Workers' Compensation

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☐ **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)

Attn: Education Research & Analysis Unit
3360 W. Sahara Ave., Suite 250
Las Vegas, Nevada 89102

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

NEVADA WORKERS' COMPENSATION CHRONICLE

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

Division of Industrial Relations Fall Edition
(September -November 2020)

Insurers' Provider Lists Due Soon

An approaching due date can certainly induce stress. Not all stress is bad though, as it can move us forward to complete an important project. In that manner, WCS respectfully reminds stakeholders of the October 1 deadline for all workers' compensation insurers in Nevada to submit their list of treating physicians and chiropractors to the Division of Industrial Relations (DIR) Workers' Compensation Section (WCS) for posting on the WCS website. This requirement originates from Nevada Revised Statutes (NRS) 616C.087(6) which states, in part:

> Each insurer shall, not later than October 1 of each year, update the list of physicians and chiropractors and file the list with the Administrator. The list must be certified by an adjuster who is licensed pursuant to chapter 684A of NRS.

There are several important aspects of this mandate that may cause confusion. The first question is who must submit provider lists to WCS. Insurers are mandated to submit their provider lists and they will be posted on the WCS website by insurer name. Insurers includes private carriers, self-insured employers and associations of self-insured employers. If an insurer contracts with multiple third-party administrators (TPAs) using different provider lists, the insurer must submit a provider list for each of their TPAs. Each insurer will be listed on the WCS website with their TPAs listed below. Users will click on the TPA name to access the appropriate provider list. TPAs will not be listed apart from the insurer. Self-insured employers will be listed separately, and associations will also be listed separately.

The next question is exactly what must be included in the provider lists posted on the WCS website. Do they need to encompass all health care providers contracted with an insurer? Insurers' provider lists do not necessarily need to include all providers contracted with the insurer. NRS 616C.087 references treating physicians and chiropractors. The WCS Treating Panel of Physicians and Chiropractors is limited to providers licensed as MDs, DOs or DCs. The statute does not address other licensed health care providers that may be contracted with insurers to perform medical services.

Insurers should be aware there are some different requirements for the WCS Treating Panel and insurer provider lists. For instance, insurers' lists must be certified by an adjuster licensed pursuant to NRS 684A. County information is also necessary for insurers to meet specific requirements in NRS 616C.087(4). County information is available for providers listed on the WCS Treating Panel.

What if an insurer's treating provider list does not meet the statutory requirements? Insurers are responsible to ensure their lists comply with all pertinent requirements. If an insurer's list does not comply with the requirements, an injured employee may choose a treating physician or chiropractor from the WCS Treating Panel [NRS 616C.087(5)].

What format is required for insurers' provider lists? The only requirement is that insurers submit their lists in an ADA-compliant PDF format. WCS will post insurers' provider lists as they are submitted to WCS, noting the date each list is received.

(continued on page 2)

Victoria Carreon Appointed Division of Industrial Relations Administrator

Victoria "Tori" Carreon is the new Division of Industrial Relations Administrator**.** Tori has dedicated her career to public service and has worked at government agencies at the state, county, and city level. She has worked for three State Legislatures (Nevada, California, and Wisconsin) and two city governments (City of Las Vegas and City of Los Angeles). She has also worked on education policy at the San Diego County Office of Education and the Guinn Center for Policy Priorities. Most recently, she worked as an Administrative Officer for the City of Las Vegas. She has a BA from Stanford University and a Master's Degree in Public Policy from the University of California – Berkeley. To give back to the community, Tori volunteers for Public Service NV, a nonprofit that inspires CCSD high school students to do public service projects. When she is not at work, Tori enjoys cooking, yoga, and playing the piano.

Inside this issue:

CARDS NEWS

WCS is pleased to announce our most recent CARDS updates, many of which are designed to streamline and improve user experience. Comprehensive instructions are available on our website, but here is a short description of the changes to be aware of:

Home Page Improvements:

- *More information about affiliated insurers/TPAs at your fingertips* – look under your insurer and TPA headers for useful information, such as: FEIN; Company ID; NCCI Carrier Code; Certificate of Authority, License, and NAIC numbers; effective, expiration and certification dates; and workers' comp status.
- *Claim numbers now display for all submitted D-38s* – on the Claim Submissions table, regardless of claim status (Pending, Rejected, or Corrections Required).

