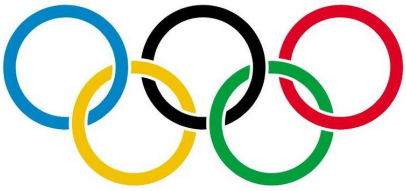
CLIENT NEWSLETTER

THE LAW OFFICE OF RICKY D. GREEN, PLLC

August 2, 2012



We hope you're enjoying the summer and staying cool. Thank you for reading our newsletters. If you have any questions about any of the newsletters or any other workers' compensation issues, please feel free to email or call us anytime. We're here to answer questions and help you handle your claims.

In this edition of the newsletter, we will look at some of the new designated doctor rules that have been adopted by the Division. The proposed rules were discussed in our November 4, 2011 newsletter. Following public comment, the rules have been amended and will go into effect on September 1, 2012.

You can view all of the adopted rules at:

http://www.tdi.texas.gov/wc/rules/adopted/documents/ddrulesm0712.pdf.

There are new designated doctor forms also. The Division has revised DWC Form-32 (Request for Designated Doctor Examination) which requires more information than the old form. It has created new DWC Form-67 (Designated Doctor Certification Application) which requires a designated doctor to fill out to get his/her certification to become and remain a designated doctor. The Division has also created DWC Form-68 (Designated Doctor Examination Data Report) which is the form a designated doctor must fill out if evaluating for extent of injury, disability or other similar issues. So, the designated doctor will fill out the DWC 69 if evaluating for maximum medical improvement and impairment rating, will fill out the DWC 68 if evaluating for extent of injury, disability or other similar issues and will fill out the DWC 73 if evaluating for return to work. The new forms are attached at the end of this newsletter.

Designated Doctor Process – Adopted Rules

The rules were amended because HB 2605 required the Division to develop a certification and recertification process for designated doctors. The new certification process includes standardized training and testing. Designated doctors will now have to be board certified to address the specific diagnoses and injuries of the injured employee. The new rules have also resulted in a revised DWC-32 form (Request for Designated Doctor Examination) as well as a new DWC-68 form (Designated Doctor Examination Data Report). The DWC-68 is to be used for examinations for extent of injury, disability, or other similar issues.

THE LAW OFFICE OF
RICKY D. GREEN, PLLC

9600 ESCARPMENT BLVD.,
SUITE 745-52
AUSTIN, TEXAS 78749

PHONE
(512) 280-0055
(866) 853-9407

FAX
(512) 280-0071

RICKY@RICKYDGREEN.COM
QUESTIONS@RICKYDGREEN.COM
WWW.RICKYDGREEN.COM

Licensed in Texas and Oklahoma

Certified as a Minority Business Enterprise

Some of the notable changes in the adopted rules are:

Section 127.1(d) – the Division must deny the request for a designated doctor examination "(4) if the insurance carrier has denied the compensability of the claim or otherwise denied liability for the claim as a whole and reported the denial to the division in accordance with §124.2 of this title (relating to Carrier Reporting and Notification Requirements) and the dispute is not yet resolved.

Section 127.1(e) – "If a division hearing officer or benefit review officer determines during a dispute regarding the compensability of a claim as a whole that an expert medical opinion would be necessary to resolve a dispute as to whether the claimed injury resulted from the claimed incident, the hearing officer or benefit review officer may order the injured employee to attend a designated doctor examination to address that issue."

Section 127.1(f) – Parties seeking a stay of an ordered designated doctor examination now have three working days to request the stay and expedited proceedings. This is a change from three straight days.

Section 127.5(e) – a rescheduled designated doctor examination cannot occur more than 21 days after the originally scheduled examination and cannot occur earlier than the originally scheduled examination.

