Workers' Compensation

FREQUENTLY ASKED QUESTIONS–MEDICAL PROVIDERS

Must I evaluate and treat every patient with a work-related injury?

In the event of an emergency, you must evaluate and treat the injured worker.

If the injury is non-emergent, it is recommended that you verify whether you are a contracted provider for that employer, insurer or third-party administrator (TPA) to ensure payment for services rendered. If you do treat the injured worker, you must complete and forward the appropriate copy of the Form C-4, *Employee's Claim for Compensation/Report of Initial Treatment* to the **correct** insurer and the **correct** employer. NRS 616B.527, NRS 616C.090

Also, it is your responsibility to inform the injured worker of his workers' compensation rights, which includes the completion of Form C-4. Form D-2, *Brief Descriptions of Rights and Benefits*, must be printed on the reverse side of the injured worker' copy of the C-4 or provided to the injured worker as a separate document with an affirmative statement acknowledging receipt. NRS 616C.090, NRS 617.352, NAC A.480

How may I obtain the Form C-4 and other necessary forms?

Forms and Worksheets may be found on the WCS website: http://dir.nv.gov/WCS/home/.

What are the Form C-4 requirements?

Within 3 working days after treating an injured worker, you must complete Form C-4, *Employee's Claim for Compensation/Report of Initial Treatment* and forward the appropriate copy to the **correct** employer and the **correct** insurer. A copy of the Form C-4 form must be retained in the injured worker's file. It is the health care provider's responsibility to contact the employer or insurer/TPA to confirm the name and address of the correct insurer/TPA. Please refer to the directions given below.

A Form C-4 must be completed even if you do not consider the injury or occupational disease to be work-related. The compensability of the claim lies with the insurer, not the health care provider, nor the employer. The Form C-4 must be completed in its entirety, including signature and date, and any limitations and/or restrictions assigned. Please note, an insurer or TPA has 30 days from receipt of the Form C-4 to accept or deny the claim. NRS 616C.040, NRS 617.352

How can my office staff locate the correct insurer/TPA?

You must send the completed Form C-4 to the correct insurer or TPA. The first step is to ask the injured worker. The next step is to contact the employer. He is required to know who his insurer is.

The Coverage Verification Service is a limited portal into the National Council on Compensation Insurance's database which allows access to private carrier information for employers. To access this portal, visit the Workers' Compensation Section website: http://dir.nv.gov/WCS/home/. The health care provider must **always** contact the insurer/TPA listed to verify the correct information.

For information on self-insured employers and associations of self-insured employers, visit the Division of Insurance Web page: http://doi.state.nv.us/ and select the "Help Me Find…" tab > Self-Insured Workers' Compensation. Select either the "Self-insured Workers' Compensation" or "Association" list.

If, despite all your efforts, you are unable to locate the correct insurer/TPA within 3 business days, you must call the WCS for assistance in locating this information. If the WCS is unable to locate the insurer at that time, you will be asked to send to the WCS the Form C-4 and any notes documenting your efforts to locate the correct insurer/TPA. NAC 616C.080

What if the injured worker or his employer asks me not to send in a Form C-4?

You must complete in its **entirety**, both the upper and lower portion of Form C-4 if a patient reports a work-related injury or condition. A copy of the Form C-4 must then be forwarded to the **correct** employer and **correct** insurer even if the injured worker has refused to complete the employee portion or you have been asked not to file. Document the injured worker's refusal on the upper portion of Form C-4.

What do I do if the employer asks me to bill him directly?

Unless the employer is self-insured, the insurer or third-party administrator is responsible for payment of any medical services provided to the injured worker relating to the accepted industrial injury and/or condition.

May a physician's assistant or nurse practitioner complete a Form C-4?

Yes, the physician or chiropractor, who has the responsibility to complete Form C-4, may delegate the completion of the form to a medical facility, physician's assistant or nurse practitioner. However, a physician must always countersign a Form C-4.

What are the consequences if I fail to complete or send in a Form C-4 on time?

Administrative fines may be imposed if Form C-4 is incomplete and/or not submitted within 3 working days to the **correct** employer and insurer. Benefit penalties and administrative fines may be imposed if a medical provider refuses to complete and distribute Form C-4 as required and/or induces or influences a patient not to file a workers' compensation claim. NRS 616C.040, NRS 616D.120

What do I do if I suspect workers' compensation fraud?

Report suspected fraud to the AG Fraud Hotline: 1-800-266-8688. More information for detecting possible fraud is available on the Attorney General website at: http://ag.nv.gov/.

What if the employer does not have workers' compensation insurance?

Send the completed Form C-4 and the bill to the WCS with a cover letter stating the employer does not have workers' compensation insurance. The WCS Employer Compliance Unit investigates suspected uninsured employers and determines whether there is coverage. Once it is determined that the employer has no coverage, the claim will then be submitted to the Uninsured Employers' Account. If accepted, the injured worker will receive the same rights and benefits afforded any other injured worker under NRS 616 and 617.

Must I obtain prior authorization for everything?

The treating physician or chiropractor must request **written authorization** before ordering or performing any one of the following services with an estimated billed amount of $200 or more:

- Treatment
- Consultation
- Diagnostic testing
- Elective hospitalization
- Any surgery which is to be performed under circumstances other than an emergency; or
- Any elective procedure

In addition, treatment for codes 97001 to 97799, exclusive of 97545, 97546, and 98925 to 98943, consisting of more than 6 visits, requires prior authorization. NAC 616C.129 Telemedicine also reaches the anticipated cost of $200 or more. Check the current Medical Fee Schedule for further information regarding telemedicine.

