



**Texas Department of Insurance**  
**Division of Workers' Compensation**  
 7551 Metro Center Drive, Suite 100 • MS-603  
 Austin, TX 78744-1645  
 (800) 252-7031 phone • (512) 804-4121 fax

Complete if known: DWC Claim # Carrier Claim #
--

**Request for Designated Doctor Examination**  
*Type or print in black ink*

**I. INJURED EMPLOYEE INFORMATION**

1. Injured Employee Name (Last, First, Middle)		2. Social Security Number
3. Date of Injury (mm-dd-yyyy)	4. Date of Birth (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 Number
		10. Fax Number

NOTE: Statutory MMI is 104 weeks after the 8<sup>th</sup> day of disability.

**II. EMPLOYER INFORMATION** *(at the time of injury)*

11. Employer's Name	12. Address (Street or P.O. Box, City State Zip)
---------------------	--

**III. INSURANCE CARRIER INFORMATION**

13. Insurance Carrier Name	14. Adjuster's Name (required for processing)
15. Address (Street or P.O. Box, City State Zip)	16. Adjuster's E-mail Address
17. Adjuster's Telephone Number and Extension (required for processing)	18. Adjuster's Fax Number

**IV. INJURED EMPLOYEE REPRESENTATIVE INFORMATION** *(if any)*

19. Representative's Name	
20. Representative's Telephone Number	21. Representative's Fax Number

**V. TREATING DOCTOR/NETWORK INFORMATION**

22. Treating Doctor's Name and License Type	23. License Number
24. Address (Street or P.O. Box, City State Zip)	25. Telephone Number
26. Fax Number	27. Workers' Compensation Health Care Network (if any)

**VI. EXAMINATION INFORMATION**

28. Provide the specific reason(s) for the requested examination. The reason(s) must indicate how the examination will resolve a dispute or assist in the progression of the claim.
29. If a previous designated doctor examination has occurred for this claim, explain any change of medical condition since that examination.
30. If approval of this request would result in TDI-DWC scheduling an examination within 60 days of a previous designated doctor examination, provide good cause as to why it is necessary to schedule this examination within 60 days.
31. List all injuries determined to be compensable by TDI-DWC or accepted as compensable by the insurance carrier.

**VII. INJURY AND TREATMENT INFORMATION:** TDI-DWC is required to obtain the following information in order to select a designated doctor. If you need assistance providing this information, contact TDI-DWC at 1-800-252-7031. If you are unsure of the injured employee's condition or treatment history, contact the treating doctor.

Complete if known:  
 DWC Claim #  
 Carrier Claim #

<b>Injury Areas</b> – Check each injury area that is part of or claimed to be part of the injury.  <b>Note: Each injury area MUST be checked, even if NO treatment has been provided.</b>	<b>General Treatment Types</b> – Check each type of treatment received on each injury area that is part of or claimed to be a part of the 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>										
<input type="checkbox"/> 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"/>
<input type="checkbox"/> 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"/>
<input type="checkbox"/> 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>										
<input type="checkbox"/> Central Nervous System (cerebrum/forebrain)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Brain Stem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> 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"/>		
<input type="checkbox"/> 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"/>		
<input type="checkbox"/> Respiratory System	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Cardiovascular System	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Hematopoietic System (blood disorders)			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Ears			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Teeth			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Nose, Throat and Related Structures			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Digestive System			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Urinary and Reproductive Systems			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Endocrine System (hormone system)			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Skin			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		
<b>Mental and Behavioral Disorders:</b>										
<input type="checkbox"/> Mental and Behavioral Disorders			<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> 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 under "Digestive System" because that is the chapter that contains instructions on how to assign an impairment rating for a hernia.

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.

Complete if known:

DWC Claim #

Carrier Claim #

**VIII. PURPOSE FOR EXAMINATION****Requester:** Check the box next to each issue you want the designated doctor to address.**Designated Doctor:** Address only the issues that are checked. **A. Maximum Medical Improvement (MMI)****Instructions for requester:** *If there is a previous certification of MMI, the following information is required.*

Certified MMI Date \_\_\_\_\_ (mm/dd/yyyy)

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

Name of the certifying doctor \_\_\_\_\_

 RME doctor  treating doctor  referral doctor**Question for the Designated Doctor to consider in the examination:** Has MMI been reached; if so, on what date?

NOTE: MMI may not be greater than the statutory MMI date shown in Section I, Injured Employee Information, Item 5.

