LCB File No. R112-98

PROPOSED REGULATION OF THE DIVISION OF INDUSTRIAL RELATIONS

STATE OF NEVADA
DEPARTMENT OF BUSINESS AND INDUSTRY
INDUSTRIAL INSURANCE REGULATION SECTION

In the matter of adoption, amendment and repeal of Regulations pertaining to:

Private Carriers, Proof of Coverage, Private Carrier's Subsequent Injury Fund, and other changes to Chapter 616B of the Nevada Administrative Code.

DIR 98-15
LCB: R112-98

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NAC 616B.023 **Value of meal as wages.**[1] Effective 7/1/99.

For the purpose of determining the average monthly wage used in the calculation of disability compensation, the reasonable value of a meal furnished by an employer to an employee is the value, if any, specified in the collective bargaining agreement between the employee and the employer. Meals will be valued by the cost to the employer per meal for the purposes of determining payroll.

NAC 616B.029 **Report of change in ownership of business**.

An employer covered by a policy for [workmen's] *workers'* compensation shall immediately report to [the system] *its insurer* any change in the ownership of the ongoing business.

SELF-INSURED EMPLOYERS

NAC 616B.400 **Purpose.**

The purpose of NAC 616B.403 to 616B.496, inclusive, is to set forth:

1. The standards and procedures of the commissioner of insurance for certifying self-insured employers; and

[1] SIIS proposes to sunset this regulation 6/30/99; DIR has not made any changes to the regulation's actual language but believes the definition should remain in the regulation.

2. The administrator's [and chief's][2] regulations governing the operation of self-insured employers' programs for providing worker's compensation, to provide adequate protection for the self-insured employers, their employees and the State of Nevada.

NAC 616B.448 **Administration of self-insurance by employer or independent contractor.**

1. A self-insured employer shall at all times maintain adequate resources for the administration of his program of self-insurance. After his program is established, the adequacy of his resources and his standards of performance for his program will be evaluated by the commissioner and the [chief] *administrator or his designated agent* on the basis of:

(a) His promptness in filing reports of accidents and occupational disease;

(b) His promptness in making first payments in cases of uncontested claims;

(c) The percentage of contested claims;

(d) The number of claimants who are reemployed or rehabilitated; and

(e) The delay between the [cutoff] *termination*[3] of compensation for temporary disabilities and the payment of compensation for permanent partial disabilities.

2. A self-insured employer may contract with another person or entity for the administration of his program of self-insurance. The acts of a person or entity in carrying out the administration shall be deemed the acts of the self-insured employer for the purposes of NAC 616B.400 to 616B.496, inclusive, *and NRS 616D.120*, and the self-insured employer is at all times responsible for compliance with chapters 616A to 618, inclusive of NRS unless specifically excepted by the provisions on self-insurance in those chapters.

3. The self-insured employer shall inform the commissioner and the [chief] *administrator or his designated agent* of the names, titles and office addresses of the persons or entity with whom he contracts to administer his program of self-insurance and the location or locations of the records required to be kept under NAC 616B.424 to 616B.496, inclusive. Before any change is made in the name, title or address of a person or entity administering the employer's program or any change is made in the location of records, the intended change must be reported in writing to the commissioner and the [chief] *administrator or his designated agent*.

4. [No self-insured employer's program of workmen's compensation may be administered from a location outside Nevada.] *A self-insured employer shall not administer a program of self-insurance from a location outside this state*.[4]

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[2] It is DIR's intention to replace "chief" with "administrator" each time it is used in NAC 616C. Please make that change in any other NAC 616C regulations.

[3] NAC 616B.558, for Associations, uses "termination" rather than "cutoff."

[4] Change is similar to language in NAC 616B.558(4).

NAC 616B.454 **Inspection and location of files for claims and other records.**[5]

1. All claim files, together with all records maintained by self-insured employers pursuant to chapters 616A to 616D, inclusive, *and 617,* of NRS or NAC 616B.424 to 616B.496, inclusive, must be kept readily available for inspection by the commissioner or [chief] *administrator,* or his representative, during normal business hours.

2. All claim files must be kept, maintained and administered in Nevada.

3. After reviewing a claim file, the commissioner or [chief] *administrator* will report his findings to the insurer.

NAC 616B.457 **Reports of claims.**[6]

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

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

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

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

(d) Any administrative or court orders modifying the wage calculation for the injured employee; and

(e) The following forms:

(1) D-5, Wage Calculation Form for Claims 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, or *D-10(b), Election of Method of Payment of Compensation for Disability Greater than 25%, as appropriate*.

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

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

(1) The number of new claims filed.

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

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[5] NAC 616B.454 is similar to NAC 616B.561 which applies to associations of self-insured employers. DIR is also proposing a similar regulation to apply to SIIS and private carriers, effective 1999. If LCB would like to combine these regulations to a "generic" one applying to all insurers, that is acceptable.

[6] NAC 616B.457 is similar to NAC 616B.562 which applies to associations of self-insured employers. DIR is also proposing a similar regulation to apply to SIIS and private carriers, effective 1999. If LCB would like to combine these regulations to a "generic" one applying to all insurers, that is acceptable.

(3) The number of claims accepted for benefits for lost time.
(4) The number of compensable fatalities.
(5) The number of claims denied.

(b) For claims for an occupational disease:
(1) The number of new claims filed.
(2) The number of claims accepted for medical benefits only.
(3) The number of claims accepted for benefits for lost time.
(4) The number of compensable fatalities.
(5) The number of claims denied.

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

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

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

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

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

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

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

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

(k) Expenditures on claims for:
(1) A temporary total disability.
(2) A temporary partial disability.
(3) A permanent total disability.
(4) A permanent partial disability.
(5) Benefits for survivors.
(6) Burial expenses.
(7) Travel and per diem expenses.
(8) All medical expenses.
(9) Vocational rehabilitation, categorized by expenditures for:
(I) Vocational rehabilitation maintenance.
(II) The payment of compensation in a lump sum in lieu of vocational rehabilitation services.
(III) Program expenses.
(IV) Administrative expenses.
(V) Other purposes.

(l) Amounts recovered:
(1) Through subrogation.
(2) From the subsequent injury fund for self-insured employers.
(3) From other sources.

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

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

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

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

4. Upon request by the administrator or his designated agent, each 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.

NAC 616B.457 **Reports of claims.** Effective 7/1/99.

