Workers' Compensation

MEDICAL BILLING

MEDICAL BILLING – PRIOR AUTHORIZATION

NRS 616C.157 - An Insurer, organization for managed care or third-party administrator shall respond to a written request for prior authorization for treatment, diagnostic testing, or consultation, within 5 working days after receiving the written request.

NAC 616C.129 - The treating physician or chiropractor must request written authorization from the insurer before ordering or performing any service with an estimated billed amount of $200 or more for:

- consultation
- diagnostic testing
- elective hospitalization
- any surgery which is to be performed under circumstances other than an emergency, or any elective procedure

NAC 616C.143 Consultation or treatment provided outside Nevada

MEDICAL BILLING – LAWS & REGULATIONS

NRS 616C.125 Insurer may contract with suppliers for provision of services and goods to injured employees

NRS 616C.135 Liability of Insurer for payment of charges for treatment related to industrial injury

NRS 616C.136 Action by insurer on bill from provider of health care; payment of interest; request for additional information; compliance with requirements. Updated requirements per Senate Bill 231, 2015 Nevada Legislature.

NRS.616C.137 Denial of payment for unrelated services

NRS 616C.138 Payment of provider upon insurers denial of authorization or responsibility

NRS 616C.260 Fees and charges for accident benefits: Restrictions; establishment and revision of schedule; powers and duties of Administrator; penalty for refusal to provide information

NAC 616C.027 Review of reduction or disallowance of bill; appeal; hearing; decision

NAC 616C.126 Treatment of injured employees in cases of severe trauma

NAC 616C.138 Billing for provision of certain supplies and services

NAC 616C.141 Requirements for programs of treatment billed under certain codes; use of codes; modifications of codes for certain services

NAC 616C.143 Prior written authorization required for consultation or treatment provided outside Nevada; emergency treatment outside Nevada

NAC 616C.145 Relative Values for Physicians: Adoption by reference; modifications; maximum unit values; initial evaluation; special reports

NAC 616C.146 Relative Value Guide of the American Society of Anesthesiologists: Adoption by reference; modifications; conversion factor; payments; basic anesthetic values

NAC 616C147 Licensed surgical centers for ambulatory patients

NAC 616C.149 Contents of bill to insurer

Workers' Compensation

FREQUENTLY ASKED QUESTIONS–MEDICAL PROVIDERS

Must I evaluate and treat every patient with a work-related injury?

In the event of an emergency, you must evaluate and treat the injured worker.

If the injury is non-emergent, it is recommended that you verify whether you are a contracted provider for that employer, insurer or third-party administrator (TPA) to ensure payment for services rendered. If you do treat the injured worker, you must complete and forward the appropriate copy of the Form C-4, *Employee's Claim for Compensation/Report of Initial Treatment* to the **correct** insurer and the **correct** employer. NRS 616B.527, NRS 616C.090

Also, it is your responsibility to inform the injured worker of his workers' compensation rights, which includes the completion of Form C-4. Form D-2, *Brief Descriptions of Rights and Benefits*, must be printed on the reverse side of the injured worker' copy of the C-4 or provided to the injured worker as a separate document with an affirmative statement acknowledging receipt. NRS 616C.090, NRS 617.352, NAC A.480

How may I obtain the Form C-4 and other necessary forms?

Forms and Worksheets may be found on the WCS website: http://dir.nv.gov/WCS/home/.

What are the Form C-4 requirements?

Within 3 working days after treating an injured worker, you must complete Form C-4, *Employee's Claim for Compensation/Report of Initial Treatment* and forward the appropriate copy to the **correct** employer and the **correct** insurer. A copy of the Form C-4 form must be retained in the injured worker's file. It is the health care provider's responsibility to contact the employer or insurer/TPA to confirm the name and address of the correct insurer/TPA. Please refer to the directions given below.

A Form C-4 must be completed even if you do not consider the injury or occupational disease to be work-related. The compensability of the claim lies with the insurer, not the health care provider, nor the employer. The Form C-4 must be completed in its entirety, including signature and date, and any limitations and/or restrictions assigned. Please note, an insurer or TPA has 30 days from receipt of the Form C-4 to accept or deny the claim. NRS 616C.040, NRS 617.352

How can my office staff locate the correct insurer/TPA?

You must send the completed Form C-4 to the correct insurer or TPA. The first step is to ask the injured worker. The next step is to contact the employer. He is required to know who his insurer is.

The Coverage Verification Service is a limited portal into the National Council on Compensation Insurance's database which allows access to private carrier information for employers. To access this portal, visit the Workers' Compensation Section website: http://dir.nv.gov/WCS/home/. The health care provider must **always** contact the insurer/TPA listed to verify the correct information.

For information on self-insured employers and associations of self-insured employers, visit the Division of Insurance Web page: http://doi.nv.gov and select the "Help Me Find…" tab > Self-Insured Workers' Compensation. Select either the "Self-insured Workers' Compensation" or "Association" list.

If, despite all your efforts, you are unable to locate the correct insurer/TPA within 3 business days, you must call the WCS for assistance in locating this information. If the WCS is unable to locate the insurer at that time, you will be asked to send to the WCS the Form C-4 and any notes documenting your efforts to locate the correct insurer/TPA. NAC 616C.080

What if the injured worker or his employer asks me not to send in a Form C-4?

You must complete in its **entirety**, both the upper and lower portion of Form C-4 if a patient reports a work-related injury or condition. A copy of the Form C-4 must then be forwarded to the **correct** employer and **correct** insurer even if the injured worker has refused to complete the employee portion or you have been asked not to file. Document the injured worker's refusal on the upper portion of Form C-4.

What do I do if the employer asks me to bill him directly?

Unless the employer is self-insured, the insurer or third-party administrator is responsible for payment of any medical services provided to the injured worker relating to the accepted industrial injury and/or condition.

May a physician's assistant or nurse practitioner complete a Form C-4?

Yes, the physician or chiropractor, who has the responsibility to complete Form C-4, may delegate the completion of the form to a medical facility, physician's assistant or nurse practitioner. However, a physician must always countersign a Form C-4.

What are the consequences if I fail to complete or send in a Form C-4 on time?

Administrative fines may be imposed if Form C-4 is incomplete and/or not submitted within 3 working days to the **correct** employer and insurer. Benefit penalties and administrative fines may be imposed if a medical provider refuses to complete and distribute Form C-4 as required and/or induces or influences a patient not to file a workers' compensation claim. NRS 616C.040, NRS 616D.120

What do I do if I suspect workers' compensation fraud?

Report suspected fraud to the AG Fraud Hotline: 1-800-266-8688. More information for detecting possible fraud is available on the Attorney General website at: http://ag.nv.gov/.

What if the employer does not have workers' compensation insurance?

Send the completed Form C-4 and the bill to the WCS with a cover letter stating the employer does not have workers' compensation insurance. The WCS Employer Compliance Unit investigates suspected uninsured employers and determines whether there is coverage. Once it is determined that the employer has no coverage, the claim will then be submitted to the Uninsured Employers' Account. If accepted, the injured worker will receive the same rights and benefits afforded any other injured worker under NRS 616 and 617.

Must I obtain prior authorization for everything?

The treating physician or chiropractor must request **written authorization** before ordering or performing any one of the following services with an estimated billed amount of $200 or more:

- Treatment
- Consultation
- Diagnostic testing
- Elective hospitalization
- Any surgery which is to be performed under circumstances other than an emergency; or
- Any elective procedure

In addition, treatment for codes 97001 to 97799, exclusive of 97545, 97546, and 98925 to 98943, consisting of more than 6 visits, requires prior authorization. NAC 616C.129 Telemedicine also reaches the anticipated cost of $200 or more. Check the current Medical Fee Schedule for further information regarding telemedicine.

What if I request prior authorization and the insurer or TPA does not respond?

An insurer must respond to a **written request** for prior authorization for treatment, diagnostic testing, or consultation within 5 working days. If the insurer does not respond within 5 working days, authorization shall be deemed to be given. However, the insurer may subsequently deny the authorization. NRS 616C.157

How many treating physicians or chiropractors may an injured worker have?

There may be only one treating physician or chiropractor unless the insurer provides prior written authorization for the injured worker to receive treatment by more than one physician or chiropractor. NRS 616C.090

Physicians and chiropractors associated with the treating physician or chiropractor may treat the injured worker during the temporary absence of the treating physician or chiropractor. Physicians in emergency departments are not considered "treating physicians." NAC 616C.129

Is a specific progress report form required?

