings of Psychiatric Impairment Due to Workers' Compensation Injuries

There will be two (2) public hearings.

DATE OF PUBLIC HEARING: April 10 & 13, 1995 TIME: 10:00 a.m.

LOCATION OF PUBLIC HEARING: Jerry West Lounge, WVU Coliseum, Morgantown-April 10,1995
Room 202, Charleston Civic Center, Charleston-April 13,1995

COMMENTS LIMITED TO: ORAL___, WRITTEN___, BOTH X

COMMENTS MAY ALSO BE MAILED TO THE FOLLOWING ADDRESS: Until May 1, 1995.

Lisa M. Kern, Counsel
Legal Services Division
P.O. Box 3922
Charleston, WV 25339-3922

The Department requests that persons wishing to make comments at the hearing make an effort to submit written comments in order to facilitate the review of these comments.

The issues to be heard shall be limited to the proposed rule.

ATTACH A **BRIEF** SUMMARY OF YOUR PROPOSAL

Andrew N. Richardson
Andrew N. Richardson

11-60

FISCAL NOTE FOR PROPOSED RULES

Rule Title: Psychiatric Impairment Guidelines

Type of Rule: Exempt
X Legislative ___Interpretive ___Procedural

Agency: Workers' Compensation Division, Bureau of Employment Programs

Address: P. O. Box 3922

Charleston, WV 25339-3922

1. Effect of Proposed Rule

	ANNUAL		FISCAL YEAR		
	INCREASE	DECREASE	CURRENT	NEXT	THEREAFTER
ESTIMATED TOTAL COST	$7,760	$0	$7,760	$0	$0
PERSONAL SERVICES	2,000	0	2,000	0	0
CURRENT EXPENSE	0	0	0	0	0
REPAIRS & ALTERNATIONS	0	0	0	0	0
EQUIPMENT	0	0	0	0	0
OTHER	5,760	0	5,760	0	0

2. Explanation of above estimates:

The personal services cost will cover the expenses for one meeting of the six member Psychiatric Sub-Panel of the Health Care Advisory Panel. This group developed these guidelines, and may be called on to meet again to review and support this document. "Other" costs reflect a one time expense for training of Division staff on the utilization of these guidelines.

3. Objectives of these rules:

To provide for guidelines for the standardization of evidence and information in the evaluation and permanent impairment rating of claimants for psychiatric disabilities arising from injuries sustained in Workers' Compensation injuries.

Rule Title: Psychiatric Impairment Guidelines

4. **Explanation of Overall Economic Impact of Proposed Rule.**

   A. **Economic Impact on State Government.**

   One time cost for the training of Division staff, in addition to the cost for the services of the panel that developed these guidelines, as references above. There is a possibility of a slight increase in Independent Medical Evaluation (IME) costs, if psychiatric evaluators spend more time on their reports due to these guidelines and charge more the evaluation. This is difficult to quantify, and should be offset by more accurate information and more efficient rating of permanent impairment under these guidelines.

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

   As referenced above, some slight increase in charges by psychiatric evaluators may be experienced, which would benefit this group. However, this could be offset by the potential to decrease payment for psychiatric testimony in litigation, as the standardization of psychiatric information as outlined in these guidelines should reduce discrepancy between medical reports.

   C. **Economic Impact on Citizens/Public at Large.**

   No significant impact anticipated.

Date: March 1, 1995

Signature of Agency Head or Authorized Representative

Andrew N. Richardson

Andrew N. Richardson
Commissioner, Bureau of Employment Programs

Summary of Proposed Exempt Legislative Rule

Guidelines for Psychiatric Permanent Impairment, Evaluations, Evidence and Ratings of Psychiatric Impairment Due to Workers' Compensation

Title 85, Series 22

This proposed rule has been recommended by the Health Care Advisory Panel. The rule provides guidelines for psychiatric impairment ratings, evaluations and evidence.

The rule has six appendices. Appendix A provides an examination guideline. Each bold face point must be addressed by the evaluator and must be reflected in the evaluator's report. The information following each bold face provides additional information to assist in the completion of the section. Appendix F is an outline of appendix A and may be used as a dictation aide in conjunction with appendix A. Appendix B lists conditions likely and unlikely to be related to trauma or work, appendix C provides the West Virginia Workers' Compensation Guidelines for Psychiatric Impairment, appendix D provides scenarios wherein psychiatric impairment is probable and appendix E provides information concerning malingers.

