ADOPTED REGULATION OF THE ADMINISTRATOR OF THE

DIVISION OF INDUSTRIAL RELATIONS OF THE

DEPARTMENT OF BUSINESS AND INDUSTRY

LCB File No. R130-14

Effective September 9, 2016

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

AUTHORITY: §1, NRS 616A.400 and 616B.021; §§2-6, 8, 12 and 23-25, NRS 616A.400; §7, NRS 616A.400 and 616C.245; §9, NRS 616A.400 and 616D.330; §10, NRS 616A.400 and 616C.065; §11, NRS 616A.400, 616C.065, 616C.235 and 616C.390; §13, NRS 616A.400 and 616C.250; §14, NRS 616A.400, 616C.245, 616C.250 and 616C.260; §§15-17, NRS 616A.400 and 616C.260; §18, NRS 616A.400 and 616C.490; §19, NRS 616A.400, 616C.130 and 616C.260; §20, NRS 616A.400 and 616C.550; §21, NRS 616A.400 and 616D.050; §22, NRS 616A.400 and 616D.120.

A REGULATION relating to industrial insurance; establishing provisions governing the transfer of claim files; revising provisions relating to the submission to an insurer of correspondence and other documents; establishing provisions governing the submission to an insurer of a written request for a determination; establishing provisions governing the purchase of a modified motor vehicle as an accident benefit; revising provisions relating to recordkeeping requirements and the maintenance of claim files; revising provisions relating to vocational rehabilitation; revising provisions relating to rating evaluations performed by a physician or chiropractor; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law prescribes the duties of the Administrator of the Division of Industrial Relations of the Department of Business and Industry relating to the administration of the provisions of title 53 of NRS relating to industrial insurance and the handling of workers' compensation claims and the payment of such claims by employers, insurers and third-party administrators. The Administrator is authorized to adopt regulations to carry out these duties. (NRS 616A.400-616A.430)

Section 1 of this regulation establishes provisions governing the transfer from one insurer or third-party administrator to another of the file of a claim of an injured employee, including the information which must be included and the persons to whom notice of such a transfer must be given.

Sections 4-6, 9, 10 and 12 of this regulation revise the duties of an insurer with regard to industrial insurance to extend those requirements to a third-party administrator as well.

Section 7 of this regulation sets forth certain requirements concerning the purchase by an insurer or employer on behalf of an injured employee of a modified motor vehicle as an accident benefit.

Sections 13, 15-17 and 19 of this regulation update provisions setting forth information regarding obtaining copies of documents adopted by reference by the Administrator.

Section 20 of this regulation revises the duties of an insurer with regard to the vocational rehabilitation counselor assigned to a claim and the plan for a program of vocational rehabilitation created for an injured employee.

Existing regulations provide that, if after a hearing the Administrator determines that an insurer, third-party administrator, organization for managed care, provider of health care or employer has committed a violation of the laws and regulations enforced by the Administrator, the Administrator will serve the entity with a copy of the findings of facts and conclusions of law and notice of the right to petition for judicial review. (NAC 616D.060) **Section 21** of this regulation includes an employee leasing company as an entity upon whom the Administrator will serve a copy of the findings of facts and conclusions of law and notice of the right to petition for judicial review.

Existing law requires firefighters, police officers and arson investigators to submit to certain physical examinations and tests to obtain industrial insurance benefits for lung disease and heart disease as occupational diseases. (NRS 617.454, 617.455, 617.457) Existing regulations require, as part of the required cardiac examinations, a urine test to determine glucose levels. (NAC 617.070) **Section 23** of this regulation provides that a blood test for glucose may also be used.

Existing regulations require the employer of an injured employee to schedule certain physical examinations of the injured employee. (NAC 617.080) **Section 24** of this regulation provides that an injured employee and his or her employer may agree in writing that the employee is responsible for scheduling such physical examinations.

Section 25 of this regulation repeals certain provisions relating to coverage required to be provided by a sole proprietor and provisions relating to elective coverage of corporate officers, volunteers and real estate brokers, broker-salespersons and salespersons.

Section 1. Chapter 616B of NAC is hereby amended by adding thereto a new section to read as follows:

1. If an insurer or third-party administrator transfers the file of a claim to another insurer or third-party administrator, the insurer or third-party administrator who transfers the file shall:

(a) Provide in a usable format to the insurer or third-party administrator who receives the file the information necessary to administer the claim.

(b) Provide in a usable format to the insurer or third-party administrator who receives the file the information necessary to comply with all reporting requirements and requests imposed by law.

(c) Continue to pay all compensation due the claimant until the insurer or third-party administrator who receives the file provides notice in writing to the insurer or third-party administrator who transferred the file that an account to pay such compensation has been established and funded.

(d) Provide to the insurer or third-party administrator who receives the file a printed report of all claims which are open on the date on which the file is transferred. The insurer or third-party administrator who transfers the file and the insurer or third-party administrator who receives the file shall retain a copy of the report for as long as necessary to assign responsibility for any failure to pay compensation, but in no event for a period of less than 2 years after the date on which the file is transferred. The report must be delivered to the insurer or third-party administrator who receives the file on or before the date on which the file is transferred and must include for each claim:

(1) The current status of the claim;

(2) For any compensation due within 90 days after the date on which the file is transferred, the dates on which the compensation is due and the anticipated period for which the compensation is due;

(3) Any pending issues and determinations;

(4) A brief summary of the history and projected outcome of the claim; and

(5) Information sufficient to enable the insurer or third-party administrator who receives the file to make timely payment of compensation and to continue administering the claims.

(e) Provide notice of the transfer by mail to:

(1) The injured employee whose claim is being transferred;

(2) The attorney or other authorized representative of the injured employee;

(3) Any person who is a provider of health care for the injured employee;

(4) Any person who is performing a rating evaluation of the injured employee;

(5) Any person who is administering the claim which is being transferred; and

(6) The Administrator and the Commissioner.

(f) Not later than 3 days after receiving a notice or other legal documentation relating to a contested claim that is before a hearing officer, appeals officer or court of competent jurisdiction:

(1) Notify, in writing, the sender of the notice or other legal documentation of the name, address and telephone number of the insurer or third-party administrator who receives the file; and

(2) Forward the notice or other legal documentation to the insurer or third-party administrator who receives the file.

2. An insurer or third-party administrator who receives a file that is transferred from another insurer or third-party administrator shall:

(a) Within 30 days after the date of the transfer, review any open claim relating to the file and determine the action to be taken with regard to each claim.

(b) In a timely manner, pay all compensation set forth in the report described in paragraph (d) of subsection 1 unless the insurer or third-party administrator issues a written determination that such compensation is not due, which written determination must set forth the right to appeal by the injured employee.

(c) Take any other action set forth in the report described in paragraph (d) of subsection 1 and any other action necessary to ensure the timely and efficient administration of claims and payment of compensation and other benefits.

Sec. 2. NAC 616B.121 is hereby amended to read as follows:

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

1. ~~[IAIABC]~~ *EDI Implementation Guide for Proof of Coverage*, which is published by the International Association of Industrial Accident Boards and Commissions. A copy of the publication may be obtained from the International Association of Industrial Accident Boards and Commissions, ~~[5610 Medical Circle, Suite 24, Madison,]~~ ***7780 Elmwood Avenue, Suite 207, Middleton,*** Wisconsin ~~[53719,]~~ ***53562,*** for the price of ~~[$50 for members and $95 for nonmembers.]~~ ***$195, or may be obtained free of charge by members at the Internet address http://www.iaiabc.org.***

2. ~~[Workers Compensation Policy Data Reporting Manual,]~~ ***Policy and Proof of Coverage Reporting Guidebook,*** 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,]~~ ***NCCI Holdings, Inc., Customer Service Center,*** 901 Peninsula Corporate Circle, Boca Raton, Florida 33487, ***or at the Internet address http://www.ncci.com, free of charge for affiliates or*** for the price of ~~[$120 for affiliates and $155]~~ ***$47*** 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,]~~ ***NCCI Holdings, Inc., Customer Service Center,*** 901 Peninsula Corporate Circle, Boca Raton, Florida 33487, ***or at the Internet address http://www.ncci.com,*** for the price of ~~[$108]~~ ***$125*** for affiliates and ~~[$149]~~ ***$250*** 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,]~~ ***NCCI Holdings, Inc., Customer Service Center,*** 901 Peninsula Corporate Circle, Boca Raton, Florida 33487, ***or at the Internet address http://www.ncci.com,*** for the price of ~~[$135]~~ ***$160*** for affiliates and ~~[$271]~~ ***$325*** for nonaffiliates.

