



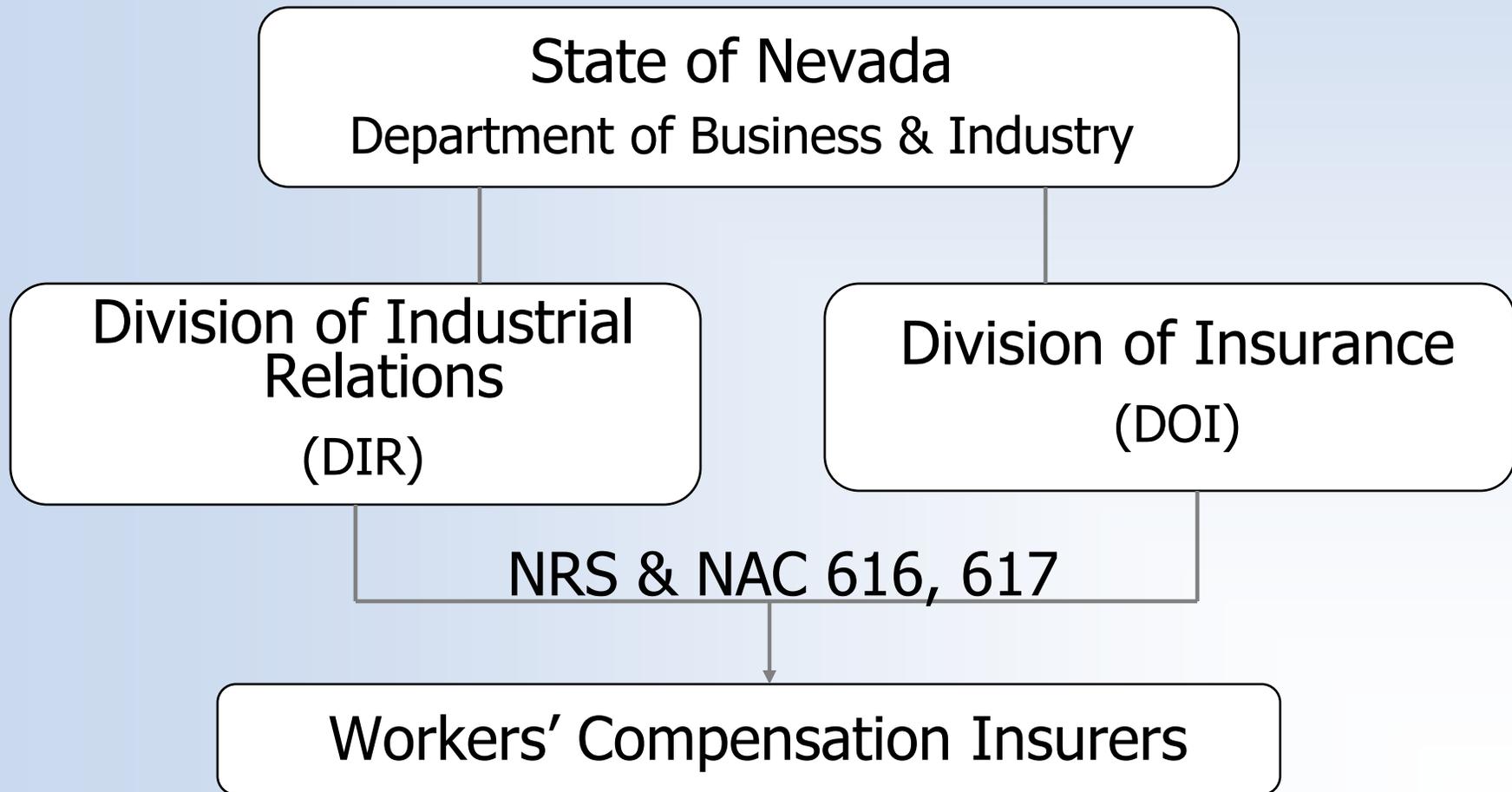
# State of Nevada Division of Industrial Relations

