Division of Industrial Relations

WORKERS' COMPENSATION SECTION

Medical Billing

Workers' Compensation Section
US Bank Building, Ste 300, 2300 W Sahara Ave, Las Vegas, NV 89112

Workers' Compensation Section

MISSION STATEMENT

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

Please submit questions in the chat box, and the Workers' Compensation Section (WCS) will answer them there.

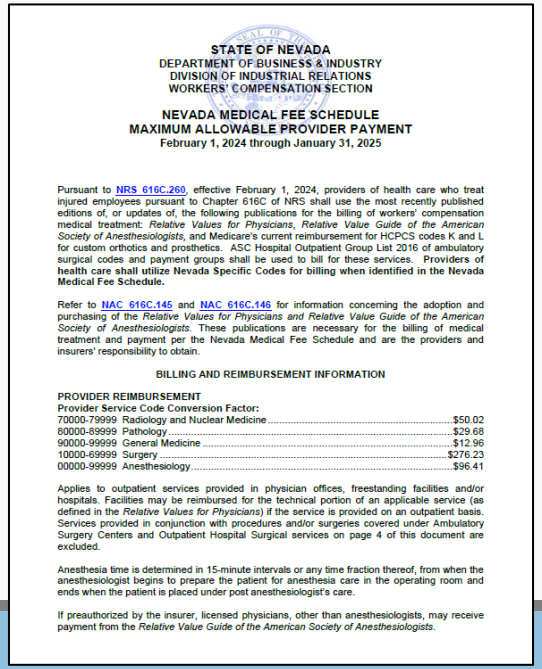
You may also email your questions to:

WCSHelp@dir.nv.gov

ACCURATE MEDICAL BILLING AND REIMBURSEMENT IS EVERYONE'S RESPONSIBILITY.

RESOURCES YOU WILL NEED

1. A COPY OF THE NEVADA MEDICAL FEE SCHEDULE (NV MFS)



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

NEVADA MEDICAL FEE SCHEDULE
MAXIMUM ALLOWABLE PROVIDER PAYMENT
February 1, 2024 through January 31, 2025

Pursuant to NRS 616C.260, effective February 1, 2024, 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

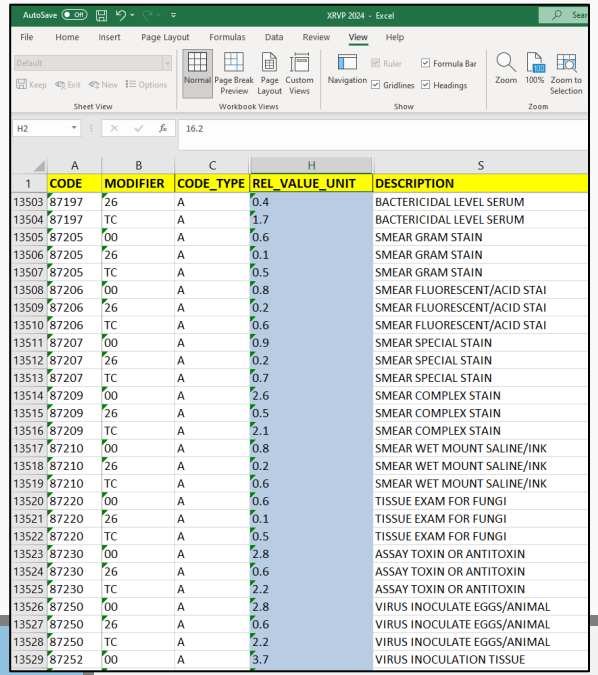
PROVIDER REIMBURSEMENT
Provider Service Code Conversion Factor:
70000-79999 Radiology and Nuclear Medicine $50.02
80000-89999 Pathology $29.68
90000-99999 General Medicine $12.96
10000-69999 Surgery $276.23
00000-99999 Anesthesiology $96.41

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*.

