ADOPTED REGULATION OF THE

DIVISION OF INDUSTRIAL RELATIONS OF THE

DEPARTMENT OF BUSINESS AND INDUSTRY

LCB File No. R108-09

Effective June 30, 2010

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

AUTHORITY: §§1, 2 and 5, NRS 616A.400; §3, NRS 616A.400 and 616A.490; §4, NRS 616A.400 and 616A.417; §6, NRS 232.680 and 616A.400; §§7 and 13, NRS 616A.400, 616C.110 and 616C.490; §8, NRS 616A.400 and 616C.110; §§9, 11, 14 and 15, NRS 616A.400 and 616C.490; §10, NRS 616A.400, 616C.135 and 616C.260; §12, NRS 616A.400 and 616C.220.

A REGULATION relating to industrial insurance; revising the name of the Industrial Insurance Regulation Section of the Division of Industrial Relations of the Department of Business and Industry to the Workers' Compensation Section; revising provisions relating to stress claims; and providing other matters properly relating thereto.

Section 1. NAC 616A.050 is hereby amended to read as follows:

616A.050 "Chief" means the Chief Administrative Officer of the **[**~~Industrial Insurance Regulation~~**]** ***Workers' Compensation*** Section.

Sec. 2. NAC 616A.140 is hereby amended to read as follows:

616A.140 **[**~~"Industrial Insurance Regulation~~**]** ***Workers' Compensation*** Section" means the **[**~~Industrial Insurance Regulation~~**]** ***Workers' Compensation*** Section of the Division of Industrial Relations of the Department of Business and Industry.

Sec. 3. NAC 616A.460 is hereby amended to read as follows:

616A.460 1. Each employer governed by the provisions of chapters 616A to 617, inclusive, of NRS shall prominently display at his place of business a poster with the language and in the format specified in Form D-1.

2. The title of the poster must be printed in not less than 20-point bold type. The required statement concerning questions and problems relating to claims must be printed in not less than 12-point bold type. The text appearing on the remainder of the poster must be printed in not less than 10-point type. The poster must be at least 11 inches by 17 inches in size.

3. Each employer shall:

(a) Display the poster as required by this section; and

(b) Advise his employees of the name, business address and telephone number of his insurer's or third-party administrator's adjuster in this State that is located nearest to the employer's place of business for their claims for workers' compensation.

4. The poster must be displayed in such a manner as to be readily visible by all employees. A poster must not be displayed unless it has been issued or approved by the ~~[Industrial Insurance Regulation]~~ ***Workers' Compensation*** Section.

Sec. 4. 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-9(c), Permanent Partial Disability Worksheet for Stress Claims Pursuant to NRS 616C.180.***

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

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

~~[(n)]~~ ***(o)*** D-11, ~~[Reaffirmation]~~ ***Reaffirmation/Retraction*** of Lump Sum Request.

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

~~[(p)]~~ ***(q)*** D-12(b), Request for Hearing - Uninsured Employer.

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

~~[(r)]~~ ***(s)*** D-14, Permanent Total Disability Report of Employment.

~~[(s)]~~ ***(t)*** D-15, Election for Nevada Workers' Compensation Coverage for Out-of-State Injury.

~~[(t)]~~ ***(u)*** D-16, Notice of Election for Compensation Benefits Under the Uninsured Employer Statutes.

~~[(u)]~~ ***(v)*** D-17, Employee's Claim for Compensation - Uninsured Employer.

~~[(v)]~~ ***(w)*** D-18, Assignment of Claim for Workers' Compensation - Uninsured Employer.

~~[(w)]~~ ***(x)*** D-21, Fatality Report.

~~[(x)]~~ ***(y)*** D-22, Notice to Employees - Tip Information.

~~[(y)]~~ ***(z)*** D-23, Employee's Declaration of Election to Report Tips.

~~[(z)]~~ ***(aa)*** D-24, Request for Reimbursement of Expenses for Travel and Lost Wages.

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

~~[(bb)]~~ ***(cc)*** D-26, Application for Reimbursement of Claim-Related Travel Expenses.

~~[(cc)]~~ ***(dd)*** D-27, Interest Calculation for Compensation Due.

~~[(dd)]~~ ***(ee)*** D-28, Rehabilitation Lump Sum Request.

~~[(ee)]~~ ***(ff)*** D-29, Lump Sum Rehabilitation Agreement.

~~[(ff)]~~ ***(gg)*** D-30, Notice of Claim Acceptance.

~~[(gg)]~~ ***(hh)*** D-31, Notice of Intention to Close Claim.

~~[(hh)]~~ ***(ii)*** D-32, Authorization Request for Additional Chiropractic Treatment.

~~[(ii)]~~ ***(jj)*** D-33, Authorization Request for Additional Physical Therapy Treatment.

~~[(jj)]~~ ***(kk)*** D-34, CMS 1500 Billing Form.

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

~~[(ll)]~~ ***(mm)*** D-36, Request for Additional Medical Information and Medical Release.

~~[(mm)]~~ ***(nn)*** D-37, Insurer's Subsequent Injury Checklist.

~~[(nn)]~~ ***(oo)*** D-38, Injured Worker Index System Claims Registration Document.

~~[(oo)]~~ ***(pp)*** D-39, Physician's Progress Report - Certification of Disability.

