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

LCB FILE NO. R134-20I

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PROPOSED REGULATION OF THE DIVISION OF INDUSTRIAL RELATIONS

WORKERS' COMPENSATION SECTION FOR THE

AMENDMENT OF CHAPTERS 616A THROUGH 617, NAC

LCB File No. Unassigned

July 6, 2020

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

AUTHORITY: §1, NRS 616A.400; NRS 616C.180(4)(a)(2) (Assembly Bill No. 492, section 4, subsection (a)(2), chapter 312, Statutes of Nevada 2019, at page ____); NRS 616C.087 (Senate Bill No. 381, section 2, subsection (6), chapter 550, Statutes of Nevada 2019, at page ____); and NRS 617.455(11) and NRS 617.457(16) (Assembly Bill No. 267, sections 4, subsections 10 and 11, and section 5, subsections 15 and 16, amending NRS 617.455 and 617.457 respectively, chapter 551, Statutes of Nevada 2017, at pages 3893-94 and 3896, respectively).

A REGULATION relating to industrial insurance; revising provisions concerning.

Legislative Counsel's Digest:

Sec. 1. Chapter 616B of NAC is hereby amended by adding thereto a new section to read as follows:

1. Except as otherwise provided in subsection 11, a private carrier may purchase an annuity payable to an employee who has filed a claim pursuant to chapters 616A to 617, inclusive, of NRS, or to the employee's beneficiary, for the compensation owed to the employee as a result of an industrial injury or occupational disease, except accident benefits, if:

(a) The annuity is purchased from an insurer authorized to do business in this State;

(b) The employee or the beneficiary is the annuitant and all payments made pursuant to the annuity will be made directly to the employee or the beneficiary; and

(c) The purchase of the annuity by the private carrier on behalf of the employee is made to provide compensation owed to the employee or the beneficiary pursuant to ***chapters 616A*** *to* ***617****, inclusive, of NRS.*

2. The purchase of an annuity pursuant to this section does not:

(a) Settle the employee's claim for compensation;

(b) Prohibit the employee from reopening or contesting the claim; or

(c) Transfer the responsibility of the private carrier to provide, in a timely manner, accurate payments of compensation owed to the employee to the insurer or any other party.

3. Each contract for an annuity purchased pursuant to this section must set forth the provisions of subsections 1 and 2.

4. An annuity purchased pursuant to this section may not be assigned.

5. A private carrier which purchases an annuity pursuant to this section shall make all payments required for the purchase of the annuity.

6. The amount of the total payments made to an employee pursuant to an annuity purchased pursuant to this section may not be less than the amount of compensation, other than accident benefits, owed to the employee pursuant to ***chapters 616A*** *to* ***617****, inclusive, of NRS.*

7. A private carrier which purchases an annuity pursuant to this section:

(a) Shall classify the purchase of the annuity as an amount paid for indemnity; and

(b) May reduce its reserve balance for indemnity for the claim by the amount of compensation owed to the employee pursuant to ***chapters 616A*** *to* ***617****, inclusive, of NRS for the period covered by the annuity.*

8. A private carrier shall submit to the Administrator and the Commissioner a list which sets forth each annuity it purchased, if any, in the preceding year. The private carrier shall provide the following information for each annuity listed in the report:

(a) The name of the employee on whose behalf the annuity was purchased;

(b) The number assigned to the claim by the association;

(c) The number of the contract for the annuity;

(d) The amount paid for the annuity; and

(e) The name of the insurer who issued the annuity.

9. The report required by section 8 shall be submitted

(a) To the Commissioner with the submission of the Annual Statement due March 1 of each year pursuant to NRS 680A.270 for private carriers; and

(b) To the Administrator with the annual report required by NAC 616B.016 for self-insured employers, associations, and private carriers.

10. An insurer who sells an annuity to a private carrier shall, within 10 days after the contract for the annuity is executed, submit a copy of that contract to the Administrator, the Commissioner and the private carrier.

11. A private carrier may, upon the approval of the Commissioner, purchase an annuity to pay the accident benefits of an employee incurred as a result of an industrial injury or occupational disease.

Sec. 2. Chapter 616C of NAC is hereby amended by adding thereto the provisions set forth as sections 3, 4 and 5 of this regulation.

Sec. 3. ***"Grievous bodily harm of a nature that shocks the conscience," as used in NRS 616C.180(4)(a)(2), means:***

(1) Decapitation (full or partial);

(2) Degloving (excluding single fingers, thumb or toes);

(3) Enucleation;

(4) Evisceration;

(5) Exposure of one or more of the following internal organs:

(a) Brain;

(b) Heart;

(c) Intestines;

(d) Kidneys;

(e) Liver; or

(f) Lungs;

(6) Impalement of such severity to significantly threaten loss of limb or life;

(7) Amputation (full or partial, excluding single fingers, thumb or toes); or

(8) Third degree burns on 9% or more of the body.

Sec. 4. ***If a private insurer solely uses salaried employees to investigate, negotiate or settle workers' compensation claims, pursuant to NRS 648A.040, and does not employ any Nevada licensed claims adjusters, the insurer's list of physicians and chiropractors required by NRS 616C.087(6), must be signed and certified as accurate by the highest ranking claims person for Nevada workers' compensation claims.***

Sec. 5. ***Except as otherwise provided by section 25 of this regulation (NAC 616C.435), concurrent wages include, without limitation, wages earned from:***

(a) Active or reserve duty with or in:

(1) The Army, Navy, Air Force, Marine Corps or Coast Guard of the United States;

(2) The Merchant Marine; or

(3) The National Guard; or

(b) Employment by:

(1) The Federal Government or any branch or agency thereof;

(2) A state, territorial, county, municipal or local government of any state or territory of the United States; or

(3) A private employer, whether that employment is full-time, part-time, temporary, periodic, seasonal or otherwise limited in term, or pursuant to contract.

5. As used in this section, "concurrent wages" means the sum of wages earned or deemed to have been earned at each place of employment, including, without limitation, the sum of any and all money earned for work of any kind or nature performed by an employee for two or more employers during the one-year period immediately preceding the date of injury or the onset of occupational disease, whether measured by an hourly rate, salary, piecework, commissions, gratuities, bonuses, per diem, value of meals, value of housing or any other employment benefit that can be fairly calculated to a monetary value expressed in an average monthly amount.

Sec. 6. NAC 616B.016 is hereby amended to read as follows:

NAC 616B.016 1. Upon the request of the Administrator, each insurer shall file a report with the Administrator which contains the following information:

(a) For claims other than claims for an occupational disease:

(1) The number of new claims filed.

(2) The number of claims for accident benefits only that were accepted by the insurer.

(3) The number of claims for benefits for lost time that were accepted by the insurer.

(4) The number of compensable fatalities.

(5) The number of claims that were denied by the insurer.

(b) For claims for an occupational disease:

(1) The number of new claims filed.

(2) The number of claims for accident benefits only that were accepted by the insurer.

(3) The number of claims for benefits for lost time that were accepted by the insurer.

(4) The number of compensable fatalities.

(5) The number of claims that were denied by the insurer.

(c) The number of requests to reopen a claim.

