



Workers' Compensation Section

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STANDARD AUDIT REQUIREMENTS

Private Carriers, Self-Insured Employers and Associations of Self-Insured Employers

Pursuant to [NRS 616B.003](#), all insurers who provide benefits to injured employees pursuant to Chapters 616A to 616D, inclusive, or Chapter 617 of Nevada Revised Statutes (NRS), shall be audited at least once every five years.

An audit will include all claims filed with a date of injury for a defined period, or a random sampling of those claims. Usually, this will be the preceding fiscal year. The period may vary to take into consideration an insurer changing claims administrators, current staffing levels or other scheduling issues.

The goal of the standard audit is to ensure injured employees receive timely and accurate benefits in accordance with the Chapters 616A and 617D, inclusive, or chapters 617 of the Nevada Revised Statutes and the Nevada Administrative Codes. Selected claim files may be reviewed for, but not limited to:

1. Timely determination regarding claim acceptance/commenced payments, or denial;
2. Timely payment of initial compensation;
3. Accurate calculation and payment of Temporary Partial Disability (TPD), Temporary Total Disability (TTD), Permanent Partial Disability (PPD), and/or Permanent Total Disability (PTD) compensation;
4. Timely and accurate payment of medical bills in accordance with the Nevada Medical Fee Schedule or as otherwise contracted;
5. Timely evaluation and offer of PPD;
6. Notification of the right of appeal concerning determination(s) made;
7. Timely responses to requests;
8. Vocational rehabilitation benefits;
9. Use of proper forms;
10. Claims administration, and
11. Violations of [NRS 616D.120](#)

Pursuant to [NRS 616B.021](#) and [NAC 616B.013](#), the Workers' Compensation Section (WCS) investigator or auditor shall be provided access to selected claim files. This includes paperless electronic claim file systems (if one is used by the insurer), electronic claim notes and payment history. If given the option, WCS may make arrangements for remote access to the electronic claims system prior to the date of this scheduled claim file review.

While remote access of the insurer's and/or claims administrator's electronic system is preferable for an efficient audit process, in-office paper copy auditing can be arranged. In these cases the entire claim file will be reviewed. A copy of the following pertinent claim file documents will be requested:

- 1) Hearing Officer and Appeals Officer Decision & Orders;
- 2) All written determinations;
- 3) All written requests for benefits & treatment;
- 4) Light duty offers/acceptance;
- 5) Documentation related to wages (D-forms, including D-38 Indexing Forms) wage letters and calculation sheets/tape;
- 6) PPD reports & calculations (all PPD forms);
- 7) Certification of disability used for payment of benefit;
- 8) C-4, C-3 and C-1 Forms; and
- 9) Closure letter(s).

WCS may request additional documents to be copied or printed. If the audit period is handled by more than one claims administrator, the audit period may be revised to the period administered by the new Third-Party Administrator (TPA).

If your paperless claims system does not place the date of receipt on received documents, please print out the corresponding system document that substantiates the date of receipt and place in sequential order of each document.

WCS may request that a representative be available during the audit to address the auditor's questions, whether remotely or in-person.

Pursuant to [NRS 616B.006](#), the following documents may be requested:

- The insurer's claims procedures manual, if one has not already been provided to this agency; or if it been updated since it was last submitted;
- Insurer policies and procedures for the payment of compensation found to be due by a hearing officer, appeals officer, court of competent jurisdiction, written settlement agreement, written stipulation or the division when carrying out its duties pursuant to chapters NRS 616A to 616D, inclusive or chapter 617;
- Copies of contracts with MCO's and/or PPO's;
- A list of those TPAs that are administering claims for the insurer, including their Nevada DOI License number. The list should include: physical address, contact person email address and telephone number;
- Separate lists of claims for:
 1. **denied** claims,
 2. **medical only** claims "*for 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*" pursuant to [NAC 616B.016\(3\)\(a\)](#),
 3. **lost time**, claims "*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), and/or vocational rehabilitation benefits*" pursuant to [NAC 616B.016\(3\)\(b\)](#), and
 4. **catastrophic** claims pursuant to [NRS 616C.700-720](#).

The lists must include the injured employees' names in alphabetical order, date of injury, claim number and if there was a Permanent Partial Disability evaluation, and/or benefit paid;

- Total expenditures for each claim with a breakdown of those expenditures to include medical payments, Temporary Total Disability (TTD), Temporary Partial Disability (TPD), rehabilitation maintenance, Permanent Partial Disability (PPD) and Permanent Total Disability (PTD) payments;
- If you need assistance with your claim list, please contact us and we can arrange to send you a template in MS Excel with preferred formatting; and
- Copies of all C-1 Forms are available during employer site visits.

All information is requested pursuant to [NRS 616A.400](#), [NRS 616B.003](#), [NRS 616B.006](#), [NAC 616A.410](#), and [NAC 616D.311](#).

All claim files should be legible and in chronological order pursuant to [NAC 616C.082 \(2\)](#).

At the conclusion of each audit day, a written Daily Site Visit Form may be jointly completed by the auditor and the representative for the insurer/claims administrator. This can be accomplished remotely via email or other electronic mean. The form can document potential violations, agreements, missing documents from claim files and other pertinent issues discovered during the audit.

At the conclusion of the audit, the auditor may ask the insurer for contact information regarding at least one insured employer (client) in order to conduct an in-person, employer site visit. The site visit choice is usually made due to employer violations found during the audit (late or incomplete mandated form submission, or lack thereof). This is also an opportunity to provide outreach education and ensure all mandated postings and forms are present at the employer's place of business. Employee surveys are left with the employer to be completed by random employees to ensure injured employees know how to report industrial injuries and how to seek treatment.

The auditor will also send out formal written findings to the insurer and their claims administrator. The written responses must be returned to the DIR within thirty (30) days, pursuant to [NAC 616A.410](#). Insurers are required to include all relevant documentation with the written responses to determine if the violation will remain in the final audit report.

This process concludes with the issuance of a Final Audit Report which may include notices of correction and/or administrative fines issued by DIR to the insurer and their claims administrator with appropriate appeal rights, if applicable. Copies of the audit report including an executive summary will be provided to The Nevada Division of Insurance.