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

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

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

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

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

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

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

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

~~[(xx)]~~ ***(yy)*** D-52, CMS (UB-92).

~~[(yy)]~~ ***(zz)*** 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, 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]~~ ***Workers' Compensation*** 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. 5. NAC 616A.510 is hereby amended to read as follows:

616A.510 1. An affidavit required pursuant to NRS 244.33505 or 268.0955 must substantively conform to Form D-25 of the ~~[Industrial Insurance Regulation]~~ ***Workers' Compensation*** Section.

2. Form D-25 is available from any office of the ~~[Industrial Insurance Regulation]~~ ***Workers' Compensation*** Section at no cost.

Sec. 6. NAC 616B.722 is hereby amended to read as follows:

616B.722 1. The amount of the estimated annual assessment made against each insurer to be used to defray:

(a) The administrative costs of the office of the Administrator, office of Legal Counsel, Administrative Services Unit and ~~[Industrial Insurance Regulation]~~ ***Workers' Compensation*** Section will be calculated by multiplying the insurer's percentage of expenditures by the amount approved in the state budget for those administrative costs.

(b) The administrative costs of the offices of the Hearings Division of the Department of Administration and the Nevada Attorney for Injured Workers for the time spent concerning

claims for workers' compensation will be calculated by multiplying the insurer's percentage of expenditures by the amount approved in the state budget for these administrative costs.

(c) The administrative costs of the Occupational Safety and Health ~~[Enforcement Section]~~ ***Administration*** and the Safety Consultation and Training Section will be calculated by multiplying the insurer's percentage of expenditures by the amount approved in the state budget for those offices.

(d) The administrative costs of the Mine Safety and Training Section will be calculated by multiplying the insurer's percentage of expenditures by the amount approved in the state budget for the Mine Safety and Training Section.

(e) The costs of the Commissioner for administering the program of self-insurance will be calculated by multiplying the percentage of expenditures of each self-insured employer and the percentage of expenditures of each association of self-insured public or private employers by the amount approved in the state budget for those costs.

(f) That portion of the cost of the Office for Consumer Health Assistance that is related to providing assistance to injured employees concerning workers' compensation will be calculated by multiplying the insurer's percentage of expenditures by the amount approved in the state budget for that cost.

(g) The administrative costs of the administration of claims against uninsured employers arising from compliance with NRS 616C.220 will be calculated by multiplying the insurer's percentage of expenditures by the amount derived by multiplying:

(1) The expected annual disbursements to be made from the Uninsured Employers' Claim Account; and

(2) The charge for the administration of claims.

(h) The administrative costs of having premium rates reviewed by the Commissioner will be calculated by multiplying the insurer's percentage of expenditures by the amount approved in the state budget for those administrative costs.

(i) The amount of disbursements from the Uninsured Employers' Claim Account will be calculated by multiplying the insurer's percentage of expenditures by the sum of expected annual disbursements to be made from the Account.

(j) The amount of disbursements from the Subsequent Injury Accounts for Self-Insured Employers and Private Carriers will be calculated by multiplying the insurer's percentage of expenditures by the sum of expected annual disbursements to be made from the Subsequent Injury Accounts for Self-Insured Employers and Private Carriers.

2. For the purposes of this section, "percentage of expenditures" means the proportion of an insurer's expected annual expenditures for claims relative to the amount of the expected annual expenditures for claims of all insurers responsible for the cost shown in a particular category of the state budget.

Sec. 7. Chapter 616C of NAC is hereby amended by adding thereto a new section to read as follows:

When performing an evaluation of a permanent partial disability for a claim accepted pursuant to NRS 616C.180, a rating physician shall use the form designated in NAC 616A.480 as Form D-9(c), Permanent Partial Disability Worksheet for Stress Claims Pursuant to NRS 616C.180, to determine the percentage of impairment under Chapter 14, "Mental and Behavioral Disorders," of the Guide.

Sec. 8. NAC 616C.002 is hereby amended to read as follows:

616C.002 1. For the purposes of NRS 616B.557, 616B.578, 616B.587, 616C.105, ***616C.392,*** 616C.490 and 617.459, the Division hereby adopts by reference the *Guides to the Evaluation of Permanent Impairment*, ~~[5th]~~ ***Fifth*** Edition, published by the American Medical Association.

2. A copy of the publication may be obtained from the Order Department, American Medical Association, P.O. Box 930876, Atlanta, Georgia 31193-0876, by telephone at (800) 621-8335, or on the Internet at ~~[www.amapress.com,]~~ ***www.amabookstore.com,*** for the price of ~~[$129]~~ ***$139*** for persons who are members of the Association, or ~~[$149]~~ ***$159*** for persons who are not members of the Association.

3. The provisions of this section do not:

(a) Constitute a change of circumstances for the purposes of NRS 616C.390.

(b) Entitle an injured employee whose permanent partial disability was rated pursuant to NRS 616C.490 before October 1, 2003, to an increase in the compensation he receives for that disability.

Sec. 9. NAC 616C.021 is hereby amended to read as follows:

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

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

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

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

(1) Completing:

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

(II) One year or more of experience concerning industrial health in private practice. The Administrator shall determine whether the experience in private practice concerning industrial health is sufficient to qualify for designation as a rating physician or chiropractor on a case-by-case basis.

