**PROPOSED REGULATION OF**

**THE DIVISION OF INDUSTRIAL RELATIONS OF**

**THE DEPARTMENT OF BUSINESS AND INDUSTRY**

**LCB File No. R121-97**

September 15, 1997

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

AUTHORITY: §§ 2-34, NRS 616C.260.

**Section 1.** Chapter 616C of NAC is hereby amended by adding thereto the provisions set forth as sections 2 to 6, inclusive, of this regulation.

**Sec. 2.** *As used in NAC 616C.120 to 616C.230, inclusive, unless the context otherwise requires, the words and terms defined in sections 3 and 4 of this regulation have the meanings ascribed to them in those sections.*

**Sec. 3.** *"Health care records" means any reports, notes, orders, photographs, X-rays or other recorded data or information which:*

*1. Is maintained in written, electronic or any other form;*

*2. Is received or produced by a provider of health care or any person employed by him; and*

*3. Contains information relating to the medical history, examination, diagnosis or treatment of an injured employee.*

**Sec. 4.** *"Provider of health care" means:*

*1. A physician licensed pursuant to chapter 630, 630A or 633 of NRS, certified physician's assistant, dentist, licensed nurse, dispensing optician, optometrist, practitioner of respiratory*

*care, licensed occupational therapist, licensed physical therapist, podiatric physician, licensed psychologist, licensed marriage and family therapist, chiropractor, doctor of Oriental medicine in any form, medical laboratory director or technician or pharmacist; or*

*2. A licensed hospital as the employer of any such person.*

**Sec. 5.** *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.* | *$150* |

*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.*

**Sec. 6.** *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.* | *$150* |

*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.*

**Sec. 7.** NAC 616C.120 is hereby amended to read as follows:

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

**Sec. 8.** NAC 616C.126 is hereby amended to read as follows:

616C.126 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 **[**medical and**]** health care services to injured employees.

**Sec. 9.** NAC 616C.129 is hereby amended to read as follows:

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

1. There may be only one treating physician or chiropractor in any one case at any one time, unless prior authorization is obtained from the insurer. *Physicians and chiropractors associated with the treating physician or chiropractor may treat the injured employee during the temporary absence of the treating physician or chiropractor. In all cases, the treating physician or chiropractor is directly responsible for the management of the health care of the injured employee.* Physicians in emergency rooms are not considered treating physicians within the meaning of NAC 616C.126 to 616C.144, inclusive.

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

3. Except as otherwise provided in this subsection, an injured employee or an insurer is not financially liable for the payment of the fees of a provider of health care who renders treatment to an injured employee for an industrial accident or occupational disease, knowing that the

injured employee is already under the care of another provider of health care. The insurer may be liable for the payment of the fees pursuant to this subsection if the insurer gives prior written approval for the treatment or good cause is shown for the treatment provided.

4. Any prescription or service ordered by a physician other than 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 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. **[**The following treatment programs must be authorized in advance by the insurer to verify the medical necessity for continued treatment:

(a)**]** A treatment program that consists of more than six visits, not including the initial evaluation, and is billed under codes **[**97010**]** *97001* to 97799, inclusive, *98925 to 98929, 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.

**[**(b) A treatment program that consists of more than six visits and is billed under acupuncture code NV00001, NV00002, or NV00003, not including the initial evaluation. A report of the status of an injured employee may be requested by an insurer at any point in the treatment process. The initial evaluation shall be deemed to be separate from the initial six treatments.**]**

**Sec. 10.** NAC 616C.132 is hereby amended to read as follows:

616C.132 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 **[**patient**]** *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.

**Sec. 11.** NAC 616C.135 is hereby amended to read as follows:

616C.135 1. When **[**a patient**]** *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.

**Sec. 12.** NAC 616C.138 is hereby amended to read as follows:

616C.138 1. Supplies and materials provided by the physician *or chiropractor* 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)," as contained in the "Relative Values for Physicians," as adopted pursuant to NAC 616C.188.

