TDI Division of Workers' Compensation

Supplemental Information

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Designated Doctor Qualification Chart

For Use on or After 04/30/2023

(28 Texas Administrative Code (TAC) §127.130)

Board Certification is NOT required for the following injuries and diagnoses. Cases are assigned based on license type.

Injuries and Diagnoses	License Type
Hand/Upper Extremities	MD, DO, DC
Lower Extremities (NO feet)	MD, DO, DC
Spine and Musculoskeletal Structures of the Torso	MD, DO, DC
Feet (including toes and heel)	MD, DO, DC, DPM
Teeth and Jaw (including temporomandibular joint)	MD, DO, DDS
Eyes (including adnexal structures)	MD, DO, OD
Mental and Behavioral Disorders	MD, DO
Other Body Areas or Systems (including, but not limited to internal systems; ear, nose, and throat; head and face; skin; cuts to skin involving underlying structures; non-musculoskeletal structures of the torso; hernia; respiratory; endocrine; hematopoietic; and urologic)	MD, DO

Board Certification by ABMS (MDs) or AOABOS (DOs) is required for the following diagnoses:

Diagnosis	ABMS (MDs)	AOABOS (DOs)
Traumatic brain injury (Including concussion and post-concussion syndrome)	Neurological Surgery Neurology PM&R[1] Psychiatry Orthopedic Surgery Occupational Medicine Dermatology Plastic Surgery Surgery Anesthesiology (pain[2]) Emergency Medicine Internal Medicine Thoracic and Cardiac Surgery Family Medicine	Neurological Surgery Neurology PM&R Psychiatry Orthopedic Surgery Preventive Medicine /Occupational - Environmental Medicine Preventative Medicine/occupational Dermatology Plastic and Reconstructive Surgery Surgery (general) Anesthesiology (pain) Emergency medicine Internal medicine Thoracic and cardiovascular surgery Family Practice and Osteopathic Manipulative Treatment
Spinal cord injuries and diagnoses, including a spinal fracture with documented neurological injury, or vascular injury, more than one spinal fracture or cauda equine syndrome.	Neurological Surgery Neurology PM&R Orthopedic Surgery Occupational Medicine	Neurological Surgery Neurology PM&R Orthopedic Surgery Preventive Medicine/Occupational – Environmental Medicine Preventative Medicine/Occupational

[1] Physical Medicine and Rehabilitation

[2] Subspecialty or certificate of a designated doctor's qualifications in pain medicine/management

Diagnosis	ABMS (MDs)	AOABOS (DOs)
Severe burns, including chemical burns (deep partial or full thickness burns, aka 2nd, 3rd or 4th degree burns)	Dermatology PM&R Plastic Surgery Orthopedic Surgery Surgery Occupational Medicine	Dermatology PM&R Plastic and Reconstructive Surgery Orthopedic Surgery Surgery (general) Preventive Medicine /Occupational or /Occupational-Environmental Medicine
Complex Regional Pain Syndrome (Reflex Sympathetic Dystrophy)	Neurological Surgery Neurology Orthopedic Surgery Plastic Surgery Anesthesiology (pain[3]) Occupational Medicine PM&R	Neurological Surgery Neurology Orthopedic Surgery Plastic Surgery Anesthesiology (pain) Preventive Medicine /Occupational or /Occupational-Environmental Medicine PM&R
Any joint dislocation; one or more fractures with vascular injury; one or more pelvis fractures; or multiple rib fractures	Emergency Medicine Orthopedic Surgery Plastic Surgery PM&R Occupational Medicine	Emergency Medicine Orthopedic Surgery Plastic Surgery PM&R Preventive Medicine /Occupational – Environmental Medicine Preventative Medicine/Occupational
Complicated infectious diseases requiring hospitalization or prolonged intravenous antibiotics, including blood borne pathogens	Internal Medicine Occupational Medicine	Internal Medicine Preventive Medicine /Occupational – Environmental Medicine Preventative Medicine/Occupational
Chemical exposure, excluding chemical burns	Internal Medicine Emergency Medicine Occupational Medicine	Internal Medicine Emergency Medicine Preventive Medicine /Occupational or /Occupational-Environmental Medicine
Heart or cardiovascular conditions	Internal Medicine Emergency Medicine Occupational Medicine Thoracic and Cardiac Surgery Family Medicine	Internal Medicine Emergency Medicine Preventive Medicine /Occupational - Environmental Medicine Preventative Medicine/occupational Thoracic and cardiovascular surgery Family Practice and Osteopathic Manipulative Treatment

[3] Subspecialty or certificate of a designated doctor's qualifications in pain medicine/management

Designated Doctor Disqualifying Associations

(28 Texas Administrative Code (TAC) §127.140)

A disqualifying association is any association that may reasonably be perceived as having potential to influence the conduct or decision of a designated doctor. Disqualifying associations may include but are not limited to:

- Receipt of income, compensation or payment of any kind not related to health care provided by the designated doctor;
- Shared investment or ownership interest;
- Contracts/agreements that provide incentives (referral fees) or payments based on volume or value, and waiver of beneficiary coinsurance and deductible amounts;
- Contracts/agreements for space or equipment rentals, personnel services, management contracts, referral services, billing services agents, document management or storage services or warranties, or any other services related to the management or operation of the doctor's practice;
- Personal or family relationships;
- A contract with the same workers' compensation health care network (Texas Insurance Code Chapter 1305) or a contract with the same political subdivision health plan (Texas Labor Code (TLC) Chapter 504) that is responsible for providing medical benefits to the injured employee;
- Any other financial arrangement that would require disclosure under the TLC or Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) rules, the Insurance Code or TDI rules; or
- Any other association with the injured employee, employer or insurance carrier that may give the appearance of preventing the designated doctor from rendering an unbiased opinion.

