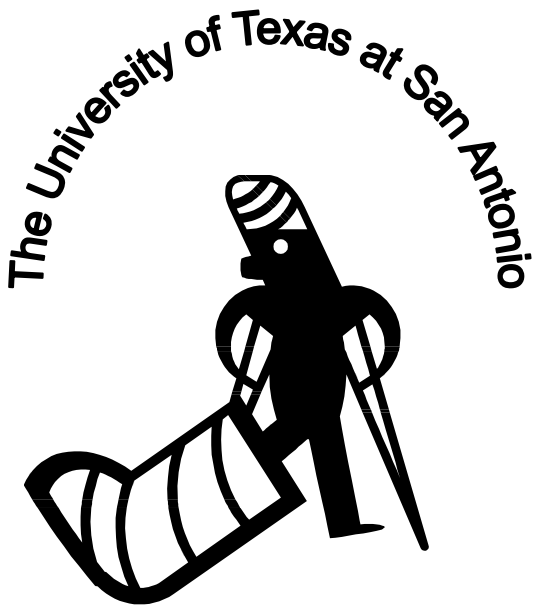



## Workers' Compensation

**All work-related injuries or illnesses must be reported.**

If the injury is an emergency, arrange for appropriate medical treatment. The employee has the right to select his or her own network physician; so please refer the employee to a Network Provider. If employee is incoherent, the supervisor or administrative staff may select an emergency facility. If possible, send a responsible employee to accompany the injured employee.

Please ensure the following forms are completed:

**EMPLOYEE'S FIRST REPORT OF INJURY OR ILLNESS**

**SUPERVISOR'S DETAILED DESCRIPTION OF INJURY/ILLNESS**

**WORKERS COMPENSATION NETWORK ACKNOWLEDGEMENT**

**PROVIDER NOTIFICATION OF ON-THE-JOB INJURY**

**WORKERS' COMPENSATION (WCI 23) REQUEST FOR PAID LEAVE**

Fax forms to (210) 458-7450 (Workers' Compensation Insurance Office in Risk and Emergency Management) within 24 hours from the time of the injury. Once the form has been faxed, send the original form through campus mail to OREM. These forms are required whether or not there is lost time from work.

Do not delay medical treatment to complete Workers' Compensation paperwork. Take all reasonable steps necessary to guard, provide warnings, or correct condition which caused the injury.
If you need assistance to accomplish the correction, call OREM at (210) 458-6851.

If you have any questions, contact the UT System Claims Analyst at (888) 802-0692.

**THE UNIVERSITY OF TEXAS SAN ANTONIO / EMPLOYEE'S FIRST REPORT OF INJURY STATEMENT**

*[Please have employee complete.]*

***PLEASE PRINT***

Name: _____ Social Security Number_____ ☐ Male ☐ Female

Social Security Number

(1) with few exceptions, the individual is entitled on request to be informed about the information that the state governmental body collects about the individual;
(2) under Sections 552.021 and 552.023 of the Government Code, the individual is entitled to receive and review the information; and
(3) under Section 559.004 of the Government Code, the individual is entitled to have the state governmental body correct information about the individual that is incorrect.

Address:

Street_____City_____County_____State_____Zip_____

Street or Box Apt.

Home Phone: (_____) _____ Campus Phone: (_____) _____ EID: _____ Date of birth:_____

Marital Status: ☐Married ☐Spouse's name: _____

☐Widowed ☐Single ☐Separated ☐ Divorced Number of Dependents: _____

Date of Injury: _____ Time of Injury: _____☐AM☐PM Job Title: _____

Injury Location: _____

Building Area Floor Room No.

Explain how and why this injury occurred (Provide as much detail as possible)

Item or equipment involved in accident:

Type of injury**:** ☐ Burn ☐ Cut/Laceration ☐ Bruise ☐ Strain ☐ Needle stick ☐ Repetitive Motion ☐ Exposure

☐ Bite ☐ Other _____ ☐ None (Incident Only)

Who witnessed the injury/illness/accident? Name(s) address and telephone number(s).

Were you advised of safety policies and procedures required for this job? ☐Yes ☐No ☐Not Applicable Type of Shoes Worn:

If no, please explain: _____

Did you notify your supervisor? ☐ Yes ☐ No If YES, date and time of notification: _____ _____

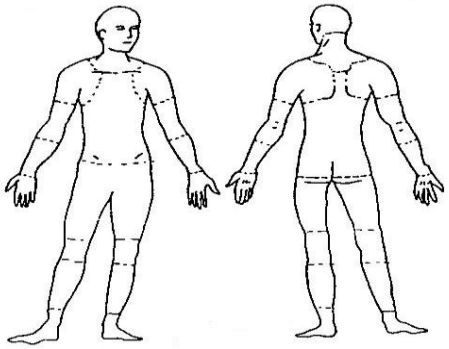
Department: _____ Supervisor: _____ Supervisor Phone: (_____) _____

****I have been offered medical attention but do not wish to receive any at this time. ** (Initial here)** _____

If requesting medical treatment, who did YOU select as your treating doctor/facility? _____ Tel. No._____
Please fill out a "Notification of Injury" form and take it with you to the physician. Contact UT System Claims Analyst at 1-888-396-6844, ASAP.