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

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

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

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

(d) Any administrative or court orders modifying the wage calculation for the injured employee; and

(e) The following forms:

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

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

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

(4) D-10(a), Election of Method of Payment of Compensation, or D-10(b), Election of Method of Payment of Compensation for Disability Greater than 25% as appropriate.

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

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

(1) The number of new claims filed.

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

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

(4) The number of compensable fatalities.

(5) The number of claims denied.

(b) For claims for an occupational disease:

(1) The number of new claims filed.

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

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

(4) The number of compensable fatalities.

(5) The number of claims denied.

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

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

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

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

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

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

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

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

(k) Expenditures on claims for:

(1) A temporary total disability.

(2) A temporary partial disability.

(3) A permanent total disability.

(4) A permanent partial disability.

(5) Benefits for survivors.

(6) Burial expenses.

(7) Travel and per diem expenses.

(8) All medical expenses.

(9) Vocational rehabilitation, categorized by expenditures for:

(I) Vocational rehabilitation maintenance.

(II) The payment of compensation in a lump sum in lieu of vocational rehabilitation services.

(III) Program expenses.

(IV) Administrative expenses.

(V) Other purposes.

(l) Amounts recovered:

(1) Through subrogation.

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

(3) From other sources.

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

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

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

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

4. Upon request by the administrator or his designated agent, each 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.

NAC 616B.466 **Notice to [chief] *administrator* of accident or occupational disease.**[7]

1. Within 30 days after an insurer receives notice of an accident or occupational disease, he shall notify the [chief] *administrator* if the accident resulted in injury to, or the disease affected or is expected to affect, two or more persons.

[7] This regulation is found in the self-insured employer♦ portion of the regulations; the language uses the broader term "insurer" rather than "self-insured employer." It is DIR's intention that this section apply to self-insured employers, associations, and the system, and in 1999, to private carriers

2. Within 48 hours after an insurer receives notice, in any form, of an accident or occupational disease resulting in a fatality, he shall notify the [chief] *administrator* of the fatality on the prescribed form, D-21.

NAC 616B.493 **Withdrawal of certificate: Continuing jurisdiction; reports; audits.**

1. After the withdrawal of a certificate, the commissioner and [chief] *administrator* retain jurisdiction over injuries sustained during the period of self-insurance until all liabilities and all responsibilities have terminated.

2. The commissioner and [chief] *administrator* will require a self-insured employer whose certificate has been withdrawn to provide any necessary reports setting forth the status of all compensable cases which remain open.

3. The commissioner and [chief] *administrator* will audit the compensable claims of any self-insured employer whose certificate has been withdrawn, and the employer shall pay the expenses incurred by the commissioner *or administrator* or his representative in conducting the audits.

NAC 616B.496 **Severability.**

If any provision of NAC 616B.400 to 616B.493, inclusive, or its application to any person, thing or circumstance is held to be invalid, the commissioner and [chief] *administrator* intend that the invalidity not affect the other provisions of those sections to the extent that they can be given effect.

ASSOCIATIONS OF SELF-INSURED EMPLOYERS

NAC 616B.558 **Administration of self-insurance by association.**

1. An association shall at all times maintain adequate resources for the administration of its program of self-insurance. After the program is established, the adequacy of the association's resources and standards of performance for the program will be evaluated by the commissioner and the [chief] *administrator or his designated agent* on the basis of:

(a) The association's promptness in filing reports of accidents and occupational disease;

(b) The association's promptness in making first payments in cases of uncontested claims;

(c) The percentage of contested claims;

(d) The number of claimants who are reemployed or rehabilitated; and

(e) The delay between the termination of compensation for temporary disabilities and the payment of compensation for permanent partial disabilities.

2. For purposes of NAC 616B.510 to 616B.512, inclusive, *and NRS 616D.120*, the acts and omissions of a third-party administrator or an association's administrator, including any violations or failures to comply with chapters 616A to 618, inclusive, of NRS, shall be deemed to be the acts or the omissions of the association.

3. An association shall inform the commissioner and the [chief] *administrator or his designated agent* of the name, title and office address of its third-party administrator and association's administer and the location of any records that the association is required by law to maintain. Before any change is made in the name, title or address of a third-party administrator or the association's administrator or any change is made in the location of

records, the intended change must be reported in writing to the commissioner and the [chief] *administrator or his designated agent*.

4. An association shall not administer a program of self-insurance from a location outside Nevada.

NAC 616B.561 **Inspection and location of files for claims and other records.**

1. An association shall ensure that all files of claims and all records maintained by the association pursuant to chapters 616A to 616D, *and 617*, inclusive, of NRS or NAC 616B.510 to 616B.612, inclusive, are available for inspection by the commissioner or [chief] *administrator,* or his representative during normal business hours.

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

3. After reviewing the file of a claim, the commissioner or [chief] *administrator* will report his findings to the association.

NAC 616B.562 **Reports of Claims**

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

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

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

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

(d) Any administrative or court orders modifying the wage calculation for the injured employee; and

(e) The following forms:

(1) D-5, Wage Calculation Form for Claims 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 or *D-10(b), Election of Method of Payment of Compensation for Disability Greater than 25%, as appropriate.*

2. On or before September 30 of each year, or as requested by the administrator or his designated agent, the 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 in lieu of vocational rehabilitation services.
(III) Program expenses.
(IV) Administrative expenses.
(V) Other purposes.
(l) Amounts recovered:
(1) Through subrogation.
(2) From the subsequent injury fund for associations of self-insured public or private employers.
(3) From other sources.
(m) Any other information requested by the administrator or his designated agent.

3. The information required pursuant to subsection 2 must, except as otherwise requested by the administrator or his designated agent, include information regarding any administrative activity during the prior fiscal year relating to:
(a) A claim for an injury that occurred during that year; and
(b) Any other claims, regardless of when the injury occurred.

4. Upon request by the administrator or his designated agent, each 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.

NAC 616B.562 **Reports of Claims**. Effective 7/1/99.

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

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

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

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

(d) Any administrative or court orders modifying the wage calculation for the injured employee; and

(e) The following forms:

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

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

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

(4) D-10(a), Election of Method of Payment of Compensation or D-10(b), Election of Method of Payment of Compensation for Disability Greater than 25%, as appropriate.

2. On or before September 30 of each year, or as requested by the administrator or his designated agent, the 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 in lieu of vocational rehabilitation services.
(III) Program expenses.
(IV) Administrative expenses.
(V) Other purposes.