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

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

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

(c) Demonstrate an understanding of:

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

(2) The *Guide*.

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

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

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

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

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

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

(e) Except as otherwise provided in subsection 5, if the physician or chiropractor passed an examination concerning an edition of the *Guide* that is not the most recent edition adopted by the Administrator to become designated as a rating physician, pass the Nevada Impairment Rating Skills Assessment Test which is administered by the American Academy of Expert Medical

Evaluators or its successor organization and which examines the practical application of the rating of disabilities in accordance with the *Guide* with a score of 75 percent or higher.

5. If an ophthalmologist or psychiatrist has been designated as a rating physician and wishes to maintain such designation, the Administrator may exempt the ophthalmologist or psychiatrist who is authorized to practice in this State from the requirements set forth in paragraphs (a), (c), (d) and (e) of subsection 4 and authorize the ophthalmologist or psychiatrist to continue to evaluate injured employees with impaired vision or brain function ***or mental or behavioral disorders*** according to his area of specialization.

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

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

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

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

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

Sec. 10. 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 is not paid in a timely manner may, within 60 days after receiving notice of the denial or reduction, or

within 60 days after the payment was due, submit a written request to the ~~[Industrial Insurance Regulation]~~ ***Workers' Compensation*** 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]~~ ***Workers' Compensation*** 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 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]~~ ***Workers' Compensation*** Section may 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 2.

Sec. 11. 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 ~~[.]~~ ***; or***

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

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

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

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

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

(a) Requesting a physician or chiropractor from the list of qualified rating physicians and chiropractors designated by the Administrator to evaluate the injured employee and determine the extent of any permanent impairment or, if the injured employee and insurer have agreed to a rating physician or chiropractor pursuant to subsection 2 of NRS 616C.490, by submitting a completed form designated in NAC 616A.480 as D-35, ~~[Request/Agreement]~~ ***Request*** for a ***Rotating Rating*** Physician or Chiropractor, to the ~~[Industrial Insurance Regulation]~~ ***Workers'***

Compensation Section within 30 days after the insurer has received the statement from a physician or chiropractor that the injured employee is ratable and stable;

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

(c) At least 3 working days before the rating evaluation, providing 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 or documentation of any previous evaluations performed to determine the extent of any of the injured employee's disabilities and any previous injury, disease or condition of the injured employee that is relevant to the evaluation being performed;

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

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

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

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

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

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

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

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

(b) Provide the injured employee with a copy of each rating evaluation performed of ~~[him;]~~ ***the injured employee;*** and

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

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

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

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

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

(c) D-11, ~~[Reaffirmation]~~ ***Reaffirmation/Retraction*** of Lump Sum Request.

Sec. 12. NAC 616C.396 is hereby amended to read as follows:

616C.396 1. The ~~[Industrial Insurance Regulation]~~ ***Workers' Compensation*** Section will investigate each claim against an uninsured employer to determine whether the claim will be assigned to the third-party administrator or insurer designated by the Division pursuant to NRS 616C.220 for the payment of benefits from the Uninsured Employers' Claim Account. The ~~[Industrial Insurance Regulation]~~ ***Workers' Compensation*** Section will refuse to assign the claim if:

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

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

(c) The notice of the claim fails to include the documents which support the claim;

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

(e) The injured employee fails to complete and return to the ~~[Industrial Insurance Regulation]~~ ***Workers' Compensation*** Section:

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

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

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

➥ within 30 days after he receives the form from the ~~[Industrial Insurance Regulation]~~ ***Workers' Compensation*** Section.

2. If the ~~[Industrial Insurance Regulation]~~ ***Workers' Compensation*** Section refuses to assign a claim, it will include in the notice required by NRS 616C.220 a statement of the right of appeal provided by that section.

Sec. 13. NAC 616C.476 is hereby amended to read as follows:

616C.476 1. A rating physician or chiropractor who performs an evaluation of a permanent partial disability shall evaluate the industrial injury or occupational disease of the injured employee as it exists at the time of the rating evaluation. The rating physician or chiropractor shall take into account any improvement or worsening of the industrial injury or occupational disease that has resulted from treatment of the industrial injury or occupational disease. The rating physician or chiropractor shall not consider any factor other than the degree of physical impairment of the whole ~~[man]~~ ***person*** in calculating the entitlement to compensation.

2. In performing an evaluation of a permanent partial disability, a rating physician or chiropractor shall not use:

(a) Chapter 14, "Mental and Behavioral Disorders," of the *Guide* ~~[:]~~ ***, unless the claim was accepted pursuant to NRS 616C.180;*** or

(b) Chapter 18, "Pain," of the *Guide*.

