DWC DIVISION OF WORKERS' COMPENSATION
CALIFORNIA DEPARTMENT OF INDUSTRIAL RELATIONS

Division of Workers' Compensation
Department of Industrial Relations
State of California

Form PR-1

Check all applicable boxes:

Section A: ☐Request for Authorization ☐Expedited Request for Authorization

Section B: ☐Progress Report ☐Change in Patient's Condition ☐Change in Treatment Plan

Section C: ☐Change in Work Status ☐Released/Discharged from Care

☐Response to RFI, as included in: ☐Section A ☐Section B ☐Section C
☐Other, as included in: ☐Section A ☐Section B ☐Section C

Patient's Last Name: First Name: Middle Initial:

Date of Injury: Click or tap to enter a date. Date of Birth: Click or tap to enter a date.

Claim Number:

Physician Name: Practice Name:

Contact Name: Mailing Address:

Unit number: City: State: Zip Code:

Telephone: Fax: E-mail:

Specialty: State License Number:

NPI Number: Primary Treating Physician: (if different from above)

Claims Administrator:

Mailing Address: Unit number: City:

State: Zip Code: Contact Name:

Email: Telephone: Fax:

I declare under penalty of perjury that I am the physician who examined the patient, this report is true and correct to the best of my knowledge, and I have not violated Labor Code section 139.3.

Physician Signature: Date:

PRIVACY NOTICE: A statement of current data collection and use policies and certain privacy rights of injured workers can be found at the following website: http://www.dir.ca.gov/od_pub/privacy.html.

Patient Name:

Claim Number:

Date: Click or tap to enter a date.

SECTION A-1. Request for Authorization (Non-Drug) ☐Check if Expedited Request
☐Resubmission, Change in Material Fact

List additional requests on a separate sheet if the space below is insufficient. For surgery requests, include full surgery orders (pre and post-operative, if known).

Request for Medical Treatment (Non-Drug)

Diagnosis	**ICD-10 Code**	**Treatment Requested** (include frequency and/or duration)	**CPT/HCPCS Code**	**Exempt: Yes / No**
		1.		
		2.		
		3.		
		4.		
		5.		

Is treatment consistent with Medical Treatment Utilization Schedule (MTUS) treatment guideline recommendation? ○ YES ○ NO

Treatment No. (as listed above)	**MTUS**	**Other Guidelines**	**Specific Citation**

Additional Physician Comments (If treatment is not consistent with the MTUS, explain, cite above and attach documentation. May also include special circumstances or other pertinent information.) (See CCR, title 8, section 9792.21.1(b)(1).)

RESCINDED

Patient Name:

Claim Number:

Date: Click or tap to enter a date.

SECTION A-1. Request for Authorization (Non-Drug) (continued…)

Send response to physician via: ☐ Fax ☐ Email ☐ Regular Mail

Claims Administrator/URO Response:

Treatment Requested	Decision	Comments

Authorizing Agent Name: Signature:

Date: Telephone Number: Fax Number:

E-mail: Authorization Number (if assigned):

Patient Name:

Claim Number:

Date: Click or tap to enter a date.

SECTION A-2. Request for Authorization (Drug) ☐Check if Expedited Request
☐Resubmission, Change in Material Fact

List additional requests on a separate sheet if the space below is insufficient.

Request for Drug ☐Check if requested drugs are related to requested non-drug treatment.

Diagnosis	**ICD-10 Code**	**Drug Requested** (include strength, form, quantity, etc.)	**Exempt: Y / N**
		1.	
		2.	
		3.	
		4.	
		5.	

Drug Requested (No. as listed above)	**MTUS**	**Other Guidelines**	**Specific Citation**

Check box to request prospective review of an exempt drug. ☐

If not exempt, explain the need for drug:

RESCINDED

Patient Name:

Claim Number:

Date: Click or tap to enter a date.