D-38 Claim Submission Options:

- *Resubmitting a "Rejected" claim is easier than ever* – start by opening the claim in the Claim Submissions table, then click "Create New Claim," select the insurer, and the new claim will appear with data from the previously rejected form pre-filled (just make sure to review all fields for accuracy).
- *Declutter Claim Submissions by deleting "Rejected" claims* – just open in the Claim Submissions table and click "Delete" (but if you wish to use the information to create a new one, make sure to do that first).

New Session Timeout Features:

- *Never get logged out without knowing again* – a warning now pops up after 15 minutes of inactivity in CARDS; if no action is taken in the next 5 minutes, the system times out and returns you to the login page.

Insurer & TPA Information Form Updates:

- *Include a "WC Safety Fund Assessment Contact" on the Insurer Information Form* – to assist the Nevada Dept. of Business & Industry with maintaining and providing accurate, up-to-date information related to insurer assessments.
- *More accurate expiration dates for insurer/TPA relationships* – when a "Relationship Expiration Date" is set, TPAs can now access the insurer's claim submissions until midnight on the day the relationship expires.
- *Add submitter information when updating the TPA Information Form* – to streamline communications during form processing.

Keep an eye out for even more CARDS updates coming later this month, including: improved accuracy in report calculations, ability to save and track the status of Insurer/TPA Information Forms, new D-38 gender options, $0 cost FTP claim submissions, and insurer/TPA relationship effective dates displayed on your homepage.

Questions about CARDS?
CARDS@dir.nv.gov For general questions, issues with login, registration, account activation and permissions.
indexing@dir.nv.gov For questions and issues relating to Claims Indexing (D-38) processing, including web portal and flat file submissions, and Claim History Reports.

Insurers' Provider Lists Due Soon

(*continued from page 1)*

Some large insurer groups own multiple insurance companies that are distinct and separate entities. Each of these separate insurance companies must submit a separate provider list to WCS. Additionally, insurers must be careful to provide their full legal name on provider lists submitted to WCS.

How do insurers submit their treating provider lists to WCS? All insurers' provider lists should be submitted via email to **medpanels@dir.nv.gov.** Paper or hardcopy lists will not be accepted. To ensure provider lists are easily identified, please note in the subject line the insurer name and that the email contains a treating provider list.

It is not possible to review all the requirements involving insurers' provider lists in a newsletter article. WCS strongly encourages all interested stakeholders to review all applicable portions of NRS 616C.087.

Katherine Godwin, BSN, RN, Chief Medical Unit, Workers' Compensation Section

State Contractors Board Programs Help Contractors Navigate Licensing Process Before Starting Work In Nevada

As residential, commercial, and public works projects regain momentum in Nevada, the State Contractors Board (NSCB) stands ready to help construction businesses obtain the appropriate licensure to legally perform work in the state. Among the licensing assistance offered, the NSCB makes several programs available to applicants aimed to expedite the application process and help navigate licensure requirements in Nevada.

First time applicants in Nevada are encouraged to participate in the NSCB's Business Assistance Program (www.nscb.nv.gov/BAP.html); a virtual two-hour presentation held via Zoom on the fourth Friday of every month that provides a detailed overview of the contractor license application. A seasoned licensing analyst walks applicants through key licensure requirements, including how to obtain a Nevada Business ID, experience and financial documentation, examination requirements, bonds and assessments, as well as sharing helpful tips, resources, and pitfalls to avoid.

For contractors who have an active license in another state, the NSCB offers a License by Endorsement Program that may allow qualified applicants the ability to request endorsement of trade exam(s) and/or experience requirements. Published on the Board's website (www.nscb.nv.gov), applicants can review the Board's State Equivalency Chart, which lists states recognized by Nevada for having substantially similar trade exam and/or experience requirements. Specific license classifications recognized by Nevada will be outlined in the chart, allowing applicants to quickly determine if they meet the criteria to request endorsement of one or both of these licensure requirements.

Recognizing the sacrifices made by our state and nation's service members, the NSCB also offers a Veteran and Military Assistance Program (www.nscb.nv.gov/MAP.html), which is available to active service members, veterans, and military spouses. In support of initiatives directed by Nevada's Governor, this program connects current and former service members with a licensing analyst who specializes in reviewing and transferring military training, education, and experience to meet Nevada's contractor licensing requirements and expedite the application process.

Once licensure has been obtained, licensees have access to a variety of online services, which the Board is regularly working to expand. Among these services, contractors have the ability to renew their license online and make changes to business information, such as change of address or contact information. The NSCB has also revised certain requirements for existing contractors looking to expand their licensure classifications to help streamline the application process.

