WEST VIRGINIA
SECRETARY OF STATE
KEN HECHLER
ADMINISTRATIVE LAW DIVISION

Form #5

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OFFICE OF WEST VIRGINIA SECRETARY OF STATE

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

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

CITE AUTHORITY: _____

RULE TYPE: PROCEDURAL _____ INTERPRETIVE _____

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

21A-2-6(1),-6(2),-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 ADOPTED: 22

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

THE ABOVE RULE IS HEREBY ADOPTED AND FILED WITH THE SECRETARY OF STATE. THE EFFECTIVE DATE OF THIS RULE IS September 22, 1995

Andrew N. Richardson

Authorized Signature
Andrew N. Richardson

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

Gaston Caperton
Governor

Andrew N. Richardson
Commissioner

August 23, 1995

The Honorable Ken Hechler
Secretary of State
State Capitol Building
Charleston, WV 25305

Re: Filing of Proposed
Legislative Rule,
Title 85, Series 22;
"Guidelines for Psychiatric
Permanent Impairment, Evaluations,
Evidence and Ratings of Psychiatric
Impairment Due to Workers'
Compensation Injuries"

Dear Secretary Hechler:

Please consider this letter to be my written approval of the above noted proposed rule.

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 of the Governor, the commissioner of the Bureau of Employment Program is empowered to promulgate rules without the consent or approval of a department secretary.

Thank you very much for your assistance in this matter.

Very truly yours,

Andrew N. Richardson
Commissioner

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

§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. -- August 23, 1995

1.4. Effective Date. -- September 22, 1995

§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.

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.

II. 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

II. 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.

I. 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

Post marked 5/1

BOWLES RICE
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May 1, 1995

BEP-LEGAL DIVISION
95 MAY -2 PM 12: 18

Lisa M. Kern, Esquire
Legal Services Division
Post Office Box 3922
Charleston, West Virginia 25339-3922

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

Dear Ms. Kern:

On behalf of our employer clients, we appreciate this opportunity to comment on the Proposed Guidelines for Psychiatric Permanent Impairment Evaluations, Evidence and Ratings of Psychiatric Impairment Due to Workers' Compensation Injuries, developed by the Workers' Compensation Division through the Health Care Advisory Panel.

The Guidelines, when implemented, should assist Division personnel in their efforts to control abuses in the workers' compensation system resulting from unnecessary, and unnecessarily prolonged, psychiatric treatment. It is our hope that the Guidelines will also increase efforts by all involved parties to accurately differentiate between psychiatric impairment which has resulted from a work-related injury and that which is related to non-occupational factors. The message to treating and evaluating physicians must be clear that only work-related conditions are the responsibility of the workers' compensation system and that the Workers' Compensation Division cannot serve as a general insurer of all medical conditions including those within the purview of psychiatrists and psychologists.

With respect to specific sections of the proposed Guidelines, we offer the following comments:

1. In defining "[w]ork injury-related psychiatric disorders" in §3.3 and "[a]ggravation, legal standard," in §3.5, we believe that the Guidelines should provide that a trivial or minor aggravation of a psychiatric disorder by a work injury or disease is insufficient. Rather, the work injury or disease should materially contribute to the development or worsening of the psychiatric condition in order to be rated and covered by the workers' compensation system.

2. Although §5.1 relating to Professional Standards for Examiners, provides that "in forming his expert opinion, the examiner must use the standard of 'Reasonable Medical Probability'", in §5.16.1 both the terms "Reasonable Medical Probability" and "Reasonable Medical Certainty" are used. This is confusing and should be corrected. It is our preference that the term "Reasonable Medical Certainty" be adopted in that the term "probability" can frequently be confused with the term "possibility," a standard which is clearly unacceptable.

3. The "pro-plaintiff evaluation biases" and "pro-defense evaluation biases" set forth in §5.2 are helpful tools which should facilitate the proper assessment of opinions expressed by both treating physicians and evaluators. Some of the factors listed, however, particularly (a), (d), and (j) under "pro-defense evaluation biases" may unnecessarily discourage critical analysis and foster a "code of silence" among psychiatrists and psychologists. "[T]he most conscientious treating physicians", a phrase used in subsection (a) under pro-defense evaluation biases is unnecessarily subjective and may result in an unconscious bias in favor of well-meaning but inadequately trained treating physicians. The present wording of subsections (f) and (g) also allows a claimant's bias against defense evaluators, whether conscious or unconscious, to be given undue weight. The Guidelines should focus not on claimants' personal, and perhaps distorted, perceptions or on their self-reporting, but rather on whether adequate documentation regarding the extent and the nature of the evaluation is provided. A suggested redrafting of the "pro-defense evaluation biases" subsection is attached hereto as Appendix A, in an effort to address these concerns.

4. The provisions of §5.2c, recognizing that "psychiatric impairment alone usually does not warrant payment of TTD" is a valuable guideline which, if followed, should help curb current abuses. As the abbreviation "TTD" is not included in the definition section, however, we suggest substituting the term "temporary total disability benefits" for clarity.

5. We recommend that §5.13.2 be redrafted to clarify that neuropsychological testing will be included in workers' compensation coverage only when the brain injury is clearly work-related or when the neuropsychological testing will materially assist the evaluator in determining whether the brain injury is work-related or is the result of some non-occupational cause.

6. In addition to those inferences which should be part of the psychological assessment, set forth in §6.1, namely, motivation and dissimulation (faking), we recommend that evaluators specifically consider the motivation of secondary gain and consider exaggeration, as distinguished from dissimulation.

7. Recognizing that neuropsychological testing is difficult to administer and evaluate properly, we applaud the requirement set forth in §6.3e, that only psychologists with documented specialized training supervise the administration of neuropsychological tests and evaluate the results.

We would additionally comment that the formatting of these regulations, including the labeling of the sub-parts and sub-sections, is sometimes confusing and difficult to follow. We recommend that the Division review the Guidelines and make improvements in that regard.

Again, we appreciate this opportunity to review these proposed Guidelines. We hope that our comments are considered constructively and that our recommendations are implemented.

Very truly yours,

BOWLES RICE MCDAVID GRAFF & LOVE

Phyllis M. Potterfield

PP/bmk

336961

B. Pro-defense evaluations biases:

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

(d). ~~The~~ Examinations consistently and routinely ~~does~~ not lead to the same findings described by the treating physician, consultants, ~~or~~ and 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~~ routinely report that the examiner as cold, harsh, unpleasant, hostile, or biased manner in questioning, but discounting reports made only after a claimant receives what is perceived by the claimant to be an unfavorable expert opinion from the defense evaluator.

(g). ~~A~~ Brief or cursory examinations ~~is~~are often reported by claimants and a review of the evaluator's written opinion supports the accuracy of those reports.

(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 without providing specific bases or reasons for the criticism.

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

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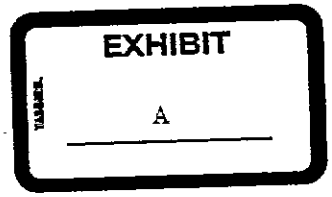

HYGEIA FACILITIES FOUNDATION, INC.
BOX 217
WHITESVILLE, WEST VIRGINIA 25209
(304) 949-4542 (304) 854-1323

March 27, 1995

Lisa M. Kern, Counsel
Legal Services Division
Post Office Box 3922
Charleston, West Virginia 25339-3922

Dear Ms. Kern:

I am writing to you to let you know of our physicians comments on the pending proposal of Guidelines for Controlled Substances and Psychiatric Permanent Impairment.

Hygeia Facilities Foundation employs five primary care providers in southern West Virginia. All five providers strongly agree with the proposed rules for controlled substances. They do feel though, that the legislation proposed for the psychiatric permanent impairment should be limited to practicing psychiatrists, not to primary care physicians.

Thank you for keeping our clinics updated in upcoming legislation.

Sincerely,

Margaret L Martin

Margaret L. Martin
Administrator

MLM/tj

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

Gaston Caperton
Governor

Andrew N. Richardson
Commissioner

August 22, 1995

The Honorable Ken Hechler
Secretary of State
State Capitol Building
Charleston, WV 25305

Re: Filing of Proposed
Legislative Rule,
Title 85, Series 22;
"Guidelines for Psychiatric
Permanent Impairment, Evaluations,
Evidence and Ratings of Psychiatric
Impairment Due to Workers'
Compensation Injuries"

Dear Secretary Hechler:

Please consider this letter to be my written approval of the above noted proposed rule.

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 of the Governor, the commissioner of the Bureau of Employment Program is empowered to promulgate rules without the consent or approval of a department secretary.

Thank you very much for your assistance in this matter.

Very truly yours,

Andrew N. Richardson
Commissioner

May 1, 1995

John Kozak, Esquire
Executive Secretary
Workers' Compensation Division
Bureau of Employment Programs
601 Morris Street
Charleston, West Virginia 25301

RE: *Comments to Title 85, Series 20, 21 and 22*

West Virginia

Self-Insurers

Association

P.O. Box 1573

Charleston

West Virginia

25326

Dear Mr. Kozak:

Please find enclosed the West Virginia Self-Insurers Association's comments to the proposed rules to Title 85, Series 20 - *Protocols and Guidelines for the Treatment of Workers' Compensation injuries*; Title 85, Series 21 - *Guidelines for Controlled Substances*; and Title 85, Series 22 - *Guidelines for Psychiatric Permanent Impairment, Evaluations, Evidence and Ratings of Psychiatric Impairment Due to Workers' Compensation Injuries*.

Sincerely,

Henry C. Bowen

Henry C. Bowen
Executive Secretary

enc.
cc: WVSIA Board of Managers
HCB/blf

WEST VIRGINIA SELF INSURERS ASSOCIATION
COMMENTS TO
TITLE 85 SERIES 20

PROTOCOLS AND GUIDELINES FOR THE TREATMENT OF WORKERS' COMPENSATION INJURIES

§ 85-20-2 -- Purpose of these Rules

The purpose of these Rules is explained in this section, as well as in the introduction, as intended to establish parameters for the treatment of claimants' work-related injuries sustained in Workers' Compensation claims. However, the guidelines for each particular type of medical condition do not adequately require that the appropriate treatment be related to a compensable injury. Rather, the protocols refer to appropriate treatment for the condition in general. For example, sub-section 17, which relates to the treatment for low back strains, begins by stating that strains and sprains are a common cause of acute low back pain encountered in the general population, and sub-section 21, which relates to carpal tunnel syndrome, provides that the disease can be caused by external factors such as diabetes, pregnancy, a tumor or tight jewelry. These regulations should provide that treatment recommended or requested be reasonably related to a compensable injury, rather than the particular condition without regard to etiology.

§ 85-20-15.4.B(a-c) -- Cervical Injury

These sections provide that analgesics, muscle relaxants, and anti-inflammatory drugs are appropriate treatment options for cervical strain/sprains. The Association does not disagree that such medication may be appropriate. The Association urges caution with regard to narcotic medication. The Association is aware that subsection 15.4.2.b provides that narcotic medication

for a prolonged period of time is improper. However, such a recommendation is too vague. Too frequently do members of the Association have employees who receive excess narcotic medication. Such medication in excess violates the purpose of this proposed rule, which is to facilitate the injured employee's return to employment, yet the treating physician who prescribes such medication often continues to certify its reasonableness. The Association urges that this rule specify the amount of time an injured employee may receive narcotic medication, or at least incorporate by reference the proposed *Guidelines for Controlled Substances*, and provide that any additional such medication be authorized only upon a detailed discussion by the doctor as to why it is necessary.

§ 85-20-15.4.B(f)

It is recommended in this sub-section that manual manipulation and mobilization is an appropriate form of treatment for a cervical strain/sprain. The Association does not believe that such treatment, *per se*, is medically unreasonable. However, it is not uncommon for such treatment to reach unreasonable proportions. The Association recommends that chiropractic treatment that includes manual manipulation and mobilization should be limited in a reasonable manner by these regulations. Specifically, the number of visits per month, and duration should be limited. The Association recommends that unless the case is exceptional, chiropractic treatment that includes manual manipulation and mobilization should not exceed one visit every two weeks for a period no longer than six months. Chiropractic manual manipulation and mobilization beyond this level should be recommended by a physician other than the injured claimant's treating chiropractor.