The physician or chiropractor must use Form D-39, *Physician's Progress Report – Certification of Disability*. The Form D-39 must be completed in its entirety to include a signature and date and any limitations and/or restrictions assigned. A copy of this form, as well as all other forms, may be obtained from the WCS website: http://dir.nv.gov/WCS/home/. NAC 616A.480

Are there workers' compensation standards of care?

Yes. The standards of care adopted by the Division of Industrial Relations are the current *Occupational Medicine Practice Guidelines* of the American College of Occupational and Environmental Medicine. These are more commonly known as the ACOEM Guidelines.The guidelines are published by Reed Group, Ltd and are available with a paid subscription. Information is available at http://www.mdguidelines.com. NRS 616C.250, NAC 616A.480

Must I prescribe generic drugs?

Yes. A provider must prescribe a generic drug in lieu of a brand name drug if the generic drug is biologically equivalent and has the same active ingredient or ingredients of the same strength, quantity and form of dosage as the brand name drug. NRS 616C.115

Is there specific language to use when the injured worker reaches maximum medical improvement?

Yes. To be consistent with statute, when the treating physician or chiropractor feels the injured worker has reached maximum medical improvement, the term "stable" should be used. If the treating physician or chiropractor deems the injured worker may have suffered a permanent impairment, the term "ratable" should also be used. NAC 616C.103

How may I join the Treating Panel of Physicians and Chiropractors?

To become a member of the Treating Panel, a licensed physician or chiropractor must complete the "Application – Panel of Treating Physicians and Chiropractors" and submit the completed application to the Henderson office of WCS for processing. Upon completion, the health care provider will be notified and an informational packet will be sent. An application may be obtained from the WCS website http://dir.nv.gov/WCS/Medical_Providers/.

Please explain billing and payment regulations.

Billings for health care services must be submitted within 90 days after the date on which the services were rendered unless good cause is shown for a later billing. In **no** event may an initial billing or request for reconsideration for health care services be submitted later than 12 months after the date on which the services were rendered unless claim acceptance is delayed beyond 12 months because of claim's litigation. The medical report must be attached to any bill sent to the insurer/TPA. Please note the following:

- An insurer must pay or deny a bill within 45 calendar days after receipt
  - If the insurer does not pay within 45 days, interest may be due to the medical provider
- An insurer is obligated to provide an explanation of benefits (EOB/EOR) for each code billed
  - An insurer cannot change billing codes

- The insurer may return the bill and request additional information

Under what circumstances may I charge an injured worker?

If a provider of health care accepts an injured worker for the treatment of an industrial injury or occupational disease, the injured worker may not be charged for any treatment related to the industrial injury or occupational disease. The insurer must be charged.

An injured worker may be charged when his employer is uninsured and WCS has issued a determination to not assign the workers' compensation claim to the Uninsured Employers' Account.

You may charge an injured worker when his claim is closed and he is seeking medical documentation to reopen the claim. You may also charge an injured worker for any treatment unrelated to the industrial injury or if his claim has been denied. Otherwise, never charge an injured worker for any treatment related to the claim. Payment may be accepted from the injured worker or his health insurer for treatment the injured worker alleges is related to the industrial injury or occupational disease *which the insurer or third-party administrator has denied liability for*.

What recourse do I have if my bill is reduced or denied?

If your bill has been reduced or denied by an insurer you may, within 60 days of receiving notice of the reduction or denial, request the WCS to review that action. The WCS will investigate and make a payment determination. NAC 616C.027

What may I bill for witness fees?

A physician or chiropractor that is called to testify is entitled to receive the same fees as witnesses in civil cases. These fees may exceed the fees in the Nevada Medical Fee Schedule. NRS 616C.350

Does Nevada have a Medical Fee Schedule?

Yes. Payment from insurers cannot exceed the Medical Fee Schedule. However, payment may be less than the Medical Fee Schedule if the provider has a contract with the insurer. The appropriate Medical Fee Schedule corresponds to the date of service.

A medical provider is to use the most recent editions, or updates of the following publications for the billing of workers' compensation: *Relative Values for Physicians*, *Relative Value Guides of the American Society of Anesthesiologists*, and Medicare's current reimbursement for HCPCS codes K & L for custom orthotics and prosthetics. ASC reimbursement, providers' service code conversion factors and the Nevada specific codes are contained in the Medical Fee Schedule on the WCS website: http://dir.nv.gov/WCS/Medical_Providers/

Where can I access the Nevada Medical Fee Schedule, ASC codes, DME and K&L codes, and the WCS Medical Unit information on the internet?

To access all of the above and more, visit the WCS website: http://dir.nv.gov/WCS/Medical_Providers/

How may I obtain more information about workers' compensation?

To obtain more information about workers' compensation, please visit the WCS website: http://dir.nv.gov/WCS/home/ or you may contact the Workers' Compensation Section: WCSHelp@dir.nv.gov

Workers' Compensation

PRESCRIPTION DRUG DIVERSION

THE HIGH COST OF DRUG ABUSE

Workers' Compensation providers spent over $3 billion providing prescriptions to injured workers last year; 52% of that amount was spent on "painkillers." The illegal use or subsequent sale of prescription drugs puts a huge strain on our health system. Drug diversion can increase costs to health care insurers by a whopping $27 billion per year. Drug diversion is defined as any use of legal prescription medications for other than the legitimate medical purpose for which the drug was prescribed. We cannot continue to overlook this type of fraud.

A recent study examined the comparative health costs of treating a drug abuser versus a non-abuser. The findings were no surprise. The average cost of treating a non-abuser was $1,830. The cost associated with a drug abuser swelled to $16,000.

Workers' compensation providers are in the best position to be able to determine if drug diversion is occurring. The person paying the bills knows, or should know with a little due diligence, the amount of prescriptions being obtained by the recipient. Plan administrators are in the best position to detect if medications are being obtained from multiple sources or if a physician is not prescribing medications in a medically appropriate manner. In either event, these suspicions need to be referred for an investigation.

An interesting trend is emerging with an increase in drug diversions. The number of injured workers taking side jobs to help offset their loss of income while receiving benefits has been decreasing nationally; primarily due to workers finding a more lucrative and untraceable source of income – the sale of their prescription meds.

The street value for pain medication is staggering. OxyContin, for example, has a 430% street markup. By prolonging treatment to obtain unnecessary pain medication, vast amounts of money can be made. In addition to extending treatment with nonexistent pain symptoms, several other drug diversion tactics are common.

Forged or altered prescriptions are a popular way to obtain illegal quantities of prescriptions. Older methods of using correction fluid to blot out the amount of pills to be obtained have given way to the use of fingernail polish remover. Prescriptions can also be altered instead of "washed." A prescription for 10 tablets can be easily made to look like 70. The patient then returns to the medical provider after a week for another prescription and the doctor is none the wiser. "Doctor shopping" is another method. Doctor shoppers visit multiple practitioners, which can easily occur if the injured worker is obtaining medications from a health insurance provider in addition to the workers' compensation provider.

Although the vast majority of practitioners are honest and provide legitimate medical care, a small percentage does engage in true criminal behavior. Investigations have focused on physicians who exchange improper prescriptions for money, other street drugs or in some instances, sex. These physicians are nothing less than drug dealers and should be treated as such.

Plan managers must become more aggressive in looking for potential drug diversions. The time for blindly writing the checks for prescription medications has long passed. If the cost of drug diversion is not reason enough, the potential for liability should be a wake up call. Recently, pharmacies have been held liable for failing to exercise due diligence by allowing overuse of pain medications. The same rationale may be applied to plan administrators if the overuse of pain medications is blindly approved time after time.

The abuse of prescription medications certainly has become a national problem. The National Institute of Health reports that 20% of Americans have abused prescription medication, and the number is growing. With cooperation between plan administrators, health care providers and law enforcement, we can start to take a bite out of this form of fraud. For more information, readers are encouraged to contact the National Association of Drug Diversion Investigators (NADDI) or visit their website at: www.naddi.org.

Anyone suspecting this type of fraud or any fraud associated with workers' compensation should contact the Attorney General's fraud hotline at **1-800-266-8688**. Other information about detecting workers' compensation fraud is also available on our website: http://ag.nv.gov/About/Criminal_Justice/Workers_comp/

Brian Kunzi; Director, Workers' Compensation Fraud Unit (Revised 3/18/2016 – updated website)

Workers' Compensation Section

Email Enrollment Request

The email enrollment form below allows you to sign up for email notification of the latest quarterly newsletter releases, upcoming trainings, and regulation changes, along with regulation hearings and workshops you can attend. In addition, you may use this form to change your current contact information or be removed from our email database.