There are over 16,400 actively licensed construction entities across the state, and the NSCB is proud to serve every one of them. Each licensee is responsible for adhering to the statutory and regulatory expectations outlined in Nevada Revised Statute and Nevada Administrative Code Chapter 624, helping reinforce the importance licensure plays on the protection of the public's health and safety; a cornerstone of the NSCB's mission.

A Nevada licensed contractor is held accountable to every governing authority that may regulate the construction industry. Serving as a public protection agency, the NSCB has a dedicated Enforcement Department that responds to and investigates all complaints against licensed and unlicensed contractors the Board receives. The investigative process may determine the validity of alleged violations, order corrective action when necessary, and/or provide a path for recourse and discipline in the event a licensed contractor does not comply with the Board's orders.

Collaborating with local and state agencies is one of the vital aspects of the Board's investigative process to best protect the public's health, safety, and welfare. NRS 624.3011 authorizes the Board to take disciplinary action against a licensee who willfully disregards or violates the state's building laws, safety or labor laws, or laws regarding industrial insurance. When violations are alleged, the Board relies on adjudicated information from partnering agencies that demonstrates the contractor violated laws outside the Contractors Board jurisdiction.

As an example, NRS 624.256 requires licensees to provide proof of industrial insurance coverage and mandates the Board to summarily suspend the license if a contractor fails to demonstrate compliance with industrial insurance laws within 30 days of being notified by the NSCB.

These united efforts demonstrate support for Nevada's construction industry and serve to promote the integrity of Nevada's hardworking, law-abiding contractors. As you consider joining Nevada's construction workforce, know the NSCB is available to answer any questions you may have and welcomes the opportunity to help you become a licensed Nevada contractor.

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Henderson, NV 89074
(702) 486-1100

Northern Nevada Office
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Reno, NV 89511
(775) 688-1141

Margi Grein, Executive Officer, Nevada State Contractors Board

Why are we wearing face coverings?

On June 25, 2020, the Governor of Nevada issued Emergency Directive 024. This directive mandated that all employees and citizens, unless exempted by the directive, shall utilize a face covering when in public. A "face covering" is defined as a covering that fully covers a person's nose and mouth, including without limitation, cloth face masks, surgical masks, towels, scarves, and bandanas. The directive does not require the use of masks rated as surgical grade, N95 or KN95.

The reason for the mandate is that current evidence suggests that COVID-19 is most commonly spread by respiratory droplets, especially when people cough and sneeze, entering through the eyes, nose, and mouth, either directly or by touching a contaminated surface. The risk of contracting COVID- 19 is reduced when both the infected person, and those around them, are wearing a face covering. COVID-19 is highly contagious and, while the science is not yet definitive we are learning more each day, facial coverings reduce the chance of transmission and protect everyone against infection.

The main role of a face covering is to reduce the release of infectious particles into the air when a person speaks, coughs, or sneezes. While no one single intervention offers complete protection, when combined with proper handwashing, social distancing and staying home when sick, face coverings can reduce the spread of COVID-19 in communities.

Research is still being conducted on whether improvised facial coverings prevent exposure to COVID-19, but it has been established that face coverings can reduce the spread of the virus from infected symptomatic and asymptomatic individuals.

People can be contagious before the onset of symptoms. Proper coverage of the nose and mouth is a critical component in decreasing the risk of spreading or contracting COVID-19.

People who are asymptomatic or pre-symptomatic can spread the virus and, when combined with social distancing and other preventative measures, face coverings can offer additional protection to the public. Face coverings protect both the wearer and individuals the wearer may interact with either directly or indirectly while in a public space.

Bob Harris, Consultation Supervisor, SCATS

COVID-19 Workers' Compensation 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 submitted and processed in CARDS that include one or both COVID-19 identifiers, through August 31, 2020:

COVID-19/Pandemic Claims	Count	Percent
Filed/Processed in CARDS	341	
Accepted	133	39.0%
Denied	208	61.0%

PTD and Survivors' COLA Reimbursement

Beginning January 1, 2020 and every January 1 thereafter, **all** Permanent Total Disability (PTD) and Survivors' Benefits Claims are entitled to receive an annual increase of 2.3% to their monthly benefit rate. The amount that is a result of the COLA (the amount of the increase) is paid by the insurer but may be reimbursable depending on the date of injury or occupational disease disablement:

- PTD Claims: dates of injury or occupational disease disablement prior to January 1, 2004
- Survivors' Benefits Claims: dates of injury or occupational disease disablement prior to July 1, 2019

To be considered for reimbursement by the DIR, eligible claims must be submitted to DIR/WCS for one-time verification of correct AMW/Monthly Rate calculation. **Due to the volume of claims affected, DIR/WCS strongly urges insurers planning to request reimbursement to submit AMW/Rate Verification for applicable claims as soon as possible but not later than December 31, 2020 to avoid processing delays.** Visit our website for instructions, forms and FAQs: http://dir.nv.gov/WCS/Insurers/. Direct questions to: COLAS@dir.nv.gov.

