Texas Department of Criminal Justice
Employee’s Report Packet for Workers’ Compensation

CONTENTS

PERS 298-1, Employee’s Guidelines for Workers’ Compensation

PERS 298-2, Employee’s Report of Injury or Illness

PERS 298-3, Employee’s Election Regarding Use of Sick and Vacation Leave C-80 (Part A) and Employee’s Other Time Election C-80 (Part B)

PERS 298-4, Authorization for Release of Information (Form No. SORM-16 9-98)

PERS 298-5, Employee’s Acknowledgement of Responsibilities Relating to Work-Related Injury or Illness

DWC FORM-48, Request for Travel Reimbursement

myMatrixx Workers’ Compensation Prescription Information

IMO Med-Select Employee Network Notification Packet

PERS 607, Workers’ Compensation Network Acknowledgement (Page two of the Employee Network Notification Packet)

DWC FORM-73, Texas Workers’ Compensation Work Status Report – This form shall be provided by the human resources representative.
Texas Department of Criminal Justice
Employee’s Guidelines for Workers’ Compensation

COMPLETION OF THE EMPLOYEE’S PACKET

♦ Complete the forms located in the PERS 298, Employee’s Report Packet for Workers’ Compensation any time you sustain a work-related injury or illness (whether or not you plan on filing a workers’ compensation claim) or when you believe you may have been exposed to a communicable disease as a result of your work-related duties. If you believe you may have been exposed to a communicable disease, you are also required to complete a PERS 305, Possible Work-Related Exposure to a Communicable Disease (Attachment A) and contact the unit coordinator of infectious disease (CID) nurse at the nearest unit for baseline testing.

It is your responsibility to review the PERS 298 packet and understand the impact that the elections on the PERS 298-3, Employee’s Election Regarding Use of Sick and Vacation Leave C-80 (Part A), and Employee’s Other Time Election C-80 (Part B) may have on your state benefits. You should contact your supervisor or human resources representative for additional information to ensure that you understand the impact of the C-80 elections.

♦ Submit the completed PERS 298 packet to your supervisor by the end of the same shift the injury or illness occurs.

♦ Designate a person to act on your behalf if you are unable to complete the PERS 298 packet, or your supervisor shall complete the PERS 298-2 for you.

♦ General guidance for each form in the PERS 298 packet:

✔ PERS 298-2, Employee’s Report of Injury or Illness: Complete each blank in Part A (1-12) and sign and date the form before you submit it to your supervisor, who shall complete Part B.

✔ PERS 298-3, Employee’s Election Regarding Use of Sick and Vacation Leave C-80 and Employee’s Other Time Election C-80 (Parts A and B): You may change your elections to Part A until you have reached your eighth day of workers’ compensation disability. The eight days do not have to be consecutive. A change to Part B may only be made when you return to work. Changes shall only affect subsequent periods of absence resulting from the work-related injury or illness that occur after you sign the revised form. The changes shall not be retroactive. As previously stated, it is your responsibility to understand how the elections you choose may impact your pay and other benefits as described under the heading “Effect of C-80 Elections on Benefits.” A description of these elections follows:

C-80 Part A: Addresses the use of accrued sick and vacation leave and establishes the initial compensation payment start date. You may not receive workers’ compensation income benefits while using accrued sick leave, including sick leave pool, donated sick leave, or extended sick leave, or accrued vacation leave. There shall be a waiting period of seven calendar days before workers’ compensation benefits begin. To the extent these benefits are available, Part A allows you to:

Election 1: Exhaust all accrued sick leave and then all or part of accrued vacation leave before receiving any workers’ compensation payments.

Election 2: Not use any accrued sick leave or vacation leave, thereby freezing your sick and vacation leave balances.

Accrued compensatory, holiday, and overtime may be used during the waiting period of seven calendar days as indicated in Part B. If you do not elect to use sick leave during the seven-day waiting period and you are on leave for your work-related injury or illness for 28 days or more, you shall receive an additional payment to reimburse you for the waiting period.

C-80 Part B: After Part A sick and vacation leave elections are made, Part B elections shall determine how accrued compensatory, holiday, and overtime are to be used during your absence due to the work-related injury or illness. To the extent you are eligible for these benefits, Part B allows you to:
Election 1: Exhaust all eligible accrued time in the following order: compensatory, holiday, and overtime.

Election 2: Not use any accrued compensatory, holiday, or overtime, thereby freezing all balances until after returning to work.

Election 3: Use a portion of accrued time, thereby freezing remaining balances until returning to work.

If you elect to freeze your accrued compensatory and holiday time and as a result of your injury are unable to use the time before it expires, the time shall not be restored.

If you elect to freeze your accrued time and upon exhaustion of the 180 days leave without pay-medical (LWOP-Medical) period you have not physically returned to work, you shall be placed on the active payroll until all accrued compensatory and holiday time is exhausted. After all accrued compensatory and holiday time is exhausted, you shall then be separated from employment and your accruals of overtime and vacation leave shall be handled in accordance with PD-49, “Leaves Other than Medical or Parental.”

- DWC FORM-48, Request for Travel Reimbursement: Please read the information provided to determine if you have travel expenses that are eligible for reimbursement.
- DWC FORM-73, Texas Workers’ Compensation Work Status Report instructions.

**EFFECT OF C-80 ELECTIONS ON BENEFITS**

While unable to work due to the work-related injury or illness, your benefits are affected. Refer to the following information and to the table entitled C-80 Election Combinations of this attachment for assistance in choosing the elections that you consider best for you.

♦ **LEAVE**

For continued employment with TDCJ, you are required to comply with PD-46, “Medical and Parental Leave,” or PD-49, “Leaves Other than Medical or Parental.” You are required to provide a DWC FORM-73 or health care provider’s statement (HCPS) before you return to work if, as a result of the work-related injury or illness you: (a) were absent for more than three days or your HCPS or DWC FORM-73 indicates restrictions; or (b) were placed in LWOP status.

When submitting a PERS 24, Leave Request, attach an HCPS for the requested leave period. The requested leave period shall not exceed six months, or the date the health care provider has indicated you may return to work.

**Leave with Pay:** While using accrued sick, vacation, compensatory, holiday, or overtime, you are on leave with pay. You may also be eligible to receive additional benefits, to include:

**Extended Sick Leave:** You are required to have at least five years of TDCJ service accrued since your most recent hire date, 56 hours of sick leave balance accrued since your most recent hire date at the onset or initial diagnosis of the current injury or illness sick leave pool request, and not have used 12 workweeks of extended sick leave in the past five years. All accrued time balances shall be exhausted.

**Sick Leave Pool:** You are required to meet the eligibility criteria in PD-50, “Sick Leave Pool,” including the requirement to have at least 12 months of TDCJ service accrued since your most recent hire date, 56 hours of sick leave balance accrued since your most recent hire date at the time of the current injury or illness sick leave pool request, and you shall not have withdrawn from the sick leave pool during the current fiscal year. All of your accrued time balances shall first be exhausted.

**Donated Sick Leave:** You are required to have exhausted all accrued sick leave, including any time you may be eligible to withdraw from the sick leave pool.

