STATE OF NEVADA
DEPARTMENT OF BUSINESS AND INDUSTRY
DIVISION OF INDUSTRIAL RELATIONS

IN THE MATTER OF THE ADOPTION OF PERMANENT REGULATION RELATING TO INDUSTRIAL INSURANCE; ESTABLISHING PROVISIONS GOVERNING THE TRANSFER OF CLAIM FILES; REVISING PROVISIONS RELATING TO SUBMISSION TO AN INSURER OF CORRESPONDENCE AND OTHER DOCUMENTS; ESTABLISHING PROVISIONS GOVERNING THE SUBMISSION TO AN INSURER OF A WRITTEN REQUEST FOR A DETERMINATION; REVISING PROVISIONS RELATING TO RECORDKEEPING REQUIREMENTS AND THE MAINTENANCE OF CLAIM FILES; REVISING PROVISIONS RELATING TO VOCATIONAL REHABILITATION; ESTABLISHING PROVISIONS GOVERNING THE PURCHASE OF A MODIFIED MOTOR VEHICLE AS AN ACCIDENT BENEFIT; REVISING PROVISIONS RELATING TO RATING EVALUATIONS PERFORMED BY A PHYSICIAN OR CHIROPRACTOR; AND PROVIDING OTHER MATTERS PROPERLY RELATING THERETO.

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LEGISLATIVE REVIEW OF ADOPTED REGULATIONS
AS REQUIRED BY NRS 233B.066
LCB FILE NO. R130-14

AMENDED INFORMATIONAL STATEMENT

The following statement is submitted for adoption of new provisions in Nevada Administrative Code (NAC) Chapters 616B and 616C; the amendment of existing provisions in NAC Chapters 616B, 616C, 616D and 617; and the repealing of existing provisions in NAC Chapters 616A, 616B and 616C.

1. A clear and concise explanation of the need for the adopted regulation.

The Division of Industrial Relations, Workers' Compensation Section's proposed regulations are needed to update existing regulations and repeal regulations which are now duplicative and unnecessary. These regulations revise outdated definitions, references to nonexistent offices and contact information for required publications; establish procedures for the transfer of claims files between insurers and third party administrators; revise provisions relating to the submission of correspondence and other documents to insurers; establish provisions relating to the submission of a written request for a determination by an insurer; establish procedures and requirements for the purchase of a modified motor vehicle as an accident benefit; revise provisions relating to recordkeeping and the maintenance of claim

files; revise provisions relating to the determination and notification of claim acceptance or denial by an insurer; establish deadlines for a physician's or chiropractor's report on the status of an injured employee; revise provisions relating to the contents and maintenance of a rating evaluation by a physician or chiropractor; revise provisions relating to vocational rehabilitation; and authorizing, under certain circumstances, an employee to schedule physical examinations for firefighters, police officers and arson investigators.

2. A description of how public comment was solicited, a summary of public responses, and an explanation of how other interested persons may obtain a copy of the summary.

Copies of the proposed regulation, notices of workshop and notices of intent to act upon a regulation were sent by U.S. mail and e-mail to over 2,450 persons who were known to have an interest in the subject of the Nevada Industrial Insurance Act and Nevada Occupational Diseases Act, as well as any persons who had specifically requested such notice. These documents were also made available at the website of the Department of Business and Industry, Division of Industrial Relations, Workers' Compensation Section, www.dirweb.state.nv.us/WCS/wcs.htm, mailed to all county libraries in Nevada and posted at the following locations:

Division of Industrial Relations
400 W. King Street, #400
Carson City, NV 89703

Department of Business and Industry
555 E. Washington Ave., #4900
Las Vegas, NV 89101

Workers' Compensation Section
1301 N. Green Valley Pkwy., #200
Henderson, NV 89074

NVOSHA
4600 Kietzke Lane, # F-153
Reno, NV 89502

Grant Sawyer Building
555 E. Washington Ave,
Las Vegas, NV 89101

Bradley Building
2501 E. Sahara Ave.
Las Vegas, NV 89104

Nevada State Library, Archives and Public Records
100 Stewart Street
Carson City, NV 89701

A workshop was held via videoconference on January 5, 2015, at 9:00 a.m. at the Nevada State College located at 303 S. Water Street, Room 119, Henderson, Nevada and Western Nevada College located at Cedar Building, Room 307, 2201 W. College Parkway, Carson City, Nevada. Thereafter on or about December 18, 2015, the Administrator of the Department of Business and Industry, Division of Industrial Relations (Administrator) issued a Notice of Intent to Act on Proposed Regulations which incorporated in the proposed amendments the suggestions of the parties attending the January 5, 2015 workshop. A public hearing was held via videoconference on February 18, 2016, at 9:00 am at the Grant Sawyer Building, 555 E. Washington Avenue, Room 4412, Las Vegas, Nevada and the Legislative Building, 401 S. Carson Street, Room 2135, Carson City, Nevada.

