Introduction to the Nevada Medical Fee Schedule 2021

State of Nevada Division of Industrial Relations

Workers' Compensation Section

NRS 616C.260

- Establishes Nevada Medical Fee Schedule (NMFS)
- Revised by February 1 each year
- Adjusted annually by the Consumer Price Index (CPI), Medical Services component
- Nat'l study required – charges billed/paid for services similar to the treatment and services provided to NV w/c patients (completed 2015)

Adopted Publications for Billing NRS 616C.260

- Relative Values for Physicians (RVP) - NAC 616C.145

  Available online only 2021

  Use narratives from RVP 2020

- Relative Value Guide of the American Society of Anesthesiologists (ASA Guide) - NAC 616C.146

- List of Ambulatory Surgical Codes and Payment Groups – see ASCOP Group List WCS website, link in MFS

Adopted Publications for Billing NRS 616C.260

- Medicare's current reimbursement for HCPCS codes K and L for custom orthotics and prosthetics
- International Classification of Diseases (ICD-10)
- AMA establishes CPT codes
- ADA establishes CDR (dental) codes

2021 Conversion Factors

Provider Service Codes	Conversion Factor
70000-79999 Radiology & Nuclear Medicine	$ 47.22
80000-89999 Pathology	$ 28.02
90000-99999 General Medicine/E&M	$ 12.24
10000-69999 Surgery	$260.77
00000-99999 Anesthesiology	$ 91.01

Clarification

- Provider Service Codes (NMFS, pg 1) may be used by hospitals, free standing facilities, physicians for outpatient services
- Excludes surgery/procedures provided in conjunction with those covered under Ambulatory Surgery Centers and Outpatient Hospital Surgical services
- Pathology & radiology codes - facilities bill technical portion, physicians bill professional portion (radiology, lab, etc); must use appropriate modifiers

Anesthesiology

Reimbursed based on 15-minute intervals, or fraction thereof, of time

- Starts: anesthesiologist begins prep for anesthesia in OR
- Ends: patient under post-anesthesiologist's care (recovery room)

Anesthesiology

Non-anesthesiologists may bill using the *ASA Guide* **only if prior authorized in writing by the insurer**

- Example: pain management procedures
- Authorized rarely

Anesthesiology: Modifier -28

- Modifier-28 must be used for services provided

  by a supervising anesthesiologist

- Reimbursement is 25 percent of the NMFS for anesthesiologist directly performing services

Knowledge Check

Anesthesiology: Modifier -29

<u>Must</u> use modifier -29 for services provided by**:**

- Nurse anesthetist (CRNA),
- Advanced practitioner of nursing (APRN); or
- Physician's assistant (PA)

Reimbursement is 85 percent of the NMFS for physicians

Other Uses of Modifier -29

Surgical Assistants:

- If employed by surgeon (RN, PA, OR tech) - reimbursed 14 percent of NMFS for surgeon

- If employed by facility (RN, PA, OR tech) - reimbursement included in surgical per diem rate

Other Uses of Modifier -29

Chiro/PT/OT Assistants:

- Chiropractor's Assistant - Reimbursed 40 percent of NMFS for chiropractors
- PT/OT Assistant - Reimbursed 50 percent of NMFS for PT/OT therapists
  - Physical therapy usually provided by PT assistant, watch for appropriate use of modifier -29
  - Physical therapists must do evaluations

Physical and Occupational Therapy

- Payment includes office visit, manipulation, modalities, mobilizations, testing, measurements, treatments, procedures, extra time
- Maximum daily **unit** value = 16 units
- May be exceeded for trauma to multiple body parts if authorized in advance
- Excludes work hardening codes 97545 and 97546

Physical and Occupational Therapy

- PT/OT codes for initial evaluations and re-evaluations based on complexity of service:
  - low
  - medium
  - high
- Descriptions in CPT book
- Time one element, not most essential element

No Downcoding!