§ 85-20-17.3.3 -- Back Injury

The Association agrees that with regard to employees who suffer low back sprain\strains who do not recover within one week, as described in subsection 17.1, and in fact do not improve within four weeks, require that a second opinion be obtained. The Association recommends that unless some evidence suggests that the alleged injury is beyond a sprain\strain, continued temporary total disability should not be certified or acknowledged by the Workers' Compensation Division, until a second opinion provided by a qualified physician supports such a determination.

§ 85-20-17.4.1.b.B-D

These sections provide that analgesics, muscle relaxants, and anti-inflammatory drugs are appropriate treatment options for low back strain/sprains. The Association does not disagree that such medication may be appropriate, but urges caution with regard to narcotic medication. The Association is aware that subsection 17.4.2.c provides that narcotic medication for a prolonged period of time is improper. However, such a recommendation is too vague. Too frequently do members of the Association have employees who receive narcotic medication in excess. The Association urges that this rule specify the amount of time an injured employee may receive narcotic medication, and that any additional such medication be authorized only upon a detailed discussion by the doctor as to why it is necessary.

§ 85-20-17.4.1.b.E,G

It is recommended that manual manipulation and mobilization is an appropriate form of treatment for a low back strain/sprain. The Association does not believe that such treatment,

per se, is medically unreasonable. However, it is not uncommon for such treatment to reach unreasonable proportions. The Association recommends that chiropractic treatment that includes manual manipulation and mobilization should be limited in a reasonable manner by these regulations. Specifically, the number of visits per month, and duration should be limited. The Association recommends that unless the case is exceptional, chiropractic treatment that includes manual manipulation and mobilization should not exceed one visit every two weeks for a period no longer than six months. Chiropractic manual manipulation and mobilization beyond this level should be recommended by a physician other than the injured claimant's treating chiropractor.

§ 85-20-18.4.a.A-C

The Association agrees that an excessive period of inactivity can inhibit the recovery process. The Association recommends, therefore, that if a period of inactivity of no more than two weeks does not improve the claimant's condition, then corrective treatment should be immediately pursued, which may include aggressive physical therapy or physical rehabilitation. The Association recommends that the Workers' Compensation Division should not tolerate an injured employee's desire or treating physician's unsupported recommendation that inactivity without further rehabilitative treatment is necessary. The Association would recommend that if the injured employee or treating physician makes such a recommendation, then a second opinion is warranted.

§ 85-21.7.1.D

This subsection provides that non-operative treatment for carpal tunnel syndrome may be extended from 0 - 3 months depending on findings and symptoms; the Association suggests

that the rules require the treating physician to certify the claimant able to return to employment, with or without restrictions, within that period of time; if temporary total disability is extended, then the treating physician should provide a detailed explanation as to why.

§ 85-20-26

The Association agrees that therapy programs are an appropriate method to help return injured employees to work; however, if extensive therapy is necessary, the Association would request that detailed therapy plan be drafted setting forth the extent of the program, as well anticipated results. The Association believes that progress reports to the physician and employer should be mandatory.

WEST VIRGINIA SELF INSURERS ASSOCIATION
COMMENTS TO
TITLE 85 SERIES 21

Guidelines for Controlled Substances

§ 85-21-1. General.

1.1. Scope . -- These rules implement the provisions of West Virginia Code, §23-4-3(a)(1) & -3(a)(2).

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

§ 85-21-2. Purpose of these rules.

The purpose of these rules is to implement the provisions of West Virginia Code, § 23-4-3(a)(1) & -3(a)(2) and § 23-4-3(a)(3) and with regard to providing guidelines to physicians for

the use of controlled substances. These rules are also to be utilized by workers' compensation in its capacity as monitor of claims.

§ 85-21-3. 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.

§ 85-21-4.

4.1. The guidelines are for use by the physicians in the management of chronic nonmalignant pain. Chronic nonmalignant paid in defined as pain persisting beyond the expected normal healing time for an injury, for which traditional medical approaches have been unsuccessful.

4.1.1. The guidelines cannot apply uniformly to every claimant. The guidelines cannot be the sole determining basis for identifying claimants at risk for a drug use problem. Mere application of the guidelines cannot substitute for a thorough assessment of the claimant or medical chart by qualified health care professionals. Workers' Compensation claimants that are presently receiving medication treatment beyond the guidelines must be addressed on a case-by-case basis.

Comment: The West Virginia Self-Insurers Association ("WVSIA") suggests that this rule require the preparation of a treatment plan for each claimant who is presently receiving treatment beyond the guidelines. In addition, the WVSIA suggests that the rule require a physician who intends to continue to prescribe medication beyond the guidelines to obtain authorization from the workers' compensation division.

4.2. Guidelines for the prescription for controlled substances schedules II - IV (refer to table § 85-21-A for controlled substances schedule).

4.2.1. Schedule II drugs should be prescribed on an outpatient basis for no longer than two weeks after initial injury or following a subsequent operative procedure.

4.2.2. Schedule III drugs should be prescribed on an outpatient basis for no longer than six weeks after initial injury or following a subsequent operative basis.

4.2.3. Schedule IV opioid drugs should be prescribed on an outpatient basis for no longer than six weeks after initial injury or following a subsequent operative basis.

4.2.4. Schedule IV sedative and anxiolytic drugs should be prescribed on an outpatient basis for no longer than six months after initial injury or following a subsequent operative procedure.

4.2.5. To prescribe medications beyond the above guidelines, authorization must be obtained from the workers' compensation division. Authorization requests must include documentation as described in Sections 4.3. and 4.5. It is recommended that providers utilize less potent medications when continued use is indicated. See Section 4.6.

4.3. Documentation recommendations for controlled substances prescribed within the guidelines.

4.3.1. A thorough medical history, physical examination, diagnosis and treatment plan should be documented, with particular attention focused on determining the cause(s) of the claimant's pain, sleeplessness or anxiety.

4.3.2. The treatment plan should include the following information:

a. A list of all current medications (with doses), including medications prescribed by other physicians (whenever possible);

b. Therapies and procedures other than medications to manage/relieve pain;

c. Consultations with health care professionals;

d. Further planned diagnostic evaluation; and

e. Follow-up plan to assess progress.

Comment: The WVSIA recommends that the treatment plan also include the duration of all of the medication currently being consumed by the claimant and an estimated duration of medications to be prescribed.

4.3.3. The above standards for documentation are being recommended for inclusion in the provider's records. These records should be submitted to the Workers' Compensation Division.

4.4. Relative contraindications for the use of controlled substances.

4.4.1. History of alcohol or other substance abuse or dependence;

4.4.2. History of chronic, high dose benzodiazepine use or prolonged opioid use;

4.4.3. History of "doctor-shopping" (seeking care for multiple physicians or history of frequent change of physicians);

4.4.4. Active alcohol or other substance abuse or dependence; and

4.4.5. Off work for more than six (6) months.

4.4.6. When special circumstances warrant the use of these drugs in the types of claimants noted above, it should be justified in the medical record, and the risks and benefits must be weighed.

Comment: The WVSIA suggests that controlled substances not be prescribed to claimants with active alcohol or substance dependence. In addition, the WVSIA suggests that the "special circumstances" that warrant the prescription of controlled substances where the prescription is contraindicated be defined.

4.5. Additional documentation required for authorization for treatment beyond the guidelines.

4.5.1. Documentation should include:

a. Description of reported pain, insomnia, or anxiety relief from each medication;

b. Justification of the continued use of controlled substances beyond the guidelines;

c. Documentation of attempts at weaning and/or tapering dosage;

d. If weaning attempts have failed (include history of contraindications); and

e. Alternative treatments under consideration.

4.5.2. Informed consent should be obtained from the claimant and include the risks and benefits of prescribed medications. The explanation should be documented, along with expected outcomes, duration of treatment, and prescribing limitations.

4.5.3. The treatment plan should be revised as new information develops which alters the plan.

4.5.4. When the provider requests authorization for surgical procedures that are likely to require medication use beyond the guidelines, please address the need for extended use in the initial authorization request so that the authorization will be reviewed prior to surgery.

4.6. Proper use of controlled substances.

4.6.1. Pain medication (opioids):

a. Adequate doses of medication in appropriate strength and frequency to control acute pain;

b. Fixed dosage schedules rather than PRN will enhance compliance and minimize the risk of addiction; and

c. Progressive use of less potent medication, tapering of doses and diminishing frequency of dosing should be used to wean the claimant off of narcotics.

4.6.2. Sedatives and anxiolytic medication;

a. The use of sedative and anxiolytic medications for six weeks or less can be effective. Benzodiazepines are preferred;

b. Use beyond several weeks should trigger exploration of depression and consultation with a mental health professional; and

c. Use for anxiety should not be continued beyond three months. Tapering is usually required.

Comment: The WVSIA suggests that the term, "mental health professional" be replaced by the term, "licensed psychiatrist." Mental health professionals, other than licensed psychiatrists, are neither authorized nor qualified to prescribe medication.

§ 85-21-5. Severability.

5.1. If any provision of these rules or the application thereof to any entity or circumstances 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.

Table § 85-21-A

a. The Controlled Substance Act of 1970 regulates the manufacturing, distribution and dispensing of drugs that have abuse potential. The Drug Enforcement Administration (DEA) within the US Department of Justice is the chief federal agency responsible for enforcement.

A. DEA Schedules: Drugs under jurisdiction of the Controlled Substances Act are divided into five schedules based on their potential for abuse and physical and psychological dependence. All controlled substances listed in Drug Facts and Comparisons are identified by schedule as follows:

Schedule I (C-I)	High abuse potential and no accepted medical use (e.g., heroin, marijuana, LSD).
Schedule II (C-II)	High abuse potential with severe dependence liability (e.g., narcotics, amphetamines, dronabinol, some barbiturates).
Schedule III (C-III)	Less abuse potential than schedule II drugs and moderate dependence liability (e.g., nonbarbiturate sedatives, nonamphetamine stimulants, limited amounts of certain narcotics).

Schedule IV (C-IV)	Less abuse potential than schedule III drugs and limited dependence liability (e.g., some sedatives, antianxiety agents, non-narcotic analgesics).
Schedule V (C-V)	Limited abuse potential. Primarily small amounts of narcotics (codeine) used as antitussives or antidiarrheals. Under federal law, limited quantities of certain c-v drugs may be purchased without a prescription directly from a pharmacist if allowed under specific state statutes. The purchaser must be at least 18 years of age and must furnish suitable identification. All such transaction must be recorded by the dispensing pharmacist.

WEST VIRGINIA SELF INSURERS ASSOCIATION
COMMENTS TO
TITLE 85 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 For the sake of consistency, reference should be made to protocols and guidelines required for "the psychiatric and psychological evaluation and examination" of claimants. As drafted, the scope of the rule addresses "psychiatric evaluation and psychological examination." It would be more consistent to use the term psychiatric and psychological throughout the rule, as opposed to using one or the other.

§ 85-22-3 -- Definitions

3.5 The definition of "aggravation" should be the result of an act, action, or circumstance "that intensifies or makes worse a psychiatric or psychological condition; an unfavorable progression of claimant's psychiatric or psychological condition." The rule as drafted refers to the worsening of a medical condition. Because this rule addresses psychiatric and psychological impairment, then the appropriate term would be the claimant's psychiatric or psychological condition. This would also be consistent with § 3.4, defining "causation," which also refers to psychiatric condition.

3.10 The definition of "temporary total disability, psychiatric" is totally off the statutory mark. Pursuant to W.Va. Code § 23-4-1f, in order for mental impairment to be compensable, it must be accompanied by a physical injury. As drafted, the definition of

psychiatric temporary total disability would allow a claimant to be considered disabled if his or her psychiatric condition "in and of itself" rendered him or her unable to function in the work setting. The definition should delete the "in and of itself" clause and instead read as follows:

> "A psychiatric condition that, in combination with a physical condition, makes the claimant unable to function in the work setting."

As proposed, this definition violates the Workers' Compensation Act.

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

5.2 This section presents a laundry list of "pro-plaintiff" and "pro-defense" evaluation "biases." These so-called biases appear to be based on apparent prejudices in and of themselves, and for the most part, may apply to any evaluator, regardless of whether the evaluation is being performed for the claimant or the employer.

Also, pursuant to § 5.2c, the guidelines for payment of temporary total disability benefits for psychiatric claims should reflect more accurately the provisions of W. Va. Code § 23-4-1f, which, as stated above, provides that in order for mental impairment to be compensable, it must be accompanied by a physical injury. This provision, as written, allows for too much speculation beyond the scope of that which is permitted by statute.

