JOE LOMBARDO
Governor

DR. KRISTOPHER SANCHEZ
Director

VICTORIA CARREÓN
Administrator

JODI MCCOLLINS
Chief Administrative Officer

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

Frequently Asked Questions regarding changes related to Nevada SB 376 (2025)

10/24/2025

Updates to Nevada's workers' compensation system were made through Senate Bill (SB) 376, impacting insurers, self-insured employers, physicians, claims administrators, and injured employees. This document provides answers to the most frequently asked questions about the changes.

1. Which types of workers' compensation claims are affected by SB376?

SB 376 only applies to occupational diseases under NRS 617.455 and NRS 617.457, which are heart and lung workers' compensation claims for firefighters, arson investigators, and police officers.

2. Does SB376 apply to current and future claims?

SB376 only applies prospectively to workers' compensation claims filed on or after October 1, 2025.

3. What is the main change introduced by SB376?

Effective October 1, 2025, SB376 allows a firefighter, arson investigator, or police officer with a heart or lung workers' compensation claim to seek treatment from a physician or chiropractic physician of their choice outside the established panel, if the Workers' Compensation Section (WCS) Treating Panel has fewer than 12 appropriate providers available at the time the claim is filed to treat the occupational disease and who can see the employee within 30 days of contact.

4. When does this alternative provider option apply?

This option applies only if, at the time the claim is filed, the WCS Treating Panel has:

- Fewer than 12 physicians or chiropractic physicians in the relevant discipline or specialization,
- Who are accepting new patients, and
- Are available to meet within 30 days of the injured employee's initial contact.

5. Where can I find a copy of the WCS Treating Panel list?

- A copy of the WCS Treating Panel of Physicians and Chiropractors can be found on the DIR website at https://dir.nv.gov/WCS/home/?csrt=312412332950895380

6. If the WCS Treating Panel does not have 12 providers in the specialty needed, who can the injured employee choose if eligible under SB376?

The injured employee may choose a physician or chiropractic physician from:

- A list of all providers in the relevant specialization who have contracts with:
    - An organization for managed care (OMC),
    - A health benefit plan, or
    - A health or casualty insurer of the employer.

Note: Relevant specialization includes cardiologists, pulmonologists, or occupational medicine providers. The chosen provider does **not** need to be pre-approved to treat workers' compensation injuries under chapters 616A to 617.

7. How can I identify eligible providers?

To identify eligible providers under an employer-sponsored health plan, employees may request a list of contracted specialists directly from the insurer administering that specific plan. This list reflects the provider network tied to the employer's health insurance coverage, which may differ from the employee's personal insurance. Use of this list ensures that referrals align with the plan's benefits, coverage limitations, and authorization requirements.

8. What happens if the WCS Treating Panel has at least 12 Providers, but none have availability?

- The statute uses a 30-day availability standard. Employees may encounter situations where providers are "accepting new patients" but have no appointment availability within 30 days.
- Employees can request a list of contracted providers from their employer's insurer, OMC, or HR department. This empowers them to make informed choices when the WCS Treating Panel is insufficient and ensures transparency in accessing care.

9. What is the 30-day "Date of Contact" rule?

- In order to use a provider that is not on the WCS Treating Panel, the injured worker must determine if any of the providers on the WCS Treating Panel are available to meet with the injured worker within 30 days of initial contact. "Contact" can include any of the following:
    - A phone call (including voicemails left for the provider or office);
    - An email or secure message; or
    - An online appointment request or scheduling attempt.

  To ensure timely access to care, injured workers should keep a record of the date and method of their first contact, such as saving confirmation emails, voicemail records, or screenshots of online submissions.

10. Can I use the SB 376 pathway for multiple specialists?

Yes. If the WCS Treating Panel does not include the necessary specialists, injured workers can use the SB 376 pathway for more than one provider.

- For example, if an injured worker is receiving care from both a cardiologist and a pulmonologist, and the WCS Treating Panel lacks both specialties, the injured worker may request out-of-network access for each provider.
- This ensures injured workers with complex or multi-condition cases receive the appropriate care without unnecessary barriers.