Payers be careful: **no downcoding for any services!**

Instead, request additional information from health care provider or deny reimbursement for disputed codes

Physical and Occupational Therapy

- If PT/OT unit value 1 day is 16 units or more, **EOB/EOR** (payer) may combine all services utilizing Nevada Specific Code NV97001 as descriptor of services
- Initial evaluation not included
- Evaluations must be identified with appropriate CPT codes

Physical and Occupational Therapy

- Initial evaluation separate from initial six treatments
- Initial evaluation may be performed on same day as first treatment
- Initial 6 visits do not *require* prior authorization from insurer/TPA although definitely recommended

Knowledge Check

Trauma Activation Fee NV00150

- Requires notification of trauma team at designated trauma hospitals in response to triage info received from EMS regarding traumatic injury
- Based on parameters NAC 450B.770, NAC 450B.105 (initial ID/care of trauma patients)
- Trauma activation fee paid in addition to charges related to eventual disposition of patient

Emergency Department (ED)

- Use NSCs (NV00100 first hr, NV00101 each additional hr or fraction thereof)
- Diagnostic services, treatment/supplies provided by ED reimbursed in addition to ED facility reimbursement
- If injured employee admitted to hospital from ED, ED charges paid in addition to per diem rate(s) for inpatient stay

Emergency Department (ED)

- Medical supplies: reimbursed at providers' actual cost, excluding tax and freight, plus 20% unless written agreement between insurer and provider for lower reimbursement

- Copy of the **manufacturers' or suppliers'** invoices from the provider required

2021 HOSPITAL REIMBURSEMENT

Use Nevada Specific Codes (NSCs)

No revenue codes

NV00200 ICU (cardiac, neuro, burn, other)….$5,643.88

NV00450 Step Down/Intermediate Care……..$4,538.09

NV00500 Med-Surg Care……$3,432.33

NV00550 Skilled Nursing/Facility……$2,352.28

NV00600 Psychiatric Care……$2,352.28

HOSPITAL REIMBURSEMENT

Use Nevada Specific Codes (NSCs)

No revenue codes

NV00650 Observation care (>23 hours).....$3,432.33

NV00675 Observation care up to 23 hrs or fraction thereof) .....$143.01 per hr

NV00700 Rehabilitation care.....$2,352.28

Hospital Reimbursement

- Includes hospital services, professional/technical services of hospital staff, other services ordered by treating/consulting physician (include OR)
- Observation Care rates apply to acute care hospital services only; **does not apply** to outpatient hospital-based/ASC services
- Rural Hospitals: additional 10% over per diem
- Hospitals in Clark County, Washoe County, and Carson City are **not** rural hospitals

Hospital Reimbursement

- **Orthopedic** hardware/prosthetic devices/implants/grafts: hospital cost, excluding tax/freight charges, plus 20%, unless contractual agreement lower reimbursement; requires manufacturers'/suppliers' invoice
- Supplies/materials (including graft/implants) in **open-heart surgery:** hospital cost, excludes tax/freight charges, plus 40%, unless contractual agreement lower reimbursement; requires manufacturers'/suppliers' invoice

Break Time

ASC/Hospital OP Reimbursement

- ASCs and outpatient hospital-based surgical centers reimbursed equally
- List of procedures/"groupers" available on DIR/WCS website, Medical Providers webpage or link in NMFS
- Unlisted codes/numeric group assignment - may be reimbursed at Group 8, billed charges or usual and customary (NV) for comparable codes, whichever **less.** Some payers use crosswalks to determine similar services leading to usual and customary. Document thoroughly, may be requested if disputed.

ASC/Hospital OP Reimbursement

- Orthopedic hardware, prosthetics, devices, implants, grafts reimbursement = cost + 20%, invoice required (see inpatient hospitalization)

- Reimbursement **cannot exceed** NV00500 regardless of the number or services provided (including unlisted codes, modifiers "51" and/or "59," or "add-on" procedures)

ASC/Hospital OP Reimbursement

- Reimbursement includes professional and technical services by ASC staff, anesthetic cost, general supplies, operating suite, medications, other diagnostic procedures
- Observation care reimbursement does not apply

ASC/Hospital OP Reimbursement

- Be aware of any modifiers that may alter payment
  - Refer to RVP/NMFS for modifiers and directives
- Multiple procedure discounts may apply
  - Primary procedures: reimbursed 100%
  - Subsequent procedures: reimbursed 50%

ASC/Hospital OP Reimbursement

Example:

Max reimbursement (NV00500) $3,432.33

Procedures:

29827	Arthroscopic rotator cuff repair	AS5
*23540	Tx clavicular fx (closed)	AS1 (mult proc)
*23600	Tx humerus fx (closed)	AS1 (mult proc)

Check ASC/Hosp OP Group List 2016 for assigned group

Identify primary procedure(s) – highest group (Group 5 in example)

ASC/Hospital OP Reimbursement

Check MFS for reimbursement for each group (Group 5, Group 1 in example)

Calculation:

- $3,432.33 - $2,297.82 (group 5)=$1,134.51
- $1,134.51 - $533.60 (group 1 @ 50%)= $600.91
- $600.91 - $533.60 (group 1 @ 50%) = only $67.31 left to reimburse any remaining procedures

Knowledge Check

Telemedicine

- Requires prior authorization ($200 or more)
- Diagnostic/other procedures during telemedicine visit may be reimbursed separately **if prior authorized** (NAC 616C.129)
- Distant site (consultant/tx dr): use appropriate E&M **code with modifier –GT**
- Originating Site fee (NV00250) includes general supplies, technical/professional services, costs of telemedicine transmission (rarely used)

Pharmaceutical

Reimburse pharmaceuticals, except for hospital inpatient, at average wholesale price (AWP) plus $12.24 dispensing fee, or provider's usual and customary price, whichever less, unless contractual agreement lower reimbursement

Pharmaceuticals provided during inpatient hospitalization included in per diem reimbursement

Physician Dispensed Medications (NRS 616C.117)

- Physician may dispense **only initial 15-day supply** of schedule II/III controlled substance

Must use pharmacy for refills

- Bills/reports must include **original manufacturer's NDC** assigned by FDA

Physician Dispensed Medications (NRS 616C.117)

- Repackaged NDC must **not** be used!
- Outpatient health care providers may not charge/seek reimbursement for dispensing nonprescription drugs to injured employees. Medications included in per diem for inpatient services.

Compound Medications

- Requires prior authorization and **must** include:
  - Physician's justification of medical necessity for, and
  - Efficacy of, compound instead of, or in addition to, standard medication
- **Utilize ACOEM Guidelines!**

Compound Medications

- Bills must include valid NDC for each active ingredient
- No reimbursement for ingredients without NDC
- Insurer and doctor must agree on quantity and reimbursement **before** medication dispensed

Durable Medical Equipment (DME)

- Reimburse at provider's cost of the supplies and materials, excluding tax and charges for freight, plus **20%**, unless contractual agreement for a lower reimbursement.
- **Manufacturer's or supplier's invoice required**

Custom Orthotics and Prosthetics

- Reimburse **custom** orthotics and prosthetics at **140% of Medicare** allowable for Nevada, unless contractual agreement for lower reimbursement

- **No invoice required**

Home Health

- Use NSCs
- Time dependent: 2 hrs or less, >2 hrs
- Visit includes travel time, charting
- Skill dependent: licensed professionals vs CNA
- Total Reimbursement for 24 hrs timeframe may not exceed NV00500

Knowledge Check

Independent Medical Evaluations (IMEs)

Must use NSCs

- NV02001 Review of medical records (up to 50 pages), evaluation (up to 2 body parts), testing, report……$1,859.05
- NV02002 Review each additional 100 pages medical records……$ 464.77

IMEs

- NV02003 Additional body part……$348.57
- NV02004 Organization of medical records in chronological order ……(per 50 pages) $50.77
- NV02000 Failure to appear for appt……$697.14

IMEs

- Medical records must be in printable format
- **Must include cover sheet indicating number of pages provided**
- All medical records must in be chronological order based on the date of service (not date of receipt)
- No D-35 Form to DIR/WCS Medical Unit
- NSC for IMEs not interchangeable with NSC for PPDs

PPD Evaluations Basics

- PPD not same as IME. PPD is impairment rating only
- **All** PPDs require D-35 Form processed by DIR/WCS (including mutual agreements, court orders)
- NAC 616C.021(6)

  A rating evaluation of a permanent partial disability may be performed by a chiropractor ***only if*** the injured employee's injury and treatment are related to his or her ***neuromusculoskeletal system*** (emphasis mine)