A copy of this summary of the public response to the proposed regulation may be obtained from Donald C. Smith, Esq. Senior Division Counsel, at Division of Industrial Relations,

1301 N. Green Valley Pkwy., #200, Henderson, NV 89074, 702-486-9070, or e-mail to donaldcsmith@business.nv.gov.

3. The number of persons who:

(a) Attended each hearing;

(b) Testified at each hearing; and

(c) Submitted to the agency written comments.

4. For each person identified in paragraphs (b) and (c) of number 3 above, the following information, if provided to the agency conducting the hearing:

(a) Name;

(b) Telephone number;

(c) Business address;

(d) Business telephone number;

(e) Electronic mail address; and

(f) Name of entity or organization represented.

At the **January 5, 2015 Workshop**, which was held at two sites via videoconference, in Henderson 11 attended; in Carson City 8 attended, with testimony received from five (5) attendees. A summary of the testimony at this public hearing follows:

Mike Livermore, Alternative Service Concepts, LLC, 639 Isbell Road, Suite 390, Reno, NV 89509-4993; Telephone: (775) 329-1181; E-mail: james.livermore@ascrisk.com.
Regarding Section 1, this new section for transferring of claims, they would like to know why is this being proposed and why is it necessary? It appears to him that it would be much simpler to require that, this printed report of all claims that are opened and the location of those files are transmitted to DIR when all the transfers take place, then DIR has all the information and can place it in the DIR's Index of Claims.

Regarding Section 2, the regulations already talk about "copies of all claim files obtained by an insurer must be maintained in this state". The regulations that are being proposed should move into the 21st century and address electronic claim files. Paper claim files aren't maintained anymore, they are kept on computer servers which are often located outside Nevada. This section needs to be completely restated to deal with electronic claim files. Moving to subsection that's being amended, that talks about "the correspondence that needs to be addressed TPA etc., etc., at one of the offices located in this state". It deletes "the correspondence and documents shall be deemed to be officially received only if they have been so addressed". Why is that language being stricken? I think the existing language is appropriate and needs to remain in the regulation. I suggest additional language that not only must it be addressed to the insurer at one of the offices within the state to but must be submitted by first class United States Mail; and an additional statement that mandates that the injured worker or their attorney or representative shall notify the insurer or their third party administrator of any changes in their mailing address, as NRS 616C.315 subsection.

Regarding Subsection 2 of Section 5 talks about the term "receipt" and this provides the definition, "to mean a written acknowledgement from the U.S. Postal Service of its acceptance for mailing" then it goes on to talk about how a "written determination by an insurer denying the claim in whole or in part". Why not just say the determination made in accordance with NRS 616C.065, subsection 10 instead of spelling it out. There's no verification in their written acknowledgement that the contents of that envelope are the so

called written determinations. I suggest that everywhere that statement is made, that the language be deleted and just insert, "the determination rendered in accordance with NRS 616C.065, subsection 10.

Regarding Section 5, subsection 6, please clarify why is this necessary? I'm sorry but they can always make a request, for anything at any time. Even if they just made the same request yesterday. Each time we have to answer that with a new determination with appeal rights so I think it's redundant and superfluous to have subsection 1 and subsection 6 at all. I'm not sure that this regulation can address that. I think that perhaps that needs to be addressed in the statute rather than in the regulations supplementing the statute. I object to Section 5, Subsections 1 and 6 on the basis that that needs to be a statutory change.

Regarding Section 7, which has to do with direct deposit, the proposed language states, we "shall within 60 days after receipt of the written notice, establish a direct deposit". I think that is probably in most cases adequate time. So I'm a little bit leery of having that mandate of 60 days without the caveat allowing for certain exceptions so maybe there should be something additionally that stating that in so far as there are no, the financial institution requested can accommodate the direct deposit or something, I would request that there be some kind of granting of an exception in certain instances, including an additional statement that the injured worker has to provide a request for a financial institution that can, in fact, accept direct deposits.

Deena Carson, Workers Comp Manager, Hometown Health, 830 Harvard Way, Reno, NV 89502; Telephone: (775) 982-3049; E-mail: DCarson@hometownhealth.com.
Further comment on Section 7, consider adding language that if the benefit of direct deposit could not be established within 60 days that a determination with appeal rights be issued to the injured worker explaining the circumstances.

Mike Livermore, Alternative Service Concepts, LLC, 639 Isbell Road, Suite 390, Reno, NV 89509-4993; Telephone: (775) 329-1181; E-mail: james.livermore@ascrisk.com.
I agree with Ms. Carson's suggestion, which would certainly make things workable.

