



National Provider Manual



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Irvine, CA 92614

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Table of Contents

Introduction.....	2
1. Summary of Procedures, Resources, Claims Submission.....	3
2. Claims Completion	4
3. Prepayment and Balanced Billing	5
4. Medical Bill Review	5
5. Adherence to Standards	5
6. Utilization Management.....	6
7. Pre-Certification	6
8. Hospital Pre-Authorization	7
9. Hospital Concurrent/Continuing Stay Review	8
10. Peer Review and Appeal Procedures	9
11. Stay at Work / Return to Work Plans.....	10
12. Credentialing/Quality Assurance Program	11
13. Grievance Procedures	11
14. Provider Data.....	11
15. Provider Appeal Process for Network Exclusion and Termination.....	12
16. EFT Provider Portal.....	12
17. Provider Demographic Information	12
18. Standards Not Referenced in the Provider Manual.....	13
19. Compliance with Regulations and CorVel Requirements.....	13
20. Texas HCN (Healthcare Network) Addendum	14
21. California MPN Addendum	20

INTRODUCTION

Welcome to CorVel's proprietary network comprised of providers in all specialties across the country. We take great pride in our preferred provider network and invite you to further your mission of building a healthy practice. Our comprehensive credentialing process ensures you are part of a quality network where in-network referrals can be trusted. Our integrated systems streamline billing and administration so you can focus on your patients, not paperwork. This provider manual is designed to help you navigate CorVel as we form a collaborative relationship with you as a healthcare provider.

1. SUMMARY OF PROCEDURES, RESOURCES, CLAIMS SUBMISSION

Summary of Procedures

- CorVel's program applies to all insurance carriers, third-party administrators, and employers participating with us.
- Identification of the workers' compensation payor may require 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.
- Submit your bills as requested either directly to the employer, payor, P.O. Box, or through an electronic process. 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

Topic	Contact	Contact Person/Department
Provider Relations/Contract Questions	Local CorVel Office	National_PPO@CorVel.com
Verification of Employment	Employer	Supervisor/Personnel
Name of Insurance Company	Employer	Supervisor/Personnel
Precertification/Preauthorization	Local CorVel Office or Insurance Carrier/TPA	CorVel Nurse/Adjuster or Carrier/TPA Adjuster
Verification of Benefits	CorVel Adjuster or Carrier/TPA Adjuster	Adjuster
Identification of CorVel Client	Local CorVel Office	National_PPO@CorVel.com

CorVel Healthcare Corporation Headquarters

1920 Main St., Suite 900
Irvine, CA 92614
Phone: (949) 851-1473
Fax: (949) 851-1469

Procedure for Submitting Claims

Clinics, hospital owned clinics, solo practitioner, and group practice bills must be submitted on a HCFA- 1500 form or as mandated by state regulations. Hospitals must submit bills on UB-04 forms or as mandated by state regulations and include an itemized bill. Ambulatory Surgery Center bills must be billed on a UB-04 form or as mandated by state regulations.

All bills are to be sent as requested either directly to the employer or payor, though requested transmittal options (i.e., PO box, electronic, etc.) The bill will be repriced in accordance with payor guidelines which include the following: State mandated fee schedule, reasonable and customary reimbursement guidelines, clinical review guidelines. Contracted CorVel PPO discounts will be applied after any state mandated fee schedule, usual, customary, and reasonable rates, and/or clinical review reductions have been applied.

Upon receipt of a properly completed claim form and supporting documentation, CorVel will return the claim to the employer or provider within at least 15 business days, or within any jurisdictional or contractual requirements for payment to the provider.

Note: Only medical expenses for work-related injuries or illnesses are to be billed to the workers' compensation claims payor.

CPT Codes

CPT codes must be used for all claims submitted on the HCFA-1500 forms.

ICD-10 Codes

CorVel billing systems accommodate ICD-10 codes. ICD-10 codes must be used for all claims submitted unless different jurisdictional guidelines are applicable.

