LCB File No. R118-02

PROPOSED REGULATION OF THE DIVISION OF INDUSTRIAL RELATIONS OF THE DEPARTMENT OF BUSINESS AND INDUSTRY

Explanation – Matter in *italics* is new and Matter in brackets[] is material to be omitted.

CHAPTER 616A - INDUSTRIAL INSURANCE: ADMINISTRATION

ADMINISTRATION

SEC. 1. NAC 616A.480 IS HEREBY AMENDED TO READ AS FOLLOWS:

NAC 616A.480 Use, alteration, printing and distribution of certain posters and forms. (NRS 616A.400, 616A.417)

1. The following posters and forms or data must be used by an insurer, employer, injured employee, provider of health care, organization for managed care or third-party administrator in the administration of claims for workers' compensation:

(a) D-1, Informational Poster - Displayed by Employer. The informational poster must include the language contained in Form D-2, and the name, business address, telephone number and contact person of:

(1) The insurer;

(2) The third-party administrator, if applicable;

(3) The organization for managed care or providers of health care with whom the insurer has contracted to provide medical and health care services, if applicable; and

(4) The name, business address and telephone number of the insurer's or third-party administrator's adjuster in this state that is located nearest to the employer's place of business.

(b) D-2, Brief Description of Your Rights and Benefits if You Are Injured on the Job.

(c) C-1, Notice of Injury or Occupational Disease (Incident Report). One copy of the form must be delivered to the injured employee, and one copy of the form must be retained by the employer. The language contained in Form D-2 must be printed on the reverse side of the employee's copy of the form, or provided to the employee as a separate document with an affirmative statement acknowledging receipt.

(d) C-3, Employer's Report of Industrial Injury or Occupational Disease. A copy of the form must be delivered to or the form must be filed by electronic transmission with the insurer or third-party administrator. The form signed by the employer must be retained by the employer. A copy of the form must be delivered to the injured employee. If the employer files the form by electronic transmission, the employer must:

(1) Transmit all fields of the form that are required to be completed, as prescribed by the administrator.

(2) Sign the form with an electronic symbol representing the signature of the employer that is:

(I) Unique to the employer;

(II) Capable of verification; and

(III) Linked to data in such a manner that the signature is invalidated if the data is altered.

(3) Acknowledge on the form that he will maintain the original report of industrial injury or occupational disease for 3 years.

If the employer moves from or ceases operation in this state, the employer shall deliver the original form to the insurer for inclusion in the insurer's file on the injured employee within 30 days after the move or cessation of operation.

(e) C-4, Employee's Claim for Compensation/Report of Initial Treatment. A copy of the form must be delivered to the insurer or third-party administrator. A copy of the form must be delivered to or the form must be filed by electronic transmission with the employer. A copy of the form must be delivered to the injured employee. The language contained in Form D-2 must be printed on the reverse side of the injured employee's copy of the form or provided to the injured employee as a separate document with an affirmative statement acknowledging receipt. The original form signed by the injured employee and the physician or chiropractor who conducted the initial examination of the injured employee must be retained by that physician or chiropractor. If the physician or chiropractor who conducted the initial examination files the form by electronic transmission, the physician or chiropractor must:

(1) Transmit all fields of the form that are required to be completed, as prescribed by the administrator.

(2) Sign the form with an electronic symbol representing the signature of the physician or chiropractor that is:

(I) Unique to the physician or chiropractor;

(II) Capable of verification; and

(III) Linked to data in such a manner that the signature is invalidated if the data is altered.

(3) Acknowledge on the form that he will maintain the original form for the claim for compensation for 3 years.

If the physician or chiropractor who conducted the initial examination moves from or ceases treating patients in this state, the physician or chiropractor shall deliver the original form to the insurer for inclusion in the insurer's file on the injured employee within 30 days after the move or cessation of treatment of patients.

(f) D-5, Wage Calculation Form for Claims Agent's Use.

(g) D-6, Injured Employee's Request for Compensation.

(h) D-7, Explanation of Wage Calculation.

(i) D-8, Employer's Wage Verification Form.

(j) D-9(a), Permanent Partial Disability Award Calculation Worksheet.

(k) D-9(b), Permanent Partial Disability Award Calculation Worksheet for Disability Over 25 Percent Body Basis.

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

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

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

(o) D-12(a), Request for Hearing - Contested Claim.

(p) D-12(b), Request for Hearing - Uninsured Employer.

(q) D-13, Injured Employee's Right to Reopen a Claim Which Has Been Closed.

(r) D-14, Permanent Total Disability Report of Employment.

(s) D-15, Election for Nevada Workers' Compensation Coverage for Out-of-State Injury.
(t) D-16, Notice of Election for Compensation Benefits Under the Uninsured Employer Statutes.
(u) D-17, Employee's Claim for Compensation - Uninsured Employer.
(v) D-18, Assignment of Claim for Workers' Compensation - Uninsured Employer.
(w) D-21, Fatality Report.
(x) D-22, Notice to Employees - Tip Information.
(y) D-23, Employee's Declaration of Election to Report Tips.
(z) D-24, Request for Reimbursement of Expenses for Travel and Lost Wages.
(aa) D-25, Affirmation of Compliance with Mandatory Industrial Insurance Requirements.
(bb) D-26, Application for Reimbursement of Claim-Related Travel Expenses.
(cc) D-27, Interest Calculation for Compensation Due.
(dd) D-28, Rehabilitation Lump Sum Request.
(ee) D-29, Lump Sum Rehabilitation Agreement.
(ff) D-30, Notice of Claim Acceptance.
(gg) D-31, Notice of Intention to Close Claim.
(hh) D-32, Authorization Request for Additional Chiropractic Treatment.
(ii) D-33, Authorization Request for Additional Physical Therapy Treatment.
(jj) D-34, ~~[Health Care Financing Administration]~~ ***CMS*** 1500 Billing Form.
(kk) D-35, Request for a Rotating Rating Physician or Chiropractor.
(ll) D-36, Request for Additional Medical Information and Medical Release.
(mm) D-37, Insurer's Subsequent Injury Checklist.
(nn) D-38, Injured Worker Index System Claims Registration Document.
(oo) D-39, Physician's Progress Report - Certification of Disability.
(pp) D-40cc, Industrial Insurance Regulation Section Noncompliance Premium.
(qq) D-40lv, Industrial Insurance Regulation Section Noncompliance Premium.
(rr) D-41, International Association of Industrial Accident Boards and Commissions POC 1.
(ss) D-43, Employee's Election to Reject Coverage and Election to Waive the Rejection of Coverage for Excluded Persons.
(tt) D-44, Election of Coverage by Employer; Employer Withdrawal of Election of Coverage.
(uu) D-45, Sole Proprietor Coverage.
(vv) D-46, Temporary Partial Disability Calculation Worksheet.
(ww) D-47, Noncompliance Notice.
(xx) D-48, Proof of Coverage Notice.
(yy) D-49, Information Page.
(zz) D-50, Policy Termination, Cancellation and Reinstatement Notice.
(aaa) D-51, Employer's Request for Hearing of Administrator's Determination.
(bbb) D-52, CMS (UB-92).
(ccc) D-53, Alternate Choice of Physician or Chiropractor.
(ddd) D-54, Alternative Choice of Treating Physician or Chiropractor.
(eee) D-55, Alternative Choice of Specialist.
(fff) D-56, Request for Information Concerning Previous Disability.
(ggg) D-57, Occupational Disease Claim Reporting.

2. In addition to the forms specified in subsection 1, the following forms must be used by each insurer in the administration of a claim for an occupational disease:

(a) OD-1, Firemen and Police Officers' Medical History Form.

(b) OD-2, Firemen and Police Officers' Lung Examination Form.

(c) OD-3, Firemen and Police Officers' Extensive Heart Examination Form.

(d) OD-4, Firemen and Police Officers' Limited Heart Examination Form.

(e) OD-5, Firemen and Police Officers' Hearing Examination Form.

(f) OD-6, Firemen and Police Officers' Sample Letter.

(g) OD-7, Information Regarding Physical Examinations for Firemen and Police Officers.

3. The forms listed in this section must be accurately completed, including, without limitation, a signature and a date if required by the form. An insurer or employer may designate a third-party administrator as an agent to sign any form listed in this section.

4. An insurer, employer, injured employee, provider of health care, organization for managed care or third-party administrator may not use a different form or change a form without the prior written approval of the administrator.

5. The industrial insurance regulation section will be responsible for printing and distributing the following forms:

(a) C-4, Employee's Claim for Compensation/Report of Initial Treatment;

(b) D-12(b), Request for Hearing - Uninsured Employer;

(c) D-16, Notice of Election for Compensation Benefits Under the Uninsured Employer Statutes;

(d) D-17, Employee's Claim for Compensation - Uninsured Employer; and

(e) D-18, Assignment of Claim for Workers' Compensation - Uninsured Employer.

6. Each insurer or third-party administrator is responsible for printing and distributing all other forms listed in this section. The provisions of this subsection do not prohibit an insurer, employer, provider of health care, organization for managed care or third-party administrator from providing any form listed in this section.

7. Upon the request of the administrator, an insurer, employer, provider of health care, organization for managed care or third-party administrator shall submit to the administrator a copy of any form used in this state by the insurer, employer, provider of health care, organization for managed care or third-party administrator in the administration of claims for workers' compensation.

CHAPTER 616B - INDUSTRIAL INSURANCE: INSURERS; LIABILITY FOR PROVISION OF COVERAGE

GENERAL PROVISIONS

SEC. 2. NAC 616B.008 IS HEREBY AMENDED TO READ AS FOLLOWS:

NAC 616B.008 Insurers: Disclosure of information. (NRS 616A.400, 616B.012)

1. To obtain information for the proper presentation of his claim in a proceeding held pursuant to chapters 616A to 616D, inclusive, of NRS, an injured employee or a person who has been authorized by the injured employee to represent him must deliver a written request to his insurer. The insurer ***or employer*** shall provide such information to the injured employee or his authorized representative within 30 days after receipt of the written request. If, at the time of receipt of the written request from the injured employee or his authorized representative, the requested information is in the possession of a third-party administrator or an organization for managed care ***or a provider of health care*** with whom the insurer has contracted, the insurer shall take all reasonable steps necessary to obtain such information.

2. To obtain confidential information pursuant to subsection 3 of NRS 616B.012, the requesting agency, department or board must deliver to the insurer a written request that must:

(a) Be written on the official letterhead of the requesting agency, department or board;

(b) State the purpose for which the requesting agency, department or board will use the requested information;

(c) Contain all pertinent information available to the requesting agency, department or board to identify:

(1) The injured employee, including, without limitation, his name, social security number, date of birth and the date of his injury; or

(2) The employer, including, without limitation, his name, the name and address of the business, the names of the owners of the business and the employer's policy number; and

(d) Contain any other information that the insurer may need to process the request.

The insurer may require additional information to process the request. The insurer shall provide the requested confidential information to the requesting agency, department or board within 30 days after receiving the written request.

3. If a request requires the insurer to report on more than one employer or more than one injured employee, the head of the requesting agency, department or board must sign the request. If a request requires the insurer to report on only one employer or injured employee, either the head of the requesting agency, department or board or his designated agent must sign the request.

4. Upon receipt of a written request made pursuant to the provisions of subsection 5 of NRS 616B.012 by the chief executive officer of any law enforcement agency of this state, the administrator will instruct the insurer to provide the information requested to the chief executive officer within 30 days after receiving the instructions from the administrator. The insurer shall provide the information requested within 30 days after receipt of such an instruction from the administrator.

5. Information provided pursuant to this section shall be provided at a reasonable fee but in no event shall exceed 10 cents per page. There shall be no charge for duplicate copies.

PROOF OF COVERAGE

General Provisions

SEC. 3. NAC 616B.103 IS HEREBY REPEALED

SEC. 4. NAC 616B.109 IS REPEALED

SEC. 5. NAC 616B.112 IS HEREBY AMENDED TO READ AS FOLLOWS:

NAC 616B.112 "Notice of error" defined. (NRS 616A.400) "Notice of error" means a notice issued by the administrator or designated agent to a private carrier ~~[or an association]~~ that proof of coverage submitted by the private carrier ~~[or association]~~ has been accepted but requires correction.

SEC. 6. NAC 616B.115 IS HEREBY AMENDED TO READ AS FOLLOWS:

NAC 616B.115 "Notice of rejection" defined. (NRS 616A.400) "Notice of rejection" means a notice issued by the administrator or designated agent to a private carrier ~~[or an association]~~ that proof of coverage submitted by the private carrier ~~[or association]~~ has not been accepted and requires correction.

SEC. 7. NAC 616B.121 IS HEREBY AMENDED TO READ AS FOLLOWS:

NAC 616B.121 Adoption by reference of certain publications. (NRS 616A.400) The administrator hereby adopts by reference the following publications:

1. IAIABC EDI Implementation Guide for Proof of Coverage, which is published by the International Association of Industrial Accident Boards and Commissions. A copy of the publication may be obtained from the International Association of Industrial Accident Boards and Commissions, ~~[1201 Wakarusa Drive, Suite C-3,]~~ ***714 Vermont Street, Suite 201,*** Lawrence, Kansas ~~[66049]~~ ***66004***, for the price of ~~[$195]~~ ***$50*** for members and ~~[$395]~~ ***$95*** for nonmembers.

