DIAGNOSTIC IMAGING

Provider Manual

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Diagnostic Imaging Provider Manual

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About CareIQ

Introduction

CareIQ, a Nationwide Medical Imaging Network, welcomes you as a participating provider in the CareIQ Network! CareIQ considers you a vital and integral member of its team as it strives to provide high-quality medical imaging services to its customers. To this end, CareIQ makes every effort to give participating Providers as much information as possible about its programs and procedures. All of this information can be found in this CareIQ Provider Manual.

Note that the policies and procedures outlined in this Provider Manual are specific to CareIQ. State-specific guidelines, regulations and statutes may take precedence over CareIQ's administrative requirements. It is the responsibility of the participating provider to be fully aware of state-specific guidelines and to comply with them as it pertains to their business.

CareIQ offers patient access to contracted Providers through insurance carriers, managed care organizations, state-insurance funds, self-insured employers and third-party administrators.

We look forward to developing and maintaining a mutually beneficial working relationship with you.

Overview

Strategic Partnerships

CareIQ, a wholly-owned subsidiary of CorVel Corporation, is a National Medical Imaging Network specializing in ancillary services and cost-containment programs for workers' compensation, group health and auto managed-care.

Our clients include workers' compensation insurance carriers, case-management companies, third-party administrators, self-insured employers and managed-care organizations. Our network produces tangible savings for our clients through our medical management programs and more importantly the quality of services and savings our contracted Providers offer our clients.

Our network Providers are recruited for their reputation in the health care community

Imaging Services

CareIQ is a full modality imaging network. Therefore, our clients have access to the full range of radiological services such as:

- MRI
- CT
- Nuclear Medicine
- Bone Scans
- Bone Densitometry
- X-Ray
- Ultrasound
- Fluoroscopy
- Angiography
- Arthrogram
- Mammography
- Myelography
- EMG-NCV

Definitions

Complaint: means any dissatisfaction expressed by a Covered Person. An initial request for services, such as request for medical services, second opinions, or a change in providers is not considered.

Covered Person means a person who is entitled to receive certain benefits with respect to health care services.
Credentialing: The process for validating and evaluating the qualifications of a licensed health care provider to participate in a workers' compensation managed care provider network.
Grievance: A written expression of dissatisfaction with medical care by a Covered Person.
Payor: An insurance carrier, including without limitation a carrier providing automobile medical liability insurance coverage, health maintenance organization, employer, third party administrator, trust, any government unit, or any other sponsor or other entity which is responsible under a Benefit Plan for paying Covered Services provided to a Covered Person and has entered into a Participation Agreement with CareIQ.
Provider: means a person or entity, which is licensed, equipped and staffed to provide services to Covered Persons for which certain benefits are available under a program for the provision of healthcare services.
Quality Assurance: A formal set of activities, which review and safeguard the quality of medical services provided to the injured employee. Quality assurance includes assessment and implementation of corrective actions to address any deficiencies identified in the quality of care and services provided to the injured employee.
Request for Services: Initial request for services, request for medical services, second opinions or a change in providers.
Rules and Regulations: All services rendered will meet state rules, regulations, and definitions included in the service agreement.
Utilization Management: The examination and evaluation of health care services to determine the appropriate use of the resources and components available within the workers compensation managed care arrangement including, retrospective, concurrent, and prospective care reviews.
STAT: Covered person identified by CareIQ or the referring physician as STAT patients must be seen on the same business day, if scheduling permits, but no later than twenty-four (24) hours of receipt of the request for said services from CareIQ.

CareIQ Scheduling Procedures

- CareIQ coordinates referrals directly from clients requesting that we schedule their patients for medical imaging services. CareIQ will select the appropriate Provider facility to render the service based on the patient's needs, referring physician's request and client's requirements. A CareIQ representative will contact the provider by telephone to schedule the patient for his/her diagnostic service.
- The Provider will make every effort to provide CareIQ with an appointment time within 24 hours (maximum of 48 hours) of receipt of the request.
- Covered Persons identified by CareIQ or the referring physician as STAT patients must be seen on the same business day, if scheduling permits, but no later than twenty-four (24) hours of receipt of the request.
- The provider must include in writing whether or not the injury is "acute", "chronic" or "unable to comment on nature of injury" as a normal component of the medical report.
- If any changes are made to the covered person's appointment (i.e. change of time, no shows, re-scheduling, additional services, etc.), CareIQ must be contacted as soon as any changes are made. If a CareIQ covered person requires additional services, the provider is required to obtain authorization prior to rendering services by contacting the CareIQ Customer Service Department at (866) 866-1101. Otherwise, the provider will not be paid for non-authorized services.
- Appointment location may not be changed without notifying CareIQ to request approval. Once approval has been granted, service location may be changed.

If, for whatever reason, Provider is unable to accommodate a Covered Person once an appointment has been made, the Provider is required to notify CareIQ immediately by contacting the Customer Service Department at (866) 866-1101. Provider must contact CareIQ and request a patient transfer to another location within their business. Provider is prohibited from referring the Covered Person to another facility for Covered Services, even if the other facility is a Participating Provider within the CareIQ network.

