CLIENT NEWSLETTER

THE LAW OFFICE OF RICKY D. GREEN, PLLC

February 29, 2012

CHANGES ON THE HORIZON

DWC announced that today Wednesday, February 29th, it has launched a redesign of its homepage on the TDI website at http://www.tdi.texas.gov/wc/indexwc.html.

The new webpage should be more user friendly, including a new tab style menu with sections to assist system participants. Some of the other changes include:

- **Topics A-Z** features an alphabetical listing of workers' compensation-related subject matter that directly links to website content.
- **Online Services** features direct links to services, including: safety violation reporting, employer coverage verification and attorney fee processing.
- **Resources** feature direct links to resources, including the Texas Labor Code, TDI-DWC rules, calendar of events and training and TDI-DWC forms.

DWC Announces Proposed Changes to DWC-32 & Proposes New Form DWC-68

The Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) announced Friday, February 24th, that it has proposed revisions to the DWC Form-032, *Request for Designated Doctor Examination*; and informally proposed a new DWC Form-068, *Designated Doctor Examination Data Report*. Both of the proposed forms are available at the end of this newsletter and can also be found here: http://www.tdi.texas.gov/wc/rules/proposedrules/index.html.

Some of the notable changes to the DWC-32 include:

- Section III, Boxes 20-24. This section now requires the insurance carrier to provide information regarding its bill review company and contact information.
- Section VI, Designated Doctor Selection Information. The matrix has been revamped and includes more diagnoses, including examples of what body parts are included.
- Section VII, Examination/Injury Information. The section requests information on any prior designated doctors.
- The DWC-32 must now be submitted to all parties, included the injured employee and their representative at the time the form is filed with DWC.

Continued...

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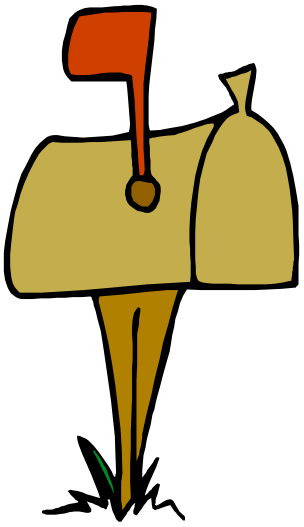
The new proposed DWC Form-068, Designated Doctor Examination Data Report, will be used when the Designated Doctor is asked to comment on Extent of Injury, Disability, or Other Similar Issues. The designated doctor will now be required to complete the DWC-68 and list which specific body parts and diagnoses are part of the compensable injury, including diagnosis codes. Section V of the form is to be used for any additional testing needed as part of the exam. The DWC-68 form is intended to help clarify any extent of injury questions and streamline the designated doctor process.

The TDI-DWC is accepting informal comments regarding the proposed revisions to the DWC Form-032 and DWC Form-068 until Monday, March 26, 2012 at 5 p.m. Central Standard Time.

Public comments may be submitted by e-mailing rulecomments@tdi.state.tx.us or mailing or delivering the comments to:

Texas Department of Insurance, Division of Workers' Compensation
Maria Jimenez
Workers' Compensation Counsel MS-4D
7551 Metro Center Drive, Suite 100
Austin, Texas 78744-1645



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

Request for Designated Doctor Examination

Type or print in black ink

I. INJURED EMPLOYEE INFORMATION

1. Injured Employee Name (First, Middle, Last)		**2. Injured Employee Social Security Number**
3. Injured Employee Address (Street or P.O. Box, City State Zip)		**4. Injured Employee County**
5. Injured Employee Primary Telephone Number ( )		**6. Injured Employee Alternate Telephone Number** ( )
7. Injured Employee Date of Birth (mm-dd-yyyy)	**8. Date of Injury** (mm-dd-yyyy)	**9. DWC Claim Number**

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

10. Employer Name	**11. Employer Telephone Number** ( )
12. Employer Address (Street or P.O. Box, City State Zip)	

III. INSURANCE CARRIER INFORMATION

13. Insurance Carrier Name	**14. Insurance Claim Number**
15. Insurance Carrier Address (Street or P.O. Box, City State Zip)	
16. Adjuster Name (First, Middle, Last)	**17. Adjuster E-mail Address**
18. Adjuster Telephone Number ( )	**19. Adjuster Fax Number** ( )

