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:	5. FOR INSURER USE ONLY
3. Injured Employee (Patient) Name:	4. Date of Birth:	
6. Date of Accident:	7. Employer Name	8. Initial visit with this physician? ☐ a) NO ☐ 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?
☐ a_1) NO ☐ a_2) YES ☐ a_3) 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?
☐ b_1) NO ☐ b_2) exacerbation ☐ b_3) aggravation ☐ b_4) UNDETERMINED as of this date
c) Are there other relevant co-morbidities that will need to be considered in evaluating or managing this patient?
☐ c_1) NO ☐ c_2) YES
d) Given your responses to the Items above, is the injury/illness in question the major contributing cause for:
☐ d_1) NO ☐ d_2) YES the reported medical condition?
☐ d_3) NO ☐ d_4) YES the treatment recommended (management/treatment plan)?
☐ d_5) NO ☐ d_6) 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:
☐ a_1) CONSULT ONLY ☐ a_2) REFERRAL & CO-MANAGE ☐ a_3) TRANSFER CARE

☐ b) Diagnostic Testing: (Specify)

☐ c) Physical Medicine. Check appropriate box and indicate specificity of services, frequency and duration below:
☐ c_1) Physical/Occupational therapy, Chiropractic, Osteopathic or comparable physical rehabilitation.
☐ c_2) Physical Reconditioning (Level II Patient Classification)
☐ c_3) 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):
☐ f_1) In-Office:
☐ f_2) Surgical Facility:
☐ f_3) Injectable(s) (e.g. pain management):

☐ g) Attendant Care:

Florida Workers' Compensation Uniform Medical Treatment/Status Reporting Form - PAGE 2

Patient Name: **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
☐ Bend			
☐ Carry			
☐ Climb			
☐ Grasp			
☐ Kneel			
☐ Lift-floor > waist			
☐ Lift-waist>overhead			
☐ Pull			
☐ Push			
☐ Reach-overhead			
☐ Sit			
☐ Squat			
☐ Stand			
☐ Twist			
☐ Walk			
☐ _			
☐ 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." *"I certify to any MMI / PIR information provided in this form."*

Physician Group: **Date:**

Physician Signature: **Physician DOH License #:**

Physician Name: **Physician Specialty:**

(print name)

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: **Date:**

(print name)

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.

- All principal physicians or physicians accepting consults, referrals or transfers of care (including physician assistants and ARNPs under the supervision of a physician) who provide initial or ongoing treatment, care or independent medical examinations.

COMPLETION EXEMPTIONS

Providers exempt from completing the DFS-F5-DWC-25 are as follows:

- Physicians providing only medical interpretation of diagnostic testing (i.e. radiographic films; lab specimens; electro-myographic findings; electro-encephalogram or electro-cardiogram tracings, etc.) without direct physician-to-patient encounter.
- Physicians performing diagnostic testing (i.e. electro-myography, eletro-nystagmography, injections, etc.) without performing a complete patient examination or evaluation. Examples of such services may be associated with nerve conduction studies, radiological studies, muscle biopsies to obtain specimens, etc.
- Anesthesiologists or ARNPs, under the supervision of a physician, who provide anesthesia services in the presence of an operating surgeon.
- Physicians functioning as a second surgeon or as an assistant surgeon and not as the primary surgeon.

COMPLETION/ SUBMISSION EXCEPTIONS

Physicians providing treatment when the patient is admitted to hospital for greater than 24 hours shall:

  - complete the Form DFS-F5-DWC-25 at the pre-admission office visit for scheduled hospital admissions, or
  - on the date of admission for unscheduled hospitalizations, and
  - upon the date of discharge.

When Form DFS-F5-DWC-25 completion is related to the injured employee's hospital admission (as listed above), the form shall be submitted to the insurer, and the employer upon request, by close of business on the next business day following completion.

- Physicians providing treatment when the patient is participating in an interdisciplinary pain management program, interdisciplinary rehabilitation program or receiving more than three times

weekly physician services (manipulation, wound care, etc.) shall complete the Form DFS-F5-DWC-25 once weekly, instead of following each visit, except when a substantive clinical change or change in functional limitations or restrictions is identified. The physician shall submit the accurately complete Form DFS-F5-DWC-25 to the insurer, and the employer upon request, by close of business on the next business day following completion of the form.

