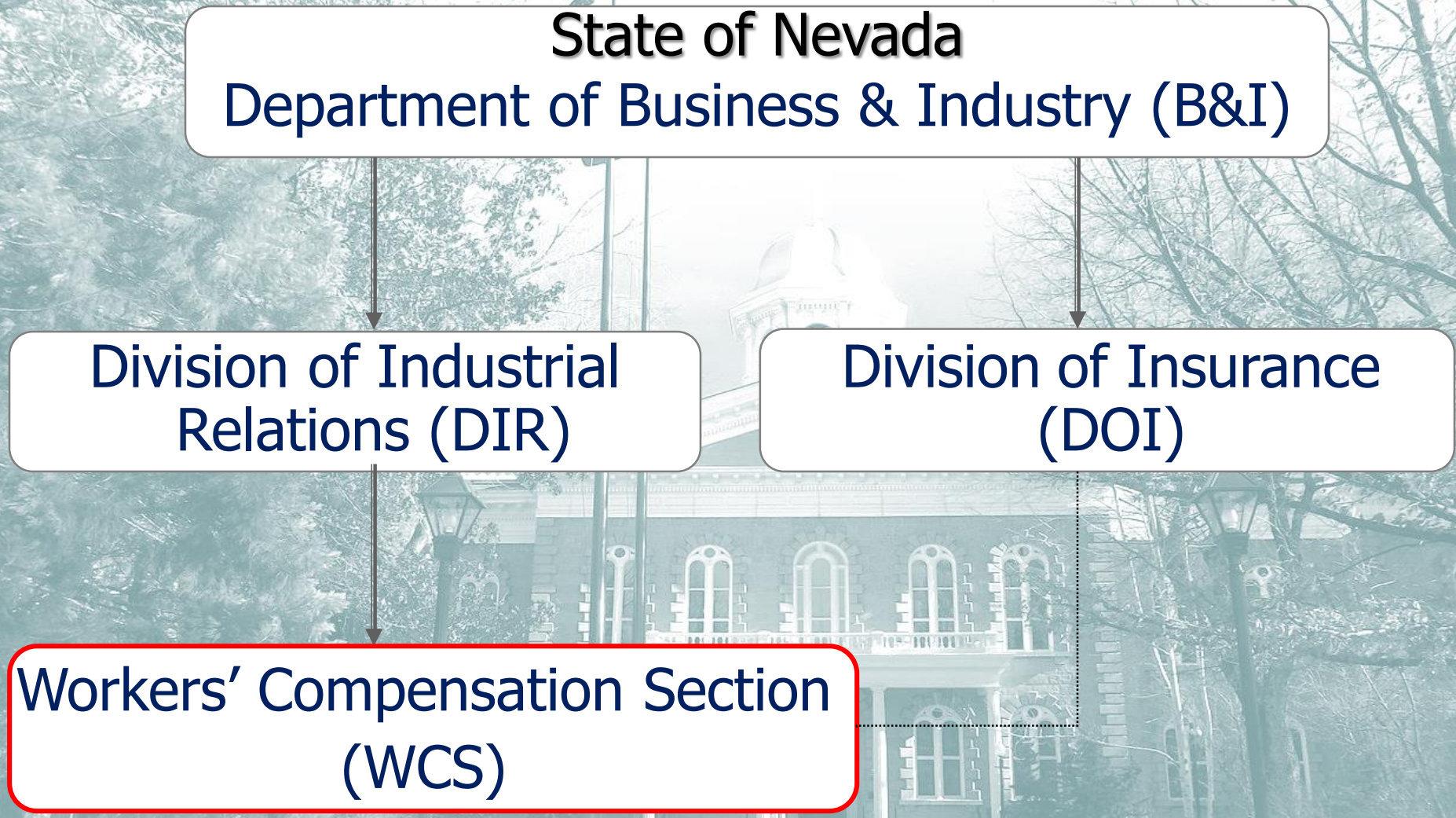

State of Nevada

Division of Industrial Relations

# Workers' Compensation Section

# Insurer/TPA Reporting

# Insurer/TPA Regulatory Structure



# Presentation Overview

**Intro**

**Insurer Reporting**

- Ongoing Reporting
- Annual Reporting (July – Dec)
- Special Data Calls

**TPA Reporting** (Autumn)

# Insurer Reporting Requirements

**Types of insurers** as defined by NRS 616A.270:

**Private Carriers** (individual underwriting companies, not groups)

**Self-insured employers (SIE)**

**Associations** of self-insured employers

# Insurer Reporting Requirements

Every Nevada insurer has a

Certificate of Authority (COA, C of A, Cert)

issued by the Division of Insurance

- Insurer Name (as listed on C of A)
- C of A Number

C of A numbers for private carriers can be found on WCS website:

Private Carrier Certificate of Authority Numbers

# Insurer Reporting Requirements

"Insurer" does **NOT** mean:

1. Third Party Administrators (TPAs)

2. Private Carrier Groups (Chartis, CNA, Liberty Mutual, etc.)

3. Insureds, Employers, or Policyholders

# Insurer Reporting Requirements

## To Report, You Must Know…

1. **What** you are (TPA, Private Carrier, SIE, etc.)
2. **Who** you are (C of A or License for TPAs)
3. **Which insurer** you are reporting for (name & number as it appears on the Nevada C of A )
4. **What** and **When** to report (NRS & NAC)

# Insurer Reporting Requirements

## DECERTIFICATION

Q: After an insurer decertifies and is inactive in Nevada, can they stop reporting?

A: **No**.

Mandatory reporting for all insurers continues even after the C of A is inactive.

# Insurer Reporting Requirements

## DECERTIFICATION

**PCs** must notify DIR/WCS of how claims incurred will be administered going forward. They remain responsible for claims incurred during their period of coverage per NRS 616B.466

**SIEs** and **Associations** (NAC 616B.493 & .575)

DIR & DOI retain jurisdiction over all claims incurred during period of self insurance and until all liabilities have terminated

# Insurer Reporting Requirements

## EXEMPTIONS

Decertified/inactive insurers may request an exemption to ongoing reporting if one of these **3 scenarios** exits:

1. During the period of self-insurance/active certificate **NO claims** were incurred

2. Liabilities for claims incurred during period of self-insurance/active certificate have been **transferred** to another insurer (i.e. LPTA)

# Insurer Reporting Requirements

## **EXEMPTIONS** (cont.)

3. All benefit eligibility and **all potential liabilities** have been **exhausted**

(i.e., claimants deceased, dependents past eligible age, claims with no reopening potential, etc.)

Send DIR/WCS a **written** request with a full explanation & evidence of one of the three scenarios

# Insurer Reporting Requirements

## Overview

**Ongoing** Reporting Requirements:

- Proof of Coverage
- Claims Indexing
- Multiple Injury Incident or Disease Exposure/Fatality
- Occupational Disease Claims
- Insurer Information Form (updates)

# Insurer Reporting Requirements

## Overview

**Annual** Reporting Requirements

- Permanent Total Disability (PTD) claims
- Insurer Information Form
- Claims Activity Report or Statement of Inactivity

# Insurer Reporting Requirements

## Ongoing Reporting Requirements

# Insurer Reporting Requirements

## Proof of Coverage (POC)

NRS 616B.461

NAC 616B.100-148

Reporting WC Policy Data to NCCI

# Insurer Reporting Requirements

## Proof of Coverage

Policy Transactions to report:

1. **New** Policies (and Binders)
2. Policy **Renewals**
3. Policy **Reinstatements**

# Insurer Reporting Requirements

## Proof of Coverage

Policy Transactions to report (cont.):

4. Policy **Reissuances**
5. Policy **Cancellations**
6. Policy **Non-renewals**
7. **Endorsements**/Policy **Changes**

# Insurer Reporting Requirements

## Proof of Coverage

POC Reporting has **3 purposes**:

1. Enables the DIR (WCS) to **enforce** the mandatory coverage provisions of NRS 616

# Insurer Reporting Requirements

## Proof of Coverage

2. Enables DIR/WCS to **route C-4s** (claims) to the correct insurer

3. Enables the public to obtain coverage information via the **Coverage Verification Service (CVS)** on the WCS website:

   http://dir.nv.gov/WCS/Home/

# Insurer Reporting Requirements

## Proof of Coverage

Who Must Report:

**Private carriers** writing Nevada workers' compensation policies must report POC data

Self-insured employers and associations of self-insured employers are not required to report

# Insurer Reporting Requirements

## Proof of Coverage
## Data Collection

- The **National Council on Compensation Insurance (NCCI)** is Nevada's POC data collection vendor
- All private carriers must submit policy data to NCCI for it to be **deemed received** by DIR/WCS

# Insurer Reporting Requirements

## Proof of Coverage
### Deadlines

Private carriers must report all required

policy transactions within **15 days** of their effective dates

# Insurer Reporting Requirements

## Proof of Coverage
## Reporting Violations

- **Late** Reporting
- **Failure** to Report
- **Incorrect** Reporting

# Insurer Reporting Requirements

## Proof of Coverage

Reporting Violations:

Per NAC 616D.415(1)(c), a fine and/or order for plan of corrective action

Fines may not exceed **$375** for initial violation or **$3000** for second or subsequent violations

# Insurer Reporting Requirements

For information on how to report POC data:

National Council on Compensation Insurance
901 Peninsula Corporate Circle
Boca Raton, FL 33487
1-800-NCCI-123 (1-800-622-4123)
www.ncci.com

# Insurer Reporting Requirements

## Claims Indexing
## NRS 616B.018

# Insurer Reporting Requirements

## Claims Indexing

The Claims Indexing System makes information concerning claimants of a Nevada insurer available to other insurers and certain other government entities.

Per NRS 616B.018 insurers must report:

- information on **initial claims**
- updates **monthly**

# Insurer Reporting Requirements

## Claims Indexing

D-38 **electronic submission** is encouraged

A hardcopy D-38 submission form is also available on our website under Forms and Worksheets

# Insurer Reporting Requirements

## Claims Indexing

**Failure** to report or reporting **errors** may result in:

- **$1000** fine for initial violation
- **$2000** for subsequent violations

# Insurer Reporting Requirements

## Claims Indexing

For information on reporting requirements and submission formats **contact**:

Cathleen Fryman, WCS Carson City

Email: cfryman@business.nv.gov

Telephone: 775-684-7267

# Insurer Reporting Requirements

## Fatality / Multiple Victim Reporting

NAC 616B.018

# Insurer Reporting Requirements

## Multiple Victim Reporting

Insurers must notify DIR/WCS within **30 days** of:

1. Any industrial accident resulting in **injury** to two or more persons, or
2. The **exposure** to a disease causing agent that has affected or is expected to affect two or more persons

Send a **letter/memo** to WCS District Manager referencing NAC 616B.018

# Insurer Reporting Requirements

## Fatality Notification

Insurer must notify DIR/WCS within **48 hours** of receiving knowledge of:

1. Fatal industrial **accident** or
2. Fatal industrial **disease incident**

Fatality Report **Form D-21** must be submitted

# Fatality Report Form D-21

Available online at http://dir.nv.gov/WCS/Home/

under Forms and Worksheets

**STATE OF NEVADA**
**DEPARTMENT OF BUSINESS AND INDUSTRY**
Division of Industrial Relations

400 West King Street, Suite 400
Carson City, Nevada 89703

1301 N. Green Valley Parkway, Suite 200
Henderson, Nevada 89074

**FATALITY REPORT**
(Pursuant to NAC 616B.018)

(Note: The insurer must notify the Administrator within 48 hours after receiving notice of fatality)

To: ADMINISTRATOR, D.I.R.