2. Workers Compensation Policy Data Reporting Manual, which is published by the National Council on Compensation Insurance. A copy of the publication may be obtained from the National Council on Compensation Insurance, Products and Services Department,~~[750 Park of Commerce Drive]~~ ***901 Peninsula Corporate Circle***, Boca Raton, Florida 33487, for the price of $96 for ~~[members]~~ ***affiliates*** and $124 for ~~[nonmembers]~~ ***non-affiliates***.

3. Basic Manual for Workers Compensation and Employers Liability Insurance, which is published by the National Council on Compensation Insurance. A copy of the publication may be obtained from the National Council on Compensation Insurance, Products and Services Department, ~~[750 Park of Commerce Drive]~~ ***901 Peninsula Corporate Circle***, Boca Raton, Florida 33487, for the price of $86 for ~~[members]~~ ***affiliates*** and $119 for ~~[nonmembers]~~ ***non-affiliates***.

4. Forms Manual of Workers Compensation and Employers Liability Insurance, which is published by the National Council on Compensation Insurance. A copy of the publication may be obtained from the National Council on Compensation Insurance, Products and Services Department, ~~[750 Park of Commerce Drive]~~ ***901 Peninsula Corporate Circle***, Boca Raton, Florida 33487, for the price of $108 for ~~[members]~~ ***affiliates*** and $217 for ~~[nonmembers]~~ ***non-affiliates***.

5. Electronic Transmission User's Guide, which is published by the National Council on Compensation Insurance. A copy of the publication may be obtained, free of charge, from the National Council on Compensation Insurance, Products and Services Department, ~~[750 Park of Commerce Drive]~~ ***901 Peninsula Corporate Circle***, Boca Raton, Florida 33487.

6. Workers Compensation Data Specifications Manual, which is published by the National Council on Compensation Insurance. A copy of the publication may be obtained from

the National Council on Compensation Insurance, Products and Services Department, ~~[750 Park of Commerce Drive]~~ ***901 Peninsula Corporate Circle***, Boca Raton, Florida 33487, for the price of $62.

Submission of Proof

SEC. 8. NAC 616B.124 IS HEREBY AMENDED TO READ AS FOLLOWS:

NAC 616B.124 Duty to submit proof to designated agent. (NRS 616A.400) For the purposes of complying with the provisions of subsection ~~[3]~~ ***2*** of ~~[NRS 616B.033 and]~~ NRS 616B.460 ***and NRS 616B.461***, a private carrier ~~[or an association]~~ shall submit proof of coverage to the designated agent.

SEC. 9. NAC 616B.127 IS HEREBY AMENDED TO READ AS FOLLOWS:

NAC 616B.127 Time limit for private carrier to submit proof; duties upon replacement of binder. (NRS 616A.400)

1. A private carrier shall submit proof of coverage to the designated agent within 15 days after the effective date of the:

(a) Issuance of a policy or binder of industrial insurance;

(b) Renewal of a policy of industrial insurance;

(c) Reinstatement of a policy of industrial insurance;

(d) Reissuance of a policy of industrial insurance;

(e) Cancellation of a policy of industrial insurance;

(f) Nonrenewal of a policy of industrial insurance; or

(g) Issuance of any endorsement of a policy of industrial insurance which materially affects the proof of coverage required by NAC 616B.100 to 616B.148, inclusive.

2. If a binder is submitted as proof of coverage pursuant to paragraph (a) and the binder is replaced by a policy of industrial insurance, proof of coverage for the policy must be submitted to the designated agent before the expiration of the binder.

3. A private carrier shall submit proof of coverage to the designated agent within 15 days of receipt of notice that an employer has changed carriers or has cancelled his policy with that carrier.

SEC. 10. NAC 616B.130 IS REPEALED

SEC. 11. NAC 616B.133 IS HEREBY AMENDED TO READ AS FOLLOWS:

NAC 616B.133 Methods for submission of proof and other information. (NRS 616A.400)

1. ~~[An association shall submit proof of coverage to the designated agent by:~~

~~(a) The United States Postal Service or any other mail delivery service by submitting Form D-41, International Association of Industrial Accident Boards and Commissions POC 1; or~~

~~(b) Electronic transmission.]~~

~~[2.]~~ A private carrier shall submit proof of coverage to the designated agent by:

(a) Electronic transmission; or

(b) The United States Postal Service or any other mail delivery service.

~~[3]~~ ***2***. If the private carrier does not use Form D-41, International Association of Industrial Accident Boards and Commissions POC 1 to submit:

(a) Information relating to a binder, it shall submit Form D-48, Proof of Coverage Notice, and a schedule of the names, addresses and federal employer identification numbers of the employers covered by the binder.

(b) Information relating to a policy, it shall submit Form D-49, Information Page.

(c) Information relating to the termination, cancellation or reinstatement of a policy, it shall submit Form D-50, Policy Termination, Cancellation and Reinstatement Notice.

~~[4]~~ ***3***. As used in this section, "electronic transmission" means the sending of information by electronic means in the manner prescribed by the designated agent, including, without limitation, by a magnetic tape, cartridge, mainframe or personal computer.

SEC. 12. NAC 616B.136 IS HEREBY AMENDED TO READ AS FOLLOWS:

NAC 616B.136 Duty of employer to provide proof to insurer. (NRS 616A.400) An employer shall, upon request, provide proof of coverage to its insurer ***and the administrator in*** the manner prescribed by the administrator. If the employer fails to provide ~~[that]~~ ***such*** information to the insurer, the insurer may notify the administrator of the failure of the employer to provide the information. ***If an employer changes insurers, the employer must notify his previous insurer of the cancellation of the former policy within 10 days of the effective date f the change.***

SEC. 13. NAC 616B.139 IS HEREBY AMENDED TO READ AS FOLLOWS:

NAC 616B.139 Designated agent may charge fee for certain services; designated agent to provide instructions for submission of proof. (NRS 616A.400) The designated agent may charge a private carrier ~~[or an association]~~ a fee in an amount that does not exceed the cost of receiving, processing and submitting proof of coverage required by the administrator. The designated agent shall provide to the private carrier ~~[or association]~~, at no cost, instruct ions for submitting proof of coverage.

CHAPTER 616C - INDUSTRIAL INSURANCE: BENEFITS FOR INJURY OR DEATH

PROVIDERS OF HEALTH CARE

SEC 14. NAC 616C.027 IS REPEALED

SEC 15. NAC 616C.030 IS HEREBY AMENDED TO READ AS FOLLOWS:

NAC 616C.030 Provision of list of providers to injured employee ***and treating physician and chiropractor***. (NRS 616A.400, 616C.090)

1. Upon the receipt of a request from an injured employee or his representative ***or the injured employee's treating physician or chiropractor,*** the:

(a) Employer;

(b) Insurer;
(c) Third-party administrator; or
(d) Organization for managed care,
shall provide ~~[a list of providers of health care who are authorized to provide medical and health care services to]~~ ***the list to*** the injured employee ***or treating physician or chiropractor within 3 working days after the date it receives the request***.

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

DETERMINATION AND PAYMENT OF BENEFITS

Claims for Compensation

SEC. 16. NAC 616C.097 IS HEREBY AMENDED TO READ AS FOLLOWS:

NAC 616C.097 Statement on written notice of determination regarding disagreement with determination.

1. Any written notice of a determination of an insurer who has contracted with an organization for managed care that relates to accident benefits must include at the bottom of the notice a statement in substantially the following form:

If you disagree with the above determination, sign, date, and briefly explain on the bottom of this notice the reason for your appeal and return this notice to your insurer within ~~[70]~~ days ~~[after the date on which the notice was mailed by the insurer]~~ ***of the determination***.

2. Any written notice of a determination of an insurer that relates to benefits, other than accident benefits provided by an insurer who has contracted with an organization for managed care, must include at the bottom of the notice a statement in substantially the following form:

If you disagree with the above determination, sign, date, and briefly explain on the bottom of this notice the reason for your appeal and return it to the Hearing Officer at the Department of Administration within 70 days after the date on which the notice was mailed by the insurer.

Accident Benefits: Provision of Care

SEC. 17. NAC 616C.103 IS HEREBY AMENDED TO READ AS FOLLOWS:

NAC 616C.103 Rating evaluation of injured employee: Requirements; award of payment; appeal. (NRS 616A.400, 616C.490)

1. For purposes of determining whether an injured employee is stable and ratable and 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. ***If an insurer proposes that an injured employee agree to specific rating physicians or chiropractors, the insurer must inform the injured employee in writing that (1) he is not required to agree with the insurer and (2) he may insist that the rating physician or chiropractor be selected in accord with subsection 3.***

3. 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 list of qualified rating physicians and chiropractors designated by the administrator to evaluate the injured employee and determine the extent of any permanent impairment 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, Request for a Rotating Rating Physician or Chiropractor, 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; 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]~~ ***Any evidence or documentation of any previous evaluations performed to determine the extent of any of the employee’s disabilities, any previous injury, disease or condition sustained by the employee relevant to the evaluation being performed***;

(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, Request for a Rotating Rating Physician or Chiropractor.**]**

(***5) The form designated in NAC 616A.480 as D-36b; Insurer Request for Information Concerning Previous Disability Evaluations, Injuries, Diseases or Conditions.***

~~[3]~~ ***4***. An insurer shall pay for the cost of travel for an injured employee to attend a rating evaluation as required by NAC 616C.105.

~~[4]~~ ***5***. Except as otherwise provided in subsection 6, 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, after it receives the properly executed award papers from the injured employee or his representative.

~~[5]~~ ***6***. 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.

~~[6]~~ ***7***. 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 that can be executed in 75 days, unless the insurer demonstrates good cause for ~~[7]~~ ***8***. 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.

~~[8]~~ ***9***. 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. 18. NAC 616C.1158 IS REPEALED

SEC. 19. NAC 616C.126 TO 616C.144, INCLUSIVE, ARE REPEALED

Reimbursement for Costs of Transportation and Meals

SEC. 20. NAC 616C.150 IS HEREBY AMENDED TO READ AS FOLLOWS:

NAC 616C.150 Eligibility and computation. (NRS 616A.400, 616C.260, 616C.365)

1. The insurer shall reimburse an injured employee for the cost of transportation ***for health care*** 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 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 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 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,

whichever is less.

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.

Accident Benefits: Billing and Payment

SEC. 21. NAC 616C.170 TO 616C.258, INCLUSIVE, ARE REPEALED

CHAPTER 616D - INDUSTRIAL INSURANCE: ADMINISTRATIVE PROCEEDINGS AND ENFORCEMENT

ADD A NEW SECTION TO CHAPTER 616D AS FOLLOWS:

1. Where it has been determined that a violation of paragraph (a), (b), (c) or (d) of subsection 1 of NRS 616D.120 has occurred, the amount of the benefit penalty to be imposed as a result of that violation, in excess of the minimum required amount of $5,000, will be determined after consideration of the degree of physical or economic harm suffered by the injured employee or his dependents as a result of the violation, the amount of compensation

found to be due the claimant and/or the number of fines and benefit penalties previously imposed against the insurer, organization for managed care, health care provider, third-party administrator or employer. The violation will be deemed to have caused physical or economic harm to the injured employee or his dependent if a preponderance of the evidence establishes:

(a) the harm would not have occurred but for the violation;

(b) the violation is a substantial factor in bringing about the harm; and

(c) there is no supervening cause that is responsible for bringing about the harm; additionally

(d) physical harm must be established by a preponderance of objective medical evidence, which must be in the form of existing medical records or medical records furnished by the complaining party..

2. For the purposes of this regulation the term "Dependent" is defined as a person who is partially or wholly dependent on the injured employee, as established by the injured employee's most recent federal income tax return preceding the occurrence of the physical or economic harm, or by other evidence that is reasonable to rely upon.

3. For the purposes of this regulation, the phrase "Physical Harm" I defined as any physiologic disorder or condition, cosmetic disfigurement of anatomic loss affecting one or more of the following body systems: neurologic, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin, and endocrine systems.

4. For the purposes of this regulation, the phrase "Major physical harm" is defined as physical harm caused by the violation that manifests itself in a complete or significant lost of the ability to engage in the activities of daily living, including, but not necessarily limited to, caring for oneself, performing manual tasks, walking, standing, sitting, seeing, hearing, speaking, breathing, learning, working, sleeping, functioning sexually and engaging in normal recreational and social activities.

5. For the purposes of this regulation, the phrase "Minor physical harm" is defined as any physical harm caused by the violation that is not major physical harm or death.

6. For the purposes of this regulation, the phrase "Permanent physical harm" is defined as harm caused by the violation that is unlikely to be alleviated in spite of medical or surgical treatment that a reasonable person is willing to undergo.

7. For the purposes of this regulation, the phrase "Temporary physical harm" is defined as harm caused by the violation that is likely to resolve with or without treatment.

8. For the purposes of this regulation, the phrase "Economic harm" is defined as harm established by a preponderance of the evidence that is caused by the violation and includes loss of money or something of monetary value; or deprivation of a reasonable expectation of a financial or monetary advantage.

