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AN ACT relating to workers' compensation; establishing provisions relating to the apportionment of percentages for present and previous disabilities; requiring an insurer to send a written determination regarding an industrial insurance claim by facsimile or other electronic transmission under certain circumstances; making compensation for an industrial injury or occupational disease subject to an attorney's lien; providing for the tolling of certain periods to request a hearing or appeal under certain circumstances; providing for an award of certain costs to a claimant who prevails in a contested claim; providing for the reservation of certain additional rights of a claimant who accepts a lump sum payment for a permanent partial disability; revising provisions governing the appointment of a vocational rehabilitation counselor for an injured employee; and providing other matters properly relating thereto.

**Legislative Counsel's Digest:**

Existing law requires, in a case where an injured employee is determined to have a permanent partial disability and there is a previous disability, an apportionment to be made by subtracting the percentage of previous disability as it existed at the time of the previous disability from the percentage of present disability as it existed at the time of the present disability. (NRS 616C.490) **Sections 1 and 7** of this bill revise these provisions to prohibit: (1) an apportionment of percentages of disabilities where no rating evaluation was performed for the previous disability unless the insurer proves by a preponderance of the evidence that certain specific medical evidence supports a specific percentage of previous disability; and (2) any reduction of the percentage of present impairment if no medical documentation or health care records of a preexisting impairment exist, unless certain other evidentiary requirements are satisfied. **Section 7** also requires an insurer to commence making installment payments to an injured employee, within a specified period of time and without requiring the employee to elect a method of payment, for that portion of an award of compensation for permanent partial disability which is not in dispute.

Existing law requires an injured employee to submit to an examination and any necessary immediate medical attention by a physician or chiropractor and requires the physician or chiropractor to complete and file a claim for compensation. (NRS 616C.010, 616C.040, 616C.075, 616C.095) **Sections 1.4, 1.6, 2.2 and 2.4** of this bill authorize the examination and treatment to be provided by a physician assistant or advanced practice registered nurse and, if so provided, require the physician assistant or advanced practice registered nurse to file a claim for compensation and provide a copy of the claim form to the injured employee.

Existing law requires an insurer to mail a written determination regarding a claim for compensation under industrial insurance. (NRS 616C.065, 617.356) **Sections 2 and 10** of this bill require the insurer to send its determination by facsimile or other electronic transmission, if so requested, to the claimant or the



person acting on behalf of the claimant and retain proof of successful transmission of the facsimile.

Existing law provides that, except in matters relating to child support, compensation payable or paid for an industrial injury or occupational disease is not assignable and is exempt from attachment, garnishment and execution. (NRS 616C.205) **Section 3** of this bill provides that such compensation may also be subject to an attorney's lien.

Existing law sets forth certain limits on the period of time in which an aggrieved party may request a hearing before a hearing officer or appeal from a decision of a hearing officer. (NRS 616C.315, 616C.345) **Sections 4 and 6** of this bill provide that periods within which a request for a hearing or an appeal may be filed may be tolled if the insurer fails to mail or, if so requested, send by facsimile or other electronic transmission a determination regarding a claim for compensation.

Existing law provides that if a contested claim for compensation is decided in favor of the claimant, he or she is entitled to an award of interest. (NRS 616C.335) **Section 5** of this bill provides that the claimant is also entitled to an award of certain costs and sets forth the procedure for requesting costs and adjudicating disputes for such costs.

Existing law provides that a claimant who elects to receive and accepts payment for a permanent partial disability in a lump sum terminates the claimant's benefits and waives certain rights regarding his or her claim, except the right to reopen his or her claim, have the claim considered by his or her insurer, certain rehabilitative services and the right to receive a benefit penalty. (NRS 616C.495) **Section 8** of this bill provides that the claimant also reserves the right to conclude or resolve any contested matter, with certain exceptions, which is pending at the time of the election of payment for a permanent partial disability in a lump sum.

Existing law authorizes an insurer or injured employee to request a vocational rehabilitation counselor to prepare a written assessment of the injured employee. (NRS 616C.550) Existing law requires the vocational rehabilitation counselor to develop a plan for a program of vocational rehabilitation for each eligible injured employee. (NRS 616C.555) Existing law further provides that where a written assessment is requested or a plan for a program of vocational rehabilitation is required and the insurer or injured employee or personal or legal representative of the injured employee are unable to agree on the appointment of a vocational rehabilitation counselor, the insurer shall submit a list of at least three vocational rehabilitation counselors to the injured employee or personal or legal representative of the injured employee. (NRS 616C.541) **Section 9** of this bill requires the counselors listed to be employed by at least three different organizations or entities.

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

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THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN  
SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

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

*1. If a rating evaluation was completed for a previous disability involving a condition, occupational disease, organ, anatomical structure or other part of the body that is identical to*



*the condition, occupational disease, organ, anatomical structure or other part of the body being evaluated for the present disability, the percentage of disability for a subsequent injury must be determined by deducting the percentage of the previous disability from the percentage of the present disability, regardless of the edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment as adopted by the Division pursuant to NRS 616C.110 used to determine the percentage of the previous disability. The compensation awarded for a permanent disability on a subsequent injury must be reduced only by the awarded or agreed upon percentage of disability actually received by the injured employee for the previous injury regardless of the percentage of the previous disability.*

*2. If no rating evaluation performed before the date of injury or onset of the occupational disease exists for apportionment of percentage of present and previous disabilities pursuant to subsection 1, the percentage of the present disability must not be reduced unless:*

*(a) The insurer proves by a preponderance of the evidence that medical documentation or health care records that existed before the date of the injury or onset of the occupational disease that resulted in the present disability demonstrate evidence that the injured employee had an actual impairment or disability involving the condition, occupational disease, organ, anatomical structure or other part of the body that is the subject of the present disability; and*

*(b) The rating physician or chiropractor states to a reasonable degree of medical or chiropractic probability that, based upon the specific information in the preexisting medical documentation or health care records, the injured employee would have had a specific percentage of disability immediately before the date of the injury or the onset of the occupational disease if, in the instant before the injury or the onset of the occupational disease, the injured employee had been evaluated under the edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment that had been adopted by the Division pursuant to NRS 616C.110.*

*3. The documentation or records relied upon pursuant to subsection 2 must provide specific references to one or more of the following:*

- (a) Diagnoses;*
- (b) Measurements;*
- (c) Imaging studies;*



(d) *Laboratory testing; or*

(e) *Other commonly relied upon medical evidence that supports the finding of a preexisting ratable impairment under the specific provisions of the edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment that had been adopted by the Division pursuant to NRS 616C.110 at the time of that rating evaluation.*

4. *If there is physical evidence of a prior surgery to the same organ, anatomical structure or other part of the body being evaluated for the present disability but no medical documentation or health care records regarding that organ, anatomical structure or other part of the body can be obtained, the rating physician or chiropractor may apportion the rating provided that the applicable requirements of subsection 2, other than any requirement to:*

(a) *Have medical documentation or health care records; or*

(b) *Base a rating upon medical documentation or health care records,*  
*↳ are satisfied.*

5. *If there is no physical evidence of a prior surgery to the same organ, anatomical structure or other part of the body being evaluated for the present disability and no medical documentation or health care records of a preexisting whole person impairment for the identical condition, occupational disease, organ, anatomical structure or other part of the body being evaluated for the present disability exist for the purposes of subsection 1 or 2, the percentage of present impairment must not be reduced by any percentage for the previous impairment.*

**Sec. 1.2.** NRS 616C.005 is hereby amended to read as follows:  
616C.005 On or before September 1 of each year:

1. An insurer shall distribute to each employer that it insures any form for reporting injuries that has been revised within the previous 12 months.

2. The Administrator shall make available to physicians , ~~and~~ chiropractors , *physician assistants and advanced practice registered nurses* any form for reporting injuries that has been revised within the previous 12 months.

**Sec. 1.4.** NRS 616C.010 is hereby amended to read as follows:

616C.010 1. Whenever any accident occurs to any employee, the employee shall forthwith report the accident and the injury resulting therefrom to his or her employer.

