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STANDARD AUDIT REQUIREMENTS

Pursuant to NRS 616B.003, every licensed Nevada insurer shall be audited at least once every five years. Historically, through statutory mandate and/or DIR/WCS policy, this frequency has ranged between three and five years.

This process begins with an audit announcement letter being issued to the insurer and their claims administrator, if applicable.

The audit will include all claims filed with a date of injury for a defined period. Typically, this will be the preceding fiscal year; however, this period can fluctuate depending on many variables, including but not limited to: the insurer changing claims administrators, current staffing levels and other scheduling issues. Depending on the total number of claims reported for the period, either all the claims will be audited or a representative sample will be chosen at random.

The goal of the 5-year compliance audit is to ensure injured employees receive timely and accurate benefits in accordance with the Chapters 616A and 617D, inclusive, or chapters 617 of the Nevada Revised Statutes and the Nevada Administrative Codes. Each claim file may be reviewed for, but not limited to:

1. Timely determination regarding claim acceptance/commenced payments, or denial;
2. Timely payment of initial compensation;
3. Accurate calculation and payment of Temporary Partial Disability (TPD), Temporary Total Disability (TTD), Permanent Partial Disability (PPD), and/or Permanent Total Disability (PTD) compensation;
4. Timely and accurate payment of medical bills in accordance with the Nevada Medical Fee Schedule or as otherwise contracted;
5. Timely evaluation and offer of PPD;
6. Notification of the right of appeal concerning determination(s) made;
7. Timely responses to requests;
8. Vocational rehabilitation benefits;
9. Use of proper forms;
10. Claims administration, and
11. Violations of NRS 616D.120

Pursuant to NRS 616B.021 and NAC 616B.013, the WCS Investigator or Auditor shall be provided access to the requested claim file. This includes paperless electronic claim file systems, (if one is used by your organization), electronic claim's notes and payment history. If given the option, we can make arrangements for remote access to your electronic claims system prior to the date of this scheduled claim file review.

While remote access of the insurer's and/or claims administrator's electronic system is preferable for an efficient audit process, as it saves both party's time and resources, in-office auditing can be arranged. If this is the case, although the entire claim file will be reviewed, prior to the Auditors' arrival, please print out or copy the following pertinent claim file documents:

1) Hearing Officer and Appeals Officer Decision & Orders;
2) All written determinations;
3) All written requests for benefits & treatment;
4) Light duty offers/acceptance;
5) Documentation related to wages (D-forms, including D-38 Indexing Forms) wage letters and calculation sheets/tape;
6) PPD reports & calculations (all PPD forms);
7) Certification of disability used for payment of benefit;
8) C-4, C-3 and C-1 Forms;
9) Closure letter(s).

The Auditor may request additional documents to be copied or printed. If the audit period is split, meaning the time period of the audit is handled by more than one claims administrator, two sets of printed/copied documents will be required in order for the prior administrator to properly respond to any violations found during their period of responsibility.

In addition, if the electronic claims system does not place the date of receipt on all claim documents, please print out the corresponding system document or metafile that substantiates the date of receipt and place in sequential order of each document.

The WCS respectfully requests that a representative be available during the audit to address the auditor's questions, whether remotely or in-person.

Pursuant to NRS 616B.006, the following documents will also need to be provided to the Auditor:

- Your claims procedures manual, if you or your claims administrator have not already provided one to this agency; or if you have already provided one and it has been updated since it was last submitted;

- Any policies and procedures for the payment of compensation found to be due by a hearing officer, appeals officer, court of competent jurisdiction, written settlement agreement, written stipulation or the division when carrying out its duties pursuant to chapters NRS 616A to 616D, inclusive or chapter 617;

- Copies of contracts with MCO's and/or PPO's;

- A list of those Third-Party Administrators that are administering claims for you, including their Nevada DOI Certificate number, the list should include, physical address, contact person and telephone number;

- Separate lists of claims for denied, medical only ("claim for med only " means in which the benefits received by the injured employee or his dependents for the duration of the claim did not include benefits for a Temporary Total Disability, Temporary Partial Disability or Permanent Total Disability) pursuant to NAC 616B.016(3)(a), lost time ("claim for benefits for lost time" means a claim in which the benefits received by the injured employee or his dependents for the duration of the claim, included benefits for a Temporary Total Disability, Temporary Partial Disability, or Permanent Total Disability), and/or vocational rehabilitation benefits pursuant to NAC 616B.016(3)(b) and catastrophic claims pursuant to NRS 616C.700-720, for the specified period of time. The lists must include the injured employees' names in alphabetical order, date of injury, claim number and if there was a Permanent Partial Disability;

- Total expenditures for each claim with a breakdown of those expenditures to include medical payments, Temporary Total Disability (TTD), Temporary Partial Disability (TPD), rehabilitation maintenance, Permanent Partial Disability (PPD) and Permanent Total Disability (PTD) payments and

- Copies of all C-1 Forms are available during employer site visits.

This information is requested pursuant to NRS 616A.400, NRS 616B.003, NRS 616B.006, NAC 616A.410, and NAC 616D.311.

All claim files should be legible and in chronological order pursuant to NAC 616C.082 (2).

At the conclusion of each audit day, a written Daily Site Visit Form will be jointly completed by the Auditor and the representative for the insurer/claims administrator. This can be accomplished remotely via email or other electronic means. The form can document potential violations, agreements, missing documents from claim files and other pertinent issues discovered during the audit.

At the conclusion of the audit, the Auditor will ask the insurer for contact information regarding at least one insured employer (client) in order to conduct and in-person, employer site visit. The site visit choice is usually made due to employer violations found during the audit (late or incomplete mandated form submission, or lack thereof). This is also an opportunity to provide outreach education and ensure all mandated postings and forms are present at the employer's place of business. Employee surveys are left with the employer to be completed by random employees to ensure injured employees know how to report industrial injuries and how to seek treatment.

The Auditor will also send out formal written findings to the insurer and their claims administrator. The written responses must be returned to the DIR within thirty (30) days, pursuant to NAC 616A.410. It is very important to include all relevant documentation with the written responses to ensure the response can be substantiated, supported and validated.

This process concludes with the issuance of a Final Audit Report issued by DIR to the insurer and their claims administrator with appropriate appeal rights, if applicable.