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Employee Notice of Network Requirements

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Important Medical Care Information for Work-Related Injuries and Illnesses

An employer that subscribes to workers' compensation must pay for medical care if you are injured at work. Your employer provides this medical care by using a certified workers' compensation health care network called CareWorks Managed Care Services. This notice explains what you need to know about the CareWorks Managed Care Services including how to get care if you are injured on the job. If you are injured, you will receive this information again along with a current list of providers.

If you have questions, please contact CareWorks Managed Care Services by mail, phone, fax, or email. The toll free number is available 24 hours a day. You can call the Network during regular work hours. The Network Assistant will be your contact person for questions or assistance.

Careworks
10535 Boyer Blvd., Ste 100
Austin, TX 78758

p: 800.580.1314 Option 1
f: 800.580.3123
e: careworkshcn@careworks.com

The following questions and answers should help you understand the Network program.

1. **What is a certified workers' compensation health care network?** It is a program certified by the state of Texas. Your employer uses CareWorks Managed Care Services to provide medical care for work injuries. The medical providers in the Network have agreed to provide quality care according to network treatment and return-to-work guidelines. These providers have agreed to bill the insurance carrier or your employer. The provider should not ask you for payment.

2. **Do I have to receive all of my medical care for my work injury from the Network no matter where I live?** Yes, if you live within a "service area" of the Network. If a specialist is needed but not available in your area, your treating doctor will contact the Network for approval for treatment outside of the Network. Appointments with Network specialists must be arranged on a timely basis within the time appropriate to the circumstances and conditions of the injured employee, but not later than 21 days after the date of the request.

3. **What is a service area?** A service area is a geographical area. Where you live depends on what service area applies. A service area must have enough different types of medical providers in that region. Enclosed with this notice is a map showing the service area(s) by county.

4. **How do I know if I live in a service area or not?** The Network can help you. You have to receive care from a network provider if you live within a service area. Treating doctors and hospitals should be available within 30 miles if you live in a non-rural area. If you live in a rural area, the treating doctor and hospital must be within 60 miles. A specialist or specialty hospital should be available within 75 miles.

5. **What if I do not live in a network service area?** Contact your insurance carrier and explain that you do not live in a service area. If the carrier disagrees, you can ask for a review. You can send any information to support your claim. The carrier must make a decision in 7 days and provide the decision in writing. The carrier must tell you the reasons for the decision. If you disagree, you may if a complaint with the Texas Department of Insurance. Instructions for fi a complaint are included in the decision. If you choose to use an out-of-network provider while waiting for the decision, you may have to pay for the medical services received. You might want to use a network provider while you are waiting for a decision. By using the network provider, you will not be responsible for payment if it is decided that you do live in a network service area.

6. **Do I have to pay for my medical care if I don't receive care from a network provider?** Possibly. If you live in a service area, your care should come from network providers unless it is an emergency. There may be times when a certain type of specialist is not available in your service area. Your treating doctor must get approval from the network before sending you to an out-of-network provider. So, if your care is provided by network doctors or you have approval for out-of-network care, you will not be

billed. If it is an emergency, you will not be billed. But, if you decide to get treatment from an out-of-network provider without getting approval from the CareWorks Managed Care Services, except in emergencies, you may have to pay for the services.

7. **Does the certified workers' compensation health care network cover the entire state?** Although some networks may cover the entire state, many do not. Some of the rural areas don't have enough providers. For those areas that do not have enough providers, an out-of-network provider may be approved.

8. **How do I find medical care if I am hurt at work?** If you have a medical emergency or need care after normal work hours, please refer to questions 12 and 13. As soon as possible, tell your employer that you have had an injury at work. If you do not have an emergency, you need to pick a treating doctor in the network. The employer or insurance carrier will give you a list of all of the treating doctors in your service area. You must pick a doctor off of the list.

   You can also obtain a listing of medical providers at www.careworksproviders.com/txhcn. Select to search by Specialty, Address, County, or State.

