

**PROPOSED REGULATION OF THE
DIVISION OF INDUSTRIAL RELATIONS OF THE
DEPARTMENT OF BUSINESS AND INDUSTRY**

LCB File No. R134-20

July 9, 2021

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

AUTHORITY: §§ 1-6, 8, 9, 17, 19-23, 27 and 34, NRS 616A.400; § 7, NRS 616A.400 and 616A.417; §§ 10-15 and 18, NRS 232.680 and 616A.400; § 16, NRS 616A.400, 616B.584 and 616B.587; §§ 24-26 and 28, NRS 616A.400 and 616C.490; §§ 29 and 30, NRS 616A.400 and 616C.420; § 31, NRS 616A.400 and 616D.120; § 32, NRS 616A.400 and 616C.555; § 33, NRS 616A.400, 617.455 and 617.457.

A REGULATION relating to industrial insurance; authorizing the purchase of an annuity to provide compensation for an industrial injury or occupational disease; prohibiting reimbursement from certain accounts for certain claim expenditures which are reimbursable to self-insured employers, associations of self-insured employers and private carriers from other sources; requiring certain information to be provided to the Administrator of the Division of Industrial Relations of the Department of Business and Industry and the Commissioner of Insurance; revising certain provisions which adopt by reference certain publications; requiring private carriers to submit proof of industrial insurance coverage by certain means and in certain formats; revising provisions governing the determination of annual expenditures for claims; requiring an insurer to report certain claim expenditures assumed and paid on behalf of another; requiring the certification of an insurer's list of treating physicians and chiropractors under certain circumstances; defining terms for the purposes of determining eligibility for compensation for certain mental injuries caused by extreme stress; revising requirements for a physician or chiropractor to be included on a panel to treat injured employees; revising requirements for the designation of a rating physician or chiropractor; revising conditions for warning, suspending and removing a physician or chiropractor from the list of rating physicians and chiropractor; requiring certain items to be contained in a claim file maintained by an insurer or third-party administrator; revising provisions governing the provision of certain items and information to an assigned rating physician or chiropractor before a rating evaluation; eliminating provisions governing the extension of vocational rehabilitation services; revising provisions governing the calculation of a benefit penalty; repealing certain provisions; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing regulations authorize, under certain conditions, a self-insured employer or association of self-insured public or private employers to purchase an annuity for the payment of workers' compensation to an injured employee or to the employee's beneficiary. (NAC 616B.471, 616B.572) **Section 2** of this regulation authorizes a private carrier to purchase an annuity for such purposes. **Sections 2, 8 and 9** of this regulation also require the private carrier, self-insured employer or association, as applicable, and insurer who sold the annuity to provide certain information relating to such annuities to the Administrator of the Division of Industrial Relations of the Department of Business and Industry and to the Commissioner of Insurance.

Sections 3 and 4 of this regulation prohibit a self-insured employer or an association of self-insured employers from receiving reimbursement from the Subsequent Injury Account for Self-Insured Employers or the Subsequent Injury Account for Associations of Self-Insured Public or Private Employers, respectively, for certain expenditures which are reimbursable from certain other sources.

Section 5 of this regulation revises the information regarding claims which an insurer must provide to the Administrator.

Section 6 of this regulation revises provisions setting forth the publications which are adopted by reference by the Administrator.

Existing regulations: (1) require a private carrier to submit proof of industrial insurance coverage to the agent designated by the Administrator to receive such proof by electronic transmission, or by the United States Postal Service or any other mail delivery service; and (2) specify the forms which the private carrier must use to submit certain information relating to a binder or policy. (NAC 616B.133) **Section 7** of this regulation revises these provisions to require a private carrier to submit such proof of coverage by electronic transmission in the format specified by certain specifications of the Workers Compensation Insurance Organizations or via the Policy Data Collection Tool of the National Council on Compensation Insurance.

Section 10 and 12 of this regulation exclude certain amounts reimbursed to an insurer from its annual expenditures for claims for the purposes of determining an annual assessment to be made against the insurer.

Existing regulations require an insurer to provide to the Division a statement of expenditures for claims. (NAC 616B.713) **Section 13** of this regulation requires an insurer who assumes the obligation to pay expenditure for claims of a self-insured employer, association of self-insured public employer or association of self-insured private employers whose certificate of authority has been withdrawn by the Commissioner to provide such a statement on behalf of the employer or association.

Existing regulations provide that the Administrator will make determinations on expenditures for claims for which a private carrier may receive reimbursement from the Subsequent Injury Account for Private Carriers. (NAC 616B.763) **Section 16** of this regulation prohibits a private carrier from receiving reimbursement from the Subsequent Injury Account for Private Carriers for certain expenditures which are reimbursable from certain other sources.

Sections 18, 19 and 20 of this regulation exclude certain amounts reimbursed to an association from its annual expenditures for claims for the purposes of determining an annual assessment to be made against the association. **Section 18** also requires an insurer who assumes the obligation to pay the expenditures for claims of an association of self-insured employers whose certificate of authority has been withdrawn by the Commissioner to provide on behalf of the association a report of expenditures made for claims of the association.

Section 22 of this regulation requires an insurer's list of treating physicians and chiropractors to be signed and certified by the insurer's highest ranking employee who is responsible for processing workers' compensation claims filed in this State if the insurer uses only salaried employees who are not adjusters licensed pursuant to chapter 684A of NRS to investigate, negotiate and settle workers' compensation claims.

Section 23 of this regulation sets forth the Administrator's interpretation of the term "grievous bodily harm of a nature that shocks the conscience" for the purpose of determining whether certain harm witnessed by a first responder is of a character that could result in a compensable mental injury caused by extreme stress.

Section 24 of this regulation revises the requirements for a physician or chiropractor to be on a panel to treat injured employees.

Section 25 of this regulation revises the requirements for the designation of a rating physician or chiropractor.

Section 26 of this regulation revises the conditions under which the Administrator will issue a warning to a physician or chiropractor on the list of rating physicians and chiropractors, or suspend or remove a physician or chiropractor from the list.

Section 27 of this regulation revises the items which must be contained in a file of a claim concerning an industrial injury or occupational disease which is maintained by an insurer or third-party administrator.

Existing regulations require an insurer to provide certain items and information to an assigned rating physician or chiropractor before a rating evaluation. (NAC 616C.103) **Section 28** of this regulation requires the party that requested the rating evaluation to provide the items and information to the assigned rating physician or chiropractor.

Existing regulations set forth certain guidelines for calculating an average monthly wage for the purpose of calculating the rate of compensation for an injured employee. (NAC 616C.435) **Section 30** of this regulation revises these guidelines to include certain wages earned in concurrent employment.

Existing law provides that a program for vocational rehabilitation may be extended, without condition or limitation, by an insurer at the insurer's sole discretion or by order of a hearing officer or appeals officer. (NRS 616C.560) **Section 32** of this regulation eliminates a provision which provides that vocational rehabilitation services may be extended if the insurer finds that good cause exists for an extension.

Section 33 of this regulation sets forth: (1) certain periods of time which must be excluded in calculating the number of days to which a benefit penalty may apply; and (2) the amount of the benefit penalty which must be imposed for each day which is not excluded from the calculation.