2. CLAIMS COMPLETION

- Solo practitioners, group practitioners, and clinics complete all fields on the HCFA-1500 form or as mandated by state regulations.
- Hospital owned clinics must also complete all fields HCFA-1500 form or as mandated by state regulations.
- Hospitals and ambulatory surgical centers must complete all fields on the UB-04 form or as mandated by state regulations.
- Enter the appropriate CPT or revenue code in the fields provided on the HCFA-1500 or UB- 04 forms. Codes that are unbundled or up coded will be adjusted per state guidelines.
- Do not discount fees prior to submission. CorVel will apply applicable 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. Unless otherwise outlined in 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 the following guidelines: State regulations, Medicare, usual, customary, and reasonable, CPT, and clinical review. Additionally, payor requirements on reimbursement contained in the PPO Agreement or provider resources page, <https://www.corvel.com/provider-relations> are included.

CorVel Review Description

CorVel reviews provider bills in accordance with the state laws of the jurisdiction of the claim or provider state based on where services were rendered. Services are reviewed for relatedness to the accepted injury. Clinical review is also completed on claims that compare billed services to supporting documentation to ensure appropriate coding. For auto claims, CorVel reviews per applicable state laws and in accordance with the client's or payor's auto policies.

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

Bills meeting pre-defined criteria are routed for review by the clinical team. Examples of pre-defined criteria include (but are not limited to): By report and unlisted codes, modifier review, complex bills, surgical procedures, facility bills. The clinical team may request and review medical records or reports 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. Duplicate billings will be processed with no additional allowance.

5. 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): Workplace Guidelines for Disability Duration (MD Guidelines)
- The Official Disability Guidelines (ODG) by MCG
- The American College of Occupational and Environmental Medicine (ACOEM)
- Medicare Guidelines
- State mandated treatment guidelines
- CorVel or payor utilization review / utilization management programs
- CorVel Rx guidelines - *See Prescription Medication Guidelines for Medical Providers available at www.corvel.com/provider-relations.*

6. UTILIZATION MANAGEMENT

The following program will be used in compliance with all applicable laws and regulations:

Utilization Management may be administered by local CorVel committees. Specific procedures may vary from state to state to ensure adherence to state laws and regulations. These policies and procedures may be amended from time to time. For details of CorVel's Utilization Management policies and procedures, please refer to the CorVel provider relations page at www.corvel.com/provider-relations.

7. PRE-CERTIFICATION

Subject to the state jurisdictional guidelines

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 Potentially 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 the designated CorVel office.

8. HOSPITAL 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 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 15 calendar days 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 72 hours of receipt of relevant information.

9. HOSPITAL 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 the evaluation, an additional length of stay may be certified.
- For requests to extend a current course of treatment, determination timelines applied include:
 - Within 24 hours of the request for a utilization management determination if it is a case involving urgent care and the request for extension was received at least 24 hours before the expiration of the currently certified period or treatments.
 - Within 72 hours of the request for a utilization management determination involving urgent care and the request for extension was received less than 24 hours before the expiration of the currently certified period or treatments.
- 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 a 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 as requested by the claims adjuster or CorVel.
- CorVel will arrange for a physician consultation by a Board-Certified physician in the same medical specialty as the treating physician.
- After the record review 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.

10. 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 or modification 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 PPO 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.

It is the policy of CorVel to notify the attending physician or ordering provider, the facility, and the worker/patient of the right to appeal any non-certification/ modified decision.

When state regulations define a deviation from the standard CorVel Appeal procedures, state requirements supersede this policy. State specific letters are created and the appeal procedure specific to that state is attached as dictated by state regulations to any non-certification/modified-certification determination.

The worker/patient, provider, or facility rendering the service has the right to initiate a standard appeal when the expedited appeal process does not resolve a difference of opinion regarding the non-certification, as allowed by the jurisdiction.