9. **How do I pick a treating doctor?** Except for emergency care, your treating doctor will provide all of your care. The treating doctor will make referrals to specialists as needed. You may pick a treating doctor from the list of network doctors where you live. This list will be given to you by your employer or insurance carrier at the time of injury. A current list of network providers in your service area is enclosed. This list is updated quarterly.

   If you need help finding a treating doctor, you may contact CareWorks Managed Care Services at 800.580.1314
   and state that you are a member of CareWorks Managed Care Services. The network will assist with helping you pick a treating doctor and/or providing you a list of providers within your service area.

   You may also use your HMO primary care doctor for your work injury. Your HMO doctor must agree to follow the network guidelines. If you decide you want to change your treating doctor, you must pick a doctor that is in the network.

   If you become dissatisfied with an alternate treating doctor you must obtain authorization from the network to select any subsequent treating doctor. You may contact the network to begin this process.

10. **What if I need to get other health care services or see a specialist?** Except for emergencies, your treating doctor will provide all of your care. If needed, the treating doctor will send you for other services. The treating doctor may also send you to a specialist. Specialist referrals must be arranged on a timely basis within the time appropriate to the circumstances and conditions of the injured employee, but not later than 21 days after the date of the request.

11. **What if there are no doctors in my area?** Please see the answer to question 5. There may be times when you can get approval for care with an out-of-network doctor. The reasons out-of-network care may be approved include: an employee who needs a different medical service or specialist not currently available to the employee, or if the employee decides to temporarily live outside the network service area. If you have questions regarding provider availability in your area, contact your adjuster or contact CareWorks Managed Care Services at 800.580.1314, Option 1.

12. **How do I obtain emergency care?** If you have a medical emergency, you should call 911 or go to the closest emergency room or urgent care center, which may be a non-contracted provider/facility.

13. **How do I obtain after-hours care?** If it is not an emergency, but you need after-hours care, you can obtain a listing of hospitals and urgent care centers at www.careworksproviders.com/txhcn. If you do not have an emergency, but simply need care after normal work hours and you go to the nearest emergency room
or urgent care center, which may be a non-contracted provider/facility, then you may be responsible for payment of services received.

14. **What medical treatment or services must be pre-approved?** Non-emergency health care requiring preauthorization shall adhere to the current requirements outlined in section 134.600 of the TDI/DWC Texas Administrative Code including:

(1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay;
(2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section;
(3) spinal surgery;
(4) all work hardening or work conditioning services;
(5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels:
(A) Level I code range for Physical Medicine and Rehabilitation, but limited to:
(i) Modalities, both supervised and constant attendance;
(ii) Therapeutic procedures, excluding work hardening and work conditioning;
(iii) Orthotics/Prosthetics Management;
(iv) Other procedures, limited to the unlisted physical medicine and rehabilitation procedure code; and
(B) Level II temporary code(s) for physical and occupational therapy services provided in a home setting;
(C) except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following:
(i) the date of injury; or
(ii) a surgical intervention previously preauthorized by the insurance carrier;

(6) any investigational or experimental service or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device but that is not yet broadly accepted as the prevailing standard of care;
(7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized return-to-work rehabilitation program;
(8) unless otherwise specified in this subsection, a repeat individual diagnostic study:
(A) with a reimbursement rate of greater than $350 as established in the current Medical Fee Guideline; or
(B) without a reimbursement rate established in the current Medical Fee Guideline;
(9) all durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expected cumulative rental);
(10) chronic pain management/interdisciplinary pain rehabilitation;
(11) drugs not included in the applicable division formulary;
(12) treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier. This requirement does not apply to drugs prescribed for claims under §§134.506, 134.530 or 134.540 of this title (relating to Pharmaceutical Benefits);
(13) any treatment for an injury or diagnosis outside the ODG guidelines;
(14) any treatment for an injury or diagnosis that is not accepted by the insurance carrier under Labor Code §408.0042 and §126.14 of this title (relating to Treating Doctor Examination to Define the Compensable Injury).