**Please designate the injured body part(s) as reported above**.

☐ Ankle ☐ Shoulder
☐ Foot ☐ Upper Arm
☐ Upper Leg ☐ Lower Arm
☐ Lower Leg ☐ Elbow
☐ Hip ☐ Wrist
☐ Knee ☐ Hand
☐ Toe(s) ☐ Fingers



☐ Head ☐ Upper Back
☐ Face ☐ Lower Back
☐ Eye(s) ☐ Buttocks
☐ Nose ☐ Abdomen (including groin)
☐ Mouth ☐ Pelvis
☐ Neck ☐ Chest

**FORWARD COMPLETED FORM TO WCI OFFICE, RISK AND EMERGENCY MANAGEMENT, PH # 458-8178, FAX 458-7450**

## INFORMATION RELEASE

The above statement is true and accurate to the best of my knowledge. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organization, institution or person that has any records or knowledge of me, or my health, to furnish to the U.T. System, UTSA Workers Compensation Office or its representative any and all information relevant to the injury or illness which I am reporting, including: medical history, consultation reports, hospital records, etc. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Signature of Employee: _____ Date: _____

**2/14/20 VERS.3.2**

THE UNIVERSITY OF TEXAS SAN ANTONIO / EMPLOYEE'S FIRST REPORT OF INJURY STATEMENT
SUPERVISOR'S DETAILED DESCRIPTION OF INJURY / ILLNESS AND ACCIDENT SCENE

*[Supervisor should complete.]*

*PLEASE PRINT*

Injured Employee: _____ Injured Employee EID#_____

President's Office (includes Audit, Compliance and Risk Services; Equal Opportunity Services; and Office of Legal Affairs)

☐ President's Office ☐ ACRS ☐ EOS ☐ OLA

Vice Presidents

☐ Academic Affairs ☐ External Relations ☐ Business Affairs ☐ Community Services

☐ Research ☐ Student Affairs Associate/Assistant VP area or College: _____

Facilities

☐ Administration ☐ Downtown/HemisFair Park Campuses ☐ Engineering and Project Management

☐ Main Campus Housekeeping ☐ Main Campus Operations & Maintenance

Date of Injury: _____ Time of Injury: _____ AM PM Job Title: _____

Injury Location: _____
Building Area Floor Room No.

1. Describe the type of work area where the accident occurred (stairs, dock, office, hallway, street, etc.)
Please explain any unusual conditions that were present at the time of the injury.

2. Based on your inquires, explain how and why this injury occurred:

2a. Cause of injury (fall, tool, machine, ground, wet floor etc.) _____

3. Who witnessed the injury/illness/accident? Name(s) address and telephone number(s).

4. Was employee doing his/her regular job? ☐ Yes ☐ No

5. Was there physical evidence of injury to the body part in question? ☐ Yes ☐ No

If yes, please describe (swelling, bruising, laceration etc.) _____

6. Does the employee speak English? ☐ Yes ☐ No If no, what language? _____

7. Injured employee's date of hire: _____ Occupation of Injured Worker: _____

Length of service in current position: _____ Length of service in Occupation: _____

8. Was the employee wearing personal protection equipment, which would have prevented the injury or occupational disease? ☐ Yes ☐ No ☐ Not Applicable

9. Was the employee advised of safety policies and procedures to prevent further occurrences? ☐ Yes ☐ No ☐ Not Applicable

10. Was medical treatment given to the employee? ☐ Yes ☐ No

11. Was the employee given the opportunity to choose their treating physician? ☐ Yes ☐ No ☐ Not Applicable

12. If taken for medical treatment, name of facility: _____

13. Did a department representative accompany the employee to the medical facility? ☐ Yes ☐ No ☐ Not Applicable

If yes, please provide the representative's name: _____

14. Has the employee lost time from work due to this injury? ☐ Yes ☐ No If yes, date lost time began: _____

14a. Has the employee returned to work? ☐ Yes ☐ No If yes, date returned to work: _____

The above statement is true and accurate to the best of my knowledge.

Supervisor Name: _____ Supervisor Signature: _____

Date: _____ Campus Ph. #: _____

**FORWARD COMPLETED FORM TO WCI OFFICE, RISK AND EMERGENCY MANAGEMENT, PH # 458-8178, FAX 458-7450**

REV 2/20

THE UNIVERSITY of TEXAS SYSTEM
FOURTEEN INSTITUTIONS. UNLIMITED POSSIBILITIES.

