

IMO MED-SELECT NETWORK®

**A Certified Texas Workers' Compensation
Health Care Network**

Employee Network Notification Packet



Notice of Network Requirements

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

1. Effective September 1, 2014, your employer is partnering with IMO Med-Select Network[®] a certified Texas workers' compensation health care network. You are covered by the Network if you live in any of the counties listed below.
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, TX 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 IMO Med-Select Network[®] service areas include the following counties:

Atascosa	Austin	Bandera	Bastrop
Bell	Bexar	Blanco	Brazoria
Burleson	Burnet	Caldwell	Cameron
Chambers	Colorado	Collin	Comal
Dallas	Denton	El Paso	Ellis
Fayette	Fort Bend	Galveston	Gonzales
Grayson	Guadalupe	Harris	Hays
Henderson	Hidalgo	Hill	Hood
Hunt	Johnson	Karnes	Kaufman
Kendall	Lee	Liberty	Medina
Montgomery	Navarro	Parker	Rains
Rockwall	San Jacinto	Smith	Starr
Tarrant	Travis	Van Zandt	Waller
Washington	Wharton	Williamson	Wilson
Wise	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 9 of this packet.
5. Except for emergencies, if you are hurt at work and live in the network service area, you must choose a treating doctor from the list of network doctors. All services and referrals are to be received from your treating doctor.
6. You have the right to select your HMO primary care physician (PCP) as your treating doctor if your HMO PCP was selected prior to your injury at work. The network prefers that you make this decision as soon as possible. Your HMO PCP must agree to abide by the workers' compensation health care network's contract and rules.
7. Except for emergencies, the network must arrange for services, including referrals to specialists, to be accessible to you on a timely basis and within the time appropriate to the circumstances and your condition, but no later than 21 days after the date of the request.
8. If you need emergency care, you may go anywhere. If you become injured after business hours and it is not an emergency, go to the closest health care facility.
9. If you cannot contact your treating doctor after business hours, and you are in need of urgent care, go to the closest urgent care facility.
10. If you do not live in a network service area, you are not required to receive care from network providers.
11. If you are hurt at work and you do not believe you live within the network service area, call the State Office of Risk Management (SORM) at 877.445.0006. SORM must review the information within seven calendar days and notify you of their decision in writing.
12. SORM may agree that you do not live in the network service area. If you receive care from an out-of-network provider, and it is later determined that you live in the network service area, you may be required to pay the bill for health care services.
13. If you disagree with SORM's decision in regards to the network service area, you may file a complaint with the Texas Department of Insurance. Complaint form information is addressed in #27.
14. Even if you believe you do not live in the network service area, you still may receive health care from network doctors and other network health care staff while your complaint is reviewed by SORM and the Texas Department of Insurance.
15. SORM will pay for services provided by the network treating doctor and other network health care providers. Except for emergency care, you may be required to pay the bill if you get care from someone other than a network doctor without approval.

16. All network doctors and other providers will bill SORM for medical services related to your compensable work injury. The employee should not be billed by the network provider. Unless there is an emergency need, the network must approve any of the following health care services before they are provided to you:
- a. 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
17. “Adverse Determination” means a determination, made through utilization review or retrospective review, that the health care services furnished or proposed to be furnished to an employee are *not* medically necessary or appropriate.
18. If the proposed health care services are for concurrent hospitalization, the person performing utilization review must, within 24 hours of receipt of the request, transmit a determination indicating whether the proposed services are pre-authorized. For all other requests for preauthorization, the person performing utilization review must issue and transmit the determination no later than three business days after the date the request is received.
19. If the network issues an adverse determination of the request for health care services, you, a person acting on your behalf, or your doctor may file a request for reconsideration by writing a letter or calling the network. Even though you can request a reconsideration of the denial yourself, the network encourages you to talk to your doctor about *filing* the reconsideration. He or she may have to send medical information to the network. This reconsideration must be submitted within 30 days of the date that your doctor receives the adverse determination in writing.
20. The network will respond to the reconsideration request within five business days of receipt demonstrating that the network has received the information. The network has up to 30 business days for the final determination. If it is a reconsideration request for concurrent review, the network will respond within three business days. The network will respond within one business day if it is a reconsideration request which involves a denial of proposed health care services involving post-stabilization treatment, life-threatening conditions or for continued length of stay in a facility.

21. Independent Review Organization (IRO) exemption: An employee with a life-threatening condition is entitled to an immediate review by an IRO and is *not* required to comply with the procedures for a reconsideration of an adverse determination.
22. If the network renders an adverse determination on a reconsideration of the following: i) a preauthorization review, ii) a concurrent review or iii) a retrospective review, the notification will include information on how to request an IRO. Requests for an IRO must be sent no later than 45 days from the date of the denial of the reconsideration.
23. If the situation is life threatening, you do not have to go through the network reconsideration process. You, the person acting on your behalf, or the requesting provider may request a review by an IRO. IRO requests shall be made to the Texas Department of Insurance on behalf of the patient by the Utilization Review Agent (URA).
24. An IRO review may be requested for several other reasons besides a life-threatening situation. The reasons may include: i) if the network denies the health care a second time by denying your reconsideration; ii) if the network denies the referral made by your treating doctor because it is not medically necessary; or iii) if the network denies your care because it is not within treatment guidelines.
25. After the review by the IRO, they will send a letter explaining their decisions. SORM will pay the IRO fees.
26. Your treating doctor may decide to leave the network. If so, and if it may harm you to immediately stop the doctor's care, SORM must pay your treating doctor for up to 90 days of continued care.
27. If you are dissatisfied with any part of the network, you can file a complaint. Any complaint must be filed within 90 days of the event with which you are dissatisfied. When a complaint is received, you will be sent a notification letter within seven days, which will describe the complaint procedures. The network will review and resolve the complaint within 30 days of receipt. *You can contact the network by:*
 - a. Calling: 877.870.0638
 - b. Writing: IMO Med-Select Network®
Attention: NetComplaint Dept.
P.O. Box 118577
Carrollton, TX 75011
 - c. E-mailing: netcomplaint@injurymanagement.com
28. The network will not retaliate if:
 - a. An employee or employer files a complaint against the network, or appeals a decision of the network, or
 - b. A provider, on behalf of the employee, files a complaint against the network or appeals a decision of the network.

29. If you file a complaint with the network and are dissatisfied with the network resolution, you may file an appeal with the Texas Department of Insurance (TDI). *You can receive a complaint form from:*
- a. The TDI website at www.tdi.texas.gov, or
 - b. Write to TDI at the following address:
Texas Department of Insurance
HMO Division, Mail Code 103-6A
P.O. Box 149104
Austin, TX 78714-9104
30. Within five business days, the network will send a letter confirming they received the appeal.
31. A list of network providers will be updated every three months, including:
- a. The names and addresses of network providers grouped by specialty. Treating doctors shall be identified and listed separately from specialists; and
 - b. Providers who are authorized to assess maximum medical improvement and render impairment ratings shall be clearly identified.
32. You can view, print, or email a provider directory online at www.injurymanagement.com.