LCB File No. R105-00

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

PROPOSED REGULATIONS OF THE ADMINISTRATOR OF THE DIVISION OF INDUSTRIAL RELATIONS OF THE DEPARTMENT OF BUSINESS AND INDUSTRY

DIR 00-1

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

Chapter 616 of NAC is hereby amended by adding thereto the provisions set forth as sections 1 through 12, inclusive, of this regulation.

Sec. 1.

If a physician or chiropractor fails to comply with the provisions of NRS 616C.040, subsection 3 or NRS 616C.475, subsection 7, that requires a physician or chiropractor to include certain information when a certification of disability is issued, the administrator or his designee may:

1. For the first violation within a 12-month period, issue a notice of correction pursuant to paragraph (a) of subsection 2 of NRS 616C.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 and subsequent violation within a 12-month period, impose an administrative fine of $1000.

Sec. 2.

1. 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 or his designee shall:

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

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

Sec. 3.

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 that require delivering a list of providers of health care to an injured employee within 3 working days upon receipt of a written request, the administrator or his designee shall:

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 subsequent violation within a 12-month period, impose an administrative fine of $1,000.

Sec. 4.

If an insurer or employer fails to comply or complies in an untimely manner with the provisions of NAC 616C.1164 that require an insurer or employer to provide a report of a medical examination within 10 days after receipt of a report, the administrator or his designee shall:

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 subsequent violation within a 12-month period, impose an administrative fine of at least $500.

Sec. 5.

If an insurer or a third-party administrator fails to comply or complies in an untimely manner with the provisions of NAC 616C.508 that require the payment of compensation for the loss of or permanent damage to a tooth, the administrator or his designee shall:

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 subsequent violation within a 12-month period, impose an administrative fine of $1,000.

Sec. 6.

All compensation payments on a claim must be mailed or made available for pick-up no later than the next working day from the date on the check for compensation.

Sec. 7.

If an insurer or third-party administrator fails to comply or complies in an untimely manner with the provisions of Section 6 of this regulation that require the issuance of compensation payment to an injured employee, the administrator or his designee shall:

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 subsequent violation within a 12-month period, impose an administrative fine of $1,000.

Sec. 8.

If an insurer, third-party administrator, organization for managed care, employer or provider of health care violates any provision of chapter 616A to 617, inclusive, of NRS or a regulation adopted pursuant thereto for which an administrative fine or other penalty is not specifically provided, the administrator or his designee shall:

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 subsequent violation within a 12-month period, impose an administrative fine of at least $500.

Note: Sec. 9 will replace NAC 616B.457, 562 and 631, which will be repealed.

Sec. 9.

1. For purposes of this section:

(a) A "medical only" claim means any claim in which payment of temporary total disability, temporary partial disability, or permanent total disability has not been paid to the injured employee or his dependents at any time during the life of the claim.

(b) A "lost time" claim means any claim in which payment of temporary total disability, temporary partial disability or permanent total disability has been paid to the injured employee or his dependents at any time during the life of the claim.

2. 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:

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

(1) The number of new claims filed.

(2) The number of medical only claims accepted.

(3) The number of lost time claims accepted.

(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 of medical only claims accepted.

(3) The number of lost time claims accepted.

(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 claim reopenings denied.
(e) The number of medical only claims reopened.
(f) The number of lost time claims reopened.
(g) The number of injured employees paid benefits for a permanent partial disability.
(h) The number of injured employees paid benefits for a permanent partial disability in a lump sum.
(i) The number of injured employees paid rehabilitation benefits.
(j) The number of injured employees paid rehabilitation benefits 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 as defined by the administrator or his designee.
(n) Total expenditures for claims reported in (k) and (l) of this section.
(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, 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.
(p) Amounts recovered:
(1) Through subrogation.
(2) From the subsequent injury fund for self-insured employers.
(3) From other sources.
(q) Any other information requested by the administrator or his designee.
3. The information required pursuant to subsection 2 must, except as otherwise requested by the administrator or his designee, include information regarding any administrative activity during the prior fiscal year, as defined by the administrator, relating to:
(a) A claim for an injury that occurred during that year; and
(b) Any other claims, regardless of when the injury occurred.

Note: Sec. 10 will replace NAC 616B.454, 561 and 634, which will be repealed.

Sec. 10.

1. An insurer shall ensure that all files of claims and all records maintained by the insurer 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 insurer.

