LCB File No. R112-08

PROPOSED REGULATION OF THE ADMINISTRATOR OF THE DIVISION OF INDUSTRIAL RELATION OF THE DEPARTMENT OF BUSINESS AND INDUSTRY

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

AUTHORITY: §§1-2, 4-6, 11 and 15, NRS 616A.400; §3, NRS 616A.400 and 616A.417; §7, NRS 616A.400**,** 616B.584**,** 616B.587**,** and 616B.590; §8**,** NRS 616A.400, 616B.584 and 616B.587 §§9 and 21**,** NRS 616A.400 and 616C.490; §10, NRS 616A.400**,** 616C.135 and 616C.260; §12**,** NRS 616A.400 and 616D.330; §13, NRS 616A.400 and 616C.065; §14, NRS 616A.400, NRS 616C.065, NRS 616C.235 and NRS 616C.390; §16, NRS 616A.400 and 616C.250; §17, NRS 616A.400**,** 616C.245**,** 616C.250 and 616C.260; §18, NRS 616A.400 and 616C.260; §19, NRS 616A.400 and 616C.260; §20, NRS 616A.400 and NRS 616C.260; §22, NRS 616A.400**,** 616C.130 and 616C.260; §23, NRS 616A.400 and 616C.220; §24, NRS 616A.400 and 616C.550; §25, NRS 616C.409; §§26, 27, 28 and 29 NRS 616A.010 and 616A.400; §30, NRS 616C.245; §31, NRS 616A.400 and 616D.050; §32, 2007 Assembly Bill 496 §19**,** NRS 616A.400 and 616D.120; §33, NRS 616C.540, 616C.543 and 616D.120.

A REGULATION relating to industrial insurance; revising outdated definitions, references to non-existent offices, and contact information for required publications; revising forms used by health care providers and insurers; revising correspondence and notification requirements; revising subsequent injury claim processing requirements to reflect statutory changes; revising standards for admittance to the rating panel of physicians and chiropractors; revising claim file content requirements; adding requirements for insurer/third-party administrator succession; adding a deadline for insurers and third-party administrators to establish an account for direct deposit; adding fines and penalties for insurers based upon conduct of their third-party administrators; defining US Postal Service "receipt"; elaborating on violations committed by uncertified vocational rehabilitation counselors; and providing other matters properly relating thereto.

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

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

Sec. 2. Chapter 616A.140 of the NAC is hereby ammended to read as follows:

NAC 616A.140 ~~[“Industrial Insurance Regulation Section”]~~ ***“Workers’ Compensation Section”*** means the ~~[Industrial Insurance Regulation Section]~~ ***Workers’ Compensation Section*** of the Division of Industrial Relations of the Department of Business and Industry.

Sec. 3. Chapter 616A.480 of the NAC is hereby amended by adding thereto the provisions set forth to read as follows:

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

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

(1) The insurer;

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

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

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

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

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

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

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

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

(I) Unique to the employer;

(II) Capable of verification; and

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

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

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

(e) C-4, Employee's Claim for Compensation/Report of Initial Treatment. A copy of the form must be delivered to the insurer or third-party administrator. A copy of the form must be delivered to or the form must be filed by electronic transmission with the employer. A copy of the form must be delivered to the injured employee. The language contained in Form D-2 must be printed on the reverse side of the injured employee's copy of the form or provided to the

injured employee as a separate document with an affirmative statement acknowledging receipt. The original form signed by the injured employee and the physician or chiropractor who conducted the initial examination of the injured employee must be retained by that physician or chiropractor. If the physician or chiropractor who conducted the initial examination files the form by electronic transmission, the physician or chiropractor must:

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

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

(I) Unique to the physician or chiropractor;

(II) Capable of verification; and

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

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

➥ If the physician or chiropractor who conducted the initial examination moves from or ceases treating patients in this State, the physician or chiropractor shall deliver the original form to the insurer for inclusion in the insurer's file on the injured employee within 30 days after the move or cessation of treatment of patients.

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

(g) D-6, Injured Employee's Request for Compensation.

(h) D-7, Explanation of Wage Calculation.

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

(j) D-9(a), Permanent Partial Disability Award Calculation Worksheet.

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

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

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

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

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

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

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

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

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

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

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

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

(w) D-21, Fatality Report.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~[(xx)]~~ ***(vv)*** D-52, ~~[CMS (UB-92).]~~ ***Alternative Choice of Physician or Chiropractor and Referral to a Specialist (NRS 616C.090)***

~~[(yy)]~~ ***(ww)*** D-53, ~~[Alternative Choice of Physician or Chiropractor and Referral to a Specialist.]~~ ***CMS (UB-04)***

2. In addition to the forms specified in subsection 1, the following forms must be used by each insurer in the administration of a claim for an occupational disease:

(a) OD-1, ~~[Firemen]~~ ***Firefighter's*** and Police ~~[Officers']~~ ***Officer's*** Medical History Form.

(b) OD-2, ~~[Firemen]~~ ***Firefighter's*** and Police ~~[Officers']~~ ***Officer's*** Lung Examination Form.

(c) OD-3, ~~[Firemen]~~ ***Firefighter's*** and Police ~~[Officers']~~ ***Officer's*** Extensive Heart Examination Form.

(d) OD-4, ~~[Firemen]~~ ***Firefighter's*** and Police ~~[Officers']~~ ***Officer's*** Limited Heart Examination Form.

(e) OD-5, ~~[Firemen]~~ ***Firefighter's*** and Police ~~[Officers']~~ ***Officer's*** Hearing Examination Form.

(f) OD-6, ~~[Firemen]~~ ***Firefighter's*** and Police ~~[Officers']~~ ***Officer's*** Sample Letter.

(g) OD-7, ~~[Firemen]~~ ***Firefighter's*** and Police ~~[Officers']~~ ***Officer's*** Physical Examination Information.