# WORKERS' COMPENSATION INSURANCE
# EMPLOYEE'S LEAVE ELECTION

Employee's Name _____ Claim Number _____ Date of Injury _____

If you have an on-the-job injury covered by workers' compensation insurance and are unable to work because of the injury, The University of Texas System will allow you to remain on the payroll by using all paid leave available to you.

If you choose to use paid leave, you must first use all available sick leave. Once all sick leave has been used, you may then choose to use one or more days of other paid leave in lieu of receiving temporary income benefits (TIBs). If you are still unable to work after using all paid leave, you will be removed from the payroll and TIBs may begin.

If you do not wish to use leave, or all leave is exhausted, please be advised:
You are not eligible for TIBs unless you miss more than 7 days of work due to your injury. This seven-day waiting period is only payable if your inability to work extends to the 14th day.

**EMPLOYEE ELECTION**

**Choose only ONE election, either Option 1 OR Option 2 below:**

☐ **OPTION 1- Paid Leave**

When I lose time from work due to this injury or illness, I elect to use all accrued sick leave to remain on the payroll.

**Once sick leave has exhausted, choose one of A, B, or C below:**

☐ A. All of my other available leave.

☐ B. A portion of my other available leave. I wish to use _____ hours of my other available leave.

☐ C. None of my other available leave.

☐ **OPTION 2- Leave Without Pay**

I do not wish to use leave, or no leave is available. Place me on leave without pay for all lost workdays.
I understand temporary income benefits (TIBs) will begin following the statutory seven-day waiting period if I have not been released to return to work.

**OFFICE USE**

**EMPLOYEE LEAVE BALANCE AS OF: ___/____/_____ (MM/DD/YYYY)**

**Sick Leave:** _____ hours **Other Leave*:** _____ hours (Include *Vacation, Compensatory, Other)*

- The first full workday covered by sick or other leave balance is ___/____/_____

**Leave Exhaustion Dates:**

- The last full workday covered by employee's **sick leave balance** is ___/____/_____
- The last full workday covered by employee's **other leave election** is ___/____/_____
- Leave without pay date is ___/____/_____

By signing below, I understand that I may not change my sick leave election once submitted. Once sick leave is exhausted, I may use all or a portion of other available leave before being placed on TIBs.

_____ _____

Employee or Employee Representative Signature Date

# *WCI Form-23 Instructions*

## Employee Instructions

Injured employees may elect to use accrued sick leave and all, some, or none of their other available leave for time missed from work due to the work-related injury. Accrued sick leave and other available leave are the amounts of paid leave available at the time of injury. The following information details the effects of the different choices available to you.

### If You Choose Option 1- Paid Leave

- You must use all accrued sick leave but may elect to use all, some, or none of your other available leave.
- All sick leave must be exhausted before other available leave may be used. Once sick leave is exhausted, you will be asked to make an election regarding other available leave.
    - If you select 1A and return to work but later have additional days of disability, you must use any accrued sick and other available leave before receiving workers' compensation income benefits.
    - If you select 1B, you must use any sick leave balance and can elect to use any hours of other available leave before receiving workers' compensation income benefits. Upon exhaustion of this choice, you may elect to use additional available leave to remain on the payroll.
    - If you select 1C, you must use any/all accrued sick leave before receiving workers' compensation income benefits.

  *Leave exhaustion- For the purposes of entitlement to income benefits, sick leave shall be considered exhausted when remaining sick leave hours are insufficient to cover a full work shift. Sick leave can be used in conjunction with other paid leave to cover a full work shift if other paid leave is elected by the employee. Other paid leave shall be considered exhausted when remaining leave hours are insufficient to cover a full work shift.*

- Workers' compensation income benefits do not begin until the eighth day of disability. Employees who are disabled for at least 14 days will receive retroactive benefits for any portion of the seven-day waiting period not paid by leave. *Note: "Disability" means the inability because of a compensable injury to obtain and retain employment at wages equivalent to the preinjury wage.*
- You will continue to receive your full pay if you have available leave and have authorized your institution to use it for your injury. If your elected leave is exhausted, you may receive income benefits to replace a portion of your lost wages. This may be 60%, 70%, or 75% of your average weekly wage depending on your employment status and wages at the time of your injury.
- It is recommended that you consult with your Human Resources department (leave management) to discuss the impact of your election on leave balances and insurance benefits should you be off work for an extended period.

### If You Choose Option 2

- You choose to not use any sick or other available leave for your compensable injury, you will be immediately placed on leave without pay for all lost days.
- You will not be eligible to receive any workers' compensation income benefits for the first seven (7) calendar days you are unable to work. If eligible, TIBs will begin on the 8th day of disability and employees who are unable to work for 14 days will receive retroactive payment of benefits for the first seven days. You will be paid at a rate of 60%, 70%, or 75% of your weekly wage depending on your wages at the time of your injury.

