



UNITED INDEPENDENT SCHOOL DISTRICT

MANAGING EMPLOYEE INJURIES

Major Injury

(Very serious injury, life threatening, traumatic, requires emergency attention)

1. Try to make injured employee as comfortable as possible.
2. Call 911.
3. Advise the Principal, Site Safety Compliance Officer (SSCO), or Department Director of the accident.
4. Call the Risk Management Department at (956) 473-6347 / (956) 473-6299 immediately and advise them of the accident. **After 5 P.M., weekends, and holidays; please call:** Cell # (956) 206-0911-Administrator on Call (AOC).
5. As soon as possible, fill out an “**Incident-Accident Report**” form and fax it to the Risk Management Department at (956) 473-6410. Also provide a copy of the report to the campus SSCO or Department Director.
6. Within 48 hours the campus/department SSCO must conduct an accident investigation using the “**Supervisor’s Accident Investigation Report**” forms. A copy of the report must be faxed to the Risk Management Department.

All Other Injuries

1. Have Employee medically assessed by the campus nurse.
2. Immediately call the Risk Management Department at (956) 473-6347 / (956) 473-6299 and advise them of the accident.
3. **After 5 P.M., weekends, and holidays; please call:** Cell # (956) 206-0911-Administrator on Call (AOC).
The Risk Management Department will coordinate follow up medical care and billing.
4. As soon as possible, the campus nurse/department SSCO should fill out and fax to the Risk Management Department a copy of the following:
 - A. “**Incident-Accident Report**” form – (MUST BE FILLED OUT BY A NURSE, PRINCIPAL, and SSCO OR SUPERVISOR).
 - B. “**Authorization for Medical Records and Reports**” form – (MUST BE FILLED OUT BY EMPLOYEE).
 - C. “**Employee Injury Report**” form – (TO BE FILLED OUT BY EMPLOYEE).

**** A copy should also be forwarded to the campus SSCO or Department Director. ****
5. Within 48 hours, the campus/department SSCO must conduct an accident investigation using the “**Supervisor’s Accident Investigation Report**” forms. A copy of the report must be faxed to the Risk Management Department.

Employees Returning to Work Procedures:

Employees injured on the job **MAY NOT** return to work without prior authorization from the Risk Management Department. The Division of Workers’ Compensation imposes certain requirements and fines for failure to comply with the return to work procedures. Please contact the Risk Management Department before allowing injured employees to return to work.



INCIDENT-ACCIDENT REPORT

Date of Injury ___/___/___ Date Reported ___/___/___ Time of Injury ___:___ a.m. / p.m.

I.D. # _____ Employee Student Other _____ Sex: Male Female

Campus/Dept. _____ Occupation _____

Name _____ S.S.# _____ - _____ - _____

Address _____ Age _____ D.O.B. _____

Home Phone No _____ Does Employee speak English? Yes

Single Married Divorce Widow Separated

Race: White Black Hispanic Asian Native American Other _____

Next of Kin _____ Address _____ Phone _____

Location of Accident/Incident _____

List of Witnesses _____ Doctor's Name _____

Nature of Accident/Incident			Part of Body Injured				
<input type="checkbox"/> Abrasion	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Eye Injury	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Eye	<input type="checkbox"/> Knee	<input type="checkbox"/> Ankle	
<input type="checkbox"/> Burn	<input type="checkbox"/> Bruise/Bump	<input type="checkbox"/> Fracture	<input type="checkbox"/> Face	<input type="checkbox"/> Leg	<input type="checkbox"/> Arm	<input type="checkbox"/> Finger	
<input type="checkbox"/> Cut	<input type="checkbox"/> Slip/Fall	<input type="checkbox"/> Laceration	<input type="checkbox"/> Teeth	<input type="checkbox"/> Chest	<input type="checkbox"/> Back	<input type="checkbox"/> Foot	
<input type="checkbox"/> Puncture	<input type="checkbox"/> Convulsion	<input type="checkbox"/> Dislocation	<input type="checkbox"/> Wrist	<input type="checkbox"/> Hand	<input type="checkbox"/> Elbow	<input type="checkbox"/> Head	
<input type="checkbox"/> Shock	<input type="checkbox"/> Sprain		<input type="checkbox"/> Other _____				
Other _____					Left	right	both

How and why injury/illness occurred? _____

Were the parents notified? Yes No Time notified ___:___ a.m. / p.m.