(l) Amounts recovered:
(1) Through subrogation.
(2) From the subsequent injury fund for associations of self-insured public or private employers.
(3) From other sources.

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

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

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

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

4. Upon request by the administrator or his designated agent, each 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.

New (similar to NAC 616B.466) **Notice to *administrator* of accident or occupational disease.**

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

2. Within 48 hours after an insurer receives notice, in any form, of an accident or occupational disease resulting in a fatality, he shall notify the administrator of the fatality on the prescribed form, D-21.

New ***Withdrawal of certificate: Continuing jurisdiction; reports; audits.***[8]

1. After the withdrawal of a certificate, the commissioner and administrator retain jurisdiction over injuries sustained during the period of self-insurance until all liabilities and all responsibilities have terminated.

[8] This language parallels NAC 616B.493.

2. The commissioner and administrator will require an association whose certificate has been withdrawn to provide any necessary reports setting forth the status of all compensable cases which remain open.

3. The commissioner and administrator will audit the compensable claims of any association whose certificate has been withdrawn, and the members of the association shall pay the expenses incurred by the commissioner or administrator or his representative in conducting the audits.

PRIVATE CARRIERS *AND THE STATE INDUSTRIAL INSURANCE SYSTEM*[9]

New. ***Reports of Claims.***[10] Effective date 7/1/99.

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

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

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

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

(d) Any administrative or court orders modifying the wage calculation for the injured employee; and

(e) The following forms:

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

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

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

(4) D-10(a), Election of Method of Payment of Compensation or D-10(b), Election of Method of Payment of Compensation for Disability Greater than 25%, as appropriate.

2. On or before September 30 of each year, or as requested by the administrator or his designated agent, 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.

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[9] It is the intent of DIR to impose the same requirements upon the SIIS and private carriers. If LCB would like to make two sections instead of combining, that is acceptable.

[10] Pursuant to NRS 616B.009, this regulation is similar to NAC 616B.457 (self-insured employers) and NAC 616B.562 (associations of self-insured employers). If LCB would like to combine these regulations to make one regulation which is applicable to all insurers, that would be acceptable or if LCB wishes to make one regulation applicable to SIIS and another to the private carriers, that is acceptable.

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

(4) The number of compensable fatalities.

(5) The number of claims denied.

(b) For claims for an occupational disease:

(1) The number of new claims filed.

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

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

(4) The number of compensable fatalities.

(5) The number of claims denied.

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

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

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

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

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

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

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

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

(k) Expenditures on claims for:

(1) A temporary total disability.

(2) A temporary partial disability.

(3) A permanent total disability.

(4) A permanent partial disability.

(5) Benefits for survivors.

(6) Burial expenses.

(7) Travel and per diem expenses.

(8) All medical expenses.

(9) Vocational rehabilitation, categorized by expenditures for:

(I) Vocational rehabilitation maintenance.

(II) The payment of compensation in a lump sum in lieu of vocational rehabilitation services.

(III) Program expenses.

(IV) Administrative expenses.

(V) Other purposes.

(l) Amounts recovered:

(1) Through subrogation.

(2) From the subsequent injury fund.

(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.

New. ***Inspection and Location of Files for Claims and Other Records.***[11] Effective 7/1/99

1. All claim files, together with all records maintained by the system or a private carrier pursuant to chapters 616A to 616D and 617, inclusive, and NAC 616B.___ to NAC 616B.____ must be kept readily available for inspection by the commissioner or administrator, or his representative, during normal business hours.

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

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

New (similar to NAC 616B.466) ***Notice to administrator of accident or occupational disease.*** Effective 7/1/99.

1. Within 30 days after the system or private carrier receives notice of an accident or occupational disease, the insurer shall notify the administrator if the accident resulted in injury to, or the disease affected or is expected to affect, two or more persons.

2. Within 48 hours after an insurer receives notice, in any form, of an accident or occupational disease resulting in a fatality, he shall notify the administrator of the fatality on the prescribed form, D-21.

New, Effective 7/1/99[12]

If the system, private carrier, or an employer intends to cancel or renew a policy of insurance issued by the system or private carrier pursuant to Chapters 616A to 617 and 687B.310 to 687B.355 of the Nevada Revised Statutes, the system or private carrier and the employer must give written notice using Form D-42 or electronically transmit[13] the information contained in Form D-42, to the administrator or his designated agent and to the system, private carrier or employer fixing the date on which the cancellation or renewal becomes effective. The notice provided by the system or private carrier on behalf of the employer will be deemed adequate notice from the employer for compliance.

New, Effective 7/1/99[14]

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[11] This is similar to NAC 616B.454 and 616B.561.

[12] NRS 616B.033 speaks to "policy of insurance." NRS 616B.026 provides that SIIS and private carriers are required to issue policies of insurance. There is no provision of associations of self-insured public or private employers to provide policies of insurance.

[13] NRS 616A.417 allows electronic transmission.

[14] NRS 616B.460 concerns notification to the administrator if employer changes insurers or allows coverage to lapse.

If an employer elects to purchase workers' compensation coverage from the system, a private carrier, or an insurer other than his present insurer, the employer shall give written notice, using Form D-42, or electronically transmit the information contained in Form D-42, to the administrator or his designated agent at least 10 days prior to the effective date of the change and provide proof of coverage. The notice provided by the system or private carrier on behalf of the employer will be deemed adequate notice from the employer for compliance.

New. Effective 7/1/99**.**

The system or each private carrier shall give written notice, using Form D-42, or electronically transmit the information contained in Form D-42 to the administrator or his designated agent if an employer has changed his insurer or has allowed his insurance to lapse within 24 hours or by the end of the next working day after:

a) the date the policy lapses,

b) the agent or insurer issues a temporary binder, or

c) the insurer issues a policy of insurance.

New. Effective 7/1/99

The system or private carrier and the employer shall use Form D-42, entitled "Intent to Cancel, Renew or Change of Insurance CarrierForm D-42" if personally serving, mailing by first class mail, or electronically transmitting the information contained in Form D-42, when serving notice to the administrator or his designated agent. The notice provided by the system or private carrier on behalf of the employer will be deemed as adequate notice of the employer for compliance with NRS 616B.033 and 616B.460 and these regulations.

New. Effective 7/1/99

If the system, private carrier or employer fails to comply or complies in an untimely manner with any provision of NRS 616B.033, 616B.460 and this regulation that requires the system or private carrier and employer to give written notice to the administrator or his designated agent, the administrator will:

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

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

(c) For the seventh through eleventh violations within a 12-month period, impose an administrative fine of at least $200.

