STATE OF NEVADA
DEPARTMENT OF BUSINESS & INDUSTRY
DIVISION OF INDUSTRIAL RELATIONS
WORKERS' COMPENSATION SECTION

NEVADA MEDICAL FEE SCHEDULE
MAXIMUM ALLOWABLE PROVIDER PAYMENT
February 1, 2023 through January 31, 2024

Pursuant to **NRS 616C.260**, effective February 1, 2023, providers of health care who treat injured employees pursuant to Chapter 616C of NRS shall use the most recently published editions of, or updates of, the following publications for the billing of workers' compensation medical treatment: *Relative Values for Physicians, Relative Value Guide of the American Society of Anesthesiologists,* and Medicare's current reimbursement for HCPCS codes K and L for custom orthotics and prosthetics. ASC Hospital Outpatient Group List 2016 of ambulatory surgical codes and payment groups shall be used to bill for these services. **Providers of health care shall utilize Nevada Specific Codes for billing when identified in the Nevada Medical Fee Schedule.**

Refer to **NAC 616C.145** and **NAC 616C.146** for information concerning the adoption and purchasing of the *Relative Values for Physicians and Relative Value Guide of the American Society of Anesthesiologists.* These publications are necessary for the billing of medical treatment and payment per the Nevada Medical Fee Schedule and are the providers and insurers' responsibility to obtain.

BILLING AND REIMBURSEMENT INFORMATION

PROVIDER REIMBURSEMENT
Provider Service Code Conversion Factor:

70000-79999	Radiology and Nuclear Medicine	$49.77
80000-89999	Pathology	$29.53
90000-99999	General Medicine	$12.90
10000-69999	Surgery	$274.86
00000-99999	Anesthesiology	$95.93

Applies to outpatient services provided in physician offices, freestanding facilities and/or hospitals. Facilities may be reimbursed for the technical portion of an applicable service (as defined in the *Relative Values for Physicians*) if the service is provided on an outpatient basis. Services provided in conjunction with procedures and/or surgeries covered under Ambulatory Surgery Centers and Outpatient Hospital Surgical services on page 4 of this document are excluded.

Anesthesia time is determined in 15-minute intervals or any time fraction thereof, from when the anesthesiologist begins to prepare the patient for anesthesia care in the operating room and ends when the patient is placed under post anesthesiologist's care.

If preauthorized by the insurer, licensed physicians, other than anesthesiologists, may receive payment from the *Relative Value Guide of the American Society of Anesthesiologists*.

Services provided by a nurse anesthetist, certified advanced practitioner of nursing or certified physician's assistant must be identified with the modifier "-29" and be reimbursed at 85 percent of the maximum allowable fee established for physicians.

Services provided by a supervising anesthesiologist must be identified by the modifier "-28" and be reimbursed at 25 percent of the maximum allowable fee established for physician.

Surgical assistant services provided by a licensed registered nurse, a certified physician's assistant, or an operating room technician employed by a surgeon for surgical assistant services must be identified with the modifier "-29" and be reimbursed at 14 percent of the maximum allowable fee for the surgeon's services rendered. Fees for surgical assistant services performed by a licensed registered nurse, a certified physician's assistant or an operating room technician employed by the hospital or surgical facility must be included in the per diem rate pursuant to NV00500.

Services provided by a certified chiropractor's assistant must be identified with the modifier "-29" and be reimbursed at 40 percent of the maximum allowable fee for chiropractors.

Services provided by a licensed physical therapist's assistant or licensed occupational therapy assistant must be identified with the modifier "-29" and be reimbursed at 50 percent of the maximum allowable fee for licensed physical therapists or licensed occupational therapists.

The maximum daily unit value allowed under codes 97001 to 97799 and 98925 to 98943, *excluding* 97545 and 97546, for those practitioners whose scope of license allows them to perform and bill for these services is 16 units. The maximum 16-unit value may be exceeded for services provided to an injured employee with trauma to multiple body parts if the insurer, third-party administrator, or organization for managed care so authorizes in advance. Any payment made per this section includes, but is not limited to, payment for the office visit, evaluations and management services, manipulation, modalities, mobilizations, testing and measurements, treatments, procedures, and extra time.