5.6 The claimant's "personal history," as a guideline, is perhaps more important in a psychiatric evaluation than any other type of evaluation. Accordingly, this section should be expanded to include the requirement of more details concerning the claimant's life, background, and family history, medical or otherwise.

5.16.1 This provision should remove reference to the West Virginia Division of Workers' Compensation, as it may be the case that the examination was performed and the report prepared for the claimant or employer.

§ 85-22-6 – Psychological Examination Guidelines

6.2 This provision, concerning guidelines for psychological examination, is unclear at the very least, and inconsistent with the entire rule at most. Specifically, it sets forth "guidelines for psychologists to use when performing psychological evaluations for the Division of Workers' Compensation." (emphasis supplied) If this statement is designed to limit use of these guidelines to those evaluations performed at the request of the Division, then this is inconsistent with the purpose as set forth in § 85-22-2, which provides:

> "This rule is applicable to evidence submitted by any party to a claim and to evidence gathered by the division."

However, if it is not intended to be limited to Division evaluators, then this provision should be reworded to provide that the guidelines are for use when performing psychological evaluations for workers' compensation purposes.

General Provisions

The Rules should contain a provision authorizing a Division decision maker to exclude from consideration any report submitted by a party which does not adhere to the guidelines set forth by the Rule.

Also, the severability provision is labelled § 85-22-7. In reality, it should be "§ 85-22-8."

Appendix B -- Conditions Likely and Unlikely to be Related to Trauma or Work

This appendix is not necessary because the only mental impairment that would be compensable would be that which is accompanied by physical injury. Accordingly, if the medical impairment is related to a trauma or work-induced injury, to a reasonable degree of certainty, then such impairment would indeed be compensable. On the other hand, the claimant's mental impairment is not related to a work-related physical injury, then it is not compensable. Many of the disorders set forth in the list in Appendix B may be the result of a physical injury which is work-related or non-work-related. Consequently, it is not necessary to make such broad generalizations about these disorders, per se.

Appendix C -- Psychiatric Evaluations and Reports

The levels of impairment appear to be arbitrary and broad in their percentage range, thus allowing for less predictability and stability in analyzing a Workers' Compensation claim where psychiatric impairment is alleged to exist.

Appendix D -- Psychiatric Impairment Probability

Like Appendix B, this appendix is unnecessary in that it is the hope of all that a psychiatric evaluation would be performed by a professional who is trained in the field of psychiatry. Accordingly, it is unlikely that such a professional would need to rely on a list containing fundamental probability of psychiatric impairment.

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March 26, 1995

James Robinson
Attorney At Law
Robinson & Rice, L.C.
P.O. Box 407
Huntington, WV 25708

Dear Mr. Robinson:

I have a copy of the note you sent to Dr. Craythorne who sent me a copy, regarding the synopsis of the rules and regulations that are going to be applied for Compensation, and I assume these are protocols to be followed by a gatekeeper family physician for referral for specialty care.

This has got to be a plaintiff lawyer's dream come true!

First of all, the flaws in the Workmen's Compensation system really have nothing to do with the medical management of these patients. Medical management in West Virginia is no different than in of the other 49 states. Secondly, in just skimming over these, I find the so called mid foot sprain, which is supposed to be a minor problem is, in my experience, a significant long term problem. That is the most blatant thing I see. Also, I can just see a family doctor sitting on some poor guy with a herniated disc, paralysis, and a foot drop, etc. waiting out the three months required, and watching his bladder go out, then watching the plaintiff's attorney come and tear him apart, and also sue the State for setting up such stupid rules.

In complicated problems, I have no objection to protocol management. However, one cannot micro-manage this problem. I think if you saddle a family practitioner with regulations, it is going to end up with poor management. I remember in the Vietnam War, the Army still was required to go out and take all shrapnel out of head injuries, and fortunately in the Navy we

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were not required to do that, and indeed the Army casualties had about a third again as many deaths from head injury as did the Navy, primarily because they had to dig around in brain tissue to bring out some hardware that did not need to be taken out, or it was at a very high risk of killing the patient in getting it out.

I have a deeply based hesitancy about administrative micro-management, and the resultant quality of care. I don't think this is going to save any money; I think it is going to in fact delay appropriate treatment on a lot of these things, and the delay of treatment in and of itself increases the disability. The so called "three month rule" which if the patient is off work for more than three months, has a much higher likelihood of not returning to work than a patient who is off less than three months.

I don't have a great stake in this personally, because I don't see Compensation cases any more unless it is on an absolute emergency basis, and I think that probably several orthopedic surgeons in this State will be joining me once they read about this, so you will have a micro-managed system with no doctors to take care of these patients.

You might pass on to these people who are passing all these rules, that they are listening to people who are quoting numbers from large metropolitan areas, etc. The State as a whole is under-served in almost all specialties. In my own specialty, orthopedic surgery, the problem is not finding patients, its closing the door at the end of the day. I think you will find that family practitioners have the same problem, internists have the same problems, and neurosurgeons have the same problem. If the Compensation Commission wishes to set up micro management of these Compensation patients, they may find they are not only micro managed, they are taking care of the patients themselves.

Sincerely,

John O. Mullen, M.D.

JOM/mas

COLLEGE OF LAW
WEST VIRGINIA UNIVERSITY

May 1, 1995

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

Re: Comments on Proposed Rules: Series 20, 21, 22

Dear Mr. Kozak:

I am submitting these comments with regard to the above proposed rules to you and the Performance Council.

First: I assume that these proposed rules have been sent to the appropriate groups and individuals within the medical community -- and not only to the usual list of people who provide comments on rules. For example, Series 20, dealing with ophthalmic conditions should be reviewed by ophthalmologists, or musculoskeletal injury treatment should be reviewed by orthopedists and physiatrists who are not on the HCAP, including those who are members of the faculty at the state's medical schools; similarly, Series 21 must be reviewed by those in the medical community, including physiatrists, who manage chronic pain and Series 22 needs to be reviewed by psychiatrists and psychologists. Without the benefit of comments from these experts, the Performance Council cannot judge the appropriateness of these recommendations. If this has not been done, I strongly urge you and the Performance Council to delay implementation until comments can be solicited from these experts. The Health Care Advisory Panel does not, and can not, represent fully the medical views of the experts in the State of West Virginia. I believe that it is essential that the medical community have some consensus regarding medical recommendations for treatment if these treatment protocols are going to be successful as a guide for improving treatment of occupationally injured workers -- and not just as a mechanism for cost containment for the Workers' Compensation Division. This is particularly important because an increasing number of physicians are expressing reluctance to accept workers' compensation claimants as patients,

because of the slow payment and intervention into medical practice by the Workers' Compensation Division. Notably, this is in sharp contrast to the current success of the Public Employees Insurance Agency health program, which (despite aggressive claims management) has achieved a fairly high level of acceptance in the provider community.[1] Inappropriate adoption of standards such as these will merely drive more providers, including many highly qualified providers, away from the population; you have an obligation to ensure that this population of work-injured people is served, and served well, by the health care provider community in West Virginia.

In part, I make this suggestion because I -- and many others who frequently comment on rules -- am not a physician. I would not presume to dispute the treatment guidelines themselves, ***to the extent they simply represent recommendations for the appropriate medical treatment for medical conditions***, since I clearly lack medical expertise.

Second: There is at least one element in these rules which appears to go beyond the issue of appropriate treatment: I am very concerned about the return to work/duration of symptoms/duration of treatment guidance which can be found in various places throughout Series 20 (see, *for example*, §§ 85-20-5.5, -6.5, -7.5, -8.5; §85-20-15.1; §85-20-15.5; §85-20-17.5 and so on) as well as in Series 22 (§85-22-5 "Norms of recovery"). My concern relates to at least three issues:

> First, the guidance in these rules does not in any way recognize the different types of work and the different levels of work disability -- not medical impairment -- which relate to the nature of work, not the nature of injury. To set a single return to work goal for each injury, without any regard to the nature of work which an individual performs, is, in many cases, inappropriate. Although this may work for certain kinds of small and specific injuries, including some eye injuries, it is not these injuries which have resulted in long periods of ttd in the past. When this same approach is used for musculoskeletal injuries, then the rule suggests that mine workers and office workers will be treated alike. For example, although noting that recovery may be of variable duration, the rule states that symptoms related to sprains and strains "generally is less than three or four weeks." See §85-20-15.1. The rule further says that treatment of strains and sprains is "not to exceed 8 weeks." See §85-20-15.5, §85-20-17.5. This creates a presumption that further treatment will not be paid for (at least without a fight) and that all workers will recuperate -- and therefore return to

---

[1] I serve as a public member of the five member Finance Board which governs the PEIA program. In that capacity, I have had the opportunity to review the financial and operating plans of that agency and to talk extensively to health care providers regarding their problems with PEIA and other state programs, including workers' compensation.

work -- in this period. Given the wide variation in the nature of these sprain/strain injuries as well as the differing demands of claimants' jobs, this provision allows for inadequate individual evaluation.

Second, the recommendation fails to take into account the highly individualized nature of recovery from injuries. In particular, the blanket assumption that recovery from psychiatric conditions "usually leads to maximum degree of recovery in 6 months" (see §85-22-5) is highly problematic. Was medical literature introduced to support this contention -- or is it simply an attempt to set administrative cost-saving guidelines? If the latter, the workers' compensation law, which requires the payment of temporary total disability until there is medical evidence that the individual has reached maximum degree of improvement or can return to work, makes this provision legally questionable.

Third, and related to these two other concerns: are these guidelines intended for use only by physicians -- or will they be used to cut off eligibility for temporary total disability benefits before an individual can return to work or to force return to work prematurely? It would be highly inappropriate to terminate ttd benefits for individuals based upon these population guidelines which fail to take into account either an individual's own healing or the work which that individual generally performs. Language should be added to both Series 20 and 22 which clearly states that, in making determinations regarding both medical and ttd indemnity benefits, the individual's specific situation will at all times be fully considered.

Third: Series 22's approach to bias (§85-22-5.2) is troubling. In particular, it would seem that a treating physician is in fact the very best physician to evaluate a claimant's condition. In fact, a variety of other disability programs give additional weight to any report filed by an applicant's treating physician, on the theory that this physician is most likely to be very familiar with the individual's condition. I found it remarkable and highly objectionable that this section says "(c). Mixing of roles - both treating and evaluating the claimant" constitutes evidence of pro-plaintiff evaluation bias. This subsection (c) should be deleted from this rule.

Fourth: To the extent that these protocols will act as guidance for medical treatment and both contain costs and improve treatment, they are clearly a good idea. To the extent, however, that they are merely used to deny additional, alternative, medically appropriate treatment or are used to force premature return to work, then they are simply another mechanism for the Workers' Compensation Division to externalize costs inappropriately to others, including health care providers and claimants. Language should be added to both Series 20 and 22 which indicates that these rules

constitute guidance and that, when supported by appropriate documentation, the Division ***shall*** consider such evidence and make determinations on a case-by-case basis, with full regard to the importance of assisting the claimant in achieving a maximum degree of medical improvement.