2. RELATIVE VALUES FOR PHYSICIANS (RVP) AS PROVIDED BY OPTUM



AutoSave Off — XRVP 2024 - Excel

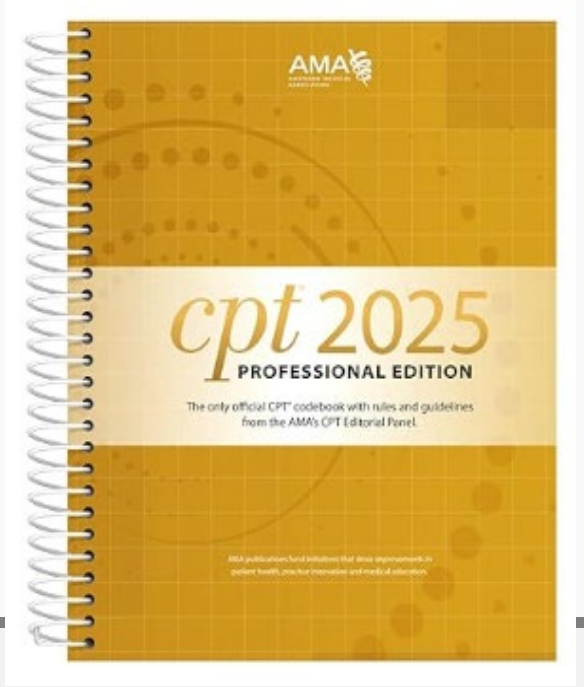
File Home Insert Page Layout Formulas Data Review View Help

Normal Page Break Preview Page Layout Custom Views — Workbook Views
Navigation Ruler Gridlines Formula Bar Headings — Show
Zoom 100% Zoom to Selection — Zoom

H2 16.2

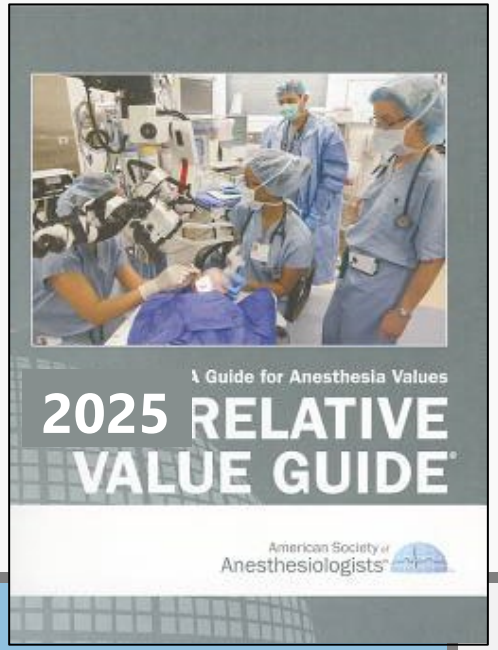
	A	B	C	H	S
1	CODE	MODIFIER	CODE_TYPE	REL_VALUE_UNIT	DESCRIPTION
13503	87197	26	A	0.4	BACTERICIDAL LEVEL SERUM
13504	87197	TC	A	1.7	BACTERICIDAL LEVEL SERUM
13505	87205	00	A	0.6	SMEAR GRAM STAIN
13506	87205	26	A	0.1	SMEAR GRAM STAIN
13507	87205	TC	A	0.5	SMEAR GRAM STAIN
13508	87206	00	A	0.8	SMEAR FLUORESCENT/ACID STAI
13509	87206	26	A	0.2	SMEAR FLUORESCENT/ACID STAI
13510	87206	TC	A	0.6	SMEAR FLUORESCENT/ACID STAI
13511	87207	00	A	0.9	SMEAR SPECIAL STAIN
13512	87207	26	A	0.2	SMEAR SPECIAL STAIN
13513	87207	TC	A	0.7	SMEAR SPECIAL STAIN
13514	87209	00	A	2.6	SMEAR COMPLEX STAIN
13515	87209	26	A	0.5	SMEAR COMPLEX STAIN
13516	87209	TC	A	2.1	SMEAR COMPLEX STAIN
13517	87210	00	A	0.8	SMEAR WET MOUNT SALINE/INK
13518	87210	26	A	0.2	SMEAR WET MOUNT SALINE/INK
13519	87210	TC	A	0.6	SMEAR WET MOUNT SALINE/INK
13520	87220	00	A	0.6	TISSUE EXAM FOR FUNGI
13521	87220	26	A	0.1	TISSUE EXAM FOR FUNGI
13522	87220	TC	A	0.5	TISSUE EXAM FOR FUNGI
13523	87230	00	A	2.8	ASSAY TOXIN OR ANTITOXIN
13524	87230	26	A	0.6	ASSAY TOXIN OR ANTITOXIN
13525	87230	TC	A	2.2	ASSAY TOXIN OR ANTITOXIN
13526	87250	00	A	2.8	VIRUS INOCULATE EGGS/ANIMAL
13527	87250	26	A	0.6	VIRUS INOCULATE EGGS/ANIMAL
13528	87250	TC	A	2.2	VIRUS INOCULATE EGGS/ANIMAL
13529	87252	00	A	3.7	VIRUS INOCULATION TISSUE