Section 127.10(a)(3) – if the designated doctor does not receive medical records by three working days before the examination, the designated doctor must report the violation "within 24 hours of not timely receiving the records. Once notified, the division shall take action necessary to ensure that the designated doctor receives the records. If the designated doctor does not receive the medical records within one working day of the examination or if the designated doctor does not have sufficient time to review the late medical records before the examination, the designated doctor shall reschedule the examination to occur no later than 21 days after receipt of the records."

Section 127.10(f) – A designated doctor asked to answer any question other than MMI/IR or return to work must complete a DWC-68 (Designated Doctor Examination Data Report) along with a narrative report.

Section 127.10(h) – If the designated doctor provides multiple certifications of MMI/IR and is also asked to address extent of injury, the carrier must pay benefits based on the conditions to which the designated doctor determines the compensable injury extends.

Section 127.20(a) – "Parties may only request clarification on issues already addressed by the designated doctor's report on issues that the designated doctor was ordered to address but did not address. Additionally, a designated doctor shall only respond to questions or requests submitted to the designated doctor in the request for clarification and shall not otherwise reconsider the doctor's previous decision, issue a new or amended decision, or provide clarification on the doctor's previous decision."

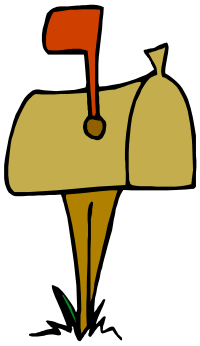
THE LAW OFFICE OF RICKY D. GREEN, PLLC
9600 Escarpment Blvd., Suite 745-52
Austin, Texas 78749
P: (512) 280-0055 F: (512) 280-0071
ricky@rickydgreen.com
www.rickydgreen.com

CLIENT NEWSLETTER

Section 127.100(a) – To be certified as a designated doctor, a doctor who is not a designated doctor must have maintained an active practice for at least three years during the doctor's career.

Section 127.130(b) – For examinations performed on or after January 1, 2013, a designated doctor is qualified if he or she meets the appropriate qualification criteria for the area of the body affected by the injury and the injured employee's diagnosis. This section also contains the proper licenses and certifications needed to perform exams on certain body parts and diagnoses.

Section 127.220(c) – The DWC-68 (Designated Doctor Examination Report) must contain all injuries determined to be compensable by the division, accepted as compensable by the insurance carrier, or the diagnosis code for each injury. The report must also provide a clearly defined answer for each question that was to be addressed. For extent of injury exams, the designated doctor should provide a diagnosis code for each disputed injury.



QUESTIONS? COMMENTS? Have questions or comments about any of the stories in the newsletter or general questions about a workers' compensation matter? Drop us a line at questions@rickydgreen.com, or give us a call at (512) 280-0055. We look forward to handling all of your workers' compensation needs.

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THE LAW OFFICE OF RICKY D. GREEN, PLLC
9600 Escarpment Blvd., Suite 745-52
Austin, Texas 78749
P: (512) 280-0055 F: (512) 280-0071

ricky@rickydgreen.com
www.rickydgreen.com

Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • MS-603
Austin, TX 78744-1645
(512) 804-4380 phone • (512) 804-4121 fax

Complete, if known:

DWC Claim #

Carrier Claim #

Request for Designated Doctor Examination

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

I. INJURED EMPLOYEE INFORMATION

1. Employee Name (First, Middle, Last)	**2. Employee Social Security Number**
3. Employee Address (Street or P.O. Box, City, State, Zip Code)	**4. Employee County**
5. Employee Primary Phone Number ( )	**6. Employee Alternate Phone Number** ( )
7. Employee Date of Birth (mm-dd-yyyy)	**8. Date of Injury** (mm-dd-yyyy)