PPD Evaluations Basics

Chiropractors may NOT rate (not exhaustive list):

- Hernias, gastrointestinal issues
- Head injuries, including concussions and traumatic brain injuries (TBI)
- Genital/urinary – incontinence, sexual dysfunction (even if related to spinal injuries)
- Skin – including scars, keloids, burns
- Vascular/circulatory issues
- PTSD

PPD Evaluations Basics

Use NSC

- NV01000 Review records, testing, evaluation and report……$901.35
- NV01001 Failure to appear……$301.03
- NV01002 Addendum clarify report……No charge
- NV01003 Addendum review additional medical records……$301.03
- NV01004 Each add'l body part (>2)……$301.03

PPD Evaluations

NV01005 Organization medical records in chronological order (DOS).....**per 50 pages** $ 50.77

NV01006 Review of records, report.....$449.79

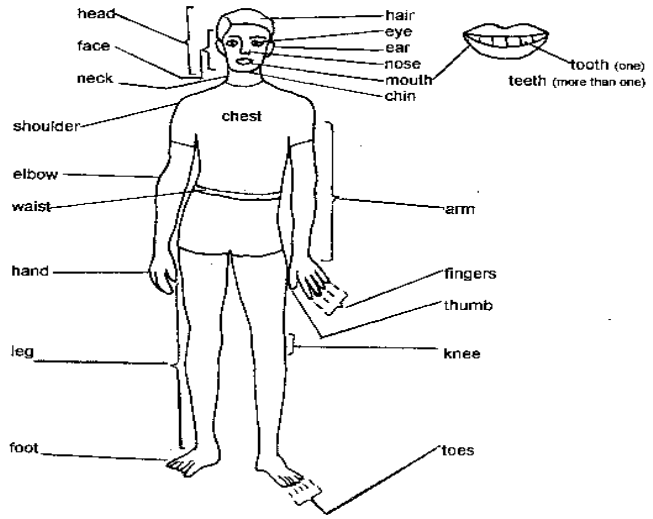
- Medical records must be in printable format
- **Must include cover sheet indicating number of pages provided**
- All medical records must in be chronological order based on the date of service (not date of receipt)

DEEP BREATH

PPD – Body Parts

Body Part Definitions **for billing only:**

- Cervical spine
- Thoracic spine
- Lumbar spine
- Pelvis



- Left upper extremity, excluding hand
- Right upper extremity, excluding hand

PPD – Body Parts

- Left/right hand, including portion below junction of middle and lower thirds left forearm (each side separate body part)
- Left/right lower extremity, each on separate body part
- Head
- Trunk
- Post-Traumatic Stress Disorder(PTSD) impairments (NRS 616C.180)

Permanent Partial Disability

- **All** PPD ratings require submission of D-35 form to DIR/WCS Medical Unit (**Las Vegas** office)
- Body part definitions same for IMEs & PPDs. Be as specific as possible on D-35 Forms (use Comments section to specify beyond body part codes listed in drop down menu)
- Chiropractors may **ONLY** rate **neuromusculoskeletal injuries** (NAC 616C.021)

Permanent Partial Disability

- PPD ratings assigned by rotation, mutual agreement, or court order – **ALL** require D-35 Form sent to DIR/WCS Medical Unit
- Always provide copy of D-35 Form processed by DIR/WCS to rater prior to rating evaluation
- Mutual agreements must be in compliance with applicable rules for all other PPD evals (i.e. use of chiropractors)

Permanent Partial Disability

- PTSD PPD evaluations done **ONLY** by **select** group of raters (few MDs/DOs, no chiropractors)
  - See Rating Panel (DIR website) for current list of PTSD raters **prior** to completing mutual agreements
- Previous PPD evaluations are part of medical records; reports **must** be submitted to all subsequent raters

Permanent Partial Disability - D-38 Forms

- All claims must be indexed (D-38 Form) prior to processing D-35 Forms
- D-38 Forms must be submitted electronically
- Write D-38 Ticket Number (TK****) on D-35 Forms
- D-35 Forms processed in order received (including corrected forms)

ALMOST DONE . . .