3. THE CPT CODE BOOK

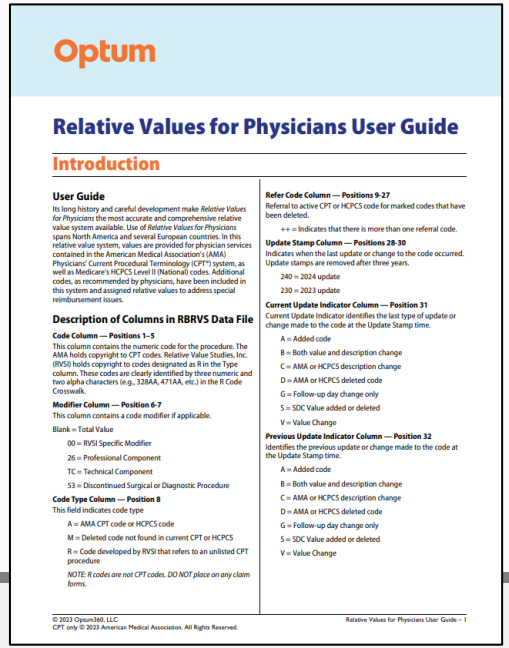


RESOURCES YOU WILL NEED

4. Relative Value Guide for Anesthesia Values



5. Relative Values for Physicians (RVP) User Guide



Optum

Relative Values for Physicians User Guide

Introduction

User Guide

Its long history and careful development make *Relative Values for Physicians* the most accurate and comprehensive relative value system available. Use of *Relative Values for Physicians* spans North America and several European countries. In this relative value system, values are provided for physician services contained in the American Medical Association's (AMA) Physicians' Current Procedural Terminology (CPT®) system, as well as Medicare's HCPCS Level II (National) codes. Additional codes, as recommended by physicians, have been included in this system and assigned relative values to address special reimbursement issues.

Description of Columns in RBRVS Data File

Code Column — Positions 1–5
This column contains the numeric code for the procedure. The AMA holds copyright to CPT codes. Relative Value Studies, Inc. (RVSI) holds copyright to codes designated as R in the Type column. These codes are clearly identified by three numeric and two alpha characters (e.g., 328AA, 471AA, etc.) in the R Code Crosswalk.

Modifier Column — Position 6-7
This column contains a code modifier if applicable.

Blank = Total Value
00 = RVSI Specific Modifier
26 = Professional Component
TC = Technical Component
53 = Discontinued Surgical or Diagnostic Procedure

Code Type Column — Position 8
This field indicates code type
A = AMA CPT code or HCPCS code
M = Deleted code not found in current CPT or HCPCS
R = Code developed by RVSI that refers to an unlisted CPT procedure
NOTE: R codes are not CPT codes. DO NOT place on any claim forms.

Refer Code Column — Positions 9-27
Referral to active CPT or HCPCS code for marked codes that have been deleted.
++ = Indicates that there is more than one referral code.

Update Stamp Column — Positions 28-30
Indicates when the last update or change to the code occurred. Update stamps are removed after three years.
240 = 2024 update
230 = 2023 update

Current Update Indicator Column — Position 31
Current Update Indicator identifies the last type of update or change made to the code at the Update Stamp time.
A = Added code
B = Both value and description change
C = AMA or HCPCS description change
D = AMA or HCPCS deleted code
G = Follow-up day change only
S = SDC Value added or deleted
V = Value Change

Previous Update Indicator Column — Position 32
Identifies the previous update or change made to the code at the Update Stamp time.
A = Added code
B = Both value and description change
C = AMA or HCPCS description change
D = AMA or HCPCS deleted code
G = Follow-up day change only
S = SDC Value added or deleted
V = Value Change