5. *Electronic Transmission User's Guide*, which is published by the National Council on Compensation Insurance. A copy of the publication may be obtained, free of charge, ~~[from the National Council on Compensation Insurance, Products and Services Department, 901 Peninsula Corporate Circle, Boca Raton, Florida 33487.]~~ ***at the Internet address http://www.ncci.com.***

6. ***WCIO*** *Workers Compensation Data Specifications Manual*, which is ~~[published]~~ ***maintained*** by the ~~[National Council on Compensation Insurance.]~~ ***Workers Compensation Insurance Organizations.*** 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.]~~ ***, free of charge, at the Internet address http://www.wcio.org.***

Sec. 3. Chapter 616C of NAC is hereby amended by adding thereto the provisions set forth as sections 4 to 7, inclusive, of this regulation.

Sec. 4. ***As used in NRS 616C.065, the Administrator interprets:***

1. The term "insurer" to include a third-party administrator.

2. The term "receipt" to mean a written acknowledgment from the United States Postal Service of its acceptance for mailing of a written determination by an insurer denying a claim in whole or in part.

Sec. 5. ***1. If an insurer fails to respond to a written request for a determination within 30 days after the date on which the request for a determination was received by the insurer, the person making the request for a determination may resubmit the request.***

2. Failure to file a request for a hearing within the period specified in subsection 3 of NRS 616C.315 does not preclude a person from submitting to an insurer a written request for a determination.

Sec. 6. ***If an insurer or third-party administrator receives a written notice from an employee or a dependent of an employee pursuant to subsection 1 of NRS 616C.409 which includes all the information required by the financial institution, the insurer or third-party administrator shall, within 60 days after receipt of the written notice:***

1. Establish direct deposit of the compensation to be paid by the insurer or third-party administrator into the account specified by the employee or dependent of the employee in the written notice; or

2. If the insurer or third-party administrator is unable to establish direct deposit of the compensation as required by subsection 1, provide to the employee or dependent of the employee a written explanation of the reason for which the insurer or third-party administrator is unable to establish direct deposit of the compensation as required by subsection 1.

Sec. 7. *1. Within 30 days after receipt from a treating physician of medical documentation satisfying the requirements of subsection 2 of NRS 616C.245, the insurer or employer providing accident benefits shall, as applicable pursuant to subsection 3 of NRS 616C.245, place an order for, purchase or modify a motor vehicle for the injured employee.*

2. The insurer or employer providing accident benefits shall determine the make and model of the motor vehicle based on the medical requirements and physical restrictions of the injured employee as set forth by the treating physician. The insurer or employer shall modify the motor vehicle to accommodate the physical restrictions of the injured employee.

3. The insurer or employer providing accident benefits shall, as applicable, purchase or modify a motor vehicle for the injured employee as needed and at least as often as every 10 years or 120,000 miles driven, whichever occurs first.

4. An injured employee who receives a motor vehicle pursuant to this section and NRS 616C.245 shall at all times maintain a policy of insurance as required by NRS 485.185 which includes comprehensive and collision coverage for the motor vehicle. Risk of physical damage to or total loss of the motor vehicle is the responsibility of the injured employee. Care and maintenance of the motor vehicle is the responsibility of the injured employee.

5. If an injured employee is not entitled to receive a motor vehicle pursuant to this section and NRS 616C.245, the insurer or employer providing accident benefits shall:

(a) Reimburse the injured employee in the manner prescribed by NAC 616C.150; or

(b) Provide transportation, where available, for the injured employee, including, without limitation, in the form of a monthly bus pass, public transportation or other appropriate means of transportation as determined by the insurer or employer, taking into consideration the medical requirements and physical restrictions of the injured employee.

Sec. 8. NAC 616C.082 is hereby amended to read as follows:

616C.082 1. An insurer, third-party administrator or organization for managed care shall ensure that ***the date of receipt of*** 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.]~~ ***is indicated on each such document or maintained in an electronically generated, verifiable report.***

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]~~ ***filed and maintained in*** 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 ***, without limitation,*** investigative reports, medical reports, and records evidencing payments of benefits, compensation or awards, remain the property of the insurer.

Sec. 9. NAC 616C.088 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. The file for each~~] ***Each file of a claim concerning an*** industrial injury or occupational disease ***that is maintained by an insurer or third-party administrator*** 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 hearing 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 or her 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,]~~ ***subparagraph,*** "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 or her of the 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 ***or the third-party administrator*** 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 communications relating to the medical disposition of a claim that must be maintained by an insurer ***or third-party administrator*** 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. 10. NAC 616C.091 is hereby amended to read as follows:

616C.091 *1.* After receipt of a claim for compensation, the insurer ***or third-party administrator*** shall give written notice of its determination to accept or deny the claim to the injured employee ***, the attorney or other authorized representative of the injured employee*** or his or her dependents and, if the injured employee's employer is not self-insured, to the injured employee's employer.

2. If the insurer ***or third-party administrator*** denies the claim [:

1.] ***in whole or in part:***

(a) The insurer ***or third-party administrator*** shall, pursuant to NRS 616C.065, notify the Administrator of the denial.

[2.] ***(b)*** The notice of denial to the injured employee ***, the attorney or other authorized representative of the injured employee*** or his or her dependents must include:

[(a)] ***(1)*** 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]

(2) A specific statement of the reasons for the denial [.

3.] ***of the claim.***

(c) The insurer ***or third-party administrator*** shall provide a copy of each notice of denial it gives pursuant to [subsection 2] ***paragraph (b)*** to the injured employee's treating physician or chiropractor.

~~[4.]~~ ***(d)*** The notice of denial required to be given to the Administrator pursuant to ~~[subsection 1]~~ ***paragraph (a)*** must include:

~~[(a)]~~ ***(1)*** A copy of the notice of denial given to the injured employee ***, the attorney or other authorized representative of the injured employee*** or his or her dependents; and

~~[(b)]~~ ***(2)*** A copy of Form C-4, Employee's Claim for Compensation/Report of Initial Treatment, that was completed by the injured employee or his or her dependents.

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

3. If the insurer or third-party administrator accepts the claim, the notice of acceptance provided to the injured employee, the attorney or other authorized representative of the injured employee or his or her dependents must include:

(a) Written notice of acceptance of the claim;

(b) A copy of Form D-52, Alternative Choice of Physician or Chiropractor; and

(c) Either:

(1) If established and available, the Internet address of the website of the insurer or third-party administrator at which the injured employee, the attorney or other authorized representative of the injured employee or his or her dependents can obtain a list of providers of health care who are authorized to provide health care services to the injured employee; or

(2) Notification that, pursuant to NAC 616C.030, the injured employee, the attorney or other authorized representative of the injured employee, his or her dependents or the treating physician or chiropractor of the injured employee may, upon written request, obtain a list of providers of health care who are authorized to provide health care services to the injured employee.

4. A written notice of determination issued by an insurer or third-party administrator must include:

(a) The claim number;

(b) The name of the employer;

(c) The name of the insurer;

(d) The name of the third-party administrator, if applicable;

(e) The date of the injury;

(f) The date of the written notice of determination;

(g) Notice that the injured employee may, pursuant to subsection 1 or 3 of NRS 616C.315, request a hearing or appeal the determination within 70 days after the determination is issued by the insurer; and

(h) The addresses of the offices of the Hearings Division of the Department of Administration located in Carson City and Las Vegas.

Sec. 11. NAC 616C.094 is hereby amended to read as follows:

616C.094 1. Except as otherwise provided in this section, within 30 days after receipt of a 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,

the injured employee and the attorney or authorized representative of the injured employee, in writing, giving the reasons for its determination and an explanation of the ~~[person's]~~ right ***of the person making the request*** to appeal ~~[.]~~ ***the determination.***

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 ~~[.]~~ ***and the injured employee or the attorney or authorized representative of the injured employee,*** in writing, specifying the reasons for its determination and an explanation of the person's right to appeal.

