Workers' Compensation

FREQUENTLY ASKED QUESTIONS–MEDICAL PROVIDERS

Must I evaluate and treat every patient with a work-related injury?

In the event of an emergency, you must evaluate and treat the injured worker.

If the injury is non-emergent, it is recommended that you verify whether you are a contracted provider for that employer, insurer or third-party administrator (TPA) to ensure payment for services rendered. If you do treat the injured worker, you must complete and forward the appropriate copy of the Form C-4, *Employee's Claim for Compensation/Report of Initial Treatment* to the **correct** insurer and the **correct** employer. NRS 616B.527, NRS 616C.090

Also, it is your responsibility to inform the injured worker of his workers' compensation rights, which includes the completion of Form C-4. Form D-2, *Brief Descriptions of Rights and Benefits*, must be printed on the reverse side of the injured worker' copy of the C-4 or provided to the injured worker as a separate document with an affirmative statement acknowledging receipt. NRS 616C.090, NRS 617.352, NAC A.480

How may I obtain the Form C-4 and other necessary forms?

Forms and Worksheets may be found on the WCS website: http://dir.nv.gov/WCS/home/.

What are the Form C-4 requirements?

Within 3 working days after treating an injured worker, you must complete Form C-4, *Employee's Claim for Compensation/Report of Initial Treatment* and forward the appropriate copy to the **correct** employer and the **correct** insurer. A copy of the Form C-4 form must be retained in the injured worker's file. It is the health care provider's responsibility to contact the employer or insurer/TPA to confirm the name and address of the correct insurer/TPA. Please refer to the directions given below.

A Form C-4 must be completed even if you do not consider the injury or occupational disease to be work-related. The compensability of the claim lies with the insurer, not the health care provider, nor the employer. The Form C-4 must be completed in its entirety, including signature and date, and any limitations and/or restrictions assigned. Please note, an insurer or TPA has 30 days from receipt of the Form C-4 to accept or deny the claim. NRS 616C.040, NRS 617.352

How can my office staff locate the correct insurer/TPA?

You must send the completed Form C-4 to the correct insurer or TPA. The first step is to ask the injured worker. The next step is to contact the employer. He is required to know who his insurer is.

The Coverage Verification Service is a limited portal into the National Council on Compensation Insurance's database which allows access to private carrier information for employers. To access this portal, visit the Workers' Compensation Section website: http://dir.nv.gov/WCS/home/. The health care provider must **always** contact the insurer/TPA listed to verify the correct information.

For information on self-insured employers and associations of self-insured employers, visit the Division of Insurance Web page: http://doi.state.nv.us/ and select the "Help Me Find..." tab > Self-Insured Workers' Compensation. Select either the "Self-insured Workers' Compensation" or "Association" list.

If, despite all your efforts, you are unable to locate the correct insurer/TPA within 3 business days, you must call the WCS for assistance in locating this information. If the WCS is unable to locate the insurer at that time, you will be asked to send to the WCS the Form C-4 and any notes documenting your efforts to locate the correct insurer/TPA. NAC 616C.080

What if the injured worker or his employer asks me not to send in a Form C-4?

You must complete in its **entirety**, both the upper and lower portion of Form C-4 if a patient reports a work-related injury or condition. A copy of the Form C-4 must then be forwarded to the **correct** employer and **correct** insurer even if the injured worker has refused to complete the employee portion or you have been asked not to file. Document the injured worker's refusal on the upper portion of Form C-4.

What do I do if the employer asks me to bill him directly?

Unless the employer is self-insured, the insurer or third-party administrator is responsible for payment of any medical services provided to the injured worker relating to the accepted industrial injury and/or condition.

May a physician's assistant or nurse practitioner complete a Form C-4?

Yes, the physician or chiropractor, who has the responsibility to complete Form C-4, may delegate the completion of the form to a medical facility, physician's assistant or nurse practitioner. However, a physician must always countersign a Form C-4.

What are the consequences if I fail to complete or send in a Form C-4 on time?

Administrative fines may be imposed if Form C-4 is incomplete and/or not submitted within 3 working days to the **correct** employer and insurer. Benefit penalties and administrative fines may be imposed if a medical provider refuses to complete and distribute Form C-4 as required and/or induces or influences a patient not to file a workers' compensation claim. NRS 616C.040, NRS 616D.120

What do I do if I suspect workers' compensation fraud?

Report suspected fraud to the AG Fraud Hotline: 1-800-266-8688. More information for detecting possible fraud is available on the Attorney General website at: http://ag.nv.gov/.

What if the employer does not have workers' compensation insurance?

Send the completed Form C-4 and the bill to the WCS with a cover letter stating the employer does not have workers' compensation insurance. The WCS Employer Compliance Unit investigates suspected uninsured employers and determines whether there is coverage. Once it is determined that the employer has no coverage, the claim will then be submitted to the Uninsured Employers' Account. If accepted, the injured worker will receive the same rights and benefits afforded any other injured worker under NRS 616 and 617.

Must I obtain prior authorization for everything?

The treating physician or chiropractor must request **written authorization** before ordering or performing any one of the following services with an estimated billed amount of $200 or more:

- Treatment
- Consultation
- Diagnostic testing
- Elective hospitalization
- Any surgery which is to be performed under circumstances other than an emergency; or
- Any elective procedure

In addition, treatment for codes 97001 to 97799, exclusive of 97545, 97546, and 98925 to 98943, consisting of more than 6 visits, requires prior authorization. NAC 616C.129 Telemedicine also reaches the anticipated cost of $200 or more. Check the current Medical Fee Schedule for further information regarding telemedicine.

What if I request prior authorization and the insurer or TPA does not respond?

An insurer must respond to a **written request** for prior authorization for treatment, diagnostic testing, or consultation within 5 working days. If the insurer does not respond within 5 working days, authorization shall be deemed to be given. However, the insurer may subsequently deny the authorization. NRS 616C.157

How many treating physicians or chiropractors may an injured worker have?