9. For the purposes of this regulation, the degree of physical or economic harm and assessing the corresponding benefit penalty amount will be determined by applying the following point schedule:

A. Each point entitles the injured employee to $1,000 in addition to the minimum required benefit penalty of $5,000:

B. Points assessed for physical harm:

Minor temporary harm	***2 points***
Major temporary harm	***5 points***
Minor permanent harm	***5 points***
Major permanent harm	***10 points***

C. Points to be assessed for amount of compensation due:

$3,001-$5,000	***1 point***
$5,001-$7,000	***2 points***
$7,001-$9,000	***3 points***
$9,001-$11,000	***4 points***
$11,001-$13,000	***5 points***
$13,001-$15,000	***6 points***
$15,001-$17,000	***7 points***
$17,001-$19,000	***8 points***
$19,001-$21,000	***9 points***
$21,000+	***10 points***

D. Points to be assessed for prior violations:

One Prior Violation	***1 point***
Two Prior Violations	***3 points***
More Than Two Prior Violations	***5 points***

The administrator shall consider only those fines and benefit penalties that have been the subject of a final determination within three years prior to the date of the administrators' determination in the pending matter.

E. Points to be assessed for economic harm:

$6,001-$7,000	***1 point***
$7,001-$8,000	***2 points***
$8,001-$9,000	***3 points***
$9,001-$10,000	***4 points***
$10,001-$11,000	***5 points***
$11,001-12,000	***6 points***
$12,001-13,000	***7 points***
$13,001-14,000	***8 points***
$14,001-15,000	***9 points***
$15,000+	***10 points***

10. In the event of death of the injured employee or his dependent, the administrator shall award the claimant the amount of $25,000.

ADD A NEW SECTION TO 616D UNDER THE HEADING "MINOR VIOLATIONS" AS FOLLOWS:

1. Except as otherwise provided in NRS 616D.120 and in Chapters 616A to 617, inclusive, of the Nevada Revised Statutes and Nevada Administrative Code, a "minor" violation of either Chapters 616A to 617, inclusive, of the Nevada Revised Statutes or the Nevada Administrative Code, is a single unintentional violation which the insurer, organization for managed care, health care provider, third-party administrator or employer agrees, in writing, to correct during the course of an investigation or audit conducted pursuant to these Chapters.

2. If the employer, insurer, third-party administrator or health care provider agrees to correct the unintentional violation during the course of an investigation or audit, the administrator will issue a notice of correction.

3. If the employer, insurer, third-party administrator or health care provider does not agree, in writing, to correct the unintentional violation during the course of an investigation or audit, the administrator may issue a fine, order a plan of corrective action, or both, as provided in NRS 616D.120.

ADD NEW SECTIONS TO 616D UNDER THE HEADING "OTHER VIOLATIONS" AS FOLLOWS:

1. Except as otherwise provided in NRS 616D.120 and in Chapters 616A to 617, inclusive, of the Nevada Revised Statutes and Nevada Administrative Code, if the administrator determines that:

(a) An insurer or third-party administrator fails to comply or complies in an untimely manner with any provision of chapter 616A, 616B, 616C, 616D or 617 of NRS or a regulation adopted pursuant thereto that requires the insurer or third-party administrator to make a determination regarding the acceptance or denial of a claim for compensation;

(b) An insurer or third-party administrator fails to comply or complies in an untimely manner with a provision of chapter 616A, 616B, 616C, 616D or 617 of NRS or a regulation adopted pursuant thereto that requires the insurer or third-party administrator to make a payment of benefits to an injured employee;

(c) An insurer, organization for managed care, provider of health care, third-party administrator or employer fails to comply or complies in an untimely manner with the provisions of NRS 616A.475, 616B.006 or 616B.009 or NAC 616A.410;

(d) A treating physician or chiropractor fails to comply or complies in an untimely manner with the provisions of NRS 616C.040, subsection 7 of NRS 616C.475, NRS 616C.040 or NRS 617.352 or of the regulations adopted pursuant thereto that require treating physicians or chiropractors to complete claim for compensation forms; or

(e) An employer fails to comply or complies in an untimely manner with the provisions of NRS 616C.045 or 617.355 or of the regulations adopted pursuant thereto that require the employer to complete a report of industrial injury or occupational disease,

the administrator may impose an administrative fine, order a plan of corrective action, or both, for an unintentional violation.

2. Except as otherwise provided in NRS 616D.120 and in Chapters 616A to 617, inclusive, of the Nevada Revised Statutes and Nevada Administrative Code, if the administrator determines that an insurer, organization for managed care, health care provider, third-party administrator or employer has committed two or more violations of the same or similar provisions of Chapters 616A to 617, inclusive, of the Nevada Revised Statutes and Nevada Administrative Code, inclusive, the administrator may impose an administrative fine, order a plan of corrective action or both, as provided in NRS 616D.120.

ADD NEW SECTIONS TO 616D UNDER THE HEADING "INTENTIONAL VIOLATIONS" AS FOLLOWS:

1. For purposes of NRS 616D.120, "intentional" violation means a violation of any provision of Chapter 616A to 617, inclusive, of Nevada Revised Statutes or any provision of Chapter 616A to 617, inclusive, of the Nevada Administrative Code. Where the employer, insured, third-party administrator or health care provider acts with purpose or design, otherwise acts to cause the consequences, desires to cause the consequences, or believes that the consequences are substantially certain to result from the act or acts.

2. The administrator may consider two or more violations of the same or similar provisions of Chapters 616A to 617, inclusive, as evidence of an intentional violation. If the administrator determines the two or more violations constitute an "intentional" violation, he will issue a fine pursuant to NRS 616D.120(1)(g) and, if appropriate, order a plan of corrective action.

TEXT OF REPEALED SECTIONS

~~[NAC 616B.103 "Association" defined. (NRS 616A.400) "Association" means an association of self-insured private employers or an association of self-insured public employers.]~~

~~[NAC 616B.109 "Designated agent" defined. (NRS 616A.400) "Designated agent" means the agent who is authorized by the administrator to receive proof of coverage from a private carrier or an association, or its representative, and submit that proof of coverage to the administrator.]~~

~~[NAC 616B.130 Time limit for association to submit certain information to designated agent; association to report proof to designated agent. (NRS 616A.400)~~
~~1. An association that is certified as such by the commissioner pursuant to NRS 616B.359 on or after July 1, 1999, shall submit information relating to its certificate and~~

membership to the designated agent on the form prescribed by the administrator within 15 days after the issuance of the certificate.

2. An association shall report proof of coverage to the designated agent within 15 days after:

(a) Any change in information relating to a member of the association that materially affects the proof of coverage required by NAC 616B.100 to 616B.148, inclusive;

(b) The addition or deletion of a member of the association; and

(c) The anniversary date of each member of the association.]

[NAC 616B.141 Failure to submit proof; notice of rejection. (NRS 616D.120) If a private carrier or an association fails to submit proof of coverage as required by the provisions of NAC 616B.100 to 616B.148, inclusive, or the proof of coverage submitted results in the issuance of a notice of rejection by the administrator or designated agent, the administrator will:

1. For the first violation in a 12-month period, issue a notice of correction.

2. For the second violation in a 12-month period, impose an administrative fine of $250.

3. For the third violation in a 12-month period, impose an administrative fine of $500.

4. For the fourth or any subsequent violation within a 12-month period, impose an administrative fine of $1,000.]

[NAC 616B.144 Notice of error; exception. (NRS 616D.120)

1. Except as otherwise provided in subsection 2, if a private carrier or an association incorrectly reports proof of coverage that results in the issuance of a notice of error by the administrator or designated agent, the administrator will:

(a) For the second violation within a 12-month period, impose an administrative fine of at least $50.

(b) For the third violation within a 12-month period, impose an administrative fine of at least $100.

(c) For the fourth violation within a 12-month period, impose an administrative fine of at least $250.

(d) For the fifth or any subsequent violation within a 12-month period, impose an administrative fine of at least $500.

2. The provisions of subsection 1 do not apply to an association that submits an incorrect report of the payroll of its members which results in the issuance of a notice of rejection by the administrator or designated agent.]

[NAC 616B.147 Failure to correct or resubmit data; exception. (NRS 616D.120)

1. Except as otherwise provided in subsection 2, if a private carrier or an association fails to correct or accurately resubmit data which was incorrect or rejected within 5 working days after the receipt of a notice of error or rejection, the administrator will:

(a) For the first violation within a 12-month period, issue a notice of correction.

(b) For the second violation within a 12-month period, impose an administrative fine of at least $50.

(c) For the third violation within a 12-month period, impose an administrative fine of at least $100.

(d) For the fourth violation within a 12-month period, impose an administrative fine of at least $250.

(e) For the fifth or any subsequent violation within a 12-month period, impose an administrative fine of at least $500.

2. The provisions of subsection 1 do not apply to an association that fails to correct or accurately resubmit the payroll of its members.]

[NAC 616C.027 Review of reduction or disallowance of bill; appeal; hearing; decision. (NRS 616A.400, 616C.135, 616C.260)

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 shall review the matter, and if it determines that issuing a written determination is appropriate, it shall 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. A provider of health care or insurer aggrieved by the determination of the industrial insurance regulation section may appeal to the administrator by filing a request for a hearing with the administrator, within 30 days after the date of the determination.

3. The provider of health care and the insurer will be the only parties to the hearing scheduled pursuant to subsection. A representative of the industrial insurance regulation section may attend the hearing. The administrator will consider the evidence presented at the hearing, including, without limitation, any evidence concerning the reduction or disallowance of the bill that was not available or the existence of which was not known to the provider of health care at the time he submitted the request to the industrial insurance regulation section pursuant to subsection 1.

4. The administrator will schedule a hearing on the matter and, after the hearing, issue a written decision. The administrator 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. The decision of the administrator is a final decision for the purposes of judicial review.]

[NAC 616C.1158 Claim received for employer to whom insurer does not provide coverage: Copy of claim provided to appropriate insurer. (NRS 616A.400, 616A.417) After receipt of a copy of a claim for compensation pursuant to NAC 616C.1156, the administrator will, if the employer is insured by another insurer, deliver by electronic transmission or other method a copy of the claim for compensation to the other insurer within 10 working days after receipt of the notification.]

[NAC 616C.126 Treatment of injured employees in cases of severe trauma. (NRS 616A.400, 616C.250, 616C.260) 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 utilize 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 who:

~~1. Are members of the panel of physicians and chiropractors established by the administrator pursuant to NRS 616C.090; or~~

~~2. Have contracted with an insurer or an organization for managed care to provide health care services to injured employees.~~**]**

~~[NAC 616C.129 Rules for treatment of injured employees by members of panel of physicians and chiropractors. (NRS 616A.400, 616C.250, 616C.260) 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,~~

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

~~5. The~~ **[**~~treating physician or chiropractor~~**]** ***health care pro***vider 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 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.]

[NAC 616C.132 Diagnostic images. (NRS 616A.400, 616C.260)

1. An insurer shall not pay for any diagnostic images if:

(a) The diagnostic images cannot be satisfactorily interpreted by a provider of health care who is certified by the American Board of Radiology, Inc., or the American Chiropractic Board of Roentgenology, or who has obtained equivalent certification as determined by the insurer; or

(b) A satisfactory report based on the diagnostic images is not received by the insurer.

2. If diagnostic images are taken which the insurer's medical or chiropractic adviser deems inadequate or unsatisfactory and payment of the charges for the diagnostic images has already been made, the insurer shall adjust payments on future billings of the physician or chiropractor who received the payment for the diagnostic images.

3. Any diagnostic images which have been taken by any provider of health care must be made available for use by subsequent consultants, to eliminate the economic waste of repeated diagnostic images and unnecessary exposure of the injured employee to radiation. Consulting providers of health care shall return all diagnostic images to the imaging facility from which they were obtained. The provider of health care who was in possession of any diagnostic images at the time that they are misplaced, lost or destroyed is liable to the insurer for the cost of those diagnostic images and the cost of obtaining new images.

4. An insurer shall not pay for any excessive or unnecessary diagnostic images.]

[NAC 616C.135 Special accommodations and nursing services. (NRS 616C.250, 616C.260)

1. When an injured employee is so severely injured as to require quiet surroundings, a private room must be arranged at the direction of the attending physician. It must be discontinued when the necessity terminates.

2. In cases of severe injury, when special nursing services are required, they may be furnished by direction of the attending physician for 10 days. Extension of special nursing services beyond 10 days must be approved by the insurer.