Section 34 of this regulation repeals provisions governing: (1) wages for concurrent employment which are included in the average monthly wage for the purpose of calculating the rate of compensation for an injured employee; and (2) certain annual payments from amounts withdrawn from the Uninsured Employers' Claim Account payable to claimants and dependents for claims for permanent total disability.

Section 1. Chapter 616B of NAC is hereby amended by adding thereto the provisions set forth as sections 2, 3 and 4 of this regulation.

Sec. 2. 1. *Except as otherwise provided in subsection 11, a private carrier may purchase an annuity payable to an employee who has filed a claim pursuant to chapters 616A to 617, inclusive, of NRS, or to the employee's beneficiary, for the compensation owed to the employee as a result of an industrial injury or occupational disease, except accident benefits, if:*

(a) The annuity is purchased from an insurer authorized to do business in this State;

(b) The employee or beneficiary is the annuitant and all payments made pursuant to the annuity will be made directly to the employee or the beneficiary; and

(c) The purchase of the annuity by the private carrier on behalf of the employee is made to provide compensation owed to the employee or the beneficiary pursuant to chapters 616A to 617, inclusive, of NRS.

2. The purchase of an annuity pursuant to this section does not:

(a) Settle the employee's claim for compensation;

(b) Prohibit the employee from reopening or contesting the claim; or

(c) Transfer the responsibility of the private carrier to provide, in a timely manner, accurate payments of compensation owed to the employee to the insurer or any other party.

3. *Each contract for an annuity purchased pursuant to this section must set forth the provisions of subsections 1 and 2.*

4. *An annuity purchased pursuant to this section may not be assigned.*

5. *A private carrier which purchases an annuity pursuant to this section shall make all payments required for the purchase of the annuity.*

6. *The amount of the total payments made to an employee pursuant to an annuity purchased pursuant to this section may not be less than the amount of compensation, other than accident benefits, owed to the employee pursuant to chapters 616A to 617, inclusive, of NRS.*

7. *A private carrier which purchases an annuity pursuant to this section:*

(a) *Shall classify the purchase of the annuity as an amount paid for indemnity; and*

(b) *May reduce its reserve balance for indemnity for the claim by the amount of compensation owed to the employee pursuant to chapters 616A to 617, inclusive, of NRS for the period covered by the annuity.*

8. *A private carrier shall submit to the Administrator and the Commissioner a report which sets forth each annuity it purchased, if any, in the preceding year. The private carrier shall provide the following information for each annuity listed in the report:*

(a) *The name of the employee on whose behalf the annuity was purchased.*

(b) *The number assigned to the claim by the private carrier.*

(c) *The number of the contract for the annuity.*

(d) *The amount paid for the annuity.*

(e) *The name of the insurer who issued the annuity.*

9. *A private carrier shall submit the report required pursuant to subsection 8 to:*

(a) The Administrator with the filing of the report which is required pursuant to NAC 616B.016; and

(b) The Commissioner with the filing of the annual statement which is required pursuant to NRS 680A.270.

10. An insurer who sells an annuity to a private carrier shall, within 10 days after the contract for the annuity is executed, submit a copy of that contract to the Administrator, the Commissioner and the private carrier.

11. A private carrier may, upon the approval of the Commissioner, purchase an annuity to pay the accident benefits of an employee incurred as a result of an industrial injury or occupational disease.

Sec. 3. *A self-insured employer may not receive reimbursement from the Subsequent Injury Account for Self-Insured Employers created by NRS 616B.554 for expenditures for:*

1. Increases in compensation for permanent total disability which are reimbursable to the self-insured employer pursuant to NRS 616C.266; or

2. Increases in death benefits which are reimbursable to the self-insured employer from the Fund for Workers' Compensation and Safety pursuant to NRS 616C.268.

Sec. 4. *An association may not receive reimbursement from the Account for expenditures for:*

1. Increases in compensation for permanent total disability which are reimbursable to the association pursuant to NRS 616C.266; or

2. Increases in death benefits which are reimbursable to the association from the Fund for Workers' Compensation and Safety pursuant to NRS 616C.268.

Sec. 5. NAC 616B.016 is hereby amended to read as follows:

616B.016 1. Upon the request of the Administrator, each insurer shall file a report with the Administrator which contains the following information:

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

- (1) The number of new claims filed.
- (2) The number of claims for accident benefits only that were accepted by the insurer.
- (3) The number of claims for benefits for lost time that were accepted by the insurer.
- (4) The number of compensable fatalities.
- (5) The number of claims that were denied by the insurer.

(b) For claims for an occupational disease:

- (1) The number of new claims filed.
- (2) The number of claims for accident benefits only that were accepted by the insurer.
- (3) The number of claims for benefits for lost time that were accepted by the insurer.
- (4) The number of compensable fatalities.
- (5) The number of claims that were denied by the insurer.

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

(d) The number of requests to reopen a claim that were denied by the insurer.

(e) The number of claims for accident benefits only that were reopened by the insurer.

(f) The number of claims for benefits for lost time that were reopened by the insurer.

(g) The number of injured employees who received benefits for a permanent partial disability.

(h) The number of injured employees who received benefits for a permanent partial disability in a lump sum.

(i) *The number of claims for which benefits for a permanent total disability were paid.*

(j) The number of claims for which an increase in compensation for a permanent total disability was paid pursuant to NRS 616C.473.

(k) The number of claims for which death benefits were paid.

(l) The number of injured employees who received benefits for vocational rehabilitation.

~~(m)~~ (m) The number of injured employees who received benefits for vocational rehabilitation in a lump sum.

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

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

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

~~(q)~~ (q) The total expenditures for claims reported in paragraphs ~~(k) and (l)~~.

~~(r)~~ (n) and (o).

(r) Expenditures on claims for:

- (1) A temporary total disability.
- (2) A temporary partial disability.
- (3) A permanent total disability.
- (4) A permanent partial disability.
- (5) Benefits for survivors.
- (6) Burial expenses.
- (7) Travel and per diem expenses.
- (8) All medical expenses.
- (9) Vocational rehabilitation, including, without limitation, expenditures for:
 - (I) Vocational rehabilitation maintenance.

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

(III) Program expenses.

(IV) Administrative expenses.

(V) Other expenses relating to vocational rehabilitation.

~~(p)~~ (s) Amounts recovered:

(1) By subrogation of claims.

(2) From the:

(I) Subsequent Injury Account for Self-Insured Employers established pursuant to NRS 616B.554;

(II) Subsequent Injury Account for Associations of Self-Insured Public or Private Employers established pursuant to NRS 616B.575; or

(III) Subsequent Injury Account for Private Carriers established pursuant to NRS 616B.584.

(3) *From the Fund for Workers' Compensation and Safety created by NRS 616B.575 for increases in compensation for permanent total disability pursuant to NRS 616C.266 and increases in death benefits pursuant to NRS 616C.268.*

(4) From other sources.

~~(q)~~ (t) Any other information requested by the Administrator.

2. The information required pursuant to subsection 1 must, except as otherwise requested by the Administrator, include information concerning any administrative activity during the previous fiscal year relating to:

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

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

3. As used in this section:

(a) “Claim for accident benefits only” means a claim in which the benefits received by the injured employee or his or her dependents for the duration of the claim did not include benefits for a temporary total disability, temporary partial disability or permanent total disability.

