ASSEMBLY BILL NO. 419–ASSEMBLYMAN CLABORN

MARCH 19, 2007

Referred to Committee on Commerce and Labor

SUMMARY—Revises various provisions governing workers' compensation. (BDR 53-154)

FISCAL NOTE: Effect on Local Government: May have Fiscal Impact.
Effect on the State: Yes.

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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; revising provisions regarding employee leasing companies; clarifying provisions relating to certain medical examinations; revising provisions relating to permanent partial disability; clarifying provisions regarding the payment of benefit penalties; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law provides for the payment of workers' compensation to an employee who is injured or killed during the course of employment or after incurring an occupational disease. (Chapters 616A-617 of NRS) Existing law requires an employee leasing company to maintain current policies of workers' compensation insurance providing coverage for each employee it leases to client companies. Existing law also requires an employee leasing company to maintain an office or similar site in this State for retaining, reviewing and auditing certain records and agreements. (NRS 616B.670-616B.697) **Section 1** of this bill requires an employee leasing company to maintain at its Nevada office records establishing that its employees are covered by current policies of workers' compensation insurance. **Section 1** also requires the company to keep such records open for public inspection during its regular business hours.

Existing law gives injured employees the right to have workers' compensation cases heard by hearing officers and appeals officers. In such cases, the hearing officers or appeals officers may refer the injured employee to a specialist for a medical examination. (NRS 616C.295-616C.385) **Sections 2 and 3** of this bill clarify that hearing officers and appeals officers may refer the injured employee to a specialist who is not on the insurer's panel of providers of health care.

Existing law requires an insurer to reopen a closed claim to consider payment for a permanent partial disability if: (1) the injured employee had an injury which qualified him for an evaluation for such a disability; (2) the insurer did not schedule the injured employee for such an evaluation; and (3) the insurer committed certain

wrongful acts regarding the claim. (NRS 616C.392) **Section 4** of this bill eliminates the requirement that the insurer must have committed certain wrongful acts to justify reopening the closed claim.

Existing law establishes a formula for determining the amount of compensation paid for a permanent partial disability. (NRS 616C.490) **Section 5** of this bill increases the amount of such compensation for injuries sustained on or after July 1, 2007.

Existing law authorizes the Administrator of the Division of Industrial Relations of the Department of Business and Industry to impose benefit penalties against insurers and other entities that violate the laws governing workers' compensation. (NRS 616D.120) **Sections 6 and 7** of this bill clarify that insurers and other entities must pay such benefit penalties within a specified period, unless a stay is granted by an appeals officer or the district court.

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

Section 1. NRS 616B.682 is hereby amended to read as follows:

616B.682 Each employee leasing company operating in this State shall ~~[maintain]~~ ***:***

1. Maintain an office or similar site in this State for retaining, reviewing and auditing its payroll records and written agreements with client companies.

2. Maintain at that office or similar site in this State records establishing that the employee leasing company maintains current policies of workers' compensation insurance providing coverage for each employee it leases to each client company.

3. Keep the records described in subsection 2 open for inspection and copying, during its regular business hours, by:

(a) Each employee it leases to each client company and any representative of each such employee; and

(b) The public.

Sec. 2. 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 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 and*** 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 ~~[.]~~ ***, 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. 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 pay to the appropriate person the charges of a provider of health care if the conditions of NRS 616C.138 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.

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.

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.

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.

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. 3. 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 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) ~~[Refer]~~ ***Order an independent medical examination and 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 ~~[.]~~ ***, 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 external review organization, submit the matter to an external review organization in accordance with NRS 616C.363 and any regulations adopted by the Commissioner.

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

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.

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. 4. NRS 616C.392 is hereby amended to read as follows:

616C.392 1. An insurer shall reopen a claim to consider the payment of compensation for a permanent partial disability if:

(a) The claim was closed and the claimant was not scheduled for an evaluation of the injury in accordance with NRS 616C.490; ***and***

(b) The claimant demonstrates by a preponderance of the evidence that, at the time that the case was closed, the claimant was, because of the injury, qualified to be scheduled for an evaluation for a permanent partial disability **.** ~~[; and~~

~~(c) The insurer has violated a provision of NRS 616D.120 with regard to the claim.]~~

2. The demonstration required pursuant to paragraph (b) of subsection 1 must be made with documentation that existed at the time that the case was closed.

