CLEAR CREEK
INDEPENDENT SCHOOL DISTRICT

Business Services
Clear Creek I.S.D

PO Box 799
League City, Texas 77574

(281) 284-0230
FAX (281) 284-9916

To: Clear Creek ISD Campus/Department Designees

From: Sharon McHenry – Clear Creek ISD Workers' Compensation Specialist

Re: Instructions for Campuses/Departments - What to Do When There Is an Injury On the Job

For Emergencies please direct employee to the nearest Hospital Emergency Room or Clinic. If possible, ensure Employee leaves with Verification of Employment for Reported WC Claim (Page 2), Optum First Fill Card (Page 3 & 4) and contact me immediately.

The Campus/Department Designee must make sure a First Report of Injury is submitted with or without the employee's assistance. Go to this link at www.tasbrmf.org to complete the First Report of Injury no later than the next business day. You do not need to log in to complete the First Report of Injury. Complete as much information as you have. See instructions on Pages 9-17.

- Have the employee sign the **Acknowledgment of the Medical Alliance** (Pages 5 & 6).
- If the employee plans to seek medical treatment, complete and give the **Verification of Employment for Reported WC Claim form** (Page 2) to the employee along with the Optum First Fill Card (Pages 3 & 4).
- Have the employee advise whether they wish to use their available leave for any possible lost time due to the on the job injury by completing and signing an **Election of Leave** form (Pages 7 & 8).

Email or Fax all signed forms and paperwork by the next business day to:

Sharon McHenry, Workers' Compensation & Unemployment Specialist
Phone: 281 284 0231
Fax: 281 284 9916
Email: smchenry@ccisd.net

Please refer the injured employee directly to Business Services for any further questions or issues regarding their workers' compensation injury. Alert me immediately if an employee misses any time, returns to work, or if there are any questions or concerns.

To search for an Alliance primary care physician in your area go to www.pswa.org website.
See Pages 18 & 19 for a list of nearby Alliance doctors and RediMD Telemedicine Process instructions.

NOTE: A First Report of Injury must be filed once the employee reports, or the campus or department is made aware of, any on the job injury, illness or incident. Group Insurance does not cover medical treatment for compensable workers' compensation injury. Employees should not pay for medical treatment for a workers' compensation injury.

Verification of Employment for a Reported Workers' Compensation Injury or Illness

Please take this form to the doctor for your first medical examination.

Employee Name_____ Date of Injury _____

Date of Birth_____ Social Security _____

Reported Work Related Injury or Illness:

_____

_____

Clear Creek ISD workers' compensation coverage provider is the Texas Association of School Boards Risk Management Fund which is a member of the Political Subdivision Workers' Compensation Alliance (the Alliance.) For emergencies, an injured employee may go to the nearest emergency room. Otherwise, all other treatment must be from an Alliance Provider listed at pswca.org.

Please submit all claim and medical billing information to:

TASB
P.O. Box 2983
Clinton, IA 52733-2983
Phone: 800.732.0153
Fax: 732.212.7009

eBill Information
Clearinghouse: WorkComp EDI
Clearinghouse website: www.workcompedi.com
TASB's Payer ID: WR902

Pre-Authorization
Phone: 800.482.7276, x9907
Fax: 888.777.8272

Issuing Signature_____ Title _____

Phone Number_____ Date _____

Providers please submit Work Status Reports and all Job Description enquiries to:

Sharon McHenry, Workers' Compensation & Unemployment Specialist
Phone: 281.284.0231
Fax: 281.284.9916
Email: smchenry@ccisd.net

For a full list of Alliance Providers please visit pswca.org.

OPTUM®

PO Box 152539
Tampa, FL 33684-2539

TASB RISK FUND

MAKING IT EASY...
TO GET WORKERS' COMPENSATION PRESCRIPTIONS FILLED.

Optum has been chosen to manage your workers' compensation pharmacy benefits for your employer or their insurer. Below is your First Fill card that will allow you to receive your injury-related prescriptions at your local pharmacy. Please fill out the card based on the instructions below.

Injured Employee:

If you need a prescription filled for a work-related injury or illness, go to an Optum Tmesys® network pharmacy. Give this temporary card to the pharmacist. The pharmacist will fill your prescription at low or no cost to you.

If your workers' compensation claim is accepted, you will receive a more permanent pharmacy card in the mail. Please use that card for other work-related injury or illness prescriptions.

Most pharmacies and all major chains are included in the network. To find a network pharmacy call 1-866-599-5426 or visit tmesys.com.

Questions? Need Help?

1-866-599-5426

OPTUM®

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

TASB Risk Mgmt. Fund — CARRIER/TPA

Clear Creek ISD — EMPLOYER

INJURED WORKER NAME

Please provide directly to Pharmacist

SOCIAL SECURITY NUMBER

DATE OF INJURY (YYMMDD)

Notice to Cardholder: Present this card to the pharmacy to receive medication for your work-related injury. To locate a pharmacy: tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	TASBFF		

NOTE: *This First Fill card is only valid for your workers' compensation injury or illness.*

Employer:

Immediately upon receiving notice of injury, fill in the information above and give this form to the employee.

tmesys®

IMP14-1813-37

OPTUM®

PO Box 152539
Tampa, FL 33684-2539

TASB RISK FUND

HACEMOS MÁS SENCILLO...

EL ABASTECIMIENTO DE LAS RECETAS MÉDICAS DEL PROGRAMA DE COMPENSACIÓN POR ACCIDENTES LABORALES.

Optum ha sido elegido para administrar los beneficios farmacéuticos de su programa de compensación por accidentes laborales para su empleador o su asegurador. Más adelante incluimos su tarjeta First Fill que le permitirá recibir las recetas médicas relacionadas con su lesión en su farmacia local. Llene esta tarjeta siguiendo las instrucciones que se indican a continuación.

Empleado lesionado:

Si necesita que se le abastezca su receta médica para una lesión o enfermedad relacionada con su trabajo, visite una farmacia de la red Optum Tmesys®. Entregue esta tarjeta temporal al farmacéutico. El farmacéutico abastecerá su receta médica bajo costo o sin costo alguno.

Si se acepta su reclamación del programa de compensación por accidentes laborales, recibirá una tarjeta permanente por correo. Use esa tarjeta para otras recetas médicas de lesiones o enfermedades relacionadas con su trabajo.

La mayoría de farmacias y todas las grandes cadenas de farmacias forman parte de la red. Para encontrar una farmacia de la red, llame al 1-866-599-5426 o visite tmesys.com.

¿Tiene alguna pregunta?
¿Necesita ayuda?

