

## Physician's Report of Work Ability (MEDCO-14)

## Instructions

- Use this form to provide detailed information about the injured worker's ability to work. Add comments to Section 4 or attach additional information as necessary. BWC uses the information to support a request for temporary total compensation.
- The treating physician must submit this form each time they see the injured worker unless they:
  - o Have been awarded permanent and total disability.
  - o Have returned to work without restrictions within seven days of the injury.
  - Are being treated after the treating physician has released them to their former position of employment (i.e., full duty job) held on the date of injury without restrictions.
- While you may use an equivalent physician-generated document (e.g., office notes, treatment plan) to the MEDCO-14, it must contain, at a minimum, the required data elements. If you've previously submitted equivalent data, indicate the date of the report on the form (e.g., 5/15/2021, office note).

**Note:** Physician assistants and nurse practitioners may complete this form; however, they may only certify temporary disability for the first six weeks after the date of injury. Subsequent periods of temporary disability require a co-signature by the treating physician.

- Fax form to the managed care organization if the employer is state-fund or to the employer if self-insured.
- Important: Failure to provide complete information may delay compensation payments to the injured worker.

	· · · · · · · · · · · · · · · · · · ·		,											
In <sub>.</sub>	jured worker name		Claim numb	er	Date of injury									
Da	ate of <i>last</i> appointment/examination	Date of <i>this</i> appointment/ex	amination	Date of <b>next</b>	appointment/examination									
	Submission type (Select one of the options below.)													
1	<ul> <li>□ Initial MEDCO-14. Proceed to Section 2.</li> <li>□ Subsequent MEDCO-14, no changes Proceed to Section 6.</li> <li>□ Subsequent MEDCO-14, with changes. Check the appropriate box "Reporting changes from the last evaluation" or "No changes" in each section.</li> </ul>													
2	Job description and work status ☐ Reporting changes from last evaluation ☐ No changes													
	Have you reviewed the injured worker's job description? ☐ Yes ☐ No													
	<ul> <li>If yes, who provided the job description □ Injured worker □ Employer □ MCO/BWC</li> <li>Does the injured worker have any physical or health restrictions related to the allowed conditions in the claim on the date of this exam? □ Yes □ No</li> <li>If yes, are the restrictions: □ Permanent? □ Temporary?</li> <li>If no, check the box to indicate the injured worker is released to return to full duty as of the date of this exam. □</li> </ul>													
	<ul> <li>Proceed to Section 6.</li> <li>If there are restrictions, can the injured worker return to their full duty job held on the date of injury as of the date of this exam? ☐ Yes ☐ No</li> <li>If yes, Proceed to Section 6.</li> <li>If no, provide date restrictions began/ and estimated full duty return-to-work date/</li> <li>Proceed to Section 3.</li> </ul>													
	Disability information		☐ Reporting changes from last evaluation ☐ No changes											
	Complete the chart below for all work-related allowed conditions being treated.													
3	Narrative description of the work-related allowed condition	Site/Location if ICD applicable			eventing full duty release to er held on the date of injury?									
					Yes □ No									
					Yes 🗆 No									
					Yes ☐ No									
					Yes 🗆 No									
		st all other conditions that <b>impact treatment</b> of the conditions listed above (e.g., co-morbidities or not yet allowed												
	List all other conditions that <b>impact tre</b> conditions).	atment of the conditions liste	ed above (e.g	., co-morbidities	or not yet allowed									

