Ohio | Bureau of Workers' Compensation

Instructions for Completing the Physician's Report of Work Ability

This form provides important information about the injured worker's ability to work.

- The treating physician must submit this form each time he/she sees the worker unless the worker has been awarded permanent and total disability or has been previously released to his/her former position without restrictions.
- Please complete this form and provide a copy to the worker during his/her office visit. Fax a copy to the appropriate managed care organization (MCO) or to the worker's employer if self-insured.
- This form or an equivalent physician-generated document may support a request for temporary total compensation. The equivalent document must contain, at a minimum, the data elements required on this form. If you have submitted previously equivalent data elements that remain the same, indicate the name of the report that reflects the worker's current condition, e.g., May 15, 2015, office note.
- You may attach additional medical documentation such as diagnostic test results and a treatment plan to this form.
- Failure to provide complete detailed information may delay or suspend compensation payments to the worker.

Instructions

MEDCO-14 submission section: You must select only one of the three choices by selecting the appropriate box. If you previously completed a MEDCO-14 and there are changes, you must indicate the changes in the appropriate section on the form, and select the yes box in that section. For all other sections, you would make no entry, and select the no box.

Employment/occupation section: Please indicate if you have reviewed a description of the injured worker's job held on the date of the injury. Please indicate all sources providing you a description of the injured worker's job. If you do not have a copy of the worker's job description, BWC or the MCO can help secure one.

Work status/Injured worker's capabilities section: Please complete this section as accurately and thoroughly as possible, as BWC will use this information to understand the worker's work status and help facilitate his/her appropriate and safe return to work either to his/her job held on the date of injury or an alternative job if he/she cannot return to the job held on the date of injury.

3A: Please indicate if the injured worker has any restrictions r**elated only to the allowed conditions in the claim.** If there are no restrictions related to the allowed conditions, indicate a release to work date for the injured worker.

3B: If there are restrictions **related only to the allowed conditions in the claim,** indicate whether or not the injured worker can return to his/her job held on the date of injury. **It is imperative that you follow all 3B instructions. This will facilitate appropriate processing of the injured worker's claim.**

3C: To facilitate BWC's efforts to safely return an injured worker to appropriate work, indicate which of the activities listed the injured worker can perform. The following definitions apply to the section on Lifting/carrying, Pushing/pulling and Activity with the percentages reflected as they relate to an eight-hour workday:

- Never – 0 percent;
- Occasionally – 1 percent to 33 percent, four to six repetitions per hour;
- Frequently – 34 percent to 66 percent, six to 12 repetitions per hour;
- Continuously – 67 percent to 100 percent, greater than 12 repetitions per hour.

We encourage you, in the space provided, to provide any additional information you believe would benefit the injured worker's safety and care relative to any return to work considerations.

Disability period information section: It is critical that if you answered No to 3B you complete this section.
4A: Please furnish the narrative description of the diagnosis(s), site/location and International Classification of Diseases code for only allowed conditions being treated. You must indicate whether the allowed condition is preventing the injured worker from returning to the job held on the date of injury.

4B: In this area you should list all other relevant conditions that impact treatment of the allowed conditions in the claim.

Clinical findings section: Provide medical rationale for the delay in the worker's recovery and the barriers to return to work.

Maximum medical improvement (MMI) section: Provide the MMI date or explain why the worker has not reached MMI. Provide the proposed treatment plan, including estimated duration.

Vocational rehabilitation section: If the worker is not a candidate for vocational rehabilitation, explain and recommend actions to help the worker return to employment.

Treating physician's signature section: Sign and date this form. Your signature indicates you have answered the questions as truthfully and completely as possible.

For more informaiton or assistance

Please contact your local BWC customer service office, or call 1-800-644-6292. You can obtain BWC forms at www.bwc.ohio.gov, at all BWC customer service offices, or by calling 1-800-644-6292 and listening to the options to reach a BWC customer service representative.

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Physician's Report of Work Ability

Injured worker name			Claim number
Date of injury	Date of last appointment/examination	Date of this appointment/examination	Date of next appointment/examination

MEDCO-14 submission (Select one of the options below.)

1

☐ I have never completed a MEDCO-14. Proceed to section 2.
☐ I have previously completed a MEDCO-14, and all of the information remains the same. ***Proceed to and complete section 8.***
☐ I have previously completed a MEDCO-14, and I am providing updates to each section checked.

Employment/Occupation Complete this section and proceed to section 3 (Updates Yes ☐ No ☐)

2

Have you reviewed the description of the injured worker's job held on the date of injury (former position of employment)? Yes ☐ No ☐
If yes - please indicate who (select all sources) provided the job description ☐ Injured worker ☐ Employer ☐ MCO ☐ BWC

Work status/Injured worker's capabilities (Updates Yes ☐ No ☐)

3A

Does the injured worker have any work restrictions related to allowed conditions in the claim? Yes ☐ No ☐
If yes, proceed to section 3B.
If no restrictions, please indicate release to work date _____/_____/_____. ***Proceed to and complete sections 6 and 8.***

3B

If there are work restrictions, can the injured worker return to his/her job held on the date of injury (former position of employment)? Yes ☐ No ☐

If yes, please indicate release to work date: _____/_____/_____. ***Proceed to sections 3C, 5, 6, and 8.***

If no, please indicate when the injured worker initially could not do the job held on the date of injury. Date:_____/_____/_____.