15. **What happens if the services above are not pre-approved?** You and your doctor will receive a letter telling you why it was denied. The letter will give you specific instructions on how to file a reconsideration. You, a person acting on your behalf, or your doctor may file a request for reconsideration. A reconsideration request must be made within 30 days of the denial. To request a reconsideration, you, the person acting on your behalf, or your doctor can contact CareWorks Managed Care Services.

    Careworks
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    e: URinfo@careworks.com
    attn: Reconsiderations

    A different doctor will review the reconsideration than did the first review. The network will send the

requestor a letter confirming the date the reconsideration request was received. The letter will be sent within 5 calendar days of receiving the request. It will include a list of the documents that must be submitted to complete the review.

The review will be completed within 30 days of the request. The network will send you or a person acting on your behalf, and your doctor a letter telling you the outcome of the review. It will list the specific medical reasons and basis for the decision. Any provider who was contacted during the review, their specialty and the state where they are licensed will be given.

You have the right to an expedited reconsideration of an adverse determination for post-stabilization, continued inpatient hospital stays, or a life-threatening condition. The expedited review shall be completed and the requestor notified within 1 calendar day of the decision. You are entitled to an immediate review of an adverse determination if you have a life-threatening condition. In this case, you are not required to comply with the procedures for a reconsideration. You may request an independent review organization review directly.

You have the right to request an independent review of a reconsideration determination by an independent review organization. A request for an independent review must be made within 45 days of the reconsideration is denied. You may get an independent review form from the Texas Department of Insurance website at www.tdi.state.tx.us. You may also mail a request to the Managed Care Quality Assurance Office, MC 111-1A, Texas Department of Insurance, PO Box 149104, Austin, TX 78714-9104.

16. **What happens if my doctor leaves the Network?** The Network has a “Continuity of Care” plan to make sure you receive the necessary care if your provider leaves the network. There are two main reasons for providers leaving.

    - At the doctor’s request.
    - At the network’s request because of quality concerns or criminal activity that could cause harm to you.

    If your doctor is terminated, you will be contacted to discuss your options. If a condition exists in which changing doctors could harm you, the network will let you continue treatment with the terminated doctor for 90 days. The Network will assist you in this process.

17. **If I am not satisfied with the Network or a Network decision, how do I file a complaint?** If you have a complaint about any network services or providers, you can file a complaint by calling, writing, or emailing CareWorks Managed Care Services. The network cannot retaliate against you, your employer,

doctor,
or any person filing for you regarding a complaint or appeal a decision of the network.

To file a complaint, you must contact CareWorks Managed Care Services within 90 days after the event.

