UTHealth
The University of Texas Health Science Center at Houston

SUPERVISOR'S FIRST REPORT OF INJURY

All **Fillable Form** versions must be printed and submitted with **original** signatures. **See instruction sheet**

ID# _____ TITLE: _____ INJURY DATE: ___/___/___ (Month / Day / Year) Time of Injury: ☐ AM ☐ PM

NAME: _____ (Last / First / MI) TELEPHONE: (___) _____ (Work#) (___) _____ (Home/Cell#)

HOME ADDRESS: _____ (Street or Box / Apt# / County / City / State / Zip Code)

Date of Birth: ___/___/___ (Month / Day / Year) SEX: ☐ Male ☐ Female

DEPARTMENT: _____ INTEROFFICE ADDRESS: _____ EMPLOYEE ____ RESIDENT____ * STUDENT ____

☐ Full Time ☐ Part Time (Check all that apply)

SUPERVISOR: ☐ Hotline Supervisor: ☐ _____ TELEPHONE: (___) _____ (Work# / Cell/Pager#)

Date Supervisor Notified: ___/___/___ (Month / Day / Year) _____ Time ☐ AM ☐ PM Witness: _____

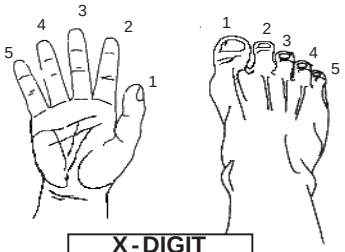
MARITAL STATUS: ☐ Married ☐ Single ☐ Divorced ☐ Widow _____ Full Name of Spouse

Accident Location:

Building name & address **Floor/Room#** **Location (ex: hall, classroom, street)**

BODY PART AFFECTED	X	Right or Left

Check Appropriately		Check Appropriately	R	L
Head		Eye		
Face		Shoulder		
Neck		Arm or Hand		
Chest		Leg or Knee		
Stomach		Ankle or Foot		
Back(Lower or Upper)		Toe		
Other		Other		



X - DIGIT

1	2	3	4	5
1	2	3	4	5

INJURY TYPE	
Check Appropriately	
Fall	
Needle Stick***See protocol	
Exposure***See protocol	
Sprain / Strain	
Burn	
Contusion / Bruise	
Bite**Describe Source Below	
Laceration / Cut	
Assault or Accident	
Eye Injury	
Other-Describe Below	
Rash	

Provide Brief Description of Reported Injury: _____

Employee/Resident has been offered medical attention but does not wish to receive any at this time. This **does not** prevent you from seeking medical attention at a later date. . . . . **(A)** **(Initial here)** _____

Employee/Resident has received a copy of the Business Procedures Memorandum (BPM) 66-10-04 concerning confidentiality of your social security number. . . . . **(B)** **(Initial here)** _____

Employee has signed Network Acknowledgement Form & received Notice of Network Requirement Packet. (Acknowledgement Form not needed for Residents or Students) . . . **(C)** **(Initial here)** _____

Signature of Injured Party Date **Signature of Supervisor** Date

INFORMATION RELEASE

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

Signature of Injured Party: _____ Date: _____

ALL INFORMATION MUST BE COMPLETED BEFORE REPORT CAN BE PROCESSED

Distribution:

Fax a copy to: Risk Management & Insurance, Phone: (713) 500-8127 or 8100, Fax (713) 500-8111
HCPC Employees should contact their supervisor or the supervisor on duty to report their injury.
Maintain a copy for department files

*Students are not covered under Workers' Compensation, this form is for record only.

***Needlestick/BBP/TB Exposure: Students Hotline# 713-500-OUCH, Employee/Residents Hotline# 713-500-3267 ext 1 or 800-770-9206.

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 form to RMI by Fax# (713)500-8111, encrypted emails to (sondra.k.faul@uth.tmc.edu) or OCB 1.330. **HCPC Employees should give form to their supervisor or supervisor on duty.

Employee ID:_____ **Name of Network:** IMO Med-Select Network

Hire Date:_____ **Department:**_____

Home Address:_____
Street Address-No PO Box or Work Address

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

_____ _____
Employee Signature **Date**

_____ _____
Printed Name **Employee Phone Number**

For more information please contact the
Office of Safety, Health, Environment & Risk Management-713.500.8127 or 8111

Disclosure of your Social Security Number ("SSN") is required in order for The University of Texas System to report as required to the Texas Department of Insurance as mandated by state law. Further disclosure of your SSN is governed by the Public Information Act (Chapter 552 of the Texas Government Code) and other applicable law.