(b) “Claim for benefits for lost time” means a claim in which the benefits received by the injured employee or his or her dependents for the duration of the claim included benefits for a temporary total disability, temporary partial disability or permanent total disability.

(c) “Vocational rehabilitation maintenance” has the meaning ascribed to it in NRS 616C.575.

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

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

1. ~~[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, 7780 Elmwood Avenue, Suite 207, Middleton, Wisconsin 53562, for the price of \$195, or may be obtained free of charge by members at the Internet address <http://www.iaiabce.org>.~~

~~—2.]~~ *Policy and Proof of Coverage Reporting Guidebook*, which is ~~[published]~~ *issued* by the National Council on Compensation Insurance. ~~[A copy of the publication]~~ *Access to the Guidebook* may be obtained ~~[from 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 \$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 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 \$125 for affiliates and \$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 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 \$160 for affiliates and \$325 for nonaffiliates.~~

~~—5.]~~

2. *Electronic Transmission User's Guide*, which is ~~[published by]~~ *available from* the National Council on Compensation Insurance. ~~[A copy of the publication]~~ *Access to the Guide* may be obtained, free of charge, at the Internet address <http://www.ncci.com>.

~~[6.]~~ 3. *WCIO Workers Compensation Data Specifications Manual*, which is maintained by the Workers Compensation Insurance Organizations. A copy of the publication may be obtained, free of charge, at the Internet address <http://www.wcio.org>.

Sec. 7. NAC 616B.133 is hereby amended to read as follows:

616B.133 ~~[H.]~~ A private carrier shall submit proof of coverage to the designated agent by:

~~[(a)]~~ 1. Electronic transmission ~~[;]~~ *in the format specified by the Workers Compensation Policy Reporting Specifications in the WCIO Workers Compensation Data Specification Manual, as adopted by reference in NAC 616B.121*; or

~~[(b)]~~ 2. The ~~[United States Postal Service or any other mail delivery service.~~

~~—2.— If the private carrier does not use Form D-41, International Association of Industrial Accident Boards and Commissions POC-1, to submit:~~

~~—(a) Information relating to a binder, it shall submit Form D-48, Proof of Coverage Notice, and a schedule of the names, addresses and federal employer identification numbers of the employers covered by the binder.~~

~~—(b) Information relating to a policy, it shall submit Form D-49, Information Page.~~

~~—(c) Information relating to the termination, cancellation or reinstatement of a policy, it shall submit Form D-50, Policy Termination, Cancellation and Reinstatement Notice.~~

~~—3.— As used in this section, “electronic transmission” means the sending of information by electronic means in the manner prescribed by the designated agent, including, without limitation, by a magnetic tape, cartridge, mainframe or personal computer.] *Policy Data Collection Tool of the National Council on Compensation Insurance, available free of charge at <http://www.ncci.com>.*~~

Sec. 8. NAC 616B.471 is hereby amended to read as follows:

616B.471 1. Except as otherwise provided in subsection ~~[10,]~~ **11**, a self-insured employer may purchase an annuity payable to an employee who has filed a claim pursuant to chapters 616A to 617, inclusive, of NRS, or to the employee’s beneficiary, for the compensation owed to the employee as a result of an industrial injury or occupational disease, except accident benefits, if:

(a) The annuity is purchased from an insurer authorized to do business in this State;

(b) The employee or the beneficiary is the annuitant and all payments made pursuant to the annuity will be made directly to the employee or the beneficiary; and

(c) The purchase of the annuity by the self-insured employer on behalf of the employee is made to provide compensation owed to the employee or the beneficiary pursuant to chapters 616A to 617, inclusive, of NRS.

2. The purchase of an annuity pursuant to this section does not:

(a) Settle the employee's claim for compensation;

(b) Prohibit the employee from reopening or contesting the claim; or

(c) Transfer the responsibility of the self-insured employer to provide, in a timely manner, accurate payments of compensation owed to the employee to the insurer or any other party.

3. Each contract for an annuity purchased pursuant to this section must set forth the provisions of subsections 1 and 2.

4. An annuity purchased pursuant to this section may not be assigned.

5. A self-insured employer who purchases an annuity pursuant to this section shall make all payments required for the purchase of the annuity.

6. The amount of the total payments made to an employee pursuant to an annuity purchased pursuant to this section may not be less than the amount of compensation, other than accident benefits, owed to the employee pursuant to chapters 616A to 617, inclusive, of NRS.

7. A self-insured employer who purchases an annuity pursuant to this section:

(a) Shall classify the purchase of the annuity as an amount paid for indemnity; and

(b) May reduce his or her reserve balance for indemnity for the claim by the amount of compensation owed to the employee pursuant to chapters 616A to 617, inclusive, of NRS for the period covered by the annuity.

8. A self-insured employer shall submit to the *Administrator and the* Commissioner ~~[, with the annual report required by NAC 616B.460, a list]~~ *a report* which sets forth each annuity he or

she purchased, if any, in the preceding year. The self-insured employer shall provide the following information for each annuity listed in the report:

- (a) The name of the employee on whose behalf the annuity was purchased;
- (b) The number assigned to the claim by the self-insured employer;
- (c) The number of the contract for the annuity;
- (d) The amount paid for the annuity; and
- (e) The name of the insurer who issued the annuity.

9. *A self-insured employer shall submit the report required pursuant to subsection 8 to:*

- (a) The Administrator with the report required of insurers pursuant to NAC 616B.016; and*
- (b) The Commissioner with the annual report required of self-insured employers pursuant to NAC 616B.460.*

10. An insurer who sells an annuity to a self-insured employer shall, within 10 days after the contract for the annuity is executed, submit a copy of that contract to the *Administrator, the* Commissioner and the self-insured employer.

~~10.~~ 11. A self-insured employer may, upon the approval of the Commissioner, purchase an annuity to pay the accident benefits owed to an employee incurred as a result of an industrial injury or occupational disease.

Sec. 9. NAC 616B.572 is hereby amended to read as follows:

616B.572 1. Except as otherwise provided in subsection ~~10.~~ 11, an association may purchase an annuity payable to an employee who has filed a claim pursuant to chapters 616A to 617, inclusive, of NRS, or to the employee's beneficiary, for the compensation owed to the employee as a result of an industrial injury or occupational disease, except accident benefits, if:

- (a) The annuity is purchased from an insurer authorized to do business in this State;

(b) The employee or the beneficiary is the annuitant and all payments made pursuant to the annuity will be made directly to the employee or the beneficiary; and

(c) The purchase of the annuity by the association on behalf of the employee is made to provide compensation owed to the employee or the beneficiary pursuant to chapters 616A to 617, inclusive, of NRS.

2. The purchase of an annuity pursuant to this section does not:

(a) Settle the employee's claim for compensation;

(b) Prohibit the employee from reopening or contesting the claim; or

(c) Transfer the responsibility of the association to provide, in a timely manner, accurate payments of compensation owed to the employee to the insurer or any other party.

3. Each contract for an annuity purchased pursuant to this section must set forth the provisions of subsections 1 and 2.

4. An annuity purchased pursuant to this section may not be assigned.

5. An association which purchases an annuity pursuant to this section shall make all payments required for the purchase of the annuity.