Only Insurance Carriers Complete Boxes 20 - 24

20. Insurance Carrier's Authorized Agent Company Name	
21. Insurance Carrier's Bill Review Agent Name	**22. Insurance Carrier's Bill Review Agent Address** (Street or P.O. Box, City State Zip)
23. Insurance Carrier's Bill Review Agent Telephone Number ( )	**24. Insurance Carrier's Bill Review Agent Fax Number** ( )

IV. TREATING DOCTOR INFORMATION

25. Treating Doctor Name	**26. Treating Doctor Telephone Number** ( )
27. Treating Doctor Address (Street or P.O. Box, City State Zip)	**28. Treating Doctor Fax Number** ( )
29. Treating Doctor License Number	**30.Treating Doctor License Type**

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

31. Representative's Name (First, Middle, Last)	For TDI-DWC Use Only
32. Representative's Telephone Number ( )	
33. Representative's E-mail Address	
34. Representative's Fax Number ( )	

VI. DESIGNATED DOCTOR SELECTION INFORMATION

35. 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.

36. 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.

37. 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, Ankle
☐ Feet	Foot, Heel, Toe
☐ Teeth and Jaws	Tooth, Jaw, Temporomandibular Joint (TMJ)
☐ Eyes	Eye, Eyelid
☐ Other Body Areas / Systems	Internal Systems; Internal Organs; Ear, Nose, and Throat; Head and Face; Skin; Mental and Behavioral Disorders
☐ Traumatic Brain Injury	N/A
☐ Spinal Cord Injuries; Profound Peripheral Neuropathy	Spinal Fractures with Documented Neurological Deficit
☐ Severe Burns (including chemical burns)	3rd or 4th Degree over 9% or Greater of the Body
☐ Dislocations, Tendon Lacerations, or 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

VII. EXAMINATION / INJURY INFORMATION

38. 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.

39. Has a previous designated doctor examination(s) been performed for this claim? ☐ Yes ☐ No
If no, skip Boxes 40 – 42 and complete Box 43. If yes, complete all Boxes in this section.

40. Name(s) of previous designated doctor(s)

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

42. 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.

43. List all injuries determined to be compensable by the TDI-DWC or accepted as compensable by the insurance carrier.

For TDI-DWC Use Only

VIII. PURPOSE FOR EXAMINATION

44. 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 (diagnosis/body parts/conditions) in question, claimed to be caused by, or naturally resulting from the accident or incident.

Describe 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 / conditions, and without it, the additional injuries / conditions would not have occurred? Include an explanation of the basis for your opinion.

☐ **D. Disability – Direct Result**

Is the injured employee currently working?
☐ Yes ☐ No
If yes, are current wages less than pre-injury wages?
☐ Yes ☐ No

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 perform the pre-injury employment a direct result of the compensable injury?

For TDI-DWC Use Only

☐ **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)

If the injured employee has been or will be offered a specific job or jobs, provide a **brief** job description(s) for the job(s). No attached job descriptions will be accepted.

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? Is the injured employee able to perform the specific job(s) described above?

☐ **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

If there was a prior examination, provide the following:
Date of the last examination: _____ (mm/dd/yyyy) Name of the examining doctor: _____

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). One example of an issue that can be requested in this box is "to determine if there is an injury resulting from the claimed incident".

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

IX. REQUESTER CERTIFICATION

45. Check the appropriate box:

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

I certify that I am authorized to request the examination and that all the information provided on this form is true and correct. 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 20, 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.

46. Signature of Requester	For TDI-DWC Use Only
47. Printed Name of Requester	
48. Date of Signature (mm/dd/yyyy)	

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 25. If any other requested information is not applicable, answer "N/A".

Where do I file the DWC Form-032?
The completed form must be faxed to (512) 804-4121 or mailed to the address shown below.

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

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

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

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: **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 94
Austin, TX 78744-1645
(800) 252-7031 phone • (512) 490-1047 fax

Designated Doctor Examination Data Report
Extent of Injury, Disability, or Other Similar Issues

I. INJURED EMPLOYEE CLAIM INFORMATION

1. Employee's Name (Last, First, Middle)	2. Date of Injury (mm-dd-yyyy)	3. Employee's Social Security Number
4. Insurance Carrier's Name	5. Insurance Carrier Claim Number	6. TDI-DWC Claim Number

II. EXAMINATION INFORMATION

7. Designated Doctor's Name	8. Designated Doctor's Mailing Address (Street or PO Box, City State Zip)	
9. Designated Doctor's License Number	10. Designated Doctor's License Jurisdiction	11. Designated Doctor's License Type
12. Designated Doctor's Telephone Number ( )	13. Examination Location (Street, City State Zip)	14. Date and Time of Appointment
15. Does the claim involve medical benefits provided through a Certified Health Care Network? ☐ Yes ☐ No If yes, provide the name of the network.		
16. 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.		

