PROPOSED REGULATION OF THE DIVISION OF

INDUSTRIAL RELATIONS OF THE DEPARTMENT OF

BUSINESS AND INDUSTRY

LCB File No. R006-97

August 4, 1997

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

AUTHORITY: NRS 616A.400, 616C.260, 616C.490, 616C.555 AND 616C.575.

Section 1. NAC 616A.410 is hereby amended to read as follows:

616A.410 If the [chief] *administrator* or his designated agent requests information in writing from *an employer,* an insurer, *a third-party administrator, an organization for managed care or a provider of health care,* the [insurer shall respond] *person from whom the information is requested shall, except as otherwise provided in NRS 616A.480 or specified in the request, ensure that the response to the request is received by the administrator or his designated agent* within 30 days after receipt of the [written] request.

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

616A.430 A brief explanation of the procedure for obtaining clarification of NAC 616A.420, 616B.457, 616C.091, 616C.094, 616C.182 to 616C.218, inclusive, 616C.423, 616C.447 or 616C.502, *or section 3 of this regulation,* or relief from the strict application

of any of their terms may be obtained from the Division of Industrial Relations, 400 West King Street, Suite 400, Carson City, Nevada 89710.

Sec. 3. Chapter 616B of NAC is hereby amended by adding thereto a new section to read as follows:

1. On claims where an award is offered for a permanent partial disability, each association shall complete for each injured employee's file and submit to the nearest office of the industrial insurance regulation section on or before the last day of each month:

(a) A report on the evaluation of a permanent partial disability by a rating physician or chiropractor;

(b) A copy of the letter offering the award to the injured employee;

(c) Documentation of payments of the award made to the injured employee; and

(d) The following forms:

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

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

(3) D-9(a), PPD Award Calculation Worksheet, or D-9(b), PPD Award Calculation Worksheet for Disability Over 25 Percent Body Basis, as appropriate.

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

2. On or before September 30 of each year, or as requested by the administrator or his designated agent, the insurer shall file a report with the administrator or his designated agent that contains the following information:

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

(1) The number of new claims filed.

(2) The number of claims accepted for accident benefits only.

(3) The number of claims accepted for benefits for lost time.

(4) The number of compensable fatalities.

(5) The number of claims denied.

(b) For claims for an occupational disease:

(1) The number of new claims filed.

(2) The number of claims accepted for medical benefits only.

(3) The number of claims accepted for benefits for lost time.

(4) The number of compensable fatalities.

(5) The number of claims denied.

(c) The number of requests to reopen a claim.

(d) The number of claims reopened for accident benefits only.

(e) The number of claims reopened for benefits for lost time only.

(f) The number of injured employees paid benefits for a permanent partial disability.

(g) The number of injured employees paid benefits for a permanent partial disability in a lump sum.

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

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

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

(k) Expenditures on claims for:

(1) A temporary total disability.

(2) A temporary partial disability.

(3) A permanent total disability.

(4) A permanent partial disability.

(5) Benefits for survivors.

(6) Burial expenses.

(7) Travel and per diem expenses.

(8) All medical expenses.

(9) Vocational rehabilitation, categorized by expenditures for:

(I) Vocational rehabilitation maintenance.

(II) The payment of compensation in a lump sum.

(III) Program expenses.

(IV) Administrative expenses.

(V) Other purposes.

(l) Amounts recovered:

(1) Through subrogation.

(2) From the subsequent injury fund for associations of self-insured public or private employers.

(3) From other sources.

(m) Any other information requested by the administrator or his designated agent.

3. The information required pursuant to subsection 2 must, except as otherwise requested by the administrator or his designated agent, include information regarding any administrative activity during the prior fiscal year relating to:

(a) A claim for an injury that occurred during that year; and

(b) Any other claims, regardless of when the injury occurred.

4. Upon request by the administrator or his designated agent, each insurer shall submit to the administrator or his designated agent copies of any form used by the insurer in the administration of its claims for workers' compensation in this state.