The following notices are being provided to you in accordance with Business Procedures Memorandum 66-10-04.

Section 7 of the Federal Privacy Act of 1974 (Historical Note, 5 U.S.C. § 552a)

DISCLOSURE OF SOCIAL SECURITY NUMBER

Section 7 of Pub. L. 93-579 provided that:

(a)(1) It shall be unlawful for any Federal, State or local government agency to deny to any individual any right, benefit, or privilege provided by law because of such individual's refusal to disclose his social security account number.

(2) [T]he provisions of paragraph (1) of this subsection shall not apply with respect to—

(A) any disclosure which is required by Federal statute, or

(B) the disclosure of a social security number to any Federal, State, or local agency maintaining a system of records in existence and operating before January 1, 1975, if such disclosure was required under statute or regulation adopted prior to such date to verify the identity of an individual.

(b) Any Federal, State, or local government agency which requests an individual to disclose his social security account number shall inform that individual whether that disclosure is mandatory or voluntary, by what statutory or other authority such number is solicited, and what uses will be made of it.''

§ 559.003. RIGHT TO NOTICE ABOUT CERTAIN INFORMATION LAWS AND PRACTICES.

With few exceptions, you are entitled on your request to be informed about the information UTHSC-H collects about you. Under Sections 552.021 and 552.023 of the Texas Government Code, you are entitled to receive and review the information. Under Section 559.004 of the Texas Government Code, you are entitled to have UTHSC-H correct information about you that is held by us and that is incorrect, in accordance with the procedures set forth in The University of Texas System Business Procedures Memorandum 32. The information that UTHSC-H collects will be retained and maintained as required by Texas records retention law (Section 441.180, et. seq. of the Texas Government Code) and rules. Different types of information are kept for different periods of time.

(a) Each state governmental body that collects information about an individual by means of a form that the individual completes and files with the governmental body in a paper format or in an electronic format on an Internet site shall prominently state, on the paper form and prominently post on the Internet site in connection with the electronic form, that:

(1) with few exceptions, the individual is entitled on request to be informed about the information that the state governmental body collects about the individual;

(2) under Sections 552.021 and 552.023 of the Government Code, the individual is entitled to receive and review the information; and

(3) under Section 559.004 of the Government Code, the individual is entitled to have the state governmental body correct information about the individual that is incorrect.

(b) Each state governmental body that collects information about an individual by means of an Internet site or that collects information about the computer network location or identity of a user of the Internet site shall prominently post on the Internet site what information is being collected through the site about the individual or about the computer network location or identity of a user of the site, including what information is being collected by means that are not obvious.

Added by Acts 2001, 77th Leg., ch. 1059, § 1, eff. Sept. 1, 2001.

STEPS TO BE TAKEN IN THE EVENT OF A NEEDLESTICK/ BLOODBORNE PATHOGEN OR TB EXPOSURE

If a Student

- Apply first aid:
  1. Clean exposed area with soap and water for at least 15 minutes.
  2. Flush mucous membranes with water or saline for at least 15 minutes.
- If the source patient is known and present, keep individual on-site for a blood draw (see below) *
- Notify instructor / clinic supervisor / hospital supervisor to report injury
- Obtain medical evaluation and treatment at:
  Student Health Services Clinic
  UTPB Suite 130
  713-500-5171
  Hours: M-F 8:30am – 5:00pm
- Call the Needlestick Hotline: 713-500-OUCH (if after hours the exposure coordinator will call you back shortly)
- Complete the 'Supervisor's First Report of Injury Form' to document the injury and submit to Risk Management & Insurance Program at OCB 1.330 or fax 713-500-8111

* In the State of Texas, you have the right to the identification, documentation, testing, and results of the source individual infectious disease status. Arrangements should be made immediately with UT Student Health Services or the hospital where the incident takes place for testing the source individual. Source individual testing should include HIV antibody, Hepatitis C antibody, and Hepatitis B surface antigen.