From: _____

Address: _____

Date: _____

Deceased: _____ D.O.B. _____ SSN: _____

Address: _____ City: _____

County: _____ State: _____

Date of Accident or onset of Occupational Disease: _____ Time: _____ A.M. P.M.

Date of Death: _____

Marital Status: _____ Name of Spouse: _____ No. of Dependents: _____

Name of Dependent: _____ D.O.B. _____ Relationship: _____

Name of Dependent: _____ D.O.B. _____ Relationship: _____

Name of Dependent: _____ D.O.B. _____ Relationship: _____

Employer: _____ Type of Business: _____

Address: _____

Deceased Employee's Occupation: _____

Exact Location of Accident (if applicable): _____

_____

Describe Accident or Occupational Disease: _____

_____

_____

_____

_____
Reported By

_____
Title

D-21 (rev. 7/99)

# Occupational Disease Claims

NRS 617.357

# Insurer Reporting Requirements

Occupational Disease Claims NRS 617.357

Insurers must inform the DIR/WCS of certain claims

diseases of the **heart** or **lungs**,
diseases that are **infectious**, or relate to **cancer**

by submitting the *Occupational Disease Claim Report* form (**Form OD-8**)

# Insurer Reporting Requirements

## Occupational Disease Claims NRS 617.357

Submit the *Occupational Disease Claim Report* form (**Form OD-8**) when these **two criteria** are met:

1. Claimant's **profession** is


firefighter,


police officer,


arson investigator, or


emergency medical attendant.

# Insurer Reporting Requirements

**And…**

2. Claim is **accepted/denied** pursuant to:

- ❑NRS 617.453 Cancer
- ❑NRS 617.455 Lung Disease
- ❑NRS 617.457 Heart Disease
- ❑NRS 617.481 Certain Contagious Diseases
- ❑NRS 617.485 Hepatitis
- ❑NRS 617.487 Hepatitis


# Form OD-8


# Occupational Disease Claim Report

State of Nevada
Department of Business and Industry
Division of Industrial Relations

## OCCUPATIONAL DISEASE CLAIM REPORT (NRS 617.357)

Submit within 30 days of acceptance/denial and any changes to the claim – **PART 1**
Submit within 30 days of appeal, closure, reopening, or confirmed diagnosis – **PARTS 1 & 2**

**PART 1**

Insurer Name:
Insurer FEIN:
Insurer Certificate Number:
Claim Number:
Claimant's Employer:

☐ Insurer
☐ TPA

Submitted by:
Company:
Address: City: State: Zip:
Telephone: Email:

Date of Injury:
Date Claim (C-4) Received by Insurer/TPA:
Claim Disposition: ☐ Accepted ☐ Denied
Date Accepted/Denied:

Reason for Denial:
☐ 1-Pending medical investigation ☐ 2-Negative test/no exposure ☐ 3-Not in course/scope
☐ 4-Not compensable/no disease ☐ 5-Late reporting ☐ 6-Failure to correct predisposing condition
☐ 7-Misc (duplicate claim, wrong insurer/uninsured, etc)

Estimated Medical Costs of Claim: $
Description of Claim:

**CLAIMANT (Choose one) & CLAIM ACCEPTED/DENIED PURSUANT TO NRS (Choose one):**

☐ **FIREFIGHTER**
- ☐ NRS 617.453 CANCER
- ☐ NRS 617.455 LUNG DISEASE
- ☐ NRS 617.457 HEART DISEASE
- ☐ NRS 617.481 CERTAIN CONTAGIOUS DISEASES
- ☐ NRS 617.485 HEPATITIS

☐ **POLICE OFFICER** (PEACE OFFICERS PER NRS 289.010 INCLUDED)
- ☐ NRS 617.455 LUNG DISEASE
- ☐ NRS 617.457 HEART DISEASE
- ☐ NRS 617.481 CERTAIN CONTAGIOUS DISEASES
- ☐ NRS 617.485 HEPATITIS
- ☐ NRS 617.487 HEPATITIS

☐ **ARSON INVESTIGATOR**
- ☐ NRS 617.455 LUNG DISEASE
- ☐ NRS 617.457 HEART DISEASE
- ☐ NRS 617.481 CERTAIN CONTAGIOUS DISEASES

☐ **EMERGENCY MEDICAL ATTENDANT**
- ☐ NRS 617.481 CERTAIN CONTAGIOUS DISEASES
- ☐ NRS 617.485 HEPATITIS

**PART 2**

**INITIAL APPEAL OF:** ☐ CLAIM DENIAL ☐ CLAIM ACCEPTANCE
Appealed by: ☐ Claimant/Dependent/Representative ☐ Employer/Insurer
Date Appeal Filed:
Hearing Date:
Decision: ☐ Affirmed ☐ Reversed ☐ Remanded ☐ Modified ☐ Dismissed ☐ Stip (Explain):
Decision Date: Decision by: ☐ Hearing Officer ☐ Appeals Officer

**SUBSEQUENT APPEAL OF DECISION BY:** ☐ **HO** ☐ **AO** ☐ **DC**
Appealed by: ☐ Claimant/Dependent/Representative ☐ Employer/Insurer
Date Appeal Filed:
Hearing Date:
Decision: ☐ Affirmed ☐ Reversed ☐ Remanded ☐ Modified ☐ Dismissed ☐ Stip (Explain):
Decision Date: Decision by: ☐ Appeals Officer ☐ District Court ☐ Supreme Court

Diagnosis Confirmed: ☐ YES ☐ NO Initial Claim Closure Date:
Date Claim Reopened (if applicable): Subsequent Claim Closure Date (if applicable):

OD-8 (1/14)

# Form OD-8

Available online at

http://dir.nv.gov/WCS/Home/

Look under

Forms and Worksheets

or

Insurer and TPA Reporting

# Insurer Reporting Requirements

Occupational Disease Claims NRS 617.357

Insurers must submit Form OD-8 to DIR/WCS within **30 days** after the claim is:

- Accepted or denied
- Appealed (acceptance or denial only)
- Affirmed, modified or reversed on appeal
- Closed or reopened

# Insurer Reporting Requirements

## Occupational Disease Claims NRS 617.357

Complete ALL spaces or submission will be 


Part 1:

- Insurer Name, FEIN, C of A Number
- Claim number (no typos please)
- Employer Name should be specific, e.g.:

Insurer - Clark County #75
Employer - UMC

Insurer - MGM Resorts International #43
Employer - Bellagio

# Insurer Reporting Requirements

Occupational Disease Claims NRS 617.357

Part 1 cont.:

- ❑ Submitted by Insurer or TPA?
- ❑ Insurer/TPA Contact Information
- ❑ Include Correct Dates
- ❑ Acceptance/Denial Reason

# Insurer Reporting Requirements

## Occupational Disease Claims NRS 617.357

Part 1 cont.:

- ❑ Include estimated medical costs (even if $0) and update at claim closure as necessary
- ❑ Claim description
- ❑ Choose **one** claimant type with **one** corresponding statute
- ❑ Notify DIR/WCS of changes by submitting updated Form OD-8

# Insurer Reporting Requirements

## Occupational Disease Claims NRS 617.357

Part 2:

Initial appeal of claim denial/acceptance and all subsequent appeals must be reported using Form OD-8

Appealed By
Date Appeal Filed
Hearing Date
Decision
Decision Date
Decision By

# Insurer Reporting Requirements

## Occupational Disease Claims NRS 617.357

Part 2 cont.:

Subsequent Appeal of Decision
Appealed By
Date Appeal Filed
Hearing Date
Decision
Decision Date
Decision By

# Insurer Reporting Requirements

Occupational Disease Claims NRS 617.357

Part 2 cont.:

Diagnosis Confirmed

Initial Claim Closure Date

Date Claim Reopened

Subsequent Claim Closure Date

# Insurer Reporting Requirements

## Occupational Disease Claims NRS 617.357

Insurers with Reportable Claims:

- ❑ Submit initial **and** updates throughout year on Form OD-8 within **30 days** of reportable activity
- ❑ Attach the C-4 claim form? **NO**

Insurers with No Calendar Year Reportable Claims:

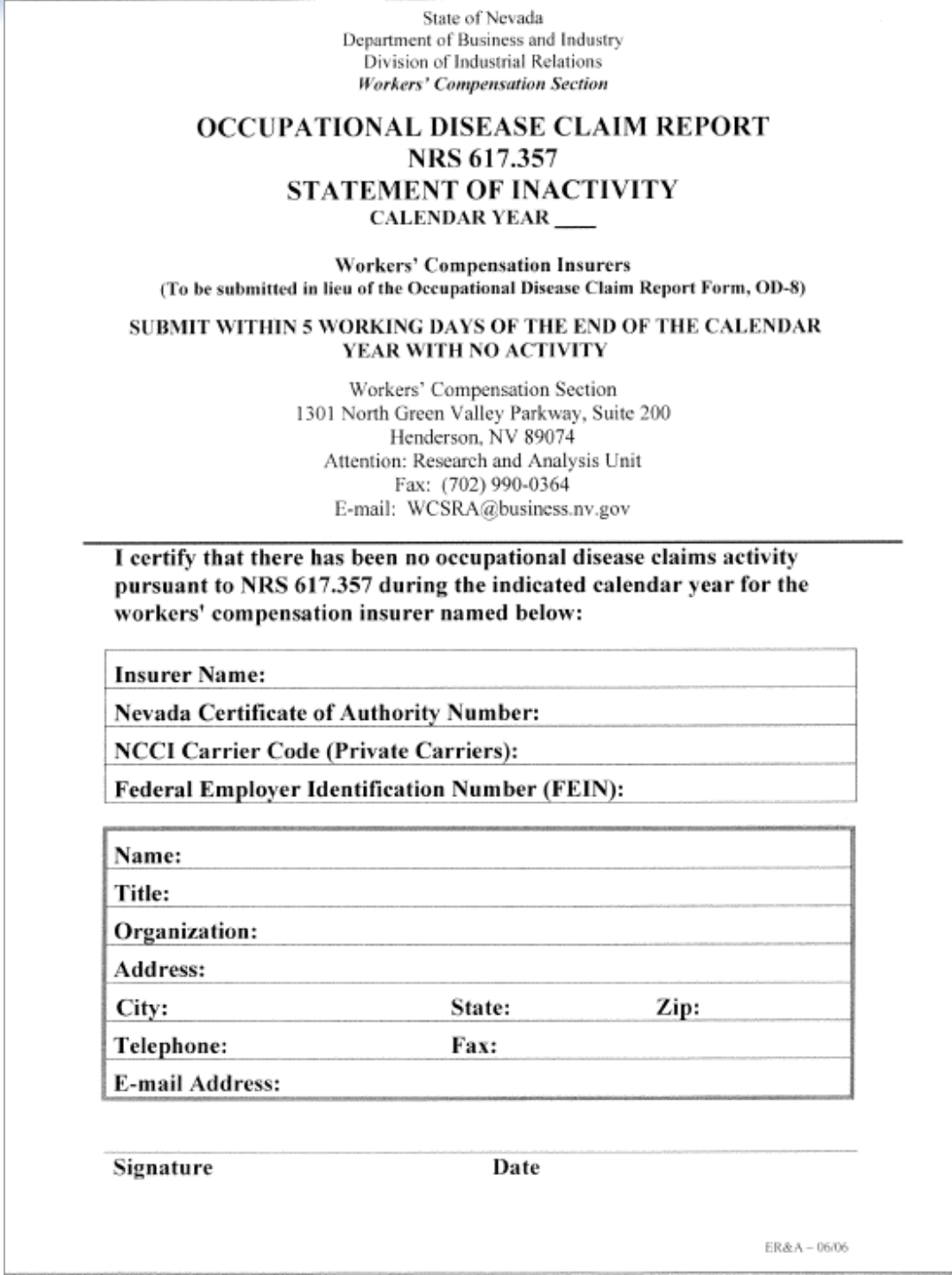
- ❑ Submit *Statement of Inactivity* within **5 working days** of calendar year-end