If the services rendered are for physical therapy or occupational therapy and the total unit value of the services provided for 1 day is 16 units or more, the payment of benefit explanation may combine all the services for that day, utilizing code NV97001 as the payment descriptor of services, except for the initial evaluation. The initial evaluation needs to be identified with the appropriate CPT code.

The initial evaluation shall be deemed to be separate from the initial six treatments. An initial evaluation may be performed on the same day as the initial treatment and must be billed under codes 97161, 97162, 97163 **or** 97165, 97166, 97167.

The first six visits billed under codes 97010 to 97799, and 98925 to 98943, excluding 97545 and 97546, do not require the prior authorization of the insurer.

TRAUMA ACTIVATION FEE REIMBURSEMENT

NV00150 Trauma Activation Fee..... $4,347.12

Requires notification of trauma team members at designated trauma hospitals in response to triage information received concerning a person who has suffered a traumatic injury as defined by NRS 450B.105. Trauma activation is based upon parameters set forth in NAC 450B.770 (Procedures for initial identification and care of patients deemed with trauma). Regardless of the disposition of the patient, all charges related to the appropriate care of the patient above and beyond the activation fee shall apply and are reimbursed per the Nevada Medical Fee Schedule.

HOSPITAL EMERGENCY DEPARTMENT FACILITY REIMBURSEMENT
Nevada Specific Codes:

NV00100	First hour for use of emergency facility	$301.49
NV00101	Each additional hour or fraction thereof for use of emergency facility	$150.74

Diagnostic services, treatment and supplies provided by the emergency department are reimbursed in addition to emergency department facility reimbursement. Medical supplies are reimbursed at the providers' actual cost, excluding tax and charges for freight, plus 20 percent, unless there is a written agreement between the insurer and provider for a lower reimbursement. Copies of the manufacturers' or suppliers' invoices from the provider are required for reimbursement. Use of treatment rooms may not be reimbursed separately as reimbursement is included in the hourly reimbursement.

An insurer shall reimburse pharmaceuticals at the average wholesale price or the provider's usual and customary price, whichever is less, unless there is a written agreement between the insurer and provider for a lower reimbursement.

If an injured employee is admitted to the hospital from the emergency department, charges related to care in the emergency department are reimbursed in addition to the per diem rate(s) for inpatient care received at the hospital.

HOSPITAL REIMBURSEMENT
Nevada Specific Codes:

NV00200	Medical-Surgical/Cardiac/Neuro/Burn/Other Intensive Care	$5,948.72
NV00450	Step-Down/Intermediate Care	$4,783.21
NV00500	Medical-Surgical Care	$3,617.71
NV00550	Skilled Nursing Care/Facility	$2,479.33
NV00600	Psychiatric Care	$2,479.33
NV00650	Observation Care (Greater than 23 hours)	$3,617.71
NV00675	Observation Care (Up to 23 hours or fraction thereof)	$150.74 per hour
NV00700	Rehabilitation Care	$2,479.33

Reimbursement for Observation Care shall be calculated at an hourly rate of $150.74 per hour, or fraction thereof, for stays 23 hours or less. Diagnostic services, treatment and supplies provided while under hourly Observation Care and are reimbursed in addition to observation care hourly reimbursement for stays 23 hours or less. Medical supplies are reimbursed at the providers' actual cost, excluding tax and charges for freight, plus 20%, unless there is a written agreement between the insurer and provider for a lower reimbursement. Copies of the manufacturers' or suppliers' invoices from the provider are required for reimbursement. Observation stays greater than 23 hours shall be reimbursed at the per diem rate noted above for Nevada Specific Code NV00650 which **includes** diagnostic services, treatment and supplies. Observation Care rates apply to acute care hospital services only; does not apply to hospital-based outpatient surgical care or ambulatory services.