2. The insurer shall reimburse the physician *or chiropractor* for those supplies and materials at the physician's *or chiropractor's* cost **[**, including tax and reasonable and customary charges for freight.**]** *of the supplies and materials, excluding tax and charges for freight, plus 20 percent.* The physician *or chiropractor* 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 **[**a patient,**]** *an injured employee,* giving consideration to the origin of the subjective pain experienced or complained of by the **[**patient.**]** *injured employee.* The physician shall reexamine the **[**patient**]** *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, **[**whether it is administered as an injection or a medication,**]** 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.

**Sec. 13.** NAC 616C.141 is hereby amended to read as follows:

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

1. If a program of treatment that is required to be billed under codes **[**97010**]** *97001* to 97799, inclusive, *or 98925 to 98929, inclusive,* is administered to **[**a patient,**]** *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**]** *97001* to 97799, inclusive, *or 98925 to 98929, inclusive,* it must be in writing and include:

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

(b) The frequency of the treatments.

3. The maximum unit value allowed for bills that include any treatment identified under codes **[**97010**]** *97001* to 97799, inclusive, *or 98925 to 98929, inclusive,* billed individually or as an item included under a different code, is as follows:

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

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

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

| Code Modifier | Time Billed | Maximum Unit Value |
|---|---|---|
| -51C | All services provided per day | 8.4 units |

4. **[**A bill for any treatment identified under codes 97010 to 97799, inclusive, must be designated with the modifier-51A, -51B, or -51C, as applicable.

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

(a) The office visit;

(b) Evaluations and management services;

(c) Manipulations;

(d) Modalities;

(e) Mobilizations;

(f) Testing and measurements;

(g) Treatments;

(h) Procedures; and

(i) Extra time.

**[**6.**]** *5.* A provider of health care shall indicate on a bill presented to an insurer for any treatment each code contained in the "Relative Values for Physicians," as adopted pursuant to NAC 616C.188, or the "Relative Value Guide of the American Society of Anesthesiologists, Inc.," as adopted pursuant to NAC 616C.194, for any services. The codes must be indicated on each bill regardless of whether the provisions of NAC 616C.073 to 616C.336, inclusive, allow for the payment of such services, the payment is requested or the item is included under a different code.

**[**7.**]** *6.* 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 **[**patient,**]** *injured employee,* a comprehensive evaluation of the **[**patient's medical**]** *injured employee's health* condition or an evaluation of specific **[**medical**]** *health* problems of the **[**patient,**]** *injured employee,* any decision made concerning the treatment required by the **[**patient,**]** *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.

**[**8.**]** *7.* Code 99080 is hereby amended to read as follows:

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

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

**[**10.**]** *9.* 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) of subsection 3. 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.

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

**[**12.**]** *11.* Surgical assistant services provided by a licensed registered nurse, a **[**licensed**]** *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 **[**licensed**]** *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 **[**4**]** *3* of NAC 616C.203.

**Sec. 14.** NAC 616C.144 is hereby amended to read as follows:

616C.144 1. Billings for health care services must be submitted within 90 days after the date on which the services were rendered unless good cause is shown for a later billing. If good cause is shown, no billing for health care services may be submitted later than 6 months after the date on which the services were rendered.

2. The insurer or a representative of the insurer may require the submission of reports on the **[**patient's**]** *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.

3. The insurer must pay or deny payment of charges within 60 days after receipt of the first bill for those charges unless good cause is shown for a later payment or denial.

4. A bill that is submitted to an organization for managed care to revise the charges contained therein must be processed and delivered to the insurer within 30 days after the bill is received.

5. A bill that is submitted for reconsideration must be received by the insurer or a person authorized by the insurer to receive such a bill no later than 6 months after the date on which the services were rendered, unless good cause is shown.

6. The insurer shall:

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

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

**Sec. 15.** NAC 616C.150 is hereby amended to read as follows:

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

(a) His residence to the place where he receives **[**medical**]** *health* care; or

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

2. The insurer shall reimburse **[**a claimant**]** *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 **[**claimant**]** *injured employee* and the decision is upheld on appeal.