1-866-599-5426

OPTUM®

WORKERS' COMPENSATION PRESCRIPTION DRUG PROGRAM

TASB Risk Mgmt. Fund — PORTADORA
Clear Creek ISD — EMPLEADOR

NOMBRE DEL TRABAJADOR LESIONADO

Por favor provea directamente al farmacéutico
NUMERO DE SEGURO SOCIAL — FECHA DE ALA LESION (AAMMDD)

Aviso para el titular de la tarjeta: Presente esta tarjeta a la farmacia para recibir los medicamentos para la lesión relacionada con su trabajo. Para ubicar una farmacia, visite tmesys.com.

Attention Pharmacists: Enter RxBIN, RxPCN and GROUP. Member ID # format is the date of injury and SSN combined as follows: YYMMDD123456789.

Tmesys is the designated PBM for this patient.

Tmesys Pharmacy Help Desk
1-800-964-2531

	NDC		Envoy
RxBIN	004261	or	002538
RxPCN	CAL	or	Envoy Acct. #
GROUP	TASBF		

NOTA: *Esta tarjeta First Fill solo es válida para una lesión o enfermedad cubierta por su programa de compensación por accidentes laborales.*

Empleador:

Inmediatamente después de recibir un aviso sobre una lesión, llene la información antes indicada y entregue este formulario al empleado.

tmesys®

IMP14-1813-37

Employee Acknowledgement of the Alliance Direct Contracting Program

I have received information that tells me how to get health care under my employer's workers' compensation coverage. 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 Alliance list of doctors designated as treating doctors.
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 to any licensed medical professional within the United States.
3. Even though my treating doctor should refer me to a specialist of providers contracted with the Alliance, I understand that I need to verify that the referral doctor is a member of the Alliance provider panel.
4. The Texas Association of School Boards Risk Management Fund will pay the treating doctor and other Alliance providers for all health care related to my compensable injury.
5. I understand that my medical and/or income benefits may be disputed if I receive health care from a provider other than an Alliance provider without prior approval from the Fund.
6. Making a false or fraudulent workers' compensation claim is a crime that may result in fines and or imprisonment.
7. If I want to change doctors after my first choice, I can do so within the first 60 days of starting treatment, and I can only choose from the Alliance list of providers. A third choice requires approval from my adjuster.

_____ _____/_____/_____

Signature Date

_____

Printed Name

I live at: _____

Street Address City, State, Zip Code

Name of Employer: Clear Creek ISD

Name of Direct Contracting Program: Political Subdivision Workers' Compensation Alliance (the Alliance)

Direct contracting service areas are subject to change. To locate a treating doctor within your area, visit the PSWCA web site at **pswca.org** or call your adjuster at 800.482.7276.

To be completed by the employer only

Please indicate whether this is the:

- ☐ Initial Employee Notification
- ☐ Injury Notification (Date of Injury:_____/_____/_____)

Do not return this form to the TASB Risk Management Fund unless requested.

Reconocimento Del Empleado Para El Programa De Contratar Directamente Con Medicos

He recibido la informacion que explica como obtener tratamientos medicos si me lastimo en el trabajo. Si estoy lastimado en el trabajo y vivo en un área de servicio descrita en esta información, entiendo que:

1. Tengo que escojer un doctor de la lista de la Alliance (PSWCA), que son señalados para tratar.
2. Debo ir a este doctor para todo el tratamiento médico para mi lesión. Si necisito un especialista, el doctor que me trata me referirá. Si necesito tratamientos de emergencia, yo entiendo que puedo ir a cualquier profesional médico licenciado dentro de los Estados Unidos.
3. Si el doctor me refiere a un especialista, yo entiendo que necesito verificar que el doctor sea un miembro del la Alliance.
4. TASB le pagara al doctor escojido y a doctores tambien que son partidos de PSWCA.
5. Puedo ser responsable de la cuenta si recibo tratamento medico de doctores que no son miembros de la Alliance y sin la aprobacion anterior de TASB.
6. Reportando un reclamo de lastimaduara falsa o fraudulenta es un crimen que puede resultar en multas y o al encarcelamiento.
7. Si deseo cambiar doctores despues de mi primera opción, puedo hacerlo dentro 60 dias de comensar mi tratamieto. Puedo solamente escojer de la lista de doctores que estan en el Alliance. La tercer opción necesita probacion de mi ajustador antes de cabiar doctor.

_____ _____/_____/_____
Firma (Signature) Fecha (Date)

_____
Nombre en imprenta (Printed Name)

_____
Direccion de domicilio incluindo cuidad, estado y zip (Address)

Nombre de empleo (Name of Employer): Clear Creek ISD
Nombre del programa de contratar doctores directament (Name of Direct Contracting Program): Political Subdivision Workers' Compensation Alliance (the Alliance)

El servicio de contratar doctores directamente en las areas de servicio, son subjetivos a cambiar. Para localizar un doctor de tratamiento en su area, visite al Internet en: **www.pswca.org** o llame a su ajustador al numero: 800.482.7276.

To be completed by the employer only

Please indicate whether this is the:
- ☐ Initial Employee Notification
- ☐ Injury Notification (Date of Injury:_____/_____/_____)

Do not return this form to the TASB Risk Management Fund unless requested.

FORM TO ELECT LEAVE BENEFITS WITH WORKERS' COMPENSATION (OFFSET—ENGLISH VERSION)

Name _____ **Employee number**_____

Position_____ **Department/Campus**_____

This employee is absent from duty because of a job-related illness or injury beginning on *(date of first absence attributable to illness or injury)*. If eligible, workers' compensation insurance may begin paying a percentage of the employee's current wages on the eighth day of absence from duty if an extended absence is required.

_____ _____

District authorized signature Date

Employee choice:

I am absent from duty because of a job-related illness or injury. I understand that I am not eligible for workers' compensation weekly income benefits until my absence exceeds seven calendar days. I also understand that the district will continue to pay its contribution toward the cost of my group health insurance coverage (if applicable) as long as I am on **paid** leave and/or family and medical leave (FMLA). I further understand that I will be responsible for paying all health insurance premiums if I am on **unpaid** leave that is not FMLA leave. I choose the following option:

- ☐ I choose to use only _____ days of available paid leave at this time.
- ☐ I choose to use all available paid leave. During the first seven days my leave will be used in full-day increments. I understand that once I begin to receive workers' compensation weekly income benefits my leave will be used in partial-day increments to supplement workers' compensation income benefits.
- ☐ I choose **not** to use any available paid leave at this time. I understand that I will not receive any regular salary payments from Clear Creek ISD while receiving weekly income benefits under workers' compensation. No available paid leave will be deducted from my leave balance. I further understand that by selecting this option, I will receive only workers' compensation income benefits for any absences resulting from my work-related illness or injury, unless and until I communicate to the district a change in my decision.