Sec. 4. NAC 616B.457 is hereby amended to read as follows:

616B.457 1. On claims where an award is offered **[**,**]** *for a permanent partial disability,* each self-insured employer shall *complete for each injured employee's file and* submit **[**the following completed forms for each claimant's file**]** to the nearest office of the industrial insurance regulation section on or before the last day of each month:

(a) **[**Wage verification;

(b) Wage calculation;

(c) Evaluation**]** *A report on the evaluation* of a permanent partial disability by a rating physician **[**;

(d) Election and method of payment;

(e) Worksheet for evaluation of a permanent partial disability; and

(f) Option letter to the claimant.

2. When a determination has been made to deny a claim, the insurer shall submit a copy of the letter of denial together with supporting documentation to the chief. The documentation must include, where applicable, copies of the employer's first report, the physician's or chiropractor's first report and any other supporting data upon which the denial was based.

3.] *or chiropractor;*

(b) A copy of the letter offering the award to the injured employee;

(c) Documentation of payments of the award made to the injured employee; and

(d) The following forms:

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

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

(3) D-9(a), PPD Award Calculation Worksheet, or D-9(b), PPD Award Calculation Worksheet for Disability Over 25 Percent Body Basis, as appropriate.

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

2. On or before September 30 of each year, or as requested by the [chief,] *administrator or his designated agent,* the insurer shall file a report with the [chief] *administrator or his designated agent* which contains the following information:

(a) [Number of industrial claims filed;

(b) Number of claims accepted;

(c) Number of claims which included lost time;

(d) Number of claims of occupational disease;

(e) Number of injured employees who were offered vocational rehabilitation services;

(f) Number of claimants who were offered awards for a permanent partial disability;

(g) Total amount of payments made on behalf of injured employees during the fiscal year;

(h) Total dollar amount of payments made on behalf of injured employees during the fiscal year; and

(i) Number of active claims.

4. The report must include:

(a) Information required by paragraphs (a) to (d), inclusive, of subsection 3, for the prior fiscal year; and

(b) Data required by paragraphs (e) to (i), inclusive, of subsection 3, which was not previously reported for each year for which the insurer provided coverage.

5.] *For claims other than claims for an occupational disease:*

(1) The number of new claims filed.

(2) The number of claims accepted for accident benefits only.

(3) The number of claims accepted for benefits for lost time.

(4) The number of compensable fatalities.

(5) The number of claims denied.

(b) For claims for an occupational disease:

(1) The number of new claims filed.

(2) The number of claims accepted for medical benefits only.

(3) The number of claims accepted for benefits for lost time.

(4) The number of compensable fatalities.

(5) The number of claims denied.

(c) The number of requests to reopen a claim.

(d) The number of claims reopened for accident benefits only.

(e) The number of claims reopened for benefits for lost time only.

(f) The number of injured employees paid benefits for a permanent partial disability.

(g) The number of injured employees paid benefits for a permanent partial disability in a lump sum.

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

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

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

(k) Expenditures on claims for:

(1) A temporary total disability.

(2) A temporary partial disability.

(3) A permanent total disability.

(4) A permanent partial disability.

(5) Benefits for survivors.

(6) Burial expenses.

(7) Travel and per diem expenses.

(8) All medical expenses.

(9) Vocational rehabilitation, categorized by expenditures for:

(I) Vocational rehabilitation maintenance.

(II) The payment of compensation in a lump sum.

(III) Program expenses.

(IV) Administrative expenses.

(V) Other purposes.

(l) Amounts recovered:

(1) Through subrogation.

(2) From the subsequent injury fund for self-insured employers.

(3) From other sources.

(m) Any other information requested by the administrator or his designated agent.

3. The information required pursuant to subsection 2 must, except as otherwise requested by the administrator or his designated agent, include information regarding any administrative activity during the prior fiscal year relating to:

(a) A claim for an injury that occurred during that year; and

(b) Any other claims, regardless of when the injury occurred.