Please estimate when the injured worker should be able to return to the job held on the date of injury for this period of restricted duty. Date:_____/_____/_____.

Proceed to section 3C.

3C

Please indicate which of the activities listed below the injured worker can perform (even if the response to 3B is "no".)

The injured worker can perform simple grasping with: ☐ Left hand ☐ Right hand ☐ Both

The injured worker can perform repetitive wrist motion with: ☐ Left hand ☐ Right hand ☐ Both

The injured worker's dominant hand is: ☐ Left ☐ Right

The injured worker can perform repetitive actions to operate foot controls or motor vehicles with: ☐ Left foot ☐ Right foot ☐ Both If the injured worker is taking prescribed medications for the allowed conditions in this claim, is the injured worker able to safely:

*Operate heavy machinery: ☐ Yes ☐ No *Drive: ☐ Yes ☐ No **Perform other critical job tasks as defined by any source listed above in section 2:* ☐ Yes ☐ No

Please indicate the following: N = Never, O = Occasionally, F = Frequently, C = Continuously										Lifting/carrying	N	O	F	C	Pushing/pulling	N	O	F	C
Activity	N	O	F	C	Activity	N	O	F	C	0 - 10 lbs.					0 to 25 lbs.				
Bend					Reach above shoulder					11 - 20 lbs.					26 to 40 lbs.				
Squat/kneel					Type/keyboard					21 - 40 lbs.					41 to 60 lbs.				
Twist/turn					Work with cold substances					41 - 60 lbs.					61 to 100 lbs.				
Climb					Work with hot substances					61 - 100 lbs.					100 + lbs.				

In an eight-hour workday, how many total hours is the injured worker able to:

Sit: ____ hours ☐ Continuously ☐ With break Walk: ____ hours ☐ Continuously ☐ With break Stand: ____ hours ☐ Continuously ☐ With break

In the space below please provide any additional information addressing the injured worker's capabilities and/or job accommodations which may not be addressed above. _____

_____

_____

_____

_____

_____

_____

Proceed to section 4.

Injured worker name	Claim number	Date of injury

Disability period information **(If 3B above is NO you must address all fields, including site/location if applicable)** (Updates Yes ☐ No ☐)

4A Complete the chart below and furnish the narrative description of the diagnosis(es), site/location, if applicable, and International Classification of Diseases (ICD) code(s) for the condition(s) being treated due to the work-related injury/disease. Please indicate if the condition is preventing the injured worker from returning to job duties he/she held on the date of injury.

Narrative description of the work-related allowed condition	Site/location if applicable	ICD code	Is the condition preventing full duty release to the job injured worker held on the date of injury?
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐

4B List all other relevant conditions that impact treatment of the conditions listed above (e.g., co-morbidities or not yet allowed conditions).

Clinical findings: Office notes can be referenced in lieu of writing clinical findings below. (Updates Yes ☐ No ☐)

5 The injured worker is progressing: ☐ As expected ☐ Better than expected ☐ Slower than expected
Provide your clinical and objective findings supporting your medical opinion outlined on this form. List barriers to return to work and reason, for the injured worker's delay in recovery.

Maximum medical improvement (MMI) (Updates Yes ☐ No ☐)

6 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: _____/_____/_____. If no, please provide the proposed treatment plan, including estimated duration of each treatment (attach additional sheet if necessary).

Note: An injured worker may need supportive treatment to maintain his or her level of function after reaching MMI. Thus, periodic medical treatment may still be requested and provided.

Vocational rehabilitation (Updates Yes ☐ No ☐)

7 Vocational rehabilitation is an individualized and voluntary program for an eligible injured worker who needs assistance in safely returning to work or in retaining employment. This program can be tailored around an injured worker's restrictions and may provide job seeking skills or necessary retraining. Is the injured worker a candidate for vocational rehabilitation services focusing on return to work?
Yes ☐ No ☐ If no, please explain why and provide your recommendations to help the injured worker return to employment.

Treating physician signature - mandatory

8 I certify the information on this form is correct to the best of my knowledge. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain payment as provided by BWC, or who knowingly accepts payment to which that person is not entitled, is subject to felony criminal prosecution and may be punished, under appropriate criminal provisions, by a fine or imprisonment or both.

Treating physician's name (please print legibly)		Address, city, state, nine-digit ZIP code, telephone and fax numbers
Treating physician's signature		
BWC provider (Peach) number	Date	