(d) The number of requests to reopen a claim that were denied by the insurer.

(e) The number of claims for accident benefits only that were reopened by the insurer.

(f) The number of claims for benefits for lost time that were reopened by the insurer.

(g) The number of injured employees who received benefits for a permanent partial disability.

(h) The number of injured employees who received benefits for a permanent partial disability in a lump sum.

(i) ***The number of claims in which permanent total disability benefits were paid.***

(j) The number of claims in which permanent total disability benefits were paid pursuant to NRS 616C.473.

(k) The number of claims in which death benefits were paid.

(l) The number of injured employees who received benefits for vocational rehabilitation.

~~(j)~~ ***(m)*** The number of injured employees who received benefits for vocational rehabilitation in a lump sum.

~~(k)~~ ***(n)*** The number of claims closed pursuant to subsection 1 of NRS 616C.235.

~~(l)~~ ***(o)*** The number of claims closed pursuant to subsection 2 of NRS 616C.235.

~~(m)~~ ***(p)*** The number of claims open at the end of the fiscal year.

~~(n)~~ ***(q)*** The total expenditures for claims reported in paragraphs (k) and (l).

~~(o)~~ ***(r)*** Expenditures on claims for:

(1) A temporary total disability.

(2) A temporary partial disability.

(3) A permanent total disability.

(4) A permanent partial disability.

(5) Benefits for survivors.

(6) Burial expenses.

(7) Travel and per diem expenses.

(8) All medical expenses.

(9) Vocational rehabilitation, including, without limitation, expenditures for:

(I) Vocational rehabilitation maintenance.

(II) The payment of compensation in a lump sum in lieu of vocational rehabilitation services.

(III) Program expenses.

(IV) Administrative expenses.

(V) Other expenses relating to vocational rehabilitation.

~~(p)~~ ***(s)*** Amounts recovered:

(1) By subrogation of claims.

(2) From the:

(I) Subsequent Injury Account for Self-Insured Employers established pursuant to NRS 616B.554;

(II) Subsequent Injury Account for Associations of Self-Insured Public or Private Employers established pursuant to NRS 616B.575; ~~[or]~~

(III) Subsequent Injury Account for Private Carriers established pursuant to NRS 616B.584 ~~[.]~~ ;

(3) ***From the Fund for Workers' Compensation and Safety for cost of living increases pursuant to NRS 616C.266 and NRS 616C.268; and***

(4) From other sources.

~~(q)~~ ***(t)*** Any other information requested by the Administrator.

2. The information required pursuant to subsection 1 must, except as otherwise requested by the Administrator, include information concerning any administrative activity during the previous fiscal year relating to:

(a) A claim for an injury that occurred during that year; and

(b) Any other claims, regardless of when the injury occurred.

3. As used in this section:

(a) "Claim for accident benefits only" means a claim in which the benefits received by the injured employee or his or her dependents for the duration of the claim did not include benefits for a temporary total disability, temporary partial disability or permanent total disability.

(b) "Claim for benefits for lost time" means a claim in which the benefits received by the injured employee or his or her dependents for the duration of the claim included benefits for a temporary total disability, temporary partial disability or permanent total disability.

(c) "Vocational rehabilitation maintenance" has the meaning ascribed to it in NRS 616C.575.

Sec. 7. NAC 616B.121 is hereby amended to read as follows:

NAC 616B.121 The Administrator hereby adopts by reference the following publications:

1. ~~[*EDI Implementation Guide for Proof of Coverage*, which is published by the International Association of Industrial Accident Boards and Commissions. A copy of the publication may be obtained from the International Association of Industrial Accident Boards and Commissions, 7780 Elmwood Avenue, Suite 207, Middleton, Wisconsin 53562, for the price of $195, or may be obtained free of charge by members at the Internet address http://www.iaiabc.org.~~

~~2.]~~ *Policy and Proof of Coverage Reporting Guidebook*, which is ~~[published]~~ ***issued*** by the National Council on Compensation Insurance. ~~[A copy of the publication]~~ ***Access to the Guidebook*** may be obtained ~~[from NCCI Holdings, Inc., Customer Service Center, 901 Peninsula Corporate Circle, Boca Raton, Florida 33487, or]~~ at ~~[the Internet address]~~ http://www.ncci.com , free of charge ~~[for affiliates or for the price of $47 for nonaffiliates]~~ .

~~[3. *Basic Manual for Workers Compensation and Employers Liability Insurance*, which is published by the National Council on Compensation Insurance. A copy of the publication may be obtained from NCCI Holdings, Inc., Customer Service Center, 901 Peninsula Corporate Circle, Boca Raton, Florida 33487, or at the Internet address http://www.ncci.com , for the price of $125 for affiliates and $250 for nonaffiliates].~~

~~4. *Forms Manual of Workers Compensation and Employers Liability Insurance*, which is published by the National Council on Compensation Insurance. A copy of the publication may be~~

~~obtained from NCCI Holdings, Inc., Customer Service Center, 901 Peninsula Corporate Circle, Boca Raton, Florida 33487, or at the Internet address http://www.ncci.com, for the price of $160 for affiliates and $325 for nonaffiliates .~~

~~5.]~~ ***2.*** *Electronic Transmission User's Guide*, which is ~~[published by]~~ ***available from*** the National Council on Compensation Insurance. ~~[A copy of the publication]~~ ***Access to the User's Guide*** may be obtained, free of charge, at ~~[the Internet address]~~ http://www.ncci.com.

~~[6.]~~ ***3.*** *WCIO Workers Compensation Data Specifications Manual*, which is maintained by the Workers Compensation Insurance Organizations. A copy of the publication may be obtained, free of charge, at ~~[the Internet address]~~ http://www.wcio.org.

Sec. 8. NAC 616B.133 is hereby amended to read as follows:

NAC 616B.133 1. A private carrier shall submit proof of coverage to the designated agent by:

(a) Electronic transmission ***in the Workers' Compensation Insurance Organizations (WCIO) Workers Compensation Policy Reporting Specifications (WCPOLS) format*** ; or

(b) The ~~[United States Postal Service or any other mail delivery service]~~ ***NCCI Policy Data Collection Tool*** .

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

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

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

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

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

Sec. 9. NAC 616B.471 is hereby amended to read as follows:

NAC 616B.471 1. Except as otherwise provided in subsection ~~[10]~~ ***11***, a self-insured employer may purchase an annuity payable to an employee who has filed a claim pursuant to chapters 616A to 617, inclusive, of NRS, or to the employee's beneficiary, for the compensation owed to the employee as a result of an industrial injury or occupational disease, except accident benefits, if:

(a) The annuity is purchased from an insurer authorized to do business in this State;

(b) The employee or the beneficiary is the annuitant and all payments made pursuant to the annuity will be made directly to the employee or the beneficiary; and

(c) The purchase of the annuity by the self-insured employer on behalf of the employee is made to provide compensation owed to the employee or the beneficiary pursuant to chapters 616A to 617, inclusive, of NRS.

