ADOPTED REGULATION OF THE ADMINISTRATOR OF

THE DIVISION OF INDUSTRIAL RELATIONS OF THE

DEPARTMENT OF BUSINESS AND INDUSTRY

LCB File No. R090-99

Effective October 28, 1999

EXPLANATION – Matter in ***italics*** is new; matter in brackets **[**~~omitted material~~**]** is material to be omitted.

AUTHORITY: §1, NRS 616A.400 and 616C.110; §§2, 3 and 7, NRS 616A.400 and 616C.090; §§4, 5 and 9-11, NRS 616A.400 and 616C.490; §6, NRS 616A.400, 616C.135 and 616C.260; §8, NRS 616A.400, 616C.065, 616C.235 and 616C.390; §12, NRS 616A.400 and 616C.235; §§13, 18 and 20-26, NRS 616A.400 and 616C.260; §§14, 15, 27 and 28, NRS 616A.400, 616C.250 and 616C.260; §16, NRS 616A.400 and 616C.130; §17, NRS 616A.400, 616C.260 and 616C.365; §19, NRS 616A.400, 616C.157 and 616C.260; §29, NRS 233B.070.

Section 1. NAC 616C.001 is hereby amended to read as follows:

616C.001 As used in this chapter, unless the context otherwise requires:

1. The words and terms defined in:

(a) NRS 616A.030 to 616A.360, inclusive; and

(b) NAC 616A.020 to 616A.270, inclusive,

FLUSH have the meanings ascribed to them in those sections.

2. "Guide" means the American Medical Association's "Guides to the Evaluation of Permanent Impairment," as adopted pursuant to NAC 616C.002.

3. "Panel of physicians and chiropractors" means the panel of physicians and chiropractors who have demonstrated special competence and interest in industrial health that the administrator is required to establish pursuant to NRS 616C.090.

Sec. 2. NAC 616C.009 is hereby amended to read as follows:

616C.009 1. ~~[The]~~ ***Except as otherwise provided in subsection 3, the*** administrator or his designated agent may suspend or remove for cause any physician or chiropractor from the panel ***of physicians and chiropractors*** upon 30 days' written notice.

2. The notice of suspension or removal must define the particular cause or causes for suspension or removal.

3. The administrator may, without giving any advance notice, suspend or remove from the panel of physicians and chiropractors a physician or chiropractor whose license has been suspended or revoked by the applicable licensing authority.

Sec. 3. NAC 616C.015 is hereby amended to read as follows:

616C.015 1. Any physician or chiropractor ***suspended or*** removed from the panel of physicians and chiropractors may petition the administrator in writing for ***a*** hearing on his ***suspension or*** removal. The petition must be delivered to the administrator no later than 10 days after the notice of ***suspension or*** removal.

2. The petition must be served by registered or certified mail directed to the division's office in Carson City, or may be served by delivering it personally to the administrator or by leaving a copy with an authorized agent at the division's office.

Sec. 4. NAC 616C.021 is hereby amended to read as follows:

616C.021 1. The designation of a rating physician or chiropractor pursuant to NRS 616C.490 must be in writing. To qualify for designation, a physician or chiropractor must:

(a) Possess the qualifications required of a physician or chiropractor who is appointed to the panel of physicians and chiropractors established pursuant to NRS 616C.090 and NAC 616C.003;

(b) Demonstrate a special competence and interest in industrial health by:

(1) Performing ratings evaluations of permanent partial disabilities when selected pursuant to NRS 616C.490, except disabilities related to an injured employee's vision or functional limitations, including deficiencies in brain function, resulting from an industrial accident or occupational disease;

(2) Scheduling and performing a rating evaluation within 30 days after receipt of a request from an insurer, a third-party administrator or an injured employee or his representative; and

(3) Serving without compensation for a period not to exceed 1 year on the panel ***to review ratings evaluations*** established pursuant to NAC 616C.023;

(c) Except as otherwise provided in subsection 2, successfully complete a course on rating disabilities that is approved by the administrator or his designated agent and pass an examination that is administered by the American Board of Independent Medical Examiners, or its successor organization; and

(d) Demonstrate an understanding of the ~~[regulations]~~ ***:***

(1) Regulations of the division related to the evaluation of permanent partial disabilities ~~[.]~~ ***; and***

(2) American Medical Association's Guides to the Evaluation of Permanent Impairment, as adopted by the division pursuant to NRS 616C.110 and NAC 616C.002.

2. The administrator or his designated agent may authorize ophthalmologists and psychiatrists who are authorized to practice in this state to attend the relevant portions of the course required by paragraph (c) of subsection 1 and, upon the recommendation of the instructor of the course, may approve an ophthalmologist or psychiatrist to evaluate injured employees with impaired vision or brain damage according to his area of specialization.

3. A rating evaluation of a permanent partial disability may be performed by a chiropractor only if the injured employee's injury and treatment is related to his neuromusculoskeletal system.

4. A rating physician or chiropractor may not rate the disability of an injured employee if the physician or chiropractor has:

(a) Previously examined or treated the injured employee for the injury related to his claim for workers' compensation; or

(b) Reviewed the health care records of the injured employee and has made recommendations regarding the likelihood of the injured employee's ratable impairment.

5. A rating evaluation of a permanent partial disability performed by a rating physician or chiropractor is subject to review by the administrator or his designated agent pursuant to the provisions of NAC 616C.023.

Sec. 5. NAC 616C.024 is hereby amended to read as follows:

616C.024 1. The administrator or his designated agent will issue a warning to any physician or chiropractor on the list of rating physicians and chiropractors designated

pursuant to NRS 616C.490, ***or*** suspend ~~[any physician or chiropractor from the list]~~ or remove any physician or chiropractor from the list if the physician or chiropractor:

(a) Commits an excessive number of errors in the performance of ratings evaluations, as determined by comparing the number of ratings found by the administrator or his designated agent to be erroneous to the total number of ratings performed by the physician or chiropractor;

(b) Violates any provision of NAC 616C.006 or commits two or more violations of any of the provisions of chapters 616A to 617, inclusive, of NRS or any other regulations adopted pursuant thereto;

(c) Is the subject of any disciplinary action ~~[which]~~ ***that*** resulted in the suspension or revocation of his license or the limitation of his practice by the applicable licensing authority;

(d) Is determined by the administrator or his designated agent to have engaged in any action detrimental to an injured employee, an employer, an insurer or the program of industrial insurance;

(e) Refuses to serve as a member of the panel ***to review ratings evaluations*** established pursuant to NAC 616C.023 or serves as a member of the panel but does not attend the meetings of the panel; or

(f) Fails to perform ratings evaluations when selected pursuant to NRS 616C.490 or schedules and fails to perform such evaluations in accordance with that section.

2. For the purposes of paragraph (a) of subsection 1, the administrator or his designated agent, after receiving the advice of the panel ***to review ratings evaluations***

established pursuant to NAC 616C.023, will determine what is an excessive number of errors in the performance of ratings evaluations.