Effective January 1, 2013, a designated doctor *shall* have a disqualifying association relevant to an examination or claim if an *agent* of the designated doctor has a disqualifying association as defined by this rule. For purposes of all applicable laws and TDI-DWC rules, any person with whom a designated doctor contracts or permits to perform designated doctor administrative duties on behalf of the designated doctor qualifies as the designated doctor's agent as defined by 28 TAC §180.1.

A designated doctor ***shall not*** perform an exam if that designated doctor has a disqualifying association. If a designated doctor learns of a disqualifying association, the designated doctor must notify the TDI- DWC within two (2) working days of learning of the disqualifying association. Performing an examination with a disqualifying association is an administrative violation.

Insurance Carriers shall notify the TDI-DWC of any disqualifying associations between the designated doctor and injured employee because of network or political subdivision affiliations within five (5) days of receiving the TDI-DWC order for the designated doctor examination.

If TDI-DWC determines that a designated doctor with a disqualifying association performed an examination, all reports by that designated doctor as a result of that exam shall be stripped of their presumptive weight.

Parties can dispute selection of a designated doctor for a particular exam or the presumptive weight of a designated doctor report based on a disqualifying association but must do so through TDI-DWC dispute resolution processes.

Designated Doctor Medical Examination Requirements

(28 Texas Administrative Code (TAC) §127.10 and §127.200)

Rules pertaining to the medical examination conducted by a designated doctor became effective September 1, 2012. Designated doctors are now required to perform designated doctor examinations in a facility currently used and properly equipped for medical examinations or other similar health care services that ensure:

- Safety;
- Privacy; and accessibility for Injured employees;
- Injured employees medical records; and
- Other records containing confidential claim information

The designated doctor is required to be **physically present** in the same room as the injured employee for the designated doctor examination or any other health care service provided to the injured employee except for referrals to another health care provider under 28 Texas Administrative Code §127.10(c). This requirement primarily applies when the designated doctor uses an ancillary health care provider to perform range of motion, strength, or sensory testing in relation to an impairment rating. When appropriate to the issue(s) addressed by the requested medical examination, the designated doctor shall apply the following required publications:

- The American Medical Association *Guides to the Evaluation of Permanent Impairment, Fourth Edition*
- Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC)-adopted return-to-work guidelines, *MDGuidelines*™.

The designated doctor shall also consider treatment guidelines that have been adopted by the TDI-DWC, Official Disability Guidelines, and other evidence-based medicine. When conducting the medical examination of the injured employee, the designated doctor is required to maintain a professional and courteous demeanor, including explaining the purpose of a designated doctor examination to the injured employee at the beginning of the examination. All reports and documents produced by the designated doctor are required to be written using appropriate, non- inflammatory language.

If a designated doctor's continued participation on a claim would require the designated doctor to exceed the scope of practice as authorized by the doctor's license, the designated doctor is required to notify TDI-DWC so another designated doctor can be assigned to the claim. Designated doctors shall NOT perform the examinations or services on a claim to which the doctor has already been assigned as a designated doctor:

- Required medical examinations;
- Utilization reviews; and
- Peer reviews

A designated doctor is required to perform any additional testing or make necessary consultation referrals (when not qualified) to resolve the issue(s) in question. Additional consultation and testing referrals by a designated doctor are not subject to preauthorization and cannot be denied retrospectively based on medical necessity, extent or compensability. When a testing or consultation referral is ordered, the designated doctor has 15 working days to complete and submit the designated doctor report. If the testing or consultation referral cannot be completed within the 15 working day time period, the designated doctor can request approval from TDI-DWC for additional time to complete the report. If an injured employee does not attend the additional testing or consultation referral, the designated doctor shall make notes in the report and complete the report based on medical examination of the injured employee, records and other available information available to the designated doctor.

Designated Doctor Medical Records Requirements

(28 Texas Administrative Code (TAC) §127.10(a) and §127.200)

Effective September 1, 2012, the treating doctor and insurance carrier must provide all required medical records (including analyses) to the designated doctor and follow up to ensure that all required records are received by the designated doctor no later than 3 working days prior to the scheduled exam. The designated doctor can receive an injured employee's confidential medical records and other records to assist in dispute resolution without a signed release from the injured employee.

If the designated doctor does not have the records 3 days prior to the scheduled exam, the designated doctor SHALL:

- Report the violation to the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) local field office.
- **NOT conduct the examination until all records are received.**

TDI-DWC will take necessary actions to ensure the designated doctor receives the medical records.

The designated doctor is required to review records received from the treating doctor, insurance carrier, TDI-DWC and any medical records provided by the injured employee **BEFORE** examining an injured employee.

The designated doctor is responsible for the retention of medical records related to the medical examination. The retention requirement for medical records related to a designated doctor examination is a minimum of 5 years or longer if required by the designated doctors licensing board. The medical records can be destroyed only after the designated doctor determines that the information is no longer needed **AND** the record retention period has expired.

