ASSEMBLY BILL NO. 338–ASSEMBLYMAN BACHE

MARCH 13, 2001

Referred to Committee on Commerce and Labor

SUMMARY—Makes various changes concerning workers' compensation. (BDR 53-711)

FISCAL NOTE: Effect on Local Government: Yes.
Effect on the State: No.

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

AN ACT relating to workers' compensation; requiring an insurer to provide copies of documents in a claimant's file within a certain time; requiring an insurer to reimburse an injured employee for medical expenses paid by the employee under certain circumstances; requiring insurers to provide certain types of notifications concerning an injured employee's right to choose physicians or chiropractors; requiring the administrator of the division of industrial relations of the department of business and industry to design a form notifying injured employees of their right to choose an alternate physician or chiropractor; allowing injured employees to choose under certain circumstances physicians or chiropractors who are not under contract with the managed care organization of the insurer; allowing an injured employee to choose any qualified physician or chiropractor to render a second determination of his percentage of disability; revising certain provisions governing eligibility for compensation for reopening a claim; revising the provisions governing offers of temporary, light-duty employment; revising the provisions governing the determination of a permanent partial disability; revising provisions governing eligibility for and length, goals and amounts of vocational rehabilitation services; authorizing a claimant to bring and maintain a certain cause of action against an insurer or a third-party administrator if the claimant does not accept a benefit penalty; and providing other matters properly relating thereto.

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

Section 1. NRS 616A.070 is hereby amended to read as follows:

616A.070 "Benefit penalty" means an additional amount of money that ***, except as otherwise provided in NRS 616D.120 and section 20 of this act,*** is payable to a claimant if the administrator has determined that a violation of any of the provisions of paragraphs (a) to (d), inclusive, of subsection 1 of NRS 616D.120 has occurred.

Sec. 2. NRS 616A.465 is hereby amended to read as follows:

616A.465 1. Except as otherwise provided in this section, the division shall:

(a) Regulate insurers pursuant to chapters 616A to 617, inclusive, of NRS;

(b) Investigate insurers regarding compliance with statutes and the division's regulations;

(c) Determine whether an employee leasing company is entitled to a certificate of registration pursuant to NRS 616B.673; and

(d) Regulate employee leasing companies pursuant to the provisions of NRS 616B.670 to 616B.697, inclusive.

2. The commissioner is responsible for reviewing rates, investigating the solvency of insurers, authorizing private carriers pursuant to chapter 680A of NRS and certifying:

(a) Self-insured employers pursuant to NRS 616B.300 to 616B.330, inclusive, and 616B.336;

(b) Associations of self-insured public or private employers pursuant to NRS 616B.350 to 616B.446, inclusive; and

(c) Third-party administrators pursuant to chapter 683A of NRS.

3. The department of administration is responsible for contested claims relating to industrial insurance pursuant to NRS 616C.310 to 616C.385, inclusive. The administrator is responsible for administrative appeals pursuant to NRS 616B.215.

4. The Nevada attorney for injured workers is responsible for legal representation of claimants pursuant to NRS 616A.435 to 616A.460, inclusive, and 616D.120.

5. The division is responsible for the investigation of complaints. ~~[If]~~ ***Except as otherwise provided in subsection 3 of section 20 of this act, if*** a complaint is filed with the division, the administrator shall cause to be conducted an investigation which includes a review of relevant records and interviews of affected persons. If the administrator determines that a violation may have occurred, the administrator shall proceed in accordance with the provisions of NRS 616D.120 and 616D.130.

6. As used in this section, "employee leasing company" has the meaning ascribed to it in NRS 616B.670.

Sec. 3. NRS 616B.021 is hereby amended to read as follows:

616B.021 1. An insurer shall provide access to the files of claims in its offices.

2. A file ~~[is]~~ ***must be*** available for inspection during regular business hours by the ~~[employee]~~ ***claimant*** or his designated agent, the employer or his designated agent and the administrator or his designated agent.

3. Upon request, the insurer shall make copies of anything in the file and may charge a reasonable fee for this service. Copies of materials in the file which are requested by the administrator or his designated agent, or the Nevada attorney for injured workers or his designated agent must be provided free of charge. ***Any copies requested by a claimant or his designated agent must be produced within 21 days after the request is made. The failure of an insurer to provide copies to a claimant or his designated agent in a timely manner pursuant to this subsection shall be***

deemed to be a minor violation for purposes of the administrative fines imposed by the administrator pursuant to subsection 2 of NRS 616D.120.

4. If a claim has been closed for at least 1 year, the insurer may microphotograph or film any of its records relating to that claim. The microphotographs or films must be placed in convenient and accessible files.

5. The administrator shall adopt regulations concerning the:

(a) Maintenance of records in a file on current or closed claims;

(b) Preservation, examination and use of records which have been microphotographed or filmed by an insurer; and

(c) Location of a file on a closed claim.

6. This section does not require an insurer to allow inspection or reproduction of material regarding which a legal privilege against disclosure has been conferred.

Sec. 4. NRS 616B.527 is hereby amended to read as follows:

616B.527 ***1.*** A self-insured employer, an association of self-insured public or private employers or a private carrier may:

~~[1.]~~ ***(a)*** Enter into a contract or contracts with one or more organizations for managed care to provide comprehensive medical and health care services to employees for injuries and diseases that are compensable pursuant to chapters 616A to 617, inclusive, of NRS.

~~[2.]~~ ***(b)*** Enter into a contract or contracts with providers of health care, including, without limitation, physicians who provide primary care, specialists, pharmacies, physical therapists, radiologists, nurses, diagnostic facilities, laboratories, hospitals and facilities that provide treatment to outpatients, to provide medical and health care services to employees for injuries and diseases that are compensable pursuant to chapters 616A to 617, inclusive, of NRS.

~~[3.]~~ ***(c)*** Require employees to obtain medical and health care services for their industrial injuries from those organizations and persons with whom the self-insured employer, association or private carrier has contracted pursuant to ~~[subsections 1 and 2,]~~ ***paragraphs (a) and (b),*** or as the self-insured employer, association or private carrier otherwise prescribes.

~~[4. Require]~~

(d) Except as otherwise provided in subsection 3 of NRS 616C.090, require employees to obtain the approval of the self-insured employer, association or private carrier before obtaining medical and health care services for their industrial injuries from a provider of health care who has not been previously approved by the self-insured employer, association or private carrier.

