

Study of Industrial Insurance



*Legislative Counsel
Bureau*

*Bulletin No.
93-8*

January 1993

STUDY OF INDUSTRIAL INSURANCE

BULLETIN NO. 93-8

JANUARY 1993

TABLE OF CONTENTS

	<u>Page</u>
Section 125 Of Senate Bill 7 Of The 1991 Legislative Session (Chapter 723, <i>Statutes of Nevada 1991</i> , pages 2388-2441).....	iii
Summary Of Recommendations.....	v
Report To The 67th Session Of The Nevada Legislature By The Legislative Committee On Industrial Insurance...	1
I. Introduction.....	1
II. Overview Of Workers' Compensation.....	4
A. Background.....	4
B. Workers' Compensation In Nevada.....	5
III. Policy Issues.....	7
A. Financial Crisis.....	7
B. State Policy Options.....	9
IV. Discussion Of Committee Findings And Recommendations.....	11
A. Major Findings.....	11
B. Recommendations.....	14
1. Determination and Payment of Industrial Insurance Claims.....	15
2. Medical Care, Compensation and Other Benefits to Injured Workers.....	22
3. Fraud in Workers' Compensation.....	28
4. The State Industrial Insurance System's Organization and Procedures.....	29
5. Employer Options for Industrial Insurance Coverage.....	30
6. Administration of Nevada's Industrial Insurance Laws.....	31

	<u>Page</u>
7. Industrial Insurance Classifications, Rates and Funds.....	31
8. Hearings and Appeals of Contested Claims.....	33
9. Occupational Safety and Health.....	35
10. Legislative Oversight Concerning Industrial Insurance.....	36
V. Selected References.....	39
VI. Appendices.....	43
Appendix A Consensus Legislation.....	45
Appendix B Suggested Legislation.....	97

CHAPTER 723

AN ACT relating to employment; including in wages for the purposes of calculating unemployment benefits and benefits to be paid under industrial insurance certain income from tips reported by employees pursuant to federal law; prohibiting a local government from issuing a new business license under certain circumstances; requiring a person who administers the industrial insurance claims of a self-insured employer to be certified; providing for an assessment against employers who provide accident benefits for injured employees; eliminating the division of occupational safety and health of the department of industrial relations; creating new divisions within the department; requiring the periodic auditing of certain industrial insurers; increasing fines for certain violations; establishing a legislative committee on industrial insurance to conduct an interim study of industrial insurance laws; making various changes relating to rights, duties and procedures relating to industrial insurance; providing penalties; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE
AND ASSEMBLY, DO ENACT AS FOLLOWS:

Sec. 125. 1. There is hereby established a legislative committee on industrial insurance consisting of four members of the senate, appointed by the senate majority leader from the members of the senate standing committee on commerce and labor, and four members of the assembly, appointed by the speaker of the assembly from the members of the assembly standing committee on labor and management.

2. The members of the committee shall select the chairman and vice chairman of the committee from among their members.

3. Any member of the committee who does not return to the legislature may continue to serve until the completion of the committee's report.

4. Any vacancy on the committee must be filled by the authority entitled to appoint the member whose position is vacant. The member appointed to fill the vacancy must have the same general qualifications as his predecessor.

5. The members of the committee may meet no more than eight times during the 1991-92 biennium at the times and places and in the manner specified by a call of the chairman. Meetings may be held in person or by telephone conference or video telecast. The director of the legislative counsel bureau or a person he has designated shall act as the nonvoting recording secretary. Five members of the committee constitute a quorum, and a quorum may exercise all the powers conferred on the committee.

6. Except during a special session of the legislature, members of the committee are entitled to receive the compensation provided for a majority of the members of the legislature during the first 60 days of the preceding regular session for each day or portion of a day during which he attends a meeting of the committee or is otherwise engaged in the business of the committee plus the per diem allowance provided for state officers and employees generally and the travel expenses provided pursuant to NRS 218.2207.

7. The salaries and expenses of the members of the committee and any other expenses incurred by the committee in carrying out its duties must be paid from the fund for workers' compensation and safety. The expenses of the committee must be reported to the legislative commission and the state industrial insurance system. The system shall forward the report to each employer insured by it.

8. The committee may:

(a) Review and evaluate the current laws of this state concerning industrial insurance.

(b) Review and evaluate the implementation of the laws concerning industrial insurance passed by the 66th session of the legislature.

(c) Prepare a report concerning its review and evaluation of those laws.

(d) Submit the report to the governor and the legislative commission before the convening of the 67th session of the legislature.

9. Any regulation proposed to be adopted as a permanent regulation during the 1991-92 biennium pursuant to authority granted by the provisions of chapter 616 of NRS must be submitted to the committee for its review.

SUMMARY OF RECOMMENDATIONS

The Legislative Committee on Industrial Insurance (S.B. 7) recommends that the 67th Session of the Nevada Legislature:

DETERMINATION AND PAYMENT OF INDUSTRIAL INSURANCE CLAIMS

Determination of Benefits

1. Provide, by statute, that preexisting, nonindustrial conditions are not properly part of the industrial disability unless the incident at work which aggravated the preexisting condition is the primary cause of the resulting disability. Furthermore, injuries suffered after an industrial injury shall be compensable only if the original industrial accident was the primary cause of the subsequent nonindustrial disability.
2. Provide, by statute, for a method for minor injuries to be recorded by the employer without reporting to the insurer. The Division of Industrial Insurance Regulation of the Department of Industrial Relations should be required to audit periodically the employer records of such injuries. (BDR 53-1154)
3. Streamline or eliminate, by statutory provision, the procedures used for injuries involving neither lost-time nor medical claims. (BDR 53-1154)
4. Require, by statute, a physician or chiropractor, not the injured worker, to establish that a late manifesting injury is actually part of the original claim. The relationship must be established by competent medical evidence.
5. Provide, by statute, clarification of the existing law on burden of proof on a claim, namely that the injured worker has the burden of proving his case by a preponderance of the evidence. If the employee files a claim after employment has been terminated, there is a rebuttable presumption that the injury did not arise out of and in the course and scope of employment. The rebuttable presumption applies only to accidental injuries and does not apply to occupational diseases.

6. Amend *Nevada Revised Statutes* 616.340 to include:
 - a. The C-3 form ("Employer's Report of Industrial Injury") should be considered documentation of an accident or incident should medical care be needed;
 - b. The claim process should commence when an injured worker seeks such treatment; and
 - c. Documentation of an injury should originate from the treating physician.
7. Amend NRS 616.500 to clarify the terms and actions required by insurers regarding the C-4 form ("Employee's Claim for Compensation/Physician's Report of Initial Treatment"). Require an insurer to accept or deny compensation only on claims filed for compensation, and clarify that the insurer is not required to accept or deny compensation on "notice of injury" reports. In addition, include provisions that require a physician's report to give the insurer a medical basis upon which to make a decision to accept or deny for medical reasons.
8. Amend NRS 616.500 to clarify the distinction between the notice of injury and the claim of compensation as follows:
 - a. The notice of injury for which compensation is payable must be given by or on behalf of the injured employee within 30 days after the accident;
 - b. The notice of injury must be served by delivery of a copy of the notice or by mailing a copy to the insurer;
 - c. Failure to give the notice of injury within 30 days is a bar to any claim for compensation, unless excused by the insurer on the grounds provided in statute;
 - d. The failure to file a claim for compensation within 90 days after the date of the accident or, in the case of death, within 1 year after the date of death, is a bar to any claim for compensation; and
 - e. The insurer shall accept or deny responsibility for compensation within 30 days after the notice of injury is received.

9. Amend NRS 616.500 as proposed by the Employer Coalition of Southern Nevada. This amendment distinguishes the "notice" from the "claim" and places different requirements for each. It provides, among other things, that the claim for compensation consists of the written notice and a written physician's certificate from a physician or chiropractor setting forth the nature and origin of the employee's injury or disease, recommended treatment and probable duty status.
10. Amend NRS 616.500 as follows:
 - a. Require an injured worker to report all accidents and injuries to his employer within a certain time frame. Eliminate the need to give notice to the insurer within 30 days;
 - b. Require an employee to file a claim at his physician's office, and provide a notice on this form that the accident must be reported to the employer;
 - c. Require the treating physician to send a copy of the C-4 form to the injured worker's employer and insurer within 3 days; and
 - d. Require that an employer send a report to his administrator within 6 days of receipt of the C-4 form.
11. Amend the statutes to address the return of an injured employee to work for light or modified duty when he cannot perform his normal job. Require that a space should be provided on the C-4 form for the physician to indicate restrictions on the worker's activities.
12. Repeal NRS 616.537 because its provisions are covered in NRS 616.605. (BDR 53-1150)

Payment of Benefits

13. Amend NRS 616.025 to make it clear that motor vehicles are only to be provided in cases of the most serious injuries and that the insurer should have discretion to modify an existing vehicle or purchase an adequate used vehicle instead of a new one. Moreover, it must be made clear that the insurer will not be responsible for the operating costs and insurance on any such vehicle.

14. Authorize, by statute, insurers to recover inadvertent overpayment of benefits by deducting the amount of the overpayment from future benefits due the injured worker. Provide that the insurer may collect only on those overpayments discovered within 30 days of the inappropriate payment and only after a hearing before the hearing officer, unless the injured worker does not appeal the insurer's determination to deduct the overpayment. The deductions must be made in a reasonable manner that will not create undue hardship to the claimant.

Subrogation Recovery

15. Amend the subrogation statutes to allow an insurer to recover proceeds available to an injured worker pursuant to his employer's policy of motor vehicle insurance that provided coverage against an uninsured or underinsured motorist.
16. Prohibit, by statute, the circumvention of the subrogation laws. Prevent circumstances where an injured worker obtains one set of payments from the insurer and another set of payments for the same injuries and losses from the employer or another person.
17. Require, by statute, that an attorney for an injured worker or the third party insurance carrier must pay the workers' compensation insurer out of their own pocket if the workers' compensation insurer is not paid when the injured worker's attorney and the third party insurance carrier have made a settlement of the third party case. Prohibit the workers' compensation insurer from selling its lien to the third party insurance carrier unless the injured worker or his attorney fails to provide information to the workers' compensation insurer concerning the action against the responsible third party.
18. Amend NRS 616.560 as proposed by the Employer Coalition of Southern Nevada. This proposal addresses, among other things, insurer and employer concerns with the *Breen* decision by Nevada's Supreme Court. The *Breen* decision requires the insurer to reduce its lien against proceeds from any tort judgment received by the claimant according to a complicated formula imposed by the Supreme Court and based on the expenses of the claimant in pursuing the tort action.

19. Allow an injured worker of an uninsured employer to receive workers' compensation benefits and also sue the uninsured employer in tort instead of the present law which requires the worker to elect between these two remedies. This would result in more recoveries against uninsured employers. The State Industrial Insurance System would be subrogated to the tort judgment so there would not be a double recovery for the injured worker.

Reopening Claims

20. Amend NRS 616.545 to restrict reopening rights as follows:
 - a. An injured worker must wait 1 year after claim closure before applying to reopen unless the employee can show by clear and convincing medical evidence that there has been a change in his medical condition and that the industrial injury is the primary cause of that change;
 - b. Except in cases where the injured worker can show by clear and convincing medical evidence that the industrial injury is the primary cause of the worsened condition, the claim cannot be reopened until 1 year after a final determination on a prior request to reopen; and
 - c. If the claim did not result in lost time and a permanent partial disability award, the claim cannot be reopened unless the request to reopen is made within 1 year after closure. After expiration of 1 year, the insurer may dispose of records concerning claims where there was no lost time and permanent partial disability.

MEDICAL CARE, COMPENSATION AND OTHER BENEFITS TO INJURED WORKERS

Medical Care

21. Amend the statutes to remove the current statutory prohibition that prevents workers' compensation insurers from engaging in or contracting for managed or coordinated health care.

In addition, direct representatives of all of the affected parties (employees, employers of all sizes, insurers, third-party administrators, State workers' compensation agencies, claimants' attorneys, medical providers of all the licensed groups and other interested persons) to work together and report to the 1993 Legislature on or before February 5, 1993, with their proposal for a managed or coordinated health care program in workers' compensation. This report should include a detailed cost-benefit analysis of the various medical cost containment proposals which were presented during the course of the Senate Bill 7 Committee's interim study, including its work session. The analysis should examine, among other things, the use of health maintenance organizations; preferred provider organizations with an open panel, preferred provider organizations with a closed panel and deductibles for claimants who choose to use providers outside the panel; a schedule of fees and charges for accident benefits which cannot exceed the usual and customary charges utilized by most third-party insurers for payment of injuries and illnesses which are not related to work; a schedule of co-payments for questionable claims; 24-hour medical coverage and incentives for employers to provide employees with group health insurance coverage; access to care in the rural areas and elsewhere; and quality of care. Furthermore, the report should examine increased peer review, increased utilization review and increased case management without any prohibition on the injured worker's freedom of choice.

22. Prohibit, by statute, a physician or chiropractor from referring an injured worker to a health facility or service in which the physician, chiropractor or an immediate family member has a financial interest.
23. Amend NRS 616.412 to remove the statutory provision which prevents the Department of Industrial Relations from requesting medical payment information from insurers in a standardized format.
24. Amend NRS 616.188 to require that the Department of Industrial Relations adopt guidelines establishing standards of care for the provision of accident benefits to employees who have suffered industrial injuries or occupational diseases; remove the provision that requires the Department of Industrial Relations to adopt regulations for such standards of care. Clarify that any provisions relating to utilization review must be adopted as guidelines and not as regulations.

25. Eliminate the cumbersome preconditions to out-of-state treatment and allow the insurer to authorize it if the out-of-state medical provider agrees to accept Nevada's medical fee schedule.

Compensation Benefits

26. Require, by statute, that individuals who retire for reasons unrelated to their industrial injury and then reopen their claims are not entitled to temporary total disability benefits, permanent total disability benefits or rehabilitation.
27. Provide, by statute, that the amount employers pay for employee health insurance coverage must be excluded from the calculation of the injured worker's average monthly wage.
28. Amend the statutes to clarify that the average monthly wage on the date of injury will always be the wage rate used to calculate benefits under the claim.
29. Prohibit, by statute, the payment of specified compensation benefits to individuals who are convicted and incarcerated after the time of their injury. Codify the existing practice which is to deny rehabilitation payments to an injured worker who is incarcerated. Furthermore, provide that a person who has been convicted and incarcerated cannot receive compensation benefits for either temporary partial disability or temporary total disability.
30. Amend the statutes to clarify that an insurer may require an injured worker to have an annual examination in order to determine if a permanent and total disability still exists. Provide that the insurer must pay for the examination, and provide a penalty if the injured worker refuses to attend the examination.
31. Amend NRS 616.585 to change the time requirements for issuing a check for temporary total disability. Under the current provisions, the insurer is required to issue a check "not less than 6 working days before the beginning" of the next payment period. Thus, the law requires the insurer to pay temporary total disability benefits before they accrue. By amendment, require the insurer to make such payment just before the "end" of the period.
32. Provide, by statute, that the employer is relieved of the responsibility of maintaining a worker on compensation if a nonindustrial cause prevents the worker from recovering from his injury.

33. Prohibit, by statute, an insurer from advancing compensation to an injured worker before it is legally due him.
34. Amend the current law which requires the rating physician and the treating physician to jointly determine the permanent partial disability from a disease of the heart or lungs. Clarify that these conditions would be rated like any other rateable disability.
35. Amend the statutes to make it easier to return an injured worker to temporary light duty by making a distinction between temporary light duty and permanent light duty and allowing an employer to return an injured worker to light duty pending a permanent duty release. Furthermore, provide that any injured worker who is released to gainful employment under medical restrictions, related to the industrial injury which temporarily preclude employment at his regular occupation, may continue to receive temporary total disability payments only if the employer declines to offer temporary light duty employment consistent with his physical residuals.
36. Amend NRS 616.027 to clarify the year of data to be used for setting the maximum wage base for workers' compensation benefits. Require that the formula for determining the maximum average monthly wage make use of the State average weekly wage as provided by the Department of Industrial Relations on or before July 1 of each year, as most recently computed by the Employment Security Department for the chronological year immediately preceding the date of the injury or accident. In addition, correct the maximum wage base figures for the years 1972 through 1980, to reflect the following schedule:

<u>Effective Date</u>	<u>Average Monthly Wage for Prior Fiscal Year</u>
July 1, 1972	\$ 688.60
July 1, 1973	727.48
July 1, 1974	1,142.21
July 1, 1975	1,211.00
July 1, 1976	1,287.44
July 1, 1977	1,377.08
July 1, 1978	1,488.46
July 1, 1979	1,591.86
July 1, 1980	1,754.95

37. Amend NRS 616.615 to make it clear that the surviving spouse who receives the benefits is the employee's spouse at the time of his death. (BDR 53-1150)
38. Require, by statute, that the insurer's permanent partial disability rating must be accepted unless there has been a mathematical error in its computation or the rating physician has failed to rate a duly accepted body part.

Vocational Rehabilitation

39. Provide, by statute, that certain items and expenses are not available as vocational rehabilitation services. Amend the statutes to make it clear that the employer does not have to provide child care services for an injured worker. In addition, clarify that the employer does not have to provide a new vehicle for the claimant or repairs for the worker's existing motor vehicle.

FRAUD IN WORKERS' COMPENSATION

40. Amend the statutes to strengthen the State Industrial Insurance System's ability to combat fraud by claimants, employers and medical providers, as follows:
 - a. Prohibit an employer from declaring bankruptcy and reopening as a similar business to avoid paying the cost of his outstanding debt to the State Industrial Insurance System for workers' compensation coverage, and require the employer to pay his debt to the system;
 - b. Prohibit the Department of Industrial Relations from imposing a fine on an insurer for deducting amounts from the claimant's future benefits that it felt the claimant had obtained by fraud, unless the insurer had no reasonable basis for making the deductions. Direct the Department of Industrial Relations, the Hearings Division of the Department of Administration and the State Industrial Insurance System to work together in developing less prohibitive language for a bill draft request to be considered by the 1993 Legislature;

- c. Provide that a claimant is not entitled to temporary total disability benefits if he is engaged in an activity, even without pay, which is a job for which people are normally paid wages. Direct the Department of Industrial Relations, the Hearings Division and State Industrial Insurance System to work together in developing less prohibitive language for a bill draft request to be considered by the 1993 Legislature;
 - d. Require an injured worker to provide the insurer with complete information regarding his prior ratings or conditions. The claimant must fully disclose both nonindustrial conditions and conditions for which he previously received an award;
 - e. Amend NRS 616.640 to specify that it is a gross misdemeanor for an employer to deduct the cost of workers' compensation coverage from the wages of an employee. Furthermore, clarify that any such violation will be prosecuted by the district attorney in the county where the employer has the principal place of business;
 - f. Provide that it is a crime for an injured worker either to fail to disclose or to conceal a material fact from an insurer in order to obtain benefits;
 - g. Amend the statutes to impose more stringent requirements and higher penalties for fraudulent acts by medical providers; and
 - h. Authorize State Industrial Insurance System fraud investigators to use standard motor vehicle license plates. Current law requires these investigators to use license plates for exempt vehicles which identify them as State vehicles.
41. Create a special unit under the Attorney General to investigate and prosecute workers' compensation fraud and other types of fraud. (BDR 18-1149)
42. Require, by statute, that cases of fraud by a medical professional must be referred to the individual's professional licensing board for appropriate action. (BDR 18-1149)

THE STATE INDUSTRIAL INSURANCE SYSTEM'S
ORGANIZATION AND PROCEDURES

43. Change the Legislature's budget and financial oversight of the State Industrial Insurance System, except for any general fund money, by removing such oversight from the Senate standing Committee on Finance and the Assembly standing Committee on Ways and Means and placing it under the Senate standing Committee on Commerce and Labor and the Assembly standing Committee on Labor and Management or any ongoing statutory committee on industrial insurance.
44. Amend the current law which requires the State Industrial Insurance System to have complete claims processing facilities in its suboffices. Allow the system to maintain existing suboffices but specify that claims processing would be done in them only if practicable. (BDR 53-1150)
45. Authorize, by statute, the State Industrial Insurance System to borrow money either by pledging its current assets or by using revenue anticipation notes which would allow the system to repay the loans out of future premium collections. This proposal would allow the State Industrial Insurance System to expand its capacity to access the capital markets for improved cash management, and it would allow the system more flexibility in managing its assets.
46. Amend the statutes to clarify that issues which should have been brought to the attention of the hearings or appeals officer, or which were taken to hearings or appeals but determined to be adverse to the employer, cannot be relitigated in front of the Manager of the State Industrial Insurance System. Furthermore, provide that the Manager may designate someone to hold the Manager hearings. (BDR 53-1155)

EMPLOYER OPTIONS FOR INDUSTRIAL INSURANCE COVERAGE

47. Authorize, by statute, two or more employers to pool together to self-insure for workers' compensation. Provide that employers who are of the same industry or who have similar experience ratings may qualify as self-insured if their combined financial resources are sufficient to make certain the prompt payment of compensation. Adopt the provisions in the National Association of Insurance Commissioners' model acts regarding workers' compensation group self-insurance for private and public employers. (BDR 53-1156)

ADMINISTRATION OF NEVADA'S INDUSTRIAL INSURANCE LAWS

48. Amend NRS 616.647 to require that notice be given to health care providers and third-party administrators of alleged violations and the time and place of the hearing concerning such violations. Although NRS 616.647 allows the Administrator of the Division of Industrial Insurance Regulation to impose fines against health care providers and third-party administrators, there is no requirement for the Administrator to provide notice of violation and hearing to those persons. (BDR 53-1150)
49. Amend NRS 616.221 to add an exception for NRS 616.427 which governs appeals from decisions relating to the Subsequent Injury Fund. (BDR 53-1150)

INDUSTRIAL INSURANCE CLASSIFICATIONS, RATES AND FUNDS

50. Authorize, by statute, the Manager of the State Industrial Insurance System to set premium rates and revise classifications subject to review by the Commissioner of Insurance. In addition, clarify that the Commissioner has jurisdiction over both premium increases and changes in the risk classifications. Furthermore, clarify that the Manager's jurisdiction to hear appeals in such matters is limited only to appeals regarding whether the employer has been properly placed in one classification as opposed to another.
51. Amend the statutes to require that the Administrator of the Division of Industrial Insurance Regulation must accept or deny a subsequent injury claim within 90 days after the claim is filed, and require the division to reimburse the insurer within 60 days after the claim has been approved.

OR

Repeal the statutes relating to the Subsequent Injury Fund. (BDR 53-1151)

52. Amend NRS 616.437 to add an administrative fine which may be assessed against employers who fail to acquire and maintain industrial insurance or fail to pay premiums on time.

HEARINGS AND APPEALS OF CONTESTED CLAIMS

53. Amend NRS 616.5422 to extend the time for filing a notice of appeal from within 30 days after the date of the hearing officer's decision to within 60 days after the decision. Furthermore, amend the provision which requires an appeals officer to schedule a hearing within 45 days after he receives notice of appeal; increase the time for setting such a hearing to the previous statutory limit of 60 days.
54. Amend NRS 616.5416 to extend the time for granting a stay of the decision of a hearing officer from 15 days to 30 days. In addition, extend the time within which a hearing officer must render his decision from 7 days to 15 days.
55. Require, by statute, that hearing and appeals officers, when ordering new permanent partial disability ratings, must select rating physicians from a rotating list of physicians, unless the insurer and the injured worker agree otherwise.
56. Provide, by statute, that hearing officers are in the unclassified service of the State and serve at the pleasure of the Director of the Department of Administration.
57. Consider using mediation at the hearings level, and direct the Hearings Division to submit a detailed mediation proposal to the 1993 Legislature.
58. Amend the statutes to provide that parties represented by legal counsel may stipulate to forego the hearing officer hearing and may proceed directly to the appeals officer hearing.
59. Amend the statutes to provide that a person who is not admitted to practice law in Nevada or who is not working under the supervision of a Nevada licensed attorney, may not represent or provide legal advice to an injured worker for remuneration.

OCCUPATIONAL SAFETY AND HEALTH

60. Amend NRS 618.383 to remove the requirement that an employer must establish a written safety program if he has a rate of occupational injury and illness that is in the highest 25 percent in this State for his standard industrial classification. Provide that the requirements for a written safety program apply only to those State Industrial Insurance System policyholders whose actual and anticipated costs for accident benefits and compensation for their employees exceeded 90 percent of the employer's manual premium in at least 2 of the 5 most recent fiscal years. In addition, amend the statutes to require the Manager of the State Industrial Insurance System to identify such policyholders and provide them with consultation concerning safety and loss control. (BDR 53-1152)
61. Amend NRS 618.835 and NRS 618.850 to:
- a. Remove the enforcement requirements for violations of asbestos abatement statutes and regulations from district attorneys and return them to the Division of Enforcement for Industrial Safety and Health, Department of Industrial Relations. Furthermore, allow the division to impose an administrative penalty of up to \$70,000 for each willful violation; and
 - b. Provide limitations which would prevent principal contractors from transferring license requirements to subcontractors or employees.

LEGISLATIVE OVERSIGHT CONCERNING INDUSTRIAL INSURANCE

62. Provide, by statute, for the continuation of the Legislative Committee on Industrial Insurance by establishing it as an ongoing statutory committee of the Nevada Legislature. Provide the committee with broad powers to review and evaluate the laws, regulations and State agencies related to workers' compensation and occupational safety and health. Provide for the membership, duties and funding of the committee, as follows:

- a. The membership of the committee consists of four members of the Senate, appointed by the Senate Majority Leader from the members of the Senate standing Committee on Commerce and Labor, and four members of the Assembly, appointed by the Speaker of the Assembly from the members of the Assembly standing Committee on Labor and Management. The members of the committee shall select the chairman and vice chairman from among their members, but the chairman for the first 2 years must be a member of the Assembly and the vice chairman must be a Senator. Thereafter, the positions of chairman and vice chairman will rotate between the Senate and Assembly every 2 years;
- b. The committee must report every 2 years before the convening of the Legislature to the Legislative Commission concerning its activities and any recommendations. The committee must meet at least four times each year, but it shall not meet more than six times in any year. The meetings may be held in person or by telephone conference or video telecast. The Director of the Legislative Counsel Bureau or his designee shall serve as the committee's nonvoting recording secretary. The committee may prescribe its own rules, but five members of the committee constitute a quorum which may exercise all the powers of the committee;
- c. The salaries and expenses of the members of the committee and at least one committee staff person (Senior Research Analyst) and any other expenses incurred by the committee in carrying out its duties must be paid from the Fund for Workers' Compensation and Safety. The expenses of the committee must be reported to the Legislative Commission and Department of Industrial Relations; and
- d. Any other provisions which are necessary to allow the committee to carry out its responsibilities.
(BDR 53-1153)

REPORT TO THE 67TH SESSION OF THE NEVADA LEGISLATURE
BY THE LEGISLATIVE COMMITTEE ON INDUSTRIAL INSURANCE

I. INTRODUCTION

Assembly Bill 1 of the 1989 Legislative Session (Chapter 856, *Statutes of Nevada 1989*, page 2064) directed the Legislative Auditor to conduct an operational audit of Nevada's workers' compensation programs. During the 1989-1990 interim, the Legislative Auditor completed five performance audits relating to industrial insurance topics (compensation and other benefits to injured workers; the Department of Industrial Relations [DIR]; hearings and appeals process; medical benefits; and the State Industrial Insurance System [SIIS]) and submitted reports which were considered by the 1991 Legislature.

In response to the findings of the legislative audits and many other concerns, the 1991 Legislature enacted Senate Bill 7 (Chapter 723, *Statutes of Nevada 1991*, pages 2388-2441), a comprehensive workers' compensation reform act. This measure made provision for a variety of strategies designed to speed up the processing of claims, the delivery of benefits and payment of providers. The bill also strengthened State regulatory oversight of employers and required new workplace safety and education programs.

Under the provisions of Section 125 of S.B. 7, the Legislature established a Legislative Committee on Industrial Insurance to review and evaluate Nevada's laws concerning industrial insurance and to prepare a report for submission to the Governor and the Legislative Commission before the convening of the 1993 Legislative Session.

Eight legislators were appointed as members of the committee. Four members were appointed by the Senate Majority Leader from the members of the Senate standing Committee on Commerce and Labor, and four members were appointed by the Speaker of the Assembly from the members of the Assembly standing Committee on Labor and Management. The committee members selected their chairman and vice chairman from among their members.

The following legislators served on the S.B. 7 Committee:

Senator Raymond C. Shaffer, Chairman
Assemblywoman Christina R. Giunchigliani, Vice Chairman
Senator Leonard V. Nevin
Senator Ann O'Connell
Senator Randolph J. Townsend
Assemblyman Morse Arberry, Jr.
Assemblyman John W. Marvel
Assemblyman John L. Norton

Legislative Counsel Bureau (LCB) staff services for the committee were provided by Donald O. Williams of the Research Division (principal staff), Jan K. Needham of the Legal Division (primary legal counsel), Denice L. Miller of the Research Division (research analyst), Leigh C. O'Neill of the Legal Division (legal counsel), and Debby Richards of the Research Division (committee secretary).

Beginning in September of 1991 and concluding in November of 1992, the committee held eight meetings, including a 2-day work session, to obtain expert and public testimony. Three of the meetings were in Las Vegas, three were in Carson City, one was in Reno and another was in Elko. The public hearings in Carson City and Las Vegas were conducted through simultaneous video teleconferences at locations in Las Vegas and Carson City, respectively.

During this interim study, the committee reviewed existing laws and the implementation of the industrial insurance legislation passed by the 1991 Legislature. It received comments and recommendations from employers, injured workers, medical providers, vocational rehabilitation specialists, claimants' attorneys, occupational safety and health professionals, third-party administrators for employers who are self-insured for workers' compensation, State agencies, local government officials, and representatives of various business groups and labor organizations. In addition, the legislators received testimony from national experts representing the National Conference of State Legislatures (NCSL) and the Workers' Compensation Research Institute.

At its work session, the committee considered 188 proposed recommendations. It adopted 62 recommendations on the following topics:

- Determination and payment of industrial insurance claims;
- Medical care, compensation and other benefits to injured workers;
- Fraud in workers' compensation;
- The State Industrial Insurance System's organization and procedures;
- Employer options for industrial insurance coverage;
- Administration of Nevada's industrial insurance laws;
- Industrial insurance classifications, rates and funds;
- Hearings and appeals of contested claims;
- Occupational safety and health; and
- Legislative oversight concerning industrial insurance.

This report contains background information on the current workers' compensation crisis in the United States. Furthermore, it presents an overview of Nevada's workers' compensation system and policy issues. The report also contains a discussion of the committee's findings and recommendations.

In this document, the committee has attempted to present its findings and recommendations in a concise form. A great amount of information was gathered during the course of the study, and much of it was provided in exhibits that became part of the committee's minutes of its meetings. All supporting documents and minutes are on file with the Research Library of LCB.

The committee wishes to thank the many individuals who contributed to this study through their correspondence or testimony in the public hearings. The committee members also recognize the cooperation and assistance provided by the staff of DIR, the Department of Insurance, the Hearings Division of the Department of Administration, the Nevada Attorney for Injured Workers (NAIW) and SIIS.

II. OVERVIEW OF WORKERS' COMPENSATION

This section presents historical and other background information on the development of workers' compensation in the U.S. In addition, it briefly describes Nevada's workers' compensation system.

A. BACKGROUND

Workers' compensation was the first social insurance system in the U.S. It developed as a consequence of the high rate of industrial accidents in the 19th and early 20th centuries. The litigation which arose out of this situation proved to be an unsatisfactory means of caring for injured workers.

American policymakers looked to Europe where the idea of workers' compensation had originated in Germany in the 1800's and later was adopted in Great Britain, France and other countries. They proposed that the right to bring legal action against an employer on the grounds of negligence be exchanged for a system whereby benefits would be paid for all injuries arising out of or in the course of employment. The costs of the work-related injuries would be allocated to the employer, not because of any presumption that he was to blame for every individual injury, but because the inherent hazards of employment were a cost of production. This "no-fault" approach soon became popular throughout the U.S.

The Federal Government and individual states began enacting legislation to cover certain high-risk government employees in the late 19th Century. Later, legislators came to realize that a workers' compensation program had to cover all employees, both private and public, in order to be effective in serving the interests of society. Between 1911 and 1920, all but six states passed universal workers' compensation statutes. The other states enacted such laws in subsequent years.

Because states traditionally have taken the lead in workers' compensation law, there is a considerable amount of diversity within the programs around the country. The basic administrative structures differ between states, the benefits vary, the methods for setting rates are different and many other basic features vary from state to state. In particular, the method of delivering workers' compensation insurance varies significantly between states.

Workers' compensation insurance is compulsory for employers in every state except New Jersey, South Carolina and Texas. Twenty-five states have state workers' compensation insurance funds in operation or authorized under law. Most of these state funds are "competitive" with private insurance companies which offer workers' compensation coverage to employers. However, Nevada and five other states (North Dakota, Ohio, Washington, West Virginia and Wyoming) operate monopolistic state funds and do not allow employers the option of obtaining coverage from private insurance companies.

Certain employers, usually large companies or public agencies with substantial assets, are allowed to become self-insured for workers' compensation in Nevada and 46 other states.

B. WORKERS' COMPENSATION IN NEVADA

Nevada was one of the first states to enact workers' compensation laws. The original industrial insurance act was adopted in 1913, and a complete revision was drafted in 1947. The State's industrial insurance laws have been amended during every regular legislative session since 1913.

Recent legislative sessions have brought major changes to the statutes relating to workers' compensation. During the 1979 Session, self-insurance was authorized for qualified employers. The self-insurance option became effective on January 1, 1980. Prior to that time, the Nevada Industrial Commission (NIC) had been the only provider of workers' compensation in the State.

The 1979 Legislature also removed the hearings process for contested claims from NIC and placed it in a new Hearings Division within the Department of Administration. The Hearings Division is responsible for the hearings and appeals process.

In 1981, the Legislature completely revised the NIC structure by splitting its insurance responsibilities from its regulatory functions. This reorganization became operational on July 1, 1982.

The SIIS was established to succeed NIC's insurance system, and it has become the insurer of the great majority of Nevada's employers, providing coverage to about 85 percent of the work force. The System is a state-authorized entity which is responsible for providing compensation benefits to

injured workers, paying their medical bills and providing rehabilitation and other services to assist injured workers in returning to work as soon as possible. It also provides loss control and safety consulting services to employers.

The Board of Directors, consisting of seven members appointed by the Governor, and the Manager (general manager) oversee the operations of SIIS. Funding for the System is derived solely from premiums paid by employers. No tax revenues support SIIS. The *Nevada Constitution* (Section 2 of Article 9) assures that workers' compensation funds are trust funds and cannot be used for any other purpose. The SIIS submits its administrative budget to the Budget Division of the Department of Administration and the Legislature for approval.

The regulatory functions of NIC were shifted into the new DIR. The department was reorganized under S.B. 7 of 1991, and it now consists of a Director and the Divisions of Administrative Services, Enforcement for Industrial Safety and Health, Preventative Safety, Mine Inspection, and Industrial Insurance Regulation. The Division of Industrial Insurance Regulation (DIIR) regulates SIIS and self-insured employers.

The Commissioner of Insurance reviews and approves SIIS premium rate increases and is responsible for certifying self-insured employers who meet certain statutory qualifications. The Department of Insurance's regulations require that an employer have a net worth of at least \$2.5 million in order to self-insure. Moreover, the posted security, which is required under the law, must be a minimum of 105 percent of the employer's expected annual incurred claims and no less than \$100,000. The department also regulates third-party administrators of self-insured programs.

As of September 1992, there were 114 self-insured employers who insured approximately 150,000 workers in the State, with the majority of these employees being in the hotel and gaming industries.

The NAIW, a State agency separate from SIIS, represents claimants free of charge at the Hearings Division's appeals level, in the State's district courts and before Nevada's Supreme Court.

III. POLICY ISSUES

The current financial crisis in workers' compensation and various state policy options are discussed in this section of the report.

A. FINANCIAL CRISIS

Workers' compensation was a relatively inexpensive program for many years, costing employers less than 1 percent of payroll. In 1972, the National Commission on State Workmen's Compensation Laws released its report which indicated that there were serious deficiencies in the various states' programs. As a result of the commission recommendations, most states expanded their programs to increase benefits and improve coverage.

During the course of the 1980's, workers' compensation costs for medical care and indemnity benefits increased at almost three times the rise in the overall Consumer Price Index (CPI). The total cost of workers' compensation in the U.S. increased from \$22.3 billion in 1980 to an estimated \$62 billion in 1991. While the average U.S. employer paid 1.26 percent of payroll for workers' compensation coverage in 1984, the same coverage cost the employer 2.25 percent of payroll in 1989. The average SIIS premium charges to Nevada employers, per \$100 of payroll, increased from \$2.47 in 1988 to \$3.31 in 1991.

The Wall Street Journal ("Comp Attrition," 1992) states that:

* * * somehow workers' comp has grown into a \$70 billion gravy train for the medical and legal professions. It now costs business an average of \$20,000 for every workplace injury, up 200% in 10 years. Yet, relatively speaking, fewer of these dollars end up in the worker's pocket, while more and more go the system's apparatus.

The factors driving workers' compensation costs in the U.S. during the last 10 years include increased medical costs, increased costs relating to litigation and the growth in new types of injuries, such as environmental-related disorders, carpal tunnel syndrome and mental stress. Industrial insurance costs for employers have almost tripled since 1972. In 1972, an average employer paid \$93 for workers' compensation coverage for each employee; by 1990, the cost was \$500 per worker.

According to the American Legislative Exchange Council (ALEC), the challenges facing workers' compensation systems in the 1990's are in the areas of benefits, litigiousness and medical cost containment (ALEC, 1990, p. 2).

Medical costs in workers' compensation have been growing up to 1.5 times higher per capita than U.S. medical costs in general. The average medical cost of a lost-time claim was \$2,100 in 1981, and the National Council on Compensation Insurance (NCCI) reports that the average medical cost rose to \$6,611 in 1990. In 1980, about 30 percent of all workers' compensation benefit dollars went to pay for health care.

Such medical costs now account for between 40 and 50 percent of all nationwide benefit expenses and over 50 percent of total workers' compensation dollars in certain states.

According to the Alliance of American Insurers, all state funds for workers' compensation reported that they were solvent, that is, their assets exceeded their liabilities, in 1984. Since that time, eight state funds have become insolvent. These insolvent funds are found in the states of Colorado, Minnesota, Montana, Nevada (SIIS), North Dakota, Ohio, West Virginia and Wyoming. In addition, the financial strength of six other state funds was seriously weakened between 1984 and the present. All of these funds have insufficient capital to mitigate losses which have resulted from the declining value of assets, the increased number of adverse claims decisions and the suppression of premium rates (Kenney, 1992, p. 1-2).

Nevada's SIIS is experiencing severe cash flow problems, losing as much as \$2 million per week, which have required the System to make use of substantial funds from its reserve/investment portfolio. For Fiscal Year (FY) 1992, SIIS reported that it would deplete its reserves by over \$92 million. Without significant changes, the System expects to deplete another \$105 million in FY 1993. This erosion of reserve funds continues to exacerbate the situation where SIIS was already underfunded in reserves by over \$378 million as of June 30, 1991 (SIIS, 1992, p. 23).

Although SIIS should have had \$1.2 billion in invested reserves on June 30, 1991, it actually had set aside only \$751 million. The System's most recent financial statement indicates that its accumulated deficit was over \$1.4 billion

as of June 30, 1992 (KPMG Peat Marwick, 1992). In the findings of the Department of Insurance's investigation of the solvency of SIIS, the accumulated deficit is reported to be over \$2.2 billion (Department of Insurance, 1993).

This financial situation is the result of inadequate premium rate levels in the 1980's and rapidly increasing costs of medical care, rehabilitation and compensation payments.

B. STATE POLICY OPTIONS

Legislatures in almost every state recently have established special task forces or study commissions on workers' compensation. Several states have held special legislative sessions devoted to this issue. The most common legislative proposals to reform workers' compensation in other states include provisions to control health care costs, reduce fraud and prevent accidents on the job.

Most states are now considering adopting some form of managed health care program in workers' compensation. Under managed care, insurers or employers have the ability to negotiate discounted rates with certain health care providers who agree to provide services to injured workers. The injured workers are encouraged or required to use these providers, and they may be subject to having their benefits reduced or paying part of the costs if they choose their own providers instead. In most cases, managed care also involves utilization review (UR) of health services.

California, Florida and Oregon are among the growing number of states which are developing 24-hour health care programs which integrate traditional health insurance coverage with workers' compensation and private disability insurance coverage. Under 24-hour policies, medical benefits are provided for all of an employee's illnesses and injuries, whether or not they are related to work. Disability benefits are provided for work-related diseases and accidents, but such benefits may be restricted or disallowed for injuries not related to the job.

The NCSL reports that several states, including California, Colorado, Connecticut, Florida, Louisiana, Massachusetts, Nebraska and Rhode Island, have recently enacted new laws to reduce fraud in workers' compensation. Some of the common methods include establishing new fraud investigation units and increasing penalties against persons who make or attempt to make fraudulent claims (Trolin, 1992, p. 35).

In 1991, the California Legislature increased the criminal penalties for fraudulent acts in its workers' compensation system and established an employer assessment for deposit in a special account to fund the investigation and prosecution of fraudulent claims. California and other states have recognized that efforts to address fraud must focus on employers, employees, health care providers, insurers and all persons involved in workers' compensation.

State attempts to address workers' compensation costs also should include efforts to prevent injuries and illnesses in the workplace. Many states are improving the means of identifying employers with high accident rates and developing targeted programs to mitigate injury and illness. California now requires employers to establish formal safety programs or face substantial fines.

