INTEROFFICE MEMORANDUM

TO: ELECTED/APPOINTED OFFICIALS AND DEPARTMENT HEADS

FROM: JUANITA ESPINO, HR DIRECTOR

SUBJECT: WORKERS' COMPENSATION

DATE: AUGUST 24, 2020

CC: SAFETY COMMITTEE

All elected/appointed officials and employees are covered by workers' compensation insurance while in the performance of their duties for Kendall County.

Any employee who suffers a job-related illness or injury is required to notify his or her supervisor within two hours. Failure to promptly report job-related injuries or illnesses might affect an employee's eligibility for benefits, or delay benefit payments.

The injured employee's supervisor shall report the injury to the Human Resources Office so the appropriate paperwork may be completed and forwarded to the insurance carrier. Also the Human Resources Office needs to authorize treatment at the clinics, unless injuries are life threatening.

The injured employee, after seeking medical attention, needs to report to the Human Resources Office to finalize the claim and obtain documents to fill prescriptions for medications, if any.

Attached are copies of the information for injured employees and the necessary forms required for a claim.

Kendall County participates under the Political Subdivision Workers' Compensation Alliance (Alliance) to manage the health care and treatment of our employees who are injured on the job. The Alliance has a panel of health care providers. A complete list of providers is available online at http://www.pswca.org or you may contact our adjuster at: Texas Association of Counties Risk Management, (mailing address) PO Box 160120, Austin, TX 78716 or toll free number 1-800-752- 6301.

The following facilities are available in our area under the Alliance:

Main Street Urgent Care, 1421 S Main St, Ste. 111, Boerne (830) 249-9995

Texas Med Clinics (numerous clinics in SA and surround area)

Methodist Boerne Emergency Center, 134 Menger Springs, Boerne (830) 331-3000

And other clinics too numerous to name

IN CASE OF AN EMERGENCY....

If the illness/injury is work-related and life-threatening, please seek medical attention for the employee or employees at the nearest emergency medical facility.

If you need further assistance contact the Human Resources Office at (830) 249-9343 or any of the Safety Committee members.

SAFETY COMMITTEE MEMBERS:

Daniel Vetter, Chairperson
Robert Kinsey, Facilities
Jeff Fincke, Loss Control Coordinator
Juanita Espino, Secretary
Darrel Lux, County Judge
Richard Chapman, Commissioner
Al Auxier, Sheriff
Corinna Speer, Auditor
Ricky Pfeiffer, Road and Bridge
Jean "Max" Maxwell, R&B Operations
Jason Barter, County Jail

Updated: 02/24/2020

EMPLOYEE'S REPORT OF INJURY

Dear Employee:

We have received a report that you were injured in the course of your employment. To process your claim efficiently, please fill in all lines completely and print legibly. **Attach additional sheets if necessary.**

Name: _____ Social Security: _____ ☐ M ☐ F
Last First MI Maiden

Address: _____ Date of Injury: _____

City: _____ State: _____ Employer: _____

Primary Phone: _____ Job Title: _____

Secondary Phone: _____ Work Schedule: _____

Email address: _____

1) What was the exact location of the accident? (street address if possible):

2) What was happening at the time? (What was going on around you, what were you doing, what were other people doing?

3) Briefly describe what exactly caused the injury:

4) What areas of your body were injured?

5) When and to whom did you report your injury? Date: _____ Time: _____

Name: _____ Title: _____ Phone Number: _____

6) List all known witnesses. (Continue on back if necessary) Name: _____ Phone: _____
Name: _____ Phone: _____ Name: _____ Phone: _____

7) Please identify your Primary Care Physician of family doctor. Name: _____ Phone: _____

8) Please list the names and phone numbers of all doctors or treatment providers you have seen for your injury:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

9) Has a doctor taken you off work? ☐ Yes ☐ No If so, when was the first day you missed work? _____

10) If the doctor took you off work, have you returned to work? ☐ Yes ☐ No If not, when do you think you will return to work? _____

11) Date of last appointment: _____ Date of Next appointment: _____

12) Have you had previous workers compensation injuries? ☐ Yes ☐ No If yes, please enter the dates of injuries and the body parts injured:

By affixing my signature, I attest that all information on this form is accurate and true.

Signature: _____ Date: _____

TEXAS ASSOCIATION *of* COUNTIES
RISK MANAGEMENT POOL

Employee Acknowledgement of PSWCA Direct Contracting Program

I have received information that informs me of my employer's election to utilize the Political Subdivision Workers Compensation Alliance (Alliance) and how to obtain health care if I should suffer a work related injury/illness.