Reporting Reminders

The 2020 quarterly editions of the Reporting Reminders column will feature detailed information on one reporting requirement and the ins and outs of that requirement. We hope to address some of the commonly asked questions and give you some guidance on how to avoid errors, follow up requests for clarification and report rejection.

Fiscal Year (FY) Claims Activity Report/Statement of Inactivity

Background:
The ***FY WCS Workers' Compensation Claims Activity Report*** *and* ***Statement of Inactivity*** is clearly the most detailed and comprehensive data call we require of insurers. Although each insurers' individual data is kept confidential, the data in aggregate is valuable to DIR/WCS as it is the only source of claims expenditure data we collect. The data is used to monitor costs associated with various benefits, compare relative costs year-over-year, answer questions from the public and other government entities within and outside the state, respond to legislative questions and requests for data, respond to industry surveys and provide analysis of the effects of new legislation.

The report is organized in 7 Parts: Claims Information, Compensation Expenditures, Medical Expenditures, Rehabilitation Expenditures, Recoveries, Summary and Identification Information, with detail information requested for each part. Because of its many uses, new line items may be added or existing line items may change slightly from year to year to enable DIR/WCS to best track the workers' compensation system. For instance, changes to the Nevada Medical Fee Schedule may result in reporting category changes or additions in Part 3 – Medical Expenditures. New legislation may result in new claim count categories in Part 1 – Claims Information and Part 2 – Compensation Expenditures.

Requirement:
- Statutory Requirement: NRS 616B.009 and NAC 616B.016
- Effective: 1979 (amended in 1981, 1993, 1995)
- Who Must Report: All insurers current and former (private carriers, self-insured employers, and associations of self-insured employers)
- Failure to Report: May result in administrative fines pursuant to NAC 616D.415(1)(d) and (2)

Method of Reporting:
- NOT reported in the CARDS portal
- Forms and instructions are located on the WCS website on the Insurer-TPA Reporting Information page
- ***FY__ Claims Activity Report*** – submitted if insurer has claims activity during the fiscal year, OR
- ***Statement of Inactivity*** – submitted only if no claims activity during the fiscal year
- The forms and instructions remain on the website until updated the next year with the new forms.
- Email forms to wcsra@dir.nv.gov as attachments

Reporting Frequency:
- Annually, for the previous fiscal year ending June 30
- DIR/WCS will email insurers and TPAs when report forms and instructions are available on the website
- Due 45 calendar days from the email request, generally during the last quarter of the calendar year

Common Mistakes:
- **Not completing the Identification Information Section at the end of the report** - We need to know which insurer the report is for and who is submitting it in case we have questions. Submitters should include accurate contact information in case WCS has to follow up.
- **Reporting late/not communicating** – Make sure you submit either the *Statement of Inactivity* or *FY__ Claims Activity Report* form by the due date to avoid possible fines. If you run into problems and don't think you will be able to meet the deadline, you may request a short extension by emailing wcsra@dir.nv.gov.
- **Submitting BOTH the *FY__Claims Activity Report* forms AND the *Statement of Inactivity*** - submit one form OR the other. You cannot have activity and no activity for the same year!
- **Submitting incomplete reports** – make sure all fields are completed. Do not leave cells blank! Enter '0' for line items with no activity to report.