The per diem rate includes all services provided by the hospital including the professional and technical services provided by members of the hospital's staff and other services ordered by the treating or consulting provider of health care. Charges for an inpatient's use of an operating room must be included in the per diem rate for the hospital.

Rural hospitals receive an additional 10% over the established per diem rate. Hospitals in Clark County, Washoe County, and Carson City are not considered rural hospitals.

The insurer shall reimburse the hospital for orthopedic hardware**,** prosthetic devices**,** implants and grafts at the provider's actual cost, excluding tax and charges for freight, plus 20 percent, unless there is a written agreement between the insurer and hospital for a lower reimbursement. Copies of the manufacturers' or suppliers' invoices from the provider are required for reimbursement.

The insurer shall reimburse the hospital for supplies and materials, including grafts and implants used in open-heart surgery at the provider's actual cost, excluding tax and charges for freight, plus 40 percent, unless there is a written agreement between the insurer and hospital for a lower reimbursement. Copies of the manufacturers' or suppliers' invoices from the provider are required for reimbursement.

AMBULATORY SURGICAL CENTER (ASC) and OUTPATIENT HOSPITAL SURGICAL REIMBURSEMENT

Group 1	$1,124.83
Group 2	$1,506.54
Group 3	$1,722.72
Group 4	$2,128.07
Group 5	$2,421.93
Group 6	$2,790.15
Group 7	$3,286.69
Group 8	$3,360.99
Group 9	$3,617.71
Unlisted CPT code	$3,360.99

Unlisted CPT codes may be reimbursed at Group 8 reimbursement, billed charges, or usual and customary reimbursement in Nevada for comparable procedure codes, whichever is less.

A list of CPT codes and their corresponding groups may be found at the Nevada Workers' Compensation Section website on the Medical Information page at:
http://dir.nv.gov/uploadedFiles/dirnvgov/content/WCS/MedicalDocs/ASCOPGroupList2016.pdf

An insurer shall reimburse an ambulatory surgical center for orthopedic hardware**,** prosthetic devices**,** and implants and grafts at the provider's actual cost, excluding tax and charges for freight, plus 20 percent, unless there is a written agreement between the insurer and provider for a lower reimbursement. Copies of the manufacturers' or suppliers' invoices from the provider are required for reimbursement.

If there is no assigned value for the surgical procedure, or if the modifier "-51" and or modifier "-59" are used, or "add-on" procedures are billed, the amount paid **shall not exceed** the surgical per diem rate for code NV00500, or the amount billed if less than the per diem rate for NV00500.

The following costs are included in the ambulatory surgical center's reimbursement: all services provided by the ambulatory surgical center, including professional and technical services provided by members of the ambulatory surgical center staff, anesthetic cost, general supplies, operating room, medication and any other diagnostic procedures.

Hospital Reimbursement rates (page 3) do not apply to hospital-based outpatient surgical care or ambulatory services, except that NV00500 is used as a maximum reimbursement level for these outpatient services.

TELEMEDICINE REIMB,URSEMENT
Nevada Specific Code:
NV00250 Telemedicine Originating Site fee..... $258.08

Reimbursement for medical facilities billing an originating site fee for telemedicine services will include all general supplies, technical services, professional services, and costs for the telemedicine transmission. Diagnostic or other procedures performed in conjunction with a telemedicine visit are separately reimbursable if prior authorized, pursuant to NAC 616C.129. **The consulting health care provider at the distant site must bill using the usual and appropriate CPT code for the service(s) provided. Do not use CPT codes specific to telemedicine. Always bill telemedicine services with a GT modifier**.

PHARMACEUTICAL REIMBURSEMENT
An insurer shall reimburse all pharmaceuticals, except those provided to an injured employee occupying a bed in the hospital, at the average wholesale price plus an $12.90 dispensing fee, or the provider's usual and customary price, whichever is less, unless there is a written agreement between the insurer and provider for a lower reimbursement.

