ADOPTED REGULATION OF THE ADMINISTRATOR OF THE

DIVISION OF INDUSTRIAL RELATIONS OF THE

DEPARTMENT OF BUSINESS AND INDUSTRY

LCB File No. R105-00

Effective March 1, 2001

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

AUTHORITY: §§1, 2, 4-13, 23, 44, 50 and 92-100, NRS 616A.400; §§3, 25, 26 and 45, NRS 616A.400 and 616A.417; §§14-18, NRS 616A.400 and 616C.090; §§19, 21, 24, 47 and 48, NRS 616A.400 and 616C.490; §20, NRS 616A.400, 616C.090 and 616C.490; §22, 616A.400, 616C.135 and 616C.260; §§27, 39, 41 and 42, NRS 616A.400, 616C.250 and 616C.260; §28, NRS 616A.400 and 616C.130; §§29-38, 40 and 43, NRS 616A.400 and 616C.260; §46, NRS 616A.400 and 616C.110; §49, NRS 616A.400, 616C.485 and 616C.495; §§51-61 and 67-91, NRS 616A.400 and 616D.120; §62, NRS 616A.400 and 616C.040; §63, NRS 616A.400 and 616C.045; §64, NRS 616A.400 and 616C.135; §65, NRS 616A.400 and 617.352; §66, NRS 616A.400 and 617.354.

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

The administrator will perform each duty he is required to perform pursuant to this chapter and chapters 616B to 617, inclusive, of NAC or will designate a person to perform the duty on his behalf.

Sec. 2. NAC 616A.430 is hereby amended to read as follows:

616A.430 A brief explanation of the procedure for obtaining clarification of NAC 616A.420, ~~[616B.457, 616B562,]~~ 616C.091, 616C.094, 616C.182 to 616C.218, inclusive, 616C.423, 616C.447 or 616C.502, or relief from the strict application of any of their terms may be obtained from the Division of Industrial Relations, 400 West King Street, Suite 400, Carson City, Nevada 89710.

Sec. 3. NAC 616A.480 is hereby amended to read as follows:

616A.480 1. The following posters and forms or data must be used by ~~[each]~~ ***an*** insurer ***, employer, injured employee, provider of health care, organization for managed care or third-party administrator*** in the administration of claims for workers' compensation:

(a) D-1, Informational Poster - Displayed by Employer. The informational poster must include the language contained in Form D-2, and the name, business address, telephone number and contact person of:

(1) The insurer;

(2) The third-party administrator, if applicable;

(3) The organization for managed care or providers of health care with whom the insurer has contracted to provide medical and health care services, if applicable; and

(4) The name, business address and telephone number of the insurer's or third-party administrator's adjuster in this state that is located nearest to the employer's place of business.

(b) D-2, Brief Description of Your Rights and Benefits if You Are Injured on the Job.

(c) C-1, Notice of Injury or Occupational Disease (Incident Report). One copy of the form must be delivered to the injured employee, and one copy of the form must be retained by the employer. The language contained in Form D-2 must be printed on the reverse side of the employee's copy of the form, or provided to the employee as a separate document with an affirmative statement acknowledging receipt.

(d) C-3, Employer's Report of Industrial Injury or Occupational Disease. A copy of the form must be delivered to or the form must be filed by electronic transmission with the insurer or third-party administrator. The form signed by the employer must be retained by the employer. A

copy of the form must be delivered to the injured employee. If the employer files the form by electronic transmission, the employer must:

(1) Transmit all fields of the form that are required to be completed, as prescribed by the administrator.

(2) Sign the form with an electronic symbol representing the signature of the employer that is:

(I) Unique to the employer;

(II) Capable of verification; and

(III) Linked to data in such a manner that the signature is invalidated if the data is altered.

(3) Acknowledge on the form that he will maintain the original report of industrial injury or occupational disease for 3 years.

FLUSH If the employer moves from or ceases operation in this state, the employer shall deliver the original form to the insurer for inclusion in the insurer's file on the injured employee within 30 days after the move or cessation of operation.

(e) C-4, Employee's Claim for Compensation/Report of Initial Treatment. A copy of the form must be delivered to the insurer or third-party administrator. A copy of the form must be delivered to or the form must be filed by electronic transmission with the employer. A copy of the form must be delivered to the injured employee. The language contained in Form D-2 must be printed on the reverse side of the injured employee's copy of the form or provided to the injured employee as a separate document with an affirmative statement acknowledging receipt. The original form signed by the injured employee and the physician or chiropractor who conducted the initial examination of the injured employee must be retained by that physician or

chiropractor. If the physician or chiropractor who conducted the initial examination files the form by electronic transmission, the physician or chiropractor must:

(1) Transmit all fields of the form that are required to be completed, as prescribed by the administrator.

(2) Sign the form with an electronic symbol representing the signature of the physician or chiropractor that is:

(I) Unique to the physician or chiropractor;

(II) Capable of verification; and

(III) Linked to data in such a manner that the signature is invalidated if the data is altered.

(3) Acknowledge on the form that he will maintain the original form for the claim for compensation for 3 years.

FLUSH If the physician or chiropractor who conducted the initial examination moves from or ceases treating patients in this state, the physician or chiropractor shall deliver the original form to the insurer for inclusion in the insurer's file on the injured employee within 30 days after the move or cessation of treatment of patients.

(f) D-5, Wage Calculation Form for Claims Agent's Use.

(g) D-6, Injured Employee's Request for Compensation.

(h) D-7, Explanation of Wage Calculation.

(i) D-8, Employer's Wage Verification Form.

(j) D-9(a), ~~[PPD]~~ ***Permanent Partial Disability*** Award Calculation Worksheet.

(k) D-9(b), ~~[PPD]~~ ***Permanent Partial Disability*** Award Calculation Worksheet for Disability Over 25 Percent Body Basis.

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

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

(n) D-11, Reaffirmation of Lump Sum Request.

(o) D-12(a), Request for Hearing ~~[.]~~ ***- Contested Claim.***

(p) D-12(b), Request for Hearing - Uninsured Employer.

(q) D-13, Injured Employee's Right to Reopen a Claim Which Has Been Closed.

(r) D-14, Permanent Total Disability Report of Employment.

(s) D-15, Election for Nevada Workers' Compensation Coverage for Out-of-State Injury.

(t) D-16, Notice of Election for Compensation Benefits Under the Uninsured Employer Statutes.

(u) D-17, Employee's Claim for Compensation - Uninsured Employer.

(v) D-18, Assignment of Claim for Workers' Compensation - Uninsured Employer.

(w) D-21, Fatality Report.

(x) D-22, Notice to Employees - Tip Information.

(y) D-23, Employee's Declaration of Election to Report Tips.

(z) D-24, Request for Reimbursement of Expenses for Travel and Lost Wages.

(aa) D-25, Affirmation of Compliance ~~[(Business Application).]~~ ***with Mandatory Industrial Insurance Requirements.***

(bb) D-26, Application for Reimbursement of Claim-Related Travel Expenses.

(cc) D-27, Interest Calculation for Compensation Due.

(dd) D-28, Rehabilitation Lump Sum Request.

(ee) D-29, Lump Sum Rehabilitation Agreement.

(ff) D-30, Notice of Claim Acceptance.

(gg) D-31, Notice of Intention to Close Claim.

(hh) D-32, Authorization Request for Additional Chiropractic Treatment.

(ii) D-33, Authorization Request for Additional Physical Therapy Treatment.

(jj) D-34, ~~[HCFA]~~ ***Health Care Financing Administration*** 1500 Billing Form.

(kk) D-35, ***Request for a*** Rotating Rating Physician ~~[/Chiropractor Request.]~~ ***or Chiropractor.***

(ll) D-36, Request for Additional Medical Information and Medical Release.

(mm) D-37, Insurer's Subsequent Injury Checklist.

(nn) D-38, Injured Worker Index System Claims Registration Document.

(oo) D-39, Physician's Progress Report - Certification of Disability.

(pp) D-40cc, ~~[HRS]~~ ***Industrial Insurance Regulation Section*** Noncompliance Premium.

(qq) D-40lv, ~~[HRS]~~ ***Industrial Insurance Regulation Section*** Noncompliance Premium.

(rr) D-41, ~~[HAIABC]~~ ***International Association of Industrial Accident Boards and Commissions*** POC 1.

(ss) D-43, ~~[Employer]~~ ***Employee's*** Election to Reject Coverage and Election to Waive the Rejection of Coverage for Excluded Persons.

(tt) D-44, Election of Coverage by Employer; Employer Withdrawal of Election of Coverage.

(uu) D-45, Sole Proprietor Coverage.

(vv) D-46, Temporary Partial Disability Calculation Worksheet.

(ww) D-47, Noncompliance Notice.

(xx) D-48, Proof of Coverage Notice.

(yy) D-49, Information Page.

(zz) D-50, Policy Termination, Cancellation and Reinstatement Notice.

(aaa) D-51, Employer's Request for Hearing of Administrator's Determination.

2. In addition to the forms specified in subsection 1, the following forms must be used by each insurer in the administration of a claim for an occupational disease:

(a) OD-1, Firemen and Police Officers' Medical History Form.

(b) OD-2, Firemen and Police Officers' Lung Examination Form.

(c) OD-3, Firemen and Police Officers' Extensive Heart Examination Form.

(d) OD-4, Firemen and Police Officers' Limited Heart Examination Form.

(e) OD-5, Firemen and Police Officers' Hearing Examination Form.

(f) OD-6, Firemen and Police Officers' Sample Letter.

(g) OD-7, Information Regarding Physical Examinations for Firemen and Police Officers.

3. ***The forms listed in this section must be accurately completed, including, without limitation, a signature and a date, if required by the form. An insurer or employer may designate a third-party administrator as an agent to sign any form listed in this section.***

4. An insurer, employer, injured employee, provider of health care ~~[or claims agent]~~ ***, organization for managed care or third-party administrator*** may not use a different form or change a form without the prior written approval of the administrator ***.*** ~~[or his designee.~~

~~4.]~~ ***5.*** The industrial insurance regulation section will be responsible for printing and distributing the following forms:

(a) C-4, Employee's Claim for Compensation/Report of Initial Treatment;

(b) D-12(b), Request for Hearing - Uninsured Employer;

(c) D-16, Notice of Election for Compensation Benefits Under the Uninsured Employer Statutes;

(d) D-17, Employee's Claim for Compensation - Uninsured Employer; and

(e) D-18, Assignment of Claim for Workers' Compensation - Uninsured Employer.

~~[5.]~~ ***6.*** Each insurer ***or third-party administrator*** is responsible for printing and distributing all other forms listed in this section. ***The provisions of this subsection do not prohibit an insurer, employer, provider of health care, organization for managed care or third-party administrator from providing any form listed in this section.***

7. Upon the request of the administrator, an insurer, employer, provider of health care, organization for managed care or third-party administrator shall submit to the administrator a copy of any form used in this state by the insurer, employer, provider of health care, organization for managed care or third-party administrator in the administration of claims for workers' compensation.

Sec. 4. Chapter 616B of NAC is hereby amended by adding thereto the provisions set forth as sections 5 to 8, inclusive, of this regulation.

Sec. 5. ***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 injured employees who received benefits for vocational rehabilitation.

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

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

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

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

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

(o) 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) Amounts recovered:

(1) By subrogation of claims.

(2) From the:

(I) Subsequent injury fund for self-insured employers established pursuant to NRS 616B.554;

(II) Subsequent injury fund for associations of self-insured public or private employers established pursuant to NRS 616B.575; or

(III) Subsequent injury fund for private carriers established pursuant to NRS 616B.584.

(3) From other sources.

(q) 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 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 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. 6. *1. An insurer shall ensure that the files of claims and records maintained by the insurer pursuant to chapters 616A to 617, inclusive, of NRS or a regulation adopted pursuant thereto are available for inspection by the commissioner or his designee or by the administrator during regular business hours.*

2. All files of the claims must be kept, maintained and administered in this state.

3. After reviewing the file of a claim, the commissioner or administrator will report his findings to the insurer.

Sec. 7. *1. Within 30 days after an insurer receives notice that an employee has been:*

(a) Involved in an accident; or

(b) In close proximity to or has had contact with a disease-causing agent that may have a harmful effect on the employee,

FLUSH ***the insurer shall notify the administrator if the accident resulted in injury to, or the exposure to the disease-causing agent affected or is expected to affect, two or more persons.***

2. Within 48 hours after the insurer receives notice of a fatality that resulted from:

(a) An accident that an employee was involved in; or

(b) The close proximity to or contact with a disease-causing agent by the employee,

FLUSH ***the insurer shall notify the administrator of the fatality by submitting Form D-21, Fatality Report, to the administrator.***

Sec. 8. ***Not later than the date that compensation is due to a claimant, an insurer or third-party administrator shall:***

1. Mail a check for compensation to the claimant; or

2. Make a check for compensation available to the claimant in the office of the insurer or third-party administrator.

Sec. 9. NAC 616B.010 is hereby amended to read as follows:

616B.010 1. Except as otherwise provided in ~~[NAC 616B.454 and 616B.561,]~~ ***section 6 of this regulation,*** copies of all claim files maintained by an insurer, third-party administrator or organization for managed care pursuant to chapters 616A to 617, inclusive, of NRS or regulations adopted pursuant thereto must be maintained in one of its offices located in this state.

2. All correspondence and other documents submitted to an insurer, third-party administrator or organization for managed care that concern a claim for compensation that is being administered pursuant to chapters 616A to 617, inclusive, of NRS or regulations adopted pursuant thereto must be addressed to the insurer, third-party administrator or organization for

managed care at one of its offices located in this state. ~~[Such]~~ ***The*** correspondence and documents shall be deemed to be officially received only if they have been so addressed.

Sec. 10. NAC 616B.133 is hereby amended to read as follows:

616B.133 1. An association shall submit proof of coverage to the designated agent by:

(a) The United States Postal Service or any other mail delivery service by submitting Form D-41, ~~[IAIABC]~~ ***International Association of Industrial Accident Boards and Commissions*** POC 1; or

(b) Electronic transmission.

2. A private carrier shall submit proof of coverage to the designated agent by:

(a) Electronic transmission; or

(b) The United States Postal Service or any other mail delivery service.

3. If the private carrier does not use Form D-41, ~~[IAIABC]~~ ***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.

4. 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. 11. NAC 616B.800 is hereby amended to read as follows:

616B.800 1. If an employer elects to cover an employee who is excluded from the benefits of chapters 616A to 617, inclusive, of NRS pursuant to NRS 616A.110 or if the employer subsequently wishes to withdraw such an election, the written statement or notice that the employer is required to provide pursuant to subsection 2 of NRS 616B.656 to his insurer and the administrator ~~[or his designated agent]~~ must be served personally or sent by first-class mail on a completed form entitled D-44, Election of Coverage by Employer and Employer Withdrawal of Election of Coverage ***,*** ~~[Pursuant to NRS 616B.656,]~~ which is prescribed by the administrator, or, if sent by electronic transmission, the notice must contain the same information as the form. The notice must be provided within 30 days after the effective date of the election or withdrawal. The employer is not required to serve ~~[such]~~ ***the*** notice on the administrator ~~[or his designated agent]~~ if notice is served on the administrator ~~[or his designated agent]~~ by the insurer on behalf of the employer.

2. If an employee that is excluded from the benefits of chapters 616A to 617, inclusive, of NRS pursuant to NRS 616A.110 rejects coverage elected by his employer pursuant to NRS 616B.656 or if the employee subsequently elects to waive such a rejection, the written notice that the employee must provide to his employer, the insurer of his employer and the administrator ~~[or his designated agent]~~ pursuant to subsection 3 of NRS 616B.656 must be served personally or sent by first-class mail on a completed form entitled D-43, ~~[Employee]~~ ***Employee's*** Election to Reject Coverage and Election to Waive the Rejection of Coverage for Excluded Persons ***,*** ~~[Pursuant to NRS 616B.656,]~~ which is prescribed by the administrator, or, if sent by electronic transmission, the notice must contain the same information as the form. The notice must be provided within 30 days after the effective date of the election or rejection. The employee is not

required to serve ~~[such]~~ ***the*** notice on the administrator ~~[or his designated agent]~~ if notice is served on the administrator ~~[or his designated agent]~~ by the insurer on behalf of the employee.

~~[3. If an employer fails to provide the notice required pursuant to NRS 616B.656 and in the manner set forth in this section, the administrator will, after notice and hearing:~~

~~(a) For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.~~

~~(b) For the second violation within a 12-month period, impose an administrative fine of not less than $250.~~

~~(c) For the third violation within a 12-month period, impose an administrative fine of not less than $500.~~

~~(d) For the fourth and each subsequent violation within a 12-month period, impose an administrative fine of not less than $1,000.]~~

Sec. 12. NAC 616B.809 is hereby amended to read as follows:

616B.809 1. If a sole proprietor elects to purchase industrial insurance pursuant to chapters 616A to 617, inclusive, of NRS or elects to pay an additional amount of premium for additional coverage or subsequently wishes to withdraw an election for coverage, the written notice that the sole proprietor is required to provide to the private carrier and the administrator ~~[or his designated agent]~~ pursuant to NRS 616B.659 must be served personally or sent by first-class mail on a completed form entitled D-45, Sole Proprietor Coverage, which is prescribed by the administrator, or, if sent by electronic transmission, the notice must contain the same information as the form. The notice must be served within 30 days after the effective date of the election or withdrawal and must be accompanied by a report of any physical examinations prescribed by the private carrier. The sole proprietor is not required to serve ~~[such]~~ ***the*** notice on

the administrator ~~[or his designated agent]~~ if notice is served on the administrator ~~[or his designated agent]~~ by the private carrier on behalf of the sole proprietor.

2. A sole proprietor for whom coverage is elective pursuant to NRS 616A.220, who meets the qualifications for elective coverage pursuant to that section and who is not otherwise required to maintain coverage pursuant to chapters 616A to 616D, inclusive, or chapter 617 of NRS, must comply with the requirements ~~[for notice]~~ set forth in NAC 616B.810.

3. Except as otherwise provided in subsection 4, for the purposes of determining premium and disability compensation, a sole proprietor who applies for coverage pursuant to NRS 616B.659 will be provided coverage at the rate provided in the manual at the deemed wage of $300 per month or, if additional premiums are received for additional coverage, at the deemed wage of $1,800 per month. A sole proprietor who:

(a) Files notice with a private carrier, pursuant to NRS 616B.659, of his election to pay for additional coverage; and

(b) Sustains an injury within the 90-day period provided by subsection 6 of NRS 616B.659,

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will be provided coverage at the deemed wage of $300 per month, notwithstanding the election to pay for additional coverage.

4. The private carrier may increase the monthly premium payable pursuant to subsection 3 based on the results of the physical examination prescribed by the private carrier.

~~[5. If a sole proprietor fails to provide the notice required pursuant to NRS 616B.659 and in the manner set forth in this section, the administrator will, after notice and hearing:~~

~~(a) For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.~~

~~(b) For the second violation within a 12-month period, impose an administrative fine of not less than $250.~~

~~(c) For the third violation within a 12-month period, impose an administrative fine of not less than $500.~~

~~(d) For the fourth and each subsequent violation within a 12-month period, impose an administrative fine of not less than $1,000.]~~

Sec. 13. Chapter 616C of NAC is hereby amended by adding thereto a new section to read as follows:

1. An insurer who requests that an injured employee submit to a rating evaluation pursuant to NRS 616C.490 shall include with the notice required pursuant to subsection 2 of NAC 616C.103:

(a) Payment for the cost of travel for the injured employee;

(b) A receipt evidencing payment for the cost of travel for the injured employee; or

(c) Any combination thereof.

2. For the purpose of determining the cost of travel for the injured employee:

(a) The insurer shall pay for the cost of travel incurred by the injured employee if the injured employee is required to travel at least 20 miles one way from:

(1) His residence to the place where the rating evaluation will be conducted; or

(2) His place of employment to the place where the rating evaluation will be conducted if the injured employee is required to be examined during his regular working hours.

(b) Except as otherwise provided in this section, payment for the cost of travel must be computed at a rate equal to:

(1) The mileage allowance for state officers and employees who use their personal vehicles for the convenience of this state; or

(2) The cost of travel actually incurred by the injured employee, if the injured employee consents to payment at that rate and the cost of travel is not more than the amount to which the injured employee would otherwise be entitled pursuant to subparagraph (1).

(c) Except as otherwise provided in this section, if the injured employee is required to travel before 7:00 a.m. or between 11:30 a.m. and 1:30 p.m., or cannot return to his residence or place of employment before 7:00 p.m., the insurer shall pay the injured employee an allowance for meals equal to:

(1) The rate allowed for state officers and employees; or

(2) The cost actually incurred by the injured employee for meals, if the injured employee consents to payment at that rate and the cost is not more than the amount to which the injured employee would otherwise be entitled pursuant to subparagraph (1).

(d) If an injured employee is required to travel at least 50 miles one way from his residence or place of employment and is required to remain away from his residence or place of employment overnight, the insurer shall pay the injured employee:

(1) The per diem allowance authorized for state officers and employees; or

(2) The cost of travel actually incurred by the injured employee,

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whichever is less.

(e) If the injured employee receives the prior approval of the insurer requesting the rating evaluation, the insurer shall pay for the cost of travel by airplane if the time, distance, convenience or cost of travel justifies the injured employee's travel by airplane.

(f) If the injured employee moves outside this state or to a new location within this state after filing a claim for compensation, the insurer shall pay the cost of travel for the injured employee to attend the rating evaluation, not to exceed $1,000.

(g) A person who travels with an injured employee is not entitled to receive payment for the cost of travel to accompany the injured employee unless there is a medical necessity that prevents the injured employee from traveling alone. The treating physician or chiropractor of the injured employee shall provide a written explanation of the medical necessity.

Sec. 14. NAC 616C.003 is hereby amended to read as follows:

616C.003 The administrator ~~[or his designated agent]~~ will appoint to the panel of physicians and chiropractors described in NRS 616C.090 ~~[, all]~~ ***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 **.** ~~[or his designated agent.]~~

Sec. 15. NAC 616C.006 is hereby amended to read as follows:

616C.006 The administrator ~~[or his designated agent]~~ will issue a warning to a physician or chiropractor on the panel of physicians and chiropractors, or suspend or remove a physician or chiropractor from the panel, for sufficient cause. Sufficient cause includes, but is not limited to, the following:

1. Fraudulent billing or reporting.

2. Failure to observe the rules of treatment set forth in NAC 616C.129.

3. Disciplinary action taken against the physician or chiropractor by the applicable licensing authority, representatives of Medicare or Medicaid, or a hospital for fraud, abuse or the quality of care provided.

