JOE LOMBARDO
Governor

DR. KRISTOPHER SANCHEZ
Director

VICTORIA CARREÓN
Administrator

JODI MCCOLLINS
Chief Administrative Officer

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

Frequently Asked Questions for the Workers' Compensation Assessments

Updated 6/12/2025

1. How do I update the contact information for Assessment purposes?
    - Assessment invoices are sent to the designated "Assessment Contact" for each insurer. Insurers can update this information in CARDS on the Insurer Information Form.

2. What should I do if I did not receive an invoice for the Workers' Compensation Assessment?
    - Assessment invoices are sent to the designated "Assessment Contact" for each insurer. Please log into CARDS and ensure all your information is correct. Insurers can update this information in CARDS on the Insurer Information Form.
    - If you are a Third Party Administrator and should be receiving invoices for a particular insurer, please ask the insurer to list you as the Assessment Contact.
    - After verifying your information in CARDS, to follow up on your invoice, please contact Business and Industry Fiscal Unit at wcassessment@business.nv.gov

3. How many Premium and Claims reports are due and when are reports due?
    - Premium and Claims Reports are sent out 3 times each calendar year January 31, July 31, and October 31. Reports are due the following month- February 28, August 31, and November 30.

4. Where on the website are the forms posted?
    - **Effective June 2, 2025, claims expenditures and premium data reports are now submitted through CARDS.** In the Forms and Tools menu, navigate to "Claims Expenditure and Premium Data." If you do not have access to CARDS or do not have permission to view this menu, please contact your account administrator to gain access. If you have questions on setting up permissions in CARDS, please contact cards@dir.nv.gov for assistance.

5. When will I be notified that the reports are due?
    - The Assessment Contact for each insurer will receive an email notifying them that the reports need to be submitted on January 31st and July 31st. It is important to ensure that the Assessment Contact information is up to date in CARDS and that the appropriate users have access to the CARDS to enter data.

6. What statute says I must complete this form?
    - NRS 616B.009 Reports required to be made by insurers.

1. All insurers shall report to the Administrator, annually or at intervals which the Administrator requires, all accidental injuries, occupational diseases, dispositions of claims and payments made pursuant to chapters 616A to 617, inclusive, of NRS or regulations adopted by the Division pursuant thereto.

NAC 616B.704 Records and reports. (NRS 232.680, 616A.400)

3. Each insurer shall provide the Division, at such times and in the form and manner prescribed by the Division, with reports of expected annual expenditures for claims, annual expenditures for claims and such other information as the Division deems necessary to calculate an estimated or final annual assessment. Each report of expenditures for claims must identify expenditures attributable to claims made by persons who were employed by the operators of mines at the time of their injuries.

NAC 616B.713 Statement of amount of expenditures for claims; amount to be used as source for determining annual expenditures for claims. (NRS 232.680, 616A.400)

1. Except as otherwise provided in NAC 616B.7755, an insurer shall provide to the Division a statement showing the amount of expenditures for claims described in NAC 616B.707 for a period designated by the Division.

2. The statement must be verified and signed by a responsible person employed by the insurer or an authorized agent thereof.

3. Amounts reported to the Division pursuant to subsection 1 will be used as the source for determining annual expenditures for claims.

NAC 616B.7755 Annual expenditures for claims: Records; reports; reductions for amounts received from subrogation or reimbursement. (NRS 616B.572, 616B.575)

2. Except as otherwise provided in this subsection and subsection 3, each association shall provide to the Division, at such times and in such form and manner as prescribed by the Division:

(a) A report that contains the annual expenditures for claims and expected annual expenditures for claims of the association;

(b) A report which contains the annual expenditures for claims of the association, divided into monthly expenditures, and which has been verified and signed by an authorized employee or agent of the association; and

(c) Any other information that the Division determines is necessary to calculate an estimated annual assessment or final annual assessment for the association.

7. Insurer A bought Insurer B. What reports do I need to submit moving forward?
    - If a private carrier acquired a private carrier or a self-insured employer acquired a self-insured employer, the entity that currently has liability for the claim's expenditures paid out during the time period requested is responsible for reporting claims expenditures and premiums on the applicable report: The Summary of Claims Expenditures Report or the Summary of Premiums Earned and Claims Expenditures Report.
    - Insurer B will need their own report filled out if they spent any amount of time in the period requested not owned by Insurer A yet. Notate on document what day they

became a part of Insurer A. Going forward you only need documentation on Insurer A.