Sec. 12. NAC 616C.097 is hereby amended to read as follows:

616C.097 1. Any written notice of a determination ~~[of an insurer who has contracted with]~~ ***by*** an organization for managed care that relates 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 ~~[your insurer within 70]~~ ***the organization for managed care at the address indicated within 14*** days after the date on which ~~[the]~~ ***this*** notice was mailed by the ~~[insurer.]~~ ***organization for managed care.***

2. Any written notice of a determination ~~[of]~~ ***by*** an insurer ***or third-party administrator*** that relates to benefits, other than accident benefits ***,*** ~~[provided by an insurer who has contracted with an organization for managed care,]~~ 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 ~~[.]~~ ***or third-party administrator.***

Sec. 13. NAC 616C.123 is hereby amended to read as follows:

616C.123 1. The most recently published edition of or update to the *Occupational Medicine Practice Guidelines*, ~~[published jointly]~~ ***developed*** by the American College of Occupational and Environmental Medicine and ***published by*** the ~~[Occupational Environmental Medicine Health Information, Inc.,]~~ ***Reed Group, Ltd.,*** 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*, the Administrator will:

(a) Post a notice of disapproval at the largest public library in each county, the State Library ***,*** ~~[and]~~ Archives ~~[,]~~ ***and Public Records,*** 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]~~ ***or not recommended by*** 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]~~ ***; and***

(e) 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 the 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, or]~~ ***the Reed Group, Ltd., 10355 Westmoor Drive, Westminster, Colorado 80021,*** by telephone at ~~[(800) 533-8046,]~~ ***(866) 889-4449 or by electronic mail at guidelines_sales@reedgroup.com,*** 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.]~~ ***$675 for a single-user license.***

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

Sec. 14. NAC 616C.129 is hereby amended to read as follows:

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

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

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 ***by the treating physician or chiropractor*** and any written authorization granted therefor are not restricted, and are subject only to the treatment prescribed by the treating physician or chiropractor and the determination of the insurer. A report of the status of an injured employee may be requested by an insurer at any time during the course of treatment. The initial evaluation shall be deemed to be separate from the initial six treatments. An initial evaluation may be performed on the same day as the initial treatment.

8. The treating physician or chiropractor shall respond in writing to an insurer's written request for a report of the status of an injured employee not later than 10 business days after receiving the request.

Sec. 15. NAC 616C.145 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*, the Administrator 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]~~ ***Optum360, 2525 Lake Park Boulevard, Salt Lake City, Utah***

84120, by telephone at (800) 464-3649 or at the Internet address

https://www.optum360coding.com, for the price of ~~[$279.95.]~~ ***$329.95.***

Sec. 16. NAC 616C.146 is hereby amended 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 or she]~~ ***the Administrator*** will:

(a) Post a notice of disapproval at the largest public library in each county, the State Library ***,*** ~~[and]~~ Archives ~~[,]~~ ***and Public Records,*** 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,]~~ ***1061 American Lane, Schaumburg, Illinois 60173-4973, by telephone at*** (847) 825-5586, ***or at the Internet address https://www.asahq.org/shop-asa,*** for the price of $25 ~~[.]~~ ***for members and $75 for nonmembers.***

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 or she 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. 17. NAC 616C.147 is hereby amended to read as follows:

616C.147 The Division hereby adopts by reference ~~[the most current complete]~~ ***:***

1. The list of eligible codes for ~~[surgical centers for ambulatory patients]~~ ***hospital-based outpatient surgery centers and Ambulatory Surgical Center (ASC) payment groups and procedures*** and the payment groups to which those codes are assigned ~~[for services rendered on and after September 7, 2005, as those codes are]~~ ***as*** set forth in ~~[the "Centers for Medicare and Medicaid Services, CMS]~~ ***"Provider Type 10: Outpatient Surgery, Hospital Based and Provider Type 46: Ambulatory Surgical Centers" maintained by the Rates Unit - Nevada Medicaid of the Division of Health Care Financing and Policy of the Department of Health and Human Services and available at the Internet address:***

http://dir.nv.gov/uploadedFiles/dirnvgov/content/WCS/MedicalDocs/ASCOPGroupList2016.pdf.

2. The codes set forth in the "Healthcare Common ~~[Procedures]~~ ***Procedure*** Coding System (HCPCS)," ~~[which is contained]~~ ***as set forth*** in the *Relative Values for Physicians* ~~[that is]~~ adopted by reference pursuant to NAC 616C.145.

Sec. 18. NAC 616C.148 is hereby amended to read as follows:

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

3. A report of a rating evaluation performed by a rating physician or chiropractor must include:

(a) All the findings of the physical examination; and

(b) References to each table or figure of the American Medical Association's Guides to the Evaluation of Permanent Impairment used by the rating physician or chiropractor to determine the permanent impairment of the injured employee.

4. A rating physician or chiropractor shall retain at least one copy of each report of a rating evaluation and all supporting documentation of the rating physician or chiropractor for a period of not less than 5 years after the date on which the rating evaluation referenced in the report of rating evaluation is performed.

Sec. 19. NAC 616C.149 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~~]~~ ***"Healthcare*** Common ~~[~~Procedures~~]~~ ***Procedure*** 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 or her employer and the date of the 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~~]~~ ***ICD-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),~~]~~ ***(ICD-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*, the Administrator will:

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

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

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

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

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

~~(b) Ingenix, 5225 Wiley Post Way, Suite 500, Salt Lake City, Utah 84116-2889, (800) 999-4600, for the price of $74.95.]~~ ***the International Classification of Diseases is available, free of charge, from the Centers for Disease Control and Prevention at the Internet address http://www.cdc.gov/nchs/icd.htm.***

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. 20. NAC 616C.555 is hereby amended to read as follows:

616C.555 An insurer shall ensure that ~~[the]~~ ***:***

1. The vocational rehabilitation counselor assigned to a claim by the insurer complies with the provisions of ~~[subsections 1, 2 and 3]~~ ***subsection 2*** of NRS ~~[616C.550]~~ ***616C.547, subsections 1 to 8, inclusive, of NRS 616C.555*** and ~~[the provisions of]~~ NAC 616C.556 ~~[.]~~ ***;***

2. The written assessment developed pursuant to NRS 616C.550 includes the document containing the information described in subsection 2 of NAC 616C.556; and

3. The plan for a program of vocational rehabilitation developed pursuant to NRS 616C.555 complies with the provisions of that section.

Sec. 21. NAC 616D.060 is hereby amended 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 ***, employee leasing company*** 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 a copy of the findings of fact and conclusions of law to be served]~~ ***Serve*** upon the insurer, third-party administrator, organization for managed care, provider of health care ***,*** ***employee leasing company*** or employer by ~~[certified mail.]~~ ***mail a copy of the findings of fact and conclusions of law.***

Sec. 22. NAC 616D.415 is hereby amended to read as follows:

616D.415 Except as otherwise provided in chapters 616A to 617, inclusive, of NRS, or in any regulation adopted pursuant thereto:

1. If the Administrator determines that:

(a) An insurer or third-party administrator has failed to comply or has complied in an untimely manner with any provision of chapter 616A, 616B, 616C, 616D or 617 of NRS, or any regulation adopted pursuant thereto, that requires the insurer or third-party administrator to make a determination regarding the acceptance or denial of a claim for compensation;

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

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

(d) An insurer, organization for managed care, provider of health care, third-party administrator, employer or employee leasing company has failed to comply or has complied in an untimely manner with any of the provisions of NRS 616A.475, 616B.006, 616B.009 ***,*** ***616C.700*** or 617.357 or NAC 616A.410 ~~[;]~~ ***or 616C.527 or paragraph (b) of subsection 1 of section 1 of this regulation;***

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

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

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

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

Sec. 23. NAC 617.070 is hereby amended to read as follows:

617.070 1. Cardiac examinations which are conducted pursuant to NRS 617.457 must include at least the following elements and must be supported by the following written material:

(a) Form OD-1, Firemen and Police Officers' Medical History Form, as prescribed by the Division and completed by the firefighter or police officer being examined;

(b) Form OD-3, Firemen and Police Officers' Extensive Heart Examination Form, as prescribed by the Division and completed by the examining physician;

(c) A stethoscopic examination of the heart;

(d) Except as otherwise provided in paragraph (e), an electrocardiogram;

(e) If the person being examined is a police officer or a salaried firefighter who is 40 years of age or older, a stress electrocardiogram, in lieu of the electrocardiogram required by paragraph (d);

(f) A blood test to determine the amounts of triglycerides and cholesterol which are present; and

(g) A ***blood or*** urine test to determine the amount of glucose which is present.