What if I request prior authorization and the insurer or TPA does not respond?

An insurer must respond to a **written request** for prior authorization for treatment, diagnostic testing, or consultation within 5 working days. If the insurer does not respond within 5 working days, authorization shall be deemed to be given. However, the insurer may subsequently deny the authorization. NRS 616C.157

How many treating physicians or chiropractors may an injured worker have?

There may be only one treating physician or chiropractor unless the insurer provides prior written authorization for the injured worker to receive treatment by more than one physician or chiropractor. NRS 616C.090

Physicians and chiropractors associated with the treating physician or chiropractor may treat the injured worker during the temporary absence of the treating physician or chiropractor. Physicians in emergency departments are not considered "treating physicians." NAC 616C.129

Is a specific progress report form required?

The physician or chiropractor must use Form D-39, *Physician's Progress Report – Certification of Disability*. The Form D-39 must be completed in its entirety to include a signature and date and any limitations and/or restrictions assigned. A copy of this form, as well as all other forms, may be obtained from the WCS website: http://dir.nv.gov/WCS/home/. NAC 616A.480

Are there workers' compensation standards of care?

Yes. The standards of care adopted by the Division of Industrial Relations are the current *Occupational Medicine Practice Guidelines* of the American College of Occupational and Environmental Medicine. The guidelines are published by Reed Group, Ltd and are available with a paid subscription. Information is available at http://www.mdguidelines.com. NRS 616C.250, NAC 616A.480

Must I prescribe generic drugs?

Yes. A provider must prescribe a generic drug in lieu of a brand name drug if the generic drug is biologically equivalent and has the same active ingredient or ingredients of the same strength, quantity and form of dosage as the brand name drug. NRS 616C.115

Is there specific language to use when the injured worker reaches maximum medical improvement?

Yes. To be consistent with statute, when the treating physician or chiropractor feels the injured worker has reached maximum medical improvement, the term "stable" should be used. If the treating physician or chiropractor deems the injured worker may have suffered a permanent impairment, the term "ratable" should also be used. NAC 616C.103

How may I join the Treating Panel of Physicians and Chiropractors?

To become a member of the Treating Panel, a licensed physician or chiropractor must complete the "Application – Panel of Treating Physicians and Chiropractors" and submit the completed application to the Henderson office of WCS for processing. Upon completion, the health care provider will be notified and an informational packet will be sent. An application may be obtained from the WCS website http://dir.nv.gov/WCS/Medical_Providers/.

Please explain billing and payment regulations.

Billings for health care services must be submitted within 90 days after the date on which the services were rendered unless good cause is shown for a later billing. In **no** event may an initial billing or request for reconsideration for health care services be submitted later than 12 months after the date on which the services were rendered unless claim acceptance is delayed beyond 12 months because of claim's litigation. The medical report must be attached to any bill sent to the insurer/TPA. Please note the following:

- An insurer must pay or deny a bill within 45 calendar days after receipt
  - If the insurer does not pay within 45 days, interest may be due to the medical provider
- An insurer is obligated to provide an explanation of benefits (EOB/EOR) for each code billed
  - An insurer cannot change billing codes

- The insurer may return the bill and request additional information

Under what circumstances may I charge an injured worker?

If a provider of health care accepts an injured worker for the treatment of an industrial injury or occupational disease, the injured worker may not be charged for any treatment related to the industrial injury or occupational disease. The insurer must be charged.

An injured worker may be charged when his employer is uninsured and WCS has issued a determination to not assign the workers' compensation claim to the Uninsured Employers' Account.

You may charge an injured worker when his claim is closed and he is seeking medical documentation to reopen the claim. You may also charge an injured worker for any treatment unrelated to the industrial injury or if his claim has been denied. Otherwise, never charge an injured worker for any treatment related to the claim. Payment may be accepted from the injured worker or his health insurer for treatment the injured worker alleges is related to the industrial injury or occupational disease *which the insurer or third-party administrator has denied liability for.*

What recourse do I have if my bill is reduced or denied?

If your bill has been reduced or denied by an insurer you may, within 60 days of receiving notice of the reduction or denial, request the WCS to review that action. The WCS will investigate and make a payment determination. NAC 616C.027

What may I bill for witness fees?

A physician or chiropractor that is called to testify is entitled to receive the same fees as witnesses in civil cases. These fees may exceed the fees in the Nevada Medical Fee Schedule. NRS 616C.350

Does Nevada have a Medical Fee Schedule?

Yes. Payment from insurers cannot exceed the Medical Fee Schedule. However, payment may be less than the Medical Fee Schedule if the provider has a contract with the insurer. The appropriate Medical Fee Schedule corresponds to the date of service.

A medical provider is to use the most recent editions, or updates of the following publications for the billing of workers' compensation: *Relative Values for Physicians*, *Relative Value Guides of the American Society of Anesthesiologists*, and Medicare's current reimbursement for HCPCS codes K & L for custom orthotics and prosthetics. ASC reimbursement, providers' service code conversion factors and the Nevada specific codes are contained in the Medical Fee Schedule on the WCS website: http://dir.nv.gov/WCS/Medical_Providers/

Where can I access the Nevada Medical Fee Schedule, ASC codes, DME and K&L codes, and the WCS Medical Unit information on the internet?

To access all of the above and more, visit the WCS website: http://dir.nv.gov/WCS/Medical_Providers/

How may I obtain more information about workers' compensation?

To obtain more information about workers' compensation, please visit the WCS website: http://dir.nv.gov/WCS/home/ or you may contact the Workers' Compensation Section: WCSHelp@business.nv.gov