Person notified: _____ Relationship: _____

Treatment and Disposition _____

Ambulance called: Time _____ Unit _____ Name of Hospital _____

Person Released to: _____ Relationship: _____

Signature _____

Nurse

Principal / Director



AUTHORIZATION FOR MEDICAL RECORDS

To Whom It May Concern:

I hereby authorize you to furnish United I.S.D./Workers' Compensation Insurance Carrier, all medical information you have concerning:

With respect to illnesses and injuries, medical histories, consultations, prescriptions, and treatments, including X-rays films, and copies of all hospital and medical records.

A photostatic copy of this authorization shall be considered as effective and valid as the original.

Your assistance and full cooperation will be appreciated.

Dated this _____ day of _____ 2____.

Name of Employee (Please Print)

Signature of Employee

- -

Social Security Number

Address:

City: _____ State: _____

Zip Code: _____



EMPLOYEE INJURY REPORT

Name of Injured Worker: _____

Supervisor: _____ Date of Injury: ____ / ____ / ____

Thoroughly describe accident (What, How, Where, Equipment, Activity, etc).

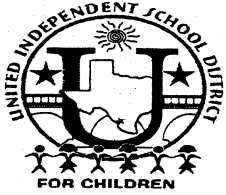
Was it an unsafe condition, act, equipment failure, etc.? Explain.

What can we do to prevent this from occurring again?

List witnesses: _____

Signature

Date



SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

Employee's Name _____

Job Title: _____ Date/Day/Time: _____

How Long in this position? _____

Review of basic job duties _____

Principal, Manager or Supervisor's **full** name: _____

Off-Site Medical _____ First Aide _____ Other _____

Part of body injured (see attached) _____

Nature of injury (see attached) _____

What is the required safety equipment for this job? _____

Injured while using all required safety equipment? Yes No

If no, why? _____

Any safety violations? (Explain) _____

Where did accident occur? _____

What happened: (What took place or what caused you to make this investigation?)



SUPERVISOR'S ACCIDENT INVESTIGATION REPORT (CONTINUED)

How did it happen? _____

Why did it happen? _____

Preventative measures (What can be done to prevent the same or similar occurrences in the future?)

Witness names, phone numbers, and statements of what happened (attach additional sheet if necessary)

Additional Comments _____

Signature of Investigator
(Principal / Manager / Supervisor)

Signature of Employee

Signature of Witness (If applicable)

Cc: Personnel Office – File
Principal / Manager / Supervisor – File

***Texas Star Network[®]
Employee Notice of
Network Requirements***

Important Contact Information:

To locate a provider, call (800) 381-8067

To contact Texas Mutual Insurance Company, visit
www.texasmutual.com or call (800) 859-5995

Texas Star Network[®]

Information, Instructions and your Rights and Obligations

Dear Employee:

Your employer has chosen *Texas Star Network[®]* to manage the health care and treatment you may receive if you are injured at work. *Texas Star Network[®]* is a certified workers' compensation health care network. The state of Texas has approved this network to provide care for work related injuries. This program includes a network of health care providers who are trained in treating work related injuries. They are also trained in getting people back to work safely. The current *Texas Star Network[®]* service areas are shown on the enclosed map.

If you are injured at work, tell your supervisor or employer immediately. The enclosed information will help you to seek care for your injury. Also, your employer will help with any questions about how to get treatment through *Texas Star Network[®]*. You may also contact Texas Mutual Insurance Company for any questions about your care and treatment for a work related injury. Texas Mutual and your employer have formed a team to provide timely health care for injured workers. The goal is to return you to work as soon as it is safe to do so.

Your Rights and Obligations...

Choosing a Treating Doctor

If you are hurt at work and you live in the network service area, you must choose a treating doctor from the *Texas Star Network[®]* provider list. This is required for you to receive coverage of the costs for the care of your work related injury. A provider listing is available through our website at www.texasmutual.com. It is updated at least every three months. It identifies providers who are taking new patients.

You also have the option to choose your current health maintenance organization (HMO) primary care physician as the treating doctor for your workers' compensation claim. In order for your HMO doctor to be approved as your treating doctor, he/she must agree to the terms of the network contract, and to agree to abide by applicable laws and regulations. If your HMO doctor is not approved, then you must see a network treating doctor.

If you were injured before your insurer contracted with the network and you live in the service area, you must choose a network treating doctor. You may also request a doctor you chose as your HMO primary care doctor before you were hurt. You must do this upon receipt of this notice.

If your treating doctor leaves the network, we will tell you in writing. You will have the right to choose another treating doctor from the list of network doctors. If your doctor leaves the network

and you have a life threatening or acute condition for which a disruption of care would be harmful to you, your doctor may request that you treat with him or her for an extra 90 days.