Oregon is often cited as an example of a state which has successfully reformed its workers' compensation system. In the 1980's, it had one of the highest industrial accident rates in the Nation and consistently ranked among the states with the highest workers' compensation costs. At a special session in 1990, the Oregon Legislature enacted legislation to reduce these costs by, among other things, redefining and limiting compensable injuries, authorizing the creation and use of managed care organizations and requiring employers with 10 or more employees to create job safety committees. Furthermore, Oregon's State Accident Insurance Fund (SAIF) Corporation established a special division to investigate and help prosecute fraud.

As a result of its reforms, Oregon reduced its average workers' compensation premium rates by over 10 percent in each of the last 3 years.

At least 21 states have adopted laws which allow medical deductibles in workers' compensation policies, and some states allow businesses to self-insure through pooling with employers engaged in similar businesses (Trolin, 1992, p. 37). Colorado's 1991 reform legislation actually reduces certain benefits for injured workers and regulates the fees charged by claimants' attorneys.

IV. DISCUSSION OF COMMITTEE FINDINGS AND RECOMMENDATIONS

A. MAJOR FINDINGS

Nevada is experiencing a crisis in its workers' compensation system, but this situation is not unique. Workers' compensation insurers throughout most of the U.S. are experiencing high ratios of losses and expenses to premiums. Although the costs of injured workers' claims are increasing significantly each year, the average premium rate increases approved for insurers are not keeping up with these costs. The costs of our system are increasing much faster than in the past, and Nevada's SIIS is considered to be insolvent under most insurance standards.

The S.B. 7 Committee focused much of its study on the operations of SIIS. Its major findings relate to the System's expenses and financial situation.

In Nevada, the number of SIIS claims has increased 62 percent over the last 9 years. Total claims expenses increased 400 percent over the last 10 years, and medical expenses have increased 450 percent over this same period. Because these increasing costs have not been matched with adequate revenues from its premium rates, the SIIS is experiencing severe cash flow problems which are depleting its invested reserves and threatening bankruptcy of the system.

Total SIIS claims expenses were expected to reach \$432 million in FY 1992, an increase of 400 percent over a 10-year period (SIIS, 1992, p. 14). The largest increase has been in medical costs which have increased over 450 percent, from \$26 million in FY 1983 to \$144 million in FY 1992. Compensation expenses have increased 300 percent during this period, from \$55 million in FY 1983 to \$220 million in FY 1992.

As indicated in Table 1, SIIS physical therapy expenditures, a small segment of medical expenses, increased from \$5.7 million in FY 1988 to \$18.4 million in FY 1992. Over the same 5-year period, expenditures for vocational rehabilitation are shown to have risen from \$15 million to \$75.5 million.

TABLE 1
SIIS PHYSICAL THERAPY AND REHABILITATION EXPENSES
FISCAL YEAR 1988 - FISCAL YEAR 1992

PHYSICAL THERAPY EXPENDITURES		VOCATIONAL REHABILITATION EXPENDITURES	
FY 92	\$18,467,000	FY 92	\$75,500,000
FY 91	13,429,000	FY 91	39,787,000
FY 90	12,922,000	FY 90	23,216,000
FY 89	7,518,000	FY 89	16,339,000
FY 88	5,799,000	FY 88	15,047,000

Source: SIIS Policy, Planning and Review Division, November 9, 1992

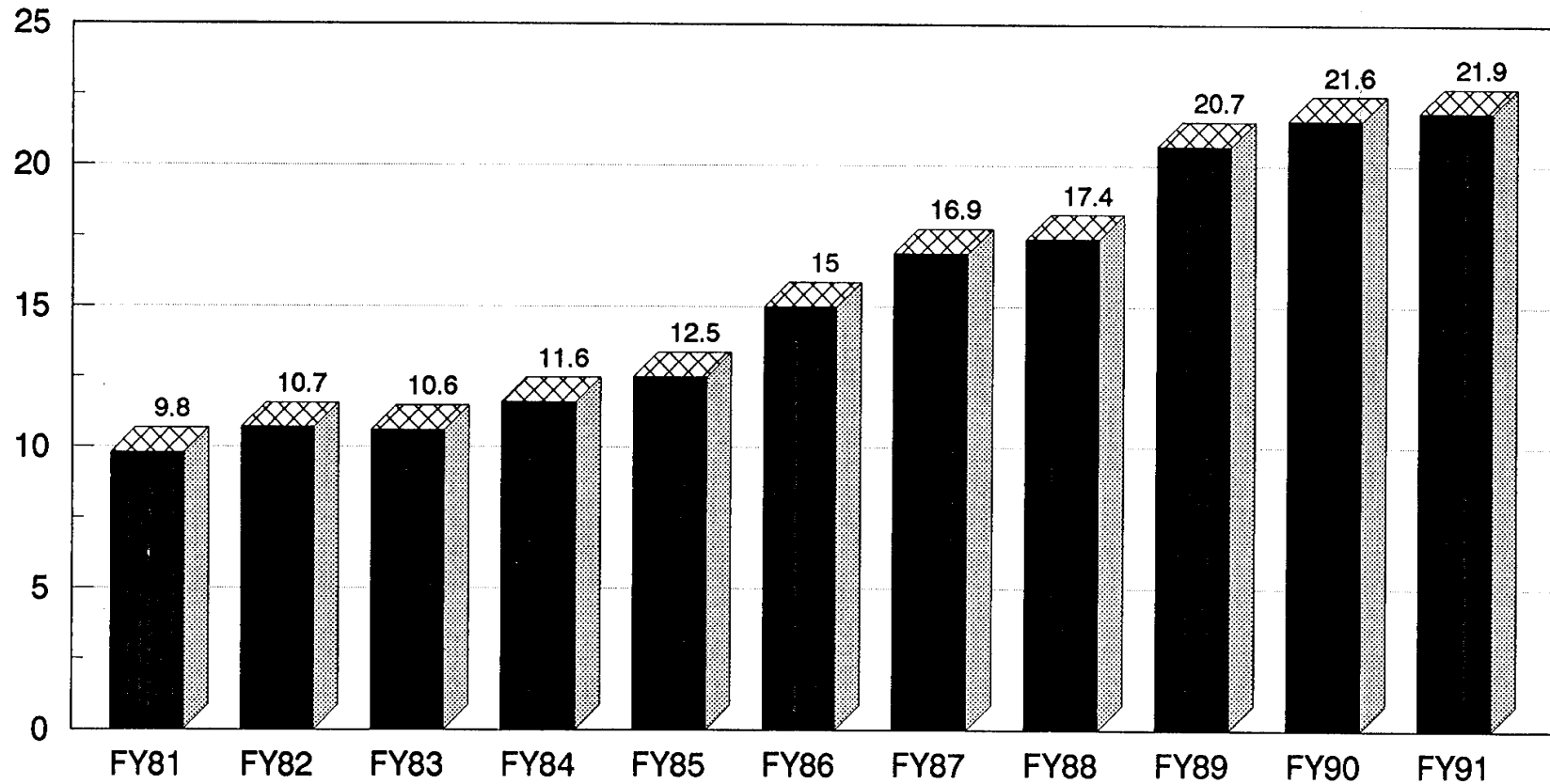
Compensation expenses include the four types of disability payments--temporary total disability (TTD); temporary partial disability (TPD); permanent partial disability (PPD); and permanent total disability (PTD)--and fatalities, funeral and other miscellaneous expenses. The average number of weeks an injured worker is on TTD or TPD has more than doubled since 1981. The average length of temporary disability increased from 9.8 weeks in FY 1981 to 21.9 weeks in FY 1991 (see Table 2).

The SIIS has reported that some of the possible causes of the increase in the duration of temporary disability include:

- Increased benefit levels generating increased utilization. Nevada statutes provide injured workers with 66 2/3 percent of their average weekly wage, subject to a maximum of 150 percent of the State average weekly wage (SAWW). Nevada's benefit schedule is adjusted annually, and the SAWW has increased more than 42 percent over the past 10 years;
- The SIIS staff case loads, which are among the highest in the U.S., and the increasing complexity of claims management;

TABLE 2
AVERAGE LENGTH OF TEMPORARY DISABILITY
SIIS CLAIMANTS

NUMBER OF WEEKS



SOURCE: SIIS "BUSINESS PLAN," JUNE 1992

DIR:DOW

FILE:SIIS2

- Recent Nevada Supreme Court decisions which have increased the length of disability by expanding the rights of claimants to reopen their claims, and other court decisions which have increased the length of disability by requiring extensive administrative documentation and procedures;
- Injured workers being more likely to retain attorneys and, therefore, appeal more decisions. In 1990, there were 9,799 hearings scheduled--a 55 percent increase over the number of hearings scheduled in 1989. There were 12,498 hearings scheduled in 1991--a 28 percent increase;

At the second level of hearings, the appeals officer hearings, there was a 54 percent increase in such hearings from 1989 to 1990 and an additional 83 percent increase from 1990 to 1991. Depending on the hearing determination, claimants can remain on benefits throughout the appeals process;

- Physicians keeping claimants on TTD benefits longer by performing more complex types of treatments, additional tests and more extensive evaluations; and
- New types and more complex injuries, such as carpal tunnel syndrome and soft tissue injuries to backs and other parts of the body (SIIS, 1992, pp. 16-19).

The costs for the types of disability other than TTD and TPD are also increasing at high rates. For example, the cost of PPD awards by SIIS increased from \$84 million in FY 1991 to \$105 million in FY 1992 and an estimated \$117.6 million in FY 1993 (Hughey, December 7, 1992).

Although Nevada's tremendous population growth over the past decade has contributed to the number of SIIS claims and the related expenses, population growth alone is not responsible for the System's financial difficulties. The failure of the System to request and receive adequate premium dollars and the uncontrolled costs of medical care, rehabilitation and compensation are the major contributors.

B. RECOMMENDATIONS

As previously mentioned, the committee approved 62 recommendations under the topics of determination and payment of claims; medical care, compensation and other benefits; fraud; SIIS organization and procedures; employer options

for industrial insurance coverage; administration of workers' compensation laws; industrial insurance classifications, rates and funds; hearings and appeals; occupational safety and health; and legislative oversight. Some of these proposals were adopted as bill draft requests (BDRs).

At its meeting on April 9, 1992, in Reno, the committee requested that representatives from certain interest groups and State agencies work together and present a consensus proposal for legislation. The report from this consensus group was considered at the committee's work session, and the group's proposed legislation was adopted in whole by the committee. See Appendix A for the consensus legislation. It is important to note that several of the proposals in the consensus document were also proposed to the committee by various individuals who were not included in the consensus group.

The following is a discussion of the committee's recommendations.

1. Determination and Payment of Industrial Insurance Claims

- Determination of Benefits

According to Nevada's Supreme Court decision in *SIIS v. Kelly*, 99 Nev. 774, 671 P.2d 29 (1983), if a disabled worker's pre-existing nonindustrial condition is aggravated by a cause relating to work, the employer is responsible for the entire condition. This case provides that the industrial component of the injury does not have to be the only or primary cause of the resulting disability, it only has to be "a" cause. The committee recognized the need to amend the statutes to require that the industrial component be at least the primary cause but not the sole cause of the resulting disability. Such an amendment should relieve employers of the responsibility for conditions which are largely nonindustrial but which have some minor industrial component.

Furthermore, in the Supreme Court's decision in *Warpinski v. SIIS*, 103 Nev. 567, 747 P.2d 227 (1987), if a worker is injured on the job and later suffers a nonindustrial aggravation to the same body part, the employer is responsible for the nonindustrial condition if "but for" the original industrial injury, the subsequent nonindustrial injury would

not have happened or would not be as severe. The committee recognized the need to more clearly define compensable injuries in the statutes and to provide that the original industrial injury must be the primary cause of the subsequent nonindustrial disability. If the contribution of the original industrial injury was very small or minor, the employer should not be responsible for every subsequent accident that occurred to that part of the claimant's body no matter how many years in the future.

Based on this discussion, the committee adopted the following recommendation:

- Provide, by statute, that preexisting, nonindustrial conditions are not properly part of the industrial disability unless the incident at work which aggravated the preexisting condition is the primary cause of the resulting disability. Furthermore, injuries suffered after an industrial injury shall be compensable only if the original industrial accident was the primary cause of the subsequent nonindustrial disability.

During the course of its study, the committee received a significant amount of testimony in support of revising the current procedures for filing job accident reports and claims for compensation. There was general agreement that minor injuries often do not need to be reported if workers do not require medical care or compensation. In addition, many employers and claim administrators proposed that the Legislature clarify and simplify the procedures for filing employer reports of industrial injury, employee claims for compensation and physician reports of initial treatment. The committee also discovered a need to clarify when late manifesting injuries can be included as part of the claim. Moreover, it proposed clarifying the existing rules on burden of proof on a claim and establishing a higher burden of proof for certain claims filed after termination of employment.

Therefore, the committee approved the following recommendations:

- Provide, by statute, for a method for minor injuries to be recorded by the employer without reporting to the insurer. The Division of Industrial Insurance Regulation of the Department of Industrial Relations should be required to audit periodically the employer records of such injuries. (BDR 53-1154)

- Streamline or eliminate, by statutory provision, the procedures used for injuries involving neither lost-time nor medical claims. (BDR 53-1154)
- Require, by statute, a physician or chiropractor, not the injured worker, to establish that a late manifesting injury is actually part of the original claim. The relationship must be established by competent medical evidence.
- Provide, by statute, clarification of the existing law on burden of proof on a claim, namely that the injured worker has the burden of proving his case by a preponderance of the evidence. If the employee files a claim after employment has been terminated, there is a rebuttable presumption that the injury did not arise out of and in the course and scope of employment. The rebuttable presumption applies only to accidental injuries and does not apply to occupational diseases.
- Amend *Nevada Revised Statutes* 616.340 to include:
 - a. The C-3 form ("Employer's Report of Industrial Injury") should be considered documentation of an accident or incident should medical care be needed;
 - b. The claim process should commence when an injured worker seeks such treatment; and
 - c. Documentation of an injury should originate from the treating physician.
- Amend NRS 616.500 to clarify the terms and actions required by insurers regarding the C-4 form ("Employee's Claim for Compensation/Physician's Report of Initial Treatment"). Require an insurer to accept or deny compensation only on claims filed for compensation, and clarify that the insurer is not required to accept or deny compensation on "notice of injury" reports. In addition, include provisions that require a physician's report to give the insurer a medical basis upon which to make a decision to accept or deny for medical reasons.
- Amend NRS 616.500 to clarify the distinction between the notice of injury and the claim of compensation as follows:
 - a. The notice of injury for which compensation is payable must be given by or on behalf of the injured employee within 30 days after the accident;

- b. The notice of injury must be served by delivery of a copy of the notice or by mailing a copy to the insurer;
 - c. Failure to give the notice of injury within 30 days is a bar to any claim for compensation, unless excused by the insurer on the grounds provided in statute;
 - d. The failure to file a claim for compensation within 90 days after the date of the accident or, in the case of death, within 1 year after the date of death, is a bar to any claim for compensation; and
 - e. The insurer shall accept or deny responsibility for compensation within 30 days after the notice of injury is received.
- Amend NRS 616.500 as proposed by the Employer Coalition of Southern Nevada. This amendment distinguishes the "notice" from the "claim" and places different requirements for each. It provides, among other things, that the claim for compensation consists of the written notice and a written physician's certificate from a physician or chiropractor setting forth the nature and origin of the employee's injury or disease, recommended treatment and probable duty status.
 - Amend NRS 616.500 as follows:
 - a. Require an injured worker to report all accidents and injuries to his employer within a certain time frame. Eliminate the need to give notice to the insurer within 30 days;
 - b. Require an employee to file a claim at his physician's office, and provide a notice on this form that the accident must be reported to the employer;
 - c. Require the treating physician to send a copy of the C-4 form to the injured worker's employer and insurer within 3 days; and
 - d. Require that an employer send a report to his administrator within 6 days of receipt of the C-4 form.

- Amend the statutes to address the return of an injured employee to work for light or modified duty when he cannot perform his normal job. Require that a space should be provided on the C-4 form for the physician to indicate restrictions on the worker's activities.
- Repeal NRS 616.537 because its provisions are covered in NRS 616.605. (BDR 53-1150)

Payment of Benefits

The committee discovered that hearing officers, appeals officers and/or the courts have ordered SIIS to provide motor vehicles to certain injured workers when it was not necessary. In response to this situation, the committee voted to recommend that the Legislature:

- Amend NRS 616.025 to make it clear that motor vehicles are only to be provided in cases of the most serious injuries and that the insurer should have discretion to modify an existing vehicle or purchase an adequate used vehicle instead of a new one. Moreover, it must be made clear that the insurer will not be responsible for the operating costs and insurance on any such vehicle.

The consensus legislation would also exclude items such as exercise equipment, spas, and memberships in health clubs from the definition of accident benefits.

The SIIS reported that there was over \$1.3 million in outstanding overpayment of compensation, travel and rehabilitation maintenance as of December 31, 1991. Some of these overpayments are the result of clerical errors, and others are the consequence of incorrect return to work information provided by the employer, claimant or physician. In some cases, the return to work date is not received in adequate time to prevent the overpayment of benefits.

These overpayments have accumulated over a period of several years. Because the Supreme Court's decision in *Ransier v. SIIS*, 104 Nev. 742, 766 P.2d 274 (1988), does not allow an insurer to recoup these costs, the committee adopted the following recommendation:

- Authorize, by statute, insurers to recover inadvertent overpayment of benefits by deducting the amount of the overpayment from future benefits due the injured worker. Provide that the insurer may collect only on those

overpayments discovered within 30 days of the inappropriate payment and only after a hearing before the hearing officer, unless the injured worker does not appeal the insurer's determination to deduct the overpayment. The deductions must be made in a reasonable manner that will not create undue hardship to the claimant.

Subrogation Recovery

Under subrogation recovery, the workers' compensation insurer has the right to recover any money owed or paid to an injured worker by an employer or another third party (private insurance company or another person) when the insurer has compensated the claimant for the same damages. The committee adopted the following recommendations to assist SIIS improve subrogation recovery and to address the concerns raised in the Nevada Supreme Court's decision in *Breen v. Caesar's Palace*, 102 Nev. 79, 715 P.2d 1070 (1986):

- Amend the subrogation statutes to allow an insurer to recover proceeds available to an injured worker pursuant to his employer's policy of motor vehicle insurance that provided coverage against an uninsured or underinsured motorist.
- Prohibit, by statute, the circumvention of the subrogation laws. Prevent circumstances where an injured worker obtains one set of payments from the insurer and another set of payments for the same injuries and losses from the employer or another person.
- Require, by statute, that an attorney for an injured worker or the third party insurance carrier must pay the workers' compensation insurer out of their own pocket if the workers' compensation insurer is not paid when the injured worker's attorney and the third party insurance carrier have made a settlement of the third party case. Prohibit the workers' compensation insurer from selling its lien to the third party insurance carrier unless the injured worker or his attorney fails to provide information to the workers' compensation insurer concerning the action against the responsible third party.
- Amend NRS 616.560 as proposed by the Employer Coalition of Southern Nevada. This proposal addresses, among other things, insurer and employer concerns with the *Breen* decision by Nevada's Supreme Court. The *Breen* decision

requires the insurer to reduce its lien against proceeds from any tort judgment received by the claimant according to a complicated formula imposed by the Supreme Court and based on the expenses of the claimant in pursuing the tort action.

- Allow an injured worker of an uninsured employer to receive workers' compensation benefits and also sue the uninsured employer in tort instead of the present law which requires the worker to elect between these two remedies. This would result in more recoveries against uninsured employers. The State Industrial Insurance System would be subrogated to the tort judgment so there would not be a double recovery for the injured worker.

Reopening Claims

The committee found that Nevada is one of 19 states which allow claimants to reopen their claims without a time limit. The other 26 states include maximum time limits on reopening requests which range from 6 months to 10 years. Four states (Connecticut, Massachusetts, Montana and Texas) do not allow any form of reopening or other modification once the claim is closed.

Recognizing the need to limit reopening rights, the committee voted to recommend that the 1993 Legislature:

- Amend NRS 616.545 to restrict reopening rights as follows:
 - a. An injured worker must wait 1 year after claim closure before applying to reopen unless the employee can show by clear and convincing medical evidence that there has been a change in his medical condition and that the industrial injury is the primary cause of that change;
 - b. Except in cases where the injured worker can show by clear and convincing medical evidence that the industrial injury is the primary cause of the worsened condition, the claim cannot be reopened until 1 year after a final determination on a prior request to reopen; and
 - c. If the claim did not result in lost time and a permanent partial disability award, the claim cannot be reopened unless the request to reopen is made within 1 year after closure. After expiration of

1 year, the insurer may dispose of records concerning claims where there was no lost time and permanent partial disability.

2. Medical Care, Compensation and Other Benefits to Injured Workers

Medical Care

Under current statutes, injured workers have the right to choose their own treating physician. Under a managed or coordinated health care system, the employer or insurer would be able to direct the worker to specific physicians or require the worker to select a physician from a restricted list of medical providers. This would allow the insurer or employer to negotiate discounted rates for medical services. On a related concern, the committee reviewed information from studies in California and Florida which indicate that health facilities owned by physicians perform more procedures per patient and have higher charges per patient than similar facilities which are not owned by physicians.

Recognizing that controlling health care costs is one of the key components to reducing the costs of workers' compensation, the committee adopted the following recommendations:

- Amend the statutes to remove the current statutory prohibition that prevents workers' compensation insurers from engaging in or contracting for managed or coordinated health care.

In addition, direct representatives of all of the affected parties (employees, employers of all sizes, insurers, third-party administrators, State workers' compensation agencies, claimants' attorneys, medical providers of all the licensed groups and other interested persons) to work together and report to the 1993 Legislature on or before February 5, 1993, with their proposal for a managed or coordinated health care program in workers' compensation. This report should include a detailed cost-benefit analysis of the various medical cost containment proposals which were presented during the course of the Senate Bill 7 Committee's interim study, including its work session. The analysis should examine, among other things, the use of health maintenance organizations; preferred provider organizations with an open panel, preferred provider organizations with a closed panel and deductibles for claimants

who choose to use providers outside the panel; a schedule of fees and charges for accident benefits which cannot exceed the usual and customary charges utilized by most third-party insurers for payment of injuries and illnesses which are not related to work; a schedule of co-payments for questionable claims; 24-hour medical coverage and incentives for employers to provide employees with group health insurance coverage; access to care in the rural areas and elsewhere; and quality of care. Furthermore, the report should examine increased peer review, increased utilization review and increased case management without any prohibition on the injured worker's freedom of choice.

- Prohibit, by statute, a physician or chiropractor from referring an injured worker to a health facility or service in which the physician, chiropractor or an immediate family member has a financial interest.
- Amend NRS 616.412 to remove the statutory provision which prevents the Department of Industrial Relations from requesting medical payment information from insurers in a standardized format.
- Amend NRS 616.188 to require that the Department of Industrial Relations adopt guidelines establishing standards of care for the provision of accident benefits to employees who have suffered industrial injuries or occupational diseases; remove the provision that requires the Department of Industrial Relations to adopt regulations for such standards of care. Clarify that any provisions relating to utilization review must be adopted as guidelines and not as regulations.
- Eliminate the cumbersome preconditions to out-of-state treatment and allow the insurer to authorize it if the out-of-state medical provider agrees to accept Nevada's medical fee schedule.

Compensation Benefits

The committee decided to provide that persons who have retired, or otherwise voluntarily removed themselves from the work force, are not entitled to be placed back on disability benefits if their claims are reopened after their retirement. Therefore, the committee adopted the following recommendation:

- **Require, by statute, that individuals who retire for reasons unrelated to their industrial injury and then reopen their claims are not entitled to temporary total disability benefits, permanent total disability benefits or rehabilitation.**

The committee found that SIIS was ordered by both appeals levels to include the amount paid by an employer for health insurance as part of an injured employee's wage base for workers' compensation. Traditionally, the cost of health insurance coverage has not been deemed part of the wage and no premium is collected on that amount. The SIIS indicated that it will have to charge employers additional premium if it must pay compensation based upon a wage that includes health insurance. To address this situation, the committee recommended that the Legislature:

- **Provide, by statute, that the amount employers pay for employee health insurance coverage must be excluded from the calculation of the injured worker's average monthly wage.**

In *SIIS v. Harrison*, 103 Nev. 543, 746 P.2d 1095 (1987), the Supreme Court ruled that an injured worker who required an amputation due to infection 8 years after the original injury should have his wage base increased to what it would have been at the time of amputation. Normally the amount of temporary total benefits is fixed at the rate of pay earned on the day of injury. Because of this court decision, the insurer has no way to adequately reserve claims and may find that it has substantial unfunded liabilities over time. In response to this problem, the committee adopted the following recommendation:

- **Amend the statutes to clarify that the average monthly wage on the date of injury will always be the wage rate used to calculate benefits under the claim.**

During the course of its study, the committee learned that there currently is no law which allows an insurer to terminate compensation benefits when an injured worker is incarcerated. According to SIIS, there are currently 10 individuals who are incarcerated and still receiving temporary disability. Therefore, the committee recommended that the 67th Legislature:

- Prohibit, by statute, the payment of specified compensation benefits to individuals who are convicted and incarcerated after the time of their injury. Codify the existing practice which is to deny rehabilitation payments to an injured worker who is incarcerated. Furthermore, provide that a person who has been convicted and incarcerated cannot receive compensation benefits for either temporary partial disability or temporary total disability.

Although there is a regulation which allows the insurer to require an injured worker to have an annual physical examination to verify that he is still disabled, the law is not very clear on this subject. The committee adopted the following recommendation to clarify the law:

- Amend the statutes to clarify that an insurer may require an injured worker to have an annual examination in order to determine if a permanent and total disability still exists. Provide that the insurer must pay for the examination, and provide a penalty if the injured worker refuses to attend the examination.

To correct an error in the current statute governing the time requirements for issuing a TTD compensation check, the committee recommended that the Legislature:

- Amend NRS 616.585 to change the time requirements for issuing a check for temporary total disability. Under the current provisions, the insurer is required to issue a check "not less than 6 working days before the beginning" of the next payment period. Thus, the law requires the insurer to pay temporary total disability benefits before they accrue. By amendment, require the insurer to make such payment just before the "end" of the period.

Some other compensation issues addressed by the committee include relieving employers of the responsibility for compensation maintenance when nonindustrial causes prevent the recovery of injured workers, prohibiting insurers from making advance payments to claimants, revising procedures for physician ratings for claimants with heart or lung diseases to conform with PPD ratings for other disabilities, and making it easier to return injured workers to temporary light duty. Thus, the committee made the following recommendations:

- Provide, by statute, that the employer is relieved of the responsibility of maintaining a worker on compensation if a nonindustrial cause prevents the worker from recovering from his injury.
- Prohibit, by statute, an insurer from advancing compensation to an injured worker before it is legally due him.
- Amend the current law which requires the rating physician and the treating physician to jointly determine the permanent partial disability from a disease of the heart or lungs. Clarify that these conditions would be rated like any other rateable disability.
- Amend the statutes to make it easier to return an injured worker to temporary light duty by making a distinction between temporary light duty and permanent light duty and allowing an employer to return an injured worker to light duty pending a permanent duty release. Furthermore, provide that any injured worker who is released to gainful employment under medical restrictions, related to the industrial injury which temporarily preclude employment at his regular occupation, may continue to receive temporary total disability payments only if the employer declines to offer temporary light duty employment consistent with his physical residuals.

The committee received testimony from injured workers that the State needs to revise its formula for determining the maximum wage base for workers' compensation benefits. It was suggested that the maximum average monthly wage be based on the State average weekly wage for the chronological year or 12 months immediately preceeding the employee's injury. In addition, the NAIW advised the committee that she discovered errors in the current statutory maximum wage base figures. In response to these concerns, the committee voted to recommend the following:

- Amend NRS 616.027 to clarify the year of data to be used for setting the maximum wage base for workers' compensation benefits. Require that the formula for determining the maximum average monthly wage make use of the State average weekly wage as provided by the Department of Industrial Relations on or before July 1 of each year, as most recently computed by the Employment Security Department for the chronological year immediately preceding the date of the injury or accident. In addition, correct the maximum wage base figures for the years 1972 through 1980, to reflect the following schedule:

<u>Effective Date</u>	<u>Average Monthly Wage for Prior Fiscal Year</u>
July 1, 1972	\$ 688.60
July 1, 1973	727.48
July 1, 1974	1,142.21
July 1, 1975	1,211.00
July 1, 1976	1,287.44
July 1, 1977	1,377.08
July 1, 1978	1,488.46
July 1, 1979	1,591.86
July 1, 1980	1,754.95

Two other compensation recommendations which were considered and adopted by the committee at its work session are as follows:

- Amend NRS 616.615 to make it clear that the surviving spouse who receives the benefits is the employee's spouse at the time of his death. (BDR 53-1150)
- Require, by statute, that the insurer's permanent partial disability rating must be accepted unless there has been a mathematical error in its computation or the rating physician has failed to rate a duly accepted body part.

Vocational Rehabilitation

The committee learned that it is not uncommon for the insurer to be ordered to pay for child care services or automobile repairs to assist an injured worker in searching for a new job. This practice ignores the fact that the worker would have had to pay for such services if he had never been injured and continued to work. Recognizing that the employer should only be responsible for providing job skills and not for providing other services, the committee recommended that the Legislature:

- Provide, by statute, that certain items and expenses are not available as vocational rehabilitation services. Amend the statutes to make it clear that the employer does not have to provide child care services for an injured worker. In addition, clarify that the employer does not have to provide a new vehicle for the claimant or repairs for the worker's existing motor vehicle.

3. Fraud in Workers' Compensation

The need to seriously address workers' compensation fraud was mentioned often in public testimony throughout the course of this study. The committee members agreed that State efforts concerning fraud must focus on employers, employees, health care providers and all parties in the workers' compensation system. Therefore, the committee adopted the following recommendations:

- Amend the statutes to strengthen the State Industrial Insurance System's ability to combat fraud by claimants, employers and medical providers, as follows:
 - a. Prohibit an employer from declaring bankruptcy and reopening as a similar business to avoid paying the cost of his outstanding debt to the State Industrial Insurance System for workers' compensation coverage, and require the employer to pay his debt to the system;
 - b. Prohibit the Department of Industrial Relations from imposing a fine on an insurer for deducting amounts from the claimant's future benefits that it felt the claimant had obtained by fraud, unless the insurer had no reasonable basis for making the deductions. Direct the Department of Industrial Relations, the Hearings Division of the Department of Administration and the State Industrial Insurance System to work together in developing less prohibitive language for a bill draft request to be considered by the 1993 Legislature;
 - c. Provide that a claimant is not entitled to temporary total disability benefits if he is engaged in an activity, even without pay, which is a job for which people are normally paid wages. Direct the Department of Industrial Relations, the Hearings Division and State Industrial Insurance System to work together in developing less prohibitive language for a bill draft request to be considered by the 1993 Legislature;
 - d. Require an injured worker to provide the insurer with complete information regarding his prior ratings or conditions. The claimant must fully disclose both nonindustrial conditions and conditions for which he previously received an award;

- e. Amend NRS 616.640 to specify that it is a gross misdemeanor for an employer to deduct the cost of workers' compensation coverage from the wages of an employee. Furthermore, clarify that any such violation will be prosecuted by the district attorney in the county where the employer has the principal place of business;
 - f. Provide that it is a crime for an injured worker either to fail to disclose or to conceal a material fact from an insurer in order to obtain benefits;
 - g. Amend the statutes to impose more stringent requirements and higher penalties for fraudulent acts by medical providers; and
 - h. Authorize State Industrial Insurance System fraud investigators to use standard motor vehicle license plates. Current law requires these investigators to use license plates for exempt vehicles which identify them as State vehicles.
- Create a special unit under the Attorney General to investigate and prosecute workers' compensation fraud and other types of fraud. (BDR 18-1149)
 - Require, by statute, that cases of fraud by a medical professional must be referred to the individual's professional licensing board for appropriate action. (BDR 18-1149)
4. The State Industrial Insurance System's Organization and Procedures

The committee considered several proposals to revise the provisions governing the organization and administrative operations of SIIS. The following recommendations were adopted:

- Change the Legislature's budget and financial oversight of the State Industrial Insurance System, except for any general fund money, by removing such oversight from the Senate standing Committee on Finance and the Assembly standing Committee on Ways and Means and placing it under the Senate standing Committee on Commerce and Labor and the Assembly standing Committee on Labor and Management or any ongoing statutory committee on industrial insurance.

- Amend the current law which requires the State Industrial Insurance System to have complete claims processing facilities in its suboffices. Allow the system to maintain existing suboffices but specify that claims processing would be done in them only if practicable. (BDR 53-1150)
- Authorize, by statute, the State Industrial Insurance System to borrow money either by pledging its current assets or by using revenue anticipation notes which would allow the system to repay the loans out of future premium collections. This proposal would allow the State Industrial Insurance System to expand its capacity to access the capital markets for improved cash management, and it would allow the system more flexibility in managing its assets.
- Amend the statutes to clarify that issues which should have been brought to the attention of the hearings or appeals officer, or which were taken to hearings or appeals but determined to be adverse to the employer, cannot be relitigated in front of the Manager of the State Industrial Insurance System. Furthermore, provide that the Manager may designate someone to hold the Manager hearings. (BDR 53-1155)

5. Employer Options for Industrial Insurance Coverage

Under a system of group self-insurance, two or more employers pool assets in order to qualify for self-insurance; the group's liabilities are likewise pooled for payment of claims. More than half the states allow group self-insurance for workers' compensation, and the National Association of Insurance Commissioners has developed model legislation for other states which may be considering such a law. Recognizing the need to provide Nevada employers with this option, the committee recommended that the 1993 Legislature enact the following BDR:

- Authorize, by statute, two or more employers to pool together to self-insure for workers' compensation. Provide that employers who are of the same industry or who have similar experience ratings may qualify as self-insured if their combined financial resources are sufficient to make certain the prompt payment of compensation. Adopt the provisions in the National Association of Insurance Commissioners' model acts regarding workers' compensation group self-insurance for private and public employers. (BDR 53-1156)

6. Administration of Nevada's Industrial Insurance Laws

The committee adopted the following BDRs to make needed technical changes to existing statutes:

- Amend NRS 616.647 to require that notice be given to health care providers and third-party administrators of alleged violations and the time and place of the hearing concerning such violations. Although NRS 616.647 allows the Administrator of the Division of Industrial Insurance Regulation to impose fines against health care providers and third-party administrators, there is no requirement for the Administrator to provide notice of violation and hearing to those persons. (BDR 53-1150)
- Amend NRS 616.221 to add an exception for NRS 616.427 which governs appeals from decisions relating to the Subsequent Injury Fund. (BDR 53-1150)

7. Industrial Insurance Classifications, Rates and Funds

According to SIIS, there has been some confusion in recent years regarding the extent of the Commissioner of Insurance's jurisdiction to hear protests of revised risk classifications. A number of employers have tried to appeal those issues to the Manager of SIIS. Based on this situation, the committee adopted the following recommendation:

- Authorize, by statute, the Manager of the State Industrial Insurance System to set premium rates and revise classifications subject to review by the Commissioner of Insurance. In addition, clarify that the Commissioner has jurisdiction over both premium increases and changes in the risk classifications. Furthermore, clarify that the Manager's jurisdiction to hear appeals in such matters is limited only to appeals regarding whether the employer has been properly placed in one classification as opposed to another.

The Subsequent Injury Fund is used to pay claims for industrial injuries incurred subsequent to a permanent physical impairment from any cause or origin. The fund was designed to encourage employers, who might otherwise want to avoid increased workers' compensation premiums, to hire workers with permanent physical impairments. The Administrator of DIIR is responsible for administering the fund, which is supported by assessments against insurers plus interest on the money in the fund.

Although the current law requires the Administrator to notify the insurer of a decision on a Subsequent Injury Fund claim within 90 days of receipt, the SIIS reported that it takes an average of 108 weeks (2 years and 3 months) to process a subsequent injury claim from the date of injury.

The Federal Americans with Disabilities Act (ADA) of 1991 is a comprehensive statute prohibiting discrimination based on disability in employment, public service and telecommunications. The committee received testimony that the Subsequent Injury Fund is no longer necessary because it appears to duplicate the provisions in the ADA.

In response to the aforementioned concerns, the committee voted to adopt the following recommendation:

- Amend the statutes to require that the Administrator of the Division of Industrial Insurance Regulation must accept or deny a subsequent injury claim within 90 days after the claim is filed, and require the division to reimburse the insurer within 60 days after the claim has been approved.

OR

Repeal the statutes relating to the Subsequent Injury Fund. (BDR 53-1151)

In its administration of the Uninsured Employers' Claim Fund, the DIR discovered that the costs of collecting money from uninsured employers is often greater than the sum of the money owed to pay for their employees' claims. The DIR proposed an addition to the administrative penalties which may be assessed employers who fail to acquire and maintain industrial insurance or who fail to pay premiums on time. Money from an additional fine would be used to offset the costs for the collection of money owed the uninsured employers' fund, for enforcement actions and to offset costs assessed against insurers for the cost of administering the fund.

The committee agreed with the DIR proposal and recommended that the Legislature:

- Amend NRS 616.437 to add an administrative fine which may be assessed against employers who fail to acquire and maintain industrial insurance or fail to pay premiums on time.

8. Hearings and Appeals of Contested Claims

The committee considered several proposals to improve the hearings and appeals process for contested claims.

Under S.B. 7 of 1991, the Legislature shortened the time limits for persons to file appeals from hearing officer decisions and for appeals officers to schedule hearings on the appeals. The committee learned that the reduced time periods do not give parties sufficient time to make decisions about an appeal or to be ready for the hearing. The result has been that appeals are routinely filed in order to preserve the parties' rights and many have been subsequently dismissed. In addition, a practice has developed where appeals hearings are set and then automatically continued. These practices have created a tremendous paperwork burden for the Hearings Division.

To address these concerns, the committee recommended that the Legislature:

- Amend NRS 616.5422 to extend the time for filing a notice of appeal from within 30 days after the date of the hearing officer's decision to within 60 days after the decision. Furthermore, amend the provision which requires an appeals officer to schedule a hearing within 45 days after he receives notice of appeal; increase the time for setting such a hearing to the previous statutory limit of 60 days.

The committee also discovered the need to lengthen the current time limits for hearing officers to render their decisions and for parties to seek a stay of the hearing officers' decisions. Therefore, the committee members voted to adopt the following recommendation:

- Amend NRS 616.5416 to extend the time for granting a stay of the decision of a hearing officer from 15 days to 30 days. In addition, extend the time within which a hearing officer must render his decision from 7 days to 15 days.

Under current law, insurers must select PPD rating physicians from a rotating list. Hearing and appeals officers are, however, given the authority to order a new PPD rating if they are not satisfied with ratings presented to them by the insurer and/or the injured worker. Recognizing that the hearings and appeals officers should follow the same requirements as the insurers, the committee recommended the following:

- **Require, by statute, that hearing and appeals officers, when ordering new permanent partial disability ratings, must select rating physicians from a rotating list of physicians, unless the insurer and the injured worker agree otherwise.**

Hearing officers are in the classified service of the State personnel system and have no fixed term of office. They remain in their position until they resign or are discharged for cause in the same manner as any other classified employee. To provide for more accountability of these quasi-judicial officers, the committee recommended that the Legislature:

- **Provide, by statute, that hearing officers are in the unclassified service of the State and serve at the pleasure of the Director of the Department of Administration.**

The committee agreed that an informal dispute resolution procedure should be utilized as early as possible in contested claims. Hearing officers could be used to mediate between parties in most cases, but parties in certain cases, such as when there is a fatality or an obvious question of law, should be allowed to skip the first hearing level and proceed directly to the appeals level. Thus, the committee approved the following recommendations:

- **Consider using mediation at the hearings level, and direct the Hearings Division to submit a detailed mediation proposal to the 1993 Legislature.**
- **Amend the statutes to provide that parties represented by legal counsel may stipulate to forego the hearing officer hearing and may proceed directly to the appeals officer hearing.**

During the interim study, the committee found that there are unqualified people who are representing injured workers and jeopardizing the ability of the claimants to receive a fair hearing. In one particular case, a person who was not a lawyer represented several injured workers and embezzled over \$100,000 of their money before he committed suicide. To ensure a higher quality of representation for injured workers and to provide some degree of financial protection, the committee voted to recommend that the Legislature:

- Amend the statutes to provide that a person who is not admitted to practice law in Nevada or who is not working under the supervision of a Nevada licensed attorney, may not represent or provide legal advice to an injured worker for remuneration.

9. Occupational Safety and Health

One of the provisions of S.B. 7 requires an employer to establish a written safety program, with specific statutory and regulatory requirements, if he has a rate of occupational injury or illness that is in the highest 25 percent in this State for his standard industrial classification. The committee discovered that this provision would require certain employers to establish these safety programs even if they had a good safety record and their own safety programs in place.

Recognizing the need to target only those employers with the most serious need for safety and loss prevention programs, the committee approved the following BDR:

- Amend NRS 618.383 to remove the requirement that an employer must establish a written safety program if he has a rate of occupational injury and illness that is in the highest 25 percent in this State for his standard industrial classification. Provide that the requirements for a written safety program apply only to those State Industrial Insurance System policyholders whose actual and anticipated costs for accident benefits and compensation for their employees exceeded 90 percent of the employer's manual premium in at least 2 of the 5 most recent fiscal years. In addition, amend the statutes to require the Manager of the State Industrial Insurance System to identify such policyholders and provide them with consultation concerning safety and loss control.
(BDR 53-1152)

The current statutes provide for misdemeanor penalties, a maximum fine of \$1,000 or 6 months in jail, for the violation of the licensing requirements for asbestos abatement. According to DIR, the misdemeanor penalties are not a deterrent and the district attorneys will not prosecute such industrial crimes. In order to address this and related issues, the committee recommended the following:

- Amend NRS 618.835 and NRS 618.850 to:
 - a. Remove the enforcement requirements for violations of asbestos abatement statutes and regulations from district attorneys and return them to the Division of Enforcement for Industrial Safety and Health, Department of Industrial Relations. Furthermore, allow the division to impose an administrative penalty of up to \$70,000 for each willful violation; and
 - b. Provide limitations which would prevent principal contractors from transferring license requirements to subcontractors or employees.