6. The amount of the total payments made to an employee pursuant to an annuity purchased pursuant to this section may not be less than the amount of compensation, other than accident benefits, owed to the employee pursuant to chapters 616A to 617, inclusive, of NRS.

7. An association which purchases an annuity pursuant to this section:

(a) Shall classify the purchase of the annuity as an amount paid for indemnity; and

(b) May reduce its reserve balance for indemnity for the claim by the amount of compensation owed to the employee pursuant to chapters 616A to 617, inclusive, of NRS for the period covered by the annuity.

8. An association shall submit to the *Administrator and the* Commissioner ~~[, with the annual report required by NAC 616B.564, a list]~~ *a report* which sets forth each annuity it purchased, if any, in the preceding year. The self-insured employer shall provide the following information for each annuity listed in the report:

- (a) The name of the employee on whose behalf the annuity was purchased;
- (b) The number assigned to the claim by the association;
- (c) The number of the contract for the annuity;
- (d) The amount paid for the annuity; and
- (e) The name of the insurer who issued the annuity.

9. *An association shall submit the report required pursuant to subsection 8 to:*

(a) The Administrator with the filing of the report which is required pursuant to NAC 616B.016; and

(b) The Commissioner with the filing of the annual report which is required pursuant to NAC 616B.564.

10. An insurer who sells an annuity to an association shall, within 10 days after the contract for the annuity is executed, submit a copy of that contract to the *Administrator, the* Commissioner and the association.

~~10.]~~ 11. An association may, upon the approval of the Commissioner, purchase an annuity to pay the accident benefits of an employee incurred as a result of an industrial injury or occupational disease.

Sec. 10. NAC 616B.686 is hereby amended to read as follows:

616B.686 “Annual expenditures for claims” means:

1. For assessments for fiscal years before fiscal year 1999-2000, the total amount of money actually paid for compensation in a fiscal year, including those costs of claims covered under a policy of reinsurance or a policy of excess insurance, by or on behalf of an insurer pursuant to chapters 616A to 617, inclusive, of NRS, reduced by any amount received from subrogation and reimbursement from the Subsequent Injury Account of the insurer.

2. For assessments for fiscal year 1999-2000 and for each subsequent fiscal year, the total amount of money actually paid for compensation in a fiscal year for injuries occurring on or after July 1, 1999, including those costs of claims covered under a policy of reinsurance or a policy of excess insurance, by an insurer or its third-party administrator pursuant to chapters 616A to 617, inclusive, of NRS, reduced by any amount received from ~~subrogation and reimbursement~~ :

(a) Subrogation;

(b) Reimbursement from the Subsequent Injury Account of the insurer ~~[-]~~ ;

(c) Reimbursement for increases in compensation for permanent total disability pursuant to NRS 616C.266; and

(d) Reimbursement from the Fund for Workers' Compensation and Safety for increases in death benefits pursuant to NRS 616C.268.

Sec. 11. NAC 616B.698 is hereby amended to read as follows:

616B.698 "Program of self-insurance" means the program established pursuant to chapters 616A to 617, inclusive, of NRS for which an employer *or association* is issued a certificate of qualification as a self-insured employer , ~~or an~~ association of self-insured *public* employers *or association of self-insured private employers, as applicable*, by the Commissioner.

Sec. 12. NAC 616B.710 is hereby amended to read as follows:

616B.710 In calculating his or her annual expenditures for claims, an insurer shall:

1. Reduce the expenditures for claims by an amount equal to the amount of money received from ~~[subrogation or reimbursement]~~ :

(a) *Subrogation*;

(b) *Reimbursement* from the insurer's Subsequent Injury Account ;

(c) *Reimbursement for increases in compensation for permanent total disability pursuant to NRS 616C.266; and*

(d) *Reimbursement from the Fund for Workers' Compensation and Safety for increases in death benefits pursuant to NRS 616C.268,*

↳ in the fiscal year in which ~~it~~ *the money* is received; and

2. Not reduce the total amount of money actually paid for compensation to an amount less than zero.

Sec. 13. NAC 616B.713 is hereby amended to read as follows:

616B.713 1. Except as otherwise provided in *subsection 2 and* NAC 616B.7755, an insurer shall provide to the Division a statement showing the amount of expenditures for claims described in NAC 616B.707 for a period designated by the Division.

2. *If an insurer assumes the obligation to pay the expenditures for claims of a self-insured employer, association of self-insured public employers or association of self-insured private employers whose certificate of authority has been withdrawn by an order of the Commissioner, the insurer must provide to the Division a statement showing the amount of expenditures for claims described in NAC 616B.707 which the insurer assumed and paid on behalf of the self-insured employer, association of self-insured public employers or association of self-insured private employers, as applicable, for a period designated by the Division.*

3. The statement *provided pursuant to subsection 1 or 2, as applicable*, must be verified and signed by a responsible person employed by the insurer or an authorized agent thereof.

~~{3.}~~ 4. Amounts reported to the Division pursuant to ~~{subsection 1}~~ *subsection 1 or 2* will be used as the source for determining annual expenditures for claims.

Sec. 14. NAC 616B.722 is hereby amended to read as follows:

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

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

(b) The administrative costs of the offices of the Hearings Division of the Department of Administration and the Nevada Attorney for Injured Workers for the time spent concerning claims for workers' compensation will be calculated by multiplying the insurer's percentage of expenditures by the amount approved in the state budget for these administrative costs.

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

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

(e) The costs of the Commissioner for administering the program of self-insurance will be calculated by multiplying the percentage of expenditures of each self-insured employer and the

percentage of expenditures of each association of self-insured public *employers* or *association of self-insured* private employers by the amount approved in the state budget for those costs.

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

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

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

(2) The charge for the administration of claims.

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

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

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

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

Sec. 15. NAC 616B.728 is hereby amended to read as follows:

616B.728 1. If the ownership of property is transferred from one self-insured employer , ~~[or]~~ association *of self-insured public employers or association of self-insured private employers* to another, or if a self-insured employer ~~[or]~~ association *of self-insured public employers or association of self-insured private employers* acquires ownership in a property for which workers’ compensation insurance is provided by a private carrier, the Division will transfer data relating to annual expenditures for claims for that property to the new owner within 30 days after receiving notification of the transfer of ownership, and the Division will recompute the estimated annual assessments for the insurers only if it finds the existence of a special circumstance justifying the recomputation.

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

3. If an association *of self-insured public employers or association of self-insured private employers* elects to give up its status as an association *of self-insured public employers or association of self-insured private employers, as applicable*, and its members elect to be insured against liability for workers’ compensation by a private carrier, the Division will recompute the

estimated annual assessment for all insurers only if it finds the existence of a special circumstance justifying the recomputation.

Sec. 16. NAC 616B.763 is hereby amended to read as follows:

616B.763 1. The Administrator will make determinations on expenditures for claims for which a private carrier may receive reimbursement from the Subsequent Injury Account for Private Carriers in accordance with the provisions of NAC 616B.707.