SECTION A-2. Request for Authorization (Drug) (continued…)

Send response to physician via: ☐ Fax ☐ Email ☐ Regular Mail

Claims Administrator/URO Response:

Treatment Requested	Decision	Comments

Authorizing Agent Name: Signature:

Date: Telephone Number: Fax Number:

E-mail: Authorization Number (if assigned):

Patient Name:

Claim Number:

Date: Click or tap to enter a date.

SECTION B: Evaluation and Management Worksheet – Contains Protected Healthcare Information

☐ **Progress Report, Condition Stable, No Changes (no new complaints, exam stable, functional improvement/ADLs stable, no change in treatment plans)**

Indicate Date of Last Report: Click or tap to enter a date.

Primary Diagnosis		ICD-10	
Secondary Diagnosis		ICD-10	
Additional Diagnosis		ICD-10	

1. Chief Complaint(s) and Brief History (include subjective complaints)

2. Physical Examination (objective findings)

3. Current Treatment Plans Including Medication (list all medications, dose, and frequency)

Patient Name:

Claim Number:

Date: Click or tap to enter a date.

SECTION B: Evaluation and Management Worksheet – Contains Protected Healthcare Information (continued…)

4. Outcomes to include Functional Improvements and Activities of Daily Living (ADL; note positive/negative/no changes related to treatment)

- ADL Goal for next visit/treatment period (explain):

5. Disability Status:

Patient Name:

Claim Number:

Date: Click or tap to enter a date.

SECTION B: Evaluation and Management Worksheet (continued) – Contains Protected Healthcare Information

6. Secondary Physician Reports (if applicable, discuss and, if appropriate, incorporate findings)

7. Discussion (indicate assessment)

8. Treatment Plan

If physician is requesting authorization for treatment, complete Section A; Request for Authorization, indicating the treatment(s), reference to treatment guidelines, and explanation as to how treatment follows the MTUS. Indicate whether any prescription for medication or supplies must be dispensed as written.

Continue same treatment plan ☐ Discharge from care ☐
(see prior reports and RFAs as needed)

Change in treatment plan – see ☐
Request for Authorization

Comments (if any, include any effects prescribed medication may have on the employee's ability to perform work duties)

Patient Name:

Claim Number:

Date: Click or tap to enter a date.

SECTION C: Work Status

Employers may only receive Section C (Work Status) as other sections contain protected healthcare information.

---

1. Patient has been instructed to

☐ Return to full duty without restrictions Date: Click or tap to enter a date.

☐ Patient is unable to return to work in any capacity for the indicated period:

Date Click or tap to enter a date. to Date Click or tap to enter a date.

State reason:

☐ Return to work with the following work restrictions:

(Restrictions below in hours unless otherwise indicated)

a. Lift/Carry Restrictions – Pounds

Lift/Carry Restrictions

Lift/Carry Restrictions – Height

(state if applicable)

b. Standing c. Walking

d. Sitting e. Climbing

f. Forward Bending g. Kneeling

h. Crawling i. Twisting

j. Keyboard

k. Grasping ☐Right ☐Left Hours

☐Bilateral

l. Pushing/Pulling ☐Right ☐Left Hours

☐Bilateral

Other (explain):

Patient Name:

Claim Number:

Date: Click or tap to enter a date.

SECTION C: Work Status (continued)

Employers may only receive Section C (Work Status) as other sections contain protected healthcare information.

---

2. Patient Status

☐ Anticipated date of return to full duty with no limitations or restrictions

Date: Click or tap to enter a date.

☐ Anticipate date of return to modified duty with limitations or restrictions

Date: Click or tap to enter a date.

☐ Anticipate date of maximum medical improvement and permanent work restrictions (if applicable).

Date: Click or tap to enter a date.

☐ Date of next visit Date: Click or tap to enter a date.

☐ Date discharged from care Date: Click or tap to enter a date.

Instructions for Treating Physician's Report (DWC Form PR-1)

Warning: Private healthcare information is contained in the Treating Physician's Report (DWC Form PR-1). The form can only go to other treating providers and to the claims administrator.