(d) For the twelfth through sixteenth violations within a 12-month period, impose an administrative fine of at least $500.

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

ORGANIZATIONS FOR MANAGED CARE AND PROVIDERS OF HEALTH CARE

NAC 616B.670 **Contracts with organizations for managed care or providers of health care**.

1. A self-insured employer *or an association of self-insured employers* who enters into a contract with an organization for managed care or a provider of health care pursuant to NRS 616B.527 shall:

(a) Submit a copy of the contract to the [chief] *administrator or his designated agent*; and

(b) Notify the [chief] *administrator or his designated agent* of any changes in the contract, including any additions to and deletions from the contract, and of the renewal of the contract. The notice must be given at the time the changes are made or the contract is renewed.

2. If the manager enters into a contract with an organization for managed care or for other health care services *pursuant to NRS 616B.515*, he shall:

(a) Submit a copy of the contract to the [chief] *administrator or his designated agent*; and

(b) Notify the [chief] *administrator or his designated agent* of any changes in the contract, including any additions to and deletions from the contract, and of the renewal of the contract. The notice must be given at the time the changes are made or the contract is renewed.

NAC 616B.670 **Contracts with organizations for managed care or providers of health care**. Effective 7/1/99.

1. A self-insured employer, an association of self-insured employers, *or private carrier* who enters into a contract with an organization for managed care or a provider of health care pursuant to NRS 616B.527 shall:

(a) Submit a copy of the contract to the administrator or his designated agent; and

(b) Notify the administrator or his designated agent of any changes in the contract, including any additions to and deletions from the contract, and of the renewal of the contract. The notice must be given at the time the changes are made or the contract is renewed.

2. If the manager enters into a contract with an organization for managed care or for other health care services pursuant to NRS 616B.515, he shall:

(a) Submit a copy of the contract to the administrator or his designated agent; and

(b) Notify the administrator or his designated agent of any changes in the contract, including any additions to and deletions from the contract, and of the renewal of the contract. The notice must be given at the time the changes are made or the contract is renewed.

ASSESSMENTS

NAC 616B.683 "**Annual disbursements" defined.**

"Annual disbursements" means the sum of all payments for compensation made in a fiscal year from:

1. The uninsured employers' fund; [or] *and*
2. The subsequent injury [fund] *funds*.

NAC 616.686 "**Annual expenditures for claims" defined**. "Annual expenditures for claims" means the total amount of money actually paid for compensation in a fiscal year by or on behalf of an insurer pursuant to chapters 616A to 617, inclusive, of NRS reduced by any amount received from subrogation and reimbursement from [the] *its* subsequent injury fund.

NAC 616B.689 **"Expected annual disbursements" defined.**

"Expected annual disbursements" means an estimate of the sum of all payments for compensation made in a fiscal year from:

1. The uninsured employers' fund; [or] *and*
2. The subsequent injury [fund] *funds*.

NAC 616B.698 "**Program of self-insurance" defined**.

"Program of self-insurance" means the program established pursuant to chapters 616A to 616 D, inclusive, *and 617* of NRS for which an employer is issued a certificate of qualification as a self-insured employer *or association of self-insured employers* by the commissioner.

NAC 616B.701 **Estimated annual assessment**.

The division will determine the estimated annual assessment to be made against each insurer in order to defray the:

1. Costs and expenses of administering the program of [workmen's] *workers'* compensation and safety; and
2. Amount of the expected annual disbursements to be made from the uninsured employers' claim fund and [the] *its* subsequent injury fund.

NAC 616B.704 **Records and reports.**[15]

1. The system, [and] each self-insured employer, *and each association of self-insured employers*, shall maintain records in this state of annual expenditures for claims, including:
   (a) Copies of checks issued.
   (b) Registers of checks issued relating to claims for workers' compensation, including voided checks;
   (c) Registers of any other payment of claims other than by check; and
   (d) Working papers used to report annual expenditures.
2. The division may require an insurer to provide a copy of any canceled check described in subsection 1. Within 15 days after he receives a written request from the division, the insurer shall provide a copy of both sides of each canceled check requested. The division may require the insurer to provide a certified copy of each canceled check requested.
3. Each insurer shall provide the division, at such times and in the form and manner prescribed by the division, with reports or expected annual expenditures for claims, annual

[15] DIR would not be opposed to the use of the word "insurer" rather than listing the entities if that is acceptable to LCB.

expenditures for claims and such other information as the division deems necessary to calculate an estimate or final annual assessment. each report of expenditures for claims must identify expenditures attributable to claims made by persons who were employed by the operators of mines at the time of their injuries.

4. The division will provide to each insurer an annual report showing the figures and sources used in calculating the estimated annual expenditures for claims.

NAC 616B.704 **Records and reports.** Effective 7/1/99.

1. The system, each self-insured employer, [and] each association of self-insured employers, *and each private carrier* shall maintain records in this state of annual expenditures for claims, including:

(a) Copies of checks issued.

(b) Registers of checks issued relating to claims for workers' compensation, including voided checks;

(c) Registers of any other payment of claims other than by check; and

(d) Working papers used to report annual expenditures.

2. The division may require an insurer to provide a copy of any canceled check described in subsection 1. Within 15 days after he receives a written request from the division, the insurer shall provide a copy of both sides of each canceled check requested. The division may require the insurer to provide a certified copy of each canceled check requested.

3. Each insurer shall provide the division, at such times and in the form and manner prescribed by the division, with reports or expected annual expenditures for claims, annual expenditures for claims and such other information as the division deems necessary to calculate an estimate or final annual assessment. each report of expenditures for claims must identify expenditures attributable to claims made by persons who were employed by the operators of mines at the time of their injuries.

4. The division will provide to each insurer an annual report showing the figures and sources used in calculating the estimated annual expenditures for claims.

NAC 616B.707 **Consideration of expenditures as expenditures for claims; value of clinical services.**

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

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

(b) Charges by a hospital.

(c) Treatment by a physician or chiropractor.

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

(e) Physical therapy.

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

(g) Travel to obtain medial care or supplies.

(h) Any other accident benefits.

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

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

(k) Death benefits.

(l) Burial expenses.

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

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

(b) Money paid *in excess of the statutory provisions regarding the calculation* for a temporary total, [or] temporary partial, *permanent partial, or permanent total disability or rehabilitation maintenance* [in excess of the average monthly wage].