2. The purchase of an annuity pursuant to this section does not:

(a) Settle the employee's claim for compensation;

(b) Prohibit the employee from reopening or contesting the claim; or

(c) Transfer the responsibility of the self-insured employer to provide, in a timely manner, accurate payments of compensation owed to the employee to the insurer or any other party.

3. Each contract for an annuity purchased pursuant to this section must set forth the provisions of subsections 1 and 2.

4. An annuity purchased pursuant to this section may not be assigned.

5. A self-insured employer who purchases an annuity pursuant to this section shall make all payments required for the purchase of the annuity.

6. The amount of the total payments made to an employee pursuant to an annuity purchased pursuant to this section may not be less than the amount of compensation, other than accident benefits, owed to the employee pursuant to chapters 616A to 617, inclusive, of NRS.

7. A self-insured employer who purchases an annuity pursuant to this section:

(a) Shall classify the purchase of the annuity as an amount paid for indemnity; and

(b) May reduce his or her reserve balance for indemnity for the claim by the amount of compensation owed to the employee pursuant to chapters 616A to 617, inclusive, of NRS for the period covered by the annuity.

8. A self-insured employer shall submit to the ***Administrator and the*** Commissioner, ~~[with the annual report required by NAC 616B.460,]~~ a list which sets forth each annuity he or she purchased, if any, in the preceding year. The self-insured employer shall provide the following information for each annuity listed in the report:

(a) The name of the employee on whose behalf the annuity was purchased;

(b) The number assigned to the claim by the self-insured employer;

(c) The number of the contract for the annuity;

(d) The amount paid for the annuity; and

(e) The name of the insurer who issued the annuity.

9. The report required by section 8 of this regulation shall be submitted as follows:

(a) To the Commissioner with the annual report required by NAC 616B.460 for self-insured employers; and

(b) To the Administrator with the annual report required by NAC 616B.016 for self-insured employers, associations, and private carriers.

~~[9.]~~ ***10.*** An insurer who sells an annuity to a self-insured employer shall, within 10 days after the contract for the annuity is executed, submit a copy of that contract to the ***Administrator, the*** Commissioner and the self-insured employer.

~~[10.]~~ ***11.*** A self-insured employer may, upon the approval of the Commissioner, purchase an annuity to pay the accident benefits owed to an employee incurred as a result of an industrial injury or occupational disease.

Sec. 10. NAC 616B.572 is hereby amended to read as follows:

NAC 616B.572 1. Except as otherwise provided in subsection ~~[10]~~ ***11***, an association may purchase an annuity payable to an employee who has filed a claim pursuant to chapters 616A to 617, inclusive, of NRS, or to the employee's beneficiary, for the compensation owed to the employee as a result of an industrial injury or occupational disease, except accident benefits, if:

(a) The annuity is purchased from an insurer authorized to do business in this State;

(b) The employee or the beneficiary is the annuitant and all payments made pursuant to the annuity will be made directly to the employee or the beneficiary; and

(c) The purchase of the annuity by the association on behalf of the employee is made to provide compensation owed to the employee or the beneficiary pursuant to chapters 616A to 617, inclusive, of NRS.

2. The purchase of an annuity pursuant to this section does not:

(a) Settle the employee's claim for compensation;

(b) Prohibit the employee from reopening or contesting the claim; or

(c) Transfer the responsibility of the association to provide, in a timely manner, accurate payments of compensation owed to the employee to the insurer or any other party.

3. Each contract for an annuity purchased pursuant to this section must set forth the provisions of subsections 1 and 2.

4. An annuity purchased pursuant to this section may not be assigned.

5. An association which purchases an annuity pursuant to this section shall make all payments required for the purchase of the annuity.

6. The amount of the total payments made to an employee pursuant to an annuity purchased pursuant to this section may not be less than the amount of compensation, other than accident benefits, owed to the employee pursuant to chapters 616A to 617, inclusive, of NRS.

7. An association which purchases an annuity pursuant to this section:

(a) Shall classify the purchase of the annuity as an amount paid for indemnity; and

(b) May reduce its reserve balance for indemnity for the claim by the amount of compensation owed to the employee pursuant to chapters 616A to 617, inclusive, of NRS for the period covered by the annuity.

8. An association shall submit to the ***Administrator and the*** Commissioner ~~[, with the annual report required by NAC 616B.564,]~~ a list which sets forth each annuity it purchased, if any, in the preceding year. The self-insured employer shall provide the following information for each annuity listed in the report:

(a) The name of the employee on whose behalf the annuity was purchased;

(b) The number assigned to the claim by the association;

(c) The number of the contract for the annuity;

(d) The amount paid for the annuity; and

(e) The name of the insurer who issued the annuity.

9. The report required by section 8 of this regulation shall be submitted as follows:

(a) To the Commissioner with the annual report required by NAC 616B.564 for associations; and

(b) To the Administrator with the annual report required by NAC 616B.016 for self-insured employers, associations of self-insured public and private employers, and private carriers.

~~[9.]~~ ***10.*** An insurer who sells an annuity to an association shall, within 10 days after the contract for the annuity is executed, submit a copy of that contract to the ***Administrator, the*** Commissioner and the association.

~~[10.]~~ ***11.*** An association may, upon the approval of the Commissioner, purchase an annuity to pay the accident benefits of an employee incurred as a result of an industrial injury or occupational disease.

Sec. 11. NAC 616B.686 is hereby amended to read as follows:

NAC 616B.686 "Annual expenditures for claims" means:

1. For assessments for fiscal years before fiscal year 1999-2000, the total amount of money actually paid for compensation in a fiscal year, including those costs of claims covered under a policy of reinsurance or a policy of excess insurance, by or on behalf of an insurer pursuant to chapters 616A to 617, inclusive, of NRS, reduced by any amount received from subrogation and reimbursement from the Subsequent Injury Account of the insurer.

2. For assessments for fiscal year 1999-2000 and for each subsequent fiscal year, the total amount of money actually paid for compensation in a fiscal year for injuries occurring on or after July 1, 1999, including those costs of claims covered under a policy of reinsurance or a policy of

excess insurance, by an insurer or its third-party administrator pursuant to chapters 616A to 617, inclusive, of NRS, reduced by any amount received from subrogation ~~[and]~~ ***,*** reimbursement from the Subsequent Injury Account of the insurer ***and reimbursement from the Fund for Workers' Compensation and Safety for cost of living increases pursuant to NRS 616C.266 and NRS 616C.268*** .

Sec. 12. NAC 616B.710 is hereby amended to read as follows:

NAC 616B.710 In calculating his or her annual expenditures for claims, an insurer shall:

1. Reduce the expenditures for claims by an amount equal to the amount of money received from subrogation ~~[or]~~ ***,*** reimbursement from the insurer's Subsequent Injury Account ***and reimbursement from the Fund for Workers' Compensation and Safety for cost of living increases pursuant to NRS 616C.266 and NRS 616C.268*** in the fiscal year in which it is received; and

2. Not reduce the total amount of money actually paid for compensation to an amount less than zero.

Sec. 13. NAC 616B.713 is hereby amended to read as follows:

NAC 616B.713 1. Except as otherwise provided in NAC 616B.7755, an insurer shall provide to the Division a statement showing the amount of expenditures for claims described in NAC 616B.707 for a period designated by the Division.

