Division of Industrial Relations (DIR) Workers' Compensation Section (WCS)

RATING PANEL OF PHYSICIANS AND CHIROPRACTORS APPLICATION

Pursuant to NRS 616C.490, DIR shall establish a list of physicians and chiropractic physicians to determine the percentage of disability in accordance with the AMA *Guides to the Evaluation of Permanent Impairment, 5th Edition*. To apply for the WCS Rating Panel of Physicians and Chiropractors, please complete the application and email it to medpanelapps@dir.nv.gov along with the following documentation:

- Current Curriculum Vitae,
- Certificate for the AMA Guides, 5th Edition Course from the American Board of Independent Medical Examiners (ABIME) or the American Academy of Expert Medical Evaluators (AAEME),
- Certificate for the Nevada Impairment Rating Skills Assessment Test (NIRSAT)
- Certificate for the Form D-9c course-Nevada Impairment Rating (IR) Stress Disorders

For any questions or concerns regarding the application, please contact the Medical Unit at medpanelapps@dir.nv.gov.

Physician/Chiropractor Applicant Information

First Name: Last Name: Middle Init:

License Type (MD/DO/DC): NV License Nbr:

Email:

Phone: Specialty(ies):

Rating Locations (All locations must be in Nevada.) Attach additional locations if needed.

Primary location highlighted in yellow.

Practice: **Phone Nbr:**

Address: **Fax Nbr:**

City: **State:** **Zip:**

Practice: **Phone Nbr:**

Address: **Fax Nbr:**

City: **State:** **Zip:**

Practice: **Phone Nbr:**

Address: **Fax Nbr:**

City: **State:** **Zip:**

Practice: **Phone Nbr:**

Address: **Fax Nbr:**

City: **State:** **Zip:**

RATING PANEL OF PHYSICIANS AND CHIROPRACTORS APPLICATION

Applicant Name: _____ Date: _____

Required Disclosures

Check yes or no to the questions below. For any yes responses to questions 2 - 8, submit relevant supporting documents with your application.

☐ YES ☐ NO 1. Have you ever been licensed in a state other than Nevada? If yes, please provide state(s) and dates below.

☐ YES ☐ NO 2. Has your license to practice medicine/chiropractic in any jurisdiction ever been denied, revoked, voluntarily or involuntarily terminated, relinquished, suspended, otherwise limited or restricted or been made subject to a program of probation, or have you ever been issued a citation or letter of reprimand by the licensing agency, or have formal or informal proceedings, or investigations, toward any of those ends ever been commenced?

☐ YES ☐ NO 3. Has disciplinary action ever been filed against you by any workers' compensation authority, Medicare, or Medicaid (CMS), medical facility, health maintenance organization, or professional practice board/society/association for fraud, medical billing fraud, substance abuse, prescribing controlled substances or quality of patient care?

☐ YES ☐ NO 4. Have you ever been sanctioned for unprofessional conduct or discriminatory treatment in the care and/or treatment of patients in any state?

☐ YES ☐ NO 5. Has your Drug Enforcement Agency or other controlled substances authorization ever been denied, revoked, voluntarily or involuntarily terminated, suspended, or restricted or have formal or informal proceedings, or investigations toward any of those ends ever been commenced?

☐ YES ☐ NO 6. Have you ever been convicted of a criminal offense other than a minor traffic violation?

☐ YES ☐ NO 7. Has the State of Nevada DIR ever issued a warning to you or imposed an administrative fine on you?

☐ YES ☐ NO 8. Have you ever been suspended or removed from the WCS Treating Panel of Physicians and Chiropractors, the WCS Rating Panel of Physicians and Chiropractors, or any other provider list as a disciplinary measure in Nevada or another state?

RATING PANEL OF PHYSICIANS AND CHIROPRACTORS APPLICATION

Applicant Name: _____ Date: _____

Attestations

Read and initial indicating your understanding and agreement with each statement below.

☐ The information provided in this application is both complete and accurate to the best of my knowledge. I understand providing inaccurate information or documentation may result in the denial of this application, and incomplete applications will not be processed.

☐ I will comply with the provisions of Chapters 616A through 617, inclusive of NRS and NAC. Failure to do so may result in disciplinary action including suspension or removal from the Rating Panel (NAC 616C.024).

☐ I will email changes to any of the information provided in this application, including, but not limited to, name of practice, address(es), email address, telephone number(s), and or licensing board status to the WCS Medical Unit at medpanels@dir.nv.gov within 14 days of the change(s).

☐ I will comply with the billing practices and reimbursement established in NRS, NAC, and the Nevada Medical Fee Schedule (NV MFS) available on the WCS Rating Panel webpage. The NV MFS is updated annually on or before February 1, and the appropriate NV MFS is determined by the date of service.

☐ I will decline randomly selected rating assignments in CARDS within two business days of notification if I lack the ability to rate the specific disability. If I do not decline an assignment within two business days, I automatically accept the assignment.

☐ I will accept all rating assignments for Permanent Partial Disability (PPD) evaluations as long as I remain active on the Rating Panel, unless I am ineligible or choose to decline.

☐ I will schedule and perform PPD evaluations within 30 days of assignment.

☐ I will serve without compensation on a review panel of rating physicians and chiropractors, for a minimum of one year, if selected by the Administrator.

☐ I will submit all PPD reports to the requestor and upload them to CARDS within 14 days after the evaluation is completed. I will submit all addendums to the requestor and upload them to CARDS within 14 days after receiving the request.

Division of Industrial Relations - Workers' Compensation Section

RATING PANEL OF PHYSICIANS AND CHIROPRACTORS APPLICATION

Applicant Name: _____ Date: _____

☐ I will email the WCS Medical Unit at medpanels@dir.nv.gov whenever I am temporarily unavailable to accept rating assignments.

☐ I will complete biennial education from the list of Administrator-approved options and submit the certificate of completion to the WCS Medical Unit at medpanels@dir.nv.gov by December 31 of every even-numbered year. The Administrator-approved options are listed on the WCS Rating Panel webpage.

☐ I have a copy of the AMA Guides to the Evaluation of Permanent Impairments, 5th Edition.

The following documentation must be submitted with the application:

☐ Current Curriculum Vitae
☐ Certificate for AMA Guides, 5th Edition course from ABIME or AAEME
☐ Certificate for NIRSAT
☐ Certificate for Form D-9c course-Nevada IR Stress Disorders

I attest that I have read and understand this completed application. I agree that my electronic signature below has the full force of the law of an original signature.

Physician Signature _____ Date _____

Designated Contact _____ Designated Contact Email _____

By submitting this application, the physician acknowledges that the designated contact person is authorized to receive communications from the WCS Medical Unit pertaining to the application.