



# Texas Department Of Insurance

## Division of Workers' Compensation

7551 Metro Center Dr. Ste.100 • MS-603

Austin, TX 78744-1609

(800) 252-7031 (512) 804-4121 fax [www.tdi.state.tx.us](http://www.tdi.state.tx.us)

DWC Claim#

Carrier Claim#

## REQUEST FOR DESIGNATED DOCTOR (DWC Form-032)

Type (or print in black ink) each item on this form.

### I. INJURED EMPLOYEE INFORMATION

1. Injured Employee Name (Last, First, M.I.)		2. Date of Birth (mm-dd-yyyy)	
3. Social Security #	4. Date of Injury (mm-dd-yyyy)		5. Date of Statutory MMI (mm-dd-yyyy)
6. Address (Street or P.O. Box, City, State, Zip)		7. County	
8. Primary Telephone Number		9. Alternate Phone / Cell Phone Number	
10. Fax Number		11. E-mail Address	
12. Representative's Name (if any)			
13. Representative's Telephone Number		14. Representative's Fax Number	

### II. EMPLOYER INFORMATION

15. Employer's Name	16. Address (Street or P.O. Box, City, State, Zip)
---------------------	--

### III. TREATING DOCTOR/NETWORK INFORMATION

17. Treating Doctor's Name and License Type		18. License Number (if known)	
19. Address (Street or P.O. Box, City, State, Zip)		20. Telephone Number	
21. Fax Number	22. Workers' Compensation Health Care Network (if any)		

### IV. INSURANCE CARRIER INFORMATION

23. Insurance Carrier Name and Address			
24. Adjuster's Name		25. Adjuster's E-mail Address	
26. Adjuster's Telephone Number and extension (if any)		27. Adjuster's Fax Number	

### V. OTHER INFORMATION

28. Requester of Exam			
<input type="checkbox"/> Injured Employee	<input type="checkbox"/> Injured Employee Representative	<input type="checkbox"/> Insurance Carrier	<input type="checkbox"/> TDI-DWC/DWC Medical Advisor

**Requesters of a designated doctor exam are encouraged to provide a copy of the completed DWC Form-032 to all parties at the time the original request is submitted to TDI-DWC.**



**VI. REASON FOR REQUEST****\*\*NOTE TO THE DESIGNATED DOCTOR\*\***

Address only those issues that are checked. Do not address additional issues unless specifically requested to do so.

**A. Maximum Medical Improvement (MMI)** *Information below is required if the requester is disputing previously certified MMI.*

**Instructions for the Requester:** If you are disputing a previously certified MMI date, provide:

Date of MMI (mm/dd/yyyy) \_\_\_\_\_ Date of certification (mm/dd/yyyy) \_\_\_\_\_

Name of the certifying doctor \_\_\_\_\_  RME doctor  treating doctor

**Question for the Designated Doctor to consider in the exam:** Has MMI been reached; and, if so, on what date? (NOTE: MMI may not be greater than the Statutory MMI date provided in Box 5. This date is 104 weeks after the 8<sup>th</sup> day of disability.)

**B. Impairment Rating (IR)** *Information below is required if the requester is disputing previously assigned IR.*

**Instructions for the Requester:** If you are disputing a previously assigned IR, provide:

Date of MMI (mm/dd/yyyy) \_\_\_\_\_ Date of certification (mm/dd/yyyy) \_\_\_\_\_ IR assigned \_\_\_\_\_

Name of the certifying doctor \_\_\_\_\_  RME doctor  treating doctor

**Question for the Designated Doctor to consider in the exam:** As of the certified MMI date, what is the Impairment Rating (IR)? (NOTE: If clinical MMI has not been reached, it is mandated by law to assign an IR based on the injured employee's condition on the statutory MMI date given in I. EMPLOYEE INFORMATION, item 5.

**C. Extent of Injury** *The information below is required.*

**Instructions for the Requester:**

1. Describe the accident or incident that caused the claimed injury.
2. List all compensable injuries not in dispute.
3. List all disputed injuries claimed to be a cause of or naturally resulting from the accident or incident.

**Questions for the Designated Doctor to consider in the exam:** Was the accident or incident giving rise to the compensable injury a cause of the additional claimed injuries or conditions? Do the claimed injuries or conditions naturally arise from the compensable injuries?