~~[5.]~~ ***2.*** An organization for managed care with whom a self-insured employer, association of self-insured public or private employers or a private carrier has contracted pursuant to this section shall comply with the provisions of NRS 616B.528, 616B.5285 and 616B.529.

Sec. 5. Chapter 616C of NRS is hereby amended by adding thereto a new section to read as follows:

If:

1. An insurer, an organization for managed care, a third-party administrator or an employer who provides accident benefits for injured employees pursuant to NRS 616C.265 denies authorization or responsibility for payment for treatment or other services provided by a provider of health care that the injured employee alleges are related to an industrial injury or occupational disease;

2. The injured employee pays in protest for the treatment or other services; and

3. A hearing officer or appeals officer ultimately determines that the treatment or other services should have been covered, or the insurer, organization for managed care, third-party administrator or employer who provides accident benefits subsequently accepts responsibility for payment,

the hearing officer or appeals officer shall order the insurer, organization for managed care, third-party administrator or employer who provides accident benefits to reimburse the injured employee for the amount paid by the injured employee, or the insurer, organization for managed care, third-party administrator or employer who provides accident benefits shall, as a part of any settlement with the injured employee, reimburse the injured employee for the amount paid by the injured employee.

Sec. 6. NRS 616C.050 is hereby amended to read as follows:

616C.050 1. An insurer shall provide to each claimant:

(a) Upon written request, one copy of any medical information concerning his injury or illness.

(b) A statement which contains information concerning the claimant's right to:

(1) Receive the information and forms necessary to file a claim;

(2) Select a treating physician or chiropractor ***and an alternate treating physician or chiropractor*** in accordance with the provisions of NRS 616C.090;

(3) Request the appointment of the Nevada attorney for injured workers to represent him before the appeals officer;

(4) File a complaint with the administrator;

(5) When applicable, receive compensation for:

(I) Permanent total disability;

(II) Temporary total disability;

(III) Permanent partial disability;

(IV) Temporary partial disability; or

(V) All medical costs related to his injury or disease;

(6) Receive services for rehabilitation if his injury prevents him from returning to gainful employment;

(7) Review by a hearing officer of any determination or rejection of a claim by the insurer within the time specified by statute; and

(8) Judicial review of any final decision within the time specified by statute.

2. ***The insurer's statement must include a copy of the form designed by the administrator pursuant to subsection 7 of NRS 616C.090 that notifies injured employees of their right to select an alternate treating physician or chiropractor.*** The administrator shall adopt regulations for the manner of compliance by an insurer with the ***other*** provisions of subsection 1.

Sec. 7. NRS 616C.090 is hereby amended to read as follows:

616C.090 1. The administrator shall establish a panel of physicians and chiropractors who have demonstrated special competence and interest in industrial health to treat injured employees under chapters 616A to 616D, inclusive, or chapter 617 of NRS. Every employer whose insurer has not entered into a contract with an organization for managed care or with providers of health care services pursuant to NRS 616B.527 shall maintain a list of those physicians and chiropractors on the panel who are reasonably accessible to his employees.

2. An injured employee whose employer's insurer has not entered into a contract with an organization for managed care or with providers of health care services pursuant to NRS 616B.527 may choose his treating physician or chiropractor from the panel of physicians and chiropractors. If the injured employee is not satisfied with the first physician or chiropractor he so chooses, he may make an alternative choice of physician or chiropractor from the panel if the choice is made within 90 days after his injury. The insurer shall notify the first physician or chiropractor in writing. The notice must be postmarked within 3 working days after the insurer receives knowledge of the change. The first physician or chiropractor must be reimbursed only for the services he rendered to the injured employee up to and including the date of notification. ~~[Any]~~ ***Except as otherwise provided in this subsection, any*** further change is subject to the approval of the insurer, which must be granted or denied within 10 days after a written request for such a change is received from the injured employee. If no action is taken on the request within 10 days, the request shall be deemed granted. Any request for a change of physician or chiropractor must include the name of the new physician or chiropractor chosen by the injured employee. ***If the treating physician or chiropractor refers the injured employee to a specialist, the insurer shall, in writing, notify the employee whether the name of more than one physician or chiropractor with that specialization is on the panel and, if so, inform the employee that he has a right to choose any one of those specialists.***

3. An injured employee whose employer's insurer has entered into a contract with an organization for managed care or with providers of health care services pursuant to NRS 616B.527 must choose his treating physician or chiropractor pursuant to the terms of that contract. If the injured employee is not satisfied with the first physician or chiropractor he so chooses, he may make an alternative choice of physician or chiropractor pursuant to the terms of the contract if the choice is made within 90 days after his injury. If the injured employee, after choosing his treating physician or chiropractor, moves to a county which is not served by the organization for managed care or providers of health care services named in the contract and the insurer determines that it is impractical for the

injured employee to continue treatment with the physician or chiropractor, the injured employee must choose a treating physician or chiropractor who has agreed to the terms of that contract unless the insurer authorizes the injured employee to choose another physician or chiropractor. ***If the treating physician or chiropractor refers the injured employee to a specialist, the insurer shall, in writing, notify the employee whether the name of more than one physician or chiropractor with that specialization is available pursuant to the terms of the contract with the organization for managed care or with providers of health care services pursuant to NRS 616B.527, as appropriate, and, if so, inform the employee that he has a right to choose any one of those specialists. If a choice of physicians or chiropractors within that specialization is not available pursuant to the terms of the contract, the injured employee may, without obtaining prior approval from the insurer, select any physician or chiropractor practicing within that area of specialization who agrees to accept the terms of the contract with the organization for managed care or with providers of health care pursuant to NRS 616B.527, as appropriate.***

4. Except when emergency medical care is required and except as otherwise provided in NRS 616C.055, the insurer is not responsible for any charges for medical treatment or other accident benefits furnished or ordered by any physician, chiropractor or other person selected by the injured employee in disregard of the provisions of this section or for any compensation for any aggravation of the injured employee's injury attributable to improper treatments by such physician, chiropractor or other person.

5. The administrator may order necessary changes in a panel of physicians and chiropractors and shall suspend or remove any physician or chiropractor from a panel for good cause shown.

6. An injured employee may receive treatment by more than one physician or chiropractor if the insurer provides written authorization for such treatment.