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

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

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

~~[5. The Industrial Insurance Regulation Section will be responsible for printing and distributing the following forms:~~

~~(a) C-4, Employee's Claim for Compensation/Report of Initial Treatment;~~

~~(b) D-12(b), Request for Hearing - Uninsured Employer;~~

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

~~(d) D-17, Employee's Claim for Compensation - Uninsured Employer; and~~

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

~~[6.]~~ **5.** Each insurer or third-party administrator is responsible for printing and distributing all other forms listed in this section. The provisions of this subsection do not prohibit an insurer, employer, provider of health care, organization for managed care or third-party administrator from providing any form listed in this section.

~~[7.]~~ **6.** Upon the request of the Administrator, an insurer, employer, provider of health care, organization for managed care or third-party administrator shall submit to the Administrator a copy of any form used in this State by the insurer, employer, provider of health care, organization for managed care or third-party administrator in the administration of claims for workers' compensation.

Sec. 4. Chapter 616A.510 of the NAC is hereby amended to read as follows:

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

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

Sec. 5. Chapter 616B.010 of the NAC is hereby amended to read as follows:

NAC 616B.010 1. Except as otherwise provided in NAC 616B.013, copies of all claim files maintained by an insurer, third-party administrator or organization for managed care pursuant to chapters 616A to 617, inclusive, of NRS or regulations adopted pursuant thereto must be maintained in one of its offices located in this State.

2. All correspondence and other documents submitted to an insurer, third-party administrator or organization for managed care that concern a claim for compensation that is being administered pursuant to chapters 616A to 617, inclusive, of NRS or regulations adopted pursuant thereto must be addressed to the insurer, third-party administrator or organization for managed care at one of its offices located in this State. ~~[The correspondence and documents shall be deemed to be officially received only if they have been so addressed.]~~

Sec. 6. Chapter 616B.121 of the NAC is hereby amended to read as follows:

616B.121 1. *IAIABC EDI Implementation Guide for Proof of Coverage*, which is published by the International Association of Industrial Accident Boards and Commissions. A copy of the publication may be obtained from the International Association of Industrial Accident Boards and Commissions, 5610 Medical Circle, Suite ~~[14]~~ ***24***, Madison, Wisconsin 53719, ***free for members online*** and for the price of ~~[$50 for members and]~~ $95 for nonmembers.

2. *Workers Compensation Policy Data Reporting Manual*, which is published by the National Council on Compensation Insurance. A copy of the publication may be obtained from the National Council on Compensation Insurance, Products and Services Department, 901 Peninsula Corporate Circle, Boca Raton, Florida 33487, for the price of $120 for affiliates and $155 for nonaffiliates.

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

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

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

6. *Workers Compensation Data Specifications Manual*, which is published by the National Council on Compensation Insurance. A copy of the publication may be obtained from the National Council on Compensation Insurance, Products and Services Department, 901 Peninsula Corporate Circle, Boca Raton, Florida 33487, for the price of $78 ***or free of charge online***.

Sec. 7. Chapter 616B.760 of the NAC is hereby amended by adding thereto the provisions set forth to read as follows:

616B.760 1. A claim against the Subsequent Injury Account for Private Carriers pursuant to NRS 616B.587 or 616B.590 must be submitted, in writing, to the Administrator.

2. A private carrier who submits a claim pursuant to subsection 1 shall include with the claim:

(a) All documents contained in the file of the claim and any other supporting documents that the private carrier relies upon or deems important for the determination of a claim; and

(b) A completed copy of the form entitled D-37, Insurer's Subsequent Injury Checklist, which is prescribed by the Administrator. A copy of the form may be obtained from the Administrator at no cost.

3. A claim submitted to the Administrator pursuant to subsection 1 must be organized in the manner prescribed in Form D-37, Insurer's Subsequent Injury Checklist.

4. A private carrier who submits a claim pursuant to subsection 1 shall, upon the request of the Administrator:

(a) Allow the Administrator to inspect the records maintained by the private carrier concerning the claim; or

***(b) Provide copies of those records to the Administrator*.**

5. The provisions of this section do not affect the authority of the Administrator to obtain additional information related to the claim from the employer or any other source after the claim is deemed to be completed.

6. The Administrator need not process incomplete applications or applications that are not in compliance with form D-37 and may return the deficient application to the applicant.

Sec. 8. Chapter 616B.766 of the NAC is hereby amended to read as follows:

616B.766 1. The Administrator will examine a claim against the Subsequent Injury Account for Private Carriers and not later than ~~[90]~~ ***120*** days after his receipt of the claim will:

(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 the claim is accepted, notify the private carrier of the verified amount of reimbursement and that the claim will be processed for payment by the State Controller.

2. An appeal from a determination of the Administrator concerning a claim against the Subsequent Injury Account for Private Carriers must be made in writing and sent directly to the appeals officer within 30 days after the date of the Administrator's determination.

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

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

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

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

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

(1) Completing:

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

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

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

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

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

(c) Demonstrate an understanding of:

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

(2) The *Guide*.

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

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

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

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

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

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

(e) Except as otherwise provided in subsection 5, ~~[if the physician or chiropractor passed an examination concerning an edition of the Guide that is not the most recent edition adopted by the Administrator to become designated as a rating physician,]~~ pass the Nevada Impairment Rating Skills Assessment Test which is administered by the American Academy of Expert Medical Evaluators or its successor organization and which examines the practical application of the rating of disabilities in accordance with the *Guide* with a score of 75 percent or higher.

5. If an ophthalmologist or psychiatrist has been designated as a rating physician and wishes to maintain such designation, the Administrator may exempt the ophthalmologist or psychiatrist

who is authorized to practice in this State from the requirements set forth in paragraphs (a), (c), (d) and (e) of subsection 4 and authorize the ophthalmologist or psychiatrist to continue to evaluate injured employees with impaired vision or brain function according to his area of specialization.

