CorVel® Corporation Workers' Compensation Program Effective Date: 12/01/13

Physical Medicine (DC/PT/OT) Plan Summary

Revised 04/15/2017

Action Required: Participation in the CorVel Corporation (CorVel) Workers' Compensation Plan network requires you to "opt-in" by completing and signing the Workers' Compensation Opt-in Form, which acknowledges you meet all requirements and agree to participate in CorVel's Workers' Compensation Plan network.

ATTENTION: Before "opting in," please verify that all providers using your tax identification number (TIN) are contracted with OptumHealth Care Solutions, LLC (Optum). If all providers under your TIN are either not contracted with the Optum® network and/or do not want to participate in this network, please do not "opt in." Your signature confirms your understanding that all providers using your TIN are considered participating in this program and you represent and warrant your authority to bind all providers using your TIN. If you currently have a direct contractual relationship with CorVel, it may remain primary unless otherwise required by applicable law.

Program Description

CorVel guides clients' claimants to participating chiropractic, physical and occupational therapy providers. CorVel utilizes its proprietary assets that include nurse case managers (triage, field and telephonic), adjusters, provider panels, and web-based PPO look-up tools accessed internally and by contracted clients. CorVel manages the care and the reimbursement process on behalf of its clients.

Program Access: This program provides direct access to the Optum-supported CorVel workers' compensation network.

Malpractice Coverage: $100,000 per incident and $300,000 aggregate is required for participation.

Reimbursement: Payment is subject to plan limitations and provider's scope of practice, up to the Optum – CorVel contracted rate for all authorized visits.

Care^{IQ} Therapy Program: Details can be found on following page.

Communication/Care Coordination

Eligibility/Verification options may be based on your state regulations. CorVel has multiple offices based on the provider location. The direct phone number to contact regarding any support required will be included on the Explanation of Review (EOR).

Optum Utilization Review/Clinical Submission

The Optum utilization review process/clinical submission form is not required, at this time, for CorVel Workers' Compensation patients/claimants/members.

DC/PT/OT – AL, AR, AZ, CA, CO, CT, DC, DE, FL, GA, IA, ID, IL, IN, KS, KY, MA, MD, ME, MO, MS, MT, NC, NE, NH, NJ, NM, NV, OH, OK, PA, RI, SC, TN, UT, VA, VT, WA, WI, WV and WY
DC only – AK, HI, MN, ND, NY and SD

Claim Submission

Submit claims to CorVel's client or directly to CorVel; specific instructions are provided at patient intake.

Claims must be submitted on CMS 1500 Forms and include supporting documents and notes. Claims must be received within 30 days from date of service, unless otherwise allowed by law, to be eligible for payment. Claims submitted late may be denied.

Claim Payment & Inquiry

For billing and claim questions, contact the adjuster managing the file or the CorVel office reviewing the bill. The specific CorVel reviewing office is listed on the EOR submitted with payment of compensable claims.

Care^{IQ} Therapy Program details can be found on following page.

Provider Status Changes

Submit demographic changes (including relocation and TIN changes) to one of the following:

Web
www.myoptumhealthphysicalhealth.com

Fax
(888) 626-1701

Mail
Optum Provider Data Mgmt.
PO Box 1459
MN103-0700
Minneapolis, MN 55440-1459

CorVel's Care^{IQ} Therapy Program (PT/OT Only)

Care^{IQ} is the exclusive contact when treatment certification is received from them.

Scheduling:

- Care^{IQ} will schedule the initial evaluation with the provider.
- The initial evaluation appointment must be scheduled within 48 hours.
- At the time of scheduling, Care^{IQ} will supply provider approval via a Certification Packet advising the patient demographics, number of visits certified, documentation requirements and billing expectations.
- Subsequent appointments will be scheduled directly between the patient and the provider.

Treatment Requirements:

- Provider must be a licensed PT, OT, PTA or COTA.
- Non-licensed personnel, i.e. Aides & Athletic Trainers, may only participate with treatment in accordance to state practice acts.

Documentation Requirements:

- Initial Evaluation Report.
- Work Requirements Questionnaire – Care^{IQ} proprietary form completed by the therapist and patient during the initial evaluation appointment.
- Progress Report, containing objective measurements, completed every 6 visits (i.e. visits 6, 12, 18, 24, etc.).
- Prescription(s) for all completed visits.
- Discharge Report indicating the reason for discharge.
- All documentation must be submitted to Care^{IQ} within 24 hours of completed appointment.

Communication Requirements:

- Provider must notify Care^{IQ} within 24 hours of any cancellation of no-show.
- Provider must notify Care^{IQ} within 24 hours when additional approval is needed.

Billing Requirements:

- Submit bills on a HCFA using standard CPT codes with an accompanying treatment note.
- Bills must be submitted within 30 days of the rendered service.

Claims Payment & Inquiry:

- Billing and claims questions, contact the Care^{IQ} Therapy Program.