## Insurer & TPA Reporting

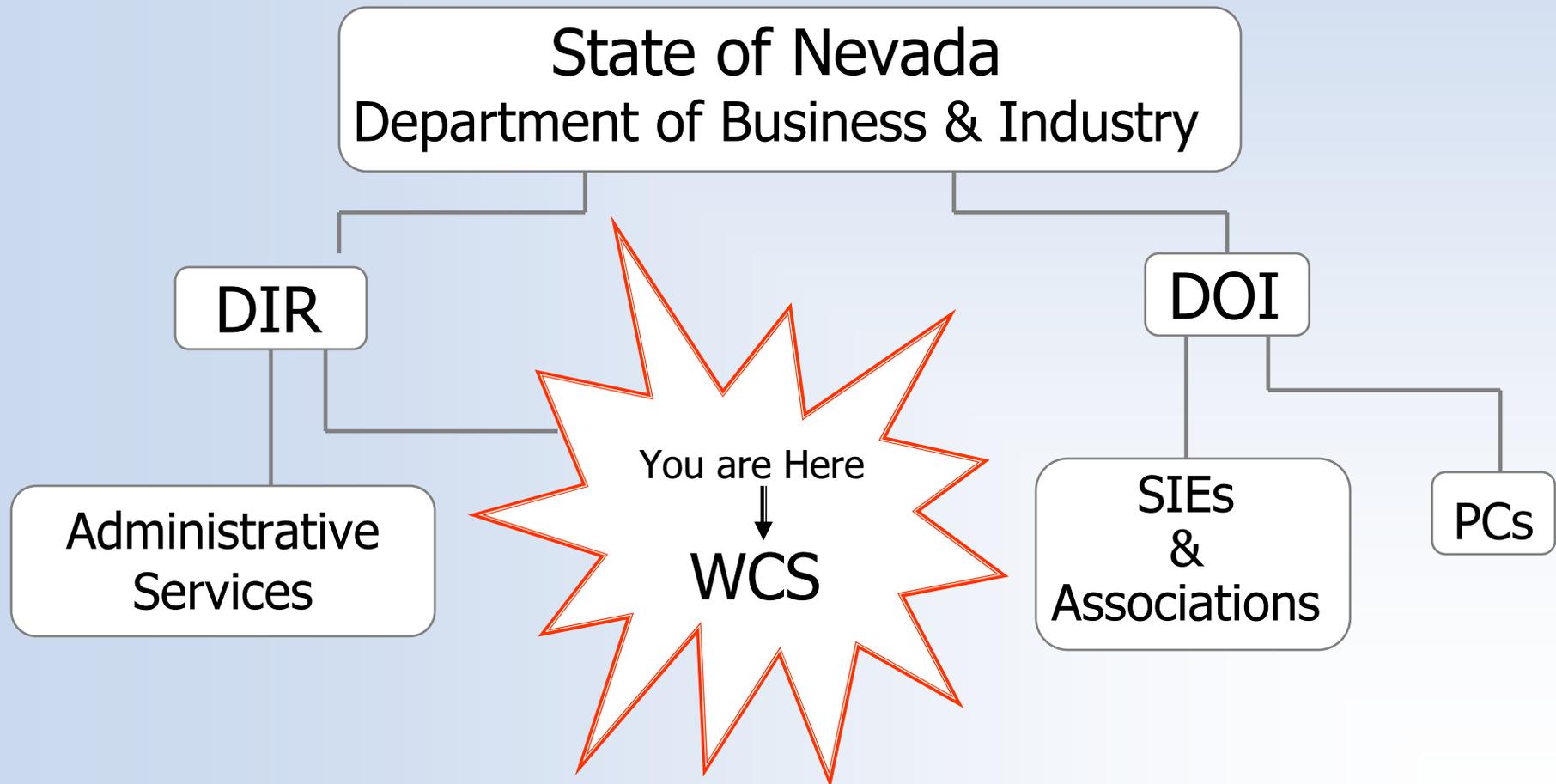


# Workers' Compensation Section

# DIR & DOI: Joint Responsibility for Regulating Insurers



# DIR & DOI: Separate Reporting Requirements



# Insurer Reporting Requirements

Every insurer has a Nevada Certificate of Authority (C of A) number issued by the Division of Insurance (DOI).

Insurer reporting must include the insurer name and Nevada Certificate of Authority number.

# Insurer Reporting Requirements

Who are insurers? (defined in NRS 616A.270)

- Private carriers (individual underwriting companies – not groups)
- Self-insured employers (SIE)
- Associations of self-insured employers

Who are NOT insurers?

- Third-party administrators (TPA)
- Private carrier groups (Chartis, CNA, Liberty Mutual, etc.)
- Insureds, employers, policyholders

# Insurer Reporting Requirements

Four things you need to know before you can report to the Workers' Compensation Section:

1. What you are (TPA, Private Carrier, SIE, etc.)
2. Who you are (correct name)
3. For which INSURER you are reporting (name & number as it appears on the Nevada Certificate of Authority )
4. What to report and when (NRS & NAC)

# Insurer Reporting Requirements

## Worksheet:

- Are you an insurer?
- What is your name and C of A number?
  
- Are you a TPA?
- Which insurers do you report for?
- What are their C of A numbers?

# Insurer Reporting Requirements

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

- SIEs and Associations ([NAC 616B.493 & .575](#))  
DIR & DOI retain jurisdiction over all claims incurred during period of self insurance until all liabilities have terminated
- PCs must notify DIR/WCS of how claims incurred will be administered after C of A is inactive

# Insurer Reporting Requirements

## Exceptions to Mandatory Reporting

- No claims incurred during the period of self-insurance or active certificate
- Liabilities for claims incurred during period of self-insurance or active certificate have been transferred to another insurer
- All potential liabilities and benefit eligibility have been exhausted (i.e., claimants deceased, dependents past eligible age, claims with no reopening potential, etc.)

Must send a written request with a full explanation for the exception

# Insurer Reporting Requirements Overview

## Ongoing Requirements (as necessary):

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

## Annual Requirements:

- Permanent Total Disability (PTD) claims
- Insurer Information Form
- WCS FY Claims Activity Report
- Statements of Inactivity, as applicable

# TPA Reporting Requirements Overview (New)

- Ongoing Requirements (as necessary)
  - Administrative changes: address, phone, fax, contacts, etc.
- Annual Requirements
  - Claims Handled Report (SB 195, 2009)
  - Records Storage Locations Reports

# Ongoing Requirements Throughout the Year (as necessary)



# Proof of Coverage (POC)

## NRS 616B.461 & NAC 616B.100-148



# Proof of Coverage (POC)

## Proof of Coverage: Data relating to WC policy

- Enables the DIR (WCS) to enforce the mandatory coverage provisions of NRS 616
- Enables DIR (WCS) to route C-4s (claims) to the proper insurer when necessary
- Enables the public to obtain coverage information via the Coverage Verification Service (CVS) on the WCS website

# Proof of Coverage

## Who Must Report:

- Private carriers writing Nevada workers' compensation policies must report POC data (Associations of self-insured public and private employers are no longer required to report.)