4. Unprofessional conduct or discriminatory treatment in the care and treatment of patients.

5. Use of any treatment which is not sanctioned by his peers or medical authority as being beneficial for the injury or disease involved.

6. Failure to comply with any order of the division issued pursuant to NAC 616C.126 to 616C.144, inclusive.

7. Commission of a felony for which he is convicted in a state or federal court.

8. Commission of any offense relating to drug abuse, including excessive prescription of drugs, for which he is convicted in a state or federal court.

9. A violation of NRS 616C.040 or 616C.135.

10. Continued failure to secure authorization for diagnostic tests which require prior authorization.

11. Continued failure to secure authorization and consultations for surgical procedures.

12. Engaging in any action that the administrator ~~[or his designated agent]~~ determines to be detrimental to an injured employee, an employer, an insurer or the program of industrial insurance.

Sec. 16. NAC 616C.009 is hereby amended to read as follows:

616C.009 1. Except as otherwise provided in subsection 3, the administrator ~~[or his designated agent]~~ may suspend or remove for cause any physician or chiropractor from the panel of physicians and chiropractors upon 30 days' written notice.

2. The notice of suspension or removal must define the particular cause or causes for suspension or removal.

3. The administrator may, without giving any advance notice, suspend or remove from the panel of physicians and chiropractors a physician or chiropractor whose license has been suspended or revoked by the applicable licensing authority.

Sec. 17. NAC 616C.012 is hereby amended to read as follows:

616C.012 The administrator ~~[or his designated agent]~~ will:

1. Immediately advise all insurers, third-party administrators and organizations for managed care located in the area served by a physician or chiropractor who has been suspended or removed by the administrator ~~[or his designated agent]~~ from the panel of physicians and chiropractors of his suspension or removal from the panel.

2. Request the insurers, third-party administrators and organizations for managed care to advise employers and employees, as appropriate, that the physician or chiropractor is not authorized to treat cases for workers' compensation.

Sec. 18. NAC 616C.018 is hereby amended to read as follows:

616C.018 1. The administrator ~~[or his designated agent]~~ will schedule a hearing for a physician or chiropractor suspended or removed from the panel of physicians and chiropractors within 15 days after the receipt of his petition for a hearing.

2. The physician or chiropractor must be notified of the administrator's decision on his petition within 5 days after the hearing.

Sec. 19. NAC 616C.021 is hereby amended to read as follows:

616C.021 1. The designation of a rating physician or chiropractor pursuant to NRS 616C.490 must be in writing. 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) Performing ratings evaluations of permanent partial disabilities when selected pursuant to NRS 616C.490, except disabilities related to an injured employee's vision or functional limitations, including deficiencies in brain function, resulting from an industrial accident or occupational disease;

(2) Scheduling and performing a rating evaluation within 30 days after receipt of a request from an insurer, a third-party administrator or an injured employee or his representative; and

(3) Serving without compensation for a period not to exceed 1 year on the panel to review ratings evaluations established pursuant to NAC 616C.023;

(c) Except as otherwise provided in subsection 2, successfully complete a course on rating disabilities that is approved by the administrator ~~[or his designated agent]~~ and pass an examination that is administered by the American Board of Independent Medical Examiners, or its successor organization; and

(d) Demonstrate an understanding of the:

(1) Regulations of the division related to the evaluation of permanent partial disabilities; and

(2) American Medical Association's ***Guides to the Evaluation of Permanent Impairment***, as adopted by ***reference by*** the division pursuant to NRS 616C.110 and NAC 616C.002.

2. The administrator ~~[or his designated agent]~~ may authorize ophthalmologists and psychiatrists who are authorized to practice in this state to attend the relevant portions of the course required by paragraph (c) of subsection 1 and, upon the recommendation of the instructor of the course, may approve an ophthalmologist or psychiatrist to evaluate injured employees with impaired vision or brain damage according to his area of specialization.

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

4. 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 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.

5. A rating evaluation of a permanent partial disability performed by a rating physician or chiropractor is subject to review by the administrator ~~[or his designated agent]~~ pursuant to the provisions of NAC 616C.023.

Sec. 20. NAC 616C.023 is hereby amended to read as follows:

616C.023 1. The administrator will establish a panel to review ratings evaluations conducted by physicians and chiropractors pursuant to NRS 616C.490. The administrator ~~[or his~~

~~designated agent]~~ will select physicians and chiropractors who perform ~~[such]~~ ratings evaluations to serve as members of the panel.

2. The members of the panel shall assist the administrator ~~[or his designated agent]~~ in reviewing ratings evaluations of permanent partial disabilities to ensure that the evaluations comply with the standards set forth in the guide and the regulations of the division.

Sec. 21. NAC 616C.024 is hereby amended to read as follows:

616C.024 1. The administrator ~~[or his designated agent]~~ 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 ~~[or his designated agent]~~ to be erroneous to the total number of ratings performed by the physician or chiropractor;

(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 license or the limitation of his practice by the applicable licensing authority;

(d) Is determined by the administrator ~~[or his designated agent]~~ 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 ~~[such]~~ ***ratings*** evaluations in accordance with that section.

2. For the purposes of paragraph (a) of subsection 1, the administrator ~~[or his designated agent,]~~ 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 ~~[or his designated agent]~~ intends to suspend or remove a physician or chiropractor from the list of rating physicians and chiropractors, he 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 ~~[or his designated agent]~~ 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 ~~[or his designated agent]~~ 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 ***.*** ~~[or his designated agent.]~~ The issuance of such a decision is a final decision for the purposes of judicial review.

Sec. 22. NAC 616C.027 is hereby amended to read as follows:

616C.027 1. A provider of health care whose bill has been reduced or disallowed may, within 60 days after receiving notice of the reduction or disallowance, submit a written request to the industrial insurance regulation section for a review of that action. The request must identify the billed item for which the review is sought and state the ground upon which the request is based. The industrial insurance regulation section ~~[will]~~ ***shall*** review the matter, ***and if it determines that issuing a written determination is appropriate, it shall*** issue a written determination and mail or deliver copies of the determination to the provider of health care and the insurer. If the determination is in the provider's favor, the insurer shall, within 30 days after receiving notice of the determination, pay him the amount ordered by the industrial insurance regulation section, unless an appeal is taken in the manner provided by subsection 2.

2. ~~[Any person]~~ ***A provider of health care or insurer*** aggrieved by the determination of the industrial insurance regulation section may appeal to the administrator ~~[or his designated agent]~~ by filing a request for a hearing with the administrator within 30 days after the date of the determination.

3. ***The provider of health care and the insurer will be the only parties to the hearing scheduled pursuant to subsection 4. A representative of the industrial insurance regulation section may attend the hearing. The administrator will consider the evidence presented at the hearing, including, without limitation, any evidence concerning the reduction or disallowance of the bill that was not available or the existence of which was not known to the provider of***

health care at the time he submitted the request to the industrial insurance regulation section pursuant to subsection 1.

4. The administrator ~~[or his designated agent]~~ will schedule a hearing on the matter and, after the hearing, issue a written decision. The administrator ~~[or his designated agent]~~ will give notice of his decision to the provider of health care and the insurer. If the decision is in the provider's favor, the insurer shall, within 10 days after receiving notice of the decision, pay the provider the amount ordered by the administrator ***.*** ~~[or his designated agent.]~~ The decision of the administrator ~~[or his designated agent]~~ is a final decision for the purposes of judicial review.

Sec. 23. NAC 616C.091 is hereby amended to read as follows:

616C.091 After receipt of a claim for compensation, the insurer shall give written notice of its determination to accept or deny the claim to the injured employee or his dependents and, if ~~[his]~~ ***the injured employee's*** employer is not self-insured, to ~~[his employer. The notice must be given within the time prescribed in NRS 616C.060.]~~ ***the injured employee's employer.*** If the insurer denies the claim:

1. ***The insurer shall, pursuant to NRS 616C.065, notify the administrator of the denial.***

2. The notice ***of denial to the injured employee or his dependents*** must include:

(a) A written statement of the right to request a hearing on the matter before a hearing officer and a form for requesting a hearing ~~[.]~~ ***; and***

(b) The reasons for the denial.

~~[2.]~~ ***3.*** The insurer shall provide a copy of ~~[the]~~ ***each*** notice ***of denial it gives pursuant to subsection 2*** to the injured employee's treating physician or chiropractor.

~~[3. The insurer shall notify the administrator of the denial by delivering by electronic transmission or mailing a copy of the determination to the administrator within 30 days after the denial.]~~

4. The notice of denial required to be given to the administrator pursuant to subsection 1 must include:

(a) A copy of the notice of denial given to the injured employee or his dependents; and

(b) A copy of Form C-4, Employee's Claim for Compensation/Report of Initial Treatment, that was completed by the injured employee or his dependents.

5. Each notice of denial must be given within the time prescribed in NRS 616C.065.

Sec. 24. NAC 616C.103 is hereby amended to read as follows:

616C.103 1. For purposes of determining whether an injured employee is stable and ratable and ~~[, therefore,]~~ 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; or

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

2. 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 written copy of that agreement and the form designated in NAC 616A.480 as D-35, ***Request for a*** Rotating Rating Physician ~~[/Chiropractor Request,]~~ ***or Chiropractor,*** to the industrial insurance regulation 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 to the assigned rating physician or chiropractor from the insurer's file 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 of a previous award of workers' compensation issued in or outside of this state for the injury or occupational disease that is the subject of the injured employee's claim;

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

(4) The form designated in NAC 616A.480 as D-35, ***Request for a*** Rotating Rating Physician ~~[/Chiropractor Request.]~~ ***or Chiropractor.***

3. ***An insurer shall pay for the cost of travel for an injured employee to attend a rating evaluation as required by section 13 of this regulation.***

4. Except as otherwise provided in subsection ~~[5,]~~ ***6,*** 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 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,

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

~~[4.]~~ ***5.*** 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.

~~[5.]~~ ***6.*** 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 him; and

(c) Notify the injured employee of the specific reasons for the disagreement and his right 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.

~~[6.]~~ ***7.*** The injured employee must receive a copy of the results of each rating evaluation performed of him before accepting an award for a permanent partial disability.

~~[7.]~~ ***8.*** 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 of Lump Sum Request.

Sec. 25. NAC 616C.1156 is hereby amended to read as follows:

616C.1156 ~~[1.]~~ If an insurer receives a claim for compensation from an injured employee and determines that the employer named in the claim for compensation is not an employer to whom the insurer provides coverage, the insurer shall, within 3 working days after making such a determination, deliver by electronic transmission or other method a copy of the claim for compensation to the administrator.

~~[2. If the insurer fails to notify the administrator as required by subsection 1 or notifies the administrator in an untimely manner, the administrator will:~~

~~(a) For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.~~

~~(b) For the second violation within a 12-month period, impose an administrative fine of not less than $100.~~

~~(c) For the third violation within a 12-month period, impose an administrative fine of not less than $250.~~

~~(d) For the fourth violation within a 12-month period, impose an administrative fine of not less than $500.~~

~~(e) For the fifth and each subsequent violation within a 12-month period, impose an administrative fine of $1,000.~~**]**

Sec. 26. NAC 616C.1158 is hereby amended to read as follows:

616C.1158 After receipt of a copy of a claim for compensation pursuant to **[**~~subsection 1 of~~**]** NAC 616C.1156, the administrator **[**~~or his designated agent~~**]** will, if the employer is insured by another insurer, deliver by electronic transmission or other method a copy of the claim for compensation to the other insurer within 10 working days after receipt of the notification.

Sec. 27. NAC 616C.141 is hereby amended to read as follows:

616C.141 1. If a program of treatment that is required to be billed under codes 97001 to 97799, inclusive, or 98925 to 98943, inclusive, is administered to an injured employee, the treatment, evaluation, manipulation, modality, mobilization procedure, testing or measurements must be administered by:

(a) A licensed physical therapist;

(b) A licensed physical therapist's assistant;

(c) A licensed occupational therapist;

(d) A licensed occupational therapy assistant;

(e) A licensed physician;

(f) A licensed chiropractor; or

(g) A certified chiropractor's assistant,

FLUSH who is acting within the authorized scope of his license or certification.

2. If a treating physician or chiropractor prescribes a program of treatment that is required to be billed under codes 97010 to 97799, inclusive, or 98925 to 98943, inclusive, it must be in writing and include:

(a) A recommendation of the modalities or procedures, or both, to be administered to specific areas of the body; and

(b) The frequency of the treatments.

3. A provider of health care shall indicate on a bill presented to an insurer for any treatment each code contained in the ***Relative Values for Physicians***, as adopted ***by reference*** pursuant to NAC 616C.188, or the ***Relative Value Guide of the American Society of Anesthesiologists***, as adopted ***by reference*** pursuant to NAC 616C.194, for any services. The codes must be indicated on each bill regardless of whether the provisions of NAC ~~[616C.073]~~ ***616C.070*** to 616C.336, inclusive, allow for the payment of ~~[such]~~ ***the*** services, the payment is requested or the item is included under a different code.

4. Any bill for an office visit that is billed under codes 90000 to 99999, inclusive, must include a written report concerning the history of the injured employee, a comprehensive evaluation of the injured employee's health condition or an evaluation of specific health problems of the injured employee, any decision made concerning the treatment required by the injured employee and all forms for submitting a claim to the insurer or billing reports that are requested by an insurer. Such a bill is not required to include a special report that is specifically requested by an insurer and is required to be billed under code 99080.

5. Services provided by a certified advanced practitioner of nursing or certified physician's assistant must be billed using the modifier-29. An insurer is financially liable for the payment of any bill using the modifier-29 pursuant to this subsection at a rate not to exceed ~~[70]~~ ***85*** percent of the maximum allowable fee established for physicians or chiropractors pursuant to paragraph (a) of subsection 4 of NAC 616C.188. The provisions of this subsection do not authorize a certified advanced practitioner of nursing or certified physician's assistant to perform any services that are not within the authorized scope of his practice.

6. Services provided by a licensed physical therapist's assistant or licensed occupational therapy assistant must be billed using modifier-29. An insurer is financially liable for the payment of any bill using modifier-29 pursuant to this subsection at a rate not to exceed 50 percent of the maximum allowable fee for licensed physical therapists or licensed occupational therapists established pursuant to paragraph (b) or (c) of subsection 4 of NAC 616C.188. The provisions of this subsection do not authorize a licensed physical therapist's assistant or licensed occupational therapy assistant to perform any services that are not within the authorized scope of his license.

7. Services provided by a certified chiropractor's assistant must be billed using modifier-29. An insurer is financially liable for the payment of any billing using modifier-29 pursuant to this subsection at a rate not to exceed 40 percent of the maximum allowable fee for chiropractors established pursuant to paragraph (a) of subsection 4 of NAC 616C.188. The provisions of this subsection do not authorize a certified chiropractor's assistant to perform any services that are not within the authorized scope of his certification.

8. Surgical assistant services provided by a licensed registered nurse, a certified physician's assistant ~~[,]~~ or an operating room technician employed by a surgeon for surgical assistant

services must be billed using modifier-29. An insurer is financially liable for the payment of any bill using modifier-29 pursuant to this subsection at a rate not to exceed 14 percent of the maximum allowable fee for the surgeon's services rendered. Fees for surgical assistant services performed by a licensed registered nurse, a certified physician's assistant or an operating room technician employed by the hospital or surgical facility must be included in the per diem rate pursuant to code NV00500 as set forth in subsection 3 of NAC 616C.203.

Sec. 28. NAC 616C.144 is hereby amended to read as follows:

616C.144 1. Billings for health care services must be submitted within 90 days after the date on which the services were rendered unless good cause is shown for a later billing. In no event may an initial billing for health care services be submitted later than 12 months after the date on which the services were rendered.

2. A provider of health care shall, within 14 days after the date on which services are rendered or the injured employee is discharged from the hospital, unless good cause is shown, submit to an insurer, a third-party administrator or an organization for managed care, a report on the services rendered. Payment is not required for those services if the report is inadequate to determine the amount due. This subsection does not require the disclosure of any information regarding which disclosure is prohibited by state or federal statute or regulation.

3. The insurer or a representative of the insurer may require the submission of reports on the injured employee's admission to and discharge from the hospital and all physician's or chiropractor's medical reports before payment of a hospital or medical bill.

4. An insurer shall pay or deny the payment of charges within 60 days after receipt by the insurer or his agent of the first bill for those charges unless:

(a) Good cause is shown for a later payment or denial; or

(b) The insurer has returned the bill to the provider of health care pursuant to paragraph ~~[(c)]~~ ***(d)*** of subsection 6.

5. A bill that is submitted for reconsideration must be:

(a) Received by the insurer or a person authorized by the insurer to receive such a bill ~~[no]~~ ***not*** later than 12 months after the date on which the services were rendered, unless good cause is shown.

(b) Processed in accordance with the requirements of subsection 4.

6. The insurer shall:

(a) ~~[Provide]~~ ***Except as otherwise provided in paragraph (b), provide*** an explanation of benefits for each code billed that includes the amounts for services that are paid and disallowed;

(b) ***If the services rendered are for physical therapy and the total unit value of the services provided for 1 day is 12 or more, combine all the services for that day and use code NV970001 on the payment;***

(c) Indicate on each payment those services which are being disallowed and the reasons for the disallowance; and

~~[(c)]~~ ***(d)*** If a bill submitted to the insurer by a provider of health care requires an adjustment because the codes set forth in the bill are incorrect:

(1) Process and provide or deny payment for that portion of the bill, if any, that does not contain incorrect codes;

(2) Return the bill to the provider of health care and request additional information or documentation concerning that portion of the bill relating to the incorrect codes; and

(3) Pay or deny payment within 60 days after receipt, by the insurer or his agent, of the resubmittal of the bill with the additional information or documentation.

Sec. 29. NAC 616C.188 is hereby amended to read as follows:

616C.188 1. Except as otherwise provided in this section, providers of health care who treat injured employees pursuant to this chapter and chapter 616C of NRS shall comply with the most recently published edition of or update to the ***Relative Values for Physicians***, which the division hereby adopts by reference.

2. The administrator ~~[or his designee]~~ will, on or before March 1 ~~[and September 1]~~ of each year, review the most recently published edition of or update to the ***Relative Values for Physicians***. Each new edition of or update to the ***Relative Values for Physicians*** shall be deemed approved by the division for use in this state from May 1 through ~~[October 31 or from November 1 through]~~ April 30, unless a notice of disapproval of the edition or update is posted pursuant to this subsection by the immediately preceding March 1 **.** ~~[or September 1, respectively.]~~ If the administrator ~~[or his designated agent]~~ wishes to disapprove a new edition of or update to the ***Relative Values for Physicians***, he will:

(a) Post a notice of disapproval at the largest public library in each county, the state library and archives, the Grant Sawyer Office Building located at 555 East Washington Avenue, Las Vegas, Nevada, and all offices of the division; and

(b) Send a notice to each person included on the mailing list that the division is required to maintain pursuant to paragraph (e) of subsection 1 of NRS 233B.0603.

FLUSH If the administrator disapproves an edition of or update to the ***Relative Values for Physicians*** the edition or update that was most recently adopted ***by reference*** or deemed approved pursuant to this section will continue in effect.

3. A copy of ***Relative Values for Physicians***, as adopted ***by reference*** pursuant to subsection 1, may be purchased from ~~[St. Anthony Publishing, Inc., P.O. Box 96561,~~

~~Washington, D.C. 20090, (800) 632-0123, at the cost~~] ***Ingenix, 5225 Wiley Post Way, Suite 500, Salt Lake City, Utah 84116-2889, (800) 999-4600, for the price*** of $239.95.

4. Except as otherwise provided in subsection 5, the maximum unit value allowed for bills that include any treatment identified in the ***Relative Values for Physicians*** under codes 97001 to 97799, inclusive, or 98925 to 98943, inclusive, whether billed individually or as an item included under a different code, is as follows:

(a) Services provided by a physician or chiropractor must be billed using the following modifiers:

Code Modifier	Time Billed	Maximum Unit Value
-51A	Up to one-half hour	7.25 units
-51B	Over one-half hour	12.5 units

(b) Services provided by a licensed physical therapist or licensed physical therapist's assistant must be billed using the following modifier:

Code Modifier	Time Billed	Maximum Unit Value
-51C	All services provided per day	12 units

(c) Services provided by a licensed occupational therapist or licensed occupational therapy assistant must be billed using the following modifier:

Code Modifier	Time Billed	Maximum Unit Value
-51D	All services provided per day	.....12 units

5. The maximum unit values set forth in subsection 4 may be exceeded for services provided to an injured employee with trauma to multiple body parts if the insurer, third-party administrator or organization for managed care ***so*** authorizes ~~[such use]~~ in advance.

6. The maximum unit value includes all services provided pursuant to this section, except materials, supplies and any evaluations conducted after an operation has been performed. Any payment made pursuant to this section must include, but is not limited to, payment for:

(a) The office visit;

(b) Evaluations and management services;

(c) Manipulations;

(d) Modalities;

(e) Mobilizations;

(f) Testing and measurements;

(g) Treatments;

(h) Procedures; and

(i) Extra time.

7. An initial evaluation ***by a licensed physical therapist or licensed occupational therapist*** that is deemed to be separate from the initial six treatments pursuant to subsection 8 of NAC 616C.129 must be billed under codes 97001 or 97003.

8. If a ***provider of*** health care ~~[provider]~~ performs a procedure described in the following chart, he shall use code 99080 from the ***Relative Values for Physicians*** and ~~[shall]~~ bill in accordance with the procedure set forth below:

Code	Procedure	Payment
99080	Special reports requested in writing by an insurer, ~~[such as]~~ ***including, without limitation,*** the review of health care data to clarify an injured employee's status or to describe extensively an injured employee's health condition in more detail than the information contained in the standard health care communication or standard reporting form.	By Report

Sec. 30. NAC 616C.191 is hereby amended to read as follows:

616C.191 1. The values contained in the schedule of ~~[reasonable]~~ fees and charges allowable for accident benefits adopted for this state pursuant to NRS 616C.260 must be multiplied by the following conversion factors for each provider of health care and the type of service:

CodeType of Service	Conversion Factor

70000-79999	Radiology and Nuclear Medicine	~~[$20.69]~~ ***$24.09***
80000-89999	Pathology	14.30
90000-99999	Medicine	~~[6.00]~~ ***6.24***
10000-69999	Surgery	~~[117.57~~
~~92980-93562~~	~~Surgery/Cardiovascular..... 117.57]~~	***135.28***

2. Payment for services listed in subsection 1 must be made in accordance with subsection 2 of NRS 616C.135 and subsection 1 of NRS 616C.260. Payments must not exceed the fees established in the schedule of ~~[reasonable]~~ fees and charges allowable for accident benefits adopted pursuant to NRS 616C.260, or the usual fee charged by that provider of health care or facility pursuant to a contract between the provider of health care and the insurer, whichever is less.