There may be only one treating physician or chiropractor unless the insurer provides prior written authorization for the injured worker to receive treatment by more than one physician or chiropractor. NRS 616C.090

Physicians and chiropractors associated with the treating physician or chiropractor may treat the injured worker during the temporary absence of the treating physician or chiropractor. Physicians in emergency departments are not considered "treating physicians." NAC 616C.129

Is a specific progress report form required?

The physician or chiropractor must use Form D-39, *Physician's Progress Report – Certification of Disability*. The Form D-39 must be completed in its entirety to include a signature and date and any limitations and/or restrictions assigned. A copy of this form, as well as all other forms, may be obtained from the WCS website: http://dir.nv.gov/WCS/home/. NAC 616A.480

Are there workers' compensation standards of care?

Yes. The standards of care adopted by the Division of Industrial Relations are the current *Occupational Medicine Practice Guidelines* of the American College of Occupational and Environmental Medicine. These are more commonly known as the ACOEM Guidelines.The guidelines are published by Reed Group, Ltd and are available with a paid subscription. Information is available at http://www.mdguidelines.com. NRS 616C.250, NAC 616A.480

Must I prescribe generic drugs?

Yes. A provider must prescribe a generic drug in lieu of a brand name drug if the generic drug is biologically equivalent and has the same active ingredient or ingredients of the same strength, quantity and form of dosage as the brand name drug. NRS 616C.115

Is there specific language to use when the injured worker reaches maximum medical improvement?

Yes. To be consistent with statute, when the treating physician or chiropractor feels the injured worker has reached maximum medical improvement, the term "stable" should be used. If the treating physician or chiropractor deems the injured worker may have suffered a permanent impairment, the term "ratable" should also be used. NAC 616C.103

How may I join the Treating Panel of Physicians and Chiropractors?

To become a member of the Treating Panel, a licensed physician or chiropractor must complete the "Application – Panel of Treating Physicians and Chiropractors" and submit the completed application to the Henderson office of WCS for processing. Upon completion, the health care provider will be notified and an informational packet will be sent. An application may be obtained from the WCS website http://dir.nv.gov/WCS/Medical_Providers/.

Please explain billing and payment regulations.

Billings 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 billing 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. The medical report must be attached to any bill sent to the insurer/TPA. Please note the following:

- An insurer must pay or deny a bill within 45 calendar days after receipt
  - If the insurer does not pay within 45 days, interest may be due to the medical provider
- An insurer is obligated to provide an explanation of benefits (EOB/EOR) for each code billed
  - An insurer cannot change billing codes

- The insurer may return the bill and request additional information

Under what circumstances may I charge an injured worker?

If a provider of health care accepts an injured worker for the treatment of an industrial injury or occupational disease, the injured worker may not be charged for any treatment related to the industrial injury or occupational disease. The insurer must be charged.

An injured worker may be charged when his employer is uninsured and WCS has issued a determination to not assign the workers' compensation claim to the Uninsured Employers' Account.

You may charge an injured worker when his claim is closed and he is seeking medical documentation to reopen the claim. You may also charge an injured worker for any treatment unrelated to the industrial injury or if his claim has been denied. Otherwise, never charge an injured worker for any treatment related to the claim. Payment may be accepted from the injured worker or his health insurer for treatment the injured worker alleges is related to the industrial injury or occupational disease *which the insurer or third-party administrator has denied liability for.*

What recourse do I have if my bill is reduced or denied?

If your bill has been reduced or denied by an insurer you may, within 60 days of receiving notice of the reduction or denial, request the WCS to review that action. The WCS will investigate and make a payment determination. NAC 616C.027

What may I bill for witness fees?

A physician or chiropractor that is called to testify is entitled to receive the same fees as witnesses in civil cases. These fees may exceed the fees in the Nevada Medical Fee Schedule. NRS 616C.350

Does Nevada have a Medical Fee Schedule?

Yes. Payment from insurers cannot exceed the Medical Fee Schedule. However, payment may be less than the Medical Fee Schedule if the provider has a contract with the insurer. The appropriate Medical Fee Schedule corresponds to the date of service.

A medical provider is to use the most recent editions, or updates of the following publications for the billing of workers' compensation: *Relative Values for Physicians*, *Relative Value Guides of the American Society of Anesthesiologists*, and Medicare's current reimbursement for HCPCS codes K & L for custom orthotics and prosthetics. ASC reimbursement, providers' service code conversion factors and the Nevada specific codes are contained in the Medical Fee Schedule on the WCS website: http://dir.nv.gov/WCS/Medical_Providers/

Where can I access the Nevada Medical Fee Schedule, ASC codes, DME and K&L codes, and the WCS Medical Unit information on the internet?

To access all of the above and more, visit the WCS website: http://dir.nv.gov/WCS/Medical_Providers/

How may I obtain more information about workers' compensation?

To obtain more information about workers' compensation, please visit the WCS website: http://dir.nv.gov/WCS/home/ or you may contact the Workers' Compensation Section: WCSHelp@business.nv.gov

Workers' Compensation

MEDICAL BILLING

MEDICAL BILLING – PRIOR AUTHORIZATION

NRS 616C.157 - An Insurer, organization for managed care or third-party administrator shall respond to a written request for prior authorization for treatment, diagnostic testing, or consultation, within 5 working days after receiving the written request.

NAC 616C.129 - The treating physician or chiropractor must request written authorization from the insurer before ordering or performing any service with an estimated billed amount of $200 or more for:

- consultation
- diagnostic testing
- elective hospitalization
- any surgery which is to be performed under circumstances other than an emergency, or any elective procedure

NAC 616C.143 Consultation or treatment provided outside Nevada

MEDICAL BILLING – LAWS & REGULATIONS

NRS 616C.125 Insurer may contract with suppliers for provision of services and goods to injured employees

NRS 616C.135 Liability of Insurer for payment of charges for treatment related to industrial injury

NRS 616C.136 Action by insurer on bill from provider of health care; payment of interest; request for additional information; compliance with requirements. Updated requirements per Senate Bill 231, 2015 Nevada Legislature.