2. *A private carrier may not receive reimbursement from the Subsequent Injury Account for Private Carriers for expenditures for:*

(a) Increases in compensation for permanent total disability which are reimbursable to the private carrier pursuant to NRS 616C.266; or

(b) Increases in death benefits which are reimbursable to the private carrier from the Fund for Workers' Compensation and Safety pursuant to NRS 616C.268.

3. The value of accident benefits furnished by a private carrier for industrial injuries or illnesses must be computed and reported pursuant to the schedule of fees and charges for accident benefits that was:

(a) Established pursuant to subsection 2 of NRS 616C.260; and

(b) In effect on the date the accident benefits were provided.

Sec. 17. NAC 616B.773 is hereby amended to read as follows:

616B.773 As used in NAC 616B.773 to 616B.7767, inclusive, *and section 4 of this regulation*, unless the context otherwise requires, the words and terms defined in NAC 616B.7731 to 616B.775, inclusive, have the meanings ascribed to them in those sections.

Sec. 18. NAC 616B.7734 is hereby amended to read as follows:

616B.7734 “Annual expenditures for claims of an association” means the aggregate sum of:

1. All money the association paid for compensation in a fiscal year pursuant to chapters 616A to 617, inclusive, of NRS reduced by any money received by the association in that fiscal year from ~~[subrogation and reimbursement]~~ :

(a) Subrogation;

(b) Reimbursement from the Account; ~~[and]~~

(c) Reimbursement for increases in compensation for permanent total disability pursuant to NRS 616C.266; and

(d) Reimbursement from the Fund for Workers' Compensation and Safety for increases in death benefits pursuant to NRS 616C.268.

2. Any money the successor organization to the State Industrial Insurance System paid for compensation in that fiscal year pursuant to chapters 616A to 617, inclusive, of NRS on behalf of a public or private employer who is a member of the association if the money was paid by the successor organization to the State Industrial Insurance System for claims that were incurred before the public or private employer became a member of the association.

Sec. 19. NAC 616B.7755 is hereby amended to read as follows:

616B.7755 1. Each association shall maintain records in this State of the annual expenditures for claims of the association. Such records must include, without limitation:

(a) Copies of all checks that have been issued for each claim;

(b) A register that documents all checks that have been issued for each claim and any voided checks related to such claims;

(c) A register that documents any other form of payment that has been made for each claim;
and

(d) Any working papers that the association used to report annual expenditures for claims of the association.

2. Except as otherwise provided in this subsection and ~~subsection~~ *subsections 3 ~~4~~ and 5*, each association shall provide to the Division, at such times and in such form and manner as prescribed by the Division:

(a) A report that contains the annual expenditures for claims and expected annual expenditures for claims of the association;

(b) A report which contains the annual expenditures for claims of the association, divided into monthly expenditures, and which has been verified and signed by an authorized employee or agent of the association; and

(c) Any other information that the Division determines is necessary to calculate an estimated annual assessment or final annual assessment for the association.

3. The Division may, by written request, require an association to provide a copy or certified copy of any check described in subsection 1. If an association receives such a request, the association shall provide the Division with a copy or certified copy, as requested, of both sides of the check not later than 15 days after the date that the association receives the request.

4. To calculate its annual expenditures for claims pursuant to this section, an association shall reduce its annual expenditures for claims made in each fiscal year by the amount of the money the association received in that fiscal year from ~~subrogation and reimbursement~~ :

(a) Subrogation;

(b) Reimbursement from the Account ~~4~~;

(c) Reimbursement for increases in compensation for permanent total disability pursuant to NRS 616C.266; and

(d) Reimbursement from the Fund for Workers' Compensation and Safety for increases in death benefits pursuant to NRS 616C.268.

5. If an insurer assumes the obligation to pay the expenditures for claims of an association whose certificate of authority has been withdrawn by an order of the Commissioner, the insurer must provide to the Division, at such times, for such period and in such form and manner as prescribed by the Division:

(a) A report that contains the expenditures for claims and expected expenditures for claims of the association;

(b) A report which contains the expenditures, divided into monthly expenditures, for claims described in NAC 616B.707 which the insurer assumed and paid on behalf of the association, and which has been verified and signed by an authorized employee or agent of the insurer; and

(c) Any other information that the Division determines is necessary to calculate an estimated annual assessment or final annual assessment for the insurer on behalf of the association.

Sec. 20. NAC 616B.7764 is hereby amended to read as follows:

616B.7764 1. For the purposes of subsection 1 of NAC 616B.7761, to calculate the annual expenditures for claims of an association for each of the immediately preceding 3 calendar years, the Division shall:

(a) Consider the reports and any other information provided to the Division by the association pursuant to NAC 616B.7755;

(b) Consider the statements obtained from the successor organization to the State Industrial Insurance System pursuant to subsection 2; and

(c) Determine which payments made by the association are to be considered expenditures for claims pursuant to subsections 3 and 4.

2. For each association, the Division shall obtain from the successor organization to the State Industrial Insurance System a statement showing:

(a) The annual expenditures for claims, divided into monthly expenditures, that were made by each public or private employer in the association before such employer became a member of the association; and

(b) The annual expenditures for claims, divided into monthly expenditures, that were made by each public or private employer in the association after such employer became a member of the association.

3. The Division shall consider money paid by an association for any of the following to be expenditures for claims:

(a) Charges by a hospital.

(b) Services of a surgeon, assisting surgeon, anesthesiologist or consulting physician.

(c) Treatment by a physician or chiropractor.

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

(e) Physical therapy.

(f) Drugs, medications, eyeglasses, dental work, prosthetic devices, orthotic devices or corrective shoes, if such items are prescribed.

(g) Travel to obtain medical care or supplies.

(h) Any other accident benefits.

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

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

(k) Death benefits.

(l) Burial expenses.

4. The Division shall not consider any of the following to be expenditures for claims:

(a) Money held in reserve by an association for any anticipated payment related to a claim.

(b) Payments for compensation for a temporary total or temporary partial disability in excess of the average monthly wage.

(c) *Payments for increases in compensation for permanent total disability which are reimbursable to the association pursuant to NRS 616C.266.*

(d) *Payments for increases in death benefits which are reimbursable to the association from the Fund for Workers' Compensation and Safety pursuant to NRS 616C.268.*

(e) Payments for legal expenses, including, without limitation, attorney's fees and costs for investigations, depositions or hearings.

~~(d)~~ (f) Payments for claims that are subsequently determined to be noncompensable.

~~(e)~~ (g) Payments for claims related to the Uninsured Employers' Claim Account.

~~(f)~~ (h) Payments for administrative expenses, including, without limitation, expenses for:

(1) Copying records;

(2) Reviewing the report of a physician contained in any file related to a claim; or

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

Sec. 21. Chapter 616C of NAC is hereby amended by adding thereto the provisions set forth as sections 22 and 23 of this regulation.