8. Do I need to submit a separate form for each of my subsidiaries?
    - Yes.

9. What does "decertified" mean?
    - A decertified insurer is a self-insured employer or association of self-insureds whose certificate of authority has been withdrawn by an order of the insurance commissioner.

10. I received a report requesting self-insured information. We are not self-insured.
    - In the case of a private carrier, you only need to fill in the self-insured information if the private carrier has entered into a loss portfolio transfer or has otherwise assumed the claims' liability for a decertified self-insured employer or association of self- insured employers. If an employer was self-insured at some point in the past and retained liability for claims, the self-insured information must be completed.

11. We already de-certified, do I have to fill out this report and why?
    - Decertified self-insured employers or associations of self-insured employers need to fill in the form if they retained liability for claims pursuant to NAC 616B.713, regardless of whether there were claims expenditures for the time period requested or not.

    - NAC 616B.713 was amended August 22, 2023 to read as follows:

NAC 616B.713 Statement of amount of expenditures for claims; amount to be used as source for determining annual expenditures for claims. (NRS 232.680**,** 616A.400**)**

1. Except as otherwise provided in subsection 2 and NAC 616B.7755, an insurer shall provide to the Division a statement showing the amount of expenditures for claims described in NAC 616B.707 for a period designated by the Division.

2. If an insurer assumes the obligation to pay the expenditures for claims of a self-insured employer, association of self-insured public employers or association of self-insured private employers whose certificate of authority has been withdrawn pursuant to this chapter and chapter 616B of NRS, the insurer must provide to the Division a statement showing the amount of expenditures for claims described in NAC 616B.707 which the insurer assumed and paid on behalf of the self-insured employer, association of self-insured public employers or association of self-insured private employers, as applicable, for a period designated by the Division.

3. The statement provided pursuant to subsection 1 or 2, as applicable, must be verified and signed by a responsible person employed by the insurer or an authorized agent thereof.

4. Amounts reported to the Division pursuant to subsection 1 or 2, as applicable, will be used as the source for determining annual expenditures for claims.

12. I haven't filled out this report in years. Why now?
    - If an insurer, as defined in NAC 616B.695, has potential liability for claims for the time period requested, you must fill in this form pursuant to NAC 616B.704(3), NAC

616B.713, and NAC 616B.7755(2). If there are no claims expenditures, report "zero" or "none."

13. How long do we have to fill out reports after de-certifying?
    - Due to the lifetime claim reopening provision in Nevada in NRS 616C.390(1)(a), the Summary of Claims Expenditures Report or the Summary of Premium Earned and Claims Expenditures Report must be completed for each future period, for as long as the insurer maintains liability for the claims, regardless of whether there are claims expenditures. If a different insurer enters into a loss portfolio transfer or otherwise assumes the claims' liability, that insurer will be responsible for submitting the applicable report in each future period. See the statutory references in question 7 for the requirement to provide this data.

14. I can't make the payment deadline; may I request an extension?
    - Penalties may be assessed for late payments. See NAC 616B.740 below.

NAC 616B.740 Penalty for late payment. (NRS 232.680**,** 616A.400**)** Except as otherwise provided in NAC 616B.7758 and 616B.7767, the Division may assess a penalty for the late payment, without good cause, of an assessment for the Fund for Workers' Compensation and Safety, the Subsequent Injury Accounts for Self-Insured Employers or Private Carriers or the Uninsured Employers' Claim Account in accordance with the provisions of NRS 616D.120.

15. How do COLAs for Permanent Total Disability and Death Benefits affect my assessment?
    - All insurers are assessed annually for COLAs authorized under AB370 and SB377 of the 2019 Legislative Session. This assessment invoice is sent out in conjunction with the Final Assessment. Effective 2024, this assessment will be sent out by May 31 each year.
    - Insurers are eligible for reimbursement of COLA payments made pursuant to AB370 and SB377. Reimbursement checks are mailed out after revenue is received for the COLA assessment. Effective 2024, reimbursements will be made by December 31 each year.