Written appeal policies and procedures are available, upon request, to any patient, provider, or facility rendering service.

Procedures

Expedited Appeal: It is noted that expedited appeals are intended for appeal request of an adverse determination of a case that involved urgent care.

1. Request to appeal the non-certification/modification determination is received by CorVel through telephone, fax, or mail from the provider, patient, or facility rendering the service.
2. The request for the appeal will be made within the appeal timeframe specified either by the jurisdiction or CorVel (not to exceed 30-calendar days from the receipt of the determination).
3. The patient, provider, or facility rendering services is given the opportunity to submit written comments, documents, records, and other information relating to the case.
4. The nurse reviewer submits the appeal request along with the initial review document with determination and additional medical records to a Peer Reviewer (one who did not complete the initial non-certification review and one who is not a subordinate of the original peer reviewer.)
5. The individual considering the appeal will consider all documents, records, or other information relating to the case as submitted by the patient, provider, or facility, without regard to whether such information was submitted or considered in the initial consideration of the case.
6. Results of the peer review and the determination of the appeal request will be provided by telephone to the requesting party within seventy-two (72) hours of the time CorVel receives the appeal request.
7. Written notification will be completed within three (3) calendar days of the date that verbal notification (of the appeal determination) occurs.
 - a. Written notification of adverse appeal determination will include the principal reason(s) for determination to uphold the original determination.
 - b. The clinical rationale of any determination not to certify will be made available upon request within 30 days of the request.
8. Determination letters will be sent to the physician, facility, patient, claims adjuster, and attorney if litigated, within three (3) calendar days from the date of the verbal notification.

Standard Appeal

Nurse Reviewer will follow expedited appeal procedure, adhering to the following timeframes: Verbal notification to the requesting party and written notification to all pertinent parties, within 30 calendar days of the date that CorVel receives the appeal request; or within the time frame allowed by the jurisdiction.

11. STAY AT WORK / RETURN TO WORK PLANS

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

Who Develops the Stay at Work/ Return to Work Plan?

The provider, the nurse case manager, the employer, and the injured worker develop the plan together with a goal of returning to work as soon as practicable. Provider is expected to participate and comply with CorVel SAW/ RTW plans for injured employees. Upon request, Provider can receive additional training on SAW/ RTW by contacting the CorVel representative.

12. CREDENTIALING/QUALITY ASSURANCE PROGRAM

Provider agrees to comply with all credentialing, re-credentialing, and quality assurance 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 and Quality Assurance requirements is a condition of Provider becoming and/or remaining a Participating Provider with CorVel.

13. GRIEVANCE PROCEDURES

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

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 to the grievant.
2. The grievance will be brought before the CorVel Quality Assurance Committee.
3. A corrective action plan will be defined and implemented.
4. Resolution will be communicated to all applicable parties.

14. PROVIDER DATA

Provider activity reports may be generated by CorVel, consistent with state law and regulations, 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 may collect internal data, customer specific data and published external data including:

- Average cost, frequency, length of treatment, claim, visit, procedure by:
 - Zip code/zip code range
 - Providers specialty
 - ICD-10 diagnosis code
 - CPT procedural code
 - Individual provider (tax identification number)
- Customer satisfaction
- Patient satisfaction

15. PROVIDER APPEAL PROCESS FOR NETWORK EXCLUSION AND TERMINATION

CorVel's intent is to comply with applicable laws and regulations when determining whether to exclude or terminate a provider from its networks. CorVel also provides appeal rights to providers who disagree with CorVel's decision to exclude or terminate a provider from a CorVel network to the extent required by state law.

16. EFT PROVIDER PORTAL

CorVel is pleased to offer a secure and accelerated way for you to receive payments. Once enrolled, participating Providers can use our Provider Portal to check on payments or submit practice demographic updates.