Physician dispensed controlled substances are addressed in NRS 616C.117.

Prior authorization is required for any compound medication or specific subset of compounds. The prior authorization request must include the prescribing physician's or chiropractor's justification of the medical necessity for and efficacy of the compound instead of or in addition to the standard medication therapies. All bills for compound medications shall list each ingredient of the compound at the individual ingredient level and, where applicable, include a valid National Drug Code (NDC) for each ingredient. The insurer and dispensing provider shall agree upon the quantity as well as the reimbursement for a compounded medication before the medication is dispensed. The insurer shall not be required to reimburse any compound ingredient which lacks a valid NDC.

DURABLE MEDICAL EQUIPMENT (DME) REIMBURSEMENT
An insurer shall reimburse the provider of health care for those medical supplies and materials provided by the health care provider at the provider's actual cost, excluding tax and charges for freight, plus 20 percent, unless there is a written agreement between the insurer and provider for a lower reimbursement. Copies of the manufacturers' or suppliers' invoice from the provider are required for reimbursement.

CUSTOM ORTHOTIC AND PROSTHETIC REIMBURSEMENT
An insurer shall reimburse custom orthotics and prosthetics at 140% of Medicare allowable for Nevada, unless there is a written agreement between the insurer and provider for a lower reimbursement. No invoice is required.

HOME HEALTH SERVICE REIMBURSEMENT
Nevada Specific Codes:
For a visit of **not more than 2 hours** and during which certain procedures are performed by a physical therapist, occupational therapist, speech therapist, skilled nurse, social worker, or dietary nutritional counselor:

NV90170 Skilled home health care ..... per visit $143.90

For a visit of **not more than 2 hours** and during which certain activities are performed by a certified nursing assistant:

NV90130 Certified nursing assistant care ..... per visit $70.12

For a visit of **more than 2 hours** and during which certain procedures are performed by a physical therapist, occupational therapist, speech therapist, skilled nurse, social worker, dietary nutritional counselor or certified nursing assistant:

NV90180 Skilled home health care .....per hour $71.93
NV90190 Certified nursing assistant care .....per hour $35.06

Payment for each 24-hour period may not exceed the per diem rate for Nevada Specific Code NV00500. A "visit" includes the time it takes the provider of health care to travel to and from the home of the injured employee to provide health care services in the home and complete any required documentation.

INDEPENDENT MEDICAL EVALUATION REIMBURSEMENT
Nevada Specific Codes:

NV02001 Review of medical records (up to 50 pages), testing, evaluation, and report (includes evaluation of up to 2 body parts) $1,959.46
NV02002 Review of each additional 100 pages of medical records (shall be prorated for increments less than 100 pages) $489.87
NV02003 Evaluation of each additional body part in excess of initial two body parts (use body part descriptions located under Permanent Partial Disability Reimbursement)..... $367.40
NV02004 Organization of medical records in chronological order based on date of service .....
..... per 50 pages $53.51
NV02000 Failure of an injured employee to appear for appointment $734.79

Nevada Specific Code NV02000 may only be billed if an injured employee is more than 30 minutes late for a scheduled appointment or cancels the appointment less than 24 hours before the scheduled appointment.

The medical records must be in a printable format and include a cover sheet indicating the number of pages provided to the physician or chiropractor.

All medical records are to be provided to the evaluator in chronological order based on date of service. Separating chronologically organized therapy notes is acceptable.

PERMANENT PARTIAL DISABILITY REIMBURSEMENT
Nevada Specific Codes:

NV01000 Review records, testing, evaluation, and report (includes evaluation of up to 2 body parts) ……..$950.04
NV01001 Failure of an injured employee to appear for appointment $317.29
NV01002 Addendum necessary to clarify original report .....No charge
NV01003 Addendum after review of additional medical records $317.29
NV01004 Review of medical records and evaluation of each additional body part in excess of initial 2 body parts $317.29
NV01005 Organization of medical records in chronological order based on the date of service.....
..... per 50 pages $53.51
NV01006 Review of records and report $474.08

Nevada Specific Code NV01001 may only be billed if an injured employee is more than 30 minutes late for a scheduled appointment or cancels the appointment less than 24 hours before the scheduled appointment.