SUBMISSION REQUIREMENTS

Physicians may submit the accurately completed Form DFS-F5-DWC-25 electronically or via facsimile contingent upon insurer agreement. Application of an electronic signature is permitted in lieu of an original physician signature. However, the physician remains responsible for the accuracy and completion of all information submitted and for the attestation statement on the Form DFS-F5-DWC-25. An ink-stamped signature is not an acceptable substitute for an original or electronic signature.

Submission requirements for all physicians certifying maximum medical improvement (MMI) and permanent impairment rating (PIR) are identified in Section V of these instructions under the heading ***Maximum Medical Improvement/Permanent Impairment Rating***.

The Form DFS-F5-DWC-25 shall be submitted to the insurer, and to the employer upon request, as follows:

- All Physicians who provide the first treatment immediately after the reported work-related injury shall submit the accurately completed Form DFS-F5-DWC-25 to the insurer, and to the employer, immediately but no later than three (3) business days after the date of service. This submission requirement must be met in order for the claim for medical or surgical treatment to be valid, pursuant to Section 440.13(4)(a), F.S.
- All **principal, consulting or referral physicians** providing subsequent treatment shall submit to the insurer, and to the employer upon request, the accurately completed Form DFS-F5-DWC-25 by close business of the next business day following each visit or a maximum of 30 days from the date of the prior Form DFS-F5-DWC-25 submission, even when the physician receives no new information since the last visit or does not re-examine the patient. The consulting or referral physician must also submit the Form DFS-F5-DWC-25 to the principal physician if directed to do so by the insurer. 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.

- The **physician accepting the transfer of care** from the principal physician shall accurately complete and submit the Form DFS-F5-DWC-25 to the insurer, and to the employer upon request, by close of business on the next business day following the first visit and following each subsequent visit or a maximum of 30-calendar days from the date of the prior Form DFS-F5-DWC-25 submission. 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.

COMPLETION INSTRUCTIONS

If additional space is required to complete an item on the form, please attach an additional sheet(s) containing the response(s). All additional sheet(s) must contain (in the upper right-hand corner) the injured employee's name, date of birth, date of accident/injury, date of visit or review and the item number to which the response applies.

DEMOGRAPHIC INFORMATION

- Items 1 through 4 and 6 through 8 – All fields must be legibly and accurately completed on the initial Form DFS-F5-DWC-25.
- Items 2, 3, 4, and 6 – Required to be legibly and accurately completed on each subsequent Form DFS-F5-DWC-25.
    - Item 1 – Enter the insurance carrier name.
    - Item 2 – Enter the date applicable to the reason the form is being completed:
        - current date of service, OR
        - date of 30-day review, OR
        - date of change in clinical status/treatment review report (including change in prescription medication).
    - Item 3 – Enter the name of the injured employee: First, middle initial, if applicable, and last.
    - Item 4 – Enter the injured employee's date of birth in MM-DD-CCYY format

- Item 6 – Enter the date of the accident, injury or illness for which treatment, care or attendance is provided.
- Item 7 – Enter the employer's name.
- Item 8 – Check box yes or no as it relates to the date of accident identified in Item 6.

SECTION I – CLINICAL ASSESSMENT

- Item 9 – Check when there is no change in your prior responses to Items 10 through 13d. If checked, proceed to Section II.
- Item 10 – One box must be checked.
    - 10a – If checked, sign the Attestation Statement on the bottom of Page 2 and submit the form.
    - 10b – Check when the injury or illness is related to employment.
    - 10c – Check when, during this visit, the relationship of employment to the injury/illness cannot be determined.

Objective Relevant Medical Findings: Pursuant to Section 440.09(1), F.S., pain or other subjective complaints alone, in the absence of objective relevant medical findings, are not compensable. Further, pursuant to Section 440.13(16)(a), F.S., abnormal anatomical findings alone, in the absence of objective relevant medical findings, shall not be an indicator of an injury or illness, a justification for the provision of remedial medical care, the assignment of restrictions, or a foundation for limitations. Objective relevant medical findings are those objective findings that correlate to the subjective complaints of the injured employee and are confirmed by the physical examination findings or diagnostic testing.