Sincerely,

Emily A. Spieler
Professor of Law

ATTENDANCE SHEET

MORGANTOWN, APRIL 10, 1995

NAME	REPRESENTING	ADDRESS
William Walter	WVUH P.T.	376 Patteson Dr. Morgantown WV 26505
Louise Hawkinberry	Employers Service Corp	PO Box 3389
Tom Mancini	legal Services	Charleston WV 25333 WC
John Kozak	BEP	CHAS.
Vicki Lenz	WVUH PT	376 Patteson Dr.
Sue Holbrey	WCD	Glenville, WV
Tim Newmie	Shenandoah Valley Pt.	Martinsburg
Jan Downey	Shenandoah valley Pt	martinsburg
Karen Oak	Shan K. Wang, M.D Orthopaedic	1346 Locust Fairmont, WV
Dave Laurie	Local 1058	MORGANTOWN
Thomas Newton	UMWA Local 1058	Reedsville.
Rick Vaglienti M.D	No. WV. Pain Mgmt Ctr	Mgtn
Thomas W Turpin.	President L.U. 1058.	Morgantown WVa
Joseph Lawson	L.U. 1058	" "
Mike Martin	Affiliated PT Serv	112 Hill St Bridgeport

ATTENDANCE SHEET

MORGANTOWN, APRIL 10, 1995

NAME	REPRESENTING	ADDRESS
JACK BRAUTIGAM	MPTA	1000 J.D. ANDERSON DR. MGTN
Debbie K Boyles	MGH	1200 JD Anderson Dr MGT
Betty Bailey	MGH	MGTN. WV
Paula Mullenax	"	"
Amy Welch-Ramsden	MtView	1160 Van Voorhis Rd.
Linda [illegible]	MtView	" "
Erin Keesler	"	" " "
Debbie McLorey	HealthSouth	2380 McGinley Rd. Monroeville PA
Roger Hammack	UMWA	

ATTENDANCE SHEET

CHARLESTON -- APRIL 13, 1995

NAME	REPRESENTING	DO YOU WISH TO SPEAK?
Tom Mancini	WC Legal Division	No
Diana McCoy	McCoy & Assoc.	No
Sarah W. Sayre	Mid-Ohio Valley Health Dept.	No.
Virginia Cash	" " " "	No
Roberta Templeton	River Cities Anesthesia	No
Teresa Jones	" " "	No
Mendy Christian PTA	Putnam General Hosp	no
(2) Karol Salazar P.T.	Putnam Gen. Hosp	~~No~~ YES
Babette Robinson	Acordia of WV	~~No~~
Tracy McClure	"	~~No~~
Nellie Cooke	"	NO
Kathy Fink	"	NO
Paul Bailey	"	NO
Judy Kirk	"	NO
Anna Lynn	"	NO
(1) Mick Bates	1. West Virginia Physical Therapy Association.	Yes.
	2. Concord/Charleston College Physical Therapy.	

ATTENDANCE SHEET

CHARLESTON -- APRIL 13, 1995

NAME	REPRESENTING	DO YOU WISH TO SPEAK?
Gina Mazzei	Bowles Rice, et. al	NO
Lynn L. Photiadis	" " " "	No
Lisa Edwards	Hyth Podiatry Assoc	NO
Paula Zwick-Perdue	Eye Consultants of Huntington	No.
Joan Tokarz	ESC	NO
Kay Moorman Cates	ESC	NO
Pam Farris	ESC	NO
Pauline Hanson	ACT	Yes No
Ed Pancake	Thos. P. Maroney, LC	NO
Angie T Lambert PT	Teays Physical Therapy Ctr	No.

ATTENDANCE SHEET

CHARLESTON -- APRIL 13, 1995

NAME	REPRESENTING	DO YOU WISH TO SPEAK?
Sandra Gill	Medi Home Care	No
[signature]	Chapmanville & Logan Long Clinic	
Pauline Hanson	ACT Foundation	~~Yes~~ No
Gary Tillis	Act Foundation	NO
(3) Scott Lloyd	UMWA District 6	~~Maybe~~ YES

Response to Comments

In response to comments received regarding Series 20 the following changes were made.

a. The word protocol was removed from the rule.

b. An old and new version of the physical medicine guideline portion had erroneously been merged. The old version was deleted.

c. The nonoperative cervical treatment guidelines were brought into line with the nonoperative lumbar treatment guidelines.

No changes were made to Series 21 and 22.

BEFORE THE WORKERS' COMPENSATION PERFORMANCE COUNCIL

IN RE: PUBLIC HEARING ON THE PROPOSED GUIDELINES SERIES 21, 22 AND 23

TRANSCRIPT OF PROCEEDING had at the public hearing in the above-referenced matter, held on Thursday, April 13, 1995, at 10:00 a.m. in Room 202, Charleston Civic Center, Charleston, West Virginia, pursuant to notice.

ANGELA A. ROBINSON, Subcontractor

REBECCA L. BAKER
Certified Court Reporter
2300 Shadyside Road #5
St. Albans, West Virginia 25177
(304) 727-2965

APPEARANCES FOR THE WORKERS' COMPENSATION PERFORMANCE COUNCIL

MR. PAUL THOMPSON

MR. FRED TUCKER

MR. THOMAS ROTENBERRY

MR. ANDY RICHARDSON

MR. EVERETT SULLIVAN

MR. THAD EPPS

MR. JOHN KOZAK

* * * * * * * * * * *

I N D E X

April 13, 1995.

MR. RICHARDSON: This is the Charleston public hearing regarding three sets of regulations being proposed by the West Virginia Workers' Compensation Division. Those sets of regulations are as follows: They are Title 85, Series 20, regarding protocols and guidelines for the treatment of selective workers' compensation injuries. Title 85, Series 21, regarding guidelines for controlled substances. And Title 85, Series 22, regarding guidelines for psychiatric permanent impairment evaluations, evidence and ratings of psychiatric impairment due to workers' compensation injuries.

If those are subject matters that you are interested in, you are in the right place. If they are not, you may want to check the schedule board out in the hall.

My name is Andy Richardson, Commissioner of Employment Programs and Chairman of the Compensation Programs Performance Council. Several members of the performance council have joined us this morning to participate in hearing your comments. If I could start

at the far left of the table, I would like each performance council member to introduce themselves and to say anything that they would like to say in introductory remarks.

MR. THOMPSON: I'm Paul Thompson just waiting to hear your comments.

MR. TUCKER: My name is Fred Tucker.

MR. ROTENBERRY: Tom Rotenberry.

MR. EPPS: Thad Epps.

MR. SULLIVAN: I'm Everett Sullivan and I'm glad to see all of you here this morning.

MR. RICHARDSON: We have other members of the performance council that are not here and were not able to join us today including Dick Humphreys from Morgantown, David Harris and Dan Shruman.

We also have some staff from the Workers' Compensation and the Bureau of Employment programs present. What I would like is for those staff members to stand and introduce themselves. One is already standing and I'll start with him.

MR. KOZAK: John Kozak. I'm the director of Legal Services for the Bureau.

issues related to manage care, issues related to rehabilitation.

DR. TULLY: I'm Dr. C. Carl Tully. I'm an M.D. I was a professor of family practice and I was a family practice physician.

MR. RICHARDSON: With that we'll move forward into the hearing. And I only have one person that says; I have two that say maybe on the sign-up sheet in their interest in speaking. I am going to defer the maybe until after the yes. And I can't read the writing of the yes. I think it's --

MR. BATES: Bates.

MR. RICHARDSON: I would recommend that in the future we include on the sign-up sheet, write legibly.

MS. HANSON: Would you put yes on there for Pauline Hanson. I did not put yes.

MR. RICHARDSON: And our next speaker will be Pauline Hanson.

MR. BATES: Good morning and first of all I would like to thank you for the opportunity to address some of these issues that have been raised for

discussion this morning. My name is Nick Bates. I'm a physical therapist working in Beckley, West Virginia. I'm here today representing myself and my professional colleagues, Columbia Heights Raleigh General Physical Therapy in Beckley as well as the West Virginia chapter of physical therapy association.

I will attempt to keep my comments brief. I would like to start with a few general things first of all and then move on to some quick comments about specific items in the guidelines that I've had the opportunity to look at.

Before the first of May, myself and colleagues from the chapter will be submitting a written physician's paper for your perusal. We haven't had the opportunity to put that together as yet. You will have that in time to reflect on that before making final decisions.

I would like to start by commending the Health Care Advisory Panel for their efforts to establish some guidelines that deal with the significant variations in the methods of care and also some of the inappropriate use that we've seen of the use of passive modalities by

unlicensed and unqualified providers.

Overall the document is to be commended. I mean, it's content, there are elements of it that are stronger than others. One item that concerns myself and my colleagues is the use of the word protocol and guideline interchangeably. In establishing guidelines I think that the Health Care Advisory Panel has done the community of health care providers dealing with these sorts of cases and the system a great service. In establishing protocols, it is the concern of myself and people that I work with that these could lead to the arbitrary setting of caps or limitations on physical procedures and rehabilitation. That issue is important.

A number of third-party payers at the moment are attempting to do this and it does not exist at the moment any firm evidence suggesting that such restrictions lead to the overall improvements in the standard of care limited to those people and that we're attempting to serve or any economic savings for the paying groups.

I have additional concern and is something

that has come to my attention the last 48 hours from the Workers' Compensation Division, also HCX which would seem to go contrary to the Health Care Advisory Panel's efforts to promote early and aggressive rehabilitation in returning these individuals to work. And this involves the pre-certification of all physical meds and procedures -- all rehabilitation procedures -- following our initial evaluation. I was advised of this yesterday and I know that very few people at the moment are aware of that.

A final general concern here would be that these guidelines, which could have been fairly wide reaching ramifications for a number of people within the state within the health care community and also for workers have not been from my point of view distributed widely. And a note is given to groups, concerned individuals and a difficulty in obtaining a copy of those guidelines has been fairly extensive and has lead me to not be ready to prepare a written position today. I will have that later on this month. I obtained my copy of the guidelines from a colleague in Martinsburg, who had contacted legal services on a

number of occasions in an attempt to obtain a copy of the documentation. He received one copy and then we was forced to photocopy the documents and distribute them immediately to our physical therapists earlier this month.

Having worked with the workers' compensation system for over 12 months, my facility for over three years, we received no notification of these revised guidelines and without his efforts, I would not have been aware of these going into place.

If I can go specifically to some of the sections of the document, Section 85-20-15.

MR. RICHARDSON: Which one?

MR. TUCKER: Which one, sir?

MR. BATES: 85-20-15. Section 15, 17.1, Page 14. In that section there of the guidelines as I'll refer to them, states that the claimants will respond to above treatments. Within four weeks the claimant must be referred to an appropriate specialists. Concern there in terms of the definition of what an appropriate specialist would be. If we turn to 20-16, 3.2, Section A under un-operative treatment.

Home cervical traction, e.g. bed of seven pounds, two hours, four times a day for seven to 10 days.

MR. TUCKER: Which page?

MR. BATES: Page 15. I'm sorry. This is difficult for me to follow as well. Concern there is with regard to the need to place specific perimeters as to the degree, length and limit on that particular procedure.

MR. TUCKER: I'm sorry. What did you say your concern with that was?

MR. BATES: In stating in bed, seven pounds, two hours, four days a week -- four hours a day for seven to ten days. That being a guideline or protocol isn't based upon any specific study or --

MR. TUCKER: Is it your concern how they derived at seven pounds, two hours, four times a day for seven to 10. Is that what your concern is, sir?

MR. BATES: Yes.

MR. TUCKER: How they derived --

MR. BATES: How they derived at that and if in arriving at that, that places unlisted restriction on the clinical decisions of those who are in a

MS. POSEY: I think it's appropriate to raise the issue of what me mean by definition of protocol and that's certainly something that Health Care Advisory Panel can consider with input from professionals who raise a legitimate concern about that.

I know that the controlled substances are certainly protocols. Well, they're not even protocols because you can alter the recommendation by giving reasons why you want to depart from the guides. So, it may be that protocols are not -- unless we specifically define what we mean by protocol, maybe that's a term we want to reconsider.

MR. BATES: A number of the issues that I will continue to raise -- and I don't wish to go down this line by line -- but if these are to be treated as protocols then I feel obliged to get into it line by line. Instead of used as guidelines and examples, suggestions e.g., then that's not necessary. And as I said, the overall contents of the document is excellent. There are some sections that are better than others and from my perspective --

MS. POSEY: Would you agree -- Carl has worked with us on these and I think -- would you agree with me that protocol does not mean a prescribed way that you have to do but what we're suggesting that these are guidelines and if a practitioner wants to provider wants to deviate from the guides, they need to give some reason why they're straying some distance from what we recommended. But as far as this is cast in stone, this is the only way you can do it, that was not the intent of the Health Care Advisory Panel.

MR. BATES: I'm sure that that is not the intent of the panel themselves being providers who deal with these situations. But as we've seen in a number of other sittings when you start out with guidelines and what you end up with is restrictive practices limits, caps.

MS. POSEY: No. That was not the intent.

MR. TUCKER: Mr. Chairman, I would like to have a point of inquiry myself. How are these individuals who are going to be living under these proposed rules that you've adopted going to approach the type of situation that this gentleman is raising?

Is each practitioner going to have inquire of HCAP or someone in the division's office to get an interpretation before they can treat anybody after they make their evaluation on that?

MR. RICHARDSON: What's contemplated is that these will be published.

MR. TUCKER: I understand that.

MR. RICHARDSON: And circulated to practitioners in the workers' compensation medicine area.