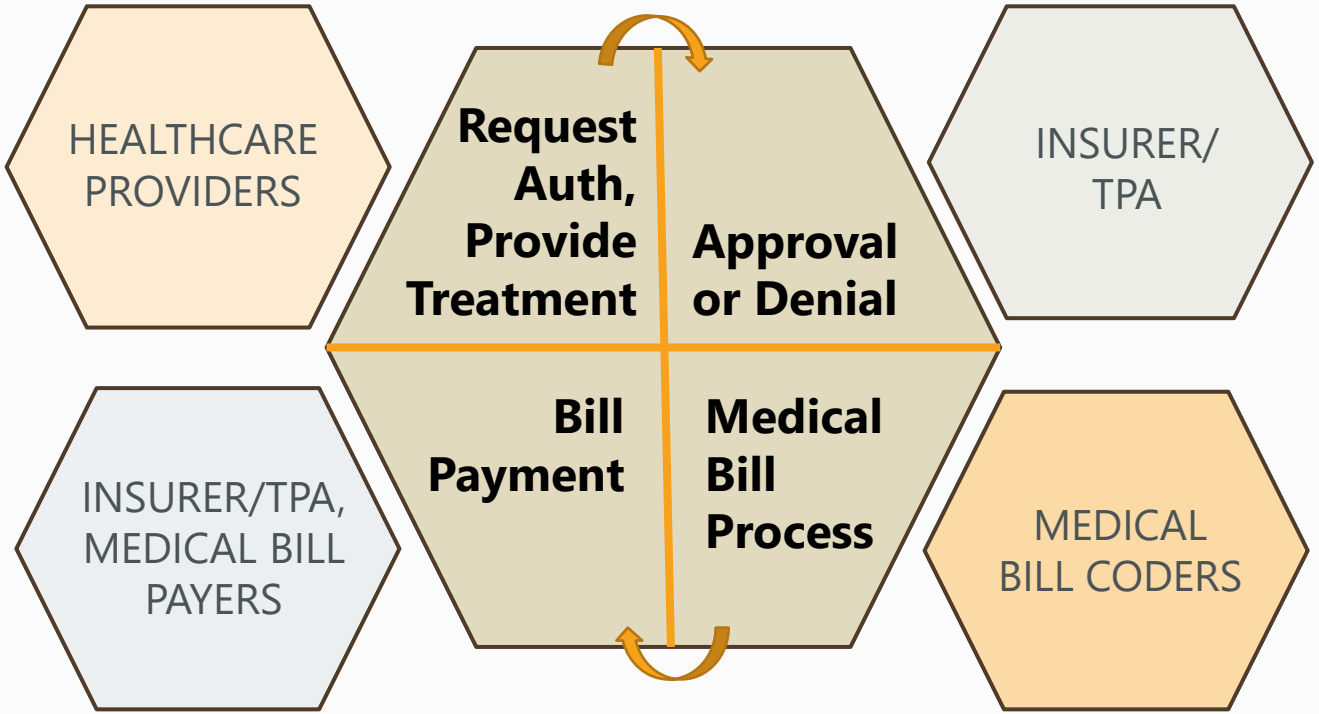
BASIC BILLING TIMELINES

HEALTHCARE PROVIDERS HAVE **90** DAYS TO BILL FROM THE DATE OF SERVICE.

INSURERS/TPAS HAVE **45** DAYS TO PAY OR DENY FROM DATE OF RECEIPT OF BILL.

HEALTHCARE PROVIDERS HAVE **60** DAYS TO APPEAL TO THE WCS WHEN BILLS HAVE BEEN DENIED, REDUCED, OR NOT PAID IN A TIMELY MANNER.

BILLING CYCLE



BILLING/ REIMBURSEMENT KEYS

1. Ensure timely billing and reimbursement.
2. Document all efforts to resolve billing issues.
3. Obtain written prior authorization when appropriate.
4. Code accurately. Use Nevada Specific Codes (NSC), CPT, ICD-9/ICD-10, HCPCs. Do not bill/pay revenue codes.
5. Do NOT use CPT codes specific for telemedicine.

BILLING/ REIMBURSEMENT KEYS

6. Be aware of contractual agreements, changes, and discounts.

7. Medical bills may be mailed to an out-of-state facility for the sole purpose of electronically scanning documents to claim files.

8. Bill procedures using appropriate modifiers.

9. Give or follow appropriate appeal rights on Explanation of Benefits (EOBs) and denial letters.

10. Be aware of legislative and Nevada Medical Fee Schedule (NV MFS) changes.

HCP RESPONSIBILITIES

NAC 616C.129 Obtain **written** *prior authorization* when the following have an estimated bill amount of $200 or more.