Regarding Section 8, subsection 1, I object to this kind of micro claims management being imposed upon the third party administrator or the insurer, spelling out in detail every step that you got to follow in certain time frames or else you're going to get smacked with a fine or some other situation. Subsection 1 talks about "placing an order for purchase and modify a motor vehicle," I think this needs to be an "or" because you're not just going to place an order for, purchase and modify. You might purchase the thing all ready and done. So I think that should be an "or" place an order for a purchase "or" modifying a motor vehicle for the injured employee. But, I think that it needs to have an additional statement. The statute talks about, if the employee, modified, you could modify a vehicle that the injured worker already owns. Well, that has to be in there. The proposed language does not conform to the statute, Subsection (a) of subsection 3, subsection 2 of NRS 616C.245. So that needs to be fixed, so that we are only purchasing, placing orders and modifying new vehicles if the injured employees don't already own it were already doing modifications to the injured workers' new vehicles.

Section 8, Subsection 2, the insurer shall determine the make and model of the motor vehicle based on the medical requirements and physical restrictions. I wanted to add the statement that if a vehicle, new or used, is purchased pursuant to subsection 3(b) or 3(c), NRS

616C.245. Subsection 3 of NRS 616C.245 already says, "…if an injured employee is entitled to receive a motor vehicle pursuant to subsection 2, a motor vehicle must be modified to allow the employee to operate it safely" And then there's an order preference. So why these regulations, when it's already in the statute, rather specifically in clear text? Subsection 3, "shall as applicable, purchase and modify as needed and at least as often as every 10 years or 120,000 miles driven, whichever occurs first". What if the injured worker doesn't provide the care and maintenance of the vehicle as required by statute? There appears a need to place language in the regulation that places the responsibility, the burden, upon the injured worker to take care of the vehicle, not just for the insured to automatically have to go out there every ten years or 120,000 miles and buy a brand new one and modify it and pay more money.

The Administrator should adopt regulations establishing a maximum benefit as stated in subsection 4, NRS 616C.245. The Administrator shall establish a maximum benefit to be paid under the provisions of this section. The DIR should place the responsibility for the injured worker to fulfill his duty of maintenance of the motor vehicle. Maybe they should be held to a standard that they have proof that they have maintained it, that they have to service it every 3000 miles or whatever it is for modern cars.

Subsection 4 says it is the responsibility of the employee to maintain the vehicle but it doesn't say what happens if they don't do it. In this whole process, workers compensation, it's not a two way street. The whole burden is on the insurer and the third party administrator to provide the benefits. And there is nothing, no responsibility placed upon the injured worker to do things like that. There's no penalty if they fail to do it. So the regulation needs to take that into account.

Deena Carson, Workers Comp Manager, Hometown Health, 830 Harvard Way, Reno, NV 89502; Telephone: (775) 982-3049; E-mail: DCarson@hometownhealth.com.
I agree there should be something in this regulation that requires, not only requires them to have coverage and do the maintenance, but that if in the event that car is totaled, and they have lapsed in their insurance, that a car is not purchased for them to replace the one they did not insure.

Jim Werbeckes, Vice President Government & Regulatory Affairs, EMPLOYERS, 10375 Professional Circle, Reno, Nevada 89521; (775) 327-2458. This issue was brought forth by Employers back in 2003. Employers wanted this regulation to put some standards and some limitations on how many vehicles we have to purchase. And you are correct, if an injured employee under today's rules got a car, we'd purchase the vehicle, turns around and smashes it tomorrow didn't have insurance, we'd be on the hook and we've had several instances where that has occured. So that is why we have requested Section 8 of this regulation. I do agree with some of Mr. Livermore's comments regarding subsection 1 of that section, putting some caveats under there. But other than that, I mean, we support this section. We would like to see this thing stay intact. I believe subsection 4 this section covers the comprehensive collision coverage on there, if they don't have it. And maybe I would like to have the DIR to go on record that if the individiual doesn't have coverage, and fails to maintain his coverage that we would not be obligated to pay for a new vehicle. On the way this is drafted today.

Mike Livermore, Alternative Service Concepts, LLC, 639 Isbell Road, Suite 390, Reno, NV 89509-4993; Telephone: (775) 329-1181; E-mail: james.livermore@ascrisk.com.

I want to thank Jim for that clarification and with that explanation I certainly support Section 8. I guess it's the injured workers' responsibility, I think it needs to be spelled out explicitly so that hearing officers, appeals officers or higher courts don't go, oh well, but how is he supposed to get to the store…buy a new one... I want it to say "failure of the injured employee to maintain insurance and/or provide appropriate maintenance or standard maintenance in the care of the vehicle will result in denial of that benefit".