☐ **NEW SUBSCRIBER** ☐ **UPDATE** ☐ **Request Removal**

PLEASE TYPE OR PRINT CLEARLY:

Business Name:	
Contact Name (First & Last):	
Email Address:	

CHECK THE **ONE** CATEGORY, WHICH BEST DESCRIBES YOUR BUSINESS:

☐ **Medical** ☐ **Third-Party Administrator** ☐ **General Employee/Employer**

☐ **Vocational Rehabilitation** ☐ **Association** ☐ **Self-Insured**

☐ **Private Carrier** ☐ **Legal**

PLEASE FILL OUT THE FORM ON THE WCS WEBSITE OR EMAIL, MAIL OR FAX THIS COMPLETED FORM TO:

WORKERS' COMPENSATION SECTION (WCS)

Attention: Education, Research & Analysis
3360 West Sahara Avenue, Suite 250 Las Vegas, NV 89102

Fax: (702)486-8712
Email: Klowry@dir.nv.gov
https//hal.nv.gov/form/EMAIL_ENROLLMENT_REQUEST

9/3/2020

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

NEVADA MEDICAL FEE SCHEDULE
MAXIMUM ALLOWABLE PROVIDER PAYMENT
February 1, 2021 through January 31, 2022

Pursuant to **NRS 616C.260**, effective February 1, 2021, 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	$47.22
80000-89999	Pathology	$28.02
90000-99999	General Medicine	$12.24
10000-69999	Surgery	$260.77
00000-99999	Anesthesiology	$91.01

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*.

Services provided by a nurse anesthetist, certified advanced practitioner of nursing or certified physician's assistant must be identified with the modifier "-29" and be reimbursed at 85 percent of the maximum allowable fee established for physicians.

Services provided by a supervising anesthesiologist must be identified by the modifier "-28" and be reimbursed at 25 percent of the maximum allowable fee established for physician.

Surgical assistant services provided by a licensed registered nurse, a certified physician's assistant, or an operating room technician employed by a surgeon for surgical assistant services must be identified with the modifier "-29" and be reimbursed at 14 percent of the maximum allowable fee for the surgeon's services rendered. Fees for surgical assistant services performed by a licensed registered nurse, a certified physician's assistant or an operating room technician employed by the hospital or surgical facility must be included in the per diem rate pursuant to NV00500.

Services provided by a certified chiropractor's assistant must be identified with the modifier "-29" and be reimbursed at 40 percent of the maximum allowable fee for chiropractors.

Services provided by a licensed physical therapist's assistant or licensed occupational therapy assistant must be identified with the modifier "-29" and be reimbursed at 50 percent of the maximum allowable fee for licensed physical therapists or licensed occupational therapists.

The maximum daily unit value allowed under codes 97001 to 97799 and 98925 to 98943, *excluding* 97545 and 97546, for those practitioners whose scope of license allows them to perform and bill for these services is 16 units. The maximum 16-unit value may be exceeded for services provided to an injured employee with trauma to multiple body parts if the insurer, third-party administrator or organization for managed care so authorizes in advance. Any payment made per this section includes, but is not limited to, payment for the office visit, evaluations and management services, manipulation, modalities, mobilizations, testing and measurements, treatments, procedures and extra time.

If the services rendered are for physical therapy or occupational therapy and the total unit value of the services provided for 1 day is 16 units or more, the payment of benefit explanation may combine all the services for that day, utilizing code NV97001 as the payment descriptor of services, except for the initial evaluation. The initial evaluation needs to be identified with the appropriate CPT code.

The initial evaluation shall be deemed to be separate from the initial six treatments. An initial evaluation may be performed on the same day as the initial treatment and must be billed under codes 97161, 97162, 97163 **or** 97165, 97166, 97167.

The first six visits billed under codes 97010 to 97799, and 98925 to 98943, excluding 97545 and 97546, do not require the prior authorization of the insurer.

TRAUMA ACTIVATION FEE REIMBURSEMENT

NV00150 Trauma Activation Fee..... $4,124.36

Requires notification of trauma team members at designated trauma hospitals in response to triage information received concerning a person who has suffered a traumatic injury as defined by NRS 450B.105. Trauma activation is based upon parameters set forth in NAC 450B.770 (Procedures for initial identification and care of patients deemed with trauma). Regardless of the disposition of the patient, all charges related to the appropriate care of the patient above and beyond the activation fee shall apply and are reimbursed per the Nevada Medical Fee Schedule.

HOSPITAL EMERGENCY DEPARTMENT FACILITY REIMBURSEMENT
Nevada Specific Codes:

NV00100 First hour for use of emergency facility.....$286.04
NV00101 Each additional hour or fraction thereof for use of emergency facility.....$143.01

Diagnostic services, treatment and supplies provided by the emergency department are reimbursed in addition to emergency department facility reimbursement. Medical supplies are reimbursed at the providers' actual cost, excluding tax and charges for freight, plus 20 percent, unless there is a written agreement between the insurer and provider for a lower reimbursement. Copies of the manufacturers' or suppliers' invoices from the provider are required for reimbursement.

An insurer shall reimburse pharmaceuticals at the average wholesale price or the provider's usual and customary price, whichever is less, unless there is a written agreement between the insurer and provider for a lower reimbursement.

If an injured employee is admitted to the hospital from the emergency department, charges related to care in the emergency department are reimbursed in addition to the per diem rate(s) for inpatient care received at the hospital.

HOSPITAL REIMBURSEMENT
Nevada Specific Codes:

NV00200 Medical-Surgical/Cardiac/Neuro/Burn/Other Intensive Care..... $5,643.88
NV00450 Step-Down/Intermediate Care..... $4,538.09
NV00500 Medical-Surgical Care..... $3,432.33
NV00550 Skilled Nursing Care/Facility..... $2,352.28
NV00600 Psychiatric Care $2,352.28
NV00650 Observation Care (Greater than 23 hours)..... $3,432.33
NV00675 Observation Care (Up to 23 hours or fraction thereof) ..... $143.01 per hour
NV00700 Rehabilitation Care..... $2,352.28

Reimbursement for Observation Care shall be calculated at an hourly rate of $143.01 per hour, or fraction thereof, for stays 23 hours or less. Diagnostic services, treatment and supplies provided while under hourly Observation Care and are reimbursed in addition to observation care hourly reimbursement for stays 23 hours or less. Medical supplies are reimbursed at the providers' actual cost, excluding tax and charges for freight, plus 20%, unless there is a written agreement between the insurer and provider for a lower reimbursement. Copies of the manufacturers' or suppliers' invoices from the provider are required for reimbursement. Observation stays greater than 23 hours shall be reimbursed at the per diem rate noted above for Nevada Specific Code NV00650 which **includes** diagnostic services, treatment and supplies. Observation Care rates apply to acute care hospital services only; does not apply to hospital-based outpatient surgical care or ambulatory services.

The per diem rate includes all services provided by the hospital including the professional and technical services provided by members of the hospital's staff and other services ordered by the treating or consulting provider of health care. Charges for an inpatient's use of an operating room must be included in the per diem rate for the hospital.

Rural hospitals receive an additional 10% over the established per diem rate. Hospitals in Clark County, Washoe County, and Carson City are not considered rural hospitals.

The insurer shall reimburse the hospital for orthopedic hardware**,** prosthetic devices**,** implants and grafts at the provider's actual cost, excluding tax and charges for freight, plus 20 percent, unless there is a written agreement between the insurer and hospital for a lower reimbursement. Copies of the manufacturers' or suppliers' invoices from the provider are required for reimbursement.

The insurer shall reimburse the hospital for supplies and materials, including grafts and implants used in open-heart surgery at the provider's actual cost, excluding tax and charges for freight, plus 40 percent, unless there is a written agreement between the insurer and hospital for a lower reimbursement. Copies of the manufacturers' or suppliers' invoices from the provider are required for reimbursement.

AMBULATORY SURGICAL CENTER (ASC) and OUTPATIENT HOSPITAL SURGICAL REIMBURSEMENT

Group 1	$1,067.19
Group 2	$1,429.33
Group 3	$1,634.44
Group 4	$2,019.02
Group 5	$2,297.82
Group 6	$2,647.17
Group 7	$3,118.26
Group 8	$3,188.76
Group 9	$3,432.33
Unlisted CPT code	$3,188.76

Unlisted CPT codes may be reimbursed at Group 8 reimbursement, billed charges, or usual and customary reimbursement in Nevada for comparable procedure codes, whichever is less.