3. Providers of health care shall use the procedure code numbers and unit values from the ***Relative Values for Physicians***, as adopted ***by reference*** pursuant to NAC 616C.188, to bill for services performed which are within the scope of their licenses.

Sec. 31. NAC 616C.194 is hereby amended to read as follows:

616C.194 1. Anesthesiologists who treat injured employees pursuant to this chapter and chapter 616C of NRS shall comply with the most recently published edition of or update to the ***Relative Value Guide of the American Society of Anesthesiologists***, which the division hereby adopts by reference.

2. The administrator ~~[or his designee]~~ will, on or before April 1 of each year, review the most recently published edition of or update to the ***Relative Value Guide of the American Society of Anesthesiologists***. Each new edition of or update to the ***Relative Value Guide of the***

American Society of Anesthesiologists shall be deemed approved by the division for use in this state on May 1 of each year, unless a notice of disapproval of the edition or update is posted pursuant to this subsection by the immediately preceding April 1. If the administrator ~~[or his designated agent]~~ wishes to disapprove a new edition of or update to the ***Relative Value Guide of the American Society of Anesthesiologists***, he will:

(a) Post a notice of disapproval at the largest public library in each county, the state library and archives, the Grant Sawyer Office Building located at 555 East Washington Avenue, Las Vegas, Nevada, and all offices of the division; and

(b) Send a notice to each person included on the mailing list that the division is required to maintain pursuant to paragraph (e) of subsection 1 of NRS 233B.0603.

FLUSH If the administrator disapproves an edition of or update to the ***Relative Value Guide of the American Society of Anesthesiologists***, the edition or update that was most recently adopted ***by reference*** or deemed approved pursuant to this section will continue in effect.

3. A copy of the ***Relative Value Guide of the American Society of Anesthesiologists***, as adopted ***by reference*** pursuant to subsection 1, may be purchased from the American Society of Anesthesiologists, 520 N. Northwest Highway, Park Ridge, Illinois 60068-2573, (847) 825-5586, for the price of $15.

4. Except as otherwise provided in this subsection, an anesthesiologist shall use the codes that are stated in the ***Relative Value Guide of the American Society of Anesthesiologists*** for each procedure which he bills and submits to an insurer. If a code for a procedure performed by an anesthesiologist is not provided in the guide, the anesthesiologist shall use the code provided for that procedure in the ***Relative Values for Physicians***, as adopted ***by reference*** pursuant to NAC 616C.188, ~~[utilizing]~~ ***using*** the appropriate conversion factor for the code that is assigned

to that procedure. The maximum allowable fee for any anesthesiology service is the basic unit value that is stated in the guide, plus the number of 15-minute intervals that the service was rendered, or any fraction thereof, multiplied by the following conversion factor:

Codes	Type of Service	Conversion Factor
00000-99999	Basic Anesthesiology	~~[$51.54]~~ ***$51.62***

5. The insurer shall pay the lesser of the provider's usual charge for his services or the maximum allowable fee calculated pursuant to subsection 4 or pursuant to a contract between the provider of health care and the insurer.

6. All basic anesthetic values must be applied to those procedures administered by a licensed physician or a certified registered nurse anesthetist.

Sec. 32. NAC 616C.197 is hereby amended to read as follows:

616C.197 1. The following procedure has the payment group assigned to it for the use of a licensed surgical center for ambulatory patients, and the insurer shall pay the following assigned amount, the billed amount or the amount agreed upon pursuant to a contract between the provider of health care and insurer, whichever is less:

Code	Type of Service	Payment Group
NV29888	Anterior cruciate ligament repair	9

2. The division adopts by reference the complete list of eligible codes for surgical centers for ambulatory patients and the payment groups to which those codes are assigned for services rendered on and after January 1, 1997, established by the Health Care Financing Administration ~~[(HCFA).]~~ ***, as amended on January 1, 2000.***

3. The following is the maximum allowable payment for each of the payment groups for fees charged by a licensed surgical center for ambulatory patients:

Payment Group	Maximum Allowable Payment
Group 1	~~[$426]~~ ***$490.16***
Group 2	~~[546]~~ ***628.23***
Group 3	~~[660]~~ ***759.40***
Group 4	~~[816]~~ ***938.89***
Group 5	~~[868]~~ ***998.72***
Group 6	~~[1024]~~ ***1,178.21***
Group 7	~~[1087]~~ ***1,221.47***
Group 8	~~[1101]~~ ***1,221.47***
Group 9	~~[1101]~~ ***1,221.47***

4. A copy of the eligible codes and payment groups adopted ***by reference*** pursuant to subsection 2 is available, free of charge, from the Division of Industrial Relations, Industrial Insurance Regulation Section:

(a) At 400 W. King Street, Suite 400, Carson City, Nevada 89703, (775) 687-3033; ~~[or]~~

(b) At 1301 North Green Valley Parkway, Suite 200, Henderson, Nevada 89014, (702) 486-9080 ~~[.]~~ ***; or***

(c) At the Internet address <http://www.state.nv.us/b&i/ir/medical.htm#medfee>.

5. Costs related to the following items must be included in allowable charges for fees charged by a surgical center for ambulatory patients:

(a) The cost of the anesthetic;

(b) General supplies;

(c) Operating room;

(d) Radiology, technical component;

(e) Pathology, technical component;

(f) Any other diagnostic procedure; and

(g) Medication.

6. An insurer shall reimburse a surgical center for ambulatory patients for orthopedic hardware and prosthetic devices in an amount equal to the center's cost for the hardware or device, excluding tax and charges for freight, plus 20 percent.

7. If an injured employee requires more than one surgical procedure to be performed at the same time, the surgical center for ambulatory patients shall bill for the surgery using modifier-51 that is contained in the ***Relative Values for Physicians***, as adopted ***by reference*** pursuant to NAC 616C.188.

8. If there is no assigned value for the surgical procedure or if the modifier-51 is used, the amount paid must not exceed the per diem rate for code NV00500 as set forth in subsection 3 of NAC 616C.203 and the code NVH0009 must be used.

Sec. 33. NAC 616C.203 is hereby amended to read as follows:

616C.203 1. The following is the maximum allowable payment per visit for the use of an emergency ~~[room:]~~ ***department:***

Code	Procedure	Maximum Allowable Payment
NV00100	First hour	~~[$33.96]~~ ***$37.67***
NV00101	Each additional hour or fraction thereof	~~[16.98]~~ ***18.84***

2. If an injured employee receives care in an emergency ~~[room]~~ ***department*** that is located on the grounds of a hospital and the time for the use of the emergency ~~[room]~~ ***department*** exceeds 60 minutes, the billing must be submitted in a report and must specify the need for the time that exceeded 60 minutes. ***If an injured employee is admitted to the hospital from the emergency department, the charges related to the care in the emergency department and the per diem rates for an inpatient who receives care at the hospital must be billed and paid separately.***

3. The following per diem rates are the maximum allowable payments for an inpatient receiving care at a hospital:

Code	Procedure	Maximum Allowable Payment

NV00200	Intensive Care	~~[$1,811.20]~~ ***$2,008.98***
NV00400	Cardiac Care.....	~~[1,663.18]~~ ***1,844.80***
NV00500	Medical-Surgical Care	~~[1,101.22]~~ ***1,221.47***
NV00900	Care for Burns.....	~~[1,663.18]~~ ***1,844.80***

4. The insurer shall pay:

(a) The per diem rate multiplied by the number of days the injured employee was hospitalized;

(b) The total amount billed for all services if that amount is less than the amount computed in paragraph (a); or

(c) The amount owed pursuant to a contract between the provider of health care and insurer.

5. The per diem rate for care provided must include all services provided by the hospital, including the professional and technical services provided by members of the hospital's staff and other services ordered by the treating or consulting provider of health care.

6. The charge for an inpatient's use of an operating room must be included in the per diem rate for hospitals.

7. The insurer shall reimburse the hospital for orthopedic hardware and prosthetic devices at the cost to the hospital of the orthopedic hardware and prosthetic devices, excluding tax and charges for freight, plus 20 percent.

8. The following is the maximum allowable payment for open heart surgery for an inpatient receiving care at a hospital for 7 days or less:

Code	Procedure	Maximum Allowable Payment
NV00410	Open Heart Surgery	~~[$15,964.43]~~ ***$17,707.75***

9. The insurer shall reimburse the hospital for supplies and materials used in open heart surgery at the cost to the hospital of the supplies and materials, excluding tax and charges for freight, plus 40 percent.

10. The treating physician shall order all preoperative laboratory and pathology tests and any other diagnostic tests to be performed on the injured employee as an outpatient before his admission to the hospital except where hospitalization preceding and during a test is generally recognized by the medical profession as a necessary and prudent precaution.

11. The following per diem rate is the maximum allowable payment for a skilled nursing care facility:

Code	Procedure	Maximum Allowable Payment
NV00550	Skilled Nursing Care Facility.....	~~[$1,026.44]~~ ***$1.138.53***

12. Except as otherwise provided in this subsection, a physician who admits an injured employee for hospitalization is responsible for directing that the injured employee be transferred to the next appropriate level of care, in or out of a hospital, or be discharged as soon as the level

of care being provided exceeds that necessary for his welfare. Payment for treatment ordered pursuant to this subsection must not exceed the per diem rates set forth in subsection 3 for code NV00500.

13. Any excessive use of hospital accommodations, as determined from evaluations of a committee on hospital utilization or an evaluation of the injured employee's health care records by a medical adviser for the insurer, may be grounds for the reduction or disallowance of hospital billings. The insurer shall inform a hospital of the reason for any such reduction or disallowance.

Sec. 34. NAC 616C.206 is hereby amended to read as follows:

616C.206 1. The following is the maximum allowable payment for home health care:

(a) For a visit which is not more than 2 hours and during which certain procedures are performed by a physical therapist, occupational therapist, speech therapist, skilled nurse, social worker or dietary nutritional counselor:

Code	Procedure	Maximum Allowable Payment
NV90170	Skilled home health care.....	~~[$68.00]~~ ***$70.68*** per visit

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

Code	Procedure	Maximum Allowable

		Payment
NV90130	Certified nursing assistant care ~~[~~$27.70~~]~~ ***$28.79*** per visit	

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

Code	Procedure	Maximum Allowable Payment
NV90180	Skilled home health care..... ~~[~~$34.25~~]~~ ***$35.60*** per hour	
NV90190	Certified nursing assistant care ... ~~[~~16.70~~]~~ ***17.36*** per hour	

2. An insurer is not financially liable for home health care services that are provided for more than 4 hours per day unless he has given prior written authorization for ~~[~~such~~]~~ ***the*** care.

3. Fees for each 24-hour period billed pursuant to this section must not exceed the per diem rate for code NV00500 as set forth in subsection 3 of NAC 616C.203.

4. For the purposes of this section, “visit” includes the time it takes the provider of health care to travel to and from the home of the injured employee ~~[~~in order~~]~~ to provide health care services in the home and ~~[~~to~~]~~ complete any required documentation of the services provided.

Sec. 35. NAC 616C.209 is hereby amended to read as follows:

616C.209 1. ~~[Billing]~~ ***Payment*** for all pharmaceuticals, except those provided to an injured employee occupying a bed in the hospital, must be:

(a) Computed at:

(1) The average wholesale price plus a $6 dispensing fee; or

(2) The pharmacy's usual and customary price,

FLUSH whichever is less; or

(b) Computed pursuant to a contract between the provider of health care and insurer.

2. The average wholesale price of each prescription must be determined by the insurer using the most ~~[current]~~ ***recent*** nationally recognized pricing guide.

3. Each insurer shall notify the ~~[chief]~~ ***administrator*** of the identity of the pricing guide he uses in determining the amount to be paid for pharmaceuticals. If the ~~[chief]~~ ***administrator*** objects to a particular pricing guide **,** he shall notify the insurer within ~~[5 working days.]~~ ***7 days after he receives the notice.*** Unless the insurer is advised that the guide is objectionable within ~~[5 working days, he]~~ ***7 days after the administrator receives the notice, the insurer*** may continue using the guide.

4. The ~~[average wholesale price, the]~~ National Drug Code and the usual and customary charge of the pharmacy for the medication must be included on each billing.

5. All drugs must be dispensed according to the provisions of NRS 616C.115.

Sec. 36. NAC 616C.212 is hereby amended to read as follows:

616C.212 1. The following is the maximum allowable payment for each rating of a permanent partial disability for each claim for workers' compensation:

Code	Procedure	Maximum Allowable

		Payment
NV01000	Review of records, testing, evaluation and report	~~[$450]~~ ***$467.73***
NV01001	Failure of an injured employee to appear for appointment	~~[150]~~ ***155.91***
NV01002	Addendum necessary to clarify original report	No charge
NV01003	Addendum after review of additional medical records	~~[150]~~ ***155.91***
NV01004	Review of medical records and evaluation of more than 2 body parts	~~[150]~~ ***155.91*** for each body part in excess of 2
NV01005	Organization of medical records in chronological order	~~[25]~~ ***25.99***
NV01006	Review of records and report	~~[225]~~ ***233.87***

2. Code NV01001 may not be billed unless the injured employee fails to:

(a) Appear for the evaluation within 15 minutes after the scheduled appointment; or

(b) Cancel the appointment within 24 hours before the scheduled appointment,

FLUSH if the injured employee is not seen on that day and all records and diagnostic images have been reviewed by the rating physician or chiropractor.

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

(a) The cervicothoracic spine.

(b) The thoracolumbar spine.

(c) The lumbosacral spine.

(d) The left upper extremity, excluding the left hand.

(e) The right upper extremity, excluding the right hand.

(f) The left hand, including that portion below the junction of the middle and lower thirds of the left forearm.

(g) The right hand, including that portion below the junction of the middle and lower thirds of the right forearm.

(h) The left lower extremity.

(i) The right lower extremity.

(j) The head.

(k) The trunk.

4. Unless good cause is shown, a rating physician or chiropractor shall mail a report of an evaluation to the insurer within ~~[10 working]~~ ***14*** days after the evaluation is completed. Unless good cause is shown, if an addendum is requested by the insurer, the rating physician or chiropractor shall mail the addendum to the insurer within ~~[10 working]~~ ***14*** days after receiving the request.

5. Unless good cause is shown, if a rating evaluation is requested by an injured employee or his representative, the rating physician or chiropractor shall mail a report of the evaluation to the injured employee or his representative within ~~[10 working]~~ ***14*** days after the evaluation is completed. Unless good cause is shown, if an addendum is requested by the injured employee or his representative, the rating physician or chiropractor shall mail the addendum to the injured employee or his representative within ~~[10 working]~~ ***14*** days after receiving the request.

Sec. 37. NAC 616C.213 is hereby amended to read as follows:

616C.213 1. The following procedure code and payment schedule must be used for preparation when an injured employee fails to appear for an independent medical evaluation scheduled by an insurer:

Code	Procedure	Maximum Allowable Payment
NV02000	Preparation when an injured employee fails to appear for an independent medical evaluation scheduled by an insurer..	~~[$150]~~ ***$155.91***

2. Code NV02000 may not be billed unless the injured employee fails to:

(a) Appear for the evaluation within 30 minutes after the scheduled appointment; or

(b) Cancel the appointment within 24 hours before the scheduled appointment,

FLUSH if the injured employee is not seen on that day and all records and diagnostic images have been reviewed by the provider of health care.

Sec. 38. NAC 616C.215 is hereby amended to read as follows:

616C.215 1. Each provider of health care shall submit a bill to the insurer which includes:

(a) His usual charge for services provided;

(b) The code for the procedure and a description of the services;

(c) The number of visits and date of each visit to his office and the procedures followed in any treatment administered during the visit;

(d) The codes for supplies and materials provided or administered to the injured employee that are set forth in the "Health Care Financing Administration, HCFA Common Procedures Coding System (HCPCS)," as contained in the ***Relative Values for Physicians***, as adopted ***by reference*** pursuant to NAC 616C.188;

(e) The name of the injured employee and his employer and the date of his injury;

(f) The tax identification number of the provider of health care; and

(g) The signature of the person who provided the service.

2. In addition to the information required by subsection 1, each physician or chiropractor shall include on his bill the ICD-9-CM codes identifying the parts of the body of the injured employee that were affected by the injury, as set forth in the ***International Classification of Diseases, 9th Revision, Clinical Modification*** (ICD-9-CM), which is hereby adopted by reference. A copy of Volumes 1, 2 and 3 of this publication may be purchased from:

(a) Channel Publishing, Ltd., P.O. Box 70723, Reno, Nevada 89570, (800) 248-2882, ~~[at a cost]~~ ***for the price*** of $99.00; ***or***

(b) ~~[Medicode Publications,]~~ ***Ingenix,*** 5225 Wiley Post Way, Suite 500, Salt Lake City, Utah 84116-2889, (800) 999-4600, ~~[at a cost of $89.95; or~~

~~(c) St. Anthony Publishing, Inc., P.O. Box 96561, Washington, D.C. 20090, (800) 632-0123, at a cost]~~ ***for the price*** of $69.95.

3. The initial bill submitted to the insurer by a licensed physical therapist or a licensed occupational therapist must be accompanied by a copy of the order for the services rendered issued by the treating physician or chiropractor. Any subsequent bill submitted to the insurer by a licensed physical therapist or a licensed occupational therapist must include a copy of the order

for the services rendered issued by the treating physician or chiropractor if the order for services rendered is changed by the treating physician or chiropractor.

Sec. 39. NAC 616C.224 is hereby amended to read as follows:

616C.224 1. The following procedure code and payment schedule must be used for all evaluations of functional capacity performed for an injured employee:

Code	Procedure	Maximum Allowable Payment
NV99060	Testing and report	~~[$141.56]~~ ***$147.14*** per hour

2. Testing performed in connection with such an evaluation must continue for not less than 2 ~~[nor]~~ ***hours and not*** more than 5 hours.

3. The evaluation must include, but is not limited to:

(a) An assessment and interpretation of the ability of the injured employee to perform work-related tasks; and

(b) The formulation of recommendations concerning the capacity of the injured employee to work safely within his physical limitations.

Sec. 40. NAC 616C.225 is hereby amended to read as follows:

616C.225 1. The following procedure code and payment schedule must be used for preparation when an injured employee fails to appear for an evaluation of functional capacity performed for the injured employee:

Code	Procedure	Maximum Allowable Payment
NV99061	Preparation when an injured employee fails to appear for an evaluation of functional capacity performed for the injured employee.	~~[$150]~~ ***$155.91***

2. Code NV99061 may not be billed unless the injured employee fails to:

(a) Appear for the evaluation within 30 minutes after the scheduled appointment; or

(b) Cancel the appointment within 24 hours before the scheduled appointment,

FLUSH if the injured employee is not seen on that day and all records and diagnostic images have been reviewed by the provider of health care.

Sec. 41. NAC 616C.227 is hereby amended to read as follows:

616C.227 1. The following procedure code and payment schedule must be used for all work hardening programs:

Code	Procedure	Maximum Allowable Payment
NV97545	Work hardening program.....	~~[$49.83]~~ ***$51.79*** per hour

2. A program billed pursuant to this section must continue:

(a) For not less than 2 ~~[nor]~~ ***hours per day and not*** more than 8 hours per day, including any time spent in preparing a report of the treatment; and

(b) For not less than 2 ~~[nor]~~ ***weeks and not*** more than 8 weeks.

3. The program must include, but is not limited to:

(a) Conditioning exercises and activities that simulate the work of the injured employee, graded to improve progressively the capacity of the injured employee to perform work; and

(b) Modalities intended to minimize the symptoms of the injured employee, including testing for endurance and range of motion.

Sec. 42. NAC 616C.230 is hereby amended to read as follows:

616C.230 1. The following procedure code and payment schedule must be used for any back school provided to an injured employee:

Code	Procedure	Maximum Allowable Payment
NV97115	Back School	~~[$49.83]~~ ***$51.79*** per hour

2. A program billed pursuant to this section must not exceed 8 hours in duration.

3. Payments for services billed under code NV97115 include the services of all instructors who participate in the program.

4. The program must include, but is not limited to:

(a) Instruction of the injured employee by a licensed physical therapist or licensed occupational therapist and by other providers of health care; and

(b) Instruction of the injured employee in body mechanics, anatomy, techniques of lifting and nutrition.

Sec. 43. NAC 616C.249 is hereby amended to read as follows:

616C.249 1. The division will calculate annual revisions to the schedule of ~~[reasonable]~~ fees and charges allowable for accident benefits as follows:

(a) The division will conduct an annual survey of payers of health care services in this state. The data to be collected must consist of:

(1) A statistically valid sample of codes identified in CPT-4 for medicine, surgery, anesthesiology, radiology and pathology;

(2) The hospital per diem rates for emergency ~~[room]~~ ***department*** stays, medical or surgery stays, intensive care unit stays, burn unit stays and cardiac care stays; and

(3) The number of treatments and amounts paid in the month of January of each calendar year, and the number of treatments and amounts paid for the same procedures in January of the preceding calendar year.

(b) Hospital per diem rates for emergency ~~[room]~~ ***department*** stays, medical or surgery stays, intensive care unit stays, burn unit stays and cardiac care stays will be included in the calculation made pursuant to paragraph (c), but will not be reported by the division using the codes identified in CPT-4.

(c) The division will calculate the annual percentage of increase or decrease for each treatment area of medicine, surgery, anesthesiology, radiology and pathology and for hospital per diem rates as follows:

(1) The division will calculate each payer's annual payments for each treatment area of medicine, surgery, anesthesiology, radiology and pathology and for hospital per diem rates as

reported in the survey for January of each calendar year, and for January of the previous calendar year.

(2) The division will compare each payer's reported payments for January of each calendar year with the corresponding payments for January of the previous calendar year to determine the payer's annual increase or decrease in payments.

(3) The division will apply a weighting factor to each payer's annual increase or decrease calculated pursuant to subparagraph (2). The division will use ~~[either]~~ the total number of treatments paid or the total payments made for the treatments provided, whichever the division determines will yield a more accurate result, as a basis for determining the weighting factor pursuant to this subparagraph.

(d) The division will compare the weighted increase or decrease factors for each payer to calculate a statewide increase or decrease for each treatment area of medicine, surgery, anesthesiology, radiology and pathology and for hospital per diem rates.

(e) The division will report the annual increase or decrease factor for each treatment area of medicine, surgery, anesthesiology, radiology and pathology and for hospital per diem rates as a percentage factor.

