

CORVEL CORP  
Form 10-K  
June 16, 2008

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**UNITED STATES SECURITIES AND EXCHANGE COMMISSION  
Washington, D.C. 20549**

**Form 10-K**

**FOR ANNUAL AND TRANSITION REPORTS PURSUANT TO SECTIONS 13 OR 15(d)  
OF THE SECURITIES EXCHANGE ACT OF 1934**

**p ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES  
EXCHANGE ACT OF 1934**

**For the fiscal year ended March 31, 2008**

**OR**

**o TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES  
EXCHANGE ACT OF 1934**

**For the transition period from to**

**Commission File Number 0-19291**

**CorVel Corporation**

*(Exact name of registrant as specified in its charter)*

**Delaware**

*(State or other jurisdiction of  
incorporation or organization)*

**2010 Main Street, Suite 600,  
Irvine, California**

*(Address of principal executive offices)*

**33-0282651**

*(I.R.S. Employer  
Identification Number)*

**92614**

*(Zip Code)*

**Registrant's telephone number, including area code:**

**(949) 851-1473**

**Securities registered pursuant to Section 12(b) of the Act:**

<b>Title of Each Class:</b>	<b>Name of Each Exchange on Which Registered:</b>
Common Stock	The NASDAQ Global Select Market, LLC

**Securities registered pursuant to Section 12(g) of the Act:**  
**None**

Indicate by check mark if the Registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes  No

Indicate by check mark if the Registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes  No

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports) and (2) has been subject to such filing requirements for the past 90 days. Yes  No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K.

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer  Accelerated filer  Non-accelerated filer  Smaller reporting company   
(Do not check if a smaller reporting company)

Indicate by check mark whether the Registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes  No

State the aggregate market value of the voting and non-voting common equity held by non-affiliates computed by reference to the price at which the common equity was last sold, or the average bid and asked price of such common equity, as of the last business day of the Registrant's most recently completed second fiscal quarter:

As of September 30, 2007, the aggregate market value of the Registrant's voting and non-voting common equity held by non-affiliates of the Registrant was approximately \$189,000,000 based on the closing price per share of \$23.12 for the Registrant's common stock as reported on the Nasdaq Global Select Market on such date multiplied by 8,191,160 shares (total outstanding shares of 13,860,622 less 5,669,462 shares held by affiliates) of the Registrant's common stock which were outstanding on such date. For the purposes of the foregoing calculation only, all of the Registrant's directors, executive officers and persons known to the Registrant to hold ten percent or greater of the Registrant's outstanding common stock have been excluded in that such persons may be deemed to be affiliates. This determination of affiliate status is not necessarily a conclusive determination for other purposes.

Indicate the number of shares outstanding of each of the Registrant's classes of common stock, as of the latest practicable date: As of May 15, 2008, there were 13,763,119 shares of the Registrant's common stock, par value \$0.0001 per share, outstanding.

#### **DOCUMENTS INCORPORATED BY REFERENCE**

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Information required by Items 10 through 14 of Part III of this Form 10-K, to the extent not set forth herein, is incorporated herein by reference to portions of the Registrant's definitive proxy statement for the Registrant's 2008 Annual Meeting of Stockholders, which will be filed with the Securities and Exchange Commission not later than 120 days after the end of the fiscal year ended March 31, 2008. Except with respect to the information specifically incorporated by reference in this Form 10-K, the Registrant's definitive proxy statement is not deemed to be filed as a part of this Form 10-K.

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**CORVEL CORPORATION**

**2008 FORM 10-K ANNUAL REPORT**

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In this report, the terms CorVel , Company , we , us , and our refer to CorVel Corporation and its subsidiaries.

**CAUTIONARY STATEMENT REGARDING FORWARD-LOOKING STATEMENTS**

This report contains forward-looking statements within the meaning of the Securities Act of 1933, as amended, and the Securities Exchange Act of 1934, as amended, including, but not limited to, the statements about our plans, strategies and prospects under the headings Business and Management s Discussion and Analysis of Financial Condition and Results of Operations and elsewhere in this report. Words such as anticipates , expects , intends , plans , predicts , believes , seeks , estimates , may , will , should , would , could , potential , continue , ongoing , and similar expressions are intended to identify forward-looking statements. These forward-looking statements are based on management s current expectations, estimates and projections about our industry, management s beliefs, and certain assumptions made by management, and we can give no assurance that we will achieve our plans, intentions or expectations. Certain important factors could cause actual results to differ materially from the forward-looking statements we make in this report. Representative examples of these factors include (without limitation):

