

STATE OF WISCONSIN



Department of Workforce Development

A Brief Introduction to Final Medical Reports

Philip Roberts and Frank Salvi
Dispute Resolution Specialists

Introduction

- An understanding of DWC's final medical report (FMR) requirement
- Proactive measures for timely claim closure
- Solutions to common problems procuring reports
- Guidance on some uncommon situations
- Questions



FMR – Who?

- Temporary disability exceeds 3 weeks
- Permanent partial disability indicated
- Surgery
 - Hernias are exempt, including when TD exceeds 3 weeks
 - Minor surgeries included; e.g., sutures, abscess drainage, etc.
- Eye injuries with 3 or more medical visits
- Traumatic hearing loss or tinnitus
 - Occupational hearing loss only claims are exempt



FMR – Where?

- Documentation must be submitted in the following formats:
 - Online – Upload documents directly via the Insurer Portal and track completion of its review (preferred method)
 - Fax – Acceptable for most correspondence
 - Mail – X-rays required to be submitted via mail; all correspondence acceptable
 - E-mail – Not acceptable unless explicitly requested; attachments sent to general mailboxes are deleted per DWD security protocol



FMR – When?

- An FMR must be submitted after one of the following conditions is met:
 - End of healing/maximum medical improvement (EOH/MMI)
 - Deceased before EOH
 - Injured worker is inadvertently unavailable before final visit to their provider (e.g., relocation outside the US, lengthy incarceration, etc.)



FMR – Why?

- Wisconsin law may require a final medical report from a treating practitioner. Wis. Stat. 102.13(2)(c)
 - Helps verify the proper amount of indemnity due
 - Not limited to form WKC-16
- IMEs, by statute, **cannot** be considered an FMR
 - No FMR necessary if an IME denies benefits in a manner that exempts the claim from FMR requirement
 - In extremely rare instances, DWC guidance may involve an IME to substantiate a PPD rating



FMR – What?

- A report must contain the following to be considered final:
 - PPD ratings according to Wis. Admin. Code DWD 80.32 for all injured parts of body, diagnoses, and sequelae
 - Office/clinic notes (if referenced by provider)
 - Operative notes for stat min surgeries
 - Anesthesia notes alone are not acceptable
 - End of healing and discharged from active treatment
 - Signed and dated by MD, DPM, DO, DC, PsyD, or PhD
- A WKC-16 is not necessary if a report contains all the above



FMR - Fingers

- Injuries involving fingers need more attention than other joints. When adjusting the claim, please take the following into consideration to avoid follow-up correspondence from DWC:
 - If amputation occurs beyond two-thirds of the distal joint, hand dominance and x-rays must be submitted
 - When range of motion is lost, a statutory minimum applies; verify the measurements are within the report



WKC-16

- Ensure diagnosis and permanent disability fields are fully completed (amputation: only if present)

MEDICAL REPORT ON INDUSTRIAL INJURY

*Obtaining your Social Security Number (SSN) is voluntary. Failure to provide it may result in an administrative penalty being levied.
The Department of Workforce Development (DWD) administers the Worker's Compensation Act, Chapter 102 Wis. Stats. The purpose of this form is to assist with the procurement of information related to or required by Chapter 102. Completion of this form is voluntary and failure to complete said form may result in a delay in the administration of Chapter 102. DWD may use the personally identifiable information (PII) it obtains from you on this form for purposes other than those for which it is being collected.

**Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave.
P.O. Box 7801
Madison, WI 53707
Telephone: (608) 266-1340
Fax: (608) 267-6364
https://dwd.wisconsin.gov/wc/
e-mail: DWDWC@dwd.wisconsin.gov**

PATIENT	WC Claim Number	Employee Name	
	Employee Social Security Number*	Employee Address	
HISTORY	Injury Date	Employee Name	Insurance Company
	History as described by patient:		
DIAGNOSIS (Please be as detailed as possible)			
PERMANENT DISABILITY (Describe permanent elements of disability, such as limitation of motion, pain, weakness, etc., and describe effect on working ability.)	What amputation present?	Comparative x-rays taken?	Stump?
	Yes ☐ No ☐	☐ Yes ☐ No ☐	☐ Healed ☐ or ☐ Tender
	Has permanent disability resulted?	Date of Last Exam	Has healing period ended?
	☐ Yes ☐ No ☐	☐ Yes ☐ No ☐	☐ Yes ☐ No ☐
Description of permanent disability (Record finger motion losses on reverse.)			
Was surgery performed as a result of accident? ☐ Yes ☐ No ☐ If Yes, state type of surgery:			
If healing has not ended, what is minimum permanent disability expected?			
PRIOR DISABILITY PROGNOSIS	What previous disability?		
	Prognosis:		
	Date injured was or will be able to return to a limited type of work: State any limitations:		
	Date injured was or will be able to return to full-time work subject only to permanent limitations: What further treatment should be given?		
Additional comments, if any:			
Date	City	Physician or Chiropractor Signature (in own writing)	
Phone Number () -	Typed or Printed Name		