**D. Disability** Only check this box if the injured employee is not working or the injured employee is earning less than pre-injury wages. *The information below is required.*

**Instructions for the Requester:**

1. Provide the dates for the claimed periods of disability. From \_\_\_\_\_ mm/dd/yyyy to \_\_\_\_\_ mm/dd/yyyy (if multiple periods, list all dates).
2. List all compensable injuries.
3. Provide injured employee's job description or describe the injured employee's duties.

**Question for the Designated Doctor to consider in the exam:** Is the compensable injury a cause of the injured employee's inability to earn pre-injury wages during the disability period(s) in question?



**VI. REASON FOR REQUEST (CONTINUED)** **E. Return to Work****Instructions for the Requester:**

1. Provide the beginning and ending dates for each period covered by this request. *(Required)*  
From \_\_\_\_\_ mm/dd/yyyy to \_\_\_\_\_ mm/dd/yyyy (if multiple periods, list all dates).
2. If you wish to offer the injured employee a specific job or jobs, give the job description(s) for the job(s) available for the injured employee. *(Optional)*
3. If you wish to know the injured employee's capacity to do work and what work activities the injured employee can perform, a job description is not needed. *(Optional)*

**Question for the Designated Doctor to consider in the exam:** Is the injured employee able to return to work in any capacity and what work activities can the injured employee perform?

**F. Return to Work for Supplemental Income Benefits (SIBs)** *Injured employees are allowed only one designated doctor exam a year after the second anniversary of SIBs. The information below is required.*

**Instructions for the Requester:**

1. Provide the beginning and ending dates for each qualifying period covered by this request.
2. Provide sufficient detail so that the designated doctor can determine the injured employee's capacity to do work and what work activities the injured employee can perform.

**Question for the Designated Doctor to consider in the exam:** Does the injured employee have any ability to return to work in any capacity for the qualifying periods, and if so, what are the abilities?

**G. Other Similar Issues** *Designated Doctor examinations **may not** be requested for developing treatment plans, determining the appropriateness of medical care, or to determine the compensability of the injury. All questions must be answered.*

**Instructions for the Requester:** Identify the issue(s) and provide sufficient detail for the designated doctor to address the issue(s). *(Required.) Example: To determine if there is an injury resulting from the claimed incident.*



**VII. INJURY AND TREATMENT INFORMATION: TDI-DWC is required to obtain the following information to select a designated doctor. If you have any questions or difficulties providing any of this required information, contact TDI-DWC at 800-252-7031 for assistance. If you are unsure of the injured employee's condition or treatment history contact the treating doctor.**

DWC Claim #: \_\_\_\_\_  
 Carrier Claim #: \_\_\_\_\_

Injury Areas – Check off each injury area that is part of or claimed to be part of the compensable injury.		General Treatment Types – Check off each type of treatment received on each injury area that is part of the workers' compensation injury and indicate if the treatment has been suspended or discontinued. <sup>1</sup>									
		Physical Medicine		Prescription Medication		Therapeutic Injections		Surgery		Behavioral Medicine	
		Check if provided	Check if discontinued	Check if used	Check if discontinued	Check if given	Check if discontinued	Check if performed	Check if released by Surgeon <sup>2</sup>	Check if provided	Check if discontinued
<b>Musculoskeletal Injuries:</b>											
1	Back and Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Hand and Upper Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Lower Extremities and Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Occupational Exposures and Injuries:</b>											
4	Central Nervous System (Cerebrum/Forebrain)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		
5	Brain Stem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		
6	Spinal cord or spinal canal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
7	Muscular and Peripheral Nervous System	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
8	Respiratory System	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		
9	Cardiovascular System	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		
10	Hematopoietic System (blood disorders)			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		
11	Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		
12	Ears			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		
13	Face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		
14	Teeth			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		
15	Nose, Throat and Related Structures			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		
16	Digestive System			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		
17	Urinary and Reproductive Systems			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		
18	Endocrine System (hormone system)			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		
19	Skin			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		
20	Mental and Behavioral Disorders			<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>	<input type="checkbox"/>
21	Chronic pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**GENERAL CATEGORIES OF TREATMENT DEFINITIONS**

- Physical Medicine** – Non-invasive treatment that involves manual movements of the affected body part. This includes treatments such as massage, myofascial release, physical therapy, manipulations, mobilizations, acupuncture, work hardening, work conditioning, etc.
- Prescription Medication** – Medication that must be obtained from a pharmacist or the prescribing doctor and that cannot be obtained without a doctor's prescription.
- Therapeutic Injections** – Includes treatments such as epidural and trigger point injections and does not include minor/routine injections such as tetanus shots, allergy shots, or IVs.
- Surgery** – An operation or other invasive treatment often performed at a hospital. This does not include minor procedures such as treating minor cuts or lacerations.
- Behavioral Medicine** – Includes treatments such as psychiatry, psychological testing and counseling, biofeedback and related disciplines.