General industry and economic conditions;

Cost of capital and capital requirements;

Competition from other managed care companies;

The Company s ability to renew and/or maintain contracts with its customers on favorable terms;

The ability to expand certain areas of the Company s business;

Shifts in customer demands;

The ability of the Company to produce market-competitive software;

Increases in operating expenses including employee wages and benefits;

Changes in regulations affecting the workers compensation, insurance and healthcare industries in general;

The ability to attract and retain key personnel;

Delays in completing financial and internal control audits;

Possible litigation and legal liability in the course of operations; and

The continued availability of financing in the amounts, at the times, and on the terms necessary to support the Company s future business.

The section entitled Risk Factors set forth in this report discusses these and other important risk factors that may affect our business, results of operations and financial condition. The factors listed above and the factors described under the heading Risk Factors and similar discussions in our other filings with the Securities and Exchange Commission are not necessarily all of the important factors that could cause actual results to differ materially from those expressed in any of our forward-looking statements. Other unknown or unpredictable factors also could have material adverse effects on our future results. Investors should consider these factors before deciding to make or maintain an

investment in our securities. The forward-looking statements included in this annual report on Form 10-K are based on information available to us as of the date of this annual report. We expressly disclaim any intent or obligation to update any forward-looking statements to reflect subsequent events or circumstances.



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**PART I**

**Item 1. *Business.***

**INTRODUCTION**

CorVel is an independent nationwide provider of medical cost containment and managed care services designed to manage the medical costs of workers' compensation and other healthcare benefits, primarily for coverage under group health and auto insurance policies. The Company's services are sold as separate services directed toward managing claims, care, networks, reimbursements and settlements. They include automated medical fee auditing, preferred provider networks, out-of-network/line-item bill negotiation and repricing, utilization review and management, medical case management, vocational rehabilitation services, early intervention, Medicare set-asides and life-care planning, and a variety of directed care services including independent medical examinations, diagnostic imaging, transportation and translation, and durable medical equipment. Some customers purchase just one service, while other customers purchase more than one service. Customers of the Company that do not purchase managed care services generally either purchase such services from other vendors, perform such services using their own resources or elect not to utilize such services for managing their costs.

Such services are provided to insurance companies, third-party administrators (TPAs), and self-administered employers to assist them in managing the medical costs and monitoring the quality of care associated with healthcare claims.

The Company was incorporated in Delaware in 1987, and its principal executive offices are located at 2010 Main Street, Suite 600, Irvine, California, 92614. The Company's telephone number is 949-851-1473.

**INDUSTRY OVERVIEW**

Workers' compensation is a federally mandated, state-legislated, comprehensive insurance program that requires employers to fund medical expenses, lost wages and other costs resulting from work-related injuries and illnesses. Workers' compensation benefits and arrangements vary extensively on a state-by-state basis and are often highly complex. State statutes and court decisions control many aspects of the compensation process, including claims handling, impairment or disability evaluation, dispute settlement, benefit amount guidelines and cost-control strategies.

Workers' compensation plans generally require employers to fund all of an employee's costs of medical treatment and a significant portion of lost wages, legal fees and other associated costs. In certain jurisdictions, provision of vocational rehabilitation is also mandatory. Typically, work-related injuries are broadly defined and injured or ill employees are entitled to extensive benefits. Employers generally are required to provide first-dollar coverage with no co-payment or deductible due from the injured or ill employee for medical coverage for employees, and are not subject to litigation by employees for benefits in excess of those provided by the relevant state statute. In most states, the extensive benefits coverage (for both medical costs and lost wages) is provided to employees through the employer's purchase of commercial insurance from private insurance companies, participation in state-run insurance funds or self-insurance.

Healthcare provider reimbursement methods vary on a state-by-state basis. As of March 31, 2008, approximately forty states have adopted fee schedules pursuant to which all healthcare providers are uniformly reimbursed. The fee schedules are set individually by each state and generally prescribe the maximum amounts that may be reimbursed for a designated procedure. In states without fee schedules, healthcare providers generally are reimbursed based on usual,

customary and reasonable fees charged in the particular state in which services are provided.