Injured worker name									Cla	aim number						Date of injury						
	Abilities, cli	nica	al fir	ndin	ıas.	and	recovery progress	sion				Rep	orting changes from las						⊥ st evaluation □ No changes			
		• Is the Injured worker taking prescribed medication for the allowed conditions that may be a safety hazard? ☐ Yes ☐ No																				
	_	Dominant hand: ☐ Right ☐ Left																				
	<ul> <li>Circle the</li> </ul>	injur	ed v	vork	ær's	phy	sical abilities for the	act	i∨iti∈	es ir	n the	cha	t be	low	and	pro	vide c	om	ments as necess	ary		
	Frequency scale									lbs.)					E	Body	y side indicator					
	N = Never	_	4 1							dent	ary	0-10					_	_ = L				
						Ligh - Me		n	0-20 0-50						<b>R</b> = Right <b>B</b> = Both							
4	<b>F</b> = Frequent 3-6 hours					H =	<b>H</b> = Heavy 0-100															
	C = Constant 6-8 hours					VH	VH = Very heavy >100 *Indicate limitations ONLY															
	Activity			quen	-		Activity		Strength				Frequency				_	Activity	Side		-	
	Sit	N		0			Floor lift (0-17")	S	<u>L</u>	M	Н	VH	N	S					t/Lateral reach			<u>В</u>
	Stand/Walk	N		0		С	Knee lift (18-29")	S	<u>L</u>	М	Н	VH	N	S	0				head reach	<u>L</u>		В
	Climb stairs	N		0		-	Waist lift (30-36")	S	L	M	Н	VH	N	S					t flex/extension			В
	Squat/Kneel	N	S			С	Chest lift (37-60")	S	L	M	Н	VH	N	S	0			Gras				В
	Crawl	N	S	0		С	Overhead lift (>60")	S	<u>L</u>	M	Н	VH	N	S	0				er manipulation	L		В
	Twist	N	S	0		С	Push/Pull	S	Ļ	M	<u>H</u>	VH	N	S	0		_		oarding	<u> </u>		В
	Bend/Stoop	N	S	0	<u> </u>	С	Carry	S	L	M	Н	VH	N	S	0	F	C	)per	rate foot controls	L	R	В
<ul> <li>If yes, describe any functional restrictions in comments below and reference the MEDCO-16 as needed.</li> <li>Provide your clinical and objective findings supporting your medical opinion. List barriers to return to work, reason(s) for delayed recovery, and proposed treatment plan (e.g., modalities, therapies, surgery), including estimated duration of each treatment or indicate if all or part of this information is in office notes (include date(s) of notes).</li> <li>Comments:</li> <li>Health and Behavioral Assessment: (HBA evaluates cognitive, emotional, social, and behavioral barriers that might impact physical health problems and treatments which are associated with the allowed physical injury in the claim.)</li> <li>Is the injured worker's recovery not progressing, or progressing slower than expected?  Yes No</li> <li>Do cognitive, emotional, social, or behavioral barriers exist that may be interfering with expected healing?  Yes No</li> <li>Vocational rehabilitation is a voluntary program for an eligible injured worker who needs assistance to remain at work or</li> </ul>														each ealth								
return to work. Is the injured worker currently able to participate in a vocational rehabilitation pro  Maximum medical improvement (MMI) status    Reporting changes from las											<u>_</u>			anc	205							
5	MMI is a treatment plateau (static or well-stabilized) at which no fundamental functional or physiological change can be expected within reasonable medical probability, in spite of continuing medical or rehabilitative procedures. Has the work-related injury(s) or occupational disease reached MMI based on the definition above? ☐ Yes ☐ No  If yes, give MMI date:/ Note: An injured worker may need supportive treatment to maintain his or her level of function after reaching MMI. So, periodic medical treatment may still be requested and, if approved, provided.																					
	Treating ph	ysic	ian'	's si	gna	iture	e – mandatory (See	exc	cept	tion	s at	the t	ор	of th	ne fo	orm.	.)					
6	a false state or who know	men /ingl nder	nt, m y ac app	isre cept ropr	pres ts p riate	senta aym e crir	orm is correct to the bation, concealment of ent to which that pe minal provisions, by a	of fa	ct, d n is	or ai not	ny o entit	ther a led, i	act o s su nt o	of franchistophic bject bot	aud to th.	to ol felo	otain i ny cri	pay min	ment as provided	by	В١	WC,
٠	Treating phy				`								inacion, only, only, initial digital oddo									
BWC provider (PEACH) number Date												Tal	anh	ono	nur	hor	- 1	Fax number				
	PAAC brovide	₽I (F	-⊏A(	J⊓)	HUI	nuel	Date						rel	ehn	one	null	nber		rax number			