2. The statement must be verified and signed by a responsible person employed by the insurer or an authorized agent thereof.

3. Amounts reported to the Division pursuant to subsection 1 will be used as the source for determining annual expenditures for claims.

4. If an insurer assumes the obligation to pay the claims expenditures of a self-insured employer or an association of self-insured public or private employers whose certificate of authority has been withdrawn by an order of the insurance commissioner that insurer shall provide the amount of the expenditures for the claims described in NAC 616B.707 it assumed and paid in the name of previously self-insured employer or association for the period designated by the Division.

Sec. 14. NAC 616B.763 is hereby amended to read as follows:

NAC 616B.763 1. The Administrator will make determinations on expenditures for claims for which a private carrier may receive reimbursement from the Subsequent Injury Account for Private Carriers in accordance with the provisions of NAC 616B.707.

2. ***Any claims expenditure which is reimbursable to an insurer for annual increases to permanent total disability benefits under NRS 616C.266 or death benefits under NRS 616C.268 will not be reimbursed.***

3. The value of accident benefits furnished by a private carrier for industrial injuries or illnesses must be computed and reported pursuant to the schedule of fees and charges for accident benefits that was:

(a) Established pursuant to subsection 2 of NRS 616C.260; and

(b) In effect on the date the accident benefits were provided.

Sec. 15. NAC 616B.7704 is hereby amended to read as follows:

NAC 616B.7704 1. Except as otherwise provided in subsection 5 of NAC 616B.7702 or paragraph (b) or (c) of subsection 1 of section 2 of this regulation [R025-18], not later than 60 days after the date on which a claim is served on the Administrator pursuant to NAC 616B.7702, the Administrator shall:

(a) Submit to the Board a recommendation concerning the approval or disapproval, in whole or in part, of:

(1) The claim;

(2) Any expenses of the self-insured employer related to the claim that the Administrator has verified pursuant to NAC 616B.707;

(3) ***Any claims expenditure which is reimbursable to a self-insured employer for annual increases to permanent total disability benefits under NRS 616C.266 or death benefits under NRS 616C.268 will not be considered a reimbursable claims expenditure from the subsequent injury account for self-insured employers;*** and

(b) Notify the self-insured employer who submitted the claim or the person designated pursuant to section 3 or 5 of this regulation [R025-18], as applicable, to accept service on behalf of the self-insured employer of that recommendation.

2. The Administrator shall include with the recommendation the information necessary for the Board to evaluate the claim and the expenses related to the claim, including, without limitation:

(a) A statement of the issues of fact and law upon which the recommendation of the Administrator is based;

(b) A copy of each document upon which the Administrator based the recommendation; and

(c) A list of each witness, if any, whom the Administrator would likely call before the Board to support the recommendation, if contested.

3. Upon receipt of the recommendation of the Administrator, the Board will render a decision disposing of:

(a) The claim; and

(b) The self-insured employer's expenses related to the claim which have been verified by the Administrator after consideration in accordance with the provisions of NAC 616B.707.

4. When rendering a decision pursuant to subsection 3 or NAC 616B.7708, the Board will approve a claim and the expenses of a self-insured employer, in whole or in part, only if the employer proves by a preponderance of the evidence that all of the requirements of NRS 616B.557 or 616B.560, as applicable, have been satisfied.

Sec. 16. NAC 616B.7734 is hereby amended to read as follows:

NAC 616B.7734 "Annual expenditures for claims of an association" means the aggregate sum of:

1. All money the association paid for compensation in a fiscal year pursuant to chapters 616A to 617, inclusive, of NRS reduced by any money received by the association in that fiscal year from subrogation ~~[and]~~ **,** reimbursement from the Account ***and reimbursement from the Fund for Workers' Compensation and Safety for cost of living increases pursuant to NRS 616C.266 and NRS 616C.268*** ; and

2. Any money the successor organization to the State Industrial Insurance System paid for compensation in that fiscal year pursuant to chapters 616A to 617, inclusive, of NRS on behalf of a public or private employer who is a member of the association if the money was paid by the successor organization to the State Industrial Insurance System for claims that were incurred before the public or private employer became a member of the association.

Sec. 17. NAC 616B.7755 is hereby amended to read as follows:

NAC 616B.7755 1. Each association shall maintain records in this State of the annual expenditures for claims of the association. Such records must include, without limitation:

(a) Copies of all checks that have been issued for each claim;

(b) A register that documents all checks that have been issued for each claim and any voided checks related to such claims;

(c) A register that documents any other form of payment that has been made for each claim; and

(d) Any working papers that the association used to report annual expenditures for claims of the association.

2. Except as otherwise provided in this subsection and subsection 3, each association shall provide to the Division, at such times and in such form and manner as prescribed by the Division:

(a) A report that contains the annual expenditures for claims and expected annual expenditures for claims of the association;

(b) A report which contains the annual expenditures for claims of the association, divided into monthly expenditures, and which has been verified and signed by an authorized employee or agent of the association; and

(c) Any other information that the Division determines is necessary to calculate an estimated annual assessment or final annual assessment for the association.

3. The Division may, by written request, require an association to provide a copy or certified copy of any check described in subsection 1. If an association receives such a request, the association shall provide the Division with a copy or certified copy, as requested, of both sides of the check not later than 15 days after the date that the association receives the request.

4. To calculate its annual expenditures for claims pursuant to this section, an association shall reduce its annual expenditures for claims made in each fiscal year by the amount of the money the association received in that fiscal year from subrogation ~~[and]~~ , reimbursement from the Account

and reimbursement from the Fund for Workers' Compensation and Safety for cost of living increases pursuant to NRS 616C.266 and NRS 616C.268 .

5. If an insurer assumes the obligation to pay the claims expenditures of an association whose certificate of authority has been withdrawn by an order of the insurance commissioner that insurer shall provide to the Division as required in subsection 2 the amount of the expenditures for the claims described in NAC 616B.707 it assumed and paid in the name of previously self-insured association for the period designated by the Division.

Sec. 18. NAC 616B.7764 is hereby amended to read as follows:

NAC 616B.7764 1. For the purposes of subsection 1 of NAC 616B.7761, to calculate the annual expenditures for claims of an association for each of the immediately preceding 3 calendar years, the Division shall:

(a) Consider the reports and any other information provided to the Division by the association pursuant to NAC 616B.7755;

(b) Consider the statements obtained from the successor organization to the State Industrial Insurance System pursuant to subsection 2; and

(c) Determine which payments made by the association are to be considered expenditures for claims pursuant to subsections 3 and 4.

2. For each association, the Division shall obtain from the successor organization to the State Industrial Insurance System a statement showing:

(a) The annual expenditures for claims, divided into monthly expenditures, that were made by each public or private employer in the association before such employer became a member of the association; and

(b) The annual expenditures for claims, divided into monthly expenditures, that were made by each public or private employer in the association after such employer became a member of the association.

3. The Division shall consider money paid by an association for any of the following to be expenditures for claims:

(a) Charges by a hospital.

(b) Services of a surgeon, assisting surgeon, anesthesiologist or consulting physician.