If you choose to freeze any portion of your accrued time balances, you shall not be eligible to apply for extended sick leave or sick leave pool.

If you choose to freeze any portion of your accrued sick leave, you shall not be eligible to receive any donated sick leave.
Leave without Pay-Medical (LWOP-Medical): Before your leave with pay is exhausted, you shall request LWOP-Medical in accordance with PD-46, “Medical and Parental Leave.”

Family and Medical Leave (FML): The human resources representative shall determine whether or not your absence due to a work-related injury or illness should be designated as FML, either with pay or without pay. You may qualify for FML if you:
- Have at least 12 months of state service;
- Suffer from a serious health condition;
- Have worked at least 1,250 hours during the previous year; and
- Have not used more than 12 workweeks of FML in the previous 12 months.

♦ INITIAL VISIT TO A HEALTH CARE PROVIDER/RETURN TO WORK
Regardless of when the injury or illness occurred, you are required to notify your supervisor as soon as you incur medical expenses resulting from the work-related injury or illness or you are off work a full shift due to the work-related injury or illness, so that your supervisor can notify the human resources representative of your change in status.

You are responsible for ensuring that the health care provider who provides medical services has been approved by the Texas Department of Insurance, Division of Workers’ Compensation (TDI-DWC) to treat IMO Med-Select Network workers’ compensation injured employees. You may call your adjuster at the State Office of Risk Management (SORM) or TDI-DWC, or access the TDI-DWC website at www.tdi.texas.gov to ensure that your health care provider treats workers’ compensation injured employees.

Upon your initial visit to an IMO Med-Select Network health care provider, you shall provide the IMO Med-Select Network health care provider with a copy of the job description that was provided to you by your supervisor. The health care provider should provide you with a completed DWC FORM-73. (The health care provider will have a DWC FORM-73 on hand, because the TDI-DWC requires health care providers to use this form.)

You are required to provide the DWC FORM-73 or an HCPS from your initial visit to your human resources representative in accordance with PD-46, “Medical and Parental Leave,” via hand carry or fax. The DWC FORM-73 or HCPS shall indicate one of the following:

1) You qualify to participate in a temporary alternate or modified duty assignment position.
   If you qualify for a temporary alternate or modified duty assignment, a verbal or written offer shall be made by the human resources representative. A rejection shall be reported to SORM and any applicable workers’ compensation benefits may be readjusted. You should continue to coordinate leave through your human resources representative in accordance with TDCJ policies.

2) Based on the restrictions indicated, you are not eligible to return to work at the present time.
   If you are absent more than three consecutive days, you shall be required to also provide your supervisor with a PERS 24, Leave Request, and an HCPS that includes the medical facts in accordance with PD-46, “Medical and Parental Leave.”

♦ SUBSEQUENT VISITS TO THE HEALTH CARE PROVIDER
If a subsequent visit to the health care provider results in a change in treatment or work restrictions, you are required to provide, via hand carry or fax, a subsequent DWC FORM-73 or HCPS to your human resources representative within one workday of the subsequent visit.

♦ RETURN TO WORK WITH ACCOMMODATIONS
Employees with permanent restrictions may apply for accommodations in accordance with PD-14, “Americans with Disabilities Act and Employment of Persons with a Permanent or Long-Term Medical Condition.”
**WORKERS’ COMPENSATION**

Workers’ compensation benefit payments replace only a percentage of your regular pay; however, the benefit payments are not subject to social security, withholding taxes, or the mandatory retirement contribution to the Employees Retirement System (ERS).

You **cannot** receive workers’ compensation payments while using accrued sick leave, sick leave pool, extended sick leave, or vacation leave.

You **can** receive workers’ compensation payments while using accrued overtime, holiday, or compensatory time if you elect to use this time on the C-80 elections.

**GROUP INSURANCE**

**Disability (if applicable):**

Payments begin after a waiting period of 30 days (short-term disability) or 90 days (long-term disability) after the date lost time began or after accrued sick leave is exhausted, whichever is greater, or after extended sick leave or sick leave pool payments cease. Payments are reduced by the amount of your workers’ compensation payments.

Long-term disability applies only if an approved attending physician certifies that you are totally disabled.

**Health Coverage:** You shall receive a detailed letter from the ERS, if you are required to make payments. Payments shall be made by cashier’s check or money order.

While on leave with pay: The state contribution to your insurance continues, and your portion of the premium shall be deducted from your paycheck.

While on LWOP designated as FML: The state contribution continues, so you shall only be responsible for paying your portion of the premium.

While on LWOP not designated as FML: No state contribution shall be paid; therefore, you shall be responsible for the entire premium if you are in LWOP status that is not designated as FML for a complete month. However, your workers’ compensation payment amount increases to compensate for the decrease in the state contribution for the employee’s health insurance only.

If you do not pay your group insurance premium, your coverage shall be cancelled effective the last day of the month for which no payment has been made. To reinstate cancelled coverage, apply through your human resources representative as soon as you return to work.

**OTHER BENEFITS**

If you are participating in voluntary benefit programs, such as 457 Deferred Compensation Plan, 401(k) TexaSaver Plan, Texas Tuition Promise Fund, TexFlex, or Service Purchase Installment Program, payroll deductions shall continue in effect until your TDCJ paycheck is no longer sufficient to cover your deductions unless you request that the deductions be discontinued at an earlier date.

**PAYMENT OF MEDICAL BILLS AND PRESCRIPTIONS**

Inform the attending physician, hospital, and pharmacist that medical claims and prescriptions are to be filed as workers’ compensation. Except for emergency care, the attending physician should request pre-certification through SORM.

If the claim is approved, liability for payment of medical services, prescriptions, etc. shall be assumed by SORM. Your human resources representative or the Workers’ Compensation Program Area, Human Resources Division, can verify that a work-related injury or illness has occurred, but neither can accept liability for payment. Claims for payment of medical bills or prescriptions shall be considered and paid by SORM only after an itemized bill is submitted to SORM which includes the employee’s name, social security number, and date of injury. Employees are responsible for providing copies of physician’s statements to adjusters as required.
The attending physician should direct any questions about workers’ compensation and mail all bills and reports to:

State Office of Risk Management
P.O. Box 13777
Austin, Texas 78711-3777
Phone 512-475-1440

♦ PROBLEMS WITH CLAIMS

Any problems you may have with claims should be referred to your SORM claims adjuster at the address and telephone number indicated above.

♦ DENIED CLAIMS

If your claim is denied by SORM and you are unable to return to work, you shall contact your human resources representative to determine your leave options. Contact your local TDI-DWC office or write your claims adjuster at the address indicated for SORM regarding your right to appeal a denied claim.

♦ FRAUD

If you knowingly or intentionally perform any of the following acts in an attempt to obtain workers’ compensation benefits, you may have committed a Class B administrative violation that is punishable by an administrative penalty not to exceed $5,000:

- Make a false or misleading material statement.
- Misrepresent or conceal a material fact.
- Fabricate, alter, conceal, or destroy a document.
- Conspire to commit an act as listed above.

♦ DENTAL

Should you require dental services for your injury that is not due to an emergency, you shall obtain pre-authorization from SORM prior to services being provided.