2. Cardiac examinations which are conducted in the sixth year of continuous service and in each year of service thereafter must include the following elements and must be supported by the following written material:

(a) Form OD-1, Firemen and Police Officers' Medical History Form, as prescribed by the Division and completed by the firefighter or police officer being examined;

(b) Form OD-4, Firemen and Police Officers' Limited Heart Examination Form, as prescribed by the Division and completed by the examining physician;

(c) A stethoscopic examination of the heart; and

(d) If the examining physician believes circumstances warrant such a test, an electrocardiogram.

Sec. 24. NAC 617.080 is hereby amended to read as follows:

617.080 ~~[The]~~

1. Except as otherwise provided in subsection 2, the employer shall:

~~[1.]~~ ***(a)*** Schedule the physical examinations, including the test of the functioning of the hearing of an employee, that are required pursuant to NRS 617.454, 617.455 and 617.457.

~~[2.]~~ ***(b)*** Maintain the records of all physical examinations, including the test of the functioning of the hearing of an employee, that are completed pursuant to NRS 617.454, 617.455 and 617.457 for at least 2 years after the death of the firefighter or police officer.

~~[3.]~~ ***(c)*** Discuss with the employee any warning from the examining physician indicating that the employee has a predisposition to the contraction of a disease of the heart or lungs.

~~[4.]~~ ***(d)*** If the employee can correct any predisposing physical condition of which he or she has been warned pursuant to ~~[subsection 3,]~~ ***paragraph (c),*** inform the employee that failure to correct the condition may exclude him or her from benefits under chapter 617 of NRS.

~~[5.]~~ ***(e)*** Pay for any additional physical examinations he or she requires which are beyond the scope of the physical examinations and tests required by NRS 617.454, 617.455 and 617.457.

2. If the employer and employee agree in writing, the employee may assume the responsibility for scheduling the physical examinations described in paragraph (a) of subsection 1.

Sec. 25. NAC 616A.430, 616B.780, 616B.786, 616B.789, 616B.792, 616B.795, 616B.796, 616B.800, 616B.809, 616B.810, 616B.812, 616B.815, 616B.818 and 616C.085 are hereby repealed.

TEXT OF REPEALED SECTIONS

616A.430 Clarification of certain provisions or relief from strict application. (NRS 616A.400)

A brief explanation of the procedure for obtaining clarification of NAC 616A.420, 616C.091, 616C.094, 616C.145 to 616C.149, inclusive, 616C.423, 616C.447 or 616C.502, or relief from the strict application of any of their terms, may be obtained from the Division of Industrial Relations, 400 West King Street, Suite 400, Carson City, Nevada 89703.

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 or her business operations that are insured by a private carrier is presumed to have established an employer-employee relationship between himself or herself 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 the 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.

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 or herself by submitting written notice to the private carrier which insures him or her that he or she 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 or her 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 or her policy with a private carrier acts at any time thereafter as a subcontractor or in alternating roles as a principal contractor and subcontractor, his or her deemed wage becomes effective on the date of his or her 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 or her employees but fails to secure and maintain coverage for himself or herself, the principal contractor is responsible for the payment of premiums for the sole proprietor during the term of the contract.

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 or her 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.

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 or herself 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.

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 or her pursuant to chapters 616A to 617, inclusive, of NRS, or based on the actual amount

paid to him or her as shown on the records of payroll maintained by the corporation, but excluding any dividends paid to him or her; 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.

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.

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 or her 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 or her 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 the employer, the insurer of the 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.

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 or her 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.

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

1. A person who is licensed pursuant to chapter 645 of NRS as a real estate broker, broker-salesperson or salesperson 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 or her occupation as a licensed real estate broker, broker-salesperson or salesperson at the deemed wage of $1,500 per month.

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 or she 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 the employer 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 the 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.

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.

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 or she is insured by a private carrier, notifies the private carrier, or if he or she 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.

3. 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.

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.

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

IN THE MATTER OF THE ADOPTION OF PERMANENT REGULATION RELATING TO INDUSTRIAL INSURANCE; ESTABLISHING PROVISIONS GOVERNING THE TRANSFER OF CLAIM FILES; REVISING PROVISIONS RELATING TO SUBMISSION TO AN INSURER OF CORRESPONDENCE AND OTHER DOCUMENTS; ESTABLISHING PROVISIONS GOVERNING THE SUBMISSION TO AN INSURER OF A WRITTEN REQUEST FOR A DETERMINATION; REVISING PROVISIONS RELATING TO RECORDKEEPING REQUIREMENTS AND THE MAINTENANCE OF CLAIM FILES; REVISING PROVISIONS RELATING TO VOCATIONAL REHABILITATION; ESTABLISHING PROVISIONS GOVERNING THE PURCHASE OF A MODIFIED MOTOR VEHICLE AS AN ACCIDENT BENEFIT; REVISING PROVISIONS RELATING TO RATING EVALUATIONS PERFORMED BY A PHYSICIAN OR CHIROPRACTOR; AND PROVIDING OTHER MATTERS PROPERLY RELATING THERETO.

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LEGISLATIVE REVIEW OF ADOPTED REGULATIONS
AS REQUIRED BY NRS 233B.066
LCB FILE NO. R130-14

AMENDED INFORMATIONAL STATEMENT

The following statement is submitted for adoption of new provisions in Nevada Administrative Code (NAC) Chapters 616B and 616C; the amendment of existing provisions in NAC Chapters 616B, 616C, 616D and 617; and the repealing of existing provisions in NAC Chapters 616A, 616B and 616C.

1. A clear and concise explanation of the need for the adopted regulation.

The Division of Industrial Relations, Workers' Compensation Section's proposed regulations are needed to update existing regulations and repeal regulations which are now duplicative and unnecessary. These regulations revise outdated definitions, references to nonexistent offices and contact information for required publications; establish procedures for the transfer of claims files between insurers and third party administrators; revise provisions relating to the submission of

correspondence and other documents to insurers; establish provisions relating to the submission of a written request for a determination by an insurer; establish procedures and requirements for the purchase of a modified motor vehicle as an accident benefit; revise provisions relating to recordkeeping and the maintenance of claim files; revise provisions relating to the determination and notification of claim acceptance or denial by an insurer; establish deadlines for a physician's or chiropractor's report on the status of an injured employee; revise provisions relating to the contents and maintenance of a rating evaluation by a physician or chiropractor; revise provisions relating to vocational rehabilitation; and authorizing, under certain circumstances, an employee to schedule physical examinations for firefighters, police officers and arson investigators.

2. A description of how public comment was solicited, a summary of public responses, and an explanation of how other interested persons may obtain a copy of the summary.

Copies of the proposed regulation, notices of workshop and notices of intent to act upon a regulation were sent by U.S. mail and e-mail to over 2,450 persons who were known to have an interest in the subject of the Nevada Industrial Insurance Act and Nevada Occupational Diseases Act, as well as any persons who had specifically requested such notice. These documents were also made available at the website of the Department of Business and Industry, Division of Industrial Relations, Workers' Compensation Section, **www.dirweb.state.nv.us/WCS/wcs.htm**, mailed to all county libraries in Nevada and posted at the following locations:

Division of Industrial Relations
400 W. King Street, #400
Carson City, NV 89703

Department of Business and Industry
555 E. Washington Ave., #4900
Las Vegas, NV 89101

Workers' Compensation Section
1301 N. Green Valley Pkwy., #200
Henderson, NV 89074

NVOSHA
4600 Kietzke Lane, # F-153
Reno, NV 89502

Grant Sawyer Building
555 E. Washington Ave,
Las Vegas, NV 89101

Bradley Building
2501 E. Sahara Ave.
Las Vegas, NV 89104

Nevada State Library, Archives and Public Records
100 Stewart Street
Carson City, NV 89701

A workshop was held via videoconference on January 5, 2015, at 9:00 a.m. at the Nevada State College located at 303 S. Water Street, Room 119, Henderson, Nevada and Western Nevada College located at Cedar Building, Room 307, 2201 W. College Parkway, Carson City, Nevada. Thereafter on or about December 18, 2015, the Administrator of the Department of Business and Industry, Division of Industrial Relations (Administrator) issued a Notice of Intent to Act on Proposed Regulations which incorporated in the proposed amendments the suggestions of the parties attending the January 5, 2015 workshop. A public hearing was held via videoconference on February 18, 2016, at 9:00 am at the Grant Sawyer Building, 555 E. Washington Avenue,

Room 4412, Las Vegas, Nevada and the Legislative Building, 401 S. Carson Street, Room 2135, Carson City, Nevada.