3. If the administrator or his designated agent intends to ***suspend or*** remove a physician or chiropractor from the list of rating physicians and chiropractors, he will cause written notice of the ***suspension or*** removal to be delivered by certified mail to the physician or chiropractor affected. The physician or chiropractor may appeal the determination of the administrator or his designated agent by filing a written notice of appeal with the administrator within ~~[30]~~ ***10*** days after the notice of ***suspension or*** removal is received. If a notice of appeal is filed in the manner provided by this subsection, the administrator or his designated agent will conduct a hearing on the matter and issue a decision in writing affirming or reversing the determination.

4. Except as otherwise provided in this subsection, the ***suspension or*** removal of a physician or chiropractor from the list of rating physicians and chiropractors becomes final and effective upon the expiration of the time permitted by subsection 3 for the filing of a notice of appeal. If a notice of appeal is filed in the manner provided by subsection 3, the ***suspension or*** removal is final and effective upon the issuance of a decision affirming the determination of the administrator or his designated agent. The issuance of such a decision is a final decision for the purposes of judicial review.

Sec. 6. NAC 616C.027 is hereby amended to read as follows:

616C.027 1. 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 industrial insurance regulation section for a review of that action. The

request must identify the billed item for which the review is sought and state the ground upon which the request is based. The industrial insurance regulation section will review the matter, issue a written determination and mail or deliver copies of the determination to the provider of health care and the insurer. If the determination is in the provider's favor, the insurer shall, within 30 days after receiving notice of the determination, pay him the amount ordered by the industrial insurance regulation section, unless an appeal is taken in the manner provided by subsection 2.

2. Any person aggrieved by the determination of the industrial insurance regulation section may appeal to the administrator or his designated agent by filing a request for a hearing with the ~~[industrial insurance regulation section]~~ ***administrator*** within 30 days after the date of the determination.

3. The administrator or his designated agent will schedule a hearing on the matter and, after the hearing, issue a written decision. The administrator or his designated agent will give notice of his decision to the provider of health care and the insurer. If the decision is in the provider's favor, the insurer shall, within 10 days after receiving notice of the decision, pay the provider the amount ordered by the administrator or his designated agent. The decision of the administrator or his designated agent is a final decision for the purposes of judicial review.

Sec. 7. NAC 616C.030 is hereby amended to read as follows:

616C.030 ***1.*** Upon the receipt of a request from an injured employee or his representative, ~~[an employer, an insurer, a third-party administrator or an organization for managed care]~~ ***the:***

(a) Employer;

(b) Insurer;

(c) Third-party administrator; or

(d) Organization for managed care,

FLUSH shall provide a list of providers of health care who are authorized to provide medical and health care services to the injured employee.

2. If the request made pursuant to subsection 1 is in writing, the:

(a) Employer;

(b) Insurer;

(c) Third-party administrator; or

(d) Organization for managed care,

FLUSH ***shall provide the list to the injured employee within 3 working days after the date it receives the request.***

Sec. 8. NAC 616C.094 is hereby amended to read as follows:

616C.094 1. Except as otherwise provided in this section, within 30 days after receipt of a ***written*** request relating to a claim made by:

(a) An injured employee, an employer, a health care provider or the attorney or other representative of any of them; or

(b) A spouse, child or parent of an injured employee who is deceased or incapacitated,

FLUSH the insurer ***, third-party administrator*** or organization for managed care shall ***, in writing,*** notify the person making the request of its determination concerning the request.

2. If the insurer ***, third-party administrator or organization for managed care*** terminates or denies any benefit ~~[or refuses to reopen a claim]~~ in response to a ***written*** request, it shall notify the person making the request, in writing, giving the reasons for its determination and an explanation of the person's right to appeal.

3. If the insurer or third-party administrator denies a written request to reopen a claim, it shall notify the person making the request and the employer of that person, in writing, specifying the reasons for its determination and an explanation of the person's right to appeal.

Sec. 9. NAC 616C.103 is hereby amended to read as follows:

616C.103 1. ~~[When a physician or chiropractor appointed to the panel of physicians and chiropractors has determined that an injured employee is stable and ratable and information in the insurer's file on the injured employee indicates the likelihood that he has a ratable impairment, according to the guide, the]~~ ***For purposes of determining whether an injured employee is stable and ratable and, therefore, entitled to an evaluation to determine the extent of any permanent impairment pursuant to this section and NRS 616C.490, the division interprets the term:***

(a) "Stable" to include, without limitation, a written indication from a physician or chiropractor that the industrial injury or occupational disease of the injured employee:

(1) Is stationary, permanent or static; or

(2) Has reached maximum medical improvement.

(b) "Ratable" to include, without limitation, a written indication from a physician or chiropractor that the medical condition of the injured employee may have:

(1) Resulted in a loss of motion, sensation or strength in a body part of the injured employee; or

(2) Resulted in a loss of or abnormality to a physiological or anatomical structure or bodily function of the injured employee.

2. An insurer shall comply with subsection 2 of NRS 616C.490, within the time prescribed in that subsection for the scheduling of an appointment, by:

(a) Requesting a physician or chiropractor from the ~~[~~panel~~]~~ ***list of qualified rating physicians and chiropractors*** designated by the administrator to evaluate the injured employee and determine the extent of any permanent impairment; ~~[~~and~~]~~

(b) Mailing written notice to the injured employee of the date, time and place of the appointment for the rating evaluation ~~[~~.

~~2.]~~ ***; and***

(c) At least 3 working days before the rating evaluation, providing to the assigned rating physician or chiropractor from the insurer's file concerning the injured employee's claim:

(1) All reports or other written information concerning the injured employee's claim produced by a physician, chiropractor, hospital or other provider of health care, including the statement from the treating physician or chiropractor that the injured employee is stable and ratable, surgical reports, diagnostic, laboratory and radiography reports and information concerning any preexisting condition relating to the injured employee's claim;

(2) Any evidence of a previous award of workers' compensation issued in or outside of this state for the injury or occupational disease that is the subject of the injured employee's claim;

(3) The form designated in NAC 616A.480 as C-4, Employee's Claim for Compensation/Report of Initial Treatment; and

(4) The form designated in NAC 616A.480 as D-35, Rotating Rating Physician/Chiropractor Request.

3. Except as otherwise provided in subsection ~~[4,]~~ ***5,*** if the rating physician or chiropractor finds that the injured employee has a ratable impairment, the insurer shall, within the time prescribed by NRS 616C.490, offer the injured employee the award to which he is entitled. The insurer shall make payment to the injured employee:

(a) Within 20 days; or

(b) If there is any child support obligation affecting the injured employee, within 35 days,

FLUSH after it receives the properly executed award papers from the injured employee or his representative.

~~[3.]~~ ***4.*** If the rating physician or chiropractor determines that the permanent impairment may be apportioned pursuant to NAC 616C.490, the insurer shall advise the injured employee of the amount by which the rating was reduced and the reasons for the reduction.

~~[4.]~~ ***5.*** If the insurer disagrees in good faith with the result of the rating evaluation, the insurer shall, within the time prescribed in NRS 616C.490:

(a) Offer the injured employee the portion of the award, in installments, which it does not dispute;

(b) Provide the injured employee with a copy of each rating evaluation performed of him; and

(c) Notify the injured employee of the specific reasons for the disagreement and his right to appeal. The notice must also set forth a ***detailed*** proposal for resolving the dispute ~~[~~.