4. Upon request by the [chief,] *administrator or his designated agent,* each insurer shall submit to the [chief] *administrator or his designated agent* copies of any form used by the insurer in the administration of [his] *its* claims for [workmen's] *workers'* compensation in [Nevada.] *this state.*

Sec. 5. NAC 616B.510 is hereby amended to read as follows:

616B.510 As used in NAC 616B.510 to 616B.612, inclusive, *and section 3 of this regulation,* unless the context otherwise requires, the words and terms defined in NAC 616B.513 to 616B.522, inclusive, have the meanings ascribed to them in those sections.

Sec. 6. Chapter 616C of NAC is hereby amended by adding thereto a new section to read as follows:

1. If an insurer or third-party administrator determines that an injured employee is eligible for vocational rehabilitation services, the insurer or third-party administrator shall submit a written plan for a program of vocational rehabilitation to the treating or examining physician or chiropractor within 60 days after making that determination.

2. A treating or examining physician or chiropractor shall, within 10 days after receiving a plan submitted pursuant to subsection 1, provide the vocational rehabilitation counselor with a written determination of whether the injured employee is capable of safely participating in the program.

3. A plan for a program of vocational rehabilitation must be approved in writing by the treating or examining physician or chiropractor before the program may be commenced.

Sec. 7. NAC 616C.003 is hereby amended to read as follows:

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

1. Are licensed under chapter 630, 633 [,] or 634 of NRS;

2. Have demonstrated special competence and interest in industrial health;

3. Are in good standing [within their respective professional groups in Nevada and] with the state regulatory bodies respectively charged with overseeing their licensing, practice and performance;

4. Have not lost staff privileges at any hospital on the basis of reviews conducted by their peers concerning the quality of care they have provided; *and*

5. [Have not been disciplined or placed on probation by the board of medical examiners, Nevada state board of chiropractic examiners or state board of osteopathic medicine; and

6.] Have not been suspended or removed from the panel of physicians and chiropractors by the [chief.] *administrator or his designated agent.*

Sec. 8. NAC 616C.006 is hereby amended to read as follows:

616C.006 The [chief will remove] *administrator or his designated agent may issue a warning to* a physician or chiropractor [from] *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 [board of medical examiners,] *applicable licensing authority,* representatives of Medicare or Medicaid, or a hospital for fraud, abuse [,] or the quality of care provided.

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

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

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

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

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

9. **[**Violation**]** *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. **[**Failure to report industrial injuries pursuant to NRS 616.345.**]** *Engaging in any action that the administrator or his designated agent determines to be detrimental to an injured employee, an employer, an insurer or the program of industrial insurance.*

Sec. 9. NAC 616C.009 is hereby amended to read as follows:

616C.009 1. The **[**chief**]** *administrator or his designated agent* may remove for cause any physician or chiropractor from the panel upon 30 days' written notice.

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

Sec. 10. NAC 616C.012 is hereby amended to read as follows:

616C.012 [1. The chief shall immediately] *The administrator or his designated agent will:*

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

2. [The employers will be requested] *Request the insurers, third-party administrators and organizations for managed care* to advise [their] *employers and* employees *, as appropriate,* that the [practitioner] *physician or chiropractor* is not authorized to treat cases for [workmen's] *workers'* compensation.

Sec. 11. NAC 616C.018 is hereby amended to read as follows:

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

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

Sec. 12. NAC 616C.027 is hereby amended to read as follows:

616C.027 1. A provider of health care whose bill has been reduced or disallowed may *, within 60 days after receiving notice of the reduction or disallowance,* submit a

written request to the industrial insurance regulation section for a review of that action. The request must identify the billed item for which the review is sought and state the ground upon which the request is based. The industrial insurance regulation section will review the matter, 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 10 days after receiving notice of the determination,* pay him the amount ordered by the industrial insurance regulation section, unless an appeal is taken in the manner provided by subsection 2.