If you believe you live outside of the service area, you may request a service area review by calling Texas Mutual Insurance Company. Within 7 days of receiving your request for review, we will tell you our decision. If you do not agree with our final decision you have the right to file a complaint with the Texas Department of Insurance. Your complaint must include your name, address, telephone number, a copy of the insurer's decision and any proof you sent to Texas Mutual Insurance Company for review. A complaint form is available on the department's web site at www.tdi.state.tx.us. You may also ask for a form by writing to the HMO Division, Mail Code 103-6A, Texas Department of Insurance, P. O. Box 149104, Austin, Texas 78714-9104.

While waiting for Texas Mutual Insurance Company to make a decision or the Texas Department of Insurance to review your complaint, you may choose to receive health care outside of the network. You may be required to pay for health care services received out of the network if it is finally decided that you do live in the network's service area.

Changing Doctors

If you become dissatisfied with your first choice of a treating doctor, you can select an alternate treating doctor from the list of network treating doctors in the service area where you live. *Texas Star Network*[®] will not deny a choice of an alternate treating doctor. Before you can change treating doctors a second time, you must get permission from *Texas Star Network*[®].

Referrals

You do not have to get a referral if you have an emergency health condition. All health care services that you request will be made available by the network on a timely basis, as required by your medical condition. This includes referrals. All health care services, including referrals, will be made available no more than 21 days after you make a request.

Payment for Health Care

Network doctors have agreed to look to Texas Mutual Insurance Company for payment for your health care. They will not look to you for payment. If you obtain health care from a doctor who is not in the network without prior approval from *Texas Star Network*[®], you may have to pay for the cost of that care. You may only access non-network health care providers and still be eligible for coverage of your medical costs if one of the following situations occurs.

- Emergency care is needed. You should go to the nearest hospital or emergency care facility.
- You do not live within a *Texas Star Network*[®] service area.
- Your treating doctor refers you to an out of network provider or facility. This referral must be approved by *Texas Star Network*[®].
- You have chosen your HMO primary care doctor. Your doctor must agree to abide by the network contract and applicable laws.

Complaints

You have the right to file a complaint with *Texas Star Network*[®]. You may do this if you are dissatisfied with any aspect of network operations. This includes a complaint about your network doctor. It may also be a general complaint about *Texas Star Network*[®].

A complainant can notify the *Texas Star Network*[®] Grievance Coordinator of a complaint by phone or in writing via mail or fax. Complaints should be forwarded to:

***Texas Star Network*[®]**
Attention: Grievance Coordinator
3200 Highland Avenue
Downers Grove, IL 60515

Phone: (800) 262-6122
FAX: (800) 737-2077
E-mail: grievance_coordinator@cvty.com

A complaint must be filed with the network grievance coordinator no later than 90 days from the date the issue occurred.

Texas law does not permit *Texas Star Network*[®] to retaliate against you if you file a complaint against the network. *Texas Star Network*[®] also can not retaliate if you appeal the decision of the network. The law does not permit *Texas Star Network*[®] to retaliate against your treating doctor if he or she files a complaint against the network or appeals the decision of the network on your behalf. You have the right to file a complaint with the Texas Department of Insurance. The Texas Department of Insurance complaint form is available on the department's web site at www.tdi.state.tx.us or you may request a form by writing to:

HMO Division, Mail Code 103-6A,
Texas Department of Insurance,
P. O. Box 149104, Austin, Texas 78714-9104.

What to do if you are injured while on the job...

If you are injured while on the job tell your employer as soon as possible. A list of network treating doctors in your service area may be available from your employer. A complete list of network treating doctors is also available online at www.texasmutual.com. Or, you may contact us directly at the following address and/or toll-free telephone number:

Texas Star Network®
720 Cool Springs Boulevard
Suite 300
Franklin, TN 37067
(800) 381-8067

We will help you get an appointment with a network doctor.

In case of an emergency...

If you are hurt at work and it is a life threatening emergency, you should go to the nearest emergency room. If you are injured at work after normal business hours or while working outside your service area, you should go to the nearest care facility.

After you receive emergency care, you may need ongoing care. You will need to select a treating doctor from the network's provider list. This list is available online at www.texasmutual.com. If you do not have internet access call (800) 381-8067 or contact your employer for a list. The doctor you choose will oversee the care you receive for your work related injury. Except for emergency care you must obtain all health care and specialist referrals through your treating doctor.