A list of CPT codes and their corresponding groups may be found at the Nevada Workers' Compensation Section website on the Medical Information page at:
http://dir.nv.gov/uploadedFiles/dirnvgov/content/WCS/MedicalDocs/ASCOPGroupList2016.pdf

An insurer shall reimburse an ambulatory surgical center for orthopedic hardware**,** prosthetic devices**,** and implants and grafts at the provider's actual cost, excluding tax and charges for freight, plus 20 percent, unless there is a written agreement between the insurer and provider for a lower reimbursement. Copies of the manufacturers' or suppliers' invoices from the provider are required for reimbursement.

If there is no assigned value for the surgical procedure, or if the modifier "-51" and or modifier "-59" are used, or "add-on" procedures are billed, the amount paid **shall not exceed** the surgical per diem rate for code NV00500, or the amount billed if less than the per diem rate for NV00500.

The following costs are included in the ambulatory surgical center's reimbursement: all services provided by the ambulatory surgical center, including professional and technical services provided by members of the ambulatory surgical center staff, anesthetic cost, general supplies, operating room, medication and any other diagnostic procedures.

Hospital Reimbursement rates (page 3) do not apply to hospital-based outpatient surgical care or ambulatory services, except that NV00500 is used as a maximum reimbursement level for these outpatient services.

TELEMEDICINE REIMBURSEMENT
Nevada Specific Code:
NV00250 Telemedicine Originating Site fee.....$244.86

Reimbursement for medical facilities billing an originating site fee for telemedicine services will include all general supplies, technical services, professional services and costs for the telemedicine transmission. Diagnostic or other procedures performed in conjunction with a telemedicine visit are separately reimbursable if prior authorized, pursuant to NAC 616C.129. **The consulting health care provider at the distant site must bill using the usual and appropriate CPT code for the service(s) provided. Do not use CPT codes specific to telemedicine. Always bill telemedicine services with a GT modifier**.

PHARMACEUTICAL REIMBURSEMENT
An insurer shall reimburse all pharmaceuticals, except those provided to an injured employee occupying a bed in the hospital, at the average wholesale price plus an $12.24 dispensing fee, or the provider's usual and customary price, whichever is less, unless there is a written agreement between the insurer and provider for a lower reimbursement.

Physician dispensed controlled substances are addressed in NRS 616C.117.

Prior authorization is required for any compound medication or specific subset of compounds. The prior authorization request must include the prescribing physician's or chiropractor's justification of the medical necessity for and efficacy of the compound instead of or in addition to the standard medication therapies. All bills for compound medications shall list each ingredient of the compound at the individual ingredient level and, where applicable, include a valid National Drug Code (NDC) for each ingredient. The insurer and dispensing provider shall agree upon the quantity as well as the reimbursement for a compounded medication before the medication is dispensed. The insurer shall not be required to reimburse any compound ingredient which lacks a valid NDC.

DURABLE MEDICAL EQUIPMENT (DME) REIMBURSEMENT
An insurer shall reimburse the provider of health care for those medical supplies and materials provided by the health care provider at the provider's actual cost, excluding tax and charges for freight, plus 20 percent, unless there is a written agreement between the insurer and provider for a lower reimbursement. Copies of the manufacturers' or suppliers invoice from the provider are required for reimbursement.

CUSTOM ORTHOTIC AND PROSTHETIC REIMBURSEMENT
An insurer shall reimburse custom orthotics and prosthetics at 140% of Medicare allowable for Nevada, unless there is a written agreement between the insurer and provider for a lower reimbursement. No invoice is required.

HOME HEALTH SERVICE REIMBURSEMENT
Nevada Specific Codes:
For a visit of **not more than 2 hours** and during which certain procedures are performed by a physical therapist, occupational therapist, speech therapist, skilled nurse, social worker or dietary nutritional counselor:

NV90170 Skilled home health care.....per visit $136.52

For a visit of **not more than 2 hours** and during which certain activities are performed by a certified nursing assistant:

NV90130 Certified nursing assistant care .....per visit $66.53

For a visit of **more than 2 hours** and during which certain procedures are performed by a physical therapist, occupational therapist, speech therapist, skilled nurse, social worker, dietary nutritional counselor or certified nursing assistant:

NV90180 Skilled home health care..... per hour $68.25
NV90190 Certified nursing assistant care ..... per hour $33.26

Payment for each 24-hour period may not exceed the per diem rate for Nevada Specific Code NV00500. A "visit" includes the time it takes the provider of health care to travel to and from the home of the injured employee to provide health care services in the home and complete any required documentation.

INDEPENDENT MEDICAL EVALUATION REIMBURSEMENT
Nevada Specific Codes:
NV02001 Review of medical records (up to 50 pages), testing, evaluation and report..... $1,859.05
NV02002 Review of each additional 100 pages of medical records (shall be prorated for increments less than 100 pages).....$464.77
NV02003 Evaluation of more than 2 body parts, for each body part in excess of (use body part descriptions located under Permanent Partial Disability Reimbursement).....$348.57
NV02004 Organization of medical records in chronological order based on date of service..... per 50 pages $50.77
NV02000 Failure of an injured employee to appear for appointment.....$697.14

Nevada Specific Code NV02000 may only be billed if an injured employee is more than 30 minutes late for a scheduled appointment or cancels the appointment less than 24 hours before the scheduled appointment.

The medical records must be in a printable format and include a cover sheet indicating the number of pages provided to the physician or chiropractor.

All medical records are to be provided to the evaluator in chronological order based on date of service. Separating chronologically organized therapy notes is acceptable.

PERMANENT PARTIAL DISABILITY REIMBURSEMENT
Nevada Specific Codes:
NV01000 Review records, testing, evaluation, and report.....$901.35
NV01001 Failure of an injured employee to appear for appointment.....$301.03
NV01002 Addendum necessary to clarify original report ..... No charge
NV01003 Addendum after review of additional medical records.....$301.03
NV01004 Review of medical records and evaluation of more than 2 body parts for each body part in excess of $301.03
NV01005 Organization of medical records in chronological order based on the date of service..... per 50 pages $50.77
NV01006 Review of records and report.....$449.79

Nevada Specific Code NV01001 may only be billed if an injured employee is more than 30 minutes late for a scheduled appointment or cancels the appointment less than 24 hours before the scheduled appointment.

The medical records must be in a printable format and include a cover sheet indicating the number of pages provided to the physician or chiropractor.

All medical records are to be provided to the evaluator in chronological order based on date of service. Separating chronologically organized therapy notes is acceptable.

For the purpose of establishing the maximum allowable payment for the review of medical records and the evaluation of musculoskeletal body parts, the following constitute one body part:

a) The cervical spine
b) The thoracic spine
c) The lumbar spine
d) The pelvis
e) The left upper extremity, excluding the left hand
f) The right upper extremity, excluding the right hand
g) The left hand, including that portion below the junction of the middle and lower thirds of the left forearm
h) The right hand, including that portion below the junction of the middle and lower third of the right forearm
i) The left lower extremity
j) The right lower extremity
k) The head
l) The trunk
m) Post-traumatic Stress Disorder Impairments (NRS 616C.180)

BACK SCHOOL REIMBURSEMENT
Nevada Specific Code:
NV97115 Back School ..... per hour $99.78

Payments for services billed under code NV97115 include the services of all instructors who participate in the program. The program must include, but is not limited to, instruction of the injured employee by a licensed physical therapist or licensed occupational therapist and by other providers of health care and instruction of the injured employee in body mechanics, anatomy, techniques of lifting and nutrition.

FUNCTIONAL CAPACITY EVALUATION REIMBURSEMENT
Nevada Specific Code:
NV99060 Procedure, testing and report..... per hour $283.52
NV99061 Failure of an injured employee to appear for an appointment.....$301.03

Testing performed in connection with such an evaluation must continue for not less than 2 hours and not more than 5 hours. The evaluation must include, but is not limited to, an assessment and interpretation of the ability of the injured employee to perform work-related tasks and the formulation of recommendations concerning the capacity of the injured employee to work safely within his/her physical limitations.

Nevada Specific Code NV99061 may only be billed if an injured employee is more than 30 minutes late for a scheduled appointment or cancels the appointment less than 24 hours before the scheduled appointment.