10. Legislative Oversight Concerning Industrial Insurance

The present industrial insurance crisis may have serious consequences for the State in the near future. In recognition of the need for the Legislature to continue its oversight of Nevada's workers' compensation laws and programs, the committee recommended that the 67th Legislature enact the following BDR:

- Provide, by statute, for the continuation of the Legislative Committee on Industrial Insurance by establishing it as an ongoing statutory committee of the Nevada Legislature. Provide the committee with broad powers to review and evaluate the laws, regulations and State agencies related to workers' compensation and occupational safety and health. Provide for the membership, duties and funding of the committee, as follows:
 - a. The membership of the committee consists of four members of the Senate, appointed by the Senate Majority Leader from the members of the Senate standing Committee on Commerce and Labor, and four members of the Assembly, appointed by the Speaker of the Assembly from the members of the Assembly standing Committee on Labor and Management. The members of the committee shall select the chairman and vice chairman from among their members, but the chairman for the first 2 years must be a member of the Assembly and the vice chairman must be a Senator. Thereafter, the positions of chairman and vice chairman will rotate between the Senate and Assembly every 2 years;

- b. The committee must report every 2 years before the convening of the Legislature to the Legislative Commission concerning its activities and any recommendations. The committee must meet at least four times each year, but it shall not meet more than six times in any year. The meetings may be held in person or by telephone conference or video telecast. The Director of the Legislative Counsel Bureau or his designee shall serve as the committee's nonvoting recording secretary. The committee may prescribe its own rules, but five members of the committee constitute a quorum which may exercise all the powers of the committee;
- c. The salaries and expenses of the members of the committee and at least one committee staff person (Senior Research Analyst) and any other expenses incurred by the committee in carrying out its duties must be paid from the Fund for Workers' Compensation and Safety. The expenses of the committee must be reported to the Legislative Commission and Department of Industrial Relations; and
- d. Any other provisions which are necessary to allow the committee to carry out its responsibilities.
(BDR 53-1153)

V. SELECTED REFERENCES

- American Legislative Exchange Council (ALEC). (1990, April). Workers' Compensation--Major Challenges Facing Systems in the 1990s. *The State Factor*, 16 (No. 8).
- Comp Attrition [Review & Outlook]. (1992, November 23). *The Wall Street Journal*, p. A14.
- Department of Insurance. (1993). *Solvency Investigation of the Nevada State Industrial Insurance System*. Carson City, Nevada.
- Hughey, Vance A. (1992, March 25). Subsequent Injury Processing. Memorandum to Scott Young, General Counsel, State Industrial Insurance System (SIIS). Carson City, Nevada: Policy, Planning and Review Division, SIIS.
- Hughey, Vance A. (1992, June 24). Claims Reopening in Other States. Memorandum to Scott Young, General Counsel, State Industrial Insurance System (SIIS). Carson City, Nevada: Policy, Planning and Review Division, SIIS.
- Hughey, Vance A. (1992, August 10). Legislative Request--Physician Ownership of Other Medical Services. Memorandum to Scott Young, General Counsel, State Industrial Insurance System (SIIS). Carson City, Nevada: Policy, Planning and Review Division, SIIS.
- Hughey, Vance A. (1992, November 9). Physical Therapy Expenses and Rehabilitation Expenses. Memorandum to Scott Young, General Counsel, State Industrial Insurance System (SIIS). Carson City, Nevada: Policy, Planning and Review Division, SIIS.
- Hughey, Vance A. (1992, December 7). Request for PPD Information. Memorandum to Scott Young, General Counsel, State Industrial Insurance System (SIIS). Carson City, Nevada: Policy, Planning and Review Division, SIIS.
- Jackson, Carol A. (1992, August 3). Proposed Legislation for the 1993 Nevada Legislature--Summary of Proposals. Memorandum to Senator Raymond C. Shaffer, Chairman, Legislative Committee on Industrial Insurance. Carson City, Nevada: Department of Industrial Relations.
- Kenney, Roger K. (1992). *Workers Compensation State Funds: Disappearing Capital*. Schaumburg, Illinois: Alliance of American Insurers.

- KPMG Peat Marwick. (1992). *State Industrial Insurance System--Financial Statements--June 30, 1992--With Independent Auditors' Report Thereon*. Las Vegas, Nevada.
- Krajewski, Frank R. (1992, July 21). Robert Ostrovsky's Recommendations. Memorandum to Members, Legislative Committee on Industrial Insurance. Carson City, Nevada: Research Division, Legislative Counsel Bureau.
- Leeder, Nancyann. (1992, July 17). 1993 Legislature--Bill Draft Request (BDR) Proposals to S.B. 7 Committee. Exhibit presented to the Legislative Committee on Industrial Insurance. Carson City, Nevada: Nevada Attorney for Injured Workers.
- Legislative Auditor. (1990). *Compensation and Other Benefits to Injured Workers*. Carson City, Nevada: Nevada Legislature.
- Legislative Auditor. (1990). *Department of Industrial Relations*. Carson City, Nevada: Nevada Legislature.
- Legislative Auditor. (1990). *Hearings and Appeals Process*. Carson City, Nevada: Nevada Legislature.
- Legislative Auditor. (1990). *Medical Benefits to Injured Workers*. Carson City, Nevada: Nevada Legislature.
- Legislative Auditor. (1990). *State Industrial Insurance System*. Carson City, Nevada: Nevada Legislature.
- Meierdierck, Jay. (1992, November 18). Legislative Request. Memorandum (FY 92 actual and FY 93 estimated expenses for total compensation, total medical, chiropractic and total rehabilitation) to Don Williams, Legislative Counsel Bureau Research. Carson City, Nevada: Planning, Policy and Review Division, State Industrial Insurance System.
- Miles, Dan. (1992, June 4). Budgetary Control of SIIS. Memorandum to Senator Raymond C. Shaffer, Chairman, Legislative Committee on Industrial Insurance. Carson City, Nevada: Fiscal Analysis Division, Legislative Counsel Bureau.
- Miller, Denice L. (1992, September 10). Self-Insurance for Workers' Compensation. Memorandum to Senator Randolph J. Townsend, Nevada State Senate. Carson City, Nevada: Research Division, Legislative Counsel Bureau.

- Miller, Denice L. (1992, September 30). Employer Pools for Workers' Compensation Insurance. Memorandum to Senator Randolph J. Townsend, Nevada State Senate. Carson City, Nevada: Research Division, Legislative Counsel Bureau.
- Miller, Denice L. (1992, October 21). Subsequent Injury Fund. Memorandum to Assemblywoman Christina R. Giunchigliani, Nevada State Assembly. Carson City, Nevada: Research Division, Legislative Counsel Bureau.
- National Conference of State Legislatures Blue Ribbon Panel on Workers' Compensation. (1992). *Recommendations to the NCSL Task Force on Workers' Compensation*. Denver, Colorado: National Conference of State Legislatures.
- National Council on Compensation Insurance. (1992). *Harnessing the Forces of Change--Issues Report, 1992--A Summary of Issues Influencing Workers Compensation*. Boca Raton, Florida.
- Rock, Glenn B. (1992, August 11). Converting SIIS Classified Employees to the Unclassified Service. Memorandum to Donald O. Williams, Principal Research Analyst, Legislative Counsel Bureau. Carson City, Nevada: Department of Personnel.
- State Industrial Insurance System (SIIS). (1992). *State Industrial Insurance System Business Plan*. Carson City, Nevada: Policy, Planning and Review Division, State Industrial Insurance System.
- Trolin, Brenda. (1992, May). Can Workers' Comp Work? *State Legislatures*, pp. 33-37.

VI. APPENDICES

	<u>Page</u>
Appendix A	
Consensus Legislation.....	45
Appendix B	
Suggested Legislation.....	97

APPENDIX A

Consensus Legislation

October 14, 1992

The Honorable Raymond Shaffer
and Members of the Standing Committee

Re: Proposed Legislative Changes

Dear Senator Shaffer and Committee Members:

The accompanying document contains proposed legislative changes to the Nevada Industrial Insurance Act and the Nevada Occupational Diseases Act. These proposals were developed in a series of meetings over a number of months and represent a consensus on some needed modifications to existing statutes by representatives from various interested parties. These changes are not the only ones that need to be made and some members of the group will be advancing other proposals on their own. However, this document represents the areas where this group reached agreement. The group consisted of the following people:

Larry Zimmerman
Bob Ostrovsky
Bryan Nix
Tim Rowe
Ray Badger
Don Jayne
Mat Dorangricchia
Scott Young

Jack Jeffrey
Dean Hardy
Chuck Verre
George McNally
Marvin Gross
Marc Hechter
Jim Spinello

We appreciate the many hours that your committee has devoted to the issue of workers' compensation. We hope that our efforts will be useful to you and will make some contribution toward addressing the pressing issues in Nevada's program.

EXPLANATION OF CONSENSUS LEGISLATION

616.025 Accident benefits

In the past, the insurer has been ordered to provide motor vehicles in some instances. Generally, this is appropriate if the injured worker has suffered quadriplegia or paraplegia. There have, however, been some instances where the insurer was ordered to provide a vehicle and the insurer felt this was unnecessary. Also, there are times when from an economic standpoint it is appropriate to modify the injured worker's existing vehicle instead of purchasing a new one. This amendment would make it clear that motor vehicles are only to be provided in cases of the most serious injuries and that the insurer should have discretion to modify an existing vehicle or purchase an adequate used vehicle instead of a new one. Further, the amendment makes it clear that, if the insurer provides a new vehicle or modifies an existing one, the insurer will not be responsible for the operating costs and insurance on the vehicle. In the past, the insurer has been ordered to pay for such items.

Subsection 2 would exclude items such as exercise equipment, spas and memberships in health clubs from the definition of accident benefits. In some instances, the insurer has been ordered to provide these benefits. These types of benefits do not substantially aid in the recovery of injured workers and are uniquely subject to abuse.

616.027 Average Monthly Wage

This amendment would clarify that the amount paid by employers for health insurance is not considered part of the employee's wage. Traditionally, the cost of health insurance coverage has not been deemed part of the wage. Therefore, no premium is collected on that. If SIIS must pay compensation based upon a wage that includes the cost of health insurance, then SIIS is going to have to charge employers additional premium. As Professor Larson notes in his treatise, historically health insurance is not considered part of a wage. He also notes that one of the probable effects of including health insurance as part of wages would be to discourage employers from providing health insurance since it would be one more item upon which their premium would be based. In one particular administrative hearing, an insurer was ordered to include the cost of health insurance as part of the wage base. This decision was reversed upon appeal in the district court but it is the type of issue that is likely to surface again and, therefore, specific statutory direction is necessary.

616.045 Compensation Defined

This amendment would make it clear that the insurer may not advance compensation to an injured worker before it is legally due. In the past, SIIS had

made such advances in hardship cases. The difficulty is that once an advance is given for one individual, there are many requests for advances from other people. Then there are constant arguments about why one person received an advance and not another. Also, there have been situations where the individual who receives an advance one time comes to rely upon the ability to get further advances and in some instances people have been advanced many months' worth of compensation. There is always the possibility that this money will not be recovered if the individual should die or if their compensation terminates for any reason sooner than anticipated. By making it clear in the law that no advances could be made, the heavy administrative burden in terms of time would be removed from the insurer because the requests simply could not be granted and they soon would cease.

616.123 Vocational rehabilitation services

This amendment would make it clear that the insurer cannot be ordered to provide child care services for injured workers nor new vehicles for them or repairs to their existing motor vehicle. It is not uncommon for the insurer to be ordered to pay for babysitting while an injured worker searches for a new job. This ignores the fact that had the worker never been injured and continued to work, the worker would have had to pay for child care anyway. Insurers also frequently find themselves ordered to repair someone's car because they allege they cannot make the required job contacts unless they have reliable transportation. Again, this approach ignores the fact that had the individual still been working, they would have been responsible for getting themselves to work and repairing their own vehicle. There are also times when insurers are ordered to purchase a vehicle for someone, for instance if their retraining involves becoming a real estate agent. The insurers and employers should only be responsible for providing job skills, and not for providing equipment that might be necessary to perform a job. This provision allows an insurer to provide such benefits in an appropriate case but prohibits the insurer from being ordered to provide these benefits by a hearing officer or appeals officer. An employer may appeal to the general manager of SIIS if the employer feels that the provision of such benefits was inappropriate in a particular case; if the general manager agrees, the charges are removed from the employer's account.

616.1725 General Powers of the System

The amendment to subsection (c) would allow SIIS to borrow money either by pledging its current assets or by using revenue anticipation notes. These notes would allow the System to repay the loans out of future premium collections. Currently, SIIS is having to sell very desirable bonds in its portfolio in order to meet its current cash needs. If it were allowed to borrow against those bonds, it could preserve them and their interest-earning capacity by borrowing at rates cheaper than the interest earned by the System on its portfolio. When the System has to liquidate portions of its portfolio, it loses the future interest earnings on those assets. When that interest income is lost, it means that the System must collect even more premium to make up for the loss of interest income. For fiscal year 1992 the System

had a negative cash flow of approximately \$92 million. The projected figure for FY 93 is something in excess of \$97 million. Investment income for fiscal year 1992 was approximately \$49 million but is anticipated to drop to \$43 million in FY 93. The book value of the SIIS reserves as to July 1, 1991 was \$667,510,000. The estimated book value as of June 30, 1992 is approximately \$577,000,000.

616.175 Offices and suboffices; telephone service.

The law presently requires SIIS to have complete claims processing facilities in its suboffices. The Reno office and the Elko office are essentially policyholder suboffices. There are no claims processing facilities there. In order to strictly comply with the statute, SIIS would either have to close those offices or transfer some of its claims staff to those areas. Currently, the transfer of personnel is not feasible. This amendment would allow the System to maintain its existing suboffices by specifying that claims processing would be done in them only if it was practicable.

616.222 Power of insurer to require counseling, training or other rehabilitative services; eligibility for vocational rehabilitation services; effective of inability of insurer to locate injured employee.

There are two proposed amendments in this section. The word "permanent" has been added in section 3(a) to make it clear that rehabilitative services are available when an injured worker suffers lasting restrictions that prevent a return to the preaccident employment. This change should be read in conjunction with subsection 8 of NRS 616.585 (please see page 21 of the proposed consensus legislation document) which allows an employer to offer certain types of light duty on an interim basis if the physical limitations are not permanent.

The second proposed change is in subsection 5. This amendment would codify the existing practice which is to deny rehabilitation payments to an injured worker who is incarcerated. There is no reason why such an individual should continue to receive support from the employer while they are in jail. They cannot participate in the training or other programs that rehabilitation offers until they are released. Therefore, their compensation should be suspended until they are able to participate in those programs and further their return to work.

616.226 Power of hearing officers, appeals officers, administrator and manage when conducting hearings or other proceedings; notification of determination by insurer.

This amendment would delete subsection 3. The appeals officers already mail copies of the decisions to the injured employee and the employer. Subsection 3 was added in the last legislative session and has imposed a substantial administrative burden on the insurers. In most cases, the physicians have no interest in the outcome of the particular decision. For instance, if the injured worker has appealed their wage base, the physician does not need to know the outcome of that issue. Sending copies of all decisions to the physicians has resulted in confusion on their part since oftentimes they do not know why they are receiving a decision. This

generates more work for the doctors and for the insurer's staff which is not justified in view of the already heavy workload.

616.340 Duties of employer when employee injured: First aid; notification of claims administrator; report of injury; reimbursement

This amendment would delete subsections 2 and 3. The essence of these subsections has been transferred to NRS 616.500 (please see page 11 through 13 of the proposed consensus legislation document). The new version of NRS 616.500 simplifies and clarifies the procedures for reporting an injury. Therefore, these two subsections have become superfluous.

616.345 Employer and physician or chiropractor to file report of injury; requirements for report; penalty for noncompliance. [Effective July 1, 1992.]

This proposal would eliminate the entire section because the essential provisions have been incorporated in NRS 616.500 infra. Like subsections 2 and 3 of NRS 616.340, this entire section is now superfluous.

616.377 Election by injured employee to receive compensation in lieu of action against uninsured employer; liability of uninsured employer; powers and duties of division; appeal of decision made by division or system.

This proposed amendment would allow an injured worker to receive workers' compensation benefits and still be able to sue an uninsured employer in tort law. Presently, the injured worker must elect to either receive workers' compensation benefits through the uninsured employers' fund or forego such benefits and sue the employer in tort law. When the injured worker elects to receive benefits from the uninsured fund, DIR must then pursue a legal action against the uninsured employer to collect the amount expended on behalf of the injured worker from the uninsured fund. By allowing the injured worker to receive workers' compensation benefits but still sue the uninsured employer, there would be an incentive for injured workers to hire private counsel who could then pursue the uninsured employer instead of placing that burden on DIR. It is believed that this would result in prompter recovery from uninsured employers since DIR has never been adequately staffed to handle these types of actions. The long term result of this amendment should be to return more money to the uninsured employers' fund which will in turn reduce the DIR assessment which is ultimately paid by the self-insured employers and the employers covered by SIIS.

616.380 Rating system

This section allows the general manager of SIIS to set premium rates and revise risk classifications subject to review by the insurance commissioner. In recent years, there has been some confusion regarding the extent of the insurance commissioner's jurisdiction to hear protests of revised risk classifications. A number of employers have tried to appeal those issues to the general manager pursuant to NRS 616.392.

This amendment makes it clear that the insurance commissioner has jurisdiction over both premium increases and changes in the risk classifications. The general manager only has jurisdiction to hear appeals regarding whether the employer has properly been placed in one classification as opposed to another.

616.392 Appeal to the manager

In addition to clarifying the respective jurisdictions of the insurance commissioner and the general manager, the amendments here make it clear that issues which should have been brought to the hearing officer or appeals officer or which were taken there but determined adversely to the employer cannot be relitigated in front of the manager. Currently, SIIS gets numerous requests for general manager hearings to write off costs that result from benefits that have been ordered by the hearing officer or the appeals officer. The employer has the right to appeal to the hearing officer or appeals officer when those issues are in those respective forums. An employer should not be allowed to forego the appeal in those forums or, if they lose in those forums, to have "a second bite at the apple" by coming to the general manager and asking him to second guess the decision already made by the hearing officer or appeals officer.

The amendment to subsection 2 also clarifies that the general manager can designate someone to hold the general manager hearings instead of doing them himself. There are so many of these hearings that the general manager cannot personally hear all of them. Such designation has always been an accepted part of administrative practice. This amendment merely codifies the existing practice.

616.427 Subsequent injury fund: Payment of cost of additional compensation resulting from subsequent injury.

The amendment to subsection 6 clarifies that the administrator of DIIR must accept or deny a subsequent injury claim within 90 days after the claim is filed. The subsequent injury fund has been plagued by delays, sometimes running into years. Although most of these delays are not the fault of DIIR, this amendment would expedite the processing of these claims. Ultimately, if the claim is granted, the employer gets relief against the amount of premium they must pay to SIIS. Therefore, it is of great concern to employers that these claims be processed timely.

The other part of the amendment requires DIIR to reimburse the insurer within 60 days after the claim has been approved. At times, there have been substantial backlogs and reimbursements that the insurers could be using and earning interest on. This provision would expedite the return of the funds to the insurer so they could be put to use on behalf of employers.

616.500 Notice of injury or death

The proposed amendment would entirely rewrite the existing 616.500 and would incorporate some of the provisions from NRS 616.340 and 616.345. The amendment is designed to eliminate some of the problems that arose from legislative changes in the last session. Those changes in part required that every

injury to an employee be reported to the insurer. This meant that employers had to report minor bumps and bruises and cuts for which no medical treatment was required and no time was lost. In turn, the insurers had to open files on each of these injuries and then process those claims through closure. This resulted in a very time-consuming administrative burden for both employers and insurers.

In its amended form, there would be a record of each accident, however minor. The form on which the accident was recorded would give instructions to the worker on how to proceed with formally filing a claim if the injury turned out later to be more severe than it initially appeared. Both the employer and the worker would have a copy so there would be a permanent record that the employee had in fact reported an accident. However, the insurer would not be notified unless the worker sought medical treatment. Once the employer became aware that medical attention was required, the six working day period to report the claim to the insurer would be triggered. Furthermore, if the physician's portion of the form indicated that the worker would lose five or more days from work, the employer would have to provide a statement of wages. This would retain the best portions of last sessions efforts to expedite the processing of claims and would also retain the fines against the employers or physicians who fail to timely report accidents.

Subsection 9 restates existing law which is that the employee has the burden of proving that the injury or occupational disease arose out of and in the course of employment by a preponderance of the evidence. Section 9 goes on to provide a new concept: If the employee reports an accident after the termination of employment, there is a rebuttable presumption that the injury did not arise out of and in the course of employment. This provision only applies to accidents as defined in NRS 616.020 and specifically does not apply to occupational diseases. This provision was felt to be necessary because of the large number of claims that are filed after someone is terminated or laid off. Clearly, there are valid reasons why an employee may sometimes not report an injury until after termination. Therefore, it would not be fair to automatically bar any claims filed after termination but it was believed to be necessary to treat these types of claims somewhat differently than a normal claim because of the potential for abuse.

Subsection 10 restores the 30 day time period for accepting or denying a claim. Experience has shown that the amendment from last session which reduced the time to 14 working days was unworkable.

616.537 Insurer required to schedule rating for injured employee after determination by treating physician or chiropractor; contents of rating evaluation.

The proposed amendment would delete this section entirely because it was partly in conflict with NRS 616.605 and partly redundant. Subsection 2 has been transferred to NRS 616.605 where it appears as a new subsection 3 (please see page 22 of the proposed consensus legislation document).

616.540 Contested claims: Appointment and term of hearing officers.

Presently, hearing officers are in the classified service and have no fixed term. They remain in their position until they resign or unless they should be discharged for cause in the same manner as any other classified employee. Because they sit as quasi-judicial officers, there should be more accountability. If a particular hearing officer repeatedly makes poor decisions, the Department of Administration should have the opportunity to replace that individual. In his testimony before the standing committee in Las Vegas on June 10, 1992, John H. Lewis, Consultant, Blue Ribbon Panel National Conference of State Legislatures Task Force on Workers' Compensation, stated that administrative hearings officers in many respects have more power than a judge in a trial court. The judge presides over the case but the actual decision is made by the jury. In an administrative setting, the hearing officer is in fact the one who makes the decision on the case, unlike a judge. Mr. Lewis noted that it is especially important in these types of situations that there be more accountability.

616.5412 Contested claims: Request for hearing; forms for request to be provided by insurer; appeals; expeditious and informal hearing required. [Effective March 1, 1993.]

Subsection 5 adds a new provision that would allow parties represented by legal counsel to forego a hearing before the hearing officer and proceed directly to the appeals officer level. While the hearing officers perform an important function, there are some cases where so much is at stake that everyone realizes that the losing party will appeal at least to the appeals officer level. This occurs when there is a pure question of law or when there is a fatality, quadriplegia or paraplegia or a stress case. In these instances, it is a waste of time for the parties and the hearing officer to proceed to a hearing which everyone knows will be immediately appealed. It also results in a delay in reaching an ultimate resolution on some of the most significant types of cases. The provision requires that the parties be represented by attorneys so that any decision to bypass the first hearing will be made in an informed manner. Additionally, a requirement was imposed that all parties agree to bypassing the first hearing so that the first level of hearings would not be undermined and only the special cases already noted would be eligible for a direct hearing before the appeals officer.

616.5415 Contested claims: Licensing of parties' representatives; employer liable for representative's violations of chapter; compensation of employer's representative must not be contingent on outcome.

Subsection 6 would prohibit people who are not admitted to practice law in this state from providing legal advice or representing injured workers for remuneration. This would not prohibit non-lawyers from representing employers nor would it prohibit labor representatives from appearing on behalf of their members. Further, it would not prohibit non-lawyers who are supervised by an attorney from representing injured workers. This provision is necessary because

there are, and have been in the past, unqualified people who are representing injured workers and jeopardizing their ability to receive a fair hearing. The most noteworthy example was the unfortunate incident involving Dave Hendricks. Mr. Hendricks was a non-lawyer who represented several injured workers. He embezzled over \$100,000 of his clients' money and then committed suicide. Had he been an attorney he would have either had malpractice insurance to protect his clients or at least his clients would have been eligible for reimbursement from the fund maintained by the state bar for victims of attorney malpractice. This provision would ensure a higher quality of representation for injured workers and afford some financial protection in cases of professional default by their representative. At the same time, it would not interfere with the right of an employer to choose a non-lawyer to represent them.

616.5416 Selection of rating physicians

Under existing law, insurers must select rating physicians from a rotating list. Hearing officers and appeals officers are given the authority to order a new PPD rating if they are not satisfied with those presented to them by the insurer and/or the injured worker. It is appropriate that if the insurer must select a rating physician from a rotating list that the hearing officers and appeals officers exercise their authority under the same requirement. This would ensure impartiality in the selection of rating physicians. The proposed amendment would, however, allow the insurer and the injured worker to select a rating physician by mutual agreement, thus promoting cooperation between the parties most vitally interested in the outcome and reducing the possibility of further appeals by a dissatisfied party.

Subsection 5 has been amended to allow the hearing officer 15 days in which to render a decision. The prior seven day limitation was too short to enable the hearing officers to adequately state the reasons for their decision.

Subsection 8 has been amended to provide 30 days during which a party may seek a stay of a hearing officer decision. The prior 15 day time limit did not allow parties sufficient time to evaluate their case and the need for a stay, nor did it allow a party opposing a stay request adequate time to respond.

616.5422 Contested claims

Subsection 1 has been amended to allow 60 days to appeal a decision from the hearing officer. This was the time limit prior to the 1991 session. Although the legislature's aim in trying to reduce the time periods for hearings was well-intentioned, in practice the 30 days did not give parties sufficient time to review a hearing officer decision and make an informed choice about an appeal. The result was that appeals were routinely filed in order to preserve the parties' rights and many were subsequently dismissed. This created a large paperwork burden for the Department of Administration and the various parties involved. Sixty days is not an unreasonable period of time to allow parties to review a decision and determine whether an appeal should be filed.

Subsection 3 has been amended to remove the requirement that the appeals officers set a hearing within 45 days after they receive the notice of appeal. During the 1991 session, the legislature was informed that this time period was unworkable. Everyone understood their desire to try and expedite hearings so that people would get the benefits that they were entitled to as soon as possible. As a practical matter, the attorneys for the insurers, the employers and the injured workers cannot be ready for a hearing within 45 days. A practice has developed where the hearing is set within 45 days and then automatically continued. Recently, because of workload burdens, the Department of Administration has shifted the responsibility for these continuances to the attorneys. This has resulted in additional phone calls and letters between SIIS attorneys and secretaries and attorneys for other parties. This paperwork and effort would be unnecessary if the appeals officers were allowed to go back to simply setting the case at the next available date.

616.5426 Selecting rating physicians

This is the same amendment that was suggested under NRS 616.5416 except that it specifically pertains to the appeals officers whereas the former section pertains to the hearing officers. It has the same effect on both of them.

**616.545 Application for increase or rearrangement of compensation;
reopening of case for changed circumstances.**

There has been a great deal of concern about the impact of lifetime reopening. This proposed amendment would retain lifetime reopening but would eliminate most of the abuses of that right which have been identified by insurers. Subsection 1 would impose a one year waiting period before a claim could be reopened unless there were exceptional circumstances. In order to reopen within one year of claim closure, the injured employee would have to demonstrate that there had been an objective change in medical condition and that the *primary* cause of the change was due to the industrial injury. The injured worker would have to prove this by clear and convincing medical evidence. In all other cases, the injured worker would have to wait one year from claim closure before the claim would be eligible for reopening.

Unless the injured worker could meet the exceptional circumstances requirement in subsection 1, the injured employee would have to wait one year after having a reopening request denied. This would prevent an abuse that is quite prevalent presently, namely, the filing of successive reopening requests as soon as the prior one has been denied. This creates an administrative burden for the insurers and generates excessive hearings at both administrative hearing levels.

Additionally, if the claim did not result in lost time and in permanent impairment, reopening rights would be limited to one year following claim closure. After the expiration of that one year period, the claim could never be reopened and the insurer would no longer be required to maintain a file or a reserve on the claim.

616.560 Subrogation

The amendment to subsection 3 would reverse the decision in Truck Insurance Exchange v. SIIS. Although SIIS has been subrogating against the employer's uninsured motorist policy for decades, the Supreme Court recently ruled that this was improper. Many employers have requested that SIIS subrogate against their uninsured policy because this gives them a credit against the claims costs which in turn reduces the amount of premium that they have to pay to SIIS. In general, it appears that the credit on the premium gives greater economic relief to the employer than any corresponding rise in the cost of their uninsured motorist coverage.

The amendment in subsection 4 is designed to prevent circumvention of the subrogation statutes. SIIS has had several instances where the employee sues the employer and even though technically the employer should be protected by the exclusive remedy, the employer makes a settlement with the injured worker to avoid the risks of litigation. This results in the injured worker getting double recovery; one set of payments from the insurer and another set of payments for the same injuries and losses from the employer. This is contrary to one of the basic tenets of workers' compensation. In one pending case, this amounts to over \$600,000 in reimbursement that the System would lose. This amendment would make it clear that such evasive devices as classifying the payment from the employer to the employee as a "gift" would not be allowed.

The amendment to subsection 6 would require attorneys representing an injured worker in a subrogation action or the third party's liability carrier to make sure that the insurer is reimbursed out of any third party recovery. SIIS has had a number of instances where the attorney for the injured worker settles with the third party and ignores the SIIS lien. The claimant then disappears and the attorneys simply shrug their shoulders and says "it's not my problem". Since the attorneys and the insurance carriers for the third party are really the ones that control the litigation and the settlement, it seems appropriate to put the legal responsibility on them to see that the insurer and ultimately the employer gets their fair share of any settlement. This amendment would require the attorneys and the private insurance carrier to pay the insurer out of their own pockets if for some reason they did not make sure that the third party or the injured worker paid the insurer.

Subsection 7 would prohibit the insurer from selling its lien to the private insurance company unless the injured worker or the injured worker's attorney refused to provide the insurer with information concerning the third party suit. Selling the lien to the third party carrier is a device that is sometimes used to avoid the workers' compensation insurer's share of the attorney's fees in the third party suit. This results in an unfairness to the injured worker and should only be allowed if the injured worker or their representative refuses to cooperate with the workers' compensation carrier in its efforts to have its lien satisfied.

616.565 Forfeiture, reduction and suspension of compensation.

The amendment in subsection 4 would relieve the employer of the responsibility of maintaining a worker on compensation if some non-industrial cause was keeping the worker from getting well. Insurers have had this situation develop when an individual gets injured, then gets pregnant and cannot undergo testing or treatment and the employer must continue to pay TTD during the whole course of the pregnancy. It also comes up in instances where the injured worker is an alcoholic and cannot undergo surgery because their liver will not tolerate the anesthesia as a result of long term alcohol consumption. This provision would, however, allow the insurer to assume responsibility for such treatment if in the insurer's discretion this would expedite the overall handling of the claim. However, a hearing officer or an appeals officer could not order the insurer to assume responsibility for such treatment.

616.585 Temporary Total Disability

The proposed amendments clarify when eligibility for temporary total disability ceases. Section 4(a) specifies that TTD stops when an employee is capable of performing gainful employment that the employee is reasonably suited for by education, training or experience. Section 4(b) allows the employer to offer temporary light duty work which might otherwise not qualify as an acceptable job offer if it was made for permanent employment. For instance, a maintenance worker in a casino who suffered a broken leg would probably not be able to perform their normal tasks. However, they might be able to fold napkins or drill dice, two admittedly menial tasks which are, however, very necessary to the casino operation. As soon as the worker was able to resume their normal duties, they would be transferred back to the maintenance department. In the meantime, they would continue to report to work on a regular schedule, continue to feel a part of the employer's organization and earn a wage rather than receiving TTD. Subsection (c) provides that a person who has been convicted and incarcerated cannot receive compensation benefits. There is currently no law that permits an insurer to terminate compensation benefits when an injured worker is incarcerated. It is necessary to specify that the individual must be convicted and incarcerated and not just in jail because of constitutional concerns that an individual who has not yet been convicted but who is deprived of compensation will not be able to provide bail for themselves.

Subsection 5 provides that the insurer may, but is not required to, issue a form to request continued compensation.

Subsection 6 clarifies an error in the existing statute. The form identified in that subsection should be sent six working days before the *ending* of the disability period, not the beginning. Subsection 6(b) provides that documentation in lieu of a completed form is acceptable if it shows a continuing disability covering the period of the specific check.

Subsection 7 requires a disability certification to include the period of disability as well as a description of the employee's work limitations and restrictions.

This will allow employers to more readily provide light duty work throughout the course of the claim as the limitations change. The certification must also be signed by a physician or a chiropractor to ensure that in fact the certification is coming from the treating physician and not from someone on the treating physician's staff.

Subsection 8 clarifies that an employee who is able to return to work with temporary restrictions may be offered a modified light duty position that does not need to meet all the requirements of the regulations dealing with permanent light duty. Many jobs are acceptable on a short term basis while the worker is recovering that would not be appropriate for full time career positions if the injured worker could not return to the preaccident job.

616.605 Permanent Partial Disability

There are several amendments in this section. Subsection 2 provides that the insurer and the injured employee may select a mutually agreeable rating physician. In the absence of such an agreement, the existing law requiring a selection from the rotating list will remain in effect.

Subsection 3 has been amended to include language from NRS 616.537. The rest of that statute was deleted because it was in conflict with existing provisions in 616.605.

The amendment in subsection 7 would require an injured worker to give the insurer information about prior ratings or prior conditions that the insurer would otherwise be unaware of. Under present law, the insurer can apportion the PPD award if part of the disability is due to a prior accident. Many times, however, the insurer has no way of knowing this unless it is disclosed. In the last session, the legislature passed NRS 616.1925 that required DIR to maintain an index of prior claims. This index can be accessed by SIIS and self-insureds to see if anyone has received a prior PPD rating. However, this index does not contain information about non-industrial cases or industrial cases from other states. Out of fairness to the employers, an injured worker should not receive compensation for a non-industrial condition or a condition that they have previously received an award for. The only way in many cases to get that information is to require the claimant to disclose it.

616.610 Temporary partial disability: Compensation.

See 616.585. This makes the rule regarding incarceration applicable to temporary partial disability payments as well as temporary total disability payments and rehabilitation payments.

616.640 The statute as presently written makes it illegal for an employer to deduct SIIS premiums from the wages of an employee. However, it does not specify what type of crime this constitutes. The proposed amendment of subsection 1 would specify that it is a gross misdemeanor.

The amendment in subsection 2 is designed to prevent a growing abuse which has the same effect as deducting SIIS premiums from a worker's wages but is done in a manner that is not presently covered by the statute. Some employers are

trying to characterize their employees as "independent contractors" and ordering them to secure their own SIIS policy. Technically, the employer is not deducting the money from the employee's wages, but the effect is the same. The proposed amendment in subsection 2 would protect contractors in the construction industry where it is presently permissible for the contractor to require a subcontractor to carry their own industrial insurance. If the subcontractor does not in fact secure that coverage, then the prime contractor is responsible for it. It makes sense to allow prime contractors to require the subcontractors to obtain their own coverage so long as the subcontractor is in fact a separate business entity.

Subsection 3 would make it clear that a violation of this section will be prosecuted by the district attorney in the county where the employer has the principal place of business. Presently, the statute only says that the employer will be prosecuted upon complaint by an employee. There has been some discussion about who should prosecute these cases and it does not make sense to provide protection for the workers and a criminal penalty and then have the matters remain unprosecuted because it is unclear who has the responsibility to go forward with the case.

616.647 Administrative fines for certain violations; hearing; appeal; revocation of certificate of self-insurance.

This amendment would repeal subsection (g) which is really unnecessary in view of existing subsection (h). Existing subsection (i) would be amended to add the words "intentionally or repeatedly" failed to comply with any provision or regulation. Currently, the statute purports to require DIIR to impose a fine for every violation. This is clearly impossible for DIIR and in fact puts them in technical violation of their own statute. The administrator should have discretion to impose fines in cases where there has been a deliberate violation or repeated failure to comply without being required to impose a sanction in every instance, a task which is clearly beyond DIIR's ability.

616.675 False statements or representations to receive compensation; prosecution; disclosure of information to assist prosecution.

NRS 616.675 is the principal statute used to prosecute fraud by injured workers. Presently, it is a crime to make a false statement or representation to obtain benefits. Insurers have encountered a number of situations where the injured worker does not make an affirmative, false statement to the insurer but rather conceals some material fact, for instance that he has indeed already returned to work. By adding the language "or who conceals a material fact", workers who fail to disclose things that should be known to the insurer will also be prosecutable. It should be noted that this language is presently in NRS 616.563. That statute allows the insurer to deduct amounts fraudulently obtained by the claimant from future benefits owed the claimant by the insurer. This amendment also clarifies that it is a crime to attempt to obtain narcotic medications from an emergency room by falsely reporting an industrial injury. In the past, prosecutors have been reluctant to

proceed on these types of cases since they are usually discovered by the insurer when the hospital presents its bill and the claim is then rejected. Prosecutors have felt that, since the workers' compensation insurer does not make any payment on the false claim that there has been no violation of Chapter 616. This amendment would make it clear that such conduct is prosecutable.

616.680 Claims for services not rendered; fraudulent acts of medical provider; liability of medical provider.

It is recommended that this section be deleted and that nine new sections be substituted. The section is the one that currently specifies what acts by medical providers are fraudulent and imposes penalties for those acts. This section was modeled on NRS 422.400 which was repealed by the 1991 session. In its place, the legislature adopted nine new statutes which are similar to the ones set out herein. These new statutes were much more specific in respect to what constitutes fraud by medical providers. Also, the penalties are more severe. Since the legislature saw fit to repeal NRS 422.400, which was virtually identical to 616.680 and substitute the more expanded statutes and penalties, it appears appropriate for SIIS to seek the same type of new legislation imposing more stringent requirements and higher penalties. The recommendation to make these changes came from the Medicaid Fraud Unit in the Attorney General's office.

616.690 Referral to health facility or service by physician or chiropractor with financial interest in facility or service prohibited [unless financial interest disclosed]; penalizing injured employee for refusal to use health facility or service prohibited.

The proposed amendment would make it illegal for a physician or chiropractor to refer an injured worker to a health facility or service in which the physician, chiropractor or an immediate family member has a financial interest. Studies have shown that such referrals tend to increase the number of medical procedures rendered to injured workers and thus increase the overall costs of the workers' compensation system. There is an inherent conflict of interest when a provider has a financial interest in another medical facility that a patient is being referred to. The Florida legislature is presently addressing this situation and the California Assembly has passed a bill prohibiting the practice. That bill is currently before the California Senate. SIIS data indicates that such referrals amount to millions of dollars each year.

617.459 Determination of percentage of disability resulting from heart or lung diseases.

The current law requires the rating physician and the treating physician to jointly determine the permanent partial disability from a disease of the heart or lungs. Insurers have found that most of the treating physicians do not want to become involved in rating their own patients. This puts them in an awkward position with their patient. Therefore, in practice insurers cannot get them to

participate. The amendment would make it clear that these conditions would be rated like any other rateable disability.

482.368 Distinguishing plates for exempt vehicles: Issuance; fees; interstate agreements; application; regulations.

The amendment in subsection 2(c) would allow investigators with SIIS to have plain license plates. Currently, SIIS fraud investigators must use the so-called exempt license plates which identify them as being a state employee. This makes it difficult for them to perform surveillance in fraud cases without being detected.

616.NEW

This amendment requires that a physician or chiropractor, not the injured worker, establish that a late manifesting injury is actually part of the original claim. The physician or chiropractor must base their opinion upon competent medical evidence and not simply the statements of the injured worker. It is not unusual to have claims where the injured worker alleges weeks, months or sometimes years after the original injury that some other body part was also involved in the claim. This amendment establishes an appropriate standard for the acceptance or denial of such late manifesting conditions.

616.NEW

This proposed statute would allow an insurer to recover inadvertent overpayments made as a result of a clerical error or improper information being supplied to the insurer by the employer. Currently, thousands of dollars each year are inadvertently paid out to claimants. Under the decision in SIIS v. Ransier, an insurer cannot recoup these payments. Other states allow the insurer to recoup the payments and even ESD in Nevada is allowed to recoup clerical overpayments. This provision would specify that the insurer only had 30 days in which to discover the inappropriate payment. This would protect injured workers from having to repay money years after a mistake. Further, the deductions could not be made until after a hearing before the hearing officer unless the injured worker failed to appeal the determination. Also, the deductions would have to be made in a reasonable manner that did not create an undue hardship to the claimant. This could be accomplished by taking a small amount out of each subsequent benefit check. It should be noted that the 1991 LCB audit recommended that insurers have the right to recoup such overpayments. A provision very similar to the proposed one was introduced in the 1991 session in AB 410 but was not enacted.

616.NEW

This amendment specifies that someone who has retired or otherwise voluntarily removed themselves from the work force for reasons unrelated to the industrial injury is not entitled to be placed back on temporary total disability if their claim is reopened after their retirement. There are no accurate figures, but it is known that there are a number of individuals who have been retired and then

reopen their claim and immediately get temporary total disability even though they are not actually missing any work.

PROPOSED CONSENSUS LEGISLATION

616.025 "Accident benefits" defined.

1. "Accident benefits" means medical, surgical, hospital or other treatments, nursing, medicine, medical and surgical supplies, crutches and apparatuses, including artificial members. The term includes medical benefits as defined by NRS 617.130 and any preventative treatment administered as a precaution to an employee who is exposed to a contagious disease while providing medical services, including emergency medical care, in the course and scope of his employment.

