

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

**NEVADA MEDICAL FEE SCHEDULE**  
**MAXIMUM ALLOWABLE PROVIDER PAYMENT**  
**February 1, 2015 through January 31, 2016**

Pursuant to [NRS 616C.260](#), effective August 16, 2014, 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 the Center for Medicare and Medicaid Services (CMS) 2007 list of ambulatory surgical codes and payment groups, and Medicare's current reimbursement for HCPCS codes K and L for custom orthotics and prosthetics. Providers of health care will utilize Nevada Specific Codes for billing when identified in the 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 .....	\$39.55
80000-89999 Pathology .....	\$23.46
90000-99999 General Medicine .....	\$10.25
10000-69999 Surgery .....	\$218.32
00000-99999 Anesthesiology .....	\$76.19

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.

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 97001 or 97003.

The first six visits billed under codes 97001 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 .....\$3,452.95

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 .....\$164.11

NV00101 Each additional hour or fraction thereof for use of emergency facility .....\$82.08

Treatment and supplies provided by the emergency department are reimbursed separately.

If an injured employee is admitted to the hospital from the emergency department, the charges related to the care in the emergency department and the per diem rates for an inpatient who receives care at the hospital are billed and paid separately.

**HOSPITAL REIMBURSEMENT**

**Nevada Specific Codes:**

NV00200 Medical-Surgical Intensive Care .....	\$3,238.27
NV00400 Medical-Surgical Cardiac Care .....	\$2,973.06
NV00500 Medical-Surgical Care .....	\$1,969.35
NV00900 Burn Care .....	\$2,973.06
NV00600 Psychiatric Care .....	\$1,969.35
NV00700 Rehabilitation Care .....	\$1,969.35
NV00550 Skilled Nursing Care Facility .....	\$1,969.35

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 cost to the hospital, excluding tax and charges for freight, plus 20 percent, unless there is a written agreement between the insurer and hospital for a lower reimbursement.

The insurer shall reimburse the hospital for supplies and materials, including grafts and implants used in open-heart surgery at the cost to the hospital, excluding tax and charges for freight, plus 40 percent, unless there is a written agreement between the insurer and hospital for a lower reimbursement.

**AMBULATORY SURGICAL CENTER (ASC) REIMBURSEMENT**

Group 1 .....	\$789.78
Group 2 .....	\$1,012.51
Group 3 .....	\$1,223.51
Group 4 .....	\$1,513.62
Group 5 .....	\$1,610.35
Group 6 .....	\$1,899.00
Group 7 .....	\$1,969.35
Group 8 .....	\$1,969.35
Group 9 .....	\$1,969.35

An insurer shall reimburse a surgical center for ambulatory patients for orthopedic hardware, prosthetic devices, and implants and grafts in an amount equal to the center’s 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.

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.

**TELEMEDICINE REIMBURSEMENT**

**Nevada Specific Code:**

NV00250 Telemedicine Originating Site fee .....\$205.00

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 physician or consultant at the distant site should bill using the appropriate CPT code 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 a \$10.25 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.

**DURABLE MEDICAL EQUIPMENT (DME) REIMBURSEMENT**

An insurer shall reimburse the provider of health care for those supplies and materials provided by a provider of health care at the provider’s cost of the supplies and materials, excluding tax and charges for freight, plus 20 percent, unless there is a written agreement between the insurer and provider for a lower reimbursement. Invoice is required.

**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 \$114.29

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 \$55.69

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 \$57.15

NV90190 Certified nursing assistant care .....per hour \$27.85

Payment for each 24-hour period may not exceed the per diem rate for 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.

**PERMANENT PARTIAL DISABILITY REIMBURSEMENT**

**Nevada Specific Codes:**

NV01000	Review records, testing, evaluation, and report .....	\$754.62
NV01001	Failure of an injured employee to appear for appointment .....	\$252.02
NV01002	Addendum necessary to clarify original report .....	No charge
NV01003	Addendum after review of additional medical records .....	\$252.02
NV01004	Review of medical records and evaluation of more than 2 body parts for each body part in excess of .....	\$252.02
NV01005	Organization of medical records in chronological order .....	\$42.50
NV01006	Review of records and report .....	\$376.57

Code NV01001 may not be billed unless the injured employee fails to appear for the evaluation within 30 minutes after the scheduled appointment, or cancels the appointment within 24 hours before the scheduled appointment.

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) Stress Impairments ([NRS 616C.180](#))

**BACK SCHOOL REIMBURSEMENT**

**Nevada Specific Code:**

NV97115	Back School .....	per hour \$83.53
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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.

**FAILURE TO APPEAR FOR INDEPENDENT MEDICAL EVALUATION**

**Nevada Specific Code:**

NV02000	Preparation when an injured employee fails to appear for an independent medical evaluation scheduled by an insurer .....	\$252.02
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The medical provider may bill code NV02000 only 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.

**FUNCTIONAL CAPACITY EVALUATION REIMBURSEMENT**

**Nevada Specific Code:**

NV99060 Procedure, testing and report .....(per hour) \$237.36

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.

**FAILURE TO APPEAR FOR FUNCTIONAL CAPACITY EVALUATION**

**Nevada Specific Code:**

NV99061 Preparation when an injured employee fails to appear for an evaluation of functional capacity performed for the injured employee .....\$252.02

The medical provider may bill code NV99061 only if an injured worker is more than 30 minutes late for a scheduled appointment or cancels the appointment less than 24 hours before the scheduled appointment.

**GENERAL INFORMATION**

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 good cause is shown for a later billing. Payment for medical service is reimbursed per 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 approve 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.

The insurer, or a person authorized by the insurer, must receive a bill submitted for reconsideration no later than 12 months after the date on which the services were rendered, unless good cause is shown.

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 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 for 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 provide or deny payment for 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) Approve 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 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**, **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://dirweb.state.nv.us/WCS/wcs.htm>