_____ _____

Employee signature Date

For Claims Reporting Purposes Only:	
For all employees: Amount of leave paid to employee: $ ____.__ Daily rate: $ _____ Period of payment: from___/___/___ through___/___/___ for ____ days **or** ____ weeks	*For hourly employees only:* Hourly rate: $____.___ Number of hours paid: _____

FORM TO ELECT LEAVE BENEFITS WITH WORKERS' COMPENSATION (OFFSET—SPANISH VERSION)

Nombre _____ **Número de empleado**_____

Posición_____ **Departamento/campus** _____

Este empleado está ausente de su trabajo debido a una enfermedad o lesión relacionada con el trabajo que comenzó en *(fecha de la primera ausencia que se atribuye a enfermedad o lesión)*. Si es elegible, el seguro de compensación de los trabajadores puede comenzar a pagar un porcentaje de los salarios actuales del empleado en el octavo día de ausencia del trabajo, en caso de que se requiera una ausencia prolongada.

_____ _____

Firma autorizada de distrito Fecha

Elección del empleado:

Me ausenté del trabajo debido a una enfermedad o lesión relacionada con el trabajo. Comprendo que no soy elegible para los beneficios de ingreso semanales de compensación para trabajadores hasta que mi ausencia exceda los siete días calendario. También comprendo que el distrito continuará pagando su aporte hacia el costo de mi cobertura de seguros médicos (si es aplicable) siempre y cuando estoy en licencia **con goce de sueldo** y/o licencia familiar o médica (FMLA). Asimismo, comprendo que seré responsable de pagar todas las primas de seguros médicos si estoy en licencia **sin goce de sueldo** que no sea una licencia FMLA. Elijo la siguiente opción:

- ☐ Elijo utilizar solamente _____ días de licencia disponible con goce de sueldo en esta oportunidad.
- ☐ Elijo utilizar todas las licencias con goce de sueldo disponibles. Durante los primeros siete días, mi licencia se utilizará en aumentos de día completo. Comprendo que, una vez que comience a recibir los beneficios de ingresos semanales de compensación de los trabajadores, mi licencia se utilizará en aumentos de día parcial para complementar los beneficios de ingreso de compensación de los trabajadores.
- ☐ Elijo **no** utilizar la licencia con goce de sueldo disponible en esta oportunidad. Comprendo que no recibiré pagos de salario regulares de Clear Creek ISD mientras reciba los beneficios de ingreso semanales conforme a la compensación de los trabajadores. No se deducirá la licencia con goce de sueldo disponible de mi saldo de licencia. Asimismo, comprendo que, al seleccionar esta opción, recibiré solamente los beneficios de ingreso de compensación de los trabajadores para las ausencias que deriven de mi enfermedad o lesión relacionada con el trabajo, a menos y hasta que comunique al distrito un cambio en mi decisión.