Emergency care does not need to be approved in advance. "Medical emergency" is defined in Texas laws. It is a medical condition that comes up suddenly. There are acute symptoms that are severe enough that a reasonable person would believe that you need immediate care or you would be harmed. That harm would include your health or bodily functions being in danger or a loss of function of any body organ or part.

Non-emergency care...

Report your injury to your employer as soon as you can. Select a treating doctor from the network's provider list. This list is available online at www.texasmutual.com. If you do not have internet access, call (800) 381-8067 or contact your employer for a list.

Treatment prescribed by your doctor may need to be approved in advance. You or your doctor are required to request approval from Texas Mutual Insurance Company for a specific treatment or services before the treatment or service is provided. You may continue to need treatment after the approved treatment is provided. For example, you may need to stay more days in the hospital than what was first approved. If so, the added treatment must be approved in advance.

The following treatment requests must be approved in advance (effective 6/1/09):

This list is not intended to be comprehensive or all-inclusive; because health care is an ever-evolving science, procedures and treatments requiring prior approval will also evolve. Participating Treating Providers should therefore verify specific preauthorization requirements by referring to the updated list posted at www.texasmutual.com

Hospital/ASC

- All non-emergency hospital or ASC (inpatient, outpatient, and observation) admissions including principle scheduled procedures and length of stay. Preauthorization request should include specific hardware, implantables, external delivery system, etc. to be utilized.

Surgery/Procedures/Integral Devices

- All non-emergency surgeries represented by AMA CPT codes 10010-69990 and/or G codes which represent a surgical procedure performed in a setting or place of service other than the doctor's office [POS 11]. Preauthorization request should include specific hardware, implantables, external delivery system, etc. to be utilized.
- All Botox Injections
- All spinal Injections (including but not limited to):
 - *Epidural Steroid Injection
 - *RFTC or Cryotherapy/Cryoablation
 - *Sacral Iliac Joint Injection
 - *Facet Injection
 - *Medial Branch Block
- Trigger Point Injections (represented by AMA CPT 20553)
- Bone Growth Stimulators
- Discograms
- Implantable Drug Delivery System
- Investigational or experimental procedures or devices as determined by ODG or listed as an AMA Category III Code.
- Stimulator Devices (including, but not limited to):
 - *TENS Units
 - *Interferential Units
 - *Neuromuscular Stimulators
 - *Dual Units
 - *Spinal Cord Stimulator
 - *Peripheral Nerve Stimulator
 - *Brain Stimulator

Physical Medicine

- Cumulative Chiropractic Treatments (including manipulations and office visits) greater than 14 visits and/or greater than 10 weeks from date of injury.
- Manipulations under Anesthesia (MUA)
- Cumulative Physical Therapy/Occupational Therapy greater than 14 visits and/or great than 10 weeks from date of injury.
- Biofeedback

Diagnostics

- All Initial and Repeat MRI and CT Scans
- Bone Density Scans
- Unless otherwise specified in this list, all repeat individual diagnostic studies (series) having a billed amount greater than \$350.
- Surface Electromyography (EMG)

Other

- Durable Medical Equipment (DME), Prosthetics and/or Orthotics, greater than \$500.00 billed (purchase or accumulated rental or combination of rental/purchase).
- Gym Memberships

Alternative Treatment (including, but not limited to):

- Acupuncture outside ODG
- Acupressure
- Yoga

Rehab Programs (including, but not limited to):

- Work Conditioning
- Work Hardening
- Chronic Pain Management Program
- Medical Rehabilitation
- Brain and Spinal Cord Rehabilitation
- Chemical Dependency Programs
- Weight Loss Programs

Nursing Home (including, but not limited to):

- Skilled nursing facility, including skilled care within the same facility.
- Convalescent Care
- Residential Care
- Assisted Living
- Group Homes

Psychological and/or Psychotherapy (including but not limited to):

- Subsequent Evaluations
- Subsequent Tests or Testing
- All Therapy
- All Biofeedback

The number to call to request one of these treatments is (888) 532-5246 or fax to (800) 852-1805. If a treatment or service request is denied, we will tell you in writing. This written notice will have information about your right to request a reconsideration or appeal of the denied treatment. It will also tell you about your right to request review by an Independent Review Organization through the Texas Department of Insurance.