## 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 the DIR (WCS)

# Proof of Coverage

## Policy Transactions to report:

1. New Policies (and Binders)
2. Policy Renewals
3. Policy Reinstatements
4. Policy Reissuances
5. Policy Cancellations
6. Policy Nonrenewals
7. Endorsements/Policy Changes

# Proof of Coverage

## Deadlines:

Private carriers must report all required policy transactions within **15 days** of their effective dates

# Proof of Coverage

## Reporting Violations:

- Late Reporting
- Failure to Report
- Incorrect Reporting

## Administrative Actions for 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

# Proof of Coverage

For information on how to report POC data:

National Council on Compensation Insurance

901 Peninsula Corporate Circle

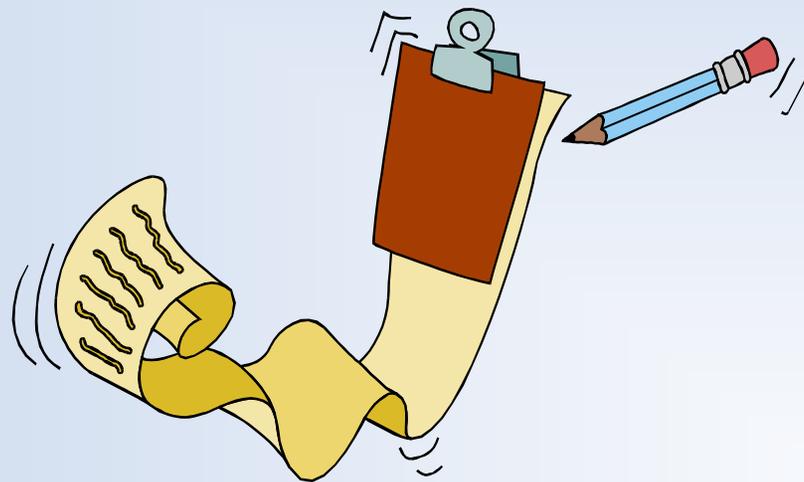
Boca Raton, FL 33487

1-800-NCCI-123 (1-800-622-4123)

[www.ncci.com](http://www.ncci.com)

# Claims Indexing

## NRS 616B.018



# Claims Indexing NRS 616B.018

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

NRS 616B.018 requires:

Submissions of initial claims information and monthly updates as specified\*

- Failure to report/reporting errors may result in \$1000 fine for initial violation and \$2000 for subsequent violation

\*WCS strongly encourages electronic submission, but D-38 form for hardcopy reporting can be found at

<http://dirweb.state.nv.us/WCS/WCS.htm> under "Workers' Compensation Forms"

# Claims Indexing NRS 616B.018

For information on reporting requirements and submission formats contact:

Cathleen Fryman, WCS Carson City

E-mail: [cfryman@business.nv.gov](mailto:cfryman@business.nv.gov)

Telephone: 775-684-7283

# Fatality/Multiple Victim Reporting NAC 616B.018



# Fatality/Multiple Victim Reporting

## NAC 616B.018

### Multiple Victim Reporting:

Insurer must notify DIR/WCS within 30 days of:

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

No specific form for reporting – a letter/memo to WCS District Manager referencing [NAC 616B.018](#) is fine.

# Fatality/Multiple Victim Reporting NAC 616B.018

## Fatality Notification:

Within 48 hours of notification insurer must notify  
DIR/WCS:

- Fatal industrial accident or
- Fatal industrial disease incident

Form D-21: Fatality Report must be submitted

# Fatality Report Form D-21

Available online at  
<http://dirweb.state.nv.us/WCS/wcs.htm>  
under "Workers'  
Compensation Forms"

**STATE OF NEVADA**  
**DEPARTMENT OF BUSINESS AND INDUSTRY**  
Division of Industrial Relations  
400 West King Street, Suite 400                      1301 N. Green Valley Parkway, Suite 200  
Carson City, Nevada 89703                              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. 1/99)

# Occupational Disease Claims

## NRS 617.357



# Occupational Disease Claims

## NRS 617.357

Insurers must submit written report of each claim for:

- Occupational disease of heart, lungs or that is infectious or relates to cancer as required by [NRS 617.357](#)

Report to DIR/WCS in writing within 30 days after claim is:

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

# Occupational Disease Claim Report Form OD-8

Available online at  
[www.dirweb.state.nv.us/WCS/wcs.htm](http://www.dirweb.state.nv.us/WCS/wcs.htm)  
 under "Workers'  
 Compensation Forms"  
 and "Insurer  
 Information"

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

**OCCUPATIONAL DISEASE CLAIM REPORT (NRS 617.357)**

Please check one only:  INITIAL REPORT  UPDATE REPORT

**ALL REPORTS (Complete this section for INITIAL REPORTS AND UPDATES)**

Date Report Submitted (to WCS): _____	
Insurer Name: _____	
Insurer Certificate Number: _____	Insurer FEIN: _____
Employer Name: _____	
Claim Number: _____	
Submitted by: _____	
Individual Name and Title (please print)	
Company: _____	Insurer <input type="checkbox"/>
Address: _____	TPA <input type="checkbox"/>
City, State, Zip: _____	Other <input type="checkbox"/>
Telephone _____	E-mail Address _____

**INITIAL & UPDATE REPORTS (Report within 30 days of acceptance/denial or any changes to the claim)**

Date Claim (C-4) Received: _____	Date of Injury: _____
Claim Disposition: <input type="checkbox"/> Accepted <input type="checkbox"/> Denied	Date Accepted/Denied: _____
Reason for Acceptance/Denial: _____	
Statute/Reg. Citation: _____	
Estimated Medical Costs of Claim: \$ _____	
Description of Nature of Claim: _____	