7. The administrator shall design a form that notifies injured employees of their right pursuant to subsections 2 and 3 to select an alternate treating physician or chiropractor and make the form available to insurers for distribution pursuant to subsection 2 of NRS 616C.050.

Sec. 8. NRS 616C.100 is hereby amended to read as follows:

616C.100 1. If an injured employee disagrees with the percentage of disability determined by a physician or chiropractor, the injured employee may obtain a second determination of the percentage of disability ~~[. If the employee wishes to obtain such a determination, he must select the next physician or chiropractor in rotation from the list of qualified physicians or chiropractors maintained by the administrator pursuant to subsection 2 of NRS 616C.490.]~~ ***from any qualified physician or chiropractor.*** If a second determination is obtained, the injured employee shall pay for the determination. If the physician or chiropractor selected to make the second determination finds a higher percentage of disability than the first physician or chiropractor, the injured employee may request a hearing

officer or appeals officer to order the insurer to reimburse the employee pursuant to the provisions of NRS 616C.330 or 616C.360.

2. The results of a second determination made pursuant to subsection 1 may be offered at any hearing or settlement conference.

Sec. 9. NRS 616C.110 is hereby amended to read as follows:

616C.110 1. For the purposes of NRS 616B.557, 616C.490 and 617.459, the division shall adopt regulations incorporating the American Medical Association's Guides to the Evaluation of Permanent Impairment by reference and may amend those regulations from time to time as it deems necessary. In adopting the Guides to the Evaluation of Permanent Impairment, the division shall consider the edition most recently published by the American Medical Association.

2. ~~[If]~~ ***Except as otherwise provided in subsection 6 of NRS 616C.490, if*** the Guides to the Evaluation of Permanent Impairment adopted by the division contain more than one method of determining the rating of an impairment, the administrator shall designate by regulation the method which must be used to rate an impairment pursuant to NRS 616C.490.

Sec. 10. NRS 616C.135 is hereby amended to read as follows:

616C.135 1. A provider of health care who accepts a patient as a referral for the treatment of an industrial injury or an occupational disease may not charge the patient for any treatment related to the industrial injury or occupational disease, but must charge the insurer. The provider of health care may charge the patient for any other unrelated services which are requested in writing by the patient.

2. The insurer is liable for the charges for approved services if the charges do not exceed:

(a) The fees established in accordance with NRS 616C.260 or the usual fee charged by that person or institution, whichever is less; and

(b) The charges provided for by the contract between the provider of health care and the insurer or the contract between the provider of health care and the organization for managed care.

3. ***A provider of health care may accept payment from an injured employee who is paying in protest pursuant to section 5 of this act for treatment or other services that the injured employee alleges are related to the industrial injury or occupational disease.***

4. If a provider of health care, an organization for managed care, an insurer or an employer violates the provisions of this section, the administrator shall impose an administrative fine of not more than $250 for each violation.

Sec. 11. NRS 616C.330 is hereby amended to read as follows:

616C.330 1. The hearing officer shall:

(a) Within 5 days after receiving a request for a hearing, set the hearing for a date and time within 30 days after his receipt of the request;

(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 refer the employee to a physician or chiropractor of his choice who has demonstrated special competence to treat the particular medical condition of the employee. 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. If an injured employee has requested payment for the cost of obtaining a second determination of his 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.

5. ***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 reimburse an injured employee for the payment of charges of a provider of health care if the conditions of section 5 of this act are satisfied.***

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

~~[6.]~~ ***7.*** The hearing officer shall render his decision within 15 days after:

(a) The hearing; or

(b) He receives a copy of the report from the medical examination he requested.

~~[7.]~~ ***8.*** The hearing officer shall render his decision in the most efficient format developed by the chief of the hearings division of the department of administration.

~~[8.]~~ ***9.*** The hearing officer shall give notice of his decision to each party by mail. He shall include with the notice of his decision the necessary forms for appealing from the decision.

~~[9.]~~ ***10.*** 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.

Sec. 12. 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 on its merits, including new evidence bearing on the matter.

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 appeals officer may refer the employee to a physician or chiropractor of his choice who has demonstrated special competence to treat the particular medical condition of the employee. 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.

4. If an injured employee has requested payment for the cost of obtaining a second determination of his 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.

5. ***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 reimburse an injured employee for the payment of charges of a provider of health care if the conditions of section 5 of this act are satisfied.***

6. Any party to the appeal 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.

~~[6.]~~ ***7.*** The appeals officer shall render his 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.

~~[7.]~~ ***8.*** The appeals officer may affirm, modify or reverse any decision made by the hearing officer and issue any necessary and proper order to give effect to his decision.

Sec. 13. NRS 616C.390 is hereby amended to read as follows:

616C.390 1. If an application to reopen a claim to increase or rearrange compensation is made in writing more than 1 year after the date on which the claim was closed, the insurer shall reopen the claim if:

(a) A change of circumstances warrants an increase or rearrangement of compensation during the life of the claimant;

(b) ~~[The primary]~~ ***A substantial contributing*** cause of the change of circumstances is the injury ***or disease*** for which the claim was originally made; and

(c) The application is accompanied by the certificate of a physician or a chiropractor showing a change of circumstances which would warrant an increase or rearrangement of compensation.

2. After a claim has been closed, the insurer, upon receiving an application and for good cause shown, may authorize the reopening of the claim for medical investigation only. The application must be accompanied by a written request for treatment from the physician or chiropractor treating the claimant, certifying that the treatment is indicated by a change in circumstances and is related to the industrial injury sustained ***or occupational disease contracted*** by the claimant.

3. If a claimant applies for a claim to be reopened pursuant to subsection 1 or 2 and a final determination denying the reopening is issued, the claimant ~~[shall]~~ ***may*** not reapply to reopen the claim until at least 1 year after the date on which the final determination is issued.

4. Except as otherwise provided in subsection 5, if an application to reopen a claim is made in writing within 1 year after the date on which the claim was closed, the insurer shall reopen the claim only if:

(a) The application is supported by medical evidence demonstrating an objective change in the medical condition of the claimant; and

(b) There is clear and convincing evidence that ~~[the primary]~~ ***a substantial contributing*** cause of the change of circumstances is the injury ***or disease*** for which the claim was originally made.

5. An application to reopen a claim must be made in writing within 1 year after the date on which the claim was closed if:

(a) The claimant was not off work as a result of the injury ~~[;]~~ ***or disease;*** and

(b) The claimant did not receive benefits for a permanent partial disability.