_____ _____

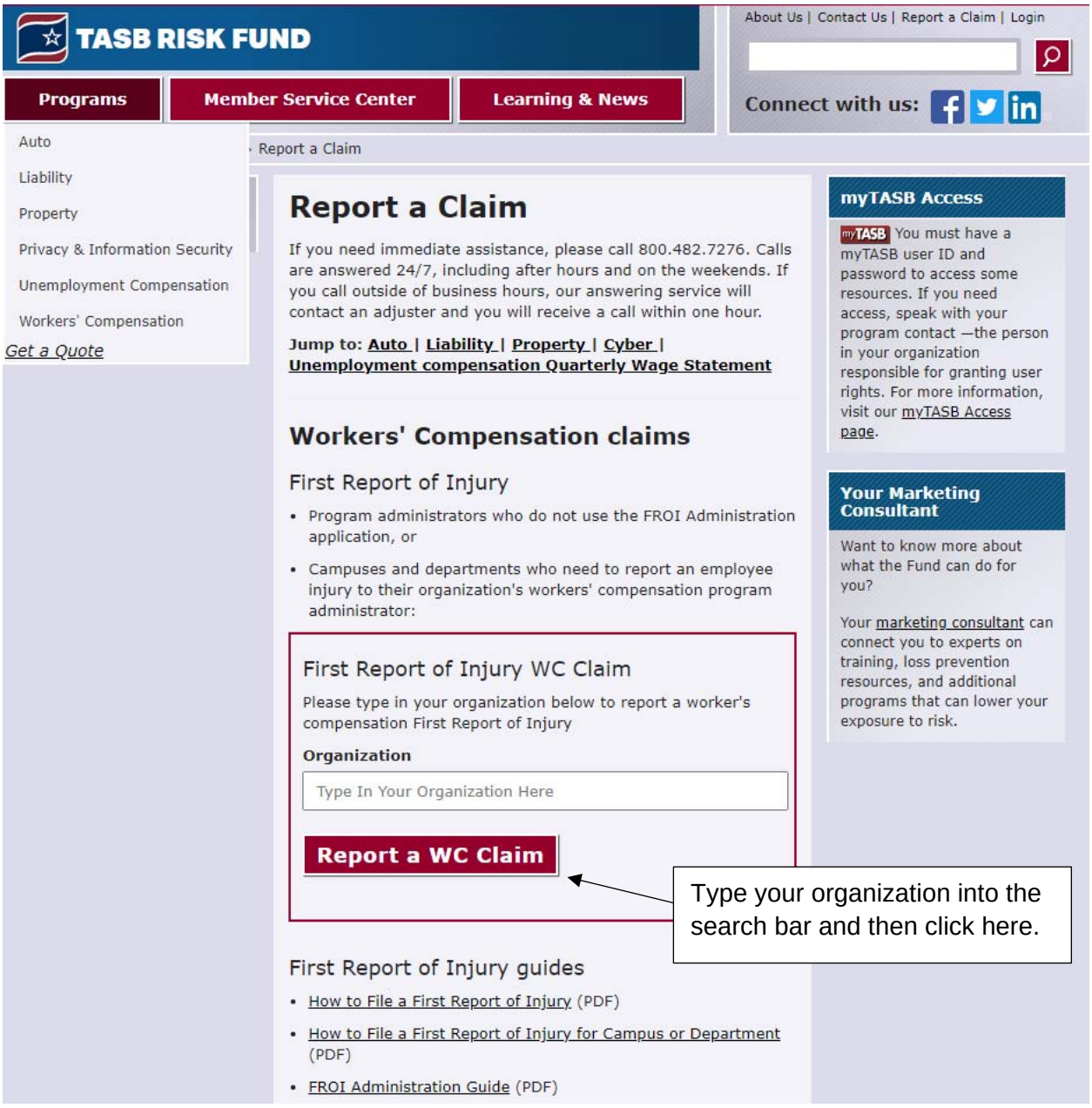
Firma del empleado Fecha

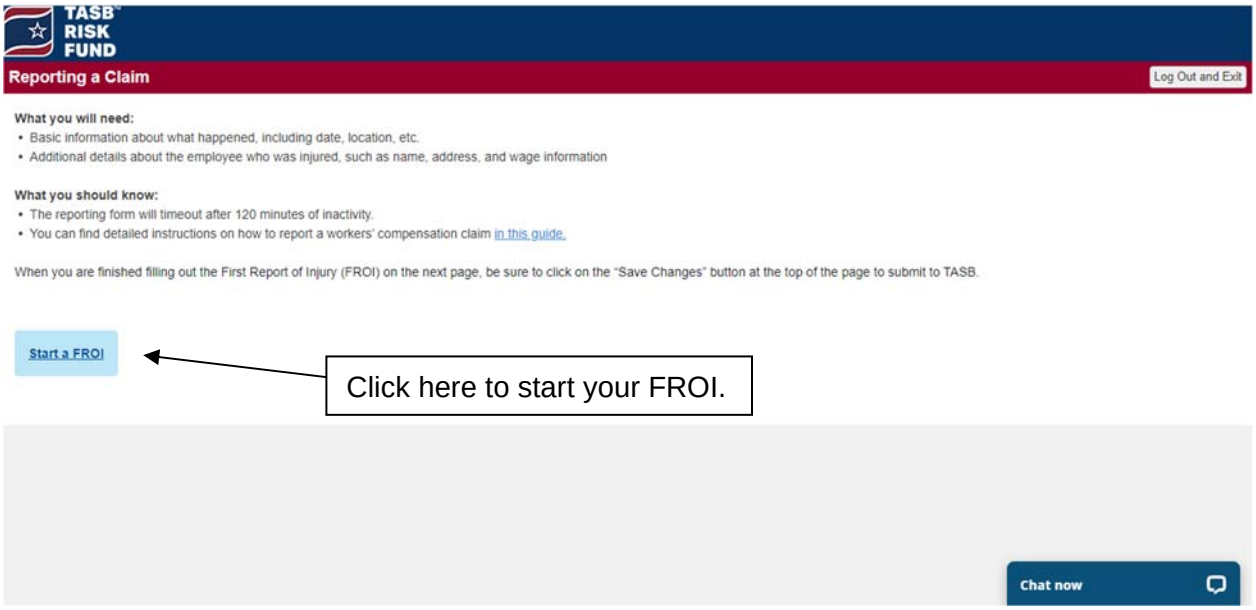
For Claims Reporting Purposes Only:	
For all employees: Amount of leave paid to employee: $ ____.__ Daily rate: $ _____ Period of payment: from___/___/___ through___/___/___ for ____ days **or** ____ weeks	*For hourly employees only:* Hourly rate: $____.___ Number of hours paid: _____

How to File a First Report of Injury

Campus or Department Instructions

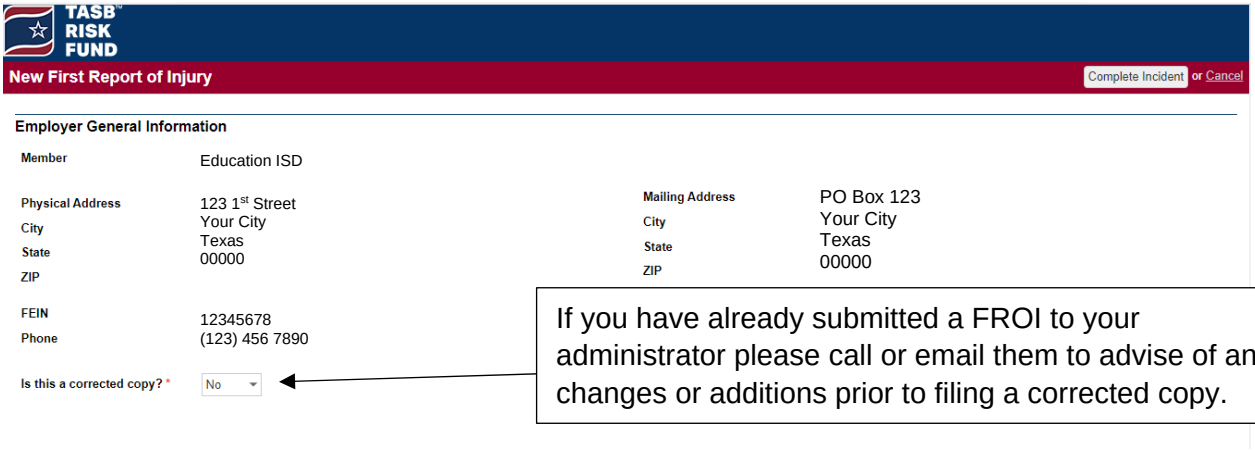
Start here: tasbrmf.org/claims





Important: Please note that all items marked with a red asterisk (*) are mandatory. If you are unsure of the correct information, please use the applicable placeholders listed in this guide. Placeholders are outlined in red.

Any placeholders or incorrect information will be corrected by your administrator upon submission.