**NATURE OF CLAIM CODE (Select from the IAIABC Codes below):**

<input type="checkbox"/> 61 ASBESTOSIS, LUNG DISEASE FROM INHALED ASBESTOS	<input type="checkbox"/> 73 CONTAGIOUS DISEASE, UNSPECIFIED
<input type="checkbox"/> 62 BLACK LUNG, CHRONIC LUNG DISEASE/COAL	<input type="checkbox"/> 74 CANCER
<input type="checkbox"/> 63 BYSSINOSIS, PNEUMOCONIOSIS FROM COTTON, FLAX	<input type="checkbox"/> 75 AIDS
<input type="checkbox"/> 64 SILICOSIS, PNEUMOCONIOSIS FROM INHALED SILICA	<input type="checkbox"/> 79 HEPATITIS C
<input type="checkbox"/> 65 RESPIRATORY DISORDERS, GASSES, FUMES, CHEMICALS, ETC.	<input type="checkbox"/> 03 ANGINA PECTORIS, CHEST PAIN
<input type="checkbox"/> 60 DUST DISEASE, ALL OTHER PNEUMOCONIOSIS	<input type="checkbox"/> 41 MYOCARDIAL INFARCTION, HEART DISEASE/CONDITIONS
	<input type="checkbox"/> 00 OTHER BE SPECIFIC _____

Symptoms/Exposure Only: (No Confirmed Diagnosis)  YES  NO

**UPDATE REPORTS ONLY (Report within 30 days of appeal, closure, reopening, or confirmed diagnosis)**

<b>Appeal(s) of Acceptance/Denial:</b>	
Date Appeal Filed: _____	
Appeal <input type="checkbox"/> 1 <sup>st</sup> <input type="checkbox"/> 2 <sup>nd</sup> <input type="checkbox"/> 3 <sup>rd</sup> <input type="checkbox"/> Other _____	Hearing Date: _____
Decision: <input type="checkbox"/> Affirmed <input type="checkbox"/> Modified <input type="checkbox"/> Reversed <input type="checkbox"/> Remanded	Decision Date: _____
Diagnosis Confirmed: <input type="checkbox"/> YES <input type="checkbox"/> NO	
Did Nature of Claim Change? <input type="checkbox"/> YES - NEW CODE # _____ <input type="checkbox"/> NO	
Additional Information/Explanation (include clarification of activity reported): _____ _____ _____	
Initial Claim Closure Date: _____	
Date Claim Reopened (if applicable): _____	
Subsequent Claim Closure Date (if applicable): _____	

# Occupational Disease Claim Report Form OD-8

First section: “All Reports” must be completed each time there is reporting (initial and updates)

- All information **MUST** be legible
- Be sure to use the correct claim number
- Report **INSURER** Name, Certificate of Authority # and FEIN
- **Employer Name** should be specific, e.g.:
  - Insurer = MGM Resorts International, Employer = Bellagio
  - Insurer= Clark County, Employer = UMC

# Occupational Disease Claim Report Form OD-8

Second section: “Initial and/or Updated Reports” must be used to show updates required by statute to be reported

- Complete ALL spaces
  - ✓ Include correct dates and update as necessary
  - ✓ Reason for Acceptance/Denial: explain WHY the claim was accepted or denied (e.g., not in course and scope of employment)
  - ✓ Include estimated medical costs (even if \$0) and update at claim closure as necessary
  - ✓ Nature of Claim Description and Code: use these to provide as much detail about the claim as available (try to avoid using “00 Other” code)

# Occupational Disease Claim Report Form OD-8

Third section: "Update Reports Only" must be completed for each change that occurs:

- If claimant appeals claim denial, "1<sup>st</sup> Appeal" box should be checked and the date entered next to "Date Appeal Filed"
- When the results of this appeal are received, use this same form to report the decision outcome and the date
- For further appeals (claimant or insurer) of acceptance or denial, update as required

# Occupational Disease Claim Report

- Reportable Claims:
  - ✓ Submit initial and updates throughout year on Form OD-8 **within 30 days** of reportable activity
  - ✓ No need to attach the C-4 claim form
- No Reportable Claims:
  - ✓ Submit Statement of Inactivity **within 5 working days** of calendar year-end

# Occupational Disease Claim Report Statement of Inactivity

Available online at  
[www.dirweb.state.nv.us/WCS/wcs.htm](http://www.dirweb.state.nv.us/WCS/wcs.htm)

“Insurer Information”

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](mailto:WCSRA@business.nv.gov)

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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:

<b>Insurer Name:</b>
<b>Nevada Certificate of Authority Number:</b>
<b>NCCI Carrier Code (Private Carriers):</b>
<b>Federal Employer Identification Number (FEIN):</b>

<b>Name:</b>
<b>Title:</b>
<b>Organization:</b>
<b>Address:</b>
<b>City:</b> _____ <b>State:</b> _____ <b>Zip:</b> _____
<b>Telephone:</b> _____ <b>Fax:</b> _____
<b>E-mail Address:</b>