Each Injury Area includes the conditions/body parts/systems listed in the corresponding section or chapter of the 4<sup>th</sup> Edition of the AMA Guides to the Evaluation of Permanent Impairment. If it is unclear which row should be selected for a given condition, consult the AMA Guides to determine which section contains the methodology for rating impairment for the condition. Example - hernias are covered in row 16 – "Digestive" because that is the chapter that contains instructions on how to assign an impairment rating for a hernia.

**NOTICE: Providing incorrect or inaccurate information regarding this request could cause an incorrect selection of the designated doctor and may result in enforcement action including administrative penalties and fines.**

1 – Indicating that a treatment has been discontinued is NOT a statement that further treatment of that sort is not medically necessary or that it will not resume at some point. Rather, it is a statement that at the time the request for a designated doctor is made, the injured employee is not actively receiving that treatment.

2 – A surgeon is considered to have released the injured employee after surgery when the injured employee has completed all follow-up visits required to verify the injured employee's recovery from the surgery. It does not mean that the injured employee has been released to return to work, been released from all medical treatment, or reached MMI.



## **Instructions for Completing the Request for Designated Doctor (DWC Form-032)**

For more information contact your local TDI-DWC Field Office at 800-252-7031.

### **Who may request that a designated doctor examination be ordered?**

The injured employee, the injured employee's representative, or the insurance carrier may request the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) to order a designated doctor examination. A designated doctor examination may not be performed more than once every 60 days. TDI-DWC may approve additional requests for an examination within the 60-day period if good cause exists. TDI-DWC may also order a designated doctor examination on its own motion.

### **For what purposes may a designated doctor exam be requested?**

To resolve questions about:

- A. maximum medical improvement;
- B. impairment rating;
- C. extent of injury;
- D. whether the injured employee's disability is a direct result of the work-related injury;
- E. ability of the injured employee to return to work;
- F. return to work and Supplemental Income Benefits (SIBs); or
- G. issues similar to those described above.

Designated doctor examinations **may not** be requested for developing treatment plans, determining the appropriateness of medical care, or for determining the compensability of the injury.

### **How do I fill out the form?**

Type (or print in black ink) each item on this form. Provide all information, such as information on the current treating doctor found in Section III. Failure to provide all information could cause a delay in processing or your request could be denied. Providing incorrect or inaccurate information regarding this request could cause an incorrect selection of the designated doctor and may result in enforcement action including administrative penalties and fines. Requesters of a designated doctor exam are encouraged to provide a copy of the completed DWC Form-032 to all parties at the time the original request is submitted to TDI-DWC.

In Section VI, some information is required from the requester. The request will not be processed without the required information.

### **Where do I send the completed form?**

Send the original, completed form to TDI-DWC at:

Texas Department of Insurance	or FAX to
Division of Workers' Compensation	(512) 804-4121
Designated Doctor Scheduling Section	
7551 Metro Center Dr., Suite 100 • MS-603	
Austin, TX 78744-1609	

### **What does TDI-DWC do?**

TDI-DWC Designated Doctor Scheduling Section staff will review the request. If the request is approved, within 10 days TDI-DWC will issue an order to the parties to conduct the exam. If it is denied, you will receive notice in writing from TDI-DWC.

### **Where do I find more information on the designated doctor process?**

Resources that answer common questions about the designated doctor process are available online at <http://www.tdi.state.tx.us/wc/hcprovider/dd.html>.

**NOTE:** With few exceptions, you are entitled on request to be informed about the information that TDI-DWC collects about you. Under §§552.021 and 552.023 of the Government Code, you are entitled to receive and review the information. Under §559.004 of the Government Code you are entitled to have TDI-DWC correct information about you that is incorrect. For more information, call the local TDI-DWC field office at 800-252-7031.