# Occupational Disease Claim Report *Statement of Inactivity*

Available online at [http://dir.nv.gov/WCS/Home/](http://dir.nv.gov/WCS/Home/)

under

Insurer and TPA Reporting



State of Nevada
Department of Business and Industry
Division of Industrial Relations
*Workers' Compensation Section*

**OCCUPATIONAL DISEASE CLAIM REPORT**
**NRS 617.357**
**STATEMENT OF INACTIVITY**
**CALENDAR YEAR ____**

**Workers' Compensation Insurers**
**(To be submitted in lieu of the Occupational Disease Claim Report Form, OD-8)**

**SUBMIT WITHIN 5 WORKING DAYS OF THE END OF THE CALENDAR YEAR WITH NO ACTIVITY**

Workers' Compensation Section
1301 North Green Valley Parkway, Suite 200
Henderson, NV 89074
Attention: Research and Analysis Unit
Fax: (702) 990-0364
E-mail: WCSRA@business.nv.gov

**I certify that there has been no occupational disease claims activity pursuant to NRS 617.357 during the indicated calendar year for the workers' compensation insurer named below:**

| | |
|---|---|
| **Insurer Name:** | |
| **Nevada Certificate of Authority Number:** | |
| **NCCI Carrier Code (Private Carriers):** | |
| **Federal Employer Identification Number (FEIN):** | |

| | | |
|---|---|---|
| **Name:** | | |
| **Title:** | | |
| **Organization:** | | |
| **Address:** | | |
| **City:** | **State:** | **Zip:** |
| **Telephone:** | **Fax:** | |
| **E-mail Address:** | | |

**Signature** **Date**

ER&A – 06/06

# Insurer Reporting Requirements

## Failure to Report

- Per NAC 616D.415(1)(d), a fine and/or order for plan of corrective action

- Fines may not exceed **$375** for initial violation or **$3000** for second or subsequent violations

# Annual Requirements

# PERMANENT TOTAL DISABILITY (PTD) CLAIMS

NRS 616C.453

# Insurer Reporting Requirements

## Permanent Total Disability Claims

NRS 616C.453 requires DIR to make annual payments to injured employees (or their dependents)

See applicable regulations: NAC 616C.526 - 527

# Insurer Reporting Requirements

NRS 616C.453 PT Benefit Criteria:

- Employee is permanently and totally disabled (**PT**) **and**
- Employee is receiving PT benefits as of **July 1** of the year in which the annual payment is made (e.g., claim is reportable in 2015 if the injured employee is receiving PT benefits as of 7/01/15); **and**
- Employee is **not** entitled to the annual increase (2.3%) per NRS 616C.473

# Insurer Reporting Requirements

## Permanent Total Disability Claims

Every insurer must:

- ❑ Submit a completed form for each reportable claim annually, within **30 days** of request with the claimant's current address

- ❑ Report every PT claim meeting the criteria of NRS 616C.453 or indicate that there are no qualifying claims to report

# Insurer Reporting Requirements

## Permanent Total Disability Claims

Annuities and Subrogation Agreements:

- PTs qualifying for this payment and for which an annuity was purchased or for which a subrogation agreement is in place **must be reported**!

Annuities and subrogation agreements do not make the claim exempt from reporting

# Insurer Reporting Requirements

## Permanent Total Disability Claims

Failure to provide PT claim information may result in administrative fines pursuant to NAC 616C.527 and NRS 616D.120

# Permanent Total Disability Claims Form

Available online at http://dir.nv.gov/WCS/Home/

under

Insurer and TPA Reporting

(submit current info)

State of Nevada
Department of Business and Industry
Division of Industrial Relations
*Workers' Compensation Section*

**PERMANENT TOTAL DISABILITY CLAIMS – NRS 616C.453**

**RESPONSE DUE BY: XXXX**

**E-MAIL:** wcsra@business.nv.gov
**FAX:** (702) 990-0364
**MAIL:** State of Nevada
Division of Industrial Relations/Workers' Compensation Section
Education, Research and Analysis Unit
1301 N. Green Valley Parkway, Suite 200
Henderson, NV 89074

1. **INSURER IDENTIFICATION:**

**Insurer Name:** _____

**Nevada Certificate of Authority Number:** _____

2. **Is this insurer responsible for any PERMANENT TOTAL (PT) disability claim for which the injured employee was receiving PT benefits as of July 1, 2012 and does not qualify for the annual increase in PT benefits pursuant to NRS 616C.473?**

**NO** ☐ IF NO, complete Section #4 at the bottom of this page and submit to the Division of Industrial Relations at the address, fax number or e-mail address above.

**YES** ☐ IF YES, provide the information listed in #3 below for EACH PT CLAIM (use a separate form for each claim) that meets the criteria above.

3. **REQUIRED CLAIM INFORMATION:**
(Supply **current** information for EACH PT claim meeting criteria in #2 above):

A. Injured Employee Name: _____
B. Injured Employee SSN: _____
C. Injured Employee Street Address: _____
D. Injured Employee City, State, Zip: _____
E. Claim Number: _____
F. Date of Injury: _____
G. Date Permanent Total Status Determined: _____
H. **Monthly** PT Rate (same as TTD rate) prior to deductions/offsets: $ _____
I. **Is the injured employee currently receiving PT benefits? (Y or N)** _____
J. If No, provide explanation and pertinent dates (i.e. incarcerated, deceased, etc.): _____

4. **COMPLETED BY:**

Name: _____ Title: _____
Company: _____
Telephone: _____ E-mail: _____
Signature*: _____ Date: _____
(*Signature not required if sent by e-mail)

(2012)
6/12

# Insurer Reporting Requirements

Permanent Total Disability Claims

Insurers with **no claims** to report:

- ❑ Complete Question 1
- ❑ Answer "**NO**" to Question 2
- ❑ Skip Question 3
- ❑ Complete Question 4

# Insurer Reporting Requirements

## Permanent Total Disability Claims

Insurers **with claims** to report:

- Complete Question 1
- Check "**YES**" for Question 2
- Complete Question 3 for each claim. Make copies of the form as needed to report only one claim per form

For insurers with claims to report, questions 1, 2, 3 and 4 must be completed on every form.

# Insurer Reporting Requirements

## Permanent Total Disability Claims

Submit by due date:

By email: WCSRA@business.nv.gov

By fax: (702) 990-0364

By mail: Division of Industrial Relations/WCS
Education, Research & Analysis Unit
1301 N Green Valley Parkway, Ste. 200
Henderson, NV 89074

# Insurer Reporting Requirements

## Insurer Information Form

NRS 616B.006

# Insurer Reporting Requirements

## Insurer Information Form

- Provides **contact information** for WCS regulatory functions
- This form is used to update our **data call list**
- Outdated information puts insurers at **risk** of failing to meet statutory responsibilities
- Provides claims office information for **Coverage Verification Service** (CVS)

# FY Insurer Information Form

## Page 1

State of Nevada
Department of Business & Industry
Division of Industrial Relations
WORKERS' COMPENSATION SECTION

**FY15 INSURER INFORMATION FORM**
**(July 1, 2014 through June 30, 2015)**
**Workers' Compensation Insurers (Active and Inactive)**

**ANNUAL DUE DATE: JANUARY 8, 2016**
(ALSO within 30 days of any changes/updates during the year)

**Email:** wcsra@business.nv.gov
**Mail:** State of Nevada
Division of Industrial Relations
Workers' Compensation Section
1301 North Green Valley Parkway, Suite 200
Henderson, NV 89074
*Attention: Research and Analysis*
**Fax:** (702) 990-0364

| **INSURER INFORMATION:** | | | |
|---|---|---|---|
| Check One: ☐ Private Carrier ☐ Self-Insured Employer ☐ Association of Self-Insured Employers | | | |
| Insurer Name (As listed on NV Certificate of Authority): | | | |
| Address: | | | |
| City: | State: | Zip: | |
| NV Certificate of Authority No.: | FEIN: | | |
| Date Certified: | Date Decertified (if applicable): | | |
| NCCI Carrier Code (Private Carriers): | NCCI Group Code (Private Carriers): | | |
| Did this carrier write WC business in NV in FY15? YES ☐ NO ☐ | | | |

| **CURRENT IN-STATE NEVADA CLAIMS OFFICE(S)/TPAs: Attach additional page for multiple TPAs. This information will be used on our online Coverage Verification Service.** | | | |
|---|---|---|---|
| Name of Administrator: | Effective Date: | | |
| Address: | | | |
| City: | State: | Zip: | |
| Contact Person: | | | |
| Telephone #: | C-4/Claims Fax #: | | |
| Email Address: | | | |

| **PREVIOUS NEVADA CLAIMS OFFICE(S)/TPAs DURING FY15:** | | |
|---|---|---|
| Previous Administrator(s) | Effective Date(s) | Date(s) Through |
| | | |

| **LOCATION OF RECORDS OTHER THAN CLAIMS OFFICE(S)/TPAs:** | | |
|---|---|---|
| Location of Records: | | |
| Address: | | |
| City: | State: | Zip: |
| Contact Person: | Title: | |
| Telephone: | | |
| Email Address: | Contract Expiration Date: | |

# FY Insurer Information Form

## Page 2

State of Nevada
Department of Business and Industry
Division of Industrial Relations
WORKERS' COMPENSATION SECTION

| *CORPORATE/WORKERS' COMPENSATION REGULATORY CONTACT (For issues relating to home office, legal, audit findings and reports, complaints, etc.): | | | |
|---|---|---|---|
| Contact Name: | | | |
| Title: | Email Address: | | |
| Company Name: | | | |
| Address: | | | |
| City: | State: | Zip: | |
| Telephone: | Fax: | | |

| COVERAGE VERIFICATION/CLAIM REPORTING CONTACT (For issues relating to routing claims, employer policy/coverage status, etc.): | | | |
|---|---|---|---|
| Contact Name: | | | |
| Title: | Email Address: | | |
| Company Name: | | | |
| Address: | | | |
| City: | State: | Zip: | |
| Telephone | Fax: | | |

| PROOF OF COVERAGE/POLICY REPORTING CONTACT (Private Carriers Only) (For issues relating to policy reporting to NCCI, proof of coverage reporting violations, etc.): | | | |
|---|---|---|---|
| Contact Name: | | | |
| Title: | Email Address: | | |
| Company Name: | | | |
| Address: | | | |
| City: | State: | Zip: | |
| Telephone: | Fax: | | |

| *STATE STATUTORY REPORTING CONTACT (For issues relating to the FY Activity Report, statistical reporting, data calls, etc.): | | | |
|---|---|---|---|
| Contact Name: | | | |
| Title: | Email Address: | | |
| Company Name: | | | |
| Address: | | | |
| City: | State: | Zip: | |
| Telephone: | Fax: | | |