(c) Treatment by a physician or chiropractor.

(d) X-ray films, computerized axial tomography scans, myelograms, magnetic resonance imaging or other diagnostic tests or procedures.

(e) Physical therapy.

(f) Drugs, medications, eyeglasses, dental work, prosthetic devices, orthotic devices or corrective shoes, if such items are prescribed.

(g) Travel to obtain medical care or supplies.

(h) Any other accident benefits.

(i) Compensation for a permanent total, temporary total, permanent partial or temporary partial disability.

(j) Costs of vocational rehabilitation services for an injured employee.

(k) Death benefits.

(l) Burial expenses.

4. The Division shall not consider any of the following to be expenditures for claims:

(a) Money held in reserve by an association for any anticipated payment related to a claim.

(b) Payments for compensation for a temporary total or temporary partial disability in excess of the average monthly wage.

(c) ***Money which is reimbursable to the association for annual increases to death benefits under NRS 616C.268 and permanent total disability benefits under NRS 616C.266.***

(d) Payments for legal expenses, including, without limitation, attorney's fees and costs for investigations, depositions or hearings.

~~[(d)]~~ ***(e)*** Payments for claims that are subsequently determined to be noncompensable.

~~[(e)]~~ ***(f)*** Payments for claims related to the Uninsured Employers' Claim Account.

~~[(f)]~~ ***(g)*** Payments for administrative expenses, including, without limitation, expenses for:

(1) Copying records;

(2) Reviewing the report of a physician contained in any file related to a claim; or

(3) Services related to the management of costs of medical care.

Sec. 19. NAC 616B.7777 is hereby amended to read as follows:

NAC 616B.7777 1. Except as otherwise provided in subsection 5 of NAC 616B.7773 or paragraph (b) or (c) of subsection 1 of section 2 of this regulation [R026-18], not later than 60 days after the date on which a claim is served on the Administrator pursuant to NAC 616B.7773, the Administrator shall:

(a) Submit to the Board a recommendation concerning the approval or disapproval , in whole or in part, of:

(1) The claim ; and

(2) Any expenses of the association related to the claim that the Administrator has verified pursuant to the provisions of NAC 616B.707; ~~[and]~~

(3) ***Any claims expenditure which is reimbursable to a self-insured employer for annual increases to permanent total disability benefits under NRS 616C.266 or death benefits under NRS 616C.268 will not be considered a reimbursable claims expenditure from the subsequent injury account for an association of self-insured public or private employers; and***

(b) Notify the association that submitted the claim or the person designated pursuant to section 3 or 5 of this regulation [R026-18], as applicable, to accept service on behalf of the association of that recommendation.

2. The Administrator shall include with the recommendation the information necessary for the Board to evaluate the claim and the expenses related to the claim, including, without limitation:

(a) A statement of the issues of fact and law upon which the recommendation of the Administrator is based;

(b) A copy of each document upon which the Administrator based the recommendation; and

(c) A list of each witness, if any, whom the Administrator would likely call before the Board to support the recommendation, if contested.

3. Upon receipt of the recommendation of the Administrator, the Board will render a decision disposing of:

(a) The claim; and

(b) The association's expenses related to the claim which have been verified by the Administrator after consideration in accordance with the provisions of NAC 616B.707.

4. When rendering a decision pursuant to subsection 3 or NAC 616B.7708, the Board will approve a claim and the expenses of an association, in whole or in part, only if the association

proves by a preponderance of the evidence that all of the requirements of NRS 616B.578 or 616B.581, as applicable, have been satisfied.

Sec. 20. NAC 616C.003 is hereby amended to read as follows:

NAC 616C.003 The Administrator will appoint to the panel of physicians and chiropractors described in NRS 616C.090 only physicians and chiropractors who:

1. Are licensed under chapter 630, 633 or 634 of NRS;

2. Have demonstrated special competence and interest in industrial health;

3. Are in good standing with the state regulatory bodies respectively charged with overseeing their licensing, practice and performance;

4. Have not lost staff privileges at any hospital on the basis of reviews conducted by their peers concerning the quality of care they have provided; ~~[and]~~

5. Have not been suspended or removed from the panel of physicians and chiropractors by the Administrator ***;***

6. Has not been convicted or disciplined by any state licensing agency, workers' compensation authority, Medicare/Medicaid (Center for Medicare and Medicaid Services) or professional practice organization for:

(a) Fraudulent activity including, but not limited to, medical billing or reporting;

(b) Abuse;

(c) Discriminatory treatment in the care and treatment of patients;

(d) Commission of a felony for which he or she is convicted in a state or federal court; or

(e) Commission of any offense relating to excessive prescription of drugs for which he or she is convicted in a state or federal court or disciplined by any state's licensing agency;

7. All applicants appointed to the Treating Panel of Physicians and Chiropractors must notify the Administrator in writing of any changes to the information provided on their application within 14 days of the change for as long as the physician/chiropractor remains on the Treating Panel of Physicians and Chiropractors. Failure to do so may result in disciplinary action, including administrative fines; and

8. Any physician or chiropractor who is an appointed member of the Treating Panel of Physicians and Chiropractors who has not provided the discipline and specialization information required pursuant to NRS 616C.087(2) to the Administrator on or before June 30, 2020 shall be removed from the Treating Panel of Physicians and Chiropractors on July 1, 2020.

Sec. 21. NAC 616C.021 is hereby amended to read as follows:

NAC 616C.021 1. The designation of a rating physician or chiropractor pursuant to NRS 616C.490 must be in writing ***or by electronic communication***.

2. To qualify for designation, a physician or chiropractor must:

(a) Possess the qualifications required of a physician or chiropractor who is appointed to the panel of physicians and chiropractors established pursuant to NRS 616C.090 and NAC 616C.003.

(b) Demonstrate a special competence and interest in industrial health by:

(1) Completing:

(I) An appropriate level of training, as determined by the Administrator, related to industrial health from a nationally recognized program that provides training related to industrial health; or

(II) ~~[One year]~~ ***Three years*** or more of experience concerning industrial health in private practice. The Administrator shall determine whether the experience in private practice concerning

industrial health is sufficient to qualify for designation as a rating physician or chiropractor on a case-by-case basis.

(2) Except as otherwise provided in subsection 3, successfully completing a course on rating disabilities, in accordance with the most recent edition of the *Guide*, that is approved by the Administrator.

(3) Except as otherwise provided in subsection 3, passing an examination on evaluating disabilities and impairments that is administered by the American Board of Independent Medical Examiners or its successor organization, or by any other organization or company recognized by the Division.

(4) Except as otherwise provided in subsection 3, passing the Nevada Impairment Rating Skills Assessment Test which is administered by the American Academy of Expert Medical Evaluators or its successor organization and which examines the practical application of the rating of disabilities in accordance with the *Guide* with a score of 75 percent or higher.

(c) Demonstrate an understanding of:

(1) The regulations of the Division related to the evaluation of permanent partial disabilities; and

(2) The *Guide*.