Deena Carson, Workers Comp Manager, Hometown Health, 830 Harvard Way, Reno, NV 89502; Telephone: (775) 982-3049; E-mail: DCarson@hometownhealth.com.
I agree.

Jim Werbeckes, Vice President Government & Regulatory Affairs, EMPLOYERS, 10375 Professional Circle, Reno, Nevada 89521; (775) 327-2458. Section 9, the way I read this is that, once the payment is approved, we are now supposed to stamp the bill approved. For what purpose? We have those dates in our claim files, they are in our electronic system. They are paid timely. They don't have a stamp dated across the top of them that these bills have been approved. The dates of approval and payment will be in the log notes and everything else that we approved the bill. We oppose subsection 2 in Section 9.

Greg Schaefer, Gallegher Bassett Services Inc., 2110 E. Flamingo Rd., #314, Las Vegas, NV 89119-0834; Telephone: (866) 889-4755; E-mail: gregory_schaefer@gbtpa.com.
Regarding Subsection 1 of Section 9, date stamping of each document received, we need to go into the 21st century. Most of the documents received by our office are received electronically, so to have to print every document that we receive electronically just to date stamp it and then rescan it back into the system is quite costly. This should be amended. If we can show when we received it electronically in the claim notes that should suffice.

Mike Livermore, Alternative Service Concepts, LLC, 639 Isbell Road, Suite 390, Reno, NV 89509-4993; Telephone: (775) 329-1181; E-mail: james.livermore@ascrisk.com.
We have moved into the electronic era and in conjunction with changing this regulation, it's time for DIR to deal with that. I don't think anyone is using paper files any more, they are all electronic. And even in the case of reopened claim files. I think it should be enough for the regulatory purpose that all it needs to be said is the insurer shall ensure, that's with an "e", ensure, when the electronic bill or claim was received, they have some kind of documentation in their claim process that they can reproduce and so that it's visible to a reviewer like a regulator, for all of these different steps. That's what our's does. Our EOB indicates the date received, the date received by the insurer, the date received by bill processor, the date payment was made, and the date of the EOB. In the actual check generating process date that is recorded the transaction date the check is issued or processed. I would like to see something of that kind occur and changing this whole regulation of 616C.082 to reflect dealing with paperless electronic claim files.

Regarding Section 9, Subsection 2, the regulation deals with paper more than anything. I haven't completely thought this through in terms of how it might read to speak to electronic stuff, electronic claim files. Probably it's okay because these things all have to, everything that gets submitted in paper is converted and submitted into electronic claim files. I would appreciate as a part of the revision of regulation NAC 616C.032 section 9 of the regulations proposed, spelled out how does DIR want this? Is it chronological by date received or what? With paper files, as the claim file grows it becomes multiple volumes and sometimes whole

filing cabinets over the course of a lifespan. It's helpful for purposes of PPD and for separating any records for rating doctors, IMEs and you name it. It's practical to have the medical records at least organized in chronological order by the date of the report. In other aspects sometimes it's practical to have, in actually administering the claim, to having the correspondence and replies organized by the date on the document, as opposed to the date it was received. Typically, for medical reports having things completely out of order by the date received because we may not get a doctor's report until months down the road. And sometimes a year. It happens they don't get resubmitted properly with the medical report or the bill. So anyway, some leeway in terms of that chronological order, in terms of medical reporting, can be kept in chronological order by the date of the report whereas, perhaps, everything else needs to be kept by date of receipt.

Regarding Section 10, what needs to be kept in the claim files, we need to know, is it okay to put the medical reports in chronological order by date of service so we can follow the medical progress? And the Doctors can see what they do in IME and everything is in order for them. When it goes to a PPD, everything is in order for them. We're required by regulation to provide them in date order, date of service order for the PPD. If we can keep them in the claim files in that order that would be nice as opposed to having to reshuffle them all, and put them back in date received.

On Section 11, I suggest the proposed language be revised from you can add more third party administrators. The insurer shall give written notice of its determination to accept or deny the claim, etc.… I think that should just simply state its determination pursuant to NRS 616C.065 subsection 1. Because I think otherwise it conflicts with that statute's subsection 5. And delete all of the language all the way up to the attorney, authorized representative, blah blah blah, appendix and beginning with and, to the injured employee's employer. I don't see why that needs to be spelled out because I thought we were supposed to provide a copy of everything we do to the employer. I guess I don't object to that.