Sec. 14. NAC 616C.487 is hereby amended to read as follows:

616C.487 The percentage of impairment in any specific rating or combination of ratings may not exceed 100 percent of the applicable extremity or of the whole ~~[man.]~~ ***person.***

Sec. 15. NAC 616C.490 is hereby amended to read as follows:

616C.490 1. If any permanent impairment from which an employee is suffering following an accidental injury or the onset of an occupational disease is due in part to the injury or disease, and in part to a preexisting or intervening injury, disease or condition, the rating physician or chiropractor, except as otherwise provided in subsection 9, shall determine the portion of the impairment which is reasonably attributable to the injury or occupational disease and the portion which is reasonably attributable to the preexisting or intervening injury, disease or condition. The injured employee may receive compensation for that portion of his impairment which is reasonably attributable to the present industrial injury or occupational disease and may not receive compensation for that portion which is reasonably attributable to the preexisting or intervening injury, disease or condition. The injured employee is not entitled to receive compensation for his impairment if the percentage of impairment established for his preexisting or intervening injury, disease or condition is equal to or greater than the percentage of impairment established for the present industrial injury or occupational disease.

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

3. A precise apportionment must be completed if a prior evaluation of the percentage of impairment is available and recorded for the preexisting impairment. The condition, organ or anatomical structure of the preexisting impairment must be identical with that subject to current evaluation. Sources of information upon which an apportionment may be based include, but are not limited to:

(a) Prior ratings of the insurer;

(b) Other ratings;

(c) Findings of the loss of range of motion; ~~[or]~~

(d) Information concerning previous surgeries ~~[.]~~ ***; or***

(e) For claims accepted pursuant to NRS 616C.180, other medical or psychological records regarding the prior mental or behavioral condition.

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

5. Except as otherwise provided in subsection 6, if a rating evaluation was completed in another state for a previous injury or disease involving a condition, organ or anatomical structure that is identical to the condition, organ or anatomical structure being evaluated for the present

industrial injury or occupational disease, or if no previous rating evaluation was performed, the percentage of impairment for the previous injury or disease and the present industrial injury or occupational disease must be determined by using the *Guide*, as adopted by reference pursuant to NAC 616C.002. The apportionment must be determined by subtracting the percentage of impairment established for the previous injury or disease from the percentage of impairment established for the present industrial injury or occupational disease.

6. If precise information is not available, and the rating physician or chiropractor is unable to determine an apportionment using the *Guide* as set forth in subsection 5, an apportionment may be allowed if at least 50 percent of the total present impairment is due to a preexisting or intervening injury, disease or condition. The rating physician or chiropractor may base the apportionment upon X rays, historical records and diagnoses made by physicians or chiropractors or records of treatment which confirm the prior impairment.

7. If there are preexisting conditions, including, without limitation, degenerative arthritis, rheumatoid variants, obesity ***,*** ~~[or]~~ congenital malformations ~~[,]~~ ***or, for claims accepted under NRS 616C.180, mental or behavioral disorders,*** the apportionment must be supported by documentation concerning the scope and the nature of the impairment which existed before the industrial injury or the onset of disease.

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

9. If no documentation exists pursuant to subsection 7 or 8, the impairment may not be apportioned.

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

IN THE MATTER OF THE ADOPTION OF PERMANENT REGULATIONS CONCERNING THE RATING OF STRESS, AS DEFINED IN NRS 616C.180, AS A PERMANENT PARTIAL DISABILITY FACTOR

LCB FILE NO. R112-08 & R108-09

_____/

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.

Section 7 of Senate Bill 195 (2009) includes revised provisions relating to stress as defined by NRS 616C.180.

Accordingly, the Division held a workshop and hearing on **July 17, 2009** and **February 16, 2010**, respectively, to hear public comment on revised regulations drafted pursuant to SB 195 (2009), including a new worksheet, **WCS Form 9c**. In conjunction with providing notice to the public and interested parties of the workshop and public hearing, the Division prepared the Small Business Impact Statement required by NRS 233B. The Division submitted the draft regulation and Small Business Impact Statement to the Legislative Counsel Bureau pursuant to NRS 233B.

A summary of the responses from the public and affected businesses is included in #2 of this Informational Statement and 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 workshop, testified at each workshop, and submitted written statements to the agency.

The workshop and hearing were conducted on, **July 17, 2009** and **February 16, 2010** at two sites via videoconference: The main site was at the Sawyer Building in Las Vegas; the other site was at Legislative Building, Room 2135, 401 South Carson Street, Carson City, Nevada. The workshop attendance and testimony totals are as follows: **July 17, 2009**, in Las Vegas, **43** people attended and **9** testified; in Carson City, **24** attended and **4** testified. The pertinent oral testimony on this matter is summarized as follows:

July 17, 2009

Susan Sayegh, SNVA: I don't see any provisions [on the worksheet] where a rating physician can identify any pre-existing non-industrial behavioral mental conditions that may allow for apportionment. It does reference apportionment with regards to a pre-injury rating, which sounds like if you had a prior stress claim then that rating would be apportioned but I don't see anywhere on here, so I would like to see anywhere on here, if possible, if this form could be modified or revised to include such instructions to the rater.

Charles Verre, DIR: We will certainly consider your testimony.

Dave Oakden, S&C Claims: One of the things in the *Guides* is they differentiate between head injuries and mental impairment – the combination of stress and head injury may result in a duplication of payment of benefits for similar outstanding findings. We should have some sort of differentiation when we have a physical injury that ends up with behavioral problems. There should be a distinction so that we don't have a duplication of benefits for the same external manifestations. We are already paying for when someone gets a head injury, we pay for some of the same types of impairments and this would be duplication of that Susan addressed – the apportionment issue, which is the only other thing that I had.

There were **3** extensive, pertinent written comments submitted by the **July 24, 2009** deadline announced at the hearing.