DENTAL REIMBURSEMENT

D0120	Periodic oral evaluation, established patient	$41.22
D0140	Limited oral evaluation, problem focused	$61.28
D0150	Comprehensive oral evaluation, new or established patient	$64.83
D0210	Intraoral, complete series of radiographic images	$101.32
D0220	Intraoral-periapical, first radiographic image	$20.98
D0230	Intraoral-periapical, each additional radiographic image	$16.53
D0330	Panoramic radiographic image	$87.04
D2740	Crown, porcelain/ceramic substrate	$919.38
D2750	Crown, porcelain fused to high noble metal	$846.40
D2950	Core buildup, including any pins when required	$198.93
D3310	Endodontic therapy, anterior tooth, excludes final restoration	$688.87
D3320	Endodontic therapy, bicuspid tooth, excludes final restoration	$798.45
D4341	Periodontal scaling and root planing, four or more teeth per quadrant	$189.60
D5110	Complete denture, maxillary	$1,233.55
D5213	Maxillary partial denture, cast metal/framework with resin denture bases, includes any conventional clasps, rests and teeth	$1,296.88
D5214	Mandibular partial denture- cast metal/framework with resin denture bases, includes any conventional clasps, rests and teeth	$1,297.42
D6010	Surgical placement of implant body	$1,634.89
D6050	Surgical placement, transosteal implant	$1,713.07
D6056	Prefabricated abutment, includes modification and placement	$455.23
D6057	Custom fabricated abutment, includes placement	$603.66
D6059	Abutment-supported porcelain fused to metal crown (high noble metal)	$1,082.68
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	$1,149.90
D6240	Pontic porcelain fused to high noble metal	$854.04
D6750	Crown, porcelain fused to high noble metal	$861.61
D7140	Extraction, erupted tooth or exposed root, elevation and/or forceps removal	$115.09
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, includes elevation of mucoperiosteal/flap if indicated	$247.64
D9223	Deep sedation/general anesthesia, each 15-minute increment or part thereof	$149.56

All other dental procedure codes may be reimbursed at the provider's usual and customary price, unless there is a written agreement between the insurer and provider for a lower reimbursement.

GENERAL INFORMATION

Reimbursement is based on appropriate coding of health care services provided as documented in the medical record.

Bills for health care services must be submitted within 90 days after the date on which the services were rendered unless good cause is shown for a later billing. In no event may an initial bill or request for reconsideration for health care services be submitted later than 12 months after the date on which the services were rendered unless claim acceptance is delayed beyond 12 months because of claim's litigation. Reimbursement for healthcare services is determined by the Nevada Medical Fee Schedule in effect at the time of the date of service.

The insurer or a representative of the insurer may require the submission of reports on the injured employee's admission to, and discharge from, the hospital and all physicians' or chiropractors' medical reports before payment of a hospital or medical bill.

An insurer shall pay or deny reimbursement of charges pursuant to **NRS 616C.136** after receipt by the insurer or his agent of the first bill for those charges unless good cause is shown for a later payment or denial. Bills received erroneously should be returned to the health care provider with an explanation.

Any physician or chiropractor who is called upon to render service in the case of an emergency or severe trauma as a result of an industrial injury may use whatever resources and techniques are necessary to cope with the situation. The treatment of injured employees in such situations is not restricted to physicians and chiropractors that are members of the Treating Panel of Physicians and Chiropractors established by the Administrator pursuant to **NRS 616C.090** or have contracted with an insurer or an organization for managed care to provide health care services to injured employees.

A provider of health care shall, within 14 days after the date on which services are rendered **or** the injured employee is discharged from the hospital, unless good cause is shown, submit to an insurer, a third-party administrator or an organization for managed care, a report on the services rendered. This subsection does not require the disclosure of any information prohibited by state or federal statute or regulation.

The insurer **shall provide** an Explanation of Benefits (EOB) for each code billed to include the amounts for services that are paid and the amounts that are reduced or disallowed. Indicate on each payment those services, which are being reduced or disallowed, and the reasons for the reduction or disallowance. The EOB must include notification to the provider of health care that within 60 days after receiving the notice of denial or reduction, they can submit a written request to the State of Nevada, Division of Industrial Relations, Workers' Compensation Section for a review of that action.

If a bill submitted to the insurer by a provider of health care requires an adjustment because the codes set forth in the bill are incorrect, the insurer shall:

(1) Process and pay or deny payment of that portion of the bill, if any, that contains correct codes;
(2) Return the bill to the provider of health care and request additional information or documentation concerning that portion of the bill relating to the incorrect codes; and

(3) Pay or deny payment within 20 days after receipt by the insurer or the insurer's agent of the resubmitted bill with the additional information or documentation.

For services which reimbursement has not been established by the Nevada Medical Fee Schedule or adopted resources, it is recommended that the insurer and provider mutually agree on reimbursement before the services are provided.

NAC 616C.143 addresses payment for consultation and treatment provided outside this State. If there is no prior written authorization that payment for the consultation or treatment will be made in accordance with the schedule of reasonable fees and charges allowable for accident benefits adopted for this State pursuant to **NRS 616C.260**, unless otherwise provided in contract between the provider of health care and the insurer, the insurer is solely responsible for the payment of all services rendered.

All providers and insurers are encouraged to review the following applicable statutes and regulations concerning the billing and payment of medical services: **NRS 616C.135**, **NRS 616C.136**, **NRS 616C.117, NAC 616C.027**, **NAC 616C.138**, **NAC 616C.141**, **NAC 616C.143**, **NAC 616C.147**, and **NAC 616C.149**. You may access these statutes and regulations on the Nevada Workers' Compensation Section website at: http://dir.nv.gov/WCS/home/.

How do I obtain a copy of the NRS, NAC, Medical Fee Schedule or other information?

The Nevada Revised Statutes (NRS) and Nevada Administrative Code (NAC) regarding workers' compensation can be obtained by contacting the Legislative Counsel Bureau, Legislative Publications at:

Reno & Carson: (775) 684-6800
Las Vegas: (702) 486-2626
All other Nevada: (877) 873-2648
www.leg.state.nv.us

The Medical Fee Schedule, HIPAA information, Treating and Rating Physicians' list, and the necessary workers' compensation forms can be accessed through the WCS website at: http://dir.nv.gov/wcs/home/

For more information you may call or write:

Department of Business and Industry
Division of Industrial Relations
Workers' Compensation Section

400 West King Street, Suite 400
Carson City, Nevada 89703
(775) 684-7270
Fax: (775) 687-6305

3660 West Sahara Ave., Suite 250
Las Vegas, Nevada 89102
(702) 486-9080
Fax: (702) 486-8713
Email: WCSHelp@dir.nv.gov

The material contained in this publication is derived from chapters 616A to 617, inclusive, of the Nevada Revised Statutes & Nevada Administrative Code, and is provided for general information purposes only. For more detailed information, please refer to the specific statute or code in its entirety.

Steps for obtaining workers' compensation insurance information

Step 1: Ask the injured employee, if possible.

Step 2: Use the **Coverage Verification Service (CVS)** on the **WCS** web-site: http://dir.nv.gov/wcs/home/

Step 3: Go to the Division of Insurance website at http://doi.nv.gov and select the "Help Me Find" tab to locate the "Self-insured Workers' Compensation". Select either the "Self-Insured Company" and/or the "Association List" tab. Use the "Find" feature to initiate search.

Step 4: Contact the employer. Document the responses from the employer.

Step 5: After completing the above steps, if you are still unable to locate coverage information, call **WCS** Las Vegas at (702) 486-9080 or Carson City at (775) 684-7270**.** If we are unable to locate coverage over the phone, you will be asked to forward a completed copy of the C-4 and verification documentation to our office for further investigation.

Step 6: ALWAYS verify coverage with the correct Insurer/TPA before sending the C-4.

Can I bill an injured employee?

No. A provider of health care who accepts a patient as a referral for the treatment of an industrial injury or an occupational disease may not charge the patient for any treatment related to the industrial injury or occupational disease, but must charge the insurer. The provider of health care may charge the patient for services that are not related to the industrial injury or occupational disease. NRS 616C.135

MEDICAL PROVIDER GUIDE

WORKERS' COMPENSATION

Email Notification
Stay connected to what's new in Nevada's workers' compensation by registering to receive email notifications.
http://dir.nv.gov/wcs/home/

PUBLISHED BY:
STATE OF NEVADA
DEPARTMENT OF BUSINESS AND INDUSTRY
WORKERS' COMPENSATION SECTION

This pamphlet is provided to inform stakeholders of some significant points concerning workers' compensation insurance in Nevada.

What is workers' compensation?

Workers' compensation is a no-fault insurance program in the State of Nevada, which provides benefits to employees who are injured on the job and protection to employers who have provided coverage at the time of injury.

What protection is provided for the employer?

