



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

Frequently Asked Questions regarding changes related to Nevada SB 317 (2025)
11/12/2025-Updated

Updates to Nevada's workers' compensation system were made through Senate Bill (SB) 317, impacting insurers, self-insured employers, physicians, claims administrators, and injured employees. This document provides answers to the most frequently asked questions about the changes.

Insurer/Third Party Administrator (TPA) Office Requirements

1. What has changed for physical office requirements in Nevada?

SB 317 amends NRS 616B.021 and 616B.027 to allow legal representatives of an insurer or third-party administrator (TPA) to operate or maintain the required physical office in Nevada. Previously, only the insurer or TPA themselves could maintain such an office.

2. Can a self-insured employer administer claims from an office outside Nevada?

Yes, under specific conditions:

- The self-insured employer and associated entities must have a combined workforce of 30,000 or more employees (NRS 616B.0275).
- Claims administrators must be available to communicate with claimants in real-time during Nevada business hours: Monday–Friday, 9:00 a.m. to 5:00 p.m. (excluding legal Nevada holidays), as required under NRS 616B.027.

3. What are the requirements for inspections of claim files at an office?

Per NRS 616B.021, the Administrator of the Division of Industrial Relations must give at least one business day notice before a claim file inspection. The inspection must take place at a Nevada-based office operated by the insurer, TPA, or their legal representative.

Maximum Amount Paid to An Employee

4. What changes were made to the determination of the maximum amount paid to any one employee under NRS 616B.222 effective October 1, 2026?

- State employees or other government employees: \$36,000 or option to use the method required for other employees below
- Other employees: 12 times the maximum average monthly wage
 - Maximum average monthly wage is established by the Division of Industrial Relations (DIR) Administrator on or before January 1 each year and is defined as 150 percent of the state average weekly wage as most recently computed by the Employment Security Division of the Department of Employment, Training and Rehabilitation, multiplied by 4.33.

Temporary Partial Disability

5. How does SB 317 affect the timing of temporary partial disability payments?

Per NRS 616C.500, for temporary partial disability (TPD), the initial payment or determination must be issued within 14 working days of receiving the “claim” (the request for TPD).

Subsequent Injury Claims

6. What changes were adopted for the Subsequent Injury Account for Associations of Self-Insured Public and Private Employers?

SB 317 makes the following changes for the Subsequent Injury Account for Associations of Self-Insured Employers per NRS 616B.575, 616B.578, and 616B.581:

- Only subsequent injuries occurring on or before September 30, 2025, are eligible for compensation from the Subsequent Injury Account.
- Subsequent injuries occurring on or after October 1, 2025, are not eligible for reimbursement from this account.
- Evaluation of claims submitted will be reviewed not later than 30 days after WCS is in receipt of the claim.
- The State Treasurer shall disburse money from the Subsequent Injury Account within 14 days of receiving a written order of the Board for Associations of Self-Insured Employers.

7. Do the changes to Subsequent Injury Claims apply to all types of insurers?

No, the changes in SB317 only apply to Associations of Self-Insured Public and Private Employers. There are no changes to subsequent injury claims for Self-Insured Employers or Private Carriers.

Administrative Fines and Notices of Corrections

8. What is the amount of a fine for an initial vs. subsequent violation?

Per NRS 616D.120(2), an Administrative Fine can be issued by the Administrator to an insurer, organization for managed care, health care provider, third-party administrator, employer or professional employer organization for failure to comply with any provision chapter 616A, 616B,

616C, 616D, or 617 of NRS. SB317 creates a new graduated fine schedule as follows

- Initial violation: no more than \$375
- Second violation of same section: no more than \$750
- Third violation of same section: no more than \$1,500
- Fourth or subsequent violation of same section: no more than \$3,000

9. When can administrative fines be issued for subsequent violations?

- Per NRS 616D.120(2), a subsequent fine may only be issued if:
 - The new violation is of the same section as a prior one, and
 - The prior violation occurred within three years of the new fine.
- If more than three years have passed or the violation concerns a different section, it must be treated as a first-time violation.

10. What is a minor, clerical, or ministerial violation?

Per NRS 616D.120(2), a violation constitutes a minor, clerical or ministerial violation if the violation does not create a financial impact to an injured employee.

