ADOPTED REGULATION OF THE ADMINISTRATOR OF THE

DIVISION OF INDUSTRIAL RELATIONS OF THE

DEPARTMENT OF BUSINESS AND INDUSTRY

LCB File No. R118-02

Effective September 7, 2005

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

AUTHORITY: §§1, 4-12 and 39, NRS 616A.400; §2, NRS 616A. 400 and 616A.417; §3, NRS 616A.400 and 616B.012; §13, NRS 616A.400, 616B.587 and 616B.590; §14, NRS 616A.400 and 616C.220; §§15 and 17, NRS 616A.400 and 616C.090; §16, NRS 616A.400, 616C.135 and 616C.260; §§18 and 19, NRS 616A.400 and 616C.490; §§20, 21 and 28 to 32, inclusive, NRS 616A.400 and 616C.260; §22, NRS 616C.250; §§23 to 26, inclusive, NRS 616A.400, 616C.250 and 616C.260; §27, NRS 616A.400, 616C.260 and 616C.365; §33, NRS 616A.400, 616C.130 and 616C.260; §§34, 35 and 36, 616A.400 and 616D.120; §§37 and 38, NRS 616A.400 and 616D.200.

A REGULATION relating to industrial insurance; revising the forms that must be used by an insurer, injured employee or provider of health care; revising information that is required to adopt certain publications by reference; revising the schedule of fees and charges for accident benefits required to be adopted by the Administrator of the Division of Industrial Relations of the Department of Business and Industry; establishing standards for determining the amount of any benefit penalty that may be required to be paid to a claimant; and providing other matters properly relating thereto.

Section 1. NAC 616A.430 is hereby amended to read as follows:

616A.430 A brief explanation of the procedure for obtaining clarification of NAC 616A.420, 616C.091, 616C.094, ~~[616C.182 to 616C.218,]~~ ***616C.188 to 616C.215,*** inclusive, 616C.423, 616C.447 or 616C.502, or relief from the strict application of any of their terms **,** may be obtained from the Division of Industrial Relations, 400 West King Street, Suite 400, Carson City, Nevada ~~[89710.]~~ ***89703.***

Sec. 2. NAC 616A.480 is hereby amended to read as follows:

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

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

(1) The insurer;

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

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

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

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

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

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

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

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

(I) Unique to the employer;

(II) Capable of verification; and

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

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

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

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

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

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

(I) Unique to the physician or chiropractor;

(II) Capable of verification; and

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

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

➥ 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), Permanent Partial Disability Award Calculation Worksheet.

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

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

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

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

(o) D-12(a), Request for Hearing - Contested Claim.

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

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

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

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

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

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

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

(w) D-21, Fatality Report.

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

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

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

(aa) D-25, Affirmation of Compliance with Mandatory Industrial Insurance Requirements.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~[(tt)]~~ ***(rr)*** D-44, Election of Coverage by Employer; Employer Withdrawal of Election of Coverage.

~~[(uu)]~~ ***(ss)*** D-45, Sole Proprietor Coverage.

~~[(vv)]~~ ***(tt)*** D-46, Temporary Partial Disability Calculation Worksheet.

~~[(ww) D-47, Noncompliance Notice.~~

~~(xx)]~~ ***(uu)*** D-48, Proof of Coverage Notice.

~~[(yy)]~~ ***(vv)*** D-49, Information Page.

~~[(zz)]~~ ***(ww)*** D-50, Policy Termination, Cancellation and Reinstatement Notice.

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

(xx) D-52, CMS (UB-92).

(yy) D-53, Alternative Choice of Physician or Chiropractor and Referral to a Specialist.

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.]~~ ***Firemen and Police Officers' Physical Examination Information.***

(h) OD-8, Occupational Disease Claim Reporting.

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

4. An insurer, employer, injured employee, provider of health care, organization for managed care or third-party administrator may not use a different form or change a form without the prior written approval of the Administrator.

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.

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

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

Sec. 3. NAC 616B.008 is hereby amended to read as follows:

616B.008 1. To obtain information for the proper presentation of his claim in a proceeding held pursuant to chapters 616A to 616D, inclusive, of NRS, an injured employee or a person who has been authorized by the injured employee to represent him must deliver a written request to his insurer ~~[.]~~ ***or employer.*** The insurer ***or employer*** shall provide such information to the injured employee or his authorized representative within 30 days after receipt of the written request. If, at the time of receipt of the written request from the injured employee or his authorized representative, the requested information is in the possession of a third-party administrator **,** or an organization for managed care ***or a provider of health care*** with whom the insurer has contracted, the insurer shall take all reasonable steps necessary to obtain such information.

2. To obtain confidential information pursuant to subsection 3 of NRS 616B.012, the requesting agency, department or board must deliver to the insurer a written request that must:

(a) Be written on the official letterhead of the requesting agency, department or board;

(b) State the purpose for which the requesting agency, department or board will use the requested information;

(c) Contain all pertinent information available to the requesting agency, department or board to identify:

(1) The injured employee, including, without limitation, his name, social security number, date of birth and the date of his injury; or

(2) The employer, including, without limitation, his name, the name and address of the business, the names of the owners of the business and the employer's policy number; and

(d) Contain any other information that the insurer may need to process the request.

➥ The insurer may require additional information to process the request. The insurer shall provide the requested confidential information to the requesting agency, department or board within 30 days after receiving the written request.

3. If a request requires the insurer to report on more than one employer or more than one injured employee, the head of the requesting agency, department or board must sign the request. If a request requires the insurer to report on only one employer or injured employee, either the head of the requesting agency, department or board or his designated agent must sign the request.

4. Upon receipt of a written request made pursuant to the provisions of subsection 5 of NRS 616B.012 by the chief executive officer of any law enforcement agency of this state, the administrator will instruct the insurer to provide the information requested to the chief executive officer within 30 days after receiving the instructions from the administrator. The insurer shall

provide the information requested within 30 days after receipt of such an instruction from the administrator.

5. Any fee charged for providing information pursuant to this section and NRS 616B.012 may not exceed 30 cents per page. If more than one copy of an item of information that is requested pursuant to this section is maintained in the records of an insurer, employer or third-party administrator, or in the records of an organization for managed care or provider of health care with whom the insurer has contracted, no fee may be charged for any duplicate copy that is provided.

Sec. 4. NAC 616B.100 is hereby amended to read as follows:

616B.100 As used in NAC 616B.100 to 616B.148, inclusive, unless the context otherwise requires, the words and terms defined in NAC ~~[616B.103 to 616B.118, inclusive,]~~ ***616B.106, 616B.109 and 616B.118*** have the meanings ascribed to them in those sections.

Sec. 5. NAC 616B.121 is hereby amended to read as follows:

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

1. ***IAIABC EDI Implementation Guide for Proof of Coverage***, which is published by the International Association of Industrial Accident Boards and Commissions. A copy of the publication may be obtained from the International Association of Industrial Accident Boards and Commissions, ~~[1201 Wakarusa Drive, Suite C-3, Lawrence, Kansas 66049,]~~ ***5610 Medical Circle, Suite 24, Madison, Wisconsin 53719,*** for the price of ~~[$195]~~ ***$50*** for members and ~~[$395]~~ ***$95*** for nonmembers.

2. ***Workers Compensation Policy Data Reporting Manual***, which is published by the National Council on Compensation Insurance. A copy of the publication may be obtained from the National Council on Compensation Insurance, Products and Services Department, ~~[750 Park~~

~~of Commerce Drive,]~~ ***901 Peninsula Corporate Circle,*** Boca Raton, Florida 33487, for the price of ~~[$96 for members and $124 for nonmembers.]~~ ***$120 for affiliates and $155 for nonaffiliates.***

3. ***Basic Manual for Workers Compensation and Employers Liability Insurance***, which is published by the National Council on Compensation Insurance. A copy of the publication may be obtained from the National Council on Compensation Insurance, Products and Services Department, ~~[750 Park of Commerce Drive,]~~ ***901 Peninsula Corporate Circle,*** Boca Raton, Florida 33487, for the price of ~~[$86 for members and $119 for nonmembers.]~~ ***$108 for affiliates and $149 for nonaffiliates.***

4. ***Forms Manual of Workers Compensation and Employers Liability Insurance***, which is published by the National Council on Compensation Insurance. A copy of the publication may be obtained from the National Council on Compensation Insurance, Products and Services Department, ~~[750 Park of Commerce Drive,]~~ ***901 Peninsula Corporate Circle,*** Boca Raton, Florida 33487, for the price of ~~[$108 for members and $217 for nonmembers.]~~ ***$135 for affiliates and $271 for nonaffiliates.***

5. ***Electronic Transmission User's Guide***, which is published by the National Council on Compensation Insurance. A copy of the publication may be obtained, free of charge, from the National Council on Compensation Insurance, Products and Services Department, ~~[750 Park of Commerce Drive,]~~ ***901 Peninsula Corporate Circle,*** Boca Raton, Florida 33487.

6. ***WCIO Workers Compensation Data Specifications Manual***, which is published by the National Council on Compensation Insurance. A copy of the publication may be obtained from the National Council on Compensation Insurance, Products and Services Department, ~~[750 Park of Commerce Drive,]~~ ***901 Peninsula Corporate Circle,*** Boca Raton, Florida 33487, for the price of ~~[$62.]~~ ***$78.***

Sec. 6. NAC 616B.124 is hereby amended to read as follows:

616B.124 For the purposes of complying with the provisions of subsection ~~[3 of NRS 616B.033 and NRS 616B.460,]~~ ***2 of NRS 616B.460 and NRS 616B.461,*** a private carrier ~~[or an association]~~ shall submit proof of coverage to the designated agent.

Sec. 7. NAC 616B.127 is hereby amended to read as follows:

616B.127 1. A private carrier shall submit proof of coverage to the designated agent within 15 days after the effective date of the:

(a) Issuance of a policy or binder of industrial insurance;

(b) Renewal of a policy of industrial insurance;

(c) Reinstatement of a policy of industrial insurance;

(d) Reissuance of a policy of industrial insurance;

(e) Cancellation of a policy of industrial insurance;

(f) Nonrenewal of a policy of industrial insurance; or

(g) Issuance of any endorsement of a policy of industrial insurance which materially affects the proof of coverage required by NAC 616B.100 to 616B.148, inclusive.

2. If a binder is submitted as proof of coverage pursuant to paragraph (a) ***of subsection 1*** and the binder is replaced by a policy of industrial insurance, proof of coverage for the policy must be submitted to the designated agent before the expiration of the binder.

3. A private carrier shall submit proof of coverage to the designated agent within 15 days after receiving notice that an employer has changed insurers or has cancelled his policy with that carrier.

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

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

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

~~(b) Electronic transmission.~~

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

(a) Electronic transmission; or

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

~~[3.]~~ ***2.*** If the private carrier does not use Form D-41, International Association of Industrial Accident Boards and Commissions POC 1 to submit:

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

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

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

~~[4.]~~ ***3.*** As used in this section, "electronic transmission" means the sending of information by electronic means in the manner prescribed by the designated agent, including, without limitation, by a magnetic tape, cartridge, mainframe or personal computer.

Sec. 9. NAC 616B.136 is hereby amended to read as follows:

616B.136 ***1.*** An employer shall, upon request, provide proof of coverage to its insurer ***and to the Administrator*** in the manner prescribed by the administrator. If the employer fails to provide that information to the insurer, the insurer may notify the administrator of the failure of the employer to provide the information.