## Employer WCI Representative Instructions

- In the office use section, you or a department timekeeper enter the employee's leave balances and as of date.
- Leave fields should include ALL available sick leave or other available leave to the employee via the institution, other than sick. This could include vacation, compensatory time, etc.
- The first full workday covered by sick or other leave will be the first full day lost from work following the date of injury. Do not list the date of injury in this field. If no sick or other leave is available, enter '0' in the related field.
- Leave exhaustion dates:
    - For sick leave, calculate and enter the last full workday that sick leave will cover the employee's work absence, based upon employee's regular work schedule.
    - For other leave elections, begin with the next workday following sick leave exhaustion and calculate the last full workday other leave hours will cover the employee's work absence, using the employee's regular work schedule.
    - Leave without pay (LWOP) date is the date the employee is to be removed from the payroll and placed on LWOP.

# The University of Texas at San Antonio
# Office of Workers' Compensation

## Provider notification of an on-the-job injury

This form shall act as your notification for your workers' compensation insurance coverage. This form is to be presented to the physician's office, hospital emergency room, pharmacy or other authorized provider that is treating you for your work related injury. If you have any questions regarding your workers compensation coverage, please contact the UTSA Workers Compensation Office at 210-458-8178

| | |
|---|---|
| Employee Name: | |
| Date of Birth: | |
| Date of Injury: | |
| SSN: | Department: |

**Provider:**
PLEASE COPY THIS FORM AND RETURN TO EMPLOYEE

This employee has claimed a work related injury and may be covered by Workers' Compensation Insurance through the University of Texas System.

The University of Texas at San Antonio is a self-funded employer. Claims are processed through the University of Texas System in Austin.

**Pre-Authorization:**
For pre-authorization, please call 214.217.5939 or toll-free at 888.466.6381 or fax to 214.217.5937 or 877.946.6638.

THIS FORM DOES NOT CERTIFY COMPENSABILITY OR GUARANTEE PAYMENT

Please submit bills, medical reports, or questions to:

The University of Texas System
Office of Risk Management
Workers' Compensation Insurance Office
P.O. Box 802082
Dallas, Texas 75380
1-888-802-0692
FAX (972) 386-7918

**Pharmacy:**
The University of Texas System has partnered with RXBridge to make filling prescriptions easy.

Please use this form as a temporary prescription card. Please process prescriptions for the worker's compensation injury only. This form is only valid if signed and dated by UTSA employer representative.

For questions or rejections, please call (833) 792-7434. Please DO NOT send employee home or have employee pay for medication(s) before calling RXBridge for assistance.

RXBridge Group #: **G7STD7** Processor: **RXBridge** Bin#: **984000**

Pcn#: **RXB** RXBridge Help Desk: **(833) 792-7434**

ID: SAN01

Next to the SAN01 enter the last 3 digits of your Social Security Number and then two-digit month and two-digit day of your injury.

(ID Example: SAN011231219

Day supply is limited to **7** days for a new injury

**Injured Employee:**

PLEASE KEEP A COPY OF THIS COMPLETED FORM FOR YOUR RECORDS

Please feel free to contact the UTSA Workers Compensation Insurance office at (210) 458-8178 to assist you in locating a Workers Compensation Treating Medical Provider.

Please contact the UT System/CCMSI Claim Adjuster at (888) 802-0692 as soon as possible, following your injury.

A permanent RXBridge prescription card specific to your injury will be forwarded directly to you within the next 3 to 5 business days.

Please take this form and your prescription(s) to a pharmacy near you. RXBridge has a network of pharmacies nationwide. If you need assistance in locating a network pharmacy near you, please call RXBridge toll free at (833) 792-7434 or "Find a Pharmacy" search tool at www.RXBridge.com/

If you are denied medication(s) at the pharmacy, please call (833) 792-7434.

**MODIFIED DUTY MAY BE AVAILABLE, PLEASE CONTACT THE UTSA WCI OFFICE AT 210-458-8178**

Employer Representative _____ Phone _____ Date _____

RxBridge

# FIRST FILL PRESCRIPTION PROCESS

## UT AT SAN ANTONIO

Upon receiving prescriptions for a work-related injury for one of your employees, please provide the injured worker with a copy of this instruction sheet or ask them to text SAN01 to toll free 833-FRSTFILL (833-377-8345). The injured worker will complete the process and then present their billing information via mobile device.

## INJURED WORKER

Please follow the below instructions to obtain your First Fill Prescription Card.

**Text**
**SAN01**
**to 833-377-8345**

### How it Works

**01**

**Text**
Text SAN01 to toll free
833-FRSTFILL (833-377-8345)

**02**

**Follow the On-Screen Step by Step Instructions**

**03**

**Receive First Fill Card**
You will receive an image of your prescription card right to your phone.

**04**

**Fill Your Prescriptions**
Present your First Fill Prescription Card along with your injury related prescription(s) to your local pharmacy.