The medical records must be in a printable format and include a cover sheet indicating the number of pages provided to the physician or chiropractor.

All medical records are to be provided to the evaluator in chronological order based on date of service. Separating chronologically organized therapy notes is acceptable.

For the purpose of establishing the maximum allowable payment for the review of medical records and the evaluation of musculoskeletal body parts, the following constitute one body part:

a) The cervical spine
b) The thoracic spine
c) The lumbar spine
d) The pelvis
e) The left upper extremity, excluding the left hand
f) The right upper extremity, excluding the right hand
g) The left hand, including that portion below the junction of the middle and lower thirds of the left forearm
h) The right hand, including that portion below the junction of the middle and lower third of the right forearm
i) The left lower extremity
j) The right lower extremity
k) The head
l) The trunk
m) Post-traumatic Stress Disorder Impairments (NRS 616C.180)

BACK SCHOOL REIMBURSEMENT

Nevada Specific Code:

NV97115 Back School .....per hour $105.17

Payments for services billed under code NV97115 include the services of all instructors who participate in the program. The program must include, but is not limited to, instruction of the injured employee by a licensed physical therapist or licensed occupational therapist and by other providers of health care and instruction of the injured employee in body mechanics, anatomy, techniques of lifting and nutrition.

FUNCTIONAL CAPACITY EVALUATION REIMBURSEMENT

Nevada Specific Code:

NV99060 Procedure, testing and report.....per hour $298.83
NV99061 Failure of an injured employee to appear for an appointment..... $317.29

Testing performed in connection with such an evaluation must continue for not less than 2 hours and not more than 5 hours. The evaluation must include, but is not limited to, an assessment and interpretation of the ability of the injured employee to perform work-related tasks and the formulation of recommendations concerning the capacity of the injured employee to work safely within his/her physical limitations.

Nevada Specific Code NV99061 may only be billed if an injured employee is more than 30 minutes late for a scheduled appointment or cancels the appointment less than 24 hours before the scheduled appointment.

DENTAL REIMBURSEMENT

D0120	Periodic oral evaluation, established patient	$43.45
D0140	Limited oral evaluation, problem focused	$64.59
D0150	Comprehensive oral evaluation, new or established patient	$68.33
D0210	Intraoral, complete series of radiographic images	$106.80
D0220	Intraoral-periapical, first radiographic image	$22.11
D0230	Intraoral-periapical, each additional radiographic image	$17.43
D0330	Panoramic radiographic image	$91.74
D2740	Crown, porcelain/ceramic substrate	$969.04
D2750	Crown, porcelain fused to high noble metal	$892.12
D2950	Core buildup, including any pins when required	$209.68
D3310	Endodontic therapy, anterior tooth, excludes final restoration	$726.08
D3320	Endodontic therapy, bicuspid tooth, excludes final restoration	$841.58
D4341	Periodontal scaling and root planing, four or more teeth per quadrant	$199.84
D5110	Complete denture, maxillary	$1,300.18
D5213	Maxillary partial denture, cast metal/framework with resin denture bases, includes any conventional clasps, rests and teeth	$1,366.93
D5214	Mandibular partial denture- cast metal/framework with resin denture bases, includes any conventional clasps, rests and teeth	$1,367.50
D6010	Surgical placement of implant body	$1,723.20
D6050	Surgical placement, transosteal implant	$1,805.59
D6056	Prefabricated abutment, includes modification and placement	$479.82
D6057	Custom fabricated abutment, includes placement	$636.27
D6059	Abutment-supported porcelain fused to metal crown (high noble metal)	$1,141.15
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	$1,212.01
D6240	Pontic porcelain fused to high noble metal	$900.17
D6750	Crown, porcelain fused to high noble metal	$908.15
D7140	Extraction, erupted tooth or exposed root, elevation and/or forceps removal	$121.31
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, includes elevation of mucoperiosteal/flap if indicated	$261.02
D9223	Deep sedation/general anesthesia, each 15-minute increment or part thereof	$157.64