*These contacts will be placed on our data call email list.

| Name of Individual Completing Form: | | | |
|---|---|---|---|
| Company: | Title: | | |
| Address: | | | |
| City: | State: | Zip: | |
| Telephone: | Fax: | | |
| Email Address: | | | |
| Signature: | Date: | | |

# Insurer Reporting Requirements

## Insurer Information Form

- Use the official (**unaltered**) form
- Submit **annually** and within **30 days** of any **changes**
- Sent out annually during the fall data call; and available throughout the year on the WCS website http://dir.nv.gov/WCS/Insurer-TPA_Reporting/

**ALL INSURERS MUST COMPLETE!**
(ACTIVE AS WELL AS INACTIVE INSURERS)

# Insurer Reporting Requirements

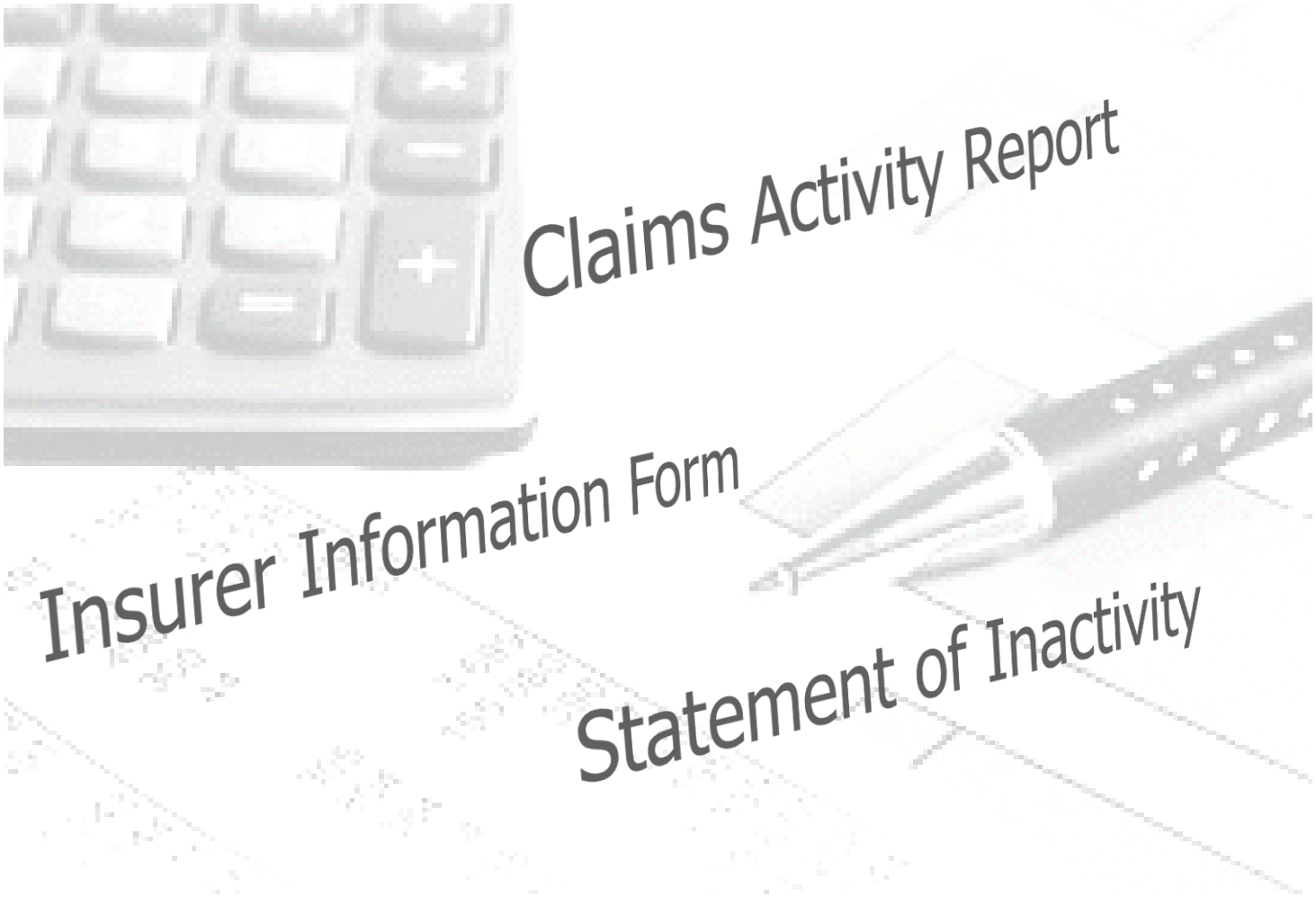
## Insurer Information Form
### Submission

Email: WCSRA@business.nv.gov

Fax: 702 990-0364

Mail: State of Nevada
Division of Industrial Relations
Workers' Compensation Section
1301 N. Green Valley Parkway, Ste. 200
Henderson, NV 89074
Attention: Research & Analysis

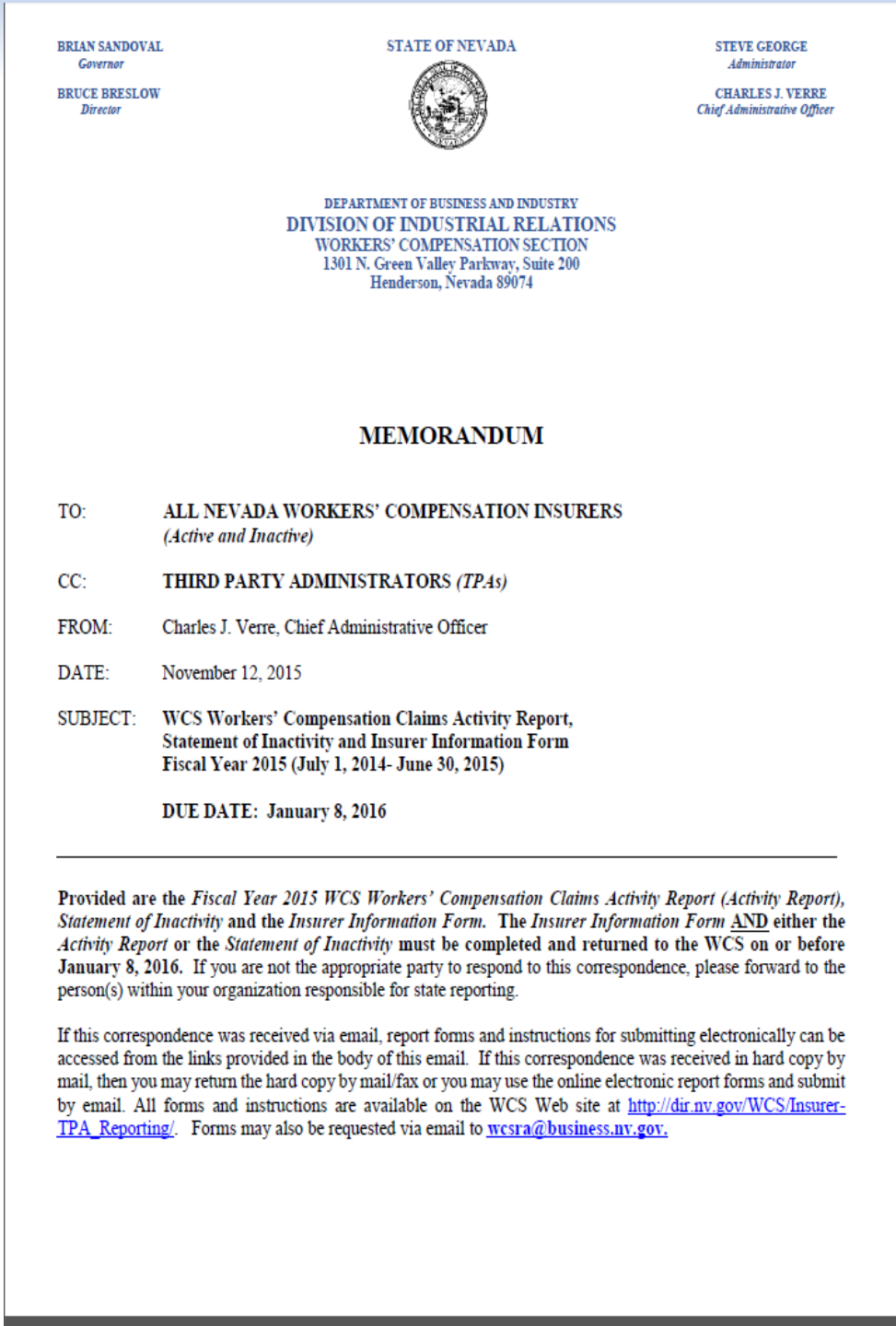
# Annual Fiscal Year Reports



# WCS FY Claims Activity Report/Insurer Information Form

## Cover Memo

Distributed annually in late fall by email for fiscal year reporting



BRIAN SANDOVAL
*Governor*

BRUCE BRESLOW
*Director*

STATE OF NEVADA

STEVE GEORGE
*Administrator*

CHARLES J. VERRE
*Chief Administrative Officer*

DEPARTMENT OF BUSINESS AND INDUSTRY
DIVISION OF INDUSTRIAL RELATIONS
WORKERS' COMPENSATION SECTION
1301 N. Green Valley Parkway, Suite 200
Henderson, Nevada 89074

**MEMORANDUM**

TO: **ALL NEVADA WORKERS' COMPENSATION INSURERS** *(Active and Inactive)*

CC: **THIRD PARTY ADMINISTRATORS** *(TPAs)*

FROM: Charles J. Verre, Chief Administrative Officer

DATE: November 12, 2015

SUBJECT: **WCS Workers' Compensation Claims Activity Report, Statement of Inactivity and Insurer Information Form Fiscal Year 2015 (July 1, 2014- June 30, 2015)**

**DUE DATE: January 8, 2016**

---

**Provided are the *Fiscal Year 2015 WCS Workers' Compensation Claims Activity Report (Activity Report), Statement of Inactivity* and the *Insurer Information Form*. The *Insurer Information Form* AND either the *Activity Report* or the *Statement of Inactivity* must be completed and returned to the WCS on or before January 8, 2016.** If you are not the appropriate party to respond to this correspondence, please forward to the person(s) within your organization responsible for state reporting.