~~5.]~~ ***that can be executed in 75 days, unless the insurer demonstrates good cause for why the proposed resolution will require more than 75 days.***

6. The injured employee must receive a copy of the results of each rating evaluation performed of him before accepting an award for a permanent partial disability.

~~[6.]~~ ***7.*** As used in this section, "award papers" means the following forms ~~[,]~~ ***designated in NAC 616A.480,*** as appropriate:

(a) D-10(a), Election of Method of Payment of Compensation.

(b) D-10(b), Election of Method of Payment of Compensation for Disability Greater than 25 Percent.

(c) D-11, Reaffirmation of Lump Sum Request.

Sec. 10. NAC 616C.103 is hereby amended to read as follows:

616C.103 1. ~~[When a physician or chiropractor appointed to the panel of physicians and chiropractors has determined that an injured employee is stable and ratable and information in the insurer's file on the injured employee indicates the likelihood that he has a ratable impairment, according to the guide, the]~~ ***For purposes of determining whether an***

injured employee is stable and ratable and, therefore, entitled to an evaluation to determine the extent of any permanent impairment pursuant to this section and NRS 616C.490, the division interprets the term:

(a) "Stable" to include, without limitation, a written indication from a physician or chiropractor that the industrial injury or occupational disease of the injured employee:

(1) Is stationary, permanent or static; or

(2) Has reached maximum medical improvement.

(b) "Ratable" to include, without limitation, a written indication from a physician or chiropractor that the medical condition of the injured employee may have:

(1) Resulted in a loss of motion, sensation or strength in a body part of the injured employee; or

(2) Resulted in a loss of or abnormality to a physiological or anatomical structure or bodily function of the injured employee.

2. An insurer shall comply with subsection 2 of NRS 616C.490, within the time prescribed in that subsection for the scheduling of an appointment, by:

(a) Requesting a physician or chiropractor from the ~~[panel]~~ ***list of qualified rating physicians and chiropractors*** designated by the administrator to evaluate the injured employee and determine the extent of any permanent impairment ~~[; and]~~ ***or, if the injured employee and insurer have agreed to a rating physician or chiropractor pursuant to subsection 2 of NRS 616C.490, by submitting a written copy of that agreement and the form designated in NAC 616A.480 as D-35, Rotating Rating Physician/Chiropractor Request, to the industrial insurance regulation section within 30 days after the insurer***

has received the statement from a physician or chiropractor that the injured employee is ratable and stable;

(b) Mailing written notice to the injured employee of the date, time and place of the appointment for the rating evaluation ~~[.~~

~~2.]~~ ***; and***

(c) At least 3 working days before the rating evaluation, providing to the assigned rating physician or chiropractor from the insurer's file concerning the injured employee's claim:

(1) All reports or other written information concerning the injured employee's claim produced by a physician, chiropractor, hospital or other provider of health care, including the statement from the treating physician or chiropractor that the injured employee is stable and ratable, surgical reports, diagnostic, laboratory and radiography reports and information concerning any preexisting condition relating to the injured employee's claim;

(2) Any evidence of a previous award of workers' compensation issued in or outside of this state for the injury or occupational disease that is the subject of the injured employee's claim;

(3) The form designated in NAC 616A.480 as C-4, Employee's Claim for Compensation/Report of Initial Treatment; and

(4) The form designated in NAC 616A.480 as D-35, Rotating Rating Physician/Chiropractor Request.

3. Except as otherwise provided in subsection ~~[4,]~~ ***5,*** if the rating physician or chiropractor finds that the injured employee has a ratable impairment, the insurer shall, within the time prescribed by NRS 616C.490, offer the injured employee the award to which he is entitled. The insurer shall make payment to the injured employee:

(a) Within 20 days; or

(b) If there is any child support obligation affecting the injured employee, within 35 days,

FLUSH after it receives the properly executed award papers from the injured employee or his representative.

~~[3.]~~ ***4.*** If the rating physician or chiropractor determines that the permanent impairment may be apportioned pursuant to NAC 616C.490, the insurer shall advise the injured employee of the amount by which the rating was reduced and the reasons for the reduction.

~~[4.]~~ ***5.*** If the insurer disagrees in good faith with the result of the rating evaluation, the insurer shall, within the time prescribed in NRS 616C.490:

(a) Offer the injured employee the portion of the award, in installments, which it does not dispute;

(b) Provide the injured employee with a copy of each rating evaluation performed of him; and

(c) Notify the injured employee of the specific reasons for the disagreement and his right to appeal. The notice must also set forth a ***detailed*** proposal for resolving the dispute ~~[.~~

~~5.]~~ ***that can be executed in 75 days, unless the insurer demonstrates good cause for why the proposed resolution will require more than 75 days.***

6. The injured employee must receive a copy of the results of each rating evaluation performed of him before accepting an award for a permanent partial disability.

~~[6.]~~ ***7.*** As used in this section, "award papers" means the following forms ~~[,]~~ ***designated in NAC 616A.480,*** as appropriate:

(a) D-10(a), Election of Method of Payment of Compensation.

(b) D-10(b), Election of Method of Payment of Compensation for Disability Greater than 25 Percent.

(c) D-11, Reaffirmation of Lump Sum Request.

Sec. 11. NAC 616C.109 is hereby amended to read as follows:

616C.109 1. If an injured employee ***, employer, insurer or third-party administrator*** is permitted by the rating physician or chiropractor to have his attorney or other representative present during a rating evaluation for a permanent partial disability, ~~[the employer of the injured employee is also entitled to have a representative present during]~~ ***that party shall, in writing and at least 5 working days before the evaluation, notify each of the other persons described and the attorney or other representative of those persons of his intent to have his attorney or other representative attend*** the evaluation. The rating physician or chiropractor may request an attorney or representative to leave the examination room or may terminate the examination:

(a) If the attorney or representative disrupts the examination; or

(b) To protect the privacy of the injured employee.

2. Nothing in this section shall be deemed to limit the right conferred by subsection 4 of NRS 616C.140.

Sec. 12. NAC 616C.112 is hereby amended to read as follows:

616C.112 The notice of intention to close a claim required by ***subsection 1 of*** NRS 616C.235 must include:

1. The provisions of subsection 2 of NRS 616C.390; and

2. An offer to the injured employee of an opportunity for him to appeal from the insurer's determination to close the claim.

Sec. 13. NAC 616C.120 is hereby amended to read as follows:

616C.120 The provisions of NAC 616C.123 to 616C.230, inclusive, do not prohibit or otherwise impair or interfere with the right of an injured employee to inspect ***or obtain*** his health care records pursuant to ***the provisions of*** NRS 629.061.

Sec. 14. NAC 616C.129 is hereby amended to read as follows:

616C.129 The members of the panel of physicians and chiropractors, approved for treatment of employees protected by workers' compensation, shall adhere to the following rules:

1. There may be only one treating physician or chiropractor in any one case at any one time, unless prior authorization is obtained from the insurer. Physicians and chiropractors associated with the treating physician or chiropractor may treat the injured employee during the temporary absence of the treating physician or chiropractor. In all cases, the treating physician or chiropractor is directly responsible for the management of the health

care of the injured employee. Physicians in emergency rooms are not considered treating physicians within the meaning of NAC 616C.126 to 616C.144, inclusive.