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

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

Sec. 13. NAC 616C.030 is hereby amended to read as follows:

616C.030 Upon the receipt of a request from an injured employee or his representative, an employer, *an* insurer, [or] *a* third-party administrator *or an 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.

Sec. 14. NAC 616C.091 is hereby amended to read as follows:

616C.091 1. After receipt of [notice of an injury, if it is the insurer's intention to deny responsibility for compensation,] *a claim for compensation,* the insurer shall give *written* notice of its [intention, in writing, to the claimant] *determination to accept or deny the claim to the injured employee* or his dependents [. Unless an extension of time is granted pursuant to NRS 616C.015 and NAC 616C.100, the] *and, if his employer is not self-insured, to his employer. The* notice must be given within the time prescribed in [subsection 7 of NRS 616C.015.

2. If the insurer's decision is a rejection of a claim or a denial of a request or a benefit, the insurer shall include with the notice of its decision a] *NRS 616C.060. If the insurer denies the claim:*

(a) The notice must include:

(1) A written statement of the right [of the claimant or his dependents] to request a hearing on the matter before a hearing officer and a form for requesting a hearing.

[3. The written notice denying the claim or benefit must include the]

(2) The reasons for the denial.

(b) The insurer shall provide a copy of the notice to the injured employee's treating physician or chiropractor.

Sec. 15. NAC 616C.094 is hereby amended to read as follows:

616C.094 1. Except as otherwise provided in this section, within 30 days after receipt of a request relating to a claim made by:

(a) **[**A claimant, his attorney, or representative; or

(b) If the claimant**]** *An injured employee, an employer, a health care provider or the attorney or other representative of any of them; or*

(b) A spouse, child or parent of an injured employee who is deceased or incapacitated, **[**his spouse, child, or parent,**]**

the insurer *or organization for managed care* shall notify the person making the request of its determination concerning the request.

2. **[**If a request requires the insurer to conduct a medical investigation of the claim and the insurer concludes that it will be unable to comply with the provisions of subsection 1 within the time required by that subsection, the insurer shall file a written application with the chief for an extension of time. The application must:

(a) Be filed with the chief before the expiration of the time otherwise permitted for compliance with the requirements of subsection 1;

(b) Be made on a form prescribed by the chief;

(c) State the amount of additional time sought; and

(d) Set forth in detail the factual basis for the requested extension.

A copy of the application must be mailed to the person making the request within 14 days after the date the application is filed with the chief. The maximum extension of time that will be granted pursuant to this subsection is 30 days after the last date otherwise permitted for compliance with the requirements of subsection 1.

3. An insurer who has received an extension of time pursuant to subsection 2 may apply to the chief for an additional extension of time. The application must:

(a) Be filed with the chief before the expiration of the time allowed by the initial extension of time;

(b) Be accompanied by the written consent of the person making the request, stating that he has no objection to the additional extension of time; and

(c) Comply with the requirements of paragraphs (b), (c), and (d) of subsection 2.

4. The maximum extension of time that will be granted pursuant to this section is 60 days, in total, after the date the insurer files its initial application for an extension of time. The chief will deny an application for an extension of time if:

(a) The insurer fails to comply with any requirement of subsection 2 or 3, whichever applies; or

(b) The chief determines that the application is the result of delay by the insurer in investigating the claim.

5. Within 14 days after it receives notice of the decision of the chief concerning its application for an extension of time, the insurer shall mail or deliver written notice of the decision to the person making the request.

6.] If the insurer terminates or denies any benefit or refuses to reopen a claim in response to a request, it shall notify the person making the request, in writing, giving the reasons for its determination and an explanation of the person's right to appeal.

Sec. 16. NAC 616C.112 is hereby amended to read as follows:

616C.112 1. When the insurer determines that the [claimant] *injured employee* has received all benefits known to be due him, the insurer shall *, if the claim does not close automatically pursuant to subsection 2 of NRS 616C.235,* close its file concerning him and notify him *in writing* of the closing.