Back School

Use NSC

NV97115..... $99.78/hr

Reimbursement includes services of all instructors

Program must include, instruction by PT/OT, other health care providers, instruction in body mechanics, anatomy, techniques of lifting and nutrition

Functional Capacity Evaluations (FCEs)

Use NSCs

NV99060 Procedure, testing, report……per hour $283.52

NV 99061 Failure to appear for appt……$301.03

Time allowed for testing/evaluation……2-5 hours

DENTAL FEE SCHEDULE

Modified schedule, not inclusive of all dental codes

Unlisted procedures: Reimburse per the provider's usual and customary price or per contractual agreement, whichever is less

General Information

- Submit bills within 90 days from date of service, not date of discharge
- Initial bill or request for reconsideration must be submitted to insurer/TPA before one year from date of service unless good cause is shown
- "Good cause" for later billing = claim acceptance delayed beyond one year due to litigation
- Reimbursement per the NMFS in effect on date of service

Prior Authorization for Out of State Providers - NAC 616C.143

When written prior authorization is given, **the insurer shall give written notice . . .** to the provider of health care/facility that:

a) payment will be made in accordance with the NV Medical Fee Schedule pursuant to NRS 616C.260, unless otherwise provided in a contract between the provider of health care or the medical facility and the insurer;

Out of State Services

- Requires written prior authorization unless emergency (NAC 616C.143)
- Prior authorization **must include** notification reimbursement per NMFS, insurer responsible for charges, may not bill injured employee, submit bill within 90 days from date of service
- If emergency, reimbursement per out of state HCP's fee schedule or HCP's usual and customary, whichever less

Timely Action on Bills (NRS 616C.136)

- Insurer/TPA may require medical records from hospital and all medical reports before payment of hospital or medical bill
- Insurer/TPA – medical bills must be paid or denied within **45 days** from date of receipt
- Bills received erroneously should be returned to the health care provider with an explanation

Emergencies (NRS 616C.090)

- Physician/chiropractor providing emergency services may use whatever resources and techniques necessary to cope with situation
- Not restricted to physicians/chiropractors on DIR Treating Panel of Physicians and Chiropractors or those contracted with insurer/TPA

Timely Submission of Medical Records

Health care providers: submit medical records to insurer/TPA within 14 days from date of service or discharge from hospital

Does not require disclosure of any information prohibited by state or federal statute or regulation

EOBs/EORs

- Required, must include each code billed, amount paid, amount reduced or disallowed, reason for disallowance
- Must include appeal rights to HCP: within **60 days** after receiving notice of bill denial or reduction, HCP may appeal to DIR/WCS review (NAC 616C.027)
- Appeal rights re: reimbursement of medical bills given to health care providers, not injured employees

Appealing To DIR/WCS

- Contact insurer/TPA in writing (email, formal letter)
- Document, document, document
- Appeal to DIR/WCS requires:
  - EOB/EOR, copy of original bill(s) and medical records
  - attempts to resolve issue – in writing (telephone calls alone are insufficient)
  - documentation substantiating issue

Appealing To DIR/WCS

- DIR/WCS also has time frames to complete investigations (varies depending on type of complaint/appeal)
- Appeal and/or complaint will be closed if information required for investigation is not provided to DIR/WCS

Appealing to DIR

- DIR/WCS = Appeal authority; not collection agency
- Must document attempts to resolve issues with involved parties before appealing to DIR/WCS
- Note: regardless of contractual relationships various entities, DIR/WCS resolves issues with insurer/TPA and holds the **insurer/TPA responsible for the actions of their contracted entities**

Bill Adjustment Required

Incorrect/unsubstantiated codes billed: **No downcoding**

Instead:

1. Reimburse HCP for portion of bill correctly coded
2. Return bill to HCP, request additional information or documentation concerning incorrect or unsubstantiated codes; and
3. Reimburse or deny payment within 20 days after receipt of resubmitted bill with additional information or documentation

REIMBURSEMENT NOT ESTABLISHED

- Medical services not listed on NMFS may still be reimbursable

- If reimbursement not established by NMFS or adopted resources, DIR/WCS **strongly recommends** insurer and HCP mutually agree on reimbursement **before** services provided

Medical Unit Contacts

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Questions

Activity Time!

Poll Question Time