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

9. Employer Name	**10. Employer Phone Number** ( )
11. Employer Address (Street or P.O. Box, City, State, Zip Code)	

III. INSURANCE CARRIER INFORMATION

12. Insurance Carrier Name	
13. Insurance Carrier Address (Street or P.O. Box, City, State, Zip Code)	
14. Adjuster Name (First, Middle, Last)	**15. Adjuster E-mail Address**
16. Adjuster Phone Number ( )	**17. Adjuster Fax Number** ( )
Only Insurance Carriers Complete Boxes 18 - 22	
18. Insurance Carrier's Authorized Agent Company Name	
19. Insurance Carrier's Bill Review Agent Name	
20. Bill Review Agent Address (Street or P.O. Box, City, State, Zip Code)	
21. Bill Review Agent Phone Number ( )	**22. Bill Review Agent Fax Number** ( )

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

23. Representative's Name (First, Middle, Last)	**24. Representative's Phone Number** ( )
25. Representative's E-mail Address	**26. Representative's Fax Number** ( )

For TDI-DWC Use Only

V. TREATING DOCTOR INFORMATION

27. Treating Doctor Name	**28. Treating Doctor Phone Number** ( )
29. Treating Doctor Address (Street or P.O. Box, City, State, Zip Code)	**30. Treating Doctor Fax Number** ( )
31. Treating Doctor License Number	**32.Treating Doctor License Type**

VI. DESIGNATED DOCTOR SELECTION INFORMATION

33. Does the claim involve medical benefits provided through a Certified Workers' Compensation Health Care Network? ☐ Yes ☐ No If yes, provide the name of the network.

34. Does the claim involve medical benefits provided through a political subdivision pursuant to §504.053(b)(2) of the Texas Labor Code, relating to directly contracting with health care providers or contracting through a health benefits pool? ☐ Yes ☐ No
If yes, provide the name of the health care plan.

35. Check all body parts and diagnoses that apply:	**Examples (not an exhaustive list)**
☐ Spine and Torso	Cervical, Thoracic, Lumbar, Sacroiliac, Sacrum, Coccyx, Pelvis, Sternum and Manubrium, Rib Cage, Chest Wall, Abdominal Wall
☐ Upper Extremities	Shoulder including Glenohumeral and Acromioclavicular Joints, Clavicle, Sternoclavicular Joint, Scapula, Forearm, Arm, Elbow, Wrist, Hand, Finger
☐ Lower Extremities (excluding feet)	Hip, Buttock, Thigh, Leg, Knee
☐ Feet	Foot, Heel, Toe
☐ Teeth and Jaw	Tooth, Jaw, Temporomandibular Joint (TMJ)
☐ Eyes	Eye, Eyelid
☐ Other Body Areas or Systems	Internal Systems; Ear, Nose, and Throat; Head and Face; Skin; Mental and Behavioral Disorders; Tendon Lacerations; Dislocations
☐ Traumatic Brain Injury	N/A
☐ Spinal Cord Injuries	Spinal cord injuries, including spinal fractures with documented neurological deficit
☐ Severe Burns (including chemical burns)	3rd or 4th degree over 9% or greater of the body
☐ Multiple Bone Fractures (excluding spinal fractures)	N/A
☐ Infectious Diseases (complicated)	Infection requiring hospitalization or prolonged intravenous antibiotics, including blood borne pathogens
☐ Complex Regional Pain Syndrome (Reflex Sympathetic Dystrophy)	N/A
☐ Chemical Exposure (excluding chemical exposure limited to skin exposure)	N/A
☐ Heart or Cardiovascular Condition	N/A

NOTE: You must provide additional injury and treatment information by completing the Addendum on page 7.

Employee's Name:

DWC Claim Number:

For TDI-DWC Use Only

VII. EXAMINATION / INJURY INFORMATION

36. 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.

37. List all injuries determined to be compensable by TDI-DWC or accepted as compensable by the insurance carrier. (If using ICD codes, you must also provide descriptions.)

38. Has a previous designated doctor examination been performed for this claim?
☐ Yes ☐ No If No, skip boxes 39 - 41.

39. Regarding the most recent designated doctor examination, provide the following information:

a. Name of the designated doctor

b. Date of the examination (mm/dd/yyyy)

40. If approval of this request would result in the Texas Department of Insurance, Division of Workers' Compensation (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.