(*continued on page 6)*

Reporting Reminders

(*continued from page 5)*

- **Reporting expenditures that are not considered "claims expenditures**" – claims expenditures are covered in NAC 616B.707. Do not report administrative costs as defined in NAC 616B.707.
- **Reporting conflicting information** – While DIR/WCS does not have the resources to audit each report submitted, we do perform reasonableness checks for each report and will require corrections or additional information from the submitter if necessary. For instance, if you reported in Part 1 paying death benefits to 5 claimants during the fiscal year, you should have death benefit expenditures reported in Part 2 – Compensation Expenditures. If you reported paying Rehab benefits on 2 claims in Part 1, you should have reported rehabilitation expenditures in Part 4. Review your report for accuracy before submitting.
- **Submitting multiple reports for the same insurer** - Insurers must ensure that reporting is done timely and accurately. If an insurer uses more than one TPA or changes TPAs during the year, the insurer is responsible for ensuring that the annual report reflects the activity for the entire year. ***DIR/WCS will not accept multiple reports for the same insurer.*** The reports will be rejected, and the insurer will be required to submit one, aggregate report representing their activity for the year.
- **Not asking questions** – This is a detailed and extensive data call. Please ask questions if you are unsure about how to report. We are happy to answer your questions if it results in getting more accurate data. Email your questions to wcsra@dir.nv.gov.

General Reporting Information:

Information on reporting requirements and forms can be found on our website 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.

FY 2021 Maximum Compensation Guidelines Posted

The state's maximum average monthly wage memo for fiscal year 2021, effective July 1, 2020, has been posted on the WCS web site. The FY 2021 maximum monthly disability compensation is $4,183.82, an increase from last year's figure.

The FY21 Maximum Compensation Guidelines memo is located on the "Important Changes" page which is accessed via the link under "What's Hot!" on the WCS home page. The link provides a chart with Maximum Compensation rates going back to FY 1975.

http://dir.nv.gov/uploadedFiles/dirnvgov/content/WCS/ImportantDocs/Max%20Comp%20FY21%20Memo%20Signed.pdf

FY 2021 Actuarial Annuity Table Posted

Victoria Carreon, Administrator of the Division of Industrial Relations, adopted the Actuarial Annuity Table for fiscal year 2021, effective July 1, 2020.

The table has been posted on the WCS web site and can be found under "What's Hot!" on the WCS home page.

http://dir.nv.gov/uploadedFiles/dirnvgov/content/WCS/ImportantDocs/WCS%20Actuarial%20Annuity%20Table%207.1.20-6.30.21%20signed.pdf

Pursuant to NRS 616C.495(5), the table must be reviewed annually by a consulting actuary.

WCS remains closed to the public but is providing services and will observe these holidays

Labor Day
Monday, September 7, 2020

Nevada Day (Observed)
Friday, October 30, 2020

Veterans Day
Wednesday, November 11, 2020

Thanksgiving
Thursday, November 26, 2020

Family Day
Friday, November 27, 2020

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WCSHelp@dir.nv.gov

Direct comments or suggestions about this newsletter to:

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Welcome Hails and Farewells and Promotions

Congratulations!

After 34 years of State service, **Debbie Atkinson** retired August 28, 2020. Debbie worked in the Workers' Compensation Section for 16 years. Her previous positions for the State include Administrative Assistant in the Immunization Program for Health and Human Services, Provider Relations Supervisor for Employers Insurance Company of Nevada (formally known as State Industrial Insurance System (SIIS)), Medical Payment Section Supervisor, and several years of processing medical bills for SIIS claims. She will greatly be missed by WCS!

2020 Training Sessions

The following classes will be taught online via Webex

WCS Basic Orientation
October 15, 2020 at 9:00 am
October 15, 2020 at 1:30 pm

Delving into the D-35
October 28, 2020 at 9:00 am

C-4 Process & Using CVS
November 4, 2020 at 9:00 am

Medical Billing
November 4, 2020 at 1:30 pm

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

Or email
krissi.garcia@dir.nv.gov

CARDS
Claims and Regulatory Data System

<<Click here to login or register>>

Questions about Workers' Compensation?
Click Here!

WCSHelp@dir.nv.gov

Office for Consumer Health
has moved:

3320 West Sahara Avenue, Suite 100
Las Vegas, NV 89102
Phone (702) 486-3587
Fax (888) 333-1597
Email Cha@govcha.nv.gov

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.**

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

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

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)

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

DIVISION OF INDUSTRIAL RELATIONS
WORKERS' COMPENSATION SECTION
EDUCATION, RESEARCH AND ANALYSIS UNIT

Medical Billing

WCS Representatives: Katherine Godwin

11/4/20 1:30 pm

Las Vegas, Nevada

Overall Training Rating:

	Not at all useful	Not very useful	Somewhat useful	Useful	Very Useful
How would you rate the usefulness of this presentation?	☐	☐	☐	☐	☐

Select your main area of interest (please choose ***one***)**:**

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Please return this training evaluation to the training staff or send it to:
DIR/WCS, Education, Research and Analysis
Email to krissi.garcia@dir.nv.gov