Many states do not permit employers to restrict a claimant's choice of provider, making it more difficult for employers to utilize managed care approaches such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs). However, in many other states, employers have the right to direct employees to a specific primary healthcare provider during the onset of a workers' compensation case, subject to the right of the employee to change physicians after a specific period. In addition, workers' compensation programs vary from state to state, making it difficult for payors and multi-state employers to adopt uniform policies to administer, manage

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and control the costs of benefits. As a result, the Company believes that managing the cost of workers' compensation requires approaches which are tailored to the specified regulatory environment in which the employer is operating. Because workers' compensation benefits are mandated by law and are subject to extensive regulation, the Company believes that payors and employers do not have the same flexibility to alter benefits as they might have with other health benefits programs.

Managed care techniques are intended to control the cost of healthcare services and to measure the performance of providers through intervention and ongoing review of services proposed and those actually provided. Managed care techniques were originally developed to stem the rising costs of group medical care. Historically, employers were slow to apply managed care techniques to workers' compensation costs primarily because the aggregate costs are relatively small compared to costs associated with group health benefits and because state-by-state regulations related to workers' compensation are far more complex than those related to group health. However, in recent years, the Company believes that employers and insurance carriers have been increasing their focus on applying managed care techniques to control their workers' compensation costs.

An increasing number of states have adopted legislation encouraging the use of workers' compensation managed care organizations (MCOs) in an effort to allow employers to control their worker's compensation costs. MCO laws generally provide employers an opportunity to channel injured employees into provider networks. In certain states, MCO laws require licensed MCOs to offer certain specified services, such as utilization management, case management, peer review and provider bill review. The Company believes that most of the MCO laws adopted to date establish a framework within which a company such as CorVel can provide its customers a full range of managed care services for greater cost control.

**FISCAL 2008 DEVELOPMENTS**

***Appointment of Chief Executive Officer***

On August 2, 2007, Daniel J. Starck, the President and Chief Operating Officer of the Company, was appointed to the additional office of Chief Executive Officer of the Company effective as of August 7, 2007. V. Gordon Clemons, previous Chief Executive Officer for the past twenty years, continues with the Company as Chairman of the Board of Directors.

***Acquisition of The Schaffer Companies Limited***

In June 2007, the Company's wholly owned subsidiary, CorVel Enterprise Comp, Inc., acquired 100% of the stock of The Schaffer Companies Ltd. (Schaffer) for \$12.6 million in cash. Schaffer is a third-party administrator headquartered in Maryland. The acquisition is expected to allow the Company to expand its service capabilities as a third-party administrator and provide claims processing services along with patient management services and network solutions services to an increased customer base. The sellers of Schaffer had the potential to receive up to an additional \$3 million in a cash-based upon the revenue collected by the Schaffer business during the one-year period after completion of the acquisition. The amount of the earn-out, if any, has not yet been determined, but the Company expects the earn-out calculation will be completed prior to the reporting of financial statements for the quarter end June 30, 2008. The results of Schaffer have been included in the Company's results for the ten month period ended March 31, 2008. For the fiscal year ended March 31, 2008, the results of the acquired business increased the Company's revenues by approximately \$9 million, or 3%.

***Company Stock Repurchase Program***

During fiscal 2008, the Company continued to repurchase shares of its common stock under a plan originally approved by the Company's Board of Directors in 1996. In June 2006, the Company's Board of Directors increased the number of shares authorized to be repurchased over the life of the plan to 12,150,000 shares after adjustment for the three-for-two stock split in the form of a 50% stock dividend in December 2006. During fiscal 2008, the Company spent \$8.2 million to repurchase 328,217 shares of its common stock. Since commencing this program in the fall of 1996, the Company has repurchased 11.7 million shares of its common stock through March 31, 2008, at a cost of \$162 million. These repurchases were funded from the Company's operating cash flows.

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### ***MedCheck Enhancements***

With the Company's continual investment in technology, development of MedCheck, the Company's propriety bill review software, is ongoing. New enhancements include the Expert Review Matrix (ERM), MedCheck Operations Dashboard (MOD), increased look-up functionality and the creation of a comprehensive data warehouse.

The development of the ERM bill search function capitalizes on advances in image processing and Artificial Intelligence (AI) to optimize medical review savings. ERM processing techniques allow specialists in each diagnosis category, regulatory jurisdiction, or benefit category access to bills across the country through MedCheck's secure server. This access permits CorVel specialists to utilize their knowledge and provide optimum review for each bill.