If this correspondence was received via email, report forms and instructions for submitting electronically can be accessed from the links provided in the body of this email. If this correspondence was received in hard copy by mail, then you may return the hard copy by mail/fax or you may use the online electronic report forms and submit by email. All forms and instructions are available on the WCS Web site at http://dir.nv.gov/WCS/Insurer-TPA_Reporting/. Forms may also be requested via email to wcsra@business.nv.gov.

# WCS FY Claims Activity Report/Insurer Information Form

## **Cover Memo** cont.



The following are report form links:
**Insurer Information Form**
**Statement of Inactivity**
**Claims Activity Report (electronic)**

The following are documents provided to assist in the completion of the reports:
Attachment 1 (Definitions)
Attachment 2 (General Instructions)
Attachment 3 (Filing Electronically)
Attachment 4 (NRS/NAC)
Attachment 5 (NAC 616B.016)

**Read and follow all instructions carefully.** Information submitted must be complete, accurate and correctly calculated. Be sure to double-check calculations before entering the final figures on the report. A **zero (0)** should be entered in all fields where there has been no activity. If a specific amount is unknown, enter "**UNK**" in the field. **Do not leave fields blank.**

An insurer having no claims activity during the fiscal year must complete and sign the *Statement of Inactivity* in lieu of the *Activity Report.* **Every** insurer**, active or inactive,** must submit the *Insurer Information Form* AND either the *Activity Report* or the *Statement of Inactivity.*

**METHODS OF REPORTING**

*Electronic Filing:*
The WCS recommends electronic filing. Read and follow the instructions (Attachment #3) for filing this report by email to: wcsra@business.nv.gov

*Hard Copy Filing:*

**By Fax:** **(702) 990-0364**

**By Mail:** State of Nevada
Division of Industrial Relations
Workers' Compensation Section
1301 North Green Valley Parkway, Suite 200
Henderson, Nevada 89074
Attention: Research and Analysis

Nevada Revised Statutes (NRS) 616B.009(1) states: "All insurers shall report to the administrator, annually or at intervals which the administrator requires, all accidental injuries, occupational diseases, dispositions of claims and payments made under chapters 616A to 617, inclusive, of NRS or regulations adopted by the division pursuant thereto." Additionally, NAC 616B.016 defines what each insurer shall report. Nevada Administrative Code (NAC) 616A.410 requires workers compensation insurers to respond to a written request of the administrator or his designated agent within 30 days after receipt of the request or as specified in the request. **Failure to return the completed forms as requested by WCS or to comply with any of the statutes and regulations mentioned herein shall result in administrative action pursuant to NAC 616D.415(1)(d).**

If you have any questions regarding this request, you may contact Research and Analysis at (702) 486-9080 or by email at wcsra@business.nv.gov.

# WCS FY Claims Activity Report/Insurer Information Form

# Attachment 1

## Definitions



State of Nevada
Department of Business and Industry
Division of Industrial Relations
*Workers' Compensation Section*

**FISCAL YEAR 20XX**
**WCS WORKERS' COMPENSATION CLAIMS ACTIVITY REPORT**

**DEFINITIONS**

**Fiscal Year 20XX (FYXX):** The period July 1, 20XX through June 30, 20XX.

**I.E.:** An injured employee.

**Medical Only Claim (Activity Rpt., Part 1, Lines C, H & M):** A claim in which the benefits received by the injured employee or his dependents for the duration of the claim do **NOT** include benefits for a temporary total disability (TTD), temporary partial disability (TPD), or permanent total disability (PTD). "Medical Only" claims, however, could have included a Permanent Partial Disability Award.

**Lost Time Claim (Activity Rpt., Part 1, lines D, I & N):** 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. (The injured employee was incapacitated from earning full wages for five or more days in a 20 day period as a result of the on the job injury/disease.)

**Hard Copy:** Forms and/or reports that are prepared for submission to the WCS by fax or mail and have been provided by mail by the WCS or obtained from the WCS Web site. The electronic format may **NOT** be used as a hard copy format to send by fax or mail. The *hard copy* format of the activity report is a 3-page report.

**Electronic:** Forms and/or reports that are prepared for electronic (by computer/e-mail) submission to the WCS and have been provided by the WCS by e-mail as described in Attachment #3 Instructions for Filing Electronically. (Report/forms attached to the e-mail report request are ready for electronic use and submission and may not be mailed or faxed.) The *electronic form* of the activity report when printed is a 6-page report, and should NOT be sent as a hard copy.

**Nevada Certificate of Authority No.:** The number issued to an insurer by the Nevada Commissioner of Insurance on the Certificate of Authority authorizing the insurer to provide coverage including industrial insurance (workers' compensation).

**NCCI Carrier Code:** The five-digit number assigned by National Council on Compensation Insurance (NCCI) to each private carrier.

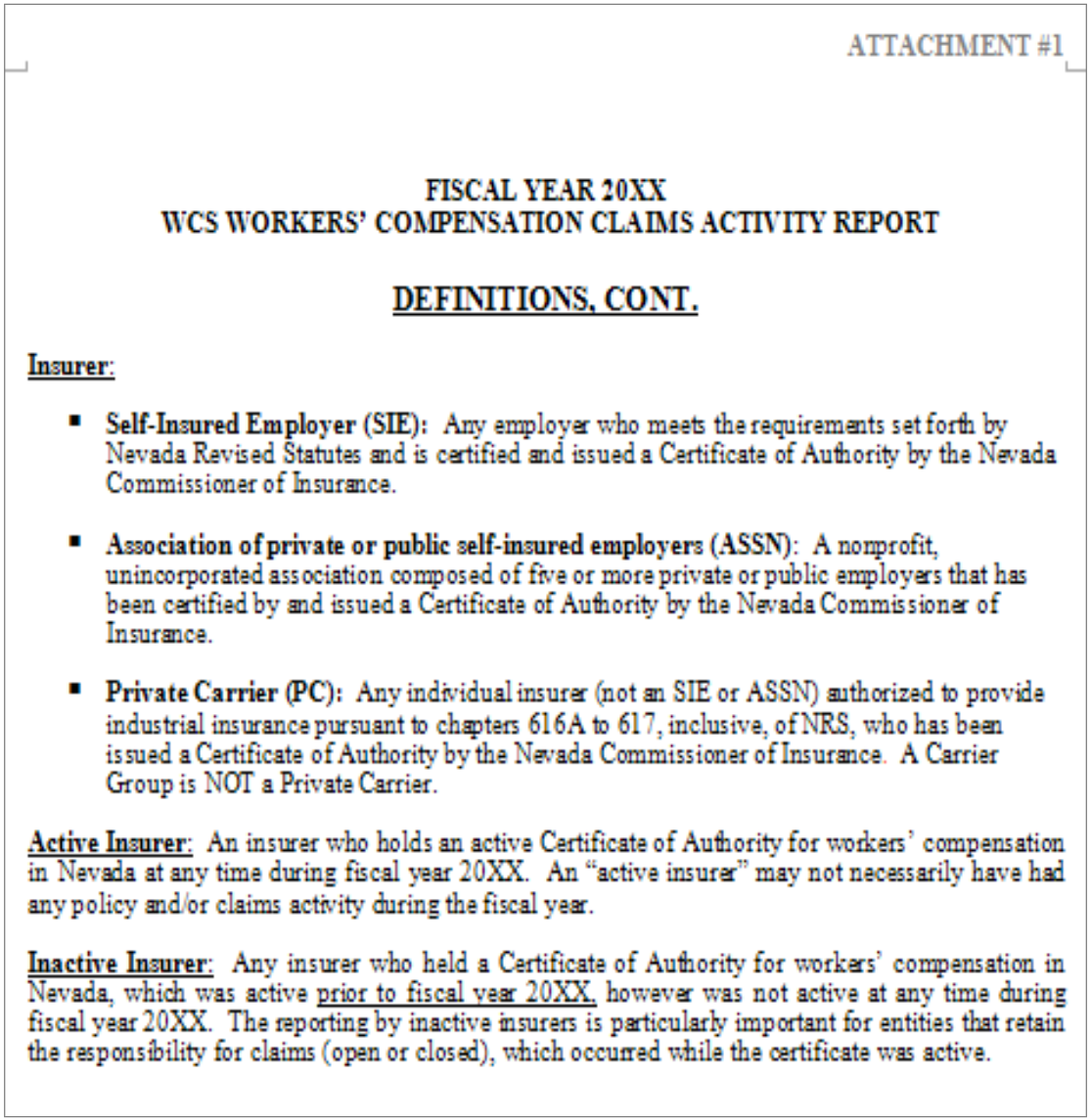
**NCCI Group Code:** The five-digit number assigned by National Council on Compensation Insurance (NCCI) to a private carrier that identifies the group of affiliated private carriers to which the carrier belongs.

**TPA – Third-Party Administrator:** A person (or persons) or management company who is hired by an insurer to provide administrative services for the insurer and administer claims.

# WCS FY Claims Activity Report/Insurer Information Form

## Attachment 1

Definitions cont.



ATTACHMENT #1

**FISCAL YEAR 20XX**
**WCS WORKERS' COMPENSATION CLAIMS ACTIVITY REPORT**

**DEFINITIONS, CONT.**

**Insurer:**

- **Self-Insured Employer (SIE):** Any employer who meets the requirements set forth by Nevada Revised Statutes and is certified and issued a Certificate of Authority by the Nevada Commissioner of Insurance.
- **Association of private or public self-insured employers (ASSN):** A nonprofit, unincorporated association composed of five or more private or public employers that has been certified by and issued a Certificate of Authority by the Nevada Commissioner of Insurance.
- **Private Carrier (PC):** Any individual insurer (not an SIE or ASSN) authorized to provide industrial insurance pursuant to chapters 616A to 617, inclusive, of NRS, who has been issued a Certificate of Authority by the Nevada Commissioner of Insurance. A Carrier Group is NOT a Private Carrier.

**Active Insurer:** An insurer who holds an active Certificate of Authority for workers' compensation in Nevada at any time during fiscal year 20XX. An "active insurer" may not necessarily have had any policy and/or claims activity during the fiscal year.

**Inactive Insurer:** Any insurer who held a Certificate of Authority for workers' compensation in Nevada, which was active prior to fiscal year 20XX, however was not active at any time during fiscal year 20XX. The reporting by inactive insurers is particularly important for entities that retain the responsibility for claims (open or closed), which occurred while the certificate was active.

# WCS FY Claims Activity Report/Insurer Information Form

## Attachment 2

## General Instructions



State of Nevada
Department of Business and Industry
Division of Industrial Relations
*Workers' Compensation Section*

**FISCAL YEAR 20XX**
**WCS WORKERS' COMPENSATION CLAIMS ACTIVITY REPORT**

**GENERAL INSTRUCTIONS**

***THIS REPORT IS TO REFLECT ALL WORKERS' COMPENSATION CLAIMS ACTIVITY OCCURRING ONLY DURING FISCAL YEAR 20XX***

**I. NEVADA INSURERS WHO MUST REPORT:**

**A. Insurers with ACTIVE Certificates of Authority for workers' compensation in Nevada:** The *Activity Report* must include all activity occurring during fiscal year 20XX that was covered by the active certificate of authority and should include payments made by excess (for self-insured employers and associations of self-insured employers) and reinsurance (for private carriers). Private carriers who are licensed to write workers' compensation in Nevada but have not done so in the fiscal year are considered to have an active certificate and are required to report annually.

