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This CorCare Participating Provider Organization Manual is intended as a general guide and is subject to change. If any conflict exists between this Manual and state, federal or local laws, Provider should follow the state, federal or local laws. If any conflict exists between this Manual and your CorVel Participating Provider Organization Agreement, Provider should follow the terms and provisions of the CorVel Participating Provider Organization Agreement.
1. SUMMARY OF PROCEDURES, RESOURCES, CLAIMS SUBMISSION

Summary of Procedures

The CorVel program applies to all insurance carriers, third-party administrators, and employers participating with CorVel.

Identification of the Workers' Compensation payor is necessary, and when unknown, this information can be obtained by contacting the employer.

Verification of benefits should be obtained by contacting the insurance carrier or employer. Precertification may be requested by the employer or adjuster. If so, follow the instructions they provide.

Unless otherwise instructed, bills for services rendered will continue to be submitted directly to the insurance carrier as is your usual practice reflecting your reasonable and customary charges. Do not apply the discount at the time of billing.

Payment will be made by the applicable payor. An explanation of review will accompany your reimbursement.

Any reduction amount below the state mandated fee schedule, below usual, customary and reasonable reimbursement and/or as a result of the PPO contract discounted rates should NOT be billed to the employee or employer except for copayments and deductibles.

Resources

<table>
<thead>
<tr>
<th>Contact</th>
<th>Contact Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Relations</td>
<td>Local CorVel Office</td>
</tr>
<tr>
<td>Verification of Employment</td>
<td>Employer</td>
</tr>
<tr>
<td>Name of Insurance Company</td>
<td>Employer</td>
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<tr>
<td>Precertification/Preauthorization</td>
<td>Local CorVel Office</td>
</tr>
<tr>
<td>Verification of Benefits</td>
<td>Insurance Carrier</td>
</tr>
<tr>
<td>Identification of CorVel Client</td>
<td>Local CorVel Office</td>
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</tbody>
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CorVel Healthcare Corporation Headquarters: 2010 Main St., Suite 600, Irvine, CA 92614
Phone: 949-851-1473
Procedure for Submitting Claims

Clinics, hospital owned clinics, solo practitioner and group practice bills must be submitted on a HCFA-1500 form. Hospitals must submit bills on UB-04 forms and include an itemized bill.

All bills are to be sent directly to the payor, unless notified otherwise. The payor will then forward the bill to CorVel for processing. The bill will be repriced in accordance with payor guidelines to the state mandated fee schedule and/or reasonable and customary reimbursement guidelines and/or Professional Review guidelines. Contracted CorVel PPO discounts will be applied after any State mandated fee schedule, Usual, Customary and Reasonable and/or Professional Review reductions have been applied. Within 3 business days of receipt of a properly completed claim form and supporting documentation, the bill will be returned by CorVel to the payor for payment to the provider.

In some instances you will be asked to forward your bills directly to CorVel for a specific insurer/employer group.

Note: Only medical expenses for work related injuries or illnesses are to be billed to the Workers’ Compensation claims payor.

CPT-4 Codes
CPT-4 codes must be used for all claims submitted on the HCFA-1500 forms. CPT-4 code books are available at the following address:
American Medical Association P.O. Box 10946 Chicago, Illinois 60610-0946

ICD-9 Codes
Diagnoses should be indicated by ICD-9 codes on the HCFA-1500 and UB-04 forms. ICD-9 code books are available from the following address:
2. CLAIMS COMPLETION

- Solo practitioners, group practitioners, and clinics complete fields 1-33 on the HCFA-1500 form. Hospital owned clinics must also complete HCFA-1500 form.
- Hospitals must complete all fields on the UB-04 form.
- Enter the appropriate CPT-4 or revenue code in the fields provided on the HCFA-500 or UB-04 forms. Codes that are unbundled or up coded will be edited per state guidelines.
- Do not discount fees prior to submission. CorVel will apply any PPO discounts to the bill in accordance with your PPO provider agreement.
3. PREPAYMENT AND BALANCED BILLING

Provider agrees that pre-payment will not be required under the terms of the CorVel PPO Agreement. Providers are not permitted to resubmit bills or bill patients or employers for any remaining balance after bill review and/or PPO reductions have been applied except for copayments and deductibles.
4. MEDICAL BILL REVIEW

Medical bill review services are conducted by CorVel or its clients according to state laws, rules and regulations on reimbursement.

CorVel Review Description

CorVel reviews provider bills in accordance with the state laws of the jurisdiction of the claim. Bills are screened for relatedness to the diagnosis/service rendered. Level of service is analyzed for comparison to actual service rendered.

