



Division of Industrial Relations

WORKERS' COMPENSATION SECTION

Medical Billing



Workers' Compensation Section
US Bank Building, Suite 300, 2300 W. Sahara Ave., Las Vegas NV 89102

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



**ACCURATE MEDICAL
BILLING AND
REIMBURSEMENT IS
EVERYONE'S
RESPONSIBILITY**

RESOURCES YOU WILL NEED

1. A COPY OF THE NEVADA MEDICAL FEE SCHEDULE

**DEPARTMENT OF BUSINESS AND INDUSTRY
DIVISION OF INDUSTRIAL RELATIONS
WORKERS' COMPENSATION SECTION**

**NEVADA MEDICAL FEE SCHEDULE
Maximum Allowable Provider Payment
February 1, 2026 through January 31, 2027**

Pursuant to [NRS 616C.260](#), effective February 1, 2026, 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	\$52.86
80000-89999 Pathology	\$31.36
90000-99999 General Medicine	\$13.70
10000-69999 Surgery	\$291.92
00000-99999 Anesthesiology	\$101.88

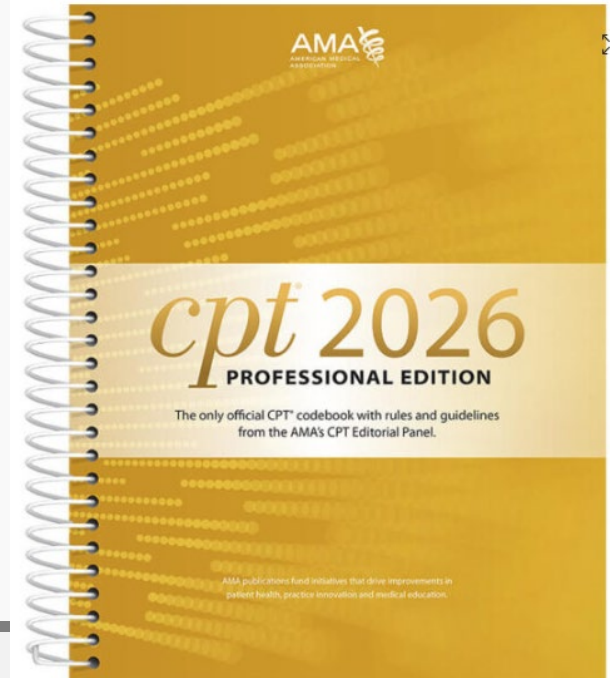
Applies to outpatient services provided in physician offices, freestanding facilities and/or hospitals. Facilities may be reimbursed for the technical portion of an applicable service (as defined in the *Relative Values for Physicians*) if the service is provided on an outpatient basis. Services provided 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.

Carson City: 1886 College Parkway, Suite 100 Carson City, Nevada 89706 - Telephone (775) 884-7270 - Fax (775) 887-3073
Las Vegas: 2300 W. Sahara Ave., Suite 300, Las Vegas, Nevada 89102 - Telephone (702) 486-9000 - Fax (702) 486-9174
<http://www.dir.nv.gov>

2. RVP (Relative Values for Physicians) AS PROVIDED BY OPTUM

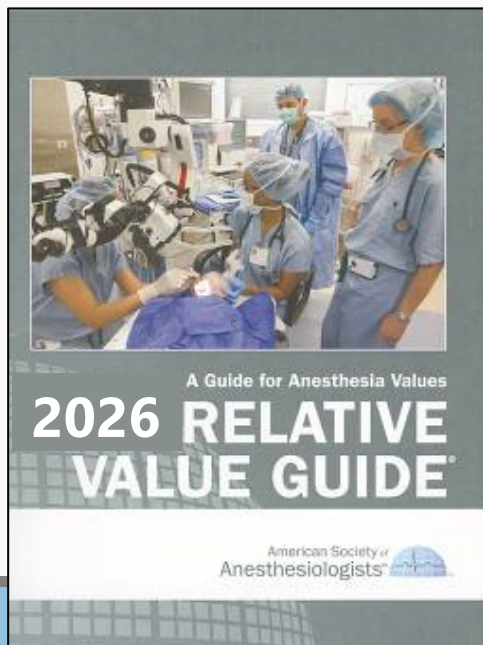
CODE	MODIFIER	CODE TYPE	REL. VALUE	UNIT	DESCRIPTION
13503	87197	26	A	0.4	BACTERICIDAL LEVEL SERUM
13504	87197	TC	A	1.7	BACTERICIDAL LEVEL SERUM
13505	87205	00	A	0.6	SMEAR GRAM STAIN
13506	87205	26	A	0.1	SMEAR GRAM STAIN
13507	87205	TC	A	0.5	SMEAR GRAM STAIN
13508	87206	00	A	0.8	SMEAR FLUORESCENT/ACID 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. A COPY OF THE CPT CODE BOOK



RESOURCES YOU WILL NEED

4. Relative Value Guide for Anesthesia Values



5. RVP (Relative Values for Physicians) 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. (RVS) 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., 325AA, 471AA, etc.) in the R Code Column.