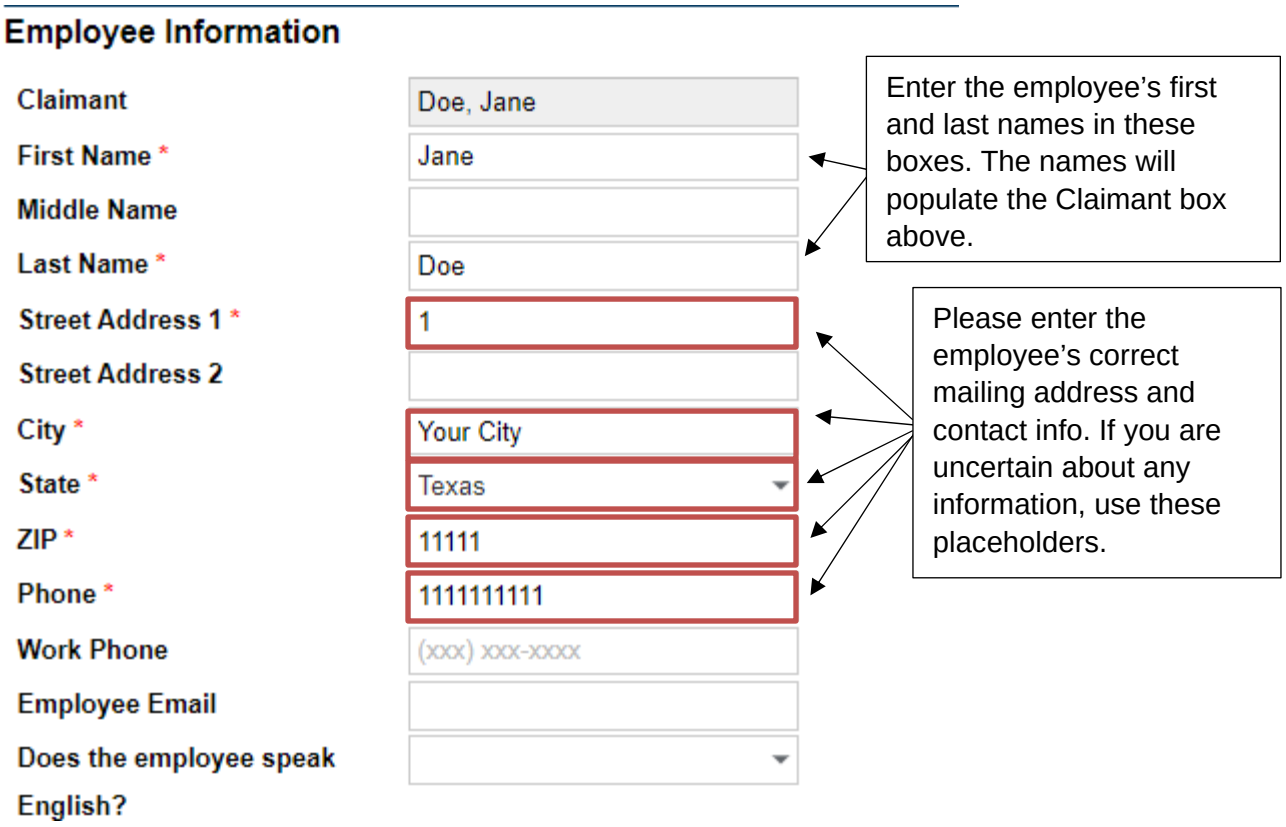


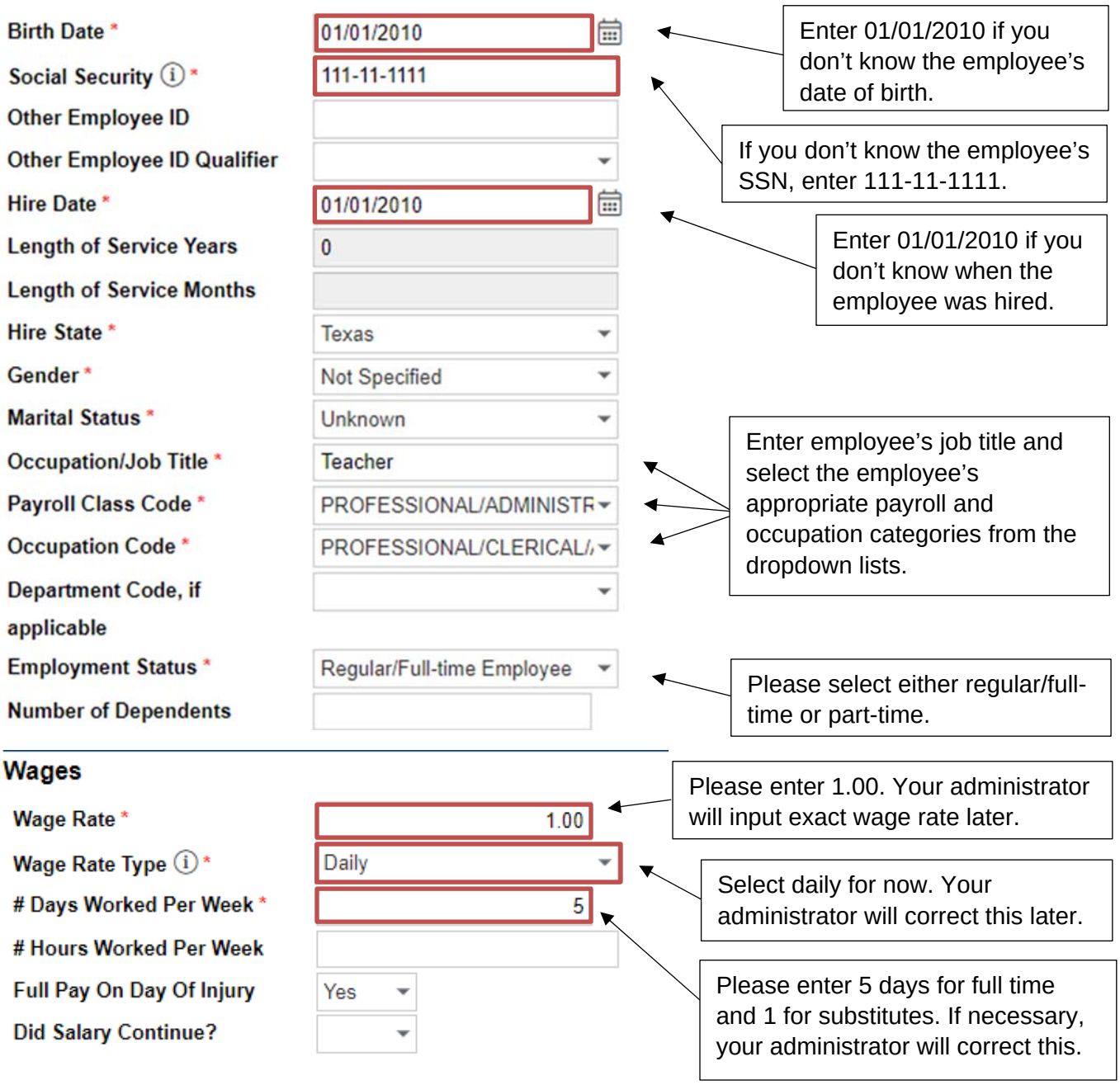
If you have already submitted a FROI to your administrator please call or email them to advise of any changes or additions prior to filing a corrected copy.