3. **[**A claimant**]** *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 **[**one**]** *1* week for **[**medical**]** *health* care or for attendance at the system's rehabilitation center 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 **[**claimant**]** *injured employee* for transportation, if the **[**claimant**]** *injured employee* consents to reimbursement at this rate and the expense is not greater than the amount to which the **[**claimant**]** *injured employee* would otherwise be entitled pursuant to paragraph (a).

5. Except as otherwise provided in subsection 6, if **[**a claimant**]** *an injured employee* must travel before 7:00 a.m. or between 11:30 a.m. and 1:30 p.m. or cannot return to his **[**home**]** *residence* or place of employment until after 7:00 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 **[**claimant**]** *injured employee* for meals, if the **[**claimant**]** *injured employee* consents to reimbursement at this rate and the expense is not greater than the amount to which the **[**claimant**]** *injured employee* would otherwise be entitled pursuant to paragraph (a).

6. The insurer shall reimburse **[**a claimant**]** *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 **[**claimant,**]** *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.

**Sec. 16.** NAC 616C.153 is hereby amended to read as follows:

616C.153 With the prior approval of the insurer, **[**a claimant**]** *an injured employee* may be reimbursed for air fare where the time, distance, convenience, or cost justifies his travel by air.

**Sec. 17.** NAC 616C.156 is hereby amended to read as follows:

616C.156 1. Unless otherwise directed or approved by the insurer or the **[**claimant's**]** *injured employee's* treating physician or chiropractor, **[**a claimant**]** *an injured employee* who chooses to obtain his **[**medical**]** *health care* services at a more distant place although adequate **[**medical**]** *health* care is available at a closer place may be reimbursed under NAC 616C.150 only for mileage to the closer place.

2. If **[**a person**]** *an injured employee* moves outside this state or to a new location within this state for his own convenience after becoming **[**a claimant,**]** *an injured employee,* the maximum mileage for one direction for which he may be reimbursed is the mileage allowable before the move or 40 miles, whichever is greater.

3. No reimbursement will be allowed for a person traveling with **[**a claimant**]** *an injured employee* unless there is a **[**medical**]** *health care* necessity that precludes the **[**claimant**]** *injured employee* from traveling alone. The **[**medical**]** *health care* necessity must be substantiated in writing by the **[**claimant's**]** *injured employee's* treating physician or chiropractor.

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

616C.170 As used in NAC 616C.170 to 616C.230, inclusive, *and sections 5 and 6 of this regulation,* unless the context otherwise requires **[**:

1. "Licensed occupational therapist" means a person who holds a license issued pursuant to chapter 640A of NRS.

2. "Report"**]** *,"report"* means an extended written narrative that meets the requirements of NAC 616C.185 and is presented to the insurer separately from any bill.

**Sec. 19.** NAC 616C.173 is hereby amended to read as follows:

616C.173 1. In defining the services for which fees will be allowed to **[**a class of medical practitioners,**]** *providers of health care,* the division will follow the principle that a **[**practitioner**]** *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 **[**a patient.**]** *an injured employee.*

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

3. The regulations of the applicable professional licensing board which establishes the principles of ethics for each respective provider of **[**medical**]** *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 **[**a particular class of medical practitioners**]** *providers of health care* are allowable.

**Sec. 20.** NAC 616C.176 is hereby amended to read as follows:

616C.176 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 **[**medical fee**]** schedule *of reasonable fees and charges allowable for accident benefits* adopted for this state pursuant to **[**NAC 616C.073 to 616C.336, inclusive,**]** *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 **[**official medical fee schedule,**]** *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.

**Sec. 21.** NAC 616C.179 is hereby amended to read as follows:

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

(a) Treatment;

(b) Diagnostic testing; *or*

(c) Consultation , **[**; or

(d) A change of a treating physician or chiropractor,**]**

within 5 working days after receiving the *written* request. If a telephone number for a facsimile machine or telecopier is supplied by a provider of health care who has submitted such a request, the insurer shall use that number to transmit the authorization or denial of authorization. If the provider does not provide a telephone number for a facsimile machine or telecopier, the date of response shall be deemed to be the date that the response is mailed.

