Doctor's Report of MMI/Permanent Impairment

C-4.3

State of New York - Workers' Compensation Board

Use this form when a patient has reached *Maximum Medical Improvement* and to render an opinion on permanent impairment, if any. (To report the first time you treated the patient, use Form C-4. For continuing treatment, use Form C-4.2.)

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.state.ny.us.

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

A. Patient's Information

1. Name:_____ (Last / First / MI) 2. Date of injury/illness: _____/_____/_____ 3. Soc. Sec. #: ___-___-_____

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

5. Patient's Account #: _____

B. Doctor's Information

1. Your name: _____ (Last / First / 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) _____ _____

Relate ICD9 codes in (1) or (2) 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)
$	$	$

D. Permanent Impairment/Work Status

1. Has the patient reached Maximum Medical Improvement? ☐ Yes ☐ No If yes, provide the date patient reached MMI:_____/_____/_____

2. Is there permanent impairment? ☐ Yes ☐ No If yes, check the boxes that apply:

☐ Schedule loss of use of member: *(Identify impairment rating according to NY Impairment Guidelines and attach separate sheet for additional body parts.)*

Body part: _____ Impairment: %_____

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

Describe findings and relevant diagnostic test results: _____

_____

_____

Explain how impairment % was determined: _____

_____

_____

☐ Disfigurement: (Describe findings) _____

_____

_____

☐ Non-Schedule losses: *(Identify impairment rating according to NY Impairment Guidelines. Attach separate sheet for additional body parts.)*

Body part: _____ Impairment: %_____

Describe findings and relevant diagnostic test results: _____

_____

_____

Explain how impairment % was determined: _____

_____

_____

☐ For multiple impairments from an injury/illness:

a. Combined aggregate impairment: %_____

b. Explain how % was determined: _____

_____

_____

3. Is patient working now? ☐ Yes at the pre-injury job ☐ Yes at other employment ☐ Not working

4. Does the patient have work limitations? ☐ Yes ☐ No If yes, check all of the following that apply:

☐ Bending/twisting	☐ Lifting	☐ Sitting
☐ Climbing stairs/ladders	☐ Operating heavy equipment	☐ Standing
☐ Environmental conditions	☐ Operation of motor vehicles	☐ Use of public transportation
☐ Kneeling	☐ Personal protective equipment	☐ Use of upper extremities

☐ Other (explain): _____

Describe/quantify the limitations: _____

_____

5. With whom have you discussed patient's returning to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A

6. Would 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

MEDICAL REPORTING

IMPORTANT - TO THE ATTENDING DOCTOR

1. This form is to be used to file reports in workers' compensation, volunteer firefighters' or volunteer ambulance workers' benefit cases as follows:

   When your patient has reached Maximum Medical Improvement and to render an opinion on permanent impairment, if any.

   All reports are to be filed with the Workers' Compensation Board, the workers' compensation insurance carrier, self-insured employer, and if the patient is represented by an attorney or licensed representative, with such representative. If the claimant is not represented, a copy must be sent to the claimant.

   Ophthalmologists use form C-5, Occupational/Physical Therapists use form OT/PT-4 and Psychologists use form PS-4 for filing reports.

2. 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.
3. This form must be signed by the attending doctor and must contain her/his authorization certificate number, code letters and NPI number.
4. **LIMITATION OF PODIATRY TREATMENT** - Podiatry treatment is limited as defined in Section 7001 of the Education Law and Section 13-k(2) of the Workers' Compensation Law.
5. **LIMITATION OF CHIROPRACTIC TREATMENT** - Chiropractic treatment is limited as defined in Section 6551 of the Education Law and the Chair's Rules Relative to Chiropractic Practice Under Section 13-l of the Workers' Compensation Law.

   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.
6. **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.

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.

BILLING INFORMATION

Complete all billing information contained on this form. Use continuation Form C-4.1, if necessary. 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 the Albany address indicated below, for information/assistance.

IMPORTANT - TO THE PATIENT

YOUR DOCTORS' BILLS (AND BILLS FOR HOSPITALS AND OTHER SERVICES OF A MEDICAL NATURE) WILL BE PAID BY YOUR EMPLOYER, THE LIABLE POLITICAL SUBDIVISION OR ITS INSURANCE COMPANY OR THE UNAFFILIATED VOLUNTEER AMBULANCE SERVICE IF YOUR CLAIM IS ALLOWED. DO NOT PAY THESE BILLS YOURSELF, UNLESS YOUR CASE IS DISALLOWED OR CLOSED FOR FAILURE TO PROSECUTE.