16. Is the Private Carrier section where we put losses (claims expenditures) from company?
    - The Private Carrier section of the Summary of Premium Earned and Claims Expenditures Report is for claims expenditures as defined by NAC 616B.707. See question 24.

17. May I have my assessment and refund sent to different locations?
    - We currently track only one mailing address per Insurer.

18. When do I receive my refund?
    - Refunds are mailed out by the end of June every calendar year. It will take approximately 10 business days to receive your check, after they are mailed out.

19. Can I skip the quarterly estimated assessment payments and just pay the final assessment payment?
    - Pursuant to NAC 616B.731, an insurer must either pay the estimated assessment in full by the first quarterly payment due date or pay the quarterly amounts due as indicated on the invoice provided by the Business and Industry Fiscal Services Unit.

NAC 616B.731 Statement of assessment; additional assessments; payment. (NRS 232.680, 616A.400)

1. The Division will issue to each insurer a statement of his or her estimated annual assessment. The statement must include the date on which the entire amount is due, or, if the insurer elects to pay the assessment in quarterly payments, the amounts and dates on which the payments are due. The Division shall send the statement by mail not less than 30 days before the date on which payment is due.

2. The Division shall not require a quarterly payment more than 30 days before the first day of that quarterly period.

3. Additional assessments to preserve the solvency of:

(a) The Fund for Workers' Compensation and Safety;

(b) The Uninsured Employers' Claim Account; and

(c) The Subsequent Injury Accounts,

➥ may be issued by the Division.

4. An insurer shall pay the assessment in full to the Division pursuant to the date established in subsection 1 or pay the quarterly assessment amounts pursuant to the dates established in subsection 1.

20. How do I confirm if I made a payment?

- Please contact the Business and Industry Fiscal Unit by email at wcassessment@business.nv.gov.

21. Do we include, on the report, denied claims and all expenses or just COMP and MED?

- The definition of expenditures to include in the report is shown in NAC 616B.707.
  - NAC 616B.707 Consideration of expenditures as expenditures for claims; computation and reporting of value of clinical services. (NRS 232.680, 616A.400)

1. The Division will consider expenditures for the following as expenditures for claims:

(a) A surgeon, assisting surgeon, anesthesiologist or consulting physician.

(b) Charges by a hospital.

(c) Treatment by a physician or chiropractor.

(d) X-ray films, computerized axial tomography (CAT) scans, myelograms, magnetic resonance imaging, and other diagnostic tests and procedures.

(e) Physical therapy.

(f) Prescribed drugs and medications, eyeglasses, dental work, prostheses, orthotic devices and corrective shoes by prescription.

(g) Travel to obtain medical care or supplies.

(h) Any other accident benefits.

(i) Compensation for a permanent total, temporary total, permanent partial or temporary partial disability.

(j) Costs of vocational rehabilitation services for an injured employee.

(k) Death benefits.

(l) Burial expenses.

2. The Division will not consider the following expenditures to be expenditures for claims:

(a) Amounts held in reserve for any anticipated expense in connection with a claim.

(b) Money paid in excess of the compensation calculated pursuant to NRS 616C.440, 616C.475, 616C.490 or 616C.500 or NAC 616C.577 for a temporary total, temporary partial, permanent total or permanent partial disability or vocational rehabilitation maintenance.

(c) Legal expenses, including, without limitation, court costs, attorney's fees, costs for depositions, investigations and hearings.

(d) Payment of an award of interest.

(e) Payment of claims in connection with the Uninsured Employers' Claim Account.

(f) Administrative expenses, including, without limitation, expenses incurred for:

(1) Copying records;

(2) Reviewing any report of a physician or chiropractor contained in a file relating to a claim; or

(3) Services relating to the management of costs of medical care.

(g) Costs incurred in a claim that is ultimately denied.

3. The value of clinical services furnished by an insurer for industrial injuries or illnesses must be computed and reported pursuant to the schedule of fees and charges for accident benefits adopted pursuant to subsection 2 of NRS 616C.260.

22. Do we include, on the report, Indemnity payments, medical expense or indemnity & medical only?
    - The definition of expenditures to include in the report is shown in NAC 616B.707 above.