Because Nevada has "exclusive remedy," the injured workers' benefits are set forth in the statutes. Employers who provide coverage for their employees at the time of injury are protected from any additional damages claimed by their employees as a result of an injury on the job. This protection is established when the injured employee opts to receive workers' compensation benefits.

What type of benefits are employees entitled to?

Nevada's Workers' Compensation Program provides a variety of benefits which are designed to assist the injured employee. These benefits may include (among others):

- Medical treatment;
- Lost time compensation (TTD/TPD);
- Permanent Partial Disability (PPD);
- Permanent Total Disability (PTD);
- Vocational Rehabilitation;
- Dependent's benefits in the event of death; and
- Other claims-related benefits or expenses (i.e., mileage)

What services require prior authorization?

The treating physician or chiropractor must request written authorization from the insurer before ordering or performing any one of the following services with an estimated billed amount of $200 or more:

- Consultation;
- Diagnostic testing;
- Elective hospitalization;
- Any surgery which is to be performed under circumstances other than an emergency; or
- Any elective procedure.

In addition, treatment for codes 97001 to 97799, exclusive of 97545, 97546, and 98925 to 98943, consisting of more than 6 visits, requires pre-authorization. NAC 616C.129

What forms are the physician or chiropractor required to fill out?

A physician or chiropractor is required to complete the Form C-4, Employee's Claim for Compensation/ Report of Initial Treatment and the Form D-39, Physician's and Chiropractor's Progress Report. The treating physician or chiropractor *must* complete the bottom portion of the C-4 in its entirety, sign, date, and forward a copy to the insurer *and* employer within 3 working days after he first treats an injured employee. The D-39 is simply a progress report that the treating physician or chiropractor may complete versus dictating a report. A copy of the D-39 or a dictated report, including any physical limitations must be forwarded to the insurer along with the bill for service. Forms may be obtained from the WCS website:
http://dir.nv.gov/WCS/Workers__Compensation_Forms_and_Worksheets/

What information is necessary when submitting a bill?

Each provider of health care must submit a bill to the insurer which includes:

- His usual charge for services provided;
- The code for the procedure and a description of the services;
- The number of visits and date of each visit to his office and the procedures followed in any treatment administered during the visit;
- The provider's invoice and the codes for supplies and materials provided or administered to the injured employee that are set forth in the "Health Care Financing Administration, HCFA Common Procedures Coding System (HCPCS)," as contained in the "Relative Values for Physicians,"
- The name of the injured employee, his employer and the date of his injury;
- The tax identification number of the provider of health care; and
- The signature of the person who provided the service.
- In addition to the above, each physician or chiropractor must include on his bill the ICD-10-CM codes as set forth in the "International Classification of Diseases, 9th Revision, Clinical Modification (ICD-10-CM)." NAC 616C.149

How long does a provider have to appeal a billing or payment issue?

A provider of health care whose bill has been reduced or disallowed may, within 60 days after receiving notice of the reduction or disallowance, submit a written request to the Workers' Compensation Section for a review of that action. The request must identify the billed item for which the review is sought and grounds upon which the request is based. NAC 616C.027

NEVADA WORKERS' COMPENSATION CHRONICLE

Department of Business & Industry
A Publication of the Workers' Compensation Section

Division of Industrial Relations Winter Edition
(December 2020 – February 2021)

Employers and Health Care Providers: Form Changes

Several changes have been made to two forms relevant to notification to injured employees of their rights and benefits.

The first is the "Brief Description of Your Rights and Benefits If You Are Injured on the Job or have an Occupational Disease" (D-1 Form). The most significant changes are to the text to clarify that the amount of any Permanent Partial Disability (PPD) award depends on the date of injury, results of a PPD evaluation and the employee's age and wage. The amount may also be reduced based on any previously received lump-sum award. The telephone number of the Workers' Compensation Section (WCS) in Carson City has been updated as well as the address of the State of Nevada Office for Consumer Health Assistance.

Employers should be aware this poster is required to be posted in a common area of each employer and supersedes all previous D-1 Forms. **Employers must ensure the most current D-1 Form is visible and easily accessible to their employees.**

The second is the "Brief Description of Rights and Benefits" (D-2 Form) which is required to be provided to injured employees when a workers' compensation claim (C-4 Form) is initiated at the health care provider's office. The changes to the D-2 Form reflect the same changes noted above relevant to the D-1 Form. The newly revised D-2 Form supersedes all previous D-2 Forms. **Health care providers are required to ensure the most current D-2 Form is given to injured employees**.

Katherine Godwin, RN, BSN, Chief Medical Unit, WCS

Division of Insurance Adjuster License Requirements

Nevada law requires individuals and business entities who adjust workers' compensation claims to be licensed with the Nevada Division of Insurance (DOI). Nevada law does not allow a licensee to hold more than one type of adjuster license. In addition, a licensee may not be licensed as an adjuster and an insurance producer.

Prior to January 1, 2020, an individual was required to complete pre-licensing education prior to applying for a license. Effective January 1, 2020, the requirement to report pre-licensing education was repealed for all license types except bail. The DOI encourages applicants to complete pre-licensing education prior to taking the licensing exam. While Nevada does not currently have any pre-licensing education courses available, the DOI encourages applicants to visit Sircon's "Lookup for Education Courses" webpage to find adjuster pre-licensing courses available with partnered states.

An individual wishing to apply for a license must first pass an examination. Then the applicant may submit an application and fingerprints for a criminal history background check to the Division of Insurance.

Information regarding the license types, requirements and application steps is available on the Insurance Division's website at http://doi.nv.gov/licensing. Please check the website regularly for updated information regarding adjuster licensing.

Stephanie M. Kerry, BSCJA/HS, Licensing Manager, Division of Insurance

Editors Note: The free training and presentations offered by the Workers' Compensation Section (WCS) are not affiliated with DOI pre-licensing education or licensing exam preparation.

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CARDS Corner

TOP 3 REASONS D-38 CLAIM SUBMISSIONS GET REJECTED

For this issue, we've compiled a list of the most common reasons D-38 Claim Submissions get "Rejected" or "Corrections Required" in CARDS. Here are the Top 3 (or 4, depending on how you look at it) things to look out for to ensure your claim submissions are successful:

Incorrect Policy Numbers & Dates. This is the #1 reason claims are rejected in CARDS. To avoid a rejection, ensure that both the policy number and policy date on the claim *match the information that was submitted to NCCI for the period covering the date of injury*.

More on Policy Numbers: Make sure the policy number does not include any additional letters or numbers that might be used for internal company purposes only.

More on Policy Dates: When dealing with a policy that has been continually renewed year-over-year, do not enter the cumulative time span of all policy periods combined. Rather, the Policy Effective and Expiration date fields should only reflect the policy period that was active at the time the injury occurred, which is typically a 1-year timespan. *(For example, let's say an injury occurred on 10/20/2020, and a claim is made on a policy that has been annually renewed since 1/10/2015. Do not enter 1/10/2015 – 1/10/2021 in the Effective/Expiration date fields. Only enter the policy period that was active at the time of the injury, which in this case is 1/10/2020 – 1/10/2021.)*

Employer FEIN Not Located Within Policy. This error occurs when the employer FEIN provided on the claim has not been reported on the policy as a Nevada employer. To keep claims from being "Rejected" for this reason, ensure that the information has been reported to NCCI.

Closing Costs or Benefits Reported on Denied Claims. This is the #1 reason claims require corrections in CARDS. A denied claim should not have any associated closing costs or benefits. To avoid this problem, make sure that denied claims have no dollar value entered in the Total Cost at Closure field. A medical provider bill for a denied claim may be considered an administrative cost, but is not a closing cost associated with the claim and cannot be reported as such.

Hayley D. Weedn, Business Process Analyst, WCS

SHARE Village Las Vegas

The Division of Industrial Relations (DIR) team collected non-perishable food items and personal products from in October and November for Nevada's veterans. Boxes of canned goods and other needed items were delivered on November 13, 2020. SHARE Village Las Vegas (formerly known as Veterans Village Las Vegas) has been caring for the needs of our Veterans and provides affordable housing for United States veterans, seniors, and those with physical challenges or terminal illnesses. This year SHARE Village Las Vegas has distributed 321,918 pounds of food, fed 35,089 people, made 3,162 of daily door to door deliveries, distributed 3,181 emergency packets and housed 715 people per night. They also help with continuing education opportunities and concierge medical and mental health services. We look forward to our ongoing relationship with such an important organization.