2. When an employer learns of an accident, whether or not it is reported, the employer may direct the employee to submit to, or the employee may request, an examination by a physician , ~~for~~



chiropractor, *physician assistant or advanced practice registered nurse*, in order to ascertain the character and extent of the injury and render medical attention which is required immediately. The employer shall:

(a) If the employer's insurer has entered into a contract with an organization for managed care or with providers of health care pursuant to NRS 616B.527, furnish the names, addresses and telephone numbers of:

(1) Two or more physicians, ~~or~~ chiropractors, *physician assistants or advanced practice registered nurses* who are qualified to conduct the examination and who are available pursuant to the terms of the contract, if there are two or more such physicians, ~~or~~ chiropractors, *physician assistants or advanced practice registered nurses* within 30 miles of the employee's place of employment; or

(2) One or more physicians, ~~or~~ chiropractors, *physician assistants or advanced practice registered nurses* who are qualified to conduct the examination and who are available pursuant to the terms of the contract, if there are not two or more such physicians, ~~or~~ chiropractors, *physician assistants or advanced practice registered nurses* within 30 miles of the employee's place of employment.

(b) If the employer's insurer has not entered into a contract with an organization for managed care or with providers of health care pursuant to NRS 616B.527, furnish the names, addresses and telephone numbers of:

(1) Two or more physicians, ~~or~~ chiropractors, *physician assistants or advanced practice registered nurses* who are qualified to conduct the examination, if there are two or more such physicians, ~~or~~ chiropractors, *physician assistants or advanced practice registered nurses* within 30 miles of the employee's place of employment; or

(2) One or more physicians, ~~or~~ chiropractors, *physician assistants or advanced practice registered nurses* who are qualified to conduct the examination, if there are not two or more such physicians, ~~or~~ chiropractors, *physician assistants or advanced practice registered nurses* within 30 miles of the employee's place of employment.

3. From among the names furnished by the employer pursuant to subsection 2, the employee shall select one of those physicians, ~~or~~ chiropractors, *physician assistants or advanced practice registered nurses* to conduct the examination, but the employer shall not require the employee to select a particular physician, ~~or~~ chiropractor, *physician assistant or advanced practice registered*



*nurse* from among the names furnished by the employer. Thereupon, the examining physician, ~~{or}~~ chiropractor, *physician assistant or advanced practice registered nurse, as applicable*, shall report forthwith to the employer and to the insurer the character and extent of the injury. The employer shall not require the employee to disclose or permit the disclosure of any other information concerning the employee's physical condition except as required by NRS 616C.177.

4. Further medical attention, except as otherwise provided in NRS 616C.265, must be authorized by the insurer.

5. This section does not prohibit an employer from requiring the employee to submit to an examination by a physician or chiropractor specified by the employer at any convenient time after medical attention which is required immediately has been completed.

6. An employee leasing company must provide to each employee covered under an employee leasing contract instructions on how to notify the leasing company supervisor and client company of an injury in plain, clear language placed in conspicuous type in a specifically labeled area of instructions given to the employee.

**Sec. 1.6.** NRS 616C.040 is hereby amended to read as follows:

616C.040 1. Except as otherwise provided in this section, a treating physician, ~~{or}~~ chiropractor, *physician assistant or advanced practice registered nurse* shall, within 3 working days after first providing treatment to an injured employee for a particular injury, complete and file a claim for compensation with the employer of the injured employee and the employer's insurer. If the employer is a self-insured employer, the treating physician, ~~{or}~~ chiropractor, *physician assistant or advanced practice registered nurse* shall file the claim for compensation with the employer's third-party administrator. If the physician, ~~{or}~~ chiropractor, *physician assistant or advanced practice registered nurse* files the claim for compensation by electronic transmission, the physician, ~~{or}~~ chiropractor, *physician assistant or advanced practice registered nurse* shall, upon request, mail to the insurer or third-party administrator the form *prescribed by the Administrator for a claim for compensation* that ~~{contains the original signatures of}~~ *is signed by* the injured employee and the physician, ~~{or}~~ chiropractor, ~~{or}~~ *physician assistant or advanced practice registered nurse*. The form must be mailed within 7 days after receiving such a request.

2. A physician, ~~{or}~~ chiropractor, *physician assistant or advanced practice registered nurse* who has a duty to file a claim



for compensation pursuant to subsection 1 may delegate the duty to *a physician assistant or an advanced practice registered nurse at a medical facility*. If the physician, ~~or~~ chiropractor, *physician assistant or advanced practice registered nurse* delegates the duty to *a physician assistant or an advanced practice registered nurse at a medical facility*:

(a) The *physician assistant or advanced practice registered nurse, as applicable, at the* medical facility must comply with the filing requirements set forth in this section; and

(b) The delegation must be in writing and signed by:

(1) The *delegating* physician, ~~or~~ chiropractor ~~;~~, *physician assistant or advanced practice registered nurse*; and

(2) An authorized representative of the medical facility.

3. A claim for compensation required by subsection 1 must ~~be~~:

(a) *Be* filed on a form prescribed by the Administrator ~~;~~; and

(b) *Be signed with the original or electronic signatures of the injured employee and:*

(1) *The physician, chiropractor, physician assistant or advanced practice registered nurse who treated the injured employee; or*

(2) *The physician assistant or advanced practice registered nurse to whom the duty to file a claim for compensation is delegated pursuant to subsection 2.*

4. If a claim for compensation is accompanied by a certificate of disability, the certificate must include a description of any limitation or restrictions on the injured employee's ability to work.

5. *A copy of the completed form that is required to be filed pursuant to subsection 3 and which is fully executed with the required original or electronic signatures must be provided to the injured employee at the time of discharge.*

6. Each physician, chiropractor ~~and~~, *physician assistant, advanced practice registered nurse and* medical facility that treats injured employees, each insurer, third-party administrator and employer, and the Division shall maintain at their offices a sufficient supply of the forms prescribed by the Administrator for filing a claim for compensation.

~~6.~~ 7. The Administrator may impose an administrative fine of not more than \$1,000 for each violation of subsection 1 on:

(a) A *treating* physician, ~~or~~ chiropractor ~~;~~, *physician assistant or advanced practice registered nurse*; or

(b) A *physician assistant or advanced practice registered nurse at a* medical facility if the duty to file the claim for compensation



has been delegated to ~~[the medical facility]~~ *him or her* pursuant to this section.

**Sec. 1.8.** NRS 616C.045 is hereby amended to read as follows:

616C.045 1. Except as otherwise provided in NRS 616B.727, within 6 working days after the receipt of a claim for compensation from a physician , ~~or~~ chiropractor, *physician assistant or advanced practice registered nurse*, or a medical facility if the duty to file the claim for compensation has been delegated to the medical facility pursuant to NRS 616C.040, an employer shall complete and file with his or her insurer or third-party administrator an employer's report of industrial injury or occupational disease.

2. The report must:

(a) Be filed on a form prescribed by the Administrator;

(b) Be signed by the employer or the employer's designee;

(c) Contain specific answers to all questions required by the regulations of the Administrator; and

(d) Be accompanied by a statement of the wages of the employee if the claim for compensation received from the treating physician , ~~or~~ chiropractor, *physician assistant or advanced practice registered nurse*, or a medical facility if the duty to file the claim for compensation has been delegated to the medical facility pursuant to NRS 616C.040, indicates that the injured employee is expected to be off work for 5 days or more.

3. An employer who files the report required by subsection 1 by electronic transmission shall, upon request, mail to the insurer or third-party administrator the form that contains the original signature of the employer or the employer's designee. The form must be mailed within 7 days after receiving such a request.

4. The Administrator shall impose an administrative fine of not more than \$1,000 on an employer for each violation of this section.

**Sec. 2.** NRS 616C.065 is hereby amended to read as follows:

616C.065 1. Except as otherwise provided in NRS 616C.136, within 30 days after the insurer has been notified of an industrial accident, every insurer shall:

(a) Accept a claim for compensation, notify the claimant or the person acting on behalf of the claimant that the claim has been accepted and commence payment of the claim; or

(b) Deny the claim and notify the claimant or the person acting on behalf of the claimant and the Administrator that the claim has been denied.