Questions about signing up:

Email: eft@corvel.com

Phone: (503) 795-3157

Fax: (866)434-2481

17. PROVIDER DEMOGRAPHIC INFORMATION

Providers are required to promptly notify CorVel of any changes or additions to demographic information for practitioners billing under Tax Identification Numbers (TINs) associated with the Preferred Provider Agreement. All updates to practice information must be reported to your designated CorVel contact or mailed to: CorVel, 1920 Main Street, Suite 900, Irvine, CA 92614, Attn: Legal Department.

18. STANDARDS NOT REFERENCED IN THE PROVIDER MANUAL

For standards related to Access and Availability, Medical Record Review, Provider Communication, Timeliness, and other documentation requirements, please reference the CorVel Preferred Provider Agreement.

For standards related to Quality Assurance, Utilization Management, Peer Review, Medical Provider Prescribers, and Grievance and Appeal procedures, visit the CorVel provider relations page at www.corvel.com/provider-relations.

19. COMPLIANCE WITH REGULATIONS AND CORVEL REQUIREMENTS

Provider agrees to comply and conform with all laws, ordinances, and regulations – including, but not limited to, applicable data protection terms, of federal, state, county, city and other authorities with respect to the performance of the Covered Services and the fulfillment of Provider's obligations and will promptly pay all fees, taxes, charges damages and penalties that may assessed against CorVel on account of Provider. Provider further agrees to comply with all CorVel's policies, procedures, and requirements, including, without limitation, CorVel Data Protection Terms, related to Provider's provision of the Covered Services.

20. TEXAS HCN (HEALTHCARE NETWORK) ADDENDUM

What is a Workers' Compensation Healthcare Network?

Workers' compensation networks are groups of doctors, hospitals, and other health care providers that work together to treat injured workers. These networks are certified by the Texas Department of Insurance (TDI). Texas law has many requirements on what networks must do in addition to providing care to injured workers.

Why is Network vs. Non-Network Important?

While many of the rules are the same for network and non-network claims there are some differences. These include preauthorization, changes in treating doctors, provision of medical care, claims processing, disputes, and other issues.

Compensability and How to Tell if an Employee is in the Network

Networks do not resolve compensability, extent of injury, MMI/IR, or indemnity issues such as income benefits. Contact the insurance payor on all workers' compensation claims to obtain information on the employee's network participation and the payor's responsibility for the claim. The provider must know if the patient is in a network, and which network that patient is under. The provider must be in the same network as the patient to treat the patient unless prior out of network approval has been given to the provider or it is an emergency.

Provision of Medical Care

Employees in the network must choose a network doctor as their treating doctor. (There are special circumstances that allow the network to approve a specialist or the employee's HMO doctor as the treating doctor.) The treating doctor is responsible for all medical care, including referrals to specialists. The network has chosen the following specialties to be treating doctors: Occupational Medicine, Physical Medicine Rehabilitation, Internal Medicine, General Practice and Family Practice MDs and DOs. All providers must follow the workers' compensation state laws and the rules of the network.

Referrals to Providers

The treating doctor is the provider who may refer to other providers. If the treating doctor refers to a network provider, no approval is needed from the network. If the treating doctor refers to a provider who is not in the network, the referral must be approved by the network before the patient receives care. Except for emergency services, preauthorization requirements still apply. Complete the Request for Out of Network Specialist form as applicable. If CorVel Corporation denies the referral request because the service is available within the network; the employee may appeal the decision through the network's complaint process.

Change in Treating Doctors

In general, the employee can make the first two choices of treating doctors, and after that, the network must approve any choices. All alternate and subsequent choices must be a network treating doctor and be pre-approved by the network. Complete the Application for Change of Treating Doctor form.