The MOD is an internal MedCheck application used to provide key metrics on behalf of CorVel's customers to help facilitate timely bill review. These reports can be organized in the form of charts, graphs, and spreadsheets. Currently, the MOD is in development for direct access to customers through the CareMC Web portal.

The Company offers a preferred provider look-up on both Websites: corvel.com, and caremc.com. During the year, the Company increased the functionality of the look-up with application enhancements. Customers can now create and develop customized, network specific panels and directories in real time.

The Company continued the development and design of its data warehouse systems capabilities. The data warehouse was designed to assist the Company and customers with expedited access to analytical data and reports. The data warehouse is updated on a nightly basis and is accessible via the CareMC Website. The Company intends to continue to invest in this technology in the coming years with focus on the timeliness of information for the Company's customers.

### ***Directed Care Network Expansions***

The Company continued investments in its directed care networks in fiscal 2008. CorVel is expanding both the breadth of care covered by its directed care networks, CareIQ, as well as the geographic coverage. Market reception for these second generation networks and their effectiveness at managing patients and controlling costs are the driving forces for this expansion.

### ***Network Solutions***

Through its network solutions services, the Company has saved over \$2 billion for its customers during fiscal 2008. The Company believes it has generated greater savings for its customers as a percentage of the medical dollars reviewed than in previous years primarily due to the enhanced rules engine in the Company's MedCheck software. The Company believes its processes are becoming more streamlined and efficient for the reasons discussed below under Systems and Technology.

### ***ePPO Sales***

The Company had continued growth in the ePPO product line stemming primarily from growth with existing large carrier customers, new managed care organizations and employer customers. ePPO is the electronic solution to CorVel's PPO network and provides the electronic intake and transmission of provider bills as well as automated pricing to the CorCare PPO Network. ePPO customers process provider bills to state mandated fee schedule or usual and customary rates, but lease PPO access to gain additional discounts afforded by PPO contracts. The Company's technological capabilities allow for electronic claim repricing solutions that are attractive to buyers of managed care services and can be integrated with their existing eCommerce products. ePPO provides access to CorVel's PPO

network of more than 400,000 quality healthcare providers through electronic interface solutions. Bills reviewed through payor systems can be electronically interfaced to the CorCare PPO database, and automatically adjusted to reflect current PPO pricing. In addition, CorCare can reimburse providers automatically, significantly reducing the expense of generating Explanations Of Review (EOR), payment to providers and year-end tax filings.

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**SYSTEMS AND TECHNOLOGY**

***Infrastructure Changes***

The Company is currently developing a processing system that will be accessible twenty-four hours a day, seven days a week. During the past year, a number of infrastructure improvements were made to reduce the amount of time spent maintaining and backing up the Company's transactional databases. Three years ago, these databases were unavailable for processing each weeknight for several hours. Currently, in the case of the Company's medical bill review application, this has been reduced to a single maintenance window each weekend. By providing continual access, the Company is positioned to conduct business within all time zones, therefore increasing the Company's ability to deliver processed bills faster.

***Adoption of Imaging Technologies and Paperless Workflow***

Utilizing scanning and automated data capture processes allows the Company to process incoming paper and electronic claims documents, including medical bills, with less manual handling and has improved the Company's workflow process.

Scanning is the process of taking a bill and transferring it to an electronic form. Optical Character Recognition (OCR) involves the automated reading of words and numbers from a digital image, such as a scanned document. The characters are translated into a standard text format, which can then be digitally manipulated. Scanning technology, OCR and Electronic Data Interchange (EDI) enable the Company to significantly cut back on manual data entry as well as reduce the other traditional costs associated with handling paper. Through the Company's internet portal, CareMC, customers can review the bills currently being processed and approve a bill for processing, which also helps to avoid the costs of paper-handling as well as expedite the payment process.

***Redundancy Center***

The Company's national data center is located in Portland, Oregon. The Company also has a redundancy center located in Ft. Worth, Texas. The redundancy center is the Company's backup processing site in the event that the Portland data center is off-line for any length of time. Currently, all of the Company's data is continually replicated to Ft. Worth so that in the event the Portland data center is offline, the redundancy center can be activated with current information within several hours. The Ft. Worth data center also hosts duplicates of the Company's Websites.