WKC-16 (R. 09/2014)

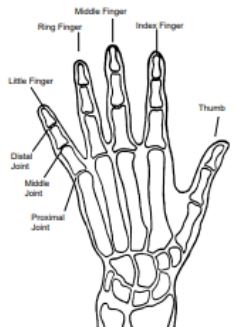
Employee Name		Employee Social Security Number	
---------------	--	---------------------------------	--

Instructions for finger injuries
Please use statutory terms in referring to fingers, such as thumbs, index, middle, ring, and little fingers, and distal, middle, and proximal joints. Where there is limitation of motion, list separately the normal range of motion in degrees, the "degrees" loss of flexion, and the "degrees" loss of extension for each joint of each finger. The Worker's Compensation Division will evaluate the loss of use due to loss of motion of the fingers.

Where there are other elements of disability of the fingers, such as deformity, weakness, pain, or lack of endurance, give your opinion on the percentage loss of use as compared to amputation for such elements of disability and specify the joint at which such loss is estimated.

Digit	Joint	Angle Ext/Flex	Normal Range of Motion	Degrees Loss Extension	Degrees Loss Flexion	Estimate % loss of use for additional factors at joint involved and reason for additional allowance
Thumb	Dist					
	Prox					
Index	Dist					
	Mid					
Mid	Dist					
	Prox					
Ring	Dist					
	Mid					
Little	Dist					
	Mid					
	Dist					
	Prox					

CIRCLE HAND INVOLVED: Right Left
DOMINANT HAND: Right Left



See DWD 80.32 & 80.33 for guides to evaluation for amputations, restrictions of motion, ankylosis, sensory loss, and surgical results for disability to the hip, knee, ankle, toes, shoulder, elbow, wrist, fingers and back.

If finger tip amputation is present, submit comparative x-rays or a statement indicating whether the bone loss was less than one-third, between one-third and two-thirds, or more than two-thirds of the distal phalanx.

If amputation is below the distal joint, submit comparative x-rays.



WKC-16-A

- Ensure the first page has been fully answered

PHYSICIAN'S REPORT ON EYE INJURIES
Refer to Ind. 80.26, Loss of vision; determination

Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave.
P.O. Box 7901
Madison, WI 53707
Telephone: (608) 265-1340
Fax: (608) 267-0394
https://dwd.wisconsin.gov/wc
e-mail: DWDCWC@dwd.wisconsin.gov

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PATIENT	WC Claim Number	Employee Name																																																																																																				
	Social Security Number*	Employer Address																																																																																																				
HISTORY	Injury Date	Insurance Company Name																																																																																																				
	Date of First Treatment	Date of Last Treatment or Exam																																																																																																				
	Which eye is injured? ☐ Right ☐ Left ☐ Both																																																																																																					
If only one eye is injured, is the other eye affected? ☐ Yes ☐ No If Yes, explain:																																																																																																						
NATURE OF INJURY AND DIAGNOSIS	Please be as detailed as possible																																																																																																					
	Is physical condition of the eyes stationary? ☐ Yes ☐ No If No, explain:	1) Did cataract form as a result of injury? ☐ Yes ☐ No 2) If cataract formed, was lens removed? ☐ Yes ☐ No 3) Has there been a surgical implant of lens? ☐ Yes ☐ No																																																																																																				
	Have all adequate and reasonable operations been attempted? ☐ Yes ☐ No																																																																																																					
	Distance → Use Snellen test letters or characters up to 20/300. Near → Use AMA Reading Card up to 14/500.																																																																																																					
CENTRAL VISUAL READINGS IMPORTANT: PLEASE FILL OUT EACH LINE COMPLETELY FOR EACH EYE	<table border="1"> <thead> <tr> <th colspan="4">After injury</th> <th colspan="4">Pre-existing before injury, including presbyopia and other conditions clearly not the result of the injury</th> </tr> <tr> <th colspan="2">Without Correction</th> <th colspan="2">With Correction</th> <th colspan="2">Without Correction</th> <th colspan="2">With Correction</th> </tr> <tr> <th>Distance</th> <th>Near</th> <th>Distance</th> <th>Near</th> <th>Distance</th> <th>Near</th> <th>Distance</th> <th>Near</th> </tr> </thead> <tbody> <tr> <td>Right</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Left</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		After injury				Pre-existing before injury, including presbyopia and other conditions clearly not the result of the injury				Without Correction		With Correction		Without Correction		With Correction		Distance	Near	Distance	Near	Distance	Near	Distance	Near	Right								Left																																																																			
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Did the employee wear glasses for pre-existing subnormal vision? ☐ Yes ☐ No																																																																																																						
Is there a record or positive indication of pre-existing subnormal vision? ☐ Yes ☐ No If Yes, Explain:																																																																																																						
PRIOR DISABILITY	Is the remaining impairment due to the injury? ☐ Yes ☐ No Explain cause:																																																																																																					
	Is there absence of useful binocular vision? ☐ Yes ☐ No																																																																																																					
	If a result of the injury, what is the percentage of additional permanent disability?																																																																																																					
	Is there any diplopia present? ☐ Yes ☐ No If Yes, this should be plotted in the chart at the right by placing an X in each square in which diplopia is found. The test is to be made with any industrially useful correction applied. Was such correction used? ☐ Yes ☐ No																																																																																																					
BINOCULAR VISION	Industrial Motor Field Chart <table border="1"> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> </table>																																																																																																					