Treatment Guidelines

The network has adopted the Occupational Medicine Practice Guidelines and ODG (Official Disability Guidelines) for the guidelines that all providers are to follow in the treatment of injured workers within the network. These guidelines were chosen to meet network requirements of being evidence-based, scientifically valid, and outcome-focused. Guidelines are required by law for networks to help reduce inappropriate or unnecessary health care while safeguarding access to necessary care. The ODG guidelines must be followed to establish medical necessity and appropriateness of care. Networks are required to monitor providers' use of treatment guidelines. Any deviation from these guidelines requires Pre-authorization.

Both guidelines can be found by contacting:

Work Loss Data Institute

169 Saxony Road, Suite 210 Encinitas, CA 92024

Phone: 800-488-5548, 760-753-9992 Fax: 760-753-9995

www.worklossdata.com E-mail ODG@worklossdata.com

Disputes

Compensability disputes for network and non-network claims are handled through the Division of Workers' Compensation. Plain language notices must also be provided to the employee and the DWC whenever the payor disputes a claim or the extent of an injury. The payor who is disputing a network claim must notify the network providers in writing. This only applies in the network setting. The payor may not deny payment until notice of dispute is issued. The payor is liable for a maximum of \$7000 total up to the point the compensability denial is issued.

Medical Necessity disputes are handled through the appeal process. An employee may file a dispute, which includes the use of a review by an Independent Review Organization.

Network fee disputes may be resolved by the network or if unresolved may proceed to judicial review. Non-network fee disputes are handled through the DWC dispute resolution process.

Preauthorization

Networks choose what items require preauthorization; therefore, the list is different from non-network claims. The time to complete preauthorization is based on calendar days and not on working days. Time for processing and appealing denials is shorter than under non-network workers' compensation. The opportunity for peer-to-peer communication is still required for denials. All appeals (reconsiderations) must be done by a different doctor than the one who made the original denial.

Services Needing Preauthorization

- Inpatient hospital admissions and all surgeries and invasive procedures done in a facility other than a doctor's office
- Length of stay, including length of stay starting the first working day after an emergency admission
- Repeat psychological evaluations, all testing, psychotherapy, and biofeedback except when a part of a preauthorized rehabilitation program

- Osteopathic manipulation, chiropractic manipulation, physical therapy, and occupational therapy, except for the first 6 sessions within 2 weeks of the date of injury or an approved surgery
- All gym/health club memberships
- All myelograms, discograms, or surface electromyograms
- All repeat EMG/NCVs and all repeat diagnostic tests billed at \$350 or greater
- All work hardening and work conditioning programs
- Pain management programs, chemical dependency, or weight loss program
- All durable medical equipment (DME) billed at \$500 or greater per item and all TENS units
- Nursing home, convalescent, residential care, and all home health practitioner services and treatments, including IV medications
- Any investigational or experimental services or devices
- Deviation from the guidelines adopted by the network
- Health care to treat an injury or diagnosis that is disputed by the payor based on Labor Code §408.0042 after the Medical Examination By The Treating Doctor to Define Compensability
- Any treatment that exceeds or deviates from the current edition of the *Official Disability Guidelines - Treatment in Workers' Comp*, (ODG), published by Work Loss Data Institute (Network Guidelines).
- Drugs identified with a status “N” in the current edition of the ODG Treatment in Workers’ Comp (ODG)/Appendix A, ODG Workers’ Compensation Drug Formulary including compounds that contain a drug with a status “N”
- Intrathecal drug delivery systems and refills of drugs with a status “N” in the ODG Formulary
- All compounded drugs require preauthorization when both prescribed and dispensed on or after 7/1/2018

Compliance

While many of the rules for networks are different from the rest of workers’ compensation there are some rules that still apply. This includes requirements to assign and report Maximum Medical Improvement and Impairment Ratings with filing of the DWC-69, filing of the DWC-73 Work Status reports and some of the billing rules.