2. If an employer changes insurers, the employer shall notify his previous insurer of the cancellation of the former policy within 10 days after the effective date of the change.

Sec. 10. NAC 616B.139 is hereby amended to read as follows:

616B.139 The designated agent may charge a private carrier ~~[or an association]~~ a fee in an amount that does not exceed the cost of receiving, processing and submitting proof of coverage required by the administrator. The designated agent shall provide to the private carrier **,** ~~[or association,]~~ at no cost, instructions for submitting proof of coverage.

Sec. 11. NAC 616B.148 is hereby amended to read as follows:

616B.148 An insurer shall, within 5 working days after it obtains information that an employer may have operated in this state without industrial insurance, ~~[submit Form D-47, Noncompliance Notice,]~~ ***give written notice of that fact*** to the Administrator.

Sec. 12. NAC 616B.707 is hereby amended to read as follows:

616B.707 1. The division will consider expenditures for the following as expenditures for claims:

(a) A surgeon, assisting surgeon, anesthesiologist or consulting physician.

(b) Charges by a hospital.

(c) Treatment by a physician or chiropractor.

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

(e) Physical therapy.

(f) Prescribed drugs and medications, eyeglasses, dental work, prostheses, orthotic devices and corrective shoes by prescription.

(g) Travel to obtain medical care or supplies.

(h) Any other accident benefits.

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

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

(k) Death benefits.

(l) Burial expenses.

2. The division will not consider the following expenditures to be expenditures for claims:

(a) Amounts held in reserve for any anticipated expense in connection with a claim.

(b) Money paid in excess of the compensation calculated pursuant to NRS 616C.440, 616C.475, 616C.490 or 616C.500 or NAC 616C.577 for a temporary total, temporary partial, permanent total or permanent partial disability or vocational rehabilitation maintenance.

(c) Legal expenses, including, without limitation, court costs, attorney's fees, costs for depositions, investigations and hearings.

(d) Payment of an award of interest.

(e) Payment of claims in connection with the uninsured employers' claim ~~[fund.]~~ ***account.***

(f) Administrative expenses, including, without limitation, expenses incurred for:

(1) Copying records;

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

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

(g) Costs incurred in a claim that is ultimately denied.

3. The value of clinical services furnished by an insurer for industrial injuries or illnesses must be computed and reported pursuant to ~~[NAC 616C.182 to 616C.230, inclusive.]~~ ***the***

schedule of fees and charges for accident benefits adopted pursuant to subsection 2 of NRS 616C.260.

Sec. 13. NAC 616B.763 is hereby amended to read as follows:

616B.763 1. The administrator will not consider the following expenditures to be expenditures for claims for which a private carrier may receive reimbursement from the subsequent injury ~~[fund]~~ ***account*** for private carriers:

(a) Amounts held in reserve for any anticipated expense in connection with a claim.

(b) Money paid in excess of the compensation calculated pursuant to NRS 616C.440, 616C.475, 616C.490 or 616C.500 or NAC 616C.577 for a temporary total, temporary partial, permanent total or permanent partial disability or vocational rehabilitation maintenance.

(c) Legal expenses, including, without limitation, court costs, attorney's fees, costs for depositions, investigations and hearings.

(d) Payment of an award of interest.

(e) Administrative expenses, including, without limitation, expenses incurred for:

(1) Copying records;

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

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

(f) Costs incurred in a claim that is ultimately denied.

2. The value of accident benefits furnished by a private carrier for industrial injuries or illnesses must be computed and reported pursuant to ~~[NAC 616C.182 to 616C.230, inclusive.]~~ ***the schedule of fees and charges for accident benefits adopted pursuant to subsection 2 of NRS 616C.260.***

Sec. 14. Chapter 616C of NAC is hereby amended by adding thereto a new section to read as follows:

1. If the Division uses the services of an attorney employed by the Division to carry out the provisions of NRS 616C.220, the Division may require the uninsured employer to pay attorney's fees in an amount equal to the gross hourly wage and all benefits paid to that employee by the Division while providing those services.

2. If the Division uses the services of an attorney who is not employed by the Division to carry out the provisions of NRS 616C.220, the Division may require the uninsured employer to pay the actual amount of the attorney's fees charged.

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

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

1. Fraudulent billing or reporting.

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

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

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

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

6. Failure to comply with any order of the division issued pursuant to ~~[NAC 616C.126 to 616C.144, inclusive.]~~ ***the schedule of fees and charges for accident benefits adopted pursuant to subsection 2 of NRS 616C.260.***

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

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

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

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

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

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

Sec. 16. NAC 616C.027 is hereby amended to read as follows:

616C.027 1. A provider of health care whose bill has been ***denied or*** reduced or ~~[disallowed]~~ ***is not paid in a timely manner*** may, within 60 days after receiving notice of the ***denial or*** reduction ***,*** or ~~[disallowance,]~~ ***within 60 days after the payment was due,*** 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 shall review the matter, and if it determines that issuing a written determination is appropriate, it shall issue a written determination and mail or deliver copies of the determination to the provider of health care and the insurer. If the determination is in the provider's favor, the insurer shall, within 30 days after

receiving notice of the determination, pay ~~[him the amount ordered by the Industrial Insurance Regulation Section,]~~ ***the bill,*** unless an appeal is taken in the manner provided by subsection 2.

2. A provider of health care or insurer aggrieved by the determination of the Industrial Insurance Regulation Section may ~~[appeal to the Administrator by filing a request for a hearing with the Administrator]~~ ***file a request for a hearing before an appeals officer. The request must be filed*** within 30 days after the date of the determination.

3. The provider of health care and the insurer will be the only parties to the hearing scheduled pursuant to subsection ~~[4. A representative of the Industrial Insurance Regulation Section may attend the hearing. The Administrator will consider the evidence presented at the hearing, including, without limitation, any evidence concerning the reduction or disallowance of the bill that was not available or the existence of which was not known to the provider of health care at the time he submitted the request to the Industrial Insurance Regulation Section pursuant to subsection 1.~~

~~4. The Administrator will schedule a hearing on the matter and, after the hearing, issue a written decision. The Administrator 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. The decision of the Administrator is a final decision for the purposes of judicial review.]~~ ***2.***

Sec. 17. NAC 616C.030 is hereby amended to read as follows:

616C.030 ~~[1.]~~ Upon the receipt of a ***written*** request from an injured employee ***,*** ~~[or]~~ his representative, ~~[the:~~

~~(a) Employer;~~

~~(b) Insurer;~~

~~(c)]~~ ***or his treating physician or chiropractor, the:***

1. Employer;

2. Insurer;

3. Third-party administrator; or

~~[(d)]~~ ***4.*** 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 the list to the injured employee]~~ within 3 working days after the date it receives the request.

Sec. 18. 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 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. ***If an insurer proposes that an injured employee agree to a rating physician or chiropractor chosen by the insurer, the insurer shall inform the injured employee in writing that the injured employee:***

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

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

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

(a) Requesting a physician or chiropractor from the list of qualified rating physicians and chiropractors designated by the administrator to evaluate the injured employee and determine the extent of any permanent impairment or, if the injured employee and insurer have agreed to a rating physician or chiropractor pursuant to subsection 2 of NRS 616C.490, by submitting a ~~[written copy of that agreement and the]~~ ***completed*** form designated in NAC 616A.480 as D-35, ~~[Request for a Rotating Rating]~~ ***Request/Agreement for a*** Physician or Chiropractor, to the industrial insurance regulation section within 30 days after the insurer has received the statement from a physician or chiropractor that the injured employee is ratable and stable;

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

(c) At least 3 working days before the rating evaluation, providing to the assigned rating physician or chiropractor from the insurer's file concerning the injured employee's claim:

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

(2) Any evidence ~~[of a previous award of workers' compensation issued in or outside of this state for the injury or occupational disease that is the subject of the injured employee's claim;]~~ ***or documentation of any previous evaluations performed to determine the extent of any of the injured employee's disabilities and any previous injury, disease or condition of the injured employee that is relevant to the evaluation being performed;***

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

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

~~3.]~~ ***; and***

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

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

~~[4.]~~ ***5.*** Except as otherwise provided in subsection ~~[6.]~~ ***7,*** if the rating physician or chiropractor finds that the injured employee has a ratable impairment, the insurer shall, within the time prescribed by NRS 616C.490, offer the injured employee the award to which he 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.

~~[5.]~~ ***6.*** If the rating physician or chiropractor determines that the permanent impairment may be apportioned pursuant to NAC 616C.490, the insurer shall advise the injured employee of the amount by which the rating was reduced and the reasons for the reduction.

~~[6.]~~ ***7.*** If the insurer disagrees in good faith with the result of the rating evaluation, the insurer shall, within the time prescribed in NRS 616C.490:

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

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

~~[7.]~~ ***8.*** 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.

~~[8.]~~ ***9.*** As used in this section, "award papers" means the following forms designated in NAC 616A.480, as appropriate:

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

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

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

Sec. 19. NAC 616C.105 is hereby amended to read as follows:

616C.105 1. An insurer who requests that an injured employee submit to a rating evaluation pursuant to NRS 616C.490 shall include with the notice required pursuant to subsection ~~[2]~~ ***3*** of NAC 616C.103:

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

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

(c) Any combination thereof.

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

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

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

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

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

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

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

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

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

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

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

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

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

➥ whichever is less.

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

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

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

Sec. 20. NAC 616C.117 is hereby amended to read as follows:

616C.117 As used in NAC 616C.117 to ~~[616C.230,]~~ ***616C.215,*** inclusive, unless the context otherwise requires, the words and terms defined in NAC 616C.118 and 616C.119 have the meanings ascribed to them in those sections.

Sec. 21. NAC 616C.120 is hereby amended to read as follows:

616C.120 The provisions of NAC 616C.123 to ~~[616C.230,]~~ ***616C.215,*** inclusive, do not prohibit or otherwise impair or interfere with the right of an injured employee to inspect or obtain his health care records pursuant to the provisions of NRS 629.061.

Sec. 22. NAC 616C.123 is hereby amended to read as follows:

616C.123 1. The ***most recently published edition of or update to the Occupational Medicine Practice Guidelines***, published jointly by the American College of Occupational and Environmental Medicine and the Occupational Environmental Medicine Health Information, Inc., is hereby adopted by reference as standards for the provision of accident benefits to employees who have suffered industrial injuries or occupational diseases.

2. ***The administrator will, on or before February 1 of each year, review the most recently published edition of or update to the Occupational Medicine Practice Guidelines. Each new edition of or update to the Occupational Medicine Practice Guidelines shall be deemed approved by the Administrator for use in this State on February 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 wishes to disapprove a new edition of or update to the Occupational Medicine Practice Guidelines, 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 disapproves an edition of or update to the Occupational Medicine Practice Guidelines, the edition or update that was most recently adopted by reference or deemed approved pursuant to this section will continue in effect.

3. Except as otherwise provided in this subsection, insurers and providers of health care shall use the ***Guidelines*** as minimum standards for evaluating and ensuring the quality of programs of treatment provided to an injured employee who is entitled to accident benefits pursuant to chapters 616A to 617, inclusive, of NRS. If a condition of the injured employee makes compliance with the ***Guidelines*** impossible or medically inadvisable and a physician or chiropractor who:

(a) Is employed by or works pursuant to a contract with the insurer or its third-party administrator or organization for managed care to provide medical advice on claims;

(b) Is licensed to practice in this State;

(c) Possesses the education, training and expertise necessary to evaluate the medical condition of the injured employee or obtains the advice or assistance necessary to evaluate the medical condition of the employee; and

(d) Has reviewed the notes of the treating physician or chiropractor, the results of any tests conducted by the treating physician or chiropractor and any relevant health care records of the injured employee,

➥ recommends to the insurer not to authorize treatment pursuant to the ***Guidelines***, the insurer may determine not to authorize treatment pursuant to the ***Guidelines***.