If a UTHealth Employee, Faculty, or Resident

- Apply first aid:
  1. Clean exposed area with soap and water for at least 15 minutes.
  2. Flush mucous membranes with water or saline for at least 15 minutes.
- If the source patient is known and present, keep individual on-site for a blood draw (see below) *
- Notify clinic / supervisor / hospital supervisor to report injury
- Obtain medical evaluation and treatment at:
  UT Health Services Clinic
  UCT Suite 1620
  713-500-3267 (select Ext. 1)
  Hours: M-F 7:00am – 4:00pm
- If after hours, call the Needlestick Hotline: 800-770-9206 (24-hr answering service will ensure exposure coordinator calls back promptly)
- Complete the 'Supervisor's First Report of Injury Form' to document the injury and submit to Risk Management & Insurance Program at OCB 1.330 or fax 713-500-8111

* In the State of Texas, you have the right to the identification, documentation, testing, and results of the source individual infectious disease status. Arrangements should be made immediately with UT Health Services or the hospital where the incident takes place for testing the source individual. UTP outlying clinics have been provided with exposure kits to draw source patient blood onsite. Source individual testing should include HIV antibody, Hepatitis C antibody, and Hepatitis B surface antigen.

If a UTPhysicians Insperity Employee

- Apply first aid:
  1. Clean exposed area with soap and water for at least 15 minutes.
  2. Flush mucous membranes with water or saline for at least 15 minutes.
- If the source patient is known and present, keep individual on-site for a blood draw (see below) *
- Notify clinic / supervisor / hospital supervisor to report injury
- Obtain medical evaluation and treatment at:
  UT Health Services Clinic
  UCT Suite 1620
  713-500-3267 (select Ext. 1)
  Hours: M-F 7:00am – 4:00pm
- If after hours, call the Needlestick Hotline: 800-770-9206 (24-hr answering service will ensure exposure coordinator calls back promptly)
- Complete the 'First Report of Injury' and Sharps Injury Log to document the injury and submit to Insperity.

* In the State of Texas, you have the right to the identification, documentation, testing, and results of the source individual infectious disease status. Arrangements should be made immediately with UT Health Services or the hospital where the incident takes place for testing the source individual. UTP outlying clinics have been provided with exposure kits to draw source patient blood onsite. Source individual testing should include HIV antibody, Hepatitis C antibody, and Hepatitis B surface antigen.

Instructions for Supervisor's First Report of Injury

1. Report work injury/illness to your supervisor. Needlestick/Bloodborne Pathogens or TB Exposures;**please see and follow protocol sheet .**

2. **Employee/Resident/Student** need to complete and sign the **Supervisor's First Report of Injury ("FRI")**; including the Information Release section. **Employees only** need to complete & sign the **Network Acknowledgment Form**. ****Submit these two forms to RMI,do not send the entire packet . The remaining pages concerning the IMO network should go to the UT Health Employee.**

3. **Employee/Resident/Student** if you choose not to seek medical attention initial **(A)**. **{This does not prevent you from seeking care at a later date}.**

4. **Employee/Resident** initial **(B)** indicating that a copy of the Business Procedures Memorandum (BPM) 66-10-04 concerning confidentiality of your social security number was received.

5. **Employee (only)** initial **(C)** indicating that the Network Acknowledgement Form & the Notice of Network Requirement Packet have been received.

6. Have your **supervisor sign and date the form.** Your supervisor's signature acknowledges the work-related injury/ illness was reported and the date the injury/illness was reported.

7. **Submit** the completed form to **RMI** by fax (713-500-8111) or encrypted email (sondra.k.faul@uth.tmc.edu).

8. **Lost Time?** Call Risk Management & Insurance ("**RMI**")/Workers' Compensation (713) 500-8127 or 8100. A **Request for Paid Leave Form** must be completed and submitted to RMI within 3 days of lost time. This applies even if personal sick or vacation time is used.

9. As of **April 1, 2013**, UT System has contracted with IMO Med-Select, a certified workers' compensation health care network, to provide medical care for employees who sustain work-related injuries/illnesses. (**This does not include Students or UT System Medical Foundation Residents**)

Non-Emergency Care: If you live within the IMO Med-Select network service area, you must seek medical care from an IMO Med-Select network provider. Your medical provider will refer you to a network specialist, if necessary. If you receive medical care from an out-of-network provider, you may be financially resonsible for the services provided should it be determined that you live within the network service area. UT Health Employee can go to the IMO website at **www.injurymanagement.com** for a list of network providers.

For your convenience UT Health Employees can be seen at UT Health Service ("UTHS") which is part of the IMO certified workers' compensation health care network. UTHS is located at 7000 Fannin, UCT 1620. Please call 713-500-3267 ext 1 for treatment . Take a copy of the Supervisor's First Report of Injury and Acknowledgement Form to the appointment. **Medical Foundation Residents** while not in the IMO network, can also be seen at UTHS.