On Section 11, one of the things that's missing from subsection 1 however, is it talks about taking copies to the injured employee, etc. but what if they're dead? You know I can't really send it to them. And I think there needs to be a caveat in there that talks about in the event of death to the person acting on behalf of the injured employee. So I think that we have to clean up the language. I don't object to the doing of this, it's just I think I would clean things up a bit, a little bit. Denial of claims, Subsection 2. Again, I would prefer just say the denial pursuant to NRS 616C.065 subsection 1(b), I think that's a simpler statement. Then it talks about, subsection (b) of subsection 2, talks about the things that have to be in the notice of denial, subsection 2 there talks about a specific statement concerning the reasons for the denial of the claim. But it doesn't really explain or define what that specific statement might be. I understand what you're trying to do because I can imagine, I guess, claims adjusters out there are just sending out a notice saying your claim is denied, appeal it. I thought that the regulations were very clear the last 25 years that you have to tell them why. Obviously that didn't happen. What's the specific statement your claim is denied because it doesn't comport to statute, well, it doesn't tell them anymore. I think maybe there needs to be a little more clarification or explanation of what is meant by "specific statement concerning reasons, citation of statute." Subsection (c) talks about providing a copy of the denials, etc., that gives pursuant to paragraph (b), denial of a claim providing it to the employee's treating physician. Well, when I look at a new claim within the first 30 days, the injured employee doesn't have, often, a treating physician, they have been to an emergency room. They have seen a doctor initially at the emergency room and they treated at the emergency room. Well, according to

regulation, as I recall, I don't remember the number, but it says that emergency room physicians can't be or aren't the treating physicians. So who are we supposed to send that to? How about the caveat, that, if the injured worker has a treating physician selected pursuant that cite the proper statute. Otherwise I can envision the DIR claims compliance auditor coming in and going, "Oh, where is your letter to the treating physician? There's no copy to the treating physician". Well, gee, they went to the ER three times. Who are we supposed to send that to? Something like that caveat would give us some room to breathe when we are audited. We'll do the best we can to send it to the appropriate party.

Subsection (d)(1), I again think rather than spelling it out just say pursuant to the statute and then cite the proper statute, 616C.051. And again for subsection 3, same objection; just say pursuant to the statute.

On Subsection 1 of Section 12, we would like to see in there the addition of the word "signed". Too often we get letters reported to be from the injured workers, has their address on it and so forth, but they're not signed, including C4 forms not signed. Seems to me that nothing is valid without the injured worker's signature. Subsection 1 would read, 'Except as otherwise provided in this section, within 30 days after receipt of a 'signed' written request 'submitted in compliance with NAC 616B.010(2),' relating to a claim made by:…". So the addition of the word "signed" before written and the addition of "submitted in compliance of 616B.010", which has to be submitted to the insurer's address.

Moving to subsection 3 of Section 12, which concerns reopening requests, my impression has been that only the injured employee can make a request to reopen. Maybe there needs to be something in there that only a "legitimate person" can make the request. Just a comment that I had because of the issue of doctors making requests to reopen. The injured worker apparently doesn't contact us or the administrator to find out how to do it. They didn't keep the paperwork we sent them with their closure documents. So, they go to the doctor and say, "Doctor it bothers me again. You need to reopen my claim." The doctor writes a report and sends it in with his bill and says we need to reopen the claim because the injured worker is here again he has got a backache its related, etc., etc. Well, there's a person making a request to reopen. And we're supposed to respond with a determination, and send copies to all these people. One, that's not a legitimate person making a request. Or it might come from someone that is not a representative of the injured worker.

On subsection 2 of Section 15, which adds the statement, "which must include notice of the right to appeal the transfer…Shall give written notice to all interested parties of the transfer of injured employee…" to a new physician … "which must include notice of the right to appeal the transfer." It's only the injured employee or their lawful representative that can appeal, not the physician, if I understand things correctly. Maybe it needs some clarification.

Deena Carson, Workers Comp Manager, Hometown Health, 830 Harvard Way, Reno, NV 89502; Telephone: (775) 982-3049; E-mail: DCarson@hometownhealth.com.
My quick question is, is this specifically to make certain that the insurers and TPA's are notifying injured workers that they are transferring their care to someone else? When we have somebody that goes to let's say to an orthopedist who decides they are not a surgical candidate, makes a referral to a physiatrist for conservative treatment, we're not doing a transfer of care, the injured worker is not requesting a transfer of care the referring physician is referring them to someone who can actually treat them. Just want some clarification concerning that. Assuming that then we should be sending out notifications when a transfer

of care is done by a treating physician. We typically do not if you're just referring them to "x" physiatrist instead of (inaudible). The injured worker disagrees with who we are sending them to.

Mike Livermore, Alternative Service Concepts, LLC, 639 Isbell Road, Suite 390, Reno, NV 89509-4993; Telephone: (775) 329-1181; E-mail: james.livermore@ascrisk.com.
On Section 15, subsection 8, I really appreciate that DIR has focused on this issue. The regulations have seldom if ever spelled out the time frames and obligations of treating physicians and others involved in the treatment of injured workers. Stating that the treating physician or chiropractor shall respond in writing to the insurer's written request not later than ten days after receiving the request. We make many other kinds of requests to doctors. Is this injured worker able to return to work? Are these restrictions okay? Can you release them to return to work? I'm not sure whether those would be interpreted as reports on the status of an injured employee.