(f) The administrator will establish the annual revision of fees for the purposes of NAC 616C.170 to 616C.191, inclusive, by comparing the annual increase or decrease percentage factor established pursuant to paragraph (c) to the maximum increase allowed as reported by the United States Department of Labor in its Consumer Price Index **,** ~~[(]~~ Medical Care Component, ~~[Professional Medical Services, for All Urban Wage Earners and Clerical Workers)]~~ using the unadjusted percentage change for January to December, inclusive, of the previous year.

2. As used in this section, "CPT-4" means the American Medical Association's "Physicians' Current Procedural Terminology," fourth edition, as contained in the ***Relative Values for Physicians***, as adopted by reference in NAC 616C.188.

Sec. 44. NAC 616C.396 is hereby amended to read as follows:

616C.396 1. The industrial insurance regulation section will investigate each claim against an uninsured employer to determine whether the claim will be assigned to the third-party administrator or insurer designated by the division pursuant to NRS 616C.220 for the payment of benefits from the uninsured employers' claim fund. The industrial insurance regulation section will refuse to assign the claim if:

(a) The private carrier has failed to exhaust its remedies by failing to charge the claim against any existing policies of the employer of the employee or any principal contractor who is liable for the payment of compensation;

(b) The claim includes a person excluded as an employee pursuant to NRS 616A.110;

(c) The notice of the claim fails to include the documents which support the claim; ~~[or]~~

(d) The claim fails to satisfy any provision of NRS 616C.220 ~~[.]~~ ***; or***

(e) The injured employee fails to complete and return to the industrial insurance regulation section:

(1) Form D-16, Notice of Election for Compensation Benefits Under the Uninsured Employer Statutes;

(2) Form D-17, Employee's Claim for Compensation - Uninsured Employer; or

(3) Form D-18, Assignment of Claim for Workers' Compensation - Uninsured Employer,

FLUSH ***within 30 days after he receives the form from the industrial insurance regulation section.***

2. If the industrial insurance regulation section refuses to assign a claim, it will include in the notice required by NRS 616C.220 a statement of the right of appeal provided by that section.

Sec. 45. NAC 616C.402 is hereby amended to read as follows:

616C.402 1. If a claim against an uninsured employer is closed, the third-party administrator or insurer designated by the division pursuant to NRS 616C.220 shall send a copy of or deliver by electronic transmission the closure notice to the division at the same time at which the notice is delivered to the injured employee pursuant to NRS 616C.235.

2. If a claim against an uninsured employer is reopened, the designated third-party administrator or insurer shall send a copy of or deliver by electronic transmission the reopening notice to the division at the same time at which the notice is delivered to the injured employee.

~~[3. If the designated third-party administrator or insurer fails to comply with subsection 1 or 2 of this section or complies in an untimely manner, the administrator will, after notice and hearing:~~

~~(a) For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.~~

~~(b) For the second violation within a 12-month period, impose an administrative fine of not less than $100.~~

~~(c) For the third violation within a 12-month period, impose an administrative fine of not less than $250.~~

~~(d) For the fourth violation within a 12-month period, impose an administrative fine of not less than $500.~~

~~(e) For the fifth and each subsequent violation within a 12-month period, impose an administrative fine of $1,000.]~~

Sec. 46. NAC 616C.476 is hereby amended to read as follows:

616C.476 1. ***A rating physician or chiropractor who performs an evaluation of a permanent partial disability shall evaluate the industrial injury or occupational disease of the injured employee as it exists at the time of the rating evaluation. The rating physician or chiropractor shall take into account any improvement or worsening of the industrial injury or occupational disease that has resulted from treatment of the industrial injury or occupational disease.***

2. A rating physician or chiropractor performing an evaluation of a permanent partial disability that is related to the spine of an injured employee shall use the "Injury Model," as described on page 3/94 of the guide, to rate the disability if the condition of the injured employee is listed in Table 70, Spine Impairment Categories for Cervicothoracic, Thoracolumbar, and Lumbosacral Regions, on page 3/108 of the guide. If none of the categories set forth in the table are applicable to the condition of the injured employee, the rating physician or chiropractor may use the "Range of Motion Model," as described on page 3/94 of the guide, to assist in categorizing the disability.

~~[2. A rating physician or chiropractor who determines that the injury of an employee with chronic spinal pain is in Spine Impairment Category I of Table 70 shall delineate the impairment rating of the whole person as follows:~~

~~(a) If there are complaints of subjective pain without objective findings of pain after a physical examination and multiple observations by providers of health care noted inconsistencies with respect to the presentation of pain, 0 percent impairment of the whole person.~~

~~(b) If there are complaints of subjective pain without objective findings of pain after a physical examination, multiple observations by providers of health care revealed consistencies~~

~~with respect to the presentation of pain and the pain interferes with the injured employee's activities of daily living or his vocational efficiency, or both, but does not preclude the injured employee from returning to his employment at the time of his injury, 1 to 2 percent impairment of the whole person.~~

~~(c) If there are complaints of subjective pain without objective findings of pain after a physical examination, multiple observations by providers of health care revealed consistencies with respect to the presentation of pain, the pain, within a degree of medical probability, results in a gradual decrease in functional work categorization, and the ability of the injured employee to carry out activities of daily living is significantly decreased or he is precluded from returning to his employment at the time of his injury, or both, 3 to 4 percent impairment of the whole person.~~

~~3. A rating physician or chiropractor shall document all ratings of impairments listed in Spine Impairment Category I of Table 70.~~

~~4.~~ ***3.*** A rating physician or chiropractor evaluating an upper extremity neurological impairment shall use Table 15, Maximum Upper Extremity Impairments Due to Unilateral Sensory or Motor Deficits or Combined Deficits of the Major Peripheral Nerves, on page 3/54 of the guide, rather than Table 16, Upper Extremity Impairment Due to Entrapment Neuropathy, on page 3/57 of the guide.

Sec. 47. NAC 616C.490 is hereby amended to read as follows:

616C.490 1. If any permanent impairment from which an employee is suffering following an accidental injury or the onset of an occupational disease is due in part to the injury or disease, and in part to a preexisting or intervening injury, disease or condition, the rating physician or chiropractor, except as otherwise provided in subsection ~~[8,]~~ ***9,*** shall determine the portion of the impairment which is reasonably attributable to the injury or occupational disease and the portion

which is reasonably attributable to the preexisting or intervening injury, disease or condition. The injured employee may receive compensation for that portion of his impairment which is reasonably attributable to the present industrial injury or occupational disease and may not receive compensation for that portion which is reasonably attributable to the preexisting or intervening injury, disease or condition. ***The injured employee is not entitled to receive compensation for his impairment if the percentage of impairment established for his preexisting or intervening injury, disease or condition is equal to or greater than the percentage of impairment established for the present industrial injury or occupational disease.***

2. Except as otherwise provided in subsection ~~[8,]~~ ***9,*** the rating of a permanent partial disability must be apportioned if there is a preexisting permanent impairment or intervening injury, disease or condition, whether it resulted from an industrial or nonindustrial injury, disease or condition.

3. ~~[The apportionment must be determined by computing the percentage of the entire impairment and deducting from that percentage the percentage of the impairment caused by the previous injury, disease or condition as it existed at the time of the industrial injury or the onset of the intervening injury, disease or condition.~~

~~4.]~~ A precise apportionment must be completed if a prior evaluation of the percentage of impairment is available and recorded for the preexisting impairment. The ~~[organs]~~ ***condition, organ*** or anatomical structure of the preexisting impairment must be identical with that subject to current evaluation. ~~[The prior percentages which were used must have been derived from the guide.]~~ Sources of information upon which an apportionment may be based include, but are not limited to:

(a) Prior ratings of the insurer;

(b) Other ratings;

(c) Findings of the loss of range of motion; or

(d) Information concerning previous surgeries.

~~[5.]~~ ***4. If a rating evaluation was completed in this state for a previous industrial injury or occupational disease involving a condition, organ or anatomical structure that is identical to the condition, organ or anatomical structure being evaluated for the present industrial injury or occupational disease, an apportionment must be determined by subtracting the percentage of impairment established for the previous industrial injury or occupational disease from the percentage of impairment established for the present industrial injury or occupational disease, regardless of the edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment used to determine the percentage of impairment for the previous industrial injury or occupational disease.***

5. Except as otherwise provided in subsection 6, if a rating evaluation was completed in another state for a previous injury or disease involving a condition, organ or anatomical structure that is identical to the condition, organ or anatomical structure being evaluated for the present industrial injury or occupational disease, or if no previous rating evaluation was performed, the percentage of impairment for the previous injury or disease and the present industrial injury or occupational disease must be determined by using the guide, as adopted by reference pursuant to NAC 616C.002. The apportionment must be determined by subtracting the percentage of impairment established for the previous injury or disease from the percentage of impairment established for the present industrial injury or occupational disease.

6. If precise information is not available, ***and the rating physician or chiropractor is unable to determine an apportionment using the guide as set forth in subsection 5, an***

apportionment may be allowed if at least 50 percent of the total present impairment is due to a preexisting or intervening injury, disease or condition ***.*** ~~[as determined by subsection 3.]~~ The rating physician or chiropractor may base the apportionment upon X-rays, historical records and diagnoses made by physicians or chiropractors or records of treatment which confirm the prior impairment.

~~[6.]~~ ***7.*** If there are preexisting conditions, ~~[such as]~~ ***including, without limitation,*** degenerative arthritis, rheumatoid variants, obesity or congenital malformations, the apportionment must be supported by documentation concerning the scope and the nature of the impairment which existed before the industrial injury or the onset of disease.

~~[7.]~~ ***8.*** A rating physician or chiropractor shall always explain the underlying basis of the apportionment as specifically as possible by citing pertinent data in the health care records or other records.

~~[8.]~~ ***9.*** If no documentation exists pursuant to subsection ~~[6 or 7,]~~ ***7 or 8,*** the impairment may not be apportioned.

Sec. 48. NAC 616C.496 is hereby amended to read as follows:

616C.496 If no factual measurement ***has been made*** of a disability ***that:***

1. Involves the same anatomical structure or the same or a related condition or organ; and

2. Is attributable to the injury from the first accident ***,*** ~~[has been made]~~

FLUSH before a disability occurs as a result of the second accident, the total disability from both accidents must not be evaluated until both injuries are stabilized following the second accident.

Sec. 49. NAC 616C.508 is hereby amended to read as follows:

616C.508 ***1.*** An injured employee is entitled to receive the following compensation for the loss of or permanent damage to a tooth:

Incisor.....$200

Cuspid 300

Bicuspid.....300

Molar 400

2. An insurer or third-party administrator shall pay an injured employee for the loss of or permanent damage to a tooth within 30 days after he is notified by the treating dentist that the dental treatment related to the tooth has been completed.

Sec. 50. Chapter 616D of NAC is hereby amended by adding thereto the provisions set forth as sections 51 to 66, inclusive, of this regulation.

Sec. 51. ***If an employer fails to provide the notice required pursuant to NRS 616B.656 in the manner set forth in NAC 616B.800, the administrator will:***

1. For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

2. For the second violation within a 12-month period, impose an administrative fine of at least $250.

3. For the third violation within a 12-month period, impose an administrative fine of at least $500.

4. For the fourth or any subsequent violation within a 12-month period, impose an administrative fine of $1,000.

Sec. 52. ***If a sole proprietor fails to provide the notice required pursuant to NRS 616B.659 in the manner set forth in NAC 616B.809, the administrator will:***

1. For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

2. For the second violation within a 12-month period, impose an administrative fine of at least $250.

3. For the third violation within a 12-month period, impose an administrative fine of at least $500.

4. For the fourth or any subsequent violation within a 12-month period, impose an administrative fine of $1,000.

Sec. 53. ***If an employer, an insurer, a third-party administrator or an organization for managed care fails to comply or complies in an untimely manner with the provisions of NAC 616C.030, the administrator will:***

1. For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

2. For the second violation within a 12-month period, impose an administrative fine of at least $250.

3. For the third violation within a 12-month period, impose an administrative fine of at least $500.

4. For the fourth violation within a 12-month period, impose an administrative fine of at least $750.

5. For the fifth or any subsequent violation within a 12-month period, impose an administrative fine of $1,000.

Sec. 54. ***If a physician or chiropractor fails to comply with the provisions of subsection 3 of NRS 616C.040 or subsection 7 of NRS 616C.475, the administrator will:***

1. For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

2. For the second violation within a 12-month period, impose an administrative fine of at least $250.

3. For the third violation with a 12-month period, impose an administrative fine of at least $500.

4. For the fourth violation within a 12-month period, impose an administrative fine of at least $750.

5. For the fifth or any subsequent violation within a 12-month period, impose an administrative fine of $1000.

Sec. 55. ***If an insurer fails to comply or complies in an untimely manner with the provisions of NAC 616C.1156, the administrator will:***

1. For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

2. For the second violation within a 12-month period, impose an administrative fine of at least $100.

3. For the third violation within a 12-month period, impose an administrative fine of at least $250.

4. For the fourth violation within a 12-month period, impose an administrative fine of at least $500.

5. For the fifth or any subsequent violation within a 12-month period, impose an administrative fine of $1,000.

Sec. 56. *If an insurer or employer fails to comply or complies in an untimely manner with the provisions of NAC 616C.1164, the administrator will:*

1. For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

2. For the second violation within a 12-month period, impose an administrative fine of at least $100.

3. For the third violation within a 12-month period, impose an administrative fine of at least $250.

4. For the fourth or any subsequent violation within a 12-month period, impose an administrative fine of $500.

Sec. 57. *If a designated third-party administrator or insurer fails to comply or complies in an untimely manner with the provisions of NAC 616C.402, the administrator will:*

1. For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

2. For the second violation within a 12-month period, impose an administrative fine of at least $100.

3. For the third violation within a 12-month period, impose an administrative fine of at least $250.

4. For the fourth violation within a 12-month period, impose an administrative fine of at least $500.

5. For the fifth or any subsequent violation within a 12-month period, impose an administrative fine of $1,000.

Sec. 58. *If an insurer or a third-party administrator fails to comply or complies in an untimely manner with the provisions of NAC 616C.508, the administrator will:*

1. For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

2. For the second violation within a 12-month period, impose an administrative fine of at least $250.

3. For the third violation within a 12-month period, impose an administrative fine of at least $500.

4. For the fourth violation within a 12-month period, impose an administrative fine of at least $750.

5. For the fifth or any subsequent violation within a 12-month period, impose an administrative fine of $1,000.

Sec. 59. *If an insurer fails to comply with the provisions of section 6 of this regulation, the administrator will:*

1. For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

2. For the second violation within a 12-month period, impose an administrative fine of at least $250.

3. For the third violation within a 12-month period, impose an administrative fine of at least $500.

4. For the fourth violation within a 12-month period, impose an administrative fine of at least $750.

5. For the fifth or any subsequent violation within a 12-month period, impose an administrative fine of $1,000.

Sec. 60. *If an insurer or third-party administrator fails to comply or complies in an untimely manner with the provisions of section 8 of this regulation, the administrator will:*

1. For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

2. For the second violation within a 12-month period, impose an administrative fine of at least $250.

3. For the third violation within a 12-month period, impose an administrative fine of at least $500.

4. For the fourth violation within a 12-month period, impose an administrative fine of at least $750.

5. For the fifth or any subsequent violation within a 12-month period, impose an administrative fine of $1,000.

Sec. 61. *If an insurer, third-party administrator, organization for managed care, employer or provider of health care commits a minor violation, as defined in NAC 616D.400, for which an administrative fine or other penalty is not otherwise provided by specific statute or regulation, the administrator will:*

1. For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

2. For the second violation within a 12-month period, impose an administrative fine of at least $100.

3. For the third violation within a 12-month period, impose an administrative fine of at least $250.

4. For the fourth or any subsequent violation within a 12-month period, impose an administrative fine of at least $500.

Sec. 62. *1. If a treating physician or chiropractor fails to comply or complies in an untimely manner with the provisions of NRS 616C.040 or of a regulation adopted pursuant thereto that require the treating physician or chiropractor to complete a claim for compensation, the administrator will:*

(a) For the first violation within a 12-month period, impose an administrative fine of at least $100.

(b) For the second violation within a 12-month period, impose an administrative fine of at least $250.

(c) For the third or any subsequent violation within a 12-month period, impose an administrative fine of at least $500.

2. If a treating physician or chiropractor fails to comply or complies in an untimely manner with the provisions of NRS 616C.040 or of a regulation adopted pursuant thereto that require the treating physician or chiropractor to file a claim for compensation, the administrator will:

(a) For the first violation within a 12-month period, impose an administrative fine of at least $250.

(b) For the second violation within a 12-month period, impose an administrative fine of at least $500.

(c) For the third violation within a 12-month period, impose an administrative fine of $750.

(d) For the fourth or any subsequent violation within a 12-month period, impose an administrative fine of $1,000.

Sec. 63. ***1. If an employer fails to comply or complies in an untimely manner with the provisions of NRS 616C.045 or of a regulation adopted pursuant thereto that require the employer to complete a report of industrial injury or occupational disease, the administrator will:***

(a) For the first violation within a 12-month period, impose an administrative fine of at least $100.

(b) For the second violation within a 12-month period, impose an administrative fine of at least $250.

(c) For the third or any subsequent violation within a 12-month period, impose an administrative fine of at least $500.

2. If an employer fails to comply or complies in an untimely manner with the provisions of NRS 616C.045 or of a regulation adopted pursuant thereto that require the employer to file a report of industrial injury or occupational disease, the administrator will:

(a) For the first violation within a 12-month period, impose an administrative fine of at least $250.

(b) For the second violation within a 12-month period, impose an administrative fine of at least $500.

(c) For the third violation within a 12-month period, impose an administrative fine of at least $750.

(d) For the fourth or any subsequent violation within a 12-month period, impose an administrative fine of $1,000.

Sec. 64. *If a provider of health care, an organization for managed care, an insurer or an employer fails to comply with the provisions of NRS 616C.135, the administrator will:*

1. For the first violation within a 12-month period, impose an administrative fine of at least $100.

2. For the second or any subsequent violation within a 12-month period, impose an administrative fine of $250.

Sec. 65. *1. If a treating physician or chiropractor fails to comply or complies in an untimely manner with the provisions of NRS 617.352 or of a regulation adopted pursuant thereto that require the treating physician or chiropractor to complete a claim for compensation, the administrator will:*

(a) For the first violation within a 12-month period, impose an administrative fine of at least $100.

(b) For the second violation within a 12-month period, impose an administrative fine of at least $250.

(c) For the third or any subsequent violation within a 12-month period, impose an administrative fine of at least $500.

2. If a treating physician or chiropractor fails to comply or complies in an untimely manner with the provisions of NRS 617.352 or of a regulation adopted pursuant thereto that

require the treating physician or chiropractor to file a claim for compensation, the administrator will:

(a) For the first violation within a 12-month period, impose an administrative fine of at least $250.

(b) For the second violation within a 12-month period, impose an administrative fine of at least $500.

(c) For the third violation within a 12-month period, impose an administrative fine of $750.

(d) For the fourth or any subsequent violation within a 12-month period, impose an administrative fine of $1,000.

Sec. 66. *1. If an employer fails to comply or complies in an untimely manner with the provisions of NRS 617.354 or of a regulation adopted pursuant thereto that require the employer to complete an employer's report of industrial injury or occupational disease, the administrator will:*

(a) For the first violation within a 12-month period, impose an administrative fine of at least $100.

(b) For the second violation within a 12-month period, impose an administrative fine of at least $250.

(c) For the third violation within a 12-month period, impose an administrative fine of at least $500.

2. If an employer fails to comply or complies in an untimely manner with the provisions of NRS 617.354 or of a regulation adopted pursuant thereto that require the employer to file an employer's report of industrial injury or occupational disease, the administrator will:

(a) For the first violation within a 12-month period, impose an administrative fine of at least $250.

(b) For the second violation within a 12-month period, impose an administrative fine of at least $500.

(c) For the third violation within a 12-month period, impose an administrative fine of at least $750.

(d) For the fourth or any subsequent violation within a 12-month period, impose an administrative fine of $1,000.

Sec. 67. NAC 616D.305 is hereby amended to read as follows:

616D.305 For the purposes of carrying out the provisions of NRS 616D.120 and NAC 616D.311 and 616D.315:

1. A decision of a court, a hearing officer, an appeals officer or the division shall be deemed to be:

(a) Any written order or decision entered by a court of competent jurisdiction, hearing officer or appeals officer, including, without limitation, a written determination that is not appealed in a timely manner;

(b) Any written decision issued by the division; and

(c) A written settlement agreement or written stipulation that is modified or changed by a court of competent jurisdiction, a hearing officer, an appeals officer or the division.

2. "Payment of compensation" means:

(a) The payment of accident, medical or other benefits to an injured employee or his dependents;

(b) The payment of accident, medical or other benefits to persons other than an injured employee or his dependents;

(c) Giving written notice to an injured employee of the date, time and place of an appointment for the receipt of accident, medical or other benefits; and

(d) Providing ***an evaluation of or*** treatment to an injured employee for an industrial injury or occupational disease for which accident, medical or other benefits are payable.

3. "Written settlement agreement" means any agreement that is in writing or in the form of minutes or a transcript.

4. "Written stipulation" means any stipulation that is in writing or in the form of minutes or a transcript.

Sec. 68. NAC 616D.345 is hereby amended to read as follows:

616D.345 1. Except as otherwise provided in NAC 616D.375, if the fraud control unit for industrial insurance established pursuant to NRS 228.420 notifies the administrator, pursuant to NRS 616D.120, that the unit will not prosecute an employer for failing to provide and secure compensation as required by the terms of chapters 616A to 616D, inclusive, of NRS or any regulation adopted pursuant thereto, the administrator ~~[or his designated agent]~~ will:

(a) For a failure to provide and secure compensation for a period of 30 days or less, impose an administrative fine in an amount that equals 10 percent of the expected annual premium of the employer or $500, whichever is greater.

(b) For a failure to provide and secure compensation for a period of more than 30 days, impose an administrative fine in an amount that equals 20 percent of the expected annual premium of the employer or $1,000, whichever is greater.

2. In no case will the administrator ~~[or his designated agent]~~ impose an administrative fine pursuant to this section that is greater than $10,000.

Sec. 69. NAC 616D.355 is hereby amended to read as follows:

616D.355 1. Except as otherwise provided in NAC 616D.375, if the fraud control unit for industrial insurance established pursuant to NRS 228.420 notifies the administrator, pursuant to NRS 616D.120, that the unit will not prosecute an employer for failing to maintain compensation as required by the terms of chapters 616A to 616D, inclusive, of NRS or any regulation adopted pursuant thereto, the administrator ~~[or his designated agent]~~ will:

(a) If the employer failed to maintain compensation for a period of 30 days or less:

(1) For the first violation, impose an administrative fine in an amount that equals 10 percent of the expected annual premium of the employer or $250, whichever is greater.