41. Explain any change of medical condition since the most recent designated doctor examination.

Employee's Name:

DWC Claim Number:

For TDI-DWC Use Only

VIII. PURPOSE FOR EXAMINATION

42. Requester: For items A through G below, check the box(es) next to the issue(s) you want the designated doctor to address and provide the requested information.

Designated Doctor: Address only the issues that are checked. If Box A or B is checked, you must file the DWC Form-069. If Box E or F is checked, you must file the DWC Form-073. If Box C, D or G is checked, you must file the DWC Form-068.

☐ **A. Maximum Medical Improvement (MMI)**

Statutory MMI Date (if any) _____ (mm/dd/yyyy)

Questions for the Designated Doctor to consider in the examination:
Has MMI been reached; if so, on what date (may not be greater than the statutory MMI date shown above)?

☐ **B. Impairment Rating (IR)**

MMI Date* (required only if Box A is not checked) _____ (mm/dd/yyyy)

*The MMI date that has been determined to be valid by a final decision of the TDI-DWC or court or by agreement of the parties.

Question for the Designated Doctor to consider in the examination: As of the MMI date, what is the IR?

☐ **C. Extent of Injury**

List all injuries (diagnoses/body parts/conditions) in question, claimed to be caused by, or naturally resulting from the accident or incident.

Describe the accident or incident that caused the claimed injury.

Question for the Designated Doctor to consider in the examination: Was the accident or incident giving rise to the compensable injury a substantial factor in bringing about the additional claimed injuries or conditions, and without it, the additional injuries or conditions would not have occurred? Include an explanation of the basis for your opinion.

Employee's Name:

DWC Claim Number:

For TDI-DWC Use Only

☐ **D. Disability – Direct Result** (check only if the injured employee is unable to obtain and retain employment at wages equivalent to the pre-injury wage)

Provide the beginning and ending* dates for the claimed periods of disability. If multiple periods, list all dates.
From _____ to _____ (mm/dd/yyyy)

*The ending date cannot be a future date. You may enter "present" for the ending date.

Question for the Designated Doctor to consider in the examination: Is the employee's inability to obtain and retain employment at wages equivalent to the pre-injury wage a direct result of the compensable injury?

☐ **E. Return to Work**

Provide the beginning and ending dates for each period covered by this request only if you are requesting the designated doctor to examine the injured employee's work status for a time other than the present. If multiple periods, list all dates.

From _____ to _____ (mm/dd/yyyy)

Questions 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)**

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)

Is the above qualifying period(s) applicable to the 9th quarter (or a subsequent quarter) of supplemental income benefits? ☐ Yes ☐ No

NOTE: Injured employees are allowed only one designated doctor examination per year after the second anniversary (8th quarter) of Supplemental Income Benefits.

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**

Identify the issue(s) and provide sufficient detail for the designated doctor to address the issue(s).

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

Employee's Name:

DWC Claim Number:

For TDI-DWC Use Only

IX. REQUESTER CERTIFICATION

43. Check the appropriate box:

☐ **Injured Employee** ☐ **Injured Employee Representative** ☐ **Insurance Carrier** ☐ **TDI-DWC**

I certify the following:

- I am authorized to request the examination;
- All the information provided on this form is true and correct; and
- I provided a copy of this request to all parties at the time the original request was submitted to TDI-DWC.

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

If "insurance carrier" is checked above, I further certify the following:
I have been authorized by the insurance carrier to provide employees of the company named in Section III, Box 18, with the insurance carrier's authorization to take all further actions and communicate with the TDI-DWC regarding this DWC Form-032 *Request for Designated Doctor Examination.* Inquiries may be made in order to:

- check the status of the request;
- inquire about the reason the request was denied;
- inquire about information for the scheduled examination; and
- inquire about any other information related to the request for the examination.