2. "Accident benefits" do not include motor vehicles except in cases of quadriplegia, paraplegia or amputation where the employee cannot be fitted with an artificial member in such a manner as to allow the employee to safely operate a motor vehicle. If a motor vehicle is allowable pursuant to this section, modification shall be made to the employee's existing motor vehicle if reasonably feasible. If modifications of the existing vehicle are not feasible, a used vehicle shall be provided with reasonable modifications if necessary. A new vehicle may only be provided if adequate modifications cannot be made to the employee's existing vehicle and no reasonably adequate used vehicle can be obtained. The determination of whether a used vehicle is reasonably adequate shall rest with the insurer's sound discretion. In no case shall the insurer be responsible for operating costs, licenses, fees or insurance coverage for any motor vehicle provided pursuant to this section.

3. "Accident benefits" do not include home exercise equipment, hot tubs, spas, jacuzzis or memberships in athletic or health clubs.

[8:168:1947; 1943 NCL § 2680.8]—(NRS A 1987, 921; 1991, 2398)

616.027 "Average monthly wage" defined.

1. Except as otherwise provided in subsection 3, "average monthly wage" means the lesser of:

(a) The monthly wage actually received or deemed to have been received by the employee on the date of the accident or injury to the employee excluding remuneration from employment:

(1) Not subject to the Nevada Industrial Insurance Act or the Nevada Occupational Diseases Act;

(2) Specified in NRS 616.255 or 617.180; and

(3) For which coverage is elective, but has not been elected; or

(b) One hundred fifty percent of the state average weekly wage as most recently computed by the employment security department during the fiscal year preceding the date of the injury or accident, multiplied by 4.33.

2. For the purposes of this section, "wage" is increased by the amount of tips reported by an employee to his employer pursuant to 26 U.S.C. 6053(a), except:

(a) Tips in a form other than cash; and

(b) Tips in cash which total less than \$20 per month.

3. For the purposes of this section, "wage" does not include the amount paid by the employer for health insurance coverage for the employee or the employee's dependents.

4. For the purpose of increasing compensation for permanent total disability pursuant to NRS 616.6262 or increasing death benefits pursuant to NRS 616.6282, "average monthly wage" has the meaning shown in the following schedule:

Average Monthly Wage Effective Date	for Prior Fiscal Year
July 1, 1973.....	\$688.60
July 1, 1974.....	727.48
July 1, 1975.....	761.47
July 1, 1976.....	807.33
July 1, 1977.....	858.29
July 1, 1978.....	918.05
July 1, 1979.....	992.31
July 1, 1980.....	1,061.24

(Added to NRS by 1973, 530; A 1975, 650; 1981, 1226; 1985, 1444; 1991, 2398)

616.045 "Compensation" defined. "Compensation" means the money which is payable to an employee or to his dependents as provided for in this chapter, and includes benefits for funerals, accident benefits and money for rehabilitative services. *The insurer may not advance any compensation to or for an injured worker before the time that it is legally payable.*

[7:168:1947; 1943 NCL § 2680.7]--(NRS A 1983, 1291)

616.123 "Vocational rehabilitation services" defined. "Vocational rehabilitation services" has the meaning ascribed to it in NRS 615.140. *"Vocational rehabilitation services" may include child care services, motor vehicles, repairs to the employee's existing motor vehicle, or tools or equipment normally provided by an employer if the insurer, in its sole discretion, determines that such services are reasonably necessary. A hearing officer or appeals officer shall not order any of the enumerated benefits for an injured employee but the employer may appeal to the general manager pursuant to NRS 616.392 if the System provides such benefits.*

(Added to NRS by 1991, 2390)

616.1725 General powers of system. The system may:

1. Use its assets to pay medical expenses, rehabilitation expenses, compensation due claimants of insured employers, and to pay salaries, administrative and other expenses.

2. Rent, lease, buy or sell property in the name of the State of Nevada, and construct and repair buildings as necessary to provide facilities for its operations.

3. *Borrow money secured by pledges on its assets or revenue anticipation notes as provided in NRS 616.____ through 616.____* {adopt statutes substantially

similar to NRS 319.270 to 319.390}. Any such borrowing shall not constitute a debt of the State of Nevada.

4. Sue and be sued in its own name.

[4]5. Enter into contracts relating to the administration of the system.

[5]6. Contract with physicians, chiropractors, hospitals, and facilities for rehabilitation for medical, surgical, and rehabilitative evaluation, treatment, care and nursing of injured persons entitled to benefits from the system.

[6]7. Contract for the services of experts and other specialists as required by the system.

[7]8. Provide for safety inspections and furnish advisory services to policyholders on measures to promote safety and health.

[8]9. Act in collecting and disbursing money necessary to administer and conduct the business of the system.

[9]10. Adopt regulations relating to the conduct of the business of the system.

[10]11. Hire personnel to accomplish its purposes and operations.

[11]12. Perform all the functions which are necessary or appropriate to carry out the administration of this chapter and chapter 617 of NRS.

(Added to NRS by 1981, 1452; A 1983, 283; 1985, 443, 1540)

616.175 Offices and suboffices; telephone service. The system shall:

1. Keep and maintain its office in Carson City, Nevada.

2. Keep and maintain suboffices at such places in the state as industrial activity warrants, and shall locate one suboffice in the Las Vegas area. *Where practicable, [S]suboffices [must] may have complete facilities for processing claims for injuries.*

3. Provide statewide, toll-free telephone service on state WATS lines to the Carson City office, and all suboffices, or accept collect calls from claimants.

[41:168:1947; 1943 NCL § 2680.41] +

[41.1:168:1947; added 1953, 712]--(NRS A 1977, 796; 1981, 1456)

616.222 Power of insurer to require counseling, training or other rehabilitative services; eligibility for vocational rehabilitation services; effective of inability of insurer to locate injured employee.

1. Except as otherwise provided in this section, to aid in returning an injured employee to work or to assist in lessening or removing any resulting handicap, the insurer shall order counseling, training or other rehabilitative services for the injured employee regardless of the date on which he first became entitled to compensation.

2. Before ordering any rehabilitative services for an injured employee there must first be a consultation with the injured employee and the treating physician or chiropractor with respect to whether the proposed program is compatible with the injured employee's age, sex and physical condition. If the services will involve a change in vocation, the consultation must also include a consultation with the employer of the injured employee and a rehabilitation counselor.

3. An injured employee is eligible for vocational rehabilitation services if:

(a) The treating physician or chiropractor approves the return of the injured employee to work but imposes *permanent* restrictions that prevent the injured employee from returning to the job he held before his injury and the employer of the injured employee does not offer employment that the employee is eligible for considering those restrictions; or

(b) During the course of treatment, the treating physician or chiropractor recommends the injured employee for assessment for vocational rehabilitation services.

4. Vocational rehabilitation services ordered by an insurer may include the formal education of the injured employee only if:

(a) The priorities set forth in NRS 616.378 for returning an injured employee to work are followed;

(b) The education is recommended by a plan of vocational rehabilitation; and

(c) A written proposal concerning the probable economic benefits to the employee and the necessity of the education is submitted to the insurer.

5. Any employee eligible for compensation other than accident benefits may not be paid those benefits if he refuses counseling, training or other rehabilitative services offered by the insurer. *Any employee who is convicted and incarcerated shall be deemed to have refused all rehabilitative services during the period of the incarceration and neither the employee nor his dependents are entitled to accrue or to be paid any money for rehabilitative services for that time period. For purposes of this section, "convicted" means an adjudication of guilt by a court of competent jurisdiction; a plea of guilty or of nolo contendere or any similar plea; or a commitment to any mental health facility for the criminally insane.*

6. If an insurer cannot locate an injured employee for whom it has ordered vocational rehabilitative services, the insurer may close his claim 21 days after the insurer determines that the employee cannot be located. The insurer must make a reasonable effort to locate the employee.

7. The reappearance of the injured employee after his claim has been closed does not automatically reinstate his eligibility for vocational rehabilitative benefits. If the employee wishes to reestablish his eligibility for such benefits, he must file a written application with the insurer to reinstate his claim. The insurer shall reinstate the employee's claim if good cause is shown for the employee's absence.

(Added to NRS by 1973, 362; A 1979, 1042; 1981, 1459; 1985, 1541; 1991, 491, 2401)

616.226 Power of hearing officers, appeals officers, administrator and manager when conducting hearings or other proceedings; notification of determination by insurer.

1. Appeals officers, the administrator and the manager, in conducting hearings or other proceedings pursuant to the provisions of this chapter or regulations adopted under this chapter may:

(a) Issue subpoenas requiring the attendance of any witness or the production of books, accounts, papers, records and documents.

(b) Administer oaths.

(c) Certify to official acts.

(d) Call and examine under oath any witness or party to a claim.

- (e) Maintain order.
 - (f) Rule upon all questions arising during the course of a hearing or proceeding.
 - (g) Permit discovery by deposition or interrogatories.
 - (h) Initiate and hold conferences for the settlement or simplification of issues.
 - (i) Dispose of procedural requests or similar matters.
 - (j) Generally regulate and guide the course of a pending hearing or proceeding.
2. Hearing officers in conducting hearings or other proceedings pursuant to the provisions of this chapter or regulations adopted under this chapter may:
- (a) Issue subpoenas requiring the attendance of any witness or the production of books, accounts, papers, records and documents that are relevant to the dispute for which the hearings or other proceeding are being held.
 - (b) Maintain order.
 - (c) Permit discovery by deposition or interrogatories.
 - (d) Initiate and hold conferences for the settlement or simplification of issues.
 - (e) Dispose of procedural requests or similar matters.
 - (f) Generally regulate and guide the course of a pending hearing or proceeding.
- [3. After a determination is made pursuant to a hearing or other proceeding, the insurer shall notify the injured employee, the employer and the physician or chiropractor who is treating the injured employee of the determination.]
- (Added to NRS by 1975, 761; A 1977, 313; 1979, 1044; 1981, 1139, 1461; 1983, 355; 1991, 832, 2402)

616.340 Duties of employer when employee injured: First aid; [notification of claims administrator; report of injury;] reimbursement.

1. Every employer within the provisions of this chapter shall, immediately upon the occurrence of an injury to any of his employees, render to the injured employee all necessary first aid, including the cost of transportation of the injured employee to the nearest place of proper treatment if the injury is such as to make it reasonably necessary for such transportation.

2. [Each such employer who is not self-insured or his agent shall notify the insurer's claims administrator in writing of the accident. The notification of the accident must be postmarked within 6 working days after receipt of knowledge of the accident if the injured employee is expected to be off work for 5 days or more, must include a statement of the wages of the injured employee. An employee of the system shall not complete any form concerning the accident for an employer unless the employer:

- (a) Is not in business;
- (b) Has not been located by the insurer within 5 working days after receipt of the notification of the accident; or
- (c) Refuses to complete the forms.

3. Each employer who files a report of an injury with the insurer shall file a full report of every known injury to the employee arising out of and in the course of his employment and resulting in his loss of life or injury. The report must be:

(a) Signed by the employer or his designee; and

(b) Furnished to the insurer in the form prescribed and contain specific answers to all questions required by the regulations of the department.

4.] An employer who is not self-insured is entitled to receive reimbursement from his insurer for the costs incurred in rendering the necessary first aid and transportation of an injured employee to the nearest place of proper treatment.

[Part 58:168:1947; 1943 NCL § 2680.58]--(NRS A 1975, 252, 826; 1979, 1489; 1981, 1165, 1469; 1985, 664; 1991, 2404)

[616.345 Employer and physician or chiropractor to file report of injury; requirements for report; penalty for noncompliance. [Effective July 1, 1992.]]

1. Every employer within the provisions of this chapter, and every physician or chiropractor who attends an injured employee within the provisions of this chapter shall file with the insurer a complete report of every known injury to the employee arising out of and in the course of his employment and resulting in his loss of life or injury.

2. Reports must be furnished to the insurer in the form prescribed, be postmarked within 3 working days after examination of the employee and contain special answers to all questions required by the regulations of the department.

3. The administrator shall impose an administrative fine on a person who fails to comply with the provisions of subsection 1. The administrator may impose a fine of not more than \$1,000 for each failure.

[Part 52:168:1947; 1943 NCL § 2680.52]--(NRS A 1981, 1166, 1470; 1985, 1542; 1991, 2407, effective July 1, 1992)]

616.377 Election by injured employee to receive compensation in lieu of action against uninsured employer; liability of uninsured employer; powers and duties of division; appeal of decision made by division or system.

1. If an employee who has been hired or who is regularly employed in this state suffers an accident or injury arising out of and in the course of his employment, and his employer has failed to provide mandatory industrial insurance coverage, the employee may [elect to] receive compensation from the uninsured employers' claim fund by:

(a) Filing a claim for compensation with the system;

(b) Filing a written notice [of his election] with the division; and

(c) Making an irrevocable assignment to the [division] system of [his] a right [of action against the uninsured employer.] *to subrogate to his recovery; in accordance with the provisions of NRS 616.560(1)(b).*

2. If the system receives a claim pursuant to subsection 1, the system shall immediately:

(a) Notify the employer of the claim; and

(b) Deliver to the division any evidence regarding the claim and any evidence indicating that the employer was uninsured.

3. For the purposes of this section, the employer has the burden of proving that he provided mandatory industrial insurance coverage for the employee.

4. Any employer who has failed to provide mandatory coverage required by the provisions of this chapter is liable for all payments made on his behalf, including any benefits, administrative costs or attorney's fees paid from the uninsured employers' claim fund or incurred by the division or department.

5. [The division:

(a) May recover from the employer the payments described in subsection 4 and any accrued interest by bringing a civil action in district court.

(b) In any civil action brought against the employer, is not required to prove that negligent conduct by the employer was the cause of the employee's injury.

(c) May enter into a contract with any person to assist in the collection of any liability of an uninsured employer.

(d) IN lieu of a civil action, may enter into an agreement or settlement regarding the collection of any liability of an uninsured employer.] *The system may recover from the employer any payments made on behalf of the employee pursuant to this chapter provided that recovery shall be pursuant to the provision of NRS 616.560.*

6. The division shall determine whether the employer was insured within 30 days after receiving notice of the claim from the employee. [Upon determining that a claim is valid, t]The division shall assign the claim to the system for administration of the claim, payment of benefits and reimbursement of costs of administration and benefits paid to the system. Upon determining that a claim is invalid, the [division] system shall notify the claimant, the named employer and the [system] division that the claim will not be assigned for benefits from the uninsured employers' claim fund.

7. Any party aggrieved by a decision regarding the administration of an assigned claim or a decision made by the division or by the system regarding any claim made pursuant to this section may appeal that decision within 60 days after the decision is rendered to the hearings division of the department of administration in the manner provided by NRS 616.5412 to 616.544, inclusive.

8. All insurers shall bear a proportionate amount of a claim made pursuant to this chapter, and are entitled to a proportionate amount of any collection made pursuant to this section as an offset against future liabilities.

9. An uninsured employer is liable for the interest on any amount paid on his claims from the uninsured employers' claim fund. The interest must be calculated at a rate equal to the prime rate at the largest bank in Nevada, as ascertained by the commissioner of financial institutions, on January 1 or July 1, as the case may be, immediately preceding the date of the claim, plus 3 percent, compounded monthly, from the date the claim is paid from the fund until payment is received by the division from the employer.

[10. Attorney's fees recoverable by the division pursuant to this section must be:

(a) If a private attorney is retained by the department, paid at the usual and customary rate for that attorney.

(b) If the attorney is an employee of the department, paid at the rate established by regulations adopted by the department.
Any money collected must be deposited to the uninsured employers' claim fund.]
(1975, p. 599; 1981, pp. 1197, 1830; 1991, ch. 723, § 63, p. 2408.)

616.380 Rating system: Application by manager; limitations.

1. In addition to the authority given the manager to determine and fix premium rates of employers as provided in NRS 616.395 to 616.405, inclusive, the manager:

(a) Shall apply that form of rating system which, in his judgment, is best calculated to rate each individual risk more equitably, predicated upon the basis of the employer's individual experience;

(b) Shall adopt equitable regulations controlling the rating of each risk, which regulations, however, must conserve to each risk the basic principles of industrial insurance; and

(c) May subscribe to a rating service of any rating organization for casualty, fidelity and surety insurance rating.

2. The rating system or any rating by a rating organization pursuant to this section is subject to the limitation that the amount of any increase or reduction of premium rate, additional charge of premiums or payment of dividends must be in the discretion of the manager.

3. The rating system provided by this section is subject to the following further limitations:

(a) All studies conducted by the manager to determine the adequacy of rate levels and the equity of rates among classifications must be conducted in the presence of an actuary designated by the commissioner.

(b) The manager shall file revised premium rates, revised classifications of employment and changes of the multiplier applied generally to classes of risk with the commissioner and give written public notice to the employers affected by the changes at least:

(1) Sixty days before the effective date of any projected change in premiums or projected change of multiplier; and

(2) Thirty days before the effective date of any change decided upon. The commissioner shall review the revised rates and classifications and advise the manager of the changes which are not consistent with NRS 686B.050 and 686B.060.

(c) Any employer affected by a change in a premium rate or a revised classification of employment may request the commissioner to hold a hearing before the effective date of the change. At the hearing, the commissioner shall consider the objections raised by any party appearing at the hearing. *The manager has no authority to hold hearings on these issues pursuant to NRS 616.392.*

(d) Premium rates may not be fixed at a level higher than that required to:

(1) Pay the obligations created by this chapter and associated administrative expenses.

(2) Provide for a reasonable reserve for claims.

(3) Provide for contingencies such as a catastrophe, economic change, change in judicial interpretations of the law, legislative amendments of the law,

deficiencies in the reserve and other events which cannot be predicted accurately and could endanger the solvency of the fund. The commissioner may order the manager to make any adjustments necessary to meet the requirements of this paragraph.

4. In determining and fixing premium rates, the manager may establish a varying schedule of rates for workers who are in the classification of employment designated as construction which reflects the varying hourly rates of wages paid to such workers.

5. Subsections 2 and 3 do not apply to rating plans made by voluntary agreement between the manager and employer which increases or reduces premiums for the employer. The voluntary rating plans may be retrospective in nature. A voluntary rating plan must be in writing and signed by the manager and the employer.

[78:168:1947; 1943 NCL § 2680.78]—(NRS A 1957, 177; 1971, 769; 1973, 600; 1979, 1046; 1981, 1472; 1983, 1306; 1985, 352; 1987, 593; 1991, 128, 130)

616.427 Subsequent injury fund: Payment of cost of additional compensation resulting from subsequent injury. Except as otherwise provided in NRS 616.428:

1. If an employee who has a permanent physical impairment from any cause or origin incurs a subsequent disability by injury arising out of and in the course of his employment which entitles him to compensation for disability that is substantially greater by reason of the combined effects of the preexisting impairment and the subsequent injury than that which would have resulted from the subsequent injury alone, the compensation due must be charged to the subsequent injury fund in accordance with regulations adopted by the administrator.

2. If the subsequent injury of such an employee results in his death and it is determined that the death would not have occurred except for the preexisting permanent physical impairment, the compensation due must be charged to the subsequent injury fund in accordance with regulations adopted by the administrator.

3. As used in this section, "permanent physical impairment" means any permanent condition, whether congenital or caused by injury or disease, of such seriousness as to constitute a hindrance or obstacle to obtaining employment or to obtaining reemployment if the employee is unemployed. For the purposes of this section, a condition is not a "permanent physical impairment" unless it would support a rating of permanent impairment of 6 percent or more of the whole man if evaluated according to the American Medical Association's Guides to the Evaluation of Permanent Impairment as adopted and supplemented by the department. The department shall adopt regulations incorporating the American Medical Association's Guides to the Evaluation of Permanent Impairment by reference and may amend such regulations from time to time as it deems necessary. In adopting the Guides to the Evaluation of Permanent Impairment, the department shall consider the edition most recently published by the American Medical Association.

4. To qualify under this section for reimbursement from the subsequent injury fund, the insurer must establish by written records that the employer had knowledge of the "permanent physical impairment" at the time the employee was hired or that the employee was retained in employment after the employer acquired such knowledge.

5. An insurer shall notify the administrator of any possible claim against the subsequent injury fund as soon as practicable, but not later than 100 weeks after the injury or death.

6. The administrator shall adopt regulations establishing procedures for submitting claims against the subsequent injury fund. The administrator [shall notify the insurer of his decision on such a claim] *must accept or deny the claim within 90 days after the claim is received[,] and notify the insurer of his decision. The administrator must reimburse the insurer within 60 days of accepting a claim. If the administrator does not accept or deny within 90 days, the claim shall be deemed accepted, but for good cause shown, the administrator may extend the time to accept or deny the claim.*

7. An appeal of any decision made concerning a claim against the subsequent injury fund must be submitted directly to the appeals officer. The appeals officer shall hear such an appeal within 45 days after the appeal is submitted to him.

(Added to NRS by 1973, 693; A 1979, 1050; 1981, 1477; 1985, 373; 1987, 453, 944; 1991, 362, 492, 502, 2414)

[616.500 Contents and service of notice of injury or death; filing of claim for compensation; acceptance or denial of responsibility for compensation by insurer. [Effective July 1, 1992.]

1. Notice of the injury for which compensation is payable under this chapter must be given to the insurer as soon as practicable, but within 30 days after the happening of the accident.

2. In the event of the death of the employee resulting from the injury, notice must be given to the insurer as soon as practicable, but within 30 days after death.

3. The notice must:

(a) Be in writing;

(b) Contain the name and address of the injured employee;

(c) Contain a statement in ordinary language of the time, place, nature and cause of the injury; and

(d) Be signed by the injured employee or by a person in his behalf, or in the event of the employee's death, by one or more of his dependents or by a person on their behalf.

4. No proceeding under this chapter for compensation for an injury may be maintained unless the injured employee, or someone on his behalf, files with the insurer a claim for compensation with respect to the injury within 90 days after the accident, or, in the event of the employee's death, within 1 year after death.

5. The notice required by this section must be served by delivery of a copy of the notice, or by mailing a copy thereof in a sealed postpaid envelope addressed to the insurer. Such mailing constitutes complete service.

6. Failure to give notice or to file a claim for compensation within the time specified in this section is a bar to any claim for compensation under this chapter, but such failure may be excused by the insurer on one or more of the following grounds:

(a) That there was good cause for the failure to give notice or file the claim.

(b) That notice for some sufficient reason could not have been made.

(c) That failure to give notice will not result in an unwarrantable charge against the state insurance fund.

(d) That failure to give notice was because of the employee's or beneficiary's mistake or ignorance of fact or of law, or of his physical or mental inability, or because of fraud, misrepresentation or deceit.

7. The insurer shall accept or deny responsibility for compensation under this chapter or chapter 617 of NRS within 14 working days after the notice provided for in this section is received. If additional information is necessary to determine liability, the administrator may, upon good cause shown by the insurer, extend the period to 45 days upon notice to the claimant. If additional information is still necessary, the administrator may, upon good cause shown by the insurer, grant a further extension if the claimant gives his written consent, but the total period may not be extended to more than 75 days.

[55:168:1947; 1943 NCL § 2680.55]—(NRS A 1969, 95; 1973, 604; 1979, 1052, 1053; 1981, 1487; 1989, 332)]

616.500 Duties of employer, physician or chiropractor and employee: Notice of injury or death, filing of claim for compensation, employer and physician or chiropractor to file report of injury, notification of claims administrator.

1. Written notice of an injury or death for which compensation is payable under this chapter must be given to the employer as soon as practicable, but within 30 days after the accident.

2. The notice required in subsection 1 of this section shall:

(a) Be given on a preprinted form, which shall be supplied by the administrator, that allows the worker to note and briefly describe the accident and sign his name. The employer, any superintendent or foreman, or any agent of the employer in charge of the work where the accident occurred shall also sign the preprinted form that describes the accident. That signature shall not be a concession by the employer of any rights or defenses. It merely acknowledges receipt by the employer or his agency of the form signed by the worker. In the event of the employee's death, the notice shall be signed by one or more of his dependents or by a person on their behalf.

(b) Include an explanation of the procedure for filing a claim for compensation, and be prepared in duplicate so that both the worker and the employer can retain copies.

3. All employers shall keep on hand a sufficient supply of the notice form.

4. A completed form shall be retained by the employer for a period of three years after the date of the incident.

5. No proceeding under this chapter for compensation for any injury may be maintained unless the injured employee, or someone on his behalf, files with the

insurer a claim for compensation with respect to the injury within 90 days after the accident, or, in the event of the employee's death, within 1 year after death. Preprinted forms for filing a claim for compensation shall be made available at all medical facilities, physician's and chiropractor's offices, the offices of the Division of Industrial Insurance Regulation, State Industrial Insurance System, the offices of third party administrators, and the offices of self-insured employers that self-administer their own workers' compensation programs. The claim for compensation form shall be completed and mailed by the treating physician within three working days of treating the employee to the employer and the insurer, in the case of a self-insured employer the claim for compensation form shall be mailed to the employer's third party administrator. Should the claim for compensation form include a certificate of disability, the certificate must include a description of the employee's work limitations and restrictions.

6. Within six working days of receipt of the claim for compensation form, or knowledge that the employee has sought medical treatment, the employer shall complete and mail an "Employer's Report of Industrial Injury or Occupational Diseases" form as prescribed by the administrator to his insurer or third party administrator. If the physician's portion of the claim for compensation form indicates five or more days will be lost from work, the "Employer's Report of Industrial Injury or Occupational Disease" must be accompanied by a statement of the wages of the injured employee. An employee of the system shall not complete any form concerning the accident for an employer unless the employer:

- (a) Is not in business;
- (b) Has not been located by the system within 5 working days after receipt of the notification of the accident; or
- (c) Refuses to complete the forms.

7. The "Employer's Report of Industrial Injury" must be:

- (a) Signed by the employer or his designee; and
- (b) Furnished to the insurer or its third party administrator in the form prescribed and contain specific answers to all questions required by the regulations of the department.

8. Failure to give notice as required in subsection 1 of this section or to file a claim for compensation as required in subsection 4 of this section is a bar to any claim for compensation under this chapter, but failure may be excused by the insurer on one or more of the following grounds:

- (a) That by reason of his injury or some other cause beyond his control the worker is prevented from giving notice or filing of a claim for compensation.
- (b) That failure to give notice was because of the employee's or beneficiary's mistake or ignorance of fact or of law, or of his physical or mental inability, or because of fraud, misrepresentation or deceit.

9. The employee has the burden of proving that his injury or occupational disease arose out of and in the course of his employment by a preponderance of the evidence. If the employee reports an accident after termination of his employment for any reason, such a report raises a rebuttable presumption that the injury did not arise out of and in the course of employment. This subsection only applies to

accidents as defined in NRS 616.020 and does not apply to occupational diseases pursuant to Chapter 617 of the NRS.

10. The insurer shall accept or deny responsibility for compensation under this chapter or chapter 617 of NRS within 30 days after the claim for compensation form, duly completed by the employee and his physician, is received.

11. The administrator may impose an administrative fine of not more than \$1,000 on an employer or physician or chiropractor that fails to comply with this section.

[616.537 Insurer required to schedule rating for injured employee after determination by treating physician or chiropractor; contents of rating evaluation.

1. An insurer shall schedule a rating for an injured employee within 30 days after the injured employee is determined to be stable and ratable by the treating physician or chiropractor.

2. A rating evaluation must include an evaluation of the loss of motion, sensation and strength of an injured employee if the injury is of a type that might have caused such a loss.

3. A self-insured employer shall refer an injured employee who is entitled to compensation for a permanent partial disability to the department for a rating by a physician or chiropractor selected in rotation from the list of qualified physicians or chiropractors designated by the administrator pursuant to subsection 2 of NRS 616.605, according to the order in which their names appear on the list.

(Added to NRS by 1991, 2398)]

616.540 Contested claims: Appointment and term of hearing officers.

1. The Director of the Department of Administration shall appoint one or more hearing officers to conduct hearings in contested claims for compensation under this chapter and Chapter 617 of NRS. Each hearing officer shall serve at the pleasure of the Director. Each hearing officer is entitled to receive an annual salary in an amount provided by law and is in the unclassified service of the state.

2. If a hearing officer determines that he has a personal interest or a conflict of interest, directly or indirectly, in any case which is before him, he shall disqualify himself from hearing the case and the case shall be assigned to another hearing officer.

616.5412 Contested claims: Request for hearing; forms for request to be provided by insurer; appeals; expeditious and informal hearing required. [Effective March 1, 1993.]

1. Any person who is subject to the jurisdiction of the hearing officers pursuant to this chapter or chapter 617 of NRS may request a hearing before a hearing officer of any matter within his authority. The insurer shall provide, without cost, the forms necessary to request a hearing to any person who requests them.

2. A person who is aggrieved by:

(a) A written determination of an insurer; or

(b) The failure of an insurer to respond within 30 days to a written request mailed to the insurer by the person who is aggrieved, may appeal from the determination or failure to respond by filing a request for a hearing before a hearing officer. Such a request must be filed within 60 days after the date on which the notice of its determination was mailed by the insurer or the unanswered written request was mailed to the insurer, as applicable. Except as otherwise provided in subsection 7 of NRS 616.500, the failure of an insurer to respond to a written request for a determination within 30 days after receipt of such a request shall be deemed by the hearing officer to be a denial of the request.

3. Failure to file a request for a hearing within the period specified in subsection 2 may be excused if the person aggrieved shows by a preponderance of the evidence that he did not receive the notice of the decision and the forms necessary to request a hearing. The claimant or employer shall notify the insurer of a change of address.

4. The hearing before the hearing officer must be conducted as expeditiously and informally as is practicable.

5. *Notwithstanding any other provisions in the Act, parties represented by legal counsel may agree to forego a hearing before the hearing officer and may proceed directly to the hearing before the appeals officer provided for in NRS 616.5422 by executing a written stipulation signed by legal counsel and their respective parties.*

(Added to NRS by 1979, 1040; A 1981, 1490; 1983, 1294; 1985, 668; 1991, 834, 2417, effective March 1, 1993)

616.5415 Contested claims: Licensing of parties' representatives; employer liable for representative's violations of chapter; compensation of employer's representative must not be contingent on outcome.

1. It is unlawful for any person who is not:

(a) Employed full time by the employer or the employee's labor organization;

(b) Admitted to practice law in this state; or

(c) Appearing without compensation on behalf of another, to represent the employer or employee at hearings of contested cases unless licensed to do so by the commissioner.

2. The commissioner shall adopt regulations which include the:

(a) Requirements for licensure of employers' and employees' representatives, including:

(1) The registration of each representative; and

(2) The filing of a copy of each written agreement for the compensation of a representative;

(b) Procedure for such licensure; and

(c) Causes for revocation of such a license, including any applicable action listed in NRS 616.647 or a violation of this section.

3. Any person who is employed by or contracts with an employer to represent the employer at hearings regarding contested claims is an agent of the employer. If the employer's representative violates any provision of this chapter, the employer is liable for any penalty assessed because of that violation.

4. An employer shall not make the compensation of any person representing him contingent in any manner upon the outcome of any contested claim.

5. The commissioner shall collect in advance and deposit with the state treasurer for credit to the state general fund the following fees for licensure as an employer's or an employee's representative:

(a) Application and license..... \$78

(b) Triennial renewal of each license..... 78

6. *It is unlawful for a person who is not admitted to practice law in this state or who is not an employee of a person admitted to practice law in this state to provide legal advice or represent an injured employee for remuneration.*

(Added to NRS by 1987, 2140; A 1989, 527)

616.5416 Contested claims: Time for hearing, notice of hearing, conduct of hearing and decision by hearing officer; referral of employee for medical examination; decision not stayed by appeal.

1. The hearing officer shall:

(a) Within 5 days after receiving a request for a hearing, set the hearing for a date and time within 30 days after his receipt of the request;

(b) Give notice by mail or by personal service to all interested parties to the hearing at least 15 days before the date and time scheduled; and

(c) Conduct hearings expeditiously and informally.

2. The notice must include a statement that the injured employee may be represented by a private attorney or seek assistance and advice from the Nevada attorney for injured workers.

3. If necessary to resolve a medical question concerning an injured employee's condition, the hearing officer may refer the employee to a physician or chiropractor chosen by the hearing officer. If the medical question concerns the rating of a permanent disability, the hearing officer may refer the employee to a physician or chiropractor designated by the administrator. *The rating physicians and chiropractors must be selected in rotation from the list of qualified physicians and chiropractors designated by the administrator as provided in NRS 616.605(2) unless the insurer and the injured worker otherwise agree to a rating physician.* The insurer shall pay the costs of any medical examination requested by the hearing officer.

4. The hearing officer may allow or forbid the presence of a court reporter and the use of a tape recorder in a hearing.

5. The hearing officer shall render his decision within [7] 15 days after:

(a) The hearing; or

(b) He receives a copy of the report from the medical examination he requested.

6. The hearing officer shall render his decision in the most efficient format developed by the chief of the hearings division of the department of administration.

7. The hearing officer shall give notice of his decision to each party by mail. He shall include with the notice of his decision the necessary forms for appealing from the decision.

8. [The decision of the hearing officer is not stayed if an appeal from that decision is taken unless a stay is granted by the hearing officer or an appeals officer within 15 days after the date on which the decision was rendered.] *The decision of a hearing officer must be complied with within 30 days after the date on which the decision was rendered unless a stay is granted by the hearing officer or appeals officer.*

(Added to NRS by 1979, 1040; A 1983, 645; 1985, 669, 864, 1547; 1991, 835, 2418)

616.5422 Contested claims: Appeal of hearing officer's decision to appeals officer; notice; effect; hearing; continuance.

1. Any party aggrieved by a decision of the hearing officer relating to a claim for compensation may appeal from the decision by filing a notice of appeal with an appeals officer within [30] 60 days after the date of the decision.

2. The filing of a notice of appeal does not automatically stay the enforcement of the decision of the hearing officer. The appeals officer may order a stay, when appropriate, upon the application of a party.

3. The appeals officer shall, within 10 days after receiving a notice of appeal, schedule a hearing for a date and time within [45] 60 days after his receipt of the notice and give notice by mail or by personal service to all parties to the appeal and their attorneys or agents at least 30 days before the date and time scheduled.

4. An appeal may be continued upon written stipulation of all parties, or upon good cause shown. *Notice of continuance must be given by mail or by personal service to all interested parties.*

5. Failure to file a notice of appeal within the period specified in subsection 1 may be excused if the party aggrieved shows by a preponderance of the evidence that he did not receive the notice of the decision and the forms necessary to appeal the decision. The claimant, employer or insurer shall notify the hearing officer of a change of address.

(Added to NRS by 1979, 1040; A 1981, 1198; 1983, 358; 1985, 50, 669; 1991, 2418)

616.5426 Contested claims: Record of hearing before appeals officer; evidence; referral to resolve medical question; transcripts; decision of appeals officer.

1. A stenographic or electronic record must be kept of the hearing before the appeals officer and the rules of evidence applicable to contested cases under chapter 233B of NRS apply to the hearing.

2. The appeals officer must hear any matter raised before him on its merits, including new evidence bearing on the matter.

3. If necessary to resolve a medical question concerning an injured employee's condition, the appeals officer may refer the employee to a physician or chiropractor chosen by the appeals officer. If the medical question concerns the rating of a permanent disability, the appeals officer may refer the employee to a physician or chiropractor designated by the administrator. *The rating physicians and chiropractors must be selected in rotation from the list of qualified physicians and chiropractors designated by the administrator as provided in NRS 616.605(2) unless*

the insurer and the injured worker otherwise agree to a rating physician. The insurer shall pay the costs of any examination requested by the appeals officer.

4. Any party to the appeal or the appeals officer may order a transcript of the record of the hearing at any time before the seventh day after the hearing. The transcript must be filed within 30 days after the date of the order unless the appeals officer otherwise orders.

5. The appeals officer shall render his decision:

(a) If a transcript is ordered within 7 days after the hearing, within 30 days after the transcript is filed; or

(b) If a transcript has not been ordered, within 30 days after the date of the hearing.

6. The appeals officer may affirm, modify or reverse any decision made by the hearing officer and issue any necessary and proper order to give effect to his decision.

(Added to NRS by 1979, 1040; A 1987, 92; 1991, 2419)

616.545 Application for increase or rearrangement of compensation; reopening of case for changed circumstances.

1. Except as otherwise provided in this section, an injured employee may apply to reopen a previous claim only after the expiration of one year following closure of the previous claim. The application must be in writing and supported by medical evidence demonstrating an objective change in the injured employee's medical condition and state that the injured employee's industrial injury is the primary cause of the change in the medical condition. If the injured employee can demonstrate the objective change in the medical condition and its primary relationship to the industrial injury by clear and convincing medical evidence, the claim may be reopened within the one year limitation.

2. Except as otherwise provided in subsection 1, if the injured employee has previously requested reopening of a claim, the injured employee may not reopen until the expiration of one year following a final determination on the previous request for reopening.

3. Treatment may not be allowed before application is made unless good cause is shown. The insurer shall, upon good cause shown, allow the cost of emergency treatment the necessity for which has been certified by a physician or a chiropractor.

4. An industrial injury claim that resulted in no lost time and no permanent partial disability award may not be reopened unless an application to reopen is received by the insurer within one (1) year following claim closure. After expiration of the one (1) year period an insurer may dispose of the records concerning a claim which has not resulted in lost time or a permanent partial disability award.

5. After a claim has been closed, the insurer, upon receiving an application and for good cause shown, may authorize the reopening of the claim for medical investigation only.

[56:168:1947; 1943 NCL § 2680.56] +

[57:168:1947; 1943 NCL § 2680.57]—(NRS A 1971, 770; 1981, 1198, 1831; 1983, 285, 1294; 1985, 1547)

616.560 Liability of third parties for damages; reduction of compensation; subrogation of insurer or administrator to rights of employee; lien on proceeds of recovery; instructions to jury; calculation of employer's premium.

1. When an employee coming under the provisions of this chapter receives an injury for which compensation is payable under this chapter and which was caused under circumstances creating a legal liability in some person, other than the employer or a person in the same employ, to pay damages in respect thereof:

(a) The injured employee, or in case of death, his dependents, may take proceedings against that person to recover damages, but the amount of the compensation to which the injured employee or his dependents are entitled under this chapter, including any future compensation under this chapter, must be reduced by the amount of the damages recovered, notwithstanding any act or omission of the employer or a person in the same employ which was a direct or proximate cause of the employee's injury.

(b) If the injured employee, or in case of death his dependents, receive compensation under this chapter, the insurer, or in case of claims involving the uninsured employers' claim fund or the subsequent injury fund, the administrator, has a right of action against the person so liable to pay damages and is subrogated to the rights of the injured employee or of his dependents to recover therefor. In any action or proceedings taken by the insurer or the administrator under this section, evidence of the amount of compensation, accident benefits and other expenditures which the insurer, the uninsured employers' claim fund or the subsequent injury fund have paid or become obligated to pay by reason of the injury or death of the employee is admissible. If in such action or proceedings the insurer or the administrator recovers more than those amounts, the excess must be paid to the injured employee or his dependents.

(c) The injured employee, or in case of death his dependents, shall first notify the insurer, or in the case of claims involving the uninsured employers' claim fund or subsequent injury fund the administrator, in writing of any action or proceedings, pursuant to this section, to be taken by the employee or his dependents.

2. In any case where the insurer or the administrator is subrogated to the rights of the injured employee or of his dependents as provided in subsection 1, the insurer or the administrator has a lien upon the total proceeds of any recovery from some person other than the employer, whether the proceeds of such recovery are by way of judgment, settlement or otherwise. The injured employee, or in the case of his death his dependents, are not entitled to double recovery for the same injury, notwithstanding any act or omission of the employer or a person in the same employ which was a direct or proximate cause of the employee's injury.

3. *The insurer is entitled to subrogate against the employer's uninsured motorist or underinsured motorist policy. The insurer may not subrogate against an uninsured or underinsured motorist policy paid for by the employee.*

4. *If, despite the exclusive remedy provision of NRS 616.270, an injured employee brings an action against his employer for the same injuries for which he received benefits pursuant to Chapter 616 or Chapter 617, the insurer shall be entitled to subrogate against any recovery or settlement paid by the employer or someone on his behalf to the same extent as provided in subsection 1 regardless of*

whether the recovery is characterized as a gift or otherwise. This section shall not be construed as allowing such actions by an injured employee against his employer.

5. The lien provided for under subsection 2 includes the total compensation expenditure incurred by the insurer, the uninsured employers' claim fund or the subsequent injury fund for the injured employee and his dependents.

[4]6. Within 15 days of the date of recovery by way of actual receipt of the proceeds of the judgment, settlement or otherwise, the injured employee or his representative *or, if the injured employee or his representative is represented by an attorney, then the attorney for the injured employee or his representative, and, the third party liability carrier* shall notify the insurer, or in the case of claims involving the uninsured employers' claim fund or subsequent injury fund the administrator, of the recovery and pay to the insurer or the administrator, respectively, the amount due under this section together with an itemized statement showing the distribution of the total recovery. *The attorney for the injured employee or the injured employee's representative or the third party carrier shall be jointly and severally liable to the insurer for all sums due to the insurer pursuant to this section if the attorney or the third party carrier has knowledge of the lien.*

7. *The insurer shall not sell its lien to the third party liability carrier unless the injured worker or the injured worker's representative or attorney refuses to provide the insurer with information concerning the action against the third party.*

[5] 8. In any trial of an action by the injured employee, or in the case of his death by his dependents, against a person other than the employer or a person in the same employ, the jury shall receive proof of the amount of all payments made or to be made by the insurer or the administrator. The court shall instruct the jury substantially as follows:

"Payment of workmen's compensation benefits by the insurer, or in the case of claims involving the uninsured employers' claim fund or subsequent injury fund the administrator, is based upon the fact that a compensable industrial accident occurred, and does not depend upon blame or fault. If the plaintiff does not obtain a judgment in his favor in this case, he is not required to repay his employer, the insurer or the administrator any amount paid to him or paid on his behalf by his employer, the insurer or the administrator.