III. DIAGNOSIS CODES FOR COMPENSABLE INJURIES

17. Refer to the DWC Form-032 you received for this examination and provide below all the injuries listed in Section VII, Box 43. For data purposes only, assign the most reasonable corresponding diagnosis code(s) for each compensable injury listed. You may assign up to four diagnosis codes for each compensable injury. Attach additional pages, if necessary.

Compensable Injury	For Data Purposes Only			
	Diagnosis Code 1	Diagnosis Code 2	Diagnosis Code 3	Diagnosis Code 4
1)				
2)				
3)				
4)				
5)				

IV. PURPOSE OF EXAMINATION

18. Issues considered during Designated Doctor's examination. Check all that apply and provide the requested information.

☐ **a) Extent of injury**

Refer to the DWC Form-032 you received for this examination and provide below all the injuries listed in Section VIII, Box 44C. Did you determine that the accident or incident giving rise to the compensable injury was a substantial factor in bringing about the additional claimed injuries/conditions, and without it, the additional injuries/conditions would not have occurred? Provide your answer below by checking Yes or No for each additional claimed injury/condition. For data purposes only, assign the most reasonable corresponding diagnosis code(s) for each additional claimed injury/condition. You may assign up to four diagnosis codes for each additional claimed injury/condition. Attach additional pages, if necessary.

Additional Claimed Injury / Condition	Yes	No	For Data Purposes Only			
			Diagnosis Code 1	Diagnosis Code 2	Diagnosis Code 3	Diagnosis Code 4
1)	☐	☐				
2)	☐	☐				
3)	☐	☐				
4)	☐	☐				
5)	☐	☐				

☐ **b) Disability - Direct Result**

- Did you determine that the employee's inability to perform the pre-injury employment is a direct result of the compensable injury? ☐ Yes ☐ No

Refer to the DWC Form-032 you received for this examination and provide the following information as shown in Section VIII, Box 44D:

- Is the injured employee currently working? ☐ Yes ☐ No
- If yes, are current wages less than pre-injury wages? ☐ Yes ☐ No
- Provide the beginning and ending dates for the claimed periods of disability? If multiple periods, list all dates.

From to (mm/dd/yyyy)

☐ **c) Other Similar Issues**

Refer to the DWC Form-032 (Section VIII, Box 44G) you received for the examination and answer the applicable question below:

Did the claimed incident cause the claimed injury? ☐ Yes ☐ No

- OR -

Was the examination for another issue? ☐ Yes ☐ No

If yes, describe the issue listed in Box 44G:

V. REFERRALS / ADDITIONAL TESTING

Referral Health Care Provider Name	Provider License Number	Date of Service (mm/dd/yyyy)	Type of Testing						
			FCE */NCV*	EMG*	X-Ray	MRI*	CT-Scan*	Psychological Testing/ Evaluation	Other
			☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐

*Functional Capacity Evaluation; Nerve Conduction Velocity; Electromyography; Magnetic Resonance Imaging; Computed Tomography Scan

VI. DESIGNATED DOCTOR'S SIGNATURE

20. Signature of Designated Doctor	21. Date of Signature

Filing Instructions:

- The DWC Form-068 must be filed when a designated doctor examination addresses issues of extent of injury, disability – direct result, or other similar issues. Do not file this form if the designated doctor examination only addressed issues of maximum medical improvement, impairment rating, and/or return to work.
- You must attach the narrative report required by 28 Texas Administrative Code §127.220, *Designated Doctor Narrative Reports*.
- The DWC Form-068, along with the narrative report, must be submitted as follows:
  - Send to the treating doctor, TDI-DWC, and the insurance carrier by facsimile or electronic transmission.
  - Send to the injured employee and the injured employee's representative (if any) by facsimile or electronic transmission if you have this information. Otherwise, you must send the reports by other verifiable means.

NOTE: 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).

For TDI-DWC Use Only