This rule requires an evaluator do a thorough examination of the claimant including a psychological examination. The evidentiary weight given to reports will be influenced by how well it demonstrates that the evaluation and examination that it memorializes were conducted in accordance with the rule.

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

SERIES 22
Guidelines for Psychiatric Permanent Impairment, Evaluations, Evidence and Ratings of Psychiatric Impairment Due to Workers' Compensation Injuries

§85-22-1. General.

1.1. Scope. -- These rules implement the provisions of West Virginia Code, §23-4-3a, §23-4-3b, §23-4-7a(h), §23-4-8, §23-4-3c and §23-4-1f regarding the protocols and guidelines required for the psychiatric evaluation and psychological examination of claimants for psychiatric disabilities arising from injuries sustained in the course of and resulting from employment.

1.2. Authority. -- West Virginia Code, §21A-2-6(1), -6(2) & -6(14); §21A-2-19; §21A-3-7(b) & -7(c), §23-1-13; and §23-1-1, §23-1-15; and §23-4-1f. 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. --

1.4. Effective Date. --

§85-22-2. Purpose of these rules.

The purpose of these rules is to implement the provisions of West Virginia Code, §23-4-3, §23-4-3b, §23-4-7a(a), - 7a(b) and -7a(h), §23-4-8 and §23-4-1f which relate to the development of guidelines for the evaluation and permanent impairment rating of claimants for psychiatric disabilities arising from injuries sustained in the course of and resulting from employment. The protocols and guidelines 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 is applicable to evidence submitted by any party to a claim and to evidence gathered by the division.

§85-22-3. Definitions.

As used in these rules, 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. Work injury-related psychiatric disorders - Those psychiatric disorders caused by or aggravated by a work injury or disease.

3.4. 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)

3.5. 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."

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

3.7. Psychiatric impairment - The loss of, loss of use of, or derangement of mental, emotional or brain functioning.

3.8. 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.

3.9. Permanent partial psychiatric impairment - Impairment that is assigned a percentage of impairment rating from the West Virginia Workers' Compensation Guidelines for Psychiatric Impairment.

3.10. 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.

3.11. 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.

§85-22-4. Evidentiary Requirements.

4.1. 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 rule, the attached dictation aid (Appendix F), guideline (Appendix A) and four additional appendices. The examiner must address and memorialize each bold face section found in the attached guideline. Appendix B lists conditions likely and unlikely to be related to trauma or work, appendix C provides a guideline and schedule for assigning impairment ratings, Appendix D provides a list illustrating when psychiatric impairment is probable and appendix E provides a list to aid in the identification of malingerers.

§85-22-5. Psychiatric Evaluation and Impairment Guidelines

5.1. Professional Standards for Examiners - Examiners for the West Virginia Workers' Compensation Guidelines for Psychiatric Impairment 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 West Virginia Workers' Compensation Guidelines for Psychiatric Impairment and applicable West Virginia 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 or disease is "more likely than not."

5.2. 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 or 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.

There is a tendency to identify with the referring sources who may subtly pressure for a favorable opinion or only

selectively support 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.

A. Pro-plaintiff evaluation biases:

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

(b). Very pessimistic vocational prognosis early in a case which has not 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.

(c). Mixing of roles - both treating and evaluating the claimant.

(d). Inappropriate legal advocacy.

(e). 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.

(f). 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.

(g). "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 of quality, cost-effective care.

(h). 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.

(i). 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.

(j). 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.

B. Pro-defense evaluation biases:

(a). Routine discounting of the findings and opinions of even the most conscientious treating physicians.

(b). The findings of no basis to otherwise well-defined permanent impairment ratings.

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

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

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

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

(g). A brief or cursory examination is often reported.

(h). Routine over-generalization of the conclusions of other doctors by further minimizing subtle positive or borderline findings.

(i). Discounting objective findings that cannot be ignored.

(j). Commenting skeptically or negatively on the competence and opinions of the treating physician.

(k). 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.

