Assembly Bill No. 281–Assemblyman Conklin

CHAPTER.....

AN ACT relating to industrial insurance; revising provisions relating to the duty of an insurer to accept or deny a claim for compensation; revising provisions relating to the selection of a physician or chiropractor by an injured employee; revising provisions relating to the denial of compensation due to discharge from employment for misconduct; revising provisions relating to the closure of a claim; creating an expedited appeals process for certain claims by police officers, firefighters and emergency medical attendants; repealing provisions requiring the reduction of compensation by the amount of federal disability insurance benefits received by an injured employee; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Under existing law, an insurer is required to accept or deny a claim for compensation within 30 days after the insurer has been notified of an industrial accident. (NRS 616C.065) **Section 2** of this bill provides that if an insurer is ordered by the Administrator of the Division of Industrial Relations of the Department of Business and Industry, a hearing or appeals officer, a district court or the Supreme Court of Nevada to make a new determination relating to a claim for compensation, such a determination must be made within 30 days after the order.

Existing law provides that an injured employee may choose an alternative treating physician or chiropractor after making his initial choice if the alternative choice is made within 90 days after the injury. (NRS 616C.090) **Section 3** of this bill clarifies existing law by providing that an injured employee may make the alternative choice without the insurer's approval if the alternative choice is made within 90 days after the injury. **Section 3** also provides that an injured employee may make a change in the treating physician or chiropractor at any time, subject to the insurer's approval. **Section 3** further requires an insurer to provide to an injured employee whose request for a change in the treating physician or chiropractor has been denied the specific reason for the denial.

Section 4 of this bill provides that the affidavit or declaration of a qualified laboratory director, chemist or any other person meeting certain qualifications may be used to prove the existence of alcohol or controlled substances in an employee's system in denying, reducing or suspending the payment of compensation for an injury. (NRS 616C.230)

Section 5 of this bill revises existing provisions governing the denial of compensation to injured employees who have been discharged for misconduct by providing that only compensation for temporary total disability may be denied. (NRS 616C.232)

Section 6 of this bill revises existing law by requiring an insurer to notify an injured employee whose claim will be closed whether an evaluation for a permanent partial disability has been scheduled or, if such an evaluation has not been scheduled, that the reason is because the insurer determined there is no possibility of a permanent impairment of any kind. (NRS 616C.235)

Sections 7 and 8 of this bill authorize certain contested claims relating to certain occupational diseases of police officers, firefighters and emergency medical attendants to be submitted directly to an appeals officer, thereby bypassing the hearing officer to whom the contested claim would need to be submitted under existing law. (NRS 616C.315) **Section 8** also requires that the appeals officer set a hearing date within 60 days after receiving a notice of any such contested claim. (NRS 616C.345) **Section 9** of this bill requires that the appeals officer render a decision for any such contested claim within 15 days after certain specified events. (NRS 616C.360)

Section 11 of this bill repeals the provisions requiring a reduction in the compensation received by an employee for temporary disability, permanent partial disability or permanent total disability by the amount of federal disability insurance benefits received by the employee. (NRS 616C.430)

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

Section 1. 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 alternative 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;

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

(VI) The hours he is absent from the place of employment to receive medical treatment pursuant to NRS 616C.477;

(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]~~ ***8*** of NRS 616C.090 that notifies injured employees of their right to select an alternative 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. 2. NRS 616C.065 is hereby amended to read as follows:

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

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

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

2. ***If an insurer is ordered by the Administrator, a hearing officer, an appeals officer, a district court or the Supreme Court of Nevada to make a new determination, including, without limitation, a new determination regarding the acceptance or denial of a claim for compensation, the insurer shall make the new determination within 30 days after the date on which the insurer has been ordered to do so.***

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

~~[3.]~~ ***4.*** Except as otherwise provided in this subsection, if an insurer unreasonably delays or refuses to pay the claim within 30 days after the insurer has been notified of an industrial accident, the insurer shall pay upon order of the Administrator an additional amount equal to three times the amount specified in the order as refused or unreasonably delayed. This payment is for the benefit of the claimant and must be paid to him with the compensation assessed pursuant to chapters 616A to 617, inclusive, of NRS. The provisions of this section do not apply to the payment of a bill for accident benefits that is governed by the provisions of NRS 616C.136.

~~[4.]~~ ***5.*** The insurer shall notify the claimant or the person acting on behalf of the claimant that a claim has been accepted or denied pursuant to subsection 1 ***or 2*** by:

(a) Mailing its written determination to the claimant or the person acting on behalf of the claimant; and

(b) If the claim has been denied, in whole or in part, obtaining a certificate of mailing.

~~[5.]~~ ***6.*** The failure of the insurer to obtain a certificate of mailing as required by paragraph (b) of subsection ~~[4]~~ ***5*** shall be deemed to be a failure of the insurer to mail the written determination of the denial of a claim as required by this section.

