Amendment No. 312

Senate Amendment to Senate Bill No. 317	(BDR 53-625)
Proposed by: Senate Committee on Commerce and Labor	
Amends: Summary: No Title: Yes Preamble: No Joint Sponsorship: No Digest: Yes	

ASSEMBLY ACTION		Initial and Date	SENATE ACTION		Initial and Date
Adopted ☐	Lost ☐		Adopted ☐	Lost ☐	
Concurred In ☐	Not ☐		Concurred In ☐	Not ☐	
Receded ☐	Not ☐		Receded ☐	Not ☐	

EXPLANATION: Matter in (1) ***blue bold italics*** is new language in the original bill; (2) variations of **green bold underlining** is language proposed to be added in this amendment; (3) ~~red strikethrough~~ is deleted language in the original bill; (4) ~~purple double strikethrough~~ is language proposed to be deleted in this amendment; (5) orange double underlining is deleted language in the original bill proposed to be retained in this amendment.

JDK/SJQ Date: 4/20/2025

S.B. No. 317—Revises provisions relating to industrial insurance. (BDR 53-625)

SENATE BILL NO. 317–SENATOR DALY

MARCH 11, 2025

Referred to Committee on Commerce and Labor

SUMMARY—Revises provisions relating to industrial insurance. (BDR 53-625)

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 industrial insurance; **[**~~establishing provisions relating to industrial providers of health care;~~**]** revising the circumstances under which the Administrator of the Division of Industrial Relations of the Department of Business and Industry may **[**~~impose a benefit penalty;~~**]** **conduct certain inspections; revising provisions relating to the calculation of certain premium costs; revising provisions relating to certain administrators; revising provisions relating to certain subsequent injury accounts; authorizing the Administrator to adopt regulations relating to physician assistants; requiring the Administrator to select a closed formulary;** revising provisions relating to an insurer's list of certain physicians and chiropractic physicians; establishing and revising various requirements for certain hearings relating to industrial insurance claims; revising provisions governing an injury or disease that is caused by stress; revising provisions governing motions to stay certain decisions and petitions for judicial review; revising requirements for payments for a period of temporary partial disability; **revising the circumstances under which the Administrator may impose certain administrative fines;** repealing provisions governing certain appeals **[**~~and~~**]** **, certain** determinations of a percentage of disability **[**~~.~~**]** **and certain audits;** and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law provides for the payment of compensation under industrial insurance if, during the course of employment, an employee is injured or killed by a workplace accident or occupational disease. (Chapters 616A-617 of NRS) **[**~~Existing law authorizes~~**]** **Section 4.1 of this bill requires** the Administrator of the Division of Industrial Relations of the Department of Business and Industry to **[**~~order~~**]** **give notice before conducting** certain **[**~~additional payments to a claimant in the form of benefit penalties, if the Administrator determines that an~~**]** **inspections at the physical office of an** insurer **[**~~, organization for managed care, health care provider,~~**]** **or** third-party administrator **[**~~, employer or professional employer organization has committed certain violations. (NRS 616A.070, 616D.120) Sections 3 and 30 of this bill additionally authorize the imposition of benefit penalties under certain~~

~~circumstances for: (1) failure to provide or unreasonably delaying payment to an injured employee or reimbursement to an insurer; or (2) concealing, falsifying or failing to provide certain evidence or documents before certain hearings which would have been useful to an injured employee in seeking benefits or compensation.~~] **For purposes of calculating the amount of a premium which is due pursuant to the terms of a policy of industrial insurance, existing law provides that the maximum amount paid to any one employee for services provided during the 12-month period during which a policy is effective shall be deemed to be $36,000. (NRS 616B.222) Section 4.2 of this bill eliminates the $36,000 amount and instead deems the maximum amount to be a calculation of the maximum average monthly wage using data computed by the Employment Security Division of the Department of Employment, Training and Rehabilitation.**

Existing law requires a third-party administrator for an association of self-insured employers to obtain a certificate as an administrator from the Commissioner of Insurance and to file with the Commissioner a surety bond for the benefit of any person damaged by any fraudulent act or conduct of the administrator. (NRS 616B.503, 683A.08524, 683A.0857) Existing law also requires the third-party administrator to file with the Commissioner an additional surety bond conditioned upon the faithful performance of its duties relative to a particular association of self-insured employers. (NRS 616B.353) Section 4.3 of this bill eliminates the requirement for a third-party administrator to file an additional surety bond relative to its duties to a particular association. Section 4.4 of this bill makes a conforming change to remove the procedure for terminating liability on the bond eliminated by section 4.3.