A copy of this summary of the public response to the proposed regulation may be obtained from Donald C. Smith, Esq. Senior Division Counsel, at Division of Industrial Relations, 1301 N. Green Valley Pkwy., #200, Henderson, NV 89074, 702-486-9070, or e-mail to donaldcsmith@business.nv.gov.

3. The number of persons who:

(a) Attended each hearing;

(b) Testified at each hearing; and

(c) Submitted to the agency written comments.

4. For each person identified in paragraphs (b) and (c) of number 3 above, the following information, if provided to the agency conducting the hearing:

(a) Name;

(b) Telephone number;

(c) Business address;

(d) Business telephone number;

(e) Electronic mail address; and

(f) Name of entity or organization represented.

At the **January 5, 2015 Workshop**, which was held at two sites via videoconference, in Henderson 11 attended; in Carson City 8 attended, with testimony received from five (5) attendees. A summary of the testimony at this public hearing follows:

Mike Livermore, Alternative Service Concepts, LLC, 639 Isbell Road, Suite 390, Reno, NV 89509-4993; Telephone: (775) 329-1181; E-mail: james.livermore@ascrisk.com.

Regarding Section 1, this new section for transferring of claims, they would like to know why is this being proposed and why is it necessary? It appears to him that it would be much simpler to require that, this printed report of all claims that are opened and the location of those files are transmitted to DIR when all the transfers take place, then DIR has all the information and can place it in the DIR's Index of Claims.

Regarding Section 2, the regulations already talk about "copies of all claim files obtained by an insurer must be maintained in this state". The regulations that are being proposed should move into the 21st century and address electronic claim files. Paper claim files aren't maintained anymore, they are kept on computer servers which are often located outside Nevada. This section needs to be completely restated to deal with electronic claim files. Moving to subsection that's being amended, that talks about "the correspondence that needs to be addressed TPA etc., etc., at one of the offices located in this state". It deletes "the correspondence and documents shall be deemed to be officially received only if they have been so addressed". Why is that language being stricken? I think the existing language is appropriate and needs to remain in the regulation. I suggest additional language that not only must it be addressed to the insurer at one of the offices within the state to but must be submitted by first class United States Mail; and an additional statement that mandates that the injured worker or their attorney or representative

shall notify the insurer or their third party administrator of any changes in their mailing address, as NRS 616C.315 subsection.

Regarding Subsection 2 of Section 5 talks about the term "receipt" and this provides the definition, "to mean a written acknowledgement from the U.S. Postal Service of its acceptance for mailing" then it goes on to talk about how a "written determination by an insurer denying the claim in whole or in part". Why not just say the determination made in accordance with NRS 616C.065, subsection 10 instead of spelling it out. There's no verification in their written acknowledgement that the contents of that envelope are the so called written determinations. I suggest that everywhere that statement is made, that the language be deleted and just insert, "the determination rendered in accordance with NRS 616C.065, subsection 10.

Regarding Section 5, subsection 6, please clarify why is this necessary? I'm sorry but they can always make a request, for anything at any time. Even if they just made the same request yesterday. Each time we have to answer that with a new determination with appeal rights so I think it's redundant and superfluous to have subsection 1 and subsection 6 at all. I'm not sure that this regulation can address that. I think that perhaps that needs to be addressed in the statute rather than in the regulations supplementing the statute. I object to Section 5, Subsections 1 and 6 on the basis that that needs to be a statutory change.

Regarding Section 7, which has to do with direct deposit, the proposed language states, we "shall within 60 days after receipt of the written notice, establish a direct deposit". I think that is probably in most cases adequate time. So I'm a little bit leery of having that mandate of 60 days without the caveat allowing for certain exceptions so maybe there should be something additionally that stating that in so far as there are no, the financial institution requested can accommodate the direct deposit or something, I would request that there be some kind of granting of an exception in certain instances, including an additional statement that the injured worker has to provide a request for a financial institution that can, in fact, accept direct deposits.

Deena Carson, Workers Comp Manager, Hometown Health, 830 Harvard Way, Reno, NV 89502; Telephone: (775) 982-3049; E-mail: DCarson@hometownhealth.com.
Further comment on Section 7, consider adding language that if the benefit of direct deposit could not be established within 60 days that a determination with appeal rights be issued to the injured worker explaining the circumstances.

Mike Livermore, Alternative Service Concepts, LLC, 639 Isbell Road, Suite 390, Reno, NV 89509-4993; Telephone: (775) 329-1181; E-mail: james.livermore@ascrisk.com.
I agree with Ms. Carson's suggestion, which would certainly make things workable.

Regarding Section 8, subsection 1, I object to this kind of micro claims management being imposed upon the third party administrator or the insurer, spelling out in detail every step that you got to follow in certain time frames or else you're going to get smacked with a fine or some other situation. Subsection 1 talks about "placing an order for purchase and modify a motor vehicle," I think this needs to be an "or" because you're not just going to place an order for, purchase and modify. You might purchase the thing all ready and done. So I think that should be an "or" place an order for a purchase "or" modifying a motor vehicle for the injured employee.

But, I think that it needs to have an additional statement. The statute talks about, if the employee, modified, you could modify a vehicle that the injured worker already owns. Well, that has to be in there. The proposed language does not conform to the statute, Subsection (a) of subsection 3, subsection 2 of NRS 616C.245. So that needs to be fixed, so that we are only purchasing, placing orders and modifying new vehicles if the injured employees don't already own it were already doing modifications to the injured workers' new vehicles.

Section 8, Subsection 2, the insurer shall determine the make and model of the motor vehicle based on the medical requirements and physical restrictions. I wanted to add the statement that if a vehicle, new or used, is purchased pursuant to subsection 3(b) or 3(c), NRS 616C.245. Subsection 3 of NRS 616C.245 already says, "…if an injured employee is entitled to receive a motor vehicle pursuant to subsection 2, a motor vehicle must be modified to allow the employee to operate it safely" And then there's an order preference. So why these regulations, when it's already in the statute, rather specifically in clear text? Subsection 3, "shall as applicable, purchase and modify as needed and at least as often as every 10 years or 120,000 miles driven, whichever occurs first". What if the injured worker doesn't provide the care and maintenance of the vehicle as required by statute? There appears a need to place language in the regulation that places the responsibility, the burden, upon the injured worker to take care of the vehicle, not just for the insured to automatically have to go out there every ten years or 120,000 miles and buy a brand new one and modify it and pay more money.

The Administrator should adopt regulations establishing a maximum benefit as stated in subsection 4, NRS 616C.245. The Administrator shall establish a maximum benefit to be paid under the provisions of this section. The DIR should place the responsibility for the injured worker to fulfill his duty of maintenance of the motor vehicle. Maybe they should be held to a standard that they have proof that they have maintained it, that they have to service it every 3000 miles or whatever it is for modern cars.

Subsection 4 says it is the responsibility of the employee to maintain the vehicle but it doesn't say what happens if they don't do it. In this whole process, workers compensation, it's not a two way street. The whole burden is on the insurer and the third party administrator to provide the benefits. And there is nothing, no responsibility placed upon the injured worker to do things like that. There's no penalty if they fail to do it. So the regulation needs to take that into account.

Deena Carson, Workers Comp Manager, Hometown Health, 830 Harvard Way, Reno, NV 89502; Telephone: (775) 982-3049; E-mail: DCarson@hometownhealth.com.
I agree there should be something in this regulation that requires, not only requires them to have coverage and do the maintenance, but that if in the event that car is totaled, and they have lapsed in their insurance, that a car is not purchased for them to replace the one they did not insure.