♦ MULTIPLE EMPLOYMENT

If you have other employment in addition to TDCJ, you may be eligible to report those wages to increase your weekly benefit. Please contact SORM directly at 512-475-1440 for additional eligibility information.
# C-80 ELECTION COMBINATIONS

<table>
<thead>
<tr>
<th>Part A</th>
<th>Part B</th>
<th>Impact of Elections on Pay and Benefits</th>
</tr>
</thead>
</table>
| 1      | 1      | Elects to use all accrued sick leave then all or part of vacation leave and other time.  
- Pay and insurance coverage continues until accrued time is depleted. See Notes 1 and 2.  
- Workers’ compensation pay begins after sick and vacation leave is depleted. See Notes 3 and 4.  
- May apply for extended sick leave and sick leave pool, if eligible, prior to all time being depleted.  
- May receive donated sick leave hours. |
| 1      | 2      | Elects to use all accrued sick leave then all or part of vacation leave and freezes other time.  
- Pay and insurance coverage continues until accrued sick and vacation leave is depleted. See Note 2.  
- Workers’ compensation pay begins after sick and vacation leave is depleted. See Note 3.  
- Ineligible to apply for extended sick leave and sick leave pool since other accrued time is not depleted.  
- May receive donated sick leave hours. |
| 1      | 3      | Elects to use all accrued sick leave then all or part of vacation leave and use a portion of other time.  
- Pay and insurance coverage continues until sick and vacation leave is depleted and other time reaches specified levels. See Notes 1 and 2.  
- Workers’ compensation pay begins after sick and vacation leave is depleted. See Notes 3 and 4.  
- Ineligible to apply for extended sick leave and sick leave pool since other accrued time is not depleted.  
- May receive donated sick leave hours. |
| 2      | 1      | Elects not to use accrued sick or vacation leave. Use other time until balances are depleted.  
- Pay and insurance coverage continues until accrued time is depleted. See Notes 1 and 2.  
- Workers’ compensation pay begins after the waiting period of seven calendar days. See Notes 3 and 4.  
- Ineligible to apply for extended sick leave and sick leave pool since sick or vacation leave is not depleted.  
- Ineligible to receive donated sick leave since sick leave is not depleted. |
| 2      | 2      | Elects not to use accrued sick or vacation leave and freezes other time.  
- Pay and insurance coverage stops. See Note 2.  
- Ineligible to apply for extended sick leave and sick leave pool since accrued sick or vacation leave or other time is not depleted.  
- Ineligible to receive donated sick leave since sick leave is not depleted. |
| 2      | 3      | Elects not to use accrued sick or vacation leave and use a portion of other time.  
- Pay and insurance coverage continues until other time reaches specified levels. See Notes 1 and 2.  
- Workers’ compensation pay begins after the waiting period of seven calendar days. See Notes 3 and 4.  
- Ineligible to apply for extended sick leave and sick leave pool since accrued sick or vacation leave or other time is not depleted.  
- Ineligible to receive donated sick leave since sick leave is not depleted. |

**Note 1:** “Other time” includes compensatory, holiday, and overtime.

**Note 2:** You are required to apply for LWOP-Medical prior to the depletion of all accrued time. If in LWOP status, you shall be responsible for the payment of all insurance premiums. If on FML, the state paid portion of the insurance premium continues, but you shall continue to be responsible for payment for any coverage, such as family, beyond that.

**Note 3:** If eligible for short term disability insurance, payments do not begin until after 30 days or sick leave is depleted, whichever is greater. You cannot draw short term disability payments and use sick leave simultaneously.

**Note 4:** You cannot draw workers’ compensation benefits while using accrued sick or vacation leave.
Texas Department of Criminal Justice
Employee’s Report of Injury or Illness

PART A: EMPLOYEE OR DESIGNEE (CLEARLY PRINT THE FOLLOWING INFORMATION)

1. Employee’s Payroll Name: ___________________________ (Last, First, MI)
   Current Mailing Address: ________________________________
   City: ___________________________ County: ___________________________
   State: ___________________________ Zip Code: ___________________________
   Social Security Number: ___________________________ Home Phone Number: ___________________________
   Date of Birth (mm/dd/yyyy): ___________________________ Gender: ___________________________

2. Marital Status (check one): ☐ Married ☐ Widowed ☐ Single ☐ Separated ☐ Divorced

3. Number of Dependent Children: ___________________________ Name of Spouse: ___________________________

4. Did you receive treatment from a physician for this injury or illness? (check one) ☐ Yes ☐ No
   Did you incur medical expenses? ☐ Yes ☐ No

5. If medical expenses were incurred, provide the following information:
   Attending Physician’s Name: ___________________________
   Hospital: ___________________________
   Mailing Address: ___________________________
   City: ___________________________ State: ___________________________ Zip Code: ___________________________

6. Date of injury or illness: ___________________________
   Time of injury or illness: ___________________________ (check one) ☐ AM ☐ PM
   Are you a third shift employee: ☐ Yes ☐ No
   If third shift, date shift actually began: ___________________________

7. Unit or department where the injury or illness occurred: ___________________________

8. Nature of injury (cut, bruise, etc.): ___________________________
   Part(s) of body affected: ___________________________

9. Detailed description of how the injury or illness occurred: ___________________________

10. Were you performing normal job duties? (check one) ☐ Yes ☐ No
    Work site where injury or illness occurred (stairs, dock, etc.): ___________________________

11. Cause of injury or illness (fall, tool, machine, offender, etc.): ___________________________

12. Full name(s) of witness(es) (If offender, include TDCJ#): ___________________________

I certify that the above injury or illness was not caused by my intent, willful misconduct, or neglect. I acknowledge receipt and understanding of the Workers’ Compensation Employee’s Guidelines.

Signature of Employee: ___________________________ Date: ___________________________

Note to Employee: With few exceptions, you are entitled upon request: (1) to be informed about the information the TDCJ collects about you; and (2) under Texas Government Code §§ 552.021 and 552.023, to receive and review the collected information. Under Texas Government Code § 559.004, you are also entitled to request, in accordance with TDCJ procedures, that incorrect information the TDCJ has collected about you be corrected.
PART B: SUPERVISOR ACKNOWLEDGEMENT OF INJURY OR ILLNESS

13. Part A of this form was completed by: (check one) □ Employee □ Designee Phone No. ( ) SSN: ________________
    If designee, full name of the designee: __________________________ SSN: ________________________

14. First full shift the employee was unable to work due to injury or illness (if no time lost, enter “NLT”): ______________

15. Was the employee able to return to work since missing a full shift? □ Yes □ No □ Did not lose full shift
    If yes, check one of the following: □ Full Duty □ Temporary Alternate/Modified Duty

16. Has the employee been placed in a leave status? (check one) □ Yes □ No
    If yes, type of leave: __________________________________________ Effective date: ________________

17. Did employee die? □ Yes □ No

18. Full Name of Supervisor: __________________________ Supervisor’s SSN: ________________________
    Date the employee reported the injury or illness to you: ________________________________

19. Employee’s choice of sick leave election (C-80, Part A) (check one) □ 1 □ 2
    Employee’s choice of other time election (C-80, Part B) (check one) □ 1 □ 2 □ 3
    Sick leave balance on date of injury: ________________ Amount of vacation time elected to be used: ________________

20. If this report is not being submitted within one workday of the occurrence of the injury or illness, check the appropriate box and complete required information:
    □ Medical expenses incurred on: __________________________
    □ First full shift missed on: __________________________
    □ Other: __________________________

The above injury or illness was reported to me as indicated above. I acknowledge receipt and understanding of the Supervisor’s Guidelines. I acknowledge the above information to be true and accurate to the best of my knowledge.