(The form below is suggested for use, but not required)

Date: Date

To: Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC)
Fax number: 512-804-4121

From: Designated Doctor Name
Designated Doctor Agent Name (if any)
Phone Number
Fax Number

Re: Injured Employee Name
DWC Claim #
Date of Injury

Designated Doctor's Notice of Exam Change or Request for Approval

☐ 1. A scheduling conflict exists, and the exam has been rescheduled to _____. Provide description of scheduling conflict below. 28 Texas Administrative Code (TAC) §127.5(h)(i)(j)

☐ 2. A scheduling conflict exists and the exam cannot be rescheduled within 21 days of the originally scheduled exam. Provide description of scheduling conflict below. 28 TAC §127.5(h)(i)(j

☐ 3. The injured employee failed to attend a rescheduled exam. 28 TAC §127.5(h)(i)(j)

☐ 4. The designated doctor is not available to perform the exam because of a disqualifying association. Provide nature of disqualifying association below. 28 TAC §127.140

☐ 5. The insurance carrier/treating doctor failed to provide the required medical records at least 3 working days prior to the exam. Notice to designated doctor: The exam must be rescheduled if the records are not received within 1 working day of the exam. 28 TAC §127.10(a)(3)

☐ 6. **Request for Approval** to change the exam address indicated on the order. Provide the proposed exam address, date and time of exam (if changed), and good cause for the change below. 28 TAC §127.5(b)

☐ 7. **Request for Approval** of additional time to complete testing or referral exam and designated doctor's report. Provide either (a) the name and specialty of referral doctor or (b) type of testing ordered; and the date of the exam or testing. 28 TAC §127.10(c)

☐ 8. Other. Provide sufficient explanation/description below.

Provide a full and complete explanation of the notification or request made to the TDI-DWC. Please note the designated doctor cannot take action on a request made until a determination is made by the TDI-DWC.

_____

_____

_____

Fax to (512) 804-4121

Designated Doctor Administrative Violations

(28 Texas Administrative Code (TAC) §127.10(a) and §127.210)

The Commissioner may revoke or suspend a designated doctor's certification as a designated doctor or otherwise sanction a designated doctor for noncompliance with28 Texas Administrative Code (TAC) §127 for any of the following:

- 4 refusals within a 90-day period to accept or perform an offered or orderedappointment for which the designated doctor is qualified;
- 4 consecutive refusals to perform, within the required timeframes, a Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) orderedappointment for which the designated doctor is qualified;
- Any refusal to accept or perform a TDI-DWC offered or ordered appointment that relates to a claim on which the doctor previously performed an examination;
- Misrepresentation or omission of pertinent facts in medical evaluation andnarrative reports;
- Submitting unnecessary referrals to other health care providers;
- Ordering or performing unnecessary testing of an injured employee as part ofthe designated doctor examination;
- Submission of inaccurate or inappropriate reports due to insufficient medicalhistory or physical examination and analysis of medical records;
- Submission of designated doctor reports that fail to include all elements of 28TAC §127.10, 127.220 and other TDI-DWC rules;
- Failure to timely respond to a request for clarification from TDI-DWC regarding the examination or any other information requested by TDI-DWC;
- Failure to successfully complete the training and testing requirements of 28 TAC §127.100
- Self-referring, including referring to a health care provider with whom the designated doctor has a disqualifying association, for treatment or becoming the treating doctor for the medical condition evaluated by the designated doctor;
- Behaving in an assaultive or abusive manner toward the injured employee; TDI- DWC or other system participants;
- Failing to maintain the confidentiality of patient medical and claim file information;
- Performing a designated doctor examination which the designated doctor was not ordered by TDI-DWC to perform; and
- Other violations of applicable statutes or rules while serving as a designated doctor.

Designated doctors are liable for all administrative violations committed by their agents on their behalf. The process for notification and appeal of a sanction is governed by 28 TAC §180.27, and any suspension, revocation or other sanctions will remain in effect pending appeal.

Designated Doctor Program Contact Information

Designated doctor operations – Outreach planning and coordination:

- Questions concerning registration for certification courses and optional trainings

Telephone (512) 804-4585
Email: opc@tdi.texas.gov

Designated doctor education:

- Required certification course and optional training content
- Required testing
- Education outreach

Telephone: (512) 804-4765
Fax: (512) 804-4769
Email: DesDoc.education@tdi.texas.gov

Designated doctor certification and recertification:

- Application and re-application process
- Deferral requests
- Voluntary surrender requests
- Verify DD certification dates and MMI/IR authorization dates

Telephone: (512) 804-4766
Fax: (512) 804-4207
Email: OMA@tdi.texas.gov (questions only, not forms)

Designated doctor examination coordination:

- Scheduling & rescheduling of DD examinations (fax only)
- Request for redesignation (fax only)
- Request to change an exam location (fax only)
- Injured employee no show notification (fax only
- Request for additional time to complete report (fax or email)

Telephone: (800) 252-7033
Fax: (512) 804-4121
Email: DDScheduler@tdi.texas.gov
Email: DDRecords@tdi.texas.gov

TXCOMP Assistance

- Assistance with TXCOMP user ID and/or password

Telephone: (800) 252-7031, option 5
Email: txcomphelp@tdi.texas.gov

CompConnection for Health Care Providers:

- Billing and reimbursement
- Medical fee dispute resolution process

Telephone: (800) 252-7031 ext. 3
Telephone: (512) 804-4000 ext. 3 (Austin area)
Email: CompConnection@tdi.texas.gov

Claims and Customer Services:

- Claims administration assistance
- Medical records not received
- Requests for extension of time to submit reports

Telephone: (800) 252-7031
Email: ddrecords@tdi.texas.gov

Hearings

- Letters of Clarification
  Telephone: (512) 804-4010
  Fax: (512) 804-4005 (Requests and Responses)

- Presiding Officer Directives
  Telephone: (512) 804-4005 (Questions only)
  Fax: (512) 804-4011

Medical fee dispute resolution

Telephone: (512) 804-4812
E-mail: mdrinquiry@tdi.texas.gov

Office of Injured Employee Counsel:

Telephone: (866) 393-6432
Email: OIECInbox@oiec.state.gov

Workers' Compensation Health Care Networks

Email: WCNET@tdi.texas.gov

Independent Review Organizations (IROs)

