



THE PULSE

Medical Unit Newsletter

Department of Business & Industry
Workers' Compensation Section

Division of Industrial Relations
Spring 2016

This newsletter is not intended to provide legal advice to the reader. Legal opinions or interpretations of statutes and regulations referenced should be sought from legal professionals.

2016 Brings Changes to Nevada's Medical Fee Schedule

Nevada Revised Statute (NRS) 616C.260 mandates the Administrator of the Division of Industrial Relations (DIR) establish and maintain a schedule of reasonable fees and charges allowable for accident benefits for injured employees. This schedule of reasonable fees and charges is what is commonly known as the Nevada Medical Fee Schedule (MFS). The MFS is revised annually according to the Consumer Price Index for medical services of the prior year. This value is not released until near the end of January the following year, thus necessitating a slight delay in posting the new MFS to no later than February 1 of each year. The same statute (NRS 616C.260) also requires that the Administrator periodically designate a vendor to compile data nationally concerning similar services provided to injured employees in Nevada "as the Administrator deems necessary" to revise the MFS. In 2014, the DIR released a request for proposal for this study and Milliman, Inc. was eventually selected as the successful vendor. The collection and benchmark analysis of data began, using as much data concerning Nevada workers' compensation claims as possible. Milliman, Inc. released their final report in January, 2015 and the process of reviewing the recommendations and soliciting stakeholder input began. Finally, on January 28, 2016, the new MFS was posted on the DIR Workers' Compensation Section website, Medical Information webpage.

There are a number of important changes to this year's MFS. Some of the "changes" noted in the MFS are not actually changes. The information reflects how the MFS has been applied for years although the information was not previously detailed in the MFS. Other information is brand new and a summary of these changes is the purpose of this article. Many reimbursement rates have also been increased. Please refer to the current MFS to reference all of these revisions.

Modifier "-28" Page 2 of the MFS describes the use of a new modifier, "-28." This modifier is to be used when an anesthesiologist supervises other licensed personnel (up to four persons) who are directly providing anesthesia services. Reimbursement is 25% of the maximum allowed for the anesthesiologist if he/she were providing the services themselves. The licensed personnel directly providing the anesthesia, must bill their services using modifier "-29" and will be reimbursed at 85% of the maximum allowed for the anesthesiologist.

Hospital Reimbursement There are three significant changes in billing inpatient hospital services. The first is the combination of various types of intensive care levels of service to one per diem reimbursement rate (NV00200). The second is the addition of a per diem reimbursement rate for various intensive care "step-down units" (NV00450). These units provide a higher level of service than that on a general medical-surgical floor and a lower level of service than is usually provided in an intensive care unit. The third change is the addition of reimbursement rates for "observation stays" (NV00650 and NV00675). Observation stays are used in different situations. An observation level of care provides health care providers time to observe a patient and determine if continued hospitalization is needed and/or until an inpatient bed is available. Observation stays often precede formal admission to the hospital or precede discharge from the hospital/emergency department. There are two different methods of calculating reimbursement based on the time spent in "observation." Page 3 of the MFS details both an hourly rate for observation stays up to 23 hours (NV00675) and a per diem rate for observation stays of more than 23 hours (NV00650). Please note, Nevada Specific Codes are required for accurate reimbursement per the MFS. Bills that do not contain Nevada Specific Codes for specific services provided and listed in the MFS may

Changes to Nevada's Medical Fee Schedule continued...

Ambulatory Surgical Center (ASC) and Outpatient Hospital Surgical Reimbursement Previously, Nevada workers' compensation used the CMS 2007 list of surgical codes and groups as do many other states. However, there is an escalating problem with unlisted codes as new CPT codes are added regularly. DIR does not have the staff or resources available to constantly review these new CPT codes and place them in the appropriate reimbursement groups for similar procedures. Fortunately, Nevada Medicaid also uses the 2007 CMS list and updates their list regularly. Therefore, Nevada workers' compensation is now utilizing Nevada Medicaid's expanded list of CPT codes and procedures. A link to this list is posted on the DIR Workers' Compensation Section's Medical Providers webpage under the list of medical fee schedules. Additional flexibility is allowed for reimbursement of unlisted codes, or those codes that are not assigned a numeric group, due to the broad range of unlisted CPT codes and payer resources. Unlisted codes may be reimbursed at the Group 8 rate, billed charges, or usual and customary reimbursement in Nevada for comparable procedure codes, whichever is **less**.

Pharmaceutical Reimbursement Senate Bill 231, passed in the 2015 legislative session and effective January 1, 2016, mandated limitations of physician dispensed controlled substances (Schedule II and III controlled substances) to an initial 15 day supply only. Although this new law has not been codified yet by the Legislative Council Bureau, the specifics of the law may be found on the Nevada Legislature website. The matter is addressed in Chapter 239, Section 1, Statutes of Nevada (2015) (Senate Bill 231, Section 1, 78th Session (2015)). As is currently DIR's practice, the MFS does not quote the applicable statutes and regulations directly; however, the MFS does contain references to these laws and many links to the applicable statutes and regulations are provided for stakeholders' convenience.