**BUSINESS PRODUCTS**

The Company offers services in two general categories, network solutions and patient management services, to assist its customers in managing the increasing medical costs of workers' compensation, group health and auto insurance, and monitoring the quality of care provided to claimants.

**Network Solutions**

The Company's Network Solutions services are a combination of medical bill review, enhanced bill review and Preferred Provider Organization (PPO). This program provides additional assurance that customers are only charged and pay for services actually delivered. Bills are evaluated, profiled and directed for the appropriate service based on state regulation, bill type and opportunity for savings for the payer.

***Proprietary Bill Review System***

Many states have adopted fee schedules, which regulate the maximum allowable fees payable under workers compensation for procedures performed by a variety of health treatment providers. Such schedules may also include fees for hospital treatment. The purpose of a fee schedule is to standardize the billing process by using uniform procedure descriptions and to set maximum reimbursement levels for each covered service.

Certain other states permit payors to pay workers compensation medical costs limited to usual and customary charges for the relevant community. The Company provides automated medical fee auditing to assist its customers



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in verifying that the fees charged by workers' compensation healthcare providers comply with state fee schedules, or are consistent with usual and customary charges.

The Company offers its fee schedule auditing through an automated medical bill review service called MedCheck, which combines automated data reporting and transmission capabilities. MedCheck consists of an online computer-based information system comprised of a proprietary software program which stores and accesses state-mandated fee schedules and usual and customary charge information.

MedCheck is also being utilized for the review of medical charges under certain non-workers' compensation insurance coverages. The MedCheck service provides the following capabilities:

- checking for provider charges which exceed charges allowable under fee schedules or usual and customary charges, in accordance with the requirements of the relevant jurisdiction;

- repricing provider bills to contractual PPO reimbursement levels;

- checking for billed services or procedures that are excessive, unnecessary or unrelated to treating the particular medical problem and duplicate billing;

- checking for unbundled billings where the medical services performed are billed in components, that result in higher total charges than would be the case if the services were billed in the aggregate;

- engaging in on-site processing of claims and Internet-based reporting tools;

- sending claims data directly to carriers' databases, thereby reducing costs due to repetitive or erroneous data entry;

- PPO management; and

- pharmacy review.

The MedCheck system can be accessed by insurers under an ASP agreement through the Company's eCommerce Website, CareMC, and through Virtual Private Networks (VPNs). The MedCheck suite can accept electronic bills and bill images, and publish EDIs to customer claims payment systems. This system integrates into the client's own workflow, automates the reimbursement of providers, allows for the application of all MedCheck fees to the individual claim file and eliminates the need for manual redundant data entry of MedCheck results by the carriers' claims personnel. The system is designed for easy access by claims adjusters and includes functionality for such part-time users within the claims payment environment.

*Preferred Provider Organization*

PPOs are groups of hospitals, physicians and other healthcare providers that offer services at pre-negotiated rates to employee groups. The Company believes that PPO networks offer the employer an additional means of managing healthcare costs by reducing the per-unit price of medical services provided to employees. The Company launched its CorCare network in 1992 and provides its customers with access to its PPO network, including more than 400,000 healthcare providers nationwide.

PPO providers are selected based on criteria such as quality, range of services, price and location. Each one is evaluated and credentialed, and then re-credentialed bi-annually by the Company. Throughout this evaluation process,

the CorCare networks are able to provide hospital, physician and special ancillary medical discounts while maintaining quality care.

CorVel has a long-term strategy of network development, providing comprehensive networks to our customers and customization of networks to meet the specific needs of our customers. The Company believes that the combination of its national PPO director's strength and presence and the local PPO developers' commitment and community involvement enables CorVel to build, support and strengthen its PPO in size, quality, depth of discount, and commitment to service.

Over 80% of the providers in our network are directly contracted. CorVel does maintain some leased network access agreements only to the extent to which they provide broader network access capabilities, such as size,

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demographics and discounts, and to the extent that they enable CorVel to provide prompt response to network expansion requests while maintaining quality assurance controls.

In total, the Company has more than 220 national, regional and local personnel supporting the CorCare network. This number includes our national PPO director, national PPO contracting manager and contracting staff, in addition to 70 locally based PPO developers who are responsible for local recruitment, contract negotiations, credentialing and re-credentialing of providers, and working with customers to develop customer specific provider networks. Each bill review unit has provider relations support staff to address provider grievances and other billing issues.