MR. TUCKER: That's not my question. If they're adopted as proposed, I'm sure that they will be distributed to the practitioners who deal with these three -- 20, 21, 22. My question is: If a practitioner is out into the private sector trying to treat people based upon these guidelines and they're particular treatment that they want -- that they feel is necessary for a person that's coming to them for treatment, does not necessarily fall within the verbiage of the proposed rules, are they going to have deal with the division or someone in the division or someone in HCAP before they can proceed with their

treatment? I think that's a viable question that needs to be answered. What I'm hearing is people that's on the HCAP saying that wasn't the intent but still the language says, you, know certain things that these --

MR. RICHARDSON: I think in the regulations, Fred, you have two different things. You've got what are considered to be best practices by the Health Care Panel and encouragement to follow that type of practice. In addition to that, you have rules. And an example would be on the drugs. The drug regulation, Series 21, that's essentially a rule. And it's a rule that says that there have got to be exceptional circumstances to go beyond that rule and it's because we've had an inordinate number of individuals in the past that would be get onto a pain pill or some other type of drug and end up with a substance abuse problem as a result of that problem.

In addition to that, the example that Mr. Bates gave a few minutes ago under Section 15.7.1, the example there would be that, you know, if a physical therapist, if a chiropractor or other handle the care of an individual with these particular problems for a

certain period of time and there was not improvement demonstrated, then there would be a requirement that that person then be referred to an orthopedic surgeon, neurosurgeon, person of that nature.

Mr. Bates raised a legitimate question regarding the terminology here of an appropriate specialist and that's the kind of input we need on these regulations. I didn't here him questioning the issue of at some juncture referring a person on to a person of greater specialty.

MR. BATES: No.

MR. RICHARDSON: It's an issue of defining precisely what kind of specialty that would be. So,, you know, is that a guideline or just a -- is that a rule or just sort of a best practice. Well, I would say that's probably kind of a rule, isn't it? If you take care of someone for a while and they're not showing improvement and you can't quantify that improvement then a few people in the practice of physical medicine would dispute that someone else probably needs to take a look at that person.

MR. ROTENBERRY: That doesn't mean he wasn't

appropriate.

MR. RICHARDSON: Well, the appropriateness is -- what they're talking about is a specialty. And, you know, basically this particular section -- and maybe I shouldn't look on that as an example -- but this particular section is oriented toward physical therapist or a chiropractic surgeon or an osteopath who does manipulations or I suppose even a family practitioner for that matter who might do manipulations. And at some juncture -- what the rule recognizes is that at some juncture that individual should be referred to a person with greater specialty to deal with the particular physical problems that that person --

MS. POSEY: If I may clarify that a little bit because a lot of people with sprain/strains get seen in an emergency room and referred to surgical specialists who have already decided within the first two to four weeks that this individual is not a surgical candidate then they would refer to the appropriate specialist, i.e., a physical medicine specialist. So, it can both ways. It's not just

physical medicine. It's whomever is treating this individual, if they've shown no improvement within 30 days, if not a documented measurable improvement, someone else from some other specialty needs to look at that individual. And, so, it can be either a neurosurgeon who has seen this individual and it's not a surgical case or it might be a physical medicine specialist whose doing something and the person is not improving. So, it can go either way.

MR. THOMPSON: Who will make the referral.

MS. POSEY: That's the beauty of your case management approach in workers' comp. The provider is not given this stuff to do in a vacuum, you're not given these and said follow them and we're not going to give you any assistance. The claims managers who manage the cases will be in contact with those providers and asking questions and finding out how the person is progressing. They'll also be talking to the injured worker who may say, I don't feel I'm improving and the physical specialist says or whatever specialist is seeing them says, "Well, we think there's an improvement," when there's some obvious disagreement

about whether improvement is there or not, then maybe a case manager needs to be face to face with the worker and the provider to find out what is going on.

So, there will be a great deal of guidance provided from workers' comp or from whomever is managing the case to assist on how to move forward with returning that injured worker to work.

DR. TULLY: May I say something about the rules? These rules were formulated by using rules and regulations from other states, like Rhode Island, Michigan, New York, California, whatever. We took the best that we could find and these are rules that are more or less suggestions and not set in stone but if in this case with the person with the cervical traction, if you're going to do this for 50 days, we think that's a variation. If you're going to use 30 pounds, we think that may be a variation. So, these are rules that we're suggesting that be used that are formulated by experts that we sort of tapped their brains and used some of our own.

MR. BATES: I do not doubt the intention nor the best effort of the Health Care Advisory Panel.

Again, I'll say, overall this is an excellent document. It's a step in the right direction. These guidelines we use more frequently many, many people would benefit. But my concern is when guidelines become protocols. On Page 39, Section 85-27.1, physical medicine guidelines were developed to avoid monitoring of 100 percent of claims where physical medicine is provided. However, these guidelines do not supersede the previous diagnostic related treatment guidelines.

These diagnostic treatment guidelines -- those guidelines I have never seen. I have been unable to obtain. These diagnostic related treatment guidelines represent a cap or a time limit or a dollar amount limit on services.

MS. POSEY: By the way, this got into the rule before we actually changed the wording and we have a written recommendation that that be changed and I can read to you what the change is if you would like to hear it.

MR. BATES: Thank you.

MS. POSEY: Physical medicine guidelines

were developed to avoid monitoring of 100 percent of claims where physical medicine is provided. Case management will begin at any point lack of progress is identified but particularly at 30 days and at 60 days after treatment has begun.

And that we propose should change that particular sentence. However, these guidelines do not supersede. We picked that up after it got into the rule and we're aware -- we think that needs to be changed.

MR. BATES: Are there other sections or--

MS. POSEY: I'm not prepared to say. That's the only one I know of at the moment.

MS. GREENWOOD: That's the only one that slipped, that there was a glitch between the guidelines that were published and the final guidelines recognized and approved by the Health Care Advisory Panel. This particular section was the only few lines of several sentences that got caught in a time warp. You're welcome to continue.

MR. BATES: That is a little bit of concern. The revised documents is not the document that we have reviewed but I can understand --

MS. POSEY: Well, we got a look at the rule and recognized that this was not the intent. So, we too agree and we understand. That's why the public hearing is here because we said, "Can we correct it?" And they said, "No. You'll have the opportunity at the public comment."

MS. GREENWOOD: There was about a week, half a week even of time there that the Performance Council met and the Health Care Advisory Panel and there was this one slippage.

MS. POSEY: We hope that's all.

MS. GREENWOOD: That is the only one. I'm confident that's the only slip between the cup and the lip.

MR. BATES: That particular issue regarding protocols and guidelines, we leave that for now with the understanding -- it is my understanding that some form of definition -- it's suggested that some form of definition needs to applied there. Is that correct or have I misunderstood our discussions regarding what is a protocol, what is a guideline?

MS. POSEY: Protocols are stiffer. What do

you think, John, does he need to address everyone of these in light of if the protocol is the assigned term then he needs to make comment about each thing that he thinks is not appropriate as protocol?

MR. RICHARDSON: He can do that now or in writing later if he'd like to do that. One of the things that occurs to me in listening to all this, I think that the revision coming out of this process is that we probably need to identify specifically which items a protocol, which is a guideline and put that into the definition.

MS. POSEY: You were talk being 27.1.2 on Page 39.

MR. BATES: I need to go back from there. A number of my comments here again pertain to that issue regarding protocols versus guideline. So, I will attempt to just quickly run through them and pick out anything that deals with other than that concern. You got lucky, I jumped all the way to the end. Section 27.10.

MR. RICHARDSON: Page?

MR. BATES: The last page, 40. Second to

last page, Page 40. In Section 26 it appears that these are the same thing.

MS. POSEY: Say again.

MR. BATES: These appear to say the same thing in the copy that I have.

MS. POSEY: Cite the numbers again.

MR. BATES: 27.10.

MS. POSEY: 27.10.

MR. BATES: 27.10-1A, 26.11. I hope I've given you the right referencing.

MS. POSEY: Now, remember one has to do with the ankle and the other has to do just with physical medicine.

MS. GREENWOOD: No. No. Appropriate intervention time-frame is 26.1.

MS. POSEY: Yeah, but it has to do with the foot and ankle.

MS. GREENWOOD: No.

MS. POSEY: It does, too. Look at the very top.

MR. RICHARDSON: Well, we will look at that. You're welcome to -- we're not putting you on

any kind of time limit.

MR. BATES: I hope to be all but finished. Again, my concern in not going through this stuff line by line is that if there are revisions made, I would like to see the revised documents before I am --

MR. TUCKER: You would like to see the revised copy, is that what you're saying, sir?

MR. BATES: Yes. Before I provide the written comments or before I become subject to these guidelines.

MR. RICHARDSON: Do you know Jack Brye? He's a physical therapy in Morgantown.

MR. BATES: No, sir, not personally.

MR. RICHARDSON: Jack is a member of the Health Care Advisory Panel and has worked, I believe, closely with other physical therapists on this. If you'll see me after the meeting, I'll give you his telephone number and you may want to contact him to discuss the background on the development of this and in addition to him we have Dr. John Deboyce from Wheeling. Do you know John?

MR. BATES: No. I've only been in this area

about 12 months.

MR. RICHARDSON: We appreciate your thoughts and comments. They are exactly why we do public hearings of this nature and the comment period is actually open until, I believe, the beginning of June, the end of May. What is the deadline?

MR. TUCKER: May 1.

MR. RICHARDSON: We've got another series out that are open until June 1. So, we look forward to your comments and I believe that you have the address where to write on any of the comments that you have on the issues. Any further questions for Mr. Bates?

MR. TUCKER: I have a couple I want to ask. Sir, you -- and if I make misstate, I'm just trying to ascertain what your comments were. One of your difficulties was using the word protocols and guidelines in describing the rules. Also, did I detect that in your statement that if these protocols or rules were adopted, you had a fear they would set a limit or cap on rehabilitation?

MR. BATES: Yes. I think the intention of the Health Care Advisory Committee was to promote

rehabilitation in returning workers to the work force as quickly as we can. Sometimes when that's attempted to be done, in doing so, you produce guidelines or suggested methods of treatment then they're latched onto by the financial arm of workers' compensation board or the division and then those suggested guidelines become caps or limits.

MR. TUCKER: So, your concern is -- if I make a false statement just feel free to correct me -- but what I ascertain what your statement was that the new rules, protocols or whatever you want to call them, as they are now that as you know them now, if they were used you would have concern that they would limit or set a cap on rehabilitation and that the standard of care would be affected.

MR. BATES: Yes. The decision making process would be taken out of the hands of those people who are able to make those decisions.

MR. TUCKER: So, your concern is that the proper to make the decision would be eliminated; is that correct?

MR. BATES: Yes. That the guidelines would

not take into account the significant variation in the clinical picture that does exist. Our best practice situations arise where that's not the case. And as we've seen it before, an attempt to do the right thing has resulted in restrictions to the service.

MR. TUCKER: And the cure becomes more of a cause than the cure; is that what you're saying?

MR. BATES: Exactly.

MR. TUCKER: And one final question. Did I understand you to say that you felt they were not aggressive enough on returning people back to the workplace?

MR. BATES: No.

MR. TUCKER: Did I misunderstand that?

MR. BATES: Yeah. Probably my accent.

MR. TUCKER: If they understand me, they can understand you. As a point of information also, you said you were not, as far as you're not on the mailing list, I guess, for --

MR. BATES: No.

MR. BATES: I think we need to try to address that somehow. I think you need to see one of

the people from legal staff and get your name on that list and I would advise anybody here, also, that's interested in doing that, do that. They are very good about -- if they know who to send them to, people are interested, they have no problem with sending those. But in all fairness, they don't really know who those are unless -- if you have a concern and your in it, I would suggest you get with one of those folks. Any other proposed rules and regulations that you might want to have comment or input, we may have to address that some way with you. I don't think there's a problem with that. I appreciate your comments and thank you for coming today, sir.

MR. RICHARDSON: There is absolutely no effort -- I mean, these are out for public comment, they're published and the state register sent out to various groups of interests and, you know, I regret that you felt you had a hard time getting a copy of those regulations but it's certainly nothing conscious. And if you would like copies of those regulations, simply give us your name address and we'll be sure these are forwarded to you each time they're

promulgated.

