Doctor's Report of MMI/Permanent Impairment C-4.3

State of New York - Workers' Compensation Board

Use this form: 1. When rendering an opinion on MMI and/or permanent impairment; or 2. In response to a request by the Workers' Compensation Board to render a decision on MMI and/or permanent impairment.

Please answer all questions completely, attaching extra pages if necessary, and submit promptly to the Board, the insurance carrier and to the patient's attorney or licensed representative, if he/she has one; if not, send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization. You may also fill out this form online at www.wcb.ny.gov.

Date(s) of Examination:_____/_____/_____ WCB Case # (if known):_____ Carrier Case #:_____

A. Patient's Information

1. Name: _____ (Last / First / MI) 2. Date of Birth: ____/____/____ 3. SSN: ___ - __ - ____

4. Address (if changed from previous report) : _____ (Number and Street / City / State / Zip Code)

5. Home phone #: (____)_____ 6. Date of injury/illness: ____/____/____ 7. Patient's Account #: _____

B. Doctor's Information

1. Your name: _____ (First / Last / MI) 2. WCB Authorization #: _____

3. WCB Rating Code:_____ 4. Federal Tax ID #: _____ The Tax ID # is the (*check one*): ☐ SSN ☐ EIN

5. Office address: _____ (Number and Street / City / State / Zip Code)

6. Billing Group or Practice Name: _____

7. Billing address: _____ (Number and Street / City / State / Zip Code)

8. Office phone #: (____)_____ 9. Billing phone #: (____)_____ 10. Treating Provider's NPI #: _____

C. Billing Information

1. Employer's insurance carrier: _____ 2. Carrier Code #: W_____

3. Insurance carrier's address: _____ (Number and Street / City / State / Zip Code)

4. Diagnosis or nature of disease or injury:

Enter ICD9 Code: ICD9 Descriptor:

(1) _____ _____

(2) _____ _____

(3) _____ _____

(4) _____ _____

Relate ICD9 codes in (1), (2), (3) or (4) to Diagnosis Code column below by line.

Dates of Service From MM	DD	YY	To MM	DD	YY	Place of Service	Leave Blank	Use WCB Codes Procedures, Services or Supplies CPT/HCPCS	MODIFIER	Diagnosis Code	$ Charges	Days/ Units	COB	Zip code where service was rendered

☐ Check here if services were provided by a WCB preferred provider organization (PPO).

Total Charge	Amount Paid (Carrier Use Only)	Balance Due (Carrier Use Only)
$	$	$

Patient's Name: _____ Date of injury/onset of illness: ____/____/____
Last First MI

D. Maximum Medical Improvement

1. Has the patient reached Maximum Medical Improvement? ☐ Yes ☐ No If yes, provide the date patient reached MMI: ____/____/____
If No, describe why the patient has not reached MMI and the proposed treatment plan (attach additional documentation, if necessary).

_____

_____

_____

E. Permanent Impairment/Work Status

1. Is there permanent impairment? ☐ Yes ☐ No
Complete either **1a. or 1b.** based on the patient's current condition, if you believe there is MMI and a permanent impairment or if directed by the Workers' Compensation Board.

If this is for Scheduled loss, please complete section **1a.** below, sign Board Authorization at the bottom of this page, and return.

☐ **a. Schedule loss of use of member or facial disfigurement:**
(Identify impairment rating according to the latest NY Guidelines and attach separate sheet for additional body parts.)

Body Part: _____ Impairment %: _____
Body Part: _____ Impairment %: _____
Body Part: _____ Impairment %: _____

Describe findings and relevant diagnostic test results: _____

_____

_____

☐ Facial Disfigurement: (Describe findings) _____

If this is for Non-Scheduled loss, please complete section **1b.** below, complete page 3, Section F, sign Board Authorization at the bottom of page 3, and return.

☐ **b. Non-Schedule losses:**
(Identify impairment class according to the latest NY Guidelines. Attach separate sheet for additional body parts.)

Body Part: _____ Impairment Table: _____ Severity Ranking: _____
Body Part: _____ Impairment Table: _____ Severity Ranking: _____
Body Part: _____ Impairment Table: _____ Severity Ranking: _____

State the basis for the impairment classification (attach additional narrative, if necessary):

History: _____

_____

Physical Findings: _____

_____

Diagnostic Test Results: _____

2. Patient's work status:
a. Is the patient working now? ☐ Yes, at the pre-injury job ☐ Yes, at other employment ☐ No, Not Working
b. Could this patient perform his/her at-injury work activities without restrictions? ☐ Yes ☐ No

If this is a Scheduled loss (1a.), Section F should NOT be completed. Please sign Board Authorization below and return.
If this is a Non-Scheduled loss (1b), please complete page 3, Section F, sign Board Authorization at the bottom of page 3, and return.