~~[6.]~~ ***7.*** Upon request, the insurer shall provide a copy of the certificate of mailing, if any, to the claimant or the person acting on behalf of the claimant.

~~[7.]~~ ***8.*** For the purposes of this section, the insurer shall mail the written determination to:

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

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

~~[8.]~~ ***9.*** As used in this section, "certificate of mailing" means a receipt that provides evidence of the date on which the insurer presented its written determination to the United States Postal Service for mailing.

Sec. 3. 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. 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 for treatment, the treating physician or chiropractor shall provide to the injured employee a list that includes the name of each physician or chiropractor with that specialization who is on the panel. After receiving the list, the injured employee shall, at the time the referral is made, select a physician or chiropractor from the list.

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 ***without the approval of the insurer*** 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 for treatment, the treating physician or chiropractor shall provide to the injured employee a list that includes the name of each physician or chiropractor with that specialization who 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. After receiving the list, the injured employee shall, at the time the referral is made, select a physician or chiropractor from the list. If the employee fails to select a physician or chiropractor, the insurer may select a physician or chiropractor with that specialization. If a physician or chiropractor with that specialization is not available pursuant to the terms of the contract,

the organization for managed care or the provider of health care services may select a physician or chiropractor with that specialization.

4. ***If the injured employee is not satisfied with the physician or chiropractor selected by himself or by the insurer, the organization for managed care or the provider of health care services pursuant to subsection 3, the injured employee may make an alternative choice of physician or chiropractor pursuant to the terms of the contract. A change in the treating physician or chiropractor may be made at any time but 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 insurer denies a request for a change in the treating physician or chiropractor under this subsection, the insurer must include in a written notice of denial to the injured employee the specific reason for the denial of the request.***

5. 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.]~~ ***6.*** 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.]~~ ***7.*** An injured employee may receive treatment by more than one physician or chiropractor if the insurer provides written authorization for such treatment.

~~[7.]~~ ***8.*** The Administrator shall design a form that notifies injured employees of their right pursuant to subsections 2 ***,*** ~~[and]~~ 3 ***and 4*** to select an alternative treating physician or chiropractor and make the form available to insurers for distribution pursuant to subsection 2 of NRS 616C.050.

Sec. 4. NRS 616C.230 is hereby amended to read as follows:

616C.230 1. Compensation is not payable pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS for an injury:

(a) Caused by the employee's willful intention to injure himself.

(b) Caused by the employee's willful intention to injure another.

(c) Proximately caused by the employee's intoxication. If the employee was intoxicated at the time of his injury, intoxication must be presumed to be a proximate cause unless rebutted by evidence to the contrary.

(d) Proximately caused by the employee's use of a controlled substance. If the employee had any amount of a controlled substance in his system at the time of his injury for which the employee did not have a current and lawful prescription issued in his name or that he was not using in accordance with the provisions of chapter 453A of NRS, the controlled substance must be presumed to be a proximate cause unless rebutted by evidence to the contrary.

2. For the purposes of paragraphs (c) and (d) of subsection 1:

(a) The affidavit or declaration of an expert or other person described in NRS ***50.310,*** 50.315 ***or 50.320*** is admissible to prove the existence of any alcohol or the existence, quantity or identity of a controlled substance in an employee's system. If the affidavit or declaration is to be so used, it must be submitted in the manner prescribed in NRS 616C.355.

(b) When an examination requested or ordered includes testing for the use of alcohol or a controlled substance, the laboratory that conducts the testing must be licensed pursuant to the provisions of chapter 652 of NRS.

3. No compensation is payable for the death, disability or treatment of an employee if his death is caused by, or insofar as his disability is aggravated, caused or continued by, an unreasonable refusal or neglect to submit to or to follow any competent and reasonable surgical treatment or medical aid.

4. If any employee persists in an unsanitary or injurious practice that imperils or retards his recovery, or refuses to submit to such medical or surgical treatment as is necessary to promote his recovery, his compensation may be reduced or suspended.

5. An injured employee's compensation, other than accident benefits, must be suspended if:

(a) A physician or chiropractor determines that the employee is unable to undergo treatment, testing or examination for the industrial injury solely because of a condition or injury that did not arise out of and in the course of his employment; and

(b) It is within the ability of the employee to correct the nonindustrial condition or injury.

➥ The compensation must be suspended until the injured employee is able to resume treatment, testing or examination for the industrial

injury. The insurer may elect to pay for the treatment of the nonindustrial condition or injury.