NRS.616C.137 Denial of payment for unrelated services

NRS 616C.138 Payment of provider upon insurers denial of authorization or responsibility

NRS 616C.260 Fees and charges for accident benefits: Restrictions; establishment and revision of schedule; powers and duties of Administrator; penalty for refusal to provide information

NAC 616C.027 Review of reduction or disallowance of bill; appeal; hearing; decision

NAC 616C.126 Treatment of injured employees in cases of severe trauma

NAC 616C.138 Billing for provision of certain supplies and services

NAC 616C.141 Requirements for programs of treatment billed under certain codes; use of codes; modifications of codes for certain services

NAC 616C.143 Prior written authorization required for consultation or treatment provided outside Nevada; emergency treatment outside Nevada

NAC 616C.145 Relative Values for Physicians: Adoption by reference; modifications; maximum unit values; initial evaluation; special reports

NAC 616C.146 Relative Value Guide of the American Society of Anesthesiologists: Adoption by reference; modifications; conversion factor; payments; basic anesthetic values

NAC 616C147 Licensed surgical centers for ambulatory patients

NAC 616C.149 Contents of bill to insurer

Workers' Compensation

PRESCRIPTION DRUG DIVERSION

THE HIGH COST OF DRUG ABUSE

Workers' Compensation providers spent over $3 billion providing prescriptions to injured workers last year; 52% of that amount was spent on "painkillers." The illegal use or subsequent sale of prescription drugs puts a huge strain on our health system. Drug diversion can increase costs to health care insurers by a whopping $27 billion per year. Drug diversion is defined as any use of legal prescription medications for other than the legitimate medical purpose for which the drug was prescribed. We cannot continue to overlook this type of fraud.

A recent study examined the comparative health costs of treating a drug abuser versus a non-abuser. The findings were no surprise. The average cost of treating a non-abuser was $1,830. The cost associated with a drug abuser swelled to $16,000.

Workers' compensation providers are in the best position to be able to determine if drug diversion is occurring. The person paying the bills knows, or should know with a little due diligence, the amount of prescriptions being obtained by the recipient. Plan administrators are in the best position to detect if medications are being obtained from multiple sources or if a physician is not prescribing medications in a medically appropriate manner. In either event, these suspicions need to be referred for an investigation.

An interesting trend is emerging with an increase in drug diversions. The number of injured workers taking side jobs to help offset their loss of income while receiving benefits has been decreasing nationally; primarily due to workers finding a more lucrative and untraceable source of income – the sale of their prescription meds.

The street value for pain medication is staggering. OxyContin, for example, has a 430% street markup. By prolonging treatment to obtain unnecessary pain medication, vast amounts of money can be made. In addition to extending treatment with nonexistent pain symptoms, several other drug diversion tactics are common.

Forged or altered prescriptions are a popular way to obtain illegal quantities of prescriptions. Older methods of using correction fluid to blot out the amount of pills to be obtained have given way to the use of fingernail polish remover. Prescriptions can also be altered instead of "washed." A prescription for 10 tablets can be easily made to look like 70. The patient then returns to the medical provider after a week for another prescription and the doctor is none the wiser. "Doctor shopping" is another method. Doctor shoppers visit multiple practitioners, which can easily occur if the injured worker is obtaining medications from a health insurance provider in addition to the workers' compensation provider.

Although the vast majority of practitioners are honest and provide legitimate medical care, a small percentage does engage in true criminal behavior. Investigations have focused on physicians who exchange improper prescriptions for money, other street drugs or in some instances, sex. These physicians are nothing less than drug dealers and should be treated as such.

Plan managers must become more aggressive in looking for potential drug diversions. The time for blindly writing the checks for prescription medications has long passed. If the cost of drug diversion is not reason enough, the potential for liability should be a wake up call. Recently, pharmacies have been held liable for failing to exercise due diligence by allowing overuse of pain medications. The same rationale may be applied to plan administrators if the overuse of pain medications is blindly approved time after time.

The abuse of prescription medications certainly has become a national problem. The National Institute of Health reports that 20% of Americans have abused prescription medication, and the number is growing. With cooperation between plan administrators, health care providers and law enforcement, we can start to take a bite out of this form of fraud. For more information, readers are encouraged to contact the National Association of Drug Diversion Investigators (NADDI) or visit their website at: www.naddi.org.

Anyone suspecting this type of fraud or any fraud associated with workers' compensation should contact the Attorney General's fraud hotline at **1-800-266-8688**. Other information about detecting workers' compensation fraud is also available on our website: http://ag.nv.gov/About/Criminal_Justice/Workers_comp/

Brian Kunzi; Director, Workers' Compensation Fraud Unit (Revised 3/18/2016 – updated website)

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

NEVADA MEDICAL FEE SCHEDULE
MAXIMUM ALLOWABLE PROVIDER PAYMENT
February 1, 2021 through January 31, 2022

Pursuant to **NRS 616C.260**, effective February 1, 2021, 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	$47.22
80000-89999	Pathology	$28.02
90000-99999	General Medicine	$12.24
10000-69999	Surgery	$260.77
00000-99999	Anesthesiology	$91.01

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..... $4,124.36

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.....$286.04
NV00101 Each additional hour or fraction thereof for use of emergency facility.....$143.01

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.

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..... $5,643.88
NV00450 Step-Down/Intermediate Care..... $4,538.09
NV00500 Medical-Surgical Care..... $3,432.33
NV00550 Skilled Nursing Care/Facility..... $2,352.28
NV00600 Psychiatric Care $2,352.28
NV00650 Observation Care (Greater than 23 hours)..... $3,432.33
NV00675 Observation Care (Up to 23 hours or fraction thereof) ..... $143.01 per hour
NV00700 Rehabilitation Care..... $2,352.28

Reimbursement for Observation Care shall be calculated at an hourly rate of $143.01 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	$1,067.19
Group 2	$1,429.33
Group 3	$1,634.44
Group 4	$2,019.02
Group 5	$2,297.82
Group 6	$2,647.17
Group 7	$3,118.26
Group 8	$3,188.76
Group 9	$3,432.33
Unlisted CPT code	$3,188.76

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 REIMBURSEMENT
Nevada Specific Code:
NV00250 Telemedicine Originating Site fee.....$244.86