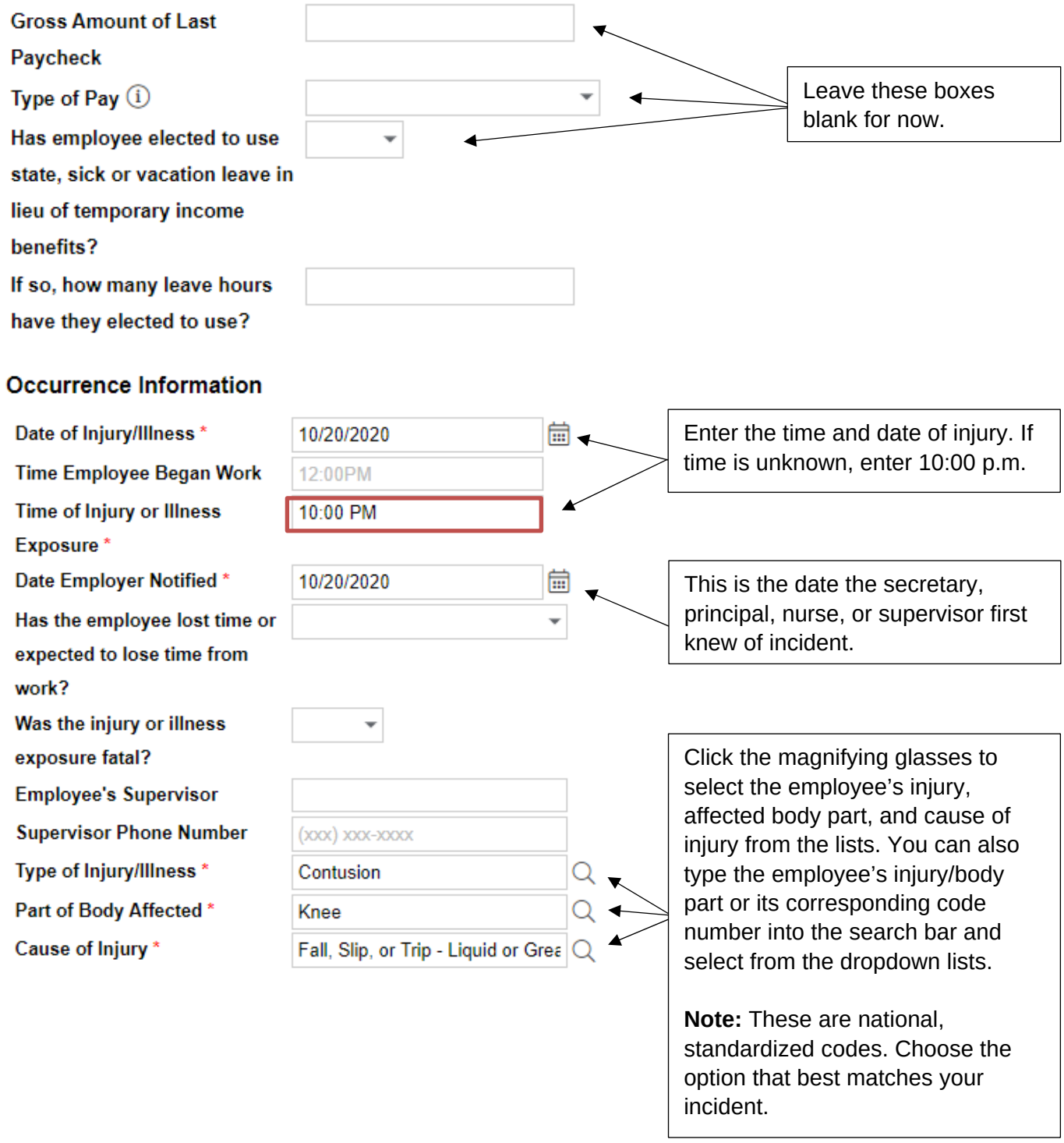
If your organization uses employee numbers, you may enter the injured employee's number here. If not, leave this blank.

Click on the magnifying glass to select the applicable location from the list.

If the injury occurred off campus, select "No" and enter the address of the injury in a box that will appear to the right.







Examples include walking, cleaning, or cooking.

Briefly explain how the injury occurred. Be concise and to the point. **Specify body part(s) and exact location and side of body.** If you need more space to complete injury description, use the "All Other Information" box at the end of this form.

Worksite location of injury ⓘ

Was employee doing their regular job?

Specify activity the employee was engaged in when the injury or illness exposure occurred *
Walking through hallway

How did the injury or illness exposure occur? ⓘ *
Slipped in puddle and fell on left hip

For example, employee slipped on wet floor in hallway while walking and fell on both knees

Is the employee seeking or expected to seek medical treatment? *
Yes

Type of Claim ⓘ *
Medical Only

Record Only is for no medical treatment, no lost time, and no questions or concerns.
Medical Only is for initial medical and/or no more than 5 days of lost time.
Lost Time/Indemnity is for ongoing medical treatment and/or lost time and all other.

Treatment Information

Medical Provider

Enter doctor/hospital information if known. These are not mandatory fields. Don't worry about inputting addresses.