44. Signature of Requester	
45. Printed Name of Requester	**46. Date of Signature** (mm/dd/yyyy)

Employee's Name:

DWC Claim Number:

For TDI-DWC Use Only

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.

Employee's Name:

DWC Claim Number:

Injury Areas – Check each injury area that is part of or claimed to be part of the injury. **Note: Each injury area MUST be checked, even if NO treatment has been provided.**	**General Treatment Types** – 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.[1]									
	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[2]	Check if provided	Check if discontinued
Musculoskeletal Injuries:										
☐ Back and Neck	☐	☐	☐	☐	☐	☐	☐	☐		
☐ Hand and Upper Extremities	☐	☐	☐	☐	☐	☐	☐	☐		
☐ Lower Extremities and Feet	☐	☐	☐	☐	☐	☐	☐	☐		
Occupational Exposures and Injuries:										
☐ Central Nervous System (cerebrum/forebrain)	☐	☐	☐	☐			☐	☐		
☐ Brain Stem	☐	☐	☐	☐			☐	☐		
☐ Spinal Cord or Spinal Canal	☐	☐	☐	☐	☐	☐	☐	☐		
☐ Muscular and Peripheral Nervous System	☐	☐	☐	☐	☐	☐	☐	☐		
☐ Respiratory System	☐	☐	☐	☐			☐	☐		
☐ Cardiovascular System	☐	☐	☐	☐			☐	☐		
☐ Hematopoietic System (blood disorders)			☐	☐			☐	☐		
☐ Eyes	☐	☐	☐	☐			☐	☐		
☐ Ears			☐	☐			☐	☐		
☐ Face	☐	☐	☐	☐			☐	☐		
☐ Teeth			☐	☐			☐	☐		
☐ Nose, Throat and Related Structures			☐	☐			☐	☐		
☐ Digestive System			☐	☐			☐	☐		
☐ Urinary and Reproductive Systems			☐	☐			☐	☐		
☐ Endocrine System (hormone system)			☐	☐			☐	☐		
☐ Skin			☐	☐			☐	☐		
Mental and Behavioral Disorders:										
☐ Mental and Behavioral Disorders			☐	☐					☐	☐
☐ Chronic pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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 4th 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.

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. The 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. The 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.

Do I have to complete all the fields on the DWC Form-032?
Failure to provide all required information on the DWC Form-032 may cause a delay in processing and your request may be returned to you.

If the injured employee does not have a treating doctor, you must specify *"No Treating Doctor"* in the space provided for the treating doctor's name in Box 27. If any other requested information is not applicable, answer "N/A".

In addition, you must complete the Addendum on page 7 for all requests.

Where do I file the DWC Form-032?
You are ***required to provide a copy of the completed DWC Form-032 to all parties*** at the time you submit the original request to the TDI-DWC. Submit the completed form to TDI-DWC by fax to (512) 804-4121 or by mail to the address shown below.

Texas Department of Insurance
Division of Workers' Compensation
Designated Doctor Examination Request Processing & Monitoring
7551 Metro Center Drive, Suite 100 • MS-603
Austin, TX 78744-1645

What does TDI-DWC do?
If the request is approved, the TDI-DWC assigns a qualified designated doctor to examine the injured employee. If there is a designated doctor who was previously assigned to the claim, the same doctor will be used as long as the doctor is still qualified and available. If the request is approved, within 10 days the TDI-DWC will issue an order to the parties regarding the examination. If the request is denied, you will receive a notice providing you with the specific reason(s) for the denial.

If you wish to dispute the 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 on the TDI website at http://www.tdi.texas.gov/wc/hcprovider/dd.html.

NOTE[1]: Title 28 Texas Administrative Code §127.1(b) (9) requires that in order to request a designated doctor examination, a request must be submitted on the form prescribed by TDI-DWC. The social security number may be used to identify the injured employee.

NOTE[2]: With few exceptions, upon your request, you are entitled to be informed about 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).

Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • MS-603
Austin, TX 78744-1645
(512) 804-4766 phone • (512) 804-4207 fax

Designated Doctor Certification Application

☐ **Initial Certification**
☐ **Recertification**
Date current certification expires, if applicable
(mm/yyyy) _____

I. APPLICANT / INDIVIDUAL INFORMATION (**not** administrative services company / agent information)

1. Name (Last, First, Middle, Suffix)	**2. Social Security Number**	**3. Date of Birth** (mm/dd/yyyy)
4. Home Mailing Address (Street or PO Box, City, State, Zip Code)		
5. Business Mailing Address (Street or PO Box, City, State, Zip Code)		
6. Home Phone Number ( )	**7. Alternate Phone Number** ( )	
8. Fax Number ( )	**9. E-mail Address**	
10. Non-English Language Spoken by Applicant ☐ Yes ☐ No If yes, specify		
11. Non-English Language Spoken by Office Personnel ☐ Yes ☐ No If yes, specify		

II. LICENSE INFORMATION (attach additional pages, if necessary)

Texas License	**Other License** (if applicable)	**Other License** (if applicable)
12. License Type	**17. License Type**	**22. License Type**
13. License Number	**18. License Number**	**23. License Number**
14. State of Registration **Texas**	**19. State of Registration**	**24. State of Registration**
15. Original Date of Issue (mm/yyyy)	**20. Original Date of Issue** (mm/yyyy)	**25. Original Date of Issue** (mm/yyyy)
16. Expiration Date (mm/yyyy)	**21. Expiration Date** (mm/yyyy)	**26. Expiration Date** (mm/yyyy)

For TDI-DWC Use Only

III. PROFESSIONAL SPECIALTY INFORMATION (attach additional pages, if necessary)

27. Primary Specialty

Are you board certified in this specialty?
☐ Yes ☐ No
If yes, provide the name of certifying board

Initial certification date (mm/yyyy)
Recertification dates, if applicable (mm/yyyy)
Expiration date, if applicable (mm/yyyy)

28. Secondary Specialty

Are you board certified in this specialty?
☐ Yes ☐ No
If yes, provide the name of certifying board

Initial certification date (mm/yyyy)
Recertification dates, if applicable (mm/yyyy)
Expiration date, if applicable (mm/yyyy)

29. Additional Specialty

Are you board certified in this specialty?
☐ Yes ☐ No
If yes, provide the name of certifying board

Initial certification date (mm/yyyy)
Recertification dates, if applicable (mm/yyyy)
Expiration date, if applicable (mm/yyyy)

IV. EDUCATION (attach additional pages, if necessary)

30. Professional Degree
☐ **Medical/Osteopathic** ☐ **Chiropractic** ☐ **Optometry** ☐ **Podiatry** ☐ **Dentistry**

31. Institution	**32. Degree**	**33. Attendance Dates** (mm/yyyy) From to
34. Address (Street or PO Box, City, State, Zip Code)		
35. Post-Graduate Education ☐ **Internship** ☐ **Residency** ☐ **Fellowship** ☐ **Teaching Appointment**	**36. Program Director**	**37. Current Program Director** (if known)
38. Institution	**39. Program Specialty**	**40. Attendance Dates** (mm/yyyy) From to
41. Address (Street or PO Box, City, State, Zip Code)		**42. Program Completed Successfully** ☐ **Yes** ☐ **No**
43. Post-Graduate Education ☐ **Internship** ☐ **Residency** ☐ **Fellowship** ☐ **Teaching Appointment**	**44. Program Director**	**45. Current Program Director** (if known)
46. Institution	**47. Program Specialty**	**48. Attendance Dates** (mm/yyyy) From to
49. Address (Street or PO Box, City, State, Zip Code)		**50. Program Completed Successfully** ☐ **Yes** ☐ **No**
51. Other Graduate-Level Education **Field of study**		
52. Institution	**53. Degree**	**54. Attendance Dates** (mm/yyyy) From to
55. Address (Street or PO Box, City, State, Zip Code)		