If you encounter any problems filling your prescriptions,
please call RxBridge toll-free at 833-RxBridge (833-792-7434)

# The University of Texas at San Antonio

## Workers' Compensation Network Acknowledgement Form

I have received information (Notice of Network Requirements & Employee Handbook Material) which informs me how to get Health Care under Workers' Compensation Insurance.

If I am hurt on the job and live in the service area described in this information, I understand that:

1. I must choose a treating doctor from the list of physicians in the ***IMO Med-Select Network®.*** (A list of physicians can be found at www.injurymanagement.com) Or, I may ask my HMO primary care physician to agree to serve as my treating doctor by completing the Selection of HMO Primary Care Physician as Workers' Compensation Treating Doctor Form # IMO MSN-5.
2. I must go to my network treating doctor for all health care for my injury. If I need a specialist, my treating doctor will refer me. If I need emergency care, I may go anywhere.
3. The insurance carrier will pay the treating doctor and other network providers.
4. I *may have to pay* the bill if I get health care from someone other than a network doctor without network approval.
5. If I receive the Notice of Network Requirements and refuse to sign the Acknowledgement Form, *I am still required to use the network*.

Please fill out the following information before signing and submitting this completed acknowledgement form. Injury Management Organization may contact you via phone, email and/or text to provide information to you and/or discuss your work injury.

**Name of Carrier:** The University of Texas System **Name of Network:** IMO Med-Select Network®

**Home Address**:_____
**Street Address – No P.O. Box or Work Address**

_____
**City** **State** **Zip Code** **County**

_____ _____ _____
**Printed Name** **Date of Injury** **Employee Phone Number**

_____ _____ _____
**Employee Signature** **Date** **Email**

For more information please contact UTSA Workers Compensation Insurance Office – 210-458-8178 or Office of Risk & Emergencey Management – 210-458-5250

# UT System

## IMO Med-Select Network® Quick Reference Card for Injured Employees

## The method to get Healthcare Services under UT System's Workers' Compensation Insurance

### IMO Med-Select Network® is the Network in which you will use to gain access to medical care for your injury.

**IMO Network Main Line or Find a Provider:**

- 214.217.5939 or 888.466.6381

**Or you may visit IMO's website at:**

- https://injurymanagement.com/find-a-provider/

**For emergency care you may seek treatment at the nearest emergency facility.**

Following notification of an injury on the job, an IMO Telephonic Case Manager, CCMSI Claims Professional/Adjuster, UT System Supervisor & RxBridge are parties to provide assistance to injured employees with medical case management and processing your workers' compensation claim. Early contacts and communication are important to ensure a smooth process and facilitate your recovery.

IMO Telephonic Case Manager (TCM):
This individual will be your assistance with facilitating medical care and helping you throughout the Network process.

CCMSI Claims Professional:
Responsible for daily claim handling including payment processing and communication with institution representatives.

UT System Claims Supervisor:
Oversees claim handling and provides continuous review/audit of all claim files.

RxBridge:
This is the party who will help you get the prescriptions you may need through the course of your injury.

**For more information about IMO please visit: www.injurymanagement.com**

### Important IMO Network Reminders:

- Acknowledgment Form — Provided by your institution, you are required to complete at the time of new hire and at the time an injury occurs. Please be sure to sign this.
- Except in medical emergencies, injured employees are required to select a treating doctor from the IMO provider panel.
- For any questions regarding your specialist or treating doctor please reach out to your IMO telephonic case manager.

**We are here to assist you. Please reach out with questions to:**
**IMO General Network/Provider Questions or to reach TCM's:**

***Phone:*** 214.217.5939
***Fax:*** 214.217.5937
***Email:*** netcare@injurymanagement.com

**CCMSI (UT's Third Party Administrator Adjuster Services)**

***Address:*** PO Box 802082, Dallas, TX 75380
***Phone:*** 888.802.0692
***Fax:*** 217.477.6813

**RxBridge (Pharmacy Services)**

***Contact Number:*** 1.833.792.7434

If you have a need for Telemedicine Services please search the IMO Provider Directory and choose the Telemedicine provider option. Some of these providers are available 24/7 to treat your work-related injury.

Your employer may have many options for return to work if you are given restrictions by your provider and may have the ability to accommodate. Please reach out to your institution's workers' compensation representative regarding this.