WKC-16-A (R. 06/2024)

FIELD VISION

Field vision taken without correction if possible using a white test object which subtends one degree and a standard perimeter with a radius of 12.9 inches (330 mm). The test object shall measure 0.223 inches (5.8 mm).
Is there any loss of the field of vision? ☐ Yes ☐ No Is it the result of the injury? ☐ Yes ☐ No
If so, indicate on the charts and table below. Sketch impaired area. Sketch areas of any scotomata.

LEFT

RIGHT

When did the last trace of inflammation disappear from the eye?

Date able to return to work:

OTHER FUNCTIONS

Certain ocular disabilities are not covered in the foregoing sections, such as disturbance of accommodation, of color vision, of adaptation to light and dark, metamorphopsia, entropion, ectropion, lagophthalmos, epiphora, and muscle disturbances not included under diplopia. Is any such disability present? If so, explain under "Remarks" below, stating whether it results from the injury, what it is, which eye, or whether both eyes are affected, and your percentage estimate of the impairment of the eye or eyes for industrial use.

Remarks:

Doctor Signature: _____ Date Signed: _____
(Required in doctor's own handwriting)

Address: _____



Incomplete Reports

- If you received a letter stating your report is not final, it is due to one of the following:
 - A missing operative note (the most common letter)
 - Submitted only an IME or considered it as an FMR
 - The report was signed by a PA-C, APRN, or DDS
 - The report lacked enough information to be final
 - AMA Guidelines were used to rate scheduled injuries
- Taking **a few minutes** to verify the integrity of submitted reports will **eliminate weeks** of turnaround



Getting Help With Unresponsive Parties

- When a treating provider is unresponsive to requests for an FMR, **upon request** DWC will assist using the following form processes:
 - Form GL15 – Letter sent to the provider with WKC-16 attached
 - Three attempts to obtain an FMR must be submitted with your request
 - Name of provider (not clinic) and address/fax necessary
 - Form GL10 – Letter sent to the injured worker to be evaluated
 - A GL15 must be sent before a GL10 is sent unless the provider indicates the patient was lost to follow-up
- We allow a 60-day follow-up period for both forms



Getting Help With Providers

- DWC will sometimes intervene with providers upon request. Issues that we will address can be, but are not limited to:
 - Providers refusing to rate injuries
 - If they defer to another provider, you must contact the subsequent provider before requesting our help
 - The treating provider retired or is no longer practicing
 - Ask to have another provider at the same clinic complete an FMR
 - Providers not understanding WI ratings guidelines/law
 - A demand of pre-payment for an FMR
 - A demand for more than \$100 for an FMR



Getting Help With Injured Workers

- DWC will also assist with issues regarding an injured worker. Some common issues and remedies include:
 - A worker skipping their final visit on a denied claim. Inform the worker that the final visit and associated costs are covered
 - A worker refusing to attend an IME. Contact us to speak to an ALJ, who will determine if your request for examination is proper and provide assistance thereafter
 - A worker has been rendered indefinitely unavailable
 - Corrections physician cannot complete FMR for incarcerated worker



Issues Postponing FMRs

- In rare instances, an injured worker may be unavailable for an extended but definite period. DWC will not reach out under those circumstances, which may include:
 - Treatment for another nonrelated work injury
 - Cessation, weight loss, or rehabilitation programs, etc.
 - Short periods of incarceration
 - Seasonal workers traveling abroad
- Upon request, DWC will extend expected report due dates to avoid surcharge as long as necessary, but we will not close a claim for these issues



Additional Tips

- Use the Insurer Portal as often as possible to update DWC of an expected FMR date
 - If you are unable to do it yourself, send an email via the Portal; do not write a note when submitting a WKC-13
- If you send letters to the injured worker, consider a cc to DWC to avoid future requests, especially investigatory
- Avoid delay inquiries by timely reporting WKC-13s after first payment of all periods of TTD or PPD (within 30 days)
- Do not assume the answer to difficult situations: contact us for guidance, and we will assist as best we can



Wisconsin Department of Workforce Development Worker's Compensation Division

(608) 266-1340

<https://dwd.wisconsin.gov/wc/>

Phil Roberts, DRS

(608) 264-8783

Philip.Roberts@dwd.wisconsin.gov

Frank Salvi, DRS

(608) 267-4327

Frank.Salvi@dwd.wisconsin.gov



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