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

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

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

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

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

Sec. 10. Chapter 616C.027 of the NAC is hereby amended to read as follows:

616C.027 1. A provider of health care whose bill has been denied or reduced or is not paid in a timely manner may, within 60 days after receiving notice of the denial or reduction, or within 60 days after the payment was due, submit a written request to the ~~[Industrial Insurance Regulation Section]~~ ***Workers' Compensation Section*** for a review of that action. The request must identify the billed item for which the review is sought and state the ground upon which the request is based. The ~~[Industrial Insurance Regulation Section]~~ ***Workers' Compensation Section*** shall review the matter, and if it determines that issuing a written determination is appropriate, it

shall issue a written determination and mail or deliver copies of the determination to the provider of health care and the insurer. If the determination is in the provider's favor, the insurer shall, within 30 days after receiving notice of the determination, pay the bill, unless an appeal is taken in the manner provided by subsection 2.

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

3. The provider of health care and the insurer will be the only parties to the hearing scheduled pursuant to subsection 2.

Sec. 11. Chapter 616C.082 of the NAC is hereby amended to read as follows:

616C.082. 1. An insurer, third-party administrator or organization for managed care shall ensure that all documents concerning claims that it receives pursuant to chapters 616A to 617, inclusive, of NRS or regulations adopted pursuant thereto indicate the date of receipt.

(a) Health care provider bills must indicate the date the insurer approved or denied payment.

(b) The insurer must retain a copy of the approved or denied bill in the claim file.

2. All claims filed with the insurer, third-party administrator or organization for managed care pursuant to subsection 1 and all documents concerning such claims must be acted upon in the chronological order of their filings, insofar as possible.

3. All documents which constitute the record of a claim filed with the insurer, third-party administrator or organization for managed care pursuant to subsection 1, including investigative

reports, medical reports, and records evidencing payments of benefits, compensation or awards, remain the property of the insurer.

Sec. 12. Chapter 616C.088 of the NAC is hereby amended to read as follows:

616C.088 ~~[1. An insurer shall maintain a file of employees' claims concerning industrial injuries and occupational disease, including, without limitation, claims which have been denied. The file must be indexed by the names and social security numbers of the injured employees.]~~

~~[2.]~~ ***1.*** The file for each industrial injury or occupational disease must contain:

(a) The employer's report of the industrial injury or occupational disease.

(b) The claim for compensation and any medical report associated with that claim that is issued after the claim is filed with the insurer.

(c) All:

(1) Applications for a stay concerning a decision on a claim for compensation made to a hearing officer, appeals officer or a court of competent jurisdiction;

(2) Written orders or decisions on a claim for compensation entered by a hearings officer, appeals officer or a court of competent jurisdiction;

(3) Written determinations made by an insurer, third-party administrator or an organization for managed care concerning a claim for compensation;

(4) Written settlement agreements or stipulations made between the injured employee and his employer or the insurer of the employer concerning a claim for compensation; and

(5) Except as otherwise provided in subparagraph (2) of paragraph (f), other documents which affect the amount, timing or denial of the payment of compensation.

➥ As used in this paragraph, "payment of compensation" has the meaning ascribed to it in subsection 2 of NAC 616D.305.

(d) A record of all compensation paid to the injured employee and all payments made to any other person in connection with the claim, for:

(1) Accident benefits;

(2) Temporary partial disability;

(3) Temporary total disability;

(4) Permanent partial disability;

(5) Permanent total disability;

(6) Death benefits; and

(7) Vocational rehabilitation,

➥ and the amount of the expected total incurred costs and the justification.

(e) A copy of any notice of termination of benefits which has been sent to the injured employee.

(f) Copies of all correspondence and other documents pertaining to the claim, including, without limitation, copies of:

(1) All medical bills incurred by the injured employee and received by the insurer; and

(2) Any notices sent to the injured employee to inform him of his right to a review or appeal,

➥ but not including records of any privileged communication between the insurer and its attorney or of any investigation conducted by or on behalf of the insurer concerning a possible violation of NRS 616D.300.

(g) All ratings performed by any physician or chiropractor.

(h) A summary of conversations or oral negotiations, or both, conducted by the insurer with the injured employee, the legal counsel who represents the injured employee or any other party other than the physician or chiropractor of the injured employee, if action is requested or taken.

(i) After the claim is closed, the log of oral ***and written*** communications relating to the medical disposition of a claim that must be maintained ***in the claim file*** by an insurer pursuant to NRS 616D.330.

~~[3.]~~ ***2.*** Each file of a claim must be retained for 2 years after the death of the injured employee.

Sec. 13. Chapter 616C.091 of the NAC is hereby amended to read as follows:

616C.091 After receipt of a claim for compensation, the insurer shall give written notice of its determination to accept or deny the claim to the injured employee***, the person acting on behalf of the injured employee,*** or ~~[his]~~ ***the injured employee's*** dependents and, if the injured employee's employer is not self-insured, to the injured employee's employer. If the insurer denies the claim:

1. The insurer shall, pursuant to NRS 616C.065, notify the Administrator of the denial.

2. The notice of denial to the injured employee, ***the person acting on behalf of the injured employee,*** or ~~[his]~~ ***the injured employee's*** dependents must include:

(a) A written statement of the right to request a hearing on the matter before a hearing officer and a form for requesting a hearing; and

(b) The reasons for the denial.

3. The insurer shall provide a copy of each notice of denial it gives pursuant to subsection 2 to the injured employee's treating physician or chiropractor.

4. The notice of denial required to be given to the Administrator pursuant to subsection 1 must include:

(a) A copy of the notice of denial given to the injured employee or his dependents; and

(b) A copy of Form C-4, Employee's Claim for Compensation/Report of Initial Treatment, that was completed by the injured employee or his dependents.

5. If the insurer accepts the claim, the insurer shall include the following with the written notification of claim acceptance:

(a) A copy of the Alternative Choice of Physicians or Chiropractors and Referral to a Specialist, D-52 form; and

(b) The insurer's or third-party administrator's Web site, if established and available, for their Preferred Provider Organization list, or notify the injured employee that upon written request he may obtain the insurers' list of providers of heath care pursuant to NAC 616C.030.

~~[5]~~ ***6***. Each notice of ***acceptance and*** denial must be given within the time prescribed in NRS 616C.065.

Sec. 14. Chapter 616C.094 of the NAC is hereby amended to read as follows:

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

(a) 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,

➥ the insurer, third-party administrator or organization for managed care shall, in writing, notify the person making the request of its determination concerning the request.