On Section 19, I applaud DIR's amendments adding subsection 3 and giving some structure and declaring the maintenance of records, so forth, for rating physicians.

Jeanette Belz representing PCI and Liberty Mutual, J. K. Belz & Associates, 10580 N. McCarran Blvd., #115-222, Reno, NV 89503; Telephone: (775) 329-0119; E-mail: jb@jkbelz.com.
On Section 20, Subsection 2, Liberty Mutual would like to comment that effective October 15, 2015 all health care providers will be converted to ICD10 in accordance with a federal mandate. And although this mandate does not specifically apply to PMT carriers Liberty Mutual and others will be making this system conversion in compliance with that federal standard to avoid duplicative systems and confusion. Although the language in the regulation appears to allow for the most recently published version ICD it is not clear if it's ICD10 because there is a specific reference to ICD9.

Mike Livermore, Alternative Service Concepts, LLC, 639 Isbell Road, Suite 390, Reno, NV 89509-4993; Telephone: (775) 329-1181; E-mail: james.livermore@ascrisk.com.
On Section 24, the addition of subsection (g) section 1, a blood or urine test the glucose for a heart/lung exam I think that's great.

On Section 25, the change to subsection 2, allows for an agreement between the employer and employee, to allow the employee to assume the responsibility for scheduling their physicals to the heart/lung exam. Generally I'm okay with that I have a concern however, with what the employee's failure to follow through with scheduling over a period of time. What the effect that might have on their entitlement to benefits. I think the statutes and regulations are fairly silent about what occurs if a police officer, firefighter, fails to have their physical. With the burden being placed upon the employer. It gives the employer the mandate under statute and regulation to schedule and regulation requires the employee to attend all physicals as scheduled. So, it becomes like a personnel action where you're given a letter to go get you physical on this particular date. You go get your physical and if you fail to do it, the employer has some personnel action or authority to deal with that and I think we tend to have some statutory authority to say, you failed to get your physicals, therefore, you undermined the employer's protections to know that you are correcting predisposing conditions. And therefore, you're defeating the purpose of the statute and potentially having the justification to deny the claim that might occur down the road.

I just want to put it on the record some concerns that I have. I'm guessing maybe it doesn't change the situation a whole lot. If the employee fails to do what he is supposed to do based on the agreement, probably the same thing would apply. So it's not an objection, it's a comment.

Written comments were received for the January 5, 2015 public workshop and shortly thereafter. A summary of the written comments follows:

January 2, 2015 Comments from Kathleen G. Bissell, CPCU, Assistant Vice President & Senior Regional Director, Liberty Mutual Insurance, Public Affairs – 01A, 71 Stevenson Street, Suite 700, San Francisco, CA 94105; Telephone (415) 276-0703. Liberty Mutual is concerned that Section 20, amending NAC 616C.149(2) refers to the most recently published edition of the *International Classification of Diseases, Clinical Modification* as (ICD-9-CM) and notes that ICD-10-CM will effective on October 15, 2015. They request that the proposed language more clearly identify which version is adopted by reference.

Written Comments received January 5, 2015 from Craig Coziahr, ProGroup Management, Inc., 575 S. Saliman Road, Carson City, NV 89701; Telephone (775) 887-2480. ProGroup is concerned that Section 8, Subsection 5(b) adds a new provision which requires an insurer or employer to "Provide transportation, where available, for the injured employee, including without limitation, in the form of a monthly bus pass, public transportation or other appropriate means of transportation as determined by the insurer or employer, taking into consideration the medical requirements and physical restrictions of the injured employee." Is this a new requirement to provide transportation to and from medical appointments or work?

ProGroup is also concerned that Section 12, Subsection 2, which amends NAC 616C.094, should be limited to written requests from the injured employee "or authorized representative."

Finally, ProGroup is concerned that Section 15, Subsection 1 as written, which amends 616C.129, extends appeal rights to the new physician or chiropractor.

Written Comments dated January 19, 2015 from Mitchell D. Forman, D.O., President of the Nevada State Medical Association, 3660 Baker Lane, #101, Reno, NV 89509, Telephone: (775) 825-6788. The Association is concerned whether the new "10 day" requirement set forth in Section 15, Subsection 8 (NAC 616C.129(8)) means business or calendar days and suggests "business" days.