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 $12.24 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 $136.52

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 $66.53

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 $68.25
NV90190 Certified nursing assistant care ..... per hour $33.26

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..... $1,859.05
NV02002 Review of each additional 100 pages of medical records (shall be prorated for increments less than 100 pages).....$464.77
NV02003 Evaluation of more than 2 body parts, for each body part in excess of (use body part descriptions located under Permanent Partial Disability Reimbursement).....$348.57
NV02004 Organization of medical records in chronological order based on date of service..... per 50 pages $50.77
NV02000 Failure of an injured employee to appear for appointment.....$697.14

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.....$901.35
NV01001 Failure of an injured employee to appear for appointment.....$301.03
NV01002 Addendum necessary to clarify original report ..... No charge
NV01003 Addendum after review of additional medical records.....$301.03
NV01004 Review of medical records and evaluation of more than 2 body parts for each body part in excess of $301.03
NV01005 Organization of medical records in chronological order based on the date of service..... per 50 pages $50.77
NV01006 Review of records and report.....$449.79

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 $99.78

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 $283.52
NV99061 Failure of an injured employee to appear for an appointment.....$301.03

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	$41.22
D0140	Limited oral evaluation, problem focused	$61.28
D0150	Comprehensive oral evaluation, new or established patient	$64.83
D0210	Intraoral, complete series of radiographic images	$101.32
D0220	Intraoral-periapical, first radiographic image	$20.98
D0230	Intraoral-periapical, each additional radiographic image	$16.53
D0330	Panoramic radiographic image	$87.04
D2740	Crown, porcelain/ceramic substrate	$919.38
D2750	Crown, porcelain fused to high noble metal	$846.40
D2950	Core buildup, including any pins when required	$198.93
D3310	Endodontic therapy, anterior tooth, excludes final restoration	$688.87
D3320	Endodontic therapy, bicuspid tooth, excludes final restoration	$798.45
D4341	Periodontal scaling and root planing, four or more teeth per quadrant	$189.60
D5110	Complete denture, maxillary	$1,233.55
D5213	Maxillary partial denture, cast metal/framework with resin denture bases, includes any conventional clasps, rests and teeth	$1,296.88
D5214	Mandibular partial denture- cast metal/framework with resin denture bases, includes any conventional clasps, rests and teeth	$1,297.42
D6010	Surgical placement of implant body	$1,634.89
D6050	Surgical placement, transosteal implant	$1,713.07
D6056	Prefabricated abutment, includes modification and placement	$455.23
D6057	Custom fabricated abutment, includes placement	$603.66
D6059	Abutment-supported porcelain fused to metal crown (high noble metal)	$1,082.68
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	$1,149.90
D6240	Pontic porcelain fused to high noble metal	$854.04
D6750	Crown, porcelain fused to high noble metal	$861.61
D7140	Extraction, erupted tooth or exposed root, elevation and/or forceps removal	$115.09
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, includes elevation of mucoperiosteal/flap if indicated	$247.64
D9223	Deep sedation/general anesthesia, each 15-minute increment or part thereof	$149.56

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/.

MEDICAL PROVIDER GUIDE

WORKERS' COMPENSATION

Email Notification
Stay connected to what's new in Nevada's workers' compensation by registering to receive email notifications.
http://dir.nv.gov/wcs/home/

PUBLISHED BY:
STATE OF NEVADA
DEPARTMENT OF BUSINESS AND INDUSTRY
WORKERS' COMPENSATION SECTION

This pamphlet is provided to inform stakeholders of some significant points concerning workers' compensation insurance in Nevada.

What is workers' compensation?

Workers' compensation is a no-fault insurance program in the State of Nevada, which provides benefits to employees who are injured on the job and protection to employers who have provided coverage at the time of injury.

What protection is provided for the employer?

Because Nevada has "exclusive remedy," the injured workers' benefits are set forth in the statutes. Employers who provide coverage for their employees at the time of injury are protected from any additional damages claimed by their employees as a result of an injury on the job. This protection is established when the injured employee opts to receive workers' compensation benefits.

What type of benefits are employees entitled to?

Nevada's Workers' Compensation Program provides a variety of benefits which are designed to assist the injured employee. These benefits may include (among others):

- Medical treatment;
- Lost time compensation (TTD/TPD);
- Permanent Partial Disability (PPD);
- Permanent Total Disability (PTD);
- Vocational Rehabilitation;
- Dependent's benefits in the event of death; and
- Other claims-related benefits or expenses (i.e., mileage)

What services require prior authorization?

The treating physician or chiropractor must request written authorization from the insurer before ordering or performing any one of the following services with an estimated billed amount of $200 or more:

- Consultation;
- Diagnostic testing;
- Elective hospitalization;
- Any surgery which is to be performed under circumstances other than an emergency; or
- Any elective procedure.

In addition, treatment for codes 97001 to 97799, exclusive of 97545, 97546, and 98925 to 98943, consisting of more than 6 visits, requires pre-authorization. NAC 616C.129

What forms are the physician or chiropractor required to fill out?

A physician or chiropractor is required to complete the Form C-4, Employee's Claim for Compensation/ Report of Initial Treatment and the Form D-39, Physician's and Chiropractor's Progress Report. The treating physician or chiropractor *must* complete the bottom portion of the C-4 in its entirety, sign, date, and forward a copy to the insurer *and* employer within 3 working days after he first treats an injured employee. The D-39 is simply a progress report that the treating physician or chiropractor may complete versus dictating a report. A copy of the D-39 or a dictated report, including any physical limitations must be forwarded to the insurer along with the bill for service. Forms may be obtained from the WCS website:
http://dir.nv.gov/WCS/Workers__Compensation_Forms_and_Worksheets/

What information is necessary when submitting a bill?