E-mail: URAGrp@tdi.texas.gov

Insurance coverage or verification

E-mail: workerscompcustomerservices@tdi.texas.gov

Texas Department of Insurance – Complaints

Visit http://www.tei.texas.gov/consumer/complfrm.html for complaint submission options

TDI Division of Workers' Compensation

Appeals Panel Decisions (APDs) for Designated Doctors

As of November 7, 2023

APD#	Subject	Relevancy
130191 150224	Maximum Medical Improvement (MMI)	The Medical Disability Guidelines (MDG) cannot be used alone, without considering the injured employee's (IE) physical examination and medical records, in determining an IE's date of MMI.
040313-s 040998-s	MMI/Impairment Rating (IR)	An IR assignment shall be based on the injured employee's condition as of the MMI date, considering the medical records and the certifying examination. 28 Texas Administrative Code (TAC) §130.1(c)(3). That rule has been interpreted to mean that the IR shall be based on the condition as of the MMI date and is not to be based on subsequent changes, including surgery.
043168 110267	MMI/IR: Consideration of Compensable Injury	The doctor evaluating permanent impairment must consider the entire compensable injury.
200978 172017 131554	MMI	An injured employee cannot be found to have not reached MMI once the statutory MMI date has passed.
211351	IR	For IR assignment there should not be internal inconsistency between the DWC-69 and the narrative report. Checking the box for "no permanent impairment" on the 69 is not the same as assigning a 0% IR.
030091-s 142524	Radiculopathy	The AMA Guides indicate that to find radiculopathy, doctors must look to see if there is a loss of relevant reflexes or unilateral atrophy with greater than a 2-centimeter decrease in circumference compared with the unaffected side [see APD 072220-s, below, for clarification that, in order to have significant signs of radiculopathy based on atrophy, the measured unilateral atrophy is 2 centimeters or more, not greater than 2 centimeters].
040924, 091039, 111710	Radiculopathy	Loss of relevant reflexes is a decrease or an absence. The AMA Guides do not require a total loss of reflexes to qualify for an IR of radiculopathy.
072220-s 141799	Radiculopathy	The AP clarified that to receive a rating for radiculopathy the IE must have significant signs of radiculopathy, such as loss of relevant reflex(es), or measured unilateral atrophy of 2 centimeters or more above or below the knee, compared to measurements on the contralateral side at the same location, and the atrophy or loss of relevant reflexes must be spine-injury-related.
051456 080375	Radiculopathy	The significant clinical signs of radiculopathy may be verified by electrodiagnostic testing; however, electrodiagnostic testing indicating radiculopathy is insufficient by itself to assign impairment for radiculopathy in the absence of significant signs of radiculopathy (loss of relevant reflexes or unilateral atrophy).

APD#	Subject	Relevancy
022509-s	Spine	In the event the evaluating doctor must choose between two or more Diagnosis-Related Estimate (DRE) categories that may apply, the range-of-motion (ROM) Model may be used in conjunction with the DRE Model as a "differentiator" to make that choice.
032336-s	Spine	The evaluating doctor may not merely choose an IR that is between the IRs provided for in the DRE categories.
090639	Spine	Radiculitis and radiculopathy are not the same condition.
030288-s	Spine	If none of the categories of the DRE Model are applicable the evaluating doctor may use the ROM Model for assigning the IR. The doctor's report must have a specific explanation why the DRE Model could not be used. A comment that the evaluator merely prefers "to use the Model that he or she feels is most appropriate" is insufficient justification for using the ROM rather than the DRE Model."
051306-s 221500	Spine Cervical, Thoracic Lumbar	In using the DRE Model, the doctor should select the region primarily involved and rate that region. If the injury is primarily to the cervical spine the rating would be for cervicothoracic spine impairment; if the injury was primarily to the thoracic spine the rating would be for thoracolumbar spine impairment; and if the injury is primarily to the lumbar spine the rating would be for lumbosacral spine impairment. If more than one spine region is impaired, the doctor determines the impairment of the other regions and combines the regional impairments using the Combined Value Chart (CVC) on page 322 of the AMA Guides to express the total spine impairment.
080966-s	Spine Guarding	Table 71, AMA Guides, page 109, lists DRE Impairment Category Differentiators. The Guarding portion of Table 71 states “muscle guarding or spasm or nonuniform loss of ROM.” By placing the word “or” between guarding, spasm and nonuniform loss of ROM, those terms are in the disjunctive. The AP held that guarding can be used as a differentiator if guarding or spasm or nonuniform loss of ROM is present or has been documented by a physician, not that all three items of guarding, spasm and non-uniform loss of ROM must be present or documented by a physician before it can be used as a differentiator.
022504-s 220745	Upper Extremity (wrist radial/ulnar deviation) Range of Motion (ROM)	Where a conflict exists between the general directions and the figures in the AMA Guides, the general directions control. The general directions for rating radial and ulnar deviation provide that the measurements be rounded to the nearest 10 degrees. Because the general directions control, the measurements for radial and ulnar deviation should be rounded to the nearest 10 degrees, not 5 degrees as provided in Figure 29 on page 3/28 of the AMA Guides.