2. If an insurer is ordered by the Administrator, a hearing officer, an appeals officer, a district court, the Court of Appeals or the Supreme Court of Nevada to make a new determination,





including, without limitation, a new determination regarding the acceptance or denial of a claim for compensation, the insurer shall make the new determination within 30 days after the date on which the insurer has been ordered to do so.

3. Payments made by an insurer pursuant to this section are not an admission of liability for the claim or any portion of the claim.

4. Except as otherwise provided in this subsection, if an insurer unreasonably delays or refuses to pay the claim within 30 days after the insurer has been notified of an industrial accident, the insurer shall pay upon order of the Administrator an additional amount equal to three times the amount specified in the order as refused or unreasonably delayed. This payment is for the benefit of the claimant and must be paid to the claimant with the compensation assessed pursuant to chapters 616A to 617, inclusive, of NRS. The provisions of this section do not apply to the payment of a bill for accident benefits that is governed by the provisions of NRS 616C.136.

5. The insurer shall notify the claimant or the person acting on behalf of the claimant that a claim has been accepted or denied pursuant to subsection 1 or 2 by:

(a) Mailing its written determination to the claimant or the person acting on behalf of the claimant ~~[(b)]~~ and

~~[(b)-(H)]~~, if the claim has been denied, in whole or in part, obtaining a certificate of mailing ~~[(b)]~~; or

*(b) If and as requested by the claimant or the person acting on behalf of the claimant, sending its written determination to the claimant or the person acting on behalf of the claimant by facsimile or other electronic transmission the proof of sending and receipt of which is readily verifiable and retaining proof of a successful transmission and receipt of the facsimile or other electronic transmission, as applicable.*

6. The failure of the insurer to ~~[(b)]~~, as applicable:

(a) *Obtain* a certificate of mailing as required by paragraph ~~[(b)]~~ (a) of subsection 5 shall be deemed to be a failure of the insurer to mail the written determination of the denial of a claim as required by this section ~~[(b)]~~; or

*(b) Retain proof of a successful transmission and receipt of the facsimile or other electronic transmission the proof of sending and receipt of which is readily verifiable as required by paragraph (b) of subsection 5 shall be deemed to be a failure of the insurer to send by facsimile or other electronic transmission the written determination regarding a claim as required by this section.*



7. The failure of the insurer to indicate the acceptance or denial of a claim for a part of the body or condition does not constitute a denial or acceptance thereof.

8. Upon request, the insurer shall provide a copy of the certificate of mailing, if any, *or proof of a successful transmission and receipt of the facsimile or other electronic transmission, as applicable*, to the claimant or the person acting on behalf of the claimant.

9. For the purposes of this section, the insurer shall ~~mail~~ *either:*

(a) *Mail* the written determination to:

~~(a)~~ (1) The mailing address of the claimant or the person acting on behalf of the claimant that is provided on the form prescribed by the Administrator for filing the claim; or

~~(b)~~ (2) Another mailing address if the claimant or the person acting on behalf of the claimant provides to the insurer written notice of another mailing address ~~;~~; *or*

(b) *If and as requested by the claimant or the person acting on behalf of the claimant, send the written determination by facsimile or other electronic transmission the proof of sending and receipt of which is readily verifiable to the claimant or the person acting on behalf of the claimant.*

10. As used in this section, “certificate of mailing” means a receipt that provides evidence of the date on which the insurer presented its written determination to the United States Postal Service for mailing.

**Sec. 2.2.** NRS 616C.075 is hereby amended to read as follows:

616C.075 *1.* If an employee is properly directed to submit to a physical examination and the employee refuses to permit the treating physician, ~~or~~ chiropractor, *physician assistant or advanced practice registered nurse* to make an examination and to render medical attention as may be required immediately, no compensation may be paid for the injury claimed to result from the accident.

*2. References to a physician assistant and an advanced practice registered nurse in this section are for the purposes of the examination and treatment of an injured employee which are authorized to be provided by a physician assistant or advanced practice registered nurse in the exclusive context of an initial examination and treatment pursuant to NRS 616C.010.*

**Sec. 2.4.** NRS 616C.095 is hereby amended to read as follows:

616C.095 *1.* The physician, ~~or~~ chiropractor, *physician assistant or advanced practice registered nurse* shall inform the



injured employee of the injured employee's rights under chapters 616A to 616D, inclusive, or chapter 617 of NRS and lend all necessary assistance in making application for compensation and such proof of other matters as required by the rules of the Division, without charge to the employee.

*2. References to a physician assistant and an advanced practice registered nurse in this section are for the purposes of the examination and treatment of an injured employee which are authorized to be provided by a physician assistant or advanced practice registered nurse in the exclusive context of an initial examination and treatment pursuant to NRS 616C.010.*

**Sec. 2.6.** NRS 616C.098 is hereby amended to read as follows:

616C.098 **1.** Certain phrases relating to a claim for compensation for an industrial injury or occupational disease and used by a physician , ~~or~~ chiropractor , *physician assistant or advanced practice registered nurse* when determining the causation of an industrial injury or occupational disease are deemed to be equivalent and may be used interchangeably. Those phrases are:

~~1.~~ (a) "Directly connect this injury or occupational disease as job incurred"; and

~~2.~~ (b) "A degree of reasonable medical probability that the condition in question was caused by the industrial injury."

*2. References to a physician assistant and an advanced practice registered nurse in this section are for the purposes of the examination and treatment of an injured employee which are authorized to be provided by a physician assistant or advanced practice registered nurse in the exclusive context of an initial examination and treatment pursuant to NRS 616C.010.*

**Sec. 2.8.** NRS 616C.130 is hereby amended to read as follows:

616C.130 **1.** The insurer shall not authorize the payment of any money to a physician , ~~or~~ chiropractor , *physician assistant or advanced practice registered nurse* for services rendered by the physician , ~~or~~ chiropractor, *physician assistant or advanced practice registered nurse*, as applicable, in attending an injured employee until an itemized statement for the services has been received by the insurer accompanied by a certificate of the physician , ~~or~~ chiropractor , *physician assistant or advanced practice registered nurse* stating that a duplicate of the itemized statement has been filed with the employer of the injured employee.

*2. References to a physician assistant and an advanced practice registered nurse in this section are for the purposes of the examination and treatment of an injured employee which are authorized to be provided by a physician assistant or advanced*



*practice registered nurse in the exclusive context of an initial examination and treatment pursuant to NRS 616C.010.*

**Sec. 3.** NRS 616C.205 is hereby amended to read as follows:

616C.205 Except as otherwise provided in this section and NRS **18.015**, 31A.150 and 31A.330, compensation payable or paid under chapters 616A to 616D, inclusive, or chapter 617 of NRS, whether determined or due, or not:

1. Is not assignable before the issuance and delivery of the check or the deposit of any payment for compensation pursuant to NRS 616C.409;

2. Is exempt from attachment, garnishment and execution; and

3. Does not pass to any other person by operation of law.

↪ In the case of the death of an injured employee covered by chapters 616A to 616D, inclusive, or chapter 617 of NRS from causes independent from the injury for which compensation is payable, any compensation due the employee which was awarded or accrued but for which a check was not issued or delivered or for which payment was not made pursuant to NRS 616C.409 at the date of death of the employee is payable to the dependents of the employee as defined in NRS 616C.505.

**Sec. 3.3.** NRS 616C.265 is hereby amended to read as follows:

616C.265 1. Except as otherwise provided in NRS 616C.280, every employer operating under chapters 616A to 616D, inclusive, of NRS, alone or together with other employers, may make arrangements to provide accident benefits as defined in those chapters for injured employees.

2. Employers electing to make such arrangements shall notify the Administrator of the election and render a detailed statement of the arrangements made, which arrangements do not become effective until approved by the Administrator.

3. Every employer who maintains a hospital of any kind for his or her employees, or who contracts for the hospital care of injured employees, shall, on or before January 30 of each year, make a written report to the Administrator for the preceding year, which must contain a statement showing:

(a) The total amount of hospital fees collected, showing separately the amount contributed by the employees and the amount contributed by the employers;

(b) An itemized account of the expenditures, investments or other disposition of such fees; and

(c) What balance, if any, remains.