Sec. 22. *If an insurer uses only salaried employees to investigate, negotiate and settle workers' compensation claims as described in subsection 4 of NRS 684A.040 and does not employ adjusters licensed pursuant to chapter 684A of NRS, the insurer's list of physicians and chiropractors required pursuant to subsection 6 of NRS 616C.087 must be signed and certified as accurate by the insurer's highest ranking employee who is responsible for processing workers' compensation claims filed in this State.*

Sec. 23. *As used in subsection 4 of NRS 616C.180, the Administrator interprets the term "grievous bodily harm of a nature that shocks the conscience" to mean:*

- 1. Full or partial decapitation;*
- 2. Degloving, excluding a thumb, a single finger or a single toe;*
- 3. Enucleation;*
- 4. Evisceration;*
- 5. Exposure of one or more of the following internal organs:*
 - (a) Brain;*
 - (b) Heart;*
 - (c) Intestines;*
 - (d) Kidneys;*
 - (e) Liver; or*
 - (f) Lungs;*
- 6. Impalement of such severity to significantly threaten loss of limb or life;*
- 7. Full or partial amputation, excluding a thumb, a single finger or a single toe; or*
- 8. Third degree burns on 9 percent or more of the body.*

Sec. 24. NAC 616C.003 is hereby amended to read as follows:

616C.003 **1.** The Administrator will appoint to the panel of physicians and chiropractors described in NRS 616C.090 only physicians and chiropractors who:

~~1.~~ **(a)** Are licensed under chapter 630, 633 or 634 of NRS;

~~2.~~ **(b)** Have demonstrated special competence and interest in industrial health;

~~3.~~ **(c)** Are in good standing with the state regulatory bodies respectively charged with overseeing their licensing, practice and performance;

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

~~5.~~

(e) Have not been suspended or removed from the panel of physicians and chiropractors by the Administrator ~~1.~~;

(f) *Have not been convicted or disciplined by any state licensing agency, workers' compensation authority, professional practice organization or the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services for:*

(1) *Fraudulent activity, including, without limitation, fraudulent medical billing or reporting;*

(2) *Abuse; or*

(3) *Discriminatory treatment in the care and treatment of patients;*

(g) *Have not been convicted in a state or federal court for the commission of a felony; and*

(h) *Have not been convicted in a state or federal court or disciplined by any state's licensing agency for the commission of any offense relating to the excessive prescribing of drugs.*

2. A physician or chiropractor who is appointed to the panel must notify the Administrator in writing of any change to the information provided in his or her application to be appointed to the panel not later than 14 days after the change for as long as he or she remains on the panel. Failure to comply with this subsection may result in disciplinary action, including, without limitation, the imposition of administrative fines.

3. he Administrator will remove from the panel any physician or chiropractor who was appointed to the panel, and who had not provided to the Administrator information indicating the disciplines and specializations described in subsection 2 of NRS 616C.087, that are practiced by the physician or chiropractor, as applicable.

Sec. 25. NAC 616C.021 is hereby amended to read as follows:

616C.021 1. The designation of a rating physician or chiropractor pursuant to NRS 616C.490 must be in writing ~~[-]~~ *or by electronic communication.*

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

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

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

(1) Completing:

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

(II) ~~[One-year]~~ *Three years* or more of experience concerning industrial health in private practice. The Administrator shall determine whether the experience in private practice

concerning industrial health is sufficient to qualify for designation as a rating physician or chiropractor on a case-by-case basis.

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

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

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

(c) Demonstrate an understanding of:

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

(2) The *Guide*.

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

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

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

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

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

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

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

5. If an ophthalmologist or psychiatrist has been designated as a rating physician and wishes to maintain such designation, the Administrator may exempt the ophthalmologist or psychiatrist who is authorized to practice in this State from the requirements set forth in paragraphs (a), (c),

(d) and (e) of subsection 4 and authorize the ophthalmologist or psychiatrist to continue to evaluate injured employees with impaired vision or brain function or mental or behavioral disorders according to his or her area of specialization.

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

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

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

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

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

Sec. 26. NAC 616C.024 is hereby amended to read as follows:

616C.024 1. The Administrator will issue a warning to any physician or chiropractor on the list of rating physicians and chiropractors designated pursuant to NRS 616C.490, or suspend or remove any physician or chiropractor from the list if the physician or chiropractor:

(a) ~~Commits an excessive number of~~ *Fails to correct* errors in ~~the performance of~~ *subsequent* ratings evaluations ~~[, as determined by comparing the number of ratings found by the Administrator to be erroneous to the total number of]~~ *after receiving three or more written responses from the panel established by the Administrator pursuant to NAC 616C.023 which*

address the same or similar errors identified in ratings performed by the physician or chiropractor;

(b) Violates any provision of NAC 616C.006 or commits two or more violations of any of the provisions of chapters 616A to 617, inclusive, of NRS or any other regulations adopted pursuant thereto;

(c) Is the subject of any disciplinary action that resulted in the suspension or revocation of his or her license or the limitation of his or her practice by the applicable licensing authority;

(d) Is determined by the Administrator to have engaged in any action detrimental to an injured employee, an employer, an insurer or the program of industrial insurance;

(e) Refuses to serve as a member of the panel to review ratings evaluations established pursuant to NAC 616C.023 or serves as a member of the panel but does not attend the meetings of the panel; or

(f) Fails to perform ratings evaluations when selected pursuant to NRS 616C.490 or schedules and fails to perform ratings evaluations in accordance with that section.

2. ~~For the purposes of paragraph (a) of subsection 1, the Administrator, after receiving the advice of the panel to review ratings evaluations established pursuant to NAC 616C.023, will determine what is an excessive number of errors in the performance of ratings evaluations.~~

~~—3.]~~ If the Administrator intends to suspend or remove a physician or chiropractor from the list of rating physicians and chiropractors, the Administrator will cause written notice of the suspension or removal to be delivered by certified mail to the physician or chiropractor affected. The physician or chiropractor may appeal the determination of the Administrator by filing a written notice of appeal with the Administrator within 10 days after the notice of suspension or removal is received. If a notice of appeal is filed in the manner provided by this subsection, the

Administrator will conduct a hearing on the matter and issue a decision in writing affirming or reversing the determination.

~~[4.]~~ **3.** Except as otherwise provided in this subsection, the suspension or removal of a physician or chiropractor from the list of rating physicians and chiropractors becomes final and effective upon the expiration of the time permitted by subsection ~~[3.]~~ **2** for the filing of a notice of appeal. If a notice of appeal is filed in the manner provided by subsection ~~[3.]~~ **2**, the suspension or removal is final and effective upon the issuance of a decision affirming the determination of the Administrator. The issuance of such a decision is a final decision for the purposes of judicial review.

Sec. 27. NAC 616C.088 is hereby amended to read as follows:

616C.088 1. 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 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 *any and all written or electronic* correspondence, *electronic mail, text messages* 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.

2. Each file of a claim must be retained for 2 years after the death of the injured employee.

Sec. 28. NAC 616C.103 is hereby amended to read as follows:

616C.103 1. For purposes of determining whether an injured employee is stable and ratable and entitled to an evaluation to determine the extent of any permanent impairment pursuant to this section and NRS 616C.490, the Division interprets the term:

(a) “Stable” to include, without limitation, a written indication from a physician or chiropractor that the industrial injury or occupational disease of the injured employee:

- (1) Is stationary, permanent or static; or
- (2) Has reached maximum medical improvement.