**For additional information on Network requirements please access the UT System Workers' Compensation Insurance website at:**
**https://www.utsystem.edu/offices/risk-management/workers-compensation-insurance-0**

# IMO MED-SELECT NETWORK®

## A Certified Texas Workers' Compensation Health Care Network

# *Notice of Network Requirements for The University of Texas System*

# IMO Med-Select Network®
# Notice of Network Requirements

1. *The University of Texas System* is using a certified workers' compensation health care network called the **IMO Med-Select Network®.**

2. For any questions you may contact IMO by:

   a. Calling IMO Med-Select Network® at 888.466.6381
   b. Writing to P.O. Box 260287, Plano, Texas 75026
   c. E-mailing questions to netcare@injurymanagement.com

3. Each certified workers' compensation network must have one or more service areas where doctors and other health care workers are available to treat you if you are hurt on the job. The network's service areas are in the following counties:

| IMO Med-Select Network® | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Anderson | Burleson | Crosby | Glasscock | Hunt | Liberty | Newton | Shackelford | Ward |
| Andrews | Burnet | Dallas | Goliad | Irion | Limestone | Nolan | Shelby | Washington |
| Angelina | Caldwell | Delta | Gonzales | Jackson | Live Oak | Nueces | Smith | Wharton |
| Aransas | Calhoun | Denton | Grayson | Jasper | Llano | Orange | Somervell | Wichita |
| Archer | Callahan | DeWitt | Gregg | Jefferson | Lubbock | Panola | Starr | Willacy |
| Atascosa | Cameron | Ector | Grimes | Jim Wells | Lynn | Parker | Sterling | Willbarger |
| Austin | Camp | El Paso | Guadalupe | Johnson | Madison | Polk | Tarrant | Williamson |
| Bandera | Cass | Ellis | Hale | Jones | Marion | Rains | Taylor | Wilson |
| Bastrop | Chambers | Falls | Hardin | Karnes | Martin | Reagan | Terry | Winkler |
| Baylor | Cherokee | Fannin | Harris | Kaufman | Matagorda | Red River | Titus | Wise |
| Bee | Clay | Fayette | Harrison | Kendall | McLennan | Refugio | Tom Green | Wood |
| Bell | Coke | Fisher | Hays | Kenedy | Medina | Robertson | Travis | |
| Bexar | Coleman | Floyd | Henderson | Kerr | Menard | Rockwall | Trinity | |
| Blanco | Collin | Fort Bend | Hidalgo | Kleberg | Midland | Runnels | Tyler | |
| Bosque | Colorado | Franklin | Hill | Lamar | Milam | Rusk | Upshur | |
| Bowie | Comal | Freestone | Hockley | Lamb | Montague | Sabine | Upton | |
| Brazoria | Concho | Frio | Hood | Lampasas | Montgomery | San Augustine | Van Zandt | |
| Brazos | Cooke | Galveston | Hopkins | Lavaca | Morris | San Jacinto | Victoria | |
| Brewster | Coryell | Garza | Houston | Lee | Nacogdoches | San Patricio | Walker | |
| Brooks | Crane | Gillespie | Howard | Leon | Navarro | Schleicher | Waller | |

4. A map of the service area with the above counties can also be viewed on the IMO website at **www.injurymanagement.com** or on page seven of this Notice of Network Requirements packet.

5. You have the right to select your HMO primary care physician (PCP) as your treating doctor if your HMO PCP was selected prior to your injury at work. The network prefers that you make this decision as soon as possible. Your HMO PCP must agree to abide by the workers' compensation health care network's contract and rules.

6. Except for emergencies, if you are hurt at work and live in the network service area, you must choose a treating doctor from the list of network doctors. All services and referrals are to be received from your treating doctor.

7. Except for emergencies, the network must arrange for services, including referrals to specialists, to be accessible to you on a timely basis and within the time appropriate to the circumstances and your condition, but no later than 21 days after the date of the request.

8. If you need emergency care, you may go anywhere. If you become injured after business hours and it is not an emergency, go to the closest health care facility.

9. If you cannot contact your treating doctor after business hours, and you are in need of urgent care, go to the closest health care facility.

10. You may not live in the network service area. If so, you are not required to receive care from network providers.

11. If you are hurt at work and you do not believe that you live within the network service area, contact your claims adjuster. The Third-Party Administrator for UT System must review the information within seven calendar days and notify you of their decision in writing.

12. UT System may agree that you do not live in the network service area**.** If you receive care from an out-of-network provider, you may have to pay the bill for health care services if it is later determined that you live in the network service area.

13. If you disagree with the decision in regard to the network service area, you may file a complaint with the Texas Department of Insurance. Complaint form information is addressed in #30 below.

14. Even if you believe you do not live in the network service area, you still may receive health care from network doctors and staff while your complaint is reviewed by the Texas Department of Insurance and the network.

15. UT System will pay for services provided by the network treating doctor and other network health care providers. Except for emergency care, you may have to pay the bill if you get care from someone other than a network doctor without approval.

16. All network doctors and other providers will only bill UT System for medical services as related to the compensable work injury. The employee should not be billed by the network provider.