~~[NAC 616C.138 Supplies and materials; narcotic analgesics; placebos. (NRS 616A.400, 616C.250, 616C.260)~~

~~1. Supplies and materials provided by the provider of health care over and above those usually included in a visit to his office or in other services rendered must be billed by report under the appropriate code set forth in the [~~"Health Care Financing Administration, HCFA Common Procedures Coding System (HCPCS),"~~] *~~"Centers for Medicare & Medicaid Services , CMS Common Procedures Coding System CCPCS)"~~* ~~as contained in the Relative Values for Physicians, as adopted pursuant to NAC 616C.188.~~

~~2. The insurer shall reimburse the provider of health care for those supplies and materials at the provider's cost of the supplies and materials, excluding tax and charges for freight, plus 20 percent. The provider of health care must be able to justify his charges to the insurer upon reasonable request.~~

~~3. Charges for narcotic analgesics will be allowed only when it is clearly evident that they were administered and prescribed by the physician in a writing which identified the narcotic and indicated the number of units to be administered and over what period.~~

~~4. A physician who is a member of the panel of physicians and chiropractors shall supervise the dosage of any narcotic analgesics and the amount of refills prescribed for an injured employee, giving consideration to the origin of the subjective pain experienced or complained of by the injured employee. The physician shall reexamine the injured employee at reasonable intervals.~~

~~5. An insurer shall not pay for any placebo administered by a physician who is a member of the panel of physicians and chiropractors, unless the physician submits a report to the insurer that contains an explanation for the need for the placebo which is acceptable to the medical adviser of the insurer.]~~

~~[NAC 616C.141 Billing: Requirements for programs of treatment billed under certain codes; use of codes; modifications of codes for certain services. (NRS 616A.400, 616C.250, 616C.260)~~

~~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,~~

~~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 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. 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 by reference pursuant to NAC 616C.188, or the Relative Value Guide of the American Society of Anesthesiologists, as adopted by reference pursuant to NAC 616C.194, for any services. The codes must be indicated on each bill regardless of whether the provisions of NAC 616C.070 to 616C.336, inclusive, allow for the payment of the services, the payment is requested or the item is included under a different code.~~

~~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.~~

~~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 85 percent of the maximum allowable fee established for physicians or chiropractors pursuant to paragraph (a) of subsection 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.~~

~~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 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.~~

~~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 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.~~

~~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.~~**]**

[NAC 616C.144 Periods for billing and processing of bills; submission of certain reports; time and procedure for insurer to pay, deny or reconsider bills. (NRS 616A.400, 616C.130)

1. Billings for health care services must be submitted to the insurer 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 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. 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:

(a) 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 (d) 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 not later than 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) Except as otherwise provided in paragraph (b), provide an explanation of benefits for each code billed that includes the amounts for services that are paid and disallowed;

(b) If the services rendered are for physical therapy and the total unit value of the services provided for 1 day is 12 or more, combine all the services for that day and use code NV970001 on the payment;

(c) Indicate on each payment those services which are being disallowed and the reasons for the disallowance; and

(d) 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.]

[NAC 616C.249 Annual revisions to schedule: Calculation. (NRS 616A.400, 616C.260)

1. The division will calculate annual revisions to the schedule of fees and charges allowable for accident benefits as follows:

(a) The division will conduct an annual survey of payers of health care services in this state. The data to be collected must consist of:

(1) A statistically valid sample of codes identified in CPT-4 for medicine, surgery, anesthesiology, radiology and pathology;

(2) The hospital per diem rates for emergency department stays, medical or surgery stays, intensive care unit stays, burn unit stays and cardiac care stays; and

(3) The number of treatments and amounts paid in the month of January of each calendar year, and the number of treatments and amounts paid for the same procedures in January of the preceding calendar year.

(b) Hospital per diem rates for emergency department stays, medical or surgery stays, intensive care unit stays, burn unit stays and cardiac care stays will be included in the calculation made pursuant to paragraph (c), but will not be reported by the division using the codes identified in CPT-4.

(c) The division will calculate the annual percentage of increase or decrease for each treatment area of medicine, surgery, anesthesiology, radiology and pathology and for hospital per diem rates as follows:

(1) The division will calculate each payer's annual payments for each treatment area of medicine, surgery, anesthesiology, radiology and pathology and for hospital per diem rates as reported in the survey for January of each calendar year, and for January of the previous calendar year.

(2) The division will compare each payer's reported payments for January of each calendar year with the corresponding payments for January of the previous calendar year to determine the payer's annual increase or decrease in payments.

(3) The division will apply a weighting factor to each payer's annual increase or decrease calculated pursuant to subparagraph (2). The division will use the total number of treatments paid or the total payments made for the treatments provided, whichever the division determines will yield a more accurate result, as a basis for determining the weighting factor pursuant to this subparagraph.

(d) The division will compare the weighted increase or decrease factors for each payer to calculate a statewide increase or decrease for each treatment area of medicine, surgery, anesthesiology, radiology and pathology and for hospital per diem rates.

(e) The division will report the annual increase or decrease factor for each treatment area of medicine, surgery, anesthesiology, radiology and pathology and for hospital per diem rates as a percentage factor.

(f) The administrator will establish the annual revision of fees for the purposes of NAC 616C.170 to 616C.191, inclusive, by comparing the annual increase or decrease percentage factor established pursuant to paragraph (c) to the maximum increase allowed as reported by the United States Department of Labor in its Consumer Price Index, Medical Care Component, using the unadjusted percentage change for January to December, inclusive, of the previous year.

2. As used in this section, "CPT-4" means the American Medical Association's "Physicians' Current Procedural Terminology," fourth edition, as contained in the Relative Values for Physicians, as adopted by reference in NAC 616C.188.

(Added to NAC by Dep't of Industrial Relations, eff. 9-16-92; A by Div. of Industrial Relations, 10-11-93; R121-97, 12-10-97, eff. 1-1-98; R105-00, 1-18-2001, eff. 3-1-2001)]

[NAC 616C.170 "Report" defined. (NRS 616A.400, 616C.260) 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.

(Added to NAC by Dep't of Industrial Relations, eff. 8-30-91; A by Div. of Industrial Relations, 10-11-93; R121-97, 12-10-97, eff. 1-1-98; R090-99, 10-28-99)]

[REVISER'S NOTE].

[The regulation of the department of industrial relations filed with the secretary of state on August 30, 1991, which substantially revised the provisions of NAC 616.587 to 616.605 [616C.170 to 616C.230], inclusive, contains the following provision not included in NAC:

"If any provision of sections 3 to 19, inclusive, of this regulation, or any amendatory provision of sections 21 to 28, inclusive, of this regulation is declared by a court of competent jurisdiction to be unenforceable, invalid, or void, in whole or in part, and judgment is entered accordingly, that section expires by limitation upon the entry of the judgment."]

[NAC 616C.173 Providers of health care allowed no undue profit; supplying drugs; ethical guidelines. (NRS 616A.400, 616C.260)

1. In defining the services for which fees will be allowed to providers of health care, the division will follow the principle that a provider of health care should not unduly profit, directly or indirectly, as a result of prescribing materials, drugs or ancillary services for the treatment of an injured employee.

2. Required drugs must be supplied through licensed suppliers pursuant to a prescription of the provider of health care.

3. The regulations of the applicable professional licensing board which establishes the principles of ethics for each respective provider of health care may be used as a guideline by the division in ruling on whether fees for services and procedures not otherwise specifically defined in fee schedules or regulations relating to providers of health care are allowable.

(Added to NAC by Div. of Industrial Insurance Regulation, eff. 2-22-88; A by Div. of Industrial Relations by R121-97, 12-10-97, eff. 1-1-98)]

[NAC 616C.176 Prior written authorization required for consultation or treatment provided outside state; emergency treatment outside state. (NRS 616A.400, 616C.260)

1. Except as otherwise provided in this section, an insurer is not financially liable for consultation or treatment that is provided outside this state unless the insurer has given prior written authorization to the provider of health care for the consultation or treatment. At the time of giving the written authorization, the insurer shall give written notice, which must include the date on which the notice is given, to the injured employee and the provider of health care that:

(a) The 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 a contract between the provider of health care and the insurer;

(b) The insurer is solely responsible for the payment of all services rendered;

(c) The injured employee is not financially liable for any part of the cost of the services rendered and must not be billed for those services; and

(d) Any bill must be submitted within 90 days after services are rendered.

2. Prior authorization for emergency treatment that is provided outside this state is not required. A provider of health care who renders emergency treatment outside this state to an injured employee subject to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS must bill for such services using the appropriate coding found in the American Medical Association's "Physician's Current Procedural Terminology" as contained in the Relative Values for Physicians, as adopted by reference in NAC 616C.188. The provider of health care shall submit a bill for all such emergency treatment and include the fees as set forth in the schedule of reasonable fees and charges allowable for accident benefits, if any, of the state in which the treatment was rendered or the usual and customary fees of the provider, whichever are less.

3. The insurer shall pay for emergency treatment according to the billing received, unless the fee is unreasonable. A fee shall be deemed to be reasonable if it is provided in accordance with the provisions of this section.

4. The burden for showing that the treatment was emergency treatment is on the injured employee and the provider of health care.

5. As used in this section, "emergency treatment" means any treatment for a new injury which is rendered within 3 days after the date of the injury or any treatment of an existing injury which, if not immediately rendered, would subject the injured employee to a significant increase in the risk of death or serious permanent physical impairment.

(Added to NAC by Div. of Industrial Relations, eff. 11-10-93; A 3-5-96; R121-97, 12-10-97, eff. 1-1-98)]

[NAC 616C.179 Response to request for prior authorization. (NRS 616A.400, 616C.157, 616C.260)

1. If a provider of health care, who has submitted 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. For purposes of determining the number of additional visits or treatments 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.

(Added to NAC by Div. of Industrial Relations, eff. 11-10-93; A 3-5-96; R121-97, 12-10-97, eff. 1-1-98; R090-99, 10-28-99)]

[NAC 616C.182 Determination of amount of payment; billing by report.

1. Each insurer shall determine the amount to be paid to a provider of health care according to NAC 616C.170 to 616C.230, inclusive, unless the insurer has entered into a contract for the provision of those benefits for less than the amounts set forth in those sections.

2. The provider of health care shall bill by report if there is insufficient information to support a unit of value. A provider of health care who bills by report shall submit the information identified in the guidelines for billing by a report for that area of treatment, contained in the Relative Values for Physicians, as adopted pursuant to NAC 616C.188.

(Added to NAC by Dep't of Industrial Relations, eff. 3-15-84; A 11-30-84; 3-17-86, eff. 3-22-86; 8-30-91; A by Div. of Industrial Relations, 10-11-93) (Substituted in revision for NAC 616.591)]

[NAC 616C.185 Contents of reports. (NRS 616A.400, 616C.130) A report submitted pursuant to NAC 616C.170 to 616C.230, inclusive, must include:

1. The complete health history of the injured employee;

2. A description of all pertinent subjective information provided by the injured employee;

3. All pertinent objective data obtained by examination and testing, unless disclosure of the data is prohibited by law;

4. An assessment of all pertinent subjective information and objective data;

5. A description of the plans for the treatment of the injured employee; and

6. In the case of a report relating to a final or discharge evaluation, a statement of the health of the injured employee, including the likelihood of a ratable impairment.]

[NAC 616C.188 Relative Values for Physicians: Adoption by reference; modifications; maximum unit values; initial evaluation; special reports. (NRS 616A.400, 616C.260)

1. 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.

2. The administrator will, on or before March 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 April 30, unless a notice of disapproval of the edition or update is posted pursuant to this subsection by the immediately preceding March 1. If the administrator 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 (c) of subsection 1 of NRS 233B.0603.

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

3. A copy of Relative Values for Physicians, as adopted by reference pursuant to subsection 1, may be purchased from Ingenix, 5225 Wiley Post Way, Suite 500, Salt Lake City, Utah 84116-2889, (800) 999-4600 for the price of $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:

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:

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 so authorizes 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 by a licensed physical therapist or licensed occupational therapist 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 provider of health care performs a procedure described in the following chart, he shall use code 99080 from the Relative Values for Physicians and bill in accordance with the procedure set forth below:

Code Procedure Payment

99080 Special reports requested in writing by an insurer,

~~including, without limitation, 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~~

~~(Added to NAC by Dep't of Industrial Relations, eff. 3-15-84; A 11-30-84; 3-17-86, eff. 3-22-86; 6-23-86; 2-18-88; 7-20-89; 2-28-90, eff. 3-19-90; A by Div. of Industrial Relations, 10-11-93; R121-97, 12-10-97, eff. 1-1-98; R090-99, 10-28-99; R105-00, 1-18-2001, eff. 3-1-2001)~~**]**

[~~NAC 616C.191 Conversion factors; limits on payments; use of procedure code numbers and unit values. (NRS 616A.400, 616C.260)~~

~~1. The values contained in the schedule of reasonable fees and charges allowable for accident benefits adopted for this state pursuant to NRS 616C.260 must be multiplied by the following conversion factors for each provider of health care and the type of service:~~

~~Code~~	~~Type of Service~~	~~Conversion Factor~~
~~70000-79999~~	~~Radiology and Nuclear Medicine~~	~~$24.09~~
~~80000-89999~~	~~Pathology~~	~~14.30~~
~~90000-99999~~	~~Medicine~~	~~6.24~~
~~10000-69999~~	~~Surgery~~	~~135.28~~

~~2. Payment for services listed in subsection 1 must be made in accordance with subsection 2 of NRS 616C.135 and subsection 1 of NRS 616C.260. Payments must not exceed the fees established in the schedule of fees and charges allowable for accident benefits adopted pursuant to NRS 616C.260, or the usual fee charged by that provider of health care or facility pursuant to a contract between the provider of health care and the insurer, whichever is less.~~

~~3. Providers of health care shall use the procedure code numbers and unit values from the Relative Values for Physicians, as adopted by reference pursuant to NAC 616C.188, to bill for services performed which are within the scope of their licenses.~~

~~(Added to NAC by Dep't of Industrial Relations, eff. 3-15-84; A 11-30-84; 3-17-86, eff. 3-22-86; 2-18-88; 7-20-89; 8-30-91; 1-24-92, eff. 12-31-91; A by Div. of Industrial Relations, 10-11-93; 3-5-96; R121-97, 12-10-97, eff. 1-1-98; R105-00, 1-18-2001, eff. 3-1-2001)~~**]**

[~~NAC 616C.194 Relative Value Guide of the American Society of Anesthesiologists: Adoption by reference; conversion factor; payments; basic anesthetic values. (NRS 616A.400, 616C.260)~~

~~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.~~

~~2. The administrator 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 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.