Bills submitted from preferred providers are identified through the MedCheck bill review process, and the submitted charges are then audited against the PPO schedule and against any applicable fee schedule or usual and customary charges. The fee approved for payment is the lower of the submitted charges or the lowest allowable fee identified. Some of the features of the Company's PPO network services include: national networks for all coverages, board certified physicians, automated provider credentialing, patient channeling, online provider look-up and printable directories.

The Company offers online provider look-up on its Website where users can locate providers in their area, see a map, get door-to-door driving directions or print a directory.

*Enhanced Bill Review Retrospective Utilization Review*

The Company offers a full line of retrospective utilization services for all medical bills including PPO management, medical bill repricing, line-item bill review, professional nurse review, Diagnosis Related Group (DRG) validation and expert fee negotiation. The service, named MedCheck Select, is designed to maximize savings opportunities and increase efficiencies for customers.

CorVel offers cost containment by examining medical bills to verify that payors are only charged for services actually delivered and that charges reflect current billing levels for comparable service.

CorVel uses a combination of industry standard usual and customary databases, as well as a proprietary nationwide database of usual and customary charges for inpatient care. The inpatient database provides usual and customary charges for detailed charges, which are specified on the itemized hospital bill.

MedCheck Select service is designed to:

- assure that billed charges are usual and customary;
- confirm services were medically necessary;
- reduce claim costs through negotiated agreements;
- substantiate, by report, charges over usual and customary;
- support the payor and patient in all appeals;
- provide review out-of-network bills;
- provide a proprietary hospital usual and customary database;

provide review by professional nurses;

provide expert fee negotiations;

validate diagnosis related groups; and

be HIPAA, AB1455, California SB 288 and SB899 compliant.

*Provider Reimbursement*

Through MedCheck, the Company has the capability to provide check writing or provider reimbursement services for its customers. The provider payment check can be added to the bill analysis to produce one combined

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document, which is mailed to the provider. MedCheck reviews bills and providers are reimbursed directly upon completion of customer approval of the EOR. This service is designed to help customers expedite claims closure.

*Pharmacy Program CorCareRX*

CorCareRX is the Company's national workers' compensation pharmacy management system. The CorCareRX Average Wholesale Price (AWP) model provides customers the amount of savings they will receive below the cost of prescriptions associated with a workers' compensation claim.

CorCareRX has been specifically designed to:

manage claimants' prescription expenses;

monitor appropriate utilization; and

ensure prescriptions are related to injury.

The CorCareRX program offers a patient identification card that limits dispensing of drugs to those specifically authorized by the physician for a specific workers' compensation injury. The program was designed to ensure that the medication an injured employee receives is appropriate for the injury and is dispensed in the appropriate quantity. CorCareRX utilizes an identification system that creates a unique number that is specific to the particular claim. The use of the CorCareRX program eliminates the handling of pharmacy bills by the employee completely. All the processing and repricing occurs electronically, so that the payor need only to approve the payment. The Company's reporting system allows the claims payor to manage and track prescription drug costs from the onset of the injury.

*Directed Care Networks CareIQ*

CorVel has expanded its network solutions with a directed care network. CareIQ, CorVel's directed care service line, offers an automated service ordering and status management system online. The Company's network service offers timely appointments and preferred pricing. Orders are fulfilled using local, preferred providers and billing and reimbursement for each transaction is automatically processed. Services also include Web-based request for service, a call center, and online reporting. CareIQ has a relationship with over 50% of the nation's credentialed facilities, offering the most extensive network of directed care services in the nation.

The Company's networks cover directed care needs for: Independent Medical Evaluations (IME), Medical Imaging (MRI, EMG, CT and Bone Scan) Durable Medical Equipment (DME), physical therapy, chiropractics, and transportation and translation services.

**Patient Management Services**

In addition to its network solutions, the Company offers CorCase, a range of patient management services, which involve working on a one-on-one basis with injured employees and their various healthcare professionals, employers and insurance company claims professionals. Patient management services are designed to monitor the medical necessity and appropriateness of healthcare services provided to workers' compensation claimants and to expedite their return-to-work. CorCase offers early intervention, utilization management and vocational rehabilitation through local branch offices and case managers in local communities. The Company's case managers work side-by-side with patients to assist them through their episode of care and return-to-work. The Company offers these services on a stand-alone basis or as an integrated component of its medical cost containment services.