- CONSULTATIONS
- DIAGNOSTIC TESTS
- ELECTIVE HOSPITALIZATIONS
- ELECTIVE SURGERIES
- ELECTIVE PROCEDURES

HCP RESPONSIBILITIES

Prior authorization for out-of-state providers **(NAC 616C.143)** must include written notification:

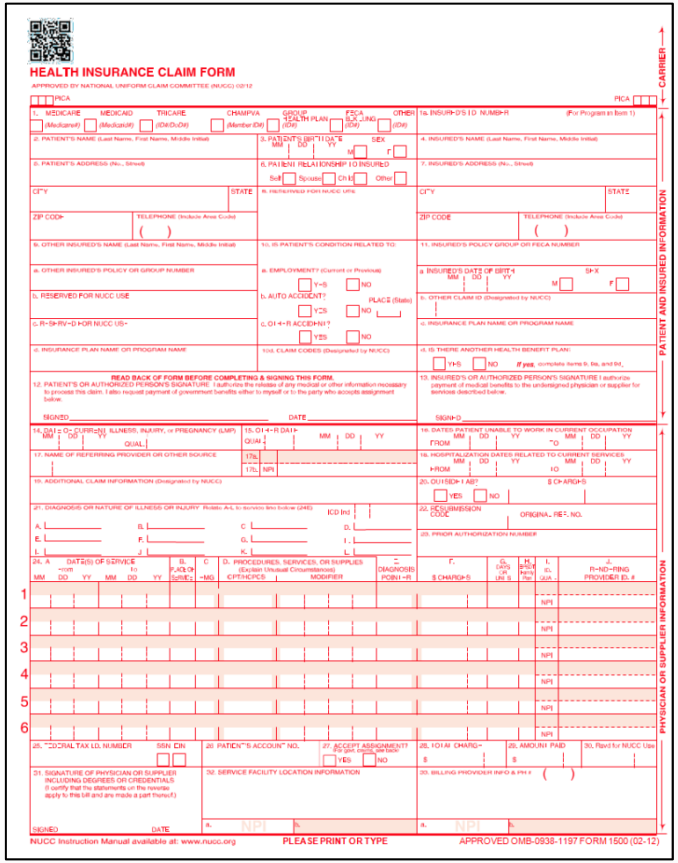
- Reimbursement per Nevada Medical Fee Schedule (NV MFS)
- Injured Employee not liable for payment and must not be billed
- Insurer solely responsible for payment
- Bill must be submitted within 90 days of service

HCP RESPONSIBILITIES

- Without written prior authorization, the insurer is not financially liable for services, except in cases of emergency.
- In cases of emergency or severe trauma, the healthcare provider may use resources and techniques necessary to cope with the situation.
- Emergency must be substantiated in medical record.

MEDICAL BILLS

Use current HCFA Form 1500 (NAC 616A.480)



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE MM DD YY QUAL

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

MEDICAL BILLS

Late billing: only if claim acceptance is delayed beyond 12 months due to litigation

ALWAYS USE

Nevada Medical Fee Schedule (NV MFS)

Nevada Specific Codes – see NV MFS

Relative Values for Physicians (RVP)

Appropriate Modifiers - see RVP, NV MFS

BILLING INJURED EMPLOYEES (NRS 616C.135)

Prohibited unless:

- Payment denied due to claim denial
- Services unrelated to injury or illness (NRS 616C.137)
- Copy of written denial letter required before billing injured employee

BILLING INJURED EMPLOYEES (NRS 616C.135)

Keep in mind:

- Compensability determinations are often appealed, may be overturned
- Injured employee may appeal compensability issues (not healthcare provider)

MEDICAL BILLS - MODIFIERS

Modifiers add to or change the story (may affect reimbursement)

MODIFIERS

- **Provide additional information**
- **Clarify**
- **Identify separation**
- **Enhance specificity**

MEDICAL BILLS - MODIFIERS

Definitions of modifiers included in:

(1) Nevada Med Fee Schedule (NV MFS):

-29 for services performed by non-physicians
-28 for supervising anesthesiologists
-GT for telemedicine services

(2) CPT Code Book

- do NOT use CPT codes specific for telemedicine
- must use codes with GT modifier

MEDICAL BILLS - MODIFIERS

Definitions of modifiers included in:

(3) Relative Values for Physicians
(for example -26 or -TC)

(4) Relative Value Guide
(American Society of Anesthesiologists)