Existing law establishes the Subsequent Injury Account for Associations of Self-Insured Public or Private Employers. (NRS 616B.575) Existing law requires money in the Account to be used to provide compensation or reimbursement in situations where an employee who has a preexisting permanent physical impairment incurs a subsequent disability by injury arising out of and in the course of employment which entitles the employee to compensation for the combined disability that is substantially greater than that which would have resulted from the subsequent injury alone. (NRS 616B.563-616B.581) Existing law and regulations require associations of self-insured public or private employers to pay an annual assessment which funds the Account. (NRS 616B.575; chapter 616B of NAC) Section 4.5 of this bill removes the authority to adopt regulations which impose such assessments from the Board for the Administration of the Subsequent Injury Account for Associations of Self-Insured Public or Private Employers, and section 33.5 of this bill voids the provisions of existing regulations relating to such assessments, thus eliminating the requirement for assessments to be paid for the Account. Sections 4.6 and 4.7 of this bill require an employee to have incurred a subsequent disability by injury on or before September 30, 2025, in order for the compensation or reimbursement provisions to apply, thus prohibiting any claims against the Account because of a subsequent disability by injury which is incurred on or after October 1, 2025.

Section 9.3 of this bill authorizes the Administrator to adopt regulations which authorize a treating physician or chiropractic physician, under certain circumstances, to delegate certain routine follow-up care of an injured employee to a physician assistant who is an employee of and under the supervision of the physician or chiropractic physician. Section 9.5 of this bill requires the Administrator to select a closed formulary that is required to be used by industrial insurers for any drug which is prescribed and dispensed for outpatient use. Section 9.7 of this bill: (1) prohibits an insurer from providing reimbursement for a drug that is not listed and approved on the formulary, when use of the formulary is required; and (2) authorizes an injured employee to appeal to a hearings officer any determination denying a request for a drug which has been recommended as medically necessary. Section 15.5 of this bill makes a conforming change relating to existing requirements for prescribing generic drugs and determining if the generic drug would not be beneficial to the health of the injured employee.

Existing law requires an insurer to keep a list of physicians and chiropractic physicians from which an injured employee may choose to receive treatment from a panel established and maintained by the Administrator. Existing law also sets forth procedures and limitations governing the removal of a physician or chiropractic physician from an insurer's list. (NRS 616C.087, 616C.090) **Section 14** of this bill: (1) prohibits an insurer from removing a

physician or chiropractic physician from the insurer's list except as expressly provided in existing law; ~~[and]~~ (2) requires an insurer to replace any physician or chiropractic physician who is removed from the list within 60 days ~~[.]~~ **; (3) authorizes certain audits and revisions of the insurer's list; and (4) revises certain filing requirements relating to the insurer's list.** ~~[Sections 4, 6, 7, 12 and 13 of this bill: (1) require an insurer to keep a list of certain providers of health care other than a physician or chiropractic physician, which section 1 of this bill designates as an "industrial provider of health care," from which an injured employee may choose to receive treatment from a panel established and maintained by the Administrator; and (2) establish certain requirements and restrictions concerning the selection of such an industrial provider of health care. Section 2 of this bill makes a conforming change so that the definition of "industrial provider of health care" applies to the provisions of existing law governing industrial insurance.~~

~~Section 8 of this bill authorizes a hearing officer or appeals officer of the Hearings Division of the Department of Administration to order any needed examination, assessment or treatment of an injured employee be conducted by any physician, chiropractic physician or industrial provider of health care who will accept the fee schedule adopted by the Administrator, whether located in this State or another state, if the hearing or appeals officer finds that there is a lack of physicians, chiropractic physicians or providers available. Section 9 of this bill establishes certain requirements for the filing and service of certain evidence and documents in advance of a hearing before a hearing officer or appeals officer.~~

~~Existing law requires a treating physician, chiropractic physician, physician assistant or advanced practice registered nurse to complete and file a claim for compensation within 3 working days after first providing treatment for an injured employee, or delegate the duty to do so to a physician assistant or advanced practice registered nurse at a medical facility. (NRS 616C.040, 616C.045) Sections 10 and 11 of this bill similarly authorize a treating physician, chiropractic physician, physician assistant or advanced practice registered nurse to delegate the duty to complete and file the claim for compensation to an industrial provider of health care.~~]