5.3. Identifying data - Provide identifying data as outlined in the attached guideline.

5.3.1. Consent - Explain to the claimant the nature and purpose of the examination.

5.4.1. Chief complaint - Ascertain the claimant's primary complaint.

5.5. History of the present illness - Chronological background and development of the symptoms or behavioral changes culminating in the present state.

5.5.1. Using the attached guideline, provide a detailed chronological accounting of the circumstances surrounding the injury and the development of the symptoms or behavioral changes culminating in the present state.

5.6. Personal history.

5.6.1. Obtain a detailed personal history from the claimant using the attached guideline.

5.7. Review of systems.

5.7.1. Provide a review of the claimant's general organ and neurological systems.

5.8. Past medical history.

5.8.1. Utilizing the attached guideline provide a complete accounting of the claimant's past medical history.

5.9. Developmental history and history of family of origin.

5.9.1. Provide a complete accounting of the claimant's developmental history utilizing the attached guideline.

5.10. Social history.

5.10.1. Using the attached guideline provide a complete accounting of the claimant's social history.

5.11. Occupational history.

5.11.1. Provide a complete record of the claimant's occupational history using the attached guideline.

5.12. Mental status.

5.12.1. Utilizing the attached guideline provide a sum total of the examiner's observations and impressions derived from the complete examination process and specific cognitive tests.

5.13. Other tests given or ordered by examiner.

5.13.1. Provide an accounting of all other tests given or ordered by the examiner. A limited physical examination and interviews with family members, co-workers, and supervisors is often helpful.

5.13.2. Psychological testing (may include separate report) must 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 traumas, brain injury from toxins, chemicals, and COPD.

5.14. Review of medical and other records.

5.14.1. 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.

5.15. Diagnosis.

5.15.1. Diagnose axis I through V according to the latest diagnostic and statistical manual of mental disorders published by the American Psychiatric Association.

5.16. Assessment, conclusions, opinions, and report preparation.

5.16.1. The psychiatric examination report to the West Virginia Division of Workers' Compensation should be thorough, complete, yet succinct, clearly written and logical in exposition. The basis of 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. 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. Separate 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 West Virginia Workers' Compensation Guidelines for Psychiatric Impairment are affected by the psychiatric disorder. Answer all questions posed by the referral source. Provide opinions on the genuineness, cause, severity, duration and extent of the psychiatric condition and impairment.

5.17. Recommendations.

5.17.1. Provide recommendation for further examinations, consultations, re-examinations, psychiatric treatment and rehabilitation recommendations.

5.18. Comments.

5.19. Signature block with degree.

§85-22-6. Psychological Examination Guidelines.

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

6.2. 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 Workers' 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).

6.3. 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-2). 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-2 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 practice in assessment of brain function and extensive clinical supervision of such clinical activities, or a graduate degree of psychology and two years of full-time post-graduate supervised training in neuropsychology in a program specifically designated for such training.

f. Integration 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.

6.4.a. 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.

§85-22-7. Appendices

7.1. The following appendices are attached hereto and are incorporated herein as if fully set forth.

a. Appendix A - The psychiatric examination guideline provides the examiner with guide by which to conduct an examination. The examiner must address all bold face headings and memorialize the the findings in his or her report.

b. Appendix B lists conditions likely and unlikely to be related to trauma or work.

c. Appendix C provides the West Virginia Workers' Compensation Guidelines for Psychiatric Impairment.

d. Appendix D provides a list illustrating when psychiatric impairment is probable.

e. Appendix E provides a list to aid in the identification of malingerers.

f. Appendix F is a dictation aid which may be used in conjunction with the guideline in Appendix A.

§85-22-7. Severability

If any provision of these rules or the application thereof to any entity or circumstance shall be held invalid, such invalidity shall not effect the provisions or the applications of these rules which can be given affect without the invalid provisions or application and to this end the provisions of these rules are declared to be severable.

Appendix A

DIVISION OF WORKERS' COMPENSATION PSYCHIATRIC EXAMINATION GUIDELINE

==========

I. Identifying Data

Claimant Name: _____
Date: _____
Social Security Number: _____
Claim Number: _____
Date of Injury: _____
Date of Birth: _____Age _____ Sex _____
Employment Status: (working, unemployment, 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, of 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 times 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 of 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 or 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. Martial and Current Family History

1. List each marriage with date or age married separated or divorce (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 martial 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/gradiosity

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-contemptous, 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 Association - 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 preservation.