Bills identified as not meeting the requirements for submission will be returned to the provider within fourteen (14) days of receipt with a written request for the specific information required.

By report, modifier 22 codes and complex procedures are frequently reviewed by licensed nurses or physician consultants. The nurses or physicians may request and review medical records or reports in order to substantiate billed services. CorVel is committed to responding to provider inquiries and reconsideration requests promptly, objectively and diplomatically.

An automated bill history search identifies duplicate billings. Provider bills are compared against claimant name, social security number, claim number and date of birth.
5. CREDENTIALING

Provider agrees to comply with all credentialing and re-credentialing policies and procedures of CorVel, which are available on www.corvel.com/provider-relations. These policies and procedures will also be sent to the provider upon written request. These policies and procedures may be amended from time to time. Provider acknowledges and agrees that satisfaction of credentialing requirements is a condition of Provider becoming and/or remaining a Participating Provider with CorVel.
6. UTILIZATION MANAGEMENT AND QUALITY ASSURANCE PROGRAM

The Utilization Management and Quality Assurance Programs is administered by the local CorVel Quality Assurance Committees. Specific procedures may vary from state to state to ensure adherence to state laws and regulations. CorVel’s Quality Assurance Committees coordinate and evaluate quality and cost effectiveness of medical care. These policies and procedures may be amended from time to time. For details of CorVel’s Utilization Management and Quality Assurance Program policies and procedures, please go to www.corvel.com/provider-relations. These policies and procedures will also be sent to the provider upon written request.
7. GRIEVANCE PROCEDURES

CorVel encourages open and effective communication through CorVel among all parties involved in the care of the injured employee.

Filing the Complaint
- All grievances must be written and delivered (email accepted) by the individual filing the complaint to the designated CorVel contact.
- CorVel will process the grievance with the goal of achieving a timely resolution among applicable parties.

Steps toward Resolution
1. CorVel will acknowledge receipt of the grievance.
2. The grievance will be brought before the local CorVel Grievance Committee or network management.
3. A corrective action plan will be defined and implemented.
4. Resolution will be communicated to all applicable parties.
8. PRE-CERTIFICATION

Outpatient Pre-Certification
For treatment plan approval/certification, contact the CorVel designated contact. In non-emergency situations, CorVel should be contacted to obtain authorization of outpatient procedures.

Treatments Subject To Pre-Certification/Pre-Authorization

- All Inpatient Hospitalizations
- Non-Emergency Diagnostic Procedures including:
  - CT Scan or MRI
  - EMG
  - Myelogram
  - Discogram
  - Bone Scan
  - Arthrogram
  - Nerve Conduction Study
- Non-Emergency Surgery
- 23 Hour Admissions, Inpatient and Outpatient
- Physical Therapy
- Chiropractic Treatment
- Work Hardening/Work Conditioning Program
- Functional Capacity Evaluation
- Health Club Referral
- Pain Management
- Durable Medical Equipment and Supplies
- Biofeedback
- Home Health Care
- Dental Services
- Psychiatric or Psychological Testing
- Repeat Baseline Diagnostic/Lab Studies
- Referral to Specialist

Treatment Authorization: Please contact your CorVel office.
9. PRE-AUTHORIZATION

The pre-admission certification program will verify the medical necessity of proposed hospital admissions and will recommend the appropriate length of stay.

Objectives
- Prevention and/or reduction of unnecessary inpatient hospitalizations.
- Determination of the appropriate length of stay and monitoring of patient’s condition throughout the hospitalization to prevent unnecessary inpatient days.
- Establish/verify the type of treatment required.
- Exploration of alternatives to inpatient treatment.
- Development and implementation of a timely discharge.
- Early identification of those critical/catastrophic case situations that would benefit from case management and early development of a plan for appropriate and cost effective care.

Process: Non-Emergency
Notification of an impending (non-emergency) hospital admission will be made to the CorVel contact person by the employer, employee, claims adjuster, provider or hospital. The pre-certification process is as follows:
- Initial demographic information is collected by CorVel.
- The CorVel nurse may contact the provider for clinical information to assist in the determination of medical necessity. Clinical information is compared to established criteria for determination of medical necessity of inpatient surgery/treatment vs. outpatient treatment or denial.
- Pre-certification decisions are made within one business day of receipt of information.
- Length of stay varies.
- Verbal notification of the certification and length of stay is communicated to the provider and to the facility.