4. Every employer who provides accident benefits pursuant to this section:



(a) Shall, in accordance with regulations adopted by the Administrator, make a written report to the Division of that employer's actual and expected annual expenditures for claims and such other information as the Division deems necessary to calculate an estimated or final annual assessment and shall, to the extent that the regulations refer to the responsibility of insurers to make such reports, be deemed to be an insurer.

(b) Shall pay the assessments collected pursuant to NRS 232.680 and 616A.430.

5. The reports required by the provisions of subsections 3 and 4 must be verified:

(a) If the employer is a natural person, by the employer;

(b) If the employer is a partnership, by one of the partners;

(c) If the employer is a corporation, by the secretary, president, general manager or other executive officer of the corporation; or

(d) If the employer has contracted with a physician or chiropractor for the hospital care of injured employees, by the physician or chiropractor.

6. No employee is required to accept the services of a physician , ~~or~~ chiropractor , *physician assistant or advanced practice registered nurse* provided by his or her employer, but may seek professional medical services of the employee's choice as provided in NRS 616C.090. Expenses arising from such medical services must be paid by the employer who has elected to provide benefits, pursuant to the provisions of this section, for the employer's injured employees.

7. Every employer who fails to notify the Administrator of such election and arrangements, or who fails to render the financial reports required, is liable for accident benefits as provided by NRS 616C.255.

*8. References to a physician assistant and an advanced practice registered nurse in this section are for the purposes of the examination and treatment of an injured employee which are authorized to be provided by a physician assistant or advanced practice registered nurse in the exclusive context of an initial examination and treatment pursuant to NRS 616C.010.*

**Sec. 3.7.** NRS 616C.270 is hereby amended to read as follows:

616C.270 1. Every employer who has elected to provide accident benefits for his or her injured employees shall prepare and submit a written report to the Administrator:

(a) Within 6 days after any accident if an injured employee is examined or treated by a physician , ~~or~~ chiropractor ~~;~~ , *physician assistant or advanced practice registered nurse*; and



(b) If the injured employee receives additional medical services.  
2. The Administrator shall review each report to determine whether the employer is furnishing the accident benefits required by chapters 616A to 616D, inclusive, of NRS.

3. The content and form of the written reports must be prescribed by the Administrator.

***4. References to a physician assistant and an advanced practice registered nurse in this section are for the purposes of the examination and treatment of an injured employee which are authorized to be provided by a physician assistant or advanced practice registered nurse in the exclusive context of an initial examination and treatment pursuant to NRS 616C.010.***

**Sec. 4.** NRS 616C.315 is hereby amended to read as follows:

616C.315 1. Any person who is subject to the jurisdiction of the hearing officers pursuant to chapters 616A to 616D, inclusive, or chapter 617 of NRS may request a hearing before a hearing officer of any matter within the hearing officer's authority. The insurer shall provide, without cost, the forms necessary to request a hearing to any person who requests them.

2. A hearing must not be scheduled until the following information is provided to the hearing officer:

(a) The name of:

- (1) The claimant;
- (2) The employer; and
- (3) The insurer or third-party administrator;

(b) The number of the claim; and

(c) If applicable, a copy of the letter of determination being appealed or, if such a copy is unavailable, the date of the determination and the issues stated in the determination.

3. Except as otherwise provided in NRS 616B.772, 616B.775, 616B.787, 616C.305 and 616C.427, a person who is aggrieved by:

(a) A written determination of an insurer; or

(b) The failure of an insurer to respond within 30 days to a written request mailed to the insurer by the person who is aggrieved, **↳** may appeal from the determination or failure to respond by filing a request for a hearing before a hearing officer. Such a request must include the information required pursuant to subsection 2 and, except as otherwise provided in subsections 4 and 5, must be filed within 70 days after the date on which the notice of the insurer's determination was mailed ***or, if requested by the claimant or the person acting on behalf of the claimant, sent by facsimile or other electronic transmission the proof of sending and receipt of which is readily verifiable*** by the insurer or the unanswered written request



was mailed to the insurer, as applicable. The failure of an insurer to respond to a written request for a determination within 30 days after receipt of such a request shall be deemed by the hearing officer to be a denial of the request.

4. The period specified in subsection 3 within which a request for a hearing must be filed may be ~~extended~~:

*(a) Extended* for an additional 90 days if the person aggrieved shows by a preponderance of the evidence that the person was diagnosed with a terminal illness or was informed of the death or diagnosis of a terminal illness of his or her spouse, parent or child.

*(b) Tolloed if the insurer fails to mail or, if requested by the claimant or the person acting on behalf of the claimant, send by facsimile or other electronic transmission the proof of sending and receipt of which is readily verifiable a determination.*

5. Failure to file a request for a hearing within the period specified in subsection 3 may be excused if the person aggrieved shows by a preponderance of the evidence that the person did not receive the notice of the determination and the forms necessary to request a hearing. The claimant or employer shall notify the insurer of a change of address.

6. The hearing before the hearing officer must be conducted as expeditiously and informally as is practicable.

7. The parties to a contested claim may, if the claimant is represented by legal counsel, agree to forego a hearing before a hearing officer and submit the contested claim directly to an appeals officer.

8. A claimant may, with regard to a contested claim arising from the provisions of NRS 617.453, 617.455, 617.457, 617.485 or 617.487 as described in subsection 2 of NRS 616C.345, submit the contested claim directly to an appeals officer pursuant to subsection 2 of NRS 616C.345 without the agreement of any other party.

**Sec. 4.5.** NRS 616C.330 is hereby amended to read as follows:

616C.330 1. The hearing officer shall:

(a) Except as otherwise provided in subsection 2 of NRS 616C.315, within 5 days after receiving a request for a hearing, set the hearing for a date and time within 30 days after his or her receipt of the request at a place in Carson City, Nevada, or Las Vegas, Nevada, or upon agreement of one or more of the parties to pay all additional costs directly related to an alternative location, at any other place of convenience to the parties, at the discretion of the hearing officer;



(b) Give notice by mail or by personal service to all interested parties to the hearing at least 15 days before the date and time scheduled; and

(c) Conduct hearings expeditiously and informally.

2. The notice must include a statement that the injured employee may be represented by a private attorney or seek assistance and advice from the Nevada Attorney for Injured Workers.

3. If necessary to resolve a medical question concerning an injured employee's condition or to determine the necessity of treatment for which authorization for payment has been denied, the hearing officer may order an independent medical examination, which must not involve treatment, and refer the employee to a physician or chiropractor of his or her choice who has demonstrated special competence to treat the particular medical condition of the employee, whether or not the physician or chiropractor is on the insurer's panel of providers of health care. If the medical question concerns the rating of a permanent disability, the hearing officer may refer the employee to a rating physician or chiropractor. The rating physician or chiropractor must be selected in rotation from the list of qualified physicians and chiropractors maintained by the Administrator pursuant to subsection 2 of NRS 616C.490, unless the insurer and injured employee otherwise agree to a rating physician or chiropractor. The insurer shall pay the costs of any medical examination requested by the hearing officer.

4. The hearing officer may consider the opinion of an examining physician, ~~or~~ chiropractor, *physician assistant or advanced practice registered nurse*, in addition to the opinion of an authorized treating physician, ~~or~~ chiropractor, *physician assistant or advanced practice registered nurse*, in determining the compensation payable to the injured employee.

5. If an injured employee has requested payment for the cost of obtaining a second determination of his or her percentage of disability pursuant to NRS 616C.100, the hearing officer shall decide whether the determination of the higher percentage of disability made pursuant to NRS 616C.100 is appropriate and, if so, may order the insurer to pay to the employee an amount equal to the maximum allowable fee established by the Administrator pursuant to NRS 616C.260 for the type of service performed, or the usual fee of that physician or chiropractor for such service, whichever is less.

6. The hearing officer shall order an insurer, organization for managed care or employer who provides accident benefits for injured employees pursuant to NRS 616C.265 to pay to the





appropriate person the charges of a provider of health care if the conditions of NRS 616C.138 are satisfied.