17. Unless there is an emergency need, the network must approve any of the following health care services before they are provided to you:

    a. Admission to a hospital or surgical procedures
    b. Mental Health Care
    c. Physical Medicine Services such as physical therapy, occupational therapy, and chiropractic
    d. Diagnostic testing
    e. Injections

f. Rehabilitation Programs including work conditioning and work hardening
g. Durable Medical Equipment billed at more than $1,000 per item
h. Treatment not addressed or not recommended by Evidence Based Guidelines
i. Prescription drugs on the "N" list and all compounds
j. Dental
k. Investigational treatment
l. Pain Medicine / Other Programs
m. Treatment for Disputed Body Parts & Conditions
n. Miscellaneous: – K-Wire removal, Chemotherapy, Radiation

18. Definition: "Adverse Determination" means a determination, made through utilization review or retrospective review, that the health care services furnished or proposed to be furnished to an employee are *not* medically necessary or appropriate.

19. If the proposed health care services are for concurrent hospitalization, the person performing utilization review must, within 24 hours of receipt of the request, transmit a determination indicating whether the proposed services are pre-authorized. For all other requests for preauthorization, the person performing utilization review must issue and transmit the determination no later than three business days after the date the request is received.

20. If the network issues an adverse determination of the request for health care services, you, a person acting on your behalf or your doctor may file a request for reconsideration by writing a letter or calling the network. Even though you can request a reconsideration of the denial yourself, the network encourages you to talk to your doctor about *filing* the reconsideration. He or she may have to send medical information to the network. This reconsideration must be submitted within 30 days of the date that your doctor receives the adverse determination in writing.

21. The network will respond to the reconsideration request within five business days of receipt demonstrating that the network has received the information. The network has up to 30 business days for the final determination. If it is a reconsideration request for concurrent review, the network will respond within three business days. The network will respond within one business day if it is a reconsideration request which involves a denial of proposed health care services involving post-stabilization treatment, life-threatening conditions or for continued length of stay in a facility.

22. Independent Review Organization (IRO) exemption: An employee with a life-threatening condition is entitled to an immediate review by an IRO and is *not* required to comply with the procedures for a reconsideration of an adverse determination.

23. If the network renders an adverse determination on a reconsideration of the following: i) a preauthorization review, ii) a concurrent review or iii) a retrospective review, the notification will include information on how to request an IRO. Requests for an IRO must be sent no later than 45 days from the date of the denial of the reconsideration.

24. If the situation is life threatening, you do not have to go through the network reconsideration process. You, the person acting in your behalf, or the requesting provider may request a review by an IRO. IRO requests shall be made to the Texas Department of Insurance on behalf of the patient by the Utilization Review Agent (URA).

25. An IRO review may be requested for several other reasons besides a life-threatening situation. The reasons may include: i) if the network denies the health care a second time by denying your reconsideration; ii) if the network denies the referral made by your treating doctor because it is not medically necessary; or iii) if the network denies your care because it is not within treatment guidelines.

26. After the review by the IRO, they will send a letter explaining their decisions. UT System will pay the IRO fees.

27. Your treating doctor may decide to leave the network. If so, and if it may harm you to immediately stop the doctor's care, UT System must pay your treating doctor for up to 90 days of continued care.

28. If you are dissatisfied with any part of the network, you can file a complaint. Any complaint must be filed within 90 days of the event that you are dissatisfied. When a complaint is received, you will be sent a notification letter within seven days, which will describe the complaint procedures. The network will review and resolve the complaint within 30 days of receipt. *You can contact the network by:*

    a. Calling: 877.870.0638
    b. Writing: IMO Med-Select Network®
       **Attention : NetComplaint Dept.**
       P.O. Box 260287
       Plano, TX 75026
    c. E-mailing: netcomplaint@injurymanagement.com

29. The network will not retaliate if:

    a. An employee or employer, who files a complaint against the network or appeals a decision of the network, or
    b. A provider who, on behalf of the employee, files a complaint against the network or appeals a decision of the network.

30. If you file a complaint with the network and are dissatisfied with the network resolution, you may file an appeal with the Texas Department of Insurance (TDI). *You can receive a complaint form from:*

    a. The TDI website at www.tdi.state.tx.us, or
    b. Write to TDI at the following address:
       **Texas Department of Insurance**
       HMO Division, Mail Code 103-6A
       P.O. Box 149104
       Austin, TX 78714-9104

