NEW YORK STATE | Workers' Compensation Board

Doctor's Report of MMI/Permanent Impairment

C-4.3

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 ICD10 Code:	ICD10 Descriptor:
(1)		
(2)		
(3)		
(4)		

Relate ICD10 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)
$	$	$

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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

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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 ___/___/___

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IMPORTANT - TO THE ATTENDING DOCTOR

The C-4.3 has been modified to accommodate the 2012 Guidelines for Determining Permanent Impairment and Loss of Wage Earning Capacity. This form is to be used to file reports in workers' compensation, volunteer firefighters' or volunteer ambulance workers' benefits cases as follows: 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.

MEDICAL REPORTING

Please ask your patient for his/her WCB Case Number and the Insurance Carrier's Case Number, if they are known to him/her, and show these numbers on your reports. In addition, ask your patient if he/she has retained a representative. If so, ask for the name and address of the representative. You are required to send copies of all reports to the patient's representative, if any.

This form must be signed by the attending doctor and must contain his/her authorization certificate number, code letters and NPI number.

A CHIROPRACTOR OR PODIATRIST FILING THIS REPORT CERTIFIES THAT THE INJURY DESCRIBED CONSISTS SOLELY OF A CONDITION(S) WHICH MAY LAWFULLY BE TREATED AS DEFINED IN THE EDUCATION LAW AND, WHERE IT DOES NOT, HAS ADVISED THE INJURED PERSON TO CONSULT A PHYSICIAN OF HIS/HER CHOICE.

HIPAA NOTICE - In order to adjudicate a workers' compensation claim, WCL13-a(4)(a) and 12 NYCRR 325-1.3 require health care providers to regularly file medical reports of treatment with the Board and the carrier or employer. Pursuant to 45 CFR 164.512 these legally required medical reports are exempt from HIPAA's restrictions on disclosure of health information.

Instructions for Completing Section D, E and F

Section D. Maximum Medical Improvement
Section D includes questions regarding maximum medical improvement (MMI). For the definition of MMI, see Chapter 1.2 of the 2012 Guidelines. A provider who finds that the patient has met MMI should so indicate and provide the approximate date of such finding (Question 1). A provider who determines that the patient has not yet reached MMI should so indicate (Question 1) and provide an explanation as to why additional improvement is expected and the proposed treatment plan.

Section E. Permanent Impairment/Work Status
Section E includes questions regarding permanent impairment/work status. A provider who finds that there is no permanent impairment (Question 1) should not file this form and use Form C-4.2 (Dr's. Progress Report). For more information on evaluating impairment, see Chapter 9.2 of the 2012 Guidelines.

A provider should complete either 1a. (Schedule loss of use of member or facial disfigurement) or 1b. (Non-Schedule losses). A provider should complete Question 2 pertaining to the patient's work status.

1a. Schedule loss of use of member or facial disfigurement. A provider should determine impairment % using the impairment guidelines in Chapters 2-8. If this is a Scheduled loss, Section F., Functional Capabilities/Exertional Abilities, should not be completed. A provider should sign the Board Authorization at the bottom of page 2 and return to the Workers' Compensation Board.

1b. Non-Schedule loss. If this is a Non-schedule loss, a provider should record the body part, impairment table and severity letter grade for each body part or system. A provider should also state the history, physical findings, and diagnostic test results that support the impairment finding. If the patient has a non-schedule impairment of a body part or system that is not covered by an impairment guideline, the provider should follow Chapter 17 and include the relevant history, physical findings, and diagnostic test results, but no severity letter grade.

In addition, if this is a Non-schedule loss, a provider should complete Section F, Functional Capabilities/Exertional Abilities. A provider should complete Section F based on the patient's current condition if they believe there is MMI and/or permanent impairment or in a response to a request by the Board to render a decision on MMI and/or permanent impairment.

Section F. Functional Capabilities/Exertional Abilities
Section F includes questions applicable to a patient who has reached MMI and has a permanent, non-schedule impairment. For more information on evaluating functional capabilities, see Chapter 9.2 of the 2012 Guidelines. A provider should measure and record the specific functional abilities and losses caused by the work-related medical impairment on Questions 1 through 5 as follows:

Question 1 - The provider should rate whether the patient can perform each of the fifteen functional abilities never, occasionally, frequently, or constantly. The provider should note the specific weight tolerances for the categories lifting/carrying and pulling/pushing. There is also room to describe any functional limitations in connection with environmental conditions (e.g., occupational asthma). Attach documentation when describing Psychiatric/neuro-behaviorial functional limitations, if applicable to a patient.

Question 2 - The provider should rate the patient's exertional ability according to the federal standards set forth by the Department of Labor.

Question 3 - The provider should note any other medical considerations arising from the permanent injury that are not captured elsewhere in Sections E and F. This includes any restrictions or limitations that may be imposed as a result of medications (e.g., narcotics) taken by the patient or other relevant medical considerations that impact work function.

Question 4 - If Yes, the provider should specifically assess the patient's ability to perform his/her at-injury work activities with restrictions.

Question 5 - If Yes, the provider should attach a detailed explanation if the patient has had an intervening injury or illness that may account for any of the functional restrictions noted in Question 1.

BILLING INFORMATION

Complete all billing information contained on this form. Use continuation Form C-4.1, if necessary. A physician who fully completes an evaluation of permanent impairment, including a full evaluation of functional limitations, on a Form C-4.3 shall be entitled to payment for a Level 5 E&M consultation code (CPT99245). The workers' compensation carrier has 45 days to pay your bill or to file an objection to it. Contact the workers' compensation carrier if you receive neither payment nor an objection within this time period. After contacting the carrier, you may, if necessary, contact the Board's Disputed Bill Unit at 866-750-5157 for information/assistance.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF-INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

All reports are to be filed by sending directly to the Workers' Compensation Board at the address below with a copy sent to the insurance carrier:

Statewide Fax Line: 877-533-0337
OR
NYS Workers' Compensation Board - Centralized Mailing, PO Box 5205, Binghamton, NY 13902-5205

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