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 by reference or deemed approved pursuant to this section will continue in effect.

3. A copy of the Relative Value Guide of the American Society of Anesthesiologists, as adopted by reference 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 $15.

4. Except as otherwise provided in this subsection, an anesthesiologist shall use the codes that are stated in the 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 by reference pursuant to NAC 616C.188, using the 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	$51.62

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 4 or pursuant to a contract between the provider of health care and the insurer.

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

(Added to NAC by Dep't of Industrial Relations, eff. 3-15-84; A 11-30-84; 3-17-86, eff. 3-22-86; 2-18-88; 7-20-89; 8-30-91; 1-24-92, eff. 12-31-91; A by Div. of Industrial Relations, 10-11-93; 3-5-96; R121-97, 12-10-97, eff. 1-1-98; R090-99, 10-28-99; R105-00, 1-18-2001, eff. 3-1-2001)]

[NAC 616C.197 Licensed surgical centers for ambulatory patients. (NRS 616A.400, 616C.260)

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, 1997, established by the **[**Health Care Financing Administration**]** ***Centers for Medicare & Medicaid Services***, as amended on January 1, 2000.

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	$490.16
Group 2	628.23
Group 3	759.40
Group 4	938.89
Group 5	998.72
Group 6	1,178.21
Group 7	1,221.47
Group 8	1,221.47
Group 9	1,221.47

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

(a) At 400 West King Street, Suite 400, Carson City, Nevada 89703, (775) 687-3033;

(b) At 1301 North Green Valley Parkway, Suite 200, Henderson, Nevada **[**89014**]** ***89074***, (702) 486-9080; or

(c) At the Internet address <>.

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 by reference 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.

(Added to NAC by Dep't of Industrial Relations, 2-28-90, eff. 3-19-90; A 1-24-92, eff. 12-31-91; A by Div. of Industrial Relations, 10-11-93; 3-5-96; R121-97, 12-10-97, eff. 1-1-98; R090-99, 10-28-99; R105-00, 1-18-2001, eff. 3-1-2001)]

[NAC 616C.200 Services performed by acupuncturist. (NRS 616C.260) Each insurer shall use the following codes for services performed by an acupuncturist:

Code	Procedure	Maximum Allowable Payment
NV00001	Initial office visit	By Report
NV00002	Subsequent office visit, including acupuncture or additional procedures	By Report
NV00003	Subsequent office visit, including moxibustion or additional procedures	By Report

(Added to NAC by Dep't of Industrial Relations, eff. 3-15-84; A 11-30-84; 3-17-86, eff. 3-22-86; A by Div. of Industrial Relations, 10-11-93; 3-5-96; R121-97, 12-10-97, eff. 1-1-98)]

[NAC 616C.203 Use of emergency department; inpatient care at hospital; skilled nursing care facility; transfer or discharge of injured employee; excessive use of hospital accommodations. (NRS 616A.400, 616C.260)

1. The following is the maximum allowable payment per visit for the use of an emergency department:

Code	Procedure	Maximum Allowable Payment
NV00100	First hour	$37.67
NV00101	Each additional hour or fraction thereof	18.84

2. If an injured employee receives care in an emergency department that is located on the grounds of a hospital and the time for the use of the emergency department exceeds 60 minutes, the billing must be submitted in a report and must specify the need for the time that exceeded 60 minutes. 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 must be billed and paid separately.

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	$2,008.98
NV00400	Cardiac Care	1,844.80
NV00500	Medical-Surgical Care	1,221.47
NV00900	Care for Burns1,	844.80

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 Payable
NV00410	Open Heart Surgery	$17,707.75

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	$1,138.53

12. 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.

(Added to NAC by Dep't of Industrial Relations, eff. 3-15-84; A 11-30-84; 3-17-86, eff. 3-22-86; 2-18-88; 7-20-89; 2-28-90, eff. 3-19-90; 8-30-91; 1-24-92, eff. 12-31-91; A by Div. of Industrial Relations, 10-11-93; 3-5-96; R121-97, 12-10-97, eff. 1-1-98; R090-99, 10-28-99; R105-00, 1-18-2001, eff. 3-1-2001)]

[NAC 616C.206 Home health care services. (NRS 616A.400, 616C.260)

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	$70.68 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	$28.79 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	$35.60 per hour
NV90190	Certified nursing assistant care	17.36 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 the 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 to provide health care services in the home and complete any required documentation of the services provided.

(Added to NAC by Dep't of Industrial Relations, 2-28-90, eff. 3-19-90; A 1-24-92, eff. 12-31-91; A by Div. of Industrial Relations, 10-11-93; 3-5-96; R121-97, 12-10-97, eff. 1-1-98; R090-99, 10-28-99; R105-00, 1-18-2001, eff. 3-1-2001)]

[NAC 616C.209 Payment for pharmaceuticals. (NRS 616A.400, 616C.260)

1. Payment for all pharmaceuticals, except those provided to an injured employee occupying a bed in the hospital, must be:

(a) Computed at:

(1) The average wholesale price plus a $6 dispensing fee; or

(2) The pharmacy's usual and customary price,

whichever is less; or

(b) Computed pursuant to a contract between the provider of health care and insurer.

2. The average wholesale price of each prescription must be determined by the insurer using the most recent nationally recognized pricing guide.

3. Each insurer shall notify the administrator of the identity of the pricing guide he uses in determining the amount to be paid for pharmaceuticals. If the administrator objects to a particular pricing guide, he shall notify the insurer within 7 days after he receives the notice. Unless the insurer is advised that the guide is objectionable within 7 days after the administrator receives the notice, the insurer may continue using the guide.

4. The National Drug Code and the usual and customary charge of the pharmacy for the medication must be included on each billing.

5. All drugs must be dispensed according to the provisions of NRS 616C.115.]

[NAC 616C.212 Rating of permanent partial disability; failure of injured employee to appear for appointment; report of evaluation. (NRS 616A.400, 616C.260)

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

Code	Procedure	Mximum Allowable Payment
NV01000	Review of records, testing, evaluation and report	$467.73
NV01001	Failure of an injured employee to appear for appointment	155.91
NV01002	Addendum necessary to clarify original report	No charge
NV01003	Addendum after review of additional medical records	155.91
NV01004	Review of medical records and evaluation of more than 2 body parts for each body part in excess of 2	155.91
NV01005	Organization of medical records in	

	chronological order	25.99
NV01006	Review of records and report	233.87

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,

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. Unless good cause is shown, a rating physician or chiropractor shall mail a report of an evaluation to the insurer within 14 days after the evaluation is completed. 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 14 days after receiving the request.

5. 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 14 days after the evaluation is completed. 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 14 days after receiving the request.**]**

[NAC 616C.213 Failure of injured employee to appear for independent medical evaluation. (NRS 616A.400, 616C.260)

1. The following procedure code and payment schedule must be used for preparation when an injured employee fails to appear for an independent medical evaluation scheduled by an insurer:

Code	Procedure	Maximum Allowable Payment
NV02000	Preparation when an injured employee fails to appear for an independent medical evaluation	

scheduled by an insurer. $155.91

2. Code NV02000 may not be billed unless the injured employee fails to:

(a) Appear for the evaluation within 30 minutes after the scheduled appointment; or

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

if the injured employee is not seen on that day and all records and diagnostic images have been reviewed by the provider of health care.

(Added to NAC by Div. of Industrial Relations by R121-97, 12-10-97, eff. 1-1-98; A by R105-00, 1-18-2001, eff. 3-1-2001)**]**

[NAC 616C.215 Contents of bill to insurer. (NRS 616A.400, 616C.260)

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),"**]** ***"Centers for Medicare & Medicaid Services, Common Procedures Coding System (CCPCS),"*** as contained in the Relative Values for Physicians, as adopted by reference 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, for the price of $99.00; or

(b) Ingenix, 5225 Wiley Post Way, Suite 500, Salt Lake City, Utah 84116-2889, (800) 999-4600, for the price of $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.

(Added to NAC by Dep't of Industrial Relations, eff. 3-15-84; A 11-30-84; A by Div. of Industrial Relations, 10-11-93; 3-5-96; R121-97, 12-10-97, eff. 1-1-98; R090-99, 10-28-99; R105-00, 1-18-2001, eff. 3-1-2001)**]**

[NAC 616C.218 Value of report of consultation included in value of consultation. The value of the report of a consultation is included in the value for the consultation.

(Added to NAC by Dep't of Industrial Relations, eff. 3-15-84) (Substituted in revision for NAC 616.599)]

[NAC 616C.221 Therapy: Performance and billing.

1. The procedures and modalities described in NAC 616C.224 to 616C.230, inclusive:

(a) Must not be performed without the prior approval of the insurer.

(b) May, except as otherwise provided by those sections, be performed by any person acting within the scope of his professional license.

2. Any bill prepared for a procedure or modality described in NAC 616C.224 to 616C.230, inclusive, must:

(a) Include the number of the license or certificate held by the person submitting the bill; and

(b) Identify the type of license or certificate held by that person.

(Added to NAC by Dep't of Industrial Relations, eff. 8-30-91; A by Div. of Industrial Relations, 10-11-93) (Substituted in revision for NAC 616.6005)]

[NAC 616C.224 Therapy: Evaluation of functional capacity. (NRS 616A.400, 616C.250, 616C.260)

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 Payment
NV99060	Testing and report	$147.14 per hour

2. Testing performed in connection with such an evaluation must continue for not less than 2 hours and not 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.

(Added to NAC by Dep't of Industrial Relations, eff. 8-30-91; A 1-24-92, eff. 12-31-91; A by Div. of Industrial Relations, 10-11-93; 3-5-96; R121-97, 12-10-97, eff. 1-1-98; R090-99, 10-28-99; R105-00, 1-18-2001, eff. 3-1-2001)]

[NAC 616C.225 Therapy: Failure of injured employee to appear for evaluation of functional capacity. (NRS 616A.400, 616C.260)

1. The following procedure code and payment schedule must be used for preparation when an injured employee fails to appear for an evaluation of functional capacity performed for the injured employee:

Code	Procedure	Maximum Allowable Payment
NV99061	Preparation when an injured	

~~employee fails to appear for an evaluation of functional capacity performed for the injured employee. $155.91~~

~~2. Code NV99061 may not be billed unless the injured employee fails to:~~
~~(a) Appear for the evaluation within 30 minutes after the scheduled appointment; or~~
~~(b) Cancel the appointment within 24 hours before the scheduled appointment,~~
~~if the injured employee is not seen on that day and all records and diagnostic images have been reviewed by the provider of health care.~~
~~(Added to NAC by Div. of Industrial Relations by R121-97, 12-10-97, eff. 1-1-98; A by R105-00, 1-18-2001, eff. 3-1-2001)~~**]**

[~~NAC 616C.227 Therapy: Work hardening programs. (NRS 616A.400, 616C.250, 616C.260)~~
~~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~~	~~$51.79 per hour~~

~~2. A program billed pursuant to this section must continue:~~
~~(a) For not less than 2 hours per day and not more than 8 hours per day, including any time spent in preparing a report of the treatment; and~~
~~(b) For not less than 2 weeks and not 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.~~
~~(Added to NAC by Dep't of Industrial Relations, eff. 8-30-91; A 1-24-92, eff. 12-31-91; A by Div. of Industrial Relations, 10-11-93; 3-5-96; R121-97, 12-10-97, eff. 1-1-98; R090-99, 10-28-99; R105-00, 1-18-2001, eff. 3-1-2001)~~**]**

[~~NAC 616C.230 Therapy: Back school. (NRS 616A.400, 616C.250, 616C.260)~~
~~1. The following procedure code and payment schedule must be used for any back school provided to an injured employee:~~

~~Code~~	~~Procedure~~	~~Maximum Allowable Payment~~
~~NV97115~~	~~Back School~~	~~$51.79 per hour~~

~~2. A program billed pursuant to this section must not exceed 8 hours in duration.~~
~~3. Payments for services billed under code NV97115 include the services of all instructors who participate in the program.~~
~~4. The program must include, but is not limited to:~~

(a) Instruction of the injured employee by a licensed physical therapist or licensed occupational therapist and by other providers of health care; and

(b) Instruction of the injured employee in body mechanics, anatomy, techniques of lifting and nutrition.

(Added to NAC by Dep't of Industrial Relations, eff. 8-30-91; A 1-24-92, eff. 12-31-91; A by Div. of Industrial Relations, 10-11-93; 3-5-96; R121-97, 12-10-97, eff. 1-1-98; R105-00, 1-18-2001, eff. 3-1-2001)**]**

[Accident Benefits: Administrative Procedures Regarding Schedule of Fees and Charges**]**

[REVISER'S NOTE.**]**

[The regulation of the department of industrial relations filed with the secretary of state on September 16, 1992, the source of NAC 616.6062 to 616.6074 **[**616C.240 to 616C.258**]**, inclusive, contains the following provisions not included in NAC:

"1. To establish a schedule of reasonable fees and charges allowable for accident benefits in compliance with NRS 616.412 **[**616C.260**]**, the department will make a conversion from the 1974 revision of the 1969 California Relative Value Studies, 5th edition, revised, to the 1991 edition of "Relative Values for Physicians," published by SysteMetrics, a subsidiary of McGraw-Hill, Inc., by using the following procedures:

(a) The department will conduct a survey to acquire a data base of not less than 3 years of billing data abstracted from bills submitted by health care providers to industrial insurers. Separate surveys will be conducted for the areas of medical treatment identified as medicine, surgery, radiology and pathology. The department will include in the data base:

(1) The code identified in CRVS for each procedure paid; and

(2) The number of treatments paid per procedure.