(2) For the second violation, impose an administrative fine in an amount that equals 25 percent of the expected annual premium of the employer or $1,000, whichever is greater.

(3) For the third violation, impose an administrative fine in an amount that equals 50 percent of the expected annual premium of the employer or $5,000, whichever is greater.

(4) For the fourth or ***any*** subsequent violation, impose an administrative fine of $10,000.

(b) If the employer failed to maintain compensation for a period of more than 30 days:

(1) For the first violation, impose an administrative fine in an amount that equals 20 percent of the expected annual premium of the employer or $500, whichever is greater.

(2) For the second violation, impose an administrative fine in an amount that equals 50 percent of the expected annual premium of the employer or $2,000, whichever is greater.

(3) For the third or ***any*** subsequent violation, impose an administrative fine of $10,000.

2. In no case will the administrator ~~[or his designated agent]~~ impose an administrative fine pursuant to this section that is greater than $10,000.

Sec. 70. NAC 616D.375 is hereby amended to read as follows:

616D.375 1. If the fraud control unit for industrial insurance established pursuant to NRS 228.420 notifies the administrator, pursuant to NRS 616D.120, that the unit will not prosecute an employer for failing to provide and secure or to maintain compensation as required by the terms of chapters 616A to 616D, inclusive, of NRS or any regulation adopted pursuant thereto and ~~[such]~~ ***that*** failure results in an uninsured claim that is assigned to the uninsured employers' claim fund pursuant to NRS 616C.220, the administrator ~~[or his designated agent]~~ will, for each violation, impose an administrative fine in an amount that equals 25 percent of the expected annual premium of the employer or $1,000, whichever is greater.

2. In no case will the administrator ~~[or his designated agent]~~ impose an administrative fine pursuant to this section that is greater than $10,000.

Sec. 71. NAC 616D.380 is hereby amended to read as follows:

616D.380 1. If the fraud control unit for industrial insurance established pursuant to NRS 228.420 notifies the administrator, pursuant to NRS 616D.120, that the unit will not prosecute an employer for knowingly making a false statement or knowingly failing to report a material fact concerning the amount of payroll upon which a premium is based in violation of NRS 616D.220 or any regulation adopted pursuant thereto, the administrator ~~[or his designated agent]~~ will:

(a) For the first violation that results in an unreported or underreported payroll, impose an administrative fine of 10 percent of the expected annual premium of the employer or $250, whichever is greater.

(b) For the second violation that results in an unreported or underreported payroll, impose an administrative fine of 25 percent of the expected annual premium of the employer or $1,000, whichever is greater.

(c) For the third violation that results in an unreported or underreported payroll, impose an administrative fine of 50 percent of the expected annual premium of the employer or $5,000, whichever is greater.

(d) For the fourth or ***any*** subsequent violation that results in an unreported or underreported payroll, impose an administrative fine of $10,000.

2. For the purpose of imposing administrative fines pursuant to this section, the administrator will not deem a second, third, fourth or subsequent violation to have occurred unless it occurs in an audit period that is subsequent to the audit period in which the previous violation occurred.

3. In no case will the administrator ~~[or his designated agent]~~ impose an administrative fine pursuant to this section that is greater than $10,000.

Sec. 72. NAC 616D.385 is hereby amended to read as follows:

616D.385 1. If the fraud control unit for industrial insurance established pursuant to NRS 228.420 notifies the administrator, pursuant to NRS 616D.120, that the unit will not prosecute an employer for knowingly misrepresenting the classification or duties of an employee in violation of NRS 616D.220 or any regulation adopted pursuant thereto, the administrator ~~[or his designated agent]~~ will:

(a) For the first violation, impose an administrative fine of 10 percent of the expected annual premium of the employer or $250, whichever is greater.

(b) For the second violation, impose an administrative fine of 25 percent of the expected annual premium of the employer or $1,000, whichever is greater.

(c) For the third violation, impose an administrative fine of 50 percent of the expected annual premium of the employer or $5,000, whichever is greater.

(d) For the fourth or ***any*** subsequent violation, impose an administrative fine of $10,000.

2. For the purpose of imposing administrative fines pursuant to this section, the administrator will not deem a second, third, fourth or subsequent violation to have occurred unless it occurs in an audit period that is subsequent to the audit period in which the previous violation occurred.

3. In no case will the administrator ~~[or his designated agent]~~ impose an administrative fine pursuant to this section that is greater than $10,000.

Sec. 73. NAC 616D.400 is hereby amended to read as follows:

616D.400 For the purposes of subsection 2 of NRS 616D.120, "minor violation" means ~~[a]~~ ***:***

1. Except as otherwise provided in section 61 of this regulation, a violation of any provision of chapter 616A, 616B, 616C, 616D or 617 of NRS or a regulation adopted pursuant thereto for which an administrative fine or other penalty is not specifically provided ~~[.]~~ ***; or***

2. A violation of any provision set forth in sections 51 to 61, inclusive, of this regulation and NAC 616D.406 to 616D.438, inclusive.

Sec. 74. NAC 616D.402 is hereby amended to read as follows:

616D.402 For the purposes of NAC 616D.400 to 616D.440, inclusive, ***and sections 51 to 61, inclusive, of this regulation,*** a person:

1. Fails to comply with a provision of chapter 616A, 616B, 616C, 616D or 617 of NRS or a regulation adopted pursuant thereto if there is an absence of action taken on the part of the person to comply with that provision.

2. Complies in an untimely manner with a provision of chapter 616A, 616B, 616C, 616D or 617 of NRS or a regulation adopted pursuant thereto if he takes action 1 or more days after the time prescribed in that provision.

3. Fails to make a payment required pursuant to a provision of chapter 616A, 616B, 616C, 616D or 617 of NRS or a regulation adopted pursuant thereto if he does not pay any portion of the amount required to be paid pursuant to that provision.

4. Makes a payment required pursuant to a provision of chapter 616A, 616B, 616C, 616D or 617 of NRS or a regulation adopted pursuant thereto in an untimely manner if he makes the payment 1 or more days after the time prescribed in that provision.

Sec. 75. NAC 616D.404 is hereby amended to read as follows:

616D.404 1. For the purposes of NAC 616D.400 to 616D.440, inclusive, ***and sections 51 to 61, inclusive, of this regulation,*** a person shall not be deemed to have committed a second or subsequent violation of a provision of chapter 616A, 616B, 616C, 616D or 617 of NRS or a regulation adopted pursuant thereto unless he has received a notice of correction for the first violation of that provision within the immediately preceding 12 months.

2. In no case will the administrator impose an administrative fine for a minor violation set forth in NAC 616D.400 to 616D.440, inclusive, that is greater than $1,000.

Sec. 76. NAC 616D.406 is hereby amended to read as follows:

616D.406 ~~[1.]~~ If an insurer, organization for managed care, ***provider of*** health care ***,*** ~~[provider,]~~ third-party administrator or employer fails to comply ***or complies in an untimely***

manner with a provision of chapter 616A, 616B, 616C ***, 616D*** or 617 of NRS ***or a regulation adopted pursuant thereto*** that requires the insurer, organization for managed care, ***provider of*** health care ***,*** ~~[provider,]~~ third-party administrator or employer to provide to an injured employee a form, notice or any other information, the administrator will:

~~[(a)]~~ ***1.*** For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

~~[(b)]~~ ***2.*** For the second violation within a 12-month period, impose an administrative fine of at least $250.

~~[(c)]~~ ***3.*** For the third violation within a 12-month period, impose an administrative fine of at least $500.

~~[(d)]~~ ***4.*** For the fourth violation within a 12-month period, impose an administrative fine of at least $750.

~~[(e)]~~ ***5.*** For the fifth or ***any*** subsequent violation within a 12-month period, impose an administrative fine of $1,000.

~~[2. If an insurer, organization for managed care, health care provider, third-party administrator or employer complies in an untimely manner with any provision of chapter 616A, 616B, 616C or 617 of NRS that requires the insurer, organization for managed care, health care provider, third-party administrator or employer to provide to an injured employee a notice, form or any other information, the administrator will:~~

~~(a) For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.~~

~~(b) For the second violation within a 12-month period, impose an administrative fine of at least $100.~~

~~(c) For the third violation within a 12-month period, impose an administrative fine of at least $250.~~

~~(d) For the fourth or subsequent violation within a 12-month period, impose an administrative fine of at least $500.~~~~]~~

Sec. 77. NAC 616D.408 is hereby amended to read as follows:

616D.408 1. If an insurer or third-party administrator fails to comply ***or complies in an untimely manner*** with any provision of chapter 616A, 616B, 616C, 616D or 617 of NRS ***or a regulation adopted pursuant thereto*** that requires the insurer or third-party administrator to make a determination regarding the acceptance or denial of a claim for compensation, the administrator will:

(a) For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

(b) For the second violation within a 12-month period, impose an administrative fine of at least $250.

(c) For the third violation within a 12-month period, impose an administrative fine of at least $500.

(d) For the fourth violation within a 12-month period, impose an administrative fine of at least $750.

(e) For the fifth or ***any*** subsequent violation within a 12-month period, impose an administrative fine of $1,000.

2. ~~[If an insurer or third-party administrator complies in an untimely manner with any provision of chapter 616A, 616B, 616C, 616D or 617 of NRS that requires the insurer or third-~~

~~party administrator to make a determination regarding the acceptance or denial of a claim for compensation, the administrator will:~~

~~(a) For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.~~

~~(b) For the second violation within a 12-month period, impose an administrative fine of at least $100.~~

~~(c) For the third violation within a 12-month period, impose an administrative fine of at least $250.~~

~~(d) For the fourth or subsequent violation within a 12-month period, impose an administrative fine of at least $500.~~~~]~~ ***An insurer shall pay any administrative fine imposed pursuant to subsection 1 in addition to any amount ordered by the administrator pursuant to NRS 616C.065.***

Sec. 78. NAC 616D.410 is hereby amended to read as follows:

616D.410 ~~[1.]~~ If an insurer ***,*** ~~[or]~~ organization for managed care ***or third-party administrator*** fails to comply ***or complies in an untimely manner*** with any provision of chapter 616A, 616B, 616C, 616D or 617 of NRS ***or a regulation adopted pursuant thereto*** that requires the insurer ***,*** ~~[or]~~ organization for managed care ***or third-party administrator*** to provide to an employer or injured employee notice of his right to file an appeal of a determination of the insurer ***,*** ~~[or]~~ organization for managed care ~~[,]~~ ***or third-party administrator,*** the administrator will:

~~[(a)]~~ ***1.*** For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

~~[(b)]~~ ***2.*** For the second violation within a 12-month period, impose an administrative fine of at least $100.

~~[(c)]~~ ***3.*** For the third ~~[or subsequent]~~ violation within a 12-month period, impose an administrative fine of at least ~~[$200.~~

~~2. If an insurer or organization for managed care complies in an untimely manner with any provision of chapter 616A, 616B, 616C, 616D or 617 of NRS that requires the insurer or organization for managed care to provide to an employer or injured employee notice of his right to file an appeal of a determination of the insurer or organization for managed care, the administrator will:~~

~~(a) For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.~~

~~(b) For the second violation within a 12-month period, impose an administrative fine of at least $50.~~

~~(c) For the third or subsequent violation within a 12-month period, impose an administrative fine of at least $100.]~~ ***$250.***

4. For the fourth or any subsequent violation within a 12-month period, impose an administrative fine of at least $500.

Sec. 79. NAC 616D.412 is hereby amended to read as follows:

616D.412 ~~[1.]~~ If an insurer, organization for managed care or third-party administrator fails to comply ***or complies in an untimely manner*** with the provisions of NAC 616C.094, the administrator will:

~~[(a)]~~ ***1.*** For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

~~[(b)]~~ ***2.*** For the second violation within a 12-month period, impose an administrative fine of at least $250.

~~[(c)]~~ ***3.*** For the third violation within a 12-month period, impose an administrative fine of at least $500.

~~[(d)]~~ ***4.*** For the fourth ~~[or subsequent]~~ violation within a 12-month period, impose an administrative fine of at least $750.

~~[(e)]~~ ***5.*** For the fifth or ***any*** subsequent violation within a 12-month period, impose an administrative fine of $1,000.

~~[2. If an insurer, organization for managed care or third-party administrator complies with the provisions of NAC 616C.094 in an untimely manner, the administrator will:~~

~~(a) For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.~~

~~(b) For the second violation within a 12-month period, impose an administrative fine of at least $100.~~

~~(c) For the third violation within a 12-month period, impose an administrative fine of at least $250.~~

~~(d) For the fourth violation within a 12-month period, impose an administrative fine of at least $500.]~~

Sec. 80. NAC 616D.414 is hereby amended to read as follows:

616D.414 1. If an insurer or third-party administrator fails to comply ***or complies in an untimely manner*** with a provision of chapter 616A, 616B, 616C, 616D or 617 of NRS or a regulation adopted pursuant thereto that requires the insurer or third-party administrator to make a payment of benefits to an injured employee, the administrator will:

(a) For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

(b) For the second violation within a 12-month period, impose an administrative fine of at least $500.

(c) For the third violation within a 12-month period, impose an administrative fine of at least $750.

(d) For the fourth or ***any*** subsequent violation within a 12-month period, impose an administrative fine of $1,000.

2. ~~[If an insurer or third-party administrator complies in an untimely manner with a provision of chapter 616A, 616B, 616C, 616D or 617 of NRS or a regulation adopted pursuant thereto that requires the insurer or third-party administrator to make a payment of benefits to an injured employee, the administrator will:~~

~~(a) For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.~~

~~(b) For the second violation within a 12-month period, impose an administrative fine of at least $200.~~

~~(c) For the third violation within a 12-month period, impose an administrative fine of at least $500.~~

~~(d) For the fourth or subsequent violation within a 12-month period, impose an administrative fine of $1,000.~~

~~3.]~~ Except as otherwise provided in subsection ~~[4,]~~ ***3,*** if an insurer or third-party administrator makes a payment of benefits to an injured employee that is less than the amount to

which the injured employee was entitled pursuant to chapters 616A to 617, inclusive, of NRS or the regulations adopted pursuant thereto, the administrator will:

(a) For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

(b) For the second violation within a 12-month period, impose an administrative fine of at least $100.

(c) For the third violation within a 12-month period, impose an administrative fine of at least $250.

(d) For the fourth or ***any*** subsequent violation within a 12-month period, impose an administrative fine of at least $500.

~~[4.]~~ ***3.*** The administrator will not impose the penalties prescribed in subsection ~~[3]~~ ***2*** unless the deficiency in the payment of benefits is more than 1 percent of the total amount which was ~~[due]~~ ***owed*** to the injured employee pursuant to chapters 616A to 617, inclusive, of NRS or the regulations adopted pursuant thereto.

Sec. 81. NAC 616D.416 is hereby amended to read as follows:

616D.416 ~~[1.]~~ If an insurer or third-party administrator fails to comply ***or complies in an untimely manner*** with the provisions of NRS 616C.490 or NAC 616C.103, the administrator will:

~~[(a)]~~ ***1.*** For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

~~[(b)]~~ ***2.*** For the second violation within a 12-month period, impose an administrative fine of at least $250.

~~[(c)]~~ ***3.*** For the third violation within a 12-month period, impose an administrative fine of at least $500.

~~[(d)]~~ ***4.*** For the fourth violation within a 12-month period, impose an administrative fine of at least $750.

~~[(e)]~~ ***5.*** For the fifth or ***any*** subsequent violation within a 12-month period, impose an administrative fine of $1,000.

~~[2. If an insurer or third-party administrator complies with the provisions of NRS 616C.490 or NAC 616C.103 in an untimely manner, the administrator will:~~

~~(a) For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.~~

~~(b) For the second violation within a 12-month period, impose an administrative fine of at least $100.~~

~~(c) For the third violation within a 12-month period, impose an administrative fine of at least $250.~~

~~(d) For the fourth or subsequent violation within a 12-month period, impose an administrative fine of at least $500.]~~

Sec. 82. NAC 616D.418 is hereby amended to read as follows:

616D.418 ~~[1.]~~ If an insurer, third-party administrator ***,*** or treating or examining physician or chiropractor fails to comply ***or complies in an untimely manner*** with the provisions of NAC 616C.558, the administrator will:

~~[(a)]~~ ***1.*** For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

~~[(b)]~~ ***2.*** For the second ~~[or subsequent]~~ violation within a 12-month period, impose an administrative fine of at least $250.

~~[2. If an insurer, third-party administrator or treating or examining physician or chiropractor complies in an untimely manner with the provisions of NAC 616C.558, the administrator will:~~

~~(a) For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.~~

~~(b) For the second or subsequent violation within a 12-month period, impose an administrative fine of at least $100.]~~

3. For the third violation within a 12-month period, impose an administrative fine of at least $500.

4. For the fourth violation within a 12-month period, impose an administrative fine of at least $750.

5. For the fifth or any subsequent violation within a 12-month period, impose an administrative fine of $1000.

Sec. 83. NAC 616D.420 is hereby amended to read as follows:

616D.420 ~~[1.]~~ If a rating physician or chiropractor fails to comply ***or complies in an untimely manner*** with the provisions of NAC 616C.212, the administrator will:

~~[(a)]~~ ***1.*** For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

~~[(b)]~~ ***2.*** For the second violation within a 12-month period, impose an administrative fine of at least $250.

~~[(c)]~~ ***3.*** For the third violation within a 12-month period, impose an administrative fine of at least $500.

~~[(d)]~~ ***4.*** For the fourth violation within a 12-month period, impose an administrative fine of at least $750.

~~[(e)]~~ ***5.*** For the fifth or ***any*** subsequent violation within a 12-month period, impose an administrative fine of $1,000.

~~[2. If a rating physician or chiropractor complies with the provisions of NAC 616C.212 in an untimely manner, the administrator will:~~

~~(a) For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.~~

~~(b) For the second violation within a 12-month period, impose an administrative fine of at least $100.~~

~~(c) For the third violation within a 12-month period, impose an administrative fine of at least $200.~~

~~(d) For the fourth or subsequent violation within a 12-month period, impose an administrative fine of at least $300.]~~

Sec. 84. NAC 616D.422 is hereby amended to read as follows:

616D.422 ~~[1.]~~ If an insurer, third-party administrator or employer fails to comply ***or complies in an untimely manner*** with any provision of chapter 616A, 616B, 616C, 616D or 617 of NRS or a regulation adopted pursuant thereto that requires the insurer, third-party administrator or employer to make a payment to a ***provider of*** health care ***,*** ~~[provider,]~~ the administrator will:

~~[(a)]~~ ***1.*** For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

~~[(b)]~~ ***2.*** For the second ~~[or subsequent]~~ violation within a 12-month period, impose an administrative fine of at least ~~[~~$125.

~~2. If an insurer, third-party administrator or employer complies in an untimely manner with any provision of chapter 616A, 616B, 616C, 616D or 617 of NRS or a regulation adopted pursuant thereto that requires the insurer, third-party administrator or employer to make a payment to a health care provider, the administrator will:~~

~~(a) For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.~~

~~(b) For the second or subsequent violation within a 12-month period, impose an administrative fine of:~~

~~(1) At least $50 if the payment is made not more than 14 days after the date on which it is due.~~

~~(2) At least $75 if the payment is made more than 14 days but not more than 28 days after the date on which it is due.~~

~~(3) At least $100 if the payment is made more than 28 days after the date on which it is due.~~

~~3. If an insurer, third-party administrator or employer makes a payment to a health care provider that is less than the amount stated on the bill received from the health care provider and the amount is less than the amount to which the health care provider is entitled pursuant to chapters 616A to 617, inclusive, of NRS or the regulations adopted pursuant thereto, the administrator will issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120. If the insurer, third-party administrator or employer does not make the correct payment within 10 days after receiving the notice of correction pursuant to paragraph (a) of~~

~~subsection 2 of NRS 616D.120, the administrator will impose an administrative fine of at least $50.]~~ ***$100.***

3. For the third violation within a 12-month period, impose an administrative fine of at least $250.

4. For the fourth or any subsequent violation within a 12-month period, impose an administrative fine of at least $500.

Sec. 85. NAC 616D.424 is hereby amended to read as follows:

616D.424 ~~[1.]~~ If an insurer or third-party administrator fails to comply ***or complies in an untimely manner*** with the provisions of NAC 616C.555, the administrator will:

~~[(a)]~~ ***1.*** For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

~~[(b)]~~ ***2.*** For the second ~~[or subsequent]~~ violation within a 12-month period, impose an administrative fine of at least $250.

~~[2. If an insurer or third-party administrator complies with the provisions of NAC 616C.555 in an untimely manner, the administrator will:~~

~~(a) For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.~~

~~(b) For the second or subsequent violation within a 12-month period, impose an administrative fine of at least $100.]~~

3. For the third violation within a 12-month period, impose an administrative fine of at least $500.

4. For the fourth violation within a 12-month period, impose an administrative fine of at least $750.

5. For the fifth or any subsequent violation within a 12-month period, impose an administrative fine of $1,000.

Sec. 86. NAC 616D.426 is hereby amended to read as follows:

616D.426 ~~[1.]~~ If an insurer or third-party administrator fails to comply ***or complies in an untimely manner*** with the provisions of subsection 5 or 6 of NRS 616C.550, the administrator will:

~~[(a)]~~ ***1.*** For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

~~[(b)]~~ ***2.*** For the second ~~[or subsequent]~~ violation within a 12-month period, impose an administrative fine of at least $250.