2. If the insurer, third-party administrator or organization for managed care terminates or denies any benefit in response to a written 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.

(a) A copy of the insurer's or third-party administrator's determination must be mailed to the injured employee.

3. If the insurer or third-party administrator denies a written request to reopen a claim, it shall notify the person making the request and the employer of that person, in writing, specifying the reasons for its determination and an explanation of the person's right to appeal.

Sec. 15. Chapter 616C.097 the NAC is hereby amended to read as follows:

616C.097 1. Any written ~~[insurer]~~ determination ~~[notice of an insurer with]~~ ***by*** an organization for managed care ~~[contract]~~ relating to accident benefits must include at the bottom of the notice a statement in substantially the following form:

> If you disagree with the above determination, sign, date, and briefly explain on the bottom of this notice the reason for your appeal and return this notice to ***name, address of organization for managed care*** ~~[your insurer]~~ within ~~[70]~~ ***14*** days after the date on which ~~[the]~~ ***this*** notice was mailed by the insurer.

2. Any written ~~[insurer]~~ determination ~~[notice]~~ of an ~~[insurer]~~ ***organization for managed care*** relating to benefits, other than accident benefits, ~~[provided by an insurer with an organization for managed care contract,]~~ must include at the bottom of the notice a statement in substantially the following form:

If you disagree with the above determination, sign, date, and briefly explain on the bottom of this notice the reason for your appeal and return it to the Hearing Officer at the Department of Administration within 70 days after the date on which the notice was mailed ~~[by the insurer]~~.

Sec. 16. Chapter 616C.123 of the NAC is hereby amended to read as follows:

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

2. The Administrator will, on or before February 1 of each year, review the most recently published edition of or update to the *Occupational Medicine Practice Guidelines*. Each new edition of or update to the *Occupational Medicine Practice Guideline*s shall be deemed approved by the Administrator for use in this State on February 1 of each year, unless a notice of disapproval of the edition or update is posted pursuant to this subsection by the immediately preceding April 1. If the Administrator wishes to disapprove a new edition of or update to the *Occupational Medicine Practice Guidelines*, he will:

(a) Post a notice of disapproval at the largest public library in each county, the State Library and Archives, the Grant Sawyer Office Building located at 555 East Washington Avenue, Las Vegas, Nevada, and all offices of the Division; and

(b) Send a notice to each person included on the mailing list that the Division is required to maintain pursuant to paragraph (e) of subsection 1 of NRS 233B.0603.

➥ If the Administrator disapproves an edition of or update to the *Occupational Medicine Practice Guidelines*, the edition or update that was most recently adopted by reference or deemed approved pursuant to this section will continue in effect.

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

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

(b) Is licensed to practice in this State;

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

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

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

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

5. A copy of the *Guidelines* may be purchased from Occupational Environmental Medicine Health Information, Inc., at ~~[8 West Street, Beverly Farms, Massachusetts 01915-2226,]~~ ***25 Northwest Point Blvd, Suite 700, Elk Grove Village, Illinois, 60007-1030*** or by telephone at ~~[(800) 533-8046]~~ ***(847) 818-1800,*** at a cost of $175 for persons who are members of the American College of Occupational and Environmental Medicine and $199 for persons who are not members of the American College of Occupational and Environmental Medicine.

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

Sec. 17. Chapter 616C.129 of the NAC is hereby amended to read as follows:

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

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

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

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

injured employee is already under the care of another provider of health care. The insurer may be liable for the payment of the fees pursuant to this subsection if the insurer gives prior written approval for the treatment or good cause is shown for the treatment provided.

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

(a) The treating physician or chiropractor; or

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

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

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

(a) Consultation;

(b) Diagnostic testing;

(c) Elective hospitalization;

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

(e) Any elective procedure.

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

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

8. The physician or chiropractor is required to respond to a written request made by the insurer within 30 days of receipt of the request.

Sec. 18. Chapter 616C.145 of the NAC is hereby amended to read as follows:

616C.145 1. Except as otherwise provided in this section, providers of health care who treat injured employees pursuant to this chapter and chapter 616C of NRS shall comply with the most recently published edition of or update to the *Relative Values for Physicians*, which the Division hereby adopts by reference.

2. The Administrator will, on or before February 1 of each year, review the most recently published edition of or update to the *Relative Values for Physicians*. Each new edition of or update to the *Relative Values for Physicians* shall be deemed approved by the Division for use in this State from February 1 through January 31, unless a notice of disapproval of the edition or update is posted pursuant to this subsection by the immediately preceding February 1. If the

Administrator wishes to disapprove a new edition of or update to the *Relative Values for Physicians*, he will:

(a) Post a notice of disapproval at the largest public library in each county, the State Library and Archives, the Grant Sawyer Office Building located at 555 East Washington Avenue, Las Vegas, Nevada, and all offices of the Division; and

(b) Send a notice to each person included on the mailing list that the Division is required to maintain pursuant to paragraph (e) of subsection 1 of NRS 233B.0603.

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

3. A copy of *Relative Values for Physicians*, as adopted by reference pursuant to subsection 1, may be purchased from Ingenix, ~~[5225 Wiley Post Way, Suite 500, Salt Lake City, Utah 84116-2889, (800) 999-4600]~~ ***12125 Technology Drive, Eden Prarie, MN 55344, (888) 445-8745*** for the price of ~~[$279.95]~~ ***$329.95.***

Sec. 19. Chapter 616C.146 of the NAC is hereby amended by adding thereto the provisions set forth to read as follows:

616C.146 1. Anesthesiologists who treat injured employees pursuant to this chapter and chapter 616C of NRS shall comply with the most recently published edition of or update to the *Relative Value Guide of the American Society of Anesthesiologists*, which the Division hereby adopts by reference.