Existing law provides that an injury or disease sustained by an employee that is caused by stress is compensable under industrial insurance if it arose out of and in the course of his or her employment. Existing law sets forth the manner by which such an injury must be proven to have arisen out of and in the course of the employment. Under existing law, with certain exceptions, such an injury is deemed to arise out of and in the course of employment only if the employee proves certain elements by clear and convincing medical or psychiatric evidence. (NRS 616C.180) **Section 17** of this bill ~~[eliminates provisions that make such method of proof the only method, with certain exceptions, by which an employee may prove that such an injury arose in and out of the course of employment. Section 17 additionally eliminates the standard of clear and convincing evidence and]~~ instead requires proof by **clear and convincing** medical, psychological or psychiatric evidence. **Section 17 also requires an insurer to maintain and submit to the Administrator a list of certain providers of mental health care from which an injured employee may choose.**

Section 20 of this bill requires the Chief of the Hearings Division of the Department of Administration to maintain and make accessible to the public on the Internet website of the Division, a calendar of all matters which are before hearing officers and appeals officers.

Sections 23 and 25 of this bill revise provisions governing the circumstances under which: (1) an appeals officer may grant a motion to stay the enforcement of the decision of a hearing officer; and (2) an appeals officer or district court may grant a motion to stay the enforcement of the decision of an appeals officer. **Sections 24 and 32** of this bill revise certain procedures for the judicial review of the decision of an appeals officer.

If a claim for a period of temporary total disability is allowed, existing law requires an industrial insurer to make the first payment within 14 working days after receipt of the initial certification of disability, and regularly thereafter. (NRS 616C.475) **Section 27** of this bill ~~[establishes the same requirements for payment when a claim]~~ **requires,** for a period of temporary partial disability ~~[is allowed.]~~ **, the first payment or a determination regarding payment to be issued within 14 working days after the insurer receives the claim.**

Existing law authorizes hearing officers and appeals officers, under certain circumstances, to allow discovery by deposition or interrogatories according to the Nevada Rules of Civil Procedure. (NRS 616D.050, 616D.090) **Sections 28 and 29** of this bill prohibit a hearing officer from allowing such discovery, and revise provisions governing the

circumstances under which an appeals officer may allow discovery. **Section 30 of this bill revises provisions relating to administrative fines which the Administrator may impose for certain violations.**

Existing law sets forth certain procedures for appealing a final determination concerning accident benefits made by an organization for managed care. (NRS 616C.305) Existing law requires, for a determination of the percentage of disability resulting from occupational disease of the heart or lungs, that the determination be made jointly by the attending physician and examining physician of a claimant, or, under certain circumstances, a designated third physician or panel of physicians. (NRS 616C.459) **Section 34** of this bill repeals those procedures and requirements, and **sections 15, 16, 18, 19, 21-23, 26 and 31** of this bill make conforming changes to remove references to those procedures and requirements from existing law. **Existing law requires the Administrator, at least every 5 years, to audit all insurers who provide benefits to injured employees, including associations of self-insured employers. (NRS 616A.270, 616B.003) Existing law also requires the Commissioner, at least annually, to audit each association of self-insured employers to verify certain information. (NRS 616B.410) Section 34 repeals the requirement that the Commissioner examine each association annually.**

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

Section 1. ~~[Chapter 678A of NRS is hereby amended by adding thereto a new section to read as follows:~~

~~*"Industrial provider of health care" means a provider of health care of the type described in subparagraphs (1) to (12), inclusive, of paragraph (b) of subsection 2 of section 6 of this act.*~~**]** **(Deleted by amendment.)**

Sec. 2. ~~[NRS 616A.025 is hereby amended to read as follows:~~

~~616A.025 As used in chapters 616A to 616D, inclusive, of NRS, unless the context otherwise requires, the words and terms defined in NRS 616A.030 to 616A.360, inclusive, *and section 1 of this act,* have the meanings ascribed to them in those sections.~~**]** **(Deleted by amendment.)**

Sec. 3. ~~[NRS 616A.070 is hereby amended to read as follows:~~

~~616A.070 "Benefit penalty" means an additional amount of money that is payable to a claimant if the Administrator has determined that a violation of any of the provisions of paragraphs (a) to (e), inclusive,~~ **[**~~(h)~~**]** ~~or~~ **[**~~(i)~~**]** ~~*(g) to (j), inclusive,* of subsection 1 of NRS 616D.120 has occurred.~~**]** **(Deleted by amendment.)**

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:~~

~~(a) Except as otherwise provided in NRS 616B.5273, 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.~~

~~(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.~~

~~(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 paragraphs (a)~~

~~and (b), or as the self-insured employer, association or private carrier otherwise prescribes.~~

~~(d) Except as otherwise provided in subsection 4 of NRS 616C.090 [,] *or subsection 4 of section 7 of this act,* 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.~~

~~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.]~~ **(Deleted by amendment.)**

Sec. 4.1. **NRS 616B.021 is hereby amended to read as follows:**

616B.021 1. An insurer shall make the files of claims available for inspection and reproduction:

(a) At an office operated by the insurer or its third-party administrator located in this State ~~[.]~~ ***, upon notice from the Administrator not less than 3 business days before the date of the inspection;*** or

(b) By electronic means.