(b) The department will calculate the maximum allowable fee for each procedure reported in the surveys by multiplying the unit value contained in the CRVS for the procedures by the existing conversion factor contained in subsection 1 of NAC 616.593 **[**616C.191**]** for the procedure.

(c) The department will multiply the maximum allowable fee for each procedure identified in the CRVS which has an equivalent code in the MHRVP by the total number of treatments billed to industrial insurers, for the separate years of data, to establish the total fee paid out for each procedure identified in the CRVS. The department will then sum the total fees paid out calculated pursuant to this paragraph.

(d) The department will multiply the MHRVP code by the total number of treatments included in the data base pursuant to subparagraph (2) of paragraph (a) of subsection 1, to determine an MHRVP factor for equivalent codes identified in the CRVS. The department will then sum the MHRVP factors calculated pursuant to this paragraph.

(e) The department will divide the sum calculated pursuant to paragraph (c) by the sum calculated pursuant to paragraph (d) to establish an equivalent gross conversion factor for each area.

(f) The department will translate some or all of the codes identified in the CRVS to codes identified in the CPT-4. The department will rely on the analysis of other nationally recognized organizations as a basis for the translation when appropriate.

(g) The department will analyze all calculations made pursuant to this subsection to arrive at conversion factors for the areas of medical treatment identified as medicine, surgery, radiology, and pathology, and will create a revised schedule of reasonable fees and charges where the total payout by industrial insurers for medical treatment for injured workers under the MHRVP will be as close as possible to the total payout made pursuant to the CRVS using the existing conversion factors contained in subsection 1 of NAC 616.593 **[**616C.191**]**.

2. As used in this section:

(a) "CPT-4" means the American Medical Association's "Physicians' Current Procedural Terminology," fourth edition, as contained in the 1991 edition of "Relative Values for Physicians," published by SysteMetrics, a subsidiary of McGraw-Hill, Inc., as adopted by reference in section 1 of regulation R193-91, filed with the secretary of state on January 24, 1992.

(b) "CRVS" means the 1974 revision of the 1969 California Relative Value Studies, 5th edition, revised, as adopted by reference in NAC 616.5925 **[**616C.188**]**.

(c) "MHRVP" means the 1991 edition of "Relative Values for Physicians," published by SysteMetrics, a subsidiary of McGraw-Hill, Inc., as adopted by reference in section 1 of regulation R193-91, filed with the secretary of state on January 24, 1992."**]**

[NAC 616C.240 Establishment of schedule: Entities to be surveyed. The entities to be surveyed for the purpose of establishing a schedule of reasonable fees and charges allowable for accident benefits may include:

1. Private providers of health insurance;

2. Health maintenance organizations; or

3. Preferred provider organizations,

whose allowable charges are based on premium income, standard underwriting principles, and loss ratio.

(Added to NAC by Dep't of Industrial Relations, eff. 9-16-92) — (Substituted in revision for NAC 616.6062)**]**

[NAC 616C.243 Establishment of schedule: Handling of data. (NRS 616C.260)

1. All data obtained in establishing a schedule of reasonable fees and charges allowable for accident benefits will:

(a) Have the identity of its source removed from the face of any document submitted to the division to maintain the confidentiality of the source.

(b) Be retained for a reasonable time, as determined by the administrator, not to exceed 5 years.

(c) Be retained in files which are dated and labeled according to subject matter.

2. Documents retained pursuant to this section will be retained at an office of the industrial insurance regulation section for a period of not less than 2 years at which time the documents may be stored at a storage facility at a different location.

3. Documents containing data obtained in establishing a schedule of reasonable fees and charges allowable for accident benefits must be disposed of in compliance with a records retention program approved by the administrator.

(Added to NAC by Dep't of Industrial Relations, eff. 9-16-92; A by Div. of Industrial Relations by R121-97, 12-10-97, eff. 1-1-98)**]**

~~[NAC 616C.246 Use of modifiers to limit maximum fees for multiple procedures. The division will, if necessary, establish reasonable limits on the maximum allowable fees for multiple procedures by the use of modifiers.~~

~~(Added to NAC by Dep't of Industrial Relations, eff. 9-16-92) (Substituted in revision for NAC 616.6066)]~~

~~[NAC 616C.249 Annual revisions to schedule: Calculation. (NRS 616A.400, 616C.260)~~

~~1. The division will calculate annual revisions to the schedule of fees and charges allowable for accident benefits as follows:~~

~~(a) The division will conduct an annual survey of payers of health care services in this state. The data to be collected must consist of:~~

~~(1) A statistically valid sample of codes identified in CPT-4 for medicine, surgery, anesthesiology, radiology and pathology;~~

~~(2) The hospital per diem rates for emergency department stays, medical or surgery stays, intensive care unit stays, burn unit stays and cardiac care stays; and~~

~~(3) The number of treatments and amounts paid in the month of January of each calendar year, and the number of treatments and amounts paid for the same procedures in January of the preceding calendar year.~~

~~(b) Hospital per diem rates for emergency department stays, medical or surgery stays, intensive care unit stays, burn unit stays and cardiac care stays will be included in the calculation made pursuant to paragraph (c), but will not be reported by the division using the codes identified in CPT-4.~~

~~(c) The division will calculate the annual percentage of increase or decrease for each treatment area of medicine, surgery, anesthesiology, radiology and pathology and for hospital per diem rates as follows:~~

~~(1) The division will calculate each payer's annual payments for each treatment area of medicine, surgery, anesthesiology, radiology and pathology and for hospital per diem rates as reported in the survey for January of each calendar year, and for January of the previous calendar year.~~

~~(2) The division will compare each payer's reported payments for January of each calendar year with the corresponding payments for January of the previous calendar year to determine the payer's annual increase or decrease in payments.~~

~~(3) The division will apply a weighting factor to each payer's annual increase or decrease calculated pursuant to subparagraph (2). The division will use the total number of treatments paid or the total payments made for the treatments provided, whichever the division determines will yield a more accurate result, as a basis for determining the weighting factor pursuant to this subparagraph.~~

~~(d) The division will compare the weighted increase or decrease factors for each payer to calculate a statewide increase or decrease for each treatment area of medicine, surgery, anesthesiology, radiology and pathology and for hospital per diem rates.~~

~~(e) The division will report the annual increase or decrease factor for each treatment area of medicine, surgery, anesthesiology, radiology and pathology and for hospital per diem rates as a percentage factor.~~

~~(f) The administrator will establish the annual revision of fees for the purposes of NAC 616C.170 to 616C.191, inclusive, by comparing the annual increase or decrease percentage factor established pursuant to paragraph (c) to the maximum increase allowed as reported by the~~

United States Department of Labor in its Consumer Price Index, Medical Care Component, using the unadjusted percentage change for January to December, inclusive, of the previous year.

2. As used in this section, "CPT-4" means the American Medical Association's "Physicians' Current Procedural Terminology," fourth edition, as contained in the Relative Values for Physicians, as adopted by reference in NAC 616C.188.

(Added to NAC by Dep't of Industrial Relations, eff. 9-16-92; A by Div. of Industrial Relations, 10-11-93; R121-97, 12-10-97, eff. 1-1-98; R105-00, 1-18-2001, eff. 3-1-2001)]

[NAC 616C.252 Annual revisions to schedule: Notice and hearing; date for adoption. (NRS 616C.260)

1. On or before August 28 of each calendar year, the division will provide notice to all interested parties of proposed amendments to the schedule of reasonable fees and charges allowable for accident benefits and set a date for a public hearing on the proposed amendments.

2. The division will adopt revisions to the schedule of reasonable fees and charges allowable for accident benefits no later than October 1 of each year.

(Added to NAC by Dep't of Industrial Relations, 9-16-92, eff. 1-1-93; A by Div. of Industrial Relations by R121-97, 12-10-97, eff. 1-1-98)]

[NAC 616C.255 Compliance with schedule: Auditing of insurer. When auditing an insurer for compliance with the schedule of reasonable fees and charges allowable for accident benefits, the industrial insurance regulation section will examine payments made for accident benefits. The examination of payments will include, but is not limited to, a review to ensure:

1. Timeliness of payment in compliance with NAC 616C.144; and

2. Correctness of payment in compliance with NAC 616C.182 to 616C.218, inclusive, and 616C.240 to 616C.258, inclusive.

(Added to NAC by Dep't of Industrial Relations, eff. 9-16-92) (Substituted in revision for NAC 616.6072)]

[NAC 616C.258 Contracting for assistance from consultants. The administrator may execute a contract with one or more private consultants to provide assistance to the administrator in:

1. Reviewing and revising the surveys used to canvass insurers and other payers for health care services to determine the amounts paid for medical treatment in this state.

2. Conducting additional surveys of insurers in this state and other payers for health care services in this state, to validate any proposed regulation amending the schedule of reasonable fees and charges allowable for accident benefits.

3. Verifying that any proposed increases in the schedule of reasonable fees and charges allowable for accident benefits are in compliance with the provisions of NRS 616C.260.

4. Periodically reviewing and updating the procedures used to calculate the schedule of reasonable fees and charges allowable for accident benefits.

(Added to NAC by Dep't of Industrial Relations, eff. 9-16-92) (Substituted in revision for NAC 616.6074) Contested Claims of Injured Employees]

[NAC 616D.402 Construction of terms. (NRS 616A.400, 616D.120) For the purposes of NAC 616D.400 to 616D.440, inclusive, a person:

1. Fails to comply with a provision of chapter 616A, 616B, 616C, 616D or 617 of NRS or a regulation adopted pursuant thereto if there is an absence of action taken on the part of the person to comply with that provision.

2. Complies in an untimely manner with a provision of chapter 616A, 616B, 616C, 616D or 617 of NRS or a regulation adopted pursuant thereto if he takes action 1 or more days after the time prescribed in that provision.

3. Fails to make a payment required pursuant to a provision of chapter 616A, 616B, 616C, 616D or 617 of NRS or a regulation adopted pursuant thereto if he does not pay any portion of the amount required to be paid pursuant to that provision.

4. Makes a payment required pursuant to a provision of chapter 616A, 616B, 616C, 616D or 617 of NRS or a regulation adopted pursuant thereto in an untimely manner if he makes the payment 1 or more days after the time prescribed in that provision.

(Added to NAC by Div. of Industrial Relations by R007-97, eff. 12-10-97; A by R105-00, 1-18-2001, eff. 3-1-2001)]

[NAC 616D.404 Prerequisite to commission of second or subsequent violation; maximum amount of administrative fine. (NRS 616A.400, 616D.120)

1. For the purposes of NAC 616D.400 to 616D.440, inclusive, a person shall not be deemed to have committed a second or subsequent violation of a provision of chapter 616A, 616B, 616C, 616D or 617 of NRS or a regulation adopted pursuant thereto unless he has received a notice of correction for the first violation of that provision within the immediately preceding 12 months.

2. In no case will the administrator impose an administrative fine for a minor violation set forth in NAC 616D.400 to 616D.440, inclusive, that is greater than $1,000.

(Added to NAC by Div. of Industrial Relations by R007-97, eff. 12-10-97; A by R105-00, 1-18-2001, eff. 3-1-2001)]

[NAC 616D.406 Failure to provide or untimely provision of form, notice or other information to injured employee. (NRS 616A.400, 616D.120) If an insurer, organization for managed care, provider of health care, third-party administrator or employer fails to comply or complies in an untimely manner with a provision of chapter 616A, 616B, 616C, 616D or 617 of NRS or a regulation adopted pursuant thereto that requires the insurer, organization for managed care, provider of health care, third-party administrator or employer to provide to an injured employee a form, notice or any other information, the administrator will:

1. For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

2. For the second violation within a 12-month period, impose an administrative fine of at least $250.

3. For the third violation within a 12-month period, impose an administrative fine of at least $500.

4. For the fourth violation within a 12-month period, impose an administrative fine of at least $750.

5. For the fifth or any subsequent violation within a 12-month period, impose an administrative fine of $1,000.

(Added to NAC by Div. of Industrial Relations by R007-97, eff. 12-10-97; A by R105-00, 1-18-2001, eff. 3-1-2001)]

~~[NAC 616D.408 Failure to make or untimely making of determination regarding acceptance or denial of claim for compensation. (NRS 616A.400, 616D.120)~~

~~1. If an insurer or third-party administrator fails to comply or complies in an untimely manner with any provision of chapter 616A, 616B, 616C, 616D or 617 of NRS or a regulation adopted pursuant thereto that requires the insurer or third-party administrator to make a determination regarding the acceptance or denial of a claim for compensation, the administrator will:~~

~~(a) For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.~~

~~(b) For the second violation within a 12-month period, impose an administrative fine of at least $250.~~

~~(c) For the third violation within a 12-month period, impose an administrative fine of at least $500.~~

~~(d) For the fourth violation within a 12-month period, impose an administrative fine of at least $750.~~

~~(e) For the fifth or any subsequent violation within a 12-month period, impose an administrative fine of $1,000.~~