SHARE VILLAGE LAS VEGAS
Bringing Veterans And Families Home

Krissi Lowry, Assistant Editor, WCS

WCS MISSION STATEMENT

The purpose of the Workers' Compensation Section is to 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.**

WCS Staff Participate in IAIABC 106th Convention

In September, WCS managers Katherine Godwin and Ruth Ryan participated in the International Association of Industrial Accident Boards and Commissions (IAIABC) 106th Convention.

The IAIABC hosts 2 major in-person events per year: The Forum in the spring and the Convention in the fall. After the Forum was cancelled due to COVID-19 concerns, the IAIABC decided to host the Convention completely online. Given the challenges facing the workers' compensation industry during the COVID-19 pandemic, the theme of the Convention was "Transform." Sessions were offered for several hours each Wednesday and Thursday throughout September. Each week had a different focus including Care Week, Intel Week, Conflict Resolution Week and Policy Week. Through a mix of presentations and panels, jurisdictional forums, committee meetings, discussion sessions, the IAIABC Convention provided education and opportunities to share information and connect industry leaders.

Katherine and Ruth sit on IAIABC Committees (Medical Issues Committee and Research and Standards Committee) and Katherine is the Vice President of the Western Association of Workers' Compensation Boards. Participation in the Forum and/or Convention is encouraged and expected for committee members. Other sessions that Katherine and Ruth attended and/or participated in were "Data Governance Activities to Support Data Quality Improvement," "Insights: What We Know About COVID-19 Workers' Compensation Claims," and the "Heads of Delegation & Associate Members' Forum" to name just a few.

Founded in 1914, the IAIABC provides information and education on workers' compensation policy, regulation, and administration and is the largest trade association of workers' compensation jurisdictional agencies in North America. The IAIABC works to improve and clarify laws, identify best practices, develop and implement standards, and provide education and information sharing.

Ruth Ryan, Research & Analysis Unit Manager, WCS

SCATS Services during the COVID-19 Pandemic

We are currently in the midst of a second, stronger surge of positive cases during the COVID-19 pandemic. The Governor of Nevada has issued a "pause" through January 15, 2021 to both businesses and citizens of Nevada. Potentially more restrictive measures are on the horizon. If you are one of the numerous businesses in the state that is having difficulty in wading through numerous directives and guidelines while trying to keep your business open, what assistance is available to you?

The Safety Consultation and Training Section (SCATS) of the Division of Industrial Relations is a free service that offers employers professional safety and health advice on a myriad of safety and health topics. If you have questions about OHSA standards or Nevada COVID directives, you can reach SCATS by calling (702) 486-9140 (Southern Nevada), 702-688-3730 (Northern Nevada) or 1-877-472-3368 statewide. SCATS has a staff of professional safety experts who will answer your questions. SCATS can also review COVID plans, provide guidance in developing COVID plans or any other safety and health topic. SCATS can also perform a walk of your facility to identify safety hazards or to provide advice on how to conform to state COVID requirements.

In addition to consultation services, SCATS also provides numerous on-line safety and health training courses. Many are 3 to 5-hour overviews of OSHA topics. All that is required is an internet ready mobile device or desktop computer. You can even use your phone to attend these classes.

SCATS also provides both construction and general industry 10 and 30- hour training courses. These classes have a few more restrictions such as the need for a camera and microphone so that SCATS staff can ensure attendance. This is a strict OSHA Training Institute requirement because an official OSHA 10 or 30– hour card is issued after the successful completion of the course. These cards are a requirement for many Nevadans who work in the construction, convention and entertainment industries. As with all services provided by SCATS, these classes are also free of charge. The only stipulation is that they are limited to the first 40 students signing into the class.

Bob Harris, Consultation Supervisor, SCATS

Task Force on Employee Misclassification Update

Senate Bill 493 passed during the 80th Nevada Legislative Session (2019) created the Task Force on Employee Misclassification. It also enacted certain provisions defining "misclassification" and other requirements for the Task Force on Employee Misclassification pursuant to Nevada Revised Statutes (NRS) sections 607.216 through 607.2195.

Governor Sisolak announced the appointment of members to the Task Force on Employee Misclassification in October 2020 (https://gov.nv.gov/News/Press/2020/Governor_Sisolak_announces_appointments_for_the_month_of_October/). The appointments included the following representatives.

(a) One person who represents an employer located in this State that employs more than 500 full-time or part-time employees.
(b) One person who represents an employer located in this State that employs 500 or fewer full-time or part-time employees.
(c) One person who is an independent contractor in this State.
(d) Two persons who represent organized labor in this State.
(e) One person who represents a trade or business association in this State.
(f) One person who represents a governmental agency that administers laws governing employee misclassification.

The Governor may also appoint two additional members to the Task Force on Employee Misclassification as appropriate. The Task Force on Employee Misclassification is expected to hold its first meeting in December 2020.

Shannon Chamber, Labor Commissioner, Office of the Labor Commissioner

Coverage Verification Service (CVS) Keeps Getting Better

In January 2006, the Workers' Compensation Section (WCS), in conjunction with the National Council on Compensation Insurance (NCCI), launched the Coverage Verification Service (CVS), a Web-based service allowing one-at-a-time searches of Nevada employers for verifying workers' compensation coverage. CVS is accessible through the Workers' Compensation Section Web site at https://dir.nv.gov/WCS/Home/ by clicking on the "COVERAGE VERIFICATION SERVICE" box.

Users can search by employer name or FEIN for a specific coverage date. Successful searches return the insurer name, policy number and employer locations covered for the coverage date indicated. The data in CVS is a subset of the policy data DIR requires insurers to report to NCCI. The quality of the information provided by CVS is directly affected by the timeliness, accuracy and completeness of the policy data reported by the carriers. ***A search resulting in no matches on CVS does not necessarily indicate that coverage does not exist for that employer.***

Over the years, WCS and NCCI have made many improvements to CVS (now also known as WCCV – Workers' Compensation Coverage Verification) to enhance the user experience. WCS added a link to claims office locations for the insurer identified in a successful search and NCCI provided access to the service on mobile devices, to name a few. In early 2021, CVS users can look forward to additional improvements and new features:

- Removing the seven-year limit on the Contains Search
- Adding the address to the search results
- Search functionality will be state specific (employer based not policy based)

The popularity of CVS is unquestioned - over 110,000 searches on CVS have been performed in 2020 alone! CVS is a particularly helpful tool for health care providers, injured employees, insurers and TPAs, attorneys and contractors to expedite claim handling, billing issues and coverage verification for subcontractors. While only employers with workers' compensation policies with private insurance carriers are included in CVS, self-insured employers and members of associations of self-insured employers may be searched on the State of Nevada Division of Insurance (DOI) Web site via links provided on the CVS page.

WCS provides an overview of how to access and use CVS in its free training "C-4 and Coverage Verification." A link to the presentation materials can be found on our website at C-4 and Coverage Verification Training Presentation.

Ruth Ryan, Research & Analysis Unit Manager, WCS

Reporting Reminders

The 2020 quarterly editions of the ***Reporting Reminders*** column feature detailed information on one reporting requirement and the ins and outs of that requirement.

TPA Information Form/ Insurer Information Form

Insurers and TPAs are required to keep the Division of Industrial Relations/Workers' Compensation Section updated on their contact information including physical and mailings addresses, locations of records, corporate and compliance contacts, to name a few. The ***Information Forms***, found in the CARDS portal, are the means by which insurers and TPAs communicate that contact information to us. The information is stored in our CARDS system. It is very important to keep this information current, as the contact information provided by insurers and TPAs is used to disseminate important information such as regulatory notices, monetary assessments, data calls, compliance issues, and assessment reporting and billing. Additionally, insurers must "link" their contracted licensed TPAs using the ***Insurer Information Form.***

TPA Information Form

Background:
Every Third-Party Administrator (TPA) licensed for workers' compensation in Nevada must complete and submit the ***TPA Information Form***.

Requirement:
Statutory Requirement: NAC 616A.410
Who Must Report: All TPAs licensed for workers' compensation
Failure to Report: May result in administrative fines pursuant to NAC 616D.415(1)(d) and (2)

Method of Reporting:
- May only be submitted through the CARDS portal
- Only CARDS users with permissions to access the ***TPA Information Form*** may submit the form
- Form is found in the "Forms and Tools" menu on the TPA user CARDS home page (if permissions have been provided)

Reporting Frequency:
- Annually and within 30 days of changes

Insurer Information Form

Background:
Every insurer – private carriers, self-insured employers and associations of self-insured employers - licensed for workers' compensation in Nevada must complete and submit the ***Insurer Information Form***. This includes decertified insurers and insurers that are licensed for workers' compensation but are not actively writing Nevada policies.

