Fee Schedule FAQs – Nevada Workers' Compensation

REV 3.22.2022

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GENERAL

What is the most recent effective date?

The most recent effective date for the Nevada Medical Fee Schedule is March 1, 2022.

What is the fee schedule based on?

The Nevada Medical Fee Schedule is comprised of the following:

- Relative Values for Physicians
- Relative Value Guide of the American Society of Anesthesiologists
- Medicare's current reimbursement for HCPCS codes K and L for custom orthotics and prosthetics
- Outpatient Hospitals and ASC
- State specific codes and values for inpatient hospital charges

Where can the fee schedule rates be found?

The Nevada Medical Fee Schedule is available on line at:

http://dir.nv.gov/WCS/Medical_Providers/

Does the state adopt NCCI?

No, the State of Nevada does not adopt the National Correct Coding Edits.

Does the state allow payment greater than billed charge?

The medical fee schedule calculates payment at the lesser of the provider's billed amount and the fee schedule value.

Is balance billing allowed?

No, a medical provider cannot attempt to collect payment from the injured worker for medical treatment.

Statute NRS 616C.135 1. A provider of health care who accepts a patient as a referral for the treatment of an industrial injury or an occupational disease may not charge the patient for any treatment related to the industrial injury or occupational disease, but must charge the insurer. The provider of health care may charge the patient for any services that are not related to the employee's industrial injury or occupational disease.

Does the state have any state reporting requirements?

No, there are no state reporting requirements for Nevada.

Does the state have any EOR requirements?

Although the state does not require a specific form, there are specific data elements that must be present. The explanation of review (EOR) must include the amounts for services that are paid, reduced, disallowed and the reasons for the reduction or disallowance. The EOR must include notification to the provider of health care that within 60 days after receiving the notice of denial or reduction, they can submit a written request to the State of Nevada, Division of Industrial Relations, Workers' Compensation Section for a review of that action.

Does the state have any bill certification requirements?

No, the Division of Industrial Relations (DIR) does not have any bill certification requirements.

Does the state have any statute of limitations for submitting a medical bill?

Yes, NRS 616C.136 reflects the following:

Bills for health care services must be submitted within 90 days after the date on which the services were rendered unless good cause is shown for a later billing. In no event may an initial bill or request for reconsideration for health care services be submitted later than 12 months after the date on which the services were rendered unless claim acceptance is delayed beyond 12 months because of claim's litigation.

Does the state have any payment time limits?

Yes, NRS 616C.136 states "Except as otherwise provided in this section, an insurer shall pay or deny a bill for accident benefits received from a provider of health care within 45 calendar days after the insurer or their-party administrator receives the bill".

How are unlisted codes and/or "by report" codes to be paid?

When a practitioner bills unlisted codes, a report must be included that adequately describes the procedure/service and the necessity of the treatment. Claims administrators/payers shall pay "by report" services based on comparable procedures or analogous codes.

What should be done if the provider bills an incorrect code?

The guidelines within the fee schedule reflect the following instructions:

If a bill submitted to the insurer by a provider of health care reflects an incorrect code, then the insurer shall:

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

Does the state guidelines allow down-coding?

The State of Nevada does not allow down-coding. The carrier should process the charge as it would for an "incorrect code".

Does the state accept/recommend any usual and customary databases?

The State of Nevada does not regulate or recommended any specific usual and customary database.

What are the rules for out-of-state provider reimbursement?

NAC 616C.143 indicates prior authorization for non-emergency treatment should be obtained from the insurer. Prior authorization for treatment that is provided outside Nevada in cases of an emergency is not required.

Has the state adopted a medical treatment guideline?

No, the DIR has not adopted medical treatment guidelines.

ANESTHESIA

Reimbursement for anesthesia services is calculated as:

[Base Unit + Time Unit + Modifying Units] * CF = Reimbursement

Modifying units = physical status and qualifying circumstances.

Anesthesia modifiers:

Modifier	Description	Payment
AA	Anesthesia Services performed personally by the anesthesiologist	100%
28	Supervising anesthesiologist	25%
29	Nurse Anesthetist or certified physician's assistant	85%

The application is automated to calculate reimbursement for anesthesia services when the anesthesia code and modifier is entered into the system. In Core, anesthesia time is entered as minutes in the **Time** field. Anesthesia time is determined in 15-minutes intervals or any time fraction thereof.