2. The notice of closing must include:

(a) The provisions of subsection 2 of NRS 616C.390; and

(b) An offer to the [claimant] *injured employee* of an opportunity for him to appeal from the insurer's [decision to close his file.] *determination pursuant to subsection 1.*

Sec. 17. NAC 616C.144 is hereby amended to read as follows:

616C.144 1. Billings for health care services must be submitted within 90 days after the date on which the services were rendered unless good cause is shown for a later billing. [If good cause is shown, no] *In no event may an initial* billing for health care services [may] be submitted later than 6 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 patient 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.

3. The insurer or a representative of the insurer may require the submission of reports on the patient'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.

[3. The]

4. If an insurer:

(a) Has not entered into a contract with another entity to revise the charges contained in a bill, the insurer must pay or deny *the* payment of charges within 60 days after receipt of the first bill for those charges unless good cause is shown for a later payment or denial.

[4. A bill that is submitted to an organization for managed care]

(b) Has entered into a contract with another entity to revise the charges contained [therein must be processed and delivered] *in a bill:*

(1) That entity must process and deliver the bill to the insurer within 30 days after the bill is received.

(2) The insurer must pay or deny the payment of charges within 30 days after receipt of the bill from that entity unless good cause is shown for a later payment or denial.

5. A bill that is submitted for reconsideration must be [received] *:*

(a) Received by the insurer or a person authorized by the insurer to receive such a bill no later than 6 months after the date on which the services were rendered, unless good cause is shown.

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

6. The insurer shall:

(a) Provide an explanation of benefits for each code billed with its payment that includes the amounts for services that are paid and disallowed; and

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

Sec. 18. NAC 616C.185 is hereby amended to read as follows:

616C.185 A report submitted pursuant to NAC 616C.170 to 616C.230, inclusive, must include:

1. The complete **[**medical**]** history of the *health of the* patient;

2. A description of **[**the objective and subjective results of any evaluation or test conducted of the patient;**]** *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 **[**established goals and**]** plans for the treatment of the **[**patient;

4. A description of the condition of the patient at the time covered by the report; and

5.**]** *injured employee; and*

6. In the case of a report relating to a final or discharge evaluation, a statement of the [patient's prognosis.] *health of the injured employee, including the likelihood of a ratable impairment.*

Sec. 19. NAC 616C.550 is hereby amended to read as follows:

616C.550 As used in NAC 616C.553 to 616C.610, inclusive, *and section 6 of this regulation,* unless the context otherwise requires:

1. "Employer" means the employer for whom an employee worked when the employee:

(a) Sustained an injury arising out of and in the course of his employment; or

(b) Was last exposed to the conditions resulting in an occupational disease,

for which the employee requires vocational rehabilitation services.

2. "Vocational rehabilitation maintenance" has the meaning ascribed to it in NRS 616C.575.

3. "Vocational rehabilitation services" may include:

(a) Counseling and guidance by a vocational rehabilitation counselor.

(b) An evaluation of the functional capacity of the injured employee and medical consultations to determine his level of participation in a program of vocational rehabilitation.

(c) Ergonomic modifications, lifting devices [,] and other reasonable accommodations approved by the insurer which would enhance the employability of the injured employee.

(d) Assistance in job placement by vocational rehabilitation counselors, with special consideration given to fitting the requirements of the job to the ability of the injured employee.

(e) Vocational testing.

(f) Programs of vocational rehabilitation.

(g) Vocational rehabilitation maintenance.

(h) A reasonable allowance for transportation.

(i) The payment of compensation in a lump sum in lieu of the provision of vocational rehabilitation services.

Sec. 20. NAC 616C.553 is hereby amended to read as follows:

616C.553 *1. If, based upon the opinion of a treating or an examining physician or chiropractor, a vocational rehabilitation counselor determines that an injured employee is not eligible for vocational rehabilitation services, the counselor shall, within 10 days after he receives that opinion, provide a copy of the opinion to the injured employee and his attorney or other representative, the employer and the insurer.*

2. If, **[**on the basis of**]** *based upon* the opinion of a consulting physician or chiropractor, an insurer finds that an injured employee is not eligible for vocational rehabilitation services, the insurer shall provide a copy of the opinion to the treating physician or chiropractor.