**B. Insurers with INACTIVE Certificates of Authority for workers' compensation in Nevada:** Any insurer who formerly held an active certificate of authority is now considered inactive if decertified by the Division of Insurance. Inactive insurers that retain the liability for claims incurred while the certificate was active must report claims activity that occurred during fiscal year 20XX. If there was no claims activity during this fiscal year, the *Statement of Inactivity* should be completed. See Item III. below.

**II. FY11 WCS WORKERS' COMPENSATION CLAIMS ACTIVITY REPORT**

**A. Complete the insurer name and identification number(s)** on the last page of the electronic form or on each page of the hard copy form.

**B. Monetary amounts must be reported in U.S. dollars,** rounded to the nearest dollar. **Do not enter cents on this report (i.e. $159.80 should be reported as $160).**

**C. All spaces must be completed**: Leave NO blank spaces on this report. Indicate no activity for a line item with a **"0"** (zero). If unable to report the activity for a line item, enter **"UNK" (Unknown). DO NOT ENTER FORMULAS, LINKS OR REFERENCES TO OTHER DOCUMENTS.**

**D. Insurers with Multiple Claims Administrators:** Insurers utilizing multiple claims administrators may not submit individual reports per TPA for Nevada claims. Only **one combined report** for all claims activity for each insurer with a certificate # will be accepted. Do **not** submit reports for individual policyholders.

# WCS FY Claims Activity Report/Insurer Information Form

## Attachment 2

General Instructions cont.



**FISCAL YEAR 20XX**
**WCS WORKERS' COMPENSATION CLAIMS ACTIVITY REPORT**

**GENERAL INSTRUCTIONS, CONT.**

**E. Private Carrier Groups:**
Private carrier groups may **not** combine individual carrier activity into one report. Each underwriting company holding a Nevada Certificate of Authority for workers' compensation must file an **individual** ***Activity Report***.

**III. STATEMENT OF INACTIVITY:**

**A.** Insurers with **no** claims activity in FY11 should submit a ***Statement of Inactivity*** in lieu of the ***Activity Report***. Insurers filing the ***Statement of Inactivity*** must also complete the ***Insurer Information Form***. See Item IV. below.

**B.** The ***Statement of Inactivity*** may be submitted electronically to the Workers' Compensation Section by e-mail (see Attachment #3, *Instructions for Filing Electronically*) or by hard copy (see below).

**IV. INSURER INFORMATION FORM: (IMPORTANT NOTE: Due to the nature of the information required on this report, it is NOT recommended that TPAs complete this report on behalf of insurers.)**

**A. ALL INSURERS** (Active or Inactive) **MUST** complete this two-page form by **DECEMBER 30, 20XX.**

**B.** Use this form and submit to the WCS within 30 days of any changes occurring during the year after the annual submission.

**C.** This form may be submitted electronically to the Workers' Compensation Section by e-mail (see Attachment #3, ***Instructions for Filing Electronically***) or by hard copy (see below).

**V. SUBMISSION OF REPORTS AND/OR FORMS:**

**A. ELECTRONICALLY** ***by e-mail to:*** wcsra@business.nv.gov. Use electronic forms only. See Attachment #3 for directions.

**B. HARD COPY** ***by fax or mail.*** Submit hard copy forms only as follows:

1. **By FAX: (702) 990-0364,** Attention: Research and Analysis
2. **By MAIL:**

State of Nevada
Division of Industrial Relations
Workers' Compensation Section
1301 N. Green Valley Parkway, Suite 200
Henderson, NV 89074
Attention: Research and Analysis

# WCS FY Claims Activity Report/Insurer Information Form

## Attachment 3

## Filing Electronically

**ATTACHMENT # 3**

State of Nevada
Department of Business and Industry
Division of Industrial Relations
*Workers' Compensation Section*

**FISCAL YEAR 2015**
**WCS WORKERS' COMPENSATION CLAIMS ACTIVITY REPORT**

**INSTRUCTIONS FOR FILING ELECTRONICALLY (EMAIL)**

The WCS requests the filing of the ***Fiscal Year 2015 WCS Workers' Compensation Insurer Information Form*** and either the ***Claims Activity Report*** or the ***Statement of Inactivity*** electronically by email. MS Excel or compatible program must be used to file the ***Fiscal Year WCS Workers' Compensation Claims Activity Report*** electronically. MS Word 2003 or compatible program must be used to file the ***Insurer Information Form*** and the ***Statement of Inactivity*** electronically. Follow the steps below for electronic reporting.

1) **THE WCS WILL ONLY ACCEPT ELECTRONIC SUBMISSIONS FROM INSURERS OR THIRD PARTY ADMINISTRATORS WHO USE THE ELECTRONIC FORMS.** These forms can be accessed from the links provided in the body of the WCS email report request. Insurers who received the report request by post may also file electronically by completing the electronic filing forms available on the WCS Web site at http://dir.nv.gov/WCS/Insurer-TPA_Reporting/ or by requesting the electronic forms by email to **wcsra@business.nv.gov**. Requests will be processed in the order they are received. If you do not receive a response within 5 working days, please resend your request or contact Research and Analysis at (702) 486-9080.

2) **COMPLETE THE ELECTRONIC FORM(S) SUPPLIED BY WCS** by entering the required information into the blank forms.

   *A)* Only enter alphanumeric values in the Activity Report form. Do not enter formulas, links or references to other forms. Reports submitted with non-alphanumeric values will be returned for correction.

   *B)* **DO NOT ALTER THE FORMS IN ANY WAY. FORMS THAT HAVE BEEN ALTERED WILL NOT BE ACCEPTED.** Save a copy for future reference. Insurers filing electronically must be able to provide signed hard copies of reports, statements and forms upon request.

3) **SUBMIT THE COMPLETED ELECTRONIC INSURER INFORMATION FORM AND EITHER THE CLAIMS ACTIVITY REPORT OR THE STATEMENT OF INACTIVITY TO WCS BY EMAIL ON/OR BEFORE JANUARY 8, 2016.** Completed reports and forms are to be submitted by email to **wcsra@business.nv.gov** as attachments.

# WCS FY Claims Activity Report/Insurer Information Form

# Attachment 4

## Statutes & Regulations



State of Nevada
Department of Business and Industry
Division of Industrial Relations
*Workers' Compensation Section*

**Excerpt from Nevada Revised Statutes (NRS)**

**NRS 616B.009 Reports required to be made by insurers.**

1. All insurers shall report to the administrator, annually or at intervals which the administrator requires, all accidental injuries, occupational diseases, dispositions of claims and payments made pursuant to chapters 616A to 617, inclusive, of NRS or regulations adopted by the division pursuant thereto.

2. Each self-insured employer and association of self-insured public or private employers shall report its reserves to the administrator in the manner prescribed in subsection 1.

(Added to NRS by 1979, 1038; A 1981, 1469; 1993, 712, 1862; 1995, 531, 2022)—(Substituted in revision for NRS 616.337)

**Excerpt from Nevada Administrative Code (NAC)**

**NAC 616B.707 Consideration of expenditures as expenditures for claims; computation and reporting of value of clinical services.** (NRS 232.680, 616A.400)

1. The Division will consider expenditures for the following as expenditures for claims:
(a) A surgeon, assisting surgeon, anesthesiologist or consulting physician.
(b) Charges by a hospital.
(c) Treatment by a physician or chiropractor.
(d) X-ray films, computerized axial tomography (CAT) scans, myelograms, magnetic resonance imaging, and other diagnostic tests and procedures.
(e) Physical therapy.
(f) Prescribed drugs and medications, eyeglasses, dental work, prostheses, orthotic devices and corrective shoes by prescription.
(g) Travel to obtain medical care or supplies.
(h) Any other accident benefits.
(i) Compensation for a permanent total, temporary total, permanent partial or temporary partial disability.
(j) Costs of vocational rehabilitation services for an injured employee.
(k) Death benefits.
(l) Burial expenses.

2. The Division will not consider the following expenditures to be expenditures for claims:
(a) Amounts held in reserve for any anticipated expense in connection with a claim.
(b) Money paid in excess of the compensation calculated pursuant to NRS 616C.440, 616C.475, 616C.490 or 616C.500 or NAC 616C.577 for a temporary total, temporary partial, permanent total or permanent partial disability or vocational rehabilitation maintenance.
(c) Legal expenses, including, without limitation, court costs, attorney's fees, costs for depositions, investigations and hearings.
(d) Payment of an award of interest.
(e) Payment of claims in connection with the Uninsured Employers' Claim Account.
(f) Administrative expenses, including, without limitation, expenses incurred for:
(1) Copying records;
(2) Reviewing any report of a physician or chiropractor contained in a file relating to a claim; or
(3) Services relating to the management of costs of medical care.
(g) Costs incurred in a claim that is ultimately denied.

3. The value of clinical services furnished by an insurer for industrial injuries or illnesses must be computed and reported pursuant to the schedule of fees and charges for accident benefits adopted pursuant to subsection 2 of NRS 616C.260.

(Added to NAC by Dep't of Industrial Relations, eff. 7-29-87; A 8-30-91; A by Div. of Industrial Relations, 3-28-94; R112-98, 12-18-98; R118-02, 9-7-2005)

# WCS FY Claims Activity Report/Insurer Information Form

## Attachment 5

Regulations



State of Nevada
Department of Business and Industry
Division of Industrial Relations
*Workers' Compensation Section*

**Excerpt from Nevada Administrative Code (NAC)**

**NAC 616B.016 Reports of claims. (NRS 616A.400)**

1. Upon the request of the administrator, each insurer shall file a report with the administrator which contains the following information:

(a) For claims other than claims for an occupational disease:
(1) The number of new claims filed.
(2) The number of claims for accident benefits only that were accepted by the insurer.
(3) The number of claims for benefits for lost time that were accepted by the insurer.
(4) The number of compensable fatalities.
(5) The number of claims that were denied by the insurer.

(b) For claims for an occupational disease:
(1) The number of new claims filed.
(2) The number of claims for accident benefits only that were accepted by the insurer.
(3) The number of claims for benefits for lost time that were accepted by the insurer.
(4) The number of compensable fatalities.
(5) The number of claims that were denied by the insurer.

(c) The number of requests to reopen a claim.
(d) The number of requests to reopen a claim that were denied by the insurer.
(e) The number of claims for accident benefits only that were reopened by the insurer.
(f) The number of claims for benefits for lost time that were reopened by the insurer.
(g) The number of injured employees who received benefits for a permanent partial disability.
(h) The number of injured employees who received benefits for a permanent partial disability in a lump sum.
(i) The number of injured employees who received benefits for vocational rehabilitation.
(j) The number of injured employees who received benefits for vocational rehabilitation in a lump sum.
(k) The number of claims closed pursuant to subsection 1 of NRS 616C.235.
(l) The number of claims closed pursuant to subsection 2 of NRS 616C.235.
(m) The number of claims open at the end of the fiscal year.
(n) The total expenditures for claims reported in paragraphs (k) and (l).
(o) Expenditures on claims for:
(1) A temporary total disability.
(2) A temporary partial disability.
(3) A permanent total disability.
(4) A permanent partial disability.
(5) Benefits for survivors.
(6) Burial expenses.
(7) Travel and per diem expenses.
(8) All medical expenses.
(9) Vocational rehabilitation, including, without limitation, expenditures for:
(I) Vocational rehabilitation maintenance.
(II) The payment of compensation in a lump sum in lieu of vocational rehabilitation services.
(III) Program expenses.
(IV) Administrative expenses.
(V) Other expenses relating to vocational rehabilitation.