3. Notwithstanding any specific statutory provision to the contrary, the consideration of whether a claimant is entitled to payment of compensation for a permanent partial disability for a claim that is reopened pursuant to this section must be made in accordance with the provisions of the applicable statutory and regulatory provisions that existed on the date on which the claim

was closed, including, without limitation, using 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 that was applicable on the date the claim was closed.

Sec. 5. 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. If an insurer contacts the 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.

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.

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.

6. 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.

7. 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 ~~[.]~~ ***, and before July 1, 2007; and***

(e) Of 0.8 percent of the claimant's average monthly wage for injuries sustained on or after July 1, 2007.

➥ 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.

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

9. 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.

10. 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.

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

12. 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. 6. 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) Induced a claimant to fail to report an accidental injury or occupational disease;

(b) Without justification, persuaded a claimant to:

(1) Settle for an amount which is less than reasonable;

(2) Settle for an amount which is less than reasonable while a hearing or an appeal is pending; or

(3) 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;

(c) Refused to pay or unreasonably delayed payment to a claimant of compensation or other relief 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 the 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 the Division has been lifted;

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

(e) Made it necessary for a claimant to initiate proceedings pursuant to chapters 616A to 616D, inclusive, or chapter 617 of NRS for compensation or other relief 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;

(f) 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;

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

(h) 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 $1,500 for each initial violation, or a fine of $15,000 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 must not be greater than $375 for an initial violation, or more than $1,500 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 the Administrator determines that a violation of any of the provisions of paragraphs (a) to (e), inclusive, or (h) 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 $37,500. 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), (d), (e) or (h) 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), (d), (e) or (h) of subsection 1. Except as otherwise provided in this section ~~[,]~~ ***and NRS 616D.140,*** 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. Proof of the payment of the benefit penalty must be submitted to the Administrator within 10 days after the date of his determination unless an appeal ~~[is]~~ ***and an application for a stay are*** 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 or premiums received that are 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 of the Office of the Attorney General 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 $15,000.

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. 7. 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 or refuse to impose a benefit penalty pursuant to NRS 616D.120, he must file a notice of appeal with an appeals officer in accordance with this section. The notice of appeal must set forth the reasons the proposed benefit penalty should or should not be imposed.

2. A person who is aggrieved by:

(a) A written determination of the Administrator; or

(b) The failure of the Administrator to respond within 90 days to a written request mailed to the Administrator by the person who is aggrieved,

➥ may appeal from the determination or failure to respond by filing a request for a hearing before an appeals officer. The request must be filed within 30 days after the date on which the notice of the Administrator's determination was mailed by the Administrator or within 100 days after the date on which the unanswered written request was mailed to the Administrator, as applicable. The failure of the Administrator to respond to a written request for a determination within 90 days after receipt of the request shall be deemed by the appeals officer to be a denial of the request.

3. ***The filing of a notice of appeal does not automatically stay a decision of the Administrator to impose a benefit penalty. The appeals officer may order a stay, when appropriate, upon the application of a party. If such an application is submitted, the decision of the Administrator 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 appeals officer after reviewing the application, the decision of the Administrator must be complied with within 10 days after the date of the refusal to grant a stay.***

4. If a notice of appeal is not filed as required by this section, the imposition of or refusal to impose the benefit penalty shall be deemed a final order and is not subject to review by any court or agency.

~~[4.]~~ ***5.*** A hearing held pursuant to this section must be conducted by the appeals officer as a hearing de novo. The appeals officer shall render a written decision on the appeal. Except as otherwise provided in this section, the provisions of NRS 616C.345 to 616C.385, inclusive, apply to an appeal filed pursuant to this section.

~~[5.]~~ ***6.*** A benefit penalty imposed pursuant to NRS 616D.120 must be paid to the claimant on whose behalf it is imposed. If such a payment is not made within the period required by ***this section or*** NRS 616D.120, 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.

~~[6.]~~ ***7.*** Any party aggrieved by a decision issued pursuant to this section by an appeals officer may appeal the decision directly to the district court. ***The filing of a notice of appeal with the district court does not automatically stay the decision of the appeals officer. The district court may order a stay, when appropriate, upon the application of a party in accordance with NRS 233B.140. If such an application is filed, the decision of the appeals officer 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 district court after reviewing the application, the decision of the appeals officer must be complied with within 10 days after the date of the refusal to grant a stay.***

Sec. 8. This act becomes effective on July 1, 2007.

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