This form is signed under penalty of perjury.
Board Authorized Health Care Provider signature:

_____ _____ _____ ____/____/____
Name Signature Specialty Date

Patient's Name: _____ Date of injury/onset of illness: ____/____/____
Last First MI

F. Functional Capabilities/Exertional Abilities

1. Please describe patient's residual functional capacities for any work at this time (not limited to the at-injury job activities):

	Never	Occasionally	Frequently	Constantly
Lifting/carrying	☐	☐ ____ lbs.	☐ ____ lbs.	☐ ____ lbs.
Pulling/pushing	☐	☐ ____ lbs.	☐ ____ lbs.	☐ ____ lbs.
Sitting	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Climbing	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐
Bending/stooping/squatting	☐	☐	☐	☐
Simple grasping	☐	☐	☐	☐
Fine manipulation	☐	☐	☐	☐
Reaching overhead	☐	☐	☐	☐
Reaching at/or below shoulder level	☐	☐	☐	☐
Driving a vehicle	☐	☐	☐	☐
Operating machinery	☐	☐	☐	☐
Temp extremes/high humidity	☐	☐	☐	☐
Environmental	☐	☐	☐	☐

Specify: _____

Psychiatric/neuro-behavioral (attach documentation describing functional limitations)

Patient's Residual Functional Capacities
- **Occasionally:** can perform activity up to 1/3 of the time.
- **Frequently:** can perform activity from 1/3 to 2/3 of the time.
- **Constantly:** can perform activity more than 2/3 of the time.

2. Please check the applicable category for the patient's exertional ability:
   - ☐ **Very Heavy Work** - Exerting in excess of 100 pounds of force occasionally, and/or in excess of 50 pounds of force frequently, and/or in excess of 20 pounds of force constantly to move objects. Physical demand requirements are in excess of those for Heavy Work.
   - ☐ **Heavy Work** - Exerting 50 to 100 pounds of force occasionally, and/or 25 to 50 pounds of force frequently, and/or 10 to 20 pounds of force constantly to move objects. Physical demand requirements are in excess of those for Medium Work.
   - ☐ **Medium Work** - Exerting 20 to 50 pounds of force occasionally, and/or 10 to 25 pounds of force frequently, and/or greater than negligible up to 10 pounds of force constantly to move objects. Physical demand requirements are in excess of those for Light Work.
   - ☐ **Light Work** - Exerting up to 20 pounds of force occasionally, and/or up to 10 pounds of force frequently and/or negligible amount of force constantly to move objects. Physical demand requirements are in excess of those for Sedentary Work. Even though the weight lifted may only be a negligible amount, a job should be rated Light Work: (1) when it requires walking or standing to a significant degree; or (2) when it requires sitting most of the time but entails pushing and/or pulling of arm or leg controls; and/or (3) when the job requires working at a production rate pace entailing the constant pushing and/or pulling of materials even though the weight of those materials is negligible. NOTE: The constant stress of maintaining a production rate pace, especially in an industrial setting, can be and is physically demanding of a worker even though the amount of force exerted is negligible.
   - ☐ **Sedentary Work** - Exerting up to 10 pounds of force occasionally and/or a negligible amount of force frequently to lift, carry, push, pull or otherwise move objects, including the human body. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time. Jobs are sedentary if walking and standing are required only occasionally and all other sedentary criteria are met.
   - ☐ **Less than Sedentary Work** - Unable to meet the requirement of Sedentary Work.

3. Other medical considerations which arise from this work related injury (including the use of pain medication such as narcotics): _____

4. Could this patient perform his/her at-injury work activities with restrictions? ☐ Yes ☐ No If Yes, specify _____

5. Has the patient had an injury/illness since the date of injury which impacts residual functional capacity?
   ☐ Yes ☐ No If YES, please attach a detailed explanation.

6. Have you discussed the patient's return to work and/or limitations with any of the following: ☐ patient ☐ patient's employer ☐ N/A

7. Would the patient benefit from vocational rehabilitation? ☐ Yes ☐ No If Yes, explain _____

This form is signed under penalty of perjury.

Board Authorized Health Care Provider signature:

Name Signature Specialty Date ____/____/____