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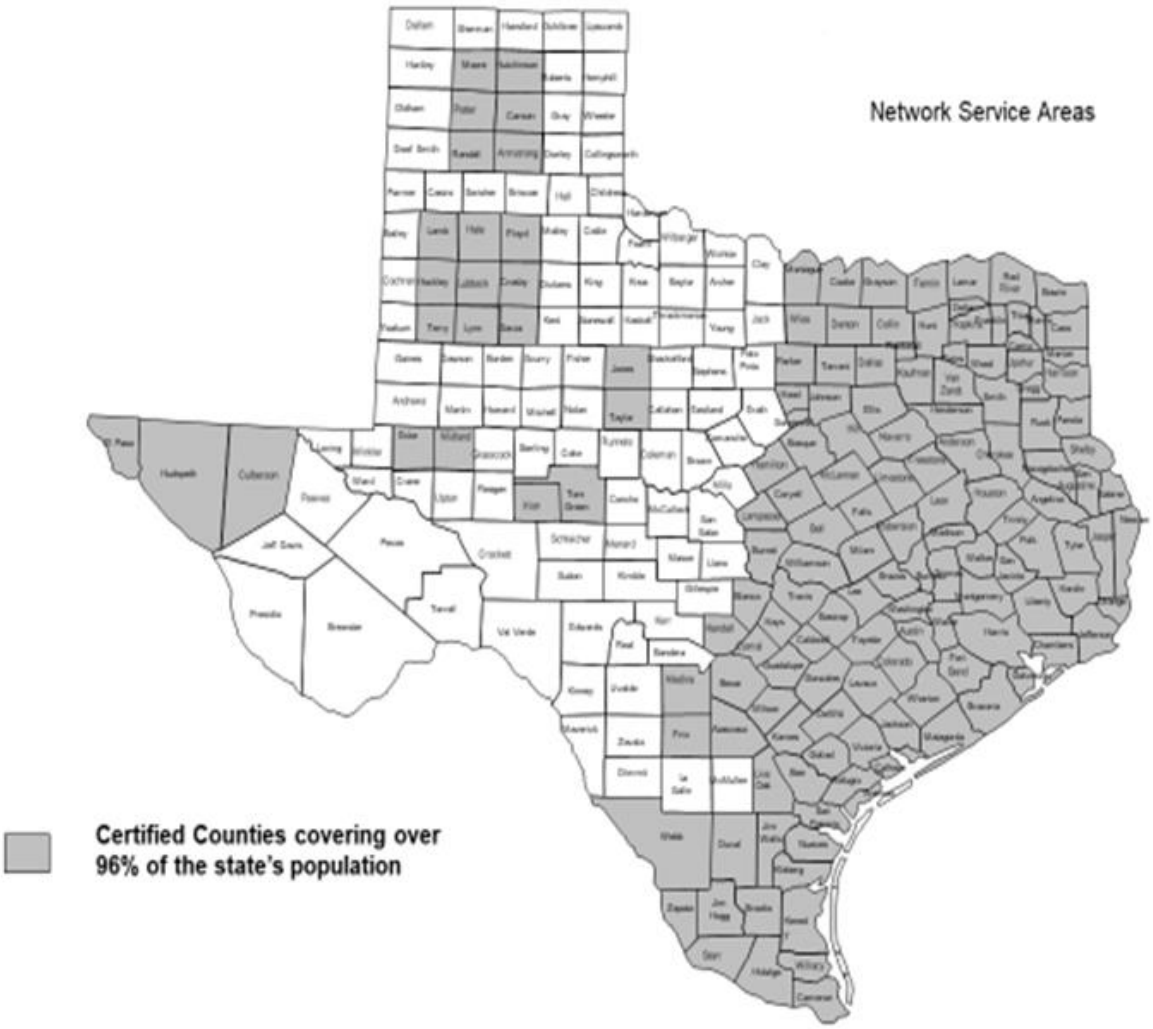
When a complaint is received, you will be sent an acknowledgment letter within 7 days. The letter will describe the complaint procedures and deadlines. CareWorks Managed Care Services will review and resolve the complaint within 30 days of receipt. You will receive a letter explaining the outcome.

If you disagree with the network's resolution of your complaint, you may file a complaint with the Texas Department of Insurance (TDI). You can obtain a copy of the complaint form at www.tdi.state.tx.us. You can also request the form from the TDI at Managed Care Quality Assurance Office, MC 111-1A, Texas Department of Insurance, PO Box 149104, Austin, TX 78714-9104.

The Texas legislature has made workers' compensation health care networks available to you and your employer. These networks should increase the quality of care provided to injured workers. This will help injured workers recover and return to work as soon as medically approved. If you have any questions, complaints' or suggestions about this program, please contact CareWorks Managed Care Services at 800.580.1314.


Network Service Areas
Certified Counties covering over 96% of the state's population

Employee Acknowledgement Form

I have received information that tells 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 doctors in the network. Or, I may ask my HMO primary care physician to agree to serve as my treating doctor.
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 Employer/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.

_____ _____

(Signature) (Date)

_____

(Printed Name)

I live at _____

(Street Address)

_____

_____

(City) (State) (Zip Code)

Name of Employer _____