~~[3.]~~ ***4.*** An insurer may authorize treatment for an injured employee that exceeds the minimum standards of the ***Guidelines*** if the provider of health care provides, in writing, to the insurer his explanation for the need of a higher standard of treatment.

~~[4.]~~ ***5.*** A copy of the ***Guidelines*** may be purchased from Occupational Environmental Medicine Health Information, Inc., at 8 West Street, Beverly Farms, Massachusetts 01915-2226, or by telephone at (800) 533-8046, at a cost of ~~[$150]~~ ***$175*** for persons who are members of the American College of Occupational and Environmental Medicine and ~~[$180]~~ ***$199*** for persons who are not members of the American College of Occupational and Environmental Medicine.

~~[5.]~~ ***6.*** As used in this section, the term "***Guidelines***" means the ***Occupational Medicine Practice Guidelines*** adopted by reference pursuant to subsection 1.

Sec. 23. NAC 616C.126 is hereby amended to read as follows:

616C.126 ~~[Any physician or chiropractor who is called upon to render service in the case of an emergency or severe trauma as a result of an industrial injury may utilize whatever resources and techniques are necessary to cope with the situation.]~~

1. The treatment of injured employees in ~~[such situations]~~ ***cases of an emergency or severe trauma*** is not restricted to physicians and chiropractors who:

~~[1.]~~ ***(a)*** Are members of the panel of physicians and chiropractors established by the Administrator pursuant to NRS 616C.090; or

~~[2.]~~ ***(b)*** Have contracted with an insurer or an organization for managed care to provide health care services to injured employees.

2. In the case of a medical emergency, a provider of health care or a medical facility that is not able to obtain prior written authorization to treat a person for an industrial injury or occupational disease shall submit to the insurer proof of the emergency and the reasons why prior authorization was impracticable to obtain. The proof must be submitted with the initial billing for the treatment that was rendered.

Sec. 24. NAC 616C.129 is hereby amended to read as follows:

616C.129 The members of the panel of physicians and chiropractors, approved for treatment of employees protected by workers' compensation, shall adhere to the following rules:

1. There may be only one treating physician or chiropractor in any one case at any one time, unless prior authorization is obtained from the insurer. Physicians and chiropractors associated with the treating physician or chiropractor may treat the injured employee during the temporary absence of the treating physician or chiropractor. In all cases, the treating physician or chiropractor is directly responsible for the management of the health care of the injured employee. Physicians in emergency rooms are not considered treating physicians within the meaning of NAC 616C.126 to ~~[616C.144,]~~ ***616C.141,*** inclusive.

2. The insurer shall give written notice to all interested persons of the transfer of an injured employee to a new physician or chiropractor.

3. Except as otherwise provided in this subsection, an injured employee or an insurer is not financially liable for the payment of the fees of a provider of health care who renders treatment to an injured employee for an industrial accident or occupational disease, knowing that the injured employee is already under the care of another provider of health care. The insurer may be

liable for the payment of the fees pursuant to this subsection if the insurer gives prior written approval for the treatment or good cause is shown for the treatment provided.

4. Any prescription or service ordered by a physician or chiropractor other than:

(a) The treating physician or chiropractor; or

(b) A physician or chiropractor associated with the treating physician or chiropractor who is treating the injured employee during the temporary absence of the treating physician or chiropractor,

➥ is not a financial liability of the insurer unless good cause is shown for the prescription or service.

5. The treating physician or chiropractor must request written authorization from the insurer before ordering or performing any one of the following services with an estimated billed amount of $200 or more:

(a) Consultation;

(b) Diagnostic testing;

(c) Elective hospitalization;

(d) Any surgery which is to be performed under circumstances other than an emergency; or

(e) Any elective procedure.

6. Any request for prior authorization to order or perform any of the services set forth in subsection 5 must contain an explanation of the need for each service to be ordered or performed. If any of the services are performed without the insurer's written authorization, the insurer is not liable for the fee for the service, unless good cause is shown for providing the services without prior authorization.

7. ~~[In the case of a medical emergency, a provider of health care who is not able to obtain prior written authorization to treat a person for an industrial injury or occupational disease shall submit to the insurer proof of the emergency and the reasons why prior authorization was impracticable to obtain. The proof must be submitted within 5 working days after the treatment is rendered.~~

~~8.]~~ A treatment program that consists of more than six visits, not including the initial evaluation, and is billed under codes 97010 to 97799, inclusive, 98925 to 98943, inclusive, ~~[or NV00001 to NV00003, inclusive,]~~ whether the visits are billed separately or included under different codes, must be authorized in advance by the insurer to verify the medical necessity for continued treatment. The first six visits do not require the prior authorization of the insurer. The number of requests for additional visits and any written authorization granted therefor are not restricted, and are subject only to the treatment prescribed by the treating physician or chiropractor and the determination of the insurer. A report of the status of an injured employee may be requested by an insurer at any time during the course of treatment. The initial evaluation shall be deemed to be separate from the initial six treatments. An initial evaluation may be performed on the same day as the initial treatment.

Sec. 25. NAC 616C.138 is hereby amended to read as follows:

616C.138 ~~[1.]~~ Supplies and materials provided by the provider of health care over and above those usually included in a visit to his office or in other services rendered must be billed by report under the appropriate code set forth in the ~~["Health Care Financing Administration, HCFA]~~ ***"Centers for Medicare and Medicaid Services, CMS*** Common Procedures Coding System (HCPCS)," as contained in the ***Relative Values for Physicians***, as adopted pursuant to NAC 616C.188.

~~[2. The insurer shall reimburse the provider of health care for those supplies and materials at the provider's cost of the supplies and materials, excluding tax and charges for freight, plus 20 percent. The provider of health care must be able to justify his charges to the insurer upon reasonable request.~~

~~3. Charges for narcotic analgesics will be allowed only when it is clearly evident that they were administered and prescribed by the physician in a writing which identified the narcotic and indicated the number of units to be administered and over what period.~~

~~4. A physician who is a member of the panel of physicians and chiropractors shall supervise the dosage of any narcotic analgesics and the amount of refills prescribed for an injured employee, giving consideration to the origin of the subjective pain experienced or complained of by the injured employee. The physician shall reexamine the injured employee at reasonable intervals.~~

~~5. An insurer shall not pay for any placebo administered by a physician who is a member of the panel of physicians and chiropractors, unless the physician submits a report to the insurer that contains an explanation for the need for the placebo which is acceptable to the medical adviser of the insurer.]~~

Sec. 26. 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 by reference pursuant to NAC 616C.188, or the ***Relative Value Guide*** of the American Society of Anesthesiologists, as adopted by reference pursuant to NAC 616C.194, for any services. The codes must be indicated on each bill regardless of whether the provisions of NAC 616C.070 to 616C.336, inclusive, allow for the payment of the services, the payment is requested or the item is included under a different code.

4. Any bill for an office visit that is billed under codes 90000 to 99999, inclusive, must include a written report concerning the history of the injured employee, a comprehensive evaluation of the injured employee's health condition or an evaluation of specific health problems of the injured employee, any decision made concerning the treatment required by the

injured employee and all forms for submitting a claim to the insurer or billing reports that are requested by an insurer. Such a bill is not required to include a special report that is specifically requested by an insurer and is required to be billed under code 99080.

~~[5. Services provided by a certified advanced practitioner of nursing or certified physician 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 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 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 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 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. 27. NAC 616C.150 is hereby amended to read as follows:

616C.150 1. The insurer shall reimburse an injured employee for the cost of transportation ***to and from the place where he receives health care*** if he is required to travel 20 miles or more, one way, from:

(a) His residence to the place where he receives health care; or

(b) His place of employment to the place where he receives health care if the care is required during his normal working hours.

2. The insurer shall reimburse an injured employee for the cost of transportation if he is required to travel 20 miles or more, one way, from his residence or place of employment to a place of hearing designated by the insurer or the department of administration if the hearing concerns an appeal by the employer or insurer from a decision in favor of the injured employee and the decision is upheld on appeal.

3. An injured employee who does not qualify for reimbursement under paragraph (a) or (b) of subsection 1 but is required to travel a total of 40 miles or more in any 1 week for health care or for attendance at a rehabilitation center designated by the insurer is entitled to be reimbursed for the cost of his transportation.

4. Except as otherwise provided in subsection 6, reimbursement for the cost of transportation must be computed at a rate equal to:

(a) The mileage allowance for state employees who use their personal vehicles for the convenience of the state; or

(b) The expense actually incurred by the injured employee for transportation, if the injured employee consents to reimbursement at this rate and the expense is not greater than the amount to which the injured employee would otherwise be entitled pursuant to paragraph (a).

5. Except as otherwise provided in subsection 6, if an injured employee must travel before 7 a.m. or between 11:30 a.m. and 1:30 p.m. or cannot return to his residence or place of employment until after 7 p.m., or any combination thereof, reimbursement for meals required to be purchased must be computed at a rate equal to:

(a) That allowed for state employees; or

(b) The expense actually incurred by the injured employee for meals, if the injured employee consents to reimbursement at this rate and the expense is not greater than the amount to which the injured employee would otherwise be entitled pursuant to paragraph (a).

6. The insurer shall reimburse an injured employee for his expenses of travel if he is required to travel 50 miles or more, one way, from his residence or place of employment and is required to remain away from his residence or place of employment overnight. Reimbursement must be computed at a rate equal to:

(a) The per diem allowance authorized for state employees; or

(b) The expenses actually incurred by the injured employee,

➥ whichever is less.

7. A claim for reimbursement of expenses governed by this section may be disallowed unless it is submitted to the insurer within 60 days after the expenses are incurred.

Sec. 28. NAC 616C.176 is hereby amended to read as follows:

616C.176 1. Except as otherwise provided in this section, an insurer is not financially liable for consultation or treatment that is provided outside this State unless the insurer has given prior written authorization to the provider of health care ***or the medical facility in which the consultation or treatment is provided*** for the consultation or treatment. At the time of giving the written authorization, the insurer shall give written notice, which must include the date on which the notice is given, to the injured employee and the provider of health care ***or the medical facility*** that:

(a) The payment for the consultation or treatment will be made in accordance with the schedule of reasonable fees and charges allowable for accident benefits adopted for this State pursuant to NRS 616C.260, unless otherwise provided in a contract between the provider of health care ***or the medical facility*** and the insurer;

(b) The insurer is solely responsible for the payment of all services rendered;

(c) The injured employee is not financially liable for any part of the cost of the services rendered and must not be billed for those services; and

(d) Any bill must be submitted within 90 days after services are rendered.

2. Prior authorization for ~~[emergency]~~ treatment that is provided outside this State ***in cases of an emergency*** is not required. A provider of health care ~~[who renders emergency treatment~~

~~outside this State~~] ***or a medical facility that renders such treatment*** to an injured employee subject to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS must bill for such services using the appropriate coding found in the American Medical Association's "Physician's Current Procedural Terminology" as contained in the ***Relative Values for Physicians***, as adopted by reference in NAC 616C.188. The provider of health care ***or medical facility*** shall submit a bill for all such ~~[emergency]~~ treatment and include the fees as set forth in the schedule of reasonable fees and charges allowable for accident benefits, if any, of the state in which the treatment was rendered or the usual and customary fees of the provider ~~[,]~~ ***or medical facility,*** whichever are less.