Requirement:
Statutory Requirement: NRS 616B.006 and NAC 616A.410
Who Must Report: All insurers – active and inactive - licensed for workers' compensation
Failure to Report: May result in administrative fines pursuant to NAC 616D.415(1)(d) and (2)

Method of Reporting:
- May only be submitted through the CARDS portal
- Only CARDS users with permissions to access the ***Insurer Information Form*** may submit the form
- Form is found in the "Forms and Tools" menu on the insurer user CARDS home page (if permissions have been provided)

Reporting Frequency:
- Annually and within 30 days of changes

(*continued on page 6)*

The 81st (2021) Session of the Nevada Legislature will begin on February 1, 2021.

Reporting Reminders

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***Information Form* Basics:**

- Updates made via TPA and Insurer ***Information Forms*** are not immediate. The submission of the form creates a "Ticket" for WCS staff to review. If there are questions about the submission, WCS will contact the submitter for clarification. Otherwise, the form will be processed and the updates will be made to the database.

- Insurers and TPAs can review their ***Information Form*** submissions in the CARDS portal under the "Filing History" tab. Here you can view the date submitted, the Ticket # associated with the submission and the status of the Ticket. **Do not submit the same information multiple times as this will create multiple Tickets and significantly increase the processing time.**

- Insurers using TPAs in Nevada for claims administration **must** "link" their TPAs using the Insurer Information Form. Insurers **may** also provide "linked" TPAs with permission to submit D-38 Claims Indexing reports in the CARDS portal on their behalf. Providing such permissions is at the discretion of the insurer; however, "linking" all contracted TPAs is required. **Important: TPAs may not "link" their insurer clients—only insurers may "link" their contracted TPAs.**

- Insurers should not list TPA contacts (i.e. TPA adjusters or mangers) in the contact blocks on their ***Insurer Information Form***. Insurers should only provide contact information in each contact block that are employees of the insurer. "Linking" your TPAs tells us that they are administering your claims.

- Do not report a PO Box address as a physical location.

- While the ***TPA Information Form*** is short and straightforward, the ***Insurer Information Form*** is somewhat lengthy and more complex. For information on how to submit the ***Insurer Information Form***, see the ***Insurer Information Form-Quick Steps*** on our website at http://dir.nv.gov/WCS/Insurer-TPA_Reporting/.

- Please be patient while WCS processes your forms – we have hundreds of insurers and TPAs submitting ***Information Forms*** in CARDS and we process them as soon as we can. If there is an immediate need for an update – to "link" a new TPA, for instance, you may email wcsra@dir.nv.gov with the Ticket # and request expedited processing. We will do our best to accommodate those requests.

General Reporting Information:
Information on reporting requirements and forms can be found on our web site at http://dir.nv.gov/WCS/Home/ under "Insurer and TPA Reporting" or go directly to our page at http://dir.nv.gov/WCS/Insurer-TPA_Reporting/. Contact the WCS Research and Analysis Unit by phone at (702) 486-9080 or by email at wcsra@dir.nv.gov if we can be of any assistance.

Ruth Ryan, Research & Analysis Unit Manager, WCS

The COLA Process—Step by Step

The 2019 Legislature made changes to benefits for PTD and Survivors' (Death) claims. Starting in January 2020, NRS 616C.473 and NRS 616C.508 require insurers to pay an annual 2.3% increase in benefits for PTD and Death claims. NRS 616C.266 and NRS 616C.268 allow insurers to be reimbursed for the costs associated with the annual increase for certain eligible claims. NRS 616A.425 (3) (g) and (h) allow the Fund for Workers' Compensation and Safety to cover the costs of the reimbursements to insurers associated with the annual increase in compensation for PTD and Death claims. The source of this funding will come from assessments on all workers' compensation insurers.

The following steps have been established for this process:

1. **AMW/Rate Verification (One-time):** In order to ensure correct benefit payment by insurers and ultimately correct reimbursement, insurers and TPAs must submit eligible claims to WCS for verification of AMW/Rate. This step must be completed before a request for reimbursement for payment of the COLA can be processed. WCS requests that AMW/Rate Verifications be submitted by December 31, 2020. See "Instructions for Submitting AMW/Rate Verification - PTD and Survivors' Benefits Claims" posted on the WCS web site.
2. **Request for Reimbursement (Annual):** Insurers and TPAs must submit requests for reimbursement of COLA payments for eligible claims no later than March 31 each year for the prior calendar year COLA payments. WCS will review reimbursement requests for approval or denial of reimbursement. See "Instructions for Submitting Requests for Reimbursement for Costs Associated with COLAs for PTD and Survivors' Benefits Claims" posted on the WCS web site.
3. **Special COLA Assessment (Annual):** After all requests for reimbursement have been processed by WCS, DIR will levy a special assessment on **all** workers' compensation insurers to cover the total amount approved for reimbursement for the prior calendar year COLA payments.
4. **Reimbursement to Insurers (Annual):** After the Special COLA Assessment has been collected from all insurers by DIR, checks will be issued by the State of Nevada Controller's Office with approved amounts for reimbursement to the Assessment Contact on file for each eligible insurer.

Direct questions to: COLAS@dir.nv.gov

Ruth Ryan, Research & Analysis Unit Manager, WCS

COVID-19 WORKERS' COMP CLAIMS

In response to COVID-19, new codes were added to the acceptable codes for reporting D-38 Claims Indexing data to allow WCS to better track claims relating to the virus. The new codes - Nature of Injury: 83 COVID-19 and Cause of Injury: 83 – Pandemic – were added in March 2020 and may be used for reporting applicable claims December 2019 or later. The codes correspond to those adopted by the Workers' Compensation Insurance Organizations (WCIO) and are used by the International Association of Industrial Accidents Boards and Commissions (IAIABC). By adopting these codes for D-38 Claims Indexing reporting, Nevada may be able to, over time, compare COVID-19 claim data with other states that use the IAIABC standard.

Nevada claims processed in CARDS that include one or both COVID-19 identifiers, through November 30, 2020:

COVID-19/Pandemic Claims	Count	Percent
Filed/Processed in CARDS	810	
Accepted	307	37.9%
Denied	503	62.1%

Ruth Ryan, Research & Analysis Unit Manager, WCS

2021 Training Sessions

The following classes will be offered online via Webex

Delving into the D-35
January 12, 2021 at 9:00 am

C-4 Forms: Health Care Provider (HCP) Responsibilities and Coverage Verification
January 27, 2021 at 9:00 am

Medical Billing
January 27, 2021 at 1:30 pm

Medical Fee Schedule
February 24, 2021 at 9:00 am

To view or register for classes
http://dir.nv.gov/WCS/Training/

Or email
krissi.garcia@dir.nv.gov

CONTACT WCS

Department of Business and Industry
Division of Industrial Relations
Workers' Compensation Section

SOUTHERN NEVADA
(702) 486-9080 / Fax: (702) 486-8712

NORTHERN NEVADA
(775) 684-7270 / Fax: (775) 687-6305

http://dir.nv.gov/WCS/Home/

WCSHelp@dir.nv.gov

Hails and Farewells and Promotions

A big welcome to **Perry Faigin** who joined DIR as our Interim Deputy Administrator on Monday, June 1, 2020. He is stationed in our Reno and Carson City Offices.

Perry Faigin comes from the Nevada Real Estate Division in the Department of Business and Industry, where has been the Deputy Administrator for the past year. Perry has worked closely with Directors, Administrators, and Agency HR on many projects and programs throughout Business and Industry since 2016. With specific experience in human resources, administration, development of policy and procedure, NRS/NAC review and development, contracts, solicitations, and operations. Perry also worked as the Chief of Administration with the Nevada Housing Division before joining the Real Estate Division in 2019.

Perry currently serves as the Vice-President, Board of Directors, for Home Means Nevada, Inc. The Foreclosure Mediation Program, a sponsored non-profit of the State of Nevada Department of Business and Industry, and recently completed his Certified Public Manager (CPM) certification in March of 2020.

He also served for 8 years in the Naval Reserves as a Supply Storekeeper with Naval Mobile Construction Battalion (NMCB) 18 and was activated during Operation Allied Force in support of flight operations at NAS Sigonella, Sicily.

Perry lives in the Reno/Sparks area with his wife of 28 years, Ruth, and their three children.

WCS remains closed to the public and will observe these holidays

Christmas Day
Friday, December 25, 2020

New Year's Day
Friday, January 1, 2021

Martin Luther King
Monday, January 18, 2021

President's Day
Monday, February 22, 2021

Direct comments or suggestions about this newsletter to:

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