MEDICAL BILLS - MODIFIERS

Ensure modifier(s) should be added

Remember that failure to use modifiers when appropriate may lead to payment denial

Overutilizing or failing to use appropriate modifier(s) may put the healthcare provider at risk

MEDICAL BUNDLING

NO adopted publications regarding “bundling” of codes for reimbursement

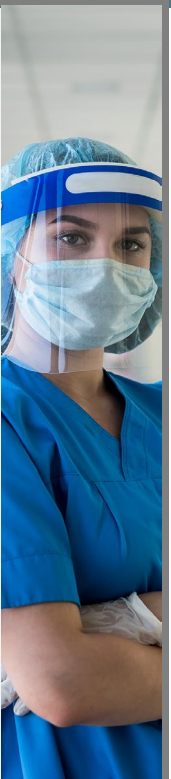
- Check CPT code book regarding codes used in conjunction with others or excluded for use in conjunction with others.
- Bundling may apply if defined contractually.

Do NOT duplicate charges; use add-on codes appropriately.

MEDICAL BILLS – OUT OF STATE (OOS)

1. Mailing medical bills Out Of State (OOS) - acceptable only to a scanning center pursuant to NAC 616B.010, revised and effective June 28, 2016
2. All medical bills must be date-stamped when received (NAC 616C.082), or if filed electronically, date received must be easily identified (no PO Boxes).

HCP RESPONSIBILITIES - DISPUTES



Efforts to resolve bill disputes must be documented in writing with timely follow-up.

1. Leaving telephone messages is insufficient to resolve medical billing disputes.
2. Ensure appropriate contact; use email and letters.

Bill/payment disputes - appeal to the Division of Industrial Relations (DIR) within 60 days of the date of the EOB or EOR (See NV MFS, NRS 616C.260, NAC 616C.027)

HCP RESPONSIBILITIES - DISPUTES

When appealing to the WCS, the following documents are required:

- Explanation of dispute with insurer, including substantiating documentation
- Copy of all medical bills
- Relevant medical records
- Copy of prior authorization
- Copy of EOB or EOR
- Documentation of efforts to resolve issue with payer

COMMON MISTAKES - HCP

- Using revenue codes only to bill services provided to injured employees
- Failure to bill using Nevada Specific Codes (NSC) – NSCs are required, see the NV MFS

COMMON MISTAKES - HCP

Billing Observation Care Inappropriately:

- Attempting to use for Emergency Department (ED) patients who are not admitted as inpatients. Only use if the patient's status has changed from ED to Observation. Admission also known as 24-hour observation.
- Attempting to use for Ambulatory Surgery Centers (ASC) or hospital-based surgery centers

If in doubt, check the NMFS!

COMMON MISTAKES - HCP

- Appealing to insurers for reconsideration when the date of service is greater than 1 year ago
- Appealing to WCS past 60 days from the date of the EOB or EOR or when the payment was due
- Using the WCS as a collection agency – no or minimal attempts to resolve billing issues independently

INSURER RESPONSIBILITIES - DISPUTES

Insurers or TPAs are also responsible to respond to questions and attempt to resolve medical billing or reimbursement disputes

- Respond to HCPs timely
- Insurers/TPAs are responsible to work with their contracted entities to resolve issues

INSURER RESPONSIBILITIES - DISPUTES

Insurers or TPAs are also responsible to respond to questions and attempt to resolve medical billing/reimbursement disputes

- Do NOT refer HCPs to contracted entities; review the dispute and work to resolve the issue(s) quickly
- Fines will be assessed against insurers or TPAs, not their contracted entities

INSURER RESPONSIBILITIES - DISPUTES

The 20/20/20 Rule

If additional information is needed:

- Insurers or TPAs must request specific information from the healthcare provider within 20 calendar days from the date the bill was received
- Healthcare providers must provide additional information to insurers or TPAs within 20 calendar days of the request
- Insurers or TPAs must approve or deny bills within 20 calendar days from the receipt of the additional information

INSURER/TPA RESPONSIBILITIES

No Downcoding Allowed!

What is downcoding?

Paying for a lower level of service than what is actually billed

Why is this unacceptable?

1. Insurers or TPAs may only reimburse billed services, and medical records must be attached to the bill (NRS 616C.130, NAC 616C.138, 141).

INSURER/TPA RESPONSIBILITIES

No Downcoding Allowed!

Why is this unacceptable?

