

## 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) 486-2800  
All other Nevada: (877) 873-2648  
[www.leg.state.nv.us](http://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 Web site at: [www.dirweb.state.nv.us/WCS/wcs.htm](http://www.dirweb.state.nv.us/WCS/wcs.htm)

For further 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

1301 North Green Valley Pkwy, Suite 200  
Henderson, Nevada 89074  
(702) 486-9080  
Fax: (702) 990-0364  
E-mail: [WCSHelp@business.nv.gov](mailto:WCSHelp@business.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://dirweb.state.nv.us/WCS/wcs.htm>

**Step 3:** Go to the **Division of Insurance Web site** at <http://doi.state.nv.us> and select the **"Self-Insured"** tab to locate the **"Self-insured Company List"** and **"Association List."** 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** Henderson 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



### E-mail Notification

Stay connected to what's new in Nevada's workers' compensation by registering to receive e-mail notifications. <http://dirweb.state.nv.us/WCS/wcs.htm>



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 C-4, Employee's Claim for Compensation/Report of Initial Treatment, and the 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://dirweb.state.nv.us/wcs/wcsform.htm>

## 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-9-CM codes as set forth in the "International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)." [NAC 616C.215](#)

## 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](#)

**STATE OF NEVADA**  
**DIVISION OF INDUSTRIAL RELATIONS**  
**Workers' Compensation Section**

**APPLICATION - PANEL OF TREATING PHYSICIANS AND CHIROPRACTORS**

Pursuant to NRS 616C.090 and NAC 616C.003 the Division of Industrial Relations will maintain a Panel of Physicians and Chiropractors to treat the industrially injured. Please complete and mail or fax this form to:

Division of Industrial Relations  
Workers' Compensation Section  
Attn: Medical Unit  
1301 N. Green Valley Parkway, Suite 200  
Henderson, NV 89074  
Phone: (702) 486-9080 Fax: (702) 990-0363

PHYSICIAN OR CHIROPRACTOR (PRINT): \_\_\_\_\_  
NAME DEGREE

SPECIALTY (PRINT): \_\_\_\_\_ LICENSE NUMBER: \_\_\_\_\_

PRIMARY BUSINESS ADDRESS (PRINT): \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

*TO RECEIVE NEWSLETTERS AND OTHER OFFICIAL  
INFORMATION, AN E-MAIL ADDRESS MUST BE GIVEN.*

- YES  \*NO Are you in good standing with your licensing board?
- \*YES  NO Have you ever been sanctioned for fraudulent billing or reporting?
- \*YES  NO Has disciplinary action ever been taken against you by your licensing authority, representatives of Medicare or Medicaid, or a hospital for fraud, abuse or the quality of care provided?
- \*YES  NO Have you ever been sanctioned for unprofessional conduct or discriminatory treatment in the care and treatment of a patient(s)?
- \*YES  NO Have you ever used any treatment which is not sanctioned by your peers or medical authority as being beneficial for the injury or disease involved?
- \*YES  NO Have you ever been convicted in a state or federal court for the commission of a felony?
- \*YES  NO Have you ever been convicted in a state or federal court for the commission of any offense relating to drug abuse, including excessive prescription of drugs?
- \*YES  NO Has the Division of Industrial Relations ever issued a warning to you or imposed an administrative fine on you?
- \*YES  NO Have you ever been suspended or removed from the Division of Industrial Relations= Panel of Treating Physicians and Chiropractors?

\*Please explain answers on the reverse side or separate sheet.

\_\_\_\_\_  
PHYSICIAN OR CHIROPRACTOR SIGNATURE

\_\_\_\_\_  
DATE

**PLEASE NOTIFY THIS OFFICE IN WRITING OF ADDRESS CHANGES.**



# 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's 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 Form C-4s and other necessary forms?**

Visit the WCS web page at: <http://dirweb.state.nv.us/wcs/wcsform.htm>

### **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 web page: <http://dirweb.state.nv.us/WCS/cvs.htm> 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.state.nv.us/> and select the Self-Insured tab.

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 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 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 their website at: <http://ag.state.nv.us/org/bcj/spd/wcfu/wcfu.html>

### **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 pre-authorization. [NAC 616C.129](#)

### **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://dirweb.state.nv.us/WCS/wcs.htm> [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* published by the American College of Occupational and Environmental Medicine. [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://dirweb.state.nv.us/WCS/medical.htm>

### **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 good cause is shown. The medical report must be attached to any bill sent to the insurer/TPA. Please note the following:

- An insurer must approve or deny a bill within 30 calendar days after receipt
  - If approved, the insurer has 30 days to pay the bill
  - If the insurer does not pay within 30 days, interest may be due to the medical provider
- An insurer is obligated to provide an explanation of benefits 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 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://dirweb.state.nv.us/WCS/medical.htm>

## **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://dirweb.state.nv.us/WCS/medical.htm>

## **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 Medical Fee Schedule. [NRS 616C.350](#)

## **How may I obtain more information about workers' compensation?**

To obtain more information about workers' compensation, please visit the WCS website: <http://dirweb.state.nv.us/WCS/wcs.htm> or you may contact the Workers' Compensation Section: [WCSHelp@business.nv.gov](mailto:WCSHelp@business.nv.gov)