(b) “Ratable” to include, without limitation, a written indication from a physician or chiropractor that the medical condition of the injured employee may have:

(1) Resulted in a loss of motion, sensation or strength in a body part of the injured employee;

(2) Resulted in a loss of or abnormality to a physiological or anatomical structure or bodily function of the injured employee; or

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

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

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

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

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

(a) Requesting a physician or chiropractor from the list of qualified rating physicians and chiropractors designated by the Administrator to evaluate the injured employee and determine the extent of any permanent impairment or, if the injured employee and insurer have agreed to a rating physician or chiropractor pursuant to subsection 2 of NRS 616C.490, by submitting a completed form designated in NAC 616A.480 as D-35, Request for a Rotating Rating Physician or Chiropractor, to the Workers' Compensation Section within 30 days after the insurer has received the statement from a physician or chiropractor that the injured employee is ratable and stable; *and*

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

~~—(c)}~~

4. At least 3 working days before ~~the~~ a rating evaluation, ~~providing~~ *the party that requested the rating evaluation must provide* to the assigned rating physician or chiropractor ~~from the insurer's file concerning the injured employee's claim:~~

~~—(1)}~~ :

(a) All reports or other written information concerning the injured employee's claim produced by a physician, chiropractor, hospital or other provider of health care, including the statement from the treating physician or chiropractor that the injured employee is stable and ratable, surgical reports, diagnostic, laboratory and radiography reports and information concerning any preexisting condition relating to the injured employee's claim;

~~(2)}~~ (b) Any evidence or documentation of any previous evaluations performed to determine the extent of any of the injured employee's disabilities and any previous injury, disease or condition of the injured employee that is relevant to the evaluation being performed;

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

~~(4)}~~ (d) The form designated in NAC 616A.480 as D-35, Request for a Rotating Rating Physician or Chiropractor; and

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

~~4.~~ 5. An insurer shall pay for the cost of travel for an injured employee to attend a rating evaluation as required by NAC 616C.105.

~~[5.]~~ 6. Except as otherwise provided in subsection ~~[7.]~~ 8, if the rating physician or chiropractor finds that the injured employee has a ratable impairment, the insurer shall, within the time prescribed by NRS 616C.490, offer the injured employee the award to which he or she is entitled. The insurer shall make payment to the injured employee:

- (a) Within 20 days; or
- (b) If there is any child support obligation affecting the injured employee, within 35 days, ↪ after it receives the properly executed award papers from the injured employee or his or her representative.

~~[6.]~~ 7. If the rating physician or chiropractor determines that the permanent impairment may be apportioned pursuant to NAC 616C.490, the insurer shall advise the injured employee of the amount by which the rating was reduced and the reasons for the reduction.

~~[7.]~~ 8. If the insurer disagrees in good faith with the result of the rating evaluation, the insurer shall, within the time prescribed in NRS 616C.490:

- (a) Offer the injured employee the portion of the award, in installments, which it does not dispute;
- (b) Provide the injured employee with a copy of each rating evaluation performed of the injured employee; and
- (c) Notify the injured employee of the specific reasons for the disagreement and the right of the injured employee to appeal. The notice must also set forth a detailed proposal for resolving the dispute that can be executed in 75 days, unless the insurer demonstrates good cause for why the proposed resolution will require more than 75 days.

~~[8.]~~ 9. The injured employee must receive a copy of the results of each rating evaluation performed of the injured employee before accepting an award for a permanent partial disability.

~~9.~~ 10. As used in this section, “award papers” means the following forms designated in NAC 616A.480, as appropriate:

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

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

(c) D-11, Reaffirmation/Retraction of Lump Sum Request.

Sec. 29. NAC 616C.420 is hereby amended to read as follows:

616C.420 As used in NAC 616C.420 to ~~616C.447,~~ 616C.444, inclusive, “average monthly wage” means the total gross value of all money, goods and services received by an injured employee from his or her employment to compensate for his or her time or services and is used as the base for calculating the rate of compensation for the injured employee.

Sec. 30. NAC 616C.435 is hereby amended to read as follows:

616C.435 1. Except as otherwise provided in this section, a history of earnings for a period of 12 weeks must be used to calculate an average monthly wage.

2. If a 12-week period of earnings is not representative of the average monthly wage of the injured employee, ~~earnings~~ *wages earned* over a period of 1 year or the full period of employment, if it is less than 1 year, may be used. ~~Earnings~~ *Wages earned* over 1 year or the full period of employment, if it is less than 1 year, must be used if the average monthly wage would be increased.

3. If an injured employee is a member of a labor organization and is regularly employed by referrals from the office of that organization, wages earned from all employers for a period of 1 year may be used. A period of 1 year using all the wages of the injured employee from all his or her employers must be used if the average monthly wage would be increased.

4. If information concerning payroll is not available for a period of 12 weeks, wages *earned* may be averaged for the available period, but not for a period of less than 4 weeks.

5. If information concerning payroll is unavailable for a period of at least 4 weeks, average ~~[earnings]~~ *wages earned* must be projected using the rate of pay on the date of the ~~[accident]~~ *injury* or illness and the projected working schedule of the injured employee.

6. If ~~[earnings]~~ *wages earned* are based on piecework and a history of earnings is unavailable for a period of at least 4 weeks, the ~~[wage]~~ *wages earned* must be determined as being equal to the average earnings of other employees doing the same work.

7. If these methods of determining a period of ~~[earnings]~~ *wages earned* cannot be applied reasonably and fairly, an average monthly wage must be calculated by the insurer at 100 percent of:

(a) The sum which reasonably represents the average monthly wage of the injured employee as defined in NAC 616C.420 to ~~[616C.447,]~~ *616C.444*, inclusive, at the time the injury or illness occurs; or

(b) The *amount determined using the* hourly wage on the day the injury or illness occurs ~~;~~ *calculated by using* and the projected working schedule ~~[-]~~ *of the injured employee.*

8. The period used to calculate the average monthly wage must consist of consecutive days, ending on the date on which the ~~[accident]~~ *injury* or ~~[disease]~~ *illness* occurred, or the last day of the payroll period preceding the ~~[accident]~~ *injury* or ~~[disease]~~ *illness* if this period is representative of the average monthly wage.

9. *Wages earned in any concurrent employment:*

(a) *Except as otherwise provided in paragraph (b), include, without limitation, wages earned from:*

(1) Active or reserve duty with or in:

(I) The Army, Navy, Air Force, Marine Corps or Coast Guard of the United States;

(II) The Merchant Marine; or

(III) The National Guard;

(2) Employment by:

(I) The Federal Government or any branch or agency thereof;

(II) A state, territorial, county, municipal or local government of any state or territory of the United States; or

(III) A private employer, whether that employment is full-time, part-time, temporary, periodic, seasonal or otherwise limited in term, or pursuant to contract.

(b) Include wages earned from an employer only if the employer is insured for workers' compensation or government disability benefits by:

(1) A private carrier;

(2) A plan of self-insurance;

(3) A workers' compensation insurance system operating under the laws of any other state or territory of the United States; or

(4) A workers' compensation or disability benefit plan provided for and administered by the Federal Government or any agency thereof.

10. As used in this section, ~~["earnings"]~~:

(a) "Wages earned" means ~~earnings received~~ wages earned from the employment in which the injury occurs and wages earned in any concurrent employment.

(b) “Wages earned in any concurrent employment” has the meaning ascribed to the term “concurrent wages” in NRS 616C.420, except as otherwise provided in paragraph (b) of subsection 9.