7. The hearing officer may allow or forbid the presence of a court reporter and the use of a tape recorder in a hearing.

8. The hearing officer shall render his or her decision within 15 days after:

(a) The hearing; or

(b) The hearing officer receives a copy of the report from the medical examination the hearing officer requested.

9. The hearing officer shall render a decision in the most efficient format developed by the Chief of the Hearings Division of the Department of Administration.

10. The hearing officer shall give notice of the decision to each party by mail. The hearing officer shall include with the notice of the decision the necessary forms for appealing from the decision.

11. Except as otherwise provided in NRS 616C.380, the decision of the hearing officer is not stayed if an appeal from that decision is taken unless an application for a stay is submitted by a party. If such an application is submitted, the decision is automatically stayed until a determination is made on the application. A determination on the application must be made within 30 days after the filing of the application. If, after reviewing the application, a stay is not granted by the hearing officer or an appeals officer, the decision must be complied with within 10 days after the refusal to grant a stay.

***12. References to a physician assistant and an advanced practice registered nurse in this section are for the purposes of the examination and treatment of an injured employee which are authorized to be provided by a physician assistant or advanced practice registered nurse in the exclusive context of an initial examination and treatment pursuant to NRS 616C.010.***

**Sec. 5.** NRS 616C.335 is hereby amended to read as follows:

616C.335 **1.** If a contested claim for compensation is decided in favor of the claimant, he or she is entitled to ~~fair~~:

(a) **An** award of interest at the rate of 9 percent on the amount of compensation due the claimant from the date the payment on the claim would be due until the date that payment is made.

(b) **As limited by subsection 2, an award of costs against the opposing party as follows:**

(1) **Clerks' fees.**

(2) **Reporters' fees for depositions, including a reporter's fee for one copy of each deposition.**



(3) *Fees for witnesses at an appeals hearing and deposing witnesses, unless the appeals officer finds that the witness was called at the instance of the prevailing party without reason or necessity.*

(4) *Reasonable fees of not more than five expert witnesses in an amount of not more than the fee allowable for an independent medical examination as set forth in the schedule of fees established by the Administrator pursuant to NRS 616C.260 for each witness, unless the appeals officer allows a fee in a greater amount after determining that the circumstances surrounding the expert's testimony were of such necessity as to require the greater amount of the fee.*

(5) *The fee of any sheriff or licensed process server for the delivery or service of any summons or subpoena used in the action, unless the appeals officer determines that the service was not necessary.*

(6) *Compensation for the official reporter or reporter pro tempore.*

(7) *Reasonable costs for photocopies.*

(8) *Reasonable costs for postage.*

(9) *Reasonable costs for travel and lodging incurred taking depositions and conducting discovery.*

(10) *Any other reasonable and necessary expense incurred in connection with the action, including reasonable and necessary expenses for computerized services for legal research.*

2. *Costs awarded pursuant to subsection 1 must be limited to the costs incurred as a result of the litigation of those issues which were decided in favor of the claimant.*

3. *If a claimant is awarded costs pursuant to subsection 1, the claimant shall serve on the insurer and the claimant's employer, not later than 15 calendar days after the decision of an appeals officer, district court, the Court of Appeals or the Supreme Court, a memorandum of the costs in the action or proceeding, which memorandum must be verified by the oath of the claimant, or the claimant's attorney or agent, or by the clerk of the claimant's attorney, stating that to the best of his or her knowledge and belief the costs are correct, and that the costs have been necessarily incurred in the action or proceeding.*

4. *Not later than 15 calendar days after receipt of service of a copy of a memorandum pursuant to subsection 3, the insurer shall issue to the claimant a determination letter regarding the requested costs, specifically stating in detail:*



*(a) The costs which are allowed pursuant to paragraph (b) of subsection 1 and subsection 2; and*

*(b) The costs which are disallowed pursuant to paragraph (b) of subsection 1 and subsection 2, along with specific reasons for the disallowance of those costs.*

*5. Costs which are allowed by the insurer pursuant to subsection 4, must be paid along with the determination letter to the claimant or, if the claimant is represented, to the claimant's counsel.*

*6. Any party aggrieved by the determination may file a request for appeal directly to an appeals officer not later than 30 days after receipt of the determination letter.*

**Sec. 6.** NRS 616C.345 is hereby amended to read as follows:

616C.345 1. Any party aggrieved by a decision of the hearing officer relating to a claim for compensation may appeal from the decision by, except as otherwise provided in subsections 9, ~~and~~ 10 ~~,~~ *and 11*, filing a notice of appeal with an appeals officer within 30 days after the date of the decision.

2. A claimant aggrieved by a written determination of the denial of a claim, in whole or in part, by an insurer, or the failure of an insurer to respond in writing within 30 days to a written request of the claimant mailed to the insurer, concerning a claim arising from the provisions of NRS 617.453, 617.455, 617.457, 617.485 or 617.487 may file a notice of a contested claim with an appeals officer. The notice must include the information required pursuant to subsection 3 and, except as otherwise provided in subsections 9 ~~and 11,~~ *to 12, inclusive*, must be filed within 70 days after the date on which the notice of the insurer's determination was mailed *or, if requested by the claimant or the person acting on behalf of the claimant, sent by facsimile or other electronic transmission the proof of sending and receipt of which is readily verifiable* by the insurer or the unanswered written request was mailed to the insurer, as applicable. The failure of an insurer to respond in writing to a written request for a determination within 30 days after receipt of such a request shall be deemed by the appeals officer to be a denial of the request. The insurer shall provide, without cost, the forms necessary to file a notice of a contested claim to any person who requests them.

3. A hearing must not be scheduled until the following information is provided to the appeals officer:

- (a) The name of:
  - (1) The claimant;
  - (2) The employer; and



- (3) The insurer or third-party administrator;
- (b) The number of the claim; and
- (c) If applicable, a copy of the letter of determination being appealed or, if such a copy is unavailable, the date of the determination and the issues stated in the determination.

4. If a dispute is required to be submitted to a procedure for resolving complaints pursuant to NRS 616C.305 and:

(a) A final determination was rendered pursuant to that procedure; or

(b) The dispute was not resolved pursuant to that procedure within 14 days after it was submitted,

↳ any party to the dispute may, except as otherwise provided in subsections 9 ~~and 10,~~ to 12, inclusive, file a notice of appeal within 70 days after the date on which the final determination was mailed to the employee, or the dependent of the employee, or the unanswered request for resolution was submitted. Failure to render a written determination within 30 days after receipt of such a request shall be deemed by the appeals officer to be a denial of the request.

5. Except as otherwise provided in NRS 616C.380, the filing of a notice of appeal does not automatically stay the enforcement of the decision of a hearing officer or a determination rendered pursuant to NRS 616C.305. The appeals officer may order a stay, when appropriate, upon the application of a party. If such an application is submitted, the decision is automatically stayed until a determination is made concerning the application. A determination on the application must be made within 30 days after the filing of the application. If a stay is not granted by the officer after reviewing the application, the decision must be complied with within 10 days after the date of the refusal to grant a stay.

6. Except as otherwise provided in subsections 3 and 7, within 10 days after receiving a notice of appeal pursuant to this section or NRS 616C.220, 616D.140 or 617.401, or within 10 days after receiving a notice of a contested claim pursuant to subsection 7 of NRS 616C.315, the appeals officer shall:

(a) Schedule a hearing on the merits of the appeal or contested claim for a date and time within 90 days after receipt of the notice at a place in Carson City, Nevada, or Las Vegas, Nevada, or upon agreement of one or more of the parties to pay all additional costs directly related to an alternative location, at any other place of convenience to the parties, at the discretion of the appeals officer; and



(b) Give notice by mail or by personal service to all parties to the matter and their attorneys or agents at least 30 days before the date and time scheduled.

7. Except as otherwise provided in subsection ~~H2-1~~ 13, a request to schedule the hearing for a date and time which is:

(a) Within 60 days after the receipt of the notice of appeal or contested claim; or

(b) More than 90 days after the receipt of the notice or claim,   
 ➔ may be submitted to the appeals officer only if all parties to the appeal or contested claim agree to the request.

