STATE OF NEW MEXICO
Workers' Compensation Administration

PROVIDER'S REPORT OF PHYSICAL ABILITY

This form shall be reimbursed if **pre-authorized and if completed at initial visit or for a change in work status or activity restrictions**, per WCA Health Care Provider Fee Schedule p. 22. Helpful guidelines on back.

1 - GENERAL INFORMATION

1 GENERAL INFORMATION

Worker Name (Last, First)		**Date of Injury**	**Visit date**	**Facility Address and Phone**
SSN-last 4 digits XXX-XX-	**Date of Birth**	**Primary Treating Provider Name**		

Visit Type: ☐Initial ☐Follow-up - **For follow-ups, is there a change in your recommendation since last visit?** ☐YES ☐NO

Diagnosis: _____

In my opinion, this diagnosis is: ☐Work-related ☐Not work-related

Maximum Medical Improvement (MMI) indications (Check one and indicate date) :

☐ Worker reached MMI on_____(date). ☐ Not at MMI but anticipated on _____ (date).

2 - WORK STATUS

2 WORK STATUS

After evaluation, I recommend this worker be (check only one option) :

☐ **OPTION 1 – Released to regular work** Status from (start date):_____ to (end date):_____
Released to hours and tasks routinely performed on the job held at the time of injury. SKIP TO SECTION 4 FOLLOW-UP

☐ **OPTION 2 – Not released to ANY work at all** Status from (start date):_____ to (end date):_____
The worker is not capable of performing ANY work activities at this time. SKIP TO SECTION 4 FOLLOW-UP

☐ **OPTION 3 – Released to modified duty** Status from (start date):_____ to (end date):_____
Released to work, **subject to the following restrictions in Section 3 ACTIVITY RESTRICTIONS** (Unmarked items indicate no restriction)

3 - ACTIVITY RESTRICTIONS

3 ACTIVITY RESTRICTIONS

Lift / Carry / Push / Pull Restrictions (if any)

Maximum cumulative hours/day →	**0**	**2**	**4**	**6**	**8**	**Other**
Lift from the floor ☐Left ☐Right	_____lbs.	_____lbs.	_____lbs.	_____lbs.	_____lbs.	
Lift from waist height ☐Left ☐Right	_____lbs.	_____lbs.	_____lbs.	_____lbs.	_____lbs.	
Carry ☐Left ☐Right	_____lbs.	_____lbs.	_____lbs.	_____lbs.	_____lbs.	
Push ☐Left ☐Right	_____lbs.	_____lbs.	_____lbs.	_____lbs.	_____lbs.	
Pull ☐Left ☐Right	_____lbs.	_____lbs.	_____lbs.	_____lbs.	_____lbs.	

Posture / Motion Restrictions (if any)

Maximum cumulative hours/day →	**0**	**2**	**4**	**6**	**8**	**Other**
Stand	☐	☐	☐	☐	☐	
Walk	☐	☐	☐	☐	☐	
Sit	☐	☐	☐	☐	☐	
Bend / Stoop	☐	☐	☐	☐	☐	
Twist	☐	☐	☐	☐	☐	
Kneel / Squat	☐	☐	☐	☐	☐	
Climb (stairs/ladder)	☐	☐	☐	☐	☐	
Drive	☐	☐	☐	☐	☐	
Grasp / Squeeze ☐Left ☐Right	☐	☐	☐	☐	☐	
Wrist (flex/extension) ☐Left ☐Right	☐	☐	☐	☐	☐	
Fine manipulation ☐Left ☐Right	☐	☐	☐	☐	☐	
Reach above shoulder ☐Left ☐Right	☐	☐	☐	☐	☐	
Reach below shoulder ☐Left ☐Right	☐	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	☐	

Miscellaneous Restrictions (if any)

☐ Max hours per day of work: _____

☐ Sit/stretch breaks of _____(# of times) per _____

Medication Restrictions (if any)

☐ Meds restrict ability to work safely (explain restrictions below)

Psychological Restrictions (if any)

☐ Psychological restrictions evident (explain restrictions below)

OTHER RESTRICTIONS / MODIFICATIONS (be specific) :

4 - FOLLOW-UP

4 FOLLOW-UP

Expected follow-up services (check all that apply and indicate dates, if known) :

Clear Form

☐ Next evaluation by treating provider on _____ (date) at _____ (time)

☐ Referral to / Consult with _____ (provider name and specialty)

☐ Physical / Occupational therapy / Chiropractic / Osteopathic Rehabilitation / Reconditioning _____ x/week for _____ weeks

☐ Other treatment / Follow-up _____

☐ Worker fully discharged from care. This is the last scheduled visit for this problem.