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, preservations, visual pattern completion test, alternating motor patterns (First-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, buccofacitl, 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, brided, 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 coworkers 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 traumas, 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 accompanies by the diagnosis, any: Partial Remission (exception 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 precipitation 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 impairments?

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, brining 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

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 or Dementia due to Head trauma or General Medical Condition (from trauma or occupational disease), Cognitive Disorder Not Otherwise Specified (Post-Concussion Syndrome)

B. Mental Disorders Due to a General Medical Condition Not Elsewhere Classified

Catatonia, Personality Change or Mental Disorder Not Otherwise Specified Due to Associated Brain Trauma or Occupatoinal Disease

C. Other Psychotic Disorders

Brief Psychotic Disorder, Psychotic Disorder due to Brain Trauma or Occupational Disease

D. Mood Disorders

Depressive Disorders
Major Depression (single episode, recurrent)
Dysthymic Disorder
Depressive Disorder Not Otherwise Specified
Mood Disorder Due to Brain Trauma or Occupational Disease

E. Anxiety Disorders

Panic Disorder (with or without Agoraphobia)
Agoraphobia without Panic
Specific Phobia
Post-Traumatic Stress Disorder
Generalized Anxiety Disorder
Anxiety Disorder Due to Brain Trauma or Occupational Disease
Anxiety Disorder Not Otherwise Specified

F. Somatoform Disorders

Conversion Disorder (Hysterical Neurosis)
Pain Disorder Associated With Psychological Factors, and or Traumatic or Occupational Disease Problem
Undifferentiated Somatoform Disorder
Somatoform Disorder Not Otherwise Specified

G. 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 or a stressor with enduring consequences) with Anxious or Depressed Mood, Disturbance of Conduct, Mixed Disturbance of Emotions and Conduct, Mixed, Disturbance of Emotions and Conduct, Unspecified

H. Psychological Factors Affecting Physical Condition

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:

Mental Retardation
Learning Disorders
Motor Skills Disorders
Communication Disorders
Pervasive Developmental Disorders
Attention Deficit and Disruptive Behavior Disorders
Feeding and Eating Disorders of Infancy or Early Childhood
Tic Disorders
Elimination Disorders
Other Disorders of Infancy, Childhood or Adolescence - (Separation, Anxiety, Mutism, Attachment Disorder, Stereotyped Movement Disorder)
Anxiety Disorders of Childhood or Adolescence (Separation Anxiety, Avoidant, and Overanxious Disorders)

B. Sexual and Gender Identity Disorders

Paraphilias
Exhibitionism, Fetishism, Frotteurism, Pedophilia, Masochism, Sadism, Transvestic Fetishism, Voyeurism, Paraphilia Not Otherwise Specified (telephone scatologia, necrophilia, partilism, zoophiliz, coprophilia, klismaphilia, urophilia)

C. Personality Disorders

Paranoid, Schizoid, Schizotypal, Antisocial, Borderline, Histrionic, Narcissistic, Avoidant, Dependent, Obsessive Compulsive, Not Otherwise Specified (Passive-Agressive, Depressive)

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

Demetias of the Alzheimer's Type
Vascular Dementia
Dementia Due to HIV Disease, Parkinson's Disease, Huntington's Disease, Pick's Disease, Creutzfeld Jakob Disease, Substance-Induced, Amnestic Disorders due to Substance-Induced Disorders

B. Psychoactive Substance Use or Induced Disorders

Alcohol Use or Induced Disorders
Amphetamine Use or Induced Disorders
Caffeine - Related Disorders
Cannabis - Related Disorders
Cocaine - Related Disorders
+Hallucinogen - Related Disorders
+Inhalant - Related Disorders

Nicotine - Related Disorders
* Opioid - Related Disorders
Phencyclidine (PCP) Related Disorders
* Sedative, Hypnotic or Anxiolytic - Related Disorders
* Other or unknown psychoactive substance-related disorders

C. Schizophreniz or Other Psychotic Disorders

Schizophrenia
Schizophreniform Disorders
Schizoaffective Disorder
Delusional Disorder
Shared Psychotic Disorder
Substance - Induced Psychotic Disorder
Psychotic Disorder Not Otherwise Specified