2. The insurer shall give written notice to all interested persons of the transfer of an injured employee to a new physician or chiropractor.

3. Except as otherwise provided in this subsection, an injured employee or an insurer is not financially liable for the payment of the fees of a provider of health care who renders treatment to an injured employee for an industrial accident or occupational disease, knowing that the injured employee is already under the care of another provider of health care. The insurer may be liable for the payment of the fees pursuant to this subsection if the insurer gives prior written approval for the treatment or good cause is shown for the treatment provided.

4. Any prescription or service ordered by a physician or chiropractor other than:

(a) The treating physician or chiropractor; or

(b) A physician or chiropractor associated with the treating physician or chiropractor who is treating the injured employee during the temporary absence of the treating physician or chiropractor,

FLUSH is not a financial liability of the insurer unless good cause is shown for the prescription or service.

5. 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:

(a) Consultation;

(b) Diagnostic testing;

(c) Elective hospitalization;

(d) Any surgery which is to be performed under circumstances other than an emergency; or

(e) Any elective procedure.

6. Any request for prior authorization to order or perform any of the services set forth in subsection 5 must contain an explanation of the need for each service to be ordered or performed. If any of the services are performed without the insurer's written authorization, the insurer is not liable for the fee for the service, unless good cause is shown for providing the services without prior authorization.

7. In the case of a medical emergency, a provider of health care who is not able to obtain prior written authorization to treat a person for an industrial injury or occupational disease shall submit to the insurer proof of the emergency and the reasons why prior authorization was impracticable to obtain. The proof must be submitted within 5 working days after the treatment is rendered.

8. A treatment program that consists of more than six visits, not including the initial evaluation, and is billed under codes ~~[97001]~~ ***97010*** to 97799, inclusive, 98925 to 98943, inclusive, or NV00001 to NV00003, inclusive, whether the visits are billed separately or included under different codes, must be authorized in advance by the insurer to verify the medical necessity for continued treatment. The first six visits do not require the prior authorization of the insurer. The number of requests for additional visits and any written authorization granted therefor are not restricted, and are subject only to the treatment

prescribed by the treating physician or chiropractor and the determination of the insurer. A report of the status of an injured employee may be requested by an insurer at any time during the course of treatment. 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.

Sec. 15. NAC 616C.141 is hereby amended to read as follows:

616C.141 ~~[The "Relative Values for Physicians," as adopted pursuant to NAC 616C.188, is hereby amended as follows:]~~

1. If a program of treatment that is required to be billed under codes 97001 to 97799, inclusive, or 98925 to 98943, inclusive, is administered to an injured employee, the treatment, evaluation, manipulation, modality, mobilization procedure, testing or measurements must be administered by:

(a) A licensed physical therapist;

(b) A licensed physical therapist's assistant;

(c) A licensed occupational therapist;

(d) A licensed occupational therapy assistant;

(e) A licensed physician;

(f) A licensed chiropractor; or

(g) A certified chiropractor's assistant,

FLUSH who is acting within the authorized scope of his license or certification.

2. If a treating physician or chiropractor prescribes a program of treatment that is required to be billed under codes ~~[97001]~~ ***97010*** to 97799, inclusive, or 98925 to 98943, inclusive, it must be in writing and include:

(a) A recommendation of the modalities or procedures, or both, to be administered to specific areas of the body; and

(b) The frequency of the treatments.

3. ~~[The maximum unit value allowed for bills that include any treatment identified under codes 97001 to 97799, inclusive, or 98925 to 98943, inclusive, billed individually or as an item included under a different code, is as follows:~~

~~(a) Services provided by a physician or chiropractor must be billed using the following modifiers:~~

FLUSH

~~Code Modifier — Time Billed — Maximum Unit Value~~

~~-51A — Up to one-half hour ..... 7.25 units~~

~~-51B — Over one-half hour ..... 12.5 units~~

~~(b) Services provided by a licensed physical therapist, licensed physical therapist's assistant, licensed occupational therapist or licensed occupational therapy assistant must be billed using the following modifier:~~

FLUSH

~~Code Modifier — Time Billed — Maximum Unit Value~~

~~51C All services provided per day..... 12 units~~

~~4. The maximum unit value includes all services provided pursuant to this section, except materials and supplies. Any payment made pursuant to this section must include, but is not limited to, payment for:~~

~~(a) The office visit;~~

~~(b) Evaluations and management services;~~

~~(c) Manipulations;~~

~~(d) Modalities;~~

~~(e) Mobilizations;~~

~~(f) Testing and measurements;~~

~~(g) Treatments;~~

~~(h) Procedures; and~~

~~(i) Extra time.~~

~~5.]~~ A provider of health care shall indicate on a bill presented to an insurer for any treatment each code contained in the "Relative Values for Physicians," as adopted pursuant to NAC 616C.188, or the "Relative Value Guide of the American Society of Anesthesiologists, **"** Inc.," as adopted pursuant to NAC 616C.194, for any services. The codes must be indicated on each bill regardless of whether the provisions of NAC

616C.073 to 616C.336, inclusive, allow for the payment of such services, the payment is requested or the item is included under a different code.

~~[6.]~~ ***4.*** Any bill for an office visit that is billed under codes 90000 to 99999, inclusive, must include a written report concerning the history of the injured employee, a comprehensive evaluation of the injured employee's health condition or an evaluation of specific health problems of the injured employee, any decision made concerning the treatment required by the injured employee and all forms for submitting a claim to the insurer or billing reports that are requested by an insurer. Such a bill is not required to include a special report that is specifically requested by an insurer and is required to be billed under code 99080.

~~[7. Code 99080 is hereby amended to read as follows:~~

~~Code~~	~~Procedure~~	~~Payment~~
~~99080~~	~~Special reports requested in writing by an insurer, such as the review of health care data to clarify an injured employee's status or to describe extensively an injured employee's health condition – more than the information contained in the standard health care communication or standard reporting form.~~	~~By Report~~

~~8.]~~ ***5.*** Services provided by a certified advanced practitioner of nursing or certified physician's assistant must be billed using the modifier-29. An insurer is financially liable for the payment of any bill using the modifier-29 pursuant to this subsection at a rate not to exceed 70 percent of the maximum allowable fee established for physicians or chiropractors pursuant to paragraph (a) of subsection ~~[3.]~~ ***4 of NAC 616C.188.*** The provisions of this subsection do not authorize a certified advanced practitioner of nursing or certified physician's assistant to perform any services that are not within the authorized scope of his practice.

~~[9.]~~ ***6.*** Services provided by a licensed physical therapist's assistant or licensed occupational therapy assistant must be billed using modifier-29. An insurer is financially liable for the payment of any bill using modifier-29 pursuant to this subsection at a rate not to exceed 50 percent of the maximum allowable fee for licensed physical therapists or licensed occupational therapists established pursuant to paragraph (b) ***or (c)*** of subsection ~~[3.]~~ ***4 of NAC 616C.188.*** The provisions of this subsection do not authorize a licensed physical therapist's assistant or licensed occupational therapy assistant to perform any services that are not within the authorized scope of his license.