Sec. 11.

If an insurer fails to comply with the provisions of Section 10 that require the maintenance of claims and records, the administrator or his designee shall:

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 subsequent violation within a 12-month period, impose an administrative fine of $1,000.

Note: Sec. 12 will replace NAC 616B.466, 568 and 637, which will be repealed.

Sec. 12.

1. For purposes of this section "exposure" is defined as proximity and/or contact with a source of a disease agent in such a manner that effective transmission of the agent or harmful effects of the agent may occur.

2. Within 30 days after an insurer receives notice of an accident or exposure, the insurer shall notify the administrator if the accident resulted in injury to, or the exposure affected or is expected to affect, two or more persons.

3. Within 48 hours after the insurer receives notice, in any form, of an accident or exposure resulting in a fatality, the insurer shall notify the administrator of the fatality on the form entitled D-21, Fatality Report, which is prescribed by the division.

Sec. 13. 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 insurer***, employer, third-party administrator, organization for managed care, and health care provider*** 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; 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 ***or his designee***.

(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. 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 treating physician or chiropractor who conducted the initial examination of the injured employee must be retained by that treating 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 ***or his designee***.

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

(i) Unique to the treating 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. 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 Award Calculation Worksheet.

(k) D-9(b), PPD 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.

(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).
(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 1500 Billing Form.
(kk) D-35, Rotating Rating Physician/Chiropractor Request.
(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, IIRS Noncompliance Premium.
(qq) D-40lv, IIRS Noncompliance Premium.
(rr) D-41, IAIABC POC 1
(ss) D-43, ~~[Employer]~~ ***Employee*** 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, Non-Compliance Notice.
(xx) D-48, Proof of Coverage Notice.
(yy) D-49, Information Page.
(zz) D-50, Policy Termination, Cancellation and Reinstatement Notice.
(ab) D-51, Request for Hearing

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. All forms must be completed accurately and thoroughly, and include signature and date, as required. Nothing in this section prohibits an employer or insurer from designating a third-party administrator as its agent for the purpose of signing forms.

~~[3]~~ ***4***. An insurer, employer, injured employee, provider of health care or claims agent 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. ***Nothing in this section prohibits a third-party administrator, organization for managed care, or provider of health care from providing any form.***

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

Sec. 14. 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]~~ ***designee*** 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 notice on the administrator or his ~~[designated agent]~~ ***designee*** if notice is served on the administrator or his ~~[designated agent]~~ ***designee*** 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, 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 ***or his designee*** 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. 15. NAC 616B.812 is hereby amended to read as follows:

616B.812 1. An employer who applies for coverage of volunteers must have an active account with a private carrier unless he is a self-insured employer or a member of an association.

2. A self-insured employer or member of an association who has elected to cover volunteers must report that election to the administrator ***or his designee.***

3. An employer's application for coverage of volunteers, whether or not the employer is self-insured, must contain:

(a) An identification of the formal program which he is sponsoring and which is manned by volunteers.

(b) The types of work being performed by the volunteers.

(c) The beginning and, if known, the ending dates of the formal program.

(d) The average number of volunteers who will be active in the program each month.

(e) The employer's agreement to maintain, as a part of his official records, a roster of active volunteers and to present the roster for audit by the payroll auditors of the private carrier.

(f) The location of the roster of active volunteers.

(g) The name of the person responsible for maintenance of the roster.

(h) The name and telephone number of a person who may be asked for information regarding the volunteers.

(i) The person in the employer's organization who is authorized to sign reports of injury when volunteers are involved.

Sec. 16. NAC 616B.815 is hereby amended to read as follows:

616B.815 1. Elective coverage of volunteers becomes effective on the date on which the employer's application for such coverage is approved and accepted:

(a) In the case of an employer who is not self-insured or a member of an association, by a private carrier.

(b) In the case of a self-insured employer or a member of an association, by the administrator ***or his designee***.

2. The private carrier shall, in the case of a sponsoring employer insured by it, assign a separate classification from the manual for the employer to use in reporting the payroll and premium of the volunteers.

3. The deemed wage of $100 is reportable for each volunteer who is on the active roster of the sponsored organization for any part of a month.