If an application to reopen a claim to increase or rearrange compensation is made pursuant to this subsection, the insurer shall reopen the claim if the requirements set forth in paragraphs (a), (b) and (c) of subsection 1 are met.

6. If an employee's claim is reopened pursuant to this section, he is not entitled to vocational rehabilitation services or benefits for a temporary total disability if, before his claim was reopened, he:

(a) Retired; or

(b) Otherwise voluntarily removed himself from the work force,

for reasons unrelated to the injury ***or disease*** for which the claim was originally made.

7. One year after the date on which the claim was closed, an insurer may dispose of the file of a claim authorized to be reopened pursuant to subsection 5, unless an application to reopen the claim has been filed pursuant to that subsection.

8. An increase or rearrangement of compensation is not effective before an application for reopening a claim is made unless good cause is shown. The insurer shall, upon good cause shown, allow the cost of emergency treatment the necessity for which has been certified by a physician or a chiropractor.

9. A claim that closes pursuant to subsection 2 of NRS 616C.235 and is not appealed or is unsuccessfully appealed pursuant to the provisions of NRS 616C.305 and 616C.315 to 616C.385, inclusive, may not be reopened pursuant to this section.

10. The provisions of this section apply to any claim for which an application to reopen the claim or to increase or rearrange compensation is made pursuant to this section, regardless of the date of the injury or accident ***or the date of disablement*** to the claimant. If a claim is reopened pursuant to this section, the amount of any compensation or benefits provided must be determined in accordance with the provisions of NRS 616C.425 ~~.~~ ***or 617.445, as appropriate.***

Sec. 14. NRS 616C.475 is hereby amended to read as follows:

616C.475 1. Except as otherwise provided in this section, NRS 616C.175 and 616C.390, every employee in the employ of an employer, within the provisions of chapters 616A to 616D, inclusive, of NRS, who is injured by accident arising out of and in the course of employment, or his dependents, is entitled to receive for the period of temporary total disability, 66 2/3 percent of the average monthly wage.

2. Except as otherwise provided in NRS 616B.028 and 616B.029, an injured employee or his dependents are not entitled to accrue or be paid any benefits for a temporary total disability during the time the injured employee is incarcerated. The injured employee or his dependents are entitled to receive such benefits when the injured employee is released from incarceration if he is certified as temporarily totally disabled by a physician or chiropractor.

3. If a claim for the period of temporary total disability is allowed, the first payment pursuant to this section must be issued by the insurer within 14 working days after receipt of the initial certification of disability and regularly thereafter.

4. Any increase in compensation and benefits effected by the amendment of subsection 1 is not retroactive.

5. Payments for a temporary total disability must cease when:

(a) A physician or chiropractor determines that the employee is physically capable of any gainful employment for which the employee is suited, after giving consideration to the employee's education, training and experience;

(b) The employer offers the employee light-duty employment or employment that is modified according to the limitations or restrictions imposed by a physician or chiropractor pursuant to subsection 7; or

(c) Except as otherwise provided in NRS 616B.028 and 616B.029, the employee is incarcerated.

6. Each insurer may, with each check that it issues to an injured employee for a temporary total disability, include a form approved by the division for the injured employee to request continued compensation for the temporary total disability.

7. A certification of disability issued by a physician or chiropractor must:

(a) Include the period of disability and a description of any physical limitations or restrictions imposed upon the work of the employee;

(b) Specify whether the limitations or restrictions are permanent or temporary; and

(c) Be signed by the treating physician or chiropractor authorized pursuant to NRS 616B.527 ~~[.]~~ ***or appropriately chosen pursuant to subsection 3 of NRS 616C.090.***

8. If the certification of disability specifies that the physical limitations or restrictions are temporary, the employer of the employee at the time of his accident ~~[is not required to comply with NRS 616C.545 to 616C.575, inclusive, and 616C.590 or the regulations adopted by the division governing vocational rehabilitation services if the employer offers]~~ ***may offer*** the employee ***temporary, light-duty employment. Any offer of temporary, light-duty employment made by the employer must:***

(a) Specify a position that:

~~[(a)]~~ ***(1)*** Is substantially similar to the employee's position at the time of his injury in relation to the location of the employment and the hours he is required to work; and

~~[(b)]~~ ***(2)*** Provides a gross wage that is:

~~[(1)]~~ ***(I)*** If the position is in the same classification of employment, equal to the gross wage the employee was earning at the time of his injury; or

~~[(2)]~~ ***(II)*** If the position is not in the same classification of employment, substantially similar to the gross wage the employee was earning at the time of his injury.

(b) Be accompanied by a written statement of whether the employer has a policy of terminating an employee who:

(1) Is absent from work without having obtained prior approval from the employer; and

(2) Cannot demonstrate a medical reason for his absence.

9. If an employer fails to provide the statement required by paragraph (b) of subsection 8 and terminates the employment of such an employee, the insurer of that employer or the self-insured employer cannot refuse to reinstate the payments for temporary total disability that the employee was receiving before accepting the temporary, light-duty employment until after the employer has given such notice and the employee is absent from work a subsequent time without having obtained prior approval from the employer and without being able to demonstrate a medical reason for his absence.

Sec. 15. 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 man" are equivalent terms.

2. 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. Unless the insurer and the injured employee otherwise agree to a rating physician or chiropractor:

(a) 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.

(b) 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. ***When an insurer contacts the physician or chiropractor to determine whether an injured employee has suffered a permanent disability and, thus, whether a rating is necessary, the insurer shall deliver to the physician or chiropractor 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.***

4. 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.

~~4.~~ ***5.*** 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. ~~No factors other than the degree of physical impairment of the whole man may be considered in~~

~~calculating the entitlement to compensation for a permanent partial disability.~~

~~5.~~ ***A rating evaluation may include a percentage of disability for a psychological impairment that results from the industrial injury.***

6. A rating evaluation of the spinal region must determine the percentage of disability as it existed before any surgical procedures were performed on the spinal region, unless the physician or chiropractor determines that the injured employee experienced major complications from the surgical procedure. If the physician or chiropractor determines that an injured employee experienced major complications from a surgical procedure performed on the spinal region, the physician or chiropractor shall include the effect of the complications when determining the percentage of disability of that injured employee. A physician or chiropractor may use any method for rating the spinal region authorized by the edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment that has been most recently adopted by the division pursuant to NRS 616C.110.