Modifier Column — Position 6-7
This column contains a code modifier if applicable.
Blank = Total Value
00 = RVS Specific Modifier
26 = Professional Component
TC = Technical Component
52 = 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 RVS 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

© 2023 Optum360, LLC
CPT only © 2023 American Medical Association. All Rights Reserved.

Relative Values for Physicians User Guide - 1

BASIC BILLING TIMELINES

HEALTHCARE PROVIDERS HAVE

90

DAYS TO BILL FROM DATE OF SERVICE.

INSURER/TPAS HAVE

45

DAYS TO PAY FROM DATE OF RECEIPT OF BILL.

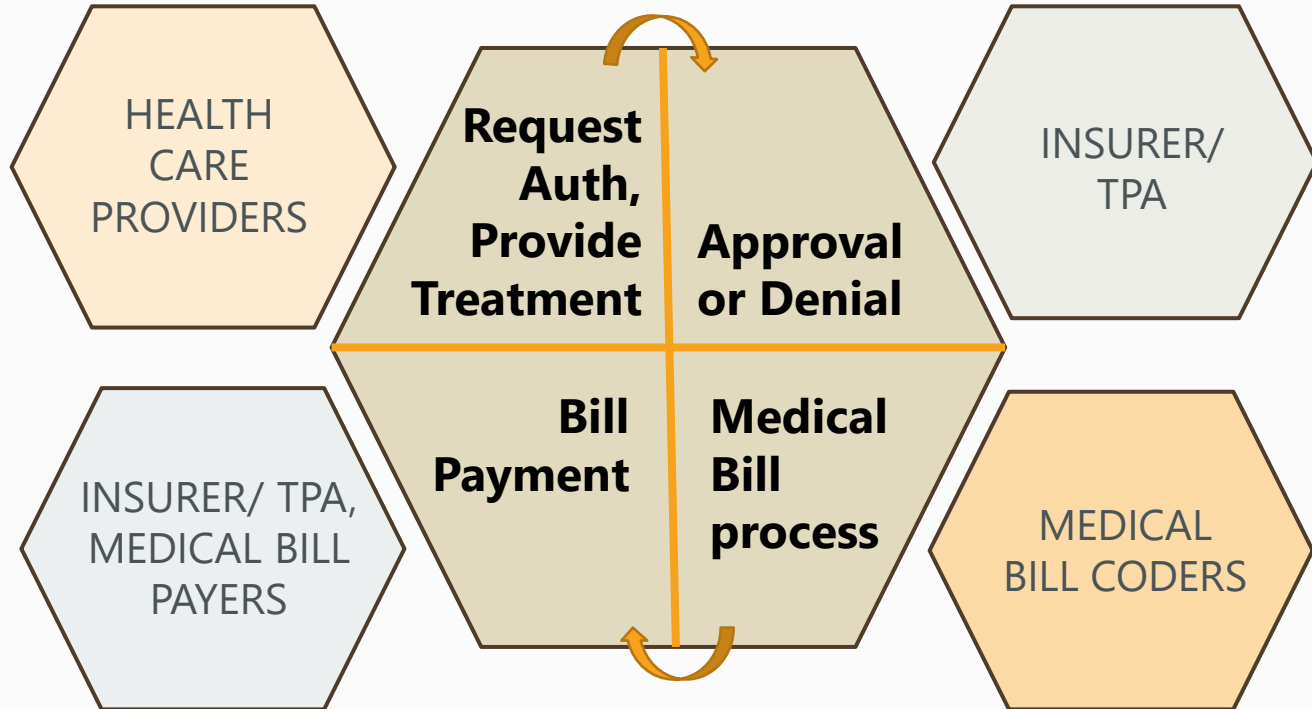
HEALTHCARE PROVIDERS HAVE

60

DAYS TO APPEAL TO WCS IN CASE OF DENIAL OR WHEN BILL IS DUE.