If I am injured on the job, I understand that:

1. I must choose a treating doctor from the list of contracted providers provided by my employer or obtain the list myself from www.pswca.org
2. I must go to my treating doctor for all health care related to my injury. If I need a specialist, my treating doctor will refer me. If I require emergency care I may go anywhere.
3. Making a false of fraudulent workers' compensation claim is a crime that may result in fines and/or imprisonment.
4. Additional information regarding the Alliance is available on TACRMP's website at www.county.org

_____

Signature Date

_____

Printed Name

I live at _____

Street Address

_____

City, State, Zip Code

_____

Name of Employer

Please indicate whether this is the:

☐ **Initial Employee Notification**

☐ **Date of Injury Notification (date of injury _____)**

PLEASE RETURN THIS FORM TO YOUR EMPLOYER

TEXAS ASSOCIATION of COUNTIES
RISK MANAGEMENT POOL

Employee Notice of
Alliance Program Requirements

Information, Instructions and your Rights and Obligations

As your employer, Kendall County has elected to utilize the Political Subdivision Workers Compensation Alliance (Alliance) to provide access to contracted physicians and healthcare providers for worker's compensation injuries.

If you are injured at work, tell your supervisor or manager immediately. This information will help you seek care for your injury. Also, your employer will help with any questions about how to get treatment. TAC RMP and your employer have formed a team to provide you with timely care and treatment for work related injuries. The goal is to provide quality medical care and return you to work as soon as it is safe to do so.

Important Contact Information

Alliance
866-997-7922
www.pswca.org

TAC RMP WC Claims
P.O. Box 160120
Austin, TX 78716
800-752-6301

Injured Employees Rights and Obligations

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 Alliance treating physicians may be available from your employer. A complete list is also available online at www.pswca.org or you may contact your adjuster directly: TAC RMP WC Claims **800-752-6301.**

In case of an emergency
If you are hurt at work, you should first notify your employer and they will assist you in locating a provider or emergency care provider.

After you receive emergency care or treatment, you may require ongoing care. You will need to select a treating doctor from the Alliance provider list. This list is available at www.pswca.org. If you do not have internet access, please call 1-800-752-6301 or contact your employer for a complete listing. 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.

Choosing a Treating Doctor
If you are injured at work you must choose a treating doctor from the Alliance panel of providers. This is **REQUIRED** for the cost of your medical care for your work related injury to be covered. A provider listing is available through the Alliance website at www.pswca.org. It is updated weekly and identifies providers who are contracted with the Alliance and accept workers' compensation patients.

If your treating physician leaves the Alliance, you will be notified and you will have the right to choose another treating doctor from the list of providers. If your doctor leaves the Alliance and you suffer a life threatening or acute condition for which a disruption of care would be harmful, your doctor will contact your adjuster to request that you treat with him/her for an additional 90 days.

Changing Doctors
If you become dissatisfied with your initial choice of treating physician, you can complete the Change of Treating Doctor Form to select a new treating doctor from the list of Alliance providers. This form is available at www.county.org and should be completed and submitted to your adjuster for approval prior to changing doctors.

Referrals
Referrals are not required for emergency care. Your treating doctor will refer you to other health care providers if necessary for your medical treatment.

Payments for Health Care
Alliance providers have agreed to bill TACRMP for payment in relation to your health care. You should not be required to make payment at the time of your treatment. You may only access non-Alliance health care providers and remain eligible for coverage of your medical costs if one of the following situations occur:

- Emergency care is needed. You should go to the nearest hospital, urgent care, or emergency care facility
- You do not live within 75 miles of a contracted provider
- Your treating physician refers you to a non-Alliance provider or facility AND your adjuster has approved the referral prior to treatment.

Non-emergency care
Once you have selected your treating physician, your adjuster will be notified and they will contact you if additional information is required.

Complaints

You have the right to file a complaint with the Alliance. You may do this if you are dissatisfied with any aspect of the operation. This includes a complaint about the Alliance or an Alliance treating physician or facility. It may also be a general complaint about the PSWCA Direct Contracting Program.

Complaints should be addressed to the PSWCA Direct Contracting Program Grievance Coordinator by phone or in writing via email or fax. Complaints should be sent to:

PSWCA Direct Contracting Program
Attention: Grievance Coordinator
P.O. Box 763
Austin, TX 78767
1-866-997-7922
customerservice@pswca.org

TEXAS ASSOCIATION of COUNTIES
RISK MANAGEMENT POOL

Notification of WC Coverage Provider

To whom it may concern:

Kendall County is covered by The Texas Association of Counties Risk Management Pool for compensable workers' compensation injuries that occur in the coverage period from 01/01/2020 to 12/31/2020.
The Pool contracts with Sedgwick to adjust its claims. All medical bills (excluding pharmacy), reports and other supporting documentation may be submitted to the following address for consideration:

TAC Risk Management Pool
P.O. Box 160120
Austin, TX 78716

800.752.6301
512.346-9321 (fax)

TACDWCforms@yorkrsg.com

Please note, all bills are subject to retrospective review, reconsideration, and preauthorization under the Texas Workers' Compensation Act.