Applicant's Name:

Applicant's SSN:

For TDI-DWC Use Only

V. ACTIVE PRACTICE / WORK HISTORY INFORMATION

Active Practice	
56. Have you maintained an active practice* for at least 3 years? ☐ Yes ☐ No *Active practice is defined as maintaining routine office hours of at least 20 hours per week for 40 weeks per year for the treatment of patients.	
Work History (attach additional pages, if necessary)	
57. Current Practice / Employer Name (if any)	**58. Start Date / End Date** (mm/yyyy) From to
59. Address (Street or PO Box, City, State, Zip Code)	
60. Previous Practice / Employer Name	**61. Start Date / End Date** (mm/yyyy) From to
62. Address (Street or PO Box, City, State, Zip Code)	
63. Previous Practice / Employer Name	**64. Start Date / End Date** (mm/yyyy) From to
65. Address (Street or PO Box, City, State, Zip Code)	
66. Previous Practice / Employer Name	**67. Start Date / End Date** (mm/yyyy) From to
68. Address (Street or PO Box, City, State, Zip Code)	

VI. WORKERS' COMPENSATION HEALTH CARE NETWORK AFFILIATIONS

List all current workers' compensation health care network (network) affiliation(s) pursuant to Insurance Code §1305 and affiliation(s) with political subdivision health care plan(s) pursuant to Texas Labor Code §504.053(b)(2). Enter the contract start date for each network and each health care plan. (attach additional pages, if necessary)	
69. Network / Health Care Plan Name	**70. Start Date** (mm/dd/yyyy)
71. Network / Health Care Plan Name	**72. Start Date** (mm/dd/yyyy)
73. Network / Health Care Plan Name	**74. Start Date** (mm/dd/yyyy)

VII. ADMINISTRATIVE SERVICES COMPANY / BILLING AGENT / OTHER AGENT AFFILIATIONS

List all current administrative services company, billing agent, and other agent affiliation(s) (attach additional pages, if necessary)	
75. Administrative Services Company / Agent Name	**76. Contract Start Date** (mm/dd/yyyy)
77. Administrative Services Company / Agent Address (Street or PO Box, City, State, Zip Code)	
78. Name of Point of Contact	**79. Phone Number of Point of Contact** ( )
80. Email Address of Point of Contact	**81. Fax Number of Point of Contact** ( )
82. Billing Agent Name	**83. Billing Agent Phone Number** ( )

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VIII. DISCLOSURE QUESTIONS (check **YES** or **NO** for each question)

84. *Licensure*	**YES**	**NO**
Has your license to practice, in your profession, ever been denied, suspended, revoked, restricted, voluntarily surrendered while under investigation, or have you ever been subject to a consent order, probation or any conditions or limitations by any state licensing board?	☐	☐
Have you ever received a reprimand or been fined by any state licensing board?	☐	☐
85. *Hospital Privileges and Other Affiliations*	**YES**	**NO**
Have your clinical privileges or Medical Staff membership at any hospital or health care institution ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical records when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or health care institution, medical staff or committee, or governing board?	☐	☐
Have you ever voluntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?	☐	☐
Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?	☐	☐
86. *Education, Training and Board Certification*	**YES**	**NO**
Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?	☐	☐
Have you ever, while under investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?	☐	☐
Have any of your board certifications or eligibility ever been revoked?	☐	☐
Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?	☐	☐
87. *DEA (Drug Enforcement Administration) or DPS (Department of Public Safety)*	**YES**	**NO**
Have your Federal DEA and/or DPS Controlled Substances Certificate(s) or authorization(s) ever been denied, suspended, revoked, restricted, denied renewal, or voluntarily relinquished?	☐	☐
88. *Medicare, Medicaid or other Governmental Program Participation*	**YES**	**NO**
Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans or programs?	☐	☐
Other sanctions or investigations?	☐	☐
Are you currently or have you ever been the subject of an investigation by any hospital, licensing authority, DEA or DPS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program?	☐	☐
To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?	☐	☐