- Medical Forms: <https://www.tdi.texas.gov/forms/form20.html>
- Medical Evaluation (MMI/IR) DWC69: <https://www.tdi.texas.gov/forms/dwc/dwc069medrpt.pdf>
- Work Status and Instructions DWC73: <https://www.tdi.texas.gov/forms/dwc/dwc073wkstat.pdf>

Providers are required to provide financial disclosure to the Division of Workers Compensation (See Fast Facts) Link to TXCOMP: [Fast Facts: Financial Disclosure \(Texas Labor Code §413.041 and 28 Texas Administrative Code §180.24\)](#)

Payment To Providers

Payment to contracted providers is subject to the requirements of the Texas Workers' Compensation Act and applicable TDI rules.

Network providers are paid according to the contract. Non-network providers will be reimbursed in accordance with the TDI/DWC fee schedule in effect on the date of service unless there is a

case-by-case agreement for fees with the network.

If a utilization review agent has preauthorized a health care service, it cannot be denied for payment for medical necessity, but it may be denied for other reasons such as relatedness to the injury or because the claim is disputed. Non-network providers providing services in conjunction with an approved service must be paid. Example: Hospitalization. Pay the radiologists, pathologists, anesthesiologists, etc.

You must submit your bills to the payor within 95 days of the date of service. You must also submit your request for reconsideration to the payor within 10 months of receipt of an explanation of review (EOB/EOR) or payment. Include with the bill documentation that justifies the service. Be sure to show the specific service provided, the complexity of the service and the necessity of the service including the preauthorization number and/or letter if any.

If you disagree with a payment on a bill, send a request for reconsideration to the payor. Clearly mark the request "RECONSIDERATION." Include a specific explanation with the request, so that the Payer will know why you feel the payment is incorrect. Email: Dallas_MedCheck@Corvel.com.

§133.250 *Reconsideration for Payment of Medical Bills.*

(b) The health care provider shall submit the request for reconsideration no later than 10 months from the date of service.

(d) A written request for reconsideration shall:

- reference the original bill and include the same billing codes, date(s) of service, and dollar amounts as the original bill;
- include a copy of the original explanation of benefits, if received, or documentation that a request for an explanation of benefits was submitted to the payor;
- include any necessary and related documentation not submitted with the original medical bill to support the health care provider's position; and
- include a bill-specific, substantive explanation in accordance with §133.3 of this title (relating to Communication Between Health Care Providers and Insurance Carriers) that provides a rational basis to modify the previous denial or payment.

If the payor asks for additional information, you must submit this within 15 days of the date you receive the request. Billing Forms: Use the appropriate most current standardized billing form for your services such as the CMS1500, UB92 (CMS1450) and ADA with the documentation of the service attached. See also <http://www.tdi.state.tx.us/wc/indexwc.html> for all DWC billing requirements.

Fee Disputes

A network fee dispute is defined as a dispute over the amount of payment due for health care services determined to be medically necessary and appropriate treatment for a compensable injury. While a complaint does not include a misunderstanding, a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the complaint, fee disputes must be filed with the network as complaints.

Complaints

Network providers must post the attached notice at each location, detailing how to file a complaint with the Texas Department of Insurance. The Network/CorVel must receive the complaint within 90 days of the event. No resolution is required if the complaint is not filed within the specified timeframe. The network will review concerns received on time if they are defined as complaints under the law.

FORM OF NOTICE OF INFORMATION ON THE COMPLAINT PROCESS FOR THE TEXAS WORKERS' COMPENSATION HEALTH CARE NETWORK

If the worker or Network provider is dissatisfied with any aspect of the Network's operations or the Network providers, they may file a complaint with the Network.

CorVel must receive the complaint within 90 days of the event. No response is required if the complaint is not filed on time. The complaint must be sent to:

**CorVel Corporation, Attention: CorVel Complaints
P.O. Box 822425 Dallas, TX 75382**

CorVel will review timely concerns that are complaints as defined by the law and do the following:

- Send a letter within 7 days with the date the complaint was received that includes the complaint procedures, deadlines, and the appeals process.
- Refer the complaint to the appropriate reviewer, who will investigate the complaint.
- Send a letter as soon as possible, but no later than 30 days from the date that the complaint was received. The letter will:
 - Explain CorVel 's resolution of the complaint;
 - State the specific reasons for the resolution;
 - State the specialization of any health care provider consulted; and
 - State that, if the person complaining is not satisfied, he can file an appeal with the Network or a complaint with TDI.