- Item 11 – One box must be checked, regardless of the date of accident.
    - 11a – Check when there is a total lack of objective relevant medical findings that correlate to the patient's chief complaint.
    - 11b – Check if applicable. If checked, enter a brief explanation of the objective relevant medical findings in area provided.
    - 11c – Check if applicable. If checked, enter a brief explanation in the area provided, e.g. pending completion of diagnostic testing.

- Item 12 – Enter the injured worker's work-injury related medical diagnosis(es). Entries are to be descriptive and not identified by ICD diagnosis code, only.

Major Contributing Cause: Pursuant to Section 440.09(1), F.S., when there is more than one cause contributing to a medical disorder, including pre-existing conditions, the work injury must be the major contributing cause for the identified disorder to be compensable. Major contributing cause means the cause that is more than 50% responsible for the injury compared to all other causes combined. Major contributing cause must be demonstrated by medical evidence only.

- Item 13 – One box must be checked in each subsection of Item $13a_1$-$13d_6$, regardless of date of accident.

  13a – Either 'a_1', 'a_2', or 'a_3' must be checked.

  13b – Either 'b_1', 'b_2', 'b_3' or 'b_4' must be checked.

  13c – Either 'c_1'or 'c_2' must be checked.

  13d – Either 'd_1'or 'd_2' must be checked and

  Either 'd_3'or 'd_4' must be checked and

  Either 'd_5'or 'd_6' must be checked.

SECTION II – PATIENT CLASSIFICATION LEVEL

The classification system, which is criteria based, comprises descriptive categories that are provided as a means to promote optimal medical decision-making, accountability and responsible medical claims handling practices. Additionally, the classification system enhances communication between the provider and the insurer, which facilitates the authorization process and the provision of medically necessary care. Proper classification of the patient is intended to:

a. Convey to insurers the complexity of services that may be required for optimal clinical management;
b. Distinguish the overall critical differences among cases that influence the intensity, scope, and cost of services provided;
c. Facilitate recognition of three varying clinical configurations that affect the medical treatment plan and treatment progress or other available benefits for an injured employee;

d. Assist the insurer in decisions related to authorization of recommended treatment plans or treatment plan revisions;

e. Ensure that on-going treatment plans and authorized reimbursable services are consistent with a high intensity, short duration treatment approach which focuses on specific clinical dysfunction, before authorization is made to a provider.

Physicians shall correlate the documented physiologic or clinical problem identified on initial examination or reassessment with the appropriate patient classification level and shall provide the insurer with the type, intensity and duration of evaluation and management services or recommended treatment plans (including consultations, referrals, diagnostic testing, physical medicine regimens, surgical, pharmaceutical or other medical interventions) for which authorization is required.

- Item 14 – 17 At least one box must be checked, regardless of date of accident.

The following ***examples*** are offered to illustrate the application of the Patient Classification Levels:

Level I

There are well-defined, objective relevant medical findings (abnormal physiology) that are consistent with the patients' subjective complaints and/or reported functional disturbances. Therefore, specific findings will correlate with prescribed treatment interventions (e.g., exercise, physical agents, pharmaceuticals, surgical repair).

- Complaints of knee pain secondary to a knee sprain with swelling, specific joint laxity and restrictions, muscle guarding, abnormal patella mechanics. Potential treatment could be physical therapy, surgery, bracing, etc.
- Complaints of intermittent back and leg pain secondary to a lumbar internal derangement (discogenic lesion) with lumbar lateral shift, palpable muscle guarding of the lumbar paravertebral musculature, positive neurology (dural signs, specific sensory disturbance, select motor deficits, specific reflex changes), characterized by specific and bio-mechanically consistent patterns of movements or activities that provoke or alleviate symptoms. Treatment options could include an extension-based rehabilitation regime, manipulation, NSAIDs, microdiscectomy, epidural steroid injections, etc.

Level II

Level I clinical findings may (or may not) still be present, but the more compelling clinical issue is regional or systemic musculoskeletal deficits or imbalances, involving strength, flexibility, endurance, or motor control (coordination).