MR. KOZAK: I would just like the record to note that we sent out 15,000 copies of summary to everybody who's on the billing system within the computer and anybody who bills us in their own name or under a name got one of those copies.

MR. RICHARDSON: Summary that's on the top --

MR. KOZAK: In a different form.

MR. BATES: My problem was not in obtaining the summary.

MS. GREENWOOD: Lisa, was not a notice sent out advising everyone that they could obtain copies from the Secretary of State office?

MS. KERN: Correct.

MR. BATES: My difficulty wasn't really -- it was with obtaining the document itself.

MS. GREENWOOD: The notice, I think, read that the document was obtainable from the Secretary of State's office.

MR. THOMPSON: I guess the question would be, are you on record? Do you bill us?

MR. BATES: Yes. Frequently.

MR. RICHARDSON: Then you got some -- thank you. So, the next speaker will be Pauline Hanson. Pauline?

MS. HANSON: Are there certain issues that can be discussed today, Mr. Richardson?

MR. RICHARDSON: This is a public hearing regarding Series 20, proposed regulations for the protocols and guidelines for the treatment of selective workers' compensation injuries. Series 21, regarding guidelines for controlled substances. And Series 22, regarding guidelines for psychiatric permanent impairment evaluations, evidence and ratings of psychiatric impairment due to workers' compensation injuries.

MS. HANSON: Well then maybe I'm not going to be able to speak because my questions were like on collections. So, maybe I'm not going to be allowed to speak if it doesn't pertain to this.

MR. KOZAK: What you may want to do is hold that until after this public hearing is over.

MR. RICHARDSON: Let us complete our public

hearing and we would certainly welcome comments or thoughts from anyone at the close of the public hearing on anything generally. But we need to stick to the subject during the public hearing period of our subject.

MR. THOMPSON: Andy, I would like to hear another example on that 16-3.2A. It was given from the other end of the table there, I think.

MR. RICHARDSON: Before we do that, if it's okay, and Pat if you'll hold that thought, let me ask if any of the -- there were a couple of folks listed as maybe and I would like to give them an opportunity if that would be okay, Paul.

MR. THOMPSON: Yes, sir.

MR. RICHARDSON: To offer their comments and then we can hear from Pat and or Dr. Tully regarding any of the actual recommendations of the Health Care Panel. After that we can adjourn the public hearing and get off the dime on the transcription process and hear any other comments.

The yes -- that's all we have that have expressed yes. I have Carol Salazar, physical therapist

from Putnam County. Would you like to speak?

MS. SALAZAR: Yes, please.

MR. RICHARDSON: Please come forward.

MS. SALAZAR: I'm Carol Salazar. I'm the director of rehab services at Putnam General Hospital. I've done a variety of physical therapy from home care to rehab to nursing home and now acute care. So, I think I have a little bit of experience when dealing with several types of injuries.

I just wanted to reiterate my mixed point about obtaining this document. It was really a very difficult thing to obtain. Thankfully a colleague in Martinsburg was able to obtain it and he copied and distributed it to us at our last meeting. I'm the co-membership chair for the state and I would be more than happy to supply anyone with a list of physical therapist for the entire state. This document came as a huge surprise to all of us who are in all aspects of care for the entire state. So, notices may have gone out but either the administrators are hogging them or we're not getting them. My CEO had no idea that this document existed, neither did my CFO.

So, on that note. Anyway what I would like to -- one point I wanted to bring up was the point that Nick made was the difference between protocol and guidelines. And I understand that some of the more specific things to do with pharmacological agents and things need protocols but it seems as though it's subjective.

How do I know when I call workers' compensation that that case worker understands the difference between a protocol and a guideline? How do I know that they're capable of making an objective decision based on -- well, we understand it says seven pounds for seven days but this is just a guideline? How do I know the next time I call that person won't say, "Well, according to these rules it says you're supposed to do this."

So, I'm concerned with the subjectivity of some of these guidelines and I want to make sure that all of your staff understands that they're guidelines versus protocols and that kind of thing. The intent may be as a guideline, but I'm not so sure it will trickle all the way down to the people I work with every day.

So, that's a concern.

Unlike Nick, I am going to go line by line but I hope that I won't be too boring. If we look at Page 14-D at the top, this is dealing with -- basically my point for this is this happens to deal with cervical muscular ligamentous injury. My concerns of the whole document is in some instances they make specifics to physical therapy, occupational therapy, etcetera, referral. But in other instances the guidelines state physical modalities and/or rehabilitative procedures may be helpful.

In some offices, chiropractor's offices, physician's offices now, there are secretaries and non-trained people doing rehabilitative procedures and billing for those things. If this was in a physical therapy office, it would be done my a trained professional.

So, I'm concerned with two things. One, who is doing the modalities? Are they trained? Is there a license number attached to who is performing that procedure? And also does this mean it is a physical medicine referral or is just that someone has an

ultrasound machine in their office and their giving ultrasound treatment.

Further on in the document, there are specific instances where it says physical medicine referral but it's not consistent throughout the document. So, I'm concerned about that.

The other concern I have is, in several of these different injuries it talks about waiting four weeks, waiting 30 days, before an appropriate specialist is consulted. What happens when that worker comes in the emergency room with a neck injury and they're given medication according to the guidelines and they go home and sit for 30 days? There is no reference here that they should be referred to someone and should be looked after for 30 days. Is the caseworker going to call them on the 31st day and say,"Are you better? What have you done for 30 days?" Or should there be something indicated in here that a referral to someone needs to be made.

You know an ankle sprain can be healed in a week if the appropriate person is brought. And, so, if you've called in the right personnel, you've gotten

that patient back to work in a week. Whereas if you didn't, they're home 30 days on workers' comp's tab. So, early referral is real important.

And I don't know if that should be a guideline from the start. I'm not sure it needs to be a surgical specialist and I'm trying to educate my ER doctors that just because someone comes in with an ankle sprain doesn't mean they need an orthopedic surgical consult. Sometimes if they just refer them to PT right from the ER, they're set. You know, I can a apply the vice principle and they're back to work within a week. So, it just depends. But I think you need to consider that. There seems to be a lag time between injury and when you look at that patient again.

Again on Page 15, the gentleman that had a question about cervical traction he's left and I was hoping I could help him with this. I'm glad again that this is just for example. But again, in this instance there's no referral here to physical therapy. Where are they going to get their home traction unit? Are they going to go down to the local pharmacy and get a traction unit to take home? Who is going to instruct

them?

MR. RICHARDSON: Ms. Salazar, he'll be right back.

MS. SALAZAR: We can go back to that. We have a lot of DME people who some are more ethical than others. We may have a run on home cervical traction units and you'll see the price go from $20 to $200 if this becomes a guideline. Home cervical traction isn't always indicated and if you look at physical therapy studies, a lot of -- this does specifically say bed but a lot of over-the-door traction is not effective, especially at seven pounds. So, I'm concern about the specifics of that and also who is giving away this equipment. I don't necessarily want to become a DME vendor but by all means, I would much rather I instruct my patients in home traction than a high school student who happens to work at the local pharmacy.

Now, referring to Page 19. This is a low back musculoligamentous injury sprain/strain under Section 17.4.2, inappropriate treatment, home traction. I might have to go to jail but I give several of my people who have ligamentous injuries traction. I think

this is something that is too specific and home traction may not be indicated but certainly --

MS. POSEY: For low back strain you do that?

MS. SALAZAR: For low back strain, absolutely.

DR. TULLY: Well, the neurosurgeons and the orthopedists tell us that it's ineffective.

MS. SALAZAR: Well, I can tell you that I can pull records of many, many people who come to me with low back strain who may not have palpable paravertebral spasm but definitely have interspinous spasm than none of my modalities can reach and the only way I can get to that spasm is to give them static traction. And they're like new human beings when you get them off the table. Home traction for that injury may not be indicated. That's very expensive. Home traction used for the lumbar spine if you get a good traction unit, you're looking at 400 or $500.

MS. POSEY: And for strain/sprain I think that's inappropriate. I don't think that's an issue.

MS. SALAZAR: It may take one visit to my office and one session of pelvic traction to get enough

of a stretch to make it worthwhile and that certainly isn't --

MS. POSEY: If you will notice 17.4.1F would cover your traction and I think they were correct that home traction is inappropriate, period. So, I don't that really should be an issue.

MS. SALAZAR: If we look at Page 22 at the top of the page, the inpatient treatment of disc. There's is no indication there -- there isn't any inpatient treatment for physical medicine. So, I'm just concerned with this, if someone is admitted with low back, will they meet the criteria for admission? Does that mean I can't get an inpatient referral or I won't meet the criteria if I get one? I have also treated several people who were admitted for one or two days because of intractable back pain who get treated by me with ice and modalities and exercise and go home feeling much better. So, we're not listed on there and I'm concerned about that.

Again, on Page 23 when you're looking at complicated after wound infection. And D and E, physical modalities and/or rehabilitative procedures.

Is that by referral or is that someone in the hospital or in the office doing that treatment? I think that needs to be specified.

Page 24 for lumbar fusion. It talks about the indications for lumbar fusion but it does not indicate anywhere in here that physical medicine is necessary. And again with someone who has had back surgery, physical medicine is definitely necessary to get them moving again and functioning.

On Page 26 at the very top of the page it talks about -- I'm sorry skip that. One thing Nick brought up that I would like to also talk about is the appropriate -- actually it's on Page 26, 20.4, the guidelines for appropriate specialty referral are as follow. One thing I'm concerned with is that -- one thing that frustrates me is I have some very complacent physicians who my patients go see once a month and they say, "Keep going to PT. Keep going to PT." And I keep saying, "PT is not helping." Is there someplace in this document where I can refer? Why can't I call workers' comp and say, "My patient is not getting better. He's been six months, once a month to this

physician who prescribes PT and medicines. Something else needs to be done."

It seems like my patients say you're the only one who will listen to me but I have no credibility when it comes to workers' compensation. You're not alone. I can decide what I want to do with my patient and prescribe his treatment for his back pain but I can't call you and say, "Boy, you're really wasting your money at a hundred bucks a visit to this doctor. I think you ought to try something else."

I think there needs to be more two-way communication. I'm there seeing my patient three to five days a week. I know what's going on with my patient. I'm not saying they're all bad physicians but there certainly are some that are not listening. And I would like to be able to pick up the phone and say, "Okay, caseworker we need to dc something about this."

We do that all the time in our hospitals. We're working with medicare guidelines. I can go to my physicians and say, "This isn't working. Can I try something else?" I think we need that kind of communication with the workers' comp system. You know,

I'm not alone. I know many other PT's who are just frustrated by the whole process.

MR. EPPS: I don't mean to interrupt your testimony but I guess my question -- I think you just answered what I was going to ask. In your relationship with the patient and the physician, what's different between workers' compensation and patients that you serve that aren't being funded by workers' comp? What's the difference?

MS. SALAZAR: There isn't much difference except that --

MR. EPPS: You spoke about the relationship between you and the physician and the inability maybe, I mean, the idea that the doctors says keep doing PT. My question is: How is that different with workers' comp as opposed to your treating of a patient that isn't covered by workers' comp that's covered by something else?

MS. SALAZAR: I think some of the difference is, for example Aetna. I'm on the phone almost everyday with Aetna. Aetna will only allow me to treat, for example, maybe for four sessions before we

have to talk again. And I think this idea of case management is a very good idea as long as it's consistent. With Aetna they will tell me, "It doesn't sound like they're getting better." Or I can call Aetna and say, "They're getting better. You only gave me four, give me two more and I know I can get them cured." So, I think there's that communication, which we've never had.

So, if your idea is to implement case management and that kind of thing, I think that will help that. But it seems like if I don't have MD or DO after my name a lot of my credibility is shot because I'm only the PT who said something. Whereas I may be the only one involved in the patient's care who has given them a thorough exam. So, that's my point.

Page 26. Now, we're talking about shoulder complex, the failure of improvement or resolution of symptoms with conservative treatment for four weeks. Again, there hasn't been a PT referral. What does that mean? Does someone strain their shoulder and go home for four weeks? What's conservative? If someone has a simple shoulder strain and they come into therapy, they

may be back to work in a week.

So, again, I'm concerned about that four weeks. That's a long time. Some conservative treatments are heat and rest and that may be fine but four weeks is an awful long time for a simple musculoskeletal strain.

Non-operative fracture subluxation on same page 20.5.1. Physical therapy beginning on four weeks and continuing up to six months. That perimeter is kind of limiting but it should be okay.