Sec. 17. NAC 616B.818 is hereby amended to read as follows:

NAC 616B.818 1. The elective coverage of volunteers remains in effect until:

(a) The electing employer, if he is insured by a private carrier, notifies the private carrier, or if he is a self-insured employer or member of an association, notifies the administrator ***or his designee***, that the coverage is to be terminated; or

(b) The administrator ***or his designee*** or the private carrier finds that an employer electing coverage has not maintained a current roster of volunteers, whichever occurs earlier.

2. If the private carrier terminates coverage pursuant to paragraph (b) of subsection 1, the private carrier must do so by the issuance of an endorsement changing the coverage of the electing employer's policy.

3. For an employer who is insured by a private carrier, the premium for any period during which coverage was active but the employer did not maintain a roster must be based on the greater of either the number of volunteers who were declared on the application for coverage, or the largest number of volunteers provided on prior rosters.

Sec. 18. NAC 616C.027 is hereby amended to read as follows:

NAC 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 review the matter, ***and, if appropriate,*** 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 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 are the only parties to the hearing. The industrial insurance regulation section is not a party to the hearing. The administrator or his designee must hear all evidence, including new evidence, concerning the reduction or disallowance.

~~[3]~~ ***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. 19. NAC 616C.030 is hereby amended to read as follows:

NAC 616C.030 1. Upon the receipt of a request from an injured employee or his representative, the:

(a) Employer;
(b) Insurer;
(c) Third-party administrator; or
(d) Organization for managed care,

shall provide a list of providers of health care who are authorized to provide medical and health care services to the injured employee.

2. If the request made pursuant to subsection 1 is in writing, the:

(a) Employer;
(b) Insurer;
(c) Third-party administrator; or
(d) Organization for managed care,

Shall ~~[~~provide~~]~~ ***deliver*** the list to the injured employee within 3 working days after the date it receives the request.

Sec. 20. 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 employer is not self-insured, to his employer. The notice must be given within the time prescribed in NRS 616C.~~[060]~~ ***065***. If the insurer denies the claim:

1. The notice ***to the injured employee*** 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. The notice to the administrator must include:

(a) A copy of the notice sent to the injured employee; and

(b) A copy of the C-4, Employee's Claim for Compensation/Report of Initial Treatment.

~~[2]~~ ***3***. The insurer shall provide a copy of the notice 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.]~~

Sec. 21. 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, Rotating Rating Physician/Chiropractor Request, 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, Rotating Rating Physician/Chiropractor Request.

(d) Paying the costs of transportation and per diem for an injured employee to attend a rating evaluation if the injured employee moved out of this state to another state or to a new location within this state prior to the rating evaluation.

3. Except as otherwise provided in subsection 5, 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,

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

4. 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. 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. 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. 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. 22. 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,

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 pursuant to NAC 616C.188, or the "Relative Value Guide of the American Society of Anesthesiologists, as adopted 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 to 616C.336, inclusive, allow for the payment of such 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. 23. NAC 616C.144 is hereby amended to read as follows:

NAC 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) 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 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) ***For services other than physical therapy, p***~~[P]~~rovide an explanation of benefits for each code billed that includes the amounts for services that are paid and disallowed;

(b) For physical therapy, if the total units for the day total 12 or more, combine all the services for the day and use code NV970001 on the payment.

(c) For physical therapy, if the total units for the day are less than 12, provide an explanation of benefits for each code billed that includes the amounts for services that are paid and disallowed;

~~[(b)]~~ ***(d)*** Indicate on each payment those services which are being disallowed and the reasons for the disallowance; and

~~[(c)]~~ ***(e)*** 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. 24. 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]~~ ***designee*** 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.

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

3. A copy of "Relative Values for Physicians," as adopted pursuant to subsection 1, may be purchased from ~~[St. Anthony Publishing, Inc., P.O. Box 96561, Washington, D.C. 20090, (800) 632-0123]~~ ***Ingenix, 5225 Wiley Post Way, Suite 500, Salt Lake City, Utah 84116-2889, (800) 999-4600***, at the cost of $~~[239.95]~~ ***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 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 physical therapist or 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 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 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. 25. 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:

Code	Type of Service	Conversion Factor
70000-79999	Radiology and Nuclear Medicine	$~~[20.69]~~ ***24.09***
80000-89999	Pathology	~~[14.30]~~ ***12.36***
90000-99999	Medicine	~~[6.00]~~ ***6.24***
10000-69999	Surgery	~~[117.57]~~***135.28***
~~[92980-93562~~	~~Surgery/Cardiovascular~~	~~117.57]~~

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 pursuant to NAC 616C.188, to bill for services performed which are within the scope of their licenses.