APD#	Subject	Relevancy
151158-s 160851	Upper Extremity Resection Arthroplasty of the Distal Clavicle	The language contained on page 3/58 is ambiguous, whereas the language on page 3/62 provides clearer instruction regarding the rating of arthroplasty procedures. Therefore, a distal clavicle resection arthroplasty that was received as treatment for the compensable injury results in 10% upper extremity impairment under Table 27 on page 3/62, which is then combined with ROM impairment, if any, as provided by the AMA Guides. The AP has previously held that impairment for a distal clavicle resection that was received as treatment for the compensable injury results in 10% UE impairment under Table 27 of the AMA Guides, which is then combined with ROM impairment, if any, as provided by the AMA Guides.
221683	Upper Extremity Resection Arthroplasty of the Distal Clavicle	The distal clavicle resection the injured employee received was not for treatment of the compensable injury and it was improper to include an impairment from Table 27 on p. 3/61 of the AMA Guides.
230890	Upper Extremity Total Shoulder Arthroplasty v. Hemiarthroplasty	Impairment cannot be assessed using Table 27, page 3/61 of the AMA Guides for a total shoulder arthroplasty if that procedure was not performed. A hemiarthroplasty is not the same as a total arthroplasty.
061569-s	Upper Extremity	Upper extremity impairments for a limb are combined using the CVC to determine the total upper extremity impairment and then the total upper extremity impairment is converted to a whole person impairment.
150931	Upper Extremity- Both Arms	If both limbs involved, calculate the whole person impairment for each separately and combine the percent using the CVC.
120897 132413	Upper Extremity Contralateral Comparison	There is no provision in the AMA Guides which require or prohibit using the contralateral side as a comparison and it is in the discretion of the certifying doctor to do so or not.
052243-s	Upper Extremity RSD/CRPS	Impairment secondary to causalgia and RSD is derived as set forth on page 3/56 of the AMA Guides "Causalgia and RSD", not from Table 17 "Impairment of Upper Extremity Due to Peripheral Vascular Disease" on page 57 of the AMA Guides.
210939	Upper Extremity RSD/CRPS	The AMA Guides, Section 3.2l page 3/89 entitled “Causalgia and RSD” instructs that “[w]hen these conditions occur in the lower extremity, they should be evaluated as for the upper extremity (UE) (Section 3.1k, page 56).”
211091-s	Lower Extremity ROM	AMA Guides on page 3/75 states that for impairments of the same lower extremity part, or different parts, the whole person impairments should be combined. This includes ROM impairments within the same joint.
132734 220150	Lower Extremity ROM	There are no specific directions in the AMA Guides which prohibit addressing loss of motion in the different directions of motions or vectors of motion in assessing impairment for a single joint. Section 3.2e does not require that a certifying doctor must only use the most severe impairment for an individual direction of motion within the same table.

APD#	Subject	Relevancy
220810	Lower Extremity ROM	There is no specific provision in the AMA Guides in the Lower Extremity section that requires ROM deficits be utilized to increase the impairment for a single joint, and it is within the certifying doctor's discretion as a matter of medical judgment to use or not use the different angles of loss of ROM in a single joint.
220893	Lower Extremity Both Limbs	The AMA Guides provide on page 3/17 that if both limbs are involved, calculate the whole-person impairment for each on a separate chart and combine the percents of each limb.
101481	Lower Extremity Peripheral Nerve Loss	The AMA Guides on page 3/88 state that all estimates listed in Table 68 are for complete motor or sensory loss of the named peripheral nerves and that partial motor loss should be estimated on the basis of strength testing.
230225	Lower Extremity Peripheral Nerve Loss	The AMA Guides provide on page 3/88 that all estimates listed in Table 68 on page 3/89 are for complete motor or sensory loss for the named peripheral nerves.
111720	Lower Extremity Amputation	A lower extremity impairment based on gait derangement for an extremity cannot exceed the impairment estimate for amputation of the extremity, which would be 40% whole person impairment.
220145	Lower Extremity Hip	Table 40 on page 3/78 of the AMA Guides describes the ROM measurements for hip extension as degrees of flexion contracture.
220810	Lower Extremity Hip	There is no specific provision in the AMA Guides in the Lower Extremity section that requires ROM deficits be utilized to increase the impairment for a single joint, and it is within the certifying doctor's discretion as a matter of medical judgment to use or not use the different angles of loss of ROM in a single joint.
072253-s 130849 191070	Hernia	To assess an impairment for a hernia-related injury under Table 7, "Classes of Hernia-related Impairment", on page 10/247 of the AMA Guides, is used to assess impairment for a hernia-related injury. there must be a palpable defect in the supporting structures of the abdominal wall. Each class listed in Table 7 for rating a hernia-related impairment requires a palpable defect in the supporting structures of the abdominal wall in conjunction with other criteria.
230137	Respiratory	The AMA Guides provide on page 5/163 that Table 8 presents criteria for estimating the extent of permanent impairment and that spirometry and single breath diffusing capacity of carbon monoxide (Dco) must be performed.

APD#	Subject	Relevancy
230102	Respiratory	Under Class 1 of Table 8 on page 5/162 of the AMA Guides, all of the listed criteria except for measured exercise capacity (VO2) max must be met. The required methodology includes, in part, measurements made from at least three acceptable spirometric tracings of forced expiration: forced vital capacity (FVC), forced expiratory volume in the first second (FEV1), and the FEV1/FVC, a predicted normal single-breath Dco Value for an individual according to age, and utilization of Table 8 (page 5/162) for estimating the extent of permanent impairment.
230999	Nerve Injuries	Chapter 4 of the AMA Guides provides for measuring impairment from nerve injuries, including neurological impairment of respiration in Section 4.3c on page 4/149.
071599-s	Skin/Peripheral Nerve	Impairment for a skin disorder under Chapter 13 of the AMA Guides may be combined with peripheral nerve impairment under Chapter 4 using the CVC to determine total impairment.
031168	Skin	Impairment for a skin disorder under Chapter 13 may be combined with impairment for loss of ROM under Chapter 3 using the CVC to determine total impairment.
162301	Skin disorders Class 1 and 2	For Class 1 and 2, Table 2 on page 13/280 of the AMA Guides, notes "[t]he signs and symptoms of disorders in classes 1 and 2 may be intermittent and not present at the time of the examination. The impact of the skin disorder on daily activities should be the primary consideration in determining the class of impairment. The frequency and intensity of the signs and symptoms and the frequency and complexity of medical treatment should guide the selection of an appropriate impairment percentage and estimate within any class."
060949 121772	Vision Loss	The AP stated that the AMA Guides require that all five steps be followed even if only one eye is injured. Subsection 8.4 page 217 lists the steps in determining impairment of the visual system and whole person. Step 1 is to determine the percentage loss of central vision for each eye combining the losses of near and distance vision. Step 2 is to determine loss of visual field for each eye. Step 3 is loss of ocular motility. Step 4, after "determining the level of impairment of each eye, use Table 7 (page [8]/219) to determine visual system impairment." Step 5 is to convert the visual system impairment to a whole person IR.