(c) Legal expenses, including but not limited to, court costs, attorney's fees, costs for depositions, investigations and hearings.

(d) [Payment of claims which are later determined to be noncompensable.

(e)] Payment of claims in connection with the uninsured employers' fund.

(f) Payment of an award of interest.

[(e)] *(g)* Administrative expenses, including but not limited to, expenses incurred for:

(1) Copying records.

(2) Reviewing the [report of a physician contained in any file relating to a claim] *reports of other physicians or chiropractors*; or

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

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

3. The value of accident benefits furnished by an insurer for industrial injuries or illnesses must be computed and reported pursuant to NAC 616C.182 to 616C.[218]*230*, inclusive.

NAC 616B.713 **Sources for determining annual expenditures for claims**.

1. The system shall provide to the division a statement showing by month the amount of annual expenditures for claims for each self-insured employer *or member of an association* incurred before becoming certified for a program of self-insurance.

2. The system shall provide to the division a statement of the amounts of expenditures for claims incurred after certification for each self-insured employer *or association.*

3. Each insurer shall submit to the division a statement showing by month his annual expenditures for claims. The statement must be verified and signed by a responsible person employed by the insurer or his authorized agent.

4. Amounts reported to the division pursuant to subsections 1, 2 and 3 will be used as sources for determining annual expenditures for claims.

NAC 616B.725 **Pro rata assessment**.

The estimated annual assessment to be made against a self-insured employer *or association* who does not participate in a program of self-insurance during a portion of a fiscal year may be calculated by the division in the proportion that the number of months in the fiscal year the insurer will be self-insured bears to the total number of months in that fiscal year. A statement of such an assessment may be issued to the insurer by the division.

NAC 616B.728 **Change in ownership of property; cancellation of certification as self-insured employer *or association***.

1. If the ownership of property is transferred from one self-insured employer *or association* to another, or if a self-insured employer acquires ownership in a property for which [workmen's] *workers'* compensation insurance is provided by the system, the division will transfer data relating to annual expenditures for claims for that property to the new owner within 30 days after receiving notification of the transfer of ownership, and the division will recompute the estimated annual assessments for the insurers only if it finds the existence of a special circumstance justifying the recomputation.

2. If a self-insured employer elects to give up his status as a self-insured employer and to be insured against liability for [workmen's] *workers'* compensation by the system, the division will recompute the estimated annual assessment for all insurers only if it finds the existence of a special circumstance justifying the recomputation.

3. *If an association elects to give up its status as an association and its members elect to be insured against liability for workers' compensation by the system, the division will recompute the estimated annual assessment for all insurers only if it finds the existence of a special circumstance justifying the recomputation*.

NAC 616B.728 **Change in ownership of property; cancellation of certification as self-insured employer or association**. Effective 7/1/99.

1. If the ownership of property is transferred from one self-insured employer or association to another, or if a self-insured employer acquires ownership in a property for which workers' compensation insurance is provided by the system *or private carrier*, the division will transfer data relating to annual expenditures for claims for that property to the new owner within 30 days after receiving notification of the transfer of ownership, and the division will recompute the estimated annual assessments for the insurers only if it finds the existence of a special circumstance justifying the recomputation.

2. If a self-insured employer elects to give up his status as a self-insured employer and to be insured against liability for workers' compensation by the system *or private carrier*, the division will recompute the estimated annual assessment for all insurers only if it finds the existence of a special circumstance justifying the recomputation.

3. If an association elects to give up its status as an association and its members elect to be insured against liability for workers' compensation by the system *or private carrier*, the division will recompute the estimated annual assessment for all insurers only if it finds the existence of a special circumstance justifying the recomputation.

NAC 616B.734 **Calculation of final assessment; issuance of statement of assessment**.

1. The division will determine, on the basis of reports issued by the state controller for the previous fiscal year relating to closing budgets and final trial balances, the amount of money disbursed from and deposited in:

(a) The fund for workers' compensation and safety;

(b) The uninsured employers' claim fund, and

(c) The subsequent injury [fund] *funds for self-insured employers, and associations.*

2. The division will calculate, in the same manner as for estimated annual assessments, the final annual assessment for each insurer for the previous fiscal year and will use:

(a) The insurer's statements relating to annual expenditures for claims for the previous fiscal year submitted pursuant to NAC 616B.713;

(b) Amounts reported for the previous fiscal year by the system pursuant to NAC 616B.713 for expenditures for claims incurred by a self-insured employer before the employer was certified for a program of self-insurance; [and]

(c) *Amounts reported for the previous fiscal year by the system pursuant to NAC 616B.713 for expenditures for claims insured by an association before the association was certified for a program of self-insurance; and*

[(c)] *(d)* The determinations made pursuant to subsection 1.

The division will issue to the insurer a statement of the final assessment.

NAC 616B.734 **Calculation of final assessment; issuance of statement of assessment**. Effective 7/1/99.

1. The division will determine, on the basis of reports issued by the state controller for the previous fiscal year relating to closing budgets and final trial balances, the amount of money disbursed from and deposited in:

(a) The fund for workers' compensation and safety;

(b) The uninsured employers' claim fund, and

(c) The subsequent injury [fund] *funds* for self-insured employers, [and] associations, *and private carriers*.

2. The division will calculate, in the same manner as for estimated annual assessments, the final annual assessment for each insurer for the previous fiscal year and will use:

(a) The insurer's statements relating to annual expenditures for claims for the previous fiscal year submitted pursuant to NAC 616B.713;

(b) Amounts reported for the previous fiscal year by the system pursuant to NAC 616B.713 for expenditures for claims incurred by a self-insured employer before the employer was certified for a program of self-insurance;

(c) Amounts reported for the previous fiscal year by the system pursuant to NAC 616B.713 for expenditures for claims incurred by an association before the association was certified for a program of self-insurance; and

(d) The determinations made pursuant to subsection 1.

The division will issue to the insurer a statement of the final assessment.

SUBSEQUENT INJURIES

Private Carriers

New, ***Subsequent injury fund; claims for reimbursement from the fund.***[16] Effective 7/1/99

1. This section applies to claims for reimbursement from the subsequent injury fund for employers insured by a private carrier.