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

3. If the insurer subsequently denies a request for authorization submitted by a provider of health care for additional visits or treatments, it shall pay for the additional visits or treatments actually provided to the injured employee, up to the number of treatments for which payment is requested by the provider of health care, before the denial of authorization is received by the provider. If the provider of health care does not provide a telephone number for a facsimile machine or telecopier, denial of authorization shall be deemed to be received 3 days after the date on which it is mailed.

**Sec. 22.** NAC 616C.185 is hereby amended to read as follows:

616C.185 A report submitted pursuant to NAC 616C.170 to 616C.230, inclusive, must include:

1. The complete medical history of the **[**patient;**]** *injured employee;*

2. A description of the objective and subjective results of any evaluation or test conducted of the **[**patient;**]** *injured employee;*

3. A description of the established goals and plans for the treatment of the **[**patient;**]** *injured employee;*

4. A description of the condition of the **[**patient**]** *injured employee* at the time covered by the report; and

5. In the case of a report relating to a final or discharge evaluation, a statement of the **[**patient's**]** *injured employee's* prognosis.

**Sec. 23.** NAC 616C.188 is hereby amended to read as follows:

616C.188 1. The division adopts by reference the following sections of the **[**1995-1996 (95.2 update)**]** *1997 (Update 96.2)* edition of "Relative Values for Physicians," except as modified by NAC 616C.138 to 616C.218, inclusive:

(a) **[**Medicine;

(b) Surgery;**]** *Surgery/Anesthesia;*

**[**(c)**]** *(b)* Radiology;

**[**(d)**]** *(c)* Pathology; **[**and

(e)**]** *(d) Medicine;*

*(e) Evaluation and Management; and*

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

(1) Transportation services **[**(A0021-A0999);**]** *(A0000-A0999);*

(2) Medical and surgical supplies **[**(A4190-A4927);**]** *(A4000-A4999);*

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

(4) Administrative, miscellaneous, and investigational (A9000-A9999);

(5) Enteral and parenteral therapy **[**(B4034-B9999);**]** *(B4000-B9999);*

(6) Durable medical equipment (E0100-E1702);

(7) *Procedures/Professional services (G0001-G0025);*

*(8)* Drugs administered other than oral method (J0110-J7799);

**[**(8)**]** *(9) Chemotherapy drugs (J9000-J9999);*

*(10)* Orthotic procedures **[**(L0100-L4380); and

(9)**]** *(L0100-L9999);*

*(11)* Prosthetic procedures (L5000-L9999) **[**.**]** *;*

*(12) Laboratory tests (P0000-P9999);*

*(13) Vision services (V0000-V2799);*

*(14) Hearing Services (V5000-V5299); and*

*(15) Speech-Language pathology services (V5300-V5399).*

2. A copy of **[**this publication**]** *"Relative Values for Physicians," as adopted pursuant to subsection 1,* may be purchased from **[**McGraw-Hill Health Management Group, 1221 Avenue of the Americas, 41st Floor, New York, New York 10020,**]** *St. Anthony Publishing, Inc., P. O. Box 96561, Washington, DC 20090, (800) 632-0123,* at the cost of **[**$249.**]** *$269.*

**Sec. 24.** NAC 616C.191 is hereby amended to read as follows:

616C.191 1. The values contained in the **[**official medical fee**]** schedule *of reasonable fees and charges allowable for accident benefits* adopted for this state pursuant to **[**NAC 616C.073 to 616C.336, inclusive,**]** *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 | **[**$20.94**]** *$20.69* |
| 80000-89999 | Pathology | **[**13.89**]** *14.30* |

| | | |
|---|---|---|
| 90000-99999 | Medicine | **[**5.97**]** *6.00* |
| 10000-69999 | Surgery | **[**109.62**]** *117.57* |
| 92980-93562 | Surgery/Cardiovascular | **[**109.62**]** *117.57* |

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. **[**Charges**]** *Payments* must not exceed the fees established **[**:

(a) By the official medical fee**]** *in the* schedule *of reasonable fees and charges allowable for accident benefits* adopted pursuant to **[**NAC 616C.073 to 616C.336, inclusive,**]** *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 . **[**; or

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

3. Physicians and chiropractors**]**

*3. Providers of health care* shall use the procedure code numbers and unit values from the "Relative Values for Physicians," as adopted pursuant to NAC 616C.188, to bill for services performed which are within the scope of their licenses. **[**Payment must be made at the same rate whether the service is performed by a physician or by a chiropractor.**]**

**Sec. 25.** NAC 616C.194 is hereby amended to read as follows:

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

1. The division adopts by reference the "Relative Value Guide of the American Society of Anesthesiologists, Inc.," copyright **[**1996,**]** *1997,* except as otherwise specifically provided in NAC 616C.182 to 616C.218, inclusive. A copy of this publication may be purchased from the

American Society of Anesthesiologists, **[**515 Busse Highway,**]** *520 N. Northwest Highway,* Park Ridge, Illinois **[**60068,**]** *60068-2573,* for the price of $10.

2. Except as otherwise provided in this subsection, an anesthesiologist shall use the codes that are stated in the guide for each procedure which he bills and submits to an insurer. If a code for a procedure performed by an anesthesiologist is not provided in the guide, the anesthesiologist shall use the code provided for that procedure in the "Relative Values for Physicians," as adopted pursuant to NAC 616C.188. 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 | **[**$49.20**]** *$51.54* |

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

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

**Sec. 26.** NAC 616C.197 is hereby amended to read as follows:

616C.197 1. **[**The following procedures have the values assigned to them 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 | Maximum Allowable Charge |
|---|---|---|
| NV29870 | Arthroscopy | $595.10 |
| | Bunionectomy: | |
| NV28291 | Unilateral | 338.13 |
| NV28292 | Bilateral | 568.05 |
| NV64721 | Carpal tunnel release | 497.72 |
| | Debridement: | |
| NV11000 | Not more than 10 percent of the surface of the body | 497.72 |
| NV11001 | Each additional 10 percent of the surface of the body | 54.10 |
| NV 64999 | Facility fee for the management of pain and nerve blocks | 265.00 |
| NV65205 | Foreign body removal | 568.05 |
| NV25111 | Ganglion cyst removal | 357.06 |
| NV20670 | Hardware removal | 654.61 |
| NV49505 | Hernia Repair | 714.12 |
| NV49555 | Hernia repair that is recurrent | 595.10 |
| | Manipulation Joints: | |
| NV27570 | With cast | 654.61 |
| NV27502 | Without cast | 568.05 |
| NV27220 | Reduction closed any extremity | 568.05 |

| | | |
|---|---|---|
| NV27224 | Reduction open any extremity | 568.05 |
| NV26055 | Release trigger finger | 416.57 |
| NV11750 | Removal of nail, finger, or toe | 324.60 |
| NV26540 | Repair ligament | 568.05 |
| NV69955 | Repair nerve | 568.05 |
| NV23420 | Repair rotator cuff | 654.61 |
| NV26500 | Repair tendon | 568.05 |
| | Scar revision: | |
| NV14000 | Ten square centimeters or less | 573.46 |
| NV14001 | More than 10 square centimeters, but less than 30.1 square centimeters | 654.61 |
| NV14300 | More than 30 square centimeters | 743.88 |
| NV45955 | Sigmoidoscopy, rigid or flexible | 238.04 |
| NV15000 | Skin graft | 743.88 |
| NV27626 | Tenosynovectomy | 476.08**]** |

*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 (HCFA).*

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

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

*3. A copy of the eligible codes and payment groups adopted pursuant to subsection 1 is available, free of charge, from the Division of Industrial Relations, Industrial Insurance Regulation Section:*

*(a) At 400 W. King Street, Suite 400, Carson City, NV 89710, (702) 687-3033; or*

*(b) At 2500 W. Washington, Suite 102, Las Vegas, NV 89106, (702) 486-5001.*

*4.* 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.