2. The physical records in a file concerning a claim filed in this State may be kept at a location outside this State if all records in the file are made available for inspection and reproduction at an office operated by the insurer or its third-party administrator that is located in this State or by computer in a microphotographic, electronic or other similar format that produces an accurate reproduction of the original. If a claim filed in this State is open, the records in the file must be reproduced and available for inspection during regular business hours within 24 hours after requested by the employee or the employee's designated agent, the employer or the employer's designated agent, or the Administrator or the Administrator's designated agent. If a claim filed in this State is closed, the records in the file must be reproduced and available for inspection during regular business hours within 14 days after requested by such persons.

3. Upon request, the insurer shall make copies or other reproductions of anything in the file and may charge a reasonable fee for this service. Copies or other reproductions of materials in the file which are requested by the Administrator or the Administrator's designated agent, or the Nevada Attorney for Injured Workers or his or her designated agent must be provided free of charge.

4. The Administrator may adopt regulations concerning the:

(a) Maintenance of records in a file on claims that are open or closed; and

(b) Preservation, examination and use of records which have been stored on computer or in a microphotographic, electronic or similar format by an insurer.

5. 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. 4.2. **NRS 616B.222 is hereby amended to read as follows:**

616B.222 ***1.*** To determine the total amount paid to employees for services performed, the maximum amount paid to any one employee during a policy year shall be deemed to be ~~[$36,000.]~~ ***an amount equal to 12 times the maximum average monthly wage. On or before January 1 of each year, the Administrator shall establish the amount of the maximum average monthly wage to take effect on January 1 of that year.***

2. As used in this section, "maximum average monthly wage" means 150 percent of the state average weekly wage as most recently computed by the Employment Security Division of the Department of Employment, Training and Rehabilitation, multiplied by 4.33.

Sec. 4.3. **NRS 616B.353 is hereby amended to read as follows:**

616B.353 1. An association of self-insured public or private employers shall:

(a) Execute an indemnity agreement jointly and severally binding the association and each member of the association to secure the payment of all compensation due pursuant to chapters 616A to 617, inclusive, of NRS. The indemnity agreement must be in a form prescribed by the Commissioner. An association may add provisions to the indemnity agreement if they are first approved by the Commissioner.

(b) Except as otherwise provided in this subsection, maintain a policy of specific and aggregate excess insurance in a form and amount required by the Commissioner. The excess insurance must be written by an insurer approved by the Commissioner. To determine the amount of excess insurance required, the Commissioner shall consider:

(1) The number of members in the association;

(2) If the association is an association of self-insured public employers, the types of governmental services provided by the members of the association;

(3) If the association is an association of self-insured private employers, the classifications of employment of the members of the association;

(4) The number of years the association has been in existence; and

(5) Such other information as the Commissioner deems necessary.

➥ Nothing in this paragraph prohibits an association from purchasing secondary excess insurance in addition to the excess insurance required by this paragraph.

(c) Collect an annual assessment from each member of the association in an aggregate amount of at least $250,000 or in an aggregate amount which the Commissioner determines is satisfactory based on an annual review conducted by the Commissioner of the actuarial solvency of the association.

(d) Except as otherwise provided in paragraph (e), deposit as security with the Commissioner a bond executed by the association as principal, and by a licensed surety, payable to the State of Nevada, and conditioned upon the payment of compensation for injuries and occupational diseases to their employees. The bond must be in an amount determined by the Commissioner to be reasonably sufficient to ensure payment of such compensation, but in no event may it be less than $100,000.

(e) In lieu of a bond, deposit with the Commissioner a like amount of lawful money of the United States or any other form of security authorized by NRS 100.065. If security is provided in the form of a savings certificate, certificate of deposit or investment certificate, the certificate must state that the amount is unavailable for withdrawal except upon order of the Commissioner.