2. The following preliminary steps must be taken:

(a) If, at the time an employee is hired, the employer has knowledge that the employee has a permanent physical impairment which would cause a hindrance in obtaining employment

[16] NRS 616B.584 provides for Private Carriers to have an SIF fund. SIIS is proposing to sunset its SIF regulations.

or reemployment if the employee is unemployed, and this permanent physical impairment would support a rating of 6 percent or more of the whole man, or

(b) If an employee is retained in employment after the employer acquires such knowledge that he has a permanent physical impairment which would support a rating of 6 percent or more of the whole man before the subsequent injury, or

(c) If an employee knowingly makes a false representation regarding his physical condition at the time of hire which forms the basis of his employment,

the private carrier must, upon obtaining this knowledge, submit a timely notice to the administrator pursuant to NRS 616B.587(5) and/or NRS 616B.590(2).

3. Any claim submitted by a private carrier for reimbursement from the subsequent injury fund must be submitted in writing to the administrator. The claim must contain all documents in the claim file and any other supporting documents which the private carrier relies upon or deems important for the determination of the claim. The claim must be submitted in a three-ring binder and be sectioned and labeled according to the Insurer's Subsequent Injury Checklist, form D-37, with all documents being in chronological order. A completed copy of the D-37 must also accompany the claim. A copy of this form may be obtained from the administrator at no cost.

4. The administrator shall examine the claim and within 90 days after his receipt of the claim shall:

(a) Notify the private carrier that a determination on the claim cannot be made and the reasons therefor; or

(b) Notify the private carrier of the acceptance or denial of the claim, and;

(c) If accepted, notify the private carrier of the verified amount of reimbursement and the claim shall then be processed for payment by the State Controller.

5. An appeal from a determination of the administrator concerning a claim against the subsequent injury fund must be made in writing and sent directly to the appeals officer within 30 days after the date of the administrator's determination.

New effective 7/1/99

Consideration of expenditures as expenditures for claims for the reimbursement from the subsequent injury fund of private carriers.

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

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

(b) Money paid in excess of the statutory provisions regarding the calculation for a temporary total, temporary partial, permanent partial, or permanent total disability or rehabilitation maintenance.

(c) Legal expenses, including but not limited to, court costs, attorney's fees, costs for depositions, investigations and hearings.

(d) Payment of an award of interest.

(e) Administrative expenses, including but not limited to, expenses incurred for:

(1) Copying records.

(2) Reviewing the reports of other physicians or chiropractors.

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

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

2. The value of accident benefits furnished by an insurer for industrial injuries or illnesses must be computed and reported pursuant to NAC 616C.182 to 616C.230, inclusive.

LIABILITY FOR PROVISION OF COVERAGE[17]

Contractors, Sole Proprietors and Corporate Officers

New (similar to NAC 616B.780) **Relationship to person hired; liability of principal contractor for premiums.** Effective 7/1/99[18]

1. An employer who hires a person to do work related to, or in furtherance of, his business operations that are insured by the system or private carrier is presumed to have established an employer-employee relationship between himself and the person performing the work in the absence of a written contract between the two parties which establishes that no employer-employee relationship exists between the two parties, in accordance with chapters 616A to 617, inclusive, of NRS.

2. If a subcontractor or independent contractor does not have an active policy with the system or private carrier the principal contractor will be assessed premiums based on:

(a) The payroll for the period of the contract with the subcontractor or independent contractor;

(b) The appropriate classification for the work performed by the subcontractor or independent contractor; and

(c) The experience modification factor of the principal contractor.

3. A principal contractor may provide the complete payroll records of the employees of each uninsured subcontractor and independent contractor. Except as otherwise provided in this subsection, if the principal contractor does not provide the payroll records of his uninsured subcontractors and independent contractors, the full contract price shall be deemed to be the payroll for the employees of the subcontractors and independent contractors. If the contract is for labor and materials or labor and equipment and evidence is provided to the system or private carrier which indicates the portion of the contract price that is for labor, that amount may be deemed the payroll for the employees of the subcontractor or independent contractor. If such an amount is not indicated in the contract, the system or private carrier will determine what portion of the contract price will be deemed the payroll for the employees of the subcontractor or independent contractor. In no case will the payroll used to calculate the premiums of the principal contractor be less than the portion of the contract price that is for labor.

4. If a subcontractor or independent contractor has a policy with the system or private but fails to pay the proper premiums, the principal contractor is liable for the amount of any unpaid premiums based on the rate and modification factor for premiums of the subcontractor or independent contractor.

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[17] SIIS has proposed to sunset the majority of these regulations as of 6/30/99.

[18] SIIS is planning to sunset NAC 616B.780 *et seq*. DIR may adopt regulations similar to some of those being sunsetted.

New (Similar to NAC 616B.783) **Determination by principal contractor of his obligation to pay premiums.** Effective 7/1/99.

1. To determine his obligation to pay premiums for industrial insurance on behalf of his subcontractors and independent contractors and their employees, a principal contractor may request, in writing, the system or private carrier to provide him the information described in this section.

2. Upon request by a principal contractor, the system or private carrier will:

(a) Provide him a written statement certifying whether or not:

(1) Each of the subcontractors and independent contractors working in his project, or whom he may hire for a contract, is insured by the system or a private carrier; and

(2) Each sole proprietor or partner who is such a contractor has elected or obtained coverage for himself under chapters 616A to 617, inclusive, of NRS.

(b) During the course of the project, notify the principal contractor whenever any of the subcontractors or independent contractors fail to pay premiums to the system or private carrier or otherwise to maintain industrial insurance.

3. Upon completion of the project, the principal contractor may request, in writing, and the system or private carrier will provide, a final statement which certifies whether or not each subcontractor or independent contractor who was previously certified as having coverage for industrial insurance has maintained it by paying all premiums due throughout the entire period of the project.

New (similar to NAC 616B.786; see NRS 616A.210) **Coverage of sole proprietors and partners acting as licensed subcontractors; relief from requirement of coverage for sole proprietor or partner acting only as principal contractor; responsibility of principal contractor for coverage of subcontractor, sole proprietor or partner.** Effective 7/1/99.

1. Sole proprietors and partners acting as subcontractors in this state who are licensed pursuant to chapter 624 of NRS shall be deemed to receive $500 per month in wages. Sole proprietors and partners acting in alternating roles as a principal contractor and subcontractor shall be deemed to receive $500 per month in wages. The type of license issued to the sole proprietor or partner pursuant to chapter 624 of NRS does not affect the coverage or deemed wage required.