D. Mood Disorders

Bipolar Disorders (Mixed, Manic, Depressed)
Cyclothymia
Bipolar Disorder Not Otherwise Specified
Substance-Induced Mood Disorder

E. Anxiety Disorders

Social Phobia
Obsessive Compulsive Disorder
Substance - Induced Anxiety Disorder

F. Somatoform Disorders

Body Dysmorphic Disorder
Undifferentiated Somatoform Disorder
Hypochondriasis
Somatization Disorder

G. Dissociative Disorders

Dissociative Amnesia
Fugue
Identity Disorder
Depersonalization Disorder

H. Sexual Disorders

Sexual Dysfunctions (unless due to a physical disorder caused by a work injury or disease) 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, remature ejaculation), sexual pain disorders (dyspareunia, vaginismus), Sexual Dysfunction Not Otherwise Specified Sexual Disorder Not Otherwise Specified

I. Eating Disorders

Anorexia Nervosa
Bulimia Nervosa

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

Dyssomnias; Insomia, Hypersomnia, Sleep-Wake Schedule Disorder
Parasomnias; Dream Anxiety Disorder, Sleep Terror Disorder, Sleepwalking Disorder, Parasomnia Not Otherwise Specified

K. **Factitious Disorders; with Physical Symptoms, Psychological Symptoms, Combined, or Not Otherwise Specified**

L. **Impulse Control Disorders Not Elsewhere Classified**

Intermittent Explosive Disorder
Kleptomania
Pathological Gambling
Pyromania
Trichotillomania
Impulse Control Disorder Not Otherwise Specified

M. **V Codes**

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

Psychiatric Evaluations, and Reports:

Consult the accompanying West Virginia Workers' Compensation Guidelines for Psychiatric Impairment.

West Virginia Workers' Compensation Guidelines for Psychiatric Impairment

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 Psychiatric Examiners to use.

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."

West Virginia Workers' Compensation Guidelines for Psychiatric Impairment

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 D

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 temporarily (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 E

Malingering

A special word of 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-inciminating 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 examination 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 of 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.

APPENDIX F
DICTATION AIDE

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. Course 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 above

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. Date 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 or 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 aggradizement/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 of 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 he 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 know 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

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: Interested Persons

FROM: Lisa M. Kern, Counsel
Legal Services Division

DATE: March 1, 1995

RE: Filing of Proposed Rules

You are receiving this notice either because you previously requested to be placed on the Workers' Compensation Division's interested person's mailing list or because we believe you will be interested in these proposed rules. The division has filed for public comment a proposal for three exempt legislative rules titled: "Protocols and Guidelines for the Treatment of Workers' Compensation Injuries," Title 85, Series 20, "Guidelines for Controlled Substances," Title 85, Series 21 and "Guidelines for Psychiatric Permanent Impairment, Evaluations, Evidence and Ratings of Psychiatric Impairment Due to Workers' Compensation Injuries," Title 85, Series 22.

A summary of each rule is enclosed for your reference. Series 20 provides treatment guidelines for eleven types of injuries. It also has a section regarding physical therapy and a section providing guidelines for physical medicine. Series 21 provides guidelines for use by a physician in the management of chronic nonmalignant pain. Series 22 provides guidelines for psychiatric impairment ratings, evaluations and evidence.

Public comments are being solicited on these proposals. The division will hold two (2) public hearings on the rules as noted on the cover sheet. Both meetings will start at 10:00 a.m. on the dates indicated and at the locations noted. We suggest that you file written comments along with any oral comments that you wish to make at the hearing. In lieu of attendance at a hearing, you may mail written comments to me at the address noted above until 5:00 p.m. on Monday, May 1, 1995. Copies of the rules can be obtained through the Secretary of State's Office.

These are exempt legislative rules which means they do not have to have the approval of the Legislature before they become effective. Following the receipt of the comments, the Compensation Programs Performance Council will review the comments, adopt such changes as they may find appropriate, and then vote to either accept or reject each proposed rule. If accepted, the rule will become effective thirty (30) days after final filing with the Secretary of State.

Your comments are invited.