3. The insurer shall pay for ~~[emergency]~~ treatment ***that is provided outside this State in cases of an emergency*** according to the billing received, unless the fee is unreasonable. A fee shall be deemed to be reasonable if it is provided in accordance with the provisions of this section.

~~[4. The burden for showing that the treatment was emergency treatment is on the injured employee and the provider of health care.~~

~~5. As used in this section, "emergency treatment" means any treatment for a new injury which is rendered within 3 days after the date of the injury or any treatment of an existing injury which, if not immediately rendered, would subject the injured employee to a significant increase in the risk of death or serious permanent physical impairment.]~~

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

616C.188 1. Except as otherwise provided in this section, providers of health care who treat injured employees pursuant to this chapter and chapter 616C of NRS shall comply with the

most recently published edition of or update to the ***Relative Values for Physicians***, which the Division hereby adopts by reference.

2. The Administrator will, on or before ~~[March]~~ ***February*** 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]~~ ***February*** 1 through ~~[April 30,]~~ ***January 31,*** unless a notice of disapproval of the edition or update is posted pursuant to this subsection by the immediately preceding ~~[March]~~ ***February*** 1. If the Administrator 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 disapproves an edition of or update to the ***Relative Values for Physicians*** the edition or update that was most recently adopted by reference or deemed approved pursuant to this section will continue in effect.

3. A copy of ***Relative Values for Physicians***, as adopted by reference pursuant to subsection 1, may be purchased from Ingenix, 5225 Wiley Post Way, Suite 500, Salt Lake City, Utah 84116-2889, (800) 999-4600 ***,*** for the price of ***$279.95.*** ~~[$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 so authorizes in advance.~~

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

~~(a) The office visit;~~

~~(b) Evaluations and management services;~~

~~(c) Manipulations;~~

~~(d) Modalities;~~

~~(e) Mobilizations;~~

~~(f) Testing and measurements;~~

~~(g) Treatments;~~

~~(h) Procedures; and~~

~~(i) Extra time.~~

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

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

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

Sec. 30. NAC 616C.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 will, on or before ~~[April]~~ ***February*** 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]~~ ***February*** 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]~~ ***February*** 1. If the Administrator 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 disapproves an edition of or update to the ***Relative Value Guide of the American Society of Anesthesiologists***, the edition or update that was most recently adopted by reference or deemed approved pursuant to this section will continue in effect.

3. A copy of the ***Relative Value Guide of the American Society of Anesthesiologists***, as adopted by reference pursuant to subsection 1, may be purchased from the American Society of Anesthesiologists, 520 N. Northwest Highway, Park Ridge, Illinois 60068-2573, 847.825.5586, for the price of ~~[$15.]~~ ***$25.***

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

~~that is stated in the Guide, plus the number of 15-minute intervals that the service was rendered, or any fraction thereof, multiplied by the following conversion factor:~~

~~Codes~~	~~Type of Service~~	~~Conversion Factor~~
~~00000-99999~~	~~Basic Anesthesiology .....~~	~~$51.62~~

~~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. 31. 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 ***hereby*** adopts by reference the ***most current*** 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, as amended on January 1, 2000.~~

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

~~Payment Group~~	~~Maximum Allowable Payment~~
~~Group 1~~	~~$490.16~~
~~Group 2~~	~~628.23~~
~~Group 3~~	~~759.40~~
~~Group 4~~	~~938.89~~
~~Group 5~~	~~998.72~~
~~Group 6~~	~~1,178.21~~
~~Group 7~~	~~1,221.47~~
~~Group 8~~	~~1,221.47~~
~~Group 9~~	~~1,221.47~~

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

(a) At 400 West King Street, Suite 400, Carson City, Nevada 89703, 775.687.3033;

(b) At 1301 North Green Valley Parkway, Suite 200, Henderson, Nevada 89014, 702.486.9080; or

(c) At the Internet address <>.

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

(a) The cost of the anesthetic;

(b) General supplies;

(c) Operating room;

(d) Radiology, technical component;

(e) Pathology, technical component;

(f) Any other diagnostic procedure; and

(g) Medication.

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

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

~~8. If there is no assigned value for the surgical procedure or if the modifier-51 is used, the amount paid must not exceed the per diem rate for code NV00500 as set forth in subsection 3 of NAC 616C.203 and the code NVH0009 must be used.~~**]** ***the effective date of this section, as those codes are set forth in the "Centers for Medicare and Medicaid Services, CMS Common Procedures Coding System (HCPCS)," which is contained in the Relative Values for Physicians that is adopted by reference pursuant to NAC 616C.188.***

Sec. 32. 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.....~~	~~$467.73~~
~~NV01001~~	~~Failure of an injured employee to appear for appointment.....~~	~~155.91~~
~~NV01002~~	~~Addendum necessary to clarify original report.....~~	~~No charge~~
~~NV01003~~	~~Addendum after review of additional medical records.....~~	~~155.91~~
~~NV01004~~	~~Review of medical records and evaluation of more than 2 body parts.....~~	~~155.91~~
~~for each body part in excess of 2~~		

~~NV01005 Organization of medical records in chronological order..... 25.99~~

~~NV01006 Review of records and report ..... 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]~~ ***:***

1. A rating physician or chiropractor shall mail a report of an evaluation ***of an injured employee*** to the insurer within 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 14 days after receiving the request.

~~[5. Unless good cause is shown, if]~~

2. 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 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 14 days after receiving the request.

Sec. 33. NAC 616C.215 is hereby amended to read as follows:

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

(a) ~~[His]~~ ***The*** 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]~~ ***the*** office ***of the provider of health care or to the medical facility*** 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]~~ ***"Centers for Medicare and Medicaid Services, CMS*** Common Procedures Coding System (HCPCS)," as contained in the ***Relative Values for Physicians***, as adopted by reference pursuant to NAC 616C.188;

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

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

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

2. In addition to the information required by subsection 1, each physician or chiropractor ***and each medical facility*** shall include on ~~[his]~~ ***the*** 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 most recently published edition of or update to*** the ***International Classification of Diseases,*** ~~[9th Revision,]~~ ***Clinical Modification*** (ICD-9-CM), which is hereby adopted by reference.

3. The Administrator will, on or before February 1 of each year, review the most recently published edition of or update to the International Classification of Diseases. Each new edition of or update to the International Classification of Diseases shall be deemed approved by the Administrator for use in this State on February 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 wishes to disapprove a new edition of or update to the International Classification of Diseases, 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 disapproves an edition of or update to the International Classification of Diseases, the edition or update that was most recently adopted by reference or deemed approved pursuant to this section will continue in effect.

4. A copy of Volumes 1, 2 and 3 of this publication may be purchased from:

(a) Channel Publishing, Ltd., P.O. Box 70723, Reno, Nevada 89570, (800) 248-2882, for the price of ~~[$99.00;]~~ ***$64.95;*** or

(b) Ingenix, 5225 Wiley Post Way, Suite 500, Salt Lake City, Utah 84116-2889, (800) 999-4600, for the price of ~~[$69.95.~~

~~3.]~~ ***$74.95.***

5. 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. Chapter 616D of NAC is hereby amended by adding thereto the provisions set forth as sections 35, 36 and 37 of this regulation.

Sec. 35. ***1. To determine the amount of a benefit penalty required to be paid pursuant to subsection 3 of NRS 616D.120, the Administrator will determine that the violation caused physical or economic harm to the injured employee or his dependents if he finds, by a preponderance of the evidence, that:***

(a) The harm would not have occurred but for the violation;

(b) The violation was a substantial factor in bringing about the harm; and

(c) There is no supervening cause that is responsible for bringing about the harm.

2. Physical harm must be established by a preponderance of objective medical evidence in the form of existing medical records or medical records furnished by the claimant.

3. The Administrator will determine the amount of a benefit penalty required to be paid pursuant to subsection 3 of NRS 616D.120 according to the following schedule. In addition to the required minimum benefit penalty of $5,000, a claimant will be awarded $1,000 for each point assessed, but in no event will the amount of the benefit penalty be greater than $25,000.

Points assessed for physical harm:

Temporary minor harm . . . . . 2 points

Temporary major harm . . . . . 5 points

Permanent minor harm . . . . . 5 points

Permanent major harm . . . . . 10 points

Death . . . . . 20 points

Points assessed for the amount of compensation found to be due the claimant:

Amount of compensation

$3,001 - $5,000 . . . . . 1 point

$5,001 - $7,000 . . . . . 2 points

$7,001 - $9,000 . . . . . 3 points

$9,001 - $11,000 . . . . . 4 points

$11,001 - $13,000 . . . . . 5 points

$13,001 - $15,000 . . . . . 6 points

$15, 001 - $17,000 . . . . . 7 points

$17,001 - $19,000 . . . . . 8 points

$19,001 - $21,000 . . . . . 9 points

An amount that is greater than $21,000. . . . . 10 points

Points assessed for prior violations:

One prior violation . . . . . 1 point

Two prior violations . . . . . 3 points

More than two prior violations . . . . . 5 points

Points assessed for economic harm:

Amount of economic harm

$6,001 - $7,000 . . . . . 1 point

$7,001 - $8,000 . . . . . 2 points

$8,001 - $9,000 . . . . . 3 points

$9,001 - $10,000 . . . . . 4 points

$10,001 - $11,000 . . . . . 5 points

$11,001 - $12,000 . . . . . 6 points

$12,001 - $13,000 . . . . . 7 points

$13,001 - $14,000 . . . . . 8 points

$14,001 - $15,000 . . . . . 9 points

More than $15,000 . . . . . 10 points

4. To determine the number of prior violations of an insurer, organization for managed care, health care provider, third-party administrator or employer, the Administrator will consider only those fines and benefit penalties imposed pursuant to paragraphs (a) to (e), inclusive, of subsection 1 of NRS 616D.120 in the immediately preceding 3 years.

5. As used in this section:

(a) "Dependent" means a person who:

(1) At the time of the violation, is:

(I) The spouse of the injured employee;

(II) A child of the injured employee and is under 18 years of age; or

(III) A child of the injured employee, is 18 years of age or older and is physically or mentally incapacitated and unable to earn a wage; or

(2) Is a parent of the injured employee, a child of the injured employee who is 18 years of age or older, a stepchild of the injured employee or a sibling of the injured employee if that person's dependency upon the injured employee is established by a federal income tax return of the injured employee or by any other reliable evidence.

(b) "Economic harm" includes:

(1) The loss of money or an item of monetary value; and

(2) The deprivation of a reasonable expectation of a financial or monetary advantage.

(c) "Permanent major harm" means physical harm that:

(1) Results in a complete or significant loss of the ability to engage in activities of daily living, including, without limitation, caring for oneself, performing manual tasks, walking,

standing, sitting, seeing, hearing, speaking, breathing, learning, working, sleeping, functioning sexually, and engaging in normal recreational and social activities; and

(2) Is unlikely to be alleviated in spite of medical treatment that a reasonable person is willing to undergo.

(d) "Permanent minor harm" means physical harm that:

(1) Does not result in a complete or significant loss of the ability to engage in activities of daily living, including, without limitation, caring for oneself, performing manual tasks, walking, standing, sitting, seeing, hearing, speaking, breathing, learning, working, sleeping, functioning sexually, and engaging in normal recreational and social activities; and

(2) Is unlikely to be alleviated in spite of medical treatment that a reasonable person is willing to undergo.