~~[10.]~~ ***7.*** Services provided by a certified chiropractor's assistant must be billed using modifier-29. An insurer is financially liable for the payment of any billing using modifier-29 pursuant to this subsection at a rate not to exceed 40 percent of the maximum allowable fee for chiropractors established pursuant to paragraph (a) of subsection ~~[3.]~~ ***4 of NAC 616C.188.*** The provisions of this subsection do not authorize a certified

chiropractor's assistant to perform any services that are not within the authorized scope of his certification.

~~[11.]~~ ***8.*** 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 billed using modifier-29. An insurer is financially liable for the payment of any bill using modifier-29 pursuant to this subsection at a rate not to exceed 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 code NV00500 as set forth in subsection 3 of NAC 616C.203.

Sec. 16. NAC 616C.144 is hereby amended to read as follows:

616C.144 1. 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 for health care services be submitted later than ~~[6]~~ ***12*** months after the date on which the services were rendered.

2. 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. Payment is not required for those services if the report is inadequate to determine the amount due. This subsection does not require the

disclosure of any information regarding which disclosure is prohibited by state or federal statute or regulation.

3. 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 physician's or chiropractor's medical reports before payment of a hospital or medical bill.

4. ~~[If an insurer:~~

~~(a) Has not entered into a contract with another entity to revise the charges contained in a bill, the insurer must]~~ ***An insurer shall*** pay or deny the payment of charges within 60 days after receipt ***by the insurer or his agent*** of the first bill for those charges unless ~~[good]~~ ***:***

(a) Good cause is shown for a later payment or denial ~~[.~~

~~(b) Has entered into a contract with another entity to revise the charges contained in a bill:~~

~~(1) That entity must process and deliver the bill to the insurer within 30 days after the bill is received.~~

~~(2) The insurer must pay or deny the payment of charges within 30 days after receipt of the bill from that entity unless good cause is shown for a later payment or denial.]~~ ***; or***

(b) The insurer has returned the bill to the provider of health care pursuant to paragraph (c) of subsection 6.

5. A bill that is submitted for reconsideration must be:

(a) Received by the insurer or a person authorized by the insurer to receive such a bill no later than ~~[6]~~ ***12*** months after the date on which the services were rendered, unless good cause is shown.

(b) Processed in accordance with the requirements of subsection 4.

6. The insurer shall:

(a) Provide an explanation of benefits for each code billed ~~[with its payment]~~ that includes the amounts for services that are paid and disallowed; ~~[and]~~

(b) Indicate on each payment those services which are being disallowed and the reasons for the disallowance ~~[.]~~ ***; and***

(c) 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:

(1) Process and provide or deny payment for that portion of the bill, if any, that does not contain incorrect codes;

(2) Return the bill to the provider of health care and request additional information or documentation concerning that portion of the bill relating to the incorrect codes; and

(3) Pay or deny payment within 60 days after receipt, by the insurer or his agent, of the resubmittal of the bill with the additional information or documentation.

Sec. 17. NAC 616C.150 is hereby amended to read as follows:

616C.150 1. The insurer shall reimburse an injured employee for the cost of transportation if he is required to travel 20 miles or more, one way, from:

(a) His residence to the place where he receives health care; or

(b) His place of employment to the place where he receives health care if the care is required during his normal working hours.

2. The insurer shall reimburse an injured employee for the cost of transportation if he is required to travel 20 miles or more, one way, from his residence or place of employment to a place of hearing designated by the insurer or the department of administration if the hearing concerns an appeal by the employer or insurer from a decision in favor of the injured employee and the decision is upheld on appeal.

3. An injured employee who does not qualify for reimbursement under paragraph (a) or (b) of subsection 1 but is required to travel a total of 40 miles or more in any 1 week for health care or for attendance at ~~[the system's]~~ ***a*** rehabilitation center ***designated by the insurer*** is entitled to be reimbursed for the cost of his transportation.

4. Except as otherwise provided in subsection 6, reimbursement for the cost of transportation must be computed at a rate equal to:

(a) The mileage allowance for state employees who use their personal vehicles for the convenience of the state; or

(b) The expense actually incurred by the injured employee for transportation, if the injured employee consents to reimbursement at this rate and the expense is not greater than the amount to which the injured employee would otherwise be entitled pursuant to paragraph (a).

5. Except as otherwise provided in subsection 6, if an injured employee must travel before ~~[7:00]~~ ***7*** a.m. or between 11:30 a.m. and 1:30 p.m. or cannot return to his residence

or place of employment until after ~~[7:00]~~ *7* p.m., or any combination thereof, reimbursement for meals required to be purchased must be computed at a rate equal to:

(a) That allowed for state employees; or

(b) The expense actually incurred by the injured employee for meals, if the injured employee consents to reimbursement at this rate and the expense is not greater than the amount to which the injured employee would otherwise be entitled pursuant to paragraph (a).

6. The insurer shall reimburse an injured employee for his expenses of travel if he is required to travel 50 miles or more, one way, from his residence or place of employment and is required to remain away from his residence or place of employment overnight. Reimbursement must be computed at a rate equal to:

(a) The per diem allowance authorized for state employees; or

(b) The expenses actually incurred by the injured employee,

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7. A claim for reimbursement of expenses governed by this section may be disallowed unless it is submitted to the insurer within 60 days after the expenses are incurred.

Sec. 18. NAC 616C.170 is hereby amended to read as follows:

616C.170 As used in NAC 616C.170 to 616C.230, inclusive, unless the context otherwise requires, "report" means an extended written narrative that meets the requirements of NAC 616C.185 **.** ~~[and is presented to the insurer separately from any bill.]~~

Sec. 19. NAC 616C.179 is hereby amended to read as follows:

616C.179 1. ~~[An insurer shall respond to a request for prior authorization for:~~

~~(a) Treatment;~~

~~(b) Diagnostic testing; or~~

~~(c) Consultation,~~

FLUSH ~~within 5 working days after receiving the written request.]~~ If a ~~[telephone number for a facsimile machine or telecopier is supplied by a]~~ provider of health care ***,*** who has submitted ~~[such]~~ a request ~~[,]~~ ***for prior authorization pursuant to NRS 616C.157, provides with that request a telephone number for its facsimile machine or telecopier,*** the insurer ***, organization for managed care or third-party administrator*** shall use that number to transmit the authorization or denial of authorization. If the provider does not provide a telephone number for a facsimile machine or telecopier, the date of response shall be deemed to be the date that the response is mailed.

2. ~~[If the insurer fails to respond to such a request within 5 working days, authorization shall be deemed to be given. The insurer may subsequently deny authorization.~~

~~3. If the insurer subsequently denies a request for authorization submitted by a provider of health care for additional visits or treatments, it shall pay for the]~~ ***For purposes of determining the number of*** additional visits or treatments ~~[actually provided to the injured employee, up to the number of treatments for which payment is requested by the provider of health care, before the denial of authorization is received by the provider. If the]~~ ***for which an insurer is responsible for payment pursuant to subsection 3 of NRS 616C.157, if a*** provider of health care does not provide a telephone number for a facsimile

machine or telecopier, denial of authorization shall be deemed to be received 3 days after the date on which it is mailed.

