

Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form - PAGE 1

BEFORE COMPLETING THIS FORM, PLEASE CAREFULLY REVIEW THE INSTRUCTIONS BEGINNING ON PAGE 3

NOTE: Health care providers shall legibly and accurately complete all sections of this form, limiting their responses to their area of expertise.

1. Insurer Name:	2. Visit/Review Date:	FOR INSURER USE ONLY
3. Injured Employee (Patient) Name:	4. Date of Birth:	5. Social Security #:
6. Date of Accident:	7. Employer Name	8. Initial visit with this physician? <input type="checkbox"/> a) NO <input type="checkbox"/> b) YES

SECTION I CLINICAL ASSESSMENT / DETERMINATIONS

9. No change in Items 9 - 13d since last reported visit. If checked, GO TO SECTION II.

10. Injury/ Illness for which treatment is sought is:
 a) NOT WORK RELATED b) WORK RELATED c) UNDETERMINED as of this date

11. Has the patient been determined to have Objective Relevant Medical Findings? Pain or abnormal anatomical findings, in the absence of objective relevant medical findings, shall not be an indicator of injury and/or illness and are not compensable.
 a) NO b) YES c) UNDETERMINED as of this date

If YES or UNDETERMINED, explain: _____

12. Diagnosis(es): _____

13. Major Contributing Cause: When there is more than one contributing cause, the reported work-related injury must contribute more than 50% to the present condition and be based on the findings in Item 11.

- a) Is there a pre-existing condition contributing to the current medical disorder?
 a₁) NO a₂) YES a₃) UNDETERMINED as of this date
- b) Do the objective relevant medical findings identified in Item 11 represent an exacerbation (temporary worsening) or aggravation (progression) of a pre-existing condition?
 b₁) NO b₂) exacerbation b₃) aggravation b₄) UNDETERMINED as of this date
- c) Are there other relevant co-morbidities that will need to be considered in evaluating or managing this patient?
 c₁) NO c₂) YES
- d) Given your responses to the Items above, is the injury/illness in question the major contributing cause for:
 d₁) NO d₂) YES the reported medical condition?
 d₃) NO d₄) YES the treatment recommended (management/treatment plan)?
 d₅) NO d₆) YES the functional limitations and restrictions determined?

SECTION II PATIENT CLASSIFICATION LEVEL

- 14. LEVEL I -** Key issue: specific, well-defined medical condition, with clear correlation between objective relevant physical findings and patients' subjective complaints. Treatment correlates to the specific findings.
- 15. LEVEL II -** Key issue: regional or generalized deconditioning (i.e. deficits in strength, flexibility, endurance, and motor control. Treatment: physical reconditioning and functional restoration.
- 16. LEVEL III -**Key issue: poor correlation between patient's complaints and objective, relevant physical findings, indicating both somatic and non-somatic clinical factors. Treatment: interdisciplinary rehabilitation and management.
- 17. LEVEL UNDETERMINED AS OF THIS DATE.**

SECTION III MANAGEMENT / TREATMENT PLAN

- 18. No clinical services indicated at this time.** If checked, GO TO SECTION IV
- 19. No change in Items 20a - 20g since last report submitted.** If checked, GO TO SECTION IV
- 20. The following proposed, subsequent clinical service(s) is/are deemed medically necessary.**
***** THIS IS A PROVIDER'S WRITTEN REQUEST FOR INSURER AUTHORIZATION OF TREATMENT OR SERVICES. *****
 - a) Consultation with or referral to a specialist. Identify principal physician: _____
Identify specialty & provide rationale:
 a₁) CONSULT ONLY a₂) REFERRAL & CO-MANAGE a₃) TRANSFER CARE
 - b) Diagnostic Testing: (Specify) _____
 - c) Physical Medicine. Check appropriate box and indicate specificity of services, frequency and duration below:
 c₁) Physical/Occupational therapy, Chiropractic, Osteopathic or comparable physical rehabilitation.
 c₂) Physical Reconditioning (Level II Patient Classification)
 c₃) Interdisciplinary Rehabilitation Program (Level III Patient Classification)
Specific instruction(s): _____
 - d) Pharmaceutical(s) (specify): _____
 - e) DME or Medical Supplies: _____
 - f) Surgical Intervention - specify procedure(s): _____
 f₁) In-Office: _____
 f₂) Surgical Facility: _____
 f₃) Injectable(s) (e.g. pain management): _____
 - g) Attendant Care: _____