~~[2. If an insurer or third-party administrator complies with the provisions of subsection 5 or 6 of NRS 616C.550 in an untimely manner, the administrator will:~~

~~(a) For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.~~

~~(b) For the second or subsequent violation within a 12-month period, impose an administrative fine of at least $100.]~~

3. For the third violation within a 12-month period, impose an administrative fine of at least $500.

4. For the fourth violation within a 12-month period, impose an administrative fine of at least $750.

5. For the fifth or any subsequent violation within a 12-month period, impose an administrative fine of $1,000.

Sec. 87. NAC 616D.432 is hereby amended to read as follows:

616D.432 ~~[1.]~~ If an insurer or third-party administrator fails to comply ***or complies in an untimely manner*** with the provisions of subsection 3 of NRS 616C.570, the administrator will:

~~[(a)]~~ ***1.*** For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

~~[(b)]~~ ***2.*** For the second violation within a 12-month period, impose an administrative fine of at least ~~[$500.~~

~~(c)]~~ ***$250.***

3. For the third violation within a 12-month period, impose an administrative fine of at least ~~[$750.~~

~~(d)]~~ ***$500.***

4. For the fourth ~~[or subsequent]~~ violation within a 12-month period, impose an administrative fine of ~~[$1,000.~~

~~2. If an insurer or third-party administrator complies with the provisions of subsection 3 of NRS 616C.570 in an untimely manner, the administrator will:~~

~~(a) For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.~~

~~(b) For the second violation within a 12-month period, impose an administrative fine of at least $200.~~

~~(c) For the third violation within a 12-month period, impose an administrative fine of at least $500.~~

~~(d) For the fourth or subsequent violation within a 12-month period, impose an administrative fine of $1,000.]~~ ***$750.***

5. For the fifth or any subsequent violation within a 12-month period, impose an administrative fine of $1,000.

Sec. 88. NAC 616D.434 is hereby amended to read as follows:

616D.434 ~~[1.]~~ If an insurer or third-party administrator fails to comply ***or complies in an untimely manner*** with the provisions of subsection 4 of NRS 616C.570, the administrator will:

~~[(a)]~~ ***1.*** For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

~~[(b)]~~ ***2.*** For the second ~~[or subsequent]~~ violation within a 12-month period, impose an administrative fine of at least $250.

~~[2. If an insurer or third-party administrator complies with the provisions of subsection 4 of NRS 616C.570 in an untimely manner, the administrator will:~~

~~(a) For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.~~

~~(b) For the second or subsequent violation within a 12-month period, impose an administrative fine of at least $100.]~~

3. For the third violation within a 12-month period, impose an administrative fine of at least $500.

4. For the fourth violation within a 12-month period, impose an administrative fine of at least $750.

5. For the fifth or any subsequent violation within a 12-month period, impose an administrative fine of $1,000.

Sec. 89. NAC 616D.436 is hereby amended to read as follows:

616D.436 ~~[1.]~~ If an insurer, organization for managed care, ***provider of*** health care ***,*** ~~[provider,]~~ third-party administrator or employer fails to comply ***or complies in an untimely manner*** with the provisions of NRS 616A.475, 616B.006 ~~[,]~~ ***or*** 616B.009 or NAC 616A.410, the administrator will:

~~[(a)]~~ ***1.*** For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

~~[(b)]~~ ***2.*** For the second violation within a 12-month period, impose an administrative fine of at least $250.

~~[(c)]~~ ***3.*** For the third violation within a 12-month period, impose an administrative fine of at least $500.

~~[(d)]~~ ***4.*** For the fourth violation within a 12-month period, impose an administrative fine of at least $750.

~~[(e)]~~ ***5.*** For the fifth or ***any*** subsequent violation within a 12-month period, impose an administrative fine of $1,000.

~~[2. If an insurer, organization for managed care, health care provider, third-party administrator or employer complies in an untimely manner with the provisions of NRS 616A.475, 616B.006, or 616B.009 or NAC 616A.410, the administrator will:~~

~~(a) For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.~~

~~(b) For the second violation within a 12-month period, impose an administrative fine of at least $100.~~

~~(c) For the third violation within a 12-month period, impose an administrative fine of at least $250.~~

~~(d) For the fourth or subsequent violation within a 12-month period, impose an administrative fine of at least $500.~~]

Sec. 90. NAC 616D.438 is hereby amended to read as follows:

616D.438 If an insurer ~~[or]~~ ***, organization for managed care, provider of health care,*** third-party administrator ***or employer*** fails to comply ***or complies in an untimely manner*** with the provisions of NAC 616A.480, the administrator will:

1. For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616D.120.

2. For the second ~~[or subsequent]~~ violation within a 12-month period, impose an administrative fine of at least $100.

3. For the third violation within a 12-month period, impose an administrative fine of at least $250.

4. For the fourth or any subsequent violation within a 12-month period, impose an administrative fine of at least $500.

Sec. 91. NAC 616D.440 is hereby amended to read as follows:

616D.440 1. If the administrator issues a notice of correction to a person or imposes an administrative fine against a person pursuant to NAC 616D.400 to 616D.440, inclusive, ***and sections 51 to 61, inclusive, of this regulation,*** the administrator may also require the person to submit to the administrator a plan of corrective action pursuant to paragraph (c) of subsection 2 of NRS 616D.120.

2. A plan of corrective action required by the administrator pursuant to subsection 1 must include a detailed description of the actions that the person who is submitting the plan will take to ensure that a subsequent violation does not occur.

Sec. 92. NAC 617.010 is hereby amended to read as follows:

617.010 This chapter applies to all firemen and police officers who are required to submit to physical examinations ***and tests*** to receive industrial insurance benefits pursuant to NRS ***617.454,*** 617.455 and 617.457 and to their employers.

Sec. 93. NAC 617.050 is hereby amended to read as follows:

617.050 The lung examinations conducted pursuant to ~~[~~NAC 617.040~~]~~ ***NRS 617.455*** must include at least the following elements and must be supported by the following written material:

1. ~~[~~Except as otherwise provided in NAC 617.110:

~~(a) A fireman or police officer must fill out the]~~ ***Form OD-1,*** Firemen and Police Officers' Medical History Form ***, as*** prescribed by the division ~~[; and~~

~~(b) The examiner must fill out the]~~ ***and completed by the fireman or police officer being examined;***

2. Form OD-2, Firemen and Police Officers' Lung Examination Form ***, as*** prescribed by the division ~~[;~~

~~2.]~~ ***and completed by the examining physician;***

3. An X-ray film of the chest ~~[must be made;~~

~~3. A]~~ ***;***

4. If the person being examined is a police officer or a salaried fireman, a pulmonary function test ~~[must be completed for police officers and salaried firemen; and~~

~~4.]~~ ***; and***

5. A stethoscopic examination of the lungs ***.*** ~~[must be performed.]~~

Sec. 94. NAC 617.070 is hereby amended to read as follows:

617.070 1. Cardiac examinations which are conducted ~~[upon employment as a fireman or police officer at the end of the fifth year of continuous service, and in each alternate year of service thereafter,]~~ ***pursuant to NRS 617.457*** must include at least the following elements and must be supported by the following written material:

(a) ~~[Except as otherwise provided in NAC 617.110:~~

~~(1) A fireman or police officer must fill out the]~~ ***Form OD-1,*** Firemen and Police Officers' Medical History Form ***, as*** prescribed by the division ~~[; and~~

~~(2) The examiner must fill out the]~~ ***and completed by the fireman or police officer being examined;***

(b) Form OD-3, Firemen and Police Officers' Extensive Heart Examination Form ***, as*** prescribed by the division ~~[;~~

~~(b)]~~ ***and completed by the examining physician;***

(c) A stethoscopic examination of the heart ~~[must be performed;~~

~~(c) An]~~ ***;***

(d) Except as otherwise provided in paragraph (e), an electrocardiogram ~~[must be made;~~

~~(d) A]~~ ***;***

(e) If the person being examined is a police officer or a salaried fireman who is 40 years of age or older, a stress electrocardiogram ~~[of all police officers and salaried firemen who are 40 years of age or older,]~~ ***,*** in lieu of the electrocardiogram required by paragraph ~~[(c), must be made;~~

~~(e)]~~ ***(d);***

(f) A blood test to determine the amounts of triglycerides and cholesterol which are present ~~[must be completed; and~~

~~(f)~~ ***; and***

(g) A urine test to determine the amount of glucose which is present ***.*** ~~must be completed.~~

2. Cardiac examinations which are conducted in the sixth year of continuous service and in each ~~alternate~~ year of service thereafter must include the following elements and must be supported by the following written material:

(a) ~~Except as otherwise provided in NAC 617.110:~~

~~(1) A fireman or police officer must fill out the~~ ***Form OD-1,*** Firemen and Police Officers' Medical History Form ***, as*** prescribed by the division ~~; and~~

~~(2) The examiner must fill out the~~ ***and completed by the fireman or police officer being examined;***

(b) Form OD-4, Firemen and Police Officers' Limited Heart Examination Form ***, as*** prescribed by the division ~~;~~

~~(b)~~ ***and completed by the examining physician;***

(c) A stethoscopic examination of the heart ~~must be performed; and~~

~~(c) An electrocardiogram must be made if the examiner~~ ***; and***

(d) If the examining physician believes circumstances warrant such a test ~~.~~ ***, an electrocardiogram.***

Sec. 95. NAC 617.075 is hereby amended to read as follows:

617.075 1. The ~~physical examinations required by NRS 617.455 and 617.457 must include a~~ test of ***the functioning of the*** hearing ~~function that consists~~ ***of an employee that is required pursuant to NRS 617.454 must consist*** of an air conduction test or a pure tone test.

2. If an air conduction test reveals a condition that is not within normal limits, the ~~patient~~ ***employee*** must undergo a bone conduction study or speech audiometry.

3. An air conduction test is acceptable for screening and to establish a baseline for further testing.

4. The person conducting the test of the functioning of the hearing of the employee must fill out Form OD-5, Firemen and Police Officers' Hearing Examination Form, as prescribed by the division.

Sec. 96. NAC 617.080 is hereby amended to read as follows:

617.080 The employer shall:

1. Schedule the physical examinations ***, including the test of the functioning of the hearing of an employee, that are*** required pursuant to NRS ***617.454,*** 617.455 and 617.457 ***.*** ~~[and NAC 617.040 and 617.060.]~~

2. Maintain the records of all physical examinations ***, including the test of the functioning of the hearing of an employee, that are*** completed pursuant to ~~[NAC 617.040 and 617.060 until]~~ ***NRS 617.454, 617.455 and 617.457 for at least 2 years after the death of*** the fireman or police officer ***.*** ~~[reaches the age of 55, whether or not he continues in his employment.]~~

3. Discuss with the employee any warning from the ~~[examiner]~~ ***examining physician*** indicating that the employee has a predisposition to the contraction of a disease of the heart or lungs.

4. If the employee can correct any predisposing physical condition of which he has been warned pursuant to subsection 3, inform the employee that failure to correct the condition may exclude him from benefits under chapter 617 of NRS.

5. Pay for any additional physical examinations he requires which are beyond the scope of the physical examinations ***and tests*** required by NRS ***617.454,*** 617.455 and 617.457.

Sec. 97. NAC 617.090 is hereby amended to read as follows:

617.090 The employee [shall:] ***must:***

1. Submit to the physical examinations ***and the test of the functioning of the hearing of an employee that are*** required by NRS ***617.454,*** 617.455 [,] ***and*** 617.457 ***,*** and by his employer ***,*** at the time scheduled by his employer unless he has a reasonable excuse for missing the scheduled examination [.

~~2. Except as otherwise provided in NAC 617.110, complete~~] ***;***

2. Complete and file with the insurer [the] ***Form OD-1,*** Firemen and Police Officers' Medical History Form ***, as*** prescribed by the division ***;*** and [sign]

3. Sign a form acknowledging receipt of the forms provided by the [examiner.] ***examining physician.***

Sec. 98. NAC 617.100 is hereby amended to read as follows:

617.100 The [examiner] ***examining physician*** who conducts [an] ***a physical*** examination pursuant to [NAC 617.040 and 617.060] ***NRS 617.455 or 617.457*** shall provide the employer and the employee with a copy of [each] ***:***

1. The form required to be completed by subsection 4 of NAC 617.075; and

2. Each of the forms required to be completed by NAC 617.050 [and] ***or*** 617.070 ***,***

FLUSH following [each] ***the*** physical examination.

Sec. 99. NAC 616A.490, 616B.454, 616B.457, 616B.466, 616B.561, 616B.562, 616B.568, 616B.631, 616B.634, 616B.637, 616B.646, 616B.670, 616C.700, 616C.710, 617.020, 617.030, 617.040, 617.060, 617.110, 617.200 and 617.210 are hereby repealed.

Sec. 100. This regulation becomes effective on March 1, 2001.

TEXT OF REPEALED SECTIONS

616A.490 Execution of blank forms by employers: Failure to comply or untimely compliance with requirements. (NRS 616A.400, 616A.480)

1. The administrator or his designated agent will impose the following administrative fines if an employer fails to comply with the provisions of NRS 616A.480 or any regulation adopted pursuant thereto:

(a) For the first violation within a 12-month period, a fine of at least $250.

(b) For a second violation within a 12-month period, a fine of at least $500.

(c) For a third or subsequent violation within a 12-month period, a fine of $1,000.

2. The administrator or his designated agent will impose the following administrative fines if an employer complies with the provisions of NRS 616A.480 in an untimely manner:

(a) For the first violation within a 12-month period, a fine of at least $50.

(b) For the second violation within a 12-month period, a fine of at least $100.

(c) For the third violation within a 12-month period, a fine of at least $250.

(d) For the fourth violation within a 12-month period, a fine of at least $500.

(e) For the fifth or subsequent violation within a 12-month period, a fine of $1,000.

3. In no case will the administrator or his designated agent impose an administrative fine pursuant to this section that is greater than $1,000.

4. The administrator or his designated agent will review for 1 year the activities of an employer who is required to pay an administrative fine pursuant to this section for a first violation.

5. For the purposes of this section, an employer:

(a) Fails to comply with the provisions of NRS 616A.480 if there is an absence of action taken on the part of the employer to comply with those provisions.

(b) Complies with the provisions of NRS 616A.480 in an untimely manner if he takes action 1 or more days after the time prescribed in that section.

616B.454 Inspection and location of files for claims and other records. (NRS 616A.400)

1. A self-insured employer shall ensure that all files of claims and all records maintained by the self-insurance employer pursuant to chapters 616A to 617, inclusive, of NRS or NAC 616B.424 to 616B.496, inclusive, are available for inspection by the commissioner or the administrator, or a representative of either of them, during normal business hours.

2. All files of claims must be kept, maintained and administered in this state.

3. After reviewing the file of a claim, the commissioner or administrator will report his findings to the self-insured employer.

616B.457 Reports of claims. (NRS 616A.400, 616B.009)

1. On claims where an award is offered for a permanent partial disability, each self-insured employer shall complete for each injured employee’s file and submit to the nearest office of the industrial insurance regulation section on or before the last day of each month:

(a) A report on the evaluation of a permanent partial disability by a rating physician or chiropractor;

(b) A copy of the letter offering the award to the injured employee;

(c) Documentation of payments of the award made to the injured employee;

(d) Any administrative or court orders modifying the wage calculation for the injured employee; and

(e) The following forms:

(1) D-5, Wage Calculation Form for Claims Adjuster's Use.

(2) D-8, Employer's Wage Verification Form.

(3) D-9(a), PPD Award Calculation Worksheet, or D-9(b), PPD Award Calculation Worksheet for Disability Over 25 Percent Body Basis, as appropriate.

(4) D-10(a), Election of Method of Payment of Compensation, or D-10(b), Election of Method of Payment of Compensation for Disability Greater Than 25%, as appropriate.

2. On or before September 30 of each year, or as requested by the administrator or his designated agent, the self-insured employer shall file a report with the administrator or his designated agent 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 accepted for accident benefits only.

(3) The number of claims accepted for benefits for lost time.

(4) The number of compensable fatalities.

(5) The number of claims denied.

(b) For claims for an occupational disease:

(1) The number of new claims filed.

(2) The number of claims accepted for medical benefits only.

(3) The number of claims accepted for benefits for lost time.

(4) The number of compensable fatalities.

(5) The number of claims denied.

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

(d) The number of claims reopened for accident benefits only.

(e) The number of claims reopened for benefits for lost time only.

(f) The number of injured employees paid benefits for a permanent partial disability.

(g) The number of injured employees paid benefits for a permanent partial disability in a lump sum.

(h) The number of claims closed pursuant to subsection 1 of NRS 616C.235.

(i) The number of claims closed pursuant to subsection 2 of NRS 616C.235.

(j) The number of claims open at the end of the fiscal year.

(k) 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, categorized by 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 purposes.

(l) Amounts recovered:

(1) Through subrogation.

(2) From the subsequent injury fund for self-insured employers.

(3) From other sources.

(m) Any other information requested by the administrator or his designated agent.

3. The information required pursuant to subsection 2 must, except as otherwise requested by the administrator or his designated agent, include information regarding any administrative activity during the prior 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.

4. Upon request by the administrator or his designated agent, each self-insured employer shall submit to the administrator or his designated agent copies of any form used by the self-insured employer in the administration of its claims for workers' compensation in this state.

616B.466 Notice to administrator of accident or occupational disease. (NRS 616A.400)

1. Within 30 days after a self-insured employer receives notice of an accident or occupational disease, the self-insured employer shall notify the administrator if the accident resulted in injury to, or the disease affected or is expected to affect, two or more persons.

2. Within 48 hours after a self-insured employer receives notice, in any form, of an accident or occupational disease resulting in a fatality, the self-insured employer shall notify the administrator of the fatality on the form entitled D-21, Fatality Report, which is prescribed by the administrator.

616B.561 Inspection and location of files for claims and other records. (NRS 616A.400)

1. An association shall ensure that all files of claims and all records maintained by the association pursuant to chapters 616A to 617, inclusive, of NRS or NAC 616B.510 to 616B.612, inclusive, are available for inspection by the commissioner or administrator, or a representative of either of them, during normal business hours.

2. All files of claims must be kept, maintained and administered in this state.

3. After reviewing the file of a claim, the commissioner or administrator will report his findings to the association.

616B.562 Reports of claims. (NRS 616A.400, 616B.009)

1. On claims where an award is offered for a permanent partial disability, each association shall complete for each injured employee's file and submit to the nearest office of the industrial insurance regulation section on or before the last day of each month:

(a) A report on the evaluation of a permanent partial disability by a rating physician or chiropractor;

(b) A copy of the letter offering the award to the injured employee;

(c) Documentation of payments of the award made to the injured employee;

(d) Any administrative or court orders modifying the wage calculation for the injured employee; and

(e) The following forms:

(1) D-5, Wage Calculation Form for Claims Adjuster's Use.

(2) D-8, Employer's Wage Verification Form.

(3) D-9(a), PPD Award Calculation Worksheet, or D-9(b), PPD Award Calculation Worksheet for Disability Over 25 Percent Body Basis, as appropriate.

(4) D-10(a), Election of Method of Payment of Compensation, or D-10(b), Election of Method of Payment of Compensation for Disability Greater Than 25%, as appropriate.

2. On or before September 30 of each year, or as requested by the administrator or his designated agent, the association shall file a report with the administrator or his designated agent that 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 accepted for accident benefits only.

(3) The number of claims accepted for benefits for lost time.

(4) The number of compensable fatalities.

(5) The number of claims denied.

(b) For claims for an occupational disease:

(1) The number of new claims filed.

(2) The number of claims accepted for medical benefits only.

(3) The number of claims accepted for benefits for lost time.

(4) The number of compensable fatalities.

(5) The number of claims denied.

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

(d) The number of claims reopened for accident benefits only.

(e) The number of claims reopened for benefits for lost time only.

(f) The number of injured employees paid benefits for a permanent partial disability.

(g) The number of injured employees paid benefits for a permanent partial disability in a lump sum.

(h) The number of claims closed pursuant to subsection 1 of NRS 616C.235.

(i) The number of claims closed pursuant to subsection 2 of NRS 616C.235.

(j) The number of claims open at the end of the fiscal year.

(k) 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, categorized by 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 purposes.

(l) Amounts recovered:

(1) Through subrogation.

(2) From the subsequent injury fund for associations of self-insured public or private employers.

(3) From other sources.

(m) Any other information requested by the administrator or his designated agent.

3. The information required pursuant to subsection 2 must, except as otherwise requested by the administrator or his designated agent, include information regarding any administrative activity during the prior 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.

4. Upon request by the administrator or his designated agent, each association shall submit to the administrator or his designated agent copies of any form used by the association in the administration of its claims for workers' compensation in this state.

616B.568 Notice to administrator of accident or occupational disease. (NRS 616A.400)

1. Within 30 days after an association receives notice of an accident or occupational disease, the association shall notify the administrator if the accident resulted in injury to, or the disease affected or is expected to affect, two or more persons.

2. Within 48 hours after an association receives notice, in any form, of an accident or occupational disease resulting in a fatality, the association shall notify the administrator of the fatality on the form entitled D-21, Fatality Report, which is prescribed by the administrator.

616B.631 Reports of claims. (NRS 616A.400)

1. On claims where an award is offered for a permanent partial disability, each private carrier shall complete for each injured employee's file and submit to the nearest office of the industrial insurance regulation section on or before the last day of each month:

(a) A report on the evaluation of a permanent partial disability by a rating physician or chiropractor;

(b) A copy of the letter offering the award to the injured employee;

(c) Documentation of payments of the award made to the injured employee;

(d) Any administrative or court orders modifying the wage calculation for the injured employee; and

(e) The following forms:

(1) D-5, Wage Calculation Form for Claims Adjuster's Use.

(2) D-8, Employer's Wage Verification Form.

(3) D-9(a), PPD Award Calculation Worksheet, or D-9(b), PPD Award Calculation Worksheet for Disability Over 25 Percent Body Basis, as appropriate.

(4) D-10(a), Election of Method of Payment of Compensation, or D-10(b), Election of Method of Payment of Compensation for Disability Greater Than 25%, as appropriate.

2. On or before September 30 of each year, or as requested by the administrator or his designated agent, each private carrier shall file a report with the administrator or his designated agent 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 accepted for accident benefits only.

(3) The number of claims accepted for benefits for lost time.

(4) The number of compensable fatalities.

(5) The number of claims denied.

(b) For claims for an occupational disease:

(1) The number of new claims filed.

(2) The number of claims accepted for medical benefits only.

(3) The number of claims accepted for benefits for lost time.

(4) The number of compensable fatalities.

(5) The number of claims denied.

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

(d) The number of claims reopened for accident benefits only.

(e) The number of claims reopened for benefits for lost time only.

(f) The number of injured employees paid benefits for a permanent partial disability.

(g) The number of injured employees paid benefits for a permanent partial disability in a lump sum.

(h) The number of claims closed pursuant to subsection 1 of NRS 616C.235.

(i) The number of claims closed pursuant to subsection 2 of NRS 616C.235.

(j) The number of claims open at the end of the fiscal year.

(k) 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, categorized by 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 purposes.

(l) Amounts recovered:

(1) Through subrogation.

(2) From a subsequent injury fund, if applicable.

(3) From other sources.

(m) Any other information requested by the administrator or his designated agent.

3. The information required pursuant to subsection 2 must, except as otherwise requested by the administrator or his designated agent, include information regarding any administrative activity during the prior 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.

4. Upon request by the administrator or his designated agent, each private carrier shall submit to the administrator or his designated agent copies of any form used by the private carrier in the administration of its claims for workers' compensation in this state.