Sec. 21. NAC 616C.556 is hereby amended to read as follows:

616C.556 *1. A vocational rehabilitation counselor shall, within 10 days after receiving a written assignment of a case from an insurer or third-party administrator, notify:*

(a) The injured employee of the assignment; and

(b) The injured employee's treating physician or chiropractor, unless the pertinent medical information has already been provided to the vocational rehabilitation counselor.

2. A written assessment developed pursuant to NRS 616C.550 must include a document that contains a description of:

[1.**]** *(a)* The nature and scope of the vocational rehabilitation benefits that the injured employee is eligible to receive;

[2.**]** *(b)* The priorities for returning the injured employee to work;

[3.**]** *(c)* Any temporary or permanent physical limitations of the injured employee; and

[4.**]** *(d)* The process for obtaining vocational rehabilitation services.

Sec. 22. NAC 616C.568 is hereby amended to read as follows:

616C.568 1. Except as otherwise provided in NRS 616C.580, an insurer shall pay the expenses incurred by an injured employee for relocating as part of a program of vocational rehabilitation if the insurer determines that the injured employee does not have a reasonable prospect of obtaining employment in the current labor market of the area of this state where the injured employee resides, considering the *:*

(a) Occupational aptitudes *of the injured employee as determined by the vocational rehabilitation counselor;* and **[**physical**]**

(b) Physical limitations of the injured employee as established by the medically objective findings of the treating physician or chiropractor.

2. The injured employee must decide whether to relocate within 30 days after the date on which he is notified by the insurer that he does not have a reasonable prospect of obtaining employment in the current labor market of the area in which he resides. If the injured employee decides to relocate, the insurer shall give the employee 30 days in which to relocate, commencing on the date on which the employee informed the insurer of his decision to relocate.

3. Except as otherwise provided in subsection 4, expenses incurred by an injured employee who has relocated as part of a program of vocational rehabilitation may include the costs of:

(a) Connections for a telephone, gas **[**,**]** and electricity;

(b) Rent for the first month;

(c) Security deposits;

(d) Utility deposits; and

(e) Assistance with moving, limited to the costs associated with:

(1) Moving not more than 10,000 pounds of household items;

(2) Driving one motor vehicle to the new location; and

(3) Renting a moving van and hiring persons to assist with loading and unloading the moving van.

The costs of using a moving company may only be included as expenses incurred for relocation if it is not feasible for the injured employee to rent a van and hire persons to assist with loading and unloading the van.

4. Expenses incurred for relocation may not include:

(a) Security deposits for pets;

(b) The cost of connections for cable television;

(c) The expenses for moving and installing a satellite for television;

(d) The expenses for moving livestock or pets; and

(e) The expenses for moving mobile homes or motor vehicles.

5. An insurer shall not pay an injured employee's expenses for relocation more than once per claim.

Sec. 23. Chapter 616D of NAC is hereby amended by adding thereto a new section to read as follows:

As used in NAC 616D.010 to 616D.060, inclusive, unless the context otherwise requires, "administrator" means the administrator or a person designated by him to conduct a hearing.

Sec. 24. NAC 616D.010 is hereby amended to read as follows:

616D.010 At any hearing, an insurer *,* [or] employer or [counsel, or claimant] *injured employee,* or counsel for [the chief] *any of them or the administrator,* may:

1. Call and examine witnesses;

2. Introduce into evidence written exhibits relevant to the issues to be decided;

3. Cross-examine opposing witnesses on any matter relevant to the issues of the case; and

4. Submit written legal arguments.

Sec. 25. NAC 616D.020 is hereby amended to read as follows:

616D.020 1. An insurer or employer may be represented in any proceeding before the **[**chief**]** *administrator* by a corporate officer, employee or other authorized representative.