Sec. 5. NRS 616C.232 is hereby amended to read as follows:

616C.232 1. If an injured employee is discharged from his employment as a result of misconduct, an insurer may deny compensation ***for temporary total disability*** to the injured employee because of that discharge for misconduct only if the insurer proves by a preponderance of the evidence that:

(a) The injured employee was discharged from his employment solely for his misconduct and not for any reason relating to his claim for compensation; and

(b) It is the injured employee's discharge from his employment for misconduct, and not his injury, that is the sole cause for the injured employee's inability to return to work with the preinjury employer.

2. An insurer waives its rights under subsection 1 if the insurer does not make a determination to deny or suspend compensation to the injured employee within 70 days after the date on which the insurer learns that the injured employee has been discharged for misconduct.

3. An insurer may not deny any compensation pursuant to this section except for compensation for temporary total disability pursuant to subsection 1.

Sec. 6. NRS 616C.235 is hereby amended to read as follows:

616C.235 1. Except as otherwise provided in subsections 2, 3 and 4:

(a) When the insurer determines that a claim should be closed before all benefits to which the claimant may be entitled have been paid, the insurer shall send a written notice of its intention to close the claim to the claimant by first-class mail addressed to the last known address of the claimant and, if the insurer has been notified that the claimant is represented by an attorney, to the attorney for the claimant by first-class mail addressed to the last known address of the attorney. The notice must include, on a separate page, a statement describing the effects of closing a claim pursuant to this section and a statement that if the claimant does not agree with the determination, he has a right to request a resolution of the dispute pursuant to NRS 616C.305 and 616C.315 to 616C.385, inclusive, including, without limitation, a statement which prominently displays the limit on the time that the claimant has to request a resolution of the dispute as set forth in NRS 616C.315. A suitable form for requesting a resolution of the dispute must be enclosed

with the notice. The closure of a claim pursuant to this subsection is not effective unless notice is given as required by this subsection.

(b) If the insurer does not receive a request for the resolution of the dispute, it may close the claim.

(c) Notwithstanding the provisions of NRS 233B.125, if a hearing is conducted to resolve the dispute, the decision of the hearing officer may be served by first-class mail.

2. If, during the first 12 months after a claim is opened, the medical benefits required to be paid for a claim are less than $300, the insurer may close the claim at any time after he sends, by first-class mail addressed to the last known address of the claimant, written notice that includes a statement which prominently displays that:

(a) The claim is being closed pursuant to this subsection;

(b) The injured employee may appeal the closure of the claim pursuant to the provisions of NRS 616C.305 and 616C.315 to 616C.385, inclusive; and

(c) If the injured employee does not appeal the closure of the claim or appeals the closure of the claim but is not successful, the claim cannot be reopened.

3. In addition to the notice described in subsection 2, an insurer shall send to each claimant who receives less than $300 in medical benefits within 6 months after the claim is opened a written notice that explains the circumstances under which a claim may be closed pursuant to subsection 2. The written notice provided pursuant to this subsection does not create any right to appeal the contents of that notice. The written notice must be:

(a) Sent by first-class mail addressed to the last known address of the claimant; and

(b) A document that is separate from any other document or form that is used by the insurer.

4. The closure of a claim pursuant to subsection 2 is not effective unless notice is given as required by subsections 2 and 3.

5. In addition to the requirements of this section, an insurer shall include in the written notice described in subsection 2:

(a) If an evaluation for a permanent partial disability has been scheduled pursuant to NRS 616C.490, a statement to that effect; or

(b) If an evaluation for a permanent partial disability will not be scheduled pursuant to NRS 616C.490, a statement explaining that the reason is because the insurer has determined there is no possibility of a permanent impairment of any kind.

Sec. 7. NRS 616C.315 is hereby amended to read as follows:

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

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

(a) The name of:

(1) The claimant;

(2) The employer; and

(3) The insurer or third-party administrator;

(b) The number of the claim; and

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

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

(a) A written determination of an insurer; or

(b) The failure of an insurer to respond within 30 days to a written request mailed to the insurer by the person who is aggrieved,

➥ may appeal from the determination or failure to respond by filing a request for a hearing before a hearing officer. Such a request must include the information required pursuant to subsection 2 and, except as otherwise provided in subsections 4 and 5, must be filed within 70 days after the date on which the notice of the insurer's determination was mailed by the insurer or the unanswered written request was mailed to the insurer, as applicable. The failure of an insurer to respond to a written request for a determination within 30 days after receipt of such a request shall be deemed by the hearing officer to be a denial of the request.

4. The period specified in subsection 3 within which a request for a hearing must be filed may be extended for an additional 90 days if the person aggrieved shows by a preponderance of the evidence that he was diagnosed with a terminal illness or was informed of the death or diagnosis of a terminal illness of his spouse, parent or child.

5. Failure to file a request for a hearing within the period specified in subsection 3 may be excused if the person aggrieved shows by a preponderance of the evidence that he did not receive the notice of the determination and the forms necessary to request a

hearing. The claimant or employer shall notify the insurer of a change of address.