Each provider of health care must submit a bill to the insurer which includes:

- His usual charge for services provided;
- The code for the procedure and a description of the services;
- The number of visits and date of each visit to his office and the procedures followed in any treatment administered during the visit;
- The provider's invoice and the codes for supplies and materials provided or administered to the injured employee that are set forth in the "Health Care Financing Administration, HCFA Common Procedures Coding System (HCPCS)," as contained in the "Relative Values for Physicians,"
- The name of the injured employee, his employer and the date of his injury;
- The tax identification number of the provider of health care; and
- The signature of the person who provided the service.
- In addition to the above, each physician or chiropractor must include on his bill the ICD-10-CM codes as set forth in the "International Classification of Diseases, 9th Revision, Clinical Modification (ICD-10-CM)." NAC 616C.149

How long does a provider have to appeal a billing or payment issue?

A provider of health care whose bill has been reduced or disallowed may, within 60 days after receiving notice of the reduction or disallowance, submit a written request to the Workers' Compensation Section for a review of that action. The request must identify the billed item for which the review is sought and grounds upon which the request is based. NAC 616C.027

Steps for obtaining workers' compensation insurance information

Step 1: Ask the injured employee, if possible.

Step 2: Use the **Coverage Verification Service (CVS)** on the **WCS** web-site: http://dir.nv.gov/wcs/home/

Step 3: Go to the Division of Insurance website at http://doi.nv.gov **and select the "Help Me Find" tab to locate the "Self-insured Workers' Compensation". Select either the "Self-Insured Company" and/or the "Association List" tab. Use the "Find" feature to initiate search.**

Step 4: Contact the employer. Document the responses from the employer.

Step 5: After completing the above steps, if you are still unable to locate coverage information, call **WCS** Las Vegas at (702) 486-9080 or Carson City at (775) 684-7270**.** If we are unable to locate coverage over the phone, you will be asked to forward a completed copy of the C-4 and verification documentation to our office for further investigation.

Step 6: ALWAYS verify coverage with the correct Insurer/TPA before sending the C-4.

Can I bill an injured employee?

No. A provider of health care who accepts a patient as a referral for the treatment of an industrial injury or an occupational disease may not charge the patient for any treatment related to the industrial injury or occupational disease, but must charge the insurer. The provider of health care may charge the patient for services that are not related to the industrial injury or occupational disease. NRS 616C.135

How do I obtain a copy of the NRS, NAC, Medical Fee Schedule or other information?

The Nevada Revised Statutes (NRS) and Nevada Administrative Code (NAC) regarding workers' compensation can be obtained by contacting the Legislative Counsel Bureau, Legislative Publications at:

Reno & Carson: (775) 684-6800
Las Vegas: (702) 486-2626
All other Nevada: (877) 873-2648
www.leg.state.nv.us

The Medical Fee Schedule, HIPAA information, Treating and Rating Physicians' list, and the necessary workers' compensation forms can be accessed through the WCS website at: http://dir.nv.gov/wcs/home/

For more information you may call or write:

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

400 West King Street, Suite 400
Carson City, Nevada 89703
(775) 684-7270
Fax: (775) 687-6305

3660 West Sahara Ave., Suite 250
Las Vegas, Nevada 89102
(702) 486-9080
Fax: (702) 486-8713
Email: WCSHelp@dir.nv.gov

The material contained in this publication is derived from chapters 616A to 617, inclusive, of the Nevada Revised Statutes & Nevada Administrative Code, and is provided for general information purposes only. For more detailed information, please refer to the specific statute or code in its entirety.

Workers' Compensation

EMAIL ENROLLMENT REQUEST

The email enrollment form below allows you to sign up for email notification of the latest quarterly newsletter releases, upcoming trainings, and regulation changes, along with regulation hearings and workshops you can attend.

In addition, you may use this form to change your current contact information or be removed from our email database.

☐ **NEW SUBSCRIBER** ☐ **UPDATE** ☐ **REMOVAL REQUEST**

PLEASE TYPE OR PRINT CLEARLY

Business Name:
Contact Name (First & Last):
Email Address:

CHECK THE **ONE** CATEGORY, WHICH BEST DESCRIBES YOUR BUSINESS

☐ **Medical**	☐ **Third-party Administrator**	☐ **General – Employee/Employer**	☐ **Vocational Rehabilitation**
☐ **Association**	☐ **Self-Insured**	☐ **Private Carrier**	☐ **Legal**

PLEASE FILL OUT THE FORM ON THE WCS WEBSITE OR EMAIL, MAIL OR FAX THIS COMPLETED FORM TO:

Workers' Compensation Section (WCS)

Attn: Education Research & Analysis Unit
3360 W. Sahara Ave., Suite 250
Las Vegas, Nevada 89102

Fax: (702) 486-8712 ATTN: Krissi
Email: klowry@dir.nv.gov
https://hal.nv.gov/form/DIRnvgov/EMAIL_ENROLLMENT_REQUEST

NEVADA WORKERS' COMPENSATION CHRONICLE

Department of Business & Industry
A Publication of the Workers' Compensation Section

Division of Industrial Relations Spring Edition
(Spring Edition March 2021 - May 2021)

Understanding Current COVID-19 Capacity Restrictions

On February 14, Governor Sisolak issued Declaration of Emergency Directive 037 in response to the observed downward trend of confirmed COVID positivity and hospitalization since mid-January. This newest Directive increased the allowable capacity on many industries throughout the state in a two-step process with the first step occurring on February 15 and the second on March 15, 2021. It is important to note that any restrictions not specifically addressed in Directive 037 stand as they have been previously stated.

Beginning February 15th, body art and piercing businesses may reopen to the public with a few limitations and restrictions in place. It is recommended that workstations be separated with partitions or walls but in lieu of a partition, clients must be separated by at least 6 feet with only one client per workstation allowed. Clients awaiting appointments must remain outside of the facility and maintain social distancing.

Limited self-service food and drinks inside retail or grocery stores may resume with disposable utensils being used when possible and limited persons at the self-serve stations. It is recommended that hand sanitizer be provided for customers with signage reminding customers to utilize sanitizer frequently.