My other problem was on Page 28. Adhesive capsulitis 20.5.5. Physical therapy tried one to six weeks. With someone with a pure adhesive capsulitis, six weeks may not be enough time and I'm concerned that that limitation. Again, you know, we may be able to call and say we're almost better but I'm concerned with that time limit.

For rotator cuff tear back on Page 27, 20.5.4 physical therapy following surgery -- excuse me that's B -- physical therapy following surgery three to six months at decreasing intervals. Right now the standard protocol for my orthopedic surgeons is absolutely no

active movement for our rotator cuff repairs for six to eight weeks, completely only passive motion to 90 degrees only in flexion. So, I'm very concerned about that limitation. It may be three months before my patients can actively scratch their head for the first time. The docs are really limiting their rehab because of their surgical procedures and so having that kind of time-frame may be very limiting on returning the patient to work.

Page 29, 21.3.3, carpal tunnel. Response to rest, splinting of wrist, steroid injection. Again there's no reference made here to any physical medicine referral. Who is giving the splints? Who is instructing on rest and application of splints? Page 30 in regards to carpal tunnel again, 21.6. The appropriate treatment consists of the following -- non-operative there is no indication for a physical medicine referral in that section at all either.

Page 31, surgical intervention -- excuse me, down at the bottom of the page, letter A. Surgical intervention is indicated by presentation and intraoperative findings. And then you have B, home

health care rehabilitation. I think that the committee is limiting themselves with home health care rehabilitation for a carpal tunnel or any kind of surgery for that does not necessarily need to be done at home.

MS. POSEY: I can tell you how this came about. The example is, you have a person who has carpal tunnel and has surgery and they have an arm missing and therefore could not give themselves self care. Therefore, someone might need home health care in the sense of homemaker duties and so on. It has nothing to do specifically with treatment. It's an example of when there's a compromise of activities of daily living due to some problem with the unaffected limb.

MS. SALAZAR: Okay. When you go down that list it talks about rehabilitations and then you have another series of A to E. If that's the concern and you want to refer someone ti home health, I think you need to indicate that there will be a rehab referral. I wouldn't want a home health aid going into the home and performing these series of interventions on someone

who was just recently postoperative for carpal tunnel. So, it does say rehabilitation but again it doesn't say by whom.

On Page 34, non-operative treatment again of the knee. It does not in 23.2.1, letter C, physical modalities and/or rehabilitative procedures again do not specifically indicate whether that's a physical medicine referral or who is giving that care.

Page 35, outpatient non-operative treatment, 24.3.1. Again physical modalities and or rehabilitative procedures, there is no indication as to who is delivering the service.

I think that is all.

MR. RICHARDSON: Ms. Salazar, you would do us a great service if your comments would also be prepared in writing --

MS. SALAZAR: Okay.

MR. RICHARDSON: -- and submitted according to the advertisements in the regulations. Are there questions?

MR. EPPS: I have a comment. I commend you for being very thorough in going through this.

MS. SALAZAR: Thank you. Sir, is there anything I can help you with the cervical traction question?

MR. THOMPSON: No. I just wanted to hear another example. It was listed under 16.3.2.

MR. RICHARDSON: Don't lose that thought, Paul. Well, thank you very, very much for your comments. Thank both of you for taking the time to come today to make these comments. The only other maybe that I have listed is here is Scott Lloyd.

MR. LLOYD: I would like to say something very quickly. My name is Scott Lloyd. I'm an attorney for the United Mine Workers, District 6. I handle all of the workers' compensation cases for union members in the northern panhandle of West Virginia who are dues paying miners in that union. Presently we have about 1,200 files, 400 of which are actively in litigation at the Office of Judges, more are mute, just in the preliminary stage.

Obviously my opinion is going to be a little bit claimant skewed and I want to point out one thing that some of things I'm going to say. My position with

the United Mine Workers is a salaried position. I receive the same amount of money regardless of how many cases I have. So, what I'm about to say is not indicated based on my fear of not getting a certain amount of recovery from a case or something along those lines. A lot of things I'm concerned about, our district doesn't even take fees on, such as temporary total disability awards.

Now, most of my -- I'm going to state these as concerns. They're really questions because I don't know how this is really going to work in implementation yet. And I'm all for -- like everyone else has said here -- I'm all for some sort of changes to help these people get quick treatment and back to work as quick as possible. The biggest problem I've seen in the years that I've been doing this is the inability to get treatment, appropriate quick treatment, which causes lengthy periods of disability, which makes rehabilitation -- and I think that any of the physical therapists would agree that when they get to them very late, there's not as much that they can do for them at that point in time.

But basically let me just -- I'm not going to go line by line. I made a few notes of a few areas and a few phrases that caused me concerns. In the rules on the treatment for the certain kinds of injuries, there are a lot of statements such at the end of the proposed treatment that the claimant should be fully recovered or have no limitations after this type of treatment.

Now, I don't know what exactly that means. I'm concerned of a crossover as to how that will be used in a sense of will -- if the treating physician sees these phrases, is he going to be afraid or somewhat hesitant to continue sending 219's down and recommending treatment if his client is not better because he wants to make sure he gets paid? Where I'm from, we're having a hard enough time keeping doctors on -- treating our people, especially psychiatrists -- I'll get to that in a minute.

It's hard enough to get these people seen and the biggest concern I spend -- I spend half my time with doctor's offices trying to help them get paid and they don't want to see clients that they think they're not going to get paid on. And I'm concerned that when

they see a guy who should be fully recovered within four weeks and they don't think he is, what are they going do? Are they going to return him to work against their better judgment or are they going to back off? What are they going to do? That's my concern.

I don't know how it's going to work in practice. I don't know if there will be any crossover between them and your agencies. Second, what if, let's say for some reason a claim is closed on a temporary total disability basis for one of these types of injuries that says he should be fully recovered within four and let's say it's closed because adequate information was not provided. If you file a reopening application from this physician, are we going get answers back that treatment modalities have been expended and the anticipated period of disability has expired, therefore, you should not be on anymore temporary total disability benefits.

I'm concerned about that because I think everyone, I mean, we have so many back injuries in the coal mine and everyone is different. Some go back in two weeks. Some of these guys are 55 years old and

have been bending for 25 years in the coal mine. Their back was already -- it's had so much degenerative disc disease or what have you in there before they had this injury, it's a lot different for them than it would be for a 22 year old who lifted something and had a minor injury and bounces right back and he's back at work. And plus, is he returning to a coal mine or is he returning to an office? That's a big difference and I am speaking solely for the coal miners. That's why I'm down here and that's our biggest concern.

Moving to the psychiatric guidelines. I realize that that is, even as a claimant's attorney, you know, I'm not -- I didn't just fall off the turnip truck. I read some of those reports; they bother me. I mean, I'm not going to sit here and tell you that -- I won't lie to you and say that I haven't tried to use them as a claimant's attorney but they do bother me. You know, I have to; it's my job. But there are some concerns there but my biggest concern -- I'm going to be honest -- my biggest concern is the type of report you're asking from these doctors -- we have a very hard time getting psychiatrist in the northern panhandle to

even see people that we think legitimately need psychiatric help. And I'm afraid that when they read -- when they read the type of report that you're requesting from them, they're going to feel that that is too much for what they get paid or don't get paid or whatever and they're not going to do it properly. That puts our claimants in a disadvantage.

I kind of noticed a conflicting -- and this is where I'm going to try to kind of point out a couple of lines here just once. On the definition section of the psychiatric guides when it talks about temporary total disability. It does give a definition for temporary total disability under the psychiatric guide, inability to return to your job essentially. Then when it goes to Page 6, C at the top it basically says -- and I'm paraphrasing -- but you can't temporary total disability on a psychiatric unless you're hospitalized, if you read that. That's the way I read it. Maybe I'm misinterpreting it but it seems to me that those two are kind of conflicting.

If you're going to define temporary total disability and the definitions, then a psychiatrist

ought to be able to put a person off of work for something other than a manic episode requiring hospitalization or, you know, something along those lines or extreme depression. Because I know our doctors, the doctors that I've dealt with find a lot of times that, you know, they don't want to put them in hospitals but they need to be treated and they need to go through a plan and work often times is part of the problem for them. You know, especially in the coal mines when you're working mandatory overtime, swing shifts, nighttime, daytime, all the time, sometimes it doesn't benefit them to be back to work and I'm just concerned. I may be reading more into it than what it says but they appear to be a little bit conflicting, if you just read them on the surface.

The other thing that bothered me and I'll give another section here, 85-22-5, 5.2, deals with the independent evaluator.

MR. RICHARDSON: Where is that?

MR. LLOYD: 85-22-5, 5.2. I didn't write the page number. I'm sorry about that.

MS. GREENWOOD: Page 3.

MR. RICHARDSON: Go ahead.

MR. LLOYD: Talking about an independent evaluator and I've assuming -- I don't know whether that means his treating psychiatrist or does that mean for disability purposes and if it means only for disability purposed, I'm confused by -- let's say you have a standard claimant now that's off six months with a herniated disc and he may never go back to the work he was doing before and he's pretty depressed about it and his MD says I think you should see a psychiatrist for a little bit. He goes over and he sees one. This doctor now under the rules now can get up to 10 visits without prior authorization. So, he starts treating him on those 10 visits but after the third he has to provide a report and then he'll be referred out to a --

MR. EPPS: Commissioner or psychiatrist?

MR. LLOYD: Eventually that commissioner or psychiatrist is going to give either a maximum improvement disability rating, what have you. From reading that, it sounds like that his treating psychiatrist would be given very little credence in any opinions he may have towards his level of disability

because he is -- the way that's written -- he is biased or because he treats this man primarily, he's not an independent evaluator. That concerns me, because like I said, it's hard enough to get these people in to see anyone let alone when it comes to the disability portion of a litigation or whatever, if that person is going to be -- these guidelines, protocols, whatever are going to be used in determining the weight or credibility of evidence because he happens to be a treating psychiatrist. That's going to hurt a lot of our people as far as maximizing their recovery on a claim and that's what they want to do.

MR. RICHARDSON: I can't find what you're referring to. Are you referring to the objective evaluator?

MR. LLOYD: Just a moment.

MS. GREENWOOD: Bottom of Page 3.

MR. TUCKER: The examiner should not be a treating physician or vice versa. Is that your concern, sir?

MR. LLOYD: Yeah. The 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. Bias in an examiner is an inherent risk performing these examinations and self-scrutiny. And then it -- let's see -- there is a tendency to identify with the referring sources. I don't know what that means.

MR. RICHARDSON: Let me see if I can clarify this. I didn't write this. This was prepared again through the Health Care Advisory Panel and in fact a subgroup of psychiatrists. But what they are saying is that a psychiatric evaluation should be conducted by an objective evaluator and then it goes on to spell out in Sub-A those type of things that might be characterized as pro-plaintiff evaluation bias. And in Sub-B, those characteristics that might be pro-defense evaluations. And, you know, I'm not sure I really understand --

MR. LLOYD: What I'm saying is, I'm not grasping by this statement in here -- I'm not grasping by this statement in here, I'm not grasping, you know, certainly there is going to be no affect on a psychiatrist being able to treat an individual. What happens when he gets his disability evaluation by one

of your physicians, one of the commissioner's examining physicians and that doctor says, "Well, he's got dysthymia It's directly related to this injury or post-dramatic stress and he's got a 20 percent permanent partial disability from this. We think he's maximally improved. He's not going to get any better. He's going to require treatment on and off for many years."

My client wants to litigate that. Based on this, I'm concerned about an overlap of evidentiary weight or credibility if the only guy he can use is his treating psychiatrist. He can't afford to go to another independent evaluator. He can't afford two or three like the employer can. He can't do that. So, he's got one and that's his treating psychiatrist. And I'm concerned about the way some of these things-- I guess it goes back to my original point, I'm not sure how these are going to work when their actually implemented. And I'm concerned about a little bit of crossover between the medical portion of your office filtering into the litigation portion of either the Office of Judges or initial decisions by your office

because of these guidelines.

MR. RICHARDSON: So, your concern is that these types of objectivity issues would chill the consideration of the treating physician's opinion on the extent of the psychiatric impairment?

MR. LLOYD: Either they would be afraid to render it or it would -- the fact of rendering it, my fear is, would make no difference anyway because of the way these guidelines are written, much more credence would be given to the one-time evaluator.