Provider Signature: _____ Date this form completed:_____

WCA PROVIDER'S REPORT OF PHYSICAL ABILITY (back page)

HELPFUL GUIDELINES / DEFINITIONS FOR HEALTH CARE PROVIDER (HCP) COMPLETING THIS FORM

BASIC INFORMATION:

- **For questions on this form:** Email the WCA Medical Cost Containment Bureau at WCA-MCC@state.nm.us or call 505-841-6042
- **Purpose of this form:** Because a prolonged workplace absence is detrimental to a worker's well-being, the WCA asks that you facilitate the recovering worker's safe, efficient return-to-work by providing interested parties a clear, quantitative description of current claim-related physical restrictions. In this way, you help employers identify suitable work and assign safe work activities.
- **When / who fills this form out:** Based on a reasonable medical probability, you as the primary treating HCP are encouraged to fill this form out at each appointment. However **you can only be reimbursed if pre-authorization is obtained AND the form is completed at the initial assessment or if there is a change in work status or activity restrictions**, as indicated in the WCA HCP Fee Schedule & Billing Instructions on page 22.
- **After you fill this form out**: Provide a copy to the worker immediately after each office visit
- Note - This form is not intended to substitute a Functional Capacity Evaluation (FCE)

DEFINITIONS OF PHYSICAL CAPACITY LEVELS (for reference only):

Sedentary - Ability to lift up to 10 lbs. occasionally or 5 lbs. frequently with sitting, walking/standing necessary to carry out duties
Light - Ability to lift up to 20 lbs. occasionally or 10 lbs. frequently, significant standing/walking or sitting with pushing/pulling of arm/leg
Medium - Ability to lift up to 50 lbs. occasionally or up to 25 lbs. frequently
Heavy - Ability to lift up to 50 lbs. occasionally or up to 50 lbs. frequently

HELPFUL GUIDELINES:

1 - GENERAL INFORMATION Fill out worker's name, last 4 digits of SSN, date of birth, date of injury, visit date, your clinic or facility name and address, your name as the primary treating HCP and your phone number

a. Visit Type: Indicate if this is an initial or follow-up visit for this worker regarding this workers' compensation injury/illness
b. For Follow-ups only: Check either YES or NO to indicate if you are making ANY change in recommendation since the last visit
c. Diagnosis: Indicate diagnosis. Underneath, check if, in your opinion the diagnosis is work-related or not work-related. Check only one box
d. Maximum medical improvement (MMI) –Check only one box. Indicate the date if the worker has reached MMI at the current visit or at a prior visit. If worker is not at MMI yet, write the date you anticipate the worker might reach MMI

2 - WORK STATUS Check the appropriate option box to indicate if the medical condition(s) resulting from this workers' compensation injury/illness will allow for this worker to return-to-work in some capacity. For each option, indicate the start and anticipated end date of your current work status recommendation. If it is permanent, you can write that in. Note: DO NOT check more than one box.

a. Option 1 - Check this box to release the worker to regular work with no restrictions. Do not fill out Section 3 ACTIVITY RESTRICTIONS. Skip to Section 4 FOLLOW-UP and sign/date
b. Option 2 - Check this box if you recommend NO work at all be performed at this time. Do not fill out Section 3 ACTIVITY RESTRICTIONS. Skip to Section 4 FOLLOW-UP and sign/date
c. Option 3 - Check this box if you feel the worker can return to work in a modified duty capacity with restrictions. Fill out Section 3 ACTIVITY RESTRICTIONS to indicate all the applicable restrictions as well as Section 4 FOLLOW-UP and sign/date

3 - ACTIVITY RESTRICTIONS Fill this section out only if you checked "Option 3 – Released to modified duty" in Section 2 WORK STATUS

- These restrictions are based on the HCP's best understanding of the employee's essential job functions
- If a particular restriction does not apply, leave it blank. All unmarked items are considered no restrictions
- Note to worker : These restrictions shoule be followed outside of work as well as at work

a. Lift / Carry / Push / Pull Restrictions: For each activity listed that you are restricting -
a1. Check "Left or "Right" if limitation is to just one side. For bilateral restrictions, check both "Left" AND "Right"
a2. Under the maximum cumulative hours/day allowed, write the maximum number of pounds the worker can handle
a3. Under "Other," indicate further instructions beyond the maximum cumulative hours/day allowed, if appropriate
– Note re lifting restrictions: If you are restricting lifting from the floor, indicate If lifting from waist height is also restricted
b. Posture / Motion Restrictions: For each activity listed that you are restricting -
b1. Where applicable, check "Left or "Right" if limitation is to just one side. For bilateral restrictions, check both "Left" AND "Right"
b2. Under the maximum cumulative hours/day allowed, write the maximum number of pounds the worker can handle
b3. Under "Other," indicate further instructions beyond the maximum cumulative hours/day allowed, if appropriate
c. Miscellaneous Restrictions: Check all restrictions that may apply and write in applicable specifics
d. Medication Restrictions: Check if medication(s) restrict work ability. Explain restrictions under "Other restrictions/modifications"
e. Psychological Restrictions: Check if psychological factors restrict work ability. Explain under "Other restrictions/modifications"
f. Other Restrictions / Modifications: If your recommendations are not indicated anywhere else on this form, write in

4 - FOLLOW-UP Fill this section out at each appointment to indicate ongoing treatment / follow-up services / referrals you are recommending. Check all that apply and indicate dates, if known

a. Next evaluation: Provide the date of the next scheduled appointment the worker has with you as the treating provider
b. Referral to / Consult with: If you are referring the worker to a specialist or other HCP, write in the HCP name and specialty
c. Physical / Occupational Therapy: Circle appropriate treatment and indicate how many times per week worker should attend
d. Other Treatment / Follow-up: Check if applicable. Write in any other treatment and/or follow-up you are recommending
e. Worker fully discharged: Check only if you are discharging the worker from any further care for this particular condition