Students should contact UT Student Health Services at 713-500-5171 for care.

Emergency Care: In an emergency situation, you should seek medical care from the nearest hospital emergency room. However, follow-up medical care should be received from a network provider.

Out-of-Network Care: If you live outside of the IMO Med-Select network service area, you are not required to be treated by an IMO Med-Select network provider. You should seek medicl care from any proivder who accepts workers' compensation insurance.

Note: Supervisor/Employer's failure to report lost days, return to work, resignations/terminations within (3) days of knowledge could result in fines up to $25,000.00 per day per occurrence issued by the Texas Department of Insurance-Divison of Workers' Compensation.

For additional information, please contact RMI (713-500-8127 or 713-500-8100) or visit the Safety, Health, Environment and Risk Management web page at

https://www.uth.edu/safety/risk-management-and-insurance/.

IMO MED-SELECT NETWORK®

A Certified Texas Workers' Compensation Health Care Network

Notice of Network Requirements for The University of Texas System

IMO Med-Select Network®
Notice of Network Requirements

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

2. For any questions you may contact IMO by:

    a. Calling IMO Med-Select Network® at 888.466.6381
    b. Writing to P.O. Box 118577, Carrollton, Texas 75011
    c. E-mailing questions to netcare@injurymanagement.com

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

1. Atascosa
2. Austin
3. Bandera
4. Bastrop
5. Bell
6. Bexar
7. Blanco
8. Brazoria
9. Brazos
10. Burleson
11. Burnet
12. Caldwell
13. Cameron
14. Chambers
15. Colorado
16. Collin
17. Comal
18. Dallas
19. Denton
20. El Paso
21. Ellis
22. Falls
23. Fayette
24. Fort Bend
25. Galveston
26. Gonzales
27. Grayson
28. Grimes
29. Guadalupe
30. Harris
31. Hays
32. Henderson
33. Hidalgo
34. Hill
35. Hood
36. Hunt
37. Jefferson
38. Johnson
39. Karnes
40. Kaufman
41. Kendall
42. Lee
43. Liberty
44. Limestone
45. McLennan
46. Medina
47. Milam
48. Montgomery
49. Navarro
50. Parker
51. Rains
52. Robertson
53. Rockwall
54. San Jacinto
55. Smith
56. Starr
57. Tarrant
58. Travis
59. Van Zandt
60. Walker
61. Waller
62. Washington
63. Wharton
64. Williamson
65. Wilson
66. Wise
67. Wood

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

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

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

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

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

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

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

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

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

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

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

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

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

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

    a. Admission to a hospital
    b. Physical therapy/occupational therapy, beyond allowable sessions
    c. Chiropractic care, beyond allowable sessions
    d. Any type of surgery
    e. Some initial and repeat diagnostic testing

f. Certain injections
g. All work hardening or work conditioning programs
h. Equipment that costs more than $1,000
i. Any investigational or experimental services or devices
j. Any treatment, service, medication, diagnostic test or durable medical equipment that falls outside of or not recommended by any one of the following Evidence Based Guidelines: i) Official Disability Guidelines; ii) American College of Occupational and Environmental Medicine; iii) Medical Disability Advisor
k. Mental health care
l. All chronic pain programs

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

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

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

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

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

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

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

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

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

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

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

    a. Calling: 877.870.0638
    b. Writing: IMO Med-Select Network®
       Attention: NetComplaint Dept.
       P.O. Box 118577
       Carrollton, TX 75011
    c. E-mailing: netcomplaint@injurymanagement.com