3. The Administrator may exempt an ophthalmologist or psychiatrist who is authorized to practice in this State from the requirements set forth in subparagraphs 2, 3 and 4 of paragraph (b) of subsection 2 and authorize an ophthalmologist or psychiatrist to evaluate injured employees with impaired vision or brain function or mental or behavioral disorders according to his or her area of specialization.

4. In order to maintain designation as a rating physician or chiropractor, the physician or chiropractor must:

(a) Except as otherwise provided in subsection 5, perform ratings evaluations of permanent partial disabilities when selected pursuant to NRS 616C.490, except disabilities related to an employee's vision or brain function resulting from an industrial accident or occupational disease;

(b) Schedule and perform a rating evaluation within 30 days after receipt of a request from an insurer, a third-party administrator or an injured employee or his or her representative;

(c) Except as otherwise provided in subsection 5, serve without compensation for a period not to exceed 1 year on the panel to review ratings evaluations established pursuant to NAC 616C.023 upon the request of the Administrator;

(d) Except as otherwise provided in subsection 5 and after the date of designation as a rating physician or chiropractor, successfully complete biennially a course that is approved by the Administrator on rating disabilities, in accordance with the American Medical Association's *Guide*; and

(e) Except as otherwise provided in subsection 5, if the physician or chiropractor passed an examination concerning an edition of the *Guide* that is not the most recent edition adopted by the Administrator to become designated as a rating physician, pass the Nevada Impairment Rating Skills Assessment Test which is administered by the American Academy of Expert Medical Evaluators or its successor organization and which examines the practical application of the rating of disabilities in accordance with the *Guide* with a score of 75 percent or higher.

5. If an ophthalmologist or psychiatrist has been designated as a rating physician and wishes to maintain such designation, the Administrator may exempt the ophthalmologist or psychiatrist who is authorized to practice in this State from the requirements set forth in paragraphs (a), (c),

(d) and (e) of subsection 4 and authorize the ophthalmologist or psychiatrist to continue to evaluate injured employees with impaired vision or brain function or mental or behavioral disorders according to his or her area of specialization.

6. A rating evaluation of a permanent partial disability may be performed by a chiropractor only if the injured employee's injury and treatment are related to his or her neuromusculoskeletal system.

7. A rating physician or chiropractor may not rate the disability of an injured employee if the physician or chiropractor has:

(a) Previously examined or treated the injured employee for the injury related to his or her claim for workers' compensation; or

(b) Reviewed the health care records of the injured employee and has made recommendations regarding the likelihood of the injured employee's ratable impairment.

8. A rating evaluation of a permanent partial disability performed by a rating physician or chiropractor is subject to review by the Administrator pursuant to the provisions of NAC 616C.023.

Sec. 22. NAC 616C.024 is hereby amended to read as follows:

NAC 616C.024 1. The Administrator will issue a warning to any physician or chiropractor on the list of rating physicians and chiropractors designated pursuant to NRS 616C.490, or suspend or remove any physician or chiropractor from the list if the physician or chiropractor:

(a) ~~[Commits an excessive number of errors in the performance of ratings evaluations, as determined by comparing the number of ratings found by the Administrator to be erroneous to the total number of ratings performed by the physician or chiropractor]~~ ***Fails to correct errors on***

subsequent rating evaluations after receiving three or more written responses from the Administrator's Permanent Partial Disability (PPD) Review Panel (NAC 616C.023) addressing the same or similar errors identified on the rater's PPD reports ;

(b) Violates any provision of NAC 616C.006 or commits two or more violations of any of the provisions of chapters 616A to 617, inclusive, of NRS or any other regulations adopted pursuant thereto;

(c) Is the subject of any disciplinary action that resulted in the suspension or revocation of his or her license or the limitation of his or her practice by the applicable licensing authority;

(d) Is determined by the Administrator to have engaged in any action detrimental to an injured employee, an employer, an insurer or the program of industrial insurance;

(e) Refuses to serve as a member of the panel to review ratings evaluations established pursuant to NAC 616C.023 or serves as a member of the panel but does not attend the meetings of the panel; or

(f) Fails to perform ratings evaluations when selected pursuant to NRS 616C.490 or schedules and fails to perform ratings evaluations in accordance with that section.

2. For the purposes of paragraph (a) of subsection 1, the Administrator, after receiving the advice of the panel to review ratings evaluations established pursuant to NAC 616C.023, will determine what is an excessive number of errors in the performance of ratings evaluations.

3. If the Administrator intends to suspend or remove a physician or chiropractor from the list of rating physicians and chiropractors, the Administrator will cause written notice of the suspension or removal to be delivered by certified mail to the physician or chiropractor affected. The physician or chiropractor may appeal the determination of the Administrator by filing a written notice of appeal with the Administrator within 10 days after the notice of suspension or removal

is received. If a notice of appeal is filed in the manner provided by this subsection, the Administrator will conduct a hearing on the matter and issue a decision in writing affirming or reversing the determination.

4. Except as otherwise provided in this subsection, the suspension or removal of a physician or chiropractor from the list of rating physicians and chiropractors becomes final and effective upon the expiration of the time permitted by subsection 3 for the filing of a notice of appeal. If a notice of appeal is filed in the manner provided by subsection 3, the suspension or removal is final and effective upon the issuance of a decision affirming the determination of the Administrator. The issuance of such a decision is a final decision for the purposes of judicial review.

Sec. 23. NAC 616C.103 is hereby amended to read as follows:

NAC 616C.103 1. For purposes of determining whether an injured employee is stable and ratable and entitled to an evaluation to determine the extent of any permanent impairment pursuant to this section and NRS 616C.490, the Division interprets the term:

(a) "Stable" to include, without limitation, a written indication from a physician or chiropractor that the industrial injury or occupational disease of the injured employee:

(1) Is stationary, permanent or static; or

(2) Has reached maximum medical improvement.

(b) "Ratable" to include, without limitation, a written indication from a physician or chiropractor that the medical condition of the injured employee may have:

(1) Resulted in a loss of motion, sensation or strength in a body part of the injured employee;

(2) Resulted in a loss of or abnormality to a physiological or anatomical structure or bodily function of the injured employee; or

(3) Resulted in a mental or behavioral disorder as the result of a claim that has been accepted pursuant to NRS 616C.180.

2. If an insurer proposes that an injured employee agree to a rating physician or chiropractor chosen by the insurer, the insurer shall inform the injured employee in writing that the injured employee:

(a) Is not required to agree with the selection of that physician or chiropractor; and

(b) May request that the rating physician or chiropractor be selected in accordance with subsection 3 and NRS 616C.490.