# WCS FY Claims Activity Report/Insurer Information Form

## Attachment 5

Regulations cont.

ATTACHMENT #5

State of Nevada
Department of Business and Industry
Division of Industrial Relations
*Workers' Compensation Section*

**NAC 616B.016 Reports of claims. (NRS 616A.400) (Continued)**

(p) Amounts recovered:
(1) By subrogation of claims.
(2) From the:
(I) Subsequent injury fund for self-insured employers established pursuant to NRS616B.554;
(II) Subsequent injury fund for associations of self-insured public or private employers established pursuant to NRS 616B.575; or
(III) Subsequent injury fund for private carriers established pursuant to NRS 616B.584.
(3) From other sources.
(q) Any other information requested by the administrator.
2. The information required pursuant to subsection 1 must, except as otherwise requested by the administrator, include information concerning any administrative activity during the previous fiscal year relating to:
(a) A claim for an injury that occurred during that year; and
(b) Any other claims, regardless of when the injury occurred.
3. As used in this section:
(a) "Claim for accident benefits only" means a claim 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.
(b) "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.
(c) "Vocational rehabilitation maintenance" has the meaning ascribed to it in NRS 616C.575.
(Added to NAC by Div. of Industrial Relations by R105-00, 1-18-2001, eff. 3-1-2001)

# Insurer Reporting Requirements

## WCS FY Claims Activity Report

**All insurers**, active and inactive, who maintain responsibility for claims – old, new, open, closed – **must report**

# Insurer Reporting Requirements

## WCS FY Claims Activity Report

Insurers with **active** certificates:

- ❑ Report all FY activity covered by C of A
- ❑ Include payments made by excess insurance (SIEs & Associations) and reinsurance (private carriers)
- ❑ Use **Statement of Inactivity** to report zero claims activity during fiscal year

# Insurer Reporting Requirements

## WCS FY Claims Activity Report

Insurers with **inactive** certificates:
(decertified by DOI or voluntarily withdrew)

- ❑ Use Claims Activity Report to report activity
- ❑ Use **Statement of Inactivity** to report zero claims activity during fiscal year

# Insurer Reporting Requirements

## WCS FY Claims Activity Report

Complete insurer name and certificate number

- On last page of electronic form
- On each page of hard-copy form

All amounts in $US ($159.80 round up to $160)

DO NOT USE FORMULAS, LINKS OR REFERENCES TO OTHER DOCUMENTS

# Insurer Reporting Requirements

## WCS FY Claims Activity Report

All spaces must be filled

- Input "**0**" for zero activity
- Input "**UNK**" if unable to report a line item
  Excessive use of "UNK" is not acceptable

Report only claims activity occurring during the FY

# Insurer Reporting Requirements

## WCS FY Claims Activity Report

Every insurer with a certificate number must submit

Private Carrier Groups (Liberty Mutual) must submit individual reports for each licensed private carrier (underwriting company)

Insurers using multiple claims administrators (TPAs) must submit one combined report per licensed insurer

Do not submit reports for individual policyholders

# Insurer Reporting Requirements

## WCS FY Claims Activity Report Submissions

**Electronic** via email (recommended)

- Distributed via email with the Annual Report request – also available on WCS website
- Complete and submit in original Excel **not pdf** file format as email attachment
- Will not be accepted if printed and submitted as a hard copy or emailed as a pdf file (6 page form)

**Hard Copy** (via fax, mail, etc. not recommended)

- Available on WCS website (3 page form)

# WCS FY Claims Activity Report

(Electronic-Excel)

## Part 1 Claims Information

**PART 1 - CLAIMS INFORMATION**

| Major Categories | All activities reported in this report must have occurred in FY15* Specific Areas | AMOUNT OF ACTIVITY IN FY15 (except line U) |
|---|---|---|
| | | |
| Occupational Injury Claims NRS 616 | A. No. of **NEW** Claims Filed/Reported in FY15 (Accepted, Denied and Pending) | |
| | B. No. of Claims Denied in FY15 | |
| | C. No. of Medical Only (1) Claims Accepted in FY15 | |
| | D. No. of Lost Time (2) Claims Accepted in FY15 | |
| | E. No. of Compensable Fatalities in FY15 | |
| | | |
| Occupational Disease Claims NRS 617 | F. No. of **NEW** Claims Filed/Reported in FY15 (Accepted, Denied and Pending) | |
| | G. No. of Claims Denied in FY15 | |
| | H. No. of Medical Only (1) Claims Accepted in FY15 | |
| | I. No. of Lost Time (2) Claims Accepted in FY15 | |
| | J. No. of Compensable Fatalities in FY15 | |
| | | |
| Claim Reopening | K. No. of Requests for Claim Reopening in FY15 of any claim | |
| | L. No. of Claim Reopening Requests Denied in FY15 | |
| | M. No. of Medical Only (1) Reopenings Granted in FY15 | |
| | N. No. of Lost Time (2) Reopenings Granted in FY15 | |
| | | |
| PPD Claims | O. No. of All Injured Employees Paid PPDs (Lump Sum and/or installments) in FY15 | |
| | P. No. of IEs Paid PPDs **Min. Lump Sum or LS w/ initial payment ONLY** (of O above) | |
| | | |
| Voc Rehab Claims | Q. No. of Injured Employees Paid Rehabilitation Benefits in FY15 (**Any listed in Part 4**) | |
| | R. No. of Injured Employees Paid Rehabilitation in a Lump Sum (**Buyout**) (of Q above) | |
| | | |
| Closed Claims | S. No. of Claims Closed Pursuant to NRS 616C.235(1) (**Medical $300 or more**) in FY15 | |
| | T. No. of Claims Closed Pursuant to NRS 616C.235(2) (**Medical under $300**) in FY15 | |
| | U. Total Expenditures for All Claims Closed (S and T above) **for the Life of those Claims** | |
| | | |
| Open Claims | V. No. of Claims for Catastrophic Injuries (NRS 616A.077) Open as of 6/30/15 | |
| | W. No. of **ALL** Open Claims (including Catastrophic) as of 6/30/15 | |

NV-FY15-WC electronic

EADY

# WCS FY Claims Activity Report
# Part 2 - Compensation Expenditures

**PART 2 - COMPENSATION EXPENDITURES**

| | Specific Areas | AMOUNT PAID IN FY15 |
|---|---|---|
| | | |
| | A. Temporary Total Disability paid on all claims in FY15 | |
| | B. Temporary Partial Disability paid on all claims in FY15 | |
| | C. Permanent Total Disability paid on all claims in FY15 | |
| | D. Permanent Partial Disability paid on all claims in FY15 | |
| | E. Survivor's Benefits paid on all claims in FY15 | |
| | F. Burial Expenses paid on all claims in FY15 | |
| | G. Travel and Per Diem paid on all claims in FY15 | |
| | H. Interest Paid Pursuant to NRS 616C.335 paid on all claims in FY15 | |
| | I. Child Support (not reported elsewhere) paid on all claims in FY15 | |
| | J. Annuities purchased in FY15 for future benefits for all claims | |
| | K. Other paid in FY15 (Enter total and attach separate list) | |
| | | |
| | TOTAL COMPENSATION EXPENSES PAID IN FY15 | $0 |

# WCS FY Claims Activity Report
# Part 3 - Medical Expenditures

**PART 3 - MEDICAL EXPENDITURES**

| Major Categories | Specific Areas and Corresponding Codes | AMOUNT PAID IN FY15 |
|---|---|---|
| | | |
| **General** | **A.** CPT Codes 00100 through 99499, Category II Codes 0001F - 7025F and Category III Codes 0019T - 0328T paid in FY15 | |
| | | |
| **E/R Hospital** | **B.** Emergency Dept. Services (NV00100-NV00101) (**Facility Fees Only**) paid in FY15 | |
| | | |
| **Inpatient Hospital** | **C.** Inpatient Hospital (NV00200, NV00400, NV00500, NV00550, NV00600, NV00700, NV00900) (**Per Diem Only**) paid in FY15 | |
| | | |
| **Ambulatory Surg. Ctrs.** | **D.** Ambulatory Surgical Ctrs. Groups 1-9 or usual and customary **(Facility Fees Only)** paid in FY15 | |
| | | |
| **Home Health** | **E.** Home Health Care (NV90130, NV90170, NV90180, NV90190) paid in FY15 | |
| | | |
| **HCPCS** | **F.** A0021 - V5364 paid in FY15 | |
| | | |
| **Miscellaneous** | **G.** PPD Evaluations (NV01000, NV01002-NV01006) Dr. report fees paid in FY15 | |
| | **H.** FCE Testing and Reports (NV99060) paid in FY15 | |
| | **I.** Back School (NV97115) paid in FY15 | |
| | **J.** Pharmaceuticals paid in FY15 | |
| | **K.** No Show Appts (PPD: NV01001; IME: NV02000; FCE: NV99061) paid in FY15 | |
| | **L.** Trauma Activation Fee (NV00150) paid in FY15 | |
| | **M.** Telemedicine (NV00250) paid in FY15 | |
| | **N.** Other paid in FY15 (Enter total and attach separate list) | |
| | | |
| | **TOTAL MEDICAL EXPENSES PAID IN FY15** | $0 |