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Have you ever received sanctions from or been the subject of investigation by any regulatory agency (e.g., CLIA, OSHA, etc.)?	☐	☐
Have you ever been investigated, sanctioned, reprimanded or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation by a hospital or health care facility of any military agency?	☐	☐
89. *Malpractice Claims History*	**YES**	**NO**
Have you had any malpractice actions within the past 5 years (pending, settled, arbitrated, mediated or litigated)?	☐	☐
90. *Criminal*	**YES**	**NO**
Have you ever been convicted of, pled guilty to, or pled *nolo contendere* to any felony that is reasonably related to your qualifications, competence, functions, or duties as a medical professional?	☐	☐
Have you ever been convicted of, pled guilty to, or pled *nolo contendere* to any felony including an act of violence, child abuse or a sexual offense?	☐	☐
Have you ever been court-martialed for actions related to your duties as a medical professional?	☐	☐
91. *Ability to Perform Job*	**YES**	**NO**
Are you currently engaged in the illegal use of drugs? NOTE: "Currently" means sufficiently recent to justify a reasonable belief that the use of drug may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.	☐	☐
Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?	☐	☐
Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients?	☐	☐
Are you unable to perform the essential functions of a designated doctor as specified in 28 Texas Administrative Code, Chapter 127 and other applicable provisions of TDI-DWC rules and the Texas Labor Code?	☐	☐

92. *Disclosure Explanations* (attach additional pages, if necessary)

If you answered “Yes” to any question(s), identify each question by number and explain below.

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IX. APPLICANT'S AUTHORIZATION, ATTESTATION AND RELEASE

I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for participation in, or with, the TDI-DWC. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

I certify that all information provided in this application is true, complete, and correct to the best of my knowledge, and that I will notify the TDI-DWC within 10 working days of any change to the information I have provided in my application or authorized to be released pursuant to the credentialing process.

I understand that I am required on my own initiative to report to the TDI-DWC any changes to the application within 30 days of the date the information changed, or from the date I become aware of such changes, and that all changes must be submitted in writing, and must be dated and signed by me.

I am aware that participation in the Texas workers' compensation system as a designated doctor is not a right and is conditioned upon compliance with Statute and Rules and my provision of quality health care, evaluations, and/or medical opinions.

I affirm that I will remain aware of and in compliance with the requirements of the Statutes and TDI-DWC Rules, including but not limited to:

- financial disclosure requirements as contained in the Texas Labor Code, Section 413.041;
- cooperating with TDI-DWC monitoring and review efforts such as audits by the TDI-DWC;
- paying audit bills when required by Statute or Rule;
- consenting to any on-site inspections consistent with TDI-DWC rules §127.200 (a) (15); and
- owning or maintaining subscriptions to the current editions of guidelines adopted by the TDI-DWC, including impairment rating, treatment, and return-to-work guidelines.

I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of certification; and/or immediate suspension or termination of certification.

93. Signature of Applicant	
94. Printed Name of Applicant	**95. Date of Signature** (mm/dd/yyyy)

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X. SUBMISSION INSTRUCTIONS

96. Check and attach the following required documents:

☐ Copy of Designated Doctor Training Certificate(s)

☐ Copy of Designated Doctor Testing Certificate(s)

Mail the completed DWC Form-067, *Designated Doctor Certification Application*, and attachments to the following address or fax to (512) 804-4207:

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

NOTE: The application is deemed received by TDI-DWC when it is received in the Designated Doctor Outreach and Oversight Section at TDI-DWC.

NOTE[1]: Title 28 Texas Administrative Code §127.100(b) requires that in order to be considered for designated doctor certification, an application must be completed on TDI-DWC's form for certification applications. The social security number may be used to identify the doctor.

NOTE[2]: With few exceptions, upon your request, you are entitled to be informed about 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).

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