A worker may file a complaint with the Texas Department of Insurance. Their website is www.tdi.state.tx.us. The address is HMO Division, Texas Department of Insurance, Mail Code 103-6A, P.O. Box 149104, Austin, TX 78714-9104.

CorVel providers will post a notice explaining how to file a complaint with the Texas Department of Insurance.

CorVel is not allowed to retaliate against a worker because they made a complaint.

CorVel is not allowed to retaliate against a provider, when acting for the worker, if the provider reasonably files a complaint against the Network or appeals a decision of the Network.

CorVel may not knowingly provide information that is untrue or misleading.

21.CALIFORNIA MPN ADDENDUM

Administrative Guidelines

Introduction

The following information is intended to assist you with administration processes related to your participation in the network.

- Scope of Services
- Referral to Hospitals, Specialists, and Other Providers
- Return to Work Policy
- Notification Procedures

Scope of Services

The following summarizes health care services available to all enrollees, as authorized by CorVel payers:

- Initial Care, primary treating and specialty services, including:
 - Consultations and referrals, as appropriate.
 - Urgent Care
- Inpatient hospital services, including:
 - Acute hospital services
 - Emergency Room Services
 - Diagnostic laboratory or X-ray services
 - Required physical therapy 1st mention of physical therapy
 - Respiratory therapy
- All ambulatory care services and other outpatient services, including:
 - Physical therapy
 - Occupational therapy
 - Ambulatory Surgery Centers
 - Other hospital services appropriately performed on an outpatient basis
 - Diagnostic laboratory and radiology services and therapeutic radiology services
 - Medically appropriate home health care services
 - Durable Medical Equipment

Referral to Hospitals, Specialists, and Other Providers

When it is medically necessary to either admit or refer CorVel patients to another provider, you should direct the patient to a network hospital or provider. For the most current referral options, please contact the Medical Assistance Department MAA.

Email: MPNAccess_hotline@CorVel.com

Phone: (855) 857-7556

Return to Work Policy

You have agreed to cooperate with CorVel's return-to-work policy, whose purpose is to encourage

an employee's return to work as soon as medically appropriate. Your responsibilities under this program are to:

- Assess and document an opinion about the patient's work status during every patient encounter.
- Communicate work status in writing on each patient to their employer, including any limitations on the patient's work activities, corresponding restrictions on leisure activities and the anticipated time these limitations must be imposed. If an injured worker is not yet able to return to work, you should telephone their status to their employer. Once restrictions have been removed, you should notify the employer in writing.
- Encourage each patient to be as active as possible within the limitations imposed by their condition and to accept modified duty when available.
- Review job descriptions when requested by employer to determine if a specific job is within the patient's current capability.
- Communicate and be prepared to discuss activity restrictions with CorVel case management nurses and physician advisors.
- If permanent restrictions are anticipated, immediately notify the employer and the CorVel case management nurse.
- Cooperate fully with vocational rehabilitation counselors and case management nurses.
- Provide copies of all reports and documentation per state guidelines to vocational rehabilitation counselors and case management nurses, should one be assigned.

Notification Procedures - Change in Operations

Please notify CorVel's California Network Relations Department in writing at Western_contracting@CorVel.com within 10 days of any change to the following items relating to your practice:

- Federal tax identification number
- Capacity (i.e., ability to see new patients)
- Address of practice location(s); including satellite offices
- Addition or termination of participating providers within the practice
- Address of billing location
- Telephone number changes
- Accepting workers' compensation