---

**Signature**

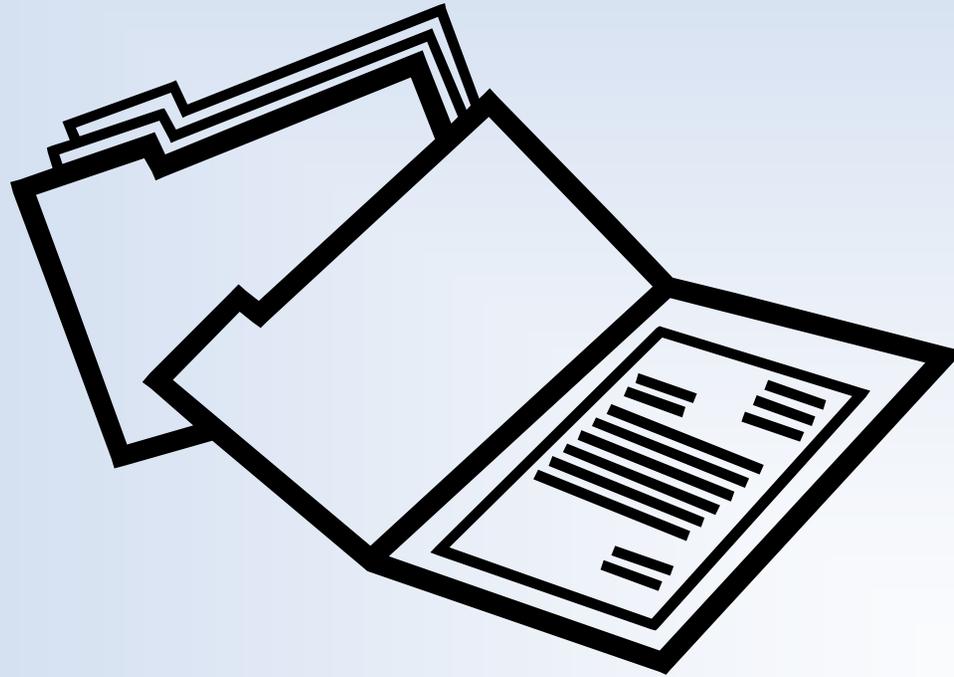
**Date**

# Occupational Disease Claim Report

## Administrative Actions for Reporting Violations:

- 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



# Permanent Total Disability (PTD) Claims

## Background:

[NRS 616C.453](#)\* requires DIR to make annual payments to injured employees (or their dependents):

- Who are permanently and totally disabled (PT) and
- Who are **not** entitled to the annual increase (2.3%) per [NRS 616C.473](#)

\*See applicable regulations: [NAC 616C.526 - 527](#)

# Permanent Total Disability Claims

## NRS 616C.453 Qualification Criteria:

- The injured employee has been deemed permanently and totally disabled; **and**
- The injured employee is receiving PT benefits as of July 1 of the year in which the annual payment is to be made (e.g., claim is reportable in 2011 if injured employee is receiving PT benefits as of 7/01/11); **and**
- The injured employee is not entitled to the annual increase in PT benefits pursuant to NRS 616C.473

# Permanent Total Disability Claims

Every insurer (includes private carriers authorized to but not currently writing workers' compensation and inactive self-insured employers):

- Must complete the proper form and supply the required information annually, within 30 days of request
- Must report every PT claim meeting the NRS 616C.453 criteria
- Must provide claimants' current address
- Or must indicate that they have no qualifying claims to report

# Permanent Total Disability Claims

## Annuities and Subrogation Agreements:

- PTs for which an annuity was purchased or for which a subrogation agreement is in place that would otherwise qualify for this payment are not exempt and **must be reported!**

# 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  
[www.dirweb.state.nv.us/WCS/wcs.htm](http://www.dirweb.state.nv.us/WCS/wcs.htm)

under "Insurer  
Information"  
(updated annually)

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](mailto: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

# PTD Claims: How to Report

## Insurers with no claims to report:

- Complete Question #1, answer “NO” to Question #2, complete Question #4 at the bottom, and promptly return the form

## Insurers with claims to report:

- Complete Question #1, answer “YES” to Question #2, complete Question #3 for each claim. Make copies of the form as needed to report only one claim per form. Questions #1, #2, and #4 must be completed on every form

# PTD Claims: How to Report

Submit to DIR by response due date:

By e-mail: [WCSRA@business.nv.gov](mailto: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

# WCS Insurer Information Form



# Insurer Information Form

Establishes the official record of current insurer contact information for WCS regulatory functions.

Outdated information puts insurers at risk of failing to meet statutory responsibilities.

# FY Insurer Information Form Page 1

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

**FYXX INSURER INFORMATION FORM**  
(July 1, 20XX through June 30, 20XX)  
Workers' Compensation Insurers (Active or Inactive)

ANNUAL DUE DATE: DECEMBER 30, 20XX  
(ALSO within 30 days of any changes/updates during the year)

**E-mail:** [wcsra@business.nv.gov](mailto: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: <input type="checkbox"/> Private Carrier <input type="checkbox"/> Self-Insured Employer <input type="checkbox"/> 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 FY11?    YES <input type="checkbox"/> NO <input type="checkbox"/>		

CURRENT NEVADA CLAIMS OFFICE (S)/TPAs: (Attach additional page if necessary) (This information will be used on our online Coverage Verification Service)		
Name of Administrator:		
Address:		
City:	State:	Zip:
Contact Person:		
Telephone #:	C-4/Claims Fax #:	
E-mail Address:		

PREVIOUS NEVADA CLAIMS OFFICE (S)/TPAs DURING FY11:		
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:		
E-mail Address:	Contract Exp Date:	

Page 1 of 2 10/11

# 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:	E-mail 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:	E-mail 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 NCCL, proof of coverage reporting violations, etc.):

Contact Name:		
Title:	E-mail 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:	E-mail Address:	
Company Name:		
Address:		
City:	State:	Zip:
Telephone:	Fax:	

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

# Insurer Information Form General Instructions

**ALL INSURERS (ACTIVE AND INACTIVE)  
MUST COMPLETE!**

Required pursuant to NRS 616B.006

- Use proper form and submit to WCS annually and within 30 days of any changes
- Contact information on page 2 must be **Insurer** contact information – not TPA

