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

NEVADA MEDICAL FEE SCHEDULE
MAXIMUM ALLOWABLE PROVIDER PAYMENT
February 1, 2011 through January 31, 2012

Pursuant to **NRS 616C.260**, effective February 1, 2011, providers of health care who treat injured employees pursuant to Chapter 616C of NRS shall use the most recently published editions of, or updates of, the following publications for the billing of workers' compensation medical treatment: *Relative Values for Physicians*, *Relative Value Guides of the American Society of Anesthesiologists,* and the Center for Medicare and Medicaid Service**s** (CMS) 2007 list of ambulatory surgical codes and payment groups, and Medicare's current reimbursement for HCPCS codes K and L for custom orthotics and prosthetics. When identified in the Medical Fee Schedule, providers of health care will utilize Nevada Specific Codes for billing.

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

BILLING AND REIMBURSEMENT INFORMATION

PROVIDER REIMBURSEMENT
Provider Service Code Conversion Factor:

70000-79999 Radiology and Nuclear Medicine…………………….……….........$35.28
80000-89999 Pathology…………………………………………….…………...$20.92
90000-99999 General Medicine…………………………………..…..………… $9.15
10000-69999 Surgery…………………………………………...…………….$194.74
00000-99999 Anesthesiology……………………………………….………...$67.96

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

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

Surgical assistant services provided by a licensed registered nurse, a certified physician's assistant, or an operating room technician employed by a surgeon for surgical assistant services must be identified with the modifier "-29" and be reimbursed at 14 percent of the maximum allowable fee for the surgeon's services rendered. Fees for surgical assistant services performed by a licensed registered nurse, a certified physician's assistant or an operating room technician employed by the hospital or surgical facility must be included in the per diem rate pursuant to NV00500.

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

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

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

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

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

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

TRAUMA ACTIVATION FEE REIMBURSEMENT

NV00150 Trauma Activation Fee………………………..…………………………$3,080.00

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

HOSPITAL EMERGENCY DEPARTMENT FACILITY REIMBURSEMENT
Nevada Specific Codes:
NV00100 First hour for use of emergency facility………………………..…………$146.38
NV00101 Each additional hour or fraction thereof for use of emergency facility………$73.21

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

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

HOSPITAL REIMBURSEMENT

Nevada specific codes and payment:

NV00200 Medical-Surgical Intensive Care……………………………………..$2888.50
NV00400 Medical-Surgical Cardiac Care……………………….……..……… $2651.94
NV00500 Medical-Surgical Care………………………………..………..…… $1756.63
NV00900 Burn Care…………………………………………….…………… $2651.94
NV00600 Psychiatric Care……………………………………………...…… $1756.63
NV00700 Rehabilitation Care……………………………………..………… $1756.63
NV00550 Skilled Nursing Care Facility…………………………………….……. $1756.63

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

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

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

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

AMBULATORY SURGICAL CENTER (ASC) REIMBURSEMENT

Group 1 ……………………………………………..……………………….…..$704.48
Group 2 …………………………………………..…………………………….. $903.15
Group 3 …………………………………………..…………………………….. $1091.36
Group 4. ……………………………………………………….………………….. $1350.14
Group 5 ……………………………………….……………………………………$1436.42
Group 6 ……………………………………….……………………………………$1693.89
Group 7 ……………………………………….……………………………………$1756.63
Group 8 ……………………………………….……………………………………$1756.63
Group 9 ……………………………………….……………………………………$1756.63

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

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

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

PHARMACEUTICAL REIMBURSEMENT
An insurer shall reimburse all pharmaceuticals, except those provided to an injured employee occupying a bed in the hospital, at the average wholesale price plus an $9.15 dispensing fee, or the provider's usual and customary price, whichever is less, unless there is a written agreement between the insurer and provider for a lower reimbursement.

DURABLE MEDICAL EQUIPMENT (DME) REIMBURSEMENT
An insurer shall reimburse the provider of health care for those supplies and materials provided by a provider of health care at the provider's cost of the supplies and materials, excluding tax and charges for freight, plus 20 percent, unless there is a written agreement between the insurer and provider for a lower reimbursement.

CUSTOM ORTHOTIC AND PROSTHETIC REIMBURSEMENT
An insurer shall reimburse custom orthotics and prosthetics at 140% of Medicare allowable for Nevada, unless there is a written agreement between the insurer and provider for a lower reimbursement.