Jim Werbeckes, Vice President Government & Regulatory Affairs, EMPLOYERS, 10375 Professional Circle, Reno, Nevada 89521; (775) 327-2458. This issue was brought forth by Employers back in 2003. Employers wanted this regulation to put some standards and some limitations on how many vehicles we have to purchase. And you are correct, if an injured employee under today's rules got a car, we'd purchase the vehicle, turns around and smashes it tomorrow didn't have insurance, we'd be on the hook and we've had several instances where that

has occured. So that is why we have requested Section 8 of this regulation. I do agree with some of Mr. Livermore's comments regarding subsection 1 of that section, putting some caveats under there. But other than that, I mean, we support this section. We would like to see this thing stay intact. I believe subsection 4 this section covers the comprehensive collision coverage on there, if they don't have it. And maybe I would like to have the DIR to go on record that if the individiual doesn't have coverage, and fails to maintain his coverage that we would not be obligated to pay for a new vehicle. On the way this is drafted today.

Mike Livermore, Alternative Service Concepts, LLC, 639 Isbell Road, Suite 390, Reno, NV 89509-4993; Telephone: (775) 329-1181; E-mail: james.livermore@ascrisk.com.
I want to thank Jim for that clarification and with that explanation I certainly support Section 8. I guess it's the injured workers' responsibility, I think it needs to be spelled out explicitly so that hearing officers, appeals officers or higher courts don't go, oh well, but how is he supposed to get to the store…buy a new one... I want it to say "failure of the injured employee to maintain insurance and/or provide appropriate maintenance or standard maintenance in the care of the vehicle will result in denial of that benefit".

Deena Carson, Workers Comp Manager, Hometown Health, 830 Harvard Way, Reno, NV 89502; Telephone: (775) 982-3049; E-mail: DCarson@hometownhealth.com.
I agree.

Jim Werbeckes, Vice President Government & Regulatory Affairs, EMPLOYERS, 10375 Professional Circle, Reno, Nevada 89521; (775) 327-2458. Section 9, the way I read this is that, once the payment is approved, we are now supposed to stamp the bill approved. For what purpose? We have those dates in our claim files, they are in our electronic system. They are paid timely. They don't have a stamp dated across the top of them that these bills have been approved. The dates of approval and payment will be in the log notes and everything else that we approved the bill. We oppose subsection 2 in Section 9.

Greg Schaefer, Gallegher Bassett Services Inc., 2110 E. Flamingo Rd., #314, Las Vegas, NV 89119-0834; Telephone: (866) 889-4755; E-mail: gregory_schaefer@gbtpa.com.
Regarding Subsection 1 of Section 9, date stamping of each document received, we need to go into the 21st century. Most of the documents received by our office are received electronically, so to have to print every document that we receive electronically just to date stamp it and then rescan it back into the system is quite costly. This should be amended. If we can show when we received it electronically in the claim notes that should suffice.

Mike Livermore, Alternative Service Concepts, LLC, 639 Isbell Road, Suite 390, Reno, NV 89509-4993; Telephone: (775) 329-1181; E-mail: james.livermore@ascrisk.com.
We have moved into the electronic era and in conjunction with changing this regulation, it's time for DIR to deal with that. I don't think anyone is using paper files any more, they are all electronic. And even in the case of reopened claim files. I think it should be enough for the regulatory purpose that all it needs to be said is the insurer shall ensure, that's with an "e", ensure, when the electronic bill or claim was received, they have some kind of documentation in their claim process that they can reproduce and so that it's visible to a reviewer like a regulator, for all of these different steps. That's what our's does. Our EOB indicates the date received, the

date received by the insurer, the date received by bill processor, the date payment was made, and the date of the EOB. In the actual check generating process date that is recorded the transaction date the check is issued or processed. I would like to see something of that kind occur and changing this whole regulation of 616C.082 to reflect dealing with paperless electronic claim files.

Regarding Section 9, Subsection 2, the regulation deals with paper more than anything. I haven't completely thought this through in terms of how it might read to speak to electronic stuff, electronic claim files. Probably it's okay because these things all have to, everything that gets submitted in paper is converted and submitted into electronic claim files. I would appreciate as a part of the revision of regulation NAC 616C.032 section 9 of the regulations proposed, spelled out how does DIR want this? Is it chronological by date received or what? With paper files, as the claim file grows it becomes multiple volumes and sometimes whole filing cabinets over the course of a lifespan. It's helpful for purposes of PPD and for separating any records for rating doctors, IMEs and you name it. It's practical to have the medical records at least organized in chronological order by the date of the report. In other aspects sometimes it's practical to have, in actually administering the claim, to having the correspondence and replies organized by the date on the document, as opposed to the date it was received. Typically, for medical reports having things completely out of order by the date received because we may not get a doctor's report until months down the road. And sometimes a year. It happens they don't get resubmitted properly with the medical report or the bill. So anyway, some leeway in terms of that chronological order, in terms of medical reporting, can be kept in chronological order by the date of the report whereas, perhaps, everything else needs to be kept by date of receipt.

Regarding Section 10, what needs to be kept in the claim files, we need to know, is it okay to put the medical reports in chronological order by date of service so we can follow the medical progress? And the Doctors can see what they do in IME and everything is in order for them. When it goes to a PPD, everything is in order for them. We're required by regulation to provide them in date order, date of service order for the PPD. If we can keep them in the claim files in that order that would be nice as opposed to having to reshuffle them all, and put them back in date received.

On Section 11, I suggest the proposed language be revised from you can add more third party administrators. The insurer shall give written notice of its determination to accept or deny the claim, etc.… I think that should just simply state its determination pursuant to NRS 616C.065 subsection 1. Because I think otherwise it conflicts with that statute's subsection 5. And delete all of the language all the way up to the attorney, authorized representative, blah blah blah, appendix and beginning with and, to the injured employee's employer. I don't see why that needs to be spelled out because I thought we were supposed to provide a copy of everything we do to the employer. I guess I don't object to that.

On Section 11, one of the things that's missing from subsection 1 however, is it talks about taking copies to the injured employee, etc. but what if they're dead? You know I can't really send it to them. And I think there needs to be a caveat in there that talks about in the event of death to the person acting on behalf of the injured employee. So I think that we have to clean up the language. I don't object to the doing of this, it's just I think I would clean things up a bit, a

little bit. Denial of claims, Subsection 2. Again, I would prefer just say the denial pursuant to NRS 616C.065 subsection 1(b), I think that's a simpler statement. Then it talks about, subsection (b) of subsection 2, talks about the things that have to be in the notice of denial, subsection 2 there talks about a specific statement concerning the reasons for the denial of the claim. But it doesn't really explain or define what that specific statement might be. I understand what you're trying to do because I can imagine, I guess, claims adjusters out there are just sending out a notice saying your claim is denied, appeal it. I thought that the regulations were very clear the last 25 years that you have to tell them why. Obviously that didn't happen. What's the specific statement your claim is denied because it doesn't comport to statute, well, it doesn't tell them anymore. I think maybe there needs to be a little more clarification or explanation of what is meant by "specific statement concerning reasons, citation of statute." Subsection (c) talks about providing a copy of the denials, etc., that gives pursuant to paragraph (b), denial of a claim providing it to the employee's treating physician. Well, when I look at a new claim within the first 30 days, the injured employee doesn't have, often, a treating physician, they have been to an emergency room. They have seen a doctor initially at the emergency room and they treated at the emergency room. Well, according to regulation, as I recall, I don't remember the number, but it says that emergency room physicians can't be or aren't the treating physicians. So who are we supposed to send that to? How about the caveat, that, if the injured worker has a treating physician selected pursuant that cite the proper statute. Otherwise I can envision the DIR claims compliance auditor coming in and going, "Oh, where is your letter to the treating physician? There's no copy to the treating physician". Well, gee, they went to the ER three times. Who are we supposed to send that to? Something like that caveat would give us some room to breathe when we are audited. We'll do the best we can to send it to the appropriate party.

Subsection (d)(1), I again think rather than spelling it out just say pursuant to the statute and then cite the proper statute, 616C.051. And again for subsection 3, same objection; just say pursuant to the statute.

On Subsection 1 of Section 12, we would like to see in there the addition of the word "signed". Too often we get letters reported to be from the injured workers, has their address on it and so forth, but they're not signed, including C4 forms not signed. Seems to me that nothing is valid without the injured worker's signature. Subsection 1 would read, 'Except as otherwise provided in this section, within 30 days after receipt of a 'signed' written request 'submitted in compliance with NAC 616B.010(2),' relating to a claim made by:…". So the addition of the word "signed" before written and the addition of "submitted in compliance of 616B.010", which has to be submitted to the insurer's address.

