Division of Industrial Relations – Workers' Compensation Section (WCS)

RATING PANEL OF PHYSICIANS AND CHIROPRACTORS APPLICATION

Pursuant to NRS 616C.490, the Division of Industrial Relations shall establish a list of physicians and chiropractic physicians to determine the percentage of disability in accordance with the AMA *Guides to the Evaluation of Permanent Impairment, 5TH Edition*. To apply to be added to the WCS Rating Panel of Physicians and Chiropractors, please complete, then email the completed application to medpanels@dir.nv.gov. The following documentation must also be provided when the application is submitted: Current Curriculum Vitae, certificates of course completion and examination results from the American Board of Independent Medical Examiner (ABIME), examination results after completion of Nevada Impairment Rating Skills Assessment Test (NIRSAT). If you have any questions, please contact the Medical Unit at medpanels@dir.nv.gov.

Physician/Chiropractor Applicant Information

First Name: Last Name: Middle Init:

License Type (MD/DO/DC): NV License Nbr:

Email:

Phone: Specialty(ies):

Rating Locations (all locations MUST be in NV) – may attach additional locations, if needed.

Primary location highlighted in yellow.

Name of Primary Practice: **Phone Nbr:**

Address: **Fax Nbr:**

City: **State:** **Zip:**

Name of Practice: **Phone Nbr:**

Address: **Fax Nbr:**

City: **State:** **Zip:**

Name of Practice: **Phone Nbr:**

Address: **Fax Nbr:**

City: **State:** **Zip:**

Name of Practice: **Phone Nbr:**

Address: **Fax Nbr:**

City: **State:** **Zip:**

RATING PANEL OF PHYSICIANS AND CHIROPRACTORS APPLICATION

Applicant Name: _____ Date: _____

Check Yes or No

Please explain answers marked with an * on a separate sheet along with supporting documentation including locations and dates.

☐ YES* ☐ NO Have you ever been licensed in a state other than Nevada? Please provide state(s) and dates.

☐ YES* ☐ NO Has your license to practice medicine/chiropractic in any jurisdiction ever been denied, revoked, voluntarily or involuntarily terminated, relinquished, suspended, otherwise limited or restricted or been made subject to a program of probation, or have you ever been issued a citation or letter of reprimand by the licensing agency, or have formal or informal proceedings, or investigations, toward any of those ends ever been commenced?

☐ YES* ☐ NO Has disciplinary action ever been filed against you by any workers' compensation authority, Medicare, or Medicaid (CMS), medical facility, health maintenance organization, or professional practice board/society/association for fraud, medical billing fraud, substance abuse, prescribing controlled substances or quality of patient care?

☐ YES* ☐ NO Have you ever been sanctioned for unprofessional conduct or discriminatory treatment in the care and/or treatment of patients in any state?

☐ YES* ☐ NO Has your Drug Enforcement Agency or other controlled substances authorization ever been denied, revoked, voluntarily or involuntarily terminated, suspended, or restricted or have formal or informal proceedings, or investigations toward any of those ends ever been commenced?

☐ YES* ☐ NO Have you ever been convicted of a criminal offense other than a minor traffic violation?

☐ YES* ☐ NO Has the State of Nevada, Division of Industrial Relations ever issued a warning to you or imposed an administrative fine on you?

☐ YES* ☐ NO Have you ever been suspended or removed from: the WCS Panel of Treating Physicians and Chiropractors, the WCS Rating Panel of Physicians and Chiropractors, or any other provider list as a disciplinary measure in Nevada or another state?

RATING PANEL OF PHYSICIANS AND CHIROPRACTORS APPLICATION

Applicant Name: _____ Date: _____

Attestations

Please read and initial indicating your understanding and agreement with each statement.

_____ The information provided is both complete and accurate to the best of my knowledge. I understand that providing inaccurate information or documentation may result in the denial of this application. Incomplete applications will not be processed.

_____ I agree to comply with the provisions of Chapters 616A through 617, inclusive, of the NRS and NAC. Failure to do so may result in disciplinary action including suspension or removal from the Rating Panel of Physicians and Chiropractors (NAC 616C.024).

_____ I agree to notify the State of Nevada, Division of Industrial Relations (DIR) Workers' Compensation Section Medical Unit in writing of any changes to any of the information provided in this application packet, including, but not limited to, name of practice, address(es), email address, telephone number(s), and/or licensing board status within 14 days of the changes.

_____ I agree to comply with the billing practices and reimbursement described in the NRS and NAC and the Nevada Medical Fee Schedule for Workers' Compensation (available at http://dir.nv.gov/WCS/home/), which is updated annually.

_____ I agree to notify WCS within two business days by email if I wish to decline a random assignment for a permanent partial disability (PPD) evaluation because I believe I do not have the ability to rate the disability at issue. If I do not decline an assignment within two business days, I automatically accept the assignment.

_____ I agree to accept all assignments for permanent partial disability (PPD) evaluations, unless an inappropriate assignment is made, as long as I remain active on the WCS Rating Panel of Physicians and Chiropractors.

_____ I agree to schedule and perform PPD evaluations within 30 days after receipt of requests.

_____ I agree to serve without compensation on a review panel of rating physicians and chiropractors, for a minimum of one year, if selected by the Administrator or designee.

_____ I agree to email/mail each PPD evaluation report to the requestor and to the DIR/WCS Medical Unit (PPDreports@dir.nv.gov) within 14 days after completing the evaluation, and email/mail each addendum to the requestor and to DIR/WCS Medical Unit within 14 days after receiving the request.

RATING PANEL OF PHYSICIANS AND CHIROPRACTORS APPLICATION

Applicant Name: _____ Date: _____

_____ I agree to immediately notify the DIR/WCS Medical Unit at medpanels@dir.nv.gov whenever I cannot accept assignments due to being temporarily unavailable or if I receive an inappropriate assignment (NAC 616C.021).

_____ I agree to complete and submit to the DIR/WCS Medical Unit documentation of biennial completion of a course approved by the Administrator on rating impairments in accordance with the AMA Guides, 5th edition.

_____ I have a copy of the *AMA Guides to the Evaluation of Permanent Impairments, 5th edition.*

The following documentation must be provided when the application is submitted:

☐ Current Curriculum Vitae,
☐ Certificate of 8-hour course completion regarding AMA Guides to the Evaluation of Permanent Impairment, 5th edition (AMA Guides, 5th edition) from the American Board of Independent Medical Examiner (ABIME),
☐ Examination results after completion of ABIME exam regarding AMA Guides, 5th edition
☐ Examination results after completion of Nevada Impairment Rating Skills Assessment Test (NIRSAT).

I attest that I have read and understood this completed application.

_____ _____

Physician/Chiropractor Applicant Original Signature Date