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

**NEVADA MEDICAL FEE SCHEDULE**  
**MAXIMUM ALLOWABLE PROVIDER PAYMENT**  
**February 1, 2015 through January 31, 2016**

Pursuant to [NRS 616C.260](#), effective August 16, 2014, providers of health care who treat injured employees pursuant to Chapter 616C of NRS shall use the most recently published editions of, or updates of, the following publications for the billing of workers' compensation medical treatment: *Relative Values for Physicians*, *Relative Value Guide of the American Society of Anesthesiologists*, and the Center for Medicare and Medicaid Services (CMS) 2007 list of ambulatory surgical codes and payment groups, and Medicare's current reimbursement for HCPCS codes K and L for custom orthotics and prosthetics. Providers of health care will utilize Nevada Specific Codes for billing when identified in the Medical Fee Schedule.

Refer to [NAC 616C.145](#) and [NAC 616C.146](#) for information concerning the adoption and purchasing of the *Relative Values for Physicians and Relative Value Guide of the American Society of Anesthesiologists*. These publications are necessary for the billing of medical treatment and payment per the Nevada Medical Fee Schedule and are the providers and insurers' responsibility to obtain.

**BILLING AND REIMBURSEMENT INFORMATION**

**PROVIDER REIMBURSEMENT**

**Provider Service Code Conversion Factor:**

70000-79999 Radiology and Nuclear Medicine .....	\$39.55
80000-89999 Pathology .....	\$23.46
90000-99999 General Medicine .....	\$10.25
10000-69999 Surgery .....	\$218.32
00000-99999 Anesthesiology .....	\$76.19

Anesthesia time is determined in 15-minute intervals or any time fraction thereof, from when the anesthesiologist begins to prepare the patient for anesthesia care in the operating room and ends when the patient is placed under post anesthesiologist's care.

If preauthorized by the insurer, licensed physicians, other than anesthesiologists, may receive payment from the *Relative Value Guide of the American Society of Anesthesiologists*.

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

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

physician's assistant or an operating room technician employed by the hospital or surgical facility must be included in the per diem rate pursuant to NV00500.

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

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

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

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

The initial evaluation shall be deemed to be separate from the initial six treatments. An initial evaluation may be performed on the same day as the initial treatment and must be billed under codes 97001 or 97003.

The first six visits billed under codes 97001 to 97799, and 98925 to 98943, excluding 97545 and 97546, do not require the prior authorization of the insurer.

#### **TRAUMA ACTIVATION FEE REIMBURSEMENT**

NV00150 Trauma Activation Fee .....\$3,452.95

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

#### **HOSPITAL EMERGENCY DEPARTMENT FACILITY REIMBURSEMENT**

##### **Nevada Specific Codes:**

NV00100 First hour for use of emergency facility .....\$164.11

NV00101 Each additional hour or fraction thereof for use of emergency facility .....\$82.08

Treatment and supplies provided by the emergency department are reimbursed separately.

If an injured employee is admitted to the hospital from the emergency department, the charges related to the care in the emergency department and the per diem rates for an inpatient who receives care at the hospital are billed and paid separately.

**HOSPITAL REIMBURSEMENT**

**Nevada Specific Codes:**

NV00200 Medical-Surgical Intensive Care .....	\$3,238.27
NV00400 Medical-Surgical Cardiac Care .....	\$2,973.06
NV00500 Medical-Surgical Care .....	\$1,969.35
NV00900 Burn Care .....	\$2,973.06
NV00600 Psychiatric Care .....	\$1,969.35
NV00700 Rehabilitation Care .....	\$1,969.35
NV00550 Skilled Nursing Care Facility .....	\$1,969.35

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

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

The insurer shall reimburse the hospital for orthopedic hardware, prosthetic devices, implants and grafts at the cost to the hospital, excluding tax and charges for freight, plus 20 percent, unless there is a written agreement between the insurer and hospital for a lower reimbursement.

The insurer shall reimburse the hospital for supplies and materials, including grafts and implants used in open-heart surgery at the cost to the hospital, excluding tax and charges for freight, plus 40 percent, unless there is a written agreement between the insurer and hospital for a lower reimbursement.

**AMBULATORY SURGICAL CENTER (ASC) REIMBURSEMENT**

Group 1 .....	\$789.78
Group 2 .....	\$1,012.51
Group 3 .....	\$1,223.51
Group 4 .....	\$1,513.62
Group 5 .....	\$1,610.35
Group 6 .....	\$1,899.00
Group 7 .....	\$1,969.35
Group 8 .....	\$1,969.35
Group 9 .....	\$1,969.35

An insurer shall reimburse a surgical center for ambulatory patients for orthopedic hardware, prosthetic devices, and implants and grafts in an amount equal to the center’s cost excluding tax and charges for freight, plus 20 percent, unless there is a written agreement between the insurer and provider for a lower reimbursement.