2. A sole proprietor or partner acting only as a principal contractor may be relieved of the requirement of maintaining coverage for himself by submitting written notice to the system or private carrier that he is acting only as a principal contractor. If the system or private carrier determines that the sole proprietor or partner is acting only as a principal contractor, the system or private carrier will terminate his deemed wage effective on the date of receipt of the written notice. The termination of the deemed wage will not be made retroactive to a date before receipt of the written notice by the system or private carrier. If, after the termination of the deemed wage, the system or private carrier determines that the sole proprietor or partner was at any time acting as a subcontractor, the system or private carrier will reinstate the deemed wage effective on the date on which it was terminated, but in no case will it be made retroactive for more than 3 years or to the date of the last audit, whichever is more recent. If a sole proprietor or partner who was determined to be acting only as a principal contractor at

the inception of his policy with the system or private carrier acts at any time thereafter as a subcontractor or in alternating roles as a principal contractor and subcontractor, his deemed wage will become effective on the date of his first subcontract, but in no case will it be made retroactive for more than 3 years or to the date of the last audit, whichever is more recent.

3. If a subcontractor, sole proprietor or partner provides coverage for his employees but fails to secure and maintain coverage for himself, the principal contractor is responsible for the payment of premiums for the subcontractor, sole proprietor or partner during the term of the contract.

New (similar to NAC 616B.789, see NRS 616B.659) **Determination of wages when uninsured sole proprietors or partners perform as subcontractors; premium payable by principal contractor.** Effective 7/1/99

1. For the purposes of determining premium and disability compensation, the wage of sole proprietors and partners who are not licensed under chapter 624 of NRS, have not elected coverage under the elective provisions of chapters 616A to 617, inclusive, of NRS and are performing as subcontractors to an insured principal contractor shall be deemed to be $300 per month or $10 per day for the period of the subcontract, except in cases where the contract specifies a wage in excess of $300 per month or $10 per day for the sole proprietor or partner.

2. For the purposes of determining premium and disability compensation, the wage of sole proprietors and partners who are licensed under chapter 624 of NRS but who have failed to open or maintain an account in good standing and who are performing as subcontractors to an insured principal contractor shall be deemed to be $500 per month or $17 per day for the period of the subcontract except in cases where the contract specifies a wage in excess of $500 per month or $17 per day for the sole proprietor or partner.

3. For the purposes of determining premium required to be paid by the principal contractor and disability compensation, the wages of employees of a sole proprietor or partner who is a subcontractor and has not obtained coverage for his employees must be the actual wages paid, if the payroll records are provided to the system or private carrier. In the absence of complete payroll records, subsection 3 of NAC 616B.780 applies.

4. The principal contractor is liable for the amount of any premiums payable as a result of the application of subsections 1, 2 and 3. The premium payable must be based on the classifications and rates which would be applicable to the subcontractor and the experience modification factor which would be applicable to the principal contractor.

New (similar to NAC 616B.792) **Coverage of sole proprietors seeking to obtain or fulfill contracts with state.** Effective 7/1/99.

1. Sole proprietors who are not licensed under chapter 624 of NRS, but who are required by statute to provide themselves with industrial insurance in order to obtain, fulfill or both obtain and fulfill a contract to furnish service to the state will be provided coverage during the term of the contract at the rate provided in the manual at the deemed wage of $300 per month.

2. If a sole proprietor who is licensed pursuant to chapter 624 of NRS accepts a state contract, coverage will be provided at the deemed wage of $500 per month whether or not the license is material to the state contract. Coverage will be provided during the term of the

contract or as long as the sole proprietor is licensed at the rate provided in the manual for licensed sole proprietors.

New (similar to NAC 616B.795) **Coverage of corporate officers.** Effective 7/1/99.

The system or private carrier will provide coverage to an officer of a corporation if the corporation is required to be insured pursuant to NRS 616B.624 or has elected to be insured pursuant to chapters 616A to 616D, inclusive, or chapter 617 of NRS, including:

1. An officer of a corporation under subchapter S of the Internal Revenue Code, who is regularly employed by the corporation in the State of Nevada, or who is from a nonreciprocating state working temporarily in Nevada, based upon the amounts deemed to be paid to him pursuant to chapters 616A to 616D and 617, inclusive, of NRS, or based on the actual amount paid to him as shown on the records of payroll maintained by the corporation, but excluding any dividends paid to him; and

2. An officer of a corporation who may be excluded pursuant to NRS 616A.110, but is required to be insured pursuant to NRS 616B.624, or elects to be insured pursuant to chapters 616A to 616D, inclusive, or chapter 617 of NRS.

New (Similar to NAC 616B.796) **Certain provisions not applicable to coverage of corporate officer.** Effective 7/1/99

The administrator will not interpret the provisions of NRS 616A.110 as affecting the requirements for the coverage of a corporate officer set forth in NRS 616B.624.

Election by Employer of Excluded Persons

New.[19]

1. Pursuant to NRS 616B.656, if an employer has in his employ an excluded employee as defined in NRS 616A.110, he may elect to cover such an employee. The employer shall notify the system in writing or by electronic transmission of the election. If he is a self-insured employer or a member of an association of self-insured public or private employers, he shall notify the administrator in writing or by electronic transmission of the election.

2. If an employee elects to reject the employer's coverage, he shall notify his employer and the system in writing or by electronic transmission of the rejection. If an employee's employer is self-insured or a member of an association, the employee shall notify his employer and the administrator in writing or by electronic transmission of the rejection.

3. An employee whose employer is insured by the system and who has rejected coverage may at any time elect to waive the rejection by notifying the system and his employer in writing or by electronic transmission of his notice waiving the rejection. An employee whose employer is self-insured or a member of an association and who has rejected coverage may at any time elect to waive the rejection by notifying his employer and the administrator in writing or by electronic transmission of his notice waiving the rejection.

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[19] Comments from the public hearing asked if the 1995 version of NRS 616B.656 meant "employer" rather than "employee."

4. If an employer wishes to withdraw his election to cover an excluded employee, the employer shall notify the system in writing or by electronic transmission of his withdrawal of coverage. If an employer is a self-insured employer or a member of an association of self-insured public or private employers, he shall notify administrator or his designated agent in writing or by electronic transmission of his withdrawal of coverage.

5. The notices shall be served to the administrator or his designated agent within 30 days from the effective date of the election or rejection.

New. Effective 7/1/99[20]

1. Pursuant to NRS 616B.656, if an employer has in his employ an excluded employee as defined in NRS 616A.110, he may elect to cover such an employee. The employer shall notify the administrator and his insurer in writing or by electronic transmission of the election.