February 16, 2016 e-mail from Chris Bosse, **Renown, 50 West Liberty Street, Suite 1100, Reno, Nevada 89501; Telephone: 775-982-5761; E-mail: cbosse@renown.org.** Renown suggested that in Section 1(1)(a) and (b) the word "usable" be stricken and that "transferreable/readily convertible" be added instead. In (1)(b) Renown also suggested the insertion of the phrase, "to administer." Finally, they requested a new paragraph (1)(d) which would allow the receiving insurer or third party administrator 60 days to create or assume existing bank accounts and require the transferring entity to continue to pay all indemnity benefits during that transition period. In (2)(a) Renown suggest a 30 to 60 day

period based on the number of open claims being transferred, rather than a flat 30 day requirement for reviewing the files and determining actions to be taken on each claim.

In Section 4, defining terms in NRS 616C.065, subsection (2), Renown suggests that "certificate of receipt" should be "certificate of service."

In Section 5(2), the language should be rewritten to allow an injured employee to file an appeal of any insurer's failure to respond to a written request, rather than the proposed language which authorizes an injured employee make another written request when the insurer failed to respond.

In Section 10, amending NAC 616C.091, Renown suggests that the phrase, "injured employee, attorney or other authorized representative of the injured employee" be rewritten to read, "injured employee and attorney or other authorized representative of the injured employee." This phrase appears in NAC 616C.091, subsections (1) and (2)(b); Section 11, amending 616C.094(3); and Section 14, amending NAC 616C.129(2).

In Section 14, amending NAC 616C.129, Renown suggests new (8) and (9) which would control when an insurer or third party administrator could request a physician's or Chiropractor's Progress Report or Certificate of Disability, and authorize the provider to charge for resending previously provided documentation.

At the **February 18, 2016 Hearing on the Notice of Intent to Act on Proposed Regulations**, which was held at two sites via videoconference, in Las Vegas 7 attended; in Carson City 5 attended, with testimony received from two (2) attendees. A summary of the testimony at this public hearing follows:

Deena Carson, WorkersChoice in Hometown Health, 830 Harvard Way, Reno, Nevada 89502; Telephone: 775-982-3232; E-mail: dcarson@HometownHealth.com: On Section 1(1)(a) and (b) where it says provides "usable format" for transfer of conversion of data, we would prefer it says something more like "transferrable readily convertible data." We also suggest a new (1)(d) to allow up to 60 days to assume existing bank accounts and requiring the transferring insurer or third party administrator to comply with paying indemnity benefits. On Section 1(2)(a) the review time for the company receiving the files should be based on the number of open claims received.

On Section 4(2) [amending NAC 616C.065(2)] in terms of "certificate of service" for the certified mail. It does not say it has to have a certified receipt. Either it does or it doesn't. I think that needs to be clarified.

Jim Werbeckes, Vice President, Government and Regulatory Affairs, Employers Insurance Group, 10375 Professional Circle, Reno, Nevada 89521; Telephone: 775-327-2458; E-mail: jwerbeckes@employers.com: On Section 7, we hope the Division will finally adopt this regulation and move forward.

Deena Carson, WorkersChoice in Hometown Health, 830 Harvard Way, Reno, Nevada 89502; Telephone: 775-982-3232; E-mail: dcarson@HometownHealth.com: Under Section 14 [amending NAC 616C.129] we suggest a new subparagraph (8) limiting the

insurer or third party administrator's ability to request a written updated Certificate of Disability or medical status report.

Jim Werbeckes, Vice President, Government and Regulatory Affairs, Employers Insurance Group, 10375 Professional Circle, Reno, Nevada 89521; Telephone: 775-327-2458; E-mail: jwerbeckes@employers.com: On Section 14 [amending NAC 616C.129] this section has no teeth and I understand trying to get physicians to do this but I don't know how we can get these reports done in a timely fashion as it appears we don't get them in a timely fashion.

No written comments were received before the March 3, 2016 deadline for written comments.

5. A description of how comment was solicited from affected businesses, a summary of their response, and an explanation how other interested persons may obtain a copy of the summary.

The Division sent by U.S. Mail and via e-mail the Notice of Public Workshops to Solicit Comments on Proposed Regulations to over 2,450 persons who were known to have an interest in the subject on Chapters 616A through 616D, inclusive, and 617 of the Nevada Administrative Code, as well as any persons who had specifically requested such notice.

A copy of this summary of the public response to the proposed regulations may be obtained from Donald C. Smith, Esq. at the Division of Industrial Relations, Legal Department, 1301 N. Green Valley Pkwy., #200, Henderson, NV 89074, telephone (702) 486-9070, or e-mail to donaldcsmith@business.nv.gov.

6. If the regulation was adopted without changing any part of the proposed regulation, a summary of the reasons for adopting the regulations without change.

A number of revisions were suggested at the February 18, 2016 hearing and written comments received before that hearing, some of which were not incorporated into the proposed regulation by the Division. Each of those suggested revisions which were not adopted is discussed separately below.