Nevadans may now enjoy public gatherings at community recreation events, fitness facilities, and gaming properties up to 35% of occupancy. This increase includes recreation activities, gyms, and similar activities. Bars, restaurants, and similar establishments may allow 35% occupancy for indoor seating as long as booths or tables are separated by 6 feet, parties are no larger than 6 persons, and all food and drink is served at the tableside. There are no capacity restrictions on outdoor dining as long as all other restrictions are maintained. Public gatherings at parks, sporting fields or courts, movie theaters, convention centers, libraries, and private clubs is limited to 35% or 100 people whichever is less. Community libraries, museums, art galleries, aquariums, and zoos may increase to 50% occupancy although any hands-on or interactive exhibits must remain closed. Houses of worship may increase their in-person services to 50% occupancy with social distancing and face covering requirements. The Governor recommends staggered, online, or drive-up services where possible.

(*continued on page 2)*

Mileage Reimbursement Rate Effective January 1, 2021

Effective **January 1, 2021**, the standard mileage reimbursement rate for transportation costs incurred while using a private vehicle while traveling on official State business has decreased from **57.5** cents per mile to **56** cents per mile.

Per NAC 616C.150, reimbursement for the cost of transportation for an injured employee, under appropriate conditions, must be computed at a rate equal to the mileage allowance for State employees.

Please advise all adjusters as soon as possible to minimize any payment errors.

Please see the 2021 Mileage Reimbursement Change Memorandum announcing the rate change on the WCS website.

Inside this issue:

Understanding Current COVID-19 Capacity Restrictions	1-2
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2021 Medical Unit Updates/ Med Fee Schedule	4
CARDS Corner	5
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Reporting Reminders	6
2021 Training Sessions	7

Understanding Current COVID-19 Capacity Restrictions

(*continued from page 1)*

Families and friends can plan and enjoy private gatherings, as long as the number of people gathered not of the same household does not to exceed 10 people for indoor gatherings and 25 people for outdoor gatherings. This number does not include people of the same household, persons experiencing homelessness, or organizations providing shelter. Social distancing and face coverings should be observed even during private gatherings.

On March 15th, the occupancy limits for gaming properties, community limits recreation events, fitness facilities, and bar and restaurant services will increase to 50%. Public gathering limits will also increase to 50% with a cap of 250 people in total.

Directive 037 allows for persons to host or attend large public gatherings upon approval of a "Large Gathering Plan" by local and state authorities. Beginning March 15th, venues with fixed seating capacity of 2,500 or more may be allowed public attendance at live events provided no more than 20% of seating capacity is filled, and general admission or "standing room only" is prohibited. Social distancing must be followed for persons of different parties and maximum of 6 persons may be seated together in one party. Staff members must provide services to only one section throughout the event with each section meeting the public gathering requirement of 250 persons. Large public gatherings without fixed seating are restricted to 250 persons or 50% of occupancy. Live performances require a minimum of 6 to 12 feet (per Directive 040) between the artist and the audience. Events other than live entertainment are not required to provide seating but must maintain social distancing.

Jana Morales, Safety Specialist, SCATS

SAFETY CONSULTATION & TRAINING SECTION

THE VALUE OF WORKPLACE SAFETY

SCATS Services

- Provide assistance in developing written safety programs
- Answer workplace safety questions
- Safety training for management, supervisors, and employees
- Video lending library
- Perform on-site workplace safety assessments
- Perform industrial hygiene services
- Safety and Health Practitioner Program

WCS MISSION STATEMENT

The purpose of the Workers' Compensation Section is to impartially serve the interests of Nevada employers and
employees by providing assistance, information, and a fair and consistent regulatory structure focused on:

- **Ensuring the timely and accurate delivery of workers' compensation benefits.**
- **Ensuring employer compliance with the mandatory coverage provisions.**

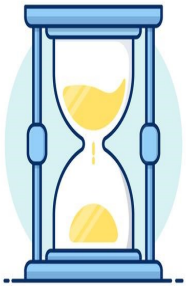
Deadline to Request COLA Reimbursement Drawing Near

The deadline for submitting Requests for Reimbursement for costs associated with COLAs paid in calendar year 2020 for eligible claims is March 31, 2021. Requests for reimbursement will only be processed for claims whose AMW/Rate have been verified by WCS. See the "COLA Info – PTD and Survivors' Benefits (Death) Claims" page on the WCS website for Forms and Instructions for *AMW/Rate Verifications* and *Requests for Reimbursement*.

The web page includes information on the 4-step COLA reimbursement process:

1) AMW/Rate Verification (One-time)
2) Request for Reimbursement (Annual)
3) Special COLA Assessment (Annual)
4) Reimbursement to Insurers (Annual)

And other resources, including:



◊ AMW/Rate Verification Instructions and Forms
◊ Request for Reimbursement Instructions and Form
◊ FAQs
◊ AB 370 and SB 377 (2019) and codified statutes
◊ Training material

Direct inquiries to COLAS@dir.nv.gov.

Attention Insurer & TPA D-38 Claim Indexing Submitters

Do you submit a high volume of D-38s? Would you like to avoid manually entering D-38s into the CARDS web portal? Maybe the Flat File Process is right for you!!

All Workers' Compensation claims are required to be reported to Workers' Compensation Section pursuant to NRS 616B.018. Once a D-38 Form (Injured Worker Index System Claims Registration Document) is submitted and WCS staff processes it, the information is placed in a data warehouse for access by CARDS. Required updates for stakeholders are accomplished by retrieving the claim in the system and entering new/updated information. Currently, the vast majority of initial submissions of D-38s by insurers and TPAs are completed via D-38 form in the CARDS web portal. A flat file submission option is also available, but not widely used.

A flat file consists of a single file of data records, stored in plain text format that can be imported into a database or data warehouse. It allows required claim information to be submitted timely and efficiently. It is safe and secure and helps to eliminate manual data entry. How does it work? Your IT department creates a process to download information from your internal computer system and format it according to our requirements. Then the file is submitted to DIR's secure FTP site. WCS Indexing staff will then upload the file into the CARDS system. The files may be submitted daily, weekly or monthly.

Insurers/TPAs are welcome to develop and use the flat file format at any time. Once your Flat File development is complete, WCS will test the file to ensure it is working correctly. Then you will be provided with login information and instructions for Flat File submission. Although we have stressed the benefits of Flat File input, industry response has been slow and mainly associated with large entities which have the IT and system resources to participate. The flat file process automates submission and eliminates the manpower requirements of CARDS D-38 input.