Signature of Supervisor: __________________________________________________________________ Date: __________________________________________________________________

Distribution:
ORIGINAL - State Office of Risk Management
COPY - Workers’ Compensation Program Area, Human Resources Division
COPY - Unit or Department Medical File
COPY - Risk Management Coordinator
COPY - Employee
Employee’s Election Regarding Use of Sick and Vacation Leave

C-80 (Part A)

(Texas Labor Code § 501.044)

Employee’s Name: _______________________________ Date of Injury or Illness: ____________________

Employee’s SSN: __________________________________________

Hours of Sick Leave Available as of Date of Injury or Illness: ________________

Hours of Vacation Leave Available as of Date of Injury or Illness: ________________

Complete Election 1 or Election 2.

**ELECTION 1 (Choose A, B, or C)**

When I lose time from work due to this injury or illness I elect to use all of my accrued sick leave AND:

- [ ] A. All of my accrued vacation leave.
- [ ] B. A portion of my accrued vacation leave (enter number of hours: ____).
- [ ] C. None of my accrued vacation leave.

* Sick leave shall be exhausted before vacation leave can be used. *

*I understand I cannot receive workers’ compensation payments while using sick leave, sick leave pool, extended sick leave, or vacation leave.*

**ELECTION 2**

- [ ] When I lose time from work due to this injury or illness, I elect to not use any accrued sick leave and not use any accrued vacation leave. I understand I shall not receive workers’ compensation payments until after the waiting period of seven calendar days.

**MONTHLY TEMPORARY INCOME BENEFITS ELECTION**

- [ ] I elect to change my Temporary Income Benefits frequency from weekly to monthly.

I have read the Employee’s Guidelines and understand the effect this election may have on my paycheck and benefits and that it shall affect any and all future occurrences of lost time as a result of this work-related injury or illness. I further understand that I MAY NOT change this Part A election after my eighth day of workers’ compensation disability and signing this form.

(Employee’s Signature/Date) ________________________________ (Supervisor’s or Human Resources Representative’s Signature/Date) ________________________________

Note to Employee: With few exceptions, you are entitled upon request: (1) to be informed about the information the TDCJ collects about you; and (2) under Texas Government Code §§ 552.021 and 552.023, to receive and review the collected information. Under Texas Government Code § 559.004, you are also entitled to request, in accordance with TDCJ procedures, that incorrect information the TDCJ has collected about you be corrected.

**Distribution:**

Reportable: ORIGINAL – State Office of Risk Management
COPY – Workers’ Compensation Program Area, Human Resources Division
COPY – Unit or Department Medical File
COPY – Employee

Not Reportable: ORIGINAL – Unit or Department Medical File
COPY – Employee
TEXAS DEPARTMENT OF CRIMINAL JUSTICE
Employee’s Other Time Election
C-80 (Part B)

Choose one of the following elections by initialing in the space beside it:

_____ ELECTION 1
When I lose time from work due to this injury or illness, I hereby elect to use all my accrued compensatory, holiday, and overtime UNTIL THE BALANCES ARE EXHAUSTED or I return to work, whichever occurs first.

_____ ELECTION 2
When I lose time from work due to this injury or illness, I hereby elect TO NOT USE ANY accrued compensatory, holiday, and overtime, thereby freezing all balances until I return to work. I understand I may not receive workers’ compensation benefits until after the waiting period of seven calendar days.

_____ ELECTION 3
When I lose time from work due to this injury or illness, I hereby elect to USE THE PORTION INDICATED below of my accrued compensatory, holiday, and overtime, thereby freezing the remaining balance until I return to work. I have indicated the total amount of time in each category to use:

A. COMPENSATORY TIME ___________ HOURS/MINUTES
B. HOLIDAY TIME ___________ HOURS/MINUTES
C. OVERTIME ___________ HOURS/MINUTES

EMPLOYEE’S NAME AS SHOWN ON PAYROLL (PRINT OR TYPE) ________________________________

EMPLOYEE’S SSN ________________________

DATE OF INJURY (mm/dd/yyyy) ________________________________

I understand:

I cannot receive workers’ compensation payments while using accrued sick leave, sick leave pool, or while on extended sick leave and vacation leave.

I shall request LWOP - Medical before my accrued leave is exhausted.

That holiday time shall be used within one year from the end of the work cycle in which the time was accrued; and compensatory time shall be used within one year from the end of the work cycle in which the time was accrued (two years for correctional staff only). If I freeze this time and it expires before I return to work, it cannot be restored.

I may not change Part B once the DWC FORM-1S, Employer’s First Report of Injury or Illness has been submitted to the State Office of Risk Management until after returning to work for one full shift. Subsequent changes to Part B shall not be retroactive.

I have read the Employee’s Guidelines and understand the effect this election may have on my benefits and that it shall affect any and all future occurrences of lost time as a result of this work-related injury or illness.

EMPLOYEE’S SIGNATURE ____________________________

DATE ____________________________

Note to Employee: With few exceptions, you are entitled upon request: (1) to be informed about the information the TDCJ collects about you; and (2) under Texas Government Code §§ 552.021 and 552.023, to receive and review the collected information. Under Texas Government Code § 559.004, you are also entitled to request, in accordance with TDCJ procedures, that incorrect information the TDCJ has collected about you be corrected.
TEXAS DEPARTMENT OF CRIMINAL JUSTICE
Authorization for Release of Information
(SORM-16)

Patient

Last Name
First Name
MI

TO WHOM IT MAY CONCERN:

You are hereby expressly authorized to release and furnish to the State Office of Risk Management, and any associate, assistant, representative, agent, or employee thereof, any and all desired information, including, but not limited to, office records, medical reports, memos, hospital records, laboratory reports, including results of any and all tests including alcohol and drug tests, x-rays, x-ray reports, including copies thereof, pertaining to the physical and mental condition which is the basis of my workers’ compensation claim. This includes not only all current and future information, but also all past medical information which is related to the injury or injuries which form the basis of my claim.

(Print name) ____________________________

Photostatic copies of this signed authorization shall be considered valid as the original.

This is not a release of claims for damages.

DATED: ____________________________  SIGNED: ____________________________

(mmd/yyyy)

PLEASE SIGN THE ABOVE MEDICAL AUTHORIZATION AND RETURN IT, SO THAT WE MAY SECURE RELEASE OF YOUR MEDICAL RECORDS.