 **B. Impairment Rating (IR)****Instructions for requester:** *If there is a previously assigned IR, the following information is required.*

Certified MMI Date \_\_\_\_\_ (mm/dd/yyyy)

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

IR assigned \_\_\_\_\_%

Name of the certifying doctor \_\_\_\_\_

 RME doctor  treating doctor  referral doctor**Question for the Designated Doctor to consider in the examination:** As of the certified MMI date, what is the Impairment Rating (IR)?

NOTE: If statutory MMI has been reached (shown in Section I, Injured Employee Information, Item 5), it is mandated by law that you assign an IR based on the injured employee's condition on the statutory MMI date, regardless of whether the injured employee has reached clinical MMI.

 **C. Extent of Injury****Instructions for the requester:** *The information below is required.*

1. List all injuries (diagnosis/body parts,/conditions) in question, claimed to be caused by, or naturally resulting from the accident or incident.
2. Describe accident or incident that caused the claimed injury (see Section VI, Examination Information, Item 31).

**Question for the Designated Doctor to consider in the examination:** Was the accident or incident giving rise to the compensable injury a cause of the additional claimed injuries or conditions and/or do the claimed injuries or conditions naturally arise from the compensable injuries? **D. Disability – Direct Result** (*Only check this box if the injured employee is not working or is earning less than pre-injury wages.*)**Instructions for the requester:** *The information below is required.*

Provide the beginning and ending dates for the claimed periods of disability. If multiple periods, list all dates.

From \_\_\_\_\_ to \_\_\_\_\_ (mm/dd/yyyy)

**Question for the Designated Doctor to consider in the examination:** Is the employee's inability to perform the pre-injury employment a direct result of the compensable injury?

Complete if known:

DWC Claim #

Carrier Claim #

VIII. PURPOSE FOR EXAMINATION (continued)

E. Return to Work

Instructions for the requester: If you wish to know the employee's ability to return to a specific job, the following is required.

- 1. Provide the beginning and ending dates for each period covered by this request. If multiple periods, list all dates.  
From \_\_\_\_\_ to \_\_\_\_\_ (mm/dd/yyyy)

- 2. If the injured employee has been or will be offered a specific job or jobs, provide a brief job description(s) for the job(s).

Question for the Designated Doctor to consider in the examination: 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 (Supplemental Income Benefits)

Instructions for the requester: The information below is required.

- 1. Provide the beginning and ending dates for each qualifying period covered by this request. If multiple periods, list all dates.  
From \_\_\_\_\_ to \_\_\_\_\_ (mm/dd/yyyy)

- 2. Is the above qualifying period(s) applicable to the 9<sup>th</sup> quarter (or a subsequent quarter) of supplemental income benefits?  
 YES  NO

- 3. If there was a prior examination, provide the following:  
Date of the last examination: \_\_\_\_\_ Name of the examining doctor: \_\_\_\_\_

NOTE: Injured employees are allowed only one designated doctor examination per year after the second anniversary (8<sup>th</sup> quarter) of SIBs.

Question for the Designated Doctor to consider in the examination: Has the injured employee's medical condition improved sufficiently to allow the employee to return to work in any capacity for the identified qualifying period(s)?

G. Other Similar Issues

Instructions for the Requester: Identify the issue(s) and provide sufficient detail for the designated doctor to address the issue(s). This information is required.

NOTE: Designated Doctor examinations **may not** be requested for developing treatment plans, determining the appropriateness of medical care, or to determine compensability.

IX. REQUESTER CERTIFICATION

Check the appropriate box:

- Injured Employee
- Injured Employee Representative
- Insurance Carrier
- TDI-DWC/DWC Medical Advisor

I certify that all the information provided on this form is true and correct and I understand that any misstatement, falsification, or omission could cause an incorrect selection of the designated doctor and may result in TDI-DWC voiding any order issued pursuant to the request or taking enforcement action, including administrative penalties and/or fines.

Signature of Requester \_\_\_\_\_ Date \_\_\_\_\_

## Frequently Asked Questions Request for Designated Doctor Examination (DWC Form-032)

### 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. TDI-DWC may also order a designated doctor examination on its own motion.

### How often can a designated doctor examination be performed?

Prior to Supplemental Income Benefits (SIBs) eligibility and during the first eight quarters of receiving SIBs, 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. After eight quarters of SIBs, a designated doctor examination may be performed no more than once per year.