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 electronic scanning documents to claim files

8. Bill procedures using appropriate modifiers

9. Give/follow appropriate appeal rights on EOBs and denial letters

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



HCP RESPONSIBILITIES

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

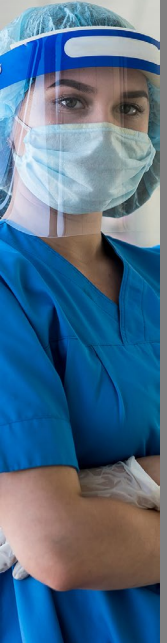
CONSULTATIONS

DIAGNOSTIC
TESTS

ELECTIVE
HOSPITALIZATIONS

ELECTIVE
SURGERIES

ELECTIVE
PROCEDURES



HCP RESPONSIBILITIES

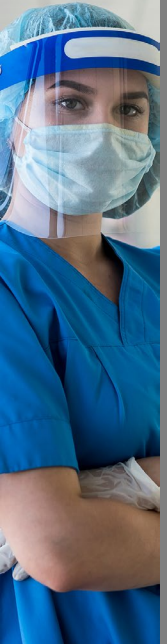
Prior authorization for out-of-state providers (**NAC 616C.143**) must include written notification:

Reimbursement per NV
Med Fee Schedule
(NMFS)

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, insurer is not financially liable for services, except in cases of emergency
- In case of emergency/severe trauma, provider may use resources and techniques necessary to cope with situation
- Emergency must be substantiated in medical record





MEDICAL BILLS



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

ALWAYS USE

NV Medical Fee
Schedule
(NMFS)

Nevada Specific
Codes – see
NMFS

Relative Values
for Physicians
(RVP)

Appropriate
Modifiers
- see RVP, NMFS



BILLING INJURED EMPLOYEES (NRS 616C.135)

Prohibited unless:

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



BILLING INJURED EMPLOYEES (NRS 616C.135)

Keep in mind:

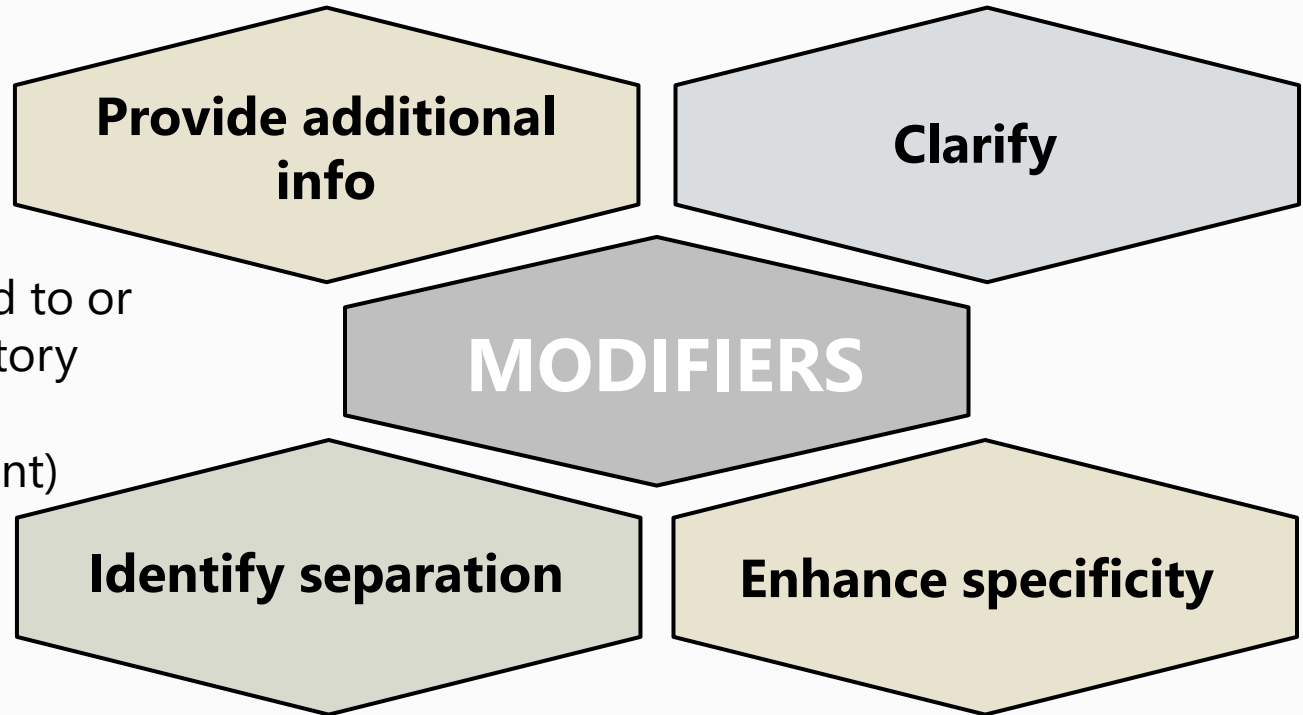
- Compensability determinations often appealed, may be overturned
- Injured employee may appeal compensability issues (not health care provider)



