

## **CorVel Corporation Grievance Policy & Procedures**

### **POLICY:**

To take appropriate, prompt corrective action when necessary to address valid complaints and grievances.

- The complaints/grievances shall be thoroughly investigated using supportive and written information from both parties.
- Complaints and grievances will be handled in a timely manner following the appropriate procedures.
- If a grievance is valid, appropriate quality improvement steps will be taken to handle the individual issue and also to prevent a recurrence.
- Education will be an important part in the corrective action process.

### **PROCEDURE:**

Your employer encourages open and effective communication between all parties involved in the Managed Care Arrangement. As a part of effective communication, your employer in conjunction with CorVel Corporation will implement the following procedures for hearing complaints and resolving grievances from injured workers and health care providers. This process allows for immediate action aimed at achieving mutual agreement for settlement among all involved parties. The designated form as prescribed by this Managed Care Arrangement will be utilized for the filing of grievances. **(See AHCA 3160-0019 (November 2000, revised 10/26/01) Grievance Form** included in this packet). The AHCA 3160-0019 (November 2000) Grievance Form is also available from your employer.

## **CorVel Corporation Grievance Policy & Procedures**

### **DEFINITIONS:**

**Request for Services** – *Initial request for services, request for medical services, second opinions, or a change in providers.*

**Complaint** - *Dissatisfaction expressed by an injured worker or provider concerning medical issues and employees' rights concerning an insurer's workers' compensation managed care arrangement.*

**Written Grievance** – *A written expression of dissatisfaction with the medical care by an injured worker by an insurer's workers' compensation managed care arrangement health care providers, utilizing the AHCA Form No. 3160-0019 (November 2000) Grievance Form*

**Urgent Grievance** – *An urgent grievance means that in the judgment of the primary care physician or medical care coordinator, the injured employee's clinical condition requires a response within 72 hours, and the clinical condition is at significant risk of deterioration if a response is not made within that timeframe.*

**Grievance Coordinator** - *A member of the CorVel Quality Assurance Committee who is responsible for the implementation and follow through of the grievance process and procedures.*

**Grievance Committee** - *A committee designated to review and resolve written grievances. The Committee will consist of three or more of: the Employer Representative, Grievance Coordinator, Case Manager, MCC and/or PCP, Medical Advisor, or CorVel Administration Representative.*

Grievances are to be mailed to:

**CorVel Corporation  
Attn.: Grievance Coordinator  
3505 Quadrangle Blvd., Suite 355  
Orlando, FL 32817  
Phone: (800) 755-7501**

If desired by the employee or provider, a meeting will be held between the Medical Advisor, Medical Case Manager and the provider during the grievance process. Upon request by the employee or CorCare provider, CorVel Corporation will allow for a meeting at its administrative offices within the service area convenient to the employee or provider.

# **CorVel Corporation**

## **Grievance Policy & Procedures**

### **GENERAL PROCEDURES:**

#### **Requests for Services**

- If the injured employee has an initial request for service, such as a request for medical services, second opinions, or a change in providers, the employee may contact their Case Manager, Adjuster, Medical Care Coordinator or the Grievance Coordinator. Initial requests for medical assistance or services are forwarded to the Medical Care Coordinator for approval or denial of the request.
- The party receiving the request for services will document the nature of the request and forward it along with the resolution to the Grievance Coordinator for tracking and trending purposes.
- At the time, the injured employee will be informed of the steps that will be taken to help resolve the particular concern, as well as, the expected time frame for resolution. It is understood that request for services must be resolved within seven (7) calendar days upon receipt of the request from the injured employee, unless the parties mutually agree to an extension. If the matter is resolved, there is no further action.
- If the request for service is denied or remains unresolved after seven (7) days of receipt, the injured employee shall be notified in writing of the results and advised of their right to make a complaint or file a written grievance. A copy of the AHCA Form No. 3160-0019 (November 2000) shall be provided to the injured employee.

#### **Complaints**

- If the injured worker has a complaint related to a medical issue, they may contact their case manager, adjuster, medical care coordinator or the grievance coordinator either telephonically or in person. Initial requests for medical assistance or services are forwarded to the managed care coordinator for approval or denial of the request.
- The party receiving the complaint will document the nature of the complaint and forward it along with the resolution to the grievance coordinator for tracking and trending purposes.

At the time, the employee will be informed of the steps that will be taken to help resolve the particular concern, as well as, the expected time frame for resolution. It is understood that complaints must be resolved within ten (10) calendar days upon receipt of a personal or telephone contact from the injured employee, unless the parties mutually agree to an extension. If the matter is resolved, there is no further action.

# **CorVel Corporation**

## **Grievance Policy & Procedures**

### **Complaints continued:**

- If the complaint is denied or remains unresolved after ten (10) days of receipt, the employee shall be notified in writing of the results and advised of their rights to activate the grievance process. The written notification shall include the name, address and toll-free telephone number of the grievance coordinator responsible for activating the grievance steps. In addition, the complainant shall be advised of their rights to contact the Division's Employee Assistance Office for additional information on rights and responsibilities and the dispute resolution process.