7. The rating physician or chiropractor shall provide the insurer with his 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 he is entitled pursuant to this section; or

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

~~6.~~ ***8.*** Each 1 percent of impairment of the whole man 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.

~~7.~~ ***9.*** Compensation benefits may be paid annually to claimants who will be receiving less than $100 a month.

~~8.~~ ***10.*** Where 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.

~~9.~~ ***11.*** 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.

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

[11.] *13.* 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. 16. 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 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 25 percent may elect to receive his 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 25 percent may elect to receive his 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 paragraph, the insurer shall pay in installments to the claimant that portion of the claimant's disability in excess of 25 percent.

(d) Any claimant injured on or after July 1, 1995, may elect to receive his compensation in a lump sum in accordance with regulations adopted by the administrator and approved by the governor. The administrator shall adopt regulations for determining the eligibility of such a claimant to receive all or any portion of his compensation in a lump sum. Such regulations may include the manner in which an award for a permanent partial disability may be paid to such a claimant in installments. Notwithstanding the provisions of NRS 233B.070, any regulation adopted pursuant to this paragraph does not become effective unless it is first approved by the governor.

2. If the claimant elects to receive his payment for a permanent partial disability in a lump sum pursuant to subsection 1, all of his benefits for compensation terminate. His acceptance of that payment constitutes a final settlement of all factual and legal issues in the case. By so accepting he waives all of his rights regarding the claim, including the right to appeal from the closure of the case or the percentage of his disability, except:

(a) His right to reopen his claim according to the provisions of NRS 616C.390; and

(b) Any counseling, training or other rehabilitative services provided by the insurer.

The claimant must be advised in writing of the provisions of this subsection when he demands his payment in a lump sum, and has 20 days

after the mailing or personal delivery of this notice within which to retract or reaffirm his demand, before payment may be made and his election becomes final.

3. 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.

4. 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 permanent partial disability before electing to receive his payment for that disability in a lump sum, the lump-sum payment must be calculated for the remaining payment of compensation.

5. 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 ~~[6]~~ ***8*** of NRS 616C.490 and actuarial annuity tables adopted by the division. The tables must be reviewed annually by a consulting actuary.

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

Sec. 17. NRS 616C.555 is hereby amended to read as follows:

616C.555 1. A vocational rehabilitation counselor shall develop a plan for a program of vocational rehabilitation for each injured employee who is eligible for vocational rehabilitation services pursuant to NRS 616C.590. The counselor shall work with the insurer and the injured employee to develop a program that is compatible with the injured employee's age, sex and physical condition.

2. If the counselor determined in the written assessment developed pursuant to NRS 616C.550 that the injured employee has existing marketable skills, the plan must consist of job placement assistance only. When practicable, the goal of job placement assistance must be to aid the employee in finding a position which pays a gross wage that is equal to or greater than 80 percent of the gross wage that he was earning at the time of his injury. An injured employee must not receive job placement assistance for more than 6 months after the date on which he was notified that he is eligible only for job placement assistance because:

(a) He was physically capable of returning to work; or

(b) It was determined that he had existing marketable skills.

3. If the counselor determined in the written assessment developed pursuant to NRS 616C.550 that the injured employee does not have existing marketable skills, the plan must consist of a program which trains or educates the injured employee and provides job placement assistance. Except as otherwise provided in NRS 616C.560, such a program must not exceed:

(a) If the injured employee has incurred ***a permanent disability as a result of which permanent restrictions on his ability to work have been imposed but no permanent physical impairment rating has been issued,***

or a permanent disability with a permanent physical impairment of ***1 percent or more but*** less than 6 percent, 9 months.

(b) If the injured employee has incurred a permanent physical impairment of 6 percent or more, but less than 11 percent, 1 year.

(c) If the injured employee has incurred a permanent physical impairment of 11 percent or more, 18 months.

The percentage of the injured employee's permanent physical impairment must be determined pursuant to NRS 616C.490.

4. A plan for a program of vocational rehabilitation must comply with the requirements set forth in NRS 616C.585.

5. ***A plan created pursuant to subsection 2 or 3 must assist the employee in finding a job or train or educate the employee and assist him in finding a job that is a part of an employer's regular business operations and from which the employee will gain skills that would generally be transferable to a job with another employer.***

6. A program of vocational rehabilitation must not commence before the treating physician or chiropractor, or an examining physician or chiropractor determines that the injured employee is capable of safely participating in the program.

~~[6.]~~ ***7.*** If, based upon the opinion of a treating or an examining physician or chiropractor, the counselor determines that an injured employee is not eligible for vocational rehabilitation services, the counselor shall provide a copy of the opinion to the injured employee, the injured employee's employer and the insurer.

~~[7.]~~ ***8.*** A plan for a program of vocational rehabilitation must be signed by a certified vocational rehabilitation counselor.

~~[8.]~~ ***9.*** If an initial program of vocational rehabilitation pursuant to this section is unsuccessful, an injured employee may submit a written request for the development of a second program of vocational rehabilitation which relates to the same injury. An insurer shall authorize a second program for an injured employee upon good cause shown.

~~[9.]~~ ***10.*** If a second program of vocational rehabilitation pursuant to subsection ~~[8]~~ ***9*** is unsuccessful, an injured employee may submit a written request for the development of a third program of vocational rehabilitation which relates to the same injury. The insurer, with the approval of the employer who was the injured employee's employer at the time of his injury, may authorize a third program for the injured employee. If such an employer has terminated operations, his approval is not required for authorization of a third program. An insurer's determination to authorize or deny a third program of vocational rehabilitation may not be appealed.

~~[10.]~~ ***11.*** The division shall adopt regulations to carry out the provisions of this section. The regulations must specify the contents of a plan for a program of vocational rehabilitation.

Sec. 18. NRS 616C.580 is hereby amended to read as follows:

616C.580 1. Except as otherwise provided in this section, vocational rehabilitation services must not be provided outside of this state. An injured employee who:

(a) Lives within 50 miles from any border of this state on the date of injury; or

(b) Was injured while temporarily employed in this state by an employer subject to the provisions of chapters 616A to 617, inclusive, of NRS who can demonstrate that, on the date of injury, his permanent residence was outside of this state,

may receive vocational rehabilitation services at a location within 50 miles from his residence if such services are available at such location.

