NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION PROVIDER'S REPORT OF PHYSICAL ABILITY

1 GENERAL INFORMATION

Worker Name (Last, First)		**Employer** NAME OF YOUR SCHOOL HERE	**Insurance Company** CCMSI - PO Box 30870 Albuquerque NM 87190
SSN-last 4 digits XXX-XX-	**Date of Birth**	**Clinic/Facility Name/Address**	**Primary Treating Provider**
Date of Injury	**Visit Date**		**Provider Phone**

Visit Type: ☐Initial ☐Follow-up - **For follow-ups, is there a change in recommendation since last visit?** ☐YES ☐NO
(If YES, please fill out all sections on the remainder of this form. If NO, you may skip to Section 4 TREATMENT/FOLLOW-UP)

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 TREATMENT/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 TREATMENT/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** (Blank items indicate no restriction)

3 ACTIVITY RESTRICTIONS

- Important note to worker: The restrictions indicated below should be followed outside of work as well as at work -

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	☐	☐	☐	☐	☐	_____
Sit	☐	☐	☐	☐	☐	_____
Kneel / Squat	☐	☐	☐	☐	☐	_____
Bend / Stoop	☐	☐	☐	☐	☐	_____
Twist	☐	☐	☐	☐	☐	_____
Walk	☐	☐	☐	☐	☐	_____
Climb (stairs/ladder)	☐	☐	☐	☐	☐	_____
Keyboard ☐Left ☐Right	☐	☐	☐	☐	☐	_____
Grasp / Squeeze ☐Left ☐Right	☐	☐	☐	☐	☐	_____
Wrist (flex/extension) ☐Left ☐Right	☐	☐	☐	☐	☐	_____
Fine manipulation ☐Left ☐Right	☐	☐	☐	☐	☐	_____
Operate foot controls ☐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 _____
☐ In extreme hot/cold environments, _____ hours/day allowed
☐ On uneven surfaces, _____ hours/day allowed
☐ At heights/scaffolding, _____ hours/day allowed
☐ No driving/operating heavy equipment
☐ Can only drive automatic transmission
☐ Must wear splint/cast at work
☐ Must use crutches at all times
☐ Must keep _____ elevated
☐ No skin contact with: _____
☐ Dressing changes necessary at work

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 TREATMENT / FOLLOW-UP

Maximum medical improvement (MMI) indications (check only one and indicate the date) :

☐ Worker has reached MMI on_____(date). Permanent impairment rating (% / body part(s))_____
☐ Not at MMI but anticipated on _____ (date)

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

☐ 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:_____

NEW MEXICO WORKERS' COMPENSATION ADMINISTRATION PROVIDER'S REPORT OF PHYSICAL ABILITY

INSTRUCTIONS / DEFINITIONS

INFORMATION FOR HEALTH CARE PROVIDERS (HCPs):

- **Purpose of this form:** Because a prolonged workplace absence is detrimental to a worker's well-being, the WCA asks that you facilitate the injured 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.
- **This report as part of your evaluation:** The WCA Health Care Provider Fee Schedule & Billing Instructions (HCP Fee Schedule) references this report. Note - completion is included as part of the HCP's service and shall not be billed as a separate line item.
- **When / who fills this form out:** Based on a reasonable medical probability, you as the primary treating HCP should fill this report out at each appointment. Note - This form is not intended to substitute a Functional Capacity Evaluation (FCE).
- **After you fill this report out:** Provide a copy to the worker immediately after each office visit. The worker should then provide a copy to their employer who will then forward to the appropriate claims administrator.

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.

INSTRUCTIONS:

1. **GENERAL INFORMATION:** Fill out worker's name, last 4 digits of SSN, date of birth, date of Injury, visit date, employer name, your clinic or facility name and address, insurance company/carrier name, your name as the primary treating HCP, 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.
     - **b1. If you check YES** to indicate **either a work status or activity restriction change**, fill out the remainder of this report in its entirety.
     - **b2. If you check NO** to indicate no change since the last visit **in either work status or ANY of the activity restrictions**, you can forego filling out Section 2 WORK STATUS and Section 3 ACTIVITY RESTRICTIONS. Skip to Section 4 TREATMENT/FOLLOW-UP. Sign/date.
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 TREATMENT/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 TREATMENT/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 TREATMENT/FOLLOW-UP and sign/date.
3. **ACTIVITY RESTRICTIONS:** Fill this section out only if you checked "Option 3 – Released to modified duty" in the previous section
   Note: If a particular restriction does not apply, leave it blank. All unmarked items are considered no restrictions.
   - **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 regarding 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 recommendations or modifications here. Circle if you are addressing restrictions or modifications. Be specific in your explanation.
4. **TREATMENT / FOLLOW-UP:** Fill this section out at each appointment to indicate your ongoing treatment / follow-up recommendations.
   - **a. Maximum medical improvement (MMI)** – Indicate here if the worker has/has not reached MMI. Check only one box.
     - **a1. Worker has reached MMI**: Check if worker is now at MMI. Write MMI date and impairment rating on all applicable body parts.
     - **a2. Not at MMI**: Check if worker is not at MMI yet. Write the date you anticipate the worker might reach MMI.
   - **b. Follow-up** – Indicate all treatment/follow-up services you are recommending. Check all that apply and indicate dates, if known.
     - **b1. Next evaluation**: Provide the date of the next scheduled appointment the worker has with you as the treating provider.
     - **b2. Referral to / Consult with**: If you are referring the worker to a specialist or other HCP, write in the HCP name and specialty.
     - **b3. Physical / Occupational Therapy**: Circle appropriate treatment and indicate how many times per week worker should attend.
     - **b4. Other Treatment / Follow-up:** Check if applicable. Write in any other treatment and/or follow-up you are recommending.
     - **b5. Worker fully discharged:** Check only if you are discharging the worker from any further care for this particular condition.

Provider signature and date: Sign and date the form.