31. Within five business days, the network will send a letter confirming they received the appeal.

32. A list of network providers will be updated every three months, including:

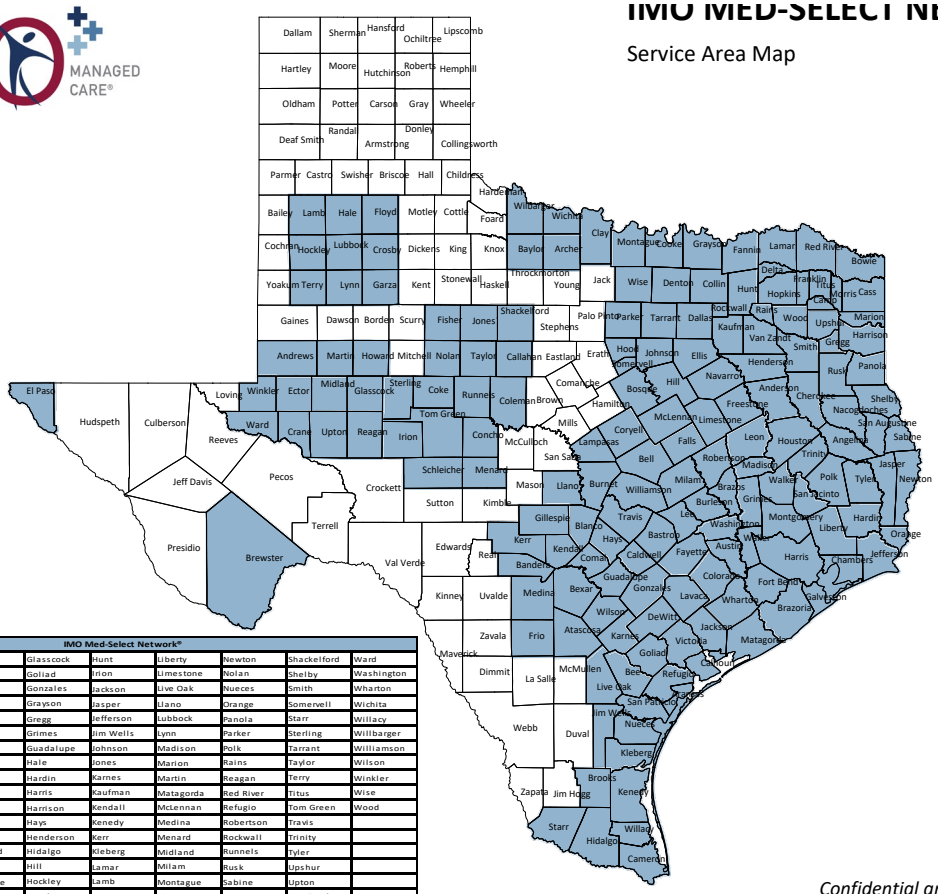
    a. The names and addresses of network providers grouped by specialty. Treating doctors shall be identified and listed separately from specialists; and
    b. Providers who are authorized to assess maximum medical improvement and render impairment ratings shall be clearly identified.

33. To obtain a provider directory:

    a. You can request a copy from your employer, or
    b. You can view, print or email a list online at www.injurymanagement.com.

# IMO MED-SELECT NETWORK®

Service Area Map




| IMO Med-Select Network® | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Anderson | Burleson | Crosby | Glasscock | Hunt | Liberty | Newton | Shackelford | Ward |
| Andrews | Burnet | Dallas | Goliad | Irion | Limestone | Nolan | Shelby | Washington |
| Angelina | Caldwell | Delta | Gonzales | Jackson | Live Oak | Nueces | Smith | Wharton |
| Aransas | Calhoun | Denton | Grayson | Jasper | Llano | Orange | Somervell | Wichita |
| Archer | Callahan | DeWitt | Gregg | Jefferson | Lubbock | Panola | Starr | Willacy |
| Atascosa | Cameron | Ector | Grimes | Jim Wells | Lynn | Parker | Sterling | Willbarger |
| Austin | Camp | El Paso | Guadalupe | Johnson | Madison | Polk | Tarrant | Williamson |
| Bandera | Cass | Ellis | Hale | Jones | Marion | Rains | Taylor | Wilson |
| Bastrop | Chambers | Falls | Hardin | Karnes | Martin | Reagan | Terry | Winkler |
| Baylor | Cherokee | Fannin | Harris | Kaufman | Matagorda | Red River | Titus | Wise |
| Bee | Clay | Fayette | Harrison | Kendall | McLennan | Refugio | Tom Green | Wood |
| Bell | Coke | Fisher | Hays | Kenedy | Medina | Robertson | Travis | |
| Bexar | Coleman | Floyd | Henderson | Kerr | Menard | Rockwall | Trinity | |
| Blanco | Collin | Fort Bend | Hidalgo | Kleberg | Midland | Runnels | Tyler | |
| Bosque | Colorado | Franklin | Hill | Lamar | Milam | Rusk | Upshur | |
| Bowie | Comal | Freestone | Hockley | Lamb | Montague | Sabine | Upton | |
| Brazoria | Concho | Frio | Hood | Lampasas | Montgomery | San Augustine | Van Zandt | |
| Brazos | Cooke | Galveston | Hopkins | Lavaca | Morris | San Jacinto | Victoria | |
| Brewster | Coryell | Garza | Houston | Lee | Nacogdoches | San Patricio | Walker | |
| Brooks | Crane | Gillespie | Howard | Leon | Navarro | Schleicher | Waller | |

0 75

Scale in Miles

October 2022

*Confidential and Proprietary*