Identifying Covered Persons

- If any other party except CareIQ attempts to schedule a CareIQ covered person directly with provider's location, provider is required to call CareIQ for authorization.

- All bills pertaining to any CareIQ covered person referred to provider's location must be submitted directly to CareIQ.
- Covered Persons are referred to a participating provider by CareIQ via telephone, followed by an authorization form including the below information:
  - Claim Number
  - Employer name
  - Covered Person's name

In the event the provider does not receive authorization from CareIQ, payment may not be guaranteed for services completed.

Verification of Physician's Orders

- The provider is required to contact the referring physician to verify the specific physician orders (prescription) for the procedure(s) to be performed. If provider fails to verify physician orders and incorrect procedure(s) are performed, CareIQ may not be liable for the payment of service(s). If the physician requests procedures, which differ from or are in addition to the specific procedure(s) contained in the original referral authorization from CareIQ, provider shall contact CareIQ immediately to request a revision to the authorization. If provider fails to notify CareIQ of the aforementioned discrepancy, CareIQ may not be liable for any of the services rendered.
- CareIQ is responsible for all contacts with Payors which are defined as our clients: insurance carriers, case management companies, third-party administrators and self-insured groups that are accessing CareIQ for all their medical imaging referrals. Only CareIQ employees are authorized to contact its Payors/clients

Standards of Care

Participating Providers are required to comply with all applicable federal and state laws, licensing requirements and professional standards. They are also required to provide covered services in accordance with generally accepted medical and surgical practices and standards.

Medical Records

Imaging Report

- Provider is prohibited from allowing referring physicians to read/interpret patient's film/scan. CareIQ will only accept reading/interpretation medical reports from Board Certified Radiologists that are credentialed by CareIQ.
- CareIQ must receive the medical imaging report, at no charge to CareIQ, within 24 hours after services have been rendered. Reports are to be faxed to CareIQ directly at 888-291-8825.

Provider Requirements

As a material condition of his/her participation in CareIQ, the participating provider must agree:

1) To obtain from covered person the requisite consent to permit CareIQ access to medical records upon request.
2) To retain the medical record for covered services rendered to covered persons for seven (7) years or as required by applicable state or federal law, whichever is longer.
3) During and upon termination of the CareIQ Provider Agreement, Providers are expected to comply with CareIQ's requirements for reasonable access to medical records. These requirements apply only to the Covered Persons of the Payors/Employers who are customers of CareIQ.

- Parties who should have access to records: CareIQ representatives or their Delegates and any duly authorized third party.
- Other disclosure: Participating Providers are required to disclose Covered Person's records as required by law.

Communications

Verification of Exam Completion and Request for Medical Records

CareIQ communicates with our providers daily via fax, email or phone inquiring as to the status of covered person's procedure that was scheduled by CareIQ. This is done when we have not received the medical report or were not notified that the patient did not complete their exam within 24 hours. To provide our clients with superior service and to maximize referrals to your facility, we need to have cooperation from you as to the status of our patients.

Attorney Requests

CareIQ does not release any information concerning billing or medical reports to any attorney's office. Advise the attorney to call the insurance company directly. Do not provide any information to the attorney's office regarding CareIQ.

Change in Information

Participating Providers must notify CareIQ immediately of any changes in name, ownership, address, phone numbers, tax ID number (include W-9 form) or billing office address. Failure to do so will be considered a breach of the Provider Service Agreement, and may result in non-payment for service. Participating providers must also notify CareIQ of any suspension, revocation, condition, limitations, qualifications or other restrictions on providers' licenses, certifications and permits by any government under which provider is authorized to provide health care services.

Billing and Claims Administration

Any correspondence in reference to a bill should include the claim number from the Explanation of Payment (EOP), covered person's name and date of treatment.

Submitting a Bill

Please submit all bills on a HCFA 1500, UB92 or the appropriate state form.

Completing a Bill

When billing for services rendered, please bill normal charges, completing all fields, and include the following information:

- When billing for supplies, an invoice needs to be attached to the HCFA 1500 or UB 92.
- Medical Report attached to HCFA 1500 or UB 92.
- Bills must be submitted to CareIQ at the Provider's Usual and Customary Rates (UCR) and the medical report must be attached.
- The bill itself must have a signature or a stamp that the signature is on file.
- The medical report attached must have the Provider's contracted radiologist's signature.
- CareIQ will not accept or be responsible for any bills submitted by a radiologist that has not been fully credentialed by CareIQ as a participating provider.

When to File a Bill

As stated in the CareIQ Provider Service Agreement, bills must be submitted within 30 days. Any bills not received by CareIQ within 60 days may, in CareIQ's sole discretion, be rejected.