3. An insurer shall comply with subsection 2 of NRS 616C.490, within the time prescribed in that subsection for the scheduling of an appointment, by:

(a) Requesting a physician or chiropractor from the list of qualified rating physicians and chiropractors designated by the Administrator to evaluate the injured employee and determine the extent of any permanent impairment or, if the injured employee and insurer have agreed to a rating physician or chiropractor pursuant to subsection 2 of NRS 616C.490, by submitting a completed form designated in NAC 616A.480 as D-35, Request for a Rotating Rating Physician or Chiropractor, to the Workers' Compensation Section within 30 days after the insurer has received the statement from a physician or chiropractor that the injured employee is ratable and stable;

(b) Mailing written notice to the injured employee of the date, time and place of the appointment for the rating evaluation; and

(c) At least 3 working days before the rating evaluation, ~~[providing]~~ ***the party requesting the rating evaluation must provide*** to the assigned rating physician or chiropractor from the insurer's file ***the following documentation*** concerning the injured employee's claim:

(1) All reports or other written information concerning the injured employee's claim produced by a physician, chiropractor, hospital or other provider of health care, including the statement from the treating physician or chiropractor that the injured employee is stable and ratable, surgical reports, diagnostic, laboratory and radiography reports and information concerning any preexisting condition relating to the injured employee's claim;

(2) Any evidence or documentation of any previous evaluations performed to determine the extent of any of the injured employee's disabilities and any previous injury, disease or condition of the injured employee that is relevant to the evaluation being performed;

(3) The form designated in NAC 616A.480 as C-4, Employee's Claim for Compensation/Report of Initial Treatment;

(4) The form designated in NAC 616A.480 as D-35, Request for a Rotating Rating Physician or Chiropractor; and

(5) The form designated in NAC 616A.480 as D-36, Request for Additional Medical Information and Medical Release.

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

5. Except as otherwise provided in subsection 7, if the rating physician or chiropractor finds that the injured employee has a ratable impairment, the insurer shall, within the time prescribed by NRS 616C.490, offer the injured employee the award to which he or she is entitled. The insurer shall make payment to the injured employee:

(a) Within 20 days; or

(b) If there is any child support obligation affecting the injured employee, within 35 days,

➥ after it receives the properly executed award papers from the injured employee or his or her representative.

6. If the rating physician or chiropractor determines that the permanent impairment may be apportioned pursuant to NAC 616C.490, the insurer shall advise the injured employee of the amount by which the rating was reduced and the reasons for the reduction.

7. If the insurer disagrees in good faith with the result of the rating evaluation, the insurer shall, within the time prescribed in NRS 616C.490:

(a) Offer the injured employee the portion of the award, in installments, which it does not dispute;

(b) Provide the injured employee with a copy of each rating evaluation performed of the injured employee; and

(c) Notify the injured employee of the specific reasons for the disagreement and the right of the injured employee to appeal. The notice must also set forth a detailed proposal for resolving the dispute that can be executed in 75 days, unless the insurer demonstrates good cause for why the proposed resolution will require more than 75 days.

8. The injured employee must receive a copy of the results of each rating evaluation performed of the injured employee before accepting an award for a permanent partial disability.

9. As used in this section, "award papers" means the following forms designated in NAC 616A.480, as appropriate:

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

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

(c) D-11, Reaffirmation/Retraction of Lump Sum Request.

Sec. 24. NAC 616C.088 is hereby amended to read as follows:

NAC 616C.088. 1. Each file of a claim concerning an industrial injury or occupational disease that is maintained by an insurer or third-party administrator must contain:

(a) The employer's report of the industrial injury or occupational disease.

(b) The claim for compensation and any medical report associated with that claim that is issued after the claim is filed with the insurer.

(c) All:

(1) Applications for a stay concerning a decision on a claim for compensation made to a hearing officer, appeals officer or a court of competent jurisdiction;

(2) Written orders or decisions on a claim for compensation entered by a hearing officer, appeals officer or a court of competent jurisdiction;

(3) Written determinations made by an insurer, third-party administrator or an organization for managed care concerning a claim for compensation;

(4) Written settlement agreements or stipulations made between the injured employee and his or her employer or the insurer of the employer concerning a claim for compensation; and

(5) Except as otherwise provided in subparagraph (2) of paragraph (f), other documents which affect the amount, timing or denial of the payment of compensation. As used in this subparagraph, "payment of compensation" has the meaning ascribed to it in subsection 2 of NAC 616D.305.

(d) A record of all compensation paid to the injured employee and all payments made to any other person in connection with the claim, for:

(1) Accident benefits;

(2) Temporary partial disability;

(3) Temporary total disability;

(4) Permanent partial disability;

(5) Permanent total disability;

(6) Death benefits; and

(7) Vocational rehabilitation,

➥ and the amount of the expected total incurred costs and the justification.

(e) A copy of any notice of termination of benefits which has been sent to the injured employee.

(f) Copies of ***any and*** all ***written or electronic*** correspondence ***, emails, text messages*** and other documents pertaining to the claim, including, without limitation, copies of:

(1) All medical bills incurred by the injured employee and received by the insurer; and

(2) Any notices sent to the injured employee to inform him or her of the right to a review or appeal,

➥ but not including records of any privileged communication between the insurer and its attorney or of any investigation conducted by or on behalf of the insurer concerning a possible violation of NRS 616D.300.

(g) All ratings performed by any physician or chiropractor.

(h) A summary of conversations or oral negotiations, or both, conducted by the insurer or the third-party administrator with the injured employee, the legal counsel who represents the injured employee or any other party other than the physician or chiropractor of the injured employee, if action is requested or taken.

(i) After the claim is closed, the log of oral communications relating to the medical disposition of a claim that must be maintained by an insurer or third-party administrator pursuant to NRS 616D.330.

2. Each file of a claim must be retained for 2 years after the death of the injured employee.

Sec. 25. NAC 616C.435 is hereby amended to read as follows:

NAC 616C.435 1. Except as otherwise provided in this section, a history of earnings for a period of 12 weeks must be used to calculate an average monthly wage.

2. If a 12-week period of earnings is not representative of the average monthly wage of the injured employee, ~~[earnings]~~ ***wages earned*** over a period of 1 year or the full period of employment, if it is less than 1 year, may be used. ~~[Earnings]~~ ***Wages earned*** over 1 year or the full period of employment, if it is less than 1 year, must be used if the average monthly wage would be increased.

3. If an injured employee is a member of a labor organization and is regularly employed by referrals from the office of that organization, wages earned from all employers for a period of 1 year may be used. A period of 1 year using all the wages of the injured employee from all his or her employers must be used if the average monthly wage would be increased.

4. If information concerning payroll is not available for a period of 12 weeks, wages ***earned*** may be averaged for the available period, but not for a period of less than 4 weeks.

5. If information concerning payroll is unavailable for a period of at least 4 weeks, average ~~[earnings]~~ ***wages earned*** must be projected using the rate of pay on the date of the ~~[accident]~~ ***injury*** or illness and the projected working schedule of the injured employee.

6. If ~~[earnings]~~ ***wages earned*** are based on piecework and a history of earnings is unavailable for a period of at least 4 weeks, the ~~[wage]~~ ***wages earned*** must be determined as being equal to the average earnings of other employees doing the same work.

7. If these methods of determining a period of ~~[earnings]~~ ***wages earned*** cannot be applied reasonably and fairly, an average monthly wage must be calculated by the insurer at 100 percent of:

(a) The sum which reasonably represents the average monthly wage of the injured employee as defined in NAC 616C.420 to 616C.447, inclusive, at the time the injury or illness occurs; or

(b) The ***amount determined using the*** hourly wage on the day the injury or illness occurs ~~[, calculated by using]~~ ***and*** the projected working schedule ***of the injured employee*** .