Sec. 26. 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]~~ ***designee*** 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. If the administrator ***or his designee*** 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 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 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]~~ ***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 pursuant to NAC 616C.188 , utilizing 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. 27. 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).

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 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.

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 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. 28. 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, those emergency department charges are considered separate from the inpatient per diem rates and are to 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. 29. 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 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. 30. 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, 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 nationally recognized pricing guide.

3. Each insurer shall notify the ~~[chief]~~ ***administrator or his designee*** of the identity of the pricing guide he uses in determining the amount to be paid for pharmaceuticals. If the ~~[chief]~~ ***administrator or his designee*** objects to a particular pricing guide he shall notify the insurer within ~~[5 working]~~ ***7*** days. Unless the insurer is advised that the guide is objectionable within ~~[5 working]~~ ***7*** days, he 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. 31. 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, 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. 32. 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, 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. 33. 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 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-***0723***, (800) 248-2882, at a cost of $~~[99.00]~~ ***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]~~ ***69.95***~~[; or~~

~~(c) St. Anthony Publishing, Inc., P.O. Box 96561, Washington, D.C. 20090, (800) 632-0123, at a cost 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. 34. 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 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. 35. 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, 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. 36. 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 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 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. 37. 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. 38. 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 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 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, ACPT-4@ means the American Medical Association=s APhysicians= Current Procedural Terminology,@ fourth edition, as contained in the ARelative Values for Physicians,@ as adopted by reference in NAC 616C.188.

Sec. 39. NAC 616C.393 is hereby amended to read as follows:

616C.393 1. If a private carrier conducts an investigation regarding a claim against an uninsured employer, a report of its findings must be prepared.

2. Upon completion of the investigation, a copy of all available information from the file, including, without limitation, the investigative report, must be sent to the administrator ***or his designee***.

Sec. 40. 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 return the completed forms D-16, D-17 and D-18 within 30 days of receipt.

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]~~ ***pursuant to NRS 616C.220(9)***.

Sec. 41. NAC 616C.476 is hereby amended to read as follows:

616C.476 1. 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 AInjury 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 ARange 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]~~.

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.

~~[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. 42. 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.

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.]~~ ***For a prior workers' compensation impairment rating done in Nevada, the percentage established for a previous injury or occupational disease involving the same condition, organ or anatomical structure is subtracted from the current percentage of impairment, regardless of the edition of the guide utilized.***

4. If an out-of-state or if no prior rating was performed, the guide, as adopted by reference pursuant to NAC 616C.002, is used to determine the current and prior rating impairments involving the same condition, organ or anatomical structure. The rating for the preexisting prior impairment is subtracted from the current impairment rating of the same condition, organ or anatomical structure.

~~[4]~~ ***5.*** 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 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]~~ ***AMA Guides to the Evaluation of Permanent Impairment.*** 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]~~ ***6.*** If precise information is not available, 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***s*** 3 ***and 4***. 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 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]~~ ***7*** or ~~[7]~~ ***8***, the impairment may not be apportioned.

Sec. 43. NAC 616C.496 is hereby amended to read as follows:

616C.496 If no factual measurement of a disability ***involving the same or structurally related condition, organ or anatomical structure***, attributable to the injury from the first accident has been made before a disability occurs as a result of a second accident, the total disability from both accidents must not be evaluated until both injuries are stabilized following the second injury.

Sec. 44. 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]~~ ***200***
Cuspid … ***300***
Bicuspid ..... ~~[300]~~ ***300***
Molar ..... ~~[400]~~ ***400***

2. Payment to an injured employee for the loss of or permanent damage to a tooth shall be made by an insurer or third-party administrator within 30 days after being notified by the treating dentist that treatment has been completed.

Sec. 45. NAC 616C.700 is hereby amended to read as follows:

616C.700 1. The administrator or his ~~[designated agent will]~~ ***designee shall*** impose the following administrative fines if a treating physician or chiropractor fails to comply ***or complies in an untimely manner*** with the provisions of NRS 616C.040 or any regulation adopted pursuant thereto ***that require the treating physician or chiropractor to file a claim for compensation***:

(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]~~ ***750***.