THANK YOU,

STATE OFFICE of RISK MANAGEMENT

Distribution:
ORIGINAL - State Office of Risk Management
COPY - Workers’ Compensation Program Area, Human Resources Division
COPY - Unit or Department Medical File
COPY - Employee

Form No. SORM-16 9-98
TEXAS DEPARTMENT OF CRIMINAL JUSTICE
Employee’s Acknowledgement of Responsibilities
Relating to Work-Related Injury or Illness

I hereby acknowledge that I have read, understood, and received the following advisement.

<table>
<thead>
<tr>
<th>Assistance</th>
<th>The TDI-DWC provides an ombudsman to assist me at no cost. The ombudsman may be reached by calling 1-800-252-7031 or the local office of the TDI-DWC.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of Time Benefits are Available</td>
<td>I recognize that benefits continue only until I have reached maximum medical improvement or until 104 weeks have elapsed from the beginning date of workers’ compensation disability, at which time other benefits may be available.</td>
</tr>
<tr>
<td>Offer of Outside Employment</td>
<td>I shall notify my TDCJ human resources representative and the State Office of Risk Management of any bona fide offer and acceptance of employment.</td>
</tr>
<tr>
<td>Employment Status</td>
<td>If I am receiving workers’ compensation benefits, I shall notify my TDCJ human resources representative and the State Office of Risk Management within one workday of getting another job.</td>
</tr>
<tr>
<td>Receipt of Wages</td>
<td>I shall report any wages received after the date of injury or illness while benefits are continuing to my TDCJ human resources representative and the State Office of Risk Management.</td>
</tr>
<tr>
<td>Warning Against Misrepresentation</td>
<td>I understand that any misrepresentation or concealment of information concerning my claim may be a violation of federal or state law.</td>
</tr>
</tbody>
</table>

**Employee:**

(Print) Last Name  First Name  MI

Title

(Area Code) (Telephone #)

**Human Resources Representative:**

(Print) Last Name  First Name  MI

Title

(Area Code) (Telephone #)

Time of Advisement  Date  Place

Employee Signature  Date

HR Representative Signature  Date

If the claimant refuses to sign the form, the human resources representative shall: (1) note the time, date, and place of the advisement and refusal to sign; and (2) sign and date the form.

**Distribution:**

ORIGINAL - Unit or Department Medical File

COPY - Employee
The TDI-DWC Rule § 134.110 provides that an injured employee may request reimbursement from the insurance carrier if the injured employee has incurred travel expenses when: (1) medical treatment for the compensable injury is not reasonably available within 30 miles from where the injured employee lives; and (2) the distance traveled to secure medical treatment is greater than 30 miles, one-way.

Employees requesting reimbursement for travel expenses shall use the DWC FORM-48, “Request for Travel Reimbursement/Solicitud De Reemboloso” form.

Employees may request their human resources representative provide them with a copy of the form or print the DWC FORM-48 from the following TDI-DWC website:

http://tdi.texas.gov/forms/dwc/dwc048trvlreim.pdf
THE STATE OFFICE OF RISK MANAGEMENT
WORKERS’ COMPENSATION PRESCRIPTION INFORMATION

Employer:
Please complete the employee information below and provide the employee with this document to take with their prescriptions to any pharmacy.

Employee Name: ____________________________
Group#: 10602772
Member ID (SSN): ________
Date of Injury: ____________
Processor: myMatrixx
Bin#: 014211

Day supply is limited to 30 days for a new injury
myMatrixx Help Desk: (877) 804-4900

Employee:
The State Office of Risk Management has partnered with myMatrixx to make filling workers’ compensation prescriptions easy.

This document serves as a temporary prescription card. A permanent prescription card specific to your injury will be forwarded directly to you within the next 3 to 5 business days.

Please take this letter and your prescription(s) to a pharmacy near you. myMatrixx has a network of over 64,000 pharmacies nationwide. If you need assistance locating a network pharmacy near you, please call myMatrixx toll free at (877) 804-4900.

IF YOU ARE DENIED MEDICATION(S) AT THE PHARMACY PLEASE CALL (877) 804-4900

Pharmacist:
Please obtain above information from the injured employee, if not already filled in by employer, to process prescriptions for the workers’ compensation injury only.

For questions or rejections please call (877) 804-4900. Please do not send patient home or have patient pay for medication(s) before calling myMatrixx for assistance.

NOTE: Certain medications are pre-approved for this patient; these medications will process without an authorization. All others will require prior approval.

FOR ALL REJECTIONS OR QUESTIONS CALL: (877) 804-4900
IMO MED-SELECT NETWORK®
A Certified Texas Workers’ Compensation Health Care Network

Employee Network Notification Packet
Workers' Compensation Network
Acknowledgement Form

I have received the Notice of Network Requirements 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® 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:

Name of Employer: Texas Department of Criminal Justice

Employee ID #: __________________________ Name of Network: IMO Med-Select Network®

Hire Date: __________________________ Department: __________________________

Home Address: __________________________________________

Street Address – No P.O. Box or Work Address

________________________________________

City __________________________ State __________________________ Zip Code __________________________ County __________________________

Employee Signature __________________________________________ Date __________________________

Printed Name __________________________________________ Employee Phone Number __________________________
Notice of Network Requirements

Important Medical Care Information for Work-Related Injuries and Illnesses:

1. Effective September 1, 2014, your employer is partnering with IMO Med-Select Network® a certified Texas workers’ compensation health care network. You are covered by the Network if you live in any of the counties listed below. **November 1, 2018 is the effective date for Lubbock county area claims.**

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, TX 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 IMO Med-Select Network® service areas include the following counties:

<table>
<thead>
<tr>
<th>Atascosa</th>
<th>Comal</th>
<th>Hale</th>
<th>Liberty</th>
<th>Tarrant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austin</td>
<td>Crosby</td>
<td>Harris</td>
<td>Limestone</td>
<td>Terry</td>
</tr>
<tr>
<td>Bandera</td>
<td>Dallas</td>
<td>Hays</td>
<td>Lubbock</td>
<td>Travis</td>
</tr>
<tr>
<td>Bastrop</td>
<td>Denton</td>
<td>Henderson</td>
<td>Lynn</td>
<td>Van Zandt</td>
</tr>
<tr>
<td>Bell</td>
<td>El Paso</td>
<td>Hidalgo</td>
<td>McLennan</td>
<td>Walker</td>
</tr>
<tr>
<td>Bexar</td>
<td>Ellis</td>
<td>Hill</td>
<td>Medina</td>
<td>Waller</td>
</tr>
<tr>
<td>Blanco</td>
<td>Falls</td>
<td>Hockley</td>
<td>Milam</td>
<td>Washington</td>
</tr>
<tr>
<td>Brazoria</td>
<td>Fayette</td>
<td>Hood</td>
<td>Montgomery</td>
<td>Wharton</td>
</tr>
<tr>
<td>Brazos</td>
<td>Floyd</td>
<td>Hunt</td>
<td>Navarro</td>
<td>Williamson</td>
</tr>
<tr>
<td>Burleson</td>
<td>Fort Bend</td>
<td>Jefferson</td>
<td>Parker</td>
<td>Wilson</td>
</tr>
<tr>
<td>Burnet</td>
<td>Galveston</td>
<td>Johnson</td>
<td>Rains</td>
<td>Wise</td>
</tr>
<tr>
<td>Caldwell</td>
<td>Garza</td>
<td>Karnes</td>
<td>Robertson</td>
<td>Wood</td>
</tr>
<tr>
<td>Cameron</td>
<td>Gonzales</td>
<td>Kaufman</td>
<td>Rockwall</td>
<td></td>
</tr>
<tr>
<td>Chambers</td>
<td>Grayson</td>
<td>Kendall</td>
<td>San Jacinto</td>
<td></td>
</tr>
<tr>
<td>Collin</td>
<td>Grimes</td>
<td>Lamb</td>
<td>Smith</td>
<td></td>
</tr>
<tr>
<td>Colorado</td>
<td>Guadalupe</td>
<td>Lee</td>
<td>Starr</td>
<td></td>
</tr>
</tbody>
</table>

Revised 9.20.18
IMO Med-Select Network®
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 9 of this packet.

