§ 9785.6. Functional Improvement Report

State of California
Division of Workers' Compensation

Functional Improvement Report (DWC Form FIR)

Date of Report:
Provider Name:

Attachments: ☐ **Rx Notes** ☐ **Other**

Section One - Routing

CONTAINS PRIVATE HEALTHCARE INFORMATION

Send document to those listed below

Claims Administrator:
Adjuster Name (if known):
Address:
City, State, Zip Code:
Phone Number:
Fax Number:

Primary Treating Physician of Record:
Name:
Address:
City, State, Zip Code:
Phone Number:
Fax Number:

Additional copy to (optional):
Name:
Address:
City, State, Zip Code:
Fax No.:

Patient and Provider Information

Patient Name:
Date of Birth:
Date of Injury:
Employer:
Claim Number:

Provider Name:
Practice Name:
Address:
City, State, Zip Code:
Phone Number:
Fax Number:
Provider Specialty/Discipline (PT/OT/Other):
State License No.:

Section Two – Treatment Status

The information below must be provided to the requesting physician and the claims administrator. You may use this form for or you may substitute or append a narrative report.

Date Treatment Began:
Date of Surgery (if applicable):

Is there Functional Improvement? ☐ Yes ☐ No (Provide details in Section Four - Summary of Care)

Participation (since starting treatment): Number of Visits: ____ Number of No Show/Cancellations: ____
Number of Visits Approved to Date: ____

New or Revised Functional Goals/Update Treatment Plan/Discharge Plan (Shared Team Plan):

Number of Additional Treatments Requested: _____ Frequency (if applicable): _____

Estimated Duration of Care Needed to Achieve Goals (if applicable): _____ or Discharged ☐

Date of Next Re-Evaluation and Progress Report:

Provider Signature (original – do not stamp): _____ **Date:** _____

Patient Name:
Provider Name:
Date of Visit:

Section Three – Summary of Care

Assessment: **Date of Assessment:**

ICF Code (optional):

Purpose of Treatment Program (check all that apply)

- ☐ Symptom Reduction/Desensitization
- ☐ Restore Work Capacity/ADL
- ☐ Mobilization/ROM
- ☐ Cognitive Issues – Safety/Judgment
- ☐ Self Care & Work Behavior for RTW
- ☐ Adaptive Equipment or Orthotics Training
- ☐ Reconditioning/Strengthening
- ☐ Gross and Fine Motor Coordination
- ☐ Implement Home Program
- ☐ Wound/Tissue Management
- ☐ Other _____

DME/Devices (e.g. orthosis):

- ☐ _____
- ☐ _____

ASSESSMENTS (May substitute discipline specific assessments)

Type of Test or Measure	Prior Progress Report Date: _____ (if applicable)	Current Progress Report Date: _____	Goal for Each Test or Measure Date Goals Set: _____ Date Goals Achieved: _____
Work Functions and/or Activities of Daily Living, Self Report of Disability (e.g., walking, driving, keyboard or lifting tolerance, Oswestry, pain scales, etc.)			
Physical Impairments (e.g., joint ROM, muscle flexibility, strength, or endurance deficits)			
Approach to Self-Care and Education. **Reduced reliance on other treatments, modalities, or medications.**			

Instructions for the Functional Improvement Report (DWC Form FIR)

Warning! Private healthcare information is contained in the DWC Form FIR.

Date of Report and Provider Name: Complete in the upper left of the report.

Attachments/Check Boxes: At the discretion of the therapy provider, additional pages may be attached to supplement the DWC Form FIR. Attachments may include the therapy provider's daily notes or other program notes.

Section One – Routing:

Mailing Address Column: The mailing address column is placed to the far left to facilitate the use of left sided window envelopes. The DWC Form FIR must be sent to the claims administrator and the primary treating physician. An additional space is provided for a third addressee, if necessary.

Patient and Therapy Provider Identification Column: Identifies the patient, date of birth, date of injury, employer, and claim number. The therapy provider's name, practice name, address, phone number, fax number, specialty, and state license number are indicated.

Section Two – Treatment Status:

Treatment Status: Indicate, as applicable, the starting date of treatment; the date of surgery; whether there is functional improvement from the beginning of treatment; and participation (number of visits/cancellations or no shows/visits approved to date). State either the new or revised functional goals or updated treatment or discharge plan. Additional spaces is provided for the number of additional treatments requested; frequency; estimated duration of care needed to achieve goals or discharge date; and the date of next evaluation.

Provider Signature: This is located just under the treatment status box.

Section Three – Summary of Care:

Overview: The purpose of Section Three is to provide a summary of the care to document progress with rehabilitation and functional improvement. The efforts of a single therapist or a whole program of care can be summarized in this section.

Assessment: The assessment of the patient is indicated in this box. The assessment must be dated (see upper right corner of page).

ICF Code (optional): The International Classification of Functioning, Disability and Health (ICF) is published by the World Health Organization (WHO) to standardize descriptions of health and disability. This is an emerging system to codify function and disability. While it is included in this form as an optional data element, providers are strongly encouraged to indicate the ICF Code.

Purpose of Treatment Program: The therapy provider must indicate the purpose of the treatment by checking the appropriate box. DME/Devices that have been provided should be indicated.

ASSESSMENTS (May substitute discipline specific assessments): Because there are numerous instruments, measures, rating scales, and tools available, the therapy provider must choose an assessment suitable for the injury or condition being treated. The importance of the assessment is to have a measure that can be used repeatedly over the course of the treatment to demonstrate improvement. It is very important to report progress over time by recording the dates of the measurements. It is also important to state the desired

outcome or goal to be achieved. There are several different categories of assessments. Test and measures with established validity and sensitivity for the diagnosis are preferred.

The improvement report must document the pertinent progress made and functional levels obtained at the end of the billing period compared to the levels shown in the initial assessment. Date progress when function can be consistently performed or when meaningful functional improvement is made.

Completion of data in each column is important to provide clear documentation of the patient's progress over time. The "Goal" column on the right should have quantitative goals for each test or measure (e.g. self-report score, ROM in degrees, amount of weight to lift, etc.). These goals may be updated over the course of treatment. Provide dates for when goals are set as well as when they are achieved.

Work Functions and/or Activities of Daily Living, Self Report of Disability (e.g., walking, driving, keyboard or lifting tolerance, Oswestry, pain scales, etc.): Objective measures of the patient's functional performance in the clinic (e.g., able to lift 10 lbs floor to waist x 5 repetitions) are preferred, but this may include self-report of functional tolerance and can document the patient's self-assessment of functional status through the use of questionnaires, pain scales, etc (Oswestry, DASH, VAS).

Physical Impairments (e.g., joint ROM, muscle flexibility, strength, or endurance deficits): Include objective measures of clinical exam findings. ROM should be documented in degrees.

Approach to Self-Care and Education/Reduced reliance on other treatments, modalities, or medications: Includes the therapy provider's assessment of the patient's compliance with a home program and motivation. The therapy provider must also indicate a progression of care with increased active interventions (as opposed to passive interventions) and reduction in frequency of treatment over course of care.