8. An appeal or contested claim may be continued upon written stipulation of all parties, or upon good cause shown.

9. The period specified in subsection 1, 2 or 4 within which a notice of appeal or a notice of a contested claim must be filed may be extended for an additional 90 days if the person aggrieved shows by a preponderance of the evidence that the person was diagnosed with a terminal illness or was informed of the death or diagnosis of a terminal illness of the person's spouse, parent or child.

10. *The period specified in subsection 2 within which a notice of appeal or a notice of a contested claim must be filed may be tolled if the insurer fails to mail or, if requested by the claimant or the person acting on behalf of the claimant, send a determination by facsimile or other electronic transmission the proof of sending and receipt of which is readily verifiable.*

11. Failure to file a notice of appeal within the period specified in subsection 1 or 4 may be excused if the party aggrieved shows by a preponderance of the evidence that he or she did not receive the notice of the determination and the forms necessary to appeal the determination. The claimant, employer or insurer shall notify the hearing officer of a change of address.

~~H1-1~~ 12. Failure to file a notice of a contested claim within the period specified in subsection 2 may be excused if the claimant shows by a preponderance of the evidence that he or she did not receive the notice of the determination and the forms necessary to file the notice. The claimant or employer shall notify the insurer of a change of address.

~~H2-1~~ 13. Within 10 days after receiving a notice of a contested claim pursuant to subsection 2, the appeals officer shall:

(a) Schedule a hearing on the merits of the contested claim for a date and time within 60 days after his or her receipt of the notice at a place in Carson City, Nevada, or Las Vegas, Nevada, or upon agreement of one or more of the parties to pay all additional costs directly related to an alternative location, at any other place of



convenience to the parties, at the discretion of the appeals officer; and

(b) Give notice by mail or by personal service to all parties to the matter and their attorneys or agents within 10 days after scheduling the hearing.

↳ The scheduled date must allow sufficient time for full disclosure, exchange and examination of medical and other relevant information. A party may not introduce information at the hearing which was not previously disclosed to the other parties unless all parties agree to the introduction.

**Sec. 6.3.** NRS 616C.350 is hereby amended to read as follows:

616C.350 1. Any physician , ~~or~~ chiropractor , *physician assistant or advanced practice registered nurse* who attends an employee within the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS in a professional capacity, may be required to testify before an appeals officer. A physician , ~~or~~ chiropractor , *physician assistant or advanced practice registered nurse* who testifies is entitled to receive the same fees as witnesses in civil cases and, if the appeals officer so orders at his or her own discretion, a fee equal to that authorized for a consultation by the appropriate schedule of fees for physicians , ~~or~~ chiropractors ~~or~~ , *physician assistants or advanced practice registered nurses, if any.* These fees must be paid by the insurer.

2. Information gained by the attending physician , ~~or~~ chiropractor , *physician assistant or advanced practice registered nurse* while in attendance on the injured employee is not a privileged communication if:

(a) Required by an appeals officer for a proper understanding of the case and a determination of the rights involved; or

(b) The information is related to any fraud that has been or is alleged to have been committed in violation of the provisions of this chapter or chapter 616A, 616B, 616D or 617 of NRS.

*3. References to a physician assistant and an advanced practice registered nurse in this section are for the purposes of the examination and treatment of an injured employee which are authorized to be provided by a physician assistant or advanced practice registered nurse in the exclusive context of an initial examination and treatment pursuant to NRS 616C.010.*

**Sec. 6.7.** NRS 616C.360 is hereby amended to read as follows:

616C.360 1. A stenographic or electronic record must be kept of the hearing before the appeals officer and the rules of evidence applicable to contested cases under chapter 233B of NRS apply to the hearing.



2. The appeals officer must hear any matter raised before him or her on its merits, including new evidence bearing on the matter.

3. If there is a medical question or dispute concerning an injured employee's condition or concerning the necessity of treatment for which authorization for payment has been denied, the appeals officer may:

(a) Order an independent medical examination and refer the employee to a physician or chiropractor of his or her choice who has demonstrated special competence to treat the particular medical condition of the employee, whether or not the physician or chiropractor is on the insurer's panel of providers of health care. If the medical question concerns the rating of a permanent disability, the appeals officer may refer the employee to a rating physician or chiropractor. The rating physician or chiropractor must be selected in rotation from the list of qualified physicians or chiropractors maintained by the Administrator pursuant to subsection 2 of NRS 616C.490, unless the insurer and the injured employee otherwise agree to a rating physician or chiropractor. The insurer shall pay the costs of any examination requested by the appeals officer.

(b) If the medical question or dispute is relevant to an issue involved in the matter before the appeals officer and all parties agree to the submission of the matter to an independent review organization, submit the matter to an independent review organization in accordance with NRS 616C.363 and any regulations adopted by the Commissioner.

4. The appeals officer may consider the opinion of an examining physician, ~~or~~ chiropractor, *physician assistant or advanced practice registered nurse*, in addition to the opinion of an authorized treating physician, ~~or~~ chiropractor, *physician assistant or advanced practice registered nurse*, in determining the compensation payable to the injured employee.

5. If an injured employee has requested payment for the cost of obtaining a second determination of his or her percentage of disability pursuant to NRS 616C.100, the appeals officer shall decide whether the determination of the higher percentage of disability made pursuant to NRS 616C.100 is appropriate and, if so, may order the insurer to pay to the employee an amount equal to the maximum allowable fee established by the Administrator pursuant to NRS 616C.260 for the type of service performed, or the usual fee of that physician or chiropractor for such service, whichever is less.

6. The appeals officer shall order an insurer, organization for managed care or employer who provides accident benefits for injured employees pursuant to NRS 616C.265 to pay to the



appropriate person the charges of a provider of health care if the conditions of NRS 616C.138 are satisfied.

7. Any party to the appeal or contested case or the appeals officer may order a transcript of the record of the hearing at any time before the seventh day after the hearing. The transcript must be filed within 30 days after the date of the order unless the appeals officer otherwise orders.

8. Except as otherwise provided in subsection 9, the appeals officer shall render a decision:

(a) If a transcript is ordered within 7 days after the hearing, within 30 days after the transcript is filed; or

(b) If a transcript has not been ordered, within 30 days after the date of the hearing.

9. The appeals officer shall render a decision on a contested claim submitted pursuant to subsection 2 of NRS 616C.345 within 15 days after:

(a) The date of the hearing; or

(b) If the appeals officer orders an independent medical examination, the date the appeals officer receives the report of the examination,

↳ unless both parties to the contested claim agree to a later date.

10. The appeals officer may affirm, modify or reverse any decision made by a hearing officer and issue any necessary and proper order to give effect to his or her decision.

***11. References to a physician assistant and an advanced practice registered nurse in this section are for the purposes of the examination and treatment of an injured employee which are authorized to be provided by a physician assistant or advanced practice registered nurse in the exclusive context of an initial examination and treatment pursuant to NRS 616C.010.***

**Sec. 7.** NRS 616C.490 is hereby amended to read as follows:

616C.490 1. Except as otherwise provided in NRS 616C.175, every employee, in the employ of an employer within the provisions of chapters 616A to 616D, inclusive, of NRS, who is injured by an accident arising out of and in the course of employment is entitled to receive the compensation provided for permanent partial disability. As used in this section, "disability" and "impairment of the whole person" are equivalent terms.

2. Except as otherwise provided in subsection 3:

(a) Within 30 days after receiving from a physician or chiropractor a report indicating that the injured employee may have suffered a permanent disability and is stable and ratable, the insurer shall schedule an appointment with the rating physician or





chiropractor selected pursuant to this subsection to determine the extent of the employee's disability.

(b) Unless the insurer and the injured employee otherwise agree to a rating physician or chiropractor:

(1) The insurer shall select the rating physician or chiropractor from the list of qualified rating physicians and chiropractors designated by the Administrator, to determine the percentage of disability in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment as adopted and supplemented by the Division pursuant to NRS 616C.110.