(e) "Physical harm" means death or any physiological disorder or condition, cosmetic disfigurement or anatomic loss affecting one or more of the following body systems:

(1) The neurological system.

(2) The musculoskeletal system.

(3) Special sense organs.

(4) The respiratory system, including, without limitation, speech organs.

(5) The cardiovascular system.

(6) The reproductive system.

(7) The digestive system.

(8) The genitourinary system.

(9) The hemic and lymphatic system.

(10) The skin.

(11) The endocrine system.

(f) "Temporary major harm" means physical harm that:

(1) Results in a complete or significant loss of the ability to engage in activities of daily living, including, without limitation, caring for oneself, performing manual tasks, walking, standing, sitting, seeing, hearing, speaking, breathing, learning, working, sleeping, functioning sexually, and engaging in normal recreational and social activities; and

(2) Is likely to be alleviated with or without medical treatment.

(g) "Temporary minor harm" means physical harm that:

(1) Does not result in a complete or significant loss of the ability to engage in activities of daily living, including, without limitation, caring for oneself, performing manual tasks, walking, standing, sitting, seeing, hearing, speaking, breathing, learning, working, sleeping, functioning sexually, and engaging in normal recreational and social activities; and

(2) Is likely to be alleviated with or without medical treatment.

Sec. 36. *1. For the purposes of NRS 616D.120, an insurer, organization for managed care, health care provider, third-party administrator or employer commits an "intentional violation" of any provision of chapter 616A, 616B, 616C, 616D or 617 of NRS, or any regulation adopted pursuant thereto, if he acts with purpose or design, otherwise acts to cause the consequences, desires to cause the consequences or believes that the consequences are substantially certain to result from the violation.*

2. The Administrator may consider two or more violations of the same or similar provisions of chapters 616A to 617, inclusive, of NRS, or any regulations adopted pursuant thereto, as evidence of an intentional violation. If the Administrator determines that two or more violations constitute an intentional violation, the Administrator will impose an

administrative fine as required by subsection 1 of NRS 616D.120 and, if appropriate, order a plan of corrective action to be submitted to the Administrator.

Sec. 37. *Except as otherwise provided in chapters 616A to 617, inclusive, of NRS, or in any regulation adopted pursuant thereto:*

1. If the Administrator determines that:

(a) An insurer or third-party administrator has failed to comply or has complied in an untimely manner with any provision of chapter 616A, 616B, 616C, 616D or 617 of NRS, or any 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;

(b) An insurer or third-party administrator has failed to comply or has complied in an untimely manner with any provision of chapter 616A, 616B, 616C, 616D or 617 of NRS, or any regulation adopted pursuant thereto, that requires the insurer or third-party administrator to make a payment of benefits to an injured employee;

(c) An insurer or employer has failed to comply or has complied in an untimely manner with any of the provisions of NRS 616B.460 or 616B.461 or NAC 616B.124 to 616B.136, inclusive;

(d) An insurer, organization for managed care, provider of health care, third-party administrator or employer has failed to comply or has complied in an untimely manner with any of the provisions of NRS 616A.475, 616B.006, 616B.009 or 617.357 or NAC 616A.410;

(e) A treating physician or chiropractor has failed to comply or has complied in an untimely manner with any of the provisions of NRS 616C.020, subsection 7 of NRS 616C.475, or NRS 616C.040 or 617.352, or any regulations adopted pursuant thereto, that require the treating physician or chiropractor to complete a claim for compensation; or

(f) An employer has failed to comply or has complied in an untimely manner with any of the provisions of NRS 616C.045 or 617.354, or any regulation adopted pursuant thereto, that require the employer to complete a report of industrial injury or occupational disease,

➥ and the Administrator determines that the violation was not an intentional violation, the Administrator may impose an administrative fine in an amount not to exceed those amounts set forth in subsection 2 of NRS 616D.120 or order a plan of corrective action to be submitted to the Administrator, or both.

2. If the Administrator determines that an insurer, organization for managed care, health care provider, third-party administrator or employer has committed two or more violations of the same or similar provisions of chapters 616A to 617, inclusive, of NRS, or any regulation adopted pursuant thereto, the Administrator may impose an administrative fine in an amount not to exceed those amounts set forth in subsection 2 of NRS 616D.120 or order a plan of corrective action to be submitted to the Administrator, or both.

Sec. 38. NAC 616D.400 is hereby amended to read as follows:

616D.400 ***1.*** For the purposes of subsection 2 of NRS 616D.120 ~~[, "minor violation" means:~~

~~1. Except]~~ ***and except*** as otherwise provided in ~~[NAC 616D.4399, a violation]~~ ***chapters 616A to 617, inclusive, of NRS, or in any regulation adopted pursuant thereto, an insurer, organization for managed care, health care provider, third-party administrator or employer commits a "minor violation"*** of any provision of chapter 616A, 616B, 616C, 616D or 617 of NRS **,** or a regulation adopted pursuant thereto ~~[for which an administrative fine or other penalty is not specifically provided; or~~

~~2. A violation of any provision set forth in NAC 616D.400 to 616D.440, inclusive.]~~ ***, if the violation is a single, unintentional violation and the insurer, organization for managed care, health care provider, third-party administrator or employer agrees, in writing, to correct the violation during the course of an investigation or audit conducted pursuant to those chapters.***

2. Except as otherwise provided in this subsection, if an insurer, organization for managed care, health care provider, third-party administrator or employer agrees, in writing, to correct a single, unintentional violation during the course of an investigation or audit, the Administrator will issue a notice of correction for that violation. The Administrator will not issue a notice of correction pursuant to this subsection if the violation does not require correction or the correction is unnecessary or moot.

3. If an insurer, organization for managed care, health care provider, third-party administrator or employer does not agree, in writing, to correct a single, unintentional violation during the course of an investigation or audit, the Administrator may impose an administrative fine in an amount not to exceed those amounts set forth in subsection 2 of NRS 616D.120 or order a plan of corrective action to be submitted to the Administrator, or both.

Sec. 39. NAC 616B.103, 616B.112, 616B.115, 616B.130, 616B.141, 616B.144, 616B.147, 616C.1158, 616C.132, 616C.135, 616C.144, 616C.170, 616C.173, 616C.179, 616C.182, 616C.185, 616C.191, 616C.200, 616C.203, 616C.206, 616C.209, 616C.213, 616C.218, 616C.221, 616C.224, 616C.225, 616C.227, 616C.230, 616C.240, 616C.243, 616C.246, 616C.249, 616C.252, 616C.255, 616C.258, 616D.402, 616D.404, 616D.406, 616D.408, 616D.410, 616D.412, 616D.414, 616D.416, 616D.418, 616D.420, 616D.422, 616D.424, 616D.426, 616D.428, 616D.430, 616D.432, 616D.434, 616D.436, 616D.438, 616D.4381, 616D.4383, 616D.4385, 616D.4387, 616D.4389, 616D.439, 616D.4391, 616D.4393,

616D.4395, 616D.4397, 616D.4399, 616D.440, 616D.443, 616D.444, 616D.445, 616D.446 and 616D.447 are hereby repealed.

TEXT OF REPEALED SECTIONS

616B.103 "Association" defined. (NRS 616A.400) "Association" means an association of self-insured private employers or an association of self-insured public employers.

616B.112 "Notice of error" defined. (NRS 616A.400) "Notice of error" means a notice issued by the Administrator or designated agent to a private carrier or an association that proof of coverage submitted by the private carrier or association has been accepted but requires correction.

616B.115 "Notice of rejection" defined. (NRS 616A.400) "Notice of rejection" means a notice issued by the Administrator or designated agent to a private carrier or an association that proof of coverage submitted by the private carrier or association has not been accepted and requires correction.

616B.130 Time limit for association to submit certain information to designated agent; association to report proof to designated agent. (NRS 616A.400)

1. An association that is certified as such by the Commissioner pursuant to NRS 616B.359 on or after July 1, 1999, shall submit information relating to its certificate and membership to the designated agent on the form prescribed by the Administrator within 15 days after the issuance of the certificate.

2. An association shall report proof of coverage to the designated agent within 15 days after:

(a) Any change in information relating to a member of the association that materially affects the proof of coverage required by NAC 616B.100 to 616B.148, inclusive;

(b) The addition or deletion of a member of the association; and

(c) The anniversary date of each member of the association.

616B.141 Failure to submit proof; notice of rejection. (NRS 616A.400, 616D.120) If a private carrier or an association fails to submit proof of coverage as required by the provisions of NAC 616B.100 to 616B.148, inclusive, or the proof of coverage submitted results in the issuance of a notice of rejection by the Administrator or designated agent, the Administrator will:

1. For the first violation in a 12-month period, issue a notice of correction.

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

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

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

616B.144 Notice of error; exception. (NRS 616A.400, 616D.120)

1. Except as otherwise provided in subsection 2, if a private carrier or an association incorrectly reports proof of coverage that results in the issuance of a notice of error by the Administrator or designated agent, the Administrator will:

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

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

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

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

2. The provisions of subsection 1 do not apply to an association that submits an incorrect report of the payroll of its members which results in the issuance of a notice of rejection by the Administrator or designated agent.

616B.147 Failure to correct or resubmit data; exception. (NRS 616A.400, 616D.120)

1. Except as otherwise provided in subsection 2, if a private carrier or an association fails to correct or accurately resubmit data which was incorrect or rejected within 5 working days after the receipt of a notice of error or rejection, the Administrator will:

(a) For the first violation within a 12-month period, issue a notice of correction.

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

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

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

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

2. The provisions of subsection 1 do not apply to an association that fails to correct or accurately resubmit the payroll of its members.

616C.1158 Claim received for employer to whom insurer does not provide coverage: Copy of claim provided to appropriate insurer. (NRS 616A.400, 616A.417) After receipt of a copy of a claim for compensation pursuant to NAC 616C.1156, the Administrator will, if the employer is insured by another insurer, deliver by electronic transmission or other method a copy of the claim for compensation to the other insurer within 10 working days after receipt of the notification.

616C.132 Diagnostic images. (NRS 616A.400, 616C.250, 616C.260)

1. An insurer shall not pay for any diagnostic images if:

(a) The diagnostic images cannot be satisfactorily interpreted by a provider of health care who is certified by the American Board of Radiology, Inc., or the American Chiropractic Board of Roentgenology, or who has obtained equivalent certification as determined by the insurer; or

(b) A satisfactory report based on the diagnostic images is not received by the insurer.

2. If diagnostic images are taken which the insurer's medical or chiropractic adviser deems inadequate or unsatisfactory and payment of the charges for the diagnostic images has already been made, the insurer shall adjust payments on future billings of the physician or chiropractor who received the payment for the diagnostic images.

3. Any diagnostic images which have been taken by any provider of health care must be made available for use by subsequent consultants, to eliminate the economic waste of repeated diagnostic images and unnecessary exposure of the injured employee to radiation. Consulting providers of health care shall return all diagnostic images to the imaging facility from which they were obtained. The provider of health care who was in possession of any diagnostic images at the time that they are misplaced, lost or destroyed is liable to the insurer for the cost of those diagnostic images and the cost of obtaining new images.

4. An insurer shall not pay for any excessive or unnecessary diagnostic images.

616C.135 Special accommodations and nursing services. (NRS 616A.400, 616C.245, 616C.250, 616C.260)

1. When an injured employee is so severely injured as to require quiet surroundings, a private room must be arranged at the direction of the attending physician. It must be discontinued when the necessity terminates.