2. Healthcare providers are responsible to bill appropriately for services provided, and medical records must substantiate the services billed.
3. Given that insurers or TPAs may not change medical records, they may not change medical bills either as both are required to be signed by the responsible healthcare provider.

INSURER/TPA RESPONSIBILITIES

Disputed Codes (NRS 616C.136)

What are insurers or TPAs to do instead? If the bill contains incorrect coding, the insurer or TPA shall:

1. Pay or deny payment for the portion of the bill that is correctly coded;
2. Return the bill to the healthcare provider and request additional information or documentation concerning the incorrect codes; and
3. Approve or deny payment within 20 days after receipt by the insurer or TPA of resubmitted bill with additional information/documentation.

INSURER/TPA RESPONSIBILITIES

NRS 616C.157 Request for prior authorization: Time to respond; effect of failure to respond in timely manner.

1. An insurer, organization for managed care or third-party administrator shall respond to a written request for prior authorization for:

(a) Treatment;

(b) Diagnostic testing; or

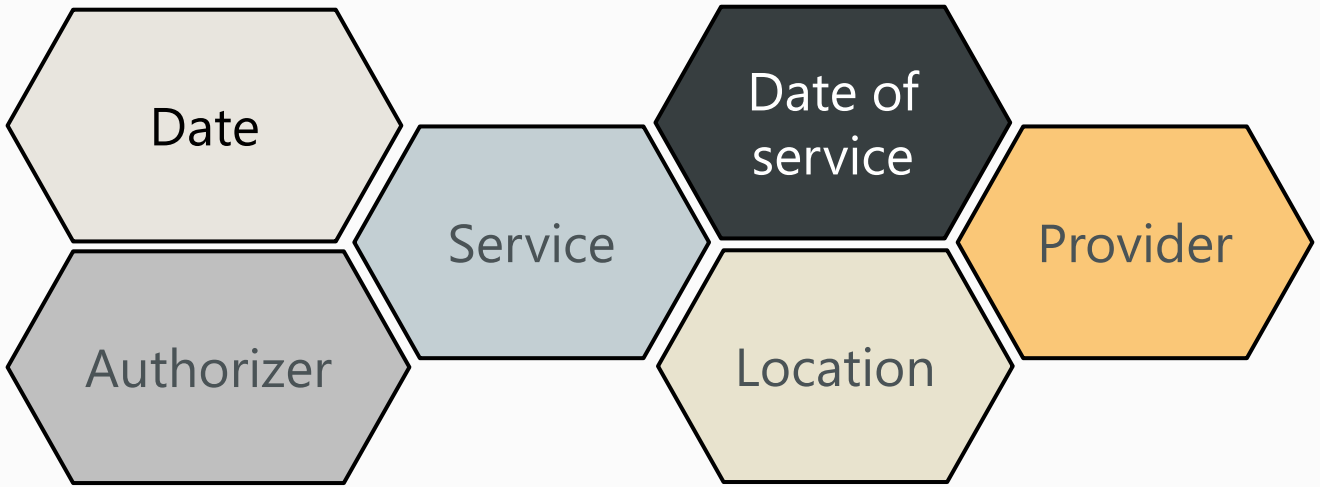
(c) Consultation,

Ê within 5 working days after receiving the written request.

2. If the insurer, organization for managed care or third-party administrator fails to respond to such a request within 5 working days, authorization shall be deemed to be given. The insurer, organization for managed care or third-party administrator may subsequently deny authorization.

INSURER/TPA RESPONSIBILITIES

Prior authorization must include:



And it must be in writing!

INSURER/TPA RESPONSIBILITIES

Know and reimburse only codes that are valid in Nevada.
Do NOT reimburse invalid codes such as revenue codes, name brand drugs when generic are available, etc.

Date stamp medical bills on date of receipt
(may be electronic, must be easily accessible).

Pay or deny medical bills within 45 days of receipt (NRS 616C.136).

INSURER/TPA RESPONSIBILITIES

Issue appropriate appeal rights – medical bill disputes resolution through insurer or TPA, appeal to the WCS (NAC 616C.027, 616C.097)

Do not simply reference regulation only.

Respond to attempts to resolve disputes.