11. Can an administrative fine be issued for a minor, clerical, or ministerial violation?

- If the Administrator finds an initial minor, clerical, or ministerial violation, a Notice of Correction (NOC) will be issued in lieu of an Administrative Fine. There are no monetary penalties associated with an NOC.
- If there is more than one minor, clerical or ministerial violation which is substantially similar across multiple claims, all such violations must be combined into a single finding in an NOC.
- If there is a second or subsequent violation of the same section for which an NOC was issued, an Administrative Fine may be issued.

Follow-up Care by Physician Assistants

12. Are treating providers allowed to delegate routine follow-up care to physician assistants?

Section 9.3 of SB317 the Administrator of DIR may adopt regulations which authorize a treating physician or chiropractic physician to delegate certain routine follow-up care of an injured employee, as determined by the Administrator, to a physician assistant who is an employee of and under the supervision of the physician or chiropractic physician. **A key statutory requirement is that the injured employee must provide consent before a physician assistant may be used. Without such consent, delegation is not permitted.** These regulations are under development.

Drug Formulary

13. Is DIR required to adopt a drug formulary?

Yes. SB 317 requires the DIR Administrator to adopt the ODG Drug Formulary:

- Effective date: Must be adopted on or before July 1, 2027. DIR adopted the ODG Drug Formulary on September 9, 2025.
- Reimbursement:
 - After July 1, 2027, insurers are required to use the formulary for outpatient services.
 - An insurer shall not provide reimbursement for any drug that is not approved in the formulary, *unless the insurer elects to approve the drug*.
 - A physician or chiropractic physician may request authorization from an insurer to prescribe a drug that is not approved if the physician believes the drug is medically necessary.
- Appeals: Injured employees may appeal to the Hearings Division if a drug is denied based on its exclusion from the formulary.

14. Will DIR have training on the new drug formulary?

Yes.

- A training presentation is available at: [PowerPoint Presentation](#)
- A webinar titled: The ODG Drug Formulary: A Comprehensive Guide for the State of Nevada will be scheduled for Wednesday, November 5, 2025 at 11:00 a.m. PST. The webinar will provide instruction per SB317 (Sec. 9.5 & 9.7) regarding the adoption and use of the ODG Formulary. Registration is available at: <https://info.mcg.com/odg-webinar-nevada.html>.

15. How does the public gain access to the Formulary?

- The ODG formulary is accessible to the public via a dedicated website without the need for a license, and users can search for drugs, print documents, and use tools such as equivalent dose calculators directly from the site.
- Basic information is available at the DIR website: [TheODGDrugFormularyAdoption](#)
- Direct link to formulary: [ODG - Formulary](#)
- While access to the basic formulary is free, additional features such as integration with evidence-based guidelines and advanced search require a subscription, which is discounted for users, however users do not need to purchase a license for basic access.

16. How often will the Drug Formulary be updated?

The ODG Drug Formulary is typically updated a few times per year. Users can always access the latest formulary at: [ODG - Formulary](#).

17. Will DIR provide notification to stakeholders of the update of the Drug Formulary?

Yes. An eblast will be sent to stakeholders notifying them of updates to the drug formulary. Information will also be available at: [TheODGDrugFormularyAdoption](#)

18. Does the drug formulary apply to emergency medical services? Inpatient services? Outpatient services?

The drug formulary is not required for emergency medical services or inpatient services.

19. What is the reimbursement responsibility of a payer in relation to the Drug Formulary?

Upon implementation of the Drug Formulary, a payer is not required to pay any medication that is listed as an “N” drug on the drug formulary or that is omitted from the formulary, *unless the insurer elects to approve the drug.*

20. Who is responsible for seeking prior authorization for an “N” medication, omitted medication, or medication that is not approved by the insurer?

The prescribing doctor should seek prior authorization prior to prescribing the medication from the payer or their identified representative. Failure to do so could result in delays in filling the prescription at the retail pharmacy.

21. What is the time frame for responding to a request for prior authorization?

According to [NRS 616C.157](#), the time frame for a payer or their designated entity to respond to a request for prior authorization is within five working days after receiving the written request.