MR. RICHARDSON: I understand.

MR. LLOYD: And I don't feel that -- with a psychiatric condition it's a little bit different when you're saying, "The guy has herniated disc L-4, L-5." You plug that into --

MR. RICHARDSON: I understand now what you're saying. And I think it's a point that needs to be addressed by the panel and given consideration.

MS. GREENWOOD: I may shed a little light from several years ago, three, four maybe when the psychiatric sub-panel was meeting. The concern here and this thing strings on if you notice 5.2 for, you

know, two full pages plus a little bit, was to spell out that the focus was really on the examiner and not the interchange between the treating and the examiner.

MR. LLOYD: Uh-huh.

MS. GREENWOOD: But to spell out, put out front potential examiner by biases as spelled out here, pro-plaintiff, pro-defense which biases are there and to display those in this document. There was no thinking at the time of diminishing the treating.

MR. LLOYD: I understand but in reality the only true independent doctor who fits into this category is yours.

MR. RICHARDSON: But the reality is, Scott, that our -- the people that do independent examinations for the division also have plaintiff oriented practices and defense oriented practices. And consequently when they conduct an independent evaluation, we want them to be cognizance of the potential for a pro-claimant oriented bias or a pro-defense oriented bias. I think that was the goal there. How many psychiatrist are there in West Virginia?

MR. LLOYD: I mean, I'm going into Ohio now

for psychiatrists.

MR. RICHARDSON: When you look at the pool of psychiatrists that you draw from, it is a sufficiently small enough pool that the independent examination process -- there's not a pool of psychiatrists over there and all they do are independent exams. In fact, most of them, in all candor, on any given situation may have conducted evaluations relative to an individual with a plaintiff or claimant oriented perspective, as well as a defense oriented.

MR. LLOYD: I don't want to belabor the point but that was a concern. The other thing and this just may be my own -- I didn't quite grasp. I think it's in the same section somewhere where it talks about claimants' doctors' reports, I believe, and it essentially says don't use big words. I mean, that's essentially what it says. And I'm wondering, whose benefit is that for. I mean, psychiatrists, I can't even talk to them half the time because that's all they do use. I mean, I have to go -- whether it be yours or the employer's or mine. You know, when you're talking

about manic depressive episodes and -- whose benefit are they talking about? Don't use big words. I mean, my question is, why don't use big words? Their profession uses big words.

MS. POSEY: I think you're talking about use of conclusive terms and statements based on the unclear named tests that place controversially or nonspecific categorical terms. See, they're using big words --

MR. LLOYD: This is the one I'm talking about, use of numerous medical eponyms and jargon that are not explained in the text of the report and are not obvious to the reader.

MR. RICHARDSON: Where are you?

MR. LLOYD: The same section she was quoting from but a little further down. Page 4, H. I mean, it's a minor point. It's just my question, what is the that? I mean, if the guy is going to use a medical definition, does he then have to go back and explain what posttraumatic stress syndrome is to someone. I mean, that's what it sounds like to me. And I don't know whose benefit that's for.

MS. GREENWOOD: This was a whole exercise

section of the psychiatric sub-panel trying to work as a panel and reconcile their inner-differences. None of it is really--

MR. LLOYD: The last thing -- I'm going to get out of here -- but the last thing I wanted to say, again, I started by saying that I'm all for and my clients are all for and my client, The United Mine Workers, is all for aggressive treatment, aggressive therapy, quick therapy, quick return to work. I'm not going -- I'm not here to just keep them off -- I don't get paid to keep them off.

The question that I'm concerned about is -- and I'll give you an example -- when you have a lot of hands in the fire, so to speak, a lot of people telling what's appropriate, what's not appropriate in these guidelines. In our typical case, we've got someone from employer service, we have, you know, a physical therapy place, we have the doctor, we have the, you know, the commissioner, maybe the treatment team now, all these people. And then you have a claimant.

An example of a gentleman who had a foot crush injury, was off on total temporary total disability,

was doing everything, had no lawyer for quite a long period of time, almost the first he was off, doing everything that was requested of him -- no disrespect to the physical therapists here, I don't mean to do that all -- and they tried him on aggressive physical therapy. That was the goal with employer services. Get him in there; get him back to work. Get him on the treadmill. Put his work boot on. Get him going. He kept telling everybody, "I'm hurting. I can't do this. There's something wrong with my foot. There is something wrong with my foot."

This goes on and on for almost a year until he finally gets to another specialist after he got a lawyer -- I'm not saying that had anything to do with that, maybe he would have got there anyway -- but the gentleman has problems now that may never be fixed. And going towards disability and the funds financial situation, had he got to the right people first off, he may not have near the degree of permanent impairment that he's going to end up with because of the long period of time and the leaning towards just physical therapy. Hurry up. Get back to work. Don't send him

to any of these other doctors.

And I like I said, I'm all for that as long as people -- and I think the physical therapists said that, too -- most of them if things aren't getting better would like to have the authority and I would like them to be able to say, get him to another doctor. Get him out of here. We're not helping him. And I think that would be very beneficial to my people because in every profession from lawyers to doctors, yeah, there's a group of people that aren't up to snuff. Everybody knows that. There's is nothing we can do about that.

But on the whole I would like people like her to have that authority to be able to do something like that or call somebody and say, "We're not helping," before this gets any worse. If it's something like RSD that has a window of treatment, you know, let's get him out of there and get him to a specialist. And as long as these in practice work that way, and some of the concerns are addressed, then I think it would be a good thing. But I'm just afraid of some of those items. That's it.

MR. RICHARDSON: Questions for Mr. Lloyd? Scott, thank you very much. Your comments are well thought out and would you please again prepare your written comments for consideration.

MR. LLOYD: Sure.

MR. TUCKER: Commissioner, I got a question. Maybe somebody could enlighten me, maybe somebody from HCAP or Dr. Tully. Why do we get into putting in on Page 4, 5 and 6 about--

MR. RICHARDSON: Where are you? On the psychiatric?

MR. TUCKER: Why do we get into putting in A, pro-claimant evaluation biases and B, pro-defense evaluation biases. Why do we get into that in putting those into a rule or a guideline? Why do we do that?

MS. POSEY: I think Judy had already answered that Fred.

MR. TUCKER: Maybe I missed it.

MS. POSEY: Yeah, I think. She said when the sub-panel worked on this material, they were aware among themselves as people who did exams for employers or employees that there were certain things that might

crop up in a report that didn't have a place there as an objective report. So, they wanted to be specific about what people should be aware of, show them up as nonobjective.

MR. TUCKER: But to me what you're doing is putting something in there that muddies the water, causes more litigation, you know, causes more confusion. Now, in all due respect to the psychiatric panel that entered this in, you know, this is the problem that I've experienced in psychiatric treatment of claimants is the fact that we get into all this B.S. and stuff, you know, put it in here to start with. You know to me and all due respect to the HCAP panel, you're creating problems.

MS. GREENWOOD: But the physicians who work on this from both sides that had -- that knew their own predispositions and those of their co-colleagues on the panel, all of them wanted to spell out, to put it on the table to make it clear what they should be looking for in reading reports. There was no disagreement between the psychiatrist that may do a few more claimant than the defense evaluations. We can take

this back to the psychiatric sub-panel and have them review it, given the comments.

I'm just giving you the history of what they were resolving within their own sub-panel and a amongst themselves.

MR. TUCKER: I would like to clarify -- maybe for ignorance -- why we needed it to start with. I'm a layman.

MS. GREENWOOD: I was just giving you the history, we can take it back to the sub-panel and have them reevaluate the placement of that particular part of the rule.

MR. RICHARDSON: Other questions or comments by the panel members? Now, Mr. Thompson you had a question on the physical --

MR. THOMPSON: I forgot what it was now.

MR. RICHARDSON: I think that if I recall correctly it was on Page 15 of the Series 20 proposal regarding protocols and guidelines for the treatment of selective workers' compensation injuries. It had home cervical traction and then a such as or e.g. in bed, seven pounds, two hours, four times a day, for seven to

ten days. You had asked Ms. Posey if she could possibly give other examples of that.

MS. POSEY: Well, I think a physical therapist would be in a better position to say what another example would be but maybe in bed with five pounds for one hour, three times a day for four days or something. Would that be -- it would be that kind of thing.

MR. BATES: I would be very happy to provide those professional services to the gentleman on the end of the table.

MS. SALAZAR: I don't think you need for example.

MR. RICHARDSON: We understand that, but he did ask for another example.

MR. BATES: There's a huge variation in the amount of force, length of time, in which something would be applied depending on the particular sort of problem with the spine or supporting structures that you were trying to treat. Anything more than about 25 might give you some concerns. Anything less than or around about five or seven, you're not going to be

doing too much at all. That's very broad, very general.

MS. POSEY: I think what the panel wanted to avoid was the idea that you send somebody home with a traction apparatus and said, do traction. They wanted a prescription by a rehab professional, physical therapist, to say what should be done.

MR. RICHARDSON: And maybe the right way to deal with that is to say in the rule that that prescription or the treatment must be articulated or something.

MS. GREENWOOD: There should be a prescription, make a generic statement rather.

MR. RICHARDSON: Mr. Thompson, did that respond to your question?

MR. THOMPSON: Yes.

MR. RICHARDSON: Other panel members, any questions, comments? After having heard comments from -- does anyone who expressed on the sign-in sheet that they did not wish to speak, has anyone reconsidered and now decided they would like to speak?

Well, then I want to thank everyone in attendance for taking the time to be here today.

Personally, I think that the insights will be useful in the further refinement of the proposals from the Health Care Advisory Panel. Again, comment period remains until --

MR. KOZAK: May 1st.

MR. RICHARDSON: Comments are to be sent to --

MR. KOZAK: Attention: Lisa Kern, Post Office Box 3922, Charleston, 25339.

MR. RICHARDSON: And with that, I declare the meeting adjourned.

(Whereupon, the hearing was concluded)

REPORTER'S CERTIFICATE

STATE OF WEST VIRGINIA,

COUNTY OF KANAWHA, to-wit:

I, Angela A. Robinson, Court Reporter and Subcontractor for Rebecca L. Baker, Official Reporter do hereby certify that the foregoing is, to the best of my skill and ability, a true and accurate transcript of all the proceedings as set forth in the caption hereof.

Angela A. Robinson

ANGELA A. ROBINSON, Court Reporter
Subcontractor for Rebecca L. Baker,
Official Reporter

DIVISION OF WORKERS' COMPENSATION PSYCHIATRIC EXAMINATION GUIDELINE

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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.

II. 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 re-existing psychiatric disorder or character pathology that would explain the current mptoms).

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

II. 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.

I. 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, hockey, 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

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STATE OF WEST VIRGINIA
SECRETARY OF STATE

95 NOV 14 PM 3:00
DEP-LEGAL DIVISION

TO: John Kozak

AGENCY: Worker's Compensation

FROM: JUDY COOPER, DIRECTOR, ADMINISTRATIVE LAW DIVISION

DATE: November 9, 1995

THE ATTACHED RULE FILED BY YOUR AGENCY HAS BEEN ENTERED INTO OUR COMPUTER SYSTEM. PLEASE REVIEW, PROOF AND RETURN IT WITH ANY CORRECTIONS. IF THERE ARE NO CORRECTIONS, PLEASE SIGN THIS MEMO AND RETURN IT TO THIS OFFICE. YOU WILL BE SENT A FINAL VERSION OF THE RULE FOR YOUR RECORDS.

PLEASE RETURN EITHER THE CORRECTED RULE OR THIS FORM WITHIN TEN (10) WORKING DAYS OF THE DATE YOU RECEIVED THIS REQUEST. CALL IF YOU HAVE ANY QUESTIONS.

SERIES: 22 TITLE: 85 Worker's Compensation

* THE ATTACHED RULE HAS BEEN REVIEWED AND IS CORRECT.

SIGNED: _____

TITLE OF PERSON SIGNING: _____

DATE: _____

****

* THE ATTACHED RULE HAS BEEN REVIEWED AND NEEDS CORRECTING. THE CORRECTIONS HAVE BEEN MARKED.

SIGNED: _____

TITLE OF PERSON SIGNING: Director, Legal Services Division

DATE: 11/21/95

NOTE: IF YOU ARE NOT THE PERSON WHO HANDLES THIS RULE, PLEASE FORWARD TO THE CORRECT PERSON.