2. The Administrator will, on or before February 1 of each year, review the most recently published edition of or update to the *Relative Value Guide of the American Society of Anesthesiologists*. Each new edition of or update to the *Relative Value Guide of the American*

Society of Anesthesiologists shall be deemed approved by the Division for use in this State on February 1 of each year, unless a notice of disapproval of the edition or update is posted pursuant to this subsection by the immediately preceding February 1. If the Administrator wishes to disapprove a new edition of or update to the *Relative Value Guide of the American Society of Anesthesiologists*, he will:

(a) Post a notice of disapproval at the largest public library in each county, the State Library and Archives, the Grant Sawyer Office Building located at 555 East Washington Avenue, Las Vegas, Nevada, and all offices of the Division; and

(b) Send a notice to each person included on the mailing list that the Division is required to maintain pursuant to paragraph (e) of subsection 1 of NRS 233B.0603.

➥ If the Administrator disapproves an edition of or update to the *Relative Value Guide of the American Society of Anesthesiologists*, the edition or update that was most recently adopted by reference or deemed approved pursuant to this section will continue in effect.

3. A copy of the *Relative Value Guide of the American Society of Anesthesiologists*, as adopted by reference pursuant to subsection 1, may be purchased from the American Society of Anesthesiologists, 520 N. Northwest Highway, Park Ridge, Illinois 60068-2573, (847) 825-5586, for the price of $25 for ***members and $75 for non-members***.

4. Except as otherwise provided in this subsection, an anesthesiologist shall use the codes that are stated in the *Relative Value Guide of the American Society of Anesthesiologists* for each procedure which he bills and submits to an insurer. If a code for a procedure performed by an anesthesiologist is not provided in the *Guide*, the anesthesiologist shall use the code provided for that procedure in the *Relative Values for Physicians*, as adopted by reference pursuant to NAC 616C.145, using the appropriate conversion factor for the code that is assigned to that procedure.

Sec. 20. Chapter 616C.147 of the NAC is hereby ammended to read as follows:

616C.147 1. The Division hereby adopts by reference the ***Center for Medicare and Medicaid Services' 2007*** ~~[most current complete]~~ list of eligible codes for surgical centers for ambulatory patients and the payment groups to which those codes are assigned ~~[for services rendered on and after September 7, 2005]~~, as those codes are set forth in the "Centers for Medicare and Medicaid Services, CMS Common Procedures Coding System (HCPCS)," which is contained in the ***Relative Values for Physicians*** that is adopted by reference pursuant to NAC 616C.145.

Sec. 21. Chapter 616C.148 of the NAC is hereby amended to read as follows:

NAC 616C.148 Unless good cause is shown:

1. A rating physician or chiropractor shall mail a report of an evaluation of an injured employee to the insurer within 14 days after the evaluation is completed. Unless good cause is shown, if an addendum is requested by the insurer, the rating physician or chiropractor shall mail the addendum to the insurer within 14 days after receiving the request.

2. If a rating evaluation is requested by an injured employee or his representative, the rating physician or chiropractor shall mail a report of the evaluation to the injured employee or his representative within 14 days after the evaluation is completed. Unless good cause is shown, if an addendum is requested by the injured employee or his representative, the rating physician or chiropractor shall mail the addendum to the injured employee or his representative within 14 days after receiving the request.

3. A rating physician or chiropractor's report must include all physical examination findings, and reference all tables utilized in the Guides to determine the injured employee's permanent impairment.

4. The rating physician or chiropractor is required to retain copies of the evaluation report and all their own supporting documentation, for 5 years, excluding those documents the insurer provided for the impairment rating pursuant to NAC 616C.103(3)(c)(1)(2)(3).

Sec. 22. Chapter 616C.149 of the NAC is hereby amended to read as follows:

616C.149 1. Each provider of health care and each medical facility shall submit a bill to the insurer which includes:

(a) The usual charge for services provided;

(b) The code for the procedure and a description of the services;

(c) The number of visits and date of each visit to the office of the provider of health care or to the medical facility and the procedures followed in any treatment administered during the visit;

(d) The codes for supplies and materials provided or administered to the injured employee that are set forth in the "Centers for Medicare and Medicaid Services, CMS Common Procedures Coding System (HCPCS)," as contained in the *Relative Values for Physicians*, as adopted by reference pursuant to NAC 616C.145;

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

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

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

2. In addition to the information required by subsection 1, each physician or chiropractor and each medical facility shall include on the bill the ICD-9-CM codes identifying the parts of the body of the injured employee that were affected by the injury, as set forth in the most recently published edition of or update to the *International Classification of Diseases, Clinical Modification* (ICD-9-CM), which is hereby adopted by reference.

3. The Administrator will, on or before February 1 of each year, review the most recently published edition of or update to the *International Classification of Diseases*. Each new edition of or update to the *International Classification of Diseases* shall be deemed approved by the Administrator for use in this State on February 1 of each year, unless a notice of disapproval of the edition or update is posted pursuant to this subsection by the immediately preceding April 1. If the Administrator wishes to disapprove a new edition of or update to the *International Classification of Diseases*, he will:

(a) Post a notice of disapproval at the largest public library in each county, the State Library and Archives, the Grant Sawyer Office Building located at 555 East Washington Avenue, Las Vegas, Nevada, and all offices of the Division; and

(b) Send a notice to each person included on the mailing list that the Division is required to maintain pursuant to paragraph (e) of subsection 1 of NRS 233B.0603.

➥ If the Administrator disapproves an edition of or update to the *International Classification of Diseases*, the edition or update that was most recently adopted by reference or deemed approved pursuant to this section will continue in effect.

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

(a) ~~[Channel Publishing, Ltd., P.O. Box 70723, Reno, Nevada 89570, (800) 248-2882]~~, ***Opamp Technical Books, 10033 North Sycamore Avenue, Los Angeles, CA 90038*** for the price of ~~[$64.95]~~ ***$84.95***; or

(b) ~~[Ingenix, 5225 Wiley Post Way, Suite 500, Salt Lake City, Utah 84116-2889, (800) 999-4600,]~~ ***Amazon.com*** for the price of ~~[$74.95]~~ ***$83.65***.

5. The initial bill submitted to the insurer by a licensed physical therapist or a licensed occupational therapist must be accompanied by a copy of the order for the services rendered

issued by the treating physician or chiropractor. Any subsequent bill submitted to the insurer by a licensed physical therapist or a licensed occupational therapist must include a copy of the order for the services rendered issued by the treating physician or chiropractor if the order for services rendered is changed by the treating physician or chiropractor.