**[**3.**]** *5.* 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 **[**10 percent.

4.**]** *20 percent.*

*6.* 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 **[**, and the insurer shall submit a payment for the surgery,**]** using modifier-51 that is contained in the "Relative Values for Physicians," as adopted pursuant to NAC 616C.188.

**[**5.**]** *7.* 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 **[**4**]** *3* of NAC 616C.203 and the code NVH0009 must be used.

**Sec. 27.** NAC 616C.200 is hereby amended to read as follows:

616C.200 Each insurer shall use the following codes for services performed by an acupuncturist:

| Code | Procedure | **[**Charge**]** *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 |

**Sec. 28.** NAC 616C.203 is hereby amended to read as follows:

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

| Code | Procedure | **[**Charge**]** *Maximum Allowable Payment* |
|---|---|---|
| NV00100 | Emergency Room | **[**$32.98**]** *$33.96* |

2. If **[**a patient is admitted to the hospital within 24 hours after he has received emergency treatment at that hospital, the fees and charges for the visit to the emergency room must be included in the maximum allowable per diem rate.

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

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

| Code | Procedure | **[**Charge**]** *Maximum Allowable Payment* |
|---|---|---|

| | | |
|---|---|---|
| NV00200 | Intensive Care | **[**$1,758.79**]** *$1,811.20* |
| NV00400 | Cardiac Care | **[**1,615.05**]** *1,663.18* |
| NV00500 | Medical-Surgical Care | **[**1,069.35b**]** *1,101.22* |
| NV00900 | Care for Burns | **[**1,615.05**]** *1,663.18* |

**[**5.**]** *4.* The insurer shall pay:

(a) The per diem rate multiplied by the number of days the **[**patient**]** *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.

**[**6.**]** *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 **[**physician.

7.**]** *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.

**[**8.**]** *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 **[**10 percent.

9.**]** *20 percent.*

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

| Code | Procedure | [Charge] *Maximum Allowable Payment* |
|---|---|---|
| NV00410 | Open Heart Surgery | [$15,502.46] *$15,964.43* |

[10.] *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 [30 percent.

11.] *40 percent.*

*10.* The treating physician shall order all preoperative laboratory and pathology tests and any other diagnostic tests to be performed on the [patient] *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.

[12.] *11.* The following per diem rate is the maximum allowable [charge] *payment* for a skilled nursing care facility:

| Code | Procedure | [Charge] *Maximum Allowable Payment* |
|---|---|---|
| NV00550 | Skilled Nursing Care Facility | $1,026.44 |

**[**13.**]** *12.* A physician who admits **[**a patient**]** *an injured employee* for hospitalization is responsible for directing that the **[**patient**]** *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. **[**The physician may discharge the patient to:

(a) His home if the patient is to be under the care of a home health care organization which provides subacute care; or

(b) A skilled nursing care facility,

so long as the cost does not exceed the per diem rate for code NV00500 as set forth in subsection 4.

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

**Sec. 29.** NAC 616C.206 is hereby amended to read as follows:

616C.206 1. The following **[**are**]** *is* the maximum allowable **[**charges per visit**]** *payment* for home health care:

(a) For a visit which is not more than **[**4**]** *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 | **[**Charge**]** *Maximum Allowable Payment* |
|---|---|---|

| | | |
|---|---|---|
| NV90170 | Skilled home health care | **[**$34.25 per hour**]** *$68.00 per visit* |

(b) For a visit which is not more than **[**4**]** *2* hours and during which certain activities are performed by a certified **[**home health aide:**]** *nursing assistant:*

| Code | Procedure | **[**Charge**]** *Maximum Allowable Payment* |
|---|---|---|
| NV90130 | Certified **[**home health**]** *nursing assistant* care | **[**$16.70 per hour**]** *$27.70 per visit* |

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

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

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

3. Fees for each 24-hour period billed pursuant to this section must not exceed the per diem rate for code NV00500 as set forth in subsection **[**4**]** *3* of NAC 616C.203.

4. For the purposes of this section, "visit" includes the time it takes the provider of health care to travel to and from the home of the injured employee in order to provide health care services in the home and to complete any required documentation of the services provided.