### **Written Grievance**

- The injured employee fills out the Grievance Form (AHCA Form 3160-0019 November 2000, revised 10/26/01).
- The grievance coordinator will provide assistance to an injured worker unable to complete the grievance form and to those persons who have improperly filed a grievance.
- Upon receipt of the written grievance, the grievance coordinator shall gather and review medical and related information pertaining to the issues being grieved. The grievance coordinator shall consult with appropriate parties and shall render a determination on the grievance within 14 calendar days of receipt. If the determination is not in favor of the requesting party, the grievance coordinator shall notify the requesting party that the grievance is being forwarded to the grievance committee for further consideration unless withdrawn in writing by the employee or provider.
- The Grievance Committee shall review information pertaining to the issues being grieved and render a determination within 30 calendar days of receipt of the grievance by the grievance committee unless the injured employee or provider and the grievance committee mutually agree to an extension that is documented in writing. If the grievance involves the collection of information outside the service area, the grievance coordinator will have fourteen (14) additional calendar days to render a determination. The grievance coordinator will notify the employee or provider in writing within seven days of receipt of the grievance by the grievance committee if additional information is required to complete the review of the grievance.
- Upon receipt of a written urgent grievance, the grievance coordinator shall consult with appropriate parties and determine a resolution or forward the urgent grievance to the grievance committee to render a determination and notify the injured employee within three (3) calendar days of receipt. If grievance coordinator has initiated an expedited grievance procedure, the injured employee shall be considered to have exhausted all managed care grievance procedures after three (3) days of receipt.
- Upon completion of the grievance procedure, the grievance coordinator shall provide written notice to the injured employee of the right to file a petition for benefits with the Division. An injured employee may contact the local Employee Assistance Office of the Division at (800) 342-1741 prior to filing a Petition for Benefits.

**CORVEL CORPORATION**

**Florida Workers' Compensation Managed Care Arrangement  
FORMAL GRIEVANCE FORM**

See Reverse Side of Form for Information Regarding Filing a Grievance

An Injured Worker or Health Care Provider may use this form to request a formal review about dissatisfaction with medical care issues provided by or on behalf of a Workers' Compensation Managed Care Arrangement.

This Grievance is Filed by:  Provider  Injured Worker or a Designate Representative  
 Family Member  Attorney  Other

Date of Injury: \_\_\_\_\_

INJURED WORKER'S/ PROVIDER'S NAME: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Work/Alternate Phone: \_\_\_\_\_

Contact if other than injured worker or provider: \_\_\_\_\_

Telephone# \_\_\_\_\_

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PRIMARY CARE/TREATING PHYSICIAN: \_\_\_\_\_

Address: \_\_\_\_\_

Office Telephone: \_\_\_\_\_

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If the space provided below is inadequate for you to fully explain your concern or the action you desire, continue your statement on a sheet of plain paper. Please be sure your name and social security number appear on each page of any attachment.

Why is this Grievance Being Filed? (Nature of the Problem):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has a grievance been previously filed?  YES  NO

IF YES Date sent? \_\_\_\_\_

Formal Grievance Form (continued-Page 2)

What Action Would You Like to See Taken?

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Have you received any information regarding your rights and responsibilities under WC Managed Care?      Yes \_\_\_\_\_      No \_\_\_\_\_

**INTENT:** The grievance procedure is intended to be self-executing and easy to use. An injured worker may call the grievance coordinator directly without completing this form. The grievance coordinator may complete the form for the injured worker. A review regarding the requested medical care will begin immediately, and a decision made within 44 days of receipt unless additional information is required from outside the service area. The review period may be extended by mutual agreement between the injured worker and the grievance coordinator, with notice provided to all other participating parties.

**The injured worker's participation in the grievance process is important to the resolution of medical issues.** Individuals reviewing the grievance may need to speak directly with and receive input from the injured worker. If the injured worker is unable to participate actively in the grievance process, a patient advocate may participate on behalf of the injured worker.

**Exemptions:** The following items are specifically excluded from the grievance process: Indemnity Benefits; Vocational Benefits; MMI and Permanent Impairment; Medical Mileage Reimbursement; Provider Payments; Compensability; and Causation. Concerns regarding any of the issues listed above should be directed to the employer, adjuster, or the Florida Division of Workers' Compensation Employee Assistance Office at 1-800-342-1741.

If the injured worker, employer, or carrier is dissatisfied with the final decision of the grievance committee, the dissatisfied party has the right to file a petition for Benefits with the Florida Division of Workers' Compensation.

Any person who, knowingly and with intent to injure, defraud, or deceive any employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony of the third degree.

Form Completed by: \_\_\_\_\_  
Injured Worker/ Provider/ Other

\_\_\_\_\_  
Date Form Completed/Signed

\_\_\_\_\_  
Signature of Grievance Coordinator

\_\_\_\_\_  
Date Grievance Coordinator Signed

MAIL TO:

**CorVel Corporation**  
**Attn: Grievance Coordinator**  
**3505 Quadrangle Blvd., Suite 355**  
**Telephone: (800) 755-7501**  
**Fax: (407) 482-3238**