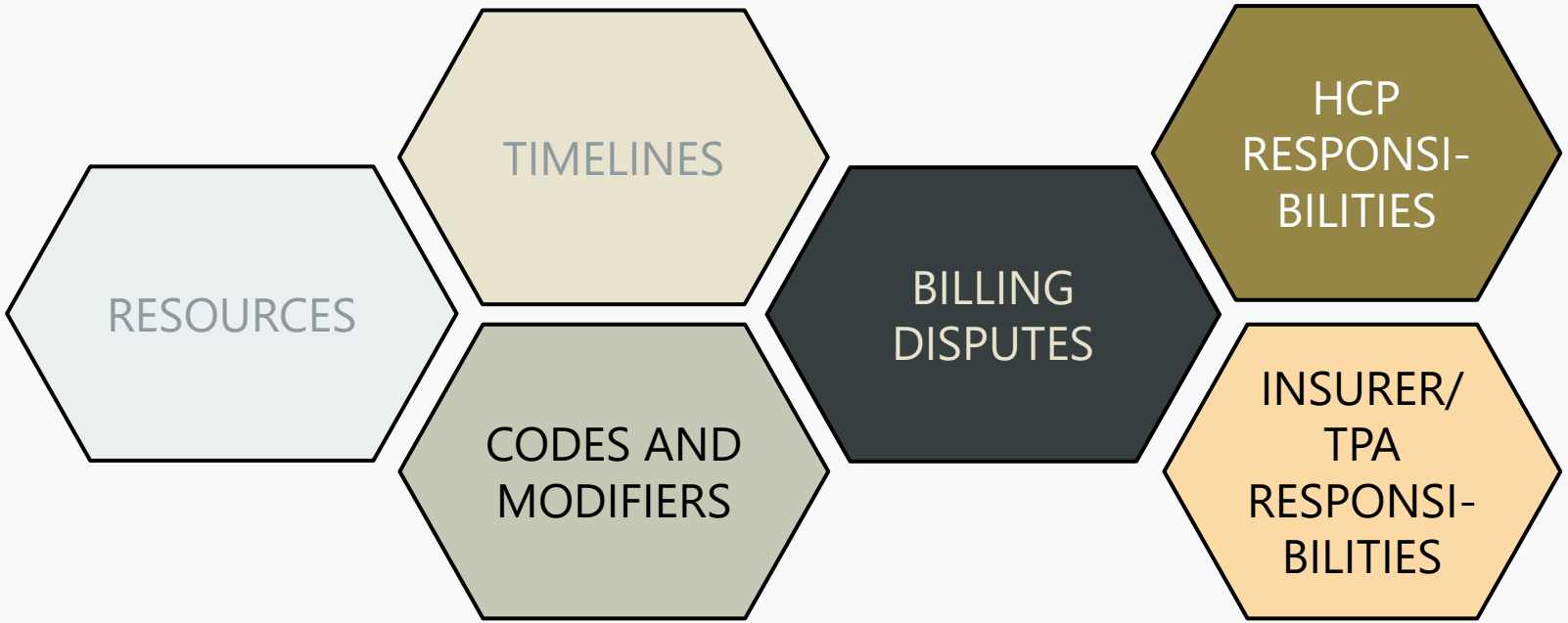
CONTRACTUAL OBLIGATIONS

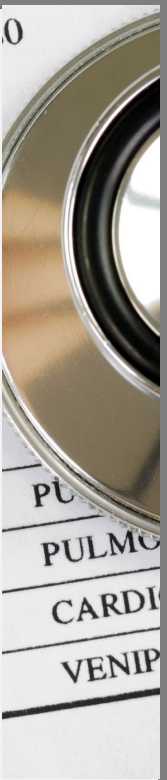
Contractual agreements may include:

- Discounted payment for medical services
- Use of National Correct Coding Initiative (CCI) edits
- Other Preferred Provider Organization (PPO) agreements or other managing entities (e.g. Multiplan)

NOTE: The WCS cannot make determinations regarding contractual issues.

REVIEW OF LESSONS





MEDICAL UNIT CONTACTS

LAS VEGAS OFFICE

Phone (702) 486-9080
Fax (702) 486-8713

C-4s/Proof of Coverage
(702) 486-9080
medunit@dir.nv.gov

D-35 Forms
medunit@dir.nv.gov

Questions/Complaints/Bill Disputes
medunit@dir.nv.gov

CARSON CITY OFFICE

Phone (775) 684-7270
Fax (775) 687-6305

Please submit unanswered questions to WCSHelp@dir.nv.gov.

THANK YOU

EJ GRAHAM, Medical Unit Chief

Workers' Compensation Section