2. In cases of severe injury, when special nursing services are required, they may be furnished by direction of the attending physician for 10 days. Extension of special nursing services beyond 10 days must be approved by the insurer.

616C.144 Periods for billing and processing of bills; submission of certain reports; time and procedure for insurer to pay, deny or reconsider bills. (NRS 616A.400, 616C.130, 616C.136, 616C.260)

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 (d) of subsection 6.

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

(a) Received by the insurer or a person authorized by the insurer to receive such a bill not later than 12 months after the date on which the services were rendered, unless good cause is shown.

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

6. The insurer shall:

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

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

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

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

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

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

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

616C.170 "Report" defined. (NRS 616A.400) As used in NAC 616C.170 to 616C.230, inclusive, unless the context otherwise requires, "report" means an extended written narrative that meets the requirements of NAC 616C.185.

616C.173 Providers of health care allowed no undue profit; supplying drugs; ethical guidelines. (NRS 616A.400, 616C.250, 616C.260)

1. In defining the services for which fees will be allowed to providers of health care, the Division will follow the principle that a provider of health care should not unduly profit, directly or indirectly, as a result of prescribing materials, drugs or ancillary services for the treatment of an injured employee.

2. Required drugs must be supplied through licensed suppliers pursuant to a prescription of the provider of health care.

3. The regulations of the applicable professional licensing board which establishes the principles of ethics for each respective provider of health care may be used as a guideline by the Division in ruling on whether fees for services and procedures not otherwise specifically defined in fee schedules or regulations relating to providers of health care are allowable.

616C.179 Response to request for prior authorization. (NRS 616A.400, 616C.157)

1. If a provider of health care, who has submitted a request for prior authorization pursuant to NRS 616C.157, provides with that request a telephone number for its facsimile machine or telecopier, the insurer, organization for managed care or third-party administrator shall use that number to transmit the authorization or denial of authorization. If the provider does not provide a telephone number for a facsimile machine or telecopier, the date of response shall be deemed to be the date that the response is mailed.

2. For purposes of determining the number of additional visits or treatments for which an insurer is responsible for payment pursuant to subsection 3 of NRS 616C.157, if a provider of health care does not provide a telephone number for a facsimile machine or telecopier, denial of authorization shall be deemed to be received 3 days after the date on which it is mailed.

616C.182 Determination of amount of payment; billing by report. (NRS 616A.400, 616C.130, 616C.260)

1. Each insurer shall determine the amount to be paid to a provider of health care according to NAC 616C.170 to 616C.230, inclusive, unless the insurer has entered into a contract for the provision of those benefits for less than the amounts set forth in those sections.

2. The provider of health care shall bill by report if there is insufficient information to support a unit of value. A provider of health care who bills by report shall submit the information identified in the guidelines for billing by a report for that area of treatment, contained in the Relative Values for Physicians, as adopted pursuant to NAC 616C.188.

616C.185 Contents of reports. (NRS 616A.400, 616C.130, 616C.260) A report submitted pursuant to NAC 616C.170 to 616C.230, inclusive, must include:

1. The complete health history of the injured employee;

2. A description of all pertinent subjective information provided by the injured employee;

3. All pertinent objective data obtained by examination and testing, unless disclosure of the data is prohibited by law;

4. An assessment of all pertinent subjective information and objective data;

5. A description of the plans for the treatment of the injured employee; and

6. In the case of a report relating to a final or discharge evaluation, a statement of the health of the injured employee, including the likelihood of a ratable impairment.

616C.191 Conversion factors; limits on payments; use of procedure code numbers and unit values. (NRS 616A.400, 616C.260)

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	$24.09
80000-89999	Pathology	14.30
90000-99999	Medicine	6.24
10000-69999	Surgery	135.28

2. Payment for services listed in subsection 1 must be made in accordance with subsection 2 of NRS 616C.135 and subsection 1 of NRS 616C.260. Payments must not exceed the fees established in the schedule of fees and charges allowable for accident benefits adopted pursuant

to NRS 616C.260, or the usual fee charged by that provider of health care or facility pursuant to a contract between the provider of health care and the insurer, whichever is less.

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

616C.200 Services performed by acupuncturist. (NRS 616A.400, 616C.260) Each insurer shall use the following codes for services performed by an acupuncturist:

Code	Procedure	Maximum Allowable Payment
NV00001	Initial office visit	By Report
NV00002	Subsequent office visit, including acupuncture or additional procedures	By Report
NV00003	Subsequent office visit, including moxibustion or additional procedures	By Report

616C.203 Use of emergency department; inpatient care at hospital; skilled nursing care facility; transfer or discharge of injured employee; excessive use of hospital accommodations. (NRS 616A.400, 616C.250, 616C.260)

1. The following is the maximum allowable payment per visit for the use of an emergency department:

Code	Procedure	Maximum Allowable Payment
NV00100	First hour	$37.67
NV00101	Each additional hour or fraction thereof	18.84

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

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

Code	Procedure	Maximum Allowable Payment
NV00200	Intensive Care	$2,008.98

NV00400	Cardiac Care	1,844.80
NV00500	Medical-Surgical Care	1,221.47
NV00900	Care for Burns	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	$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	$1,138.53

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.

616C.206 Home health care services. (NRS 616A.400, 616C.260)

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	$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	$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	$35.60 per hour
NV90190	Certified nursing assistant care	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 the care.

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

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

616C.209 Payment for pharmaceuticals. (NRS 616A.400, 616C.260)

1. 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 recent nationally recognized pricing guide.

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

4. 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.

616C.213 Failure of injured employee to appear for independent medical evaluation. (NRS 616A.400, 616C.260)

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	$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.

616C.218 Value of report of consultation included in value of consultation. (NRS 616A.400, 616C.260) The value of the report of a consultation is included in the value for the consultation.

616C.221 Therapy: Performance and billing. (NRS 616A.400, 616C.250, 616C.260)

1. The procedures and modalities described in NAC 616C.224 to 616C.230, inclusive:

(a) Must not be performed without the prior approval of the insurer.

(b) May, except as otherwise provided by those sections, be performed by any person acting within the scope of his professional license.

2. Any bill prepared for a procedure or modality described in NAC 616C.224 to 616C.230, inclusive, must:

(a) Include the number of the license or certificate held by the person submitting the bill; and

(b) Identify the type of license or certificate held by that person.

616C.224 Therapy: Evaluation of functional capacity. (NRS 616A.400, 616C.250, 616C.260)

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	$147.14 per hour

2. Testing performed in connection with such an evaluation must continue for not less than 2 hours and not more than 5 hours.

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

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

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

616C.225 Therapy: Failure of injured employee to appear for evaluation of functional capacity. (NRS 616A.400, 616C.260)

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.	$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.

616C.227 Therapy: Work hardening programs. (NRS 616A.400, 616C.250, 616C.260)

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	$51.79 per hour

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

(a) For not less than 2 hours per day and not more than 8 hours per day, including any time spent in preparing a report of the treatment; and

(b) For not less than 2 weeks and not more than 8 weeks.

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

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

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

616C.230 Therapy: Back school. (NRS 616A.400, 616C.250, 616C.260)

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	$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.

616C.240 Establishment of schedule: Entities to be surveyed. (NRS 616A.400, 616C.260) The entities to be surveyed for the purpose of establishing a schedule of reasonable fees and charges allowable for accident benefits may include:

1. Private providers of health insurance;

2. Health maintenance organizations; or

3. Preferred provider organizations,

➥ whose allowable charges are based on premium income, standard underwriting principles, and loss ratio.

616C.243 Establishment of schedule: Handling of data. (NRS 616A.400, 616C.260)

1. All data obtained in establishing a schedule of reasonable fees and charges allowable for accident benefits will:

(a) Have the identity of its source removed from the face of any document submitted to the Division to maintain the confidentiality of the source.

(b) Be retained for a reasonable time, as determined by the Administrator, not to exceed 5 years.

(c) Be retained in files which are dated and labeled according to subject matter.

2. Documents retained pursuant to this section will be retained at an office of the Industrial Insurance Regulation Section for a period of not less than 2 years at which time the documents may be stored at a storage facility at a different location.

3. Documents containing data obtained in establishing a schedule of reasonable fees and charges allowable for accident benefits must be disposed of in compliance with a records retention program approved by the Administrator.

616C.246 Use of modifiers to limit maximum fees for multiple procedures. (NRS 616A.400, 616C.260) The Division will, if necessary, establish reasonable limits on the maximum allowable fees for multiple procedures by the use of modifiers.

616C.249 Annual revisions to schedule: Calculation. (NRS 616A.400, 616C.260)

1. The Division will calculate annual revisions to the schedule of 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 department stays, medical or surgery stays, intensive care unit stays, burn unit stays and cardiac care stays; and

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

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

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

(1) The Division will calculate each payer's annual payments for each treatment area of medicine, surgery, anesthesiology, radiology and pathology and for hospital per diem rates as reported in the survey for January of each calendar year, and for January of the previous calendar year.

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

(3) The Division will apply a weighting factor to each payer's annual increase or decrease calculated pursuant to subparagraph (2). The Division will use 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, using the unadjusted percentage change for January to December, inclusive, of the previous year.

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

616C.252 Annual revisions to schedule: Notice and hearing; date for adoption. (NRS 616A.400, 616C.260)

1. On or before August 28 of each calendar year, the Division will provide notice to all interested parties of proposed amendments to the schedule of reasonable fees and charges allowable for accident benefits and set a date for a public hearing on the proposed amendments.

2. The Division will adopt revisions to the schedule of reasonable fees and charges allowable for accident benefits no later than October 1 of each year.

616C.255 Compliance with schedule: Auditing of insurer. (NRS 616A.400, 616C.260) When auditing an insurer for compliance with the schedule of reasonable fees and charges allowable for accident benefits, the Industrial Insurance Regulation Section will examine payments made for accident benefits. The examination of payments will include, but is not limited to, a review to ensure:

1. Timeliness of payment in compliance with NAC 616C.144; and

2. Correctness of payment in compliance with NAC 616C.182 to 616C.218, inclusive, and 616C.240 to 616C.258, inclusive.

616C.258 Contracting for assistance from consultants. (NRS 616A.400, 616C.260) The Administrator may execute a contract with one or more private consultants to provide assistance to the Administrator in:

1. Reviewing and revising the surveys used to canvass insurers and other payers for health care services to determine the amounts paid for medical treatment in this State.

2. Conducting additional surveys of insurers in this State and other payers for health care services in this State, to validate any proposed regulation amending the schedule of reasonable fees and charges allowable for accident benefits.

3. Verifying that any proposed increases in the schedule of reasonable fees and charges allowable for accident benefits are in compliance with the provisions of NRS 616C.260.

4. Periodically reviewing and updating the procedures used to calculate the schedule of reasonable fees and charges allowable for accident benefits.

616D.402 Construction of terms. (NRS 616A.400, 616D.120) For the purposes of NAC 616D.400 to 616D.440, inclusive, a person:

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

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

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

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

616D.404 Prerequisite to commission of second or subsequent violation; maximum amount of administrative fine. (NRS 616A.400, 616D.120)

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

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

616D.406 Failure to provide or untimely provision of form, notice or other information to injured employee. (NRS 616A.400, 616D.120) If an insurer, organization for managed care, provider of health care, third-party administrator or employer fails to comply or complies in

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

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

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

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

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

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

616D.408 Failure to make or untimely making of determination regarding acceptance or denial of claim for compensation. (NRS 616A.400, 616D.120)

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

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

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

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

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

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

2. An insurer shall pay any administrative fine imposed pursuant to subsection 1 in addition to any amount ordered by the Administrator pursuant to NRS 616C.065.