616B.634 Inspection and location of files for claims and other records. (NRS 616A.400)

1. Each private carrier shall ensure that all files of claims and all records maintained by the private carrier pursuant to chapters 616A to 617, inclusive, of NRS or any regulations adopted pursuant thereto, are available for inspection by the commissioner or administrator, or his representative, during normal business hours.

2. All files of claims must be kept, maintained and administered in this state.

3. After reviewing the file of a claim, the commissioner or administrator will report his findings to the private carrier.

616B.637 Notice to administrator of accident or occupational disease. (NRS 616A.400)

1. Within 30 days after a private carrier receives notice of an accident or occupational disease, the private carrier shall notify the administrator if the accident resulted in injury to, or the disease affected or is expected to affect, two or more persons.

2. Within 48 hours after a private carrier receives notice, in any form, of an accident or occupational disease resulting in a fatality, the private carrier shall notify the administrator of the fatality on the form entitled D-21, Fatality Report, which is prescribed by the administrator.

616B.646 Requirements for notice to administrator by private carrier if employer changes insurer or allows coverage to lapse. (NRS 616A.400, 616B.460) The notice required to be provided to the administrator by a private carrier pursuant to subsection 3 of NRS 616B.460 if the private carrier has notice that an employer has changed his insurer or has allowed his insurance to lapse must be served personally or sent by first-class mail on a completed form entitled D-42, Intent to Cancel, Renew or Change of Insurance Carrier Form, which is prescribed by the administrator, or, if sent by electronic transmission, the notice must contain the same information as the form.

616B.670 Contracts with organizations for managed care or providers of health care. (NRS 616A.400) A self-insured employer, an association of self-insured employers or a private carrier that enters into a contract with an organization for managed care or a provider of health care pursuant to NRS 616B.527 shall:

1. Submit a copy of the contract to the administrator or his designated agent; and

2. Notify the administrator or his designated agent of any changes in the contract, including, without limitation, any additions to and deletions from the contract, and of the renewal of the contract. The notice must be given at the time the changes are made or the contract is renewed.

616C.700 Treating physician or chiropractor: Failure to file or untimely filing of claim for compensation. (NRS 616A.400, 616C.040)

1. The administrator or his designated agent will impose the following administrative fines if a treating physician or chiropractor fails to comply with the provisions of NRS 616C.040 or any regulation adopted pursuant thereto:

(a) For the first violation within a 12-month period, a fine of at least $250.

(b) For a second violation within a 12-month period, a fine of at least $500.

(c) For a third or subsequent violation within a 12-month period, a fine of $1,000.

2. The administrator or his designated agent will impose the following administrative fines if a treating physician or chiropractor complies with the provisions of NRS 616C.040 in an untimely manner:

(a) For the first violation within a 12-month period, a fine of at least $50.

(b) For the second violation within a 12-month period, a fine of at least $100.

(c) For the third violation within a 12-month period, a fine of at least $250.

(d) For the fourth violation within a 12-month period, a fine of at least $500.

(e) For the fifth or subsequent violation within a 12-month period, a fine of $1,000.

3. In no case will the administrator or his designated agent impose an administrative fine pursuant to this section that is greater than $1,000.

4. The administrator or his designated agent will review for 1 year the activities of a treating physician or chiropractor who is required to pay an administrative fine pursuant to this section for a first violation.

5. For the purposes of this section, a treating physician or chiropractor:

(a) Fails to comply with the provisions of NRS 616C.040 if there is an absence of action taken on the part of the treating physician or chiropractor to comply with those provisions.

(b) Complies with the provisions of NRS 616C.040 in an untimely manner if he takes action 1 or more days after the time prescribed in that section.

616C.710 Employer: Failure to file or untimely filing of report of industrial injury or occupational disease. (NRS 616A.400, 616C.045)

1. The administrator or his designated agent will impose the following administrative fines if an employer fails to comply with the provisions of NRS 616C.045 or any regulation adopted pursuant thereto:

(a) For the first violation within a 12-month period, a fine of at least $250.

(b) For a second violation within a 12-month period, a fine of at least $500.

(c) For a third or subsequent violation within a 12-month period, a fine of $1,000.

2. The administrator or his designated agent will impose the following administrative fines if an employer complies with the provisions of NRS 616C.045 in an untimely manner:

(a) For the first violation within a 12-month period, a fine of at least $50.

(b) For the second violation within a 12-month period, a fine of at least $100.

(c) For the third violation within a 12-month period, a fine of at least $250.

(d) For the fourth violation within a 12-month period, a fine of at least $500.

(e) For the fifth or subsequent violation within a 12-month period, a fine of $1,000.

3. In no case will the administrator or his designated agent impose an administrative fine pursuant to this section that is greater than $1,000.

4. The administrator or his designated agent will review for 1 year the activities of an employer who is required to pay an administrative fine pursuant to this section for a first violation.

5. For the purposes of this section, an employer:

(a) Fails to comply with the provisions of NRS 616C.045 if there is an absence of action taken on the part of the employer to comply with those provisions.

(b) Complies with the provisions of NRS 616C.045 in an untimely manner if he takes action 1 or more days after the time prescribed in that section.

617.020 Definitions. As used in this chapter, unless the context otherwise requires:

1. "Examiner" means any person authorized to conduct the physical examinations required by NRS 617.455 and 617.457.

2. "Physician" means any person licensed to practice medicine pursuant to chapter 630 of NRS.

617.030 Qualifications of examiner. The examiner must be:

1. A physician;

2. A physician's assistant who is licensed pursuant to chapter 630 of NRS and who is acting under the direction of a physician; or

3. A licensed practical nurse or a registered nurse who is licensed pursuant to chapter 632 of NRS and who is acting under the direction of a physician.

617.040 Lung examinations: Frequency. A fireman or a police officer shall submit to a lung examination:

1. Within the 60 days before or the 60 days after his employment as a fireman or police officer;

2. Within the 6 months before or the 6 months after the end of his second year of employment; and

3. Thereafter, at any time during each subsequent year of service.

617.060 Cardiac examinations: Frequency. A fireman or a police officer shall submit to a cardiac examination:

1. Within the 60 days before or the 60 days after his employment as a fireman or police officer;

2. Within the 6 months before or the 6 months after the end of his fifth year of continuous service; and

3. Thereafter, at any time during each subsequent year of service.

617.110 Alternate forms. Forms which are different from those required by NAC 617.050, 617.070 and 617.090 may be used if the forms contain the same information as those which are prescribed by the division.

617.200 Treating physician or chiropractor: Failure to file or untimely filing of claim for compensation. (NRS 616A.400, 617.352)

1. The administrator or his designated agent will impose the following administrative fines if a treating physician or chiropractor fails to comply with the provisions of NRS 617.352 or any regulation adopted pursuant thereto:

(a) For the first violation within a 12-month period, a fine of at least $250.

(b) For a second violation within a 12-month period, a fine of at least $500.

(c) For a third or subsequent violation within a 12-month period, a fine of $1,000.

2. The administrator or his designated agent will impose the following administrative fines if a treating physician or chiropractor complies with the provisions of NRS 617.352 in an untimely manner:

(a) For the first violation within a 12-month period, a fine of at least $50.

(b) For the second violation within a 12-month period, a fine of at least $100.

(c) For the third violation within a 12-month period, a fine of at least $250.

(d) For the fourth violation within a 12-month period, a fine of at least $500.

(e) For the fifth or subsequent violation within a 12-month period, a fine of $1,000.

3. In no case will the administrator or his designated agent impose an administrative fine pursuant to this section that is greater than $1,000.

4. The administrator or his designated agent will review for 1 year the activities of a treating physician or chiropractor who is required to pay an administrative fine pursuant to this section for a first violation.

5. For the purposes of this section, a treating physician or chiropractor:

(a) Fails to comply with the provisions of NRS 617.352 if there is an absence of action taken on the part of the treating physician or chiropractor to comply with those provisions.

(b) Complies with the provisions of NRS 617.352 in an untimely manner if he takes action 1 or more days after the time prescribed in that section.

617.210 Employer: Failure to file or untimely filing of report of industrial injury or occupational disease. (NRS 616A.400, 617.354)

1. The administrator or his designated agent will impose the following administrative fines if an employer fails to comply with the provisions of NRS 617.354 or any regulation adopted pursuant thereto:

(a) For the first violation within a 12-month period, a fine of at least $250.

(b) For a second violation within a 12-month period, a fine of at least $500.

(c) For a third or subsequent violation within a 12-month period, a fine of $1,000.

2. The administrator or his designated agent will impose the following administrative fines if an employer complies with the provisions of NRS 617.354 in an untimely manner:

(a) For the first violation within a 12-month period, a fine of at least $50.

(b) For the second violation within a 12-month period, a fine of at least $100.

(c) For the third violation within a 12-month period, a fine of at least $250.

(d) For the fourth violation within a 12-month period, a fine of at least $500.

(e) For the fifth or subsequent violation within a 12-month period, a fine of $1,000.

3. In no case will the administrator or his designated agent impose an administrative fine pursuant to this section that is greater than $1,000.

4. The administrator or his designated agent will review for 1 year the activities of an employer who is required to pay an administrative fine pursuant to this section for a first violation.

5. For the purposes of this section, an employer:

(a) Fails to comply with the provisions of NRS 617.354 if there is an absence of action taken on the part of the employer to comply with those provisions.

(b) Complies with the provisions of NRS 617.354 in an untimely manner if he takes action 1 or more days after the time prescribed in that section.

LCB File No. R105-00

NOTICE OF ADOPTION OF REGULATION

The Division of Industrial Relations of the Department of Business and Industry adopted regulations pertaining to the schedule of fees and charges for accident benefits under Nevada Revised Statutes, Chapter 616A through 617, and other amendments to Chapters 616A, 616B, 616C, 616D, and 617 of the Nev. Administrative Code on December 13, 2000.

INFORMATIONAL STATEMENT

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

In the Matter of the Adoption and
Amendments of Regulations Pertaining to: DIR No: 00-1P

the Schedule of Fees and Charges for Accident Benefits under Nevada Revised Statutes, Chapters 616A through 617 and other amendments to Chapters 616A, 616B, 616C, 616D and 617 of the Nevada Administrative Code. LCB NO: R105-00

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INFORMATIONAL STATEMENT

The following statement is submitted by the Division of Industrial Relations for adopted amendments to Nevada Administrative Code (NAC) 616A-D and 617.

1. A description of how comments were solicited from the public and affected businesses, a summary of response from the public and affected businesses, and an explanation how other interested persons may obtain a copy of the summary.

On May 3, 2000, Notices of Public Workshop were mailed to third-party administrators, self-insured employers, health care providers, members of self-insured associations, private carriers, and the persons who requested to be placed on the DIR mailing list. On May 18, 2000, the Notices of Public Workshop were posted or deposited in overnight mail for posting in the main branch of every county library, the State Library, the Las Vegas, and Carson City offices of the Division of Industrial Relations (DIR).

On May 23, 2000, at 10:00 a.m., DIR held a public workshop at the Grant Sawyer Building, 555 Washington Street, Room 4412, Las Vegas, NV 89101 and via videoconference at the Legislative Building at 401 South Carson Street, Room 3138, Carson City, NV 89701 regarding proposed amendments adopt regulations to:

- Amend fine schedules for statutory and regulatory regulations;
- Adopt regulations concerning reimbursement of medical bills when a claim has been reopened;
- Amend and possible repeal some occupational disease regulations concerning the physical examinations required for fire fighters and police officers;
- Amend the regulations regarding the designation of a person by the Administrator;
- Amend regulations concerning posters, forms and data to clarify that portions of the regulation apply to employers, third-party administrators, managed care organizations, and health care providers, and to require the forms be completed accurately and thoroughly;
- Repeal of various parallel regulations that specifically referenced private carriers, self-insured employers and self-insured associations.
- Adopt regulations containing the same requirements but referring to "insurers" instead of the specific type of insurer. For example, DIR is considering repealing portions of NAC 616B.457, NAC 616B.562, and NAC 616B.631 regarding the documents that must be submitted to DIR when a permanent partial disability award is offered; it proposes to repeal those three parallel regulations and adopt a similar regulation that applies to all insurers;
- Amend NAC 616B.646 to change the form name and number from D-42, Intent to Cancel, Renew or Change of Insurance Carrier Form, to D-41, IAIABC POC1 and amendment of NAC 616C.091 to change the statutory reference from NAC 616C.060 to NAC 616C.065 to reflect the statutory change that became effective July 1, 1999;
- Amend NAC 616C.103 to add a requirement concerning the costs of transportation and per diem for an injured employee to attend a permanent partial disability evaluation;
- Amend NAC 616C.188 to reflect that the Relative Values for Physicians is now published annually rather than semiannually;
- Amend the schedule of reasonable fees and charges allowable for accident benefits [medical fee schedule] as required by NRS 616C.260. DIR contracted with Ingenix to survey the fifteen largest private providers of health insurance in Nevada to determine the annual percentage of increase or decrease for treatment between January 1998 and January 1999 as required by NAC 616C.249. Ingenix found the changes in Nevada paid data from January 1998 to January 1999 to be as follows:

Radiology and Nuclear Medicine	+ 16.44 %
Pathology	- 13.58 %
Medicine	+ 3.94 %
Surgery	+ 15.06 %
Anesthesiology	+ 0.16 %
Hospital	+ 10.92%

As a point of reference, the Medical Care Component of the Consumer Price Index for the same time period was 2.95 %. The DIR Advisory Council met on March 24, 2000 and approved DIR's proposal to amend the regulations to reflect the increases and decreases determined by the Ingenix survey.

- Pursuant to Senate Bill 37, DIR also proposes to delete the phrase "Professional Medical Services, for All Urban Wage Earners and Clerical Workers" from the Medical Care Component description in NAC 616C.249;
- Amend NAC 616C.203 to clarify that emergency department charges are considered separate from inpatient per diem rates if an injured employee is admitted to the hospital;
- Amend NAC 616C.209, changing the word "billing" to "payment" and NAC 616C.212 to change "10 working days" to "14 days;"
- Amend NAC 616C.215 to reflect price change of the ICD-9-CM;

- Amend the regulations concerning the Uninsured Employer Claim Fund (NAC 616C.393 *et seq*.). Additionally, DIR proposes to amend NAC 616C.396 to add a time requirement for an injured employee to complete and return the D-16, D-17, and D-18 forms for uninsured employers' claims;
- Amend NAC 616C.476 to remove the rating assignment of 1- 4 % for Spine Impairment Category I; to change the word "may" to "shall" regarding the rating physician or chiropractor's use of the "Range of Motion Model" when none of the "Injury Model" categories apply. DIR is also considering adding a section to clarify that the injured employee is rated as he presents at the time of rating (to reflect any improvement or worsening of the condition due to medical treatment) and a section regarding loss of motion segment integrity;
- Amend the apportionment regulations to clarify the regulation only applies when the same condition, organ or anatomical structure is involved and regardless of the edition of the guide; additionally, DIR is considering how to apportion out-of-state workers' compensation ratings and whether apportionment should occur prior to the combination of other body parts.

On October 6 through 10, 2000, Notices of Public Hearing were posted or deposited in overnight mail for posting in the main branch of every county library, the State Library, the Las Vegas, and Carson City offices of the Division of Industrial Relations (DIR) and mailed to third-party administrators, self-insured employers, health care providers, members of self-insured associations, private carriers, and the persons who requested to be placed on the DIR mailing list. On October 9, 2000 DIR also provided Notices of Public Hearing via facsimile to organizations that represent small business owners.

On November 21, 2000, at 1:00 p.m., DIR held a public hearing at the Department of Transportation, 123 West Washington Street, Training Room, Las Vegas, NV 89101 and via videoconference at the Department of Transportation, 1263 South Stewart Street, Room 314, Carson City, NV 89712 regarding proposed amendments to NAC Chapters 616A-617.

Both the Notice of Public Workshop and the Notice of Intent to Amend Regulations regarding the Schedule of Fees and Charges for Accident Benefits under Nevada Revised Statutes, Chapters 616A through 617 and other amendments to Chapters 616A, 616B, 616C, 616D and 617 of the Nevada Administrative Code contained notices soliciting public comment and the method in which public comment would be received.

Interested persons may obtain a copy of this informational statement, which contains a summary of the comments received from affected businesses or a copy of the written comments by calling or writing to:

Division of Industrial Relations
Legal Section
400 W. King Street, Suite 402
Carson City, Nevada 89703
(775) 687-3354

Division of Industrial Relations
Legal Section
1301 N. Green Valley Parkway, Suite 200
Henderson, NV 89104
(702) 486-9072

2. The number of persons who attended each hearing, testified at each hearing, and submitted written statements to the agency.

The number of persons who:

(a) Attended the May 23, 2000 workshop in Las Vegas:
Sixty-six people signed the attendance sheet.

(b) Attended the May 23, 2000 workshop in Carson City:
Thirty-three people signed the attendance sheet.

(c) Spoke at the workshops: Twenty-one.

1) Nancyann Leeder, Nevada Attorney for Injured Workers, indicated that the fines in Sections 1, 2, 3, 4, 5, 7, 11, 12, 15, 46, and 48 *et seq*. were too low. With regards to Sections 1 and 2, she indicated the insurer's failure to provide an office or maintain an office in Nevada was an intentional act as defined by NRS 616D.120(1)(g) and each should be a $10,000 fine. She thought Sec. 3 concerning the certificate of disability should not be classified as a minor violation as a claimant's being denied benefits due to the incompleteness of a certificate of disability is a major violation to the claimant. For Sec. 4, she indicated a claimant who notifies a collection agency he is not responsible for the charge and if the credit rating is not changed, the matter is not a "minor" violation and should be considered a major violation. She thought Sec. 7 concerning the payment of compensation for the loss or permanent damage of a tooth was an intentional act and should result in an initial fine of $1,000 and a second violation of $10,000. She stated the fines proposed in Sec. 15 were "woefully inadequate." She was opposed to the deletion of Sec. 43(2) concerning Category I as there are objective findings.
2) VaDonna Rivera, Director of Operations for Specialty Health, asked in Sec. 4 if medical providers could bill the claimant if his claim was in a "denied pending investigation" status.
3) Ann Davison, Fremont Corporation, thought Sec. 4 should include collection agencies. With regards to Sec. 13, she stated it duplicated information submitted to NCCI. She suggested a form for reporting the information required in Sec. 16. She asked if signatures were really needed or if electronic signatures were acceptable in Sec. 18 as actual signatures were sometimes

difficult to obtain. She agreed with Ms. Simon's comments in Sec. 43(3) to change "shall" to "may."

4) Victor Albanese, Occupational Healthcare Management Services, commented on Sec. 4 that third-party administrators should not be the ones to police the problem. He agreed with Mr. Lane's analysis of Sec. 8. He agreed with Mr. Lane concerning electronic filing in Sec. 18. He stated that Sec. 25 conflicted with NAC 616C.156; he asked if the phrase "arranging the costs of transportation" meant "paying" and wondered if the claimant moved the appointment. He suggested Sec. 44(3) state the specific edition of the *Guides* that should be used. He suggested that the same edition of the *Guides* be used for apportionment purposes. DIR explained since the 4th edition of the *AMA Guides to the Evaluation of Physical Impairment* has back categories which change in increments of 5%, a claimant with a 3% range of motion under the 2nd edition would either have the number rounded up or down prior to apportionment and the proposed method would simply subtract the prior award from the current award which DIR believes is more fair to the parties. He asked if Sec. 46 would require the injured employee to make an election of method of payment; since this is a "scheduled" injury, there is no need for election.
5) Jerry Collier Lane, Attorney at Law, commented on Sec. 4; he thought it was the responsibility of the claimant's attorney to notify the collection agency. He did not think there was any statutory authority for Sec. 8, which would require a health care provider to reimburse a claimant who paid a bill prior to his claim being reopened. Since Sec. 9 imposed a fine schedule for violations of Sec. 8, he objected to the section on the same grounds as stated for Sec. 8; he also noted that DIR can remove health care providers from its list of treating physicians and chiropractors. He suggested expressing a time period in Sec. 14(3) in which the administrator will report his findings. He had a comment on section as to Sec. 15 and how quickly must the report be mailed. He agreed with Ms. Bissell that electronic filing should be allowed in Sec. 18 and that if a request was made, a hard copy would be made for inspection. He disagreed with a new section discussed by Charles Verre, Chief Administrative Officer for the Industrial Insurance Regulation Section (IIRS) which proposed to allow medical bill disputes to be adjudicated by the Department of Administration rather than by IIRS; he noted that the claimant is not a real party in interest and therefore the hearing should not be conducted by a hearing officer or an appeals officer with the Department of Administration. He disagreed with DIR's proposal to have insurers responsible for the cost of travel for a claimant's permanent partial disability evaluation, even if the injured worker moved for his own convenience; he noted some claimants move out of this country.
6) Lynn Grandlund, Employers of Nevada, felt that Sec. 5 (concerning the delivery of a list of health care providers at the claimant's request) was too weak; she indicated that insurers were not complying with this requirement and that insurance agents are responsible for giving the information to the employers. She strongly supported Sec. 14's requirement that the case

management occur in Nevada. She agreed with Ms. Simon's comments on Sec. 43(3) and changing the word "shall" to "may."

7) John McGlamery, Associate General Counsel for Employers Insurance Company of Nevada, thought the word "providing" in Sec. 5 was too vague, he suggested changing it to "mailing." In Sec. 6, which requires an insurer to provide within ten days a copy of the medical examination report, he suggested using the word "send" rather than "provide." Concerning Sec. 8, he agreed with Mr. Lane that the remedy would be a $1,000 or $10,000 fine under NRS 616D.120(1). He stated the proposed fines against health care providers was too low in Sec. 9. He indicated the time frames in Sec. 13 should be explicit (should it be the time payment was made" or when the claim was accepted and noted a calendar year could vary from a fiscal year). He indicated that the difficulty with Sec. 6 is that occupational diseases are cumulative in effect. He asked how the Consumer Price Index in Sec. 40 was determined. He thought Sec. 43(4) should be changed to reflect that x-rays would not be taken unless the rating physician or chiropractor requested them. He had questions regarding which *Guides* would be used in Sec. 44(5).
8) Bryan Stockton, Associate General Counsel for Employers Insurance Company of Nevada, disagreed with the current wording of Sec. 6; he indicated the wording as written made it a strict liability issue; he suggested using words similar to NRS 616D.120(1) concerning "unreasonably delayed or refused." He had the same comments regarding Sec. 7. With regards to Sec. 10, he said "voucher" was undefined and suggested perhaps the phrase "check"; he also thought the 24 hours requirement might be unreasonable and would need more study. He asked if Sec. 46 required an award if the tooth had been repaired. He disagreed with the proposed fines in Sec. 48 *et seq*. as they are "strict liability" fines in his opinion.
9) Kathleen Bissel, American Insurance Association, agreed with the comments made by Mr. Stockton concerning Sec. 7; she thought "unreasonable" should be defined and said she would provide written comments. She agreed with Mr. Lane's analysis of Sec. 8. She indicated the elements in Sec. 13 should follow those with the EDI IAIABC format and that "fiscal year" should be defined. She had questions concerning the word "maintains" in Sec. 14 and wanted to allow the use of micrographics and electronic filing. With regard to Sec. 16, she thought the reporting to DIR was duplicative of the reporting made to NCCI. She wanted Sec. 18 to allow electronic filing. She thought the D41 form in Sec. 19 was "awful" and suggested using the NCCI Form WC 890609B.
10) Sandra Simon, Nevada Self Insured Association, disagreed with Sec. 8 which would require a health care provider to reimburse a claimant who paid a bill prior to his claim being reopened; she thought DIR should "go after" the health care provider, not the insurer. She agreed with Mr. Lane's comments regarding Sec. 25 and did not believe the insurer should be responsible for travel expenses if the claimant moves. She suggested with Sec. 43(3) that used the word "shall" and suggested it be changed to "may." She suggested deleting an award for loss or permanent damage to a tooth in Sec. 46;

however, the statutes require DIR to set the amount of compensation so this could not be done without a legislative change.