# Insurer Information Form General Instructions

Form e-mailed with Annual Report Packet and also available on website

<http://dirweb.state.nv.us/WCS/wcs.htm>

May submit electronically or by hard copy

E-mail: [WCSRA@business.nv.gov](mailto: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

# WCS Fiscal Year Claims Activity Report



# WCS FY Claims Activity Report/Insurer Information Form Cover Memo Page 1

\* Distributed annually  
(late summer/early fall)  
by e-mail for fiscal year  
reporting

BRIAN SANDOVAL  
Governor

WCS Contact Information  
(702) 454-0080  
Fax: (702) 498-0064  
<http://dirweb.state.nv.us>



TERRY JOHNSON  
Director

DONALD E. JAYNE, CPCU  
Administrator

CHARLES J. VERRA  
Chief Administrative Officer

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

## MEMORANDUM

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

CC: THIRD PARTY ADMINISTRATORS (TPAs)

FROM: Charles J. Verre, Chief Administrative Officer

DATE: November 10, 2011

SUBJECT: WCS Workers' Compensation Claims Activity Report,  
Statement of Inactivity and Insurer Information Form  
Fiscal Year 2011 (July 1, 2010- June 30, 2011)

DUE DATE: December 30, 2011

Provided are the Fiscal Year 2011 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 December 30, 2011. 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 e-mail, 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://dirweb.state.nv.us/WCS/insurer.htm>. Forms may also be requested via e-mail to [wcsra@business.nv.gov](mailto:wcsra@business.nv.gov).

# WCS FY Claims Activity Report/Insurer Information Form Cover Memo Page 2

Page 2  
Fiscal Year 2011  
WCS Workers' Compensation Claims Activity Report  
November 10, 2011

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 e-mail to: [wcsra@business.nv.gov](mailto:wcsra@business.nv.gov)

##### ***Hard Copy Filing:***

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

**By Mail to:** 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 e-mail at [wcsra@business.nv.gov](mailto:wcsra@business.nv.gov).

WCS FY Claims  
Activity Report/Insurer  
Information Form  
Attachment 1  
Definitions  
Page 1

ATTACHMENT #1

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 Page 2

## 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 Page 1

ATTACHMENT #2

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 Page 2

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](mailto: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 20XX  
WCS WORKERS' COMPENSATION CLAIMS ACTIVITY REPORT

**INSTRUCTIONS FOR FILING ELECTRONICALLY (E-MAIL)**

The WCS requests the filing of the *Fiscal Year 20XX WCS Workers' Compensation Insurer Information Form* and either the *Claims Activity Report* or the *Statement of Inactivity* electronically by e-mail. 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 e-mail 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://www.dirweb.state.nv.us/WCS/insurer.htm> or by requesting the electronic forms by e-mail to [wcsra@business.nv.gov](mailto: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 E-MAIL ON/OR BEFORE DECEMBER 30, 20XX.** Completed reports and forms are to be submitted by e-mail to [wcsra@business.nv.gov](mailto: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  
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Attachment 5  
Regulations  
Page 1

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  
Page 2

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 NRS 616B.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)

# WCS FY Claims Activity Report General Instructions

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

- Insurers with **active** certificates (C of A)
  - All activity in the fiscal year covered by C of A
  - Include payments made by excess insurance (SIEs & Associations) and reinsurance (private carriers)
  - Private carriers with active WC license must report even if no business has been written
  - If no claims activity during fiscal year, use **Statement of Inactivity**

# WCS FY Claims Activity Report General Instructions

- Insurers with **inactive** certificates (C of A) (Insurers who formerly held an active certificate and have been decertified by DOI or voluntarily withdrew certificate)
  - Must report claims activity while claims are active
  - If no claims activity during fiscal year, use **Statement of Inactivity**

# WCS FY Claims Activity Report General Instructions

## Claims Activity Report Completion:

- Complete insurer name and C of A#
  - On each page of hard-copy form;
  - On last page of electronic form
- Monetary amounts in \$US (round to the nearest dollar, e.g. \$159.80 = \$160)
- All spaces are required and must be filled
  - No activity = "0"
  - If unable to report a line item, use "UNK"
    - Excessive use of "UNK" is not acceptable

**DO NOT USE FORMULAS, LINKS OR REFERENCES TO  
OTHER DOCUMENTS**

# WCS FY Claims Activity Report General Instructions

Report only claims activity occurring during the fiscal year

- Insurers using multiple claims administrators (TPAs) must submit **one combined report** for all claims activity for that insurer with that C of A number
- Do not submit reports for individual policyholders
- Private Carrier Groups (e.g., St. Paul Travelers, Liberty Mutual, etc) must submit individual reports for each private carrier (underwriting company) authorized to write workers' compensation in Nevada

# WCS FY Claims Activity Report General Instructions

## Submissions of Reports/Forms:

### Electronic (via e-mail) recommended

- ✓ Electronic form is distributed via e-mail with the Annual Report request – also available on WCS website
- ✓ Complete and submit as an Excel (not .pdf) e-mail attachment
- ✓ Will not be accepted if printed and submitted as a hard copy or e-mailed as a .pdf file (6 pg form)

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

- ✓ Available on WCS website (different form – 3 pg form)