Physical Status Modifiers:

Modifier	Description	Unit Value
P1	A normal healthy person	0
P2	A patient with mild systemic disease	0
P3	A patient with severe systemic disease	1
P4	A patient with severe systemic disease that is a constant threat to life	2
P5	A moribund patient who is not expected to survive without the operation	3
P6	A declared brain-dead patient whose organs are being removed for donor purposes	0

Qualifying Circumstances:

Code	Description	Unit Value
99100	Anesthesia for patient of extreme age: under one year and over seventy	1
99116	Anesthesia complicated by utilization of total body hypothermia	5
99135	A patient with severe systemic disease	5
99140	A patient with severe systemic disease that is a constant threat to life	2

SURGERY

Multiple Procedure Rule Discount

Multiple surgical procedures performed on the same day, by the same practitioners may be subject to multiple surgery reductions and are reimbursed 100% for the first procedure, and 50% for each subsequent procedure.

Multiple Endoscopic Procedures

Multiple endoscopic procedures are not addressed within the fee schedule. If billed, CORE is automated to apply the multiple procedure rule discount when applicable.

Assistant Surgery

Assistant surgery by a physician, licensed registered nurse, certified physician's assistant, or an operating room technician employed by a surgeon for surgical assistant payment is applied based on the modifier appended to the surgical procedure code as follows:

Modifier	Description	Payment
29	Registered Nurse, Physiscian Assistant, or Operating Room Technician	14%
80	Assistant Surgeon	20%
81	Minimum Assistant Surgeon	10%
82	Assistant Surgeon (when a qualified resident surgeon is not available)	20%

Bilateral Procedures

Bilateral procedures are not addressed with the fee schedule. If billed, CORE is automated to apply the multiple procedure rule discount when applicable.

Co-Surgery

Co-surgery procedures are not addressed within the Medical Fee Schedule.

Team Surgery

Team surgery procedures are not addressed within the Medical Fee Schedule.

RADIOLOGY

Where applicable, the fee schedule has separate rates for the whole component, technical (modifier –TC) and professional (modifier -26) component of radiology procedures.

LABORATORY AND PATHOLOGY

Where applicable, the fee schedule has separate rates for the whole component, technical component (modifier – TC) and professional component (modifier – 26) of pathology and laboratory tests.

MEDICINE

Physical Medicine

The fee schedule states "The maximum daily unit value allowed under codes 97001 to 97799 and 98925 to 98943, excluding 97545 and 97546, for those practitioners whose scope of license allows them to perform and bill for these services is 16 units.

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

Prior to 02/01/2017, the initial evaluation shall be deemed to be separate from the initial six treatments. An initial evaluation may be performed on the same day as the initial treatment and must be billed under codes 97001 or 97003.

Effective for dates of service beginning 2/01/2017 CPT codes 97161 – 97168 should be listed when billing for a physical or occupational evaluation.

Services provided by various certified/licensed health care practitioners must be billed using modifier 29 and reimbursed a percentage of the maximum allowable fee as follows:

Description	Payment
Certified chiropractor's assistant	**40%** of maximum allowable fee for chiropractors
Licensed physical therapist's assistant or licensed occupational therapists	**50%** of maximum allowable fee for occupational therapy assistant for licensed physical therapist

Nevada Specific Codes:

Code	Description
NV97115	PBack School per hour (not over 8 hours in duration).

Functional Capacity Evaluation Reimbursement

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

CORE is automated to calculate reimbursement in compliance with the above guidelines.

Nevada Specific Codes:

Code	Description
NV99060	Procedure testing and report.
NV99061	Failure of an injured employee to appear for an appointment.

EVALUATION AND MANAGEMENT

E/M services may be payable to physicians, chiropractors, physician assistants, nurse practitioners and clinical nurse specialists. E/M services are not payable to physical and occupational therapists.

Services provided by non-physician providers are paid at 85% of the fee schedule value when modifier -29 is appended to the E/M code.

AMBULANCE

Ambulance services are not addressed within the Nevada Medical Fee Schedule. CORE will consider these services as "by-report".

DENTAL

The State of Nevada has assigned fee schedule values to a limited number of dental services. All remaining dental services that are not listed will be reimbursed as "by-report".

DURABLE MEDICAL EQUIPMENT/PROSTHETICS, ORTHOTICS, SUPPLIES (DMEPOS)

DMEPOS are payable at the provider's cost of the supplies and materials, excluding tax and charges for freight, plus **20%**, unless there is a written agreement between the insurer and provider for a lesser reimbursement.

INPATIENT HOSPITAL (ACUTE-CARE)

Diagnostic services, treatment and supplies provided by the emergency department are reimbursed in addition to emergency department facility reimbursement.

Supplies are separately reimbursed at the providers' actual cost, excluding tax and charges for freight, plus 20 percent, unless there is a written agreement between the insurer and provider for a lower reimbursement. Copies of the manufacturers' or suppliers' invoices from the provider are required for reimbursement.