These services are performed to maximize results and minimize costs. CorCase services are provided by trained and certified professionals in nursing and vocational counseling. The central focus of CorCase is to leverage quality care in order to manage claim costs. With the use of early intervention, nurses are able to gather and analyze medical treatment information and discuss with the employer the current job requirements of the injured worker, accommodations for modified work and gather any further information, which may assist in caring for the injured worker. This service positively impacts patient cases by utilizing proactive measures throughout the episode of care.

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CorCase utilizes CorVel's proprietary CareMC software to help determine available indemnity payments from the employer and coordinate case management information and issues. Protocols regarding length of disability are incorporated to guide the management of cases. Management and operations reports, electronic data interchange and billing are additional features of the software.

### *Medical Case Management*

The Company offers medical case management services where the injury is catastrophic or complex in nature or where prolonged recovery is anticipated. The medical management components of CorVel's program focuses on medical intervention, management and appropriateness. In these cases, the Company's case managers confer with the attending physician, other providers, the patient and the patient's family to identify the appropriate rehabilitative treatment and most cost-effective healthcare alternatives. The program is geared towards offering the injured party prompt access to appropriate medical providers who will provide quality cost-effective medical care. Case managers may coordinate the services or care required and may arrange for special pricing of the required services.

### *Early Intervention*

The Company believes that the earlier it becomes involved in an episode of care, the greater the impact on the healthcare outcome. The Company's early intervention program begins a series of steps that are designed to promote an employee's timely return-to-work including immediate telephonic assessment to ensure that an appropriate course of treatment is established and adhered to through the entire episode of care. CorVel's early intervention program features: automated, immediate notification, immediate patient assessment, clinical protocols and guidelines, channeling to preferred providers, private labeling options and telephonic case management.

### *Telephonic Case Management*

Telephonic case management is designed to facilitate and promote patient care and patient progression through the healthcare system. The case manager, through telephonic contact with the patient and/or family, facilitates communication between the patient, insurer and healthcare providers in order to accelerate return-to-work.

### *Claims Administration*

Since January 2007, the Company has been a TPA offering a comprehensive integrated platform of workers compensation and liability claims management and medical management services. Through this service, the Company serves clients in the self-insured or commercially insured market through alternative loss funding methods, and provides them with a complete range of services, including claims administration, case management, and medical bill review. In addition to the field investigation and evaluation of claims, the Company also may provide initial loss reporting services for claims, loss mitigation services such as medical bill review and vocational rehabilitation, administration of trust funds established to pay claims and risk management information services.

### *Utilization Management*

Utilization Management programs review proposed ambulatory care to determine: appropriateness, frequency, duration and setting. These programs utilize experienced registered nurses, proprietary medical treatment protocols and computer systems technology in an effort to avoid unnecessary treatments and associated costs. Processes in Utilization Management include: injury review, diagnosis and treatment plan; contact and negotiate provider's treatment requirements; certify appropriateness of treatment parameters and/or additional treatment requests; and respond to provider requests for additional treatment.

*Pre-certification of Hospitalization*

The pre-admission certification program verifies the medical necessity of proposed hospital admissions and determines the appropriate length of stay. The CorVel staff of nurses and reviewers, assisted by an automated medical rules/protocols system and backed up by physician consultants, individually evaluates every hospital admissions request. Pre-certification objectives include the following: determine appropriateness of proposed or emergent hospitalization; determine the medical necessity for hospital admission/inpatient care; explore



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alternatives to inpatient treatment; if inpatient care is required, determine the appropriate length of stay and monitor the patient's condition throughout the hospitalization to prevent unnecessary inpatient days; channel the patient to a CorVel PPO provider/facility; and develop and implement a timely discharge plan.

### *Inpatient Utilization Review*

The Company offers pre-certification and concurrent utilization review services. The Company's pre-certification service is designed to be utilized prior to the injured employee's admission to the hospital. Upon notification by a claims manager or employer, a Company nurse reviews the appropriateness of the proposed plan of care, the need for inpatient hospitalization, and the appropriate length of stay. Under the Company's concurrent review service the nurse reviewers monitor the medical necessity and appropriateness of the patient's continued hospitalization through regular contact with the hospital and the patient's physician and may identify cases that lend themselves to alternate treatment settings or home care.