Sec. 20. NAC 616C.188 is hereby amended to read as follows:

616C.188 1. ~~[The]~~ ***Except as otherwise provided in this section, providers of health care who treat injured employees pursuant to this chapter and chapter 616C of NRS shall comply with the most recently published edition of or update to the "Relative Values for Physicians" which the*** division ***hereby*** adopts by reference **.** ~~[the following sections of the July 1997 (Update 97.1) edition of "Relative Values for Physicians," except as modified by NAC 616C.138 to 616C.218, inclusive:~~

~~(a) Surgery/Anesthesia;~~

~~(b) Radiology;~~

~~(c) Pathology;~~

~~(d) Medicine;~~

~~(e) Evaluation and Management; and~~

~~(f) Health Care Financing Administration, HCFA Common Procedures Coding System (HCPCS), for:~~

~~(1) Transportation services (A0000-A0999);~~

~~(2) Medical and surgical supplies (A4000-A4999);~~

~~(3) Additional ostomy supplies (A5051-A5149);~~

~~(4) Administrative, miscellaneous and investigational (A6020-A9505);~~

~~(5) Enteral and parenteral therapy (B4034-B9999);~~

~~(6) Dental procedures (D0110-D9999);~~

~~(7) Durable medical equipment (E0100-E1702);~~

~~(8) Procedures/Professional services (G0001-G0025);~~

~~(9) Drugs administered other than oral method (J0110-J7799);~~

~~(10) Chemotherapy drugs (J9000-J9999);~~

~~(11) Orthotic procedures (L0100-L9999);~~

~~(12) Prosthetic procedures (L5000-L9999);~~

~~(13) Laboratory tests (P0000-P9999);~~

~~(14) Vision services (V0000-V2799);~~

~~(15) Hearing Services (V5000-V5299); and~~

~~(16) Speech-Language pathology services (V5336-V5399).]~~

2. ***The administrator or his designee will, on or before March 1 and September 1 of each year, review the most recently published edition of or update to the "Relative Values for Physicians." Each new edition of or update to the "Relative Values for Physicians" shall be deemed approved by the division for use in this state from May 1 through October 31 or from November 1 through April 30, unless a notice of disapproval of the edition or update is posted pursuant to this subsection by the immediately preceding March 1 or September 1, respectively. If the administrator or his designated agent wishes to disapprove a new edition of or update to the "Relative Values for Physicians," he will:***

(a) Post a notice of disapproval at the largest public library in each county, the state library and archives, the Grant Sawyer Office Building located at 555 East Washington Avenue, Las Vegas, Nevada, and all offices of the division; and

(b) Send a notice to each person included on the mailing list that the division is required to maintain pursuant to paragraph (e) of subsection 1 of NRS 233B.0603.

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If the administrator disapproves an edition of or update to the "Relative Values for Physicians" the edition or update that was most recently adopted or deemed approved pursuant to this section will continue in effect.

3. A copy of "Relative Values for Physicians," as adopted pursuant to subsection 1, may be purchased from St. Anthony Publishing, Inc., P.O. Box 96561, Washington, D.C. 20090, (800) 632-0123, at the cost of ~~[$269.]~~ ***$239.95.***

4. Except as otherwise provided in subsection 5, the maximum unit value allowed for bills that include any treatment identified in the "Relative Values for Physicians" under codes 97001 to 97799, inclusive, or 98925 to 98943, inclusive, whether billed individually or as an item included under a different code, is as follows:

(a) Services provided by a physician or chiropractor must be billed using the following modifiers:

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Code Modifier	***Time Billed***	***Maximum Unit Value***
-51A	***Up to one-half hour***	***7.25 units***
-51B	***Over one-half hour***	***12.5 units***

(b) Services provided by a licensed physical therapist or licensed physical therapist's assistant must be billed using the following modifier:

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Code Modifier	*Time Billed*	*Maximum Unit Value*
-51C	*All services provided per day*	*.....12 units*

(c) Services provided by a licensed occupational therapist or licensed occupational therapy assistant must be billed using the following modifier:

Code Modifier	*Time Billed*	*Maximum Unit Value*
-51D	*All services provided per day*	*.....12 units*

5. The maximum unit values set forth in subsection 4 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 authorizes such use in advance.

6. The maximum unit value includes all services provided pursuant to this section, except materials, supplies and any evaluations conducted after an operation has been performed. Any payment made pursuant to this section must include, but is not limited to, payment for:

(a) The office visit;

(b) Evaluations and management services;

(c) Manipulations;

(d) Modalities;

(e) Mobilizations;

(f) Testing and measurements;

(g) Treatments;

(h) Procedures; and

(i) Extra time.

7. An initial evaluation that is deemed to be separate from the initial six treatments pursuant to subsection 8 of NAC 616C.129 must be billed under codes 97001 or 97003.

8. If a health care provider performs a procedure described in the following chart, he shall use code 99080 from the "Relative Values for Physicians" and shall bill in accordance with the procedure set forth below:

Code	*Procedure*	*Payment*
99080	*Special reports requested in writing by an insurer, such as the review of health care data to clarify an injured employee's status or to describe extensively an injured employee's health condition in more detail than the information contained in the standard health care communication or standard reporting form.*	*By Report*

Sec. 21. NAC 616C.194 is hereby amended to read as follows:

616C.194 ~~[Health care services provided by an anesthesiologist must be billed by the anesthesiologist and paid by the insurer, as follows:~~

~~1. The~~]

1. Anesthesiologists who treat injured employees pursuant to this chapter and chapter 616C of NRS shall comply with the most recently published edition of or update to the "Relative Value Guide of the American Society of Anesthesiologists" which the division ***hereby*** adopts by reference ***.*** [~~the "Relative Value Guide of the American Society of Anesthesiologists, Inc.," copyright 1997, except as otherwise specifically provided in NAC 616C.182 to 616C.218, inclusive.~~]

2. The administrator or his designee will, on or before April 1 of each year, review the most recently published edition of or update to the "Relative Value Guide of the American Society of Anesthesiologists." Each new edition of or update to the "Relative Value Guide of the American Society of Anesthesiologists" shall be deemed approved by the division for use in this state on May 1 of each year, unless a notice of disapproval of the edition or update is posted pursuant to this subsection by the immediately preceding April 1. If the administrator or his designated agent wishes to disapprove a new edition of or update to the "Relative Value Guide of the American Society of Anesthesiologists," he will:

(a) Post a notice of disapproval at the largest public library in each county, the state library and archives, the Grant Sawyer Office Building located at 555 East Washington Avenue, Las Vegas, Nevada, and all offices of the division; and

(b) Send a notice to each person included on the mailing list that the division is required to maintain pursuant to paragraph (e) of subsection 1 of NRS 233B.0603.