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Patient Name: _____ Soc.Sec.#: _____ D/A: _____ Visit/Review Date: _____

SECTION IV FUNCTIONAL LIMITATIONS AND RESTRICTIONS

Assignment of limitations or restrictions must be based upon the injured employee's specific clinical dysfunction or status related to the work injury. However, the presence of objective relevant medical findings does not necessarily equate to an automatic limitation or restriction in function.

- 21 No functional limitations identified or restrictions prescribed as of the following date: _____.
- 22. The injured workers' functional limitations and restrictions, identified in detail below, are of such severity that he/she cannot perform activities, even at a sedentary level (e.g. hospitalization, cognitive impairment, infection, contagion), as of the following date: _____. *Use additional sheet if needed.*
- 23. The injured worker may return to activities so long as he/she adheres to the functional limitations and restrictions identified below. Identify ONLY those functional activities that have specific limitations and restrictions for this patient. Identify joint and/or body part _____. *Use additional sheet if needed.*

Functional Activity	Load	Frequency & Duration	ROM/ Position & Other Parameters
<input type="checkbox"/> Bend			
<input type="checkbox"/> Carry			
<input type="checkbox"/> Climb			
<input type="checkbox"/> Grasp			
<input type="checkbox"/> Kneel			
<input type="checkbox"/> Lift-floor > waist			
<input type="checkbox"/> Lift-waist>overhead			
<input type="checkbox"/> Pull			
<input type="checkbox"/> Push			
<input type="checkbox"/> Reach-overhead			
<input type="checkbox"/> Sit			
<input type="checkbox"/> Squat			
<input type="checkbox"/> Stand			
<input type="checkbox"/> Twist			
<input type="checkbox"/> Walk			
<input type="checkbox"/> _			
<input type="checkbox"/> Other			

COMMENTS:

Other choices; Skin Contact/ Exposure; Sensory; Hand Dexterity; Cognitive; Crawl; Vision; Drive/Operate Heavy Equipment; Environmental Conditions: heat, cold, working at heights, vibration; Auditory; Specific Job Task(s); etc.

NOTE: Any functional limitations or restrictions assigned above apply to both on and off the job activities, and are in effect until the next scheduled appointment unless otherwise noted or modified prior to the appointment date.

Specify those functional limitations and restrictions, in Item 23, which are permanent if MMI / PIR have been assigned in Item 24.

SECTION V MAXIMUM MEDICAL IMPROVEMENT / PERMANENT IMPAIRMENT RATING

- 24. Patient has achieved maximum medical improvement?
 - a) YES, Date: _____
 - b) NO
 - c) Anticipated MMI date: _____
 - d) Anticipated MMI date cannot be determined at this time. Future Medical Care Anticipated: e) Yes f) No
- Comments: _____
- 25. _____ % Permanent Impairment Rating (body as a whole) Body part/system: _____
- 26. Guide used for calculation of Permanent Impairment Rating (based on date of accident - see instructions):
 - a) 1996 FL Uniform PIR Schedule
 - b) Other, specify _____
- 27. Is a residual clinical dysfunction or residual functional loss anticipated for the work-related injury?
 - a) YES
 - b) NO
 - c) Undetermined at this time.

SECTION VI FOLLOW-UP

28. Next Scheduled Appointment Date & Time: _____

SECTION VII ATTESTATION STATEMENT

"As the Physician, I hereby attest that all responses herein have been made, in accordance with the instructions as part of this form, to a reasonable degree of medical certainty based on objective relevant medical findings, are consistent with my medical documentation regarding this patient, and have been shared with the patient."