Moving to subsection 3 of Section 12, which concerns reopening requests, my impression has been that only the injured employee can make a request to reopen. Maybe there needs to be something in there that only a "legitimate person" can make the request. Just a comment that I had because of the issue of doctors making requests to reopen. The injured worker apparently doesn't contact us or the administrator to find out how to do it. They didn't keep the paperwork we sent them with their closure documents. So, they go to the doctor and say, "Doctor it bothers me again. You need to reopen my claim." The doctor writes a report and sends it in with his bill and says we need to reopen the claim because the injured worker is here again he has got a backache its related, etc., etc. Well, there's a person making a request to reopen. And we're

supposed to respond with a determination, and send copies to all these people. One, that's not a legitimate person making a request. Or it might come from someone that is not a representative of the injured worker.

On subsection 2 of Section 15, which adds the statement, "which must include notice of the right to appeal the transfer…Shall give written notice to all interested parties of the transfer of injured employee…" to a new physician … "which must include notice of the right to appeal the transfer." It's only the injured employee or their lawful representative that can appeal, not the physician, if I understand things correctly. Maybe it needs some clarification.

Deena Carson, Workers Comp Manager, Hometown Health, 830 Harvard Way, Reno, NV 89502; Telephone: (775) 982-3049; E-mail: DCarson@hometownhealth.com.
My quick question is, is this specifically to make certain that the insurers and TPA's are notifying injured workers that they are transferring their care to someone else? When we have somebody that goes to let's say to an orthopedist who decides they are not a surgical candidate, makes a referral to a physiatrist for conservative treatment, we're not doing a transfer of care, the injured worker is not requesting a transfer of care the referring physician is referring them to someone who can actually treat them. Just want some clarification concerning that. Assuming that then we should be sending out notifications when a transfer of care is done by a treating physician. We typically do not if you're just referring them to "x" physiatrist instead of (inaudible). The injured worker disagrees with who we are sending them to.

Mike Livermore, Alternative Service Concepts, LLC, 639 Isbell Road, Suite 390, Reno, NV 89509-4993; Telephone: (775) 329-1181; E-mail: james.livermore@ascrisk.com.
On Section 15, subsection 8, I really appreciate that DIR has focused on this issue. The regulations have seldom if ever spelled out the time frames and obligations of treating physicians and others involved in the treatment of injured workers. Stating that the treating physician or chiropractor shall respond in writing to the insurer's written request not later than ten days after receiving the request. We make many other kinds of requests to doctors. Is this injured worker able to return to work? Are these restrictions okay? Can you release them to return to work? I'm not sure whether those would be interpreted as reports on the status of an injured employee.

On Section 19, I applaud DIR's amendments adding subsection 3 and giving some structure and declaring the maintenance of records, so forth, for rating physicians.

Jeanette Belz representing PCI and Liberty Mutual, J. K. Belz & Associates, 10580 N. McCarran Blvd., #115-222, Reno, NV 89503; Telephone: (775) 329-0119; E-mail: jb@jkbelz.com.
On Section 20, Subsection 2, Liberty Mutual would like to comment that effective October 15, 2015 all health care providers will be converted to ICD10 in accordance with a federal mandate. And although this mandate does not specifically apply to PMT carriers Liberty Mutual and others will be making this system conversion in compliance with that federal standard to avoid duplicative systems and confusion. Although the language in the regulation appears to allow for the most recently published version ICD it is not clear if it's ICD10 because there is a specific reference to ICD9.

Mike Livermore, Alternative Service Concepts, LLC, 639 Isbell Road, Suite 390, Reno, NV 89509-4993; Telephone: (775) 329-1181; E-mail: james.livermore@ascrisk.com.
On Section 24, the addition of subsection (g) section 1, a blood or urine test the glucose for a heart/lung exam I think that's great.

On Section 25, the change to subsection 2, allows for an agreement between the employer and employee, to allow the employee to assume the responsibility for scheduling their physicals to the heart/lung exam. Generally I'm okay with that I have a concern however, with what the employee's failure to follow through with scheduling over a period of time. What the effect that might have on their entitlement to benefits. I think the statutes and regulations are fairly silent about what occurs if a police officer, firefighter, fails to have their physical. With the burden being placed upon the employer. It gives the employer the mandate under statute and regulation to schedule and regulation requires the employee to attend all physicals as scheduled. So, it becomes like a personnel action where you're given a letter to go get you physical on this particular date. You go get your physical and if you fail to do it, the employer has some personnel action or authority to deal with that and I think we tend to have some statutory authority to say, you failed to get your physicals, therefore, you undermined the employer's protections to know that you are correcting predisposing conditions. And therefore, you're defeating the purpose of the statute and potentially having the justification to deny the claim that might occur down the road.

I just want to put it on the record some concerns that I have. I'm guessing maybe it doesn't change the situation a whole lot. If the employee fails to do what he is supposed to do based on the agreement, probably the same thing would apply. So it's not an objection, it's a comment.

Written comments were received for the January 5, 2015 public workshop and shortly thereafter. A summary of the written comments follows:

January 2, 2015 Comments from Kathleen G. Bissell, CPCU, Assistant Vice President & Senior Regional Director, Liberty Mutual Insurance, Public Affairs – 01A, 71 Stevenson Street, Suite 700, San Francisco, CA 94105; Telephone (415) 276-0703. Liberty Mutual is concerned that Section 20, amending NAC 616C.149(2) refers to the most recently published edition of the *International Classification of Diseases, Clinical Modification* as (ICD-9-CM) and notes that ICD-10-CM will effective on October 15, 2015. They request that the proposed language more clearly identify which version is adopted by reference.

Written Comments received January 5, 2015 from Craig Coziahr, ProGroup Management, Inc., 575 S. Saliman Road, Carson City, NV 89701; Telephone (775) 887-2480. ProGroup is concerned that Section 8, Subsection 5(b) adds a new provision which requires an insurer or employer to "Provide transportation, where available, for the injured employee, including without limitation, in the form of a monthly bus pass, public transportation or other appropriate means of transportation as determined by the insurer or employer, taking into consideration the medical requirements and physical restrictions of the injured employee." Is this a new requirement to provide transportation to and from medical appointments or work?

ProGroup is also concerned that Section 12, Subsection 2, which amends NAC 616C.094, should be limited to written requests from the injured employee "or authorized representative."

Finally, ProGroup is concerned that Section 15, Subsection 1 as written, which amends 616C.129, extends appeal rights to the new physician or chiropractor.

Written Comments dated January 19, 2015 from Mitchell D. Forman, D.O., President of the Nevada State Medical Association, 3660 Baker Lane, #101, Reno, NV 89509, Telephone: (775) 825-6788. The Association is concerned whether the new "10 day" requirement set forth in Section 15, Subsection 8 (NAC 616C.129(8)) means business or calendar days and suggests "business" days.

February 16, 2016 e-mail from Chris Bosse, **Renown, 50 West Liberty Street, Suite 1100, Reno, Nevada 89501; Telephone: 775-982-5761; E-mail: cbosse@renown.org.** Renown suggested that in Section 1(1)(a) and (b) the word "usable" be stricken and that "transferreable/readily convertible" be added instead. In (1)(b) Renown also suggested the insertion of the phrase, "to administer." Finally, they requested a new paragraph (1)(d) which would allow the receiving insurer or third party administrator 60 days to create or assume existing bank accounts and require the transferring entity to continue to pay all indemnity benefits during that transition period. In (2)(a) Renown suggest a 30 to 60 day period based on the number of open claims being transferred, rather than a flat 30 day requirement for reviewing the files and determining actions to be taken on each claim.

In Section 4, defining terms in NRS 616C.065, subsection (2), Renown suggests that "certificate of receipt" should be "certificate of service."

In Section 5(2), the language should be rewritten to allow an injured employee to file an appeal of any insurer's failure to respond to a written request, rather than the proposed language which authorizes an injured employee make another written request when the insurer failed to respond.