Malani L. Katchka, NSIA

We represent the Nevada Self-Insurers Association. In regard to your "Draft Regulation Pursuant to SB 195, Secs. 1.5, 15," we believe that Section 7 on page 10 should be amended. In light of Judge Wall's June 9, 2008 Decision and Order, NAC 616C.476(2) should be amended as follows:

> 2. In performing an evaluation of a permanent partial disability, a rating physician or chiropractor shall not use:
>
> (a) Chapter 14, "Mental and Behavioral Disorders" of the Guide unless the claim was accepted pursuant to NRS 616C.180; or
>
> (b) Chapter 18, "Pain" of the Guide; or
>
> (c) The additional 1 to 3 percent for limitations on the activities of daily living in determining the percentage of impairment for the spine under Chapter 15 of the Guide.
>
> 3. In performing an evaluation of a permanent partial disability, a rating physician or chiropractor shall not rate pain or the result of a physical impairment.
>
> Until the Nevada Supreme Court rules or until Case No. A515815 is resolved, rating physicians and chiropractors shall comply with Judge Wall's August 2, 2008 Order for Partial Stay Pending Appeal.

Tina Sanchez, Nevada Self-Insured Association (NSIA)

- **Section 7—Rating for "traumatic stress" under NRS 616C.180:**

A) First, since this proposed redraft of regulations includes provisions which are the subject of direct court orders in recent litigation

proscribing certain concepts or inclusions, litigation counsel for the Association handling this case will be submitting separate comments with respect to this proposed regulation. B) As testified to at the workshop, there should be some specific clarification as to apportionment and proration—both as it relates to a) physical impairment separate from the rating under Section 616C.180 and/or b) netting out the effects of prior injuries—and ensuring that the regulation and forms are clear on quantifying the exact effect of the specific injury under "180." One suggestion was to specify the way or ways (three were identified) that these could/should be accomplished in the regulation so that any confusion about how to calculate and apportion correctly was reduced or eliminated. We believe that it would be beneficial to specifically list the 3 criterion for apportionment as specified in NAC 616C.490 on the actual forms provided with your draft regulations. We will be happy to draft or discuss specifics with you at your convenience.

B) Because of the confusion and misunderstanding it causes, your notices and summaries ought to make clear for any future purposes that only "traumatic stress" or "danger stress" specifically compensable under NRS 616C.180 is involved, and not general references to "stress." There is already a big education curve to clarify just exactly what the 2009 Legislature actually passed as to specifics, which this broad notice exacerbated with respect to changes regarding "stress" and it would be helpful to all material educated people that this type of psychological injury is all that is being addressed consistent with 616C.180(3)

C) Attached you will find a response from Impairment Resources with comments and answers to questions provided by our Association. We believe that you will find this information helpful in finalizing this regulation. (Attachment 1)

Steve and Norma LeClair, Le Clair Behavioral Health

Question #1: Division of Industrial Relations has proposed requiring rating physicians to use the attached worksheet. It was developed in Colorado for their WC system. Would you and possibly Dr. Brigham take a look at it and see if it comports with the AMA Guides? Are there any changes that you recommend?

The worksheet conforms to many of the basic requirements of Chapter 14 of the AMA Guides. Please see our response to your question #2, below, regarding some important suggestions on how to improve the discrimination and validity of the worksheet and associated rating process as well as minimize the potential for overlapping ratings with other Chapters. We have two minor concerns and one major concern about the worksheet and the process it outlines. We will address the two minor concerns first and then do our best to tackle the third.

Section III.1. Activities of Daily Living. We like the fact that in the major heading (Areas of Function) it is clearly instructed to *Rate only impairments due strictly to the psychiatric condition.* We absolutely agree, however we need to point out that many professionals will struggle with that instruction because they won't know how to do it. They will, in fact, say that impairments associated with the mental disorder and physical disorders (long-standing physical limitations and chronic pain associated with a shoulder injury or well-documented low back problem, for instance) can't be reliably separated. They can, in fact, be separated and should be separated if they are to use the Guides, Chapter 14 properly. We would suggest that you hold fast on this requirement.

Here is the difficulty we see in the way these specific areas of ADL's are worded. It appears to us that you have too many ADL's associated with specific physical activities and not enough that fully reflect ADL's from a psychosocial point of view. ADL's typically are divided into basic ADL's (self care and basic activities), instrumental ADL's (financial responsibility, planning activities, shopping, travel) and some specialized ADL's (sexual activity and sleep), which can often be included among the basic ADL's. The current list on page 3 has very few instrumental ADL's and focuses too much on some very specific physical activities that are associated with ADL's from a physical disorder point of view, but not from a psychosocial point of view. We strongly suggest the following editing:

Self-care, personal hygiene (*---as stated on the form---)*
Communication (*expressive and receptive communication, ~~writing, typing, seeing, hearing, speaking)~~*
~~Physical Activity~~
~~Sensory Functions~~
~~Nonspecialized hand activities~~
Personal financial management
Planning one's day and making independent decisions about one's life
Identify one's needs and shopping for household necessities and groceries
Planning and preparing meals
Travelling independently, driving or using public transportation independently (DELETE REMAINDER: SUGGESTIONS ASSOCIATED WITH SPECIFIC TYPES OF DISORDERS SHOULD NOT BE ON THIS FORM – THAT'S THE PROFESSIONAL'S JOB.)
Sexual function (*---as stated on the form---)*
Sleep (*---as stated on the form---)*

The changes above create a much more appropriate listing of ADL's for use in the psychological context and also minimize overlap and misunderstanding.