Physician Group: _____ Date: _____
 Physician Signature: _____ Physician DOH License #: _____
 Physician Name: _____ (print name) Physician Specialty: _____

If any direct billable services for this visit were rendered by a provider other than a physician, please complete sections below:

"I hereby attest that all responses herein relating to services I rendered have been made, in accordance with the instructions as part of this form, to a reasonable degree of medical certainty based on objective relevant medical findings, are consistent with my medical documentation regarding this patient, and have been shared with the patient."

Provider Signature: _____ Provider DOH License #: _____
 Provider Name: _____ (print name) Date: _____

FORM DFS-F5-DWC-25

COMPLETION/SUBMISSION INSTRUCTIONS

GENERAL INFORMATION

The Form DFS-F5-DWC-25 has been adopted by the Florida Division of Workers' Compensation in Rule 69L-7.602, F.A.C., as the required reporting form for physicians to recommend medical treatment/ services and report the medical status of the injured employee to insurers/employers including the establishment of the date of maximum medical improvement and assignment of permanent impairment rating, when applicable, pursuant to Sections 440.13(4)(a) and 440.15(3)(d), F.S. The Form DFS-F5-DWC-25 shall be submitted by the provider to the insurer, and to the employer upon request, upon the occurrence of any actionable event (change in treatment plan, regime, therapies, prescriptions, or functional limitations or restrictions), and following the injured employee achieving maximum medical improvement, in accordance with the conditions and timeframes established in this rule. In instances where the form is submitted without the occurrence of any actionable event, receipt of new information or patient re-examination, it is anticipated that the provider will submit the form reflecting an unchanged patient status. No Form DFS-F5-DWC-25 shall be required in the instances defined in the Completion Exemptions section of these instructions.

Insurers/employers and providers shall utilize only the Form DFS-F5-DWC-25 for physician reporting of the injured employee's medical treatment/status. Any other reporting forms may not be used in lieu of or supplemental to the Form DFS-F5-DWC-25.

Accurate completion of the Form DFS-F5-DWC-25 and the terms used herein do not create any access to medical services or alter any conditions associated with the provision or reimbursement of medical services other than as allowed in Section 440.13, F.S.

No reimbursement shall be made for completion of the Form DFS-F5-DWC-25. The Form DFS-F5-DWC-25 is the exclusive form to be used when reporting establishment of the date of maximum medical improvement and assignment of an impairment rating. It is the physician's primary responsibility in treating the injured employee to apply provisions of Sections 440.09 and 440.13, F.S. when:

- a. Evaluating an injury or illness,

- b. Ordering, prescribing or rendering remedial treatment care or attendance, and
- c. Assigning functional limitations or restrictions.

COMPLETION GUIDELINES

Physicians completing the Form DFS-F5-DWC-25 must apply the following guidelines:

- Accurate completion and submission of the Form DFS-F5-DWC-25 does not fulfill the provider requirement to obtain prior insurer approval and authorization for referrals, consultations, treatment plans, and/or other medically necessary services.
- Accurate completion and submission of the Form DFS-F5-DWC-25 is in addition to medical billing forms required pursuant to this rule.
- The Form DFS-F5-DWC-25 does not replace physician notes, medical records or required medical billing reports.
- Physician notes, medical records, or other relevant diagnostic tests and evaluations must be consistent with all information submitted on the Form DFS-F5-DWC-25, and shall document additional details of the medical services rendered to the injured employee.
- A copy of the Form DFS-F5-DWC-25 shall become part of the permanent medical records of the injured employee retained by the physician.
- Physicians shall provide a copy of the accurately completed Form DFS-F5-DWC-25 to the employer, upon request.

COMPLETION REQUIREMENTS

Providers required to complete the Form DFS-F5-DWC-25 are as follows:

- All physicians, including physician assistants and advanced registered nurse practitioners (ARNPs) under the supervision of a physician, who provide direct billable services immediately following the reported work related injury, regardless of location.
- Physicians providing preliminary treatment, care or attendance in the emergency room of a hospital licensed under Chapter 395, F.S. shall be required to accurately complete Items 1-8, 10, 11, 12, Section IV, and sign the Attestation Statement in Section VII.