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

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

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

Sec. 8. NRS 616C.345 is hereby amended to read as follows:

616C.345 1. Any party aggrieved by a decision of the hearing officer relating to a claim for compensation may appeal from the decision by, except as otherwise provided in subsections ~~[8 and 9,]~~ ***9 and 10,*** filing a notice of appeal with an appeals officer within 30 days after the date of the decision.

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

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

(a) The name of:

(1) The claimant;

(2) The employer; and

(3) The insurer or third-party administrator;

(b) The number of the claim; and

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

~~[3.]~~ ***4.*** If a dispute is required to be submitted to a procedure for resolving complaints pursuant to NRS 616C.305 and:

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

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

➥ any party to the dispute may, except as otherwise provided in subsections ~~[8 and 9,]~~ ***9 and 10,*** file a notice of appeal within 70 days after the date on which the final determination was mailed to the employee, or his dependent, or the unanswered request for resolution was submitted. Failure to render a written determination within 30 days after receipt of such a request shall be deemed by the appeals officer to be a denial of the request.

~~[4.]~~ ***5.*** Except as otherwise provided in NRS 616C.380, the filing of a notice of appeal does not automatically stay the enforcement of the decision of a hearing officer or a determination rendered pursuant to NRS 616C.305. The appeals officer may order a stay, when appropriate, upon the application of a party. If such an application is submitted, the decision is automatically stayed until a determination is made concerning the application. A determination on the application must be made within 30 days after the filing of the application. If a stay is not granted by the officer after reviewing the application, the decision must be complied with within 10 days after the date of the refusal to grant a stay.

~~[5.]~~ ***6.*** Except as otherwise provided in subsections ~~[2 and 6,]~~ ***3 and 7,*** within 10 days after receiving a notice of appeal pursuant to this section or NRS 616C.220, 616D.140 or 617.401, or within 10 days after receiving a notice of a contested claim pursuant to subsection 7 of NRS 616C.315, the appeals officer shall:

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

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

~~[6. A]~~

7. Except as otherwise provided in subsection 12, a request to schedule the hearing for a date and time which is:

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

(b) More than 90 days after the receipt of the notice or claim,

➥ may be submitted to the appeals officer only if all parties to the appeal or contested claim agree to the request.

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

~~[8.]~~ ***9.*** The period specified in subsection 1 ***, 2*** or ~~[3]~~ ***4*** within which a notice of appeal ***or a notice of a contested claim*** must be filed may be extended for an additional 90 days if the person aggrieved shows by a preponderance of the evidence that he was diagnosed with a terminal illness or was informed of the death or diagnosis of a terminal illness of his spouse, parent or child.

~~[9.]~~ ***10.*** Failure to file a notice of appeal within the period specified in subsection 1 or ~~[3]~~ ***4*** may be excused if the party aggrieved shows by a preponderance of the evidence that he did not receive the notice of the determination and the forms necessary to appeal the determination. The claimant, employer or insurer shall notify the hearing officer of a change of address.

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

12. Within 10 days after receiving a notice of a contested claim pursuant to subsection 2, the appeals officer shall:

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

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

➥ The scheduled date must allow sufficient time for full disclosure, exchange and examination of medical and other

relevant information. A party may not introduce information at the hearing which was not previously disclosed to the other parties unless all parties agree to the introduction.

Sec. 9. 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) 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 contested case*** or the appeals officer may order a transcript of the record of the hearing at any time before the seventh day after the hearing. The transcript must be filed within 30 days after the date of the order unless the appeals officer otherwise orders.

7. ~~[The]~~ ***Except as otherwise provided in subsection 8, 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 shall render his decision on a contested claim submitted pursuant to subsection 2 of NRS 616C.345 within 15 days after:***

(a) The date of the hearing; or

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

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

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

Sec. 10. 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 ***or 4*** 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 may offer temporary, light-duty employment to the employee. If the employer makes such an offer, the employer shall confirm the offer in writing within 10 days after making the offer. The making, acceptance or rejection of an offer of temporary, light-duty employment pursuant to this subsection does not affect the eligibility of the employee to receive vocational rehabilitation services, including compensation, and does not exempt the employer from complying with NRS 616C.545 to 616C.575, inclusive, and 616C.590 or the regulations adopted by the Division governing vocational rehabilitation services. Any offer

of temporary, light-duty employment made by the employer must specify a position that:

(a) 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;

(b) Provides a gross wage that is:

(1) 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) 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; and

(c) Has the same employment benefits as the position of the employee at the time of his injury.

Sec. 11. NRS 616C.430 is hereby repealed.

Sec. 12. 1. This section and sections 1 to 6, inclusive, 10 and 11 of this act become effective on July 1, 2009.

2. Sections 7, 8 and 9 of this act become effective on October 1, 2009.