(d) For the fourth 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.]~~

The administrator or his designee shall impose the following administrative fines if a treating physician or chiropractor fails to comply or complies in an untimely manner with the provisions of NRS 616C.040 or any regulation adopted pursuant thereto that require the treating physician or chiropractor to complete a claim for compensation:

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

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

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

~~[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.]~~

Sec. 46. NAC 616C.710 is hereby amended to read as follows:

616C.710 1. The administrator or his ~~[designated agent will]~~ ***designee shall*** impose the following administrative fines if an employer fails to comply ***or complies in an untimely manner*** with the provisions of NRS 616C.045 or any regulation adopted pursuant thereto ***that require the employer to file a report of industrial injury or occupational disease***:

(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]~~ ***750***.

(d) For the fourth 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.~~**]**

The administrator or his designee shall impose the following administrative fines if an employer fails to comply or complies in an untimely manner with the provisions of NRS 616C.045 or any regulation adopted pursuant thereto that require the employer to complete a report of industrial injury or occupational disease:

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

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

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

~~[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.~~**]**

Sec. 47. 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. 48. 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 ***or his designee***, 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]~~ ***designee*** 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 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 subsequent violation, impose an administrative fine of $10,000.

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

Sec. 49. NAC 616D.400 is hereby amended to read as follows:

616D.400 ***1. Subject to subsection 2 of this section,*** ~~[F]~~ ***f***or the purposes of subsection 2 of NRS 616D.120, "minor violation" means 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.

2. Those violations referenced in sections 1, 3, 4, 5, 7, 8 and 11 of the proposed regulations and in NAC 616D.406 through NAC 616D.438, inclusive, shall be deemed as minor violations.

Sec. 50. NAC 616D.406 is hereby amended to read as follows:

616D.406 ~~[1.]~~ If an insurer, organization for managed care, 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, health care provider, third-party administrator or employer to provide to an injured employee a form, notice or any other information, the administrator ***or his designee*** ~~[will]~~ ***shall***:

~~[(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 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. 51. 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 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 ***or his designee*** ~~[will]~~ ***shall, in addition to NRS 616C.065***:

~~[(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 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.]~~

Sec. 52. 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 regulation adopted pursuant thereto*** 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 ***or third-party administrator***, the administrator ***or his designee*** ~~[will]~~ ***shall***:

~~[(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]~~ ***250***.

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

~~[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.]~~

Sec. 53. 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 ***that require a determination concerning a request relating to a claim***, the administrator ***or his designee*** ~~[will]~~ ***shall***:

~~[(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 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. 54. 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 ***or his designee*** ~~[will]~~ ***shall***:

(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 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.]~~***2***. 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 ***or his designee*** ~~[will]~~ ***shall***:

(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.

~~[4.]~~***3***. The administrator ***or his designee*** ~~[will]~~ ***shall*** 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 to the injured employee pursuant to chapters 616A to 617, inclusive, of NRS or the regulations adopted pursuant thereto.

Sec. 55. 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 ***that require the timely scheduling of a permanent partial disability evaluation***, the administrator ***or his designee*** ~~[will]~~ ***shall***:

~~[(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 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. 56. NAC 616D.418 is 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 ***that require a timely plan for a program of vocational rehabilitation***, the administrator ***or his designee*** ~~[will]~~ ***shall***:

~~[(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**.**

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 subsequent violation within a 12-month period, impose an administrative fine of $1,000.

~~[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.]~~

Sec. 57. 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 ***that require the timely submission of a permanent partial disability evaluation report***, the administrator ***or his designee*** ~~[will]~~ ***shall***:

~~[(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 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. 58. 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 health care provider, the administrator ***or his designee*** ~~[will]~~ ***shall***:

~~[(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]~~ ***100*****.**

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

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

~~[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.~~**]**

Sec. 59. 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 ***that require a vocational rehabilitation counselor to comply with the provisions of subsections 1, 2 and 3 of NRS 616C.550 and NAC 616C.550 regarding a written assessment***, the administrator ***or his designee*** ~~[will]~~ ***shall***:

~~[(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**.**

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 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 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.~~**]**

Sec. 60. 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 ***that require the insurer to deliver a copy of a vocational rehabilitation report***, the administrator ***or his designee*** ~~[will]~~ ***shall***:

~~[(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**.**

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 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 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.]~~

Sec. 61. 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 ***that require payment for a program of on-the-job training***, the administrator ***or his designee*** ~~[will]~~ ***shall***:

~~[(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]~~ ***250*****.**

~~[(c)]~~ ***3.*** For the third violation within a 12-month period, impose an administrative fine of at least $~~[750]~~ ***500*****.**

~~[(d)]~~ ***4.*** For the fourth ~~[or subsequent]~~ violation within a 12-month period, impose an administrative fine of $~~[1,000]~~ ***750***.