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

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

**TELEMEDICINE REIMBURSEMENT**

**Nevada Specific Code:**

NV00250 Telemedicine Originating Site fee .....\$205.00

Reimbursement for medical facilities billing an originating site fee for telemedicine services will include all general supplies, technical services, professional services and costs for the telemedicine transmission. Diagnostic or other procedures performed in conjunction with a telemedicine visit are separately reimbursable if prior authorized, pursuant to NAC 616C.129. The consulting physician or consultant at the distant site should bill using the appropriate CPT code with a GT modifier.

**PHARMACEUTICAL REIMBURSEMENT**

An insurer shall reimburse all pharmaceuticals, except those provided to an injured employee occupying a bed in the hospital, at the average wholesale price plus a \$10.25 dispensing fee, or the provider’s usual and customary price, whichever is less, unless there is a written agreement between the insurer and provider for a lower reimbursement.

**DURABLE MEDICAL EQUIPMENT (DME) REIMBURSEMENT**

An insurer shall reimburse the provider of health care for those supplies and materials provided by a provider of health care at the provider’s cost of the supplies and materials, excluding tax and charges for freight, plus 20 percent, unless there is a written agreement between the insurer and provider for a lower reimbursement. Invoice is required.

**CUSTOM ORTHOTIC AND PROSTHETIC REIMBURSEMENT**

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

**HOME HEALTH SERVICE REIMBURSEMENT**

**Nevada Specific Codes:**

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

NV90170 Skilled home health care .....per visit \$114.29

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

NV90130 Certified nursing assistant care .....per visit \$55.69

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

NV90180 Skilled home health care .....per hour \$57.15

NV90190 Certified nursing assistant care .....per hour \$27.85

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

**PERMANENT PARTIAL DISABILITY REIMBURSEMENT**

**Nevada Specific Codes:**

NV01000	Review records, testing, evaluation, and report .....	\$754.62
NV01001	Failure of an injured employee to appear for appointment .....	\$252.02
NV01002	Addendum necessary to clarify original report .....	No charge
NV01003	Addendum after review of additional medical records .....	\$252.02
NV01004	Review of medical records and evaluation of more than 2 body parts for each body part in excess of .....	\$252.02
NV01005	Organization of medical records in chronological order .....	\$42.50
NV01006	Review of records and report .....	\$376.57

Code NV01001 may not be billed unless the injured employee fails to appear for the evaluation within 30 minutes after the scheduled appointment, or cancels the appointment within 24 hours before the scheduled appointment.

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

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

**BACK SCHOOL REIMBURSEMENT**

**Nevada Specific Code:**

NV97115	Back School .....	per hour \$83.53
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Payments for services billed under code NV97115 include the services of all instructors who participate in the program. The program must include, but is not limited to instruction of the injured employee by a licensed physical therapist or licensed occupational therapist and by other providers of health care and instruction of the injured employee in body mechanics, anatomy, techniques of lifting and nutrition.

**FAILURE TO APPEAR FOR INDEPENDENT MEDICAL EVALUATION**

**Nevada Specific Code:**

NV02000	Preparation when an injured employee fails to appear for an independent medical evaluation scheduled by an insurer .....	\$252.02
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The medical provider may bill code NV02000 only if an injured employee is more than 30 minutes late for a scheduled appointment or cancels the appointment less than 24 hours before the scheduled appointment.

**FUNCTIONAL CAPACITY EVALUATION REIMBURSEMENT**

**Nevada Specific Code:**

NV99060 Procedure, testing and report .....(per hour) \$237.36

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

**FAILURE TO APPEAR FOR FUNCTIONAL CAPACITY EVALUATION**

**Nevada Specific Code:**

NV99061 Preparation when an injured employee fails to appear for an evaluation of functional capacity performed for the injured employee .....\$252.02

The medical provider may bill code NV99061 only if an injured worker is more than 30 minutes late for a scheduled appointment or cancels the appointment less than 24 hours before the scheduled appointment.

**GENERAL INFORMATION**

Bills for health care services must be submitted within 90 days after the date on which the services were rendered unless good cause is shown for a later billing. In no event may an initial bill or request for reconsideration for health care services be submitted later than 12 months after the date on which the services were rendered unless good cause is shown for a later billing. Payment for medical service is reimbursed per the Nevada Medical Fee Schedule in effect at the time of the date of service.

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

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

The insurer, or a person authorized by the insurer, must receive a bill submitted for reconsideration no later than 12 months after the date on which the services were rendered, unless good cause is shown.

Any physician or chiropractor who is called upon to render service in the case of an emergency or severe trauma as a result of an industrial injury may use whatever resources and techniques are necessary to cope with the situation. The treatment of injured employees in such situations is not restricted to physicians and chiropractors that are members of the panel of physicians and chiropractors established by the

Administrator pursuant to [NRS 616C.090](#) or have contracted with an insurer or an organization for managed care to provide health care services to injured employees.

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

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

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

- (1) Process and provide or deny payment for that portion of the bill, if any, that contains correct codes;
- (2) Return the bill to the provider of health care and request additional information or documentation concerning that portion of the bill relating to the incorrect codes; and
- (3) Approve or deny payment within 20 days after receipt by the insurer or the insurer's agent of the resubmitted bill with the additional information or documentation.

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

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

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