APD#	Subject	Relevancy
042912-s	Syncope	Syncope is rated for impairment under Table 22 entitled "Impairments Related to Syncope or Transient Loss of Awareness" on page 4/152 of the AMA Guides, and not under Table 5 on page 4/143.
051277 961699	Mental and Behavioral Disorders	Although Chapter 14 of the AMA Guides does not provide impairment percentages in the Table entitled "Classifications of Impairments Due to Mental and Behavioral Disorders", the certifying doctor may consider Chapter 4 relating to the Nervous System to calculate the impairment percentage for mental and behavioral disorders from Chapter 14. Chapter 4 at page 142 of the AMA Guides, the first column, provides that the criteria for evaluating the emotional and behavioral impairments in Table 3 of Chapter 4 relate to the criteria for mental and behavioral impairments in Chapter 14.
030622 961699	Mental and Behavioral Disorders	An IR for a mental or behavioral disorder must be supported by objective clinical or laboratory findings. The mental or behavioral disorder must be permanent to be rated for impairment.
231193	Mental and Behavioral Disorders	Section 4.1: The Central Nervous System – Cerebrum or Forebrain on page 4/140 of the AMA Guides provides that a patient may have more than one of nine types of cerebral dysfunction, which are identified as: (1) disturbances of consciousness and awareness; (2) aphasia or communication disturbances; (3) mental status and integrative functioning abnormalities; (4) emotional or behavioral disturbances; (5) special types of preoccupation or obsession; (6) major motor or sensory abnormalities; (7) movement disorders; (8) episodic neurologic disorders; and (9) sleep and arousal disorders. The AMA Guides provide that the most severe of the first five of the nine categories of cerebral dysfunction should be used to represent the cerebral impairment, and any impairments in the last four categories may be combined with the most severe of the first five categories.
002967	Aggravation	A claimed injury that causes additional damage or harm to the physical structure of the body. May include any naturally resulting disease or infection. Can include an enhancement, acceleration or worsening or an underlying condition.
120311-s	Extent of Injury	Differential diagnosis is not required to establish expert medical causation evidence.
141797	Extent of Injury	Designated doctors must address all disputed injuries listed by the requestor when assessing extent of injury.
221016	Extent of Injury	Designated doctors must have all of the injured employee's medical records to determine the extent of the compensable injury. The treating doctor and insurance carrier shall provide to the designated doctor copies of all the injured employee's medical records in their possession relating to the medical condition to be evaluated by the designated doctor. 28 TAC §127.10(a) and (b).

APD#	Subject	Relevancy
210067	Extent of Injury	The designated doctor must perform additional testing when necessary to resolve the issue in question. 28 TAC §127.10(c).
220009	IR Adjustments	The adjustments under page 2/9 of the AMA Guides provide for additional impairment in cases where: (1) treatment of an illness results in apparent remission of symptoms, but the patient has not regained his or her prior good health; and (2) pharmaceuticals themselves may lead to impairment.
090692-s	IR Adjustments	Adjustments to IR for effects of treatment or lack of treatment on page 2/9 – should be applicable to circumstances of injured employee's case to be used to assess impairment.
121131-s	Lifetime Income Benefits (LIBs)4 - Imbecility or Incurable Insanity	Discusses the concept beyond Texas Labor Code § 408.161(a)(6) and strictly legal definitions and looks to case law. The AP cited case law that contained instructive language on the definition of incurable insanity or imbecility. The AP noted that case law stated a worker's mental illness is "insanity" if he or she suffers severe social dysfunction and a worker's intellectual impairment is "imbecility" if he or she suffers severe cognitive dysfunction, and that social or cognitive dysfunction is "severe" if it affects the quality of the worker's personal, non-vocational life in significant activity comparably to the loss of two members or sight of both eyes, and is incurable if it is unlikely that normal functioning can be restored.
070063-s	LIBs	The AP cited prior APDs and case law rejecting the argument that because the IE had a spinal injury, the only way the IE could prove entitlement to LIBs was to show permanent and complete paralysis of his legs under Section 408.161(a)(5). The AP cited to case law that had approved entitlement to LIBs based on the total and permanent loss of use of the legs and/or feet, as total loss of use is defined in *Travelers Insurance Co. v. Seabolt*, 361 S.W.2d 204 (Tex. 1962), where the injury was to the spine. Also, the AP cited case law that had rejected the argument that the standards applied to loss of use under the prior law should not apply to cases decided under the 1989 Act.

DISCLAIMER: This list of APD decisions is provided as a quick reference guide, which does not constitute a substitute for review of the relevant APD in its entirety.

4 Effective: Dates of injury prior to September 1, 2023. House Bill (H.B.) 2468 of the 88th Texas Legislature, Regular Session (R.S.), amends Texas Labor Code Section 408.161, for dates of injury on or after September 1, 2023.