29. The network will not retaliate if:

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

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

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

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

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

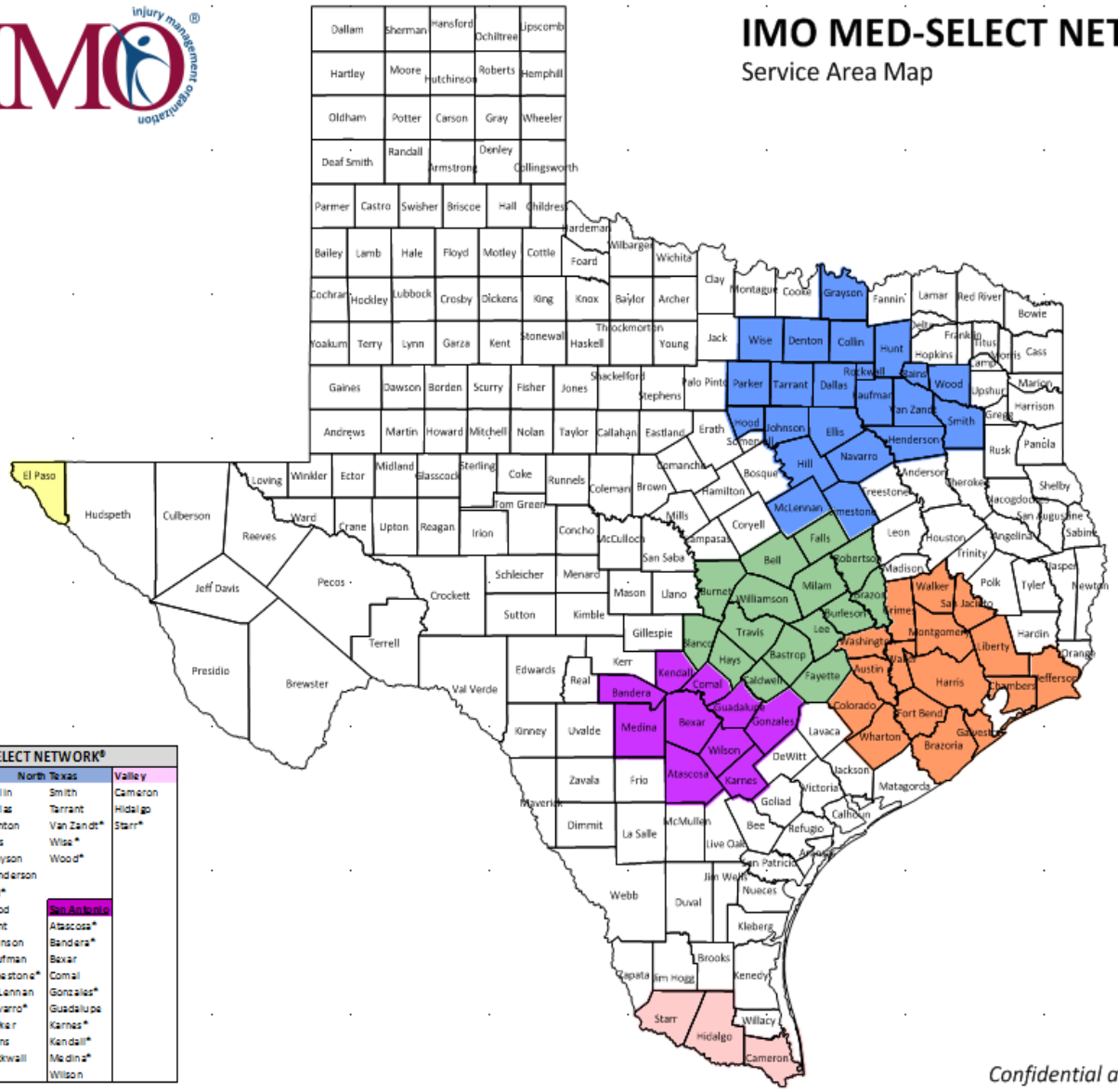
    a. The names and addresses of network providers grouped by specialty. Treating doctors shall be identified and listed separately from specialists; and
    b. Providers who are authorized to assess maximum medical improvement and render impairment ratings shall be clearly identified.

33. To obtain a provider directory:

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

IMO MED-SELECT NETWORK®

Service Area Map



IMO MED-SELECT NETWORK®				
Austin	Houston	North Texas		Valley
Bastrop	Austin*	Collin	Smith	Cameron
Bell	Brazoria	Dallas	Tarrant	Hidalgo
Blanco*	Chambers	Denton	Van Zandt*	Starr*
Brazos	Colorado*	Ellis	Wise*	
Burleson*	Fort Bend	Grayson	Wood*	
Bumet	Galveston	Henderson		
Caldwell	Grimes*	Hill*		
Falls*	Harris	Hood	San Antonio	
Fayette*	Jefferson	Hunt	Atascosa*	
Hays	Liberty	Johnson	Bandera*	
Lee*	Montgomery	Kaufman	Bexar	
Milam*	San Jacinto*	Limestone*	Comal	
Robertson*	Walker*	McLennan	Gonzales*	
Travis	Waller	Navarro*	Guadalupe	
Williamson	Washington*	Parker	Karnes*	
	Wharton*	Rains	Kendall*	
El Paso		Rockwall	Medina*	
El Paso			Wilson	

*Rural Counties

Confidential and Proprietary