Texas Star Network[®] Service Area Map (As of February 2008)
 Network service areas are subject to change



– A list of the counties in the network service area is contained on the next page –

Texas Star Network[®] Service Area County List (As of February 2008)
Network service areas are subject to change

ANDERSON	CRANE	HASKELL	MARION	SAN AUGUSTINE
ANDREWS	CROSBY	HAYS	MARTIN	SAN JACINTO
ANGELINA	DALLAM	HEMPHILL	MASON	SAN PATRICIO
ARANSAS	DALLAS	HENDERSON	MATAGORDA	SAN SABA
ARCHER	DAWSON	HIDALGO	MCCULLOCH	SCHLEICHER
ARMSTRONG	DEAF SMITH	HILL	MCLENNAN	SCURRY
ATASCOSA	DELTA	HOCKLEY	MCMULLEN	SHACKELFORD
AUSTIN	DENTON	HOOD	MEDINA	SHELBY
BAILEY	DEWITT	HOPKINS	MENARD	SHERMAN
BANDERA	DICKENS	HOUSTON	MIDLAND	SMITH
BASTROP	DONLEY	HOWARD	MILAM	SOMERVELL
BAYLOR	DUVAL	HUDSPETH	MILLS	STARR
BEE	EASTLAND	HUNT	MITCHELL	STEPHENS
BELL	ECTOR	HUTCHINSON	MONTAGUE	STERLING
BEXAR	EL PASO	IRION	MONTGOMERY	STONEWALL
BLANCO	ELLIS	JACK	MOORE	SWISHER
BORDEN	ERATH	JACKSON	MORRIS	TARRANT
BOSQUE	FALLS	JASPER	MOTLEY	TAYLOR
BOWIE	FANNIN	JEFFERSON	NACOGDOCHES	TERRY
BRAZORIA	FAYETTE	JIM HOGG	NAVARRO	THROCKMORTON
BRAZOS	FISHER	JIM WELLS	NEWTON	TITUS
BRISCOE	FLOYD	JOHNSON	NOLAN	TOM GREEN
BROOKS	FORT BEND	JONES	NUECES	TRAVIS
BROWN	FRANKLIN	KARNES	OCHILTREE	TRINITY
BURLESON	FREESTONE	KAUFMAN	OLDHAM	TYLER
BURNET	FRIO	KENDALL	ORANGE	UPSHUR
CALDWELL	GAINES	KENEDY	PALO PINTO	UPTON
CALHOUN	GALVESTON	KENT	PANOLA	UVALDE
CALLAHAN	GARZA	KERR	PARKER	VAN ZANDT
CAMERON	GILLESPIE	KIMBLE	PARMER	VICTORIA
CAMP	GLASSCOCK	KLEBERG	PECOS	WALKER
CARSON	GOLIAD	LAMAR	POLK	WALLER
CASS	GONZALES	LAMB	POTTER	WARD
CASTRO	GRAY	LAMPASAS	RAINS	WASHINGTON
CHAMBERS	GRAYSON	LAVACA	RANDALL	WEBB
CHEROKEE	GREGG	LEE	REAGAN	WHARTON
CLAY	GRIMES	LEON	REAL	WICHITA
COCHRAN	GUADALUPE	LIBERTY	RED RIVER	WILBARGER
COKE	HALE	LIMESTONE	REEVES	WILLACY
COLEMAN	HALL	LIPSCOMB	REFUGIO	WILLIAMSON
COLLIN	HAMILTON	LIVE OAK	ROBERTS	WILSON
COLORADO	HANSFORD	LLANO	ROBERTSON	WINKLER
COMAL	HARDIN	LOVING	ROCKWALL	WISE
COMANCHE	HARRIS	LUBBOCK	RUNNELS	WOOD
CONCHO	HARRISON	LYNN	RUSK	YOAKUM
COOKE	HARTLEY	MADISON	SABINE	YOUNG
CORYELL				

Employee Acknowledgment of Workers' Compensation Network

I have received information that tells me how to get health care under my employer's workers' compensation insurance.

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

1. I must choose a treating doctor from the list of doctors in the network.
2. I must go to my 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 might have to pay the bill if I get health care from someone other than a network doctor without network approval.
5. Making a false or fraudulent workers' compensation claim is a crime that may result in fines and or imprisonment.

Signature Date

Printed Name

I live at: _____
Street Address

City State Zip Code

Name of Employer: United Independent School District

Name of Network: *Texas Star Network*®

Network service areas are subject to change.

Call (800) 381-8067 if you need a network treating provider.

Please indicate whether this is the:	
<input type="checkbox"/>	Initial Employee Notification
<input checked="" type="checkbox"/>	Injury Notification (Date of Injury: ____ / ____ / ____)

**DO NOT RETURN THIS FORM TO TEXAS MUTUAL
INSURANCE COMPANY UNLESS REQUESTED**