# WCS FY Claims Activity Report
# Part 4 - Rehabilitation Expenditures

**PART 4 - REHABILITATION EXPENDITURES**

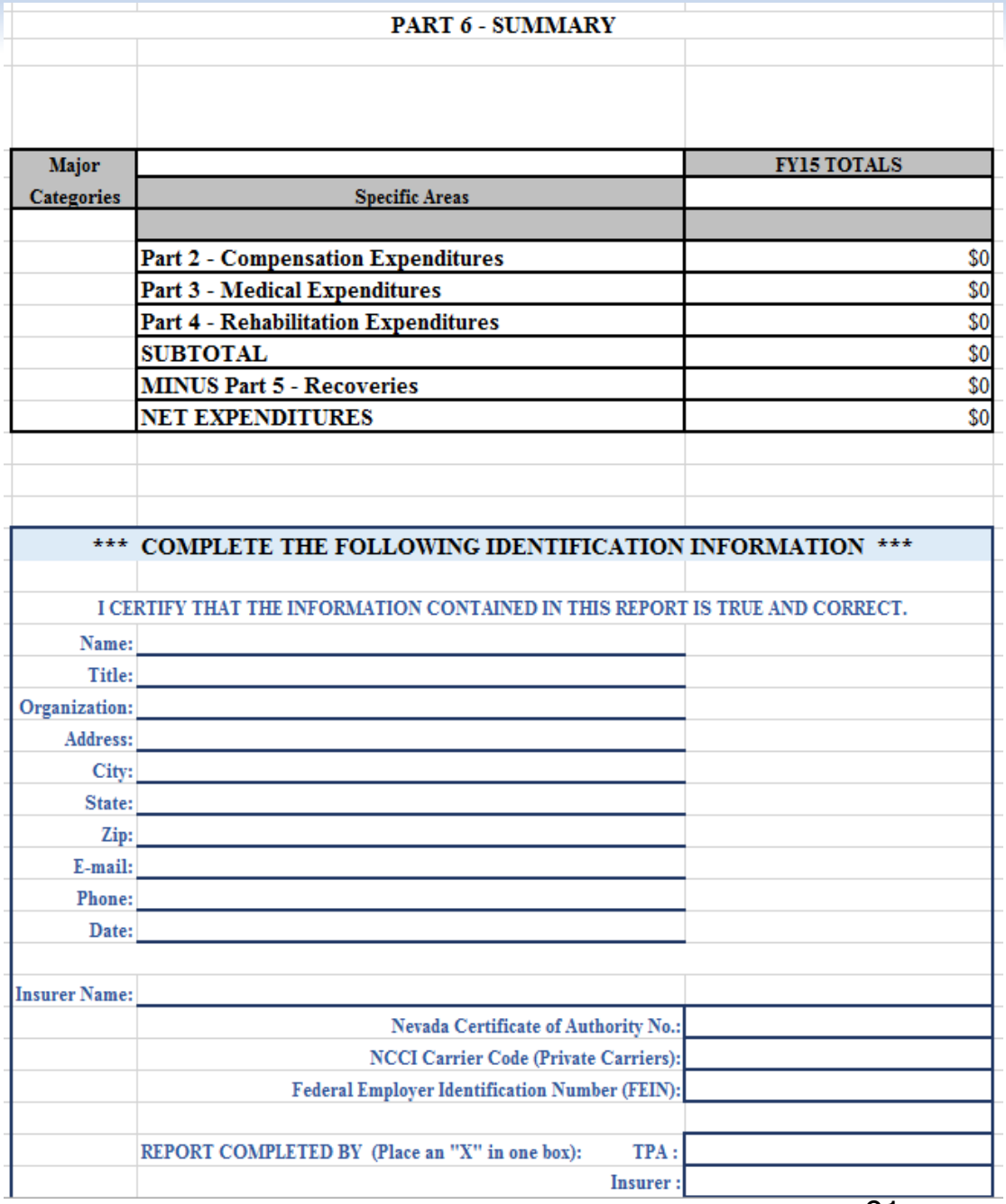
| | Specific Areas | AMOUNT PAID IN FY15 |
|---|---|---|
| | | |
| | A. Maintenance Payments (Paid instead of TTD while in Rehab.) paid in FY15 | |
| | B. Rehabilitation Buy Outs (Lump Sum) paid in FY15 (See Part 1, Line R.) | |
| | C. Program Expenses paid in FY15 (Schooling, training, supplies, etc.) | |
| | D. Administrative Expenses paid in FY15 (Vendor Expenses) | |
| | E. Other paid in FY15 (Enter total and attach separate list) | |
| | | |
| | TOTAL REHABILITATION EXPENSES PAID IN FY15 | $0 |

# WCS FY Claims Activity Report
# Part 5 - Recoveries

| Q | R | S |
|---|---|---|
| | **PART 5 - RECOVERIES** | |
| | | **AMOUNT RECOVERED IN FY15** |
| | **Specific Areas** | |
| | | **(ENTER POSITIVE (+) VALUES ONLY)** |
| | **A.** Subrogation Recoveries in FY15 | |
| | **B.** Subsequent Injury Fund (Payments received in FY15) | |
| | **C.** Reimbursements from Excess Insurance (SIEs and Assocs Only) in FY15 | |
| | **D.** Reimbursements from Reinsurance (Private Carriers Only) in FY15 | |
| | **E.** Reimbursements from Deductibles (Private Carriers Only) in FY15 | |
| | **F.** Other (Enter total and attach separate list) in FY15 | |
| | | |
| | **TOTAL AMOUNT RECOVERED IN FY15** | $0 |

# WCS FY Claims Activity Report

## Part 6 - Summary



PART 6 - SUMMARY

| Major Categories | Specific Areas | FY15 TOTALS |
|---|---|---|
| | Part 2 - Compensation Expenditures | $0 |
| | Part 3 - Medical Expenditures | $0 |
| | Part 4 - Rehabilitation Expenditures | $0 |
| | SUBTOTAL | $0 |
| | MINUS Part 5 - Recoveries | $0 |
| | NET EXPENDITURES | $0 |

*** COMPLETE THE FOLLOWING IDENTIFICATION INFORMATION ***

I CERTIFY THAT THE INFORMATION CONTAINED IN THIS REPORT IS TRUE AND CORRECT.

Name:
Title:
Organization:
Address:
City:
State:
Zip:
E-mail:
Phone:
Date:

Insurer Name:

Nevada Certificate of Authority No.:
NCCI Carrier Code (Private Carriers):
Federal Employer Identification Number (FEIN):

REPORT COMPLETED BY (Place an "X" in one box): TPA :
Insurer :

# Insurer Reporting Requirements

## Statement of Inactivity

- Insurers with zero claims activity in the fiscal year must submit a ***Statement of Inactivity*** instead of the *Claims Activity Report*
- Insurers must also submit the ***Insurer Information Form***
- *Statement of Inactivity* may be submitted electronically or by hardcopy

# WCS FY Statement of Inactivity

State of Nevada
Department of Business and Industry
Division of Industrial Relations
WORKERS' COMPENSATION SECTION

## FY15 STATEMENT OF INACTIVITY

(JULY 1, 2014 THROUGH JUNE 30, 2015)
Workers' Compensation Insurers (Active and Inactive)
Submit in lieu of the *FY15 WCS Workers' Compensation Claims Activity Report*

**DUE DATE: JANUARY 8, 2016**

**Email:** wcsra@business.nv.gov
**Mail:** State of Nevada
Division of Industrial Relations
Workers' Compensation Section
1301 North Green Valley Parkway, Suite 200
Henderson, NV 89074
*Attention: Research and Analysis*
**Fax:** (702) 990-0364

***I certify that there has been no claims activity during Fiscal Year 2015 for the workers' compensation insurer named below.***

| |
|---|
| **Insurer Name:** |
| **Nevada Certificate of Authority Number:** |
| **NCCI Carrier Code (Private Carriers):** |
| **NCCI Group Code (Private Carriers if applicable):** |
| **Federal Employer Identification Number (FEIN):** |

| | | |
|---|---|---|
| **Completed by:** | | |
| **Title:** | | |
| **INSURER** ☐ | **TPA** ☐ | **OTHER** ☐ |
| **Company:** | | |
| **Address:** | | |
| **City:** | **State:** | **Zip:** |
| **Telephone:** | **Fax:** | |
| **Email Address:** | | |

**Signature** **Date**

Rev. 11/15

# TPA Reporting

# TPA Reporting Requirements

## TPA Information Form

- ❑ Contact Information
- ❑ Claims Handled Data NRS 616D.120(4)(b)
- ❑ Records Storage Locations

Use the TPA Information Form throughout the year to report changes to address, phone, fax, contacts, etc.

# TPA Info Form


# FY-- TPA Information Form

State of Nevada
Department of Business & Industry
Division of Industrial Relations
WORKERS' COMPENSATION SECTION

## FY15 TPA INFORMATION FORM

(July 1, 2014 through June 30, 2015)
Workers' Compensation Third Party Administrators

**DUE DATE: OCTOBER 21, 2015**
(ALSO submit this form within 30 days of any changes/updates during the year)

**Email:** wcsra@business.nv.gov
**Mail:** State of Nevada
Division of Industrial Relations
Workers' Compensation Section
1301 North Green Valley Parkway, Suite 200
Henderson, NV 89074
*Attention: Research and Analysis*
**Fax:** (702) 990-0364

**Every Third Party Administrator must supply the following information to the DIR no later than October 21, 2015. Failure to provide this information may result in administrative fines pursuant to NAC 616A.410 and NAC 616D.415.**

**This form can also be found on the DIR Web site at** http://dir.nv.gov/WCS/Insurer-TPA_Reporting/

| **Main Physical Nevada Address** | | |
|---|---|---|
| TPA Name: | | TPA License # |
| Street: | | FEIN # |
| City: | State: | Zip: |
| Contact Name: | Title: | |
| Phone: | Fax: | |
| Email: | C-4/Claims Nevada Fax: | |
| **Main Mailing Address** (If different from physical address; for out-of-state addresses attach a waiver) | | |
| Street: | | |
| City: | State: | Zip: |
| Contact Name (If different from above): | | Title: |
| Phone: | Fax: | |
| Email: | | |
| **Additional Address** (If applicable; for out-of-state addresses you must attach a waiver) | | |
| ☐ Physical Nevada Address ☐ Mailing | | |
| Street: | | |
| City: | State: | Zip: |
| Contact Name (If different from above) : | | Title: |
| Phone: | Fax: | |
| Email: | C-4/Claims Nevada Fax: | |

# TPA Info Form


# FY-- TPA Information Form p. 2

State of Nevada
Department of Business and Industry
Division of Industrial Relations
WORKERS' COMPENSATION SECTION

## FY15 TPA INFORMATION FORM

| **Additional Address** (If applicable; for out-of-state addresses you must attach a waiver; for more locations add attachment) | | |
|---|---|---|
| ☐ Physical Nevada Address ☐ Mailing | | |
| Street: | | |
| City: | State: | Zip: |
| Contact Name (If different from above): | | Title: |
| Phone: | | Fax: |
| Email: | | C-4/Claims Nevada Fax: |

## OFF-SITE LOCATION OF RECORDS

| Add attachment for additional off-site locations | | |
|---|---|---|
| Location of Records: | | |
| Street: | | |
| City: | State: | Zip: |
| Contact Name: | Title: | |
| Telephone: | | |
| Email Address: | Contract Exp Date: | |

## STATEWIDE WORKERS' COMPENSATION CLAIMS HANDLED DATA

The Administrator of the Division of Industrial Relations (DIR) is required by NRS 616D.120(4) to take into consideration the number of workers' compensation claims handled during a specified period when calculating a benefit penalty. The DIR has defined "claims handled" to be the sum of workers' compensation claims accepted, denied, and reopened in a given fiscal year.

| **Number of claims:** | **Accepted (A)** | **Denied (B)** | **Reopened (C)** | **Total WC Claims Handled (A+B+C)** |
|---|---|---|---|---|
| **FY15** (7/1/14 – 6/30/15) | | | | |

| Name of Individual Completing Form: | | |
|---|---|---|
| Company: | Title: | |
| Street: | | |
| City: | State: | Zip: |
| Telephone: | Fax: | |
| Email Address: | | |
| Signature: | Date: | |

# Research and Analysis Unit


Email: WCSRA@business.nv.gov

Phone: 702 486-9080

Fax: 702 990-0364

Mail: State of Nevada
Division of Industrial Relations
Workers' Compensation Section
1301 N. Green Valley Parkway, Ste. 200
Henderson, NV 89074
Attention: Research & Analysis Unit


Website: http://dir.nv.gov/WCS/Home/

# Questions