Appeals Panel Decision Manual Acronyms

Acronym	Phrase
Act	Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001
AIDS	Acquired Immune Deficiency Syndrome
AMA	American Medical Association
AP	Appeals Panel
APA	Administrative Procedure Act
APD	AP Decision
AWW	Average Weekly Wage
BRC	Benefit Review Conference
BRO	Benefit Review Officer
BCTS	Bilateral Carpal Tunnel Syndrome
BFOE	Bona Fide Offer of Employment
CAD	Coronary Artery Disease
CE	Claim Employer
CCH	Contested Case Hearing
CPR	Cardiopulmonary Resuscitation
CRPS	Complex Regional Pain Syndrome, was RSD, Reflex Sympathetic Dystrophy
CTS	Carpal Tunnel Syndrome
CVC	Combined Values Chart
D&O	Decision and Order (Hearing Officer's)
DARS	Department of Assistive and Rehabilitative Services formerly (TRC)
DB	Death Benefits
DD	Designated Doctor
Department	Texas Department of Insurance (TDI)
Division	Division of Workers' Compensation (DWC)
DOI	Date of Injury
DRE	Diagnosed-Related Estimates
DSM III R 1	Diagnostic and Statistical Manual of Mental Disorders (3rd edition ? revised)
DW	Deceased Worker
DWC-52	Application for Supplemental Income Benefits
ER	Emergency Room
FCE	Functional Capacity Evaluation
FMLA	Federal Medical Leave Act
FO	Field Office
Guides 3rdEd.	Guides to the Evaluation of Permanent Impairment, third edition, second printing,dated February 1989, published by the American Medical Association
Guides 4thEd.	AMA Guides (1st, 2nd, 3rd, or 4th printing, including corrections and changes as issuedby the AMA prior to May 16, 2000), fourth edition
HCN	Health Care Network
HD	Hearings Division
HNP	Herniated Nucleus Pulposus
HO	Hearing Officer
IC	Insurance Carrier
IIBs	Impairment Income Benefits
IPE	Individualized Plan for Employment
IR	Impairment Rating

Acronym	Phrase
IRO	Independent Review Organization
IW	Injured Worker
LIBs	Lifetime Income Benefits
LHWCA	Longshore and Harbor Workers' Compensation Act
LMSI	Loss of Motion Segment Integrity
LOC	Letter of Clarification
MDA	Medical Disability Advisor
MDR	Medical Dispute Resolution
MMI	Maximum Medical Improvement
MRD	Medical Review Division
MVA	Motor Vehicle Accident
OAO	Official Action Officer
ODG	Official Disability Guidelines
PIP	Personal Injury Protection
PT	Physical Therapist
PTSD	Post Traumatic Stress Disorder
ROM	Range of Motion
ROMM	Range of Motion Model
RME	Required Medical Examination
RSD	Reflex Sympathetic Dystrophy-now CRPS-Complex Regional Pain Syndrome
SS	Spinal Surgery
SIBs	Supplemental Income Benefits
SIF	Subsequent Injury Fund
TD	Treating Doctor
TIBs	Temporary Income Benefits
TRC	Texas Rehabilitation Commission (Department of Assistive and Rehabilitative Services)
TWC	Texas Workforce Commission
TWCC	Texas Workers' Compensation Commission
URA	Utilization Review Agent
VRP	Vocational Rehabilitation Program

Designated Doctor Certification Process

DD Certification (28 TAC §127.100)

In order to serve as a DD, a doctor must:

- Submit certificates of successful completion of DWC required training and testingon the duties of a DD under the Act of Rules, including demonstrated proficient knowledge of currently adopted edition of the AMA *Guides to the Evaluation of Permanent Impairment* and DWC adopted treatment and return-to-work guidelines
- Submit a **COMPLETE** application (DWC Form-067)
- Be licensed in Texas
- Maintain an active practice (routine office hours of at least 20 hours per week/ 40weeks per year for the treatment of patients) for **at least 3 years after licensureduring their career**
- Own or subscribe to the currently adopted edition
- of the AMA *Guides* (4th Edition) and all return-to-work and treatment guidelines adopted by DWC

Approval certifies a doctor for a 2-year term

- Includes effective and expiration dates
- Includes examination qualification criteria
- (under new 28 TAC §127.130) that DWC has assigned to DD based on requisitelicensure and board certification

Doctors shall be denied certification for

- Failing to submit required information
- Failure to submit a correct/complete application
- Failure to disclose orders and/or practice restrictions, reprimands, etc.
- Relevant practice/certification restriction, or other related issue (including DWC)
- Other activities that warrant denial of application

DD Recertification (28 TAC §127.110)

- A DD previously admitted to the DD list must renew by having completed all DWC required training within the past 12 months, and passed the DWC required test on or after 05/13/13
- Own or subscribe to the currently adopted edition (4th Edition) of the AMA Guidesand all return-to-work and treatment guidelines adopted by DWC
- Submit a COMPLETE application (DWC Form-067)

Must submit a complete DWC Form-067 at least *45 days in advance of expiration date*

- DWC will not assign new exams to a DD during the
- ***45 days*** prior to expiration of the DD's certification if required recertification information is not received
- DD may still provide services on previously assigned claims
- 30-day grace period for recertification after expiration

Doctors can be denied recertification for:

- **Changes to any information submitted on application must besubmitted to DWC within 10 working days**
- **Update information including disclosure of any orders, etc.**
    - Orders and/or practice restrictions received from state licensing board, certification authority or other state/federal agencies (including DWC) constitutes a basis for denial
    - A reprimand or fine paid to a state licensing board or state agency
    - Requesting unnecessary referral examinations or testing or failing to comply with financial disclosure requirements when requesting referrals or ordering testing
    - Other activities that warrant denial of recertification application, including but not limited to:
        - Quality of DD's past reports
        - DD's history of complaints
        - Excess requests for deferral from the DDL
        - Pattern of overturned reports by DWC or court
        - Demonstrated lack of ability to apply or properly consider AMA Guides or DWC adopted return-to-work and treatment guidelines
        - Demonstrated lack of ability to consistently perform DD exams in a timely manner
        - Demonstrated failure to identify disqualifying associations
        - Demonstrated lack of ability to ensure confidentiality of employee medical records or claim information
        - Any other grounds allowing DWC to sanction a health care provider under the Texas Workers' Compensation Act or DWC Rules