5. For the fifth 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.]~~

Sec. 62. 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 ***that require the reimbursement of wages to a training employer***, the administrator ***or his designee*** ~~[will]~~ ***shall***:

~~[(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**.**

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 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 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.]~~

Sec. 63. NAC 616D.436 is hereby amended to read as follows:

616D.436 ~~[1.]~~ If an insurer, organization for managed care, 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, 616B.009 or NAC 616A.410 ***that require the submission of information to the administrator or his designee***, the administrator ***or his designee*** ~~[will]~~ ***shall***:

~~[(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 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. 64. NAC 616D.438 is hereby amended to read as follows:

616D.438 If an insurer ~~[or]~~, third-party administrator, ***organization for managed care, employer or health care provider*** fails to comply ***or complies in an untimely manner*** with the provisions of NAC 616A.480 ***that require the use of certain posters and forms or data in the administration of claims***, the administrator ***or his designee*** ~~[will]~~ ***may***:

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, a fine of at least $250.

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

Sec. 65. 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 to receive industrial insurance benefits pursuant to NRS ***617.454***, 617.455 and 617.457 and to their employers.

Sec. 66. 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 Firemen and Police Officers= Medical History Form prescribed by the ~~[~~system~]~~ ***division***; ~~[~~and~]~~

~~(b)~~ ***2.*** The ~~[~~examiner~]~~ ***examining physician*** must fill out the Firemen and Police Officers= Lung Examination Form prescribed by the ~~[~~system~]~~ ***division***;

~~[~~2.~]~~ ***3***. An X-ray film of the chest must be made;

~~[~~3.~]~~ ***4***. A pulmonary function test must be completed for police officers and salaried firemen; and

~~[~~4.~]~~ ***5***. A stethoscopic examination of the lungs must be performed.

Sec. 67. NAC 617.070 is hereby amended to read as follows:

617.070 1. Cardiac examinations which are conducted ***pursuant to NRS 617.457*** ~~[~~upon employment as a salaried fireman or police officer at the end of the fifth year of continuous service, and in each ~~[~~alternate~]~~ year of service thereafter,~]~~ 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)*** A fireman or police officer must fill out the Firemen and Police Officers= Medical History Form prescribed by the ~~[~~system~]~~ ***division***; ~~[~~and~]~~

~~[~~(2)~]~~ ***(b)*** The ~~[~~examiner~]~~ ***examining physician*** must fill out the Firemen and Police Officers= Extensive Heart Examination Form prescribed by the ~~[~~system~]~~ ***division***;

~~[~~(b)~]~~ ***(c)*** A stethoscopic examination of the heart must be performed;

~~[~~(c)~]~~ ***(d)*** An electrocardiogram must be made;

~~[~~(d)~]~~ ***(e)*** 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)~~ ***(d)***, must be made;

~~[~~(e)~]~~ ***(f)*** A blood test to determine the amounts of triglycerides and cholesterol which are present must be completed; and

~~[~~(f)~]~~ ***(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)*** A fireman or police officer must fill out the Firemen and Police Officers= Medical History Form prescribed by the ~~[~~system~]~~ ***division***; ~~[~~and~]~~

~~[~~(2)~]~~ ***(b)*** The ~~[~~examiner~]~~ ***examining physician*** must fill out the Firemen and Police Officers= Limited Heart Examination Form prescribed by the ~~[~~system~]~~ ***division***;

~~[~~(b)~]~~ ***(c)*** A stethoscopic examination of the heart must be performed; and

~~[~~(c)~]~~***(d)*** An electrocardiogram must be made if the ~~[~~examiner~]~~ ***examining physician*** believes circumstances warrant such a test.

Sec. 68 NAC 617.075 is hereby amended to read as follows:

617.075 1. The physical examinations required by NRS ~~[~~617.455 and 617.457~]~~ ***617.454*** must include a test of hearing function that consists 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 examiner must fill out the Firemen and Police Officers= Hearing Examination Form prescribed by the division.