2. An injured employee, who:

(a) Is eligible for vocational rehabilitation services pursuant to NRS 616C.590; and

(b) Resides outside of this state but does not qualify to receive vocational rehabilitation services outside of this state pursuant to subsection 1,

may execute a written agreement with the insurer which provides for the payment of compensation in a lump sum in lieu of the provision of vocational rehabilitation services pursuant to NRS 616C.595. The amount of the lump sum must not exceed ~~[$15,000.]~~ ***$25,000.***

3. An injured employee who resides outside of this state but does not qualify to receive vocational rehabilitation services outside of this state pursuant to subsection 1 may receive the vocational rehabilitation services to which he is entitled pursuant to NRS 616C.545 to 616C.575, inclusive, and 616C.590 if he relocates to:

(a) This state; or

(b) A location within 50 miles from any border of this state,

at his own expense, if such services are available at such location.

Sec. 19. NRS 616C.590 is hereby amended to read as follows:

616C.590 1. Except as otherwise provided in this section, an injured employee is not eligible for vocational rehabilitation services, unless:

(a) The treating physician or chiropractor approves the return of the injured employee to work but imposes permanent restrictions that prevent the injured employee from returning to the position that he held at the time of his injury;

(b) The injured employee's employer does not offer employment that ~~[the]~~ ***:***

(1) The employee is eligible for considering the restrictions imposed pursuant to paragraph (a); and

(2) Provides a gross wage that is equal to or greater than 80 percent of the gross wage that the employee was earning at the time of his injury; and

(c) The injured employee is unable to return to gainful employment ***with any other employer*** at a gross wage that is equal to or greater than 80 percent of the gross wage that ~~[he]~~ ***the employee*** was earning at the time of his injury.

2. If the treating physician or chiropractor imposes permanent restrictions on the injured employee for the purposes of paragraph (a) of subsection 1, he shall specify in writing:

(a) The medically objective findings upon which his determination is based; and

(b) A detailed description of the restrictions.

The treating physician or chiropractor shall deliver a copy of the findings and the description of the restrictions to the insurer.

3. If there is a question as to whether the restrictions imposed upon the injured employee are permanent, the employee may receive vocational rehabilitation services until a final determination concerning the duration of the restrictions is made.

4. Vocational rehabilitation services must cease as soon as the injured employee is no longer eligible for the services pursuant to subsection 1.

5. An injured employee is not entitled to vocational rehabilitation services solely because the position that he held at the time of his injury is no longer available.

6. An injured employee or his dependents are not entitled to accrue or be paid any money for vocational rehabilitation services during the time the injured employee is incarcerated.

7. Any injured employee eligible for compensation other than accident benefits may not be paid those benefits if he refuses counseling, training or other vocational rehabilitation services offered by the insurer. Except as otherwise provided in NRS 616B.028 and 616B.029, an injured employee shall be deemed to have refused counseling, training and other vocational rehabilitation services while he is incarcerated.

8. If an insurer cannot locate an injured employee for whom it has ordered vocational rehabilitation services, the insurer may close his claim 21 days after the insurer determines that the employee cannot be located. The insurer shall make a reasonable effort to locate the employee.

9. The reappearance of the injured employee after his claim has been closed does not automatically reinstate his eligibility for vocational rehabilitation benefits. If the employee wishes to reestablish his eligibility for such benefits, he must file a written application with the insurer to reinstate his claim. The insurer shall reinstate the employee's claim if good cause is shown for the employee's absence.

Sec. 20. Chapter 616D of NRS is hereby amended by adding thereto a new section to read as follows:

1. A cause of action may be brought and maintained against an insurer or a third-party administrator, by a claimant who has not accepted a benefit penalty pursuant to NRS 616D.120, which alleges that the insurer or third-party administrator has, with knowledge of or reckless disregard for his lack of a justification, denied or unreasonably delayed payment of compensation to that claimant.

2. A claimant may pursue a cause of action against an insurer or third-party administrator pursuant to subsection 1 and file a complaint with the administrator alleging a violation of any of the provisions of paragraphs (a) to (d), inclusive, of subsection 1 of NRS 616D.120, but may not accept a benefit penalty from that insurer or third-party administrator unless he first waives, in writing, all rights to:

(a) Proceed in the previously instituted action; and

(b) Bring any future action against the insurer or third-party administrator pursuant to subsection 1.

Such a claimant must deliver to the insurer or third-party administrator the written waiver within 5 days after the insurer or third-party administrator attempts to deliver the benefit penalty to the claimant.

3. If a claimant who has brought a cause of action against an insurer or third-party administrator pursuant to subsection 1 does not wish to participate in an investigation conducted by the administrator pursuant to NRS 616D.130 against that insurer or third-party administrator, the claimant may notify the administrator that he is pursuing a cause of action against that insurer or third-party administrator pursuant to subsection 1 and is waiving his right to receive a benefit penalty from that insurer or third-party administrator. If a claimant notifies the administrator that he is pursuing a cause of action against an insurer or third-party administrator pursuant to subsection 1, the administrator shall not require the claimant to participate in the investigation concerning that insurer or third-party administrator and shall not impose a benefit penalty on that insurer or third-party administrator.

4. A claimant who:

(a) Wishes to preserve his right to bring or maintain a cause of action against an insurer or third-party administrator pursuant to subsection 1; and

(b) Is offered a benefit penalty by that insurer or third-party administrator pursuant to an order of the administrator issued pursuant to subsection 3 of NRS 616D.120,

must refuse to accept the benefit penalty and must deliver to the insurer or third-party administrator a written refusal to accept the benefit penalty within 5 days after the insurer or third-party administrator attempts to deliver the benefit penalty.

Sec. 21. NRS 616D.010 is hereby amended to read as follows:

616D.010 Except as otherwise provided in NRS 616A.020, 616B.600 and 616C.190, ***and section 20 of this act,*** no penalty or remedy provided in this chapter or chapter 616A, 616B or 616C of NRS is exclusive of any other penalty or remedy, but is cumulative and in addition to every other penalty or remedy and may be exercised without exhausting and without regard to any other penalty or remedy provided by those chapters or any other statute.

Sec. 22. NRS 616D.030 is hereby amended to read as follows:

616D.030 1. ~~[No]~~ ***Except as otherwise provided in section 20 of this act, no*** cause of action may be brought or maintained against an insurer or a third-party administrator who violates any provision of this chapter or chapter 616A, 616B, 616C or 617 of NRS.