### For what purposes may a designated doctor examination be requested?

To resolve questions about:

- maximum medical improvement (MMI)
- impairment rating (IR)
- extent of injury
- whether the injured employee's disability is a direct result of the work-related injury
- ability of the injured employee to return to work
- return to work for Supplemental Income Benefits (SIBs)
- other issues similar to those described above

**Note:** A *Request for Designated Doctor Examination* may not be submitted to dispute or disagree with a designated doctor assessment. If you would like to dispute a designated doctor's assessment, submit a *Request for Benefit Review Conference (DWC Form-045)*.

### Do I have to complete all the fields on the DWC Form-032?

Failure to provide all required information on the DWC Form-032 will cause a delay in processing and your request will be returned to you. Answer "NA" if the requested information is not applicable.

#### SECTION V. TREATING DOCTOR/NETWORK INFORMATION

If the injured employee does not have a treating doctor, you must specify "*No Treating Doctor*" in the space provided for the doctor's name.

#### SECTION VII. INJURY AND TREATMENT INFORMATION

Requests will not be accepted without the completed Matrix. Check the applicable box(es) on the left of the Matrix for each injury area that is part of or claimed to be part of the injury even if no treatment has been provided.

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.

#### SECTION VIII. PURPOSE FOR EXAMINATION

Box A – If you are disputing a previously certified MMI, Box A must be completed. If you have multiple previously certified MMI dates, provide information regarding your first valid certification of MMI.

Box B – If you are disputing a previously certified IR, Box B must be completed. If maximum medical improvement has not been previously certified by a doctor, Box B cannot be requested without Box A. If you are requesting an IR examination without an MMI examination, include information regarding the MMI date determined to be valid by a final decision of TDI-DWC or court or by agreement of the parties.

Box D – The "claimed periods of disability" cannot include a future date. You may provide "*present*" for the ending date.

Box E – The “periods covered by this request” cannot include a future date. You may provide “*present*” for the ending date. If offering a specific job or jobs, provide a **brief** job description(s) in the space provided. No attached job descriptions will be accepted.

Box F – The “periods covered by this request” cannot include a future date. You may provide “*present*” for the ending date.

Box G – One example of an issue that can be requested in this box is “to determine if there is an injury resulting from the claimed incident.”

### **SECTION IX. REQUESTER CERTIFICATION**

The requester must sign and date this form to acknowledge that the injury and treatment information provided are complete and accurate. Failure to sign and date the form will result in TDI-DWC returning your request to you.

#### **Where do I file the DWC Form-032?**

The completed form should be mailed to the address shown below or faxed to (512) 804-4121.

Texas Department of Insurance  
Division of Workers' Compensation  
Designated Doctor Scheduling Section  
7551 Metro Center Drive, Suite 100 • MS-603  
Austin, TX 78744-1645

NOTE: Attachments to the form (Plain Language Notices, DWC Form-069s, etc.) or supplemental pages will not be accepted with the request.

Requesters of a designated doctor examination 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.

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

The TDI-DWC Designated Doctor Scheduling (DDS) section will review the request to ensure its completeness and accuracy, and review the claim file history to verify the reasons for the request are valid. If the request is approved, the DDS section will assign a qualified designated doctor to examine the injured employee. If there is a previously assigned designated doctor to the claim, the same doctor will be used as long as the doctor is still qualified and available. Within 10 days after approval, TDI-DWC will issue an order to the parties regarding the examination. If the request should be returned to you, you will receive a *Notice of Returned Request for Designated Doctor Examination* providing you with the specific reason(s) TDI-DWC was unable to process your request.

TDI-DWC may deny a request for a designated doctor examination if the request is frivolous as determined by the Commissioner of Workers' Compensation or Commissioner's designee.

If you wish to dispute TDI-DWC's approval or denial of a *Request for Designated Doctor Examination*, you are entitled to seek an expedited Contested Case Hearing under 28 Texas Administrative Code §140.3.

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

For more information contact your local TDI-DWC Field Office at 1-800-252-7031. Additional resources that answer common questions about the designated doctor process are also available online at <http://www.tdi.state.tx.us/wc/hcprovider/dd.html>.

**NOTE: With few exceptions, upon your request, you are entitled to be informed about the information TDI-DWC collects about you; receive and review the information (Government Code, §§552.021 and 552.023); and have TDI-DWC correct information that is incorrect (Government Code, §559.004).**