MEDICAL BILLS - MODIFIERS



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



MEDICAL BILLS - MODIFIERS

Definitions of modifiers included in:

(1) Nevada Med Fee Schedule (NMFS):

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

(2) CPT Code Book

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



MEDICAL BILLS - MODIFIERS

Definitions of modifiers included in:

- (3) Relative Values for Physicians
(for example -26/-TC)
- (4) Relative Value Guide
(American Society of Anesthesiologists)



MEDICAL BILLS - MODIFIERS

Ensure modifier(s) should be added

Remember failure to use modifier when appropriate may lead to payment denial

Over-utilizing or failure to use appropriate modifier(s) may put provider at risk



MEDICAL BUNDLING

NO adopted publications regarding “bundling” of codes for reimbursement



- check CPT code book re: 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)

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)

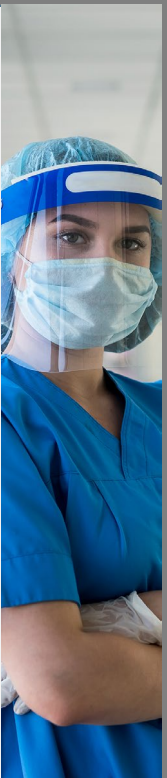


HCP RESPONSIBILITIES - DISPUTES

Efforts to resolve bill disputes must be written, documented, timely follow up

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

Bill/payment disputes - appeal to DIR within 60 days from date of EOB/EOR (See NV Medical Fee Schedule, NRS 616C.260, NAC 616C.027)



HCP RESPONSIBILITIES - DISPUTES

When appealing to WCS, the following documents are required:

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



COMMON MISTAKES - HCP

- Using revenue codes only to bill services provided to NV workers' compensation patients
- Failure to bill using Nevada Specific Codes (NSC) – NSCs are required, see the Nevada Medical Fee Schedule



COMMON MISTAKES - HCP

Billing Observation Care inappropriately:

- Attempting to use for ED patients who are not admitted as inpatients. Only use if the patient's status has changed from ER to Observation Admission aka 24-Hr Obs.
- 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 date of service > 1 year ago
- Appealing to WCS past 60 days from date of denial or when date is due
- Using WCS as collection agency – no/minimal attempts to resolve billing issue independently



INSURER RESPONSIBILITIES - DISPUTES

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

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



INSURER RESPONSIBILITIES - DISPUTES

Insurers/ 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 insurer/TPA, not their contracted entities



INSURER RESPONSIBILITIES - DISPUTES

The 20/20/20 Rule

If additional information is needed:

- Insurer/TPA must request specific info from health care provider within 20 calendar days from date bill received
- Health care provider must provide additional info to insurer/TPA within 20 calendar days of request
- Insurer/TPA must approve or deny bill within 20 calendar days from receipt of additional info



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



INSURER/TPA RESPONSIBILITIES

Disputed Codes (NRS 616C.136)

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

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

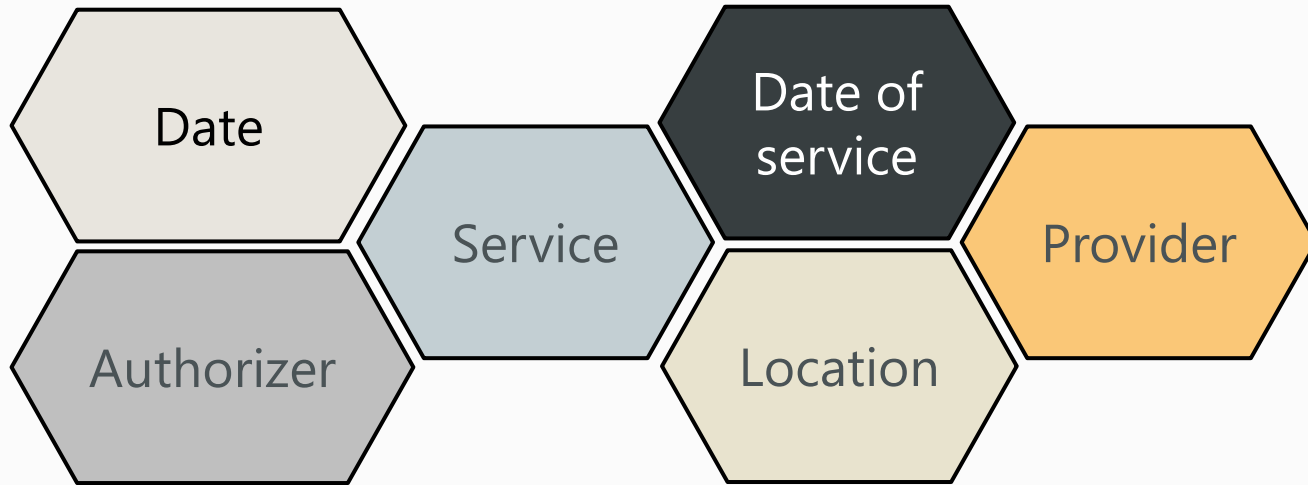
Ê within 5 working days after receiving the written request.