2. ~~[The]~~ ***Except as otherwise provided in section 20 of this act, the*** administrative fines provided for in NRS 616B.318 and 616D.120 are the exclusive remedies for any violation of this chapter or chapter 616A, 616B, 616C or 617 of NRS committed by an insurer or a third-party administrator.

Sec. 23. NRS 616D.050 is hereby amended to read as follows:

616D.050 1. Appeals officers, the administrator, and the administrator's designee, in conducting hearings or other proceedings pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS or regulations adopted pursuant to those chapters may:

(a) ~~[Issue]~~ ***Except as otherwise provided in subsection 3 of section 20 of this act, issue*** subpoenas requiring the attendance of any witness or the production of books, accounts, papers, records and documents.

(b) Administer oaths.

(c) Certify to official acts.

(d) ~~[Call]~~ ***Except as otherwise provided in subsection 3 of section 20 of this act, call*** and examine under oath any witness or party to a claim.

(e) Maintain order.

(f) Rule upon all questions arising during the course of a hearing or proceeding.

(g) Permit discovery by deposition or interrogatories.

(h) Initiate and hold conferences for the settlement or simplification of issues.

(i) Dispose of procedural requests or similar matters.

(j) Generally regulate and guide the course of a pending hearing or proceeding.

2. Hearing officers, in conducting hearings or other proceedings pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS or regulations adopted pursuant to those chapters, may:

(a) Issue subpoenas requiring the attendance of any witness or the production of books, accounts, papers, records and documents that are relevant to the dispute for which the hearing or other proceeding is being held.

(b) Maintain order.

(c) Permit discovery by deposition or interrogatories.

(d) Initiate and hold conferences for the settlement or simplification of issues.

(e) Dispose of procedural requests or similar matters.

(f) Generally regulate and guide the course of a pending hearing or proceeding.

Sec. 24. NRS 616D.120 is hereby amended to read as follows:

616D.120 1. Except as otherwise provided in this section, if the administrator determines that an insurer, organization for managed care, health care provider, third-party administrator or employer has:

(a) Through fraud, coercion, duress or undue influence:

(1) Induced a claimant to fail to report an accidental injury or occupational disease;

(2) Persuaded a claimant to settle for an amount which is less than reasonable;

(3) Persuaded a claimant to settle for an amount which is less than reasonable while a hearing or an appeal is pending; or

(4) Persuaded a claimant to accept less than the compensation found to be due him by a hearing officer, appeals officer, court of competent jurisdiction, written settlement agreement, written stipulation or the

division when carrying out its duties pursuant to chapters 616A to 617, inclusive, of NRS;

(b) Refused to pay or unreasonably delayed payment to a claimant of compensation found to be due him by a hearing officer, appeals officer, court of competent jurisdiction, written settlement agreement, written stipulation or the division when carrying out its duties pursuant to chapters 616A to 616D, inclusive, or chapter 617 of NRS, if the refusal or delay occurs:

(1) Later than 10 days after the date of the settlement agreement or stipulation;

(2) Later than 30 days after the date of the decision of a court, hearing officer, appeals officer or division, unless a stay has been granted; or

(3) Later than 10 days after a stay of the decision of a court, hearing officer, appeals officer or division has been lifted;

(c) Refused to process a claim for compensation pursuant to chapters 616A to 616D, inclusive, or chapter 617 of NRS;

(d) Made it necessary for a claimant to initiate proceedings pursuant to chapters 616A to 616D, inclusive, or chapter 617 of NRS for compensation found to be due him by a hearing officer, appeals officer, court of competent jurisdiction, written settlement agreement, written stipulation or the division when carrying out its duties pursuant to chapters 616A to 616D, inclusive, or chapter 617 of NRS;

(e) Failed to comply with the division's regulations covering the payment of an assessment relating to the funding of costs of administration of chapters 616A to 617, inclusive, of NRS;

(f) Failed to provide or unreasonably delayed payment to an injured employee or reimbursement to an insurer pursuant to NRS 616C.165; or

(g) Intentionally failed to comply with any provision of, or regulation adopted pursuant to, this chapter or chapter 616A, 616B, 616C or 617 of NRS,

the administrator shall impose an administrative fine of $1,000 for each initial violation, or a fine of $10,000 for a second or subsequent violation.

2. Except as otherwise provided in chapters 616A to 616D, inclusive, or chapter 617 of NRS, if the administrator determines that an insurer, organization for managed care, health care provider, third-party administrator or employer has failed to comply with any provision of this chapter or chapter 616A, 616B, 616C or 617 of NRS, or any regulation adopted pursuant thereto, the administrator may take any of the following actions:

(a) Issue a notice of correction for:

(1) A minor violation, as defined by regulations adopted by the division; or

(2) A violation involving the payment of compensation in an amount which is greater than that required by any provision of this chapter or chapter 616A, 616B, 616C or 617 of NRS, or any regulation adopted pursuant thereto.

The notice of correction must set forth with particularity the violation committed and the manner in which the violation may be corrected. The

provisions of this section do not authorize the administrator to modify or negate in any manner a determination or any portion of a determination made by a hearing officer, appeals officer or court of competent jurisdiction or a provision contained in a written settlement agreement or written stipulation.

(b) Impose an administrative fine for:

(1) A second or subsequent violation for which a notice of correction has been issued pursuant to paragraph (a); or

(2) Any other violation of this chapter or chapter 616A, 616B, 616C or 617 of NRS, or any regulation adopted pursuant thereto, for which a notice of correction may not be issued pursuant to paragraph (a).

The fine imposed may not be greater than $250 for an initial violation, or more than $1,000 for any second or subsequent violation.

(c) Order a plan of corrective action to be submitted to the administrator within 30 days after the date of the order.