- A post-op lumbar fusion or rotator cuff repair patient, with or without prolonged immobilized, now needing an intensive, prolonged physical reconditioning program to normalize the clinical mechanics and restore functional levels.
- A sub-acute lumbar disc or knee ACL patient whose functional capability has been lowered substantively by his clinical condition, or is below that required for his current or targeted work, and therefore requires more extensive physical reconditioning and specific functional restoration.
- A patient who has other health related issues (i.e. obesity, vascular or pulmonary compromise) that are impeding recovery, rehabilitation, and functional restoration.

Level III

Level I clinical findings may (or may not) still be present, and Level II physical deconditioning deficits are typically, but not always, still an issue. The more compelling clinical issue is poor correlation between the patients' complaints and the objective, relevant physical findings, thereby indicating both somatic and non-somatic (i.e. psychological, vocational, legal) clinical factors. As there is a multi-faceted problem, treatment should be interdisciplinary rehabilitation and management.

- A chronic pain patient
- A post-op spine patient who has to return to a physically demanding occupation and whose emotional concerns and fears have impeded progress or response to treatment.
- A poorly-defined low back pain patient who has had multiple medical opinions regarding the proper course of treatment, or even the specific nature and extent of the illness, thereby resulting in dispute, litigation, delayed recovery and difficulties in return to work.

In summary, properly assigned Patient Classification Levels will correlate with the key indicators, identified as level specific, in the chart below:

Key clinical driver	**Level I**	**Level II**	**Level III**
Somatic - specific dysfunction	**YES**	Y or N	Y or N
Somatic - deconditioning	N	**YES**	Y or N
Non-somatic – pain, psych, voc	N	N	**YES**

SECTION III – MANAGEMENT / TREATMENT PLAN

The accurate completion of this section and submission of the Form DFS-F5-DWC-25 constitutes a provider's written request for insurer authorization of treatment or services. Insurers are responsible to provide a response pursuant to Section 440.13(3), F.S.

- Item 18 – Check only if the injured worker has no anticipated need for on-going medical services, including pharmaceutical management of a condition. If checked, MMI must be established and PIR assigned. If checked, proceed to Section IV.
- Item 19 – Check only when there is no change in your prior responses to Items 20a – 20g. If checked, proceed to Section IV.
- Item 20 – At least one box must be checked if neither Item 18 nor Item 19 is checked. All appropriate boxes shall be checked and written entries completed, as applicable, based on physician recommendation(s), regardless of date of accident. The principal physician, maintaining overall management of the care, must be specified in the space provided.

    20a – Check only for consultation with or referral to a specialist. If checked, only specify the consulting/referral physician's specialty.

    $20a_1$ – Check when requesting a single visit for consultative services only. General management, oversight and coordination of care will remain the responsibility of the principal physician.

    $20a_2$ – Check when requesting a specialist to evaluate the patient and provide treatment/management of a specific clinical problem. General management, oversight and coordination of care will remain the responsibility of the principal physician.

    $20a_3$ – Check when requesting a transfer of care to another physician. Enter the name of the specialist accepting the transfer of care in the space labeled 'Identify principal physician'. When checked, the current provider is indicating he/she will no longer provide care or treatment to the injured worker (patient).

    20b – If checked, itemize the diagnostic test(s) needed.

20c – If checked, must check 'c_1', 'c_2' or 'c_3'. A written entry is required in the space labeled "Specific Instruction(s)".

20d – If checked, must list specific drugs or pharmaceutical products.

20e – If checked, must list specific durable medical equipment or medical supplies, including quantity.

20f – If checked, must check 'f_1', 'f_2' or 'f_3'. A written entry is required that specifies the recommended procedure(s) CPT codes may be listed in place of or in accompaniment to the description of procedures.

20g – If checked, must indicate the professional level of attendant care, frequency and duration.

SECTION IV – DETERMINATION OF FUNCTIONAL LIMITATIONS AND RESTRICTIONS

The determination of functional limitations and restrictions under this section is intended to provide information to the employer/insurer regarding modifications that may be needed to the injured employee's work activity or assignment. If MMI/PIR has been assigned, the physician MUST indicate when functional limitation(s) or restriction(s) are permanent.