FLUSH ***If the administrator disapproves an edition of or update to the "Relative Value Guide of the American Society of Anesthesiologists" the edition or update that was most recently adopted or deemed approved pursuant to this section will continue in effect.***

3. A copy of ~~[this publication]~~ ***the "Relative Value Guide of the American Society of Anesthesiologists," as adopted pursuant to subsection 1,*** may be purchased from the American Society of Anesthesiologists, 520 N. Northwest Highway, Park Ridge, Illinois 60068-2573, ***(847) 825-5586,*** for the price of ~~[$10.~~

~~2.]~~ ***$15.***

4. Except as otherwise provided in this subsection, an anesthesiologist shall use the codes that are stated in the ~~[guide]~~ ***"Relative Value Guide of the American Society of Anesthesiologists"*** for each procedure which he bills and submits to an insurer. If a code for a procedure performed by an anesthesiologist is not provided in the guide, the anesthesiologist shall use the code provided for that procedure in the "Relative Values for Physicians," as adopted pursuant to NAC 616C.188 ***,*** utilizing the ~~[anesthesia]~~ ***appropriate*** conversion factor ~~[.]~~ ***for the code that is assigned to that procedure.*** The maximum allowable fee for any anesthesiology service is the basic unit value that is stated in the guide, plus the number of 15-minute intervals that the service was rendered, or any fraction thereof, multiplied by the following conversion factor:

Codes	Type of Service	Conversion Factor
00000-99999	Basic Anesthesiology	$51.54

~~[3.]~~ ***5.*** The insurer shall pay the lesser of the provider's usual charge for his services or the maximum allowable fee calculated pursuant to subsection ~~[2]~~ ***4*** or pursuant to a contract between the provider of health care and the insurer.

~~[4.]~~ ***6.*** All basic anesthetic values must be applied to those procedures administered by a licensed physician or a certified registered nurse anesthetist.

Sec. 22. NAC 616C.197 is hereby amended to read as follows:

616C.197 1. The following procedure has the payment group assigned to it for the use of a licensed surgical center for ambulatory patients and the insurer shall pay the following assigned amount, the billed amount or the amount agreed upon pursuant to a contract between the provider of health care and insurer, whichever is less:

Code	Type of Service	Payment Group
NV29888	Anterior cruciate ligament repair	9

2. The division adopts by reference the complete list of eligible codes for surgical centers for ambulatory patients and the payment groups to which those codes are assigned for services rendered on and after January 1, ~~[1998,]~~ ***1997,*** established by the Health Care Financing Administration (HCFA).

3. The following is the maximum allowable payment for each of the payment groups for fees charged by a licensed surgical center for ambulatory patients:

Payment Group	Maximum Allowable Payment
Group 1	$426
Group 2	546
Group 3	660
Group 4	816
Group 5	868
Group 6	1024
Group 7	1087
Group 8	1101
Group 9	1101

4. A copy of the eligible codes and payment groups adopted pursuant to subsection 2 is available, free of charge, from the Division of Industrial Relations, Industrial Insurance Regulation Section:

(a) At 400 W. King Street, Suite 400, Carson City, Nevada ~~[89710,]~~ ***89703,*** (775) 687-3033; or

(b) At ~~[2500 W. Washington, Suite 102, Las Vegas, Nevada 89106, (702) 486-5001.]~~ ***1301 North Green Valley Parkway, Suite 200, Henderson, Nevada 89014 (702) 486-9080.***

5. Costs related to the following items must be included in allowable charges for fees charged by a surgical center for ambulatory patients:

(a) The cost of the anesthetic;

(b) General supplies;

(c) Operating room;

(d) Radiology, technical component;

(e) Pathology, technical component;

(f) Any other diagnostic procedure; and

(g) Medication.

6. An insurer shall reimburse a surgical center for ambulatory patients for orthopedic hardware and prosthetic devices in an amount equal to the center's cost for the hardware or device, excluding tax and charges for freight, plus 20 percent.

7. If an injured employee requires more than one surgical procedure to be performed at the same time, the surgical center for ambulatory patients shall bill for the surgery using modifier-51 that is contained in the "Relative Values for Physicians," as adopted pursuant to NAC 616C.188.

8. If there is no assigned value for the surgical procedure or if the modifier-51 is used, the amount paid must not exceed the per diem rate for code NV00500 as set forth in subsection 3 of NAC 616C.203 and the code NVH0009 must be used.

Sec. 23. NAC 616C.203 is hereby amended to read as follows:

616C.203 1. The following is the maximum allowable payment per visit for the use of an emergency room:

Code	Procedure	Maximum Allowable Payment
NV00100	~~[Emergency Room]~~ ***First hour***	$33.96
NV00101	***Each additional hour or fraction thereof***	***$16.98***

2. If an injured employee receives care in an emergency room that is located on the grounds of a hospital and the time for the use of the emergency room exceeds 60 minutes, the billing must be submitted in a report ~~[.]~~ ***and must specify the need for the time that exceeded 60 minutes.***

3. The following per diem rates are the maximum allowable payments for an inpatient receiving care at a hospital:

Code	Procedure	Maximum Allowable Payment
NV00200	Intensive Care	$1,811.20
NV00400	Cardiac Care	1,663.18
NV00500	Medical-Surgical Care	1,101.22
NV00900	Care for Burns	1,663.18

4. The insurer shall pay:

(a) The per diem rate multiplied by the number of days the injured employee was hospitalized;

(b) The total amount billed for all services if that amount is less than the amount computed in paragraph (a); or

(c) The amount owed pursuant to a contract between the provider of health care and insurer.

5. The per diem rate for care provided must include 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.

6. The charge for an inpatient's use of an operating room must be included in the per diem rate for hospitals.

7. The insurer shall reimburse the hospital for orthopedic hardware and prosthetic devices at the cost to the hospital of the orthopedic hardware and prosthetic devices, excluding tax and charges for freight, plus 20 percent.

8. The following is the maximum allowable payment for open heart surgery for an inpatient receiving care at a hospital for 7 days or less:

Code	Procedure	Maximum Allowable Payment

NV00410	Open Heart Surgery	$15,964.43

9. The insurer shall reimburse the hospital for supplies and materials used in open heart surgery at the cost to the hospital of the supplies and materials, excluding tax and charges for freight, plus 40 percent.

10. The treating physician shall order all preoperative laboratory and pathology tests and any other diagnostic tests to be performed on the injured employee as an outpatient before his admission to the hospital except where hospitalization preceding and during a test is generally recognized by the medical profession as a necessary and prudent precaution.

11. The following per diem rate is the maximum allowable payment for a skilled nursing care facility:

Code	Procedure	Maximum Allowable Payment
NV00550	Skilled Nursing Care Facility	$1,026.44

12. ~~[A]~~ ***Except as otherwise provided in this subsection, a*** physician who admits an injured employee for hospitalization is responsible for directing that the injured employee be transferred to the next appropriate level of care, in or out of a hospital, or be discharged as soon as the level of care being provided exceeds that necessary for his welfare. ***Payment***

for treatment ordered pursuant to this subsection must not exceed the per diem rates set forth in subsection 3 for code NV00500.

13. Any excessive use of hospital accommodations, as determined from evaluations of a committee on hospital utilization or an evaluation of the injured employee's health care records by a medical adviser for the insurer, may be grounds for the reduction or disallowance of hospital billings. The insurer shall inform a hospital of the reason for any such reduction or disallowance.