In Section 10, amending NAC 616C.091, Renown suggests that the phrase, "injured employee, attorney or other authorized representative of the injured employee" be rewritten to read, "injured employee and attorney or other authorized representative of the injured employee." This phrase appears in NAC 616C.091, subsections (1) and (2)(b); Section 11, amending 616C.094(3); and Section 14, amending NAC 616C.129(2).

In Section 14, amending NAC 616C.129, Renown suggests new (8) and (9) which would control when an insurer or third party administrator could request a physician's or Chiropractor's Progress Report or Certificate of Disability, and authorize the provider to charge for resending previously provided documentation.

At the **February 18, 2016 Hearing on the Notice of Intent to Act on Proposed Regulations**, which was held at two sites via videoconference, in Las Vegas 7 attended; in Carson City 5 attended, with testimony received from two (2) attendees. A summary of the testimony at this public hearing follows:

Deena Carson, WorkersChoice in Hometown Health, 830 Harvard Way, Reno, Nevada 89502; Telephone: 775-982-3232; E-mail: dcarson@HometownHealth.com: On Section 1(1)(a) and (b) where it says provides "usable format" for transfer of conversion of data, we would prefer it says something more like "transferrable readily convertible data." We also suggest a new (1)(d) to allow up to 60 days to assume existing bank accounts and requiring the transferring insurer or third party administrator to comply with paying indemnity benefits. On Section 1(2)(a) the review time for the company receiving the files should be based on the number of open claims received.

On Section 4(2) [amending NAC 616C.065(2)] in terms of "certificate of service" for the certified mail. It does not say it has to have a certified receipt. Either it does or it doesn't. I think that needs to be clarified.

Jim Werbeckes, Vice President, Government and Regulatory Affairs, Employers Insurance Group, 10375 Professional Circle, Reno, Nevada 89521; Telephone: 775-327-2458; E-mail: jwerbeckes@employers.com: On Section 7, we hope the Division will finally adopt this regulation and move forward.

Deena Carson, WorkersChoice in Hometown Health, 830 Harvard Way, Reno, Nevada 89502; Telephone: 775-982-3232; E-mail: dcarson@HometownHealth.com: Under Section 14 [amending NAC 616C.129] we suggest a new subparagraph (8) limiting the insurer or third party administrator's ability to request a written updated Certificate of Disability or medical status report.

Jim Werbeckes, Vice President, Government and Regulatory Affairs, Employers Insurance Group, 10375 Professional Circle, Reno, Nevada 89521; Telephone: 775-327-2458; E-mail: jwerbeckes@employers.com: On Section 14 [amending NAC 616C.129] this section has no teeth and I understand trying to get physicians to do this but I don't know how we can get these reports done in a timely fashion as it appears we don't get them in a timely fashion.

No written comments were received before the March 3, 2016 deadline for written comments.

5. A description of how comment was solicited from affected businesses, a summary of their response, and an explanation how other interested persons may obtain a copy of the summary.

The Division sent by U.S. Mail and via e-mail the Notice of Public Workshops to Solicit Comments on Proposed Regulations to over 2,450 persons who were known to have an interest in the subject on Chapters 616A through 616D, inclusive, and 617 of the Nevada Administrative Code, as well as any persons who had specifically requested such notice.

A copy of this summary of the public response to the proposed regulations may be obtained from Donald C. Smith, Esq. at the Division of Industrial Relations, Legal Department, 1301 N. Green

Valley Pkwy., #200, Henderson, NV 89074, telephone (702) 486-9070, or e-mail to donaldcsmith@business.nv.gov.

6. If the regulation was adopted without changing any part of the proposed regulation, a summary of the reasons for adopting the regulations without change.

A number of revisions were suggested at the February 18, 2016 hearing and written comments received before that hearing, some of which were not incorporated into the proposed regulation by the Division. Each of those suggested revisions which were not adopted is discussed separately below.

A suggestion was made that in Section 1, subsections (1)(a) and (b) the word "usable" be stricken and that "transferrable/readily convertible" be added instead. The Division believes that the regulation as proposed is more appropriate because the suggested change could be perceived as placing an unnecessary burden on the transferring insurer or third-party administrator.

A suggestion was made that Section 1, subsection (1)(b) the phrase, "to administer and" be inserted before the word "comply." This suggestion change appears redundant.

A suggestion was made that Section 1 have a new paragraph subsection (1)(d) which would allow the receiving insurer or third party administrator 60 days to create or assume existing bank accounts and require the transferring entity to continue to pay all indemnity benefits during that transition period. The proposed regulation as drafted requires that compensation payments be made by the transferring insurer or third-party administrator, until accounts have been established and funded with the receiving entity and a specific time period to accomplish this task appears to be an unnecessary interference by the Division.

On Section 1, subsection (2)(a) a suggestion was made that a 30 day limitation to review transferred claim files be expanded to 30 to 60 days based on the number of open claims being transferred. This suggestion was not incorporated into the proposed regulation as the receiving entity will know the number of claims being transferred and should staff appropriately during the transition to assure that all appropriate benefits are being provided to injured employees.

A suggestion was made that Section 5 subsection (2), the language should be rewritten to allow an injured employee to file an appeal of any insurer's failure to respond to a written request. This suggestion was not incorporated because the proposed regulation is considered clearer than the proposed language.

A suggestion was made that in Section 10, amending NAC 616C.091, the phrase, "injured employee, attorney or other authorized representative of the injured employee" be rewritten to read, "injured employee and attorney or other authorized representative of the injured employee." This same phrase also appears in NAC 616C.091, subsections (1) and (2)(b); Section 11, amending 616C.094(3); and Section 14, amending NAC 616C.129(2). This suggested change was not incorporated into the proposed regulation as the language as drafted is appropriate.

A suggestion was made that Section 14, amending NAC 616C.129, include new subsections (8) and (9) which would control when an insurer or third party administrator could request a physician's or Chiropractor's Progress Report or Certificate of Disability, and authorize the provider to charge for resending previously provided documentation. This language was not incorporated into the proposed regulation as it would overly complicate the medical reporting and create an additional expense to the insurer.

7. The estimated economic effect of the adopted regulation on the businesses which it is to regulate and on the public. These must be stated separately, and each case must include:

(a) Both adverse and beneficial effects; and

(b) Both immediate and long-term effects.

(a) Both adverse and beneficial effects.

There are no adverse or beneficial economic effects that would impact regulated businesses. The possible adverse economic effects, if any, on the regulated businesses might be small changes in their processes and procedures in handling specific issues. The beneficial economic effects on the regulated businesses are additional clarity in the existing regulations. There are no adverse or beneficial economic effects that would impact the general public.

(b) Both immediate and long-term effects.

There are no immediate or long-term economic effects that would impact regulated businesses. The possible immediate economic effects, if any, on the regulated businesses might be small changes in their processes and procedures in handling specific issues. The long-term economic effects on the regulated businesses are additional clarity in the existing regulations. There are no immediate or long-term economic effects that would impact the general public.

8. The estimated cost to the agency for enforcement of the adopted regulation.

There is no additional cost to the agency for enforcement of this regulation.

9. A description of any regulations of other state or government agencies, which the proposed regulation overlaps or duplicates and a statement explaining why the duplication or overlapping is necessary. If the regulation overlaps or duplicates a federal regulation, the name of the regulating federal agency.

There are no other state or government agency regulations that the proposed amendments duplicate.

10. If the regulation includes provisions that are more stringent than a federal regulation which regulates the same activity, a summary of such provisions.

The proposed regulation does not include any provisions which duplicate or are more stringent than existing federal, state or local standards.

11. If the regulation provides a new fee or increases an existing fee, the total annual amount the agency expects to collect and the manner in which the money will be used.

The proposed regulations do not provide for a new fee or increase an existing fee.

12. Is the proposed regulation likely to impose a direct and significant economic burden upon a small business or directly restrict the formation, operation or expansion of a small business? What methods did the agency use in determining the impact of the regulation on a small business?

The Administrator has determined that the proposed regulation does not impose a direct and significant economic burden upon a small business or restrict the formation, operation or expansion of a small business. In making this determination the Administrator considered the purpose and scope of the proposed and potential regulation changes in conjunction with existing regulations. Based on this review, the Division determined that these regulations may have some minimal financial impact on insurers, third-party administrators, employee leasing companies and the employers of firefighters, police officers and arson investigators, which may be required to revise their business processes and will not directly restrict the formation, operation or expansion of a small business.