Where to Send the Bill

CareIQ
550 Congressional Boulevard
Suite 300
Carmel, IN 46032

Billing Contact Information

CareIQ Billing Department
Phone: 866-866-1101 Option 2
Email: CareIQ_Billing@CorVel.com
Fax #: 866-913-1547

Post-Payment Audits

Post-payment audits may be conducted periodically by CareIQ or a designated CareIQ representative. Necessary documentation must be made available (e.g. the Covered Person's medical records) to ensure a successful audit. Reimbursement for reasonable copying costs for documentation up to the maximum amount permitted or required by the applicable Workers' Compensation laws and/or regulations will occur.

Denials

If a bill is denied you will receive a form letter indicating why the bill was denied.

Provider Will Not Be Paid If

- The patient did not show up for the appointment.
- The patient was late for the appointment and provider cancelled.
- Incomplete studies resulting inability to read and diagnosis (patient could not complete service).
- For any unused dosage.
- Issues with the quality of films: image was not clear and/or too much movement.
- Provider rendered additional service that was not pre-authorized by CareIQ.
- Provider performed a procedure that was different from what is written on the patient's script or CareIQ authorization. Provider must verify any discrepancies between script and authorization with CareIQ.
- For any of the above mentioned, the provider is prohibited from billing Payor, CareIQ, or the patient.

Provider Relations

Purpose

To ensure that you are satisfied with your participation in the network, the Provider Relations staff is prepared to assist you. Please contact Provider Relations at 866-866-1101 or CareIQ_Provider_Relations@CorVel.com if you have questions, comments or concerns regarding any of the following:

- The provider manual and/or administrative process
- Contractual provisions in your Provider Service Agreement
- You must notify the Provider Relations department in writing to report any changes in your network participation.
- In addition to this manual, the Provider Relations staff is available upon request to conduct training sessions to help you and/or your staff understands participation requirements.

CareIQ Provider Performance Evaluation

CareIQ will employ the following objectives when evaluating a participating provider's performance:

- Quality of care as measured by clinical data pertaining to patient outcomes and the appropriateness of care;
- Efficiency of care as measured by clinical and financial data pertaining to the costs of health care delivered to covered persons;
- Covered Person satisfaction as reported by covered persons, covering their assessments of accessibility, the technical quality of health care, the quality of patient provider relations, the comfort of the practice setting;
- Compliance with Administrative Requirements as measured by provider's systems for record-keeping, information transmission and cooperation
- Quality of films and radiologist reports
- CareIQ utilizes a Medical Director to review films or reports if concerns do arise with quality or interpretation of radiology films or services.

Participating Providers may be requested to assist CareIQ in its development and administration of performance standards; such cooperation is mandated.

Provider Corrective Action Plan

Overview

CareIQ has developed a provider corrective action plan as an aid to maintaining compliance with specific requirements. The goal of the corrective action plan is to educate providers as to these required procedures by imposing a systematic progression of corrective action plans when violations occur repeatedly. Providers who cannot comply after several penalties are imposed may have their participation terminated. We recognize that violations may occur inadvertently and are not necessarily reflective of a provider's support of the requirements. Therefore, the corrective action plan must be implemented reasonably and fairly, and must provide ample opportunity for information and formal response.

Action Plan Outline

The following corrective action plan shall be levied as described below when violations occur:

1) First Violation: Phone call
2) Second Violation:
    a) Phone Call
    b) Written Warning Notification
3) Remediation or Disenrollment
    a) Written Notification
    b) Report to appropriate state agency

Grievance and Appeals Process

Overview: CareIQ has two specific procedures for Participating Providers to follow for a complaint, grievance or the appeal of a decision. All procedures are based on CareIQ's Complaint and Grievance Procedures as they apply to injured workers, employers, providers and others involved in the treatment of a Covered Person.

A complaint is an informal concern expressed orally, may be submitted by telephone, and must be made within sixty (60) days of the event-giving rise to the complaint. A grievance is a formal complaint submitted in writing and is to be sent to CareIQ 550 Congressional Boulevard, Suite 300, Carmel, IN 46032

A grievance must be submitted within one (1) year of the event. An appeal is a request for reconsideration of a decision made by CareIQ.

Contact CareIQ Provider Relations at CareIQ_Provider_Relations@CorVel.com to request a copy of the formal appeals process.

CorVel Credentialing Program

CareIQ utilizes CorVel's Credentialing program. The Credentialing Program of CorVel Corporation is comprehensive to help ensure that its practitioners and organizational providers meet the standards of professional licensure and certification. The process enables CorVel to recruit and retain a quality network of practitioners and ensure ongoing access to care. It consistently and periodically assesses and evaluates a practitioner's or organizational provider's ability to deliver quality care between credentialing and recredentialing cycles. The Credentialing Program enables CorVel to ensure that all practitioners and organizational providers are continuously in compliance with CorVel policies and procedures, and any other applicable regulatory and/or accreditation entity's requirements and/or standards.

For more information regarding the CorVel Credentialing Program, please visit the CorVel Provider Resources page at http://www.CorVel.com/provider-relations/provider-resources/.