Section III.3 – Concentration, Persistence and Pace. There is too much overlap to the current listing of functions. We would suggest a re-ordering and revision that would minimize overlap and relate more effectively to the purpose of this aspect of the assessment process:

Maintain focused attention and concentration on a specific task
Memory, immediate and remote
Ability to abstract or understand concepts
Basic problem solving
Perform simple, routine repetitive tasks
Persist, focus and work on tasks to completion
Maintain a work pace that is required for successful task completion

Section III.4 – Deterioration or Decompensation in Complex or Worklike Settings. This is a larger, conceptual issue. Many groups have misunderstood this area of functioning and have operationally defined it as a measure of whether someone can work or not. This apparently is the

focus of #4 on this worksheet. What this does is to transform it from a measure of impairment (an objective concept) to a measure of disability (a highly subjective, individualized concept). In actuality, all four of the functional areas combined provide guidance regarding someone's capacity to work (still subjective, however).

Here is a more effective description of functional area #4: *It reflects a repeated failure to adapt to stressful circumstances (particularly those in complex or work-like settings.) In the face of such circumstances the individual may withdraw from the situation or experience exacerbation of signs and symptoms of a mental disorder; that is, decompensate and have difficulty maintaining activities of daily living, continuing social relationships, and completing tasks.*

Analysis of this functional area is based on documentation of behavior or situations *that have occurred* in complex or worklike settings, and is not based solely on what the clinician believes will likely occur in the future based on information gained from psychological or psychiatric assessments and the characteristics of the DSM-IV-TR diagnosis. In addition, the evidence of deterioration or decompensation need not be derived from precisely comparable environments (e.g., the former work setting). Evidence of the person's experiences of deterioration or decompensation in other comparable complex or worklike settings that have increased the experience of stress may be adequate. This includes school, treatment settings, legal settings, and other formal, *complex* environments.

So, we are looking for evidence of sustained withdrawal, decompensation or deterioration *in reaction to* stressors experienced in these types of settings. If someone reacts negatively in one of these settings, takes time to collect themselves and is able to continue on, that is evidence of only a minimal to mild degree of impairment (most likely minimal). If they react and take hours or even days to recover, that is evidence of a mild to moderate degree of impairment. If they react and decompensate or deteriorate for a sustained period (1-2 weeks or more), that is evidence of moderate to marked impairment or above. It may be important to consider rating this area of function somewhat differently and require evidence of the type of decompensation or deterioration and the length of time it lasted.

We would suggest something such as this:

0 – No evidence of decompensation or deterioration in complex or work-like settings

1 – Evidence of minimal d&d in complex or work-like settings that required one hour or less to abate

2 – Evidence of mild d&d in complex or work-like settings that required less that one day to abate

3 – Evidence of moderate d&d in complex or work-like settings that required a few days to abate

4 – Evidence of marked d&d in complex or work-like settings that required 1 to 4 weeks to abate

5 – Evidence of extreme d&d in complex or work-like settings that required greater than 4 weeks to abate

6 – Evidence of maximum d&d in complex or work-like settings that has not abated following treatment an the passage of reasonable time

Please document the evidence that supports the above rating, reflecting the type and degree of decompensation or deterioration and the length of time it was experienced by the person:

We have never created a worksheet for this specific functional area, but the above reflects the way we approach it in our own assessment practice. It would require additional discussion and work, but an approach such as the one above is critical. The current worksheet methodology is not appropriate and will likely skew the results upward to higher levels of impairment that are not consistent with the intent of the Guides.

Question #2: Are there checks and balances in the Guides so that a person doesn't get rated twice for the same thing – i.e. some of the findings and ADL's for psych seem to possibly overlap with awards they may receive for other body parts – like a head injury, if there was one in the claim. Do the Guides prevent duplication? Does this worksheet adequately allow for the prevention of duplication?

There are some checks and balances built into the Guides. In order for them to be effective, however, they have to be expanded somewhat, clarified and spelled out in any tool such as the one Colorado uses and you intend to use. The current tool begins to clarify that issue (in the scoring instructions), but does not fully succeed.

One important point to address is consistent with your question – how can we be sure that limitations in ADL's, in particular, that may be rated in relation to another body system are not duplicated under Chapter 14 (mental and behavioral disorders). Another specific point is related to the difference in limitations in ADL's and interpersonal/social interactions that can be attributed to a traumatic brain injury (Chapter 4) as opposed to limitations that are directly related to a *separate and distinct* mental disorder ratable under Chapter 14.

- The first step is to be certain that the person's condition meets all of the specific criteria for a DSM-IV-TR diagnosis. We like #1 on page 1 for that reason. Here, however, is something to watch carefully. Many providers, particularly when they are working with someone in the worker's compensation system, identify diagnoses that sound like DSM-IV-TR diagnoses, but really aren't. *Examples: Chronic Pain Syndrome, depression, neurotic depression, situational depression, post-concussion disorder, mood disorder due to pain or work-related injury, anxiety disorder due to work-related injury, and so on.* While we like the first criterion, it is very important for claim adjudicators and others in the Nevada system to get the book out, check the numbers and make certain this is a valid diagnosis. Please don't assume anything.