~~2. An insurer shall pay any administrative fine imposed pursuant to subsection 1 in addition to any amount ordered by the administrator pursuant to NRS 616C.065.~~

~~(Added to NAC by Div. of Industrial Relations by R007-97, eff. 12-10-97; A by R105-00, 1-18-2001, eff. 3-1-2001)]~~

~~[NAC 616D.410 Failure to provide to employer or employee or untimely provision of notice of right to file appeal of determination. (NRS 616A.400, 616D.120) If an insurer, organization for managed care or third-party administrator fails to comply or complies in an untimely manner with any provision of chapter 616A, 616B, 616C, 616D or 617 of NRS or a regulation adopted pursuant thereto that requires the insurer, organization for managed care or third-party administrator to provide to an employer or injured employee notice of his right to file an appeal of a determination of the insurer, organization for managed care or third-party administrator, the administrator will:~~

~~1. For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.~~

~~2. For the second violation within a 12-month period, impose an administrative fine of at least $100.~~

~~3. For the third violation within a 12-month period, impose an administrative fine of at least $250.~~

~~4. For the fourth or any subsequent violation within a 12-month period, impose an administrative fine of at least $500.~~

~~(Added to NAC by Div. of Industrial Relations by R007-97, eff. 12-10-97; A by R105-00, 1-18-2001, eff. 3-1-2001)]~~

~~[NAC 616D.412 Failure to provide or untimely provision of notice of determination concerning request relating to claim. (NRS 616A.400, 616D.120) If an insurer, organization for managed care or third-party administrator fails to comply or complies in an untimely manner with the provisions of NAC 616C.094, the administrator will:~~

1. For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

2. For the second violation within a 12-month period, impose an administrative fine of at least $250.

3. For the third violation within a 12-month period, impose an administrative fine of at least $500.

4. For the fourth violation within a 12-month period, impose an administrative fine of at least $750.

5. For the fifth or any subsequent violation within a 12-month period, impose an administrative fine of $1,000.

(Added to NAC by Div. of Industrial Relations by R007-97, eff. 12-10-97; A by R105-00, 1-18-2001, eff. 3-1-2001)]

[NAC 616D.414 Failure to pay, untimely payment of or underpayment of benefits to injured employee. (NRS 616A.400, 616D.120)

1. If an insurer or third-party administrator fails to comply or complies in an untimely manner with a provision of chapter 616A, 616B, 616C, 616D or 617 of NRS or a regulation adopted pursuant thereto that requires the insurer or third-party administrator to make a payment of benefits to an injured employee, the administrator will:

(a) For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

(b) For the second violation within a 12-month period, impose an administrative fine of at least $500.

(c) For the third violation within a 12-month period, impose an administrative fine of at least $750.

(d) For the fourth or any subsequent violation within a 12-month period, impose an administrative fine of $1,000.

2. Except as otherwise provided in subsection 3, if an insurer or third-party administrator makes a payment of benefits to an injured employee that is less than the amount to which the injured employee was entitled pursuant to chapters 616A to 617, inclusive, of NRS or the regulations adopted pursuant thereto, the administrator will:

(a) For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

(b) For the second violation within a 12-month period, impose an administrative fine of at least $100.

(c) For the third violation within a 12-month period, impose an administrative fine of at least $250.

(d) For the fourth or any subsequent violation within a 12-month period, impose an administrative fine of at least $500.

3. The administrator will not impose the penalties prescribed in subsection 2 unless the deficiency in the payment of benefits is more than 1 percent of the total amount which was owed to the injured employee pursuant to chapters 616A to 617, inclusive, of NRS or the regulations adopted pursuant thereto.

(Added to NAC by Div. of Industrial Relations by R007-97, eff. 12-10-97; A by R105-00, 1-18-2001, eff. 3-1-2001)]

~~[NAC 616D.416 Failure to comply or untimely compliance with requirements regarding scheduling of rating evaluation of injured employee and compensation for permanent partial disability. (NRS 616A.400, 616D.120) If an insurer or third-party administrator fails to comply or complies in an untimely manner with the provisions of NRS 616C.490 or NAC 616C.103, the administrator will:~~

~~1. For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.~~

~~2. For the second violation within a 12-month period, impose an administrative fine of at least $250.~~

~~3. For the third violation within a 12-month period, impose an administrative fine of at least $500.~~

~~4. For the fourth violation within a 12-month period, impose an administrative fine of at least $750.~~

~~5. For the fifth or any subsequent violation within a 12-month period, impose an administrative fine of $1,000.~~

~~(Added to NAC by Div. of Industrial Relations by R007-97, eff. 12-10-97; A by R105-00, 1-18-2001, eff. 3-1-2001)]~~

~~[NAC 616D.418 Failure to comply or untimely compliance with requirements for submission and approval or denial of plan for program of vocational rehabilitation. (NRS 616A.400, 616D.120) If an insurer, third-party administrator, or treating or examining physician or chiropractor fails to comply or complies in an untimely manner with the provisions of NAC 616C.558, the administrator will:~~

~~1. For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.~~

~~2. For the second violation within a 12-month period, impose an administrative fine of at least $250.~~

~~3. For the third violation within a 12-month period, impose an administrative fine of at least $500.~~

~~4. For the fourth violation within a 12-month period, impose an administrative fine of at least $750.~~

~~5. For the fifth or any subsequent violation within a 12-month period, impose an administrative fine of $1,000.~~

~~(Added to NAC by Div. of Industrial Relations by R007-97, eff. 12-10-97; A by R105-00, 1-18-2001, eff. 3-1-2001)]~~

~~[NAC 616D.420 Failure to comply or untimely compliance with requirements regarding mailing of report of rating evaluation of permanent partial disability of injured employee. (NRS 616A.400, 616D.120) If a rating physician or chiropractor fails to comply or complies in an untimely manner with the provisions of NAC 616C.212, the administrator will:~~

~~1. For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.~~

~~2. For the second violation within a 12-month period, impose an administrative fine of at least $250.~~

~~3. For the third violation within a 12-month period, impose an administrative fine of at least $500.~~

4. For the fourth violation within a 12-month period, impose an administrative fine of at least $750.

5. For the fifth or any subsequent violation within a 12-month period, impose an administrative fine of $1,000.

(Added to NAC by Div. of Industrial Relations by R007-97, eff. 12-10-97; A by R105-00, 1-18-2001, eff. 3-1-2001)]

[NAC 616D.422 Failure to pay, untimely payment of or underpayment of health care provider. (NRS 616A.400, 616D.120) If an insurer, third-party administrator or employer fails to comply or complies in an untimely manner with any provision of chapter 616A, 616B, 616C, 616D or 617 of NRS or a regulation adopted pursuant thereto that requires the insurer, third-party administrator or employer to make a payment to a provider of health care, the administrator will:

1. For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

2. For the second violation within a 12-month period, impose an administrative fine of at least $100.

3. For the third violation within a 12-month period, impose an administrative fine of at least $250.

4. For the fourth or any subsequent violation within a 12-month period, impose an administrative fine of at least $500.

(Added to NAC by Div. of Industrial Relations by R007-97, eff. 12-10-97; A by R105-00, 1-18-2001, eff. 3-1-2001)]

[NAC 616D.424 Failure to ensure or untimely ensuring that vocational rehabilitation counselor complies with certain provisions. (NRS 616A.400, 616D.120) If an insurer or third-party administrator fails to comply or complies in an untimely manner with the provisions of NAC 616C.555, the administrator will:

1. For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

2. For the second violation within a 12-month period, impose an administrative fine of at least $250.

3. For the third violation within a 12-month period, impose an administrative fine of at least $500.

4. For the fourth violation within a 12-month period, impose an administrative fine of at least $750.

5. For the fifth or any subsequent violation within a 12-month period, impose an administrative fine of $1,000.

(Added to NAC by Div. of Industrial Relations by R007-97, eff. 12-10-97; A by R105-00, 1-18-2001, eff. 3-1-2001)]

[NAC 616D.426 Failure to comply or untimely compliance with requirements regarding determination that assessment of injured employee is impractical or for delivery of assessment or report. (NRS 616A.400, 616D.120) If an insurer or third-party administrator fails to comply or complies in an untimely manner with the provisions of subsection 5 or 6 of NRS 616C.550, the administrator will:

1. For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

2. For the second violation within a 12-month period, impose an administrative fine of at least $250.

3. For the third violation within a 12-month period, impose an administrative fine of at least $500.

4. For the fourth violation within a 12-month period, impose an administrative fine of at least $750.

5. For the fifth or any subsequent violation within a 12-month period, impose an administrative fine of $1,000.

(Added to NAC by Div. of Industrial Relations by R007-97, eff. 12-10-97; A by R105-00, 1-18-2001, eff. 3-1-2001)]

[NAC 616D.428 Commencement of program of vocational rehabilitation before determining that injured employee is capable of safe participation. (NRS 616D.120) If an insurer or third-party administrator fails to comply with the provisions of subsection 5 of NRS 616C.555, the administrator will:

1. For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

2. For the second or subsequent violation within a 12-month period, impose an administrative fine of at least $250.

(Added to NAC by Div. of Industrial Relations by R007-97, eff. 12-10-97)]

[NAC 616D.430 Failure to execute agreement with employer before injured employee participates in program for on-the-job training. (NRS 616D.120) If an insurer or third-party administrator fails to comply with the provisions of subsection 2 of NRS 616C.570, the administrator will:

1. For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

2. For the second or subsequent violation within a 12-month period, impose an administrative fine of at least $100.

(Added to NAC by Div. of Industrial Relations by R007-97, eff. 12-10-97)]

[NAC 616D.432 Failure to pay or untimely payment of wages of injured employee who is participating in program for on-the-job training. (NRS 616A.400, 616D.120) If an insurer or third-party administrator fails to comply or complies in an untimely manner with the provisions of subsection 3 of NRS 616C.570, the administrator will:

1. For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

2. For the second violation within a 12-month period, impose an administrative fine of at least $250.

3. For the third violation within a 12-month period, impose an administrative fine of at least $500.

4. For the fourth violation within a 12-month period, impose an administrative fine of $750.

5. For the fifth or any subsequent violation within a 12-month period, impose an administrative fine of $1,000.

(Added to NAC by Div. of Industrial Relations by R007-97, eff. 12-10-97; A by R105-00, 1-18-2001, eff. 3-1-2001)]

[NAC 616D.434 Failure to reimburse or untimely reimbursement of training employer for wages paid to injured employee. (NRS 616A.400, 616D.120) If an insurer or third-party administrator fails to comply or complies in an untimely manner with the provisions of subsection 4 of NRS 616C.570, the administrator will:

1. For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

2. For the second violation within a 12-month period, impose an administrative fine of at least $250.

3. For the third violation within a 12-month period, impose an administrative fine of at least $500.

4. For the fourth violation within a 12-month period, impose an administrative fine of at least $750.

5. For the fifth or any subsequent violation within a 12-month period, impose an administrative fine of $1,000.

(Added to NAC by Div. of Industrial Relations by R007-97, eff. 12-10-97; A by R105-00, 1-18-2001, eff. 3-1-2001)]

[NAC 616D.436 Failure to provide or untimely provision of information to administrator. (NRS 616A.400, 616D.120) If an insurer, organization for managed care, provider of health care, third-party administrator or employer fails to comply or complies in an untimely manner with the provisions of NRS 616A.475, 616B.006 or 616B.009 or NAC 616A.410, the administrator will:

1. For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

2. For the second violation within a 12-month period, impose an administrative fine of at least $250.

3. For the third violation within a 12-month period, impose an administrative fine of at least $500.

4. For the fourth violation within a 12-month period, impose an administrative fine of at least $750.

5. For the fifth or any subsequent violation within a 12-month period, impose an administrative fine of $1,000.

(Added to NAC by Div. of Industrial Relations by R007-97, eff. 12-10-97; A by R105-00, 1-18-2001, eff. 3-1-2001)]

[NAC 616D.438 Failure to comply with provisions regarding required posters and forms. (NRS 616A.400, 616D.120) If an insurer, organization for managed care, provider of health care, third-party administrator or employer fails to comply or complies in an untimely manner with the provisions of NAC 616A.480, the administrator will:

1. For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

2. For the second violation within a 12-month period, impose an administrative fine of at least $100.

3. For the third violation within a 12-month period, impose an administrative fine of at least $250.

4. For the fourth or any subsequent violation within a 12-month period, impose an administrative fine of at least $500.

(Added to NAC by Div. of Industrial Relations by R007-97, eff. 12-10-97; A by R105-00, 1-18-2001, eff. 3-1-2001)]

[NAC 616D.4381 Failure of employer to provide notice of election for coverage or withdrawal of election for coverage for excluded employees. (NRS 616A.400, 616D.120) If an employer fails to provide the notice required pursuant to NRS 616B.656 in the manner set forth in NAC 616B.800, the administrator will:

1. For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

2. For the second violation within a 12-month period, impose an administrative fine of at least $250.

3. For the third violation within a 12-month period, impose an administrative fine of at least $500.

4. For the fourth or any subsequent violation within a 12-month period, impose an administrative fine of $1,000.

(Added to NAC by Div. of Industrial Relations by R105-00, 1-18-2001, eff. 3-1-2001)]

[NAC 616D.4383 Failure of sole proprietor to provide notice of election for coverage or withdrawal of election for coverage. (NRS 616A.400, 616D.120) If a sole proprietor fails to provide the notice required pursuant to NRS 616B.659 in the manner set forth in NAC 616B.809, the administrator will:

1. For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

2. For the second violation within a 12-month period, impose an administrative fine of at least $250.

3. For the third violation within a 12-month period, impose an administrative fine of at least $500.

4. For the fourth or any subsequent violation within a 12-month period, impose an administrative fine of $1,000.

(Added to NAC by Div. of Industrial Relations by R105-00, 1-18-2001, eff. 3-1-2001)]

[NAC 616D.4385 Failure to provide or untimely provision of list of providers of health care to injured employee. (NRS 616A.400, 616D.120) If an employer, an insurer, a third-party administrator or an organization for managed care fails to comply or complies in an untimely manner with the provisions of NAC 616C.030, the administrator will:

1. For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

2. For the second violation within a 12-month period, impose an administrative fine of at least $250.

3. For the third violation within a 12-month period, impose an administrative fine of at least $500.

4. For the fourth violation within a 12-month period, impose an administrative fine of at least $750.

5. For the fifth or any subsequent violation within a 12-month period, impose an administrative fine of $1,000.

(Added to NAC by Div. of Industrial Relations by R105-00, 1-18-2001, eff. 3-1-2001)]

[NAC 616D.4387 Failure to comply with requirements regarding inclusion of certain information upon issuance of certificate of disability. (NRS 616A.400, 616D.120) If a physician or chiropractor fails to comply with the provisions of subsection 3 of NRS 616C.040 or subsection 7 of NRS 616C.475, the administrator will:

1. For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

2. For the second violation within a 12-month period, impose an administrative fine of at least $250.

3. For the third violation within a 12-month period, impose an administrative fine of at least $500.

4. For the fourth violation within a 12-month period, impose an administrative fine of at least $750.

5. For the fifth or any subsequent violation within a 12-month period, impose an administrative fine of $1000.

(Added to NAC by Div. of Industrial Relations by R105-00, 1-18-2001, eff. 3-1-2001)]

[NAC 616D.4389 Failure to comply or untimely compliance with requirements regarding claim received for employer to whom insurer does not provide coverage. (NRS 616A.400, 616D.120) If an insurer fails to comply or complies in an untimely manner with the provisions of NAC 616C.1156, the administrator will:

1. For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

2. For the second violation within a 12-month period, impose an administrative fine of at least $100.

3. For the third violation within a 12-month period, impose an administrative fine of at least $250.

4. For the fourth violation within a 12-month period, impose an administrative fine of at least $500.

5. For the fifth or any subsequent violation within a 12-month period, impose an administrative fine of $1,000.

(Added to NAC by Div. of Industrial Relations by R105-00, 1-18-2001, eff. 3-1-2001)]

[NAC 616D.439 Failure to provide or untimely provision by insurer or employer of copies of report of medical examination. (NRS 616A.400, 616D.120) If an insurer or employer fails to comply or complies in an untimely manner with the provisions of NAC 616C.1164, the administrator will:

1. For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

2. For the second violation within a 12-month period, impose an administrative fine of at least $100.

3. For the third violation within a 12-month period, impose an administrative fine of at least $250.

4. For the fourth or any subsequent violation within a 12-month period, impose an administrative fine of $500.

(Added to NAC by Div. of Industrial Relations by R105-00, 1-18-2001, eff. 3-1-2001)]

[NAC 616D.4391 Failure to comply or untimely compliance with requirements regarding notice of closure or reopening of claim. (NRS 616A.400, 616D.120) If a designated third-party administrator or insurer fails to comply or complies in an untimely manner with the provisions of NAC 616C.402, the administrator will:

1. For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

2. For the second violation within a 12-month period, impose an administrative fine of at least $100.

3. For the third violation within a 12-month period, impose an administrative fine of at least $250.

4. For the fourth violation within a 12-month period, impose an administrative fine of at least $500.

5. For the fifth or any subsequent violation within a 12-month period, impose an administrative fine of $1,000.

(Added to NAC by Div. of Industrial Relations by R105-00, 1-18-2001, eff. 3-1-2001)]

[NAC 616D.4393 Failure to comply or untimely compliance with requirements regarding compensation for loss of or permanent damage to tooth. (NRS 616A.400, 616D.120) If an insurer or a third-party administrator fails to comply or complies in an untimely manner with the provisions of NAC 616C.508, the administrator will:

1. For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

2. For the second violation within a 12-month period, impose an administrative fine of at least $250.

3. For the third violation within a 12-month period, impose an administrative fine of at least $500.

4. For the fourth violation within a 12-month period, impose an administrative fine of at least $750.

5. For the fifth or any subsequent violation within a 12-month period, impose an administrative fine of $1,000.

(Added to NAC by Div. of Industrial Relations by R105-00, 1-18-2001, eff. 3-1-2001)]

[NAC 616D.4395 Failure to comply with requirements regarding inspection, maintenance and location of files for claims and other records. (NRS 616A.400, 616D.120) If an insurer fails to comply with the provisions of NAC 616B.013, the administrator will:

1. For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

2. For the second violation within a 12-month period, impose an administrative fine of at least $250.

3. For the third violation within a 12-month period, impose an administrative fine of at least $500.

4. For the fourth violation within a 12-month period, impose an administrative fine of at least $750.

5. For the fifth or any subsequent violation within a 12-month period, impose an administrative fine of $1,000.

(Added to NAC by Div. of Industrial Relations by R105-00, 1-18-2001, eff. 3-1-2001)]

[NAC 616D.4397 Failure to comply or untimely compliance with requirements regarding payment of compensation to claimant. (NRS 616A.400, 616D.120) If an insurer or third-party administrator fails to comply or complies in an untimely manner with the provisions of NAC 616B.021, the administrator will:

1. For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

2. For the second violation within a 12-month period, impose an administrative fine of at least $250.

3. For the third violation within a 12-month period, impose an administrative fine of at least $500.

4. For the fourth violation within a 12-month period, impose an administrative fine of at least $750.

5. For the fifth or any subsequent violation within a 12-month period, impose an administrative fine of $1,000.

(Added to NAC by Div. of Industrial Relations by R105-00, 1-18-2001, eff. 3-1-2001)]

[NAC 616D.4399 Minor violations not covered by specific statute or regulation. (NRS 616A.400, 616D.120) If an insurer, third-party administrator, organization for managed care, employer or provider of health care commits a minor violation, as defined in NAC 616D.400, for which an administrative fine or other penalty is not otherwise provided by specific statute or regulation, the administrator will:

1. For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

2. For the second violation within a 12-month period, impose an administrative fine of at least $100.

3. For the third violation within a 12-month period, impose an administrative fine of at least $250.

4. For the fourth or any subsequent violation within a 12-month period, impose an administrative fine of at least $500.

(Added to NAC by Div. of Industrial Relations by R105-00, 1-18-2001, eff. 3-1-2001)]

[NAC 616D.440 Plan of corrective action: Authority of administrator; contents. (NRS 616A.400, 616D.120)

1. If the administrator issues a notice of correction to a person or imposes an administrative fine against a person pursuant to NAC 616D.400 to 616D.440, inclusive, the administrator may also require the person to submit to the administrator a plan of corrective action pursuant to paragraph (c) of subsection 2 of NRS 616D.120.

2. A plan of corrective action required by the administrator pursuant to subsection 1 must include a detailed description of the actions that the person who is submitting the plan will take to ensure that a subsequent violation does not occur.

Other Violations

[NAC 616D.443 Failure to comply or untimely compliance with provisions regarding completion or filing of claim for compensation for treatment of injured employee by treating physician or chiropractor. (

NAC 616D.443 Failure to comply or untimely compliance with provisions regarding completion or filing of claim for compensation for treatment of injured employee by treating physician or chiropractor. (NRS 616A.400, 616C.040)

1. If a treating physician or chiropractor fails to comply or complies in an untimely manner with the provisions of NRS 616C.040 or of a regulation adopted pursuant thereto that require the treating physician or chiropractor to complete a claim for compensation, the administrator will:

(a) For the first violation within a 12-month period, impose an administrative fine of at least $100.

(b) For the second violation within a 12-month period, impose an administrative fine of at least $250.

(c) For the third or any subsequent violation within a 12-month period, impose an administrative fine of at least $500.

2. If a treating physician or chiropractor fails to comply or complies in an untimely manner with the provisions of NRS 616C.040 or of a regulation adopted pursuant thereto that require the treating physician or chiropractor to file a claim for compensation, the administrator will:

(a) For the first violation within a 12-month period, impose an administrative fine of at least $250.

(b) For the second violation within a 12-month period, impose an administrative fine of at least $500.

(c) For the third violation within a 12-month period, impose an administrative fine of $750.

(d) For the fourth or any subsequent violation within a 12-month period, impose an administrative fine of $1,000.

(Added to NAC by Div. of Industrial Relations by R105-00, 1-18-2001, eff. 3-1-2001)]

[NAC 616D.444 Failure to comply or untimely compliance with provisions regarding completion or filing of report of industrial injury or occupational disease by employer. (NRS 616A.400, 616C.045)

1. If an employer fails to comply or complies in an untimely manner with the provisions of NRS 616C.045 or of a regulation adopted pursuant thereto that require the employer to complete a report of industrial injury or occupational disease, the administrator will:

(a) For the first violation within a 12-month period, impose an administrative fine of at least $100.

(b) For the second violation within a 12-month period, impose an administrative fine of at least $250.

(c) For the third or any subsequent violation within a 12-month period, impose an administrative fine of at least $500.

2. If an employer fails to comply or complies in an untimely manner with the provisions of NRS 616C.045 or of a regulation adopted pursuant thereto that require the employer to file a report of industrial injury or occupational disease, the administrator will:

(a) For the first violation within a 12-month period, impose an administrative fine of at least $250.

(b) For the second violation within a 12-month period, impose an administrative fine of at least $500.

(c) For the third violation within a 12-month period, impose an administrative fine of at least $750.

(d) For the fourth or any subsequent violation within a 12-month period, impose an administrative fine of $1,000.

(Added to NAC by Div. of Industrial Relations by R105-00, 1-18-2001, eff. 3-1-2001)]

[NAC 616D.445 Failure to comply with provisions regarding charges to insurer for approved treatment by provider of health care and liability of insurer for charges. (NRS 616A.400, 616C.135) If a provider of health care, an organization for managed care, an insurer or an employer fails to comply with the provisions of NRS 616C.135, the administrator will:

1. For the first violation within a 12-month period, impose an administrative fine of at least $100.

2. For the second or any subsequent violation within a 12-month period, impose an administrative fine of $250.

(Added to NAC by Div. of Industrial Relations by R105-00, 1-18-2001, eff. 3-1-2001)]

[NAC 616D.446 Failure to comply or untimely compliance with provisions regarding completion or filing of claim for compensation for treatment of employee who has incurred occupational disease by treating physician or chiropractor. (NRS 616A.400, 617.352)

1. If a treating physician or chiropractor fails to comply or complies in an untimely manner with the provisions of NRS 617.352 or of a regulation adopted pursuant thereto that require the treating physician or chiropractor to complete a claim for compensation, the administrator will:

(a) For the first violation within a 12-month period, impose an administrative fine of at least $100.

(b) For the second violation within a 12-month period, impose an administrative fine of at least $250.

(c) For the third or any subsequent violation within a 12-month period, impose an administrative fine of at least $500.

2. If a treating physician or chiropractor fails to comply or complies in an untimely manner with the provisions of NRS 617.352 or of a regulation adopted pursuant thereto that require the treating physician or chiropractor to file a claim for compensation, the administrator will:

~~(a) For the first violation within a 12-month period, impose an administrative fine of at least $250.~~

~~(b) For the second violation within a 12-month period, impose an administrative fine of at least $500.~~

~~(c) For the third violation within a 12-month period, impose an administrative fine of $750.~~

~~(d) For the fourth or any subsequent violation within a 12-month period, impose an administrative fine of $1,000.~~

~~(Added to NAC by Div. of Industrial Relations by R105-00, 1-18-2001, eff. 3-1-2001)~~**]**

[~~NAC 616D.447 Failure to comply or untimely compliance with provisions regarding completion or filing of report of industrial injury or occupational disease by employer. (NRS 616A.400, 617.354)~~

~~1. If an employer fails to comply or complies in an untimely manner with the provisions of NRS 617.354 or of a regulation adopted pursuant thereto that require the employer to complete an employer's report of industrial injury or occupational disease, the administrator will:~~

~~(a) For the first violation within a 12-month period, impose an administrative fine of at least $100.~~

~~(b) For the second violation within a 12-month period, impose an administrative fine of at least $250.~~

~~(c) For the third violation within a 12-month period, impose an administrative fine of at least $500.~~

~~2. If an employer fails to comply or complies in an untimely manner with the provisions of NRS 617.354 or of a regulation adopted pursuant thereto that require the employer to file an employer's report of industrial injury or occupational disease, the administrator will:~~

~~(a) For the first violation within a 12-month period, impose an administrative fine of at least $250.~~

~~(b) For the second violation within a 12-month period, impose an administrative fine of at least $500.~~

~~(c) For the third violation within a 12-month period, impose an administrative fine of at least $750.~~

~~(d) For the fourth or any subsequent violation within a 12-month period, impose an administrative fine of $1,000.~~

~~(Added to NAC by Div. of Industrial Relations by R105-00, 1-18-2001, eff. 3-1-2001)~~**]**