Another new addition to pharmaceutical reimbursement in the MFS is prior authorization and billing requirements for compound medications. The prescribing physician or chiropractor must include justification of the medical necessity for and efficacy of the compounded medication instead of, or in addition to, standard medication therapies. The health care provider and the insurer/third-party administrator (TPA) must agree on both the quantity of the medication to be dispensed as well as reimbursement for the compound medication **before** the medication is dispensed. Medical bills for compound medications must list each ingredient of the compound and include a National Drug Code (NDC) for each ingredient. The insurer/TPA is not required to reimburse any compound ingredient lacking a valid NDC. Pursuant to NRS 616C.135, the health care provider may not charge an injured employee for services related to their accepted workers' compensation claim. Therefore, the prior authorization and billing requirements for compound medications should be carefully noted by involved parties.

Independent Medical Evaluations (IMEs) Stakeholders requested DIR designate a reimbursement methodology and rate for IMEs. Again, there is broad variation in the complexity and time required for these evaluations. So therefore, methodology described on page 6 of the MFS includes a base rate (NV02001) and additional fees for review of medical records (NV02002), more than two body parts (NV02003) and organization of medical records chronologically by date of service (not date of receipt NV02004). There is also a fee for failure of an injured employee to appear for an appointment (NV02000). The description of a "body part" is the same as that used for permanent partial disability (PPD) evaluations on pages 6-7 of the MFS. Both IMEs and PPD evaluations now require the requester include a cover sheet indicating the number of pages of medical records provided to the physician or chiropractor.

Dental Reimbursement Many payers have contractual agreements with dental providers for reimbursement of various dental services. Nevertheless, stakeholders requested development of a dental fee schedule. Pages 7-8 of the MFS reflects the top dental codes billed in Nevada. The list includes the dental codes correlated with the most costly services as well as those billed most frequently. Remember, the MFS reflects the maximum reimbursement allowable; contractual discounts may still apply.

General Information Interested parties should be aware of two other changes. Initial medical bills or requests for reconsideration will not be accepted unless claim acceptance is delayed beyond one year due to claim's litigation. Secondly, NRS 616C.136 was changed in the 2015 legislative session. Awaiting codification, Senate Bill 231 also changes the time requirements for medical bill payment. Medical bills must now be denied or paid within 45 days from the date of receipt by the insurer/TPA.

As noted above, this summary is not inclusive of all updates to the MFS. Please review the current MFS for additional information. Questions or requests for additional clarification may be addressed to the Medical Unit in either the Carson City or Henderson DIR offices.

New WCS Website



After many starts and stops and rumored launches, the new WCS website has finally arrived. This website uses a more compact and space-efficient layout that makes links easier to find and ensures that information is usually no more than two clicks away.

Here's a quick site overview: the current "picture window" or main slide window alternates with photos of attractive, happy workers with a "Save the Date" slide of the 2016 Workers' Compensation Educational Conference, Aug. 18 -19. In the future, other information will be placed in the rotation with clickable links. And the conference slide will double as a registration link. On the landing page's right side a "What's Hot" area is the place for high-demand items such as the newsletter, important changes (e.g. mileage rate, maximum compensation guidelines, etc.), forms, WCSHelp and more.

In the bottom third of the page are the carousel blocks. These

photos, which will move when we add more, are a row of quick-access links for the Coverage Verification Service, C-4 processing information, the employer information page, links to NRS/NAC 616A-D/617, insurer/TPA reporting instructions and forms and related agency links to associated divisions and groups such as the Nevada Division of Insurance, the Nevada Attorney General's Workers' Compensation Fraud Unit and the National Council on Compensation Insurance, among others.

Farther down the page is the "initiative block" content under the grey bars. Here are more frequently used links including both the Rating and Treating Panels of Physicians and Chiropractors, the 2016 Medical Fee Schedule, and complaint forms to name a few.

Another striking difference site users will notice is that hovering over the "Workers' Comp" option in the brown DIR section bar produces a popup selection including dedicated information pages for employers, insurers, injured workers and medical providers. Click on the link for medical providers to access all manner of essential information and resources.

-Michael Brooks, Manager, ER&A Unit

WCS Medical Unit

Henderson Office

702-486-9080

Katherine Godwin, BSN, RN

kgodwin@business.nv.gov

Charles Newell, Compliance Investigator

canewell@business.nv.gov

Cynthia Hernandez, Admin Assistant

cyhernandez@business.nv.gov



Carson City Office

775-684-7270

Karen Beattie, BSN, RN

kbeattie@business.nv.gov

Terri Mills, Compliance Investigator

tmills@business.nv.gov