With the exception of emergency treatment, if the county participates in the Political Subdivision Workers' Compensation Alliance (Alliance), the treating doctor must be chosen from a list of Alliance doctors located at www.pswca.org. Please contact your adjuster at the number above for additional information.

Texas Association of Counties
Risk Management Pool

P.O. Box 160120
Austin, TX

(800) 752-6301

Texas Association of Counties Risk Management Pool
Workers' Compensation Prescription Information

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

Employee Name:	
Group#:	10602730
Member ID (SSN):	
Date of Injury:	
Processor:	myMatrixx
Bin#:	014211
Day supply is limited up to 30 days for a new injury.	
myMatrixx Help Desk: (877) 804-4900	

Employer Signature:	Phone	Date

Juanita Espino - HR Director

Employee:
Texas Association of Counties Risk Management Pool 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. This form does not certify compensability or guarantee payment.

Please take this letter and your prescription(s) to a pharmacy near you. myMatrixx has a network of over 4,680 pharmacies in Texas and 65,000 pharmacies nationwide. If you need assistance locating a network pharmacy near you, please call myMatrixx toll free at (877) 804-4900, or you can visit www.mymatrixx.com.

TO LOCATE AN APPROVED DOCTOR OR HEALTHCARE PROVIDER, PLEASE VISIT: WWW.PSWCA.ORG

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.

FOR ALL REJECTIONS OR QUESTIONS CALL: (877) 804-4900

OFFICE OF INJURED EMPLOYEE COUNSEL
NORMAN DARWIN, PUBLIC COUNSEL

Notice of Injured Employee Rights and Responsibilities in the Texas Workers' Compensation System

As an injured employee in Texas, you have the right to free assistance from the Office of Injured Employee Counsel (OIEC). This assistance is offered at local offices across the State. These local offices also provide other workers' compensation system services from the Texas Department of Insurance (TDI). TDI is the State agency that administers and regulates the workers' compensation system through the Division of Workers' Compensation (DWC).

Many services provided by OIEC and DWC can be completed over the telephone. You can contact OIEC by calling the toll-free telephone number 1-866-EZE-OIEC (l-866-393-6432). Additional information, including office locations, is available on the Internet at: www.oiec.texas.gov. You can contact DWC by calling the toll-free telephone number 1-800- 252-7031. Information about DWC is available on the Internet at: www.tdi.texas.gov.

Your Rights in the Texas Workers' Compensation System:

1. **You have the right to hire an attorney to help you with your workers' compensation claim.**
   For assistance locating an attorney, contact the State Bar of Texas' lawyer referral service at 1-877-983-9227 or http://www.texasbar.com/. Attorney referral information can also be found on OIEC's website at www.oiec.texas.goy.

2. **You have the right to receive assistance from OIEC if you do not have an attorney.**
   OIEC Customer Service Representatives and Ombudsmen are available to answer your questions and provide assistance with your workers' compensation claim by calling OIEC or visiting an OIEC office. **You must sign a written authorization before an OIEC employee can access information on your claim.** Call or visit an OIEC office to fill out the written authorization. Customer Service Representatives and Ombudsmen are trained in the field of workers' compensation and can help you with scheduling a dispute resolution proceeding about your workers' compensation claim. An Ombudsman can also assist you at a benefit review conference (BRC), contested case hearing (CCH), and an appeal. However, Ombudsmen cannot make decisions for you or give legal advice.

3. **You may have the right to receive medical and income benefits regardless of who was at fault for your injury, with certain exceptions. Your beneficiaries may be entitled to death and burial benefits.**
   Information about the exceptions can be found at www.tdi.texas.gov or by visiting with OIEC staff.

4. **You may have the right to receive medical care to treat your workplace injury or illness for as long as it is medically necessary and related to the workplace injury.**
   You may have the right to reimbursement of your incurred expenses after traveling to attend a medical appointment or required medical examination if the trip meets qualifying conditions.

5. **You may have the right to receive income benefits for your work-related injury.**
   There are several types of income benefits and eligibility requirements. Information on the types of income benefits that may be available and the eligibility requirements can be found at www.tdi.texas.gov or by visiting with OIEC staff.

6. **You may have the right to dispute resolution regarding income and medical benefits.**
   You may request Medical Dispute Resolution if you disagree with the insurance carrier regarding medical benefits. You may request Indemnity (Income) Dispute Resolution if you disagree with the insurance carrier regarding income benefits. The law provides that your dispute proceedings will be held within 75 miles from your residence.