- Item 21 – Check box only if the injured employee is identified as having no functional limitations and no work restrictions are prescribed at this visit. If checked, the effective date of release to work without restrictions must be entered in the space provided.
- Item 22 – Check box only if the injured employee cannot perform work, even at a sedentary level. If checked, detailed written entry is required in the applicable spaces labeled: Load, Frequency & Duration, and ROM (Range of Motion)/Position & Other Parameters. If checked, the effective date of restrictions and limitations must be entered in the space provided. When completed during a hospital pre-admission visit, indicate "hospital admission" and enter the anticipated date of hospitalization in the date area. The date entered must be equal to or greater than the date of form completion.
- Item 23 – Check box only if the injured employee may return to work with limitations and restrictions as identified below. Written entry is required to identify the specific joint or body part

effected, as applicable. If checked, each applicable Functional Activity must be checked and followed by detailed written entry in the applicable spaces labeled: Load, Frequency & Duration, and ROM/Position & Other Parameters.

List *only* functional limitation(s) and restriction(s), i.e. those activities, movements, postures/positions, or environments, and to what extent, the injured employee should modify.

Use an extra sheet if additional space is needed.

Example #1

☐ 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 or restrictions for this patient. Identify joint and/or body part _____. Use additional sheet if needed.

Functional Activity	Load	Frequency & Duration	ROM/ Position & Other Parameters
☐ Stand	N/A	No > 30min per/bout to next visit	5-10min break between bouts (sit/lie/self-stretch)
☐ Walk			

Example #2

Functional Activity	Load	Frequency & Duration	ROM/ Position & Other Parameters
☐ Kneel			
☐ Lift-floor > waist	No > 40 lbs	3-5 lifts per/hr for next 2 wks	Use leg lift, maintain lordosis (lumbar curve)
☐ Reach-overhead			

Example #3

Functional Activity	Load	Frequency & Duration	ROM/ Position & Other Parameters
☐ Bend			
☐ Squat	N/A	Prohibited - permanent	Replace with sit, kneel, or half-kneel
☐ Other			

Example #4

Functional Activity	Load	Frequency & Duration	ROM/ Position & Other Parameters
☐ Squat			
☐ Other - R Shldr Elev	N/A	Prohibited to next visit	No >90deg.R. Shldr flex or abd - active or passive
☐ Other			

Example #5

Functional Activity	Load	Frequency & Duration	ROM/ Position & Other Parameters
☐ Squat			
☐ Other-Wound Contact	N/A	Prohibited to next visit	Avoid dirt, water, excessive heat/cold
☐ Other			

Example #6

Functional Activity	Load	Frequency & Duration	ROM/ Position & Other Parameters
☐ Squat			
☐ Other- Cognitive deficit	N/A	Permanent	See Attached Sheet
☐ Other			

Example of additional sheet:

Patient Name: John Doe
Date of Birth: MM-DD-CCYY
Date of Accident: 1-1-05
Date of Service: 1-3-05

Item 23.
Cognitive Dysfunction - Cannot: follow written instructions, perform multi-tasking activities or perform calculations; requires frequent supervision.

Note: Limitations and restrictions will be applied as documented. If there are any applicable ***global activity*** restrictions, in conjunction with specific functional activity limitations and restrictions, regarding the injured employee's overall work schedule, please specify in the 'Frequency & Duration' section. *If additional space is needed, enter details in the 'Comments' section or attach an extra sheet.*

Sample limitations and restrictions for global activities:

- no more than 4 hours per day for the next 3 weeks
- no more than 3 days per week (alternating with days off) until the next visit
- may not work during non-daylight hours – permanent

SECTION V – MAXIMUM MEDICAL IMPROVEMENT/PERMANENT IMPAIRMENT RATING

Pursuant to Section 440.15(3)(d)1, F.S., which applies to all dates of accident, a physician shall establish the date of maximum medical improvement, including determination of any permanent physical limitations or activity restrictions, and shall assign a permanent impairment rating for the work injury. All physicians involved in the care of any injured employee for a specific work related injury shall accurately complete Section V on the Form DFS-F5-DWC-25. When multiple physicians are involved and certify MMI /PIR, each physician shall independently complete and send the Form DFS-F5-DWC-25 to the injured employee within three business days following the visit, and to the principal treating physician, the insurer, and the employer upon request, by close of business on the next business day following the visit.

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.