2. Except as otherwise provided in subsection 3, in addition to complying with the requirements of subsection 1, an association of self-insured private employers shall:

(a) At the time of initial qualification and until the association has operated successfully as a qualified association of self-insured private employers for 3 years, as determined by the Commissioner, have a combined tangible net worth of all members in the association of at least $2,500,000, as evidenced by a statement of tangible net worth provided to the Division of Insurance of the Department of Business and Industry by an independent certified public accountant; or

(b) After 3 years of successful operation as a qualified association of self-insured private employers, as determined by the Commissioner, have combined net cash flows from operating activities plus net cash flows from financing activities of all members in the association of five times the average of claims paid for each of the last 3 years or $7,500,000, whichever is less.

3. In lieu of complying with the requirements of subsection 2, the association's administrator shall ensure that a solvency bond, in a form prescribed by the Commissioner and in an aggregate amount of at least $2,500,000, is deposited with the Commissioner by the association or members of the association on behalf of the association.

4. The association's administrator shall deposit with the Commissioner a bond executed by the association's administrator as principal, and by a licensed surety, payable to the State of Nevada, and conditioned upon the faithful performance of his or her duties. The bond must be in an amount determined by the Commissioner.

5. ~~[Any third-party administrator providing claims services for the association shall deposit with the Commissioner a bond executed by the third-party administrator as principal, and by a licensed surety, payable to the State of Nevada, and conditioned upon the faithful performance of its duties. The bond must be in an amount determined by the Commissioner.~~

~~6.]~~ The Commissioner may increase or decrease the amount of any bond or money required to be deposited by this section in accordance with chapter 681B of NRS and the Commissioner's regulations for loss reserves in casualty insurance. If the Commissioner requires an association ~~[,]~~ *or* association's administrator ~~[or third-party administrator]~~ to increase its deposit, the Commissioner may specify the form of the additional security. The association ~~[,]~~ *or* association's administrator ~~[or third-party administrator]~~ shall comply with such a requirement within 60 days after receiving notice from the Commissioner.

~~[7.]~~ *6.* The Account for Associations of Self-Insured Public and Private Employers is hereby created in the State Agency Fund for Bonds. All money received by the Commissioner pursuant to this section must be deposited with the State Treasurer to the credit of the Account. All claims against this Account must be paid as other claims against the State are paid.

Sec. 4.4. **NRS 616B.440 is hereby amended to read as follows:**

616B.440 1. For the purposes of NRS 616B.350 to 616B.446, inclusive, an association of self-insured public or private employers is insolvent if it is unable to pay its outstanding obligations as they mature in the regular course of its business.

2. If an association of self-insured public or private employers becomes insolvent, institutes any voluntary proceeding pursuant to the Bankruptcy Act or is named in any voluntary proceeding thereunder, makes a general or special assignment for the benefit of creditors or fails to pay compensation pursuant to chapters 616A to 616D, inclusive, or chapter 617 of NRS after an order for the payment of any claim becomes final, the Commissioner may, after giving at least 10 days' notice to the association and any insurer or guarantor, use money or interest on securities, sell securities or institute legal proceedings on surety bonds deposited with the Commissioner pursuant to NRS 679B.175 to the extent necessary to make those payments.

3. A licensed surety providing a surety bond pursuant to NRS 616B.353 may terminate liability on its surety bond by giving the Commissioner and the association ~~[,]~~ *or* association's administrator ~~[or third-party administrator]~~ 90 days' written notice. The termination does not limit liability that was incurred under the surety bond before the termination.

Sec. 4.5. **NRS 616B.575 is hereby amended to read as follows:**

616B.575 1. There is hereby created in the Fund for Workers' Compensation and Safety in the State Treasury the Subsequent Injury Account for Associations of Self-Insured Public or Private Employers, which may be used only to make payments in accordance with the provisions of NRS 616B.578 and

616B.581. The Board shall administer the Account based upon recommendations made by the Administrator pursuant to subsection ~~[8.]~~ ***7.***

2. All ~~[assessments,]~~ penalties, bonds, securities and all other properties received, collected or acquired by the Board for the Subsequent Injury Account for Associations of Self-Insured Public or Private Employers must be delivered to the custody of the State Treasurer.

3. All money and securities in the Account must be held by the State Treasurer as custodian thereof to be used solely for workers' compensation for employees of members of Associations of Self-Insured Public or Private Employers.

4. The State Treasurer ~~[may]~~ ***shall*** disburse money from the Account ~~[only upon]~~ ***within 14 days after receiving a*** written order of the Board.