Physician/Hospital Name

Address

City

State

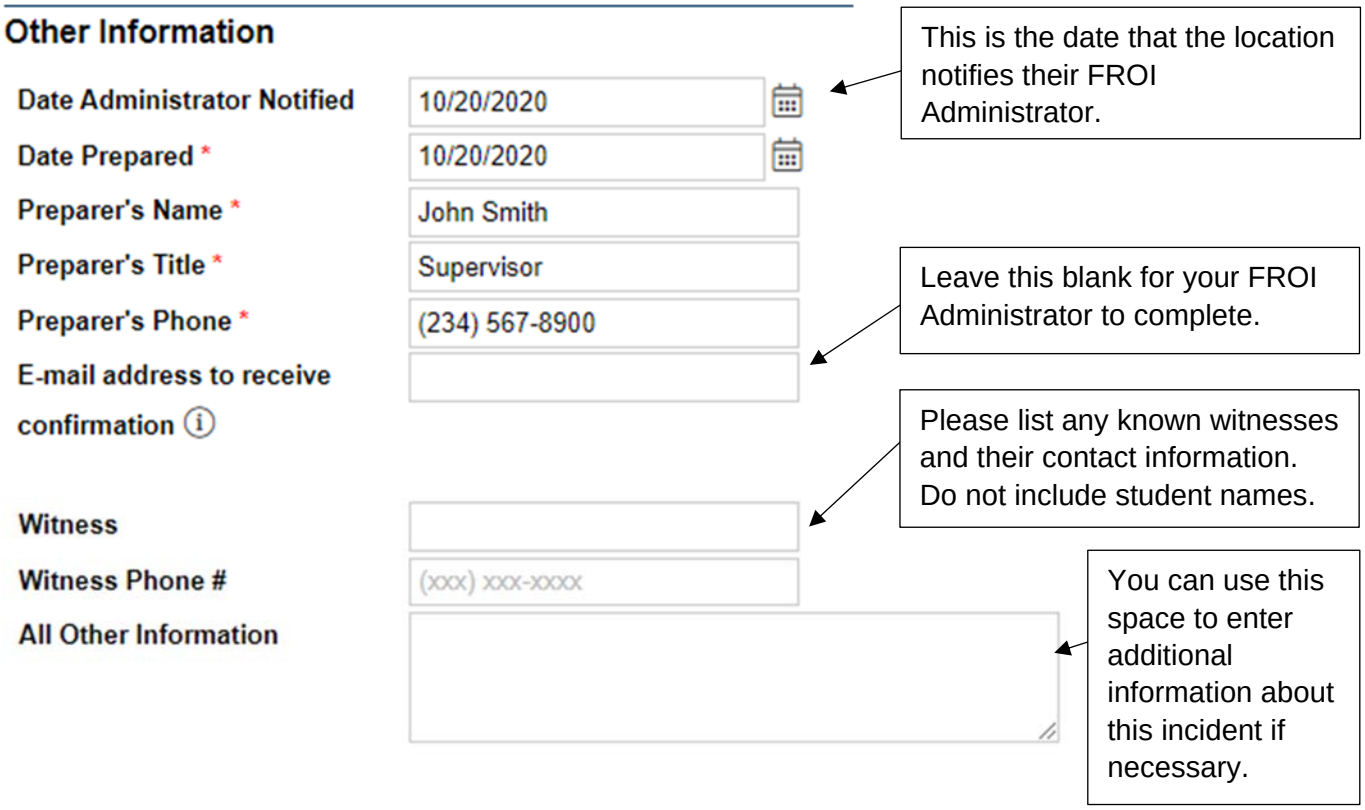
ZIP ##### ####

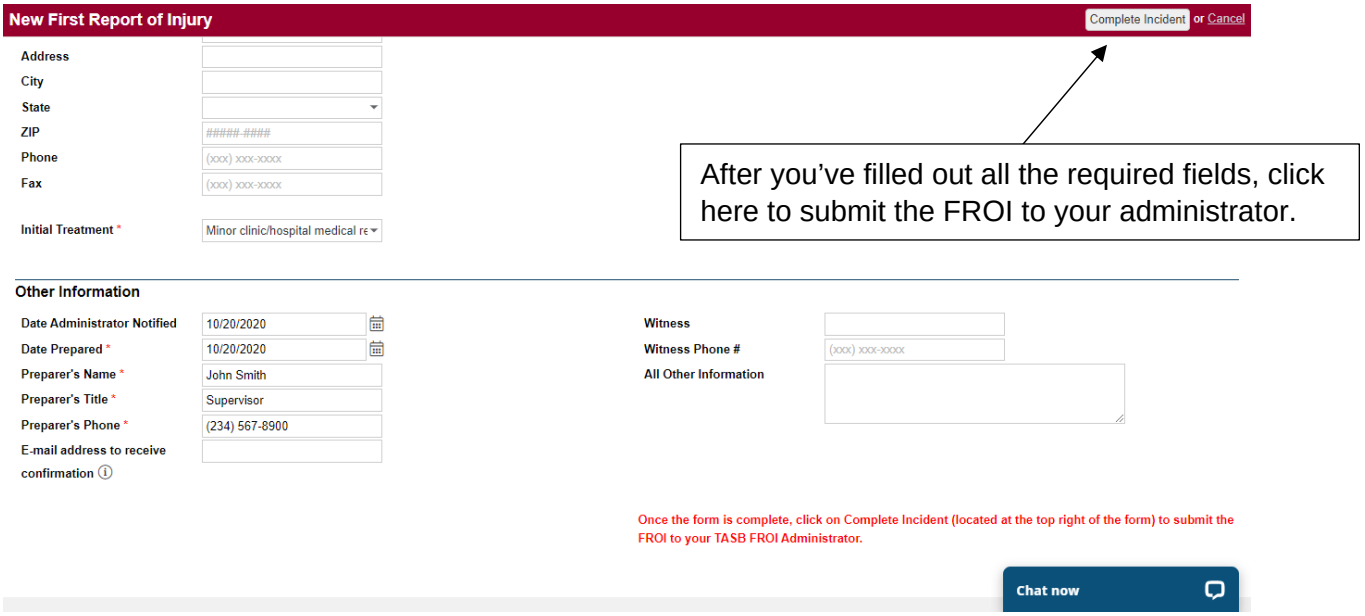
Phone (xxx) xxx-xxxx

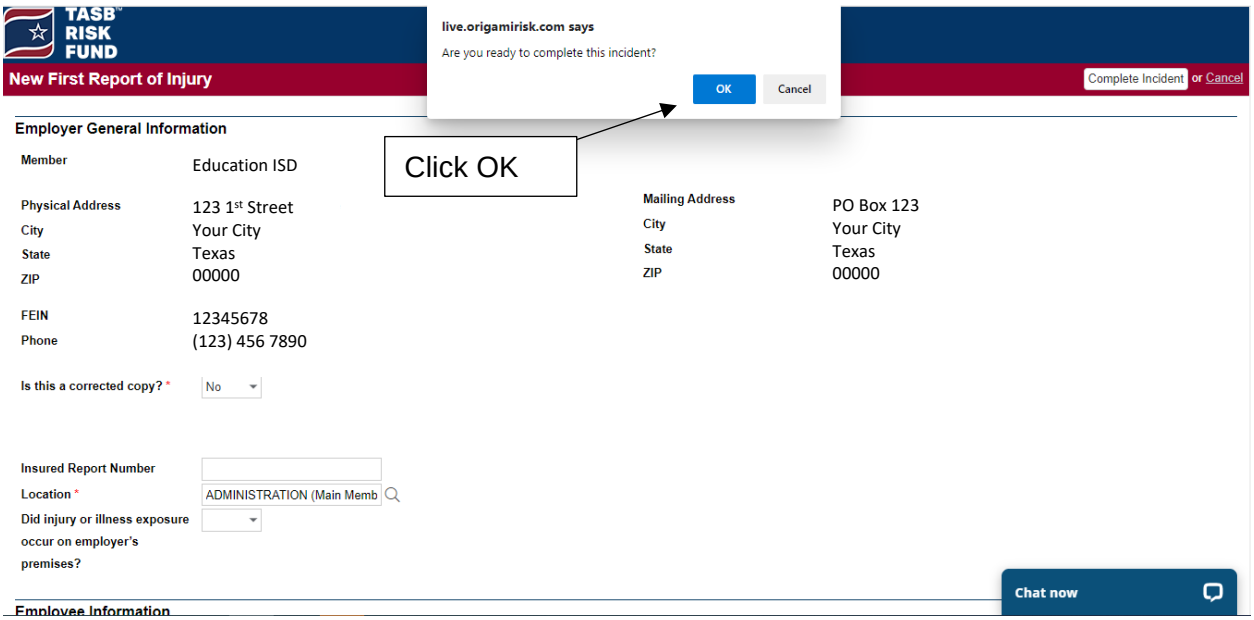
Fax (xxx) xxx-xxxx

This field is mandatory. Select the appropriate option from the dropdown list.