If you decide that the plaintiff is entitled to judgment against the defendant, you shall find his damages in accordance with the court's instructions on damages and return your verdict in the plaintiff's favor in the amount so found without deducting the amount of any compensation benefits paid to or for the plaintiff. The law provides a means by which any compensation benefits will be repaid from your award."

[6]9. For the purposes of calculating an employer's premium, the employer's account with the system must be credited with an amount equal to that recovered by the system from a third-party pursuant to this section, less the system's share of the expense of litigation incurred in obtaining the recovery, except that the total credit must not exceed the amount of compensation actually paid or reserved by the system on the injured employee's claim.

[75:168:1947; A 1949, 659; 1943 NCL § 2680.75]—(NRS A 1957, 519; 1973, 498; 1977, 216, 424; 1979, 1055; 1981, 1491; 1991, 2419)

616.565 Forfeiture, reduction and suspension of compensation.

1. Compensation is not payable pursuant to the provisions of this chapter for an injury:

(a) Caused by the employee's willful intention to injure himself.

(b) Caused by the employee's willful intention to injure another.

(c) Proximately caused by the employee's intoxication, whether by alcohol or a controlled substance. If the employee was intoxicated at the time of his injury, intoxication must be presumed to be a proximate cause unless rebutted by evidence to the contrary.

2. No compensation is payable for the death, disability or treatment of an employee if his death is caused by, or insofar as his disability may be aggravated, caused or continued by, an unreasonable refusal or neglect to submit to or to follow any competent and reasonable surgical treatment or medical aid.

3. If any employee persists in an unsanitary or injurious practice that imperils or retards his recovery, or refuses to submit to such medical or surgical treatment as is necessary to promote his recovery, his compensation may be reduced or suspended.

4. *When an employee is unable to undergo treatment or testing for an industrial condition as a result of a condition that does not arise out of and in the course of employment, all compensation benefits except medical benefits, must be suspended until the employee is able to resume treatment or examination if any physician or chiropractor determines that, but for the non-industrial condition, the employee could be treated or examined for the industrial condition, if correction of the non-industrial condition is within the ability of the employee. The insurer must not be required to pay for treatment of the non-industrial condition, but the insurer, in its sole discretion, may elect to pay for the treatment.*

[70:168:1947; 1943 NCL § 2680.70] +

[71:168:1947; 1943 NCL § 2680.71] +

[72:168:1947; 1943 NCL § 2680.72]--(NRS A 1979, 1057; 1981, 1198; 1991, 2421)

616.585 Temporary total disability: Compensation. [Effective July 1, 1992.]

1. Every employee in the employ of an employer, within the provisions of this chapter, who is injured by accident arising out of and in the course of employment, or his dependents, is entitled to receive for the period of temporary total disability, 66 2/3 percent of the average monthly wage.

2. If a claim for the period of temporary total disability is allowed, the first payment pursuant to this section must be issued by the insurer within 14 working days after receipt of the initial certification of disability.

3. Any increase in compensation and benefits effected by the amendment of subsection 1 is not retroactive.

4. For purposes of the payment of benefits for a temporary total disability under this section, [the period of] temporary total disability *payments* cease[s] when:

(a) Any physician or chiropractor determines that the employee is *physically* capable of any gainful employment *that the employee is reasonably suited for by education, training or experience; or,*

(b) The employer offers the employee modified or light duty employment within the limitations and restrictions imposed by any physician or chiropractor pursuant to subsection 9; or

(c) Upon the conviction and subsequent incarceration of the employee. If convicted and incarcerated, neither the employee nor his dependents are entitled to accrue or be paid any compensation for temporary total disability for the period of the incarceration. Payment of compensation may commence upon release of the employee from incarceration if the employee is certified temporarily totally disabled as required in subsection 1. For purposes of this section, "convicted" means an adjudication of guilt by a court of competent jurisdiction; a plea of guilty or of nolo contendere or any similar plea; or a commitment to any mental health facility for the criminally insane.

5. Each insurer [shall] may, with each check that it issues to an injured employee for a temporary total disability, include a form approved by the department for the injured employee to request continued compensation for the temporary total disability.

6. The insurer shall issue to the injured employee, not less than 6 working days before the [beginning] ending of the period specified in the form, a check for the compensation due the employee for that period, if:

(a) The injured employee has completed and returned the form to the insurer; or

(b) There is documentation with the insurer which indicates a continuing disability covering the period of the check.

A check shall be deemed delivered upon the date that it is postmarked, if it is properly addressed and the postage is prepaid.

7. Each and every disability certification from a physician or chiropractor must include the period of disability and a description of the employee's work limitations and restrictions. The disability certification must be signed by the physician or chiropractor.

8. If an injured employee is released to return to work with physical limitations that are incompatible with a return to the injured employee's preaccident position, the treating physician must specify in writing what the injured employee's physical limitations are and whether these limitations are permanent or temporary in nature. If the limitations are temporary, then the preaccident employer may offer a modified position and need not comply with the requirements of NAC 616.085 so long as the position being offered is substantially similar to the preaccident position in: (a) location of employment; (b) employment shift, and (c) rate of pay.

[Part 59:168:1947; A 1949, 659; 1951, 485; 1953, 292; 1955, 901]--(NRS A 1957, 72; 1959, 201; 1963, 837; 1965, 226; 1966, 43; 1969, 472; 1971, 322; 1973, 531; 1975, 253; 1983, 1295; 1985, 1548; 1991, 2422, effective July 1, 1992)

616.605 Permanent partial disability: Compensation. [Effective March 1, 1993.]

1. Every employee, in the employ of an employer within the provisions of this chapter, who is injured by an accident arising out of and in the course of employment is entitled to receive the compensation provided for permanent partial

disability. As used in this section "disability" and "impairment of the whole man" are equivalent terms.

2. Within 30 days after receiving from the treating physician or chiropractor chosen pursuant to NRS 616.342 a report indicating that the injured employee may have suffered a permanent disability and is stable and ratable, the insurer shall schedule an appointment with a rating physician or chiropractor to determine the extent of the employee's disability. The insurer shall select a physician or chiropractor from a group of rating physicians and chiropractors designated by the administrator, to determine the percentage of disability in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment as adopted and supplemented by the department pursuant to subsection 3 of NRS 616.427. *Unless the insurer and the injured employee otherwise agree, r[R]ating physicians and chiropractors must be selected in rotation from the list of qualified physicians and chiropractors designated by the administrator, according to their area of specialization and the order in which their names appear on the list.*

3. *A rating evaluation must include an evaluation of loss of motion, sensation and strength of an injured employee if the injury is of a type that might have caused such a loss.* No factors other than the degree of physical impairment of the whole man may be considered in calculating the entitlement to compensation for a permanent partial disability.

4. The rating physician or chiropractor shall provide the insurer with his evaluation of the injured employee. After receiving the evaluation, the insurer shall, within 14 days, provide the employee with a copy of the evaluation and notify the employee:

- (a) Of the compensation to which he is entitled pursuant to this section; or
- (b) That he is not entitled to benefits for permanent partial disability.

5. Each 1 percent of impairment of the whole man must be compensated by a monthly payment of 0.5 percent of the claimant's average monthly wage for injuries sustained before July 1, 1981, and 0.6 percent for injuries sustained on or after July 1, 1981. Compensation must commence on the date of the injury or the day following the termination of temporary disability compensation, if any, whichever is later, and must continue on a monthly basis for 5 years or until the claimant is 70 years of age, whichever is later.

6. Compensation benefits may be paid annually to claimants who will be receiving less than \$100 a month.

7. Where there is a previous disability, as the loss of one eye, one hand, one foot, or any other previous permanent disability, the percentage of disability for a subsequent injury must be determined by computing the percentage of the entire disability and deducting therefrom the percentage of the previous disability as it existed at the time of the subsequent injury. *Prior to the evaluation, upon request from the insurer and on a form prescribed by the administrator, the employee must disclose to the insurer all information concerning any previous disability evaluations wherever performed and any prior injuries, diseases or conditions, which may affect the evaluation performed pursuant to this section.*

8. The department may adopt schedules for rating permanent disabilities resulting from injuries sustained before July 1, 1973, and reasonable regulations to carry out the provisions of this section.

9. The increase in compensation and benefits effected by the amendment of this section is not retroactive for accidents which occurred before July 1, 1973.

10. This section does not entitle any person to double payments for the death of a workman and a continuation of payments for a permanent partial disability, or to a greater sum in the aggregate than if the injury had been fatal.

[63:168:1947; A 1949, 659; 1953, 292] – (NRS A 1959, 204; 1966, 46; 1967, 691; 1969, 475; 1971, 326; 1973, 531; 1975, 605; 1977, 1006; 1979, 1057; 1981, 1170, 1493, 1653; 1983, 428, 1295; 1985, 308, 374; 1987, 78; 1991, 493, 2423, 2424, effective March 1993)

616.610 Temporary partial disability: Compensation.

(1) Every employee in the employ of an employer, within the provisions of this chapter, who shall be injured by accident arising out of and in the course of employment, shall be entitled to receive for temporary partial disability the difference between the wage earned after the injury and the compensation which the injured person would be entitled to receive if temporarily totally disabled when the wage is less than the compensation, but for a period not to exceed 24 months during the period of disability.

(2) *For purposes of the payment of benefits for a temporary partial disability under this section, the period of temporary partial disability ceases upon conviction and subsequent incarceration of the employee. If convicted and incarcerated, neither the employee nor his dependents are entitled to accrue or be paid any compensation for temporary total disability for the period of the incarceration. Payment of compensation may commence upon release of the employee from incarceration if the employee meets the requirements of subsection 1. For purposes of this section, "convicted" means an adjudication of guilt by a court of competent jurisdiction; a plea of guilty or of nolo contendere or any similar plea; or a commitment to any mental health facility for the criminally insane.*

[61:168:1947; A 1953, 292]—(NRS A 1967, 878; 1973, 533)

616.640 Prohibited deductions from wages of employee.

1. [It is unlawful for an] Any employer [to] who makes any charge against any employee or [to] who deducts from the wages of any employee any sum of money to meet the costs, in whole or in part, of the liability incurred by the employer by reason of his acceptance or rejection of this chapter[.], is guilty of a gross misdemeanor.

2. *Except as permitted in NRS 616.286 and 616.288, any employer who requires an employee to provide and secure his own compensation according to the terms, conditions and provisions of this chapter or Chapter 617 for any and all personal injuries by accident or occupational diseases sustained by an employee arising out of and in the course of the employment is guilty of a gross misdemeanor.*

3. Any employer violating this section shall be prosecuted by the District Attorney in the county where the employer has its principal place of business within this state upon complaint of any employee who submits proper evidence of a violation.

616.647 Administrative fines for certain violations; hearing; appeal; revocation of certificate of self-insurance.

1. If the administrator has reason to believe that an insurer, health care provider, third-party administrator or employer has:

- (a) Induced a claimant for compensation to fail to report an accidental injury or occupational disease;
- (b) Persuaded a claimant to settle for an amount which is less than reasonable;
- (c) Persuaded a claimant to settle for an amount which is less than reasonable while a hearing or an appeal is pending;
- (d) Persuaded a claimant to accept less than the compensation found to be due him by a hearing officer or appeals officer;
- (e) Refused to pay or unreasonably delayed payment to a claimant of compensation found to be due him by a hearing officer or appeals officer;
- (f) Made it necessary for a claimant to resort to proceedings against the employer or insurer for compensation found to be due him by a hearing officer or appeals officer;
- (g) [Failed to comply with regulations of the department for the acceptance and rejection of claims, determination and calculation of a claimant's average monthly wage, determination and payment of compensation, delivery of accident benefits and reporting relating to these matters; or
- (h)] Failed to comply with the department's regulations covering the payment of an assessment relating to the funding of costs of administration of this chapter and chapter 617 of NRS; or
- [(i)] *(h) Intentionally or repeatedly f[Failed to comply with any provision of, or regulation adopted pursuant to, this chapter or chapter 617 of NRS,* the administrator shall set a date for a hearing. The date must be no sooner than 30 days after notice is served upon the insurer or employer of the alleged action and the time and place of the hearing.

2. If, after an evidentiary hearing, the administrator determines that the insurer or employer has committed the alleged act, the administrator [shall] *may* issue a notice of violation imposing a proposed administrative fine of:

- (a) Not more than \$250 for each initial violation of subsection 1 which was not intentional; or
- (b) Not more than \$1,000 for each intentional or repeated violation of subsection 1.
- (c) Not more than \$1,000 for each act in violation of any other provisions of subsection 1.

3. In addition to any fine imposed pursuant to subsection 2, the administrator may assess against an insurer who violates any regulation concerning the reporting of claims expenditures used to calculate an assessment an administrative penalty of up to twice the amount of any underpaid assessment.

4. If a person wishes to contest a notice of violation issued pursuant to subsection 2, he must file a notice of appeal with the division within 30 days after

the notice is issued, showing why the proposed fine should not be imposed against him.

5. If a notice of appeal is filed as required by subsection 4, the administrator shall issue a complaint setting forth the factual basis for his determination that a violation has occurred. The person against whom a complaint is issued shall file an answer to the complaint within 30 days after the complaint is issued. The answer must be accompanied by any documentary evidence upon which the person relies and, if the person desires a hearing on the matter, by a request for hearing. If an answer and a request for hearing are filed as required by this subsection, the administrator shall set a date for a hearing on the matter, which must be no sooner than 30 days after the answer and request for hearing are filed.

6. If a notice of appeal or an answer is not filed as required by this section, the notice of violation shall be deemed a final order and is not subject to review by any court or agency.

7. A hearing held pursuant to this section must be conducted by the administrator or a person designated by him. A record of the hearing must be kept but it need not be transcribed unless it is requested by the person against whom the order or notice of violation has been issued and that person pays the cost of transcription.

8. An administrative fine imposed pursuant to this section must be paid to the division. If the violation for which the fine is levied was committed by a person while acting within the course and scope of his agency or employment, the fine must be paid by his principal or employer. The fine may be recovered in a civil action brought in the name of the division in a court of competent jurisdiction in the county in which the violation occurred or in which the person against whom the fine is levied has his principal place of business.

9. Two or more fines of \$1,000 levied by the administrator in 1 year for acts enumerated in subsection 1 must be considered by the commissioner as evidence for the revocation of a certificate of self-insurance.

10. The commissioner may withdraw the certification of a self-insured employer if, after a hearing, it is shown that the self-insured employer:

(a) Intentionally or repeatedly violated the provisions of paragraph [(g)] (h) of subsection 1; or

(b) Violated any other provision of subsection 1.

(Added to NRS by 1981, 1453; A 1985, 864; 1989, 1593; 1991, 2427)

616.675 False statements or representations to receive compensation; prosecution; disclosure of information to assist prosecution.

1. Any person who willfully makes a false statement or representation or who conceals a material fact to obtain or attempt to obtain, any benefit, including a controlled substance, or payment under the provisions of this chapter, either for himself or for any other person, is guilty of a gross misdemeanor.

2. If a claimant is convicted of violating the provisions of subsection 1, he:

(a) Forfeits all right to compensation under this chapter after conviction for the offense; and

(b) Is liable for the reasonable costs incurred by the insurer to investigate and act upon the false claim, and for the payments or benefits fraudulently obtained.

[3]4. The attorney general or the district attorney of the county in which the employer has a place of business or the defendant resides may prosecute all criminal actions for the violation of the provisions of subsection 1.

[4]5. Upon request, a state agency shall furnish to the attorney general or a district attorney, information which would assist in the prosecution of a claimant alleged to have violated the provisions of subsection 1.

[73:168:1947; 1943 NCL § 2680.73]—(NRS A 1957, 29; 1983, 646; 1989, 1190)

[616.680 Claims for services not rendered; fraudulent acts of medical provider; liability of medical provider.

1. A person who files with the insurer a claim for services rendered to an injured employee, when in fact and in truth such services were not performed, is guilty of a gross misdemeanor.

2. A person who provides medical care or other services to an injured employee shall not knowingly:

- (a) Obtain or attempt to obtain a payment to which he is not entitled;
- (b) Accept a payment in an amount greater than that to which he is entitled;
- (c) Falsify a report or document required by an insurer relating to payments for services rendered or supplies furnished by him; or
- (d) Accept, solicit or offer any bribe or rebate, whether in money or in kind, in connection with services rendered or supplies furnished by him.

3. In addition to the penalty prescribed in subsection 1, a provider of medical care, remedial care or other services who willfully violates the provisions of subsection 2 is liable for:

- (a) An amount equal to three times the amount unlawfully obtained;
- (b) Not less than a \$500 fine for each unlawful act; and
- (c) Any reasonable expense incurred by the insurer in enforcing this section.

4. A provider of medical care, remedial care or other services who accepts a payment without knowledge that it is in excess of the amount to which he is entitled is liable for the repayment of the excess amount. It is a defense to an action brought pursuant to this subsection that the provider of health care returned or attempted to return the amount which was in excess of that to which he was entitled within 30 days after receiving it.

[53.1:168:1947; added 1953, 319]—(NRS A 1981, 1499; 1989, 1191)]

The following nine new sections replace NRS 616.680.

616.NEW "Charge" defined

"Charge" means a communication, whether oral, written, electronic or magnetic which is used to identify specific goods, items or services as reimbursable pursuant to this chapter or Chapter 617, or which may be used to determine a rate of payment pursuant to this chapter or Chapter 617.

616.NEW "Records" defined

"Records" means medical, professional or business records relating to the treatment or care of an injured worker, or to a good or a service provided to an injured worker, or to rates paid for such a good or a service.

616.NEW "Sign" defined

"Sign" means to affix a signature directly or indirectly by means of handwriting, typewriter, stamp, computer impulse or other means.

616.NEW Responsibility for false claim, statement or representation

For the purposes of NRS 616.NEW and 616.NEW:

1. A person shall be deemed to have known that a charge, statement or representation was false if he knew, or by virtue of his position, authority or responsibility had reason to know, of the falsity of the charge, statement or representation.

2. A person shall be deemed to have made or caused to be made a charge, statement or representation if he:

(a) Had the authority or responsibility to:

(1) Make the charge, statement or representation;

(2) Supervises another who made the charge, statement or representation;

or

(3) Authorizes the making of the charge, statement or representation, whether by operation of law, business or professional practice, or office procedure; and

(b) Exercised that authority or responsibility or failed to exercise that authority or responsibility and, as a direct or indirect result, the false statement was made.

616.NEW Offenses regarding false charges, statements or representations; penalty. *A person commits an offense and shall be punished as provided in NRS 205.380 if with respect to this chapter or Chapter 617 he:*

1. Submits a charge or causes it to be made, knowing the charge to be false, in whole or in part, by commission or omission;

2. Makes or causes to be made a statement or representation for use in obtaining or seeking to obtain authorization to provide specific goods or services, knowing the statement or representation to be false, in whole or in part, by commission or omission; or

3. Makes or causes to be made a statement or representation for use by another in obtaining goods or services pursuant to this chapter or Chapter 617, knowing the statement or representation to be false, in whole or in part, by commission or omission.

616.NEW Statement regarding truth and accuracy of charges, reports and invoices; perjury; presumption concerning person who signs statement on behalf of provider.

1. Each invoice for payment for goods or services provided to an injured worker must contain a statement that all matters stated therein are true and

accurate, signed by a natural person who is the provider of health care or is authorized to act for the provider, under the pains and penalties of perjury.

2. A person is guilty of perjury and shall be punished as provided in NRS 199.120 if he signs or submits, or causes to be signed or submitted, such a statement, knowing that the invoice contains information which is false, in whole or in part, by commission or by omission.

3. For the purposes of this section, a person who signs on behalf of a provider of health care is presumed to have the authorization of the provider of health care and to be acting at his direction.

616.NEW Offenses regarding sale, purchase or lease of goods, services, materials or supplies; penalty.

1. Except as otherwise provided in subsection 2, a person shall not:

(a) While acting on behalf of a provider of health care, purchase or lease goods, services, materials or supplies for which payment may be made, in whole or in part, pursuant to this chapter or Chapter 617, and solicit or accept anything of additional value in return for or in connection with the purchase or lease;

(b) Sell or lease to or for the use of a provider of health care goods, services, materials or supplies for which payment may be made, in whole or in part, pursuant to this chapter or Chapter 617, and offer, transfer or pay anything of additional value in connection with or in return for the sale or lease; or

(c) Refer a person to a provider of health care for goods or services for which payment may be made, in whole or in part, pursuant to this chapter or Chapter 617, and solicit or accept anything of value in connection with the referral.

2. Paragraphs (a) and (b) of subsection 1 do not apply if the additional value transferred is:

(a) A refund or discount made in the ordinary course of business;

(b) Reflected by the books and records of the person transferring or receiving it; and

(c) Reflected in the charges submitted to the insurer.

3. A person shall not, while acting on behalf of a provider of health care providing goods or services to an injured worker pursuant to this chapter or Chapter 617, charge, solicit, accept or receive anything of additional value in addition to the amount legally payable pursuant to this chapter or chapter 617 in connection with the provision of the goods or services.

4. Any person who violates this section, if the value of the thing or any combination of things unlawfully solicited, accepted, offered, transferred, paid, charged or received:

(a) Is less than \$250, is guilty of a gross misdemeanor.

(b) Is \$250 or more, shall be punished by imprisonment in the state prison for not less than 1 year nor more than 10 years, or by a fine of not more than \$10,000, or by both fine and imprisonment.

616.NEW *Intentional failure to maintain adequate records; intentional destruction of records; penalties.*

1. A person is guilty of a gross misdemeanor if, upon submitting a charge for or upon receiving payment for goods or services pursuant to this chapter or Chapter 617, he intentionally fails to maintain such records as are necessary to disclose fully the nature of the goods or services for which a charge was submitted or payment was received or such records as are necessary to disclose fully all income and expenditures upon which rates of payment were based, for at least five years after the date on which payment was received.

2. A person who intentionally destroys such records within 5 years after the date payment was received shall be punished by imprisonment in the state prison for not less than 1 year nor more than 6 years, or by a fine of not more than \$5,000, or by both a fine and imprisonment. These records must be made available to the General Manager or the administrator upon reasonable advance request.

616.NEW *Civil penalty imposed for certain violations; defense; liability of health care provider for excess amount unknowingly accepted.*

1. A provider of health care who receives payment to which he is not entitled by reason of a violation of NRS NEW, NEW, NEW or NEW is liable for:

- (a) An amount equal to three times the amount unlawfully obtained;
- (b) Not less than \$5,000 for each act of deception;
- (c) An amount equal to three times the total of the reasonable expenses incurred by the state in enforcing this section; and
- (d) Payment of interest on the amount of the excess payment at the rate fixed pursuant to NRS 99.040 for the period from the date upon which payment was made to the date upon which repayment is made.

2. A criminal action need not be brought against the provider of health care before civil liability attaches under this section.

3. A provider of health care who unknowingly accepts a payment in excess of the amount to which he is entitled is liable for the repayment of the excess amount. It is a defense to any action brought pursuant to this subsection that the provider of health care returned or attempted to return the amount which was in excess of that to which he was entitled within a reasonable time after receiving it.

4. Any penalty or repayment of money collected pursuant to this section is hereby payable to the insurer who made the payment to the health care provider. In the case of the State Industrial Insurance System, any penalty or repayment collected pursuant to this section shall be deposited in the State Insurance Fund.

616.690 *Referral to health facility or service by physician or chiropractor with financial interest in facility or service prohibited [unless financial interest disclosed]; penalizing injured employee for refusal to use health facility or service prohibited.*

1. A physician or chiropractor attending an injured employee shall not refer that employee to a health facility or service in which the physician or chiropractor or an immediate family member or a business partner has a financial interest, including an interest as a limited partner, [unless he first discloses that interest in

writing to the injured employee and the insurer. Upon the request of an injured employee to whom such a disclosure is made, the physician or chiropractor shall provide the injured employee with a referral to a health facility or service in which the physician or chiropractor does not have a financial interest]. The injured employee must not be penalized for refusing to use a health facility or service in which the physician or chiropractor has a financial interest, if the injured employee promptly notifies the insurer in writing of his objection to using the facility or service.

2. As used in this section, "health facility" means any facility in or through which services related to the care and observation of patients, the diagnosis of human diseases, the treatment and rehabilitation of patients or other related services are provided. The term includes any parent, affiliate, subsidiary or partner of such a facility and any other entity which has a primary purpose of providing a benefit to such a facility. *For purposes of this section, "immediate family member" means a grandparent, parent, stepparent, spouse, brother or sister, child, stepchild, grandchild.*

(Added to NRS by 1991, 2391)

617.459 Determination of percentage of disability resulting from heart or lung diseases.

[1.] *Unless the insurer and the injured worker otherwise agree, t[T]he percentage of disability resulting from an occupational disease of the heart or lungs must be determined by [jointly by the claimant's attending physician and the examining] the rating physician in the appropriate specialty selected from the rotating list of physicians maintained by the administrator as provided in NRS 616.605(2), in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment as adopted and supplemented by the department pursuant to subsection 3 of NRS 616.427.*

[2. If the claimant's attending physician and the designated examining physician do not agree upon the percentage of disability, they shall designate a physician specializing in the branch of medicine which pertains to the disease in question to make the determination. If they do not agree upon the designation of such a physician, each shall choose one physician so specializing, and two physicians so chosen shall choose a third specialist in that branch. The resulting panel of three physicians shall, by majority vote, determine the percentage of disability in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment as adopted and supplemented by the department pursuant to subsection 3 of NRS 616.427.]

(Added to NRS by 1981, 850; A 1981, 1538; 1987, 1313; 1991, 494, 2431)

482.368 Distinguishing plates for exempt vehicles: Issuance; fees; interstate agreements; application; regulations.

1. Except as otherwise provided in subsection 2, the department shall provide suitable distinguishing license plates for exempt vehicles. These plates must be displayed on the vehicles in the same manner as provided for privately owned

vehicles. The fee for the issuance of the plates is \$5. Any license plates authorized by this section must be immediately returned to the department when the vehicle for which they were issued ceases to be used exclusively for the purpose for which it was exempted from the privilege and use tax.

2. License plates furnished for:

(a) Those automobiles which are maintained for and used by the governor or under the authority and direction of the chief parole and probation officer, the state contractors' board and auditors, the state fire marshal, the investigation division of the department and any authorized federal or out-of-state law enforcement agency;

(b) One automobile used by the department of prisons, three automobiles used by the department of wildlife, two automobiles used by the Caliente youth center and four automobiles used by the Nevada youth training center;

(c) Vehicles of a city, county or the state[, except any assigned to the state industrial insurance system,] if authorized by the department for purposes of law enforcement or work related thereto or such other purposes as are approved upon proper application and justification; and

(d) Automobiles maintained for and used by investigators of the following:

(1) The state gaming control board;

(2) The division of brand inspection of the state department of agriculture;

(3) The attorney general;

(4) City or county juvenile officers;

(5) District attorneys' offices;

(6) Public administrators' offices;

(7) Public guardians' offices;

(8) Sheriffs' offices; and

(9) Police departments in the state,

must not bear any distinguishing mark which would serve to identify the automobiles as owned by the state, county or city. These license plates must be issued annually for \$12 per plate or, if issued in sets, per set.

3. The director may enter into agreements with departments of motor vehicles of other states providing for exchanges of license plates of regular series for automobiles maintained for and used by investigators of the law enforcement agencies enumerated in paragraph (d) of subsection 2, subject to all of the requirements imposed by that paragraph, except that the fee required by that paragraph must not be charged.

4. Applications for the licenses must be made through the head of the department, board, bureau, commission, school district or irrigation district, or through the chairman of the board of county commissioners of the county or town or through the mayor of the city, owning or controlling the vehicles, and no plate or plates may be issued until a certificate has been filed with the department showing that the name of the department, board, bureau, commission, county, city, town, school district or irrigation district, as the case may be, and the words "For Official Use Only" have been permanently and legibly affixed to each side of the vehicle, except those vehicles enumerated in subsection 2.

5. As used in this section, "exempt vehicle" means a vehicle exempt from the privilege tax, except one owned by the United States.

6. The department shall adopt regulations governing the use of all license plates provided for in this section. Upon a finding by the department of any violation of its regulations, it may revoke the violator's privilege of registering vehicles pursuant to this section.

[Part 6:202:1931; A 1941, 51; 1949, 511; 1953, 52]—(NRS A 1957, 61, 744; 1961, 386, 630; 1963, 693; 1967, 166; 1969, 130; 1973, 85, 290, 1123; 1977, 290; 1979, 254, 931; 1981, 1529, 2006; 1983, 728; 1985, 927, 1354, 1936; 1989, 557, 1961; 1991, 2313)

616.NEW Where a physician or chiropractor initiates treatment for an injury or disease of an employee after the initial report of the injury or disease and where the medical records of the case do not mention the injury or disease for which the treatment is being initiated, the physician or chiropractor must establish a causal relationship by competent medical evidence between the newly developed injury or disease and the original accident in order for the late manifesting condition to be considered a part of the claim.

616.NEW

1. If, within 30 days after payment is made to an injured worker, an insurer determines that it has overpaid the injured worker as a result of a clerical error in his calculation of the amount of payment, the insurer may deduct the amount of the overpayment from any future benefits related to that claim, other than medical benefits, to which the injured worker is entitled. The deductions must be made in a reasonable manner so as not to create an undue hardship to the claimant.

2. If the insurer proposes to reduce a payment pursuant to subsection 1, the insurer shall:

(a) Notify the injured worker in writing of its determination; and

(b) Inform the injured worker of his right to a hearing before a hearing officer to contest the determination. Unless the injured worker does not file a timely appeal, no deduction may be made until after a hearing pursuant to NRS 616.5412.

616.NEW An employee who has retired or otherwise voluntarily removed himself from the work force altogether, for reasons unrelated to the industrial injury, is not entitled to temporary total disability, permanent total disability or vocational rehabilitation if his claim is reopened pursuant to NRS 616.545.

APPENDIX B

Suggested Legislation

	<u>Page</u>
BDR 18-1149 Requires attorney general to establish fraud control unit for industrial insurance.....	99
BDR 53-1150 Makes various changes relating to industrial insurance.....	121
BDR 53-1151 Eliminates subsequent injury fund for industrial insurance.....	131
BDR 53-1152 Revises manner in which certain employers in the state industrial insurance system are identified for purposes of required safety program.....	143
BDR 53-1153 Establishes legislative committee on state industrial insurance system.....	147
BDR 53-1154 Makes various changes to provisions governing procedures for reporting industrial injuries and filing claims for compensation.....	153
BDR 53-1155 Revises statutory provision governing which issues may be appealed to manager of state industrial insurance system and authorizes manager's designee to hold hearings and issue administrative determinations.....	169
BDR 53-1156 Authorizes associations of public or private employers to provide self-insurance against liability for industrial accidents and occupational diseases.....	175

SUMMARY--Requires attorney general to establish fraud control unit for industrial insurance. (BDR 18-1149)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to industrial insurance; providing that the attorney general has primary jurisdiction to investigate and prosecute certain violations relating to industrial insurance; requiring the attorney general to establish a fraud control unit for industrial insurance; authorizing the occupational boards of certain providers of medical care to take disciplinary action against those providers for certain fraudulent acts related to services rendered to injured employees; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN
SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 228 of NRS is hereby amended by adding thereto a new section to read as follows:

1. The attorney general has primary jurisdiction to investigate and prosecute violations of NRS 616.635 and 616.675 to 616.700, inclusive, and any fraud in the administration of chapter 616 or 617 of NRS or in the provision of industrial insurance benefits.

2. *For this purpose, he shall establish within his office a fraud control unit for industrial insurance. The unit must consist of a group of qualified persons, including, without limitation, an attorney, an auditor and an investigator.*

3. *The attorney general, acting through the unit established pursuant to subsection 2, is the single state agency responsible for the investigation and prosecution of violations of NRS 616.635 and 616.675 to 616.700, inclusive, and any fraud in the administration of chapter 616 or 617 of NRS or in the provision of industrial insurance benefits.*

4. *The attorney general shall protect the privacy of persons who are eligible to receive benefits pursuant to the provisions of chapter 616 or 617 of NRS and establish procedures to prevent the misuse of information obtained in carrying out this section.*

5. *When acting pursuant to NRS 228.175, 228.410 or this section, the attorney general may commence his investigation and file a criminal action without leave of court, and he has exclusive charge of the conduct of the prosecution.*

6. *The attorney general shall report the name of any person who has been convicted of violating any of the provisions of subsection 1 or 2 of NRS 616.680 to the occupational board that issued the person's license or certificate to provide medical care, remedial care or other services in this state.*

Sec. 2. NRS 616.675 is hereby amended to read as follows:

616.675 1. Any person who willfully makes a false statement or representation to obtain any benefit or payment under the provisions of this

chapter, either for himself or for any other person, is guilty of a gross misdemeanor.

2. If a claimant is convicted of violating the provisions of subsection 1, he:

(a) Forfeits all right to compensation under this chapter after conviction for the offense; and

(b) Is liable for the reasonable costs incurred by the insurer to investigate and act upon the false claim, and for the payments or benefits fraudulently obtained.

3. The attorney general [or the district attorney of the county in which the employer has a place of business or the defendant resides] may prosecute all criminal actions for the violation of the provisions of subsection 1.

4. Upon request, a state agency shall furnish to the attorney general [or a district attorney,] information which would assist in the prosecution of a claimant alleged to have violated the provisions of subsection 1.

Sec. 3. NRS 630.301 is hereby amended to read as follows:

630.301 The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Conviction of a felony, any offense involving moral turpitude or any offense relating to the practice of medicine or the ability to practice medicine. A plea of nolo contendere is a conviction for the purposes of this subsection.

2. *Conviction of violating any of the provisions of subsection 1 or 2 of NRS 616.680.*

3. The suspension, modification or limitation of the license to practice any type of medicine by any other jurisdiction or the surrender of the license or

discontinuing the practice of medicine while under investigation by any licensing authority, a medical facility, a branch of the armed services of the United States, an insurance company, an agency of the Federal Government or an employer.

[3.] 4. Gross or repeated malpractice, which may be evidenced by claims of malpractice settled against a practitioner.

Sec. 4. NRS 630A.340 is hereby amended to read as follows:

630A.340 The following acts, among others, constitute grounds for initiating disciplinary action or denying the issuance of a license:

1. Unprofessional conduct.

2. Conviction of:

(a) A violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in chapter 454 of NRS;

(b) A felony;

(c) *A violation of any of the provisions of subsection 1 or 2 of NRS 616.680;*

(d) Any offense involving moral turpitude; or

[(d)] (e) Any offense relating to the practice of homeopathic medicine or the ability to practice homeopathic medicine.

A plea of nolo contendere to any offense listed in paragraph (a), (b), (c) , [or] (d) *or* (e) shall be deemed a conviction.

3. The suspension, modification or limitation of a license to practice any type of medicine by any other jurisdiction.

4. The surrender of a license to practice any type of medicine or the discontinuance of the practice of medicine while under investigation by any licensing authority, medical facility, facility for the dependent, branch of the Armed Forces of the United States, insurance company, agency of the Federal Government or employer.

5. Gross or repeated malpractice, which may be evidenced by claims of malpractice settled against a practitioner.

6. Professional incompetence.

Sec. 5. NRS 631.3475 is hereby amended to read as follows:

631.3475 The following acts, among others, constitute unprofessional conduct:

1. Malpractice;
2. Professional incompetence;
3. Suspension or revocation of his license to practice dentistry, the imposition of a fine or other disciplinary action by any agency of another state authorized to regulate the practice of dentistry in that state;
4. More than one act by the dentist or dental hygienist constituting substandard care in the practice of dentistry or dental hygiene;
5. Administering, dispensing or prescribing any controlled substance or any dangerous drug as defined in chapter 454 of NRS, if it is not required to treat the dentist's patient;
6. Chronic or persistent inebriety or addiction to a controlled substance, to such an extent as to render him unsafe or unreliable as a practitioner, or such gross immorality as tends to bring reproach upon the dental profession; [or]

7. Conviction of a felony or misdemeanor involving moral turpitude or which relates to the practice of dentistry in this state, or conviction of any criminal violation of this chapter [.] ; *or*

8. *Conviction of violating any of the provisions of subsection 1 or 2 of NRS 616.680.*

Sec. 6. NRS 632.320 is hereby amended to read as follows:

632.320 The board may deny, revoke or suspend any license applied for or issued pursuant to this chapter, or take other disciplinary action against a licensee, upon determining that he:

1. Is guilty of fraud or deceit in procuring or attempting to procure a license pursuant to this chapter.

2. Is guilty of a felony or any offense involving moral turpitude, in which case the record of conviction is conclusive evidence thereof.

3. *Has been convicted of violating any of the provisions of subsection 1 or 2 of NRS 616.680.*

4. Is unfit or incompetent by reason of gross negligence or recklessness in carrying out usual nursing functions.

[4.] 5. Is habitually intemperate or is addicted to the use of any controlled substance.

[5.] 6. Is mentally incompetent.

[6.] 7. Is guilty of unprofessional conduct, which includes but is not limited to the following:

(a) Conviction of practicing medicine without a license in violation of chapter 630 of NRS, in which case the record of conviction is conclusive evidence thereof.

(b) Procuring, or aiding, abetting, attempting, agreeing or offering to procure or assist at, a criminal abortion.

(c) Impersonating any applicant or acting as proxy for an applicant in any examination required pursuant to this chapter for the issuance of a license.

(d) Impersonating another licensed practitioner.

(e) Permitting or allowing another person to use his certificate for the purpose of nursing the sick or afflicted.

(f) Repeated malpractice, which may be evidenced by claims of malpractice settled against him.

[7.] 8. Has willfully or repeatedly violated the provisions of this chapter. The voluntary surrender of a license issued pursuant to this chapter is prima facie evidence that the licensee has committed or expects to commit a violation of this chapter.

[8.] 9. Is guilty of aiding or abetting anyone in a violation of this chapter.

[9.] 10. Has falsified an entry on a patient's medical chart concerning a controlled substance.

[10.] 11. Has falsified information which was given to a physician, pharmacist or dentist to obtain a controlled substance.

[11.] 12. Has had a license to practice nursing suspended or revoked in another jurisdiction. A certified copy of the order of suspension or revocation is prima facie evidence of the suspension or revocation.

[12.] 13. Has engaged in conduct likely to deceive, defraud or endanger a patient or the general public.

Sec. 7. NRS 633.511 is hereby amended to read as follows:

633.511 The grounds for initiating disciplinary action pursuant to this chapter are:

1. Unprofessional conduct.
2. Conviction of:
 - (a) A violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in chapter 454 of NRS;
 - (b) A felony; [or]
 - (c) *A violation of any of the provisions of subsection 1 or 2 of NRS 616.680;*
- or*
- (d) Any offense involving moral turpitude.
3. The suspension of the license to practice osteopathic medicine by any other jurisdiction.
4. Gross or repeated malpractice, which may be evidenced by claims of malpractice settled against a practitioner.
5. Professional incompetence.

Sec. 8. NRS 634.140 is hereby amended to read as follows:

634.140 The grounds for initiating disciplinary action pursuant to this chapter are:

1. Unprofessional conduct.
2. Conviction of:

(a) A violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in chapter 454 of NRS;

(b) A felony; [or]

(c) *A violation of any of the provisions of subsection 1 or 2 of NRS 616.680;*
or

(d) Any offense involving moral turpitude.

3. Suspension or revocation of the license to practice chiropractic by any other jurisdiction.

4. Gross or repeated malpractice.

5. Referring an injured employee to a health facility in which the licensee has a financial interest unless he first discloses that interest pursuant to NRS 616.690.

Sec. 9. NRS 634A.170 is hereby amended to read as follows:

634A.170 The board may refuse to issue or may suspend or revoke any license for any one or any combination of the following causes:

1. Conviction of [a felony, conviction of any] :

(a) *A felony;*

(b) *Any offense involving moral turpitude [or conviction of a] ;*

(c) *A violation of any state or federal law regulating the possession, distribution or use of any controlled substance, as shown by a certified copy of the record of the court; or*

(d) *A violation of any of the provisions of subsection 1 or 2 of NRS 616.680;*

2. The obtaining of or any attempt to obtain a license or practice in the profession for money or any other thing of value, by fraudulent misrepresentations;
3. Gross or repeated malpractice, which may be evidenced by claims of malpractice settled against a practitioner;
4. Advertising by means of a knowingly false or deceptive statement;
5. Advertising, practicing or attempting to practice under a name other than one's own;
6. Habitual drunkenness or habitual addiction to the use of a controlled substance;
7. Using any false, fraudulent or forged statement or document, or engaging in any fraudulent, deceitful, dishonest or immoral practice in connection with the licensing requirements of this chapter;
8. Sustaining a physical or mental disability which renders further practice dangerous;
9. Engaging in any dishonorable, unethical or unprofessional conduct which may deceive, defraud or harm the public, or which is unbecoming a person licensed to practice under this chapter;
10. Using any false or fraudulent statement in connection with the practice of Oriental medicine or any branch thereof;
11. Violating or attempting to violate, or assisting or abetting the violation of, or conspiring to violate any provision of this chapter;
12. Being adjudicated incompetent or insane;
13. Advertising in an unethical or unprofessional manner;

14. Obtaining a fee or financial benefit for any person by the use of fraudulent diagnosis, therapy or treatment;

15. Willful disclosure of a privileged communication;

16. Failure of a licensee to designate the nature of his practice in the professional use of his name by the term doctor of Oriental medicine, doctor of acupuncture or acupuncture assistant, as the case may be;

17. Willful violation of the law relating to the health, safety or welfare of the public or of the regulations adopted by the state board of health;

18. Administering, dispensing or prescribing any controlled substance, except for the prevention, alleviation or cure of disease or for relief from suffering; and

19. Performing, assisting or advising in the injection of any liquid silicone substance into the human body.

Sec. 10. NRS 635.130 is hereby amended to read as follows:

635.130 1. The board, after notice and hearing, and upon any cause enumerated in subsection 2, may take one or more of the following disciplinary actions:

(a) Refuse to renew a license.