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

Trauma

State specific code **NV00150,** Trauma Activation, is to be used when billing and may be paid under the following fee schedule conditions:

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

CORE is automated to identify designated trauma hospitals in Nevada. If the user does not bill utilizing a valid trauma hospital, CORE will disallow with reason code S1. Reason code S1 states: The procedure has been disallowed as this hospital does not normally provide the service.

Data Entry Requirements

The following guidelines identify the key fields required for accurate inpatient pricing in CORE:

On the **Provider Record** screen:

- **Prov Type** - 10

On the **Data Entry** screen:

- **UB04** - Y

On the **Additional Info** screen:

- **Date Admit** - Enter the Admission Date (FL12 on the UB-04)
- **Bill Type** - Enter the Type of Bill (FL4 on the UB-04)
- **B.O.S. Date** - Enter the Beginning date (FL6 on the UB-04)
- **E.O.S. Date** - Enter the Ending date (FL6 on the UB-04)
- **Facility Type** - A (Acute Care Facility) or O (use for all other facility types)
- **Billed DRG** - Enter the DRG (FL71 on the UB-04)

On the **DRG Header Input** screen:

- **DRG Y/N** - Y (Acute Care Facility) or N (use for CAH, Rehab, Psych, LTCH)
- **Pat Status** - Enter the Discharge Status (FL17 on the UB-04)
- **Medicare ID** - Enter the facility's Medicare Provider Number (MPN)
- **DRG Code** - Auto-populates per the DRG Grouper output. User may manually override.

When entering state specific codes, CORE is automated to calculate reimbursement at the lesser of the billed charges or the per diem values listed in the fee schedule and assigns RC ZE (Your billing has been paid in accordance with the Inpatient Hospital Fee Schedule) for explanation.

Nevada Specific Codes:

Code	Description
NV00200	Medical-Surgical/Cardiac/Neuro/Burn/Other Intensive Care.
NV00450	Step-Down/Intermediate Care.
NV00500	Medical-Surgical Care.
NV00550	Skilled Nursing Care/Facility.
NV00600	Psychiatric Care.
NV00650	Observation Care (Greater than 23 hours)
NV00675	Observation Care (Up to 23 hours or fraction thereof)
NV00700	Rehabilitation Care

OUTPATIENT HOSPITAL & AMBULATORY SURGERY CENTER

Outpatient surgical facility charges and ambulatory surgical center charges are to be reimbursed based on the fee schedule guidelines. CORE is automated to calculate reimbursement at the lesser of the billed amount or the ASC/OP Group value, not to exceed the per diem value of state specific code NV00500.

Reimbursement for prescription medications is calculated at the lesser of the billed amount or the average wholesale price plus a $12.24 dispensing fee.

CONTROLLED/COMPOUND MEDICATIONS

Chapter 239, Section 1, Statues of Nevada (2015) (Senate Bill 231, Section 1, 78th Session (2015)) addresses physician dispensed controlled substances:

Prior authorization is required for any controlled medication or specific subset of compounds. The prior authorization request must include the prescribing physician's or chiropractor's justification of the medical necessary for and efficacy of the compound instead of or in addition to the standard medication therapies. It is recommended that the insurer and provider mutually agree on the amount and reimbursement before the medication(s) is dispensed.

STATE SPECIFIC PROCEDURES & SERVICES

CORE is automated to calculate reimbursement for State Specific Procedures and Services in compliance with the fee schedule guidelines.

INDEPENDENT MEDICAL EXAMINATIONS (IME)

Nevada Specific Codes:

Code	Description
NV01000	Review records, testing, evaluation, and report.
NV01001	Failure of an injured employee to appear fox appointment.
NV01002	Addendum necessary to clarify original report.
NV01003	Addendum after review of additional medical records.
NV01004	Review of medical records and evaluation of more than 2 body parts for each body part in excess of.
NV01005	Organization of medical records in chronological order based on the date of service (per 50 pages).
NV01006	Review of records and report.
NV02001	Review of medical records (up to 50 pages), testing, evaluation and report.
NV02002	Review of each additional 100 pages of medical records (shall be prorated for increments less than 100 pages).
NV02003	Evaluation of more than 2 body parts, for each body part in excess of (use body part descriptions located under Permanent Partial Disability Reimbursement).
NV02004	Organization of medical records in chronological order based on date of service.
NV02000	Failure of an injured employee to appear for an appointment.

HOME HEALTH AGENCY

Nevada Specific Codes:

Description	Time Limits
NV90170 Skilled home health care	**Not more than 2 hours**
NV90130 Certified nursing assistant care	**Not more than 2 hours**
NV90180 Skilled home health care	**Not more than 2 hours**
NV90190 Certified nursing assistant care	**Not more than 2 hours**

TELEMEDICINE

Nevada Specific Codes:

Code	Description
NV00250 Skilled home health care	Telemedicine Originating Site fee