3. ~~[If]~~ ***Unless a claimant has notified the administrator that, pursuant to subsection 3 of section 20 of this act, the claimant is pursuing a cause of action against an insurer or third-party administrator and waiving his right to receive a benefit penalty, if*** the administrator determines that a violation of any of the provisions of paragraphs (a) to (d), inclusive, of subsection 1 has occurred, the administrator shall order the insurer, organization for managed care, health care provider, third-party administrator or employer to pay to the claimant a benefit penalty in an amount that is not less than $5,000 and not greater than $25,000. To determine the amount of the benefit penalty, the administrator shall consider the degree of physical harm suffered by the injured employee or his dependents as a result of the violation of paragraph (a), (b), (c) or (d) of subsection 1, the amount of compensation found to be due the claimant and the number of fines and benefit penalties previously imposed against the insurer, organization for managed care, health care provider, third-party administrator or employer pursuant to this section. If this is the third violation within 5 years for which a benefit penalty has been imposed against the insurer, organization for managed care, health care provider, third-party administrator or employer, the administrator shall also consider the degree of economic harm suffered by the injured employee or his dependents as a result of the violation of paragraph (a), (b), (c) or (d) of subsection 1. Except as otherwise provided in this section, the benefit penalty is for the benefit of the claimant and must be paid directly to him within 10 days after the date of the administrator's determination. If the claimant is the injured employee and he dies before the benefit penalty is paid to him, the benefit penalty must be paid to his estate. ***If the claimant has, pursuant to section 20 of this act, brought an action against an insurer or third-party administrator who is subject to an order of the administrator pursuant to this section, the insurer or third-party administrator is not required to pay the penalty to the claimant if the claimant:***

(a) Refuses to deliver a written waiver pursuant to subsection 2 of section 20 of this act; or

(b) Delivers to the insurer or third-party administrator a written refusal to accept the benefit penalty pursuant to subsection 4 of section 20 of this act.

Proof of the payment of the benefit penalty ***, the claimant's refusal to deliver a written waiver or the claimant's refusal to accept the benefit penalty*** must be submitted to the administrator within 10 days after the date of his determination unless an appeal is filed pursuant to NRS 616D.140. Any compensation to which the claimant may otherwise be entitled pursuant to chapters 616A to 616D, inclusive, or chapter 617 of NRS must not be reduced by the amount of any benefit penalty received pursuant to this subsection.

4. In addition to any fine or benefit penalty imposed pursuant to this section, the administrator may assess against an insurer who violates any regulation concerning the reporting of claims expenditures used to calculate an assessment an administrative penalty of up to twice the amount of any underpaid assessment.

5. If:

(a) The administrator determines that a person has violated any of the provisions of NRS 616D.200, 616D.220, 616D.240, 616D.300, 616D.310 or 616D.350 to 616D.440, inclusive; and

(b) The fraud control unit for industrial insurance established pursuant to NRS 228.420 notifies the administrator that the unit will not prosecute the person for that violation,

the administrator shall impose an administrative fine of not more than $10,000.

6. Two or more fines of $1,000 or more imposed in 1 year for acts enumerated in subsection 1 must be considered by the commissioner as evidence for the withdrawal of:

(a) A certificate to act as a self-insured employer.

(b) A certificate to act as an association of self-insured public or private employers.

(c) A certificate of registration as a third-party administrator.

7. The commissioner may, without complying with the provisions of NRS 616B.327 or 616B.431, withdraw the certification of a self-insured employer, association of self-insured public or private employers or third-party administrator if, after a hearing, it is shown that the self-insured employer, association of self-insured public or private employers or third-party administrator violated any provision of subsection 1.

Sec. 25. NRS 616D.140 is hereby amended to read as follows:

616D.140 1. If a person wishes to contest a decision of the administrator to impose an administrative fine or benefit penalty pursuant to this chapter or chapter 616A, 616B, 616C or 617 of NRS, he must file a notice of appeal with the division within 10 days after receipt of the administrator's decision, showing why the proposed fine or benefit penalty should not be imposed.

2. If a notice of appeal is filed as required by subsection 1, the administrator shall, in accordance with the provisions of NRS 233B.121, issue a notice of hearing that must include a date for a hearing on the matter, which must be no sooner than 30 days after the notice of appeal is filed. The administrator may grant a continuance of the hearing upon a showing of good cause.

3. ~~[If]~~ ***Except as otherwise provided in this subsection, if*** a notice of appeal is not filed as required by this section, the imposition of the fine or benefit penalty shall be deemed a final order and is not subject to review by any court or agency. ***If the claimant on whose behalf a benefit penalty is imposed:***

(a) Refused to deliver to an insurer or third-party administrator a written waiver pursuant to subsection 2 of section 20 of this act; or

(b) Delivered a written refusal to accept the benefit penalty pursuant to subsection 4 of section 20 of this act,

the imposition of a benefit penalty against the insurer or third-party administrator shall not be deemed a final order pursuant to this subsection.

4. Except as otherwise provided in NRS 616A.467, a hearing held pursuant to this section must be conducted by the administrator or a person designated by him. A record of the hearing must be kept but it need not be transcribed unless it is requested by the person against whom the order or notice of violation has been issued and that person pays the cost of transcription. The administrator shall render a written decision on the appeal.

5. An administrative fine imposed pursuant to this chapter or chapter 616A, 616B, 616C or 617 of NRS must be paid to the division. If the violation for which the fine is levied was committed by a person while acting within the course and scope of his agency or employment, the fine must be paid by his principal or employer. The fine may be recovered in a civil action brought in the name of the division in a court of competent jurisdiction in the county in which the violation occurred or in which the person against whom the fine is levied has his principal place of business.

6. ~~[A]~~ ***Except as otherwise provided in subsection 3 of NRS 616D.120, a*** benefit penalty imposed pursuant to NRS 616D.120 must be paid to the claimant on whose behalf it is imposed. If such payment is not made within the period required by NRS 616D.120 ~~[,]~~ ***and the insurer or third-party administrator cannot demonstrate that the claimant refused to deliver a written waiver or delivered a written refusal to accept the benefit penalty pursuant to subsection 2 or 4 of section 20 of this act,*** the benefit penalty may be recovered in a civil action brought by the administrator on behalf of the claimant in a court of competent jurisdiction in the county in which the claimant resides, in which the violation occurred or in which the person who is required to pay the benefit penalty has his principal place of business.

7. Any party aggrieved by a decision of the administrator rendered pursuant to this section may appeal the decision directly to the district court.

Sec. 26. NRS 617.510 is hereby amended to read as follows:

617.510 Except as otherwise provided in NRS 617.017, ***and section 20 of this act,*** no penalty or remedy provided in this chapter is exclusive of any other penalty or remedy, but is cumulative and in addition to every other penalty or remedy and may be exercised without exhausting and without regard to any other penalty or remedy provided by this chapter or any other statute.

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