If a non-treating physician certifies MMI/PIR, that physician must report on the Form DFS-F5-DWC-25 such determinations to the treating physician, the insurer and the employee, within ten calendar days of the visit.

The principal treating physician shall report the date of maximum medical improvement (MMI), including any physical limitations, and permanent impairment rating on the Form DFS-F5-DWC-25 and provide a copy to the injured employee within three business days following the visit, the insurer, and to the employer upon request by close of business on the next business day following the visit.

- Item 24 – Applies to all dates of accident. Item 24 shall be accurately completed by checking the appropriate box to indicate the physician:

24a – can determine a date MMI has been achieved. If checked, the MMI date must be entered in the space provided and either 24e or 24f must be checked, to indicate the determination of anticipated future medical care.

24b – can determine MMI has not been achieved.

24c – can determine the anticipated the date MMI will be achieved. Date of anticipated MMI must be entered in the space provided.

24d – cannot anticipate the date MMI will be achieved.

24e – Check only if MMI has been established, PIR assigned and the physician has determined with a high-degree of medical certainty, that the patient WILL require future medical care or treatment which is directly attributed to the work-related injury identified in Item 6. Anticipated future medical care shall be indicated by completing applicable items in Section III – Management/Treatment Plan and detailed in the physician’s complete written medical report.

24f – Check only if MMI has been established, PIR assigned and the physician has determined with a high-degree of medical certainty, that the patient WILL NOT require any future medical care or treatment which is directly attributed to the work-related injury identified in Item 6.

- Item 25 – Both percent of permanent impairment and body part/system shall be completed if MMI has been established and PIR assigned. The permanent impairment percentage shall be

calculated to the body as a whole. Enter the body part or system involved in calculating the permanent impairment rating. *Use an extra sheet if necessary.*

The Permanent Impairment Rating (PIR) Guides shown below are to be utilized by the physician to calculate the injured employee's permanent impairment rating pursuant to Rule 69L-7.604, F.A.C. The physician shall check Item 26a when using the 1996 FL Uniform PIR Schedule to determine the impairment rating. If any other impairment-rating guide is used, the physician shall check Item 26b and enter the name of the appropriate guide. Additionally, the physician must include documentation in the medical record to indicate which guide was used to calculate the permanent impairment rating.

For dates of accident:

Prior to and through 6/30/90	AMA Guide
7/1/90 through 10/31/92	Minnesota Disability Schedules
11/1/92 through 1/6/97	1993 FL Impairment Guide
1/7/97 to present	1996 FL Uniform Permanent Impairment Rating Schedule

- Item 26 – The guide used for calculation of Permanent Impairment Rating shall be identified.
26a – Check box if the 1996 FL Uniform PIR Schedule was used to calculate PIR.
26b – Check box and identify from the list above by writing the name of the impairment rating schedule used to calculate PIR.
- Item 27 – Either Item 27a , Item 27b or Item 27c shall be checked based on the physician's anticipation of residual clinical dysfunction or residual functional loss related to the work injury.

SECTION VI – FOLLOW UP

- Item 28 – Enter the scheduled appointment date and time for the patient to return for follow up care. If no appointment is pre-determined, provide brief explanation such as, “as needed” “discharged from care”, “transfer”, etc.

SECTION VII – ATTESTATION STATEMENT

- The Principal/Consulting/Referral Physician authorized to provide remedial care and treatment for the injured employee must accurately complete the ‘Physician Group’, ‘Date’, ‘Signature’, ‘License Number’, ‘Printed Name’ and ‘Physician Specialty’ areas of this section on all Forms DFS-F5-DWC-25 prepared by the physician or under his/her direction.

- If a provider other than a physician rendered any direct billable services for this visit, the non-physician licensed provider must accurately complete the ‘Signature’, ‘License Number’, ‘Printed Name’ and ‘Date’ areas of this section. If only the Principal/Consulting/Referral Physician provided direct billable services, enter ‘N/A’ to indicate not applicable.