Sec. 31. NAC 616C.527 is hereby amended to read as follows:

616C.527 1. An insurer shall provide any information required by the Administrator to carry out the provisions of ~~NAC 616C.526 and~~ NRS ~~616C.453.~~ **616C.473.**

2. An insurer who violates subsection 1 is subject to administrative action pursuant to NRS 616D.120.

Sec. 32. NAC 616C.559 is hereby amended to read as follows:

616C.559 1. In developing a program of vocational rehabilitation for an industrially injured employee, the insurer shall consider the injured employee’s experience, skills and desires.

2. A program of vocational rehabilitation must be outlined in writing. The outline for an individual program must:

- (a) Show the amount of money budgeted;
- (b) Contain a justification of the expense; and
- (c) Include a description of:
 - (1) The nature and the length of the program;
 - (2) The skills that the injured employee will acquire; and
 - (3) The dates on which the program will begin and end.

3. The insurer or a vocational rehabilitation counselor shall explain the planned program of vocational rehabilitation to the injured employee. Before an injured employee may participate in a program of vocational rehabilitation, the insurer and the employee must execute a written

agreement that contains the outline for the program. A copy of the agreement must be delivered to the injured employee and his or her rights and duties under the agreement must be explained to him or her.

4. The injured employee must acknowledge:

(a) Receipt of a dated copy of the proposed agreement for the program of vocational rehabilitation;

(b) That the program has been explained to him or her; and

(c) That he or she agrees to the conditions of the program.

5. A copy of the written agreement must be sent to the employer of the injured employee.

~~[6. If the insurer finds that good cause exists for the extension, the injured employee may be provided vocational rehabilitation services after the date on which the program would otherwise end pursuant to the provisions of NRS 616C.560.]~~

Sec. 33. Chapter 617 of NAC is hereby amended by adding thereto a new section to read as follows:

For the purposes of this section, subsection 11 of NRS 617.455 and subsection 16 of NRS 617.457:

1. In calculating the number of days from the date on which an appeal of a determination regarding the denial of a claim is made until the date on which the claimant ultimately prevails, all of the following periods of time must be excluded:

(a) The day on which the determination was made;

(b) If an appeal is pending before a hearing officer, appeals officer, district court judge or any other appellate proceeding:

(1) The number of days in excess of 70 days between the date on which the appeal is filed with the appeals office and the date of the first hearing.

(2) If the claimant or his or her representative requests a continuance of any hearing and the request is granted, from the date on which the request was filed or requested to the date of the next scheduled hearing.

(3) If the claimant or his or her representative agree to a continuance of any hearing and the continuance is granted, from the earliest of:

(I) The date on the electronic mail which requests a continuance of the hearing; and

(II) The earliest date of a signature on the stipulation for the continuance of the hearing,

↳ to the date of the next scheduled hearing.

(4) If a hearing is canceled or continued by the hearing officer, appeals officer, district court judge or any other person who was to conduct an appellate proceeding, from the date of the cancellation or continuance to the date of the next scheduled hearing.

(5) If a hearing officer or appeals officer enters an interim order to resolve a medical question pursuant to subsection 3 of NRS 616C.330 or subsection 3 of NRS 616C.360, from the date on which the hearing officer or appeals officer finds that there is a medical question until the date on which the insurer provides the claimant or his or her representative with a copy of the report of the medical examination which was requested to resolve the medical question.

(6) If a hearing is held, from the date on which the hearing commenced until the date on which the person who conducted the hearing issues an appealable final decision or order in the appeal.

(7) If the claimant or his or her representative does not supply appropriate medical reporting to support acceptance of the claim before the insurer makes a determination to deny the claim, from the date on which the determination is made until the date on which the insurer receives appropriate medical reporting to support acceptance of the claim.

(8) If the claimant or his or her representative fails to cooperate with the insurer's investigation of the claim, from the date on which the determination is made until the date on which the insurer receives reasonable cooperation and concludes, or should have concluded, its investigation.

(9) If the claimant or his or her representative files an appeal of a decision by a hearing officer, appeals officer or district court judge, from the date of the decision which is appealed until the date on which the appeal is filed.

2. If any of the periods of time set forth in paragraph (b) of subsection 1 overlap, each day must be counted only once in calculating the total number of days for the determination of a benefit penalty.

3. The amount of the benefit penalty for each day which is not excluded pursuant to subsection 1 must be imposed as follows:

(a) There must be no benefit penalty imposed if:

(1) An appeal is ordered to be remanded to the insurer for a new determination; or

(2) The insurer denies the claim pending medical investigation and, in a timely manner, conducts such an investigation,

↳ which results in the insurer issuing a determination of claim acceptance.

(b) A benefit penalty of \$100 must be imposed for each day if the insurer has factual reporting, medical reporting or both, which supports a good faith argument for the initial denial of the claim.

(c) A benefit penalty of \$200 must be imposed for each day if the insurer does not have any credible factual reporting or medical reporting which support the denial or continued denial of the claim.

4. As used in this section, the term “ultimately prevails” means that the matter was litigated to conclusion and the final outcome was determined by a hearing officer, appeals officer, district court judge or appellate court judge. The term does not include the conclusion of any appeal which is reached pursuant to a stipulation between the parties.

Sec. 34. NAC 616C.447 and 616C.526 are hereby repealed.

TEXT OF REPEALED SECTIONS

616C.447 Concurrent employment. (NRS 616A.400, 616C.420) The average monthly wage of an employee who is employed by two or more employers covered by a private carrier or by a plan of self-insurance on the date of a disabling accident or disease is equal to the sum of the wages earned or deemed to have been earned at each place of employment. The insurer shall advise an injured employee in writing of his or her entitlement to compensation for concurrent employment at the time of the initial payment of the compensation.

616C.526 Annual payments to certain claimants and dependents of claimants. (NRS 616A.400, 616C.453)

1. The Administrator will make an annual payment to each claimant or dependent who is entitled as of July 1 to receive such a payment for a permanent total disability pursuant to NRS 616C.453. The amount of the payment to each claimant or dependent is equal to two-fifths of the amount the Administrator withdraws from the Uninsured Employers' Claim Account for this purpose divided by the total number of claimants and dependents entitled to be paid and:

(a) If the claimant or dependent receives compensation of less than \$1,000 per month, an additional amount that is equal to two-fifths of the amount the Administrator withdraws from the Uninsured Employers' Claim Account divided by the total number of claimants and dependents entitled to be paid pursuant to this paragraph; or

(b) If the claimant or dependent receives compensation of \$1,000 per month or more, but less than \$1,500 per month, an additional amount that is equal to one-fifth of the amount the Administrator withdraws from the Uninsured Employers' Claim Account divided by the total number of claimants and dependents entitled to be paid pursuant to this paragraph.

2. As used in this section:

(a) "Claimant" means a person who is entitled to receive compensation pursuant to chapters 616A to 617, inclusive, of NRS for a permanent total disability and is not entitled to an annual increase in that compensation pursuant to NRS 616C.473.

(b) "Compensation" means compensation a claimant or dependent is entitled to receive pursuant to chapters 616A to 617, inclusive, of NRS for a permanent total disability.

(c) "Dependent" means a dependent of a claimant.