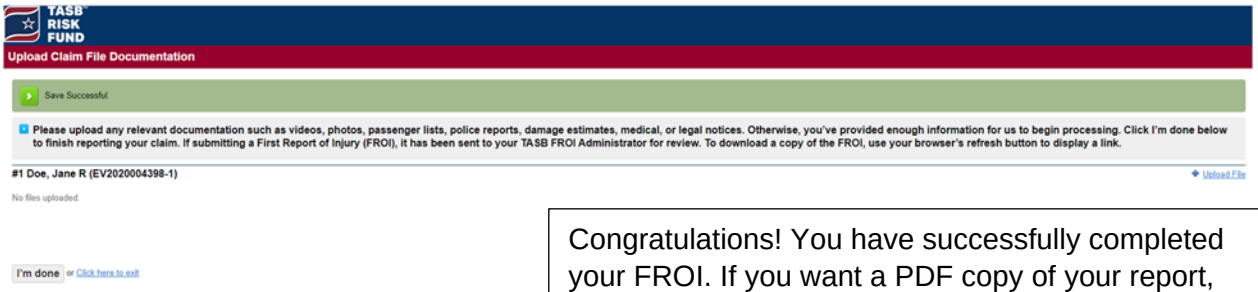
Initial Treatment *
Minor clinic/hospital medical re



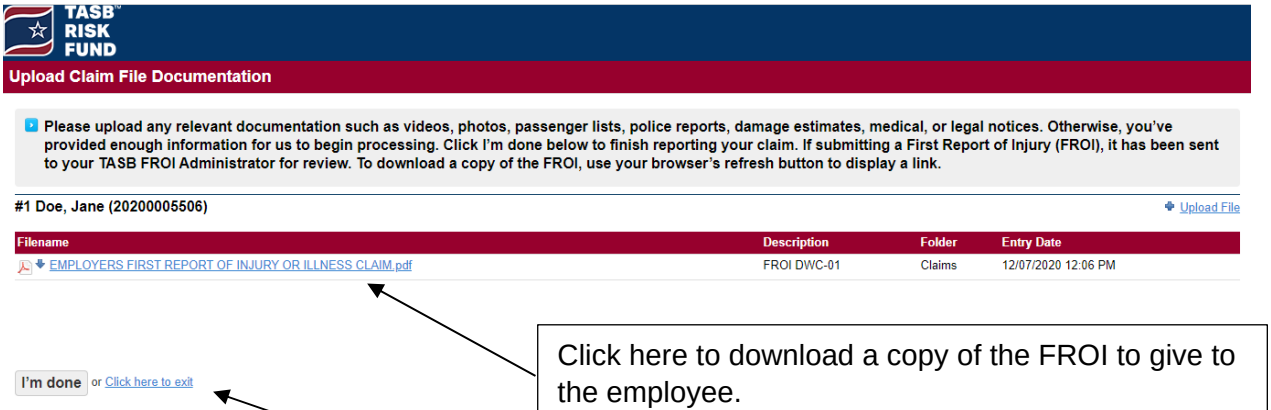




Click OK



Congratulations! You have successfully completed your FROI. If you want a PDF copy of your report, refresh your browser and a link will appear.



Click here to download a copy of the FROI to give to the employee.

When you're ready, click here to exit the application.

Business Services
Clear Creek I.S.D

PO Box 799
League City, Texas 77574

(281) 284-0230
FAX (281) 284-9916

List of Alliance Doctors

An employee that has a life-threatening injury should go to the nearest hospital emergency room for treatment. Stand Alone Emergency Rooms are <u>not covered</u> under Clear Creek ISD Workers' Comp Insurance.

Non-Life-Threatening Injuries:

Now Available for Workers' Compensation Injuries:

Next Level Urgent Care
2560 E. League City Pkwy, Ste. B, League City, TX 77573
Tel: 281 783-8162 Fax: 832-706-2295
HRS: Sunday through Saturday 9:00 AM – 9:00 PM

RediMD Telemedicine
Tel: 888-733-4635
HRS: 24 Hours/7 days a week

Next Level Urgent Care
8325 Broadway St., Suite 220, Pearland, Texas 77581
Tel: 281 783-8162 Fax 832-706-2295
HRS: Sunday through Saturday 9:00 AM – 9:00 PM

Next Level Urgent Care
7315 Fairmont Pkwy, Suite 110
Pasadena, TX 77505
Tel: 281 783-8162 Fax 832-706-2295
HRS: Sunday through Saturday 9:00 AM – 9:00 PM

Wellnow Health
676 FM 517 Road West, Dickinson, TX 77539
Tel: 409-572-2535 – Fax: 409-572-2480
HRS: **M-F**: 8:00 AM – 5:00 PM, 9:00 AM - 2:00 PM

Direct contracting services are subject to change. To locate additional treating doctors within your area, visit PSWCA at www.pswca.org or call your adjuster at 800 482-7276.

Revised 01-15-2024

WORKERS COMPENSATION TELEMEDICINE PROCESS

Process for injured worker:

1. The employee's First Report of Accident online form will need to be submitted to TASBRMF before the employee can setup an appointment with RediMD.

2. The nurse, department designee, supervisor, or injured employee calls RediMD (888-733-4635) and reports the injury and a customer service rep with RediMD sets up an appointment with the doctor.

3. The injured worker determines what time they would like to see/speak to a RediMD doctor.

    - The RediMD doctor will be available to see the injured worker in 5 to 10 minutes from the initial reporting of the injury to RediMD.

4. The RediMD doctor will conduct a Telemedicine visit with the injured worker and confirm the compensable injuries reported by the injured worker. (The doctor will read back the exact statement the injured worker reported to RediMD to determine and agree on the compensable injuries.)

5. If a follow up Telemedicine visit is necessary, the doctor and the injured worker will schedule a time and date for the follow up visit. The injured worker will get a conformation email or text immediately upon scheduling the follow up visit.

6. RediMD will notify/remind the injured worker the day before their scheduled visit via email and a phone call.

7. The doctor will complete the necessary paperwork and DWC-73 forms. RediMD will send over all the notes via fax or email to TASBRMF, the Division of Workers' Compensation, and the employer.

8. The company can call the treating doctor at their convenience to discuss the case and go over work restrictions, if necessary.

9. The injured workers DWC forms and notes will be uploaded to RediMD's portal where pre-determined staff will have access to retrieve at any time. The staff will be given a log in and password on RediMD that will only show them their employee's DWC forms and notes.