Sec. 24. NAC 616C.206 is hereby amended to read as follows:

616C.206 1. The following is the maximum allowable payment for home health care:

(a) For a visit which is 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:

Code	Procedure	Maximum Allowable Payment
NV90170	Skilled home health care	$68.00 per visit

(b) For a visit which is not more than 2 hours and during which certain activities are performed by a certified nursing assistant:

Code	Procedure	Maximum Allowable Payment
NV90130	Certified nursing assistant care	$27.70 per visit

(c) For a visit which is 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:

Code	Procedure	Maximum Allowable Payment
NV90180	Skilled home health care	$34.25 per hour
NV90190	Certified nursing assistant care	16.70 per hour

2. An insurer is not financially liable for home health care services that are provided for more than 4 hours per day unless he has given prior written authorization for such care.

3. Fees for each 24-hour period billed pursuant to this section must not exceed the per diem rate for code NV00500 as set forth in subsection 3 of NAC 616C.203.

4. For the purposes of this section, “visit” includes the time it takes the provider of health care to travel to and from the home of the injured employee in order to provide

health care services in the home and to complete any required documentation of the services provided.

Sec. 25. NAC 616C.212 is hereby amended to read as follows:

616C.212 1. The following is the maximum allowable payment for each rating of a permanent partial disability for each claim for workers' compensation:

Code	Procedure	Maximum Allowable Payment
NV01000	Review of records, testing, evaluation and report	$450
NV01001	Failure of an injured employee to appear for appointment	150
NV01002	Addendum necessary to clarify original report	No charge
NV01003	Addendum after review of additional medical records	150
NV01004	Review of medical records and evaluation of more than 2 body parts	150 for each body part in excess of 2
NV01005	Organization of medical records in chronological order	25
NV01006	***Review of records and report***	***225***

2. Code NV01001 may not be billed unless the injured employee fails to:

(a) Appear for the evaluation within 15 minutes after the scheduled appointment; or

(b) Cancel the appointment within 24 hours before the scheduled appointment,

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if the injured employee is not seen on that day and all records and diagnostic images have been reviewed by the rating physician or chiropractor.

3. 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 cervicothoracic spine.

(b) The thoracolumbar spine.

(c) The lumbosacral spine.

(d) The left upper extremity, excluding the left hand.

(e) The right upper extremity, excluding the right hand.

(f) The left hand, including that portion below the junction of the middle and lower thirds of the left forearm.

(g) The right hand, including that portion below the junction of the middle and lower thirds of the right forearm.

(h) The left lower extremity.

(i) The right lower extremity.

(j) The head.

(k) The trunk.

4. ~~[A]~~ ***Unless good cause is shown, a*** rating physician or chiropractor shall mail a report of an evaluation to the insurer within ~~[15]~~ ***10*** working days after the evaluation is completed. ~~[If]~~ ***Unless good cause is shown, if*** an addendum is requested by the insurer,

the rating physician or chiropractor shall mail the addendum to the insurer within 10 working days after receiving the request.

5. ~~[If]~~ ***Unless good cause is shown, if*** a rating evaluation is requested by an injured employee or his representative, the rating physician or chiropractor shall mail a report of the evaluation to the injured employee or his representative within ~~[15]~~ ***10*** working days after the evaluation is completed. ~~[If]~~ ***Unless good cause is shown, if*** an addendum is requested by the injured employee or his representative, the rating physician or chiropractor shall mail the addendum to the injured employee or his representative within 10 working days after receiving the request.

Sec. 26. NAC 616C.215 is hereby amended to read as follows:

616C.215 1. Each provider of health care shall submit a bill to the insurer which includes:

(a) His usual charge for services provided;

(b) The code for the procedure and a description of the services;

(c) The number of visits and date of each visit to his office and the procedures followed in any treatment administered during the visit;

(d) 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," as adopted pursuant to NAC 616C.188;

(e) The name of the injured employee and his employer and the date of his injury;

(f) The tax identification number of the provider of health care; and

(g) The signature of the person who provided the service.

2. In addition to the information required by subsection 1, each physician or chiropractor shall include on his bill the ICD-9-CM codes identifying the parts of the body of the injured employee that were affected by the injury, as set forth in the "International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)," which is hereby adopted by reference. A copy of Volumes 1, 2 and 3 of this publication may be purchased from:

(a) Channel Publishing, Ltd., P.O. Box 70723, Reno, Nevada 89570, (800) 248-2882, at a cost of $99.00;

(b) Medicode Publications, 5225 Wiley Post Way, Suite 500, Salt Lake City, Utah 84116-2889, (800) 999-4600, at a cost of ~~[$69.95;]~~ ***$89.95;*** or

(c) St. Anthony Publishing, Inc., P.O. Box 96561, Washington, D.C. 20090, (800) 632-0123, at a cost of ~~[$74.95.]~~ ***$69.95.***

3. The initial bill submitted to the insurer by a licensed physical therapist or a licensed occupational therapist must be accompanied by a copy of the order for the services rendered issued by the treating physician or chiropractor. Any subsequent bill submitted to the insurer by a licensed physical therapist or a licensed occupational therapist must include a copy of the order for the services rendered issued by the treating physician or chiropractor if the order for services rendered is changed by the treating physician or chiropractor.

~~[4. If any payment to a provider of health care requires adjustment because of the codes set forth in the bill submitted to the insurer, the insurer shall process for payment any~~

~~portion of the bill that is not in question and return the bill to the provider and request additional documentation of the services, supplies or materials provided.]~~

Sec. 27. NAC 616C.224 is hereby amended to read as follows:

616C.224 1. The following procedure code and payment schedule must be used for all evaluations of functional capacity performed for an injured employee:

Code	Procedure	Maximum Allowable ~~[Charge]~~ ***Payment***
NV99060	Testing and report	$141.56 per hour

2. Testing performed in connection with such an evaluation must continue for not less than 2 nor more than 5 hours.

3. The evaluation must include, but is not limited to:

(a) An assessment and interpretation of the ability of the injured employee to perform work-related tasks; and

(b) The formulation of recommendations concerning the capacity of the injured employee to work safely within his physical limitations.

Sec. 28. NAC 616C.227 is hereby amended to read as follows:

616C.227 1. The following procedure code and payment schedule must be used for all work hardening programs:

Code	Procedure	Maximum Allowable

		Payment
NV97545	Work hardening program	$49.83 per hour
~~[NV97546~~	~~Extra time~~	~~49.83 per hour]~~

2. A program billed pursuant to this section must continue:

(a) For not less than 2 nor more than 8 hours per day, including any time spent in preparing a report of the treatment; and

(b) For not less than 2 nor more than 8 weeks.

3. The program must include, but is not limited to:

(a) Conditioning exercises and activities that simulate the work of the injured employee, graded to improve progressively the capacity of the injured employee to perform work; and

(b) Modalities intended to minimize the symptoms of the injured employee, including testing for endurance and range of motion.

Sec. 29. 1. This section, sections 1 to 9, inclusive, and 11 to 28, inclusive, become effective on October 28, 1999.

2. Section 9 of this regulation expires by limitation on December 31, 1999.

3. Section 10 of this regulation becomes effective on January 1, 2000.