A suggestion was made that in Section 1, subsections (1)(a) and (b) the word "usable" be stricken and that "transferrable/readily convertible" be added instead. The Division believes that the regulation as proposed is more appropriate because the suggested change could be perceived as placing an unnecessary burden on the transferring insurer or third-party administrator.

A suggestion was made that Section 1, subsection (1)(b) the phrase, "to administer and" be inserted before the word "comply." This suggestion change appears redundant.

A suggestion was made that Section 1 have a new paragraph subsection (1)(d) which would allow the receiving insurer or third party administrator 60 days to create or assume existing bank accounts and require the transferring entity to continue to pay all indemnity benefits during that transition period. The proposed regulation as drafted requires that compensation

payments be made by the transferring insurer or third-party administrator, until accounts have been established and funded with the receiving entity and a specific time period to accomplish this task appears to be an unnecessary interference by the Division.

On Section 1, subsection (2)(a) a suggestion was made that a 30 day limitation to review transferred claim files be expanded to 30 to 60 days based on the number of open claims being transferred. This suggestion was not incorporated into the proposed regulation as the receiving entity will know the number of claims being transferred and should staff appropriately during the transition to assure that all appropriate benefits are being provided to injured employees.

A suggestion was made that Section 5 subsection (2), the language should be rewritten to allow an injured employee to file an appeal of any insurer's failure to respond to a written request. This suggestion was not incorporated because the proposed regulation is considered clearer than the proposed language.

A suggestion was made that in Section 10, amending NAC 616C.091, the phrase, "injured employee, attorney or other authorized representative of the injured employee" be rewritten to read, "injured employee and attorney or other authorized representative of the injured employee." This same phrase also appears in NAC 616C.091, subsections (1) and (2)(b); Section 11, amending 616C.094(3); and Section 14, amending NAC 616C.129(2). This suggested change was not incorporated into the proposed regulation as the language as drafted is appropriate.

A suggestion was made that Section 14, amending NAC 616C.129, include new subsections (8) and (9) which would control when an insurer or third party administrator could request a physician's or Chiropractor's Progress Report or Certificate of Disability, and authorize the provider to charge for resending previously provided documentation. This language was not incorporated into the proposed regulation as it would overly complicate the medical reporting and create an additional expense to the insurer.

7. The estimated economic effect of the adopted regulation on the businesses which it is to regulate and on the public. These must be stated separately, and each case must include:

(a) Both adverse and beneficial effects; and

(b) Both immediate and long-term effects.

(a) Both adverse and beneficial effects.

There are no adverse or beneficial economic effects that would impact regulated businesses. The possible adverse economic effects, if any, on the regulated businesses might be small changes in their processes and procedures in handling specific issues. The beneficial economic effects on the regulated businesses are additional clarity in the existing regulations. There are no adverse or beneficial economic effects that would impact the general public.

(b) Both immediate and long-term effects.

There are no immediate or long-term economic effects that would impact regulated businesses. The possible immediate economic effects, if any, on the regulated businesses might be small changes in their processes and procedures in handling specific issues. The long-term economic effects on the regulated businesses are additional clarity in the existing regulations. There are no immediate or long-term economic effects that would impact the general public.

8. The estimated cost to the agency for enforcement of the adopted regulation.

There is no additional cost to the agency for enforcement of this regulation.

9. A description of any regulations of other state or government agencies, which the proposed regulation overlaps or duplicates and a statement explaining why the duplication or overlapping is necessary. If the regulation overlaps or duplicates a federal regulation, the name of the regulating federal agency.

There are no other state or government agency regulations that the proposed amendments duplicate.

10. If the regulation includes provisions that are more stringent than a federal regulation which regulates the same activity, a summary of such provisions.

The proposed regulation does not include any provisions which duplicate or are more stringent than existing federal, state or local standards.

11. If the regulation provides a new fee or increases an existing fee, the total annual amount the agency expects to collect and the manner in which the money will be used.

The proposed regulations do not provide for a new fee or increase an existing fee.

12. Is the proposed regulation likely to impose a direct and significant economic burden upon a small business or directly restrict the formation, operation or expansion of a small business? What methods did the agency use in determining the impact of the regulation on a small business?

The Administrator has determined that the proposed regulation does not impose a direct and significant economic burden upon a small business or restrict the formation, operation or expansion of a small business. In making this determination the Administrator considered the purpose and scope of the proposed and potential

regulation changes in conjunction with existing regulations. Based on this review, the Division determined that these regulations may have some minimal financial impact on insurers, third-party administrators, employee leasing companies and the employers of firefighters, police officers and arson investigators, which may be required to revise their business processes and will not directly restrict the formation, operation or expansion of a small business.