11) Leslie Bell, St. Mary's/CDS CompFirst, spoke on Sec. 8 and indicated NRS 616C.135 should be amended. She suggested DIR delete the phrase "On or before September 30 of each year, or" in subsection (1) so it would read "As requested by the administrator . . ."
12) Paul Aakervik, Willis Caroon, asked for a definition of "voucher" in Sec. 10 and indicated that a third-party administrator sends the voucher to the self-insured employer that cuts the check. He questioned the need for Sec. 16(1) and asked if DIR needed to know if 2 people were hospitalized because of an accident or occupational disease. He was concerned that DIR provide enough "lead-time" with regard to the date Sec. 26 goes into effect; he noted sufficient time was needed to retrain staff and reprogram computers to reflect the medical fee schedule changes proposed. He stated it was very costly to make price adjustments for bills that had been paid under the previous fee schedule. He asked for a definition of "permanent damage to a tooth" in Sec. 46; it was explained that the American Dental Association was unable to provide DIR a definition of that phrase which is used in the statute.
13) Pat Hoek, Specialty Risk Services, noted in Sec. 18 that the person taking the information is noted on the bottom of the form.
14) Michael McGroarty, Attorney at Law, spoke in opposition to Sec. 25, when a claimant moves out-of-state for his own convenience the insurer is not responsible for the entire travel expense for medical treatment. Ron Hubel, Industrial Medical Group, disagreed with Sec. 27 as the values in the schedule of reasonable fees and charges did not consider "co-pays."
15) Greg Gilbert, Concentra Health Services, thought the fee schedule contains a discrepancy in the unit value for physical therapy.
16) Bob Badell, University Medical Center, thought Sec. 27 needed changes in the Relative Value for Physicians.
17) Patricia Walquist, Mandalay Resort Group, agreed with the comments of Ms. Simon on Sec. 43(3) in changing "shall" to "may."
18) Gregory Chech, D.C., spoke concerning Sec. 43(4) concerning the loss of motion segment integrity. He suggested motion segment integrity x-rays are needed on some non-surgical claims. He requested a definition of "structural inclusion."
19) David Rovetti, D.C., indicated the "Injury Model" is better in Sec. 43.
20) Barbara Gruenewald, Nevada Trial Lawyers, spoke against lowering the fine amounts in Sec. 76 through 78. She also opposed the repeal of NAC 617.020 (Sec. 89) which defined "examiner" and should include "physician assistants" in rural counties. DIR noted that Chapter 617 has amended the heart/lung statutes and no longer uses the phrase "examiner" but uses "examining physician."

(d) Attended the November 21, 2000 public hearing in Henderson:
Thirty-one people signed the attendance sheet.

(e) Attended the November 21, 2000 public hearing in Carson City:
Twenty people signed the attendance sheet.

(f) Testified at the November 21, 2000 public hearings: Six.

1) Maureen Brower, Waddams and Oakridge, requested DIR delete proposed Sec. 6 as it did not explicitly allow electronic records. She also questioned whether it was necessary for the claim to be administered in Nevada.
2) Jack Kim, Sierra Insurance Group, questioned Sec. 8 about printing checks prior to the date issued. He thought that the "next working day" requirement was too stringent.
3) Ann Davison, Cambridge/Fremont, objected to Sec. 8 and thought the "next working day" requirement was too strict.
4) Donna Sweger, Deputy NAIW, opposed to Sec. 13(f) as drafted by the Legislative Counsel Bureau; she suggested DIR return to the language it proposed in its workshop which would require the insurer to pay for the travel costs of an injured worker to attend a permanent partial disability evaluation, regardless if he had moved out-of-state for his own convenience. She distinguished medical treatment and medical evaluations; the former has limitations on travel if the injured employee moves for his own convenience but the insurer pays the entire travel costs for the latter under NAC 616C.115. Because a PPD evaluation is a one-time evaluation, it is similar to a medical investigation and should be paid by the insurer. She opposed Sec. 47(2) that was drafted to be consistent with Clark County District Court Judge Hardcastle's decision. DIR noted that Washoe District Court Judge Steinheimer issued a decision in October, 2000 which was contrary to Judge Hardcastle's.
5) Ron Hubel, Industrial Medical Group, requested Sec. 22 add the phrase "within 30 days"; he said in the past it sometimes took nine months to get a determination issue. He supported raising the reimbursement from 70% to 85% in Sec. 27.
6) Vivian Gordon, Republic Services, suggested clarification in Sec. 23(4) that travel for out-of-state travel for permanent partial disability evaluations not exceed $1,000. She also suggested clarification for Sec. 48 that it be the "percentage received" instead of the "percentage rated" to cover the situations in which the amount of the permanent partial disability award is stipulated.

(g) Submitted written comments to the agency prior to, during, or following the Workshops and Public Hearings: Twenty-three.

1) Rodney Sled, Director of Human Resources for Barrick Goldstrike, wrote on May 19, 2000 that he disagreed with Sec. 15 evaluation of the regulation to allow the rating physician to use the loss of range of motion in a permanent partial disability; he wanted the word "may" to be used rather than "shall."
2) Stephanie Johnson, Regional Contract Manager for Associated Pathologists Laboratories, wrote on May 19, 2000 that as "Nevada's largest laboratory, we

strongly object tot he proposed 13.58% decrease for lab/pathology services" and believe an increase is justified. She noted the Consumer Price Index for the time period increased by 2.95% and Medicare increased reimbursement for pathology services by 15% (1998-2000). She noted "[t]here appear to be two significant exceptions in your data set that have skewed this analysis. We believe that we can demonstrate that this data or its interpretation is in error."

3) Barbara Gruenewald, Attorney at Law, wrote on May 24, 2000 that Sec. 90 should be changed to include "in any county or city in the State of Nevada that has less than a population of 10,000 people, an examiner may be a physician assistant who is licensed pursuant to Chapter 630 of NRS and who is acting under the direction of a physician; or a licensed practical nurse or registered nurse who is licensed pursuant to Chapter 632 of NRS and who is acting under the direction of a physician." She wrote another letter objecting to amending NAC 616C.476 to have an injured employee rated at the time of the rating evaluation, regardless of whether the condition is improved or worsened as a result of treatment. She was concerned it "may open the door to PPD evaluators using their own subjective judgment to reduce PPD awards." She also objected to DIR's lowering fine amounts in Sec. 47-48, 52-53, 55, 57, 63, 66, and 76-77.
4) Marvin Gross, Attorney at Law, wrote a letter dated May 25, 2000, objecting to amending NAC 616C.476 to have an injured employee rated at the time of the rating evaluation, regardless of whether the condition is improved or worsened as a result of treatment. His basis was "your Agency was advised by Judge Hardcastle that the addition of regulatory language which seeks to add to or diminish from the American Medical Association Guidelines to the Evaluation of Permanent Impairment, was improper. I believe this proposed regulation has the same problem with it."
5) Lisa M. Anderson, Attorney at Law, wrote a letter dated May 25, 2000, objecting to amending NAC 616C.476 to have an injured employee rated at the time of the rating evaluation, regardless of whether the condition is improved or worsened as a result of treatment. She was concerned it "may open the door to PPD evaluators using their own subjective judgment to reduce PPD awards."
6) Aubrey Goldberg, Attorney at Law, wrote a letter dated May 25, 2000, identical to Ms. Anderson's.
7) John R. Gordon, Attorney at Law, wrote a letter dated May 25, 2000, identical to Ms. Anderson's.
8) John A. Greenman, Attorney at Law, wrote a letter dated May 25, 2000, identical to Ms. Anderson's.
9) Gabriel Martinez, Attorney at Law, wrote a letter dated May 25, 2000, identical to Ms. Anderson's.
10) Paul Raby, Attorney at Law, wrote a letter dated May 25, 2000, identical to Ms. Anderson's.
11) Ester Rodriguez, Attorney at Law, wrote a letter dated May 25, 2000, identical to Ms. Anderson's. Her letter included a "DIIR Regulations Alert" from Ms.

Gruenewald to "All Worker's compensation Attorneys" with a proposed letter attached.

12) Gerald Welt, Attorney at Law, wrote a letter dated May 25, 2000, very similar to Ms. Anderson's, noting "the AMA Guides loose [sic] what integrity they posses if their fundamentals are altered."

13) Raymond Badger, Attorney at Law, wrote a letter dated May 26, 2000, also opposed to amending NAC 616C.476. His objection was it "directly contravenes the intent of the authors of the fourth edition of the AMA Guides as it applies to impairments of the spinal region evaluated under Chapter 3." He indicated that on page 3/100, the authors of the Guide state "surgery to treat an impairment does not modify the original impairment estimate, which remains the same in spite of any changes in signs or symptoms that may follow surgery and irrespective of whether the patient has a favorable or unfavorable response to treatment." He notes that Dr. Talmage wrote an article concerning the situation in which medical treatment worsens the condition; Dr. Talmage suggested "major post-operative spinal complications should be rated, and the rating for the complications should be combined with the rating for the injury." (Mr. Badger's emphasis). He suggested NAC 616C.476 read "Except for the evaluation of spine impairments under Chapter 3 of the fourth edition of the Guides, the injured employee shall be evaluated as he presents at the time of the rating evaluation, taking into account any improvement or worsening of the condition as a result of treatment of the industrial injury."

14) Kathleen Bissell, CPCU, Assistant Vice President for American Insurance Association, wrote a letter dated May 26, 2000 "question[ing] the appropriateness of allowing an injured worker to be reimbursed directly for examinations from re-opened claims" in Sec. 8; she recommended Sec. 8 and the fine provision of Sec. 9 be deleted. With regard to Sec. 13, "[t]o the extent that the data elements meet the standards established by the IAIABC utilizing the EDI format, we have no objection" but asked DIR to review the data elements "an assure that all redundant and additional data elements be removed" as they would require "costly, inefficient manual reporting." She also asked that the term "fiscal year" be more specific. She thought Sec. 14 could be "broadly interpreted" and should "more specifically allow for the access of claims files and records in an electronic or micrographic format." She also wanted Sec. 14(3) to state a time specific period during which the agency must report its findings to the insurer." She suggested adding the phrase "in hard copy, electronic, micrographic or digital format" to Sec. 14(2) and the phrase "within 60 days" to Sec. 14(3). With regard to Sec. 16 she suggested the deletion "to the extent that this section requires specific reporting outside the standards established by IAIABC, EDI or as reported to NCCI." She recommended deletion of Sec. 18 which allow a "unique electronic symbol to verify each employer's completion of a C-3 form" as it is difficult and time-consuming. She stated "the electronic signature verification process . . . in many cases is not available and frequently requires processing delays while the insurer or TPA secures signature verification." She indicated

in practice, her members do not favor the IAIABC POC 1 form and prefers "NCCI form WC 89 6 09B that is acceptable in many other states." She thought that Sec. 52 through 66 regarding compliance with Nevada laws and regulations in a "timely manner" was "vague and could expose an insurer to unreasonable liability for failure to comply." She suggested changing "fails to comply or complies in an untimely manner as "fails to comply with in a reasonable time or within 30 days unless otherwise indicated.

15) VaDonna Rivera, Director of Operations for Specialty Health wrote a letter dated May 26, 2000, concerning Sec. 4 and asked to exclude a "penalty for failure to comply if the patient is billed after receipt of "denied pending" notices and/or" have NRS 616C.065 clarified to "allow these 'denied pending' situations and/or" clarify "NAC 616.091 . . . to state that ALL communications regarding compensability and medical status of the claim be courtesy copied immediately to the medical providers."
16) Donald Jayne, CPCU, Jayne & Associates, Inc. Management Consultations, wrote a letter dated May 26, 2000 on behalf of Nevada Self-Insureds Association. NSIA suggested the phrase "all reasonable efforts" in Sec. 8 was too vague and unnecessary as "DIR has the authority and the methods necessary to enforce the reimbursement of out-of-pocket expenses by the injured worker from the provider of medical care." NSIA opposes Sec. 25, because "if the injured worker has moved, for their [sic] own convenience after becoming a claimant, out of state or to a new location within this state that the injured worker is responsible for the expenses as referenced in NAC 616C.156." NSIA wants Sec. 43 to use the word "may" rather than "shall" to allow rating physicians to exercise judgment.
17) Leslie Bell, Director of CDS CompFirst, wrote a letter dated May 31, 2000, concerning Sec. 8. She suggested a third subsection which would read "A provider of health care who has been paid by an injured employee for an examination to reopen a claim, or for treatment received on a claim that is rejected but ultimately found to be the responsibility of the insurer, shall reimburse the injured employee within 30 days after receiving written notification from the insurer that the claim has been reopened or accepted." She suggested Sec. 13(1) be modified as follows "as requested by the administrator or his designee, each insurer shall file a report with the administrator or his designee which contains the following information: "If an annual deadline is imposed, she suggested this language "on or before September 30 of each year, upon request by the administrator or his designee each insurer shall file an report with the administrator or his designee which contains the following information. . . ."
18) Mark Webb, Vice President, State Affairs, American Insurance Association wrote a letter dated November 20, 2000 regarding Section 6, which would require that all claim workers' compensation files be "kept, maintained and administered" in Nevada. He urged DIR "to take full advantage of available technology to carry out its basic responsibilities without imposing unnecessary costs on carriers and employers." AIA also urged DIR to amend Section 6 "to provide an electronic alternative to the in-state claim file

requirement. The ability to retrieve electronic versions of important claim documents should be an alternative to keeping paper copies of those documents in the state. The section should also be revised to remove any suggestion or requirement that activities related to claim administration, management, and adjusting must occur in the state." AIA believes that any data reporting requirements, including those in Section 5, should be applied to public and private self-insured employers, if they are applied to insurance companies [*N.B.* These requirements already apply to all insurers, including public and private self-insured employers. *See* NAC 616B.457 (self-insured employers), NAC 616B.562 (associations), and NAC 616C.631 (private carrier) which DIR proposes to repeal and replace with a general regulation applying to <u>all</u> insurers.] AIA also requested that a minimum 18 months should be provided initially to develop and put in place the systems that would enable carriers to comply with the requirement, and that 6 months time should be provided to comply with each request. [*N.B.* NAC 616C.631 which requires private carrier to make the reporting proposed in Section 5 was adopted on December 18, 1998 and was effective on July 1, 1999; NAC 616B.457 concerns self-insured employers that have been required to report those elements since June 29, 1984]. AIA wondered why DIR proposed to change the 70% to 85% of the physician/chiropractor's rate for certified advanced nurse practitioners and physician's assistants who perform those services. AIA "was surprised to read that [DIR] does not believe the substantial increases in fees paid to medical providers will have any adverse economic effects on the public" and is "troubled that such significant changes in the fee schedule could be adopted without some understanding of how the changes are likely to impact the system." It urged DIR "to assess the potential impact of the proposed fee increases before proposing their final adoption."

19) VaDonna Rivera, Director of Operations, Specialty Health, wrote a letter dated November 27, 2000, regarding Sec. 27 of DIR's proposed regulation. She indicated that instead of changing the percent of allowance for a certified nurse practitioner from 70% to 85% as DIR proposes, that the section be completely eliminated. Although Ron Hubel indicated the change was consistent with Medicare, Mr. Rivera stated "[t]he Medicare modifiers for nurse practitioners were eliminated effective August 1, 1999." She stated "group health insurance policies do not discount nurse practitioner services," and the modifier "should be eliminated to provide payment consistent with group health payments."

20) Donald E. Jayne, CPCU, Jayne & Associates, Inc. on behalf of CDS of Nevada, the third-largest third-party administrator in Nevada, wrote a letter dated November 28, 2000, regarding Section 6(2) [claims files being maintained and administered in Nevada]; CDS does not believe it appropriate at this time to consider eliminating this subsection as it would be contrary to the current statutory language. The time frame of "next working day" in Section 8 [issuing checks after being processed] "places an unreasonable timeframe on third-party administrators." Because of "zero balance accounts," he believes there needs to be a "reasonable" amount of time for the

TPA's to secure funding from these self-insured employers." He suggested a "more practical period of time would be three to five days, which would allow for review of the expenditures by the self-insured employer and proper funding of the insured's fiduciary account."

21) Charlene Foerschler, Specialty Health Clinic, MSN, RN, C-FNP, wrote a letter dated November 28, 2000, regarding concern in regards to reimbursement issues for nurse practitioners under NAC 616C.141. She and her colleagues had "great concern" regarding the reimbursement issue in Sec. 6 and found the proposed change from 70 percent" to 85 percent "very disparaging. Apparently, this 85% is proposed and supported because it is consistent with reimbursement for nurse practitioners under Medicare regulations." They contend that the health care services "provide[d] at Specialty Health Clinic, are NOT provided for under the Medicare program; therefore, reimbursement should not be at a reduced rate, but instead should be paid at 100% of the maximum allowable fee established for physicians …" (original emphasis). She stated "NEVADA is one of the states that mandate the coverage of nurse practitioner services . . . as provided in their various health insurance laws. It is required that nurse practitioner serves must be covered if the service is a covered service in a given insurance plan. [Adapted from: Blue Cross and Blue Shield Issue Brief: State Mandated. Health Insurance Laws, September 1990. Updated 1992, ANA, Division of Governmental Affairs.] As Primary Care Providers, we bill using the CPT codes for Primary Care Services, and are reimbursed the full fee, not a percentage." She asks the 85% modifier be completely eliminated to allow 100% reimbursement for her services.
22) Stephanie Johnson, Regional Contract Manager for Associated Pathologists Laboratories, wrote a letter dated November 28, 2000, regarding proposed amendment of the Schedule of Reasonable Fees for lab/pathology services. She would like to propose the data from contributor number 8 [which is weighted the most heavily] be removed from the Lab/Pathology Paid Data Table. She believes that the data from contributor 8 or the interpretation is in error because if it is compared with the paid data percent change from other contributors, there is a large discrepancy with the next closest overall contribution of -1.28. By removing contributor 8's data, the change from 1998 to 1999 is "approximately 0.00%."
23) Ann Davison, Claims Manager for Fremont Corporation, wrote a letter on December 4, 2000 [DIR asked that the comments be submitted by 5:00 p.m. on November 28, 2000] suggesting Sec. 8 be changed to read "An insurer or third party administrator must have proof that a check for compensation to a claimant, was mailed to the claimant or made available to the claimant in the office of the insurer or third party administrator no later than the date said payment was due."

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

The Division of Industrial Relations did change portions of the proposed regulation based upon comments received from the public and affected businesses.

4. The estimated economic effect of the adopted regulation on the business which it is to regulate and on the public.

(a) On regulated business:

Adverse: Based upon the proposed changes in the schedule of fees and charges, insurers will be paying more for fees and charges for some services than they do under existing regulations. Amendment to NAC 616C.103 proposes to require the insurer to pay the costs related to a permanent partial disability evaluation for an injured employee who has moved out-of-state or who has moved to a new location within the state; DIR believes this situation is relatively infrequent and that cost of transportation and per diem does not impose a significant economic burden on an insurer as it is limited to maximum of $1,000 for a claimant to attend his permanent partial disability evaluation. DIR intends to modify its administrative fine schedule. For insurers, third-party administrators, employers, medical care providers who comply with the law, there will be no economic impact on them; those who do not comply with the law, the economic impact will depend on their level of noncompliance.

Beneficial: Based upon the proposed changes in the schedule of fees and charges, there does not appear to be a direct beneficial economic impact on the regulated business. However, the schedule may be a factor for some physicians and chiropractors who decide to continue to provide medical services to workers' compensation claimants; thus insurers will be have a larger group of health care providers to furnish medical services to its injured workers. This may provide a higher quality of care.

Immediate: Insurers and those who render services pursuant to the schedule of fees and charges will be required to implement the changes, thus incurring, in some cases, costs associated with training and system changes.

Long Term: The Division of Industrial Relations anticipates little long-term economic impact on the regulated business.

(b) On the general public:

Adverse: There are no known or adverse economic effects on the general public expected as a result of the proposed regulations given that the regulations 1) assure that the fees and charges for accident benefits do no exceed the fees and charges usually paid for similar treatment and 2) assure that the fees and charges for accident benefits are not unfairly discriminatory as between persons legally qualified to provide the particular service for which the fees and charges are sought.

Beneficial: The beneficial effects on the general public are that the regulations 1) assure that the fees and charges for accident benefits do not exceed the fees and charges usually paid for similar treatment and 2) assure that the fees and chares for accident benefits are not unfairly discriminatory as between persons legally qualified to provide the particular service for which the fees and charges are sought

Immediate: The Division of Industrial Relations anticipates little immediate economic impact on the public business.

Long Term: The Division of Industrial Relations anticipates little long-term economic impact on the public.

5. The estimated cost to the agency for enforcement of the adopted regulations:

The estimated cost to the Division for enforcement is no greater than the enforcement costs associated with existing regulations, which is minimal.

6. 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.

The Division of Industrial Relations is not aware of any overlap or duplication between the proposed regulation and any other state or governmental regulation.

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

The proposed regulation is not more stringent than a federal regulation regulating the same activity.

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

The proposed regulations will not result in any new or increased fee to regulated businesses or public.

DATED this ____ day of December, 2000.

By: _____

ROGER BREMNER, Administrator
Department of Business and Industry
Division of Industrial Relations
400 West King Street, Suite 400
Carson City, Nevada 89703

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