(b) Suspend or revoke a license.

(c) Place a licensee on probation.

(d) Impose a fine not to exceed \$1,000.

2. The board may take disciplinary action against a licensee for any of the following causes:

(a) The making of a false statement in any affidavit required of the applicant for application, examination or licensure under this chapter.

(b) Lending the use of the holder's name to an unlicensed person.

(c) If the holder is a podiatrist, his permitting an unlicensed person in his employ to practice as a podiatry hygienist.

(d) Habitual indulgence in the use of alcohol or any controlled substance which impairs the intellect and judgment to such an extent as in the opinion of the board incapacitates the holder in the performance of his professional duties.

(e) Conviction of a crime involving moral turpitude.

(f) *Conviction of violating any of the provisions of subsection 1 or 2 of NRS 616.680.*

(g) Conduct which in the opinion of the board disqualifies him to practice with safety to the public.

[(g)] (h) The commission of fraud by or on behalf of the licensee regarding his license or practice.

[(h)] (i) Gross incompetency.

[(i)] (j) Affliction of the licensee with any mental or physical disorder which seriously impairs his competence as a podiatrist or podiatry hygienist.

[(j)] (k) False representation by or on behalf of the licensee regarding his practice.

[(k)] (l) Unethical or unprofessional conduct.

[(l)] (m) Willful or repeated violations of this chapter or regulations adopted by the board.

[(m)] (n) Willful violation of the regulations adopted by the state board of pharmacy.

Sec. 11. NRS 636.295 is hereby amended to read as follows:

636.295 The following acts, conduct, omissions, or mental or physical conditions, or any of them, committed, engaged in, omitted, or being suffered by a licensee, constitute sufficient cause for disciplinary action:

1. Affliction of the licensee with any communicable disease likely to be communicated to other persons.

2. Commission by the licensee of a felony or a gross misdemeanor involving moral turpitude of which he has been convicted and from which he has been sentenced by a final judgment of a federal or state court in this or any other state, the judgment not having been reversed or vacated by a competent appellate court and the offense not having been pardoned by executive authority.

3. *Conviction of any of the provisions of subsection 1 or 2 of NRS 616.680.*

4. Commission of fraud by or on behalf of the licensee in obtaining his license or a renewal thereof, or in practicing optometry thereunder.

[4.] 5. Habitual drunkenness or addiction to any controlled substance.

[5.] 6. Gross incompetency.

[6.] 7. Affliction with any mental or physical disorder or disturbance seriously impairing his competency as an optometrist.

[7.] 8. Making false or misleading representations, by or on behalf of the licensee, with respect to optometric materials or services.

[8.] 9. Practice by the licensee, or attempting or offering so to do, while he is in an intoxicated condition.

[9.] 10. Perpetration of unethical or unprofessional conduct in the practice of optometry.

[10.] 11. Willfully and repeatedly violating provisions of this chapter or regulations adopted by the board.

Sec. 12. NRS 637.150 is hereby amended to read as follows:

637.150 Upon proof to the satisfaction of the board that an applicant or holder of a license:

1. Has been adjudicated insane;
2. Habitually uses any controlled substance or intoxicant;
3. Has been convicted of a crime involving moral turpitude;
4. *Has been convicted of violating any of the provisions of subsection 1 or 2 of NRS 616.680;*

5. Has advertised in any manner which would tend to deceive, defraud or mislead the public;

[5.] 6. Has presented to the board any diploma, license or certificate that has been signed or issued unlawfully or under fraudulent representations, or obtains or has obtained a license to practice in the state through fraud of any kind;

[6.] 7. Has been convicted of a violation of any federal or state law relating to a controlled substance;

[7.] 8. Has violated any regulation of the board;

[8.] 9. Has violated any provision of this chapter;

[9.] 10. Is incompetent;

[10.] 11. Is guilty of unethical or unprofessional conduct as determined by the board;

[11.] 12. Is guilty of repeated malpractice, which may be evidenced by claims of malpractice settled against a practitioner; or

[12.] 13. Is guilty of a fraudulent or deceptive practice as determined by the board,

the board may, in the case of an applicant, refuse to grant him a license, or may, in the case of a holder of a license, place him on probation, reprimand him privately or publicly, require him to pay an administrative fine of not more than \$10,000, suspend or revoke his license, or take any combination of these disciplinary actions.

Sec. 13. NRS 637A.250 is hereby amended to read as follows:

637A.250 The board may revoke or suspend a license after a hearing which discloses that the licensee:

1. Has been convicted of a felony or a misdemeanor involving moral turpitude.

2. *Has been convicted of violating any of the provisions of NRS 616.680.*

3. Obtained the license by fraud or misrepresentation.

[3.] 4. Obtained any fee by fraud or misrepresentation.

[4.] 5. Has made any false or fraudulent statements concerning hearing aids.

[5.] 6. Has been guilty of negligence, incompetence or misconduct in the fitting of any hearing aid.

[6.] 7. Has loaned or transferred his license to another person.

[7.] 8. Willfully violated any law of this state or any provision of this chapter regulating hearing aid specialists.

[8.] 9. Is habitually intemperate.

Sec. 14. NRS 637B.250 is hereby amended to read as follows:

637B.250 The grounds for initiating disciplinary action pursuant to this chapter are:

1. Unprofessional conduct.
 2. Conviction of:
 - (a) A violation of any federal or state law regarding the possession, distribution or use of any controlled substance or any dangerous drug as defined in chapter 454 of NRS;
 - (b) A felony; [or]
 - (c) *A violation of any of the provisions of subsection 1 or 2 of NRS 616.680;*
- or*
- (d) Any offense involving moral turpitude.
 3. Suspension or revocation of a license to practice audiology or speech pathology by any other jurisdiction.
 4. Gross or repeated malpractice, which may be evidenced by claims of malpractice settled against a practitioner.
 5. Professional incompetence.

Sec. 15. NRS 639.210 is hereby amended to read as follows:

639.210 The board may suspend or revoke any certificate, license, registration or permit issued pursuant to this chapter, and deny the application

of any person for a certificate, license, registration or permit, if the holder or applicant:

1. Is not of good moral character;
2. Is guilty of habitual intemperance;
3. Becomes or is intoxicated or under the influence of liquor, any depressant drug or a controlled substance, unless taken pursuant to a physician's prescription, while on duty in any establishment licensed by the board;
4. Is guilty of unprofessional conduct or conduct contrary to the public interest;
5. Is addicted to the use of any controlled substance;
6. Has been convicted of a violation of any law or regulation of the Federal Government or of this or any other state related to controlled substances, dangerous drugs, drug samples, or the wholesale or retail distribution of drugs;
7. Has been convicted of a felony or other crime involving moral turpitude, dishonesty or corruption;
8. *Has been convicted of violating any of the provisions of subsection 1 or 2 of NRS 616.680;*
9. Has willfully made to the board or its authorized representative any false statement which is material to the administration or enforcement of any of the provisions of this chapter;
- [9.] 10. Has obtained any certificate, certification, license or permit by the filing of an application, or any record, affidavit or other information in support thereof, which is false or fraudulent;

[10.] 11. Has violated any provision of the Federal Food, Drug and Cosmetic Act or any other federal law or regulation relating to prescription drugs;

[11.] 12. Has violated, attempted to violate, assisted or abetted in the violation of or conspired to violate any of the provisions of this chapter or any law or regulation relating to drugs, the manufacture or distribution of drugs or the practice of pharmacy, or has knowingly permitted, allowed, condoned or failed to report a violation of any of the provisions of this chapter or any law or regulation relating to drugs, the manufacture or distribution of drugs or the practice of pharmacy committed by the holder of a certificate, license, registration or permit;

[12.] 13. Has failed to renew his certificate, license or permit by failing to submit the application for renewal or pay the renewal fee therefor;

[13.] 14. Has had his certificate, license or permit suspended or revoked in another state on grounds which would cause suspension or revocation of a certificate, license or permit in this state;

[14.] 15. Has, as a managing pharmacist, violated any provision of law or regulation concerning recordkeeping or inventory in a store over which he presides, or has knowingly allowed a violation of any provision of this chapter or other state or federal laws or regulations relating to the practice of pharmacy by personnel of the pharmacy under his supervision;

[15.] 16. Has repeatedly been negligent, which may be evidenced by claims of malpractice settled against him; or

[16.] 17. Has failed to maintain and make available to a state or federal officer any records in accordance with the provisions of this chapter or chapter 453 or 454 of NRS.

Sec. 16. NRS 640.160 is hereby amended to read as follows:

640.160 1. The board, after due notice and hearing, and upon any ground enumerated in subsection 2, may take one or more of the following actions:

- (a) Refuse to issue a license or temporary license to any applicant.
- (b) Refuse to renew the license or temporary license of any person.
- (c) Suspend or revoke the license or temporary license of any person.
- (d) Place any person who has been issued a license or temporary license on probation.
- (e) Impose an administrative fine which does not exceed \$5,000 on any person who has been issued a license.

2. The board may take action pursuant to subsection 1 if an applicant or person who has been licensed pursuant to this chapter:

- (a) Is habitually drunk or is addicted to the use of a controlled substance.
- (b) Has been convicted of violating any state or federal law relating to controlled substances.
- (c) Is, in the judgment of the board, guilty of immoral or unprofessional conduct.
- (d) Has been convicted of any crime involving moral turpitude.
- (e) *Has been convicted of violating any of the provisions of subsection 1 or 2 of NRS 616.680.*

(f) Is guilty, in the judgment of the board, of gross negligence in his practice as a physical therapist which may be evidenced by claims of malpractice settled against a practitioner.

[(f)] (g) Has obtained or attempted to obtain a license by fraud or material misrepresentation.

[(g)] (h) Has been declared insane by a court of competent jurisdiction and has not thereafter been lawfully declared sane.

[(h)] (i) Has entered into any contract or arrangement which provides for the payment of an unearned fee to any person following his referral of a patient.

[(i)] (j) Has employed as a physical therapist any unlicensed physical therapist or physical therapist whose license has been suspended.

[(j)] (k) Has had his license to practice physical therapy suspended, revoked or in any way limited by another jurisdiction.

[(k)] (l) Is determined to be professionally incompetent by the board.

[(l)] (m) Has violated any provision of this chapter or the board's regulations.

Sec. 17. NRS 641.230 is hereby amended to read as follows:

641.230 The board may suspend the license of a psychologist, place a psychologist on probation, revoke the license of a psychologist, require remediation for a psychologist or take any other action specified by regulation if the board finds by a preponderance of the evidence that the psychologist has:

1. Been convicted of a felony.

2. Been convicted of any crime or offense that reflects the inability of the psychologist to practice psychology with due regard for the health and safety of others.

3. *Been convicted of violating any of the provisions of subsection 1 or 2 of NRS 616.680.*

4. Engaged in gross malpractice or repeated malpractice or gross negligence in the practice of psychology.

[4.] 5. Aided or abetted the practice of psychology by a person not licensed by the board.

[5.] 6. Made any fraudulent or untrue statement to the board.

[6.] 7. Violated a regulation adopted by the board.

[7.] 8. Had his license to practice psychology suspended or revoked by another state.

[8.] 9. Failed to report to the board within 30 days the revocation, suspension or surrender of a license or certificate to practice psychology issued by another state.

[9.] 10. Violated or attempted to violate, directly or indirectly, or assisted in or abetted the violation of or conspired to violate a provision of this chapter.

[10.] 11. Performed or attempted to perform any professional service while impaired by alcohol, drugs or by a mental or physical illness, disorder or disease.

Sec. 18. NRS 652.220 is hereby amended to read as follows:

652.220 A license may be denied, suspended or revoked if the laboratory, laboratory director or any technical employee of the laboratory:

1. Violates any provision of this chapter;
2. Makes any misrepresentation in obtaining a license;
3. Has been convicted of a felony;
4. *Has been convicted of violating any of the provisions of subsection 1 or 2 of NRS 616.680;*
5. Is guilty of unprofessional conduct;
- [5.] 6. Knowingly permits the use of the name of a licensed laboratory or its director by an unlicensed laboratory; or
- [6.] 7. Fails to meet the minimum standards prescribed by the board.

SUMMARY--Makes various changes relating to industrial insurance.

(BDR 53-1150)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: No.

AN ACT relating to industrial insurance; defining "surviving spouse" for purposes of industrial insurance; making various other changes relating to the administration of industrial insurance; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN
SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. NRS 616.175 is hereby amended to read as follows:

616.175 The system shall:

1. Keep and maintain its office in Carson City, Nevada.
2. Keep and maintain suboffices at such places in the state as industrial activity warrants, and shall locate one suboffice in the Las Vegas area.
[Suboffices] *If determined practicable by the system, a suboffice must have complete facilities for processing claims for injuries.*

3. Provide statewide, toll-free telephone service on state WATS lines to the Carson City office, and all suboffices, or accept collect calls from claimants.

Sec. 2. NRS 616.221 is hereby amended to read as follows:

616.221 Except as otherwise provided in NRS 616.377 , 616.427, 616.647 and 617.275, any party who is aggrieved by a decision of the administrator may appeal that decision directly to the district court.

Sec. 3. NRS 616.615 is hereby amended to read as follows:

616.615 If an injury by accident arising out of and in the course of employment causes the death of an employee in the employ of an employer, within the provisions of this chapter, the compensation is known as a death benefit, and is payable as follows:

1. In addition to any other compensation payable pursuant to this chapter, burial expenses are payable in an amount not to exceed \$5,000. When the remains of the deceased employee and the person accompanying the remains are to be transported to a mortuary or mortuaries, the charge of transportation must be borne by the insurer if the transportation is not beyond the continental limits of the United States.

2. To the surviving spouse of the deceased employee, 66 2/3 percent of the average monthly wage is payable until his death or remarriage, with 2 years' compensation payable in one lump sum upon remarriage.

3. In the event of the subsequent death of the surviving spouse:

- (a) Each surviving child of the deceased employee must share equally the compensation theretofore paid to the surviving spouse but not in excess thereof, and it is payable until the youngest reaches the age of 18 years.

- (b) If the children have a guardian, the compensation on account of them may be paid to the guardian.

4. Upon the remarriage of a surviving spouse with children:

(a) The surviving spouse must be paid 2 years' compensation in one lump sum and further benefits must cease; and

(b) Each child must be paid 15 percent of the average monthly wage, up to a maximum family benefit of $66 \frac{2}{3}$ percent of the average monthly wage.

5. If there are any surviving children of the deceased employee under the age of 18 years, but no surviving spouse, then each such child is entitled to his proportionate share of $66 \frac{2}{3}$ percent of the average monthly wage for his support.

6. Except as otherwise provided in subsection 7, if there is no surviving spouse or child under the age of 18 years, there must be paid:

(a) To a parent, if wholly dependent for support upon the deceased employee at the time of injury causing his death, $33 \frac{1}{3}$ percent of the average monthly wage.

(b) To both parents, if wholly dependent for support upon the deceased employee at the time of injury causing his death, $66 \frac{2}{3}$ percent of the average monthly wage.

(c) To each brother or sister until he or she reaches the age of 18 years, if wholly dependent for support upon the deceased employee at the time of injury causing his death, his proportionate share of $66 \frac{2}{3}$ percent of the average monthly wage.

7. The aggregate compensation payable pursuant to subsection 6 must not exceed $66 \frac{2}{3}$ percent of the average monthly wage.

8. In all other cases involving a question of total or partial dependency:

(a) The extent of the dependency must be determined in accordance with the facts existing at the time of the injury.

(b) If the deceased employee leaves dependents only partially dependent upon his earnings for support at the time of the injury causing his death, the monthly compensation to be paid must be equal to the same proportion of the monthly payments for the benefit of persons totally dependent as the amount contributed by the deceased employee to the partial dependents bears to the average monthly wage of the deceased employee at the time of the injury resulting in his death.

(c) The duration of compensation to partial dependents must be fixed in accordance with the facts shown, but may not exceed compensation for 100 months.

9. Compensation payable to a surviving spouse is for the use and benefit of the surviving spouse and the dependent children, and the insurer may, from time to time, apportion such compensation between them in such a way as it deems best for the interest of all dependents.

10. In the event of the death of any dependent specified in this section before the expiration of the time during which compensation is payable to him, funeral expenses are payable in an amount not to exceed \$5,000.

11. Except as otherwise provided in paragraphs (a) and (b), the entitlement of any child to receive his proportionate share of compensation pursuant to this section ceases when he dies, marries or reaches the age of 18 years. A child is entitled to continue to receive compensation pursuant to this section if he is:

(a) Over 18 years of age and incapable of self-support, until such time as he becomes capable of self-support; or

(b) Over 18 years of age and enrolled as a full-time student in an accredited vocational or educational institution, until he reaches the age of 22 years.

12. For the purposes of this section, "surviving spouse" means a surviving husband or wife who was married to the employee at the time of the employee's death.

Sec. 4. NRS 616.647 is hereby amended to read as follows:

616.647 1. If the administrator has reason to believe that an insurer, health care provider, third-party administrator or employer has:

(a) Induced a claimant for compensation to fail to report an accidental injury or occupational disease;

(b) Persuaded a claimant to settle for an amount which is less than reasonable;

(c) Persuaded a claimant to settle for an amount which is less than reasonable while a hearing or an appeal is pending;

(d) Persuaded a claimant to accept less than the compensation found to be due him by a hearing officer or appeals officer;

(e) Refused to pay or unreasonably delayed payment to a claimant of compensation found to be due him by a hearing officer or appeals officer;

(f) Made it necessary for a claimant to resort to proceedings against the employer or insurer for compensation found to be due him by a hearing officer or appeals officer;

(g) Failed to comply with regulations of the department for the acceptance and rejection of claims, determination and calculation of a claimant's average monthly wage, determination and payment of compensation, delivery of accident benefits and reporting relating to these matters;

(h) Failed to comply with the department's regulations covering the payment of an assessment relating to the funding of costs of administration of this chapter and chapter 617 of NRS; or

(i) Failed to comply with any provision of, or regulation adopted pursuant to, this chapter or chapter 617 of NRS,
the administrator shall set a date for a hearing. The date must be no sooner than 30 days after notice is served upon the insurer , *health care provider*, *third-party administrator* or employer of the alleged action and the time and place of the hearing.

2. If, after an evidentiary hearing, the administrator determines that the insurer , *health care provider*, *third-party administrator* or employer has committed the alleged act, the administrator shall issue a notice of violation imposing a proposed administrative fine of:

(a) Not more than \$250 for each initial violation of subsection 1 which was not intentional; or

(b) Not more than \$1,000 for each intentional or repeated violation of subsection 1.

3. In addition to any fine imposed pursuant to subsection 2, the administrator may assess against an insurer who violates any regulation concerning the reporting of claims expenditures used to calculate an

assessment an administrative penalty of up to twice the amount of any underpaid assessment.

4. If a person wishes to contest a notice of violation issued pursuant to subsection 2, he must file a notice of appeal with the division within 30 days after the notice is issued, showing why the proposed fine should not be imposed against him.

5. If a notice of appeal is filed as required by subsection 4, the administrator shall issue a complaint setting forth the factual basis for his determination that a violation has occurred. The person against whom a complaint is issued shall file an answer to the complaint within 30 days after the complaint is issued. The answer must be accompanied by any documentary evidence upon which the person relies and, if the person desires a hearing on the matter, by a request for hearing. If an answer and a request for hearing are filed as required by this subsection, the administrator shall set a date for a hearing on the matter, which must be no sooner than 30 days after the answer and request for hearing are filed.

6. If a notice of appeal or an answer is not filed as required by this section, the notice of violation shall be deemed a final order and is not subject to review by any court or agency.

7. A hearing held pursuant to this section must be conducted by the administrator or a person designated by him. A record of the hearing must be kept but it need not be transcribed unless it is requested by the person against whom the order or notice of violation has been issued and that person pays the cost of transcription.

8. An administrative fine imposed pursuant to this section must be paid to the division. If the violation for which the fine is levied was committed by a person while acting within the course and scope of his agency or employment, the fine must be paid by his principal or employer. The fine may be recovered in a civil action brought in the name of the division in a court of competent jurisdiction in the county in which the violation occurred or in which the person against whom the fine is levied has his principal place of business.

9. Two or more fines of \$1,000 levied by the administrator in 1 year for acts enumerated in subsection 1 must be considered by the commissioner as evidence for the revocation of a certificate of self- insurance.

10. The commissioner may withdraw the certification of a self-insured employer if, after a hearing, it is shown that the self-insured employer:

(a) Intentionally or repeatedly violated the provisions of paragraph (g) of subsection 1; or

(b) Violated any other provision of subsection 1.

Sec. 5. NRS 616.537 is hereby repealed.

TEXT OF REPEALED SECTION

616.537 Insurer required to schedule rating for injured employee after determination by treating physician or chiropractor; contents of rating evaluation.

1. An insurer shall schedule a rating for an injured employee within 30 days after the injured employee is determined to be stable and ratable by the treating physician or chiropractor.

2. A rating evaluation must include an evaluation of the loss of motion, sensation and strength of an injured employee if the injury is of a type that might have caused such a loss.

3. A self-insured employer shall refer an injured employee who is entitled to compensation for a permanent partial disability to the department for a rating by a physician or chiropractor selected in rotation from the list of qualified physicians or chiropractors designated by the administrator pursuant to subsection 2 of NRS 616.605, according to the order in which their names appear on the list.

SUMMARY--Eliminates subsequent injury fund for industrial insurance.

(BDR 53-1151)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: No.

AN ACT relating to industrial insurance; eliminating the subsequent injury fund; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN
SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 616 of NRS is hereby amended by adding thereto a new section to read as follows:

The department shall adopt regulations incorporating the American Medical Association's Guides to the Evaluation of Permanent Impairment by reference and may amend those regulations from time to time as it deems necessary. In adopting the Guides to the Evaluation of Permanent Impairment, the department shall consider the edition most recently published by the American Medical Association.

Sec. 2. NRS 616.560 is hereby amended to read as follows:

616.560 1. When an employee coming under the provisions of this chapter receives an injury for which compensation is payable under this chapter and which was caused under circumstances creating a legal liability in some person,

other than the employer or a person in the same employ, to pay damages in respect thereof:

(a) The injured employee, or in case of death, his dependents, may take proceedings against that person to recover damages, but the amount of the compensation to which the injured employee or his dependents are entitled under this chapter, including any future compensation under this chapter, must be reduced by the amount of the damages recovered, notwithstanding any act or omission of the employer or a person in the same employ which was a direct or proximate cause of the employee's injury.

(b) If the injured employee, or in case of death his dependents, [receive] *receives* compensation under this chapter, the insurer, or in case of claims involving the uninsured employers' claim [fund or the subsequent injury] fund, the administrator, has a right of action against the person so liable to pay damages and is subrogated to the rights of the injured employee or of his dependents to recover therefor. In any action or proceedings taken by the insurer or the administrator under this section, evidence of the amount of compensation, accident benefits and other expenditures which the insurer [,] *or* the uninsured employers' claim fund [or the subsequent injury fund] have paid or become obligated to pay by reason of the injury or death of the employee is admissible. If in such action or proceedings the insurer or the administrator recovers more than those amounts, the excess must be paid to the injured employee or his dependents.

(c) The injured employee, or in case of death his dependents, shall first notify the insurer, or in the case of claims involving the uninsured employers'

claim fund [or subsequent injury fund] the administrator, in writing of any action or proceedings, pursuant to this section, to be taken by the employee or his dependents.

2. In any case where the insurer or the administrator is subrogated to the rights of the injured employee or of his dependents as provided in subsection 1, the insurer or the administrator has a lien upon the total proceeds of any recovery from some person other than the employer, whether the proceeds of such recovery are by way of judgment, settlement or otherwise. The injured employee, or in the case of his death his dependents, [are] *is* not entitled to double recovery for the same injury, notwithstanding any act or omission of the employer or a person in the same employ which was a direct or proximate cause of the employee's injury.

3. The lien provided for under subsection 2 includes the total compensation expenditure incurred by the insurer [,] *or* the uninsured employers' claim fund [or the subsequent injury fund] for the injured employee and his dependents.

4. Within 15 days of the date of recovery by way of actual receipt of the proceeds of the judgment, settlement or otherwise, the injured employee or his representative shall notify the insurer, or in the case of claims involving the uninsured employers' claim fund [or subsequent injury fund] the administrator, of the recovery and pay to the insurer or the administrator, respectively, the amount due under this section together with an itemized statement showing the distribution of the total recovery.

5. In any trial of an action by the injured employee, or in the case of his death by his dependents, against a person other than the employer or a person

in the same employ, the jury shall receive proof of the amount of all payments made or to be made by the insurer or the administrator. The court shall instruct the jury substantially as follows:

"Payment of workmen's compensation benefits by the insurer, or in the case of claims involving the uninsured employers' claim fund [or subsequent injury fund] the administrator, is based upon the fact that a compensable industrial accident occurred, and does not depend upon blame or fault. If the plaintiff does not obtain a judgment in his favor in this case, he is not required to repay his employer, the insurer or the administrator any amount paid to him or paid on his behalf by his employer, the insurer or the administrator.

If you decide that the plaintiff is entitled to judgment against the defendant, you shall find his damages in accordance with the court's instructions on damages and return your verdict in the plaintiff's favor in the amount so found without deducting the amount of any compensation benefits paid to or for the plaintiff. The law provides a means by which any compensation benefits will be repaid from your award."

6. For the purposes of calculating an employer's premium, the employer's account with the system must be credited with an amount equal to that recovered by the system from a third-party pursuant to this section, less the system's share of the expenses of litigation incurred in obtaining the recovery, except that the total credit must not exceed the amount of compensation actually paid or reserved by the system on the injured employee's claim.

Sec. 3. NRS 616.605 is hereby amended to read as follows:

616.605 1. Every employee, in the employ of an employer within the provisions of this chapter, who is injured by an accident arising out of and in the course of employment is entitled to receive the compensation provided for permanent partial disability. As used in this section "disability" and "impairment of the whole man" are equivalent terms.

2. Within 30 days after receiving from the treating physician or chiropractor chosen pursuant to NRS 616.342 a report indicating that the injured employee may have suffered a permanent disability and is stable and ratable, the insurer shall schedule an appointment with a rating physician or chiropractor to determine the extent of the employee's disability. The insurer shall select a physician or chiropractor from a group of rating physicians and chiropractors designated by the administrator, to determine the percentage of disability in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment as adopted and supplemented by the department pursuant to [subsection 3 of NRS 616.427.] *section 1 of this act*. Rating physicians and chiropractors must be selected in rotation from the list of qualified physicians and chiropractors designated by the administrator, according to their area of specialization and the order in which their names appear on the list.

3. No factors other than the degree of physical impairment of the whole man may be considered in calculating the entitlement to compensation for a permanent partial disability.

4. The rating physician or chiropractor shall provide the insurer with his evaluation of the injured employee. After receiving the evaluation, the insurer

shall, within 14 days, provide the employee with a copy of the evaluation and notify the employee:

- (a) Of the compensation to which he is entitled pursuant to this section; or
- (b) That he is not entitled to benefits for permanent partial disability.

5. Each 1 percent of impairment of the whole man must be compensated by a monthly payment of 0.5 percent of the claimant's average monthly wage for injuries sustained before July 1, 1981, and 0.6 percent for injuries sustained on or after July 1, 1981. Compensation must commence on the date of the injury or the day following the termination of temporary disability compensation, if any, whichever is later, and must continue on a monthly basis for 5 years or until the claimant is 70 years of age, whichever is later.

6. Compensation benefits may be paid annually to claimants who will be receiving less than \$100 a month.

7. Where there is a previous disability, as the loss of one eye, one hand, one foot, or any other previous permanent disability, the percentage of disability for a subsequent injury must be determined by computing the percentage of the entire disability and deducting therefrom the percentage of the previous disability as it existed at the time of the subsequent injury.

8. The department may adopt schedules for rating permanent disabilities resulting from injuries sustained before July 1, 1973, and reasonable regulations to carry out the provisions of this section.

9. The increase in compensation and benefits effected by the amendment of this section is not retroactive for accidents which occurred before July 1, 1973.

10. This section does not entitle any person to double payments for the death of a workman and a continuation of payments for a permanent partial disability, or to a greater sum in the aggregate than if the injury had been fatal.

Sec. 4. NRS 617.459 is hereby amended to read as follows:

617.459 1. The percentage of disability resulting from an occupational disease of the heart or lungs must be determined jointly by the claimant's attending physician and the examining physician designated by the insurer, in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment as adopted and supplemented by the department pursuant to [subsection 3 of NRS 616.427.] *section 1 of this act.*

2. If the claimant's attending physician and the designated examining physician do not agree upon the percentage of disability, they shall designate a physician specializing in the branch of medicine which pertains to the disease in question to make the determination. If they do not agree upon the designation of such a physician, each shall choose one physician so specializing, and two physicians so chosen shall choose a third specialist in that branch. The resulting panel of three physicians shall, by majority vote, determine the percentage of disability in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment as adopted and supplemented by the department pursuant to [subsection 3 of NRS 616.427.] *section 1 of this act.*

Sec. 5. NRS 616.4261, 616.427 and 616.428 are hereby repealed.

Sec. 6. At the close of the fiscal year 1992-93, the state controller shall transfer the assets and liabilities of the subsequent injury fund, to the extent

that the assets are not encumbered for the fiscal year 1992-93, to the state insurance fund.

Sec. 7. This act becomes effective on July 1, 1993.

TEXT OF REPEALED SECTIONS

616.4261 Subsequent injury fund: Establishment; purpose; disbursements; investments; assessment rates, payments and penalties.

1. There is hereby established as a trust fund in the state treasury the subsequent injury fund, which may be used only to make payments in accordance with the provisions of NRS 616.427 and NRS 616.428. The administrator shall administer the fund.

2. All assessments, penalties, bonds, securities and all other properties received, collected or acquired by the administrator for the subsequent injury fund must be delivered to the custody of the state treasurer.

3. All money and securities in the fund must be held in trust by the state treasurer as custodian thereof to be used solely for workers' compensation.

4. The state treasurer may disburse money from the fund only upon written order of the state controller.

5. The state treasurer shall invest money of the fund in the same manner and in the same securities in which he is authorized to invest state general

funds which are in his custody. Income realized from the investment of the assets of the fund must be credited to the fund.

6. The director must adopt regulations for the establishment and administration of assessment rates, payments and penalties. Assessment rates must reflect the relative hazard of the employments covered by the insurers, and must be based upon expected annual expenditures for claims.

7. The commissioner shall assign an actuary to review the establishment of assessment rates. The rates must be filed with the commissioner 30 days before their effective date. Any insurer who wishes to appeal the rate so filed must do so pursuant to NRS 679B.310.

616.427 Subsequent injury fund: Payment of cost of additional compensation resulting from subsequent injury. Except as otherwise provided in NRS 616.428:

1. If an employee who has a permanent physical impairment from any cause or origin incurs a subsequent disability by injury arising out of and in the course of his employment which entitles him to compensation for disability that is substantially greater by reason of the combined effects of the preexisting impairment and the subsequent injury than that which would have resulted from the subsequent injury alone, the compensation due must be charged to the subsequent injury fund in accordance with regulations adopted by the administrator.

2. If the subsequent injury of such an employee results in his death and it is determined that the death would not have occurred except for the preexisting permanent physical impairment, the compensation due must be charged to the

subsequent injury fund in accordance with regulations adopted by the administrator.

3. As used in this section, "permanent physical impairment" means any permanent condition, whether congenital or caused by injury or disease, of such seriousness as to constitute a hindrance or obstacle to obtaining employment or to obtaining reemployment if the employee is unemployed. For the purposes of this section, a condition is not a "permanent physical impairment" unless it would support a rating of permanent impairment of 6 percent or more of the whole man if evaluated according to the American Medical Association's Guides to the Evaluation of Permanent Impairment as adopted and supplemented by the department. The department shall adopt regulations incorporating the American Medical Association's Guides to the Evaluation of Permanent Impairment by reference and may amend such regulations from time to time as it deems necessary. In adopting the Guides to the Evaluation of Permanent Impairment, the department shall consider the edition most recently published by the American Medical Association.

4. To qualify under this section for reimbursement from the subsequent injury fund, the insurer must establish by written records that the employer had knowledge of the "permanent physical impairment" at the time the employee was hired or that the employee was retained in employment after the employer acquired such knowledge.

5. An insurer shall notify the administrator of any possible claim against the subsequent injury fund as soon as practicable, but not later than 100 weeks after the injury or death.

6. The administrator shall adopt regulations establishing procedures for submitting claims against the subsequent injury fund. The administrator shall notify the insurer of his decision on such a claim within 90 days after the claim is received.

7. An appeal of any decision made concerning a claim against the subsequent injury fund must be submitted directly to the appeals officer. The appeals officer shall hear such an appeal within 45 days after the appeal is submitted to him.

616.428 Subsequent injury fund: Reimbursement of insurer for cost of additional compensation resulting from subsequent injury.

1. An insurer who pays compensation due to an employee who has a permanent physical impairment from any cause or origin and incurs a subsequent disability by injury arising out of and in the course of his employment which entitles him to compensation for disability that is substantially greater by reason of the combined effects of the preexisting impairment and the subsequent injury than that which would have resulted from the subsequent injury alone is entitled to be reimbursed from the subsequent injury fund if:

(a) The employee knowingly or willfully made a false representation as to his physical condition at the time he was hired by the employer;

(b) The employer relied upon the false representation and this reliance formed a substantial basis of the employment; and

(c) A causal connection existed between the false representation and the subsequent disability.

If the subsequent injury of the employee results in his death and it is determined that the death would not have occurred except for the preexisting permanent physical impairment, any compensation paid is entitled to be reimbursed from the subsequent injury fund.

2. An insurer shall notify the administrator of any possible claim against the subsequent injury fund pursuant to this section no later than 60 days after the date of the subsequent injury or the date the insurer learns of the employee's false representation, whichever is later.

SUMMARY--Revises manner in which certain employers in the state industrial insurance system are identified for purposes of required safety program. (BDR 53-1152)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: No.

AN ACT relating to state industrial insurance system; revising the manner in which certain employers who must provide a safety program are identified; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN
SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. NRS 616.1722 is hereby amended to read as follows:

616.1722 1. The manager shall make available a program, using a videotape cassette or other means of presentation, concerning the rights and responsibilities of employers and employees pursuant to this chapter and chapter 617 of NRS. The manager shall provide written notification concerning the availability of the program to each chamber of commerce in Nevada and to each statewide association for a business or industry. The program must be available to community organizations, businesses, employers and employees upon request.

2. The manager shall provide each:

(a) Employer who attends a program, a certificate which certifies that he has completed the program described in subsection 1. The employer shall post the certificate in his business in a place that is readily accessible and visible to his employees.

(b) Employee who attends a program, a card which certifies that he has completed the program described in subsection 1.

3. The manager shall identify those employers whose [employees sustained injuries during the preceding calendar year at a rate that he determines is significantly greater than the rate of injuries for that industry as a whole.] *actual and anticipated cost for accident benefits and compensation paid to the employees of the employer is greater than 90 percent of the premium paid by the employer in at least 2 of the 5 most recent fiscal years.* The manager shall provide consultation *in accordance with NRS 618.383* concerning safety to such employers.

4. If an employer refuses to consult with the manager concerning safety, the manager may assess the employer an administrative penalty of not more than \$1,000 or adjust the premium rate of the employer.

Sec. 2. NRS 618.383 is hereby amended to read as follows:

618.383 1. An employer *who is identified by the manager of the state industrial insurance system pursuant to subsection 3 of NRS 616.1722* shall establish a written safety program . [if he has a rate of occupational injury and illness that is in the highest 25 percent in this state for his standard industrial classification.]

2. The written safety program must include:

(a) The establishment of a training program for employees concerning safety in the workplace, particularly in those areas where there have been recurring injuries.

(b) The establishment of a safety committee which includes, whenever possible, an equal number of representatives of employees and employers. If the employees are represented by a labor organization, the representatives of employees must be selected by the employees and not appointed by the employer.

(c) Training on identifying potential hazards in the workplace.

(d) The review and application of state and federal statutes, regulations and standards concerning occupational safety and health.

(e) A requirement for the periodic consultation of the employer with the division of enforcement for industrial safety and health of the department.

3. A representative of employees while engaging in the business of a safety committee, including attendance at meetings, inspections or any other activity of the committee, must be paid by his employer as if that employee were engaged in his usual work activities.

4. The administrator of the division of preventative safety of the department shall develop and provide each employer with a written manual which includes:

(a) Information concerning safety, health and emergencies in the workplace, and the establishment of a training program for employees with regard to those matters;

(b) A listing and description of safe work practices; and

(c) Guidelines for the establishment of a safety committee.

5. Any other employer may establish a written safety program and a safety committee.

6. An employer [who has a rate of occupational injury and illness that is in the highest 25 percent in this state for his standard industrial classification,] *who is identified by the manager of the state industrial insurance system pursuant to subsection 3 of NRS 616.1722*, who employs 25 or more persons and who hires temporary employees shall hold a meeting and provide specialized training concerning safety for those temporary employees before they begin work at each site or as soon as possible thereafter.

7. The manager of the state industrial insurance system shall increase by 3 percent the premium of any employer who violates the provisions of subsection 1, and shall transfer any additional premium received by him pursuant to this subsection to the department for use by the division of preventative safety.

[8. The administrator of the division of enforcement for industrial safety and health may grant an exemption from any of the provisions of this section to an employer who has a rate of occupational injury and illness that is in the lowest 25 percent of all employers in this state.]

SUMMARY--Establishes legislative committee on state industrial insurance system. (BDR 53-1153)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: Yes.

AN ACT relating to the state industrial insurance system; establishing a legislative committee on industrial insurance; directing the committee to review and evaluate laws, regulations and state agencies related to worker's compensation and occupational safety and health; requiring the commissioner of insurance to report to the committee quarterly concerning the solvency of the system; requiring the committee to make biennial reports to the legislature; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN
SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. The legislature hereby finds and declares that:

1. The solvency of the state industrial insurance system is essential to ensure that money is available to provide adequate compensation to workers in this state who are involved in industrial accidents or suffer from occupational diseases.

2. As the demands upon the system have increased and become more complex, it has become increasingly difficult to administer the system in a manner which is both efficient and effective.

3. A consistent and timely review of the appropriateness and effectiveness of the laws governing the administration of the state industrial insurance system is a constituent part of the proper administration of the system.

4. The expenses of the legislative committee on industrial insurance are administrative expenses incidental to providing compensation for industrial accidents and occupational diseases and may therefore appropriately be paid from the fund for workers' compensation and safety.

Sec. 2. Chapter 616 of NRS is hereby amended by adding thereto the provisions set forth as sections 3 to 7, inclusive, of this act.

Sec. 3. *As used in sections 3 to 7, inclusive, of this act, "committee" means the legislative committee on industrial insurance.*

Sec. 4. 1. *There is hereby established a legislative committee on industrial insurance consisting of:*

(a) Four members of the senate, appointed by the majority leader of the senate from the members of the senate standing committee on commerce and labor; and

(b) Four members of the assembly, appointed by the speaker of the assembly from the members of the assembly standing committee on labor and management.

2. The committee shall select a chairman and vice chairman from among its members. The first chairman of the committee must be a member of the

assembly, and the first vice chairman must be a member of the senate. Thereafter, the positions of chairman and vice chairman of the committee must alternate each biennium between the houses of the legislature. Each such officer shall hold office for a term of 2 years commencing on July 1 of each odd-numbered year.

3. The term of each member of the committee is 2 years. A member may be reappointed, and there is no limit on the number of terms that a member may serve. A member of the committee who does not return to the legislature may continue to serve until the next session of the legislature convenes.

4. A vacancy on the committee must be filled in the same manner as the original appointment.

5. The committee shall report to the legislative commission concerning its activities and any recommendations on or before September 1 next preceding the convening of each regular session of the legislature.

Sec. 5. 1. The committee shall meet at least four times each year, but may not hold more than six meetings in any 1 year. The meetings may be held in person, by telephone conference or video telecast. The director of the legislative counsel bureau or his designee shall serve as the nonvoting recording secretary for the committee.

2. The committee shall prescribe rules for its own management. Five members of the committee constitute a quorum which may exercise all the powers of the committee.

3. Except during a regular or special session of the legislature, a member of the committee is entitled to receive the compensation provided for a majority of

the members of the legislature during the first 60 days of the preceding regular session for each day or portion of a day during which he attends a meeting of the committee or is otherwise engaged in the business of the committee plus the per diem allowance provided for state officers and employees generally and the travel expenses provided pursuant to NRS 218.2207. The committee shall report annually to the legislative commission and the department of industrial relations concerning its expenses.

4. The salaries and expenses of the committee must be paid from the fund for workers' compensation and safety established pursuant to NRS 616.423.

Sec. 6. *The committee may:*

- 1. Investigate the solvency of the system.*
- 2. Review and evaluate the current laws of this state concerning industrial insurance.*
- 3. Review and evaluate the current regulations and programs of agencies of this state concerning industrial insurance.*
- 4. Analyze the overall system of industrial insurance to avoid duplication of services and achieve the most efficient use of all available resources.*
- 5. Conduct investigations and hold hearings in connection with its review and analysis.*
- 6. Apply for any available grants and accept any gifts, grants or donations to aid the committee in carrying out its duties pursuant to this chapter.*
- 7. Direct the legislative counsel bureau to assist in its research, investigations, review and analysis.*

8. *Recommend to the legislature as a result of its investigation and review any appropriate legislation.*

Sec. 7. The commissioner of insurance shall report quarterly to the committee concerning the solvency of the system.

Sec. 8. NRS 232.680 is hereby amended to read as follows:

232.680 1. The cost of carrying out the provisions of NRS 232.550 to 232.700, inclusive, and of supporting the department , [and] its various divisions *and the legislative committee on industrial insurance established pursuant to section 4 of this act* must be paid from assessments payable by each:

(a) Insurer based upon expected annual expenditures for claims; and

(b) Employer who provides accident benefits for injured employees pursuant to NRS 616.415, based upon his expected annual expenses of providing those benefits.