5. 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.

6. 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.

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 urgent care facility.

10. If you do not live in a network service area, you are not required to receive care from network providers.

11. If you are hurt at work and you do not believe you live within the network service area, call the State Office of Risk Management (SORM) at 877.445.0006. SORM must review the information within seven calendar days and notify you of their decision in writing.

12. SORM may agree that you do not live in the network service area. If you receive care from an out-of-network provider, and it is later determined that you live in the network service area, you may be required to pay the bill for health care services.

13. If you disagree with SORM’s decision in regards to the network service area, you may file a complaint with the Texas Department of Insurance. Complaint form information is addressed in #27.

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

15. SORM will pay for services provided by the network treating doctor and other network health care providers. Except for emergency care, you may be required 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 bill SORM for medical services related to your compensable work injury. The employee should not be billed by the network provider. Unless there is an emergency need, the network must approve any of the following health care services before they are provided to you:

   a. Hospital and Surgical Care  
   b. Mental Health Care  
   c. Physical Medicine Services  
   d. Diagnostic Testing  
   e. Injections  
   f. Rehabilitation Programs  
   g. Durable Medical Equipment  
   h. Treatment not address or not recommended by Evidence Based Guidelines  
   i. Drugs  

17. “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.  

18. 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.  

19. 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.  

20. 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.
21. 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 reconsideration of an adverse determination.

22. 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.

23. If the situation is life threatening, you do not have to go through the network reconsideration process. You, the person acting on 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).

24. 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.

25. After the review by the IRO, they will send a letter explaining their decisions. SORM will pay the IRO fees.

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

27. 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 with which 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
      P.O. Box 260287
      Plano, TX 75026
   c. E-mailing: netcomplaint@injurymanagement.com

28. The network will not retaliate if:

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

Revised 9.20.18
IMO Med-Select Network®
29. 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.texas.gov](http://www.tdi.texas.gov), 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

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

31. 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.

32. You can view, print, or email a provider directory online at [www.injurymanagement.com](http://www.injurymanagement.com).
Attention Participating Network Employee

- Show this card to each and every medical provider that treats you for your work-related injury.
- With the exception of emergency medical care, you must treat with a network provider.
- This card is for information purposes only and does not guarantee coverage.

Please contact IMO at 888.466.6381 with any questions.

WORKERS’ COMPENSATION IDENTIFICATION CARD

FOR WORKERS’ COMPENSATION HEALTH CARE NETWORK ONLY

Attention Provider

- With the exception of emergency and initial medical treatment, you are required to notify the network of all referrals.
- You must also be an approved network provider.
- Contact the IMO Med-Select Network® to verify if you are an approved provider, or with questions regarding medical services.

IMO Contact Information:
Phone: 888.466.6381, Fax: 877.946.6638
Email: netcare@injurymanagement.com

Send Medical Bill to:
State Office of Risk Management, PO Box 13777, Austin, TX 78711
Find a Provider Search Instructions

www.injurymanagement.com

The snapshots below show samples of the following: 1) A visual of the website homepage where the “Find a Provider” search can be easily located on the blue bar across the middle or under the “Services” tab; 2) A visual of the page where the “Find a Provider” search and database are located; 3) Step 1 and 2 of the search process; 4) Search results format based on a sample zip code.
Step 1: Define Your Search
One or more of the following can be used to define your search.

Define Your Search

Enter Your Zip Code: [ ]

Tell us Your Preferred Distance: 🌟 Less than 5 Miles 🌟 15 Miles 🌟 30 Miles 🌟 60 Miles 🌟 75 Miles

Search by Practice / Facility Name: [ ]

Search by Provider Last Name: [ ]

Search by Provider Tax ID Number: [ ]

Search by City Name: [ ]

Step 2: Choose Your Provider Type
Select the provider type you want to search and use the dropdown menus to best narrow your criteria.

Choose Your Provider Type

- **Treating Doctors**: The IMO Med-Select Network requires your treating doctor to be a physician chosen from the network directory and who is a licensed Medical Doctor (MD) or Doctor of Osteopathy (DO). Treating doctors' primary service must be one of the following: Family Practice / Family Medicine, General Practice / General Medicine, Occupational Medicine, Internal Medicine or Physical Medicine & Rehabilitation (in El Paso only).
  - Select Treating

- **Specialists / Facilities**: Your treating doctor must be the one to refer you to a specialist.
  - Select Specialty

- **MMI/IR Physicians**: Your treating doctor must be the one to refer you to a Maximum Medical Improvement and/or an Impairment Rating Physician.

- **All Providers**: Your treating doctor must be the one to refer you to a Maximum Medical Improvement, Impairment Rating Physician or Specialist.

[Search] [Reset]
Review Search Results

After Steps 1 and 2 are submitted, you will see the below information shown in this sample snapshot including the option to print and email the list, in addition to Google Map directions if desired.

To view the “Provider Details” page, click on the “Practice / Facility Name” in red you wish to see.

For further questions, please contact the IMO Med-Select Network® at 888.466.6381.
IMO Med-Select Network®
Frequently Asked Questions

1. What is a certified Texas workers’ compensation health care network?

   It is a program that has been certified by the State of Texas to provide health care services to you if you become injured at work.

2. What is Injury Management Organization, Inc. (IMO)?

   IMO is a Certified Utilization Review Agent (URA) and the parent company to the IMO Med-Select Network®. IMO provides Case Management, Preauthorization, Medical Bill Review, Industry Care Programs, along with other health care management services.

3. How do I find out more about the IMO Med-Select Network®?

   - Visit website at www.injurymanagement.com
   - Write to: IMO Med-Select Network®, P.O. Box 260287, Plano, TX75026
   - Call the Network Main Line: 214.217.5939 or 888.466.6381
   - Call the Customer Care Line: 214.217.5936 or 877.870.0638

4. What is a service area?

   A service area is any county where the network operates with physicians and other health care providers to care for injured employees. If the network lists a county as part of its service area there will be providers for all zip codes in that county ready to provide health care services to the injured employees. If you live in a county covered by a service area, you are required to use a network provider.

5. What should I do if I move to a different zip code?

   Notify your employer immediately to assist them in making sure that the network has service area coverage for you.