**Sec. 30.** NAC 616C.209 is hereby amended to read as follows:

616C.209 1. Billing for all pharmaceuticals, except those provided to **[**a patient**]** *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 current nationally recognized pricing guide.

3. Each insurer shall notify the chief of the identity of the pricing guide he uses in determining the amount to be paid for pharmaceuticals. If the chief objects to a particular pricing guide he shall notify the insurer within 5 working days. Unless the insurer is advised that the guide is objectionable within 5 working days, he may continue using the guide.

4. The average wholesale price, 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.

**Sec. 31.** NAC 616C.212 is hereby amended to read as follows:

616C.212 1. The following are the maximum allowable **[**charges**]** *payments* for each rating of a permanent partial disability for each claim for workers' compensation:

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

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. A rating physician or chiropractor shall mail a report of an evaluation to the insurer within 15 working days after the evaluation is completed. If an addendum is requested by the

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

**Sec. 32.** NAC 616C.215 is hereby amended to read as follows:

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

(a) His usual charge for services provided;

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

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

(d) The codes for supplies and materials provided or administered to the injured employee that are set forth in the "Health Care Financing Administration, HCFA Common Procedures Coding System (HCPCS)," as contained in the "Relative Values for Physicians," as adopted pursuant to NAC 616C.188;

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

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

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

2. In addition to the information required by subsection 1, each physician or chiropractor shall include on his bill the ICD-9-CM codes identifying the parts of the body of the injured employee that were affected by the injury, as set forth in the "International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)," which is hereby adopted by reference. A copy of *Volumes 1, 2 and 3 of* this publication may be purchased from **[**Med-Index Publications, P.O. Box 27116, Salt Lake City, Utah 84127, at the cost of $59.95.**]** *:*

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

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

*(c) St. Anthony Publishing, Inc., P. O. Box 96561, Washington, DC 20090, (800) 632-0123, at a cost of $74.95.*

3. Any 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.

4. If any payment to a provider of health care requires adjustment because of the codes set forth in the bill submitted to the insurer, the insurer shall *process for payment any portion of the bill that is not in question and* return the bill to the provider and request additional documentation of the services, supplies, or materials provided.

**Sec. 33.** NAC 616C.224 is hereby amended to read as follows:

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

| Code | Procedure | **[**Charge**]** *Maximum Allowable Payment* |
|---|---|---|
| NV99060 | Testing and report | **[**$140.90**]** *$141.56* per hour |

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

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

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

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

**Sec. 34.** NAC 616C.227 is hereby amended to read as follows:

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

| Code | Procedure | **[**Charge**]** *Maximum Allowable Payment* |
|---|---|---|
| NV97545 | Work hardening program | **[**$49.60**]** *$49.83* per hour |
| NV97546 | Extra time | **[**49.60**]** *49.83* per hour |

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

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

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

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

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

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

**Sec. 35.** NAC 616C.230 is hereby amended to read as follows:

616C.230 1. The following procedure code and payment schedule must be used for any back school provided to an injured employee:

| Code | Procedure | **[**Charge**]** *Maximum Allowable Payment* |
|---|---|---|
| NV97115 | Back School | **[**$49.60**]** *$49.83* 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.

**Sec. 36.** NAC 616C.243 is hereby amended to read as follows:

616C.243 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 **[**the**]** *an* office of the industrial insurance regulation section **[**located in Carson City,**]** 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.

**Sec. 37.** NAC 616C.249 is hereby amended to read as follows:

616C.249 1. The division will calculate annual revisions to the schedule of reasonable 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 room 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 room 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. **[**In determining reasonable per diem allowances for hospitals, the division will consider data obtained from the Nevada Hospital Association which has been reviewed by the health division of the department of human resources.**]**

(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 either 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, Professional Medical Services, for All Urban Wage Earners and Clerical Workers) 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.

**Sec. 38.** NAC 616C.252 is hereby amended to read as follows:

616C.252 1. On or before **[**July 31**]** *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.

**Sec. 39.** This regulation becomes effective on December 1, 1997.