Sec. 69. NAC 617.080 is hereby amended to read as follows:

617.080 The employer shall:

1. Schedule the physical examinations required pursuant to NRS ***617.454***, 617.455 and 617.457 and NAC 617.040, ~~[and]~~ 617.060, ***and 617.075.***

2. Maintain the records of all physical examinations completed pursuant to NAC 617.040, ~~[and]~~ 617.060***, and 617.075*** ~~[until]~~ ***for at least two 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 required by NRS 617.455 and 617.457.

Sec. 70. NAC 617.090 is hereby amended to read as follows:

617.090 The employee shall:

1. Submit to the physical examinations 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 and file with the ~~[system]~~ ***insurer*** the Firemen and Police Officers= Medical History Form prescribed by the ~~[system]~~ ***division*** and sign a form acknowledging receipt of the forms provided by the ~~[examiner]~~ ***examining physician***.

Sec. 71. NAC 617.100 is hereby amended to read as follows:

617.100 The ~~[examiner]~~ ***examining physician*** who conducts an examination pursuant to NAC 617.040,~~[and]~~ 617.060, ***and 617.075*** shall provide the employer and the employee with a copy of each of the forms required to be completed by NAC 617.050, ~~[and]~~ 617.070 ***and 617.075(4)*** following each physical examination.

Sec. 72. NAC 617.200 is hereby amended to read as follows:

617.200 1. The administrator or his ~~[designated agent will]~~ ***designee shall*** impose the following administrative fines if a treating physician or chiropractor fails to comply ***or complies in an untimely manner*** with the provisions of NRS 617.352 or any regulation adopted pursuant thereto ***that require the treating physician or chiropractor to file a claim for compensation***:

(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]~~ 750.

(d) For the fourth 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.~~**]**

The administrator or his designee shall impose the following administrative fines if a treating physician or chiropractor fails to comply or complies in an untimely manner with the provisions of NRS 617.352 or any regulation adopted pursuant thereto that require the treating physician or chiropractor to complete a claim for compensation:

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

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

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

~~**[**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.~~**]**

Sec. 73. NAC 617.210 is hereby amended to read as follows:

617.210 1. The administrator or his ~~**[**designated agent will~~**]** ***designee shall*** impose the following administrative fines if an employer fails to comply ***or complies in an untimely manner*** with the provisions of NRS 617.354 or any regulation adopted pursuant thereto ***that require the employer to file a report of industrial injury or occupational disease***:

(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~~**]** ***750***.

(d) For the fourth 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.~~**]**

The administrator or his designee shall impose the following administrative fines if an employer fails to comply or complies in an untimely manner with the provisions of NRS 617.354 or any regulation adopted pursuant thereto that require the employer to complete a report of industrial injury or occupational disease:

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

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

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

~~**[**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.~~]

Sec. 74. NAC 616A.490 is hereby repealed.

~~616A.490 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.~~

Sec. 75. NAC 616B.454 is hereby repealed.

~~616B.454 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.~~

Sec. 76. NAC 616B.457 is hereby repealed.

~~616B.457 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.

Sec. 77. NAC 616B.466 is hereby repealed.

~~616B.466 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.~~

Sec. 78. NAC 616B.561 is hereby repealed.

~~616B.561 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.~~

Sec. 79. NAC 616B.562 is hereby repealed.

~~616B.562 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.~~

Sec. 80. NAC 616B.568 is hereby repealed.

~~616B.568 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.~~

Sec. 81. NAC 616B.631 is hereby repealed.

~~616B.631 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.~~

~~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 the 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]~~ *1* ~~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.~~

Sec. 82. NAC 616B.634 is hereby repealed.

~~616B.634 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.~~

Sec. 83. NAC 616B.637 is hereby repealed.

~~616B.637 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.~~

~~3. 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.~~

Sec 84. NAC 616B.646 is hereby repealed:

~~616B.646 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.~~

Sec. 85. NAC 616B.670 is hereby repealed.

~~616B.670 1. 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.~~

Sec. 86. NAC 617.020 is hereby repealed.

~~617.020 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.~~

~~3. "System" means the state industrial insurance system.~~

Sec. 87. NAC 617.030 is hereby repealed.

~~617.030 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.~~

Sec. 88. NAC 617.110 is hereby repealed.

~~617.110 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 system.~~

Sec. 89. NAC 617.040 is hereby repealed:

~~617.040 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.~~

Sec. 90. NAC 617.060 is hereby repealed:

~~617.060 A fireman or 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.~~

Sec. 91.

All sections become effective January 1, 2001.

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