6. May I use a P.O. Box for my official address when I participate in the network?

   No. The network requires a physical address in order to ensure all communication reaches the injured employee.
7. Where does the network operate?

The network operates in the following counties or service areas:

<table>
<thead>
<tr>
<th>Atascosa</th>
<th>Comal</th>
<th>Hale</th>
<th>Liberty</th>
<th>Tarrant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austin</td>
<td>Crosby</td>
<td>Harris</td>
<td>Limestone</td>
<td>Terry</td>
</tr>
<tr>
<td>Bandera</td>
<td>Dallas</td>
<td>Hays</td>
<td>Lubbock</td>
<td>Travis</td>
</tr>
<tr>
<td>Bastrop</td>
<td>Denton</td>
<td>Henderson</td>
<td>Lynn</td>
<td>Van Zandt</td>
</tr>
<tr>
<td>Bell</td>
<td>El Paso</td>
<td>Hidalgo</td>
<td>McLennan</td>
<td>Walker</td>
</tr>
<tr>
<td>Bexar</td>
<td>Ellis</td>
<td>Hill</td>
<td>Medina</td>
<td>Waller</td>
</tr>
<tr>
<td>Blanco</td>
<td>Falls</td>
<td>Hockley</td>
<td>Milam</td>
<td>Washington</td>
</tr>
<tr>
<td>Brazoria</td>
<td>Fayette</td>
<td>Hood</td>
<td>Montgomery</td>
<td>Wharton</td>
</tr>
<tr>
<td>Brazos</td>
<td>Floyd</td>
<td>Hunt</td>
<td>Navarro</td>
<td>Williamson</td>
</tr>
<tr>
<td>Burleson</td>
<td>Fort Bend</td>
<td>Jefferson</td>
<td>Parker</td>
<td>Wilson</td>
</tr>
<tr>
<td>Burnet</td>
<td>Galveston</td>
<td>Johnson</td>
<td>Rains</td>
<td>Wise</td>
</tr>
<tr>
<td>Caldwell</td>
<td>Garza</td>
<td>Karnes</td>
<td>Robertson</td>
<td>Wood</td>
</tr>
<tr>
<td>Cameron</td>
<td>Gonzales</td>
<td>Kaufman</td>
<td>Rockwall</td>
<td></td>
</tr>
<tr>
<td>Chambers</td>
<td>Grayson</td>
<td>Kendall</td>
<td>San Jacinto</td>
<td></td>
</tr>
<tr>
<td>Collin</td>
<td>Grimes</td>
<td>Lamb</td>
<td>Smith</td>
<td></td>
</tr>
<tr>
<td>Colorado</td>
<td>Guadalupe</td>
<td>Lee</td>
<td>Starr</td>
<td></td>
</tr>
</tbody>
</table>

Revised 9.14.18
IMO Med-Select Network®
8. Form Requirements

a. Will I need to sign any forms? Your employer will provide you with a Notice of Network Requirements and an Acknowledgement Form. You will also be presented with an Acknowledgement Form for signature at the time of injury.

b. What will happen if I choose not to sign the Acknowledgement Form? If you refuse to sign the Acknowledgement Form, you are still required to participate in the network.

9. Who is responsible for paying for my medical care if I receive treatment outside of the network?

If you receive care from an out-of-network provider, you may be financially responsible for the health care services if it is determined that you live in the network service area.

10. Who can be a network treating doctor?

The IMO Med-Select Network® requires your treating doctor to be a physician chosen from the network directory who is a licensed Medical Doctor (MD) or Doctor of Osteopathy (DO). The treating doctor must be a specialist in Family Practice, General Practice, Internal Medicine or Occupational Medicine; in El Paso, TX, your treating doctor may hold any of the above listed specialties or be a specialist in Physical Medicine Rehabilitation.

11. How do I choose my treating doctor?

After an injury occurs, you must choose your treating doctor from the network provider list. If you need help, you may call a network customer care representative for assistance at 888.466.6381 Monday-Friday 8-5 p.m. CST or online at www.injurymanagement.com and click “Find a Provider.” If your injury requires emergency care, you may be treated in any emergency care facility.

12. May I select my HMO primary care doctor for my network treating doctor?

As a State of Texas employee, you have a choice of group health insurance plan. Not all of them are HMO plans. If you are covered by an HMO plan, and have already selected a primary care doctor, prior to your injury, you may request to choose your HMO primary care doctor as your workers’ compensation treating doctor. This can be done by completing the Network Form # IMO MSN-5. To obtain this form, please contact the IMO Med-Select Network® at 888.466.6381 or email netcare@injurymanagement.com. The network will contact your HMO doctor to participate in the network. If your doctor does not agree or does not meet the certified network qualification requirements to participate in the network you must choose a treating doctor from the network list.

If you are uncertain of whether you are covered by an HMO plan, please contact the appropriate human resources representative for clarification.

13. How do I nominate a doctor?

a. The IMO Med-Select Network® is pleased to receive nominations to add providers to our network. The first step is to fill out a nomination form available on the IMO website at www.injurymanagement.com or by contacting SORM. The network has a nomination form and

Revised 9.14.18
IMO Med-Select Network®
credentialing process that must be completed prior to any doctor being considered as a network provider.

b. The network will contact your doctor about participating in the network. If your doctor does not agree or does not meet the certified network qualification requirements, you must choose another treating doctor from the network list.

14. Am I required to see a doctor close to my residence?

Although the network must provide you with access to a treating doctor within a 30-mile radius of your residence, you can choose any treating doctor on the list of treating doctors in the network.

15. Can my chiropractor or my orthopedic surgeon be my treating doctor?

No, the treating doctor must be a specialist in Family Practice, General Practice, Internal Medicine, or Occupational Medicine; in El Paso, TX, all specialists listed above or Physical Medicine Rehabilitation. For treatment by any other type of specialist, including a chiropractor or orthopedic surgeon, you must be referred by your treating doctor.

16. Do you have physician assistants or nurse practitioners in the certified network?

No, the certified network does not have physician assistants or nurse practitioners contracted to treat injured employees at this time. You may be treated by one of the above if it is under the direction of a medical doctor in the certified network.

17. Can I change my treating doctor?

You are limited to the changes you can make. These limits are set to ensure that you have quality and continuity in your care.

a. Change #1 is called the alternate choice. When you contact the network, you will be asked to complete the Request for Alternate Treating Doctor Form # IMO MSN-1. The network will not deny your request for your selection of an alternate choice.

b. Change #2 is called your subsequent change. If you have used your alternate choice of treating doctor and you are still dissatisfied, you must request and receive permission from the network for the subsequent change of treating doctor.

You will need to contact the network at:

- Telephone: 214.217.5939 or toll free 888.466.6381
- E-mail: netcare@injurymanagement.com or,
- By faxing the completed form to 214.217.5937 or 877.946.6638
- You may also mail a copy of the Request For Subsequent Change in Treating Doctor Form # IMO MSN-7 to: IMO Med-Select Network®, P.O. Box 118577, Carrollton, TX 75011
- Complaints: netcomplaint@injurymanagement.com
18. What do I do if my treating doctor dies, retires, or leaves the network?