Sec. 23. Chapter 616C.396 of the NAC is hereby amended to read as follows:

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

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

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

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

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

(e) The injured employee fails to complete and return to the Industrial Insurance Regulation Section:

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

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

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

➥ within 30 days after he receives the form from the Industrial Insurance Regulation Section.

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

Sec. 24. Chapter 616C.555 of the NAC is hereby amended to read as follows:

616C.555 An insurer shall ensure that the vocational rehabilitation counselor assigned to a claim by the insurer complies with the provisions of ~~[subsections 1, 2 and 3 of NRS 616C.550]~~ ***NRS 616C.547, subsections 1 – 10 of NRS 616C.555*** and the provisions of NAC 616C.556.

Sec. 25. Chapter 616C of the NAC is hereby amended by adding thereto the provisions set forth as a new section to read as follows:

If an insurer or third-party administrator receives a written notice from an employee or dependent of an employee pursuant to NRS 616C.409 (1), the insurer or third-party administrator has 30 days from the date of receipt to establish direct deposit to the account specified in the written notice.

Sec. 26. Chapter 616C of the NAC is hereby amended by adding thereto the provisions set forth as a new section to read as follows:

When claims records are transferred from one insurer or third-party administrator to another, the transferring insurer or third-party administrator shall:

(a) Ensure that the new insurer or third-party administrator has the information necessary to administer claims and make timely payment of compensation.

(b) Ensure that the new insurer or third-party administrator has the information necessary to comply with all State reporting requirements and requests.

(c) Provide the information in a format usable by the new insurer or third-party administrator.

(d) Produce, transmit and retain a printed Open Claims List of all open claims as of the date of transfer, containing sufficient information to enable the new insurer or third-party administrator to make timely payment of compensation and continue administration of the claims.

(1) The Open Claims List must include the current status of the claim, the due dates and anticipated duration of any compensation which is due or is known may be due within 90 days of the date of transfer, pending issues and determinations, a brief summary of the history and projected outcome of the claim, and any other matters necessary to ensure the quick and efficient payment of compensation and administration of the claims.

(2) The Open Claims List must be delivered to the new insurer or third-party administrator on or before the date of transfer.

(3) The Open Claims List must be retained by the insurers and/or both third-party administrators as long as necessary for the purpose of assigning responsibility for failure to pay compensation but in no event no less than two years from the date of transfer.

(e) Mail a Notice of Transfer of Administration to those claimants, health care providers, designated legal representatives, and others involved with treatment, rating or administrative matters of each claimant of the new insurer or third-party administrator.

(f) For a period of one year after the date of transfer, forward to the new insurer or third-party administrator, within 3 working days of receipt, all documents pertaining to claims from the former insurer or third-party administrator and mail a Notice of transfer of Administration to the sender.

(g) For a period of one year after the date of transfer, tell all persons calling regarding the transferred claims that the claim is being handled by a new insurer or third-party administrator and provide the address and phone number of the new insurer or third-party administrator.

3. The new insurer or third-party administrator must pay in a timely manner all compensation described on the Open Claims List unless that insurer or third-party administrator issues a written determination, with appropriate appeal rights, that such compensation is not due. The new insurer or third-party administrator must take any other action indicated on the Open Claims List and all other actions necessary to ensure the quick and efficient payment of compensation, other benefits, and administration of claims.

4. The new insurer or third-party administrator must review each open file within 30 days of the date of transfer and determine what action must be taken for each file.

5. Within 3 working days of receipt of a notice or other legal documentation pertaining to contested claim matters before a hearing officer, appeals officer or court of competent jurisdiction, the former insurer or third-party administrator shall notify, in writing, the sender of the notice or legal documentation of the contact information for the new insurer or third-party administrator and then forward that notice or legal documentation to the new insurer or third-party administrator.

Sec. 27. Chapter 616C of the NAC is hereby amended by adding thereto the provisions set forth as a new section to read as follows***:***

1. Insurers may be fined or penalized for the conduct of their third-party administrators. Benefit penalties and fines may be imposed upon insurers for the combined or individual conduct of third-party administrators. For purposes of the imposition of benefit penalties and

fines, the third-party administrators are deemed agents of the insurer. Separate fines and benefit penalties may not be levied against different parties for the same violation.

2. If the Administrator determines violations of 616A to 616D, inclusive, or Chapter 617 of NRS, or any regulation adopted pursuant thereto have occurred, but is unable to determine which third-party administrator is in violation, appropriate fines and benefit penalties shall be levied against the insurer.

3. A succession in insurers or third-party administrators may not be asserted as a defense against the imposition of a fine or benefit penalty.

Sec. 28. Chapter 616C of the NAC is hereby amended by adding thereto the provisions set forth as a new section to read as follows:

1. All written determinations issued by the insurer must contain the following: The claim number, employer, insurer, third-party administrator (if applicable), the date of injury, date of notice, and specific body parts accepted and body parts denied (if applicable). In addition, appeal rights must be provided that include the 70-day deadline to file an appeal, the addresses of the Hearings Divisions in Carson City and Las Vegas.

Sec. 29. Chapter 616C of the NAC is hereby amended by adding thereto the provisions set forth as a new section to read as follows:

1. As used in NRS 616C.065, subsection 8, "receipt" means a written acknowledgment from the United States Postal Service as having received the insurer's or third-party administrator's written determination denying a claim in whole or in part.

Sec. 30. Chapter 616C of the NAC is hereby amended by adding thereto the provisions set forth as a new section to read as follows:

1. Upon receipt of medical documentation from the treating physician, the insurer shall within 30 days complete the process of purchasing and modifying a vehicle for the injured employee.

2. The insurer shall determine the model and make of the vehicle based on the medical requirements and physical restrictions of the injured employee.

3. The insurer will modify the vehicle to meet the physical restrictions of the injured employee. The insurer will provide a modified vehicle as needed every 8 years or 100,000 miles, whichever comes first, and in no case may total expenses exceed $250,000, unless good cause is shown.