Designated Doctor Duties and Responsibilities

(28 Texas Administrative Code (TAC) §127.200)

All Designated Doctors shall:

- Perform designated doctor examinations in a facility currently used and properly equipped for medical examinations that ensures safety, privacy, and accessibility injured employees, injured employees' medical records and other records containing confidential claim information.
- Ensure the confidentiality of medical records, analyses, and forms provided to or generated by the designated doctor.
- Ensure destruction of these medical records after retention expires and DD determines information is no longer needed.
- Ensure all agreements with those permitted to perform DD administrative duties (including billing and scheduling duties) on behalf of DD:
    - Are in writing and signed by DD and contracting person
    - Define administrative duties that may be performed on behalf of DD.
- Require person with whom DD contracts to comply with all confidentiality provisions of Texas Labor Code and all other applicable laws.
- Comply with 28 TAC Chapter 133 medical billing and payment requirements.
- Do not constitute improper inducements under TLC §415.036 and 28 TAC §180.25.
- Are made available to DWC upon request.
- Notify DWC in writing and in advance if DD voluntarily decides to defer DD's availability to receive offers of examinations for personal or other reasons and specify durations of and reason for deferral.
- Notify DWC in writing and in advance if DD no longer wishes to practice as DD before *DD's current certification expires.*
    - A DD who no longer wished to practice as a DD, before DD's current certification expires, must expressly surrender DD's certification in a signed, Written statement to DWC.
- Be **physically present** in same room as injured employee for DD examination or any other health care service provided to injured employee that is NOT referred to another health care provider under 28 TAC § 127.10(c).
- Apply the appropriate edition of the American Medical Association guides to the Evaluation of Permanent Impairment and division-adopted return-to-work guidelines.
- Provide DWC with updated information within 10 working days of change in any of information provided to DWC on doctor's application for certification or recertification as a DD.

Designated Doctor Duties and Responsibilities

(28 Texas Administrative Code (TAC) §127.200) – *Continued*

- Maintain a professional and courteous demeanor when performing duties of a DD, including:
  - Explaining purpose of DD examination to injured employee at beginning of examination.
  - Using non-inflammatory, appropriate language in all reports and documents produced by DD.
- File a complaint
  - Online: http://www.tdi.texas.gov/consumer/complfrm.html
  - By fax: 512-490-1030
  - By email: DWC-CRCSIntakeunit@tdi.texas.gov
  - By mail:

    Texas Department of Insurance
    Division of Workers' Compensation
    7551 Metro Center Dr., Suite 100, MS-603
    Austin, TX 78744

- Respond timely to all DWC inquiries regarding appointments, clarification, documents and all other inquiries.
- Notify DWC if a DD's continued participation on a claim would require DD to exceed the scope of practice authorized by doctor's license.
- **Not perform** required medical examinations, utilization review, peer reviews, or *on a claim to which a DD has already been assigned as DD*.
- Consent to and cooperate during any on-site visits by DWC pursuant to 28 TAC §180.4 to ensure DD compliance with the Act and applicable DWC rules. * *DWC will notify DD in advance or at the time of specific duties being investigated at the time of the visit*.
- Identify themselves at the beginning of every DD examination, cooperate with all DWC audits and quality reviews, and comply with all applicable laws and rules.
- Bill and receive payment for DD examinations in accordance with 28 TAC Chapters 133 and 134.
- Comply with all accommodation requirements of Title II of the Americas with Disabilities Act (ADA).
  - When DD receives request for accommodation, they should make every effort to provide accommodation.
  - If not able to provide accommodation, injured employee should be instructed to contact the local DWC field office prior to performing the examination.

Designated Doctor Minimum Narrative Report Requirements

(28 Texas Administrative Code (TAC) §127.220)

Designated doctor narrative reports must, at a minimum:

- Identify the questions the Texas Department of Insurance, Division of Workers' Compensationordered the designated doctor to address *and:*
  - Provide a clearly defined answer to ordered question(s);
  - Not answer question(s) not ordered to be addressed; and
  - Sufficiently explain how the designated doctor determined the answer(s) within areasonable degree of medical probability.
- Include general information regarding the identity of:
  - Designated doctor;
  - Injured employee;
  - Employer;
  - Treating doctor; and
  - Insurance carrier.
- Summarize additional testing conducted or referrals made including:
  - Identity of referral health care provider;
  - Types of tests conducted or referrals made and dates the tests or referral examination(s) occurred; and
  - Explain why testing/referral was necessary to resolve a question at issue in the examination.
- State the date of the examination and address where the examination took place.
- List specific medical records or other documents the designated doctor reviewed including dates of those documents and which, if any, were provided by the injured employee.
- Include a narrative description of and documentation of the time the designated doctor began and completed the following:
  - Taking the medical history;
  - Physically examining the injured employee; and
  - Engaging in medical decision making.
- Be signed by the designated doctor who performed the exam.
- Include a statement of no known disqualifying association.
- Include a certification of date the report was sent to all required recipients and in the required manner; and
- Indicate the report was reviewed and approved in final form by the designated doctor.

For report requirements from all rule chapters, see the *Narrative Report and Form Requirements* document at: Designated doctor narrative report and form requirements (texas.gov)