2. **[**The chief may appoint the Nevada attorney for injured workers' office to represent a claimant whose employment is under NRS 616.255 or 616.256.

3.**]** Any attorney appearing on behalf of a party in a proceeding before the **[**chief**]** *administrator* must be licensed to practice law before all the courts of this state.

Sec. 26. NAC 616D.030 is hereby amended to read as follows:

616D.030 A hearing before the **[**chief**]** *administrator* may be continued by the **[**chief**]** *administrator* upon:

1. His own motion for good cause;

2. The written stipulation of the parties to the proceeding if written approval is given by the **[**chief**]** *administrator* and the continuance is obtained not less than 5 days before the scheduled hearing; or

3. An affidavit showing good cause filed by a party to the proceeding not less than 5 days before the scheduled hearing.

Sec. 27. NAC 616D.040 is hereby amended to read as follows:

616D.040 1. Within the times prescribed in subsection 2, each party shall file with the **[**chief**]** *administrator* and serve upon all other parties:

(a) All documents to be introduced as evidence at the hearing;

(b) A statement of the issues to be raised;

(c) A list of witnesses, a brief summary of proposed testimony and a statement indicating whether any of the testimony is to be taken by use of the telephone; and

(d) An estimate of the length of time required to present the case, including rebuttal testimony and argument.

2. The materials required by subsection 1 must be filed:

(a) By the appellant, at least 14 days before the scheduled hearing.

(b) By a respondent, at least 7 days before the scheduled hearing.

3. The **[**chief**]** *administrator* may upon his own motion file a statement of position.

Sec. 28. NAC 616D.050 is hereby amended to read as follows:

616D.050 At a hearing before the **[**chief,**]** *administrator,* any relevant *testimony or other* evidence may be admitted, except where precluded by law, if it is reasonably reliable.

Sec. 29. NAC 616D.060 is hereby amended to read as follows:

616D.060 If, after a hearing, the **[**chief**]** *administrator* determines that the insurer *, third-party administrator, organization for managed care, provider of health care* or employer has committed the alleged violation, the **[**chief**]** *administrator* will:

1. Prepare written findings of fact and conclusions of law;

2. Give notice [to the insurer or employer of his] *of the* right to [appeal;] *file a petition for judicial review within 30 days after service of the decision;* and

3. Cause a copy of the findings of fact and conclusions of law to be served upon the insurer *, third-party administrator, organization for managed care, provider of health care* or employer by certified mail.

Sec. 30. NAC 616C.100 is hereby repealed.

TEXT OF REPEALED SECTION

616C.100 Requests for extensions of time: Form; contents; denial; notice of decision.

1. A request for an extension of time made by an insurer pursuant to subsection 7 of NRS 616C.015 must:

(a) Be made on a form approved by the chief; and

(b) State the reason for and length of the requested extension.

A copy of the request must be mailed or delivered to the claimant.

2. A further extension of time, in addition to an extension granted pursuant to subsection 1, may be granted if a request is made as provided in this subsection. In addition

to complying with the requirements of subsection 1, a request for an additional extension of time must be accompanied by:

(a) A copy of any documents provided by the insurer to the claimant in connection with the request; and

(b) The written consent of the claimant to the granting of the request.

3. The chief will deny a request for an extension of time if he determines that the request is the result of:

(a) Delay by the insurer in investigating the claim; or

(b) Failure by the employer of the claimant to submit to the insurer any information it requires to complete its investigation of the claim.

4. Within 14 days after it receives notice of the decision of the chief concerning its request for an extension of time, the insurer shall mail or deliver to the claimant written notice of the decision. The requirements of this subsection are satisfied if the insurer:

(a) Furnishes the claimant with a copy of the request, as processed by the industrial insurance regulation section; and

(b) Notes in its file relating to the claim that such a copy has been furnished.

5. A request for an extension of time governed by this section must be made before the expiration of the time provided by subsection 7 of NRS 616C.015 for compliance with the provisions of that subsection. A request for an additional extension of time must be made before the expiration of the initial extension of time.