4. If an injured employee requests a replacement modified vehicle due to accident, mechanical malfunction or any other circumstance, the insurer shall provide a modified vehicle if the injured employee is able to demonstrate that the injured employee will drive the replacement vehicle and that the inoperable or damaged vehicle purchased by the insurer cannot be repaired.

5. The insurer shall provide mileage reimbursement for all claim-related travel.

6. If the injured worker does not qualify to receive a replacement vehicle, he shall be provided transportation to all claim-related appointments. Transportation may be provided in the form of a monthly transportation pass, door-to-door public transportation service, or other means as determined by the insurer, taking into consideration the injured employee's medical condition.

Sec. 31. Chapter 616D.060 of the NAC is hereby ammended to read as follows:

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

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

2. Give notice of the right to file a petition for judicial review within 30 days after service of the decision; and

3. ~~[Cause]~~ ***Mail*** 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. 32. Chapter 616D.411 of the NAC is hereby amended by adding thereto the provisions set forth to read as follows:

NAC 616D.411 1. To determine the amount of a benefit penalty required to be paid pursuant to subsection 3 of NRS 616D.120, the Administrator will determine that the violation caused physical or economic harm to the injured employee or his dependents if he finds, by a preponderance of the evidence, that:

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

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

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

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

3. The Administrator will determine the amount of a benefit penalty required to be paid pursuant to subsection 3 of NRS 616D.120 according to the following schedule. In addition to

the required minimum benefit penalty of $5,000, a claimant will be awarded $1,625 for each point assessed, but in no event will the amount of the benefit penalty be greater than $37,500.

Points assessed for physical harm:

Temporary minor harm..... 2 points

Temporary major harm..... 5 points

Permanent minor harm..... 5 points

Permanent major harm..... 10 points

Death..... 20 points

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

Amount of compensation

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

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

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

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

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

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

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

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

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

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

Points assessed for prior violations:

One prior violation..... 1 point

Two prior violations..... 3 points

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

Points assessed for economic harm:

Amount of economic harm

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

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

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

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

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

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

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

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

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

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

4. To determine the number of prior violations of an insurer, organization for managed care, health care provider, third-party administrator or employer, the Administrator will consider only those fines and benefit penalties imposed pursuant to paragraphs (a) to (e), inclusive, and (h) of subsection 1 of NRS 616D.120 in the immediately preceding 5 years. ***The Administrator will not consider benefit penalties imposed pursuant to subsection 3b of NRS 616D.120.***

5. As used in this section:

(a) “Dependent” means a person who:

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

(I) The spouse of the injured employee;

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

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

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

(b) “Economic harm” includes:

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

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

(c) “Permanent major harm” means physical harm that:

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

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

(d) “Permanent minor harm” means physical harm that:

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

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

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

(1) The neurological system.

(2) The musculoskeletal system.

(3) Special sense organs.

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

(5) The cardiovascular system.

(6) The reproductive system.

(7) The digestive system.

(8) The genitourinary system.

(9) The hemic and lymphatic system.

(10) The skin.

(11) The endocrine system.

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

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

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

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

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

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

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

Sec. 33. Chapter 616D of the NAC is hereby amended by adding thereto the provisions set forth as a new section to read as follows:

Violations of NRS 616D.120(9) committed by uncertified counselors may result in the Administrator imposing a fine on the supervising certified vocational rehabilitation counselor in the uncertified counselor's chain of authority.

Sec. 34. NAC 616B.780, 616B.786, 616B.789, 616B.792, 616B.795, 616B.796, 616B.800, 616B.809, 616B.810, 616B.812, 616B.815, 616B.818, 616C.085, 616C.112, and 616D.335 are hereby repealed.

TEXT OF REPEALED SECTIONS

NAC 616B.780 Establishment of employer-employee relationship; liability of principal contractor for premiums. (NRS 616A.400**)**

1. An employer who hires a person to do work related to, or in furtherance of, his business operations that are insured by a 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 a private carrier, the principal contractor must 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 complete 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 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 private carrier shall determine what portion of the contract price will be deemed the payroll for the employees of the subcontractor or independent

contractor. In no case may 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 a private carrier 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.

NAC 616B.786 Coverage of sole proprietor acting as subcontractor or principal contractor. (NRS 616A.400**)**

1. A sole proprietor acting as a subcontractor in this State who is licensed pursuant to chapter 624 of NRS shall be deemed to receive $500 per month in wages. A sole proprietor 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 pursuant to chapter 624 of NRS does not affect the coverage or deemed wage required.

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

3. If a sole proprietor acting as a subcontractor 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 sole proprietor during the term of the contract.

NAC 616B.789 Use of wages in determining premium and disability compensation; liability of principal contractor for premiums. (NRS 616A.400**)**

1. For the purposes of determining premium and disability compensation, the wage of a sole proprietor who is not licensed pursuant to chapter 624 of NRS, has not elected coverage under the elective provisions of chapters 616A to 617, inclusive, of NRS and is performing as a subcontractor to an insured principal contractor shall be deemed to be $300 per month or $10 per day for the period of the subcontract, unless the contract specifies a wage greater than $300 per month or $10 per day for the sole proprietor.

2. For the purposes of determining premium and disability compensation, the wage of a sole proprietor who is licensed pursuant to chapter 624 of NRS but who has failed to open or maintain an account in good standing and who is performing as a subcontractor to an insured principal contractor shall be deemed to be $500 per month or $17 per day for the period of the subcontract unless the contract specifies a wage greater than $500 per month or $17 per day for the sole proprietor.

3. For the purposes of determining the premium required to be paid by the principal contractor and disability compensation, the wages of an employee of a sole proprietor 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 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 that would be applicable to the subcontractor and the experience modification factor which would be applicable to the principal contractor.

NAC 616B.792 Coverage of sole proprietor seeking to obtain or fulfill contract with State. (NRS 616A.400**)**

1. A sole proprietor who is not licensed pursuant to chapter 624 of NRS, but who is required by statute to provide industrial insurance for himself 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.