# WCS FY Claims Activity Report (Electronic-Excel)

## Part 1 Claims Information

INSURER: _____		NV Certificate of Authority No. :
NCCI Carrier Code (Private Carriers): _____		Insurer FEIN:
<b>PART 1 - CLAIMS INFORMATION</b>		
<b>Major Categories</b>	<b>All activities reported in this report must have occurred in FY11*</b>	<b>AMOUNT OF ACTIVITY IN FY11 (except line U)</b>
	<b>Specific Areas</b>	
<b>Occupational Injury Claims NRS 616</b>	A. No. of NEW Claims Filed/Reported in FY11 (Accepted, Denied and Pending)	
	B. No. of Claims Denied in FY11	
	C. No. of Medical Only <sup>(1)</sup> Claims Accepted in FY11	
	D. No. of Lost Time <sup>(2)</sup> Claims Accepted in FY11	
	E. No. of Compensable Fatalities in FY11	
<b>Occupational Disease Claims NRS 617</b>	F. No. of NEW Claims Filed/Reported in FY11 (Accepted, Denied and Pending)	
	G. No. of Claims Denied in FY11	
	H. No. of Medical Only <sup>(1)</sup> Claims Accepted in FY11	
	I. No. of Lost Time <sup>(2)</sup> Claims Accepted in FY11	
	J. No. of Compensable Fatalities in FY11	
<b>Claim Reopening</b>	K. No. of Requests for Claim Reopening in FY11 of any claim	
	L. No. of Claim Reopening Requests Denied in FY11	
	M. No. of Medical Only <sup>(1)</sup> Reopenings Granted in FY11	
	N. No. of Lost Time <sup>(2)</sup> Reopenings Granted in FY11	
<b>PPD Claims</b>	O. No. of All Injured Employees Paid PPDs (Lump Sum and/or installments) in FY11	
	P. No. of IEs Paid PPDs Min. Lump Sum or LS w/ initial payment Only (of O above)	
<b>Voc Rehab Claims</b>	Q. No. of Injured Employees Paid Rehabilitation Benefits in FY11 (Any listed in Part 4)	
	R. No. of Injured Employees Paid Rehabilitation in a Lump Sum (Buyout) (of Q above)	
<b>Closed Claims</b>	S. No. of Claims Closed Pursuant to NRS 616C.235(1) (Medical \$300 or more) in FY11	
	T. No. of Claims Closed Pursuant to NRS 616C.235(2) (Medical under \$300) in FY11	
	U. Total Expenditures for All Claims Closed (S and T above) for the Life of those Claims	\$
<b>Open Claims</b>	V. No. of Open Claims as of 6/30/11	

# WCS FY Claims Activity Report

## Part 2 - Compensation Expenditures

<b>PART 2 - COMPENSATION EXPENDITURES</b>		
	<b>Specific Areas</b>	<b>AMOUNT PAID IN FY11</b>
	A. Temporary Total Disability paid on all claims in FY11	\$
	B. Temporary Partial Disability paid on all claims in FY11	\$
	C. Permanent Total Disability paid on all claims in FY11	\$
	D. Permanent Partial Disability paid on all claims in FY11	\$
	E. Survivor's Benefits paid on all claims in FY11	\$
	F. Burial Expenses paid on all claims in FY11	\$
	G. Travel and Per Diem paid on all claims in FY11	\$
	H. Interest Paid Pursuant to NRS 616C.335 on all claims in FY11	\$
	I. Child Support (not reported elsewhere) paid on all claims in FY11	\$
	J. Annuities purchased in FY11 for future benefits for all claims	\$
	K. Other paid in FY11 (Enter total and attach separate list)	\$
	<b>TOTAL COMPENSATION EXPENSES PAID IN FY11</b>	<b>\$</b>

# WCS FY Claims Activity Report

## Part 3 - Medical Expenditures

<b>PART 3 - MEDICAL EXPENDITURES</b>		
<b>Major Categories</b>	<b>Specific Areas and Corresponding Codes</b>	<b>AMOUNT PAID IN FY11</b>
<b>General</b>	A. CPT Codes 00100 through 99607, Category II Codes 0001F - 7025F and Category III Codes 0016T - 0261T paid in FY11	\$
<b>E/R Hospital</b>	B. Emergency Dept. Services (NV00100-NV00101) ( <b>Facility Fees Only</b> ) paid in FY11	\$
<b>Inpatient Hospital</b>	C. Inpatient Hospital (NV00200, NV00400, NV00500, NV00550, NV00600, NV00700, NV00900) ( <b>Per Diem Only</b> ) paid in FY11	\$
<b>Ambulatory Surg. Ctrs.</b>	D. Ambulatory Surgical Ctrs. Groups 1-9 or usual and customary ( <b>Facility Fees Only</b> ) paid in FY11	\$
<b>Home Health</b>	E. Home Health Care (NV90130, NV90170, NV90180, NV90190) paid in FY11	\$
<b>HCPCS</b>	F. A0021 - V5364 paid in FY11	\$
<b>Miscellaneous</b>	G. PPD Evaluations (NV01000, NV01002-NV01006) Dr. report fees paid in FY11	\$
	H. FCE Testing and Reports (NV99060) paid in FY11	\$
	I. Back School (NV97115) paid in FY11	\$
	J. Pharmaceuticals paid in FY11	\$
	K. No Show Appts (PPD: NV01001; IME: NV02000; FCE: NV99061) paid in FY11	\$
	L. Trauma Activation Fee (NV00150) paid in FY11	\$
	M. Other paid in FY11 (Enter total and attach separate list)	\$
<b>TOTAL MEDICAL EXPENSES PAID IN FY11</b>		<b>\$</b>

# WCS FY Claims Activity Report

## Part 4 - Rehabilitation Expenditures

<b>PART 4 - REHABILITATION EXPENDITURES</b>		
	Specific Areas	AMOUNT PAID IN FY11
	A. Maintenance Payments (Paid instead of TTD while in Rehab.) paid in FY11	\$
	B. Vocational Rehabilitation Buy Outs (Lump Sum) paid in FY11 (See Part 1, Line R.)	\$
	C. Program Expenses paid in FY11 (Schooling, training, supplies, etc.)	\$
	D. Administrative Expenses paid in FY11 (Vendor Expenses)	\$
	E. Other paid in FY11 (Enter total and attach separate list)	\$
	<b>TOTAL REHABILITATION EXPENSES PAID IN FY11</b>	<b>\$</b>