Questions regarding submitting claims data using the Flat File format should be directed to CARDS Claims Indexing Coordinator, Patricia Barchus, at indexing@dir.nv.gov or by calling 702-486-9091.

Dock Williams Jr, Northern Regional Manager, WCS

2021 Medical Unit Updates: Nevada Medical Fee Schedule and *Relative Values for Physicians*

The 2021 Nevada Medical Fee Schedule (NMFS) is posted on the Division of Industrial Relations (DIR) Workers' Compensation Section (WCS) website at https://dir.nv.gov/WCS/Medical_Providers/ . There are no significant changes to this year's NMFS due to the pandemic. As usual, reimbursement levels have been revised according to the Consumer Price Index for 2020 as required in NRS 616C.260(2).

There is another significant change that stakeholders should be made aware of, although not to the NMFS itself. The most recent edition of the *Relative Values for Physicians* (RVP) is a required resource for medical billing and reimbursement concerning Nevada workers' compensation according to NAC 616C.145(1). Previously, the RVP has been published by Optum 360[0]. However, the 2021 edition is available online only via subscription. Unfortunately, the narratives included in previous editions of the RVP were excluded from the 2021 edition. The narratives included in the 2020 edition of the RVP will continue to be in effect in 2021 until further notice. For further information, including subscription questions, stakeholders must contact Optum 360[0] at optum360coding.com.

Katherine Godwin, RN, BSN, Chief Medical Unit, WCS

COVID-19 WORKERS' COMP CLAIMS

In response to COVID-19, new codes were added to the acceptable codes for reporting D-38 Claims Indexing data to allow WCS to better track claims relating to the virus. The new codes - Nature of Injury: 83 COVID-19 and Cause of Injury: 83 – Pandemic – were added in March 2020 and may be used for reporting applicable claims December 2019 or later. The codes correspond to those adopted by the Workers' Compensation Insurance Organizations (WCIO) and are used by the International Association of Industrial Accidents Boards and Commissions (IAIABC). By adopting these codes for D-38 Claims Indexing reporting, Nevada may be able to, over time, compare COVID-19 claim data with other states that use the IAIABC standard.

Nevada claims processed in CARDS that include one or both COVID-19 identifiers, through February 28, 2021:

COVID-19/Pandemic Claims	Count	Percent
Filed/Processed in CARDS	1447	
Accepted	515	36%
Denied	932	64%

Ruth Ryan, Research & Analysis Unit Manager, WCS

January COLA Increase Reminder

Insurers and TPAs: Injured employees receiving Permanent Total Disability (PTD) benefits and dependents receiving Survivor's benefits should have received a 2.3% increase in their monthly benefit rate in January 2021 pursuant to NRS 616C.473 and NRS 616C.508.

CARDS Corner

BASIC TIPS ON TPA ACCESS: INSURER CONTROL

This issue of CARDS Corner covers some of the basics of TPA access in CARDS, based on some of the most frequently asked questions we receive from TPA and insurer users. The main point to remember is that ***insurers solely control the access that TPAs have in CARDS on their behalf (neither WCS nor TPAs have the ability to give TPAs access to insurer claims)***.

Insurers Must Link Their TPAs. For an insurer and TPA to be associated in CARDS, the insurer must list the TPA in the "Related TPAs" section on its Insurer Information Form, and then submit the Form to be processed by WCS. Once WCS staff processes the Form, the relationship will show up on the homepage of both the insurer's and the TPA's CARDS accounts. *Note: Linking a TPA and insurer does not automatically give the TPA access to the insurer's claims, but it is the first step.*

Insurer Controls TPA Access to D-38 Claim Submissions. TPAs are only able to create and administer claims on an insurer's behalf if the insurer has given the TPA "Global Access" in CARDS. Without Global Access, a TPA cannot view or perform any claims related functions for the insurer in CARDS. To give a TPA Global Access:

Remember – Global Access permissions can only be given to TPAs that are linked to the insurer, as described above.

Only insurer-users with CARDS Admin privileges can assign Global Access.

An insurer Admin user must log in to their CARDS account and click the "User Access" tab in the "Forms and Tools" drop-down on their homepage, then locate the TPA to be given Global Access and click the "Edit" button at the end of the row; when the "Update Global TPA Access" pop-up appears, click to check the box labeled "D-38 Claims Indexing Form".

Insurer Must Keep Effective and Expiration Dates Updated. Effective and Expiration Dates for insurer/TPA relationships can be viewed in the "Associated Insurers" or "Associated TPAs" section on your CARDS account homepage. Entering an Effective Date for the relationship is required; however the Expiration Date may be entered or left blank. If an insurer has set the Expiration Dates for any of its linked TPAs, the insurer must be diligent in updating them any time an insurer/TPA relationship continues beyond the set Expiration Date, because *the TPA loses access to all insurer claims administration and data once expired (even if the TPA has Global Access)*. Update Effective and Expiration Dates in the "Related TPAs" section of the Insurer Information Form. The changes will be reflected on the insurer's and TPA's CARDS accounts once the Form is submitted and processed by WCS staff.

Hayley D. Weedn, Business Process Analyst, WCS

2020 Occupational Disease Claims Report

The calendar year 2020 Occupational Disease Claim Report is now available on the WCS website.
The report compiles data reported by insurers to WCS as required by NRS 617.357 relating to claims for heart, lung, cancer, and certain contagious diseases filed by policeman, fireman, emergency medical attendants and arson investigators.

DIR/WCS has been collecting data reported by insurers pursuant to NRS 617.357 since 2001. Reports for calendar years 2014 through 2019 can be found on the Insurer-TPA Reporting page on the WCS web site. Reports for years prior to 2014 are available upon request to wcsra@dir.nv.gov.

Ruth Ryan, Research & Analysis Unit Manager, WCS

Reporting Reminders

Insurers and TPAs are required to submit certain reports in the *Claims and Regulatory Data System* (**CARDS**) web portal and other reports outside of the portal, via email or to NCCI, our proof of coverage data collection vendor. Be sure to visit our Insurer-TPA Reporting page on the WCS website for more information on these and other reporting topics.