- We like instruction #3 and may suggest a small addition to make sure it reflects what you are trying to say. Most professionals would agree that mental disorders really don't reach a point of true MMI, so different wording may be helpful. Our suggestion:

> 3. Determination of a rating of permanent mental or behavioral impairment shall be limited to mental or behavioral disorder impairments not likely to remit with further mental health treatments *and have reached a point of relative stability.*

- We like the wording of instruction #4 regarding chronic pain but suggest that you consider expanding this exclusion in a way that will truly clarify *what is and what is not* considered a ratable impairment associated with a mental disorder. We suggest an instruction similar to the following:

> 5. The specific impairments are limitations in functioning that are *caused by* the mental disorder or *complicated by* the mental disorder. A functional limitation that can be explained by: a) a physical disorder (e.g., mobility, strength, flexibility, ability to reach or grasp, ability to use transportation effectively, limitations due to physical pain or the perception of pain, etc.); b) a defined neurological impairment (a mental status or emotional/behavioral impairment rated under Chapter 4); or c) lack of opportunity to participate in behaviors or other intervening life circumstances (financial limitations that limit recreational or social pursuits, lack of vocational opportunities in the local economy, lack of skill to participate in a specific activity, etc.) *is not included as evidence of impairment.* When a mental disorder complicates or contributes in a defined manner to a physical impairment, the degree of impairment that can be attributed to the mental disorder is documented under Chapter 14.

We are somewhat ambivalent about the overall rating process used in the worksheet approach, but it is more of a minor professional difference than something truly substantive. Overall, it's a pretty solid approach that allows for *reproducibility*, which is one aspect of reliability that is essential for this type of rating and allows other professionals to review the rating process to ensure validity. We do have one additional suggestion about the scoring instructions that may help to increase the validity and appropriateness of ratings in this specific area. Scoring instruction 5.d.i. would benefit from rewording to soften a judgmental point of view and increase the expectation that the decisions are based on objective information. Here is our suggested rewording:

> 5.d.i. Factors influencing *the reliability and validity of the data upon which the impairment rating is based*, such as *indicators* of symptom magnification, *objective clinical observations,* or the presence or absence of corroborating information from *objective, standardized* psychological or neuropsychological testing;

(What this recommended editing does is change "patient believability" to "data reliability and validity", thereby softening the language and minimizing a potentially judgmental point of view. It also shifts the highly subjective concept of "clinical judgment" to an expectation of requiring the documentation of objective information. This moves away from the mysterious concept of justifying something based on "professional opinion" alone rather than relying on objective information. This will create an expectation that both psychiatrists and psychologists will document objective clinical signs of the mental disorder and associated impairment from their clinical interview and history. It will also create an expectation that information from standardized, objective psychometric instruments are the primary source of assessment information rather than transparent, subjective self-report instruments that are often problematic in medical legal settings.

The hearing was conducted on **February 16, 2010**, at two sites via videoconference: the main site was at the Sawyer Building in Las Vegas; the other site was at the Legislative Building in Carson City. In Las Vegas, **36** people attended and **13** testified; in Carson City, **15** attended and **5** testified. The pertinent oral testimony is presented as follows:

George Ross, NSIA: anybody who has any knowledge of what took place in California is very aware of the kind of abuse that can take place in a stress claim and the law as redrafted and passed was very careful to circumscribe and very clearly delineate that any stress claims result from a traumatic situation. Having said that it, they are very difficult to measure and to judge. And so our basic sense was that we wouldn't have agreed to that if we didn't realize that there were situations where people would legitimately have a problem. The problem is that we wanted to make sure that the opportunity to get that treatment was not abused and does not open a loophole that you could drive a train through. That it be used when it should be as the law describes and it should be done appropriately.

Section 7 of the regulations on page 78, we would like to make sure which specialties of physicians are eligible to provide ratings for mental and behavioral disorders.

In section 9, we believe that the WCS should include a requirement that psychiatrists and ophthalmologists pass a test established by the WCS as it pertains to ratings for impaired vision, brain function, or mental and behavioral disorders. They should not be exempt from a testing requirement, and we believe that the WCS has an obligation to ensure that rating physicians assigned by the agency understand the fifth edition of the AMA Guide in the rating process in general.

This will also help to ensure that physicians including psychiatrists, rating stress pursuant to claims except per NRS 616 C.180 understand the process of how to delineate between and apportion out non-industrial mental and behavioral impairments. We are definitely concerned that we could have some doubling up here of impairments. And we would like to know if the WCS has inquired as to whether testing is required for specialties to perform ratings in other states. We also had some concerns on page 96 about how the State is going to handle activities of daily living as it pertains to rating claims accepted pursuant to NRS 616C .180.

We did submit last summer some recommendations for modifications to the DIR proposed mental impairment rating worksheet, that suggestion was dated August 6, did refer back to prior ratings and to make sure to look at pre-existing and intervening injuries, diseases or conditions with a separate form to calculate a rating from those to be subtracted from the present impairment which would be judged. To make sure that we could look at different impairments that were already there as compared to new ones.