The department shall adopt regulations which establish formulas of assessment which result in an equitable distribution of costs among the insurers and employers who provide accident benefits for injured employees.

2. Federal grants may partially defray the costs of the divisions.

3. Assessments made against insurers by the department after the adoption of regulations must be used to defray all costs and expenses of administering the program of workmen's compensation, including the payment of:

(a) All salaries and other expenses in administering the division of industrial insurance regulation, the division of administrative services, the division of enforcement for industrial safety and health, the division of preventative safety

and the division of mine inspection, including the costs of the office and staff of the director.

(b) All salaries and other expenses of administering NRS 616.253 to 616.2539, inclusive, the offices of the hearings division of the department of administration and the programs of self-insurance and review of premium rates by the commissioner of insurance.

(c) *All salaries and other expenses of the legislative committee on industrial insurance established pursuant to section 4 of this act.*

(d) Claims against uninsured employers arising from compliance with NRS 616.377.

Sec. 9. This act becomes effective on July 1, 1993.

SUMMARY--Makes various changes to provisions governing procedures for reporting industrial injuries and filing claims for compensation.
(BDR 53-1154)

FISCAL NOTE: Effect on Local Government: No.
 Effect on the State or on Industrial Insurance: No.

AN ACT relating to industrial insurance; requiring an employee to report an industrial injury to his employer; authorizing a claim for compensation to be filed only after an injured employee has sought medical treatment; requiring a physician or chiropractor who is treating an injured employee to file a claim for compensation with the employee's employer; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN
SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 616 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 5, inclusive, of this act.

Sec. 2. 1. *Within 6 working days after the receipt of a claim for compensation or knowledge that an employee has sought medical treatment for an injury arising out of and in the course of his employment, whichever occurs*

first, an employer shall complete and submit a report of the injury to his insurer or third-party administrator.

2. The report must:

(a) Be on the form prescribed by the administrator for reporting an injury and contain specific answers to all questions required by the regulations of the department.

(b) Be signed by the employer or his designee.

(c) Include a statement of the wages of the employee if the claim for compensation indicates that the employee is expected to be off work for 5 days or more.

(d) Be served by delivery or by mailing a copy in a sealed postpaid envelope addressed to the insurer or third-party administrator. Such mailing constitutes complete service.

3. An employee of the system shall not complete a report of the injury for an employer unless the employer:

(a) Is not in business;

(b) Has not been located by the insurer within 5 working days after receipt of a claim for compensation; or

(c) Refuses to complete the report.

4. The administrator may impose an administrative fine of not more than \$1,000 on an employer for each violation of this section.

Sec. 3. *1. Except as otherwise provided in subsection 2, an employee or, in the event of the death of the employee, his dependent is barred from recovering compensation pursuant to the provisions of this chapter if:*

(a) The employee or his dependent failed to file notice of the injury pursuant to NRS 616.500; or

(b) The employee's treating physician or chiropractor failed to file a claim for compensation pursuant to NRS 616.345 and the employee or his dependent failed to file a claim for compensation pursuant to section 4 of this act.

2. An insurer may excuse the failure to file the notice of injury or claim for compensation if:

(a) The failure was because of the physical or mental inability of the employee or his dependent or because of other circumstances beyond the control of the employee or his dependent; or

(b) The failure was because of the employee's or his dependent's mistake or ignorance of fact or of law, or because of fraud, misrepresentation or deceit.

Sec. 4. *1. If an employee has sought medical treatment for an injury arising out of and in the course of his employment and the employee or, in the event of the death of the employee, his dependent, discovers that a claim for compensation has not been filed pursuant to NRS 616.345, the employee, his dependent or a person acting on behalf of the dependent, may file a claim for compensation.*

2. The claim for compensation must be:

(a) On the form prescribed by the administrator for filing a claim for compensation.

(b) Filed with the employee's employer, and the insurer or third-party administrator, within 90 days after receipt of knowledge that the treating

physician or chiropractor of the employee failed to file a claim for compensation pursuant to NRS 616.345.

(c) Served by delivery or by mailing a copy in a sealed postpaid envelope addressed to the employer, and to the insurer or third-party administrator. Such mailing constitutes complete service.

Sec. 5. *An insurer shall accept or deny responsibility for compensation under this chapter or chapter 617 of NRS within 30 working days after a claim for compensation is received.*

Sec. 6. NRS 616.220 is hereby amended to read as follows:

616.220 The administrator shall:

1. Prescribe by regulation the time within which adjudications and awards must be made.

2. *Regulate and prepare a form for use by:*

(a) An employee or his dependent to provide notice of an injury pursuant to NRS 616.500. The form must include an explanation of the procedure for filing a claim for compensation.

(b) A physician or chiropractor to file a claim for compensation pursuant to NRS 616.345.

(c) An employee or his dependent to file a claim for compensation pursuant to section 4 of this act and the provisions of chapter 617 of NRS.

(d) An employer to file the report of injury pursuant to section 2 of this act.

3. Regulate [forms of notices, claims and] other blank forms deemed proper and advisable.

[3.] 4. Prescribe by regulation the methods by which an insurer may approve or reject claims, and may determine the amount and nature of benefits payable in connection therewith. Every such approval, rejection and determination is subject to review by a hearing officer.

[4.] 5. Provide by regulation for adequate notice to each claimant of his right:

(a) To review by a hearing officer of any determination or rejection by the insurer.

(b) To judicial review of any final decision.

[5.] 6. Prescribe by regulation the criteria by which an insurer who orders rehabilitative services for an injured [worker] *employee* must provide those services.

[6.] 7. Prescribe by regulation the method for reimbursing an injured [worker] *employee* for expenses necessarily incurred for travel more than 20 miles one way from his residence or place of employment to his destination as a result of an industrial injury.

[7.] 8. Except with respect to any matter committed by specific statute to the regulatory authority of another person or agency, adopt such other regulations as he deems necessary to carry out the provisions of this chapter and chapter 617 of NRS.

Sec. 7. NRS 616.340 is hereby amended to read as follows:

616.340 1. Every employer within the provisions of this chapter shall, immediately upon the occurrence of an injury to any of his employees, render to the injured employee all necessary first aid, including the cost of

transportation of the injured employee to the nearest place of proper treatment if the injury is such as to make it reasonably necessary for such transportation.

2. [Each such employer who is not self-insured or his agent shall notify the insurer's claims administrator in writing of the accident. The notification of the accident must be postmarked within 6 working days after receipt of knowledge of the accident and, if the injured employee is expected to be off work for 5 days or more, must include a statement of the wages of the injured employee. An employee of the system shall not complete any form concerning the accident for an employer unless the employer:

- (a) Is not in business;
- (b) Has not been located by the insurer within 5 working days after receipt of the notification of the accident; or
- (c) Refuses to complete the forms.

3. Each employer who files a report of an injury with the insurer shall file a full report of every known injury to the employee arising out of and in the course of his employment and resulting in his loss of life or injury. The report must be:

- (a) Signed by the employer or his designee; and
- (b) Furnished to the insurer in the form prescribed and contain specific answers to all questions required by the regulations of the department.

4.] An employer who is not self-insured is entitled to receive reimbursement from his insurer for the costs incurred in rendering the necessary first aid and transportation of an injured employee to the nearest place of proper treatment.

Sec. 8. NRS 616.345 is hereby amended to read as follows:

616.345 1. [Every employer within the provisions of this chapter, and every] *The treating* physician or chiropractor [who attends an injured employee within the provisions of this chapter shall file with the insurer a complete report of every known injury to the employee arising] *of an injured employee shall complete and file a claim for compensation with the employee's employer, and the insurer or third-party administrator, if:*

(a) The employee informed the physician or chiropractor that the injury arose out of and in the course of his employment [and resulting in his loss of life or injury.

2. Reports must be furnished to the insurer in the form prescribed, be postmarked within 3 working days after the examination of the employee and contain special answers to all questions required by the regulations of the department.

3.] *or the physician or chiropractor has reason to believe that the injury arose out of and in the course of the employee's employment; and*

(b) At the request of the physician or chiropractor, the employee provided the name of his employer.

2. *The claim for compensation must:*

(a) Be on the form prescribed by the administrator for filing a claim for compensation.

(b) Be filed within 3 working days after the physician or chiropractor treated the employee.

(c) Describe any limitations or restrictions on the employee's ability to work.

(d) Indicate whether the employee is expected to be off work 5 days or more.

(e) Be served by delivery or by mailing a copy in a sealed postpaid envelope addressed to the employer, and to the insurer or third-party administrator. Such mailing constitutes complete service.

3. Each physician, chiropractor and medical facility that treats an injured employee, each insurer, third-party administrator and employer, and the division and department shall maintain at their offices a sufficient supply of the forms prepared by the administrator for filing a claim for compensation.

4. The administrator [shall] may impose an administrative fine [on a person who fails to comply with the provisions of subsection 1. The administrator may impose a fine] of not more than \$1,000 for each [failure.] violation of this section.

Sec. 9. NRS 616.365 is hereby amended to read as follows:

616.365 If [the accident and injury are not reported by the employee or his physician or chiropractor forthwith, as described in this chapter or if the injured employee or those in charge of him (the injured employee being a party to the refusal) refuse] *an employee is properly directed to submit to a physical examination and the employee refuses* to permit the treating physician or chiropractor to make an examination and to render medical attention as may be required immediately, no compensation may be paid for the injury claimed to result from the accident . [; but the insurer may relieve the injured person or his dependents from loss or forfeiture of compensation if he finds that:

1. The circumstances attending the failure on the part of the employee, or of his physician or chiropractor, to report the accident and injury are such as to have excused the employee and his physician or chiropractor for the failure so to report; and

2. Relieving the employee or his dependents from the consequences of the failure to report will not result in an unwarrantable charge against the insurer.]

Sec. 10. NRS 616.377 is hereby amended to read as follows:

616.377 1. If an employee who has been hired or who is regularly employed in this state suffers an accident or injury arising out of and in the course of his employment, and his employer has failed to provide mandatory industrial insurance coverage, the employee may elect to receive compensation from the uninsured employers' claim fund [by:

(a) Filing a] *if:*

(a) A claim for compensation *is filed* with the system [;

(b) Filing a] *pursuant to NRS 616.345 or section 4 of this act;*

(b) *The employee files* written notice of his election with the division; and

(c) [Making] *The employee makes* an irrevocable assignment to the division of his right of action against the uninsured employer.

2. If the system receives a claim pursuant to subsection 1, the system shall immediately:

(a) Notify the employer of the claim; and

(b) Deliver to the division any evidence regarding the claim and any evidence indicating that the employer was uninsured.

3. For the purposes of this section, the employer has the burden of proving that he provided mandatory industrial insurance coverage for the employee.

4. Any employer who has failed to provide mandatory coverage required by the provisions of this chapter is liable for all payments made on his behalf, including any benefits, administrative costs or attorney's fees paid from the uninsured employers' claim fund or incurred by the division or department.

5. The division:

(a) May recover from the employer the payments described in subsection 4 and any accrued interest by bringing a civil action in district court.

(b) In any civil action brought against the employer, is not required to prove that negligent conduct by the employer was the cause of the employee's injury.

(c) May enter into a contract with any person to assist in the collection of any liability of an uninsured employer.

(d) In lieu of a civil action, may enter into an agreement or settlement regarding the collection of any liability of an uninsured employer.

6. The division shall determine whether the employer was insured within 30 days after receiving notice of the claim from the employee. Upon determining that a claim is valid, the division shall assign the claim to the system for administration of the claim, payment of benefits and reimbursement of costs of administration and benefits paid to the system. Upon determining that a claim is invalid, the division shall notify the claimant, the named employer and the system that the claim will not be assigned for benefits from the uninsured employers' claim fund.

7. Any party aggrieved by a decision regarding the administration of an assigned claim or a decision made by the division or by the system regarding any claim made pursuant to this section may appeal that decision within 60 days after the decision is rendered to the hearings division of the department of administration in the manner provided by NRS 616.5412 to 616.544, inclusive.

8. All insurers shall bear a proportionate amount of a claim made pursuant to this chapter, and are entitled to a proportionate amount of any collection made pursuant to this section as an offset against future liabilities.

9. An uninsured employer is liable for the interest on any amount paid on his claims from the uninsured employers' claim fund. The interest must be calculated at a rate equal to the prime rate at the largest bank in Nevada, as ascertained by the commissioner of financial institutions, on January 1 or July 1, as the case may be, immediately preceding the date of the claim, plus 3 percent, compounded monthly, from the date the claim is paid from the fund until payment is received by the division from the employer.

10. Attorney's fees recoverable by the division pursuant to this section must be:

(a) If a private attorney is retained by the department, paid at the usual and customary rate for that attorney.

(b) If the attorney is an employee of the department, paid at the rate established by regulations adopted by the department.

Any money collected must be deposited to the uninsured employers' claim fund.

Sec. 11. NRS 616.500 is hereby amended to read as follows:

616.500 1. [Notice of the injury for which compensation is payable under this chapter must be given to the insurer] *Except as otherwise provided in subsection 2, an employee shall provide written notice of an injury arising out of and in the course of his employment to his employer as soon as practicable, but within 30 days after the accident.*

2. In the event of the death of the *injured* employee resulting from the injury, [notice must be given to the insurer] *a dependent of the employee, or a person acting on behalf of the dependent, shall provide written notice of the injury to the employee's employer as soon as practicable, but within 30 days after death.*

3. The notice of *injury* must:

(a) Be [in writing;] *on the form prepared by the administrator for providing notice of an injury.*

(b) Contain the name and address of the injured employee . [;]

(c) Contain a statement in ordinary language of the time, place, nature and cause of the injury . [; and]

(d) Be signed by the injured employee or by a person on his behalf, or in the event of the [employee's death, by one or more of his dependents] *death of the injured employee, by his dependent* or by a person [on their behalf.

4. No proceeding under this chapter for compensation for an injury may be maintained unless the injured employee, or someone on his behalf, files with the insurer a claim for compensation with respect to the injury within 90 days

after the accident, or, in the event of the employee's death, within 1 year after death.

5. The notice required by this section must be] *acting on behalf of the dependent.*

(e) *Be served by delivery [of a copy of the notice,] or by mailing a copy [thereof] in a sealed postpaid envelope addressed to the [insurer.] employer.* Such mailing constitutes complete service.

[6. Failure to give notice or to file a claim for compensation within the time specified in this section is a bar to any claim for compensation under this chapter, but such failure may be excused by the insurer on one or more of the following grounds:

(a) That there was good cause for the failure to give notice or file the claim.

(b) That notice for some sufficient reason could not have been made.

(c) That failure to give notice will not result in an unwarrantable charge against the state insurance fund.

(d) That failure to give notice was because of the employee's or beneficiary's mistake or ignorance of fact or of law, or of his physical or mental inability, or because of fraud, misrepresentation or deceit.

7. The insurer shall accept or deny responsibility for compensation under this chapter or chapter 617 of NRS within 14 working days after the notice provided for in this section is received. If additional information is necessary to determine liability, the administrator may, upon good cause shown by the insurer, extend the period to 45 days upon notice to the claimant. If additional information is still necessary, the administrator may, upon good cause shown

by the insurer, grant a further extension if the claimant gives his written consent, but the total period may not be extended to more than 75 days.]

4. Upon receipt of the notice of injury, the employer, the injured employee's supervisor or the agent of the employer who was in charge of the type of work or the area where the accident occurred shall sign the notice of injury. The signature of the employer or his agent shall not be deemed to be a waiver of any of the employer's defenses or rights. The employer shall:

(a) Provide a signed copy of the notice of injury to the injured employee or, in the event of the death of the injured employee, to his dependent.

(b) Retain a copy of the notice of injury for 3 years after the accident.

(c) Make a copy of the notice of injury available to the division or the department upon request.

(d) Maintain a sufficient supply of the forms prepared by the administrator for providing notice of an injury.

(e) Provide such a form to an employee upon request.

5. The administrator may impose an administrative fine of not more than \$1,000 on an employer for each violation of subsection 4.

Sec. 12. NRS 616.5412 is hereby amended to read as follows:

616.5412 1. Any person who is subject to the jurisdiction of the hearing officers pursuant to this chapter or chapter 617 of NRS may request a hearing before a hearing officer of any matter within his authority. The insurer shall provide, without cost, the forms necessary to request a hearing to any person who requests them.

2. A person who is aggrieved by:

(a) A written determination of an insurer; or

(b) The failure of an insurer to respond within 30 days to a written request mailed to the insurer by the person who is aggrieved, may appeal from the determination or failure to respond by filing a request for a hearing before a hearing officer. Such a request must be filed within 60 days after the date on which the notice of its determination was mailed by the insurer or the unanswered written request was mailed to the insurer, as applicable. Except as otherwise provided in [subsection 7 of NRS 616.500,] *this section*, the failure of an insurer to respond to a written request for a determination within 30 days after receipt of such a request shall be deemed by the hearing officer to be a denial of the request. *If additional information is necessary for an insurer to respond to a written request for a determination, the hearing officer may, for good cause shown, extend the period to 45 days upon notice to the claimant. If additional information is still necessary, the hearing officer may grant a further extension if the claimant gives his written consent, but the total period may not be extended to more than 90 days after the date the written request for a determination was mailed to the insurer.*

3. Failure to file a request for a hearing within the period specified in subsection 2 may be excused if the person aggrieved shows by a preponderance of the evidence that he did not receive the notice of the determination and the forms necessary to request a hearing. The claimant or employer shall notify the insurer of a change of address.

4. The hearing before the hearing officer must be conducted as expeditiously and informally as is practicable.

Sec. 13. NRS 616.543 is hereby amended to read as follows:

616.543 1. No judicial proceedings may be instituted for compensation for an injury or death under this chapter unless:

(a) A claim for compensation is filed as provided in NRS [616.500;] *616.345 or section 4 of this act*; and

(b) A final decision of an appeals officer has been rendered on such claim.

2. Judicial proceedings instituted for compensation for an injury or death, under this chapter are limited to judicial review of the decision of an appeals officer.

SUMMARY--Revises statutory provision governing which issues may be appealed to manager of state industrial insurance system and authorizes manager's designee to hold hearings and issue administrative determinations. (BDR 53-1155)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: No.

AN ACT relating to industrial insurance; revising the statutory provision governing which issues may be appealed to the manager of the state industrial insurance system; authorizing a person designated by the manager to hold hearings and issue administrative determinations; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN
SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. NRS 616.226 is hereby amended to read as follows:

616.226 1. Appeals officers, the administrator , [and] the manager [,] *and the manager's designee*, in conducting hearings or other proceedings pursuant to the provisions of this chapter or regulations adopted under this chapter may:

(a) Issue subpoenas requiring the attendance of any witness or the production of books, accounts, papers, records and documents.

(b) Administer oaths.

- (c) Certify to official acts.
- (d) Call and examine under oath any witness or party to a claim.
- (e) Maintain order.
- (f) Rule upon all questions arising during the course of a hearing or proceeding.
- (g) Permit discovery by deposition or interrogatories.
- (h) Initiate and hold conferences for the settlement or simplification of issues.
- (i) Dispose of procedural requests or similar matters.
- (j) Generally regulate and guide the course of a pending hearing or proceeding.

2. Hearing officers in conducting hearings or other proceedings pursuant to the provisions of this chapter or regulations adopted under this chapter may:

(a) Issue subpoenas requiring the attendance of any witness or the production of books, accounts, papers, records and documents that are relevant to the dispute for which the hearing or other proceeding [are] *is* being held.

- (b) Maintain order.
- (c) Permit discovery by deposition or interrogatories.
- (d) Initiate and hold conferences for the settlement or simplification of issues.
- (e) Dispose of procedural requests or similar matters.
- (f) Generally regulate and guide the course of a pending hearing or proceeding.

3. After a determination is made pursuant to a hearing or other proceeding, the insurer shall notify the injured employee, the employer and the physician or chiropractor who is treating the injured employee of the determination.

Sec. 2. NRS 616.230 is hereby amended to read as follows:

616.230 If any person disobeys an order of an appeals officer, a hearing officer, the administrator , [or] the manager [,] *or the manager's designee*, or a subpoena issued by the manager, *manager's designee*, administrator, appeals officer, hearing officer, inspector or examiner, or refuses to permit an inspection, or as a witness, refuses to testify to any matter for which he may be lawfully interrogated, the district judge of the county in which the person resides, on application of the appeals officer, *the* hearing officer, the administrator , [or] the manager [,] *or the manager's designee*, shall compel obedience by attachment proceedings as for contempt, as in the case of disobedience of the requirements of subpoenas issued from the court on a refusal to testify therein.

Sec. 3. NRS 616.235 is hereby amended to read as follows:

616.235 1. Each officer who serves a subpoena is entitled to receive the same fees as a sheriff.

2. Each witness who appears, in obedience to a subpoena which has been issued pursuant to this chapter, before an appeals officer, a hearing officer, the administrator , [or] the manager *or the manager's designee*, is entitled to receive for his attendance the fees and mileage provided for witnesses in civil cases in courts of record.

3. The appeals officer, hearing officer, administrator , [or] manager *or manager's designee* shall:

(a) Authorize payment from his administrative budget of the fees and mileage due to such a witness; or

(b) Impose those costs upon the party at whose instance the witness was subpoenaed or, for good cause shown, upon any other party.

Sec. 4. NRS 616.245 is hereby amended to read as follows:

616.245 1. A transcribed copy of the evidence and proceedings, or any specific part thereof, of any final hearing or investigation, made by a stenographer appointed by an appeals officer, a hearing officer, the administrator , [or] the manager [,] *or the manager's designee*, being certified by that stenographer to be a true and correct transcript of the testimony in the final hearing or investigation, or of a particular witness, or of a specific part thereof, and carefully compared by him with his original notes, and to be a correct statement of the evidence and proceedings had on the final hearing or investigation so purporting to be taken and transcribed, may be received in evidence with the same effect as if the stenographer had been present and testified to the facts so certified.

2. A copy of the transcript must be furnished on demand to any party upon the payment of the fee required for transcripts in courts of record.

Sec. 5. NRS 616.392 is hereby amended to read as follows:

616.392 1. [Any party] *Except as otherwise provided in subsection 2, a principal contractor or an owner of property acting as a principal contractor aggrieved by a letter issued pursuant to NRS 616.288 or an employer aggrieved*

by a written decision of an employee of the system *on a matter* relating to [employers' accounts, including but not limited to matters concerning audits and the classification of risks,] *the employer's account* may appeal from the letter or decision by filing a notice of appeal with the manager *or his designee* within 30 days after the date of the letter or decision.

2. *An employer shall not seek to remove costs that have been charged to his account by appealing to the manager or his designee any issue that relates to a claim for compensation if the issue was raised, or could have been raised, before a hearing officer or an appeals officer pursuant to NRS 616.5412 or 616.5422.*

3. The decision of the manager *or his designee* is the final and binding administrative determination of an appeal relating to the issuance of final certificates or employers' accounts under this chapter, and the whole record consists of all evidence taken at the hearing before the manager *or his designee* and any findings of fact and conclusions of law based thereon.

4. *As used in this section, matters relating to an employer's account include, but are not limited to, an audit of the employer's account and a determination of the appropriate classification of risk for an employer's business.*

Sec. 6. NRS 616.5424 is hereby amended to read as follows:

616.5424 At any time 10 or more days before a scheduled hearing before an appeals officer, the administrator , [or] the manager [,] *or the manager's designee*, a party shall mail or deliver to the opposing party any affidavit which he proposes to introduce into evidence and notice to the effect that unless the opposing party, within 7 days after the mailing or delivery of such affidavit,

mails or delivers to the proponent a request to cross-examine the affiant, his right to cross-examine the affiant is waived and the affidavit, if introduced into evidence, will have the same effect as if the affiant had given sworn testimony before the appeals officer, the administrator , [or] the manager [,] *or the manager's designee*.

Sec. 7. NRS 616.544 is hereby amended to read as follows:

616.544 If a party petitions the district court for judicial review of a final decision of an appeals officer , [or] the manager [,] *or the manager's designee*, and the petition is found by the district court to be frivolous or brought without reasonable grounds, the district court may order costs and a reasonable attorney's fee to be paid by the petitioner.

SUMMARY--Authorizes associations of public or private employers to provide self-insurance against liability for industrial accidents and occupational diseases. (BDR 53-1156)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State or on Industrial Insurance: No.

AN ACT relating to industrial insurance; authorizing an association of public or private employers to provide self-insurance against liability for industrial accidents and occupational diseases; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN
SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 616 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 32, inclusive, of this act.

Sec. 2. *"Association of self-insured private employers" means a nonprofit, unincorporated association composed of five or more private employers that has been issued a certificate by the commissioner indicating that the combined administrative and financial resources of the members of the association are sufficient to make certain the prompt payment of all compensation under this chapter and chapter 617 of NRS.*

Sec. 3. *"Association of self-insured public employers" means a nonprofit, unincorporated association composed of five or more public employers that has been issued a certificate by the commissioner indicating that the combined administrative and financial resources of the members of the association are sufficient to make certain the prompt payment of all compensation under this chapter and chapter 617 of NRS.*

Sec. 4. *"Private employer" means any person, other than a public employer, who has in service any person under a contract of hire.*

Sec. 5. *"Public employer" means the state and a county, city, school district and public or quasi-public corporation within this state.*

Sec. 6. *"Service company" means a person who provides services to an association of self-insured public or private employers that are not provided by a third-party administrator, including, but not limited to, services relating to:*

- 1. The adjustment of claims;*
- 2. Programs for loss control and occupational safety;*
- 3. The compilation of statistics and the preparation of required reports;*
- 4. The calculation of assessments and fees required to be paid by the members of the association; and*
- 5. The administration of a claims account.*

Sec. 7. 1. *A group of employers may not act as an association of self-insured public employers or as an association of self-insured private employers unless the group has been issued a certificate to do so by the commissioner.*

2. An association of public or private employers that wishes to be issued a certificate must file with the commissioner an application for certification.

3. *The application must include:*

(a) *The name of the association.*

(b) *The address of:*

(1) *The principal office of the association.*

(2) *The location where the books and records of the association will be maintained.*

(c) *The date the association was organized.*

(d) *The name and address of each member of the association.*

(e) *The names of the initial members of the board of trustees and the name of the initial third-party administrator of the association.*

(f) *Such other information as the commissioner may require.*

4. *The application must be accompanied by:*

(a) *A nonrefundable filing fee of \$250.*

(b) *Proof of compliance with section 8 of this act.*

(c) *A copy of any agreements entered into with a third-party administrator or any service company.*

(d) *A copy of the bylaws of the association.*

(e) *A copy of an agreement jointly and severally binding the association and each member of the association to secure the payment of all compensation due under this chapter and chapter 617 of NRS.*

(f) *A financial statement, on a form acceptable to the commissioner, that shows the financial ability of the association to pay all compensation due under this chapter and chapter 617 of NRS.*

(g) Proof that each member of the association will pay to the association on a date specified by the commissioner, an amount equal to not less than 25 percent of that member's estimated annual assessment for the first year. The payment shall be deemed to be a part of the assessment required to be paid by each member for the first year of self-insurance if certification is issued to the association.

Sec. 8. 1. *An association of self-insured public or private employers shall:*

(a) Execute an indemnity agreement jointly and severally binding the association and each member of the association to secure the payment of all compensation due under this chapter and chapter 617 of NRS. The indemnity agreement must be in a form prescribed by the commissioner. An association may add provisions to the indemnity agreement if they are first approved by the commissioner.

(b) Except as otherwise provided in this subsection, maintain a policy of specific and aggregate excess insurance in a form and amount required by the commissioner. The excess insurance must be written by an insurer approved by the commissioner. To determine the amount of excess insurance required, the commissioner shall consider:

(1) The number of members in the association;

(2) If the association is an association of self-insured public employers, the types of governmental services provided by the members of the association;

(3) If the association is an association of self-insured private employers, the classifications of employment of the members of the association;

(4) The number of years the association has been in existence; and

(5) Such other information as the commissioner deems necessary.

(c) For the first year of self-insurance, collect an assessment from each member of the association in an aggregate amount of at least \$250,000. Each year thereafter, the association shall collect an assessment in an aggregate amount of at least \$500,000.

(d) Except as otherwise provided in paragraph (e), deposit with the commissioner a bond executed by the association as principal, and by a corporation qualified under the laws of this state as surety, payable to the State of Nevada, and conditioned upon the payment of compensation for injuries and occupational diseases to their employees. The bond must be in an amount determined by the commissioner to be reasonably sufficient to ensure payment of such compensation, but in no event may it be less than \$100,000.

(e) In lieu of a bond, deposit with the commissioner a like amount of lawful money of the United States or any other form of security authorized by NRS 100.065. If security is provided in the form of a savings certificate, certificate of deposit or investment certificate, the certificate must state that the amount is unavailable for withdrawal except upon order of the commissioner.

2. In addition to complying with the requirements of subsection 1, an association of self-insured private employers shall maintain a combined net worth of all members in the association of at least \$1,000,000.

3. Any third-party administrator of the association shall deposit with the commissioner a bond executed by the third-party administrator as principal, and by a corporation qualified under the laws of this state as surety, payable to the

State of Nevada, and conditioned upon the faithful performance of his duties. The bond must be in an amount determined by the commissioner.

4. Any service company providing claims services for the association shall deposit with the commissioner a bond executed by the service company as principal, and by a corporation qualified under the laws of this state as surety, payable to the State of Nevada, and conditioned upon the faithful performance of its duties. The bond must be in an amount determined by the commissioner.

5. The commissioner may increase or decrease the amount of any bond or money required to be deposited by this section in accordance with chapter 681B of NRS and his regulations for loss reserves in casualty insurance. If the commissioner requires an association, third-party administrator or service company to increase its deposit, the commissioner may specify the form of the additional security. The association, third-party administrator or service company shall comply with such a requirement within 30 days after receiving notice from the commissioner.

6. The account for associations of self-insured public and private employers is hereby created in the state agency fund for bonds. All money received by the commissioner pursuant to this section must be deposited with the state treasurer to the credit of the account. All claims against this account must be paid as other claims against the state are paid.

Sec. 9. 1. The commissioner shall grant or deny an application for certification as an association of self-insured public or private employers within 60 days after receiving the application. If the commissioner is unable to act upon the application within this 60-day period, he may extend the period for

granting or denying the application, but for not longer than an additional 60 days.

2. Upon determining that an association is qualified as an association of self-insured public or private employers, the commissioner shall issue a certificate to that effect to the association and the administrator.

3. A certificate issued under this section remains in effect until withdrawn by the commissioner or canceled at the request of the association. Coverage for an association granted a certificate becomes effective on the date of certification or the date specified in the certificate.

4. The commissioner shall not grant a request to cancel a certificate unless the association has insured or reinsured all incurred obligations with an insurer authorized to do business in this state pursuant to an agreement filed with and approved by the commissioner. The agreement must include coverage for actual claims and claims filed with the association but not reported, and the expenses associated with those claims.

Sec. 10. *1. An association certified as an association of self-insured public or private employers directly assumes the responsibility for providing compensation due the employees of the members of the association and their beneficiaries under this chapter and chapter 617 of NRS.*

2. An association is not required to pay the premiums required of other employers pursuant to this chapter and chapter 617 of NRS but is relieved from other liability for personal injury to the same extent as are other employers.

3. The claims of employees and their beneficiaries resulting from injuries while in the employment of a member of an association must be handled in the

manner provided by this chapter, and the association is subject to the regulations of the department with respect thereto.

4. The security deposited pursuant to section 8 of this act does not relieve an association from responsibility for the administration of claims and payment of compensation under this chapter.

Sec. 11. 1. An association of self-insured public or private employers must be operated by a board of trustees consisting of at least five members whom the members of the association elect for terms set forth in the bylaws of the association. If the association is an association of self-insured:

(a) Public employers, the members of the board of trustees must be officers or employees of the public employers who are members of the association.

(b) Private employers, at least two-thirds of the members of the board of trustees must be employees, officers or directors of the members of the association. No third-party administrator or service company employed by the association, or any owner, officer, employee or other person affiliated with the third-party administrator or the service company, may serve as a member of the board of trustees. Each member of the board of trustees must be a resident of this state or an officer of a corporation authorized to do business in this state.

2. The board of trustees of an association shall:

(a) Ensure the prompt payment of any compensation due under this chapter or chapter 617 of NRS.

(b) Take such actions as are necessary to protect the assets of the association.

(c) Employ a third-party administrator to carry out the policies of the board of trustees, provide administrative services and manage claims.

(d) Employ an independent certified public accountant to prepare the statement of financial condition required by section 19 of this act.

(e) Maintain minutes of its meetings and make the minutes available for inspection by the commissioner.

3. The board of trustees of an association shall not:

(a) Extend credit to any member of the association for the payment of that member's annual assessment, except pursuant to a payment plan approved by the commissioner.

(b) Borrow any money from the association or in the name of the association, except in the ordinary course of its business, without the prior approval of the commissioner.

Sec. 12. *1. The board of trustees of an association of self-insured public or private employers is responsible for the money collected and disbursed by the association.*

2. The board of trustees shall:

(a) Establish a claims account in a financial institution in this state approved by the commissioner. Except as otherwise provided in subsection 3, at least 70 percent of the annual assessment collected by the association from its members must be deposited in this account to pay:

(1) Claims;

(2) Expenses related to those claims;

(3) The costs associated with the association's policy of excess insurance;
and

(4) Assessments, payments and penalties related to the subsequent injury fund and the uninsured employers' claim fund.

(b) Establish an administrative account in a financial institution in this state approved by the commissioner. The amount of the annual assessment collected by the association that is not deposited in its claims account must be deposited in this account to pay the administrative expenses of the association.

3. The commissioner may authorize an association to deposit less than 70 percent of its annual assessment in its claims account if the association presents evidence to the satisfaction of the commissioner that:

(a) More than 30 percent of the association's annual assessment is needed to maintain its programs for loss control and occupational safety; and

(b) The association's policy of excess insurance attaches at less than 70 percent.

4. The board of trustees may invest the money of the association not needed to pay the obligations of the association pursuant to chapter 682A of NRS.

Sec. 13. *1. A service company employed by an association of self-insured public or private employers, or an employee, officer or director of such a company, may not have a direct or indirect financial interest in the third-party administrator of the association.*

2. The third-party administrator of an association of self-insured public or private employers, or an employee, officer or director of the third-party administrator, may not be an employee, officer or director of a service company employed by the association or have a direct or indirect financial interest in that service company.

3. Any contract entered into by an association of self-insured public or private employers and a service company or third-party administrator must include a provision which states that, unless the commissioner otherwise provides, the service company or third-party administrator shall administer all claims and other obligations of the association to their conclusions during the period of the contract.

Sec. 14. 1. If an employer wishes to become a member of an association of self-insured public or private employers, the employer must:

(a) Submit an application for membership to the board of trustees or third-party administrator of the association; and

(b) Enter into an indemnity agreement as required by section 8 of this act.

2. The membership of the applicant becomes effective when each member of the association approves the application or on a later date specified by the association. The application for membership and the action taken on the application must be maintained as permanent records of the board of trustees.

3. A member of an association may terminate his membership at any time.

4. The members of an association may cancel the membership of any member of the association in accordance with the bylaws of the association.

5. The association shall:

(a) Notify the commissioner and the administrator of the termination or cancellation of the membership of any member of the association within 10 days after the termination or cancellation; and

(b) At the expense of the member whose membership is terminated or canceled, maintain coverage for that member for 30 days after notice is given

pursuant to paragraph (a), unless the association first receives notice from the administrator that the member has:

(1) Provided and secured compensation according to the terms, conditions and provisions of this chapter for any injury sustained by an employee arising out of and in the course of his employment;

(2) Been certified as a self-insured employer pursuant to NRS 616.293; or

(3) Become a member of another association of self-insured public or private employers.

6. An association is liable for the payment of any compensation required to be paid by a member of the association under this chapter or chapter 617 of NRS during his period of membership. The insolvency or bankruptcy of a member does not relieve the association of liability for the payment of such compensation.

Sec. 15. *An association of self-insured public or private employers shall notify the commissioner of any change in the information submitted in its application for certification or in the manner of its compliance with section 8 of this act not later than 30 days after the change.*

Sec. 16. 1. *The commissioner may examine the books, records, accounts and assets of an association of self-insured public or private employers as he deems necessary to carry out the provisions of sections 7 to 32, inclusive, of this act.*

2. The expense of any examination conducted pursuant to this section must be paid by the association.

Sec. 17. *An association of self-insured public or private employers shall be deemed to have appointed the commissioner as its resident agent to receive all*

legal process and any demand or notice authorized by law to be served upon the association for as long as the association is obligated to pay any compensation under this chapter or chapter 617 of NRS.

Sec. 18. *1. An association of self-insured public employers may merge with another association of self-insured public employers if:*

(a) The resulting association assumes in full all obligations of the merging associations; and

(b) The merger is approved by the commissioner.

2. An association of self-insured private employers may merge with another association of self-insured private employers if:

(a) The members of the merging associations are engaged in the same or similar classifications of employment;

(b) The resulting association assumes in full all obligations of the merging associations; and

(c) The merger is approved by the commissioner.

3. The commissioner shall conduct a hearing on the proposed merger if any member of the merging associations so requests. The commissioner may on his own motion conduct such a hearing.

Sec. 19. *1. An association of self-insured public or private employers shall file with the commissioner a statement of financial condition prepared by an independent certified public accountant. The statement must be filed on or before December 31 of each year and contain information for the previous fiscal year.*

2. *The statement required by subsection 1 must be in a form prescribed by the commissioner and include, but is not limited to:*

(a) A statement of the reserves for:

(1) Actual claims and expenses;

(2) Claims filed with the association but not reported, and the expenses associated with those claims;

(3) Assessments that are due, but not paid; and

(4) Unpaid debts, which must be shown as liabilities.

(b) An actuarial opinion regarding reserves that is prepared by a member of the American Academy of Actuaries or another specialist in loss reserves identified in the annual statement adopted by the National Association of Insurance Commissioners. The actuarial opinion must include a statement of:

(1) Actual claims and the expenses associated with those claims; and

(2) Claims filed with the association but not reported, and the expenses associated with those claims.

3. *The commissioner may adopt a uniform financial reporting system for associations of self-insured public and private employers to ensure the accurate and complete reporting of financial information.*

4. *The commissioner may require the filing of such other reports as he deems necessary to carry out the provisions of this section, including, but not limited to:*

(a) Audits of the payrolls of the members of an association of self-insured public or private employers;

(b) Reports of losses; and

(c) Quarterly financial statements.

Sec. 20. *1. Except as otherwise provided in subsection 2, the annual assessment required to be paid by each member of an association of self-insured public or private employers must be calculated by a rating organization approved by the commissioner and based on the premium rate for the standard industrial classification of that member, adjusted by the member's individual experience. If approved by the commissioner, payments of assessments may be reduced by an amount based on the association's level of expenses and loss experience.*

2. If approved by the commissioner, an association may calculate the annual assessment required to be paid by each member of the association. An assessment calculated by the association must be based on at least 5 years of the member's individual experience.

Sec. 21. *1. The commissioner shall cause to be conducted at least annually an audit of each association of self-insured public or private employers in order to verify:*

(a) The standard industrial classification of each member of the association;

(b) The individual experience of each member of the association;

(c) The payroll of each member of the association; and

(d) The assessment required to be paid by each member of the association.

2. The audit required by this section must be conducted by an auditor approved by the commissioner.

3. A report of the audit must be filed with the commissioner in a form required by the commissioner.

4. *The association or any member of the association may request a hearing before the commissioner to object to any standard industrial classification assigned to a member of the association as a result of the audit. If the commissioner determines that the assessment required to be paid by any member of the association is:*

(a) Insufficient because of the standard industrial classification assigned to him, the commissioner shall order the association to collect from that member any amount required to recover the deficiency.

(b) Excessive because of the standard industrial classification assigned to him, the commissioner shall order the association to pay to the member the excess amount collected.

5. *The expenses of any audit conducted pursuant to this section must be paid by the association.*

Sec. 22. 1. *If the assets of an association of self-insured public or private employers exceed the amount necessary for the association to:*

(a) Pay its obligations and administrative expenses;

(b) Carry reasonable reserves; and

(c) Provide for contingencies,

the board of trustees of the association may declare and distribute dividends to the members of the association.

2. *Any dividend declared pursuant to subsection 1 must be distributed not less than 12 months after the end of the fiscal year.*

3. *A dividend may be paid only to those members who are members of the association for the entire fiscal year. The payment of a dividend must not be*

conditioned upon the member continuing his membership in the association after the fiscal year.

4. An association shall give to each prospective member of the association a written description of its plan for distributing dividends when he applies for membership in the association.

Sec. 23. *1. Each association of self-insured public or private employers shall adopt a plan for the payment of annual assessments by the members of the association which must be approved by the commissioner.*

2. The plan must include a requirement for:

(a) An initial payment, in advance, of a portion of the annual assessment due from each member of the association. If the association is an association of self-insured public employers, the initial payment must be in an amount approved by the commissioner. If the association is an association of self-insured private employers, the initial payment must be in an amount equal to at least 25 percent of the member's annual assessment.

(b) Payment of the balance of the annual assessment due in quarterly or monthly installments.

Sec. 24. *Each association of self-insured public or private employers shall maintain:*

1. Actuarially appropriate loss reserves. Such reserves must include reserves for:

(a) Actual claims and the expenses associated with those claims; and

(b) Claims filed with the association but not reported, and the expenses associated with those claims.

2. Reserves for uncollected debts based on the experience of the association or other associations.

Sec. 25. 1. If the assets of an association of self-insured public or private employers are insufficient to make certain the prompt payment of all compensation under this chapter and chapter 617 of NRS and to maintain the reserves required by section 24 of this act, the association shall immediately notify the commissioner of the deficiency and:

(a) Transfer any surplus acquired from a previous fiscal year to the current fiscal year to make up the deficiency;

(b) Transfer money from its administrative account to its claims account;

(c) Collect an additional assessment from its members in an amount required to make up the deficiency, if approved by each member of the association; or

(d) Take any other action to make up the deficiency which is approved by the commissioner.