616D.410 Failure to provide to employer or employee or untimely provision of notice of right to file appeal of determination. (NRS 616A.400, 616D.120) If an insurer, organization for managed care or third-party administrator fails to comply or complies in an untimely manner with any provision of chapter 616A, 616B, 616C, 616D or 617 of NRS or a regulation adopted pursuant thereto that requires the insurer, organization for managed care or third-party administrator to provide to an employer or injured employee notice of his right to file an appeal of a determination of the insurer, organization for managed care or third-party administrator, the Administrator will:

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

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

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

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

616D.412 Failure to provide or untimely provision of notice of determination concerning request relating to claim. (NRS 616A.400, 616D.120) If an insurer, organization for managed care or third-party administrator fails to comply or complies in an untimely manner with the provisions of NAC 616C.094, the Administrator will:

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

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

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

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

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

616D.414 Failure to pay, untimely payment of or underpayment of benefits to injured employee. (NRS 616A.400, 616D.120)

1. If an insurer or third-party administrator fails to comply or complies in an untimely manner with a provision of chapter 616A, 616B, 616C, 616D or 617 of NRS or a regulation

adopted pursuant thereto that requires the insurer or third-party administrator to make a payment of benefits to an injured employee, the Administrator will:

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

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

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

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

2. Except as otherwise provided in subsection 3, if an insurer or third-party administrator makes a payment of benefits to an injured employee that is less than the amount to which the injured employee was entitled pursuant to chapters 616A to 617, inclusive, of NRS or the regulations adopted pursuant thereto, the Administrator will:

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

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

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

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

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

616D.416 Failure to comply or untimely compliance with requirements regarding scheduling of rating evaluation of injured employee and compensation for permanent partial disability. (NRS 616A.400, 616D.120) If an insurer or third-party administrator fails to comply or complies in an untimely manner with the provisions of NRS 616C.490 or NAC 616C.103, the Administrator will:

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

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

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

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

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

616D.418 Failure to comply or untimely compliance with requirements for submission and approval or denial of plan for program of vocational rehabilitation. (NRS 616A.400, 616D.120) If an insurer, third-party administrator, or treating or examining physician or

chiropractor fails to comply or complies in an untimely manner with the provisions of NAC 616C.558, the Administrator will:

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

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

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

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

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

616D.420 Failure to comply or untimely compliance with requirements regarding mailing of report of rating evaluation of permanent partial disability of injured employee. (NRS 616A.400, 616D.120) If a rating physician or chiropractor fails to comply or complies in an untimely manner with the provisions of NAC 616C.212, the Administrator will:

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

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

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

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

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

616D.422 Failure to pay, untimely payment of or underpayment of health care provider. (NRS 616A.400, 616D.120) If an insurer, third-party administrator or employer fails to comply or complies in an untimely manner with any provision of chapter 616A, 616B, 616C, 616D or 617 of NRS or a regulation adopted pursuant thereto that requires the insurer, third-party administrator or employer to make a payment to a provider of health care, the Administrator will:

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

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

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

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

616D.424 Failure to ensure or untimely ensuring that vocational rehabilitation counselor complies with certain provisions. (NRS 616A.400, 616D.120) If an insurer or third-party administrator fails to comply or complies in an untimely manner with the provisions of NAC 616C.555, the Administrator will:

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

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

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

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

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

616D.426 Failure to comply or untimely compliance with requirements regarding determination that assessment of injured employee is impractical or for delivery of assessment or report. (NRS 616A.400, 616D.120) If an insurer or third-party administrator fails to comply or complies in an untimely manner with the provisions of subsection 5 or 6 of NRS 616C.550, the Administrator will:

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

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

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

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

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

616D.428 Commencement of program of vocational rehabilitation before determining that injured employee is capable of safe participation. (NRS 616D.120) If an insurer or third-party administrator fails to comply with the provisions of subsection 5 of NRS 616C.555, the Administrator will:

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

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

616D.430 Failure to execute agreement with employer before injured employee participates in program for on-the-job training. (NRS 616D.120) If an insurer or third-party administrator fails to comply with the provisions of subsection 2 of NRS 616C.570, the Administrator will:

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

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

616D.432 Failure to pay or untimely payment of wages of injured employee who is participating in program for on-the-job training. (NRS 616A.400, 616D.120) If an insurer or third-party administrator fails to comply or complies in an untimely manner with the provisions of subsection 3 of NRS 616C.570, the Administrator will:

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 $750.

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

616D.434 Failure to reimburse or untimely reimbursement of training employer for wages paid to injured employee. (NRS 616A.400, 616D.120) If an insurer or third-party administrator fails to comply or complies in an untimely manner with the provisions of subsection 4 of NRS 616C.570, the Administrator will:

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

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

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

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

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

616D.436 Failure to provide or untimely provision of information to Administrator. **(NRS 616A.400, 616D.120)** If an insurer, organization for managed care, provider of health care, third-party administrator or employer fails to comply or complies in an untimely manner with the provisions of NRS 616A.475, 616B.006 or 616B.009 or NAC 616A.410, the Administrator will:

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

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

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

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

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

616D.438 Failure to comply with provisions regarding required posters and forms. **(NRS 616A.400, 616D.120)** If an insurer, organization for managed care, provider of health care, third-party administrator or employer fails to comply or complies in an untimely manner with the provisions of NAC 616A.480, the Administrator will:

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

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

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

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

616D.4381 Failure of employer to provide notice of election for coverage or withdrawal of election for coverage for excluded employees. (NRS 616A.400, 616D.120) If an employer fails to provide the notice required pursuant to NRS 616B.656 in the manner set forth in NAC 616B.800, the Administrator will:

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

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

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

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

616D.4383 Failure of sole proprietor to provide notice of election for coverage or withdrawal of election for coverage. (NRS 616A.400, 616D.120) If a sole proprietor fails to provide the notice required pursuant to NRS 616B.659 in the manner set forth in NAC 616B.809, the Administrator will:

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

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

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

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

616D.4385 Failure to provide or untimely provision of list of providers of health care to injured employee. (NRS 616A.400, 616D.120) If an employer, an insurer, a third-party administrator or an organization for managed care fails to comply or complies in an untimely manner with the provisions of NAC 616C.030, the Administrator will:

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

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

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

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

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

616D.4387 Failure to comply with requirements regarding inclusion of certain information upon issuance of certificate of disability. (NRS 616A.400, 616D.120) If a

physician or chiropractor fails to comply with the provisions of subsection 3 of NRS 616C.040 or subsection 7 of NRS 616C.475, the Administrator will:

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

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

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

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

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

616D.4389 Failure to comply or untimely compliance with requirements regarding claim received for employer to whom insurer does not provide coverage. (NRS 616A.400, 616D.120) If an insurer fails to comply or complies in an untimely manner with the provisions of NAC 616C.1156, the Administrator will:

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

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

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

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

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

616D.439 Failure to provide or untimely provision by insurer or employer of copies of report of medical examination. (NRS 616A.400, 616D.120) If an insurer or employer fails to comply or complies in an untimely manner with the provisions of NAC 616C.1164, the Administrator will:

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

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

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

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

616D.4391 Failure to comply or untimely compliance with requirements regarding notice of closure or reopening of claim. (NRS 616A.400, 616D.120) If a designated third-party administrator or insurer fails to comply or complies in an untimely manner with the provisions of NAC 616C.402, the Administrator will:

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

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

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

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

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

616D.4393 Failure to comply or untimely compliance with requirements regarding compensation for loss of or permanent damage to tooth. (NRS 616A.400, 616D.120) If an insurer or a third-party administrator fails to comply or complies in an untimely manner with the provisions of NAC 616C.508, the Administrator will:

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

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

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

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

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

616D.4395 Failure to comply with requirements regarding inspection, maintenance and location of files for claims and other records. (NRS 616A.400, 616D.120) If an insurer fails to comply with the provisions of NAC 616B.013, the Administrator will:

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

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

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

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

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

616D.4397 Failure to comply or untimely compliance with requirements regarding payment of compensation to claimant. (NRS 616A.400, 616D.120) If an insurer or third-party administrator fails to comply or complies in an untimely manner with the provisions of NAC 616B.021, the Administrator will:

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

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

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

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

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

616D.4399 Minor violations not covered by specific statute or regulation. (NRS 616A.400, 616D.120) If an insurer, third-party administrator, organization for managed care, employer or provider of health care commits a minor violation, as defined in NAC 616D.400, for which an administrative fine or other penalty is not otherwise provided by specific statute or regulation, the Administrator will:

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

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

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

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

616D.440 Plan of corrective action: Authority of Administrator; contents. (NRS 616A.400, 616D.120)

1. If the Administrator issues a notice of correction to a person or imposes an administrative fine against a person pursuant to NAC 616D.400 to 616D.440, inclusive, the Administrator may also require the person to submit to the Administrator a plan of corrective action pursuant to paragraph (c) of subsection 2 of NRS 616D.120.

2. A plan of corrective action required by the Administrator pursuant to subsection 1 must include a detailed description of the actions that the person who is submitting the plan will take to ensure that a subsequent violation does not occur.

616D.443 Failure to comply or untimely compliance with provisions regarding completion or filing of claim for compensation for treatment of injured employee by treating physician or chiropractor. (NRS 616A.400, 616C.040)

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

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

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

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

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

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

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

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

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

616D.444 Failure to comply or untimely compliance with provisions regarding completion or filing of report of industrial injury or occupational disease by employer. (NRS 616A.400, 616C.045)

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

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

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

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

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

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

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

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

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

616D.445 Failure to comply with provisions regarding charges to insurer for approved treatment by provider of health care and liability of insurer for charges. (NRS 616A.400, 616C.135) If a provider of health care, an organization for managed care, an insurer or an employer fails to comply with the provisions of NRS 616C.135, the Administrator will:

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

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

616D.446 Failure to comply or untimely compliance with provisions regarding completion or filing of claim for compensation for treatment of employee who has incurred occupational disease by treating physician or chiropractor. (NRS 616A.400, 617.352)

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

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

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

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

2. If a treating physician or chiropractor fails to comply or complies in an untimely manner with the provisions of NRS 617.352 or of a regulation adopted pursuant thereto that require the treating physician or chiropractor to file a claim for compensation, the Administrator will:

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

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

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

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

616D.447 Failure to comply or untimely compliance with provisions regarding completion or filing of report of industrial injury or occupational disease by employer. (NRS 616A.400, 617.354)

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

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

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

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

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

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

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

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

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

NOTICE OF ADOPTION OF PROPOSED REGULATION
LCB File No. R118-02

The Division of Industrial Relations of the Department of Business and Indsutry adopted regulations assigned LCB File No. R118-02 which pertain to chapters 616A, 616B, 616c and 616D of the Nevada Administrative Code on July 1, 2005.

Notice date: 2/17/2003
Hearing date: 3/19/2003
Date of adoption by agency: 7/1/2005
Filing date: 9/7/2005

INFORMATIONAL STATEMENT

1. A description of how comments were solicited from the public and affected businesses, a summary of responses from the public and affected businesses and an explanation of how other interested persons may obtain a copy of the summary.

The Division held two public workshops on November 29, 2001. Both workshops were conducted by a videoconference connecting Las Vegas and Carson City.