22. Is there a specific prior authorization process, form or format to utilize when requesting prior authorization?

No. The Division of Industrial Relations has not established a formal process, form or format. Payers should notify and communicate their reasonable process details to doctors prescribing medication for their injured workers. Authorization requests must be in writing and may be submitted through electronic means.

23. What happens if the payer or their designated entity fails to respond to a request in the required timeframe?

According to NRS 616C.157, authorization shall be deemed to be given for purposes of the prior authorization requirement. The payer may subsequently deny authorization; however, if the payer subsequently denies a request for authorization submitted by a provider for additional medication fills or a new prescription for the same medication, it shall pay for the additional fills from the original prescription actually provided to the injured employee, up to the number of fills for which payment is requested by the provider before the denial of authorization is received by the provider.

24. Who can approve a request for authorization for a prescribed medication?

The insurer, organization for managed care, or third-party administrator.

25. What recourse is there for the prescribing doctor when a request for prior authorization is denied?

Under SB 317, if the insurer denies the request of a physician or chiropractic physician, the injured employee or his or her representative may appeal the determination of the insurer to a hearings

officer in the manner provided by NRS 616C.315.

26. What will happen when an “N” drug, or omitted drug, or drug that has not been approved by the insurer, is dispensed without being approved through the prior authorization process?

The payer is not responsible for reimbursement.

27. Is there a time frame or grandfathering of medications being taken by injured workers prior to the final implementation of the Drug Formulary?

An insurer may, until January 1, 2028, provide reimbursement for a drug that is dispensed to an injured employee after July 1, 2027, if:

- The injured employee sustained the injury for which a claim was made on or after January 1, 2027, and on or before July 1, 2027; and
- The injured employee was originally prescribed the drug in connection with their claim on or after January 1, 2027, and on or before July 1, 2027.

Note: For existing claims prior to January 1, 2027, prescribing providers should plan for transitioning injured workers off of “N” drugs, omitted drugs, or drugs not approved by the insurer prior to the July 1, 2027 implementation date or, if medically necessary, work with the payer to obtain authorization ongoing.

28. Who do I contact for help and support?

ODG will provide a support structure, including a monitored email help desk with broad coverage across time zones, ensuring timely responses to user inquiries about the formulary.

Mental Health Care Provider List

29. What is a provider of mental health care?

Per NRS 616C.180, “provider of mental health care” means a psychiatrist, a licensed psychologist, a licensed clinical professional counselor or a licensed marriage and family therapist.

30. What are the requirements for the new mental health provider list?

- Per NRS 616C.180, an insurer shall maintain a list of providers of mental health care who have agreed to accept and treat injured employees pursuant to this section, from which an injured employee has the right to choose a mental health care provider of his or her choice.
- For each county whose population is 100,000 or more, the list must include not less than 12 providers of mental health care.
- On or after September 1 and on or before October 1 of each year, each insurer shall update the mental health provider list and submit it to DIR. This list shall be submitted in conjunction with the insurer’s Treating Provider List.
- If the mental health provider list contains a provider of mental health care that does not accept and treat patients pursuant to this section, an injured employee may choose any

provider of mental health care who agrees to accept the schedule of fees and charges established by the Nevada Medical Fee Schedule.

31. How does SB 317 affect mental health claims?

Under updated NRS 616C.180, claimants with stress-related injuries must provide clear and convincing medical, psychological, or psychiatric evidence that the condition arose out of and in the course of employment.

Treating Provider Lists

32. What changes are new for submitting Insurer Treating Providers Lists?

Per NRS 616C.087, the new submission date range for insurer treating provider lists is September 1 – October 1 annually.

Other changes include:

- A TPA may file a single list on behalf of more than one insurer.
- New Insurer Treating Provider List Requirements
 - o A list of mental health care providers is required by NRS 616C.180. This list should be included in the same file as the treating provider list.
 - o The list no longer needs to include at least 12 of the following types of providers:
 - ♣ Neurologists;
 - ♣ Psychiatrists; or
 - ♣ General Practice or Family Medicine.