REPORTING IN CARDS:

- ✓ ***Insurer Information Form:*** One of the most important functions of the ***Insurer Information Form*** is for insurers to notify WCS of the insurer's contracted TPA(s) by "linking" them in CARDS using this web form. Linking not only satisfies the requirement for insurers to notify DIR of their TPA relationships, it also allows insurers to grant permission to their linked TPA(s) to submit required claims data (D-38s) on their behalf. Insurers must also use this form to notify WCS of any changes in insurer regulatory contact information (name, address, email, phone and fax numbers, etc.) for corporate, compliance, state reporting and other functions. In July 2020, the WC Safety Fund Assessment contact information was added as a newly required block on the ***Insurer Information Form***.

  Insurer Information Forms are required to be submitted via our CARDS web portal annually and within 30 days of any changes. For information on how to submit the ***Insurer Information Form***, see the Quick Steps guide on our website on the Insurer-TPA Reporting page.

- ✓ ***TPA Information Form***: TPAs must also notify WCS of any changes in contact information within 30 days by submitting the ***TPA Information Form*** via the CARDS web portal.

- ✓ ***D-38 Injured Worker Index System Claims Registration Document***: Required for all claims, accepted and denied, within 30 days of determination and updated during the life of the claim.

- ✓ For information on CARDS, please visit the CARDS Information Page on our website.

NON-CARDS REPORTING:

- ✓ ***Coming Soon:*** The ***FY20 WCS Workers' Compensation Claims Activity Report*** pursuant to NRS 616B.009 and NAC 616B.016. WCS has not requested this report yet and the forms and instructions are not yet available. Links to the blank form and instructions will be updated on our website at Insurer-TPA Reporting and an email notifying insurers and TPAs of the request and due date will be coming soon.

- ✓ A ***D-35 Request for a Rotating Physician or Chiropractor*** must be submitted to WCS prior to any PPD impairment evaluation being scheduled with a rater. Before WCS can process a D-35, the claim must be reported to the Claims Index System. If the claim has not been reported, the insurer or TPA must submit the ***D-38 Injured Worker Index System Claims Registration Document*** via the CARDS web portal or by submitting the fillable form found on our website.

- ✓ ***(OD-8) Occupational Disease Claim Report(s) (NRS 617.357)*** is an ongoing reporting requirement. Claims filed relating to heart, lung, cancer, and certain contagious diseases filed by policeman, fireman, emergency medical attendants and arson investigators are required to be reported within 30 days of acceptance or denial and updated throughout the life of the claim. **Please remember to report updates to reportable claims such as appeals and decision information, estimated claim costs, claim closure and reopening information. Claims for COVID-19 are not reportable under NRS 617.357.**

- ✓ ***Proof of Coverage (POC):*** Private carriers must also report information to NCCI within 15 days of the effective date of the issuance, renewal, cancellation, nonrenewal, reinstatement or reissuance of a policy of workers' compensation insurance. Private carriers are reminded that nonrenewal transactions are required to be reported, even though Nevada is not a continuous coverage state. **See NCCI Circular *FYI-POC-NV-2019-01* on our website for more information**.

  Information on reporting requirements and forms can be found on the WCS website under "Insurer and TPA Reporting" or go directly to our page at Insurer-TPA Reporting. Contact the WCS Research and Analysis Unit by phone at (702) 486-9080 or by email at wcsra@dir.nv.gov if we can be of any assistance.

2021 Training Sessions

The following classes will be offered online via Webex

C-4 Forms: Health Care Provider (HCP) Responsibilities and Coverage Verification
April 7, 2021 at 9:00 am

Medical Billing
April 7, 2021 at 1:30 pm

Basic Orientation
April 13, 2021 at 9:00 am

Basic Orientation
April 13, 2021 at 1:00 pm

To register for classes click on the session above

Or email
klowry@dir.nv.gov

CONTACT WCS

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

SOUTHERN NEVADA
(702) 486-9080 / Fax: (702) 486-8712

NORTHERN NEVADA
(775) 684-7270 / Fax: (775) 687-6305

http://dir.nv.gov/WCS/Home/

WCSHelp@dir.nv.gov

Direct comments or suggestions about this newsletter to:

Workers' Compensation Section
Las Vegas Office
Ruth Ryan, Editor
Krissi Lowry, Assistant Editor

rryan@dir.nv.gov
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Workers' Compensation is pleased to welcome **Valerie Hall**, RN to the WCS Medical Unit. Valerie will be based in the Las Vegas office where she recently transferred from the Division of Health Care Financing and Policy, Care Coordination Unit. She is a Registered Nurse who also holds a BS in Business Administration/ Accounting from California State Polytechnic University and an MBA with an emphasis in Healthcare Management from Western Governors University. Valerie is a welcome addition to the Medical Unit in LV. In her spare time, she enjoys gardening. Welcome, Valerie!

Please welcome **Mallory Otto** to Workers' Compensation Section as the new Administrative Assistant III in the Carson City Claims Indexing Unit. Mallory has worked with the State of Nevada since August of 2017 with the Department of Taxation as an Administrative Assistant I, then promoted and moved to Division of Public and Behavioral Health as an Administrative Assistant II. When not at work, she enjoys hunting, fishing, finding natural hot springs, and doing outdoor activities with family and friends.

Welcome **Barbara Foster** to Workers' Compensation Section as the new Compliance/Audit Investigator III in the Benefit Penalty unit. She is a dedicated Workers' Compensation professional, who has been working for insurance companies, third party administrators, insurance agents and employers for over 25 years. She comes to the Division of Industrial Relations, Workers' Compensation Unit most recently from the Department of Transportation, where she managed the workers' compensation program.

Barbara has also worked with facilitation of Drug and Alcohol programs and is certified in Office Ergonomics.

WCS remains closed to the public and will observe this holiday

Memorial Day
Monday, May 31, 2021

Questions about Workers' Compensation?
Click Here!

WCSHelp@dir.nv.gov

CARDS
Claims and Regulatory Data System
<<Click here to login or register>>