11. Can the injured employee pay for the treatment themselves?

Yes. If the injured employee seeks treatment under this provision, it may be paid for by:

- The injured employee directly,
- A health insurer, or
- A casualty insurer on the employee's behalf.

12. Can the injured employee or insurer be reimbursed for the costs?

Yes. SB376 allows full reimbursement of the amount paid by:

- The injured employee, or
- The health or casualty insurer who covered the treatment.

13. How can reimbursement be requested?

The party seeking reimbursement must submit a written request to the:

- Employer, or
- Employer's insurer, OMC, or third-party administrator (TPA).

14. Is there a sample reimbursement request format I can use?

Yes. A template can make it easier to submit a complete and accurate reimbursement request the first time, especially if you've paid out of pocket.
A complete request typically includes:

- Injured worker name and contact information;
- Date(s) of service;
- Provider name and specialty;
- Description of the treatment/services;
- Reason for service or medical necessity, including any referral or prior authorization details;
- Identity of who paid for the treatment;
- Documentation of amount paid and proof of payment (e.g., receipts or invoices);
- Documentation that there were fewer than 12 providers in the medical specialty on the WCS Treating Panel at the time of the claim who are accepting new patients and are available to meet with the injured worker within 30 days of initial contact.

Providing this information up front can help speed up processing and reduce the chance of denial.

15. What is the deadline for reimbursement?

The employer, insurer, OMC, or TPA must reimburse the amount requested within 30 days of receiving a complete request.

16. What do I do if I don't receive reimbursement for the costs within 30 days after receipt of the request?

- The injured worker can file a complaint using the link located on the DIR/WCS website at https://cards.nv.gov/form/form-public-complaint. The complaint will be assigned to a Compliance Audit Investigator with the WCS Medical Unit.
- The Medical Unit can also be contacted for more information at medunit@dir.nv.gov or 702-486-9080.

17. What happens if the investigation shows that reimbursement was not provided within 30 days of receipt as required?

If the Administrator determines that an insurer, organization for managed care or third-party administrator has failed to fully reimburse an injured employee, health insurer or casualty insurer, as applicable, within 30 days, the Administrator shall order reimbursement of two times the amount of reimbursement that remains unpaid on the date the Administrator issues the order.

18. What can I do if my reimbursement request is denied by the insurer/Third Party Administrator?

If your reimbursement is denied, like any other Insurer determination, you can file an appeal with the Nevada Department of Administration, Hearings Division at www.hearings.nv.gov/efile and follow the steps for initiating a Request for Hearing (NRS 616C.315 and NRS 616C.345).
If you are an unrepresented litigant, you may mail a notice of appeal to: Department of Administration, Hearings Office, 2200 South Rancho Drive, Suite 220, Las Vegas, NV 89102 or the

Department of Administration, Hearings Office, 1050 East William Street, Suite 450, Carson City, Nevada 89701.

Important items to keep in mind:

- Appeals must be submitted within 70 days after the notice of the insurer's determination is sent.
- Include any supporting documentation such as receipts, correspondence, or medical records.
- Provide clear and complete information during the appeal can help prevent delays.

19. Does this change override the existing WCS Treating Panel system under NRS 616C.090?

No. This change adds a conditional alternative. The employee can only choose an outside provider if the WCS Treating Panel does not meet the required minimum number of timely available providers in the relevant field.

20. Does this mean any physician or chiropractor can be chosen?

No. The provider must still be:

- In the relevant discipline or specialization, and
- Have a contract with the employer's OMC, health plan, or insurer.

21. Does SB376 affect compensability of claims?

No. These changes only apply to access to treatment and reimbursement. The standard rules governing claim compensability under chapters 616A to 617 of NRS still apply.

Need More Information?

For further assistance or to view the full text of SB 376, visit the Nevada Legislature's website, https://www.leg.state.nv.us/App/NELIS/REL/83rd2025/Bill/12671/Text# , or contact the Nevada Division of Industrial Relations (DIR).