# WCS FY Claims Activity Report

## Part 5 - Recoveries

<b>PART 5 - RECOVERIES</b>		
	Specific Areas	<b>AMOUNT RECOVERED IN FY11</b>
		(ENTER POSITIVE (+) VALUES ONLY)
	A. Subrogation Recoveries in FY11	\$
	B. Subsequent Injury Fund (Payments received in FY11)	\$
	C. Reimbursements from Excess Insurance (SIEs and Assocs Only) in FY11	\$
	D. Reimbursements from Reinsurance (Private Carriers Only) in FY11	\$
	E. Reimbursements from Deductibles (Private Carriers Only) in FY11	\$
	F. Other (Enter total and attach separate list) in FY11	\$
	<b>TOTAL AMOUNT RECOVERED IN FY11</b>	<b>\$</b>

# WCS FY Claims Activity Report

## Part 6 - Summary

PART 6 - SUMMARY		
	Specific Areas	FY11 TOTALS
	<b>Part 2 - Compensation Expenditures</b>	<b>S</b>
	<b>Part 3 - Medical Expenditures</b>	<b>S</b>
	<b>Part 4 - Rehabilitation Expenditures</b>	<b>S</b>
	<b>SUBTOTAL</b>	<b>S</b>
	<b>Minus Part 5 - Recoveries</b>	<b>S</b>
	<b>NET EXPENDITURES</b>	<b>S</b>
<b>FY11</b> = July 1, 2010 through June 30, 2011		
<b>I certify that the information contained in this report is true and correct.</b>		
<b>Name (Please Print):</b>		
<b>Signature:</b>		
<b>Report Completed By:</b> _____ <b>Insurer</b> _____ <b>TPA</b> _____ <b>Other</b>		
<b>Name:</b> _____		
<b>Title:</b> _____		
<b>Organization:</b> _____		
<b>Address:</b> _____		
<b>City:</b> _____ <b>State:</b> _____ <b>Zip:</b> _____		
<b>Telephone:</b> _____ <b>FAX:</b> _____		
<b>E-mail Address:</b> _____		



# Statement of Inactivity General Instructions

## Statement of Inactivity

- ✓ Insurers with no claims activity in the fiscal year should submit a **Statement of Inactivity** instead of the **Activity Report**
- ✓ Insurers filing a **Statement of Inactivity** must also complete the **Insurer Information Form**
- ✓ **Statement of Inactivity** may be submitted electronically or by hardcopy

# TPA Reporting



# TPA Claims Handled Report

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

**THIRD-PARTY ADMINISTRATORS (TPAs)  
FY 2011 CLAIMS HANDLED REPORT**

**RESPONSE DUE BY: XXXX**

E-MAIL: [wcsra@business.nv.gov](mailto: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

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

Every TPA must supply the following information to the DIR no later than XXXX. 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://www.dirweb.state.nv.us/WCS/wcs.htm>.

**1. THIRD-PARTY ADMINISTRATOR (TPA) IDENTIFICATION:**

TPA Name:				
Street:				
City:		State:		Zip:
Versa License Number:				
Federal Employer Identification Number:				

**2. TPA CLAIMS HANDLED DATA:**

Number of claims:	Accepted	Denied	Reopened	Total Claims Handled
FYXX (X/XX - XX/XX)				

**3. COMPLETED BY:**

Name: \_\_\_\_\_ Title: \_\_\_\_\_  
Company: \_\_\_\_\_  
Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Signature\*: \_\_\_\_\_ Date: \_\_\_\_\_

(\*Signature not required if sent by e-mail)

(Internal) Date Logged: \_\_\_\_/\_\_\_\_/XX

# TPA Record Storage Locations

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

## THIRD-PARTY ADMINISTRATORS (TPAs) RECORDS STORAGE LOCATIONS

RESPONSE DUE BY: AUGUST 16, 2010

E-MAIL: [wcsra@business.nv.gov](mailto: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

The Administrator of the Division of Industrial Relations (DIR) is required by NRS 616B.021 and 616B.024 to ensure proper storage/destruction of records. Every third-party administrator must supply the following information to the DIR no later than August 16, 2010. 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://www.dirweb.state.nv.us/WCS/wcs.htm>.

### 1. THIRD-PARTY ADMINISTRATOR (TPA) IDENTIFICATION:

TPA Name: \_\_\_\_\_  
Street: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Versa License Number \_\_\_\_\_

### 2. STORAGE LOCATIONS OFF-SITE (Add attachment for additional off-site records storage locations):

Location of Records: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_  
Storage Contract: Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

### 3. COMPLETED BY:

Name: \_\_\_\_\_ Title: \_\_\_\_\_  
Company: \_\_\_\_\_  
Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Signature\*: \_\_\_\_\_ Date: \_\_\_\_\_  
(\*Signature not required if sent by e-mail) (7/10)

(Internal) Date Logged: \_\_\_\_/\_\_\_\_/10

# Contacting WCS/RA

WCS/Research & Analysis Unit

1301 N. Green Valley Parkway, Ste. 200

Henderson, NV 89074

Telephone 702 486-9118

Fax 702 990-0364

E-mail: [WCSRA@business.nv.gov](mailto:WCSRA@business.nv.gov)

Shortcut to website:

<http://dirweb.state.nv.us/wcs/era.htm>