### *Vocational Rehabilitation*

In certain states, vocational rehabilitation is a legislated benefit of workers' compensation, which assists the employee's return to former employment or another job function with similar economic value. The Company offers vocational services to reduce workers' compensation costs and expedite the injured employee's return-to-work.

CorVel offers vocational services to evaluate the claimant's education, training and experience. Vocational services include work capacity assessments, job analysis, transferable skill analysis, job modification, vocational testing, job placement assistance, labor market surveys and retraining. By working with the employer, the Company's case managers can provide job modification or light-duty alternatives until the physician lifts the claimant's physical restrictions. In addition, CorVel can evaluate partial payment claims if the claimant returns to work in a new position, working for less than their pre-injury wage. Services included by the Company's vocational case managers include:

- ergonomic assessments;
- rehabilitation plans;
- transferable skills analysis;
- labor market survey;
- job seeking skills training;
- resume development;
- vocational assessment;
- job analysis, development and placement;
- expert testimony; and
- ADA compliance.

### *Life Care Planning*

Life Care Planning is a tool used to project long-term future needs, services and related costs associated with catastrophic injury. CorVel's Life Care Plans summarize extensive amounts of medical data and compile it into a comprehensive report for future care requirements, producing improved outcomes and timely resolution of claims.

*Medicare Set-Asides*

A Medicare Set-Aside Allocation (MSA) is a process used to demonstrate to Medicare that adequate funds are available to cover the cost of future medical care and Medicare will not be assigned as the primary payor.

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### *Critical Stress Incident Debrief*

Crisis Counseling is used to minimize the effects of stress on employees following a traumatic event and maintain employees on their jobs following a critically stressful incident. Examples of such events include: experiencing or witnessing a physical assault, observing or suffering a catastrophic injury, and violence in the workplace.

### **CareMC**

CareMC (<http://www.caremc.com>) has become the application platform for all of the Company's primary service lines and delivers immediate access to customers. CareMC offers customers direct access to the Company's primary services, Network Solutions, Patient Management and Claims Management. CareMC allows for electronic communication and reporting between providers, payors, employers and patients. Features of the Website include: request for service, FNOL (first notice of loss), appointment scheduling, online bill review, claims information management, treatment calendar, medical bill adjudication and automated provider reimbursement. Through the CareMC Website, users can:

- request services online;

- manage files throughout the life of the claim;

- receive and relay case notes from case managers; and

- integrate information from multiple claims management sources into one database.

The CareMC Website facilitates healthcare transaction processing. Using artificial intelligence techniques, the Website provides situation alerts and event triggers, to facilitate prompt and effective decisions. Users of CareMC can quickly see where event outliers are occurring within the claims management process. If costs exceed pre-determined thresholds or activities fall outside expected timelines, decision-makers can be quickly notified. Large amounts of information are consolidated and summarized to help customers focus on the critical issues.

### **Scanning Services**

In 2003, the Company acquired Portland, Oregon based ScanOne, a provider of scanning, optical character recognition and document management services. This acquisition expanded the Company's existing office automation service line and all offices are selling scanning and document management, the services previously sold by ScanOne. The Company has added scanning operations to approximately 40 of the Company's larger offices around the country calling them Capture Centers.

With the scanning capability, the Company is able to store claim documents and organize the information by document type with the documents readily available on-line. The benefits of scanning are threefold: the service reduces costs, saves time and increases productivity. On the front-end of the scanning process, optical character recognition and electronic data interchange, can enable organizations to significantly cut back on manual data entry and paper shuffling. It also increases reporting, sorting and indexing capabilities. With scanning, customers are able to electronically view documents and images, obtain information in real-time, reduce overhead, staffing, and paper storage costs.

Our ScanOne service also offers a Web interface ([www.onlinedocumentcenter.com](http://www.onlinedocumentcenter.com)) providing immediate access to documents and data called the Online Document Center (ODC). Secure document review, approval, transaction workflow and archival storage are available at subscription-based pricing.

Aside from our ScanOne services, we actively pursue marketing initiatives to customers in the following fields: accounting, insurance carrier, hospital administration, clinics and legal field.

**INDUSTRY, CUSTOMERS AND MARKETING**

The Company focuses on four major industries around the country: workers compensation, auto insurance, group health and municipalities.

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