8. The period used to calculate the average monthly wage must consist of consecutive days, ending on the date on which the ~~[accident]~~ ***injury*** or ~~[disease]~~ ***illness*** occurred, or the last day of the payroll period preceding the ~~[accident]~~ ***injury*** or ~~[disease]~~ ***illness*** if this period is representative of the average monthly wage.

9. As used in this section, ~~["earnings"]~~ ***"wages earned"*** means ~~[earnings received]~~ ***wages earned*** from the employment in which the injury ***or illness*** occurs and in any concurrent employment.

Sec. 26. NAC 616C.527 is hereby amended to read as follows:

NAC 616C.527 1. An insurer shall provide any information required by the Administrator to carry out the provisions of ~~[NAC 616C.526 and NRS 616C.453]~~ ***NRS 616C.473***.

2. An insurer who violates subsection 1 is subject to administrative action pursuant to NRS 616D.120.

Sec. 27. NAC 616C.559 is hereby amended to read as follows:

NAC 616C.559 1. In developing a program of vocational rehabilitation for an industrially injured employee, the insurer shall consider the injured employee's experience, skills and desires.

2. A program of vocational rehabilitation must be outlined in writing. The outline for an individual program must:

(a) Show the amount of money budgeted;

(b) Contain a justification of the expense; and

(c) Include a description of:

(1) The nature and the length of the program;

(2) The skills that the injured employee will acquire; and

(3) The dates on which the program will begin and end.

3. The insurer or a vocational rehabilitation counselor shall explain the planned program of vocational rehabilitation to the injured employee. Before an injured employee may participate in a program of vocational rehabilitation, the insurer and the employee must execute a written agreement that contains the outline for the program. A copy of the agreement must be delivered to the injured employee and his or her rights and duties under the agreement must be explained to him or her.

4. The injured employee must acknowledge:

(a) Receipt of a dated copy of the proposed agreement for the program of vocational rehabilitation;

(b) That the program has been explained to him or her; and

(c) That he or she agrees to the conditions of the program.

5. A copy of the written agreement must be sent to the employer of the injured employee.

~~[6. If the insurer finds that good cause exists for the extension, the injured employee may be provided vocational rehabilitation services after the date on which the program would otherwise end pursuant to the provisions of NRS 616C.560.]~~

Sec. 28. Chapter 617 of NAC is hereby amended by adding thereto a new section to read as follows:

In calculating the number of days from the date an appeal of a claim denial determination is made until the claimant prevails under NRS 617.455(11) or NRS 617.457(16), the following periods of time shall be excluded:

1. The day the determination was made;

2. If an appeal is pending before a hearing officer, appeals officer, district court judge or any other appellate proceeding:

(a) The number of days in excess of 70 days between the date of filing an appeal with the appeals office and the first hearing date;

(b) If the claimant or his or her representative requests a continuance of any hearing which is granted, from the day the request was filed or requested to the date of the next scheduled hearing;

(c) If the claimant or his or her representative agree to a continuance of any hearing which is granted, from the date of the email requesting a continuance of the hearing or the earliest signature date on the stipulation to the date of the next scheduled hearing;

(d) If the hearing is canceled or continued by the hearing officer, appeals officer, district court judge or any other person conducting an appellate proceeding, from the date of the cancelation or continuance to the date of the next scheduled hearing;

(e) If a hearing officer or appeals officer enters an interim order to resolve a medical question under NRS 616C.330(3) or NRS 616C.345(3), from the date the Hearing officer or appeals officer finds that there is a medical question until the date the insurer provides a copy of the resulting medical reporting to the claimant or his or her representative;

(f) If a hearing is held, from the date the hearing commenced until the date the person conducting the hearing issues an appealable final decision or order in such appeal;

(g) If the claimant or his representative has not supplied appropriate medical reporting which supports the acceptance of the claim before the insurer's determination denying the claim, from the date the determination was made until the insurer receives appropriate medical reporting supporting acceptance of the claim;

(h) If the claimant or his representative has failed to cooperate with the investigation of the claim by the insurer, from the date the determination was made until the insurer receives reasonable cooperation and concluded or should have concluded its investigation;

(i) If the claimant or his or representative files an appeal of a hearing officer decision, an appeals officer decision or a district court decision, from the date of the decision being appealed until the date the appeal is filed;

(j) If any of the above-listed periods of time overlap, each day may only be counted once in calculating the total number of days in the benefit penalty calculation;

3. The amount of the benefit penalty for each non-excluded day shall be as follows:

(a) There shall be no daily penalty if an appeal is ordered to be remanded to the insurer for a new determination or the insurer denies the claim pending medical investigation and timely conducts such investigation which results in the insurer issuing a claim acceptance determination;

(b) The daily penalty amount shall be $100 per day if the insurer has factual reporting, medical reporting or both which supports a good faith argument for the initial claim denial;

(c) The daily penalty amount shall be $200 per day if the insurer does not have any credible factual reporting or medical reporting which supports the denial or continued denial of the claim.

4. The phrase "ultimately prevails" means that matter was litigated to conclusion and the final outcome was determined by a hearing officer, appeals officer, district court or appellate court and does not include appeals which are concluded by a stipulation between the parties.

Sec. 29. NAC 616C.447 and NAC 616C.526 are hereby repealed.

TEXT OF REPEALED SECTIONS

NAC 616C.447 Concurrent employment. The average monthly wage of an employee who is employed by two or more employers covered by a private carrier or by a plan of self-insurance on the date of a disabling accident or disease is equal to the sum of the wages earned or deemed to have been earned at each place of employment. The insurer shall advise an injured employee in writing of his or her entitlement to compensation for concurrent employment at the time of the initial payment of the compensation.

NAC 616C.526 Annual payments to certain claimants and dependents of claimants.

1. The Administrator will make an annual payment to each claimant or dependent who is entitled as of July 1 to receive such a payment for a permanent total disability pursuant to NRS 616C.453. The amount of the payment to each claimant or dependent is equal to two-fifths of the

amount the Administrator withdraws from the Uninsured Employers' Claim Account for this purpose divided by the total number of claimants and dependents entitled to be paid and:

(a) If the claimant or dependent receives compensation of less than $1,000 per month, an additional amount that is equal to two-fifths of the amount the Administrator withdraws from the Uninsured Employers' Claim Account divided by the total number of claimants and dependents entitled to be paid pursuant to this paragraph; or

(b) If the claimant or dependent receives compensation of $1,000 per month or more, but less than $1,500 per month, an additional amount that is equal to one-fifth of the amount the Administrator withdraws from the Uninsured Employers' Claim Account divided by the total number of claimants and dependents entitled to be paid pursuant to this paragraph.

2. As used in this section:

(a) "Claimant" means a person who is entitled to receive compensation pursuant to chapters 616A to 617, inclusive, of NRS for a permanent total disability and is not entitled to an annual increase in that compensation pursuant to NRS 616C.473.

(b) "Compensation" means compensation a claimant or dependent is entitled to receive pursuant to chapters 616A to 617, inclusive, of NRS for a permanent total disability.

(c) "Dependent" means a dependent of a claimant.