2. If the association wishes to transfer any surplus from one fiscal year to another, the association must first notify the commissioner of the transfer.

3. The commissioner shall order the association to make up any deficiency pursuant to subsection 1 if the association fails to do so within 30 days after notifying the commissioner of the deficiency. The association shall be deemed insolvent if it fails to:

(a) Collect an additional assessment from its members within 30 days after being ordered to do so by the commissioner; or

(b) Make up the deficiency in any other manner within 60 days after being ordered to do so by the commissioner.

Sec. 26. 1. The commissioner may issue an order requiring an association of self-insured public or private employers or a member of the association to cease and desist from engaging in any act or practice found to be in violation of any provision of sections 7 to 32, inclusive, of this act or any regulation adopted pursuant thereto.

2. If the commissioner determines that an association or a member of the association has violated an order to cease and desist, the commissioner may impose an administrative fine of not more than \$10,000 for each violation of the order, not to exceed an aggregate amount of \$100,000, or withdraw the certificate of the association, or both.

Sec. 27. 1. The commissioner may impose an administrative fine for each violation of any provision of sections 7 to 32, inclusive, of this act or any regulation adopted pursuant thereto. The amount of the fine may not exceed \$1,000 for each violation or an aggregate amount of \$10,000.

2. The commissioner may withdraw the certificate of an association of self-insured public or private employers if:

- (a) The association's certificate was obtained by fraud;*
- (b) The application for certification contained a material misrepresentation;*
- (c) The association is found to be insolvent;*
- (d) The association fails to pay any penalty, fee or assessment required by the provisions of this chapter;*
- (e) The association fails to comply with any of the provisions of this chapter or any regulation adopted pursuant thereto;*

(f) The association fails to comply with any order of the commissioner within the time prescribed by the provisions of this chapter or in the order of the commissioner; or

(g) The association or its third-party administrator misappropriates, converts, illegally withholds or refuses to pay any money to which a person is entitled and that was entrusted to the association in its fiduciary capacity.

3. If the commissioner withdraws the certification of an association of self-insured public or private employers, each employer who is a member of the association remains liable for his obligations incurred before and after the order of withdrawal.

4. Any employer who is a member of an association whose certification is withdrawn shall, on the effective date of the withdrawal, qualify as an employer pursuant to NRS 616.305.

Sec. 28. *1. Before any action may be taken pursuant to subsection 2, the commissioner shall arrange an informal meeting with an association of self-insured public or private employers to discuss and seek correction of any conduct which would be grounds for withdrawal of the certificate of the association.*

2. Before the withdrawal of the certificate of any association of self-insured public or private employers, the commissioner shall give written notice to the association by certified mail that its certificate will be withdrawn 10 days after receipt of the notice unless, within that time, the association corrects the conduct set forth in the notice as the reason for the withdrawal or submits a written request for a hearing to the commissioner.

3. *If the association requests a hearing:*

(a) *The commissioner shall set a date for a hearing within 20 days after receiving the request and give the association at least 10 business days' notice of the time and place of the hearing.*

(b) *A record of the hearing must be kept, but it need not be transcribed unless requested by the association with the cost of transcription to be charged to the association.*

(c) *Within 5 business days after the hearing, the commissioner shall either affirm or disaffirm the withdrawal and give the association written notice thereof by certified mail. If withdrawal of certification is affirmed, the withdrawal becomes effective 10 business days after the association receives notice of the affirmance unless within that period the association corrects the conduct which was ground for the withdrawal or petitions for judicial review of the affirmance.*

4. *If the withdrawal of certification is affirmed following judicial review, the withdrawal becomes effective 5 days after entry of the final decree of affirmance.*

Sec. 29. 1. *If for any reason the status of an association of self-insured public or private employers as an association of self-insured employers is terminated, the security deposited under section 8 of this act must remain on deposit for a period of at least 36 months in such an amount as is necessary to secure the outstanding and contingent liability arising from accidental injuries or occupational diseases secured by the security, or to assure the payment of*

claims for aggravation and payment of claims under NRS 616.545 based on such accidental injuries or occupational diseases.

2. At the expiration of the 36-month period, or such other period as the commissioner deems proper, the commissioner may accept in lieu of any security so deposited a policy of paid-up insurance in a form approved by the commissioner.

Sec. 30. *Any association of self-insured public or private employers that is aggrieved by a decision of the commissioner may petition for judicial review in the manner provided by chapter 233B of NRS.*

Sec. 31. *1. For the purposes of sections 7 to 32, inclusive, of this act, an association of self-insured public or private employers is insolvent if it is unable to pay its outstanding obligations as they mature in the regular course of its business.*

2. If an association of self-insured public or private employers becomes insolvent, institutes any voluntary proceeding under the Bankruptcy Act or is named in any voluntary proceeding thereunder, makes a general or special assignment for the benefit of creditors or fails to pay compensation under this chapter or chapter 617 of NRS after an order for the payment of any claim becomes final, the commissioner may, after giving at least 10 days' notice to the association and any insurer or guarantor, use money or interest on securities, sell securities or institute legal proceedings on surety bonds deposited with the commissioner to the extent necessary to make those payments.

3. A corporation providing a surety bond under section 8 of this act may terminate liability on its surety bond by giving the commissioner and the

association, third-party administrator or service company 90 days' written notice. The termination does not limit liability that was incurred under the surety bond before the termination. If the association fails to requalify as an association of self-insured public or private employers on or before the termination date, the association's certificate is withdrawn when the termination becomes effective.

Sec. 32. *The commissioner may adopt such regulations as are necessary to carry out the provisions of sections 7 to 32, inclusive, of this act.*

Sec. 33. NRS 616.015 is hereby amended to read as follows:

616.015 As used in this chapter, unless the context otherwise requires, the words and terms defined in NRS 616.020 to 616.120, inclusive, *and sections 2 to 6, inclusive, of this act*, have the meanings ascribed to them in those sections.

Sec. 34. NRS 616.067 is hereby amended to read as follows:

616.067 Persons who perform volunteer work in any formal program which is being conducted:

1. Within a state or local public organization;
 2. By a federally assisted organization; or
 3. By a private, incorporated, nonprofit organization which provides services to the general community,
- and who are not specifically covered by any other provisions of this chapter, while engaged in such volunteer work, may be deemed by the system, or by a self-insured employer [,] *or an employer who is a member of an association of self-insured public or private employers*, for the purposes of this chapter, as employees of that organization at a wage of \$100 per month . [and] *Such*

persons are entitled to the benefits of this chapter when the organization approves coverage and complies with the provisions of this chapter and regulations adopted pursuant to it.

Sec. 35. NRS 616.068 is hereby amended to read as follows:

616.068 Persons other than students who, under a written agreement between a public agency and a private organization, perform volunteer work for a private organization as part of a public program and who are not specifically covered by any other provisions of this chapter, while engaging in that volunteer work, may be deemed by the system, or by a self-insured employer [,] *or an employer who is a member of an association of self-insured public or private employers*, for the purposes of this chapter, as employees of the public agency at a wage of \$100 per month . [and] *Such persons* are entitled to the benefits of this chapter when the public agency complies with the provisions of this chapter and the regulations adopted under it.

Sec. 36. NRS 616.1103 is hereby amended to read as follows:

616.1103 "Insurer" includes [the] :

1. *The state industrial insurance system* [, self-insured employers and those] ;
2. *A self-insured employer;*
3. *An association of self-insured public employers;*
4. *An association of self-insured private employers; and*
5. *Those employers covered under the provisions of NRS 616.255 and 616.256.*

Sec. 37. NRS 616.182 is hereby amended to read as follows:

616.182 1. Except as otherwise provided in this section, the department of industrial relations shall regulate insurers under this chapter and chapter 617 of NRS and investigate insurers regarding compliance with statutes and the department's regulations.

2. The commissioner of insurance is responsible for reviewing rates, investigating the solvency of insurers and certifying self-insured employers , *associations of self-insured public or private employers* and third-party administrators pursuant to NRS 616.291 to 616.298, inclusive, NRS 616.338 , [and] chapter 683A of NRS [.] *and sections 7 to 32, inclusive, of this act.*

3. The department of administration is responsible for administrative appeals relating to workers' compensation pursuant to NRS 616.541 to 616.544, inclusive. The system is responsible for administrative appeals pursuant to NRS 616.392.

4. The Nevada attorney for injured workers is responsible for legal representation of claimants pursuant to NRS 616.253 to 616.2539, inclusive.

5. The division of industrial insurance regulation is responsible for the investigation of complaints. If a complaint is filed with the division by an employee of a self-insured employer [.] *or an employer who is a member of an association of self-insured public or private employers,* or by a third-party administrator or provider of medical care regarding compliance [of a self-insured employer] with statutes or the department's regulations, the administrator shall cause to be conducted an investigation which includes a review of relevant records and interviews of affected persons.

6. If an investigation conducted pursuant to subsection 5 indicates that a self-insured employer *or an association of self-insured public or private employers* has failed to comply with a statute or regulation, the administrator may order that an evidentiary hearing take place. Upon a finding that material noncompliance has occurred, the administrator shall impose a fine of not more than \$1,000 against the self-insured employer [.] *or the association*. Two or more findings of material noncompliance within a 12-month period constitute grounds for the suspension of the self-insured employer's *or association's* certification by the commissioner of insurance.

Sec. 38. NRS 616.187 is hereby amended to read as follows:

616.187 1. The director shall cause to be conducted at least every 3 years an audit of all insurers who provide benefits to injured employees pursuant to this chapter or chapter 617 of NRS. The director shall cause to be conducted each year on a random basis additional partial audits of any insurer who has a history of violations of the provisions of this chapter or chapter 617 of NRS, or the regulations adopted pursuant thereto, as determined by the director.

2. The director shall require the use of standard auditing procedures and shall establish a manual to describe the standard auditing procedures. The manual must include:

- (a) Specific audit objectives;
- (b) Standards for documentation;
- (c) Policies for supervisory review;
- (d) Policies for the training of auditors;
- (e) The format for the audit report; and

(f) Procedures for the presentation, distribution and retention of the audit report.

3. The commissioner and the director shall establish a procedure for sharing information between the department of insurance and the department concerning the qualifications of employers as self-insured employers pursuant to NRS 616.291 [.] *or as an association of self-insured public or private employers pursuant to section 8 of this act.*

4. On or before March 1 of each year, the director shall make a report of each audit to the legislature, if it is in session, or to the interim finance committee if the legislature is not in session.

Sec. 39. NRS 616.1925 is hereby amended to read as follows:

616.1925 1. The director shall establish a method of indexing claims for compensation that will make information concerning the claimants of one insurer available to other insurers.

2. The index of claims must include claims filed with:

(a) The system; [and]

(b) Self-insured employers after January 1, 1984 [.] ; *and*

(c) *Associations of self-insured public or private employers after October 1, 1993.*

3. Every self-insured employer *and association of self-insured public or private employers* shall provide information as required by the director for establishing and maintaining the index of claims.

4. If an employee files a claim with an insurer, the insurer is entitled to receive from the director a list of the prior claims of the employee. If the

insurer desires to inspect the files related to the prior claims, he must obtain the written consent of the employee.

5. Any information obtained from the index of claims must be admitted into evidence in any hearing before an appeals officer, a hearing officer or the administrator.

6. The department may assess and collect a reasonable fee for its services provided pursuant to this section. The fee must be payable monthly or at such other intervals as determined by the director.

Sec. 40. NRS 616.2233 is hereby amended to read as follows:

616.2233 The system shall cooperate with the commissioner in the performance of his duties pursuant to this chapter, and shall provide the commissioner with any information, statistics or data in its records which pertain to any employer who is making application to become self-insured [.] or who is self-insured [.] , *or who is becoming or who is a member of an association of self-insured public or private employers.*

Sec. 41. NRS 616.2235 is hereby amended to read as follows:

616.2235 1. Except as otherwise provided in subsection 2, each self-insured employer , *association of self-insured public or private employers* and other employer covered under the provisions of NRS 616.255 and 616.256 shall compensate the system, the office of the Nevada attorney for injured workers or the hearings division of the department of administration, as appropriate, for all services which the system, the occupational safety and health review board, the Nevada attorney for injured workers, the hearing officers and the appeals officers provide to those employers if the rate is established by a

regulation of the system. The cost of any service for which a rate is not established by regulation must be negotiated by the employer *or association* and the system, the Nevada attorney for injured workers or the division, as appropriate, before the employer *or association* is charged for the service.

2. All compensation must be on the basis of actual cost and not on a basis which includes any subsidy for the system, the office of the Nevada attorney for injured workers, the division or other employers.

Sec. 42. NRS 616.228 is hereby amended to read as follows:

616.228 1. Any disciplinary action taken by a hearing officer or panel pursuant to NRS 616.425 is subject to the same procedural requirements which apply to disciplinary actions taken by the commissioner or administrator, and the board or panel has the same powers and duties given to the commissioner or administrator in relation thereto.

2. A decision of the hearing officer or panel relating to the imposition of an administrative fine is a final decision in a contested case. Any party aggrieved by a decision of the officer or panel to withdraw the certification of a self-insured employer *or an association of self-insured public or private employers* may appeal that decision to the commissioner.

Sec. 43. NRS 616.275 is hereby amended to read as follows:

616.275 Where the state, county, municipal corporation, school district, a metropolitan police department, a city under special charter and commission form of government, or a contractor under such governmental entities, is the employer, the provisions of this chapter for the payment of compensation and the amount thereof, and, unless the employer is self-insured [,] *or a member of*

an association of self-insured public employers, for the payment of premiums to the state insurance fund and the accident benefit fund, for any injury sustained by an employee are conclusive, compulsory and obligatory upon both employer and employee without regard to the number of persons in the service of any such employer.

Sec. 44. NRS 616.282 is hereby amended to read as follows:

616.282 1. The manager shall notify the state contractors' board within 10 days after the system becomes aware that a contractor's coverage has lapsed.

2. The commissioner shall notify the state contractors' board within 10 days after a contractor's certificate of qualification as a self-insured employer is canceled or withdrawn [.] *or he is no longer a member of an association of self-insured public or private employers.*

Sec. 45. NRS 616.301 is hereby amended to read as follows:

616.301 1. A person shall not act as a third-party administrator for a self-insured [employer's plan of self-insurance] *employer or an association of self-insured public or private employers* without a certificate issued by the commissioner pursuant to NRS 683A.085.

2. A person who acts as a third-party administrator for a self-insured [employer's plan of self-insurance] *employer or an association of self-insured public or private employers* pursuant to this chapter shall:

(a) Administer from one or more offices located in this state all of the claims arising under each plan of self-insurance that he administers and maintain in those offices all of the records concerning those claims;

(b) Administer each plan of self-insurance directly, without subcontracting with another third-party administrator; and

(c) Upon the termination of his contract with a self-insured employer [,] *or an association of self-insured public or private employers*, transfer forthwith to a certified third-party administrator chosen by the employer *or association* all of the records in his possession concerning claims arising under the plan of self-insurance.

3. The commissioner may, under exceptional circumstances, waive the requirements of subsection 2.

Sec. 46. NRS 616.303 is hereby amended to read as follows:

616.303 The commissioner shall impose an administrative fine, not to exceed \$1,000 for each violation, and may withdraw the certification of any third-party administrator who:

1. Fails to comply with regulations of the commissioner regarding reports or other requirements necessary to carry out the purposes of this chapter; or

2. Violates any provision of NRS 616.301 or any regulation adopted by the commissioner or the administrator concerning the administration of [the employer's] *a* plan of self-insurance.

Sec. 47. NRS 616.305 is hereby amended to read as follows:

616.305 1. Where the employer, as provided by this chapter, has given notice of an election to accept the terms of this chapter, and the employee has not given notice of an election to reject the terms of this chapter, the employer shall provide and secure, and the employee shall accept, compensation in the

manner provided by this chapter for all personal injuries sustained arising out of and in the course of the employment.

2. Every employer electing to be governed by the provisions of this chapter, before becoming entitled to the benefits of this chapter , must comply with all conditions and provisions of this chapter during the period of his election.

3. Failure on the part of any employer to pay all the premiums , [or] to maintain a certificate of self-insurance in force *or to maintain membership in an association of self-insured public or private employers* as required by the provisions of this chapter operates as a rejection of the terms of this chapter. In the event of any rejection of this chapter, or the terms hereof, [such] *the* rejecting employer shall post a notice of rejection of the terms of the chapter upon his premises in a conspicuous place. The employer at all times shall maintain the notice or notices so provided for the information of his employees.

Sec. 48. NRS 616.315 is hereby amended to read as follows:

616.315 1. An employer in this state having in his employment any employee excluded from the benefits of this chapter under NRS 616.060 may elect to cover such employees under the provisions of this chapter in the manner provided in this section.

2. The election on the part of the employer must be made by filing with the system, or with the administrator if he is a self-insured employer [,] *or a member of an association of self-insured public or private employers*, a written statement that he accepts the provisions of this chapter which, when filed, operates to subject him to the provisions of this chapter until the employer

files in the office of the system, or of the administrator if he is a self-insured employer [,] *or a member of an association of self-insured public or private employers*, a notice in writing that he withdraws his election.

3. An employee in the service of any such employer shall be deemed to have accepted, and is subject to, the provisions of this chapter if, at the time of the accident for which compensation is claimed:

(a) The employer charged with liability is subject to the provisions of this chapter, whether *or not* the employee has actual notice thereof ; [or not;] and

(b) The employee has not given to his employer and to the system notice in writing that he elects to reject the provisions of this chapter.

4. An employee who has rejected the provisions of this chapter may at any time thereafter elect to waive the rejection by giving notice in writing to his employer and to the system which becomes effective when filed with the system.

Sec. 49. NRS 616.325 is hereby amended to read as follows:

616.325 1. Except as *otherwise* provided in subsection 2, every employer shall furnish the system or the administrator, upon request, all information required to carry out the purposes of this chapter. The administrator, or any person employed by the administrator for that purpose, may examine, under oath, any employer or officer, agent or employee thereof.

2. Every self-insured employer *or association of self-insured public or private employers* shall furnish the system or the administrator, upon request, all information required to carry out the purposes of this chapter. The

administrator or any person employed by him for that purpose, may examine, under oath, any employer or officer, agent or employee thereof.

3. Every insured employer shall keep on hand constantly a sufficient supply of blank forms furnished by the insurer.

Sec. 50. NRS 616.337 is hereby amended to read as follows:

616.337 All self-insured employers *and associations of self-insured public or private employers* shall report to the administrator, annually or at intervals which the administrator requires, all accidental injuries, occupational diseases, dispositions of claims, reserves and payments made under this chapter, chapter 617 of NRS or regulations adopted by the department pursuant thereto.

Sec. 51. NRS 616.340 is hereby amended to read as follows:

616.340 1. Every employer within the provisions of this chapter shall, immediately upon the occurrence of an injury to any of his employees, render to the injured employee all necessary first aid, including the cost of transportation of the injured employee to the nearest place of proper treatment if the injury is such as to make it reasonably necessary for such transportation.

2. Each such employer who is not self-insured *or a member of an association of self-insured public or private employers*, or his agent, shall notify the insurer's claims administrator in writing of the accident. The notification of the accident must be postmarked within 6 working days after receipt of knowledge of the accident and, if the injured employee is expected to be off work for 5 days or more, must include a statement of the wages of the injured employee. An employee of the system shall not complete any form concerning the accident for an employer unless the employer:

- (a) Is not in business;
- (b) Has not been located by the insurer within 5 working days after receipt of the notification of the accident; or
- (c) Refuses to complete the forms.

3. Each employer who files a report of an injury with the insurer shall file a full report of every known injury to the employee arising out of and in the course of his employment and resulting in his loss of life or injury. The report must be:

- (a) Signed by the employer or his designee; and
- (b) Furnished to the insurer in the form prescribed and contain specific answers to all questions required by the regulations of the department.

4. An employer who is not self-insured *or a member of an association of self-insured public or private employers* is entitled to receive reimbursement from his insurer for the costs incurred in rendering the necessary first aid and transportation of an injured employee to the nearest place of proper treatment.

Sec. 52. NRS 616.355 is hereby amended to read as follows:

616.355 1. Any physician or chiropractor who attends an employee within the provisions of this chapter or chapter 617 of NRS in a professional capacity, may be required to testify before an appeals officer. A physician or chiropractor who testifies is entitled to receive the same fees as witnesses in civil cases and, if the appeals officer so orders at his own discretion, a fee equal to that authorized for a consultation by the appropriate schedule of fees for physicians or chiropractors. These fees must be paid by the system , [or]

the self-insured employer [.] *or the association of self-insured public or private employers.*

2. Information gained by the attending physician or chiropractor while in attendance on the injured employee is not a privileged communication if required by an appeals officer for a proper understanding of the case and a determination of the rights involved.

Sec. 53. NRS 616.390 is hereby amended to read as follows:

616.390 Except for self-insured employers [.] *and employers who are members of an association of self-insured public or private employers,* all employers becoming contributors to the state insurance fund or the accident benefit fund, pursuant to the provisions of NRS 616.315, must be placed in a separate class, the premium rates of which must be sufficient to provide an adequate fund for the payment of the proportionate administrative expense and compensation on account of injuries and death of employees of this class.

Sec. 54. NRS 616.395 is hereby amended to read as follows:

616.395 1. Except for a self-insured employer [.] *or an employer who is a member of an association of self-insured public or private employers,* every employer within, and those electing to be governed by, the provisions of this chapter, with the exception of the state, counties, municipal corporations, cities and school districts, shall provide the system with a bond executed by the employer as principal, and by a corporation qualified under the laws of this state as surety, payable to the State of Nevada and conditioned upon the proper payment of premiums. All premium rates in effect on July 1, 1947, must be continued in full force until changed as provided by law.

2. Every employer within or electing to be governed by the provisions of this chapter who enters into business or resumes operations shall, before commencing or resuming operations, notify the manager of that fact, accompanying the notification with an estimate of his monthly payroll, and pay the premium on the payroll for the first 2 months of operations.

3. The amount of the bond required by this section must be determined by the manager in such a manner as he deems proper.

4. In lieu of a bond the employer may deposit with the system, under such terms as the manager may prescribe, a like amount of lawful money of the United States or any other form of security authorized by NRS 100.065. If security is provided in the form of a savings certificate, certificate of deposit or investment certificate, the required amount must be rounded up to the next larger integral multiple of \$100, and the certificate must state that the amount is unavailable for withdrawal except by direct and sole order of the manager.

5. All money received by the system pursuant to this section must be deposited with the state treasurer to the credit of the state insurance fund.

Sec. 55. NRS 616.400 is hereby amended to read as follows:

616.400 1. Except for a self-insured employer [,] *or an employer who is a member of an association of self-insured public or private employers*, every employer within, and those electing to be governed by, the provisions of this chapter, shall, on or before the 25th day of the month immediately after the end of the assigned reporting period , furnish the system with a true and accurate payroll for that period showing:

(a) The total amount paid to employees for services performed;

(b) The amount of tips reported to him by every employee pursuant to 26 U.S.C. § 6053(a), whose tips in cash totaled \$20 or more; and

(c) A segregation of employment in accordance with the requirements of the system,

together with the premium due thereon.

2. In determining the total amount paid to employees by each employer for services performed during a year, the maximum amount paid by each employer to any one employee during the year shall be deemed to be \$36,000.

3. Any employer by agreement in writing with the manager may arrange for the payment of premiums in advance for a period of more than 60 days.

4. Failure of any employer to comply with the provisions of this section and NRS 616.395 operates as a rejection of this chapter, effective at the expiration of the period covered by his estimate. The manager shall notify the administrator of each such rejection.

5. If an audit of the accounts or actual payroll of an employer shows that the actual premium earned exceeds the estimated premium paid in advance, the manager may require the payment of money sufficient to cover the deficit, together with such amount as in his judgment constitutes an adequate advance premium for the period covered by the estimate.

6. The manager shall notify any employer or his representative by first-class mail of any failure on his part to comply with the provisions of this section. The notice or its omission does not modify or waive the requirements or effective rejection of this chapter as otherwise provided in this chapter.

7. The system may impose a penalty not to exceed 4 percent of the premiums which are due or \$15, whichever is greater, for the failure of an employer to submit the information and premium required in subsection 1 within the time allowed, unless the employer has applied for and been granted an extension of that time by the manager.

Sec. 56. NRS 616.401 is hereby amended to read as follows:

616.401 1. An employer shall:

(a) Make a copy of each report that an employee files with the employer pursuant to 26 U.S.C. § 6053(a) to report the amount of his tips to the United States Internal Revenue Service;

(b) Submit the copy to the system upon request and retain another copy for his records or , if the employer is self-insured [,] *or a member of an association of self-insured public or private employers*, retain the copy for his records; and

(c) If he is not self-insured [,] *or a member of an association of self-insured public or private employers*, pay the system the premiums for the reported tips at the same rate as he pays on regular wages.

2. The department shall adopt regulations specifying the form of the declaration required pursuant to subsection 1.

3. The system , [or the] self-insured employer *or association* shall calculate compensation for an employee on the basis of wages paid by the employer plus the amount of tips reported by the employee pursuant to 26 U.S.C. § 6053. Reports made after the date of injury may not be used for the calculation of compensation.

4. An employer shall notify his employees of the requirement to report income from tips for the purposes of calculating his federal income tax and for including the income in the computation of benefits pursuant to this chapter.

5. The administrator shall adopt such regulations as are necessary to carry out the provisions of this section.

Sec. 57. NRS 616.405 is hereby amended to read as follows:

616.405 1. Except for a self-insured employer [,] *or an employer who is a member of an association of self-insured public employers*, as soon as possible after the expiration of each quarter year, every state office, department, board, commission, bureau, agency or institution, operating by authority of law, and the auditor or comptroller of each county, and the clerk of each municipal corporation, city, and school district, shall furnish the manager with a true and accurate payroll of the state office, department, board, commission, bureau, agency or institution, and county, metropolitan police department, municipal corporation, city, or school district, showing:

(a) The aggregate number of shifts worked during the preceding quarter.

(b) The total amount paid to employees for services performed during the quarter.

(c) A segregation of employment in accordance with the requirements of the system.

2. Each of the state offices, departments, boards, commissions, bureaus, agencies and institutions shall submit claims for the amount of premiums due to the system . [; and each] *Each* of the auditors, comptrollers and clerks shall make up and submit to the respective governing boards of each county,

metropolitan police department, municipal corporation, city, and school district, for approval, claims for the amount of premiums due the system.

Sec. 58. NRS 616.420 is hereby amended to read as follows:

616.420 1. If the administrator finds that the employer is furnishing the requirements of accident benefits in such a manner that there are reasonable grounds for believing that the health, life or recovery of the employee is being endangered or impaired thereby, or that an employer has failed to provide benefits pursuant to NRS 616.415 for which he has made arrangements, the administrator may, upon application of the employee, or upon his own motion, order a change of physicians or chiropractors or of any other requirements of accident benefits.

2. If the administrator orders a change of physicians or chiropractors or of any other accident benefits, the cost of the change must be borne by the system , [or] the self-insured employer [.] *or the association of self-insured public or private employers.*

3. The cause of action of an insured employee against an employer insured by the system must be assigned to the system.

Sec. 59. NRS 616.425 is hereby amended to read as follows:

616.425 1. Except as otherwise provided in subsection 3, all premiums, contributions, penalties, bonds, securities and all other properties received, collected or acquired by the system pursuant to the terms of this chapter:

(a) Must be credited on the records of the system to the state insurance fund.

(b) Constitute, for the purpose of custody thereof, the state insurance fund, which must be held by the manager as custodian thereof for the benefit of employees and their dependents within the provisions of this chapter. The manager is liable on his official bond for the faithful performance of his custodial duty.

2. The commissioner or the administrator may delegate to a hearing officer or panel his authority to take any disciplinary action pursuant to NRS 616.294, 616.2945 or 616.647, *or section 26 or 27 of this act*, impose and collect administrative fines pursuant to those sections and deposit the money in the fund for workers' compensation and safety.

3. If a hearing officer or panel is not authorized to take disciplinary action pursuant to subsection 2 and the commissioner or the administrator deposits the money collected from the imposition of administrative fines with the state treasurer for credit to the state general fund, he may present a claim to the state board of examiners for recommendation to the interim finance committee if money is needed to pay attorney's fees or the costs of an investigation, or both.

Sec. 60. NRS 616.490 is hereby amended to read as follows:

616.490 1. If the provisions of this chapter relative to compensation for injuries to or death of employees become invalid because of any adjudication, or are repealed, the period intervening between the occurrence of an injury or death, not previously compensated for under this chapter by lump sum payment or completed monthly payments, and [such] *the* repeal or the rendition of the final adjudication of the validity [shall] *must* not be computed

as a part of the time limited by law for the commencement of any action relating to [such] *the* injury or death if the action is commenced within 1 year after [such] *the* repeal or adjudication.

2. In any such action , any sum paid out of the state insurance fund or by a self-insured employer *or an association of self-insured public or private employers* by reason of injury to an employee by whom, or by whose dependents, the action is prosecuted, [shall] *must* be taken into account and credited upon the recovery as payment.

Sec. 61. NRS 616.520 is hereby amended to read as follows:

616.520 1. Except as otherwise provided in subsection 4 of NRS 616.260, *if* an employee who has been hired or is regularly employed in this state [,] receives personal injury by accident arising out of and in the course of such employment outside of this state, he, or his dependents in case of his death, are entitled to receive compensation according to the law of this state, and such compensation is the exclusive remedy of the employee or dependents.

2. The provisions of this section apply only to those injuries received by the employee within 6 months after leaving this state, unless before the expiration of the 6-month period the employer has filed with the system or, in the case of a self-insured employer [,] *or an association of self-insured public or private employers*, with the administrator notice that he has elected to extend the coverage *for a greater period . [of time.]*

Sec. 62. NRS 616.530 is hereby amended to read as follows:

616.530 1. If an employee who has been hired or is regularly employed in this state receives personal injury by accident arising out of and in the course

of such employment outside this state, and he, or his personal or legal representatives, dependents or next of kin commence any action or proceeding in any other state to recover any damages or compensation for the injury or death from his employer, the act of commencing such action or proceeding constitutes an irrevocable waiver of all compensation for the injury or death to which persons would otherwise have been entitled under the laws of this state.

2. If the injured employee, his personal or legal representatives, dependents or next of kin recover a final judgment against the employer for damages arising out of the injury or death in any court of competent jurisdiction in any other state, the compensation which would otherwise have been payable under the laws of this state, up to the full amount thereof, but less any sums previously paid for the injury or death, must be applied in satisfaction of the judgment as follows:

(a) Upon receipt of an authenticated copy of the final judgment and writ of execution or other process issued in aid thereof, the insurer shall forthwith determine the total amount of compensation which would have been payable under the laws of this state [had] *if a claim therefor had* been made to the insurer. In the case of compensation payable in installments, the insurer shall convert it into a lump sum amount by such system of computation as the administrator deems proper.

(b) The insurer shall thereupon order to be paid in full or partial satisfaction of the judgment a sum not to exceed the total amount of compensation computed as provided in this section or the amount of the judgment, whichever is [the lesser.] *less*.

(c) Except for a self-insured employer [,] *or an employer who is a member of an association of self-insured public or private employers*, if the judgment is satisfied fully by the employer before any payment by the system pursuant to paragraph (b), the amount payable thereunder must be paid to the employer.

Sec. 63. NRS 616.537 is hereby amended to read as follows:

616.537 1. An insurer shall schedule a rating for an injured employee within 30 days after the injured employee is determined to be stable and ratable by the treating physician or chiropractor.

2. A rating evaluation must include an evaluation of the loss of motion, sensation and strength of an injured employee if the injury is of a type that might have caused such a loss.

3. A self-insured employer *or an employer who is a member of an association of self-insured public or private employers* shall refer an injured employee who is entitled to compensation for a permanent partial disability to the department for a rating by a physician or chiropractor selected in rotation from the list of qualified physicians or chiropractors designated by the administrator pursuant to subsection 2 of NRS 616.605, according to the order in which their names appear on the list.

Sec. 64. NRS 616.5414 is hereby amended to read as follows:

616.5414 If an employee of a self-insured employer *or an employer who is the member of an association of self-insured public or private employers* is dissatisfied with a decision of his employer [,] *or the association*, he may request a hearing before the hearing officer.

Sec. 65. NRS 616.6283 is hereby amended to read as follows:

616.6283 1. Each person who is receiving or is entitled to receive compensation for a permanent total disability pursuant to NRS 616.580 or a death benefit pursuant to NRS 616.615 for an industrial injury or occupational disease which occurred before July 1, 1975, is entitled to receive compensation of not less than \$400 each month.

2. A self-insured employer *or an association of self-insured public or private employers* shall provide for the increase in monthly compensation required by subsection 1 for each person who would be entitled to receive the increase if the provisions of this section were applicable to the employer *[.] or association*.

3. A person who is entitled to receive an increase in his monthly compensation pursuant to subsection 1 is not required to accept that increase.

4. The administrator shall adopt regulations to carry out the provisions of this section.

Sec. 66. NRS 616.647 is hereby amended to read as follows:

616.647 1. If the administrator has reason to believe that an insurer, health care provider, third-party administrator or employer has:

(a) Induced a claimant for compensation to fail to report an accidental injury or occupational disease;

(b) Persuaded a claimant to settle for an amount which is less than reasonable;

(c) Persuaded a claimant to settle for an amount which is less than reasonable while a hearing or an appeal is pending;

(d) Persuaded a claimant to accept less than the compensation found to be due him by a hearing officer or appeals officer;

(e) Refused to pay or unreasonably delayed payment to a claimant of compensation found to be due him by a hearing officer or appeals officer;

(f) Made it necessary for a claimant to resort to proceedings against the employer or insurer for compensation found to be due him by a hearing officer or appeals officer;

(g) Failed to comply with regulations of the department for the acceptance and rejection of claims, determination and calculation of a claimant's average monthly wage, determination and payment of compensation, delivery of accident benefits and reporting relating to these matters;

(h) Failed to comply with the department's regulations covering the payment of an assessment relating to the funding of costs of administration of this chapter and chapter 617 of NRS; or

(i) Failed to comply with any provision of, or regulation adopted pursuant to, this chapter or chapter 617 of NRS,
the administrator shall set a date for a hearing. The date must be no sooner than 30 days after notice is served upon the insurer or employer of the alleged action and the time and place of the hearing.

2. If, after an evidentiary hearing, the administrator determines that the insurer , *health care provider, third-party administrator* or employer has committed the alleged act, the administrator shall issue a notice of violation imposing a proposed administrative fine of:

(a) Not more than \$250 for each initial violation of subsection 1 which was not intentional; or

(b) Not more than \$1,000 for each intentional or repeated violation of subsection 1.

3. In addition to any fine imposed pursuant to subsection 2, the administrator may assess against an insurer who violates any regulation concerning the reporting of claims expenditures used to calculate an assessment an administrative penalty of up to twice the amount of any underpaid assessment.

4. If a person wishes to contest a notice of violation issued pursuant to subsection 2, he must file a notice of appeal with the division within 30 days after the notice is issued, showing why the proposed fine should not be imposed against him.

5. If a notice of appeal is filed as required by subsection 4, the administrator shall issue a complaint setting forth the factual basis for his determination that a violation has occurred. The person against whom a complaint is issued shall file an answer to the complaint within 30 days after the complaint is issued. The answer must be accompanied by any documentary evidence upon which the person relies and, if the person desires a hearing on the matter, by a request for hearing. If an answer and a request for hearing are filed as required by this subsection, the administrator shall set a date for a hearing on the matter, which must be no sooner than 30 days after the answer and request for hearing are filed.

6. If a notice of appeal or an answer is not filed as required by this section, the notice of violation shall be deemed a final order and is not subject to review by any court or agency.

7. A hearing held pursuant to this section must be conducted by the administrator or a person designated by him. A record of the hearing must be kept but it need not be transcribed unless it is requested by the person against whom the order or notice of violation has been issued and that person pays the cost of transcription.

8. An administrative fine imposed pursuant to this section must be paid to the division. If the violation for which the fine is levied was committed by a person while acting within the course and scope of his agency or employment, the fine must be paid by his principal or employer. The fine may be recovered in a civil action brought in the name of the division in a court of competent jurisdiction in the county in which the violation occurred or in which the person against whom the fine is levied has his principal place of business.

9. Two or more fines of \$1,000 levied by the administrator in 1 year for acts enumerated in subsection 1 must be considered by the commissioner as evidence for the [revocation] *withdrawal* of a certificate [of self-insurance.] *to act as a self-insured employer or an association of self-insured public or private employers.*

10. The commissioner may withdraw the certification of a self-insured employer *or an association of self-insured public or private employers* if, after a hearing, it is shown that the self-insured employer [:] *or association:*

(a) Intentionally or repeatedly violated the provisions of paragraph (g) of subsection 1; or

(b) Violated any other provision of subsection 1.

Sec. 67. Chapter 617 of NRS is hereby amended by adding thereto a new section to read as follows:

1. An association that is certified as an association of self-insured public or private employers directly assumes the responsibility for providing compensation due the employees of the members of the association and their beneficiaries under this chapter.

2. An association is not required to pay the contributions required of employers by NRS 617.310.

3. The claims of employees and their beneficiaries resulting from occupational diseases while in the employment of a member of an association must be handled in the manner provided by this chapter, and the association is subject to the regulations of the department with respect thereto.

4. The security deposited pursuant to section 8 of this act does not relieve the association from responsibility for the administration of claims and payment of compensation under this chapter.

5. An association of self-insured public or private employers qualifying under the provisions of this chapter must comply with the provisions of section 8 of this act.

Sec. 68. NRS 617.310 is hereby amended to read as follows:

617.310 Except for a self-insured employer [,] *or an employer who is a member of an association of self-insured public or private employers*, every employer within the provisions of this chapter and every employer electing to be governed by the provisions of this chapter, before becoming entitled to the benefits of this chapter in the providing and securing of compensation to his

employees, shall pay to the system, for the occupational diseases fund and the medical benefits fund, in the manner and at the times prescribed for the payment of premiums in chapter 616 of NRS, premiums in amounts fixed by the manager.

Sec. 69. NRS 617.410 is hereby amended to read as follows:

617.410 Compensation for disability sustained on account of occupational disease by an employee, or the dependents of [such] *an* employee as defined in this chapter, must be paid from the occupational diseases fund or , if the employee is employed by a self-insured employer [,] *or an employer who is a member of an association of self-insured public or private employers*, then by the employer [,] *or the association*.

Sec. 70. NRS 232.550 is hereby amended to read as follows:

232.550 As used in NRS 232.560 to 232.700, inclusive, unless the context otherwise requires:

1. "Department" means the department of industrial relations.
2. "Director" means the director of the department of industrial relations.
3. "Insurer" includes [the] :

(a) *The* state industrial insurance system [, self-insured employers, and those] ;

(b) *A self-insured employer;*

(c) *An association of self-insured public employers;*

(d) *An association of self-insured private employers; and*

(e) *Those* employers covered under the provisions of NRS 616.255 and 616.256.

Sec. 71. NRS 244.33505 is hereby amended to read as follows:

244.33505 1. In a county in which a license to engage in a business is required, the board of county commissioners shall not issue such a license unless the applicant for the license signs an affidavit affirming that the business:

(a) Has received coverage by the state industrial insurance system required pursuant to chapter 616 of NRS;

(b) Maintains a valid certificate of self-insurance pursuant to chapter 616 of NRS; [or]

(c) *Is a member of an association of self-insured public or private employers;*
or

(d) Is not subject to the provisions of chapter 616 of NRS.

2. In a county in which such a license is not required, the board of county commissioners shall require a business, when applying for a post office box, to submit to the board the affidavit required by subsection 1.

3. Each board of county commissioners shall submit to the administrator monthly a list of the names of those businesses which have submitted an affidavit required by subsections 1 and 2.

4. Upon receiving an affidavit required by this section, a board of county commissioners shall provide the owner of the business with a document setting forth the rights and responsibilities of employers and employees to promote safety in the workplace, in accordance with regulations adopted by the division of preventative safety of the department of industrial relations pursuant to NRS 618.376.

Sec. 72. NRS 268.0955 is hereby amended to read as follows:

268.0955 1. In an incorporated city in which a license to engage in a business is required, the city council or other governing body of the city shall not issue such a license unless the applicant for the license signs an affidavit affirming that the business:

(a) Has received coverage by the state industrial insurance system required pursuant to chapter 616 of NRS;

(b) Maintains a valid certificate of self-insurance pursuant to chapter 616 of NRS; [or]

(c) *Is a member of an association of self-insured public or private employers;*
or

(d) Is not subject to the provisions of chapter 616 of NRS.

2. In an incorporated city in which such a license is not required, the city council or other governing body of the city shall require a business, when applying for a post office box, to submit to the governing body the affidavit required by subsection 1.

3. Each city council or other governing body of an incorporated city shall submit to the administrator monthly a list of the names of those businesses which have submitted an affidavit required by subsections 1 and 2.

4. Upon receiving an affidavit required by this section, the city council or other governing body of an incorporated city shall provide the applicant with a document setting forth the rights and responsibilities of employers and employees to promote safety in the workplace, in accordance with regulations

adopted by the division of preventative safety of the department of industrial relations pursuant to NRS 618.376.

Sec. 73. NRS 624.256 is hereby amended to read as follows:

624.256 Before granting an original or renewal of a contractor's license to any applicant who has one or more employees, the board shall require that the applicant submit to the board:

1. Proof of industrial insurance and insurance for occupational diseases which covers his employees; [or]

2. A copy of his certificate of qualification as a self-insured employer which was issued by the commissioner of insurance [.] ; *or*

3. *If the applicant is a member of an association of self-insured public or private employers, a copy of the certificate issued to the association by the commissioner of insurance.*