Process: Emergency
Emergency admissions generally are not pre-certified. Rather, certification review is initiated by CorVel upon notification of the admission. This process is as follows:
- CorVel is notified of emergency admission by employer, employee, claims adjuster, provider or hospital.
- CorVel contacts the physician and/or the facility utilization review department for clinical information and treatment plan to assist in the determination of medical necessity. Clinical information is compared to established criteria for determination of medical necessity of inpatient surgery/treatment and continued stay. An initial length of stay is assigned.
• Generally the certification decision is made within one business day of receipt of relevant information.
10. CONCURRENT/CONTINUING STAY REVIEW

The hospital is contacted by CorVel at appropriate intervals during the inpatient stay (based on days originally authorized) to assist in the determination of medical necessity of continued inpatient stay.

The process is as follows:

- CorVel contacts the facility to determine if discharge has occurred. If planned discharge is going to be delayed, facility and/or physician must provide additional information for evaluation of medical necessity. Clinical information is compared to established criteria for medical necessity of continued stay. Based on outcome of evaluation, an additional length of stay maybe certified.
- Notification of the decision regarding extension of stay or additional services resulting from concurrent review is communicated to the facility and the physician.
- The maximum length of stay for re-certification is usually for a period of five days unless there are extenuating circumstances. Most often, the stay is extended for one to three days based on the treatment plan.

Discharge Planning

- Early discharge will be facilitated whenever feasible. Information relevant to discharge such as environment, home health care, equipment needs, treatment needs, etc. must be provided for review by CorVel.

Dispute Resolution for Provider for Pre-Certification/Pre-Authorization or Concurrent/Continuing Stay Review

The steps in resolving a dispute arising between provider and an insurer regarding Sections 8-10 are as follows:

- Provider must submit a written request for reconsideration to CorVel.
- Provider must submit any medical information available requested by the claims adjuster or CorVel.
- CorVel will arrange for a physician consult by a Board Certified physician in the same medical specialty as the treating physician.
- After a review of the record is completed, a conference with the treating physician may occur.
- The treating physician and other applicable parties are notified by CorVel of the dispute resolution decision.
11. PEER REVIEW AND APPEAL PROCEDURES

Formal Peer Review and Appeal Procedures shall govern those appeals which are initiated by providers of CorVel workers' compensation health care services and related to a denial of medical services as described in CorVel's Utilization Management Program, available at www.corvel.com/provider-relations. This procedure does not apply to provider terminations, which are addressed in Term and Termination of your CorVel Agreement. These policies and procedures may be amended from time to time. Provider acknowledges and agrees that satisfaction of credentialing requirements is a condition of Provider becoming and/or remaining a Participating Provider with CorVel.
12. PROVIDER DATA

Provider activity reports are generated by CorVel to monitor achievement of defined objectives as well as to monitor treatment averages and performance comparisons of network providers with their peers in any given geographical area or specialty. These reports monitor and measure the variability of health care provider practices, identify aberrant providers and help to manage and enhance outcomes.

CorVel uses internal data, customer specific data and published external data to show:

- Average cost, frequency, length of treatment, claim, visit, procedure by:
  - Zip code/zip code range
  - Provider specialty
  - ICD-9 diagnosis code
  - CPT procedural code
  - Individual provider (tax id#)
- Customer satisfaction
- Patient satisfaction
13. ADHERENCE TO STANDARDS

CorVel Network providers are expected to follow established clinical guidelines and protocols including but not limited to:

- Milliman Care Guidelines
- Optimed
- MEDecision
- Institute for Healthcare Improvement (IHI) Protocols
- Medical Disability Advisor (Presley Reed) Protocols
- The Official Disability Guidelines (ODG)
- The American College of Occupational and Environmental Medicine (ACOEM)
- Medicare Guidelines
- CorVel or payor utilization review / utilization management programs
- CorVel Rx guidelines (See CorVel Rx Policy) available at www.corvel.com/provider-relations
14. RETURN TO WORK PLANS

Good communication through the return to work (RTW) process is essential to achieve optimal outcomes. One of the most effective communication tools is a Return to Work Plan. It allows for each applicable party to understand the expectations of RTW.

Who develops the Return to Work Plan?
The provider, the nurse case manager, the employer and the injured worker develop the plan together with a goal of return to work as soon as practicable.

Provider is expected to participate and comply with CorVel RTW plans for injured employees.

Upon request, Provider can receive additional training on RTW by contacting the CorVel representative.
15. PROVIDER APPEAL POLICY FOR NETWORK NON-SELECTION OR TERMINATION

It is CorVel’s intent to comply with applicable laws and regulations when determining whether to include a provider in its networks. It is also CorVel’s policy to provide appropriate appeal and fair procedure rights to providers who disagree with CorVel’s decision to exclude the provider from a CorVel network or CorVel’s decision to terminate the provider from a CorVel network. For purpose and appeal rights of this policy go to www.corvel.com/provider-relations.