7. **You have the right to choose a treating doctor.**
   If you are in a Workers' Compensation Health Care Network (network), you must choose your doctor from the network's treating doctor list. You may change your treating doctor once without network approval. If you are not in a network, you may initially

choose any doctor who is willing to treat your workers' compensation injury; however, changing your treating doctor must be pre-approved by the DWC if you are not in a network. If you are employed by a political subdivision (e.g. city, county, school district,) you must follow its rules for choosing a treating doctor. It is important to follow all the rules in the workers' compensation system. If you do not follow these rules, you may be held responsible for payment of medical bills. OIEC staff can help you to understand these rules.

8. **You have the right for your workers' compensation claim information to be kept confidential.**
   In most cases, the contents of your claim file cannot be obtained by others. Some parties have a right to know what is in your claim file, such as your employer or your employer's insurance carrier. Also, an employer that is considering hiring you may get limited information about your claim from DWC.

Your Responsibilities in the Texas Workers' Compensation System

1. **You have the responsibility to tell your employer if you have been injured at work while performing the duties of your job. You must tell your employer within 30 days of the date you were injured or first knew your injury or illness might be work-related.**

2. **You have the responsibility to know if you are in a Workers' Compensation Health Care Network (network).**
   If you do not know whether you are in a network, ask the employer you worked for at the time of your injury. If you are in a network, you have the responsibility to follow the network rules. If there is something you do not understand, ask your employer or call OIEC. If you would like to file a complaint about a network, call TDI's Customer Help Line at 1-800-252-3439 or file a complaint online at http://www.tdi.texas.gov/consumer/complfrm.html#wc.

3. **If you worked for a political subdivision (e.g., city, county, school district) at the time of your injury, you have the responsibility to find out how to receive medical treatment.**
   Your employer should be able to provide you with the information you will need in order to determine which health care providers can treat you for your workplace injury.

4. **You have the responsibility to tell your doctor how you were injured and whether the injury is work-related.**

5. **You have the responsibility to send a completed Employee's Claim for Compensation for a Work-Related Injury or Occupational Claim Form (DWC041) to DWC.**
   You have one year to send the form after you were injured or first knew that your illness might be work-related. Send the completed DWC041 form even if you already are receiving benefits. You may lose your right to benefits if you do not timely send the completed claim form to DWC. For a copy of the DWC041 form you may contact DWC or OIEC.

6. **You have the responsibility to provide your current address, telephone number, and employer information to DWC and the insurance carrier. DWC can be contacted at 1-800-252-7031.**

7. **You have the responsibility to tell DWC and the insurance carrier anytime there is a change in your employment status or wages.** (Examples of changes include: you stop working because of your injury; you start working; or you are offered a job).

8. **Eligible beneficiaries or persons seeking death and burial benefits have the responsibility to send a completed Beneficiary Claim for Death Benefits (DWC-042) to DWC within one year following the employee's date of death.**

9. **You are prohibited from making frivolous or fraudulent claims or demands.**

Supervisor's Accident Investigation

(To be completed by the employee's supervisor or other responsible official)

Location where accident occurred	**Employer's Premises: Y / N Job Site: Y / N**	**Date of accident or illness**
Who was injured?	**Employee Name**	**Time of Accident AM PM**

Length of time with firm	**Job title or occupation**	**Name of Dept.**	**How long has employee worked at job where injury or illness occurred?**
What property/equipment was damaged?			**Property/equipment owned by?**
What was employee doing when injury/illness occurred? What machine or tool was being used?			
What type of operation?			
How did injury/illness occur? List all objects and substances involved.			
Part of body affected/injured?			**Any prior physical conditions? If so, what? Yes / No**
Nature and extent of injury/illness and property damaged (be specific)			

PLEASE INDICATE ALL OF THE FOLLOWING WHICH CONTRIBUTED TO THE INJURY OR ILLNESS AND/OR PROPERTY DAMAGE:

_____**Failure to lockout**	_____**Improper maintenance**	_____**Poor housekeeping**
_____**Failure to secure**	_____**Improper protective equipment**	_____**Poor ventilation**
_____**Horseplay**	_____**Inoperative safety device**	_____**Unsafe arrangement or process**
_____**Improper dress**	_____**Lack of training or skill**	_____**Unsafe equipment**
_____**Improper guarding**	_____**Operating without authority**	_____**Unsafe position**
_____**Improper instruction**	_____**Physical or mental impairment**	_____**Other** _____

Supervisor's corrective action to ensure this type of accident does not recur: _____

_____

_____

Was employee trained in the appropriate use of Personal Protective Equipment/Proper safety procedure?..... Yes No

Was employee cautioned for failure to use Personal Protective Equipment/Proper safety procedure?..... Yes No

Did employee promptly report the injury/illness? ..... Yes No

Is there modified duty available?..... Yes No

_____ _____

Supervisor's Signature **Supervisor's Name**

_____ _____

Phone Number **Date**