The first workshop was on legislative changes during the 2001 session regarding assessments Assembly Bill (A.B. 48), proof of coverage information, Assembly Bill 47 (A.B. 47), medical fee schedule, Assembly Bill 44 (A.B. 44), payments of bills for accident benefits, Senate Bill 99 (S.B. 99). Significantly, A.B. 44 contained a provision that exempted the medical fee schedule from the regulation adoption requirements of the Nevada Administrative Procedure Act ("NAPA"). Thus, this informational statement does not include the medical fee schedule. This informational statement does, however, include other matters contained in A.B. 44, including the amendments to NRS 616B.021 and 616B.027.

The second workshop was on benefit penalties (NRS 616D.120), the American Medical Association's *Guides to the Evaluation of Permanent Impairment* (NRS 616C.110), administrative fines, premium penalties and attorney's fees charged to uninsured employers (NRS 616D.120, 616C.220, 616D.200 and 616D.220).

Prior to the workshops, the Division received a written comment from an attorney, R. Trent McAuliffe. Mr. McAuliffe requested that the Division amend several regulations to set a fixed-fee for copies of medical records (NAC 616B.008), contracts with health care providers (NAC 616C.030), rating employees at the time of the evaluation (NAC 616C.476, minor violations (NAC 616D.400) and increasing the time period for calculating administrative fines (NAC 616D.404). Mr. McAuliffe also wanted the Division adopt new regulations concerning peremptory challenges and imposing a benefit penalty for improper use of an injured workers' social security number. He also proposed eliminating a portion of NAC 616C.476 and NAC 616D.406 through 616D.447, inclusive, in their entirety.

At the first workshop, twenty-one (21) people were in attendance in Carson City; forty-four (44) people attended in Las Vegas.

There were no public comments concerning assessments (A.B. 48). The Division received two comments concerning coverage information. Mark Sekrnan, American Insurance Association, testified in Las Vegas. He wanted to clarify that electronic notification was permitted. Mary Alice Galt, Esq., testifying from Carson City, wanted the Division to clarify that employers still were required to post workers' compensation information.

The Division received two comments concerning NRS 616B.021 and 616B.027. Jim Wadharns, Esq., testifying from Carson City, representing the American Insurance Association, was concerned that the Division was not giving effect to statutory changes that authorized insurers to maintain workers' compensation claims files in another state. Mr. Wadharns indicated that, in his opinion, the statutory changes evidenced a legislative intent to authorize the management of workers compensation claims in another state.

Pat Huek, representing Specialty Risk Services, testifying from Las Vegas, noted the language in the statutes required the workers' compensation insurer to maintain an office in Nevada with a person authorized to act for the insurer. In her opinion, this language meant that an insurer could not merely staff an office with a clerk. She did suggest, however, that the statutory language in NRS 616B.021 and 6l6B.027 be clarified.

The Division also received two comments in Carson City concerning the implementation of the medical fee schedule. Cliff King of the Division of Insurance (DOI) requested that the Division make medical fee schedule changes early enough to permit the National Council on Compensation Insurance (NCCI), to calculate appropriate loss costs in their annual filing. This request we echoed by Maggie Karpuk of NCCI.

Trent McAuliffe, Esq. appeared in Carson City and offered testimony consistent with his letter to the Division.

At the second workshop, eleven (11) people were in attendance in Carson City; twenty (20) people attended in Las Vegas.

Trent McAuliffe, Esq., stated that he found the point system used for calculating benefit penalties inconsistent, particularly in cases of death. He suggested raising the point system to recognize death as the most serious violation.

Based on comments received during the workshop process, the Division proceeded to draft proposed regulations. The proposed regulations were submitted to the legislative counsel bureau on June 27, 2002. On August 6, 2002 the proposed regulations (LCB File No. R118-02) were returned in a revised form.

Based in part on the Division's focus on issues related to the medical fee schedule, the Division elected not to hold public hearings on the proposed regulations until March 19, 2003.

Prior to the public hearing the Division received written comments from David G. Rovetti, D.C. and the Alliance of American Insurers ("MA").

Dr. Rovetti suggested that the Division's amendment to NAC 6l6C.103 was insufficient. Dr. Rovetti requested that the Division amend the regulation to inform injured workers: (1) a permanent physical impairment rating determines the amount of money a injured worker receives; (2) impairment ratings vary from examiner to examiner; and (3) a random assignment of raters results in a fair and unbiased examination.

The AIA expressed concern respecting "intentional violations." The AIA suggested that the penalties for intentional violations would result in a "chilling" effect. The AIA therefore, urged the Division to strike the intentional violation provisions.

The public hearing on March 19, 2003 was conducted via videoconference from Las Vegas to a Carson City location. Thirty-seven (37) people attended the hearing in Las Vegas; fourteen (14) people attended in Carson City.

In Las Vegas, Ken Thomas of Nevada Audit Services testified. Mr. Thomas contended that the repeal of medical fee regulations was inconsistent with provisions of the NAPA. Mr. Thomas also wanted to address specific reimbursement issues relating to the medical fee schedule.

Jackie Cox of Specialty Health testified from Carson City. Ms. Cox also wants to address aspects of the medical fee schedule. She was also opposed any change in medical billing forms and the repeal of the medical fee schedule.

Don Smith, Associate General Counsel, Employers Insurance Company of Nevada, testified from Carson City. Mr. Smith questioned the consolidation and availability of the D-53 through D-55 forms. He also suggested that sixty cents a page was the appropriate rate to pay for all pages copied from a claim file. Mr. Smith also testified regarding the proposed reporting requirements; he suggested that the Division was mandating "double reporting." Finally, like Ms. Cox, he questioned why the Division was repealing all the regulations related to the medical fee schedule.

David Oakden of S & C Claims testified from Las Vegas. Mr. Oaken also questioned why copied duplicate pages of an injured worker's claim file would not be reimbursed. He pointed out that the pages were "date sensitive" thus, he stated, billing for all copied pages in the claim file was appropriate. Mr. Oakden also objected to requiring a response to a "verbal" request for a health care provider list. In his opinion, a written request should be required. Mr. Oakden also noted that the Division included "stepchild" instead of "adopted stepchild" in the proposed regulations. Finally, he wanted the effective date of the regulations to be changed.

In the benefit penalty area of the proposed regulations Bridget Wyszomirski of OHMS, Leslie Bell of Nevada Self-Insured Association ("NSIA"), Jeanette Belz of Liberty Mutual Insurance and Don Smith testified. Ms. Wyszornirski, testifying from Las Vegas, requested clarification regarding the amount of the benefit penalty in cases of death. Ms. Bell, testifying from Carson City, noted the difficulties faced by the Division in adopting regulations in this area. Ms. Belz,

also testifying from Carson City, noted that Liberty Mutual was a member of the American Insurance Association ("AIA") and, thus, joined in their comments. Mr. Smith objections were numerous. Overall, he believed the regulations were arbitrary and capricious. Specifically, he questioned whether the proposed regulations could result in a minimum fine of $5,000 as authorized by statute. He also challenged consideration of economic and physical harm, as well as the number of violations, in determining the amount of a benefit penalty.

Subsequent to the public hearing, the Division received written comments from Employers Insurance Company of Nevada ("EICN') and Nevada Audit Services (“NAS”).

EICN requested that the Division increase the charge for copies from ten cents per page to sixty. While EICN supported having employers notify their previous insurer within ten (10) days of cancellation, EICN was concerned that the proposed regulations regarding benefit penalties would result in a substantial burden because of the time and expense associated with the hearing process. EICN also expressed concerns regarding the factors used to calculate the benefit penalties and administrative fines. Finally, EICN suggested that the Division retain some regulations related to the payment of medical bills.

NAS shared EICN's concerns respecting the repeal of regulations related to the payment of medical bills. NAS also raised issues related to the medical fee schedule.

During the review process, the Division determined it would proceed with regulations concerning the American Medical Association's *Guides to the Evaluation of Permanent Impairment* (5th Edition) as a separate matter. Hence, this informational statement does not address the adoption of the 5th Edition; for information (including the informational statement) concerning the adoption of the 5th Edition, see LCB
File No.: R060-03. The regulations relating to the 5th Edition were filed with the Secretary of State on September 8, 2003.

In addition, the Division proceeded to hold a series of workshops to consider the recommendations of Milliman USA, an independent consulting and actuarial firm retained to develop recommendations concerning the Medical Fee Schedule. The workshops were held independent of the requirements of the NAPA and are, therefore, not addressed in this informational statement.

A copy of this informational statement may be obtained by contacting the Division of Industrial Relations' Workers' Compensation Section at the following locations:

Workers' Compensation Section
1301 N. Green Valley Pkwy., #200
Henderson, NV 89074
Telephone: (702) 486-9080

Workers' Compensation Section
400 W. King St., #400
Carson City, NV 89703
Telephone: (775) 684-7270

2. The number of persons who attended the hearing, testified at each hearing, and submitted written statements to the agency.

The Division held two public workshops on November 29, 2001. Both workshops were conducted by a videoconference connecting Las Vegas and Carson City. At the first workshop, twenty-one (21) people were in attendance in Carson City; forty-four (44) people attended in Las Vegas. In total, seven people testified. The Division received one (1) written comment.

At the second workshop, eleven (11) people were in attendance in Carson City; twenty (20) people attended in Las Vegas. One (1) person testified. The Division received two (2) written comments.

On March 19, 2003, the Division conducted a public hearing on the proposed regulations. The hearing was conducted by a videoconference connecting Las Vegas and Carson City. Thirty-seven (37) people attended the hearing in Las Vegas; fourteen (14) people attended in Carson City. A total of seven (7) people testified. The Division received a total of four (4) written comments.

3. If the regulations were adopted without changing any part of the proposed regulations, a summary of the reasons for adopting the regulations without changes.

The regulations were changed as a result of comments received.

4. The estimated economic effect of the adopted regulations on the businesses, which it is to regulate, and on the public.

Adverse: The Division believes that the immediate adverse economic effect of the regulations on businesses is minimal. The Division also believes the long-term adverse economic effect of the regulations on businesses is also minimal. The regulations do not increase fines or penalties. The regulations also do not impose any significant regulatory burdens associated with compliance.

The Division believes that there is no immediate adverse economic effect of the regulations on the public. The Division also believes there is no long-term adverse economic effect of the regulations on the public. The regulations also do not impose any significant regulatory burdens associated with compliance.

Beneficial: The Division believes that the immediate beneficial economic effect of the regulations on businesses is minimal. The Division also believes the long-term beneficial effect of the regulations on businesses is also minimal. The regulations, could in some cases, result in a decrease in administrative fines. The regulations do not decrease any significant regulatory burdens associated with compliance.

The Division believes that there is no immediate beneficial economic effect of the regulations on the public. The Division also believes there is no long-term beneficial economic effect of the

regulations on the public. The regulations do not decrease any significant regulatory burdens associated with compliance.

5. The estimated cost to the agency for enforcement of the adopted regulations.

The Division estimates that the cost of implementation and enforcement is minimal. The Division already enforces substantially similar regulations.

6. A description of any regulations of other state or government agencies that the proposed regulations overlap or duplicate and a statement explaining why the duplication or overlapping is necessary. If the regulations overlap or duplicate a federal regulation, the name of the regulating federal agency.

The Division believes that the proposed regulations do not overlap or duplicate any existing regulations.

7. If the regulations include provisions which are more stringent than a federal regulation which regulates the same activity, a summary of such provisions.

The proposed regulations are not required by federal law; there is no equivalent federal law.

8. If the regulations provide a new fee or increase in existing fees, the total annual amount the agency expects to collect and the manner in which the money will be used.

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