(2) Rating physicians and chiropractors must be selected in rotation from the list of qualified physicians and chiropractors designated by the Administrator, according to their area of specialization and the order in which their names appear on the list unless the next physician or chiropractor is currently an employee of the insurer making the selection, in which case the insurer must select the physician or chiropractor who is next on the list and who is not currently an employee of the insurer.

3. Notwithstanding any other provision of law, an injured employee or the legal representative of an injured employee may, at any time, without limitation, request that the Administrator select a rating physician or chiropractor from the list of qualified physicians and chiropractors designated by the Administrator. The Administrator, upon receipt of the request, shall immediately select for the injured employee the rating physician or chiropractor who is next in rotation on the list, according to the area of specialization.

4. If an insurer contacts a treating physician or chiropractor to determine whether an injured employee has suffered a permanent disability, the insurer shall deliver to the treating physician or chiropractor that portion or a summary of that portion of the American Medical Association's Guides to the Evaluation of Permanent Impairment as adopted by the Division pursuant to NRS 616C.110 that is relevant to the type of injury incurred by the employee.

5. At the request of the insurer, the injured employee shall, before an evaluation by a rating physician or chiropractor is performed, notify the insurer of:

(a) Any previous evaluations performed to determine the extent of any of the employee's disabilities; and

(b) Any previous injury, disease or condition sustained by the employee which is relevant to the evaluation performed pursuant to this section.



↳ The notice must be on a form approved by the Administrator and provided to the injured employee by the insurer at the time of the insurer's request.

6. Unless the regulations adopted pursuant to NRS 616C.110 provide otherwise, a rating evaluation must include an evaluation of the loss of motion, sensation and strength of an injured employee if the injury is of a type that might have caused such a loss. Except in the case of claims accepted pursuant to NRS 616C.180, no factors other than the degree of physical impairment of the whole person may be considered in calculating the entitlement to compensation for a permanent partial disability.

7. The rating physician or chiropractor shall provide the insurer with his or her evaluation of the injured employee. After receiving the evaluation, the insurer shall, within 14 days, provide the employee with a copy of the evaluation and notify the employee:

(a) Of the compensation to which the employee is entitled pursuant to this section; or

(b) That the employee is not entitled to benefits for permanent partial disability.

8. Each 1 percent of impairment of the whole person must be compensated by a monthly payment:

(a) Of 0.5 percent of the claimant's average monthly wage for injuries sustained before July 1, 1981;

(b) Of 0.6 percent of the claimant's average monthly wage for injuries sustained on or after July 1, 1981, and before June 18, 1993;

(c) Of 0.54 percent of the claimant's average monthly wage for injuries sustained on or after June 18, 1993, and before January 1, 2000; and

(d) Of 0.6 percent of the claimant's average monthly wage for injuries sustained on or after January 1, 2000.

↳ Compensation must commence on the date of the injury or the day following the termination of temporary disability compensation, if any, whichever is later, and must continue on a monthly basis for 5 years or until the claimant is 70 years of age, whichever is later.

9. Compensation benefits may be paid annually to claimants who will be receiving less than \$100 a month.

10. ~~Except as otherwise provided in subsection 11, if~~ **If** there is a previous disability, ~~[as the loss of one eye, one hand, one foot, or any other previous permanent disability.]~~ the percentage of disability for a subsequent injury must be determined ~~[by computing the percentage of the entire disability and deducting therefrom the percentage of the previous disability as it existed at the time of the subsequent injury.]~~ **pursuant to section 1 of this act.**



11. ~~If a rating evaluation was completed for a previous disability involving a condition, organ or anatomical structure that is identical to the condition, organ or anatomical structure being evaluated for the present disability, the percentage of disability for a subsequent injury must be determined by deducting the percentage of the previous disability from the percentage of the present disability, regardless of the edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment as adopted by the Division pursuant to NRS 616C.110 used to determine the percentage of the previous disability. The compensation awarded for a permanent disability on a subsequent injury must be reduced only by the awarded or agreed upon percentage of disability actually received by the injured employee for the previous injury regardless of the percentage of the previous disability.]~~ *In the event of a dispute over an award of compensation for permanent partial disability, the insurer shall commence making installment payments to the injured employee for that portion of the award that is not in dispute:*

*(a) Not later than the date by which such payment is required pursuant to subsection 8 or 9, as applicable; and*

*(b) Without requiring the injured employee to make an election whether to receive his or her compensation in installment payments or in a lump sum.*

12. The Division may adopt schedules for rating permanent disabilities resulting from injuries sustained before July 1, 1973, and reasonable regulations to carry out the provisions of this section.

13. The increase in compensation and benefits effected by the amendment of this section is not retroactive for accidents which occurred before July 1, 1973.

14. This section does not entitle any person to double payments for the death of an employee and a continuation of payments for a permanent partial disability, or to a greater sum in the aggregate than if the injury had been fatal.

**Sec. 8.** NRS 616C.495 is hereby amended to read as follows:

616C.495 1. Except as otherwise provided in NRS 616C.380, an award for a permanent partial disability may be paid in a lump sum under the following conditions:

(a) A claimant injured on or after July 1, 1973, and before July 1, 1981, who incurs a disability that does not exceed 12 percent may elect to receive his or her compensation in a lump sum. A claimant injured on or after July 1, 1981, and before July 1, 1995, who incurs a disability that does not exceed 30 percent may elect to receive his or her compensation in a lump sum.



(b) The spouse, or in the absence of a spouse, any dependent child of a deceased claimant injured on or after July 1, 1973, who is not entitled to compensation in accordance with NRS 616C.505, is entitled to a lump sum equal to the present value of the deceased claimant's undisbursed award for a permanent partial disability.

(c) Any claimant injured on or after July 1, 1981, and before July 1, 1995, who incurs a disability that exceeds 30 percent may elect to receive his or her compensation in a lump sum equal to the present value of an award for a disability of 30 percent. If the claimant elects to receive compensation pursuant to this paragraph, the insurer shall pay in installments to the claimant that portion of the claimant's disability in excess of 30 percent.

(d) Any claimant injured on or after July 1, 1995, and before January 1, 2016, who incurs a disability that:

(1) Does not exceed 25 percent may elect to receive his or her compensation in a lump sum.

(2) Exceeds 25 percent may:

(I) Elect to receive his or her compensation in a lump sum equal to the present value of an award for a disability of 25 percent. If the claimant elects to receive compensation pursuant to this sub-subparagraph, the insurer shall pay in installments to the claimant that portion of the claimant's disability in excess of 25 percent.

(II) To the extent that the insurer has offered to provide compensation in a lump sum up to the present value of an award for disability of 30 percent, elect to receive his or her compensation in a lump sum up to the present value of an award for a disability of 30 percent. If the claimant elects to receive compensation pursuant to this sub-subparagraph, the insurer shall pay in installments to the claimant that portion of the claimant's disability in excess of 30 percent.

(e) Any claimant injured on or after January 1, 2016, and before July 1, 2017, who incurs a disability that:

(1) Does not exceed 30 percent may elect to receive his or her compensation in a lump sum.

(2) Exceeds 30 percent may elect to receive his or her compensation in a lump sum equal to the present value of an award for a disability of 30 percent. If the claimant elects to receive compensation pursuant to this subparagraph, the insurer shall pay in installments to the claimant that portion of the claimant's disability in excess of 30 percent.

(f) Any claimant injured on or after July 1, 2017, who incurs a disability that exceeds 30 percent may elect to receive his or her compensation in a lump sum equal to the present value of an award



for a disability of up to 30 percent. If the claimant elects to receive compensation pursuant to this paragraph, the insurer shall pay in installments to the claimant that portion of the claimant's disability in excess of 30 percent.

(g) If the permanent partial disability rating of a claimant seeking compensation pursuant to this section would, when combined with any previous permanent partial disability rating of the claimant that resulted in an award of benefits to the claimant, result in the claimant having a total permanent partial disability rating in excess of 100 percent, the claimant's disability rating upon which compensation is calculated must be reduced by such percentage as required to limit the total permanent partial disability rating of the claimant for all injuries to not more than 100 percent.