IF YOU HAVE ANY QUESTIONS CONCERNING THIS NOTICE OR YOUR CASE, OR WITH RESPECT TO YOUR RIGHTS UNDER THE WORKERS' COMPENSATION LAW, OR THE VOLUNTEER FIREFIGHTERS' OR VOLUNTEER AMBULANCE WORKERS' LAWS, YOU SHOULD CONSULT THE NEAREST OFFICE OF THE BOARD FOR ADVICE. **ALWAYS USE THE CASE NUMBERS SHOWN ON THE OTHER SIDE OFTHIS NOTICE,** OR ON OTHER PAPERS RECEIVED BY YOU, IF YOU FIND IT NECESSARY TO COMMUNICATE WITH THE BOARD OR THE CARRIER. ALSO, MENTION YOUR SOCIAL SECURITY NUMBER IF YOU WRITE OR CALL THE BOARD.

IMPORTANTE PARA EL PACIENTE

LAS FACTURAS POR SERVICIOS MEDICOS INCLUYENDO HOSPITALES Y TODO SERVICIO DE NATURALEZA MEDICA SERA PAGADO POR EL PATRONO O POR LA ENTIDAD RESPONSABLE O SU COMPANIA DE SEGUROS SEGUN SEA EL CASO; SI SU RECLAMACION ES APROBADA. NO PAGUE ESTAS FACTURAS A MENOS QUE SU CASO SEA DESESTIMADO EN SU FONDO O ARCHIVADO POR NO REALIZAR LOS TRAMITES CORRESPONDIENTES.

SI USTED TIENE ALGUNA PREGUNTA, EN RELACION A ESTA NOTIFICACION O A SU CASO O EN RELACION A SUS DERECHOS BAJO LA LEY DE COMPENSACION OBRERA O LA LEY DE BOMBEROS VOLUNTARIOS O LA LEY DE SERVICIOS DE AMBULANCIAS VOLUNTARIOS DEBE COMUNICARSE CON LA OFICINA MAS CERCANA DE LA JUNTA PARA ORIENTACION. SIEMPRE USE EL NUMERO DEL CASO QUE APARECE EN LA PARTE DEL FRENTE DE ESTA NOTIFICACION, O EN OTROS DOCUMENTOS RECIBIDOS POR USTED. SI LE ES NECESARIO COMUNICARSE CON LA JUNTA O CON EL "CARRIER."

TAMBIEN MENCIONE EN SU COMUNICACION ORAL O ESCRITA SU NUMERO DE SEGURO SOCIAL.

WORKERS' COMPENSATION BOARD DISTRICT OFFICES

Reports should be filed by sending directly to the appropriate WCB district office (DO) at the address below with a copy sent to the insurance carrier:

Albany DO - 100 Broadway-Menands, Albany NY 12241 866-750-5157 (for accidents in the following counties: Albany, Clinton, Columbia, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Ulster, Warren, Washington)
Binghamton DO - State Office Building, 44 Hawley Street, Binghamton NY13901 866-802-3604 (for accidents in the following counties: Broome, Chemung, Chenango, Cortland, Delaware, Otsego, Schuyler, Sullivan, Tioga, Tompkins)
Buffalo DO - 369 Franklin Street, Buffalo NY 14202 866-211-0645 (for accidents in the following counties: Cattaraugus, Chautauqua, Erie, Niagara)
Rochester DO - 130 Main Street West, Rochester NY 14614 866-211-0644 (for accidents in the following counties: Allegany, Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Steuben, Wayne, Wyoming, Yates)
Syracuse DO - 935 James Street, Syracuse NY 13203 866-802-3730 (for accidents in the following counties: Cayuga, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego,St. Lawrence)
Downstate Centralized Mailing - PO Box 5205, Binghamton NY, 13902-5205 for all DO's in NYC 800-877-1373; in Hempstead 866-805-3630; in Hauppauge 866-681-5354; in Peekskill 866-746-0552 (for accidents in the following counties: Bronx, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Westchester)

Statewide Fax Line: 877-533-0337