HOME HEALTH SERVICE REIMBURSEMENT
Nevada Specific Codes:
For a visit of not more than 2 hours and during which certain procedures are performed by a physical therapist, occupational therapist, speech therapist, skilled nurse, social worker or dietary nutritional counselor:

NV90170 Skilled home health care…………………………………………….....per visit $101.94

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

NV90130 Certified nursing assistant care…………………..……………………. per visit $49.67

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

NV90180 Skilled home health care……………………..…………………….....per hour $50.98
NV90190 Certified nursing assistant care………………………………………per hour $24.84

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

PERMANENT PARTIAL DISABILITY REIMBURSEMENT
Nevada Specific Codes:
NV01000 Review records, testing, evaluation, and report……………..………….. $673.12
NV01001 Failure of an injured employee to appear for appointment…….………...$224.80
NV01002 Addendum necessary to clarify original report…………….……………No charge
NV01003 Addendum after review of additional medical records……….……….$224.80
NV01004 Review of medical records and evaluation of more than 2 body parts
for each body part in excess of …………………..……………………..…...$224.80
NV01005 Organization of medical records in chronological order…………………$37.91
NV01006 Review of records and report…………………………………………..$335.89

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

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

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

BACK SCHOOL REIMBURSEMENT
Nevada Specific Code:
NV97115 Back School………………………………………..………………...per hr $74.50

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

FAILURE TO APPEAR FOR INDEPENDENT MEDICAL EVALUATION
Nevada Specific Code:
NV02000 Preparation when an injured employee fails to appear for an independent medical evaluation scheduled by an insurer……………………..…………..….$224.80

NV02000 may not be billed unless the injured employee fails to appear for the evaluation within 30 minutes after the scheduled appointment or cancels the appointment within 24 hours before the scheduled appointment.

FUNCTIONAL CAPACITY EVALUATION REIMBURSEMENT
Nevada Specific Code:
NV99060 Procedure, Testing and report……………………………………… per hr $211.73

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

FAILURE TO APPEAR FOR FUNCTIONAL CAPACITY EVALUATION
Nevada Specific Code:
NV99061 Preparation when an injured employee fails to appear for an evaluation of functional capacity performed for the injured employee………...……………………………. $224.80

NV99061 may not be billed unless the injured employee fails to appear for the evaluation within 30 minutes after the scheduled appointment or cancels the appointment within 24 hours before the scheduled appointment.

GENERAL INFORMATION
Billings for health care services must be submitted within 90 days after the date on which the services were rendered unless good cause is shown for a later billing. In no event may an initial billing for health care services be submitted later than 12 months after the date on which the services were rendered unless good cause is shown for a later billing.

Payment for medical service is reimbursed per the Nevada Medical Fee Schedule in effect at the time of the date of service.

Any physician or chiropractor who is called upon to render service in the case of an emergency or severe trauma as a result of an industrial injury may use whatever resources and techniques are necessary to cope with the situation. The treatment of injured employees in such situations is not restricted to physicians and chiropractors that are members of the panel of physicians and chiropractors established by the administrator pursuant to **NRS 616C.090** or have contracted with an insurer or an organization for managed care to provide health care services to injured employees.

A provider of health care shall, within 14 days after the date on which services are rendered or the injured employee is discharged from the hospital, unless good cause is shown, submit to an insurer, a third-party administrator or an organization for managed care, a report on the services rendered. 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.

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.

An insurer shall pay or deny the payment of charges pursuant to **NRS 616C.136** after receipt by the insurer or his agent of the first bill for those charges unless good cause is shown for a later payment or denial; or the insurer has returned the bill to the provider of health care.

The insurer must receive a bill that is submitted for reconsideration 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.

The insurer shall provide an explanation of benefits for each code billed that includes the amounts for services that are paid and disallowed. Indicate on each payment those services, which are being disallowed, and the reasons for the disallowance. The provider of health care whose bill has been denied or reduced **must be notified** that within 60 days after receiving the notice of denial or reduction, they can submit a written request to the Workers' Compensation Section for a review of that action.

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

(1) Process and provide or deny payment for that portion of the bill, if any, that 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) Approve or deny payment within 20 days after receipt, by the insurer or his agent, of the resubmittal of the bill with the additional information or documentation.

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 or more, the payment of benefit explanation may combine all the services for that day, utilizing code NV97001 as the payment descriptor of services, except for the initial evaluation. The initial evaluation needs to be identified with the appropriate CPT code in the payment of benefit explanation.

There is no established reimbursement for home intravenous therapy; therefore, it is recommended that the insurer and provider mutually agree to a reimbursement before the services are provided.

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

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