You are all probably familiar with Dr. Christopher Brigham. He is one of the editors of the AMA guide, fifth and sixth addition, our group consulted with Dr. Bingham and asked him for his opinion on how we might want to go forward as well.

(Reads excerpt from comments by Dr. Brigham). "The fifth edition does not identify a methodology to derive a numerical personal impairment from the categorical ratings. In fact, it indicates the following, translating these guidelines for rating individual impairment on ordinal skills into a method of assigning percentage of impairment as if valid estimates can be made on precisely measured interval can not be done reliably. It is therefore important, that the state of Nevada identifies and accepts a standardized analogous methodology that will direct the evaluators to a consistent and meaningful numeric impairment. Such analogous methodology does exist and can be taught to raters. The lack of clear direction makes the process of using Chapter 14, in either the fourth or fifth edition of the Guides, a very challenging undertaking. Inconsistency in the assessment approach results in inconsistent outcomes and a potential increase in disputed ratings. To increase both the clarity and consistency the following should occur 1) create a consistent understanding across clinicians who conduct a rating evaluation to focus on impairment evaluation for mental and behavioral disorders; 2) establish a consistent approach to the evaluation of current function; 3) develop a single standard analogous method to derive a numerical rating for mental and behavioral disorders."

He goes on to say that they have developed a way to do that. We hope that you do devise a training methodology and that you compose a test to ensure that those who people who are evaluating understand our laws and how it should be done in a rigorous and consistent manner.

There were **3** written comments submitted by the **March 8, 2010** deadline announced at the hearing. These comments are as follows:

Evan Beavers, Nevada Attorney for Injured Workers

NAC 616C.103(8) should include a requirement to provide the injured worker the calculation sheet identified in subsection (a) as D9(a) or D9(b).

Scott Forbes, DC

I feel that trained chiropractic physicians are equally capable of performing impairment ratings for psychological stress claims as other medical providers except for of course psychologists or psychiatrists.

Jennifer Kruger, NSIA

Senate Bill 195 (2009) revises provisions relating to stress claims. (pp. 78-98)

SB. 195 permitted claims for stress only in very narrow circumstances. In light of the rampant abuses regarding stress claims in California in prior years, NSIA regards it as imperative that DIR exercise the utmost care in developing and implementing regulations in this area. We recognize that in a few serious cases, traumatic stress does result, and we accept that such individuals deserve compensation. However, DIR must take every step possible to prevent approvals where they are not deserved and to prevent duplicate benefits in which multiple doctors rate the individual for the same disability. We make the following recommendations:

Sec 7. DIR should clearly identify what specialties of physicians are eligible to provide ratings for Mental and Behavioral Disorders.

Sec 9. Psychiatrists and ophthalmologists should pass a test established by the Workers' Compensation Section as it pertains to radings for impaired vision, brain function, or mental and behavioral disorders. They absolutely should not be exempted from a testing requirement. The WCS has an obligation to insure that rating physicians assigned by their agency understand the 5th Edition of the AMA Guides and the rating process in general. This requirement will also help insure that physicians including psychiatrists who rate stress pursuant to claims accepted per NRS 616C.180 understand the process of how to delineate between, and apportion out, non-industrial mental or behavioral impairments.

Worksheet Draft p. 98. On August 9, 2009, Tina Sanchez submitted by email to you and Mr. Wiles a recommended modification to DIR's proposed mental impairment rating worksheet. That modification is included with this letter as Attachment 1. This page explicitly provides a procedure to avoid rating duplication (and therefore both inadvertently or intentionally higher benefits than the regulations as carefully implemented would have permitted).

Mr. Ross included a lengthy quotation from a communication we receive from Dr. Christopher R. Bingham with regard to the difficulty of assessing and rating mental and behavioral impairment in a consistent manner and of translating that rating to a numerical scale. Dr. Bingham noted that a training program exists to overcome this problem. Rather than repeat Mr. Ross' excerpts from Dr. Bingham's communication here, we have attached his entire email to us as Attachment 2. We respectfully request that you take his discussion very seriously; improper implementation of this new provision would constitute a most serious threat to Nevada's equitable and balanced privatized workers' compensation system.

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 Division did not substantially change the wording of the proposed regulations. The suggestions provided by the oral testimony during the workshop and hearing and the written comments submitted by the announced deadline helped solidify the choice of a stress calculation worksheet based on a model used in Colorado that appears to avoid many of the pitfalls noted in oral and written testimony. Other regulation language remained unchanged because it is required to reflect the Workers' Compensation Section's current name and the addition of stress as a permanent partial disability rating factor, including using psychiatrists to evaluate mental or behavioral disorders.

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 there is an adverse economic effect of the regulations on regulated businesses, in the long-term, as insurers that pay permanent partial disability claims must now include another disability factor for compensation.

Beneficial: The Division believes that there are beneficial effects, in the long-term, for disabled employees who suffer from long-term stress as defined by NRS 616C.180.

The regulations also do not impose 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 costs of the enforcing and administering this regulation will be minimal.

6. A description of any regulations of other state or government agencies, which 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 state, federal or other government 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.

There is no federal regulation that regulates the same activity.

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 ongoing new fees or an increase in existing fees.