If your current treating doctor dies, retires, or leaves the network you are allowed a change of treating doctor at any time during your care.

19. What if I don’t live in the service area?

If you do not live in the service area, you are not required to receive health care from the certified network. You should contact your Claims Coordinator or SORM to discuss this matter.

20. The Notice of Network Requirements states that I must receive medical care from the network if I live in the network service area. How is “live” defined?

Where an employee lives includes:

a. The employee’s principal residence for legal purposes, including the physical address which the employee represented to the employer as the employee’s address;

b. A temporary residence necessitated by employment; or

c. A temporary residence taken by the employee primarily for the purpose of receiving assistance with routine daily activities because of the compensable injury.

28 Texas Administrative Code §10.2(a) (14)

21. What if I need to be referred to a specialist?

If you need a specialist, your treating doctor will refer you. You must go to a health care provider in the network, except in emergencies and other special circumstances. All referrals to a specialist must be approved by your treating doctor. Appointments with specialists are to be set no later than 21 days after the date of the request. If there is an urgent medical need, a shorter time period may be appropriate.

22. What if I need a specialist that is not in the network?

If your treating doctor decides there is no provider or facility in the network that can provide the treatment you need for your compensable injury, he or she will contact the network for permission to send you to a provider outside of the network.

Your treating doctor is required to submit to the network a completed referral called a Request for Out-of-Network Specialist Form # IMO MSN-4. The network will approve or deny the request within seven days of receiving this form from the treating doctor.

You and your treating doctor will be notified by telephone and in writing if the request is not approved. The notice will also explain the appeal process.
23. What is Telephonic Case Management?

When you are injured at work you may be provided with a Telephonic Case Manager (TCM) to assist with coordination of your medical needs. A TCM is a licensed and certified medical professional that will help coordinate the medical services that your doctor recommends. The TCM will also provide education and help with communication between you and your doctor and employer. The network wants you to have the best quality of care and a safe stay-at-work/return-to-work health outcome.

24. What is considered to be an emergency?

As defined by the Texas Insurance Code:

“Medical Emergency” means the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:

a. Placing the patient’s health or bodily functions in serious jeopardy; or

b. Serious dysfunction of any body part or organ.

25. How do I receive emergency care?

You should seek treatment from the nearest urgent care facility or hospital emergency room if emergency care is necessary. The network provider directory lists urgent care centers and hospitals that participate in the network.

26. How can I get a network provider directory?

Your employer will have a network provider directory available. A network provider directory also will be available at:

a. IMO website: www.injurymanagement.com

b. Or you may call us directly at:
   • Network Main Line – 214.217.5939 or 888.466.6381
   • Customer Care – 214.217.5936 or 877.870.0638

27. Will medical services need prior approval?

- Emergency care never requires preauthorization.
- Initial evaluation for physical therapy and occupational therapy does not require preauthorization.

Some medical services must be approved in advance. Unless there is an emergency need, your treating doctor must contact the network for approval prior to providing the following health care services:

IMO Network Preauthorization List

1. Hospital and Surgical Care
   a. All inpatient admissions including length of stay and, when necessary, extending the authorized length of stay
b. All inpatient and outpatient surgical procedures performed in hospital or Ambulatory Surgical Center (ASC)

2. Mental Health Care
   a. All psychological/psychiatric services after the completion of the initial evaluation.

3. Physical Medicine Services (regardless of location)
   a. Osteopathic or chiropractic manipulations after the first six sessions occurring within 30 days following the initial treatment date.
   b. Physical or occupational therapy outside of the first six sessions beginning within 30 days following the initial treatment date or up to 12 sessions beginning within 60 days following surgical intervention.
   c. Physical therapy services following injections (ESIs, Facet, Medial Branch Blocks, Rhizotomies).
   d. Physical therapy services following surgery for hardware removal.

4. Diagnostic Testing
   a. CT myelograms and discogram CTs
   b. Repeat Diagnostics

5. Injections:
   a. Epidural Steroid Injections (ESIs) and Facet Injections
   b. Medial branch blocks and Rhizotomies

6. Rehabilitation Programs
   a. Work hardening, work conditioning, and outpatient rehabilitation regardless of accreditation
   b. Pain management, chemical dependency, and weight loss

7. Durable Medical Equipment: (DME) billed at $1000 or greater per item, either cumulative rental or purchased. All electrical and/or neuromuscular stimulators including transcutaneous electrical stimulators (TENS) or interferential stimulators

8. Treatment not addressed or not recommended by Evidence Based Guidelines: Unless pre-approved as part of a treatment plan.

9. Drugs identified with a status of “N” in the current edition of the Official Disability Guidelines Treatment in Workers’ Compensation (ODG)/Appendix A, the ODG Workers’ Compensation Drug Formulary and any updates and any compound that contains such a drug.

28. What happens if I am unable to work?

Your Telephonic Case Manager will work with your doctor, employer, and adjuster to coordinate possible work programs to accommodate your restrictions while rehabilitating.

29. How do I file a complaint?

   a. If you are dissatisfied with any aspect of the network, you may file a complaint by completing the Complaint Form # IMO MSN-3.

   b. You must file the complaint within 90 days of the event about which you are dissatisfied.

   c. To obtain and submit this form you can contact the Network Complaint Dept. by:

       ● Writing: P.O. Box 118577, Carrollton, TX 75011
       ● Calling: 877.870.0638
       ● E-mailing: netcomplaint@injurymanagement.com
d. The network will respond to your complaint with a letter of acknowledgment within seven calendar days after receipt of the complaint.

e. Every complaint will be investigated and resolved within 30 calendar days after receipt of the complaint.

f. The network will send a letter to you explaining its decision and recommendations.

30. How do I file an appeal?

a. If you are dissatisfied with the complaint response, you must submit your appeal either by calling the network at 877.870.0638 or writing to the network. This process does not require a form completion, but you may use the Complaint Form # IMO MSN-3 and check the appropriate box to indicate that you are filing an appeal:

IMO Med-Select Network® Attention:
NetAppeal Committee
P.O. Box 260287
Plano, TX 75026

b. File the appeal within 15 days of receiving the decision letter.

c. The network will send a letter when it receives the appeal and once again when the decision is made.

31. What should I do next, if I do not agree with the network’s complaint or appeal resolution?

If you are dissatisfied with the network’s complaint or appeal resolution, you may file a complaint with the Texas Department of Insurance (TDI). A complaint form can be accessed at:

a. TDI website at www.tdi.texas.gov, or

b. TDI HMO Division at the following address: HMO Division, Mail Code 103-6A, Texas Department of Insurance, P.O. Box 149104, Austin, TX 78714-9104.
TEXAS DEPARTMENT OF CRIMINAL JUSTICE
DWC FORM-73 Notification

Beginning May 1, 2006, health care providers must use the DWC FORM-73, “Texas Workers’ Compensation Work Status Report,” which replaced the TWCC FORM-73, “Texas Workers’ Compensation Work Status Report.”

The new form may be obtained from the following TDI-DWC Texas Department of Insurance, Division of Workers’ Compensation forms webpage:

http://www.tdi.texas.gov/forms/dwc/dwc073wkstat.pdf