All other dental procedure codes may be reimbursed at the provider's usual and customary price, unless there is a written agreement between the insurer and provider for a lower reimbursement.

GENERAL INFORMATION

Reimbursement is based on appropriate coding of health care services provided as documented in the medical record.

Bills 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 bill 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. Reimbursement for healthcare services is determined by the Nevada Medical Fee Schedule in effect at the time of the date of service.

The insurer or a representative of the insurer may require the submission of reports on the injured employee's admission to, and discharge from, the hospital and all physicians' or chiropractors' medical reports before payment of a hospital or medical bill.

An insurer shall pay or deny reimbursement of charges pursuant to **NRS 616C.136** after receipt by the insurer or his agent of the first bill for those charges unless good cause is shown for a later payment or denial. Bills received erroneously should be returned to the health care provider with an explanation.

Any physician or chiropractor who is called upon to render service in the case of an emergency or severe trauma as a result of an industrial injury may use whatever resources and techniques are necessary to cope with the situation. The treatment of injured employees in such situations is not restricted to physicians and chiropractors that are members of the Treating Panel of Physicians and Chiropractors established by the Administrator pursuant to **NRS 616C.090** or have contracted with an insurer or an organization for managed care to provide health care services to injured employees.

A provider of health care shall, within 14 days after the date on which services are rendered **or** the injured employee is discharged from the hospital, unless good cause is shown, submit to an insurer, a third-party administrator or an organization for managed care, a report on the services rendered. This subsection does not require the disclosure of any information prohibited by state or federal statute or regulation.

The insurer **shall provide** an Explanation of Benefits (EOB) for each code billed to include the amounts for services that are paid and the amounts that are reduced or disallowed. Indicate on each payment those services, which are being reduced or disallowed, and the reasons for the reduction or disallowance. The EOB must include notification to the provider of health care that within 60 days after receiving the notice of denial or reduction, they can submit a written request to the State of Nevada, Division of Industrial Relations, Workers' Compensation Section for a review of that action.

If a bill submitted to the insurer by a provider of health care requires an adjustment because the codes set forth in the bill are incorrect, the insurer shall:

(1) Process and pay or deny payment of that portion of the bill, if any, that contains correct codes;
(2) Return the bill to the provider of health care and request additional information or documentation concerning that portion of the bill relating to the incorrect codes; and

(3) Pay or deny payment within 20 days after receipt by the insurer or the insurer's agent of the resubmitted bill with the additional information or documentation.

For services which reimbursement has not been established by the Nevada Medical Fee Schedule or adopted resources, it is recommended that the insurer and provider mutually agree on reimbursement before the services are provided.

NAC 616C.143 addresses payment for consultation and treatment provided outside this State. If there is no prior written authorization that payment for the consultation or treatment will be made in accordance with the schedule of reasonable fees and charges allowable for accident benefits adopted for this State pursuant to **NRS 616C.260**, unless otherwise provided in contract between the provider of health care and the insurer, the insurer is solely responsible for the payment of all services rendered.

All providers and insurers are encouraged to review the following applicable statutes and regulations concerning the billing and payment of medical services: **NRS 616C.135**, **NRS 616C.136**, **NRS 616C.117, NAC 616C.027**, **NAC 616C.138**, **NAC 616C.141**, **NAC 616C.143**, **NAC 616C.147**, and **NAC 616C.149**. You may access these statutes and regulations on the Nevada Workers' Compensation Section website at: http://dir.nv.gov/WCS/home/.