NAC 616B.795 Coverage of corporate officers. (NRS 616A.400**)** A private carrier shall 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 617, inclusive, of NRS, including, without limitation:

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 the State of Nevada, based upon the amounts deemed to be paid to him pursuant to chapters 616A to 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 617, inclusive, of NRS.

NAC 616B.796 Certain provisions not applicable to coverage of corporate officer. (NRS 616A.110**,** 616A.400**,** 616B.624**)** 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.

NAC 616B.800 Coverage for excluded employees. (NRS 616A.400**,** 616B.656**)**

1. If an employer elects to cover an employee who is excluded from the benefits of chapters 616A to 617, inclusive, of NRS pursuant to NRS 616A.110 or if the employer subsequently wishes to withdraw such an election, the written statement or notice that the employer is required to provide pursuant to subsection 2 of NRS 616B.656 to his insurer and the Administrator must be served personally or sent by first-class mail on a completed form entitled D-44, Election of Coverage by Employer and Employer Withdrawal of Election of Coverage, which is prescribed by the Administrator, or, if sent by electronic transmission, the notice must contain the same

information as the form. The notice must be provided within 30 days after the effective date of the election or withdrawal. The employer is not required to serve the notice on the Administrator if notice is served on the Administrator by the insurer on behalf of the employer.

2. If an employee that is excluded from the benefits of chapters 616A to 617, inclusive, of NRS pursuant to NRS 616A.110 rejects coverage elected by his employer pursuant to NRS 616B.656 or if the employee subsequently elects to waive such a rejection, the written notice that the employee must provide to his employer, the insurer of his employer and the Administrator pursuant to subsection 3 of NRS 616B.656 must be served personally or sent by first-class mail on a completed form entitled D-43, Employee's Election to Reject Coverage and Election to Waive the Rejection of Coverage for Excluded Persons, which is prescribed by the Administrator, or, if sent by electronic transmission, the notice must contain the same information as the form. The notice must be provided within 30 days after the effective date of the election or rejection. The employee is not required to serve the notice on the Administrator if notice is served on the Administrator by the insurer on behalf of the employee.

NAC 616B.809 Elected coverage for sole proprietors. (NRS 616A.400**,** 616B.659**)**

1. If a sole proprietor elects to purchase industrial insurance pursuant to chapters 616A to 617, inclusive, of NRS or elects to pay an additional amount of premium for additional coverage or subsequently wishes to withdraw an election for coverage, the written notice that the sole proprietor is required to provide to the private carrier and the Administrator pursuant to NRS 616B.659 must be served personally or sent by first-class mail on a completed form entitled D-45, Sole Proprietor Coverage, which is prescribed by the Administrator, or, if sent by electronic transmission, the notice must contain the same information as the form. The notice must be served within 30 days after the effective date of the election or withdrawal and must be

accompanied by a report of any physical examinations prescribed by the private carrier. The sole proprietor is not required to serve the notice on the Administrator if notice is served on the Administrator by the private carrier on behalf of the sole proprietor.

2. A sole proprietor for whom coverage is elective pursuant to NRS 616A.220, who meets the qualifications for elective coverage pursuant to that section and who is not otherwise required to maintain coverage pursuant to chapters 616A to 616D, inclusive, or chapter 617 of NRS, must comply with the requirements set forth in NAC 616B.810.

3. Except as otherwise provided in subsection 4, for the purposes of determining premium and disability compensation, a sole proprietor who applies for coverage pursuant to NRS 616B.659 will be provided coverage at the rate provided in the manual at the deemed wage of $300 per month or, if additional premiums are received for additional coverage, at the deemed wage of $1,800 per month. A sole proprietor who:

(a) Files notice with a private carrier, pursuant to NRS 616B.659, of his election to pay for additional coverage; and

(b) Sustains an injury within the 90-day period provided by subsection 6 of NRS 616B.659,

➥ will be provided coverage at the deemed wage of $300 per month, notwithstanding the election to pay for additional coverage.

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

NAC 616B.810 Elected coverage for real estate broker, broker-salesman or salesman. (NRS 616A.220**,** 616A.400**)**

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 617, inclusive, of NRS may elect coverage pursuant to NRS 616A.220 by submitting to a 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.

NAC 616B.812 Application for coverage of volunteers. (NRS 616A.400**,** 616B.656**)**

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

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

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

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

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

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

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

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

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

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

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

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

NAC 616B.815 Coverage for volunteers: Effective date; classifications; payroll to be reported. (NRS 616A.400**,** 616B.656**)**

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

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

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

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

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

NAC 616B.818 Termination of coverage for volunteers. (NRS 616A.400**,** 616B.656**)**

1. The elective coverage of volunteers remains in effect until:

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

(b) The Administrator or the private carrier finds that an employer electing coverage has not maintained a current roster of volunteers,

➥ whichever occurs earlier.

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

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

NAC 616C.085 Log of claims. (NRS 616A.400**)** Each insurer shall maintain a log of claims. The log must contain the following information:

1. The name of the injured employee.

2. The date on which the alleged injury occurred or disease was reported to the employer.

3. A brief description of the alleged accident and injury of occupational disease, including, without limitation, a statement as to the type of any benefits paid.

4. An entry to indicate whether the claim has been denied.

NAC 616C.112 Notice of intention to close claim. (NRS 616A.400**,** 616C.235**)** The notice of intention to close a claim required by subsection 1 of NRS 616C.235 must include:

1. The provisions of subsection 2 of NRS 616C.390; and

2. An offer to the injured employee of an opportunity for him to appeal from the insurer's determination to close the claim.

NAC 616D.335 Order for cessation of business: Compliance. (NRS 616A.400**,** 616D.110**)**

1. The representative of the Administrator who delivers the order of cessation of business shall remain at the place of employment or jobsite to witness that the employer immediately orders all employees and other persons present to leave the place of employment or jobsite and that all operations are terminated.

2. If the representative of the Administrator observes that the terms of the order are not carried out immediately, the representative must contact the nearest law enforcement agency by the most expeditious means and request that the agency render assistance in enforcing the terms of the order.