2. If the claimant elects to receive his or her payment for a permanent partial disability in a lump sum pursuant to subsection 1, all of the claimant's benefits for compensation terminate. ~~[The]~~ *Except as otherwise provided in paragraph (d), the* claimant's acceptance of that payment constitutes a final settlement of all factual and legal issues in the case. By so accepting the claimant waives all of his or her rights regarding the claim, including the right to appeal from the closure of the case or the percentage of his or her disability, except:

(a) The right of the claimant to:

(1) Reopen his or her claim in accordance with the provisions of NRS 616C.390; or

(2) Have his or her claim considered by his or her insurer pursuant to NRS 616C.392;

(b) Any counseling, training or other rehabilitative services provided by the insurer; ~~[and]~~

(c) The right of the claimant to receive a benefit penalty in accordance with NRS 616D.120 ~~[-~~ *→]*; and

*(d) The right of the claimant to conclude or resolve any contested matter which is pending at the time that the claimant executes his or her election to receive his or her payment for a permanent partial disability in a lump sum. The provisions of this paragraph do not apply to:*

*(1) The scope of the claim;*

*(2) The claimant's stable and ratable status; and*

*(3) The claimant's average monthly wage.*

3. The claimant, when he or she demands payment in a lump sum ~~[-]~~ *pursuant to subsection 2,* must be provided with a written notice which prominently displays a statement describing the effects



of accepting payment in a lump sum of an entire permanent partial disability award, any portion of such an award or any uncontested portion of such an award, and that the claimant has 20 days after the mailing or personal delivery of the notice within which to retract or reaffirm the demand, before payment may be made and the claimant's election becomes final.

~~§ 4.~~ 4. Any lump-sum payment which has been paid on a claim incurred on or after July 1, 1973, must be supplemented if necessary to conform to the provisions of this section.

~~§ 5.~~ 5. Except as otherwise provided in this subsection, the total lump-sum payment for disablement must not be less than one-half the product of the average monthly wage multiplied by the percentage of disability. If the claimant received compensation in installment payments for his or her permanent partial disability before electing to receive payment for that disability in a lump sum, the lump-sum payment must be calculated for the remaining payment of compensation.

~~§ 6.~~ 6. The lump sum payable must be equal to the present value of the compensation awarded, less any advance payment or lump sum previously paid. The present value must be calculated using monthly payments in the amounts prescribed in subsection 8 of NRS 616C.490 and actuarial annuity tables adopted by the Division. The tables must be reviewed annually by a consulting actuary and must be adjusted accordingly on July 1 of each year by the Division using:

(a) The most recent unisex "Static Mortality Tables for Defined Benefit Pension Plans" published by the Internal Revenue Service; and

(b) The average 30-Year Treasury Constant Maturity Rate for March of the current year as reported by the Board of Governors of the Federal Reserve System.

~~§ 7.~~ 7. If a claimant would receive more money by electing to receive compensation in a lump sum than the claimant would if he or she receives installment payments, the claimant may elect to receive the lump-sum payment.

**Sec. 9.** NRS 616C.541 is hereby amended to read as follows:

616C.541 Where a written assessment is requested pursuant to NRS 616C.550 or where a plan for a program of vocational rehabilitation is required pursuant to NRS 616C.555, a vocational rehabilitation counselor must be appointed as follows:

1. The insurer and the injured employee or personal or legal representative of the injured employee shall agree on the selection of a vocational rehabilitation counselor . ~~§~~



2. If the insurer or injured employee or personal or legal representative of the injured employee are unable to agree on the appointment of a vocational rehabilitation counselor, the insurer shall submit a list of at least three vocational rehabilitation counselors *who are employed by at least three different organizations or entities* to the injured employee or personal or legal representative of the injured employee. ~~§~~

3. The injured employee or personal or legal representative of the injured employee shall select a vocational rehabilitation counselor from the list provided by the insurer pursuant to subsection 2 within 7 days after receiving the list provided by the insurer pursuant to subsection 2. ~~§~~

4. The vocational rehabilitation counselor that is selected by the injured employee or personal or legal representative of the injured employee pursuant to subsection 1 or 3 must be assigned to provide all vocational rehabilitation services for the claim pursuant to this section and NRS 616C.530 to 616C.600, inclusive. ~~§ and~~

5. After a vocational rehabilitation counselor is selected and assigned pursuant to this section, an injured employee or personal or legal representative of the injured employee may only rescind the selection of the vocational rehabilitation counselor with the consent of the insurer.

**Sec. 9.5.** NRS 616C.545 is hereby amended to read as follows:

616C.545 **1.** If an employee does not return to work for 28 consecutive calendar days as a result of an injury arising out of and in the course of his or her employment or an occupational disease, the insurer shall contact the treating physician, ~~or~~ chiropractor, *physician assistant or advanced practice registered nurse* to determine whether:

~~1-1~~ **(a)** There are physical limitations on the injured employee's ability to work; and

~~2-1~~ **(b)** The limitations, if any, are permanent or temporary.

**2. *References to a physician assistant and an advanced practice registered nurse in this section are for the purposes of the examination and treatment of an injured employee which are authorized to be provided by a physician assistant or advanced practice registered nurse in the exclusive context of an initial examination and treatment pursuant to NRS 616C.010.***

**Sec. 10.** NRS 617.356 is hereby amended to read as follows:

617.356 **1.** An insurer shall accept or deny a claim for compensation under this chapter and notify the claimant or the person acting on behalf of the claimant pursuant to NRS 617.344 that the claim has been accepted or denied within 30 working days



after the forms for filing the claim for compensation are received pursuant to both NRS 617.344 and 617.352.

2. The insurer shall notify the claimant or the person acting on behalf of the claimant that a claim has been accepted or denied pursuant to subsection 1 by:

(a) Mailing its written determination to the claimant or the person acting on behalf of the claimant ~~[(b)]~~ and

~~[(b)]~~ ~~[(a)]~~, if the claim has been denied, in whole or in part, obtaining a certificate of mailing ~~[(a)]~~; or

*(b) If and as requested by the claimant or the person acting on behalf of the claimant, sending its written determination to the claimant or the person acting on behalf of the claimant by facsimile or other electronic transmission the proof of sending and receipt of which is readily verifiable and retaining proof of a successful transmission and receipt of the facsimile or other electronic transmission, as applicable.*

3. The failure of the insurer to ~~[(obtain)]~~, as applicable:

(a) *Obtain* a certificate of mailing as required by paragraph ~~[(b)]~~ (a) of subsection 2 shall be deemed to be a failure of the insurer to mail the written determination of the denial of a claim as required by this section ~~[(a)]~~; or

*(b) Retain proof of a successful transmission and receipt of the facsimile or other electronic transmission the proof of sending and receipt of which is readily verifiable, as applicable, as required by paragraph (b) of subsection 2 shall be deemed to be a failure of the insurer to send by facsimile or other electronic transmission the written determination regarding a claim as required by this section.*

4. Upon request, the insurer shall provide a copy of the certificate of mailing, if any, *or proof of a successful transmission and receipt of the facsimile or other electronic transmission the proof of sending and receipt of which is readily verifiable, as applicable*, to the claimant or the person acting on behalf of the claimant.

5. For the purposes of this section, the insurer shall ~~[(mail)]~~ either:

(a) *Mail* the written determination to:

~~[(a)]~~ (1) The mailing address of the claimant or the person acting on behalf of the claimant that is provided on the form prescribed by the Administrator for filing the claim; or

~~[(b)]~~ (2) Another mailing address if the claimant or the person acting on behalf of the claimant provides to the insurer written notice of another mailing address ~~[(a)]~~; or





*(b) If and as requested by the claimant or the person acting on behalf of the claimant, send the written determination by facsimile or other electronic transmission the proof of sending and receipt of which is readily verifiable to the claimant or person acting on behalf of the claimant.*

6. As used in this section, “certificate of mailing” means a receipt that provides evidence of the date on which the insurer presented its written determination to the United States Postal Service for mailing.

**Sec. 11.** The amendatory provisions of this act apply prospectively with regard to any claim pursuant to chapters 616A to 616D, inclusive, or 617 of NRS which is open on the effective date of this act.

**Sec. 12.** This act becomes effective upon passage and approval.