Please note: While the requirement to include at least 12 neurologists, psychiatrists, or general/family practice doctors has been removed, **NRS 616C.087(3) still mandates that no fewer than 8 providers in these specialties must be listed**, unless fewer than 8 exist on the DIR panel. In such cases, the list must include all available providers in that specialty. If more than 8 exist on the DIR panel for these disciplines, **insurers must still include at least 8 neurologists, psychiatrists, and general/family practice physicians.**

33. Who must the Treating Provider Lists be certified by?

- An adjuster who is licensed pursuant to NRS 684; or
- The insurer's highest-ranking employee who is responsible for processing workers' compensation claims filed in this state if the insurer uses only salaried employees pursuant to NRS 684A.040(4) to investigate, negotiate, and settle workers' compensation claims. See [R076-23 Sec. 9](#).

34. Is there a specific format that must be used for Insurer Treating Provider Lists?

NRS 616C.087(12) requires the Administrator to develop a uniform format for insurer treating provider lists. A regulation to accomplish this is under development. Until a regulation is finalized, no specific format is required.

While a uniform format is still under development, **NRS 616C.087(12) already requires that all insurer provider lists be in a format that is easily searchable**, including, but not limited to, an

indexed database, a PDF, a filterable spreadsheet, or a CSV file.

35. Are Insurer Treating Provider Lists required to be submitted through CARDS?

No.

36. What are the Insurer Treating Providers List submission requirements?

List Submission Requirements:

- Please email lists to medpanels@dir.nv.gov
- Subject Line: Include the insurer's name and that provider list(s) are attached.
- List(s) are to include the submission date, and the name and license number of the certified adjuster, or the highest-ranking salaried employee who is responsible for processing workers' compensation claims.

The Insurers' Treating Providers List will be published on the same webpage as the instructions.

https://dir.nv.gov/WCS/Medical_Providers/

37. What is the obligation of an insurer to ensure providers on their treating provider list treat injured workers?

Per NRS 616C.087, an insurer shall ensure that any physician or chiropractic physician on the insurer's list accepts and treats patients in the discipline or specialization for which the physician or chiropractic physician is listed. **If the insurer fails to do so, an injured employee may choose a physician or chiropractic physician from DIR's Treating Panel.**

38. What flexibility does an insurer have to add or remove providers from their Treating Provider List under NRS 616C.087?

- An insurer may add providers to their list at any time throughout the year.
- An insurer may remove a provider through the following means:
 - Voluntary removal- NRS 616C.087(9)
 - A provider may ask in writing to be removed from the list;
 - A provider may cancel a contract with the insurer or TPA;
 - Involuntary removal- NRS 616C.087(10)
 - A provider may be removed for good cause if the provider died or is disabled, the provider's license has been revoked or suspended, or the provider has been convicted of a felony or a violation of NRS 616D.
 - A provider may be removed by the Administrator of DIR upon finding that the provider has failed to comply with the standards for treatment; or that the provider does not accept and treat injured workers.

Beginning **September 1 through October 1, 2026**, and during the same 31-day window every 3 years thereafter, an insurer may audit and remove providers from its list. **This removal window is strictly limited to that 31-day period.** Insurers should not interpret the language to mean removal can occur at any time.

Furthermore, **any updated list filed after removal must still comply with all requirements of NRS 616C.087.**

39. May an insurer update contact information for a provider on their Treating Provider List at any time?

Yes.

40. What is an insurer's obligation if a provider is removed from DIR's treating panel pursuant to NRS 616C.087(9) or (10)?

If a physician or chiropractic physician is removed from an insurer's list pursuant NRS 616C.087(9) or (10), within 60 days after the date of removal the insurer shall replace the physician or chiropractic physician on the list as may be required to maintain compliance with the minimum number of providers required in each specialty. If the insurer fails to do so, an injured employee may choose a physician or chiropractic physician from DIR's Treating Panel.

Other

41. Is a rating physician or chiropractic physician limited to evaluating only the body parts and conditions listed on a D-35 Form?

No. The rater may evaluate any body part or condition accepted in a claim using the American Medical Association's Guides to the Evaluation of Permanent Impairment. Per NRS 616C.490(2)(b)(1), the role of the rater is "...to determine the percentage of disability in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment as adopted and supplemented by the Division pursuant to NRS 616C.110."

Need More Information?

For further assistance or to view the full text of SB 317, visit the Nevada Legislature's website, [SB317](#) , or contact the Nevada Division of Industrial Relations (DIR).