2. If an employee elects to reject the employer's coverage, he shall notify his employer, the administrator and the employer's insurer in writing or by electronic transmission of the rejection.

3. An employee who has rejected coverage may at any time elect to waive the rejection by notifying his employer, the administrator, and the employer's insurer in writing or by electronic transmission of his notice waiving the rejection.

4. If an employer wishes to withdraw his election to cover an excluded employee, the employer shall notify his insurer and the administrator in writing or by electronic transmission of his withdrawal of coverage.

5. The notices shall be served to the administrator or his designated agent within 30 days from the effective date of the election or rejection.

New

The employee shall use Form D-43[21] entitled "Employee Election to Reject Coverage; and Election to Waive the Rejection of Coverage for Excluded Persons Pursuant to NRS 616B.656," and the employer shall use Form D-44 entitled "Election of Coverage by Employer, and Employer Withdrawal of Election of Coverage Pursuant to NRS 616B.656" when serving notice to the administrator or his designated agent. A notice provided by the insurer on behalf of the employer or employee will be deemed as adequate notice of the employer and employee for compliance with NRS 616B.656.

New

If an employer fails to comply or complies in an untimely manner with NRS 616B.656 or this regulation that requires the employer to submit a D-44 form to the administrator or his designated agent, the administrator will:

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[20] Comments from the public hearing asked if the 1995 version of NRS 616B.656 meant "employer" rather than "employee."

[21] DIR has made amendments to NAC 616A (DIR 98-5/LCB R093-98); this form will need to be added to NAC 616A.480.

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

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

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

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

New. Effective 7/1/99.[22]

Pursuant to NRS 616B.659, if a sole proprietor elects to purchase workers' compensation coverage or withdraws his election of coverage, the sole proprietor shall give notice in writing to the system or private carrier and the administrator or his designated agent at least 30 days from the effective date of the policy and provide proof of coverage or within 30 days following the effective date of the withdrawal. A notice provided by the insurer on behalf of the sole proprietor will be deemed as adequate notice of the sole proprietor for compliance with NRS 616B.659.

New. Effective 7/1/99.

A sole proprietor shall be deemed to be receiving a wage of $300 per month, unless at least 90 days before an injury for which he requests coverage, he files written notice with the administrator or his designated agent and the system or private carrier, that he elects to pay an additional amount of premium for additional coverage. If the insurer receives the required premium, the sole proprietor shall be deemed to be receiving a wage of $1,800 per month. A notice provided by the insurer on behalf of the sole proprietor will be deemed as adequate notice of the sole proprietor for compliance with NRS 616B.659.

New. Effective 7/1/99.

The sole proprietor shall use Form D-45, entitled "Sole Proprietor Coverage" when serving notice to the system or private carrier and the administrator or his designated agent, election of coverage, withdrawal of elective coverage or notice to pay an additional amount of premium for additional coverage. A notice provided by the system or private carrier on behalf of the sole proprietor will be deemed as adequate notice of the of the sole proprietor for compliance with NRS 616B.659.

New. Effective 7/1/99.

If a sole proprietor fails to comply or complies in an untimely manner with NRS 616B.659 or this regulation that requires the sole proprietor to submit a D-45 form to the administrator or his designated agent, the administrator will:

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[22] SIIS plans to sunset NAC 616B.809 effective 6/30/99.

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

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

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

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

New (similar to NAC 616B.809) **Elected coverage for sole proprietorships and partnerships.** 7/1/99.

1. Sole proprietors and working partners for whom coverage is elective pursuant to NRS 616B.659, who meet the qualifications for coverage under the provisions of chapters 616A to 617, inclusive, of NRS, may apply for coverage by completing and filing with the system or private carrier a form specified by the administrator and a report of physical examinations as prescribed by the insurer.

2. Sole proprietors and working partners for whom coverage is elective pursuant to NRS 616A.220, who meet the qualifications for elective coverage under that section and who are not otherwise required to maintain coverage pursuant to chapters 616A to 616D, inclusive, or chapter 617 of NRS, may apply for coverage by complying with the provisions of NAC 616B.___.

3. Except as otherwise provided in subsection 6, sole proprietors and partners who apply for coverage pursuant to subsection 1 will be provided coverage at the rate provided in the manual at the deemed wage of $300 per month or, if additional premiums are received for additional coverage, at the deemed wage of $1,800 per month. Sole proprietors and partners who:

(a) File notice with the system or private carrier, pursuant to NRS 616B.659, of their election to pay for additional coverage; and

(b) Sustain injury within the 90-day period provided by subsection 6 of NRS 616B.659, will be provided coverage at the deemed wage of $300 per month, notwithstanding the election to pay for additional coverage.

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

New (similar to 616B.810) **Elected coverage for real estate broker, broker-salesman or salesman.** Effective 7/1/99.

1. A person who is licensed pursuant to chapter 645 of NRS as a real estate broker, broker-salesman or salesman and who is not otherwise required to maintain coverage pursuant to chapters 616A to 616D, inclusive, or chapter 617 of NRS may request coverage pursuant to NRS 616A.220 by submitting to the system or private carrier:

(a) An original application for industrial insurance; or

(b) A separate election form or a letter signed by the licensee.

2. A licensee who elects coverage pursuant to NRS 616A.220 will be assigned a classification based on his occupation as a licensed real estate broker, broker-salesman or salesman at the deemed wage of $1,500 per month.

616B.812 **Application for coverage of volunteers**.

1. An employer who applies for coverage of volunteers must have an active account with the system unless he is a self-insured employer *or a member of an association*.

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

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

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

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

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

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

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

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

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

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

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

616B.812 **Application for coverage of volunteers**. Effective 7/1/99.

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

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

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

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

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

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

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

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

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

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

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

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

616B.815 **Coverage for volunteers: Effective date; classifications; payroll to be reported.**

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

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

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

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

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

616B.815 **Coverage for volunteers: Effective date; classifications; payroll to be reported.** Effective 7/1/99.

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

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

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

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

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

New (similar to 616B.818) **Termination of coverage for volunteers.** Effective 7/1/99.

1. The elective coverage of volunteers remains in effect until the earliest of the following events:

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

(b) The administrator or the insurer finds that an employer electing coverage has not maintained a current roster of volunteers.

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

3. For employers who are insured by the system or private carrier, the premium for any period during which coverage was active but no rosters were maintained is based on the greater of either the number of volunteers who were declared on the application for coverage, or the largest number provided on prior rosters.