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 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 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/TPA, appeal to WCS (NAC 616C.027, 616C.097)

Do not simply reference regulation only

Respond to attempts to resolve disputes





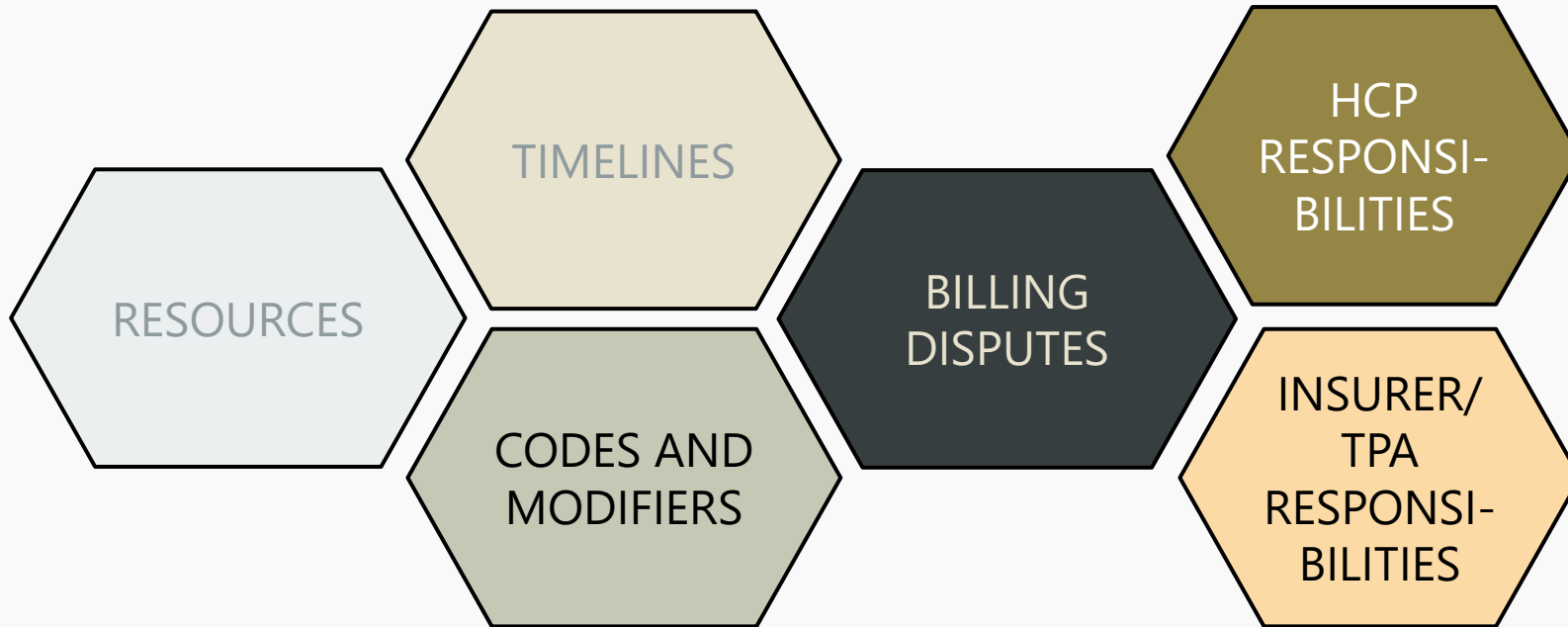
CONTRACTUAL OBLIGATIONS

Contractual agreements may include:

- Discounted payment for medical services
- Use of CCI edits
- Other PPO agreements or other managing entities (e.g. Multiplan)

NOTE: 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



QUESTIONS?





THANK YOU

Medical Unit

Workers' Compensation Section