Overview: The Treating Physician's Report (DWC Form PR-1) is a multipurpose form that allows the treating physician to access a Request for Authorization, Progress Report, and a Work Status. The first page reflecting information pertinent to identification of a claim, including all fields in the physician information section, should be completed and the physician signature box must be signed as required by law. Thereafter, any or all of the sections of the form may be used as fits the needs of the specific situation. This means that the physician need only submit the applicable sections of the report based on the checkboxes the physician marks at the top of page 1 of the form.

Section Checkboxes: Check the appropriate box at the top of the form to indicate the purpose of the form as one or more of the following:

Section A-1 / A-2: Request for Authorization (RFA)

Note that when completing a request for authorization, the physician has a choice to complete the request for a non-drug (A-1) and/or a drug (A-2) treatment.

- Note that an expedited Request for Authorization should be expedited based on an imminent and serious threat to the employee's health. A request for expedited review must be supported by documentation substantiating the employee's condition.

Note if resubmission of a previously denied request based on a change in material facts regarding the employee's condition. A resubmission is appropriate if the facts that provided the basis for the initial utilization review decision have subsequently changed such that the decision is no longer applicable to the employee's current condition. Include documentation supporting your claim.

Section A must contain all the information needed to substantiate the request for authorization. If the request is to continue a treatment plan or therapy, please attach documentation indicating progress, if applicable.

- ✓ If the request is for treatment which requires separate but related associated treatments, all treatments should be listed.
- ✓ List the diagnosis (required), the ICD Code (required), the specific service/good requested (required), and applicable CPT/HCPCS code (if known).
- ✓ Include, as necessary, the frequency, duration, quantity, etc. Reference to specific guidelines used to support treatment should also be included, but is not mandatory.
- ✓ For requested treatment that is: (a) inconsistent with a Medical Treatment Utilization Schedule (MTUS) treatment guideline; or (b) for a condition or injury not addressed by a MTUS treatment guideline, you should follow the MTUS Medical Evidence Search Sequence and provide information to support your request.

Physician Notification: If applicable, the physician may indicate how they want to receive the claims administrator's response to a request for authorization of treatment by marking the appropriate checkbox in the line just above the "Claims Administrator/URO Response" section.

Claims Administrator/URO Response: Upon receipt of an RFA, a claims administrator must respond within the timeframes and in the manner set forth in Labor Code section 4610 and California Code of

Regulations, title 8, section 9792.9.1 et seq. Responses should address all requested treatments, including those that are separate from but related to a primary treatment request. To communicate its approval on requested treatment, the claims administrator may (but is not required to) complete the lower portion of Section A of the DWC Form PR-1 and send it back to the requesting provider. If multiple treatments are requested, indicate in comments section if any individual request is being denied or referred to utilization review.

Section B: Evaluation and Management Worksheet

- Progress Report
- Change in Patient's Condition
- Change in Treatment Plan

Select all applicable choices as noted above.

Then complete Section B to include documentation of diagnosis and provide the following requested information as applicable for the purpose of the report:

- ✓ Chief Complaint and Brief History
- ✓ Physical Examination
- ✓ Previous Treatment Plan including Medication
- ✓ Outcomes related to Functional Improvement and Activities of Daily Living
- ✓ Secondary Physician Reports (as applicable)
- ✓ Discussion and Assessment
- ✓ New Treatment Plan
- ✓ Additional Comments

Section C: Work Status

- Change in Work Status
- Released/discharged from Care

Section C can be used to provide the employee's work status. When completed, this section of the PR-1 provides instructions regarding the employees work activities and status.

Routing Information: This form must be signed by the treating physician and may be mailed, faxed, or electronically submitted through the use of a secure, encrypted e-mail system to the address, fax number, or e-mail address designated by the claims administrator for this purpose. The requesting physician must complete all identifying information as best as possible and at least with respect to herself/himself and the claims administrator.