5. The State Treasurer shall invest money of the Account in the same manner and in the same securities in which the State Treasurer is authorized to invest State General Funds which are in the custody of the State Treasurer. Income realized from the investment of the assets of the Account must be credited to the Account.

6. The Board shall adopt regulations for the establishment and administration of ~~[assessment rates,]~~ payments and penalties. ~~[Assessment rates must result in an equitable distribution of costs among the associations of self-insured public or private employers and must be based upon expected annual expenditures for claims for payments from the Subsequent Injury Account for Associations of Self-Insured Public or Private Employers.]~~

7. ~~[The Commissioner shall assign an actuary to review the establishment of assessment rates. The rates must be filed with the Commissioner 30 days before their effective date. Any association of self-insured public or private employers that wishes to appeal the rate so filed must do so pursuant to NRS 679B.310.~~

~~8.]~~ The Administrator shall:

(a) Evaluate any claim submitted to the Board for payment or reimbursement from the Subsequent Injury Account for Associations of Self-Insured Public or Private Employers and ***, not later than 30 days after receiving the claim,*** recommend to the Board any appropriate action to be taken concerning the claim; and

(b) Submit to the Board any other recommendations relating to the Account.

Sec. 4.6. **NRS 616B.578 is hereby amended to read as follows:**

616B.578 Except as otherwise provided in NRS 616B.581:

1. If an employee of a member of an association of self-insured public or private employers has a permanent physical impairment from any cause or origin and incurs ***, on or before September 30, 2025,*** a subsequent disability by injury arising out of and in the course of his or her employment which entitles the employee to compensation for disability that is substantially greater by reason of the combined effects of the preexisting impairment and the subsequent injury than that which would have resulted from the subsequent injury alone, the compensation due must be charged to the Subsequent Injury Account for Associations of Self-Insured Public or Private Employers in accordance with regulations adopted by the Board.

2. If the subsequent injury of such an employee ***incurred on or before September 30, 2025,*** results in his or her death and it is determined that the death would not have occurred except for the preexisting permanent physical impairment, the compensation due must be charged to the Subsequent Injury Account for Associations of Self-Insured Public or Private Employers in accordance with regulations adopted by the Board.

3. As used in this section, "permanent physical impairment" means any permanent condition, whether congenital or caused by injury or disease, of such

seriousness as to constitute a hindrance or obstacle to obtaining employment or to obtaining reemployment if the employee is unemployed. For the purposes of this section, a condition is not a "permanent physical impairment" unless it would support a rating of permanent impairment of 6 percent or more of the whole person if evaluated according to the American Medical Association's Guides to the Evaluation of Permanent Impairment as adopted and supplemented by the Division pursuant to NRS 616C.110.

4. To qualify under this section for reimbursement from the Subsequent Injury Account for Associations of Self-Insured Public or Private Employers, the association of self-insured public or private employers must establish by written records that the employer had knowledge of the "permanent physical impairment" at the time the employee was hired or that the employee was retained in employment after the employer acquired such knowledge.

5. An association of self-insured public or private employers must submit to the Board a claim for reimbursement from the Subsequent Injury Account for Associations of Self-Insured Public or Private Employers.

6. The Board shall adopt regulations establishing procedures for submitting claims against the Subsequent Injury Account for Associations of Self-Insured Public or Private Employers. The Board shall notify the Association of Self-Insured Public or Private Employers of its decision on such a claim within 120 days after the claim is received.

7. An appeal of any decision made concerning a claim against the Subsequent Injury Account for Associations of Self-Insured Public or Private Employers must be submitted directly to the district court.

Sec. 4.7. **NRS 616B.581 is hereby amended to read as follows:**

616B.581 1. An association of self-insured public or private employers that pays compensation due to an employee who has a permanent physical impairment from any cause or origin and incurs ***, on or before September 30, 2025,*** a subsequent disability by injury arising out of and in the course of his or her employment which entitles the employee to compensation for disability that is substantially greater by reason of the combined effects of the preexisting impairment and the subsequent injury than that which would have resulted from the subsequent injury alone is entitled to be reimbursed from the Subsequent Injury Account for Associations of Self-Insured Public or Private Employers if:

(a) The employee knowingly made a false representation as to his or her physical condition at the time the employee was hired by the member of the Association of Self-Insured Public or Private Employers;

(b) The employer relied upon the false representation and this reliance formed a substantial basis of the employment; and

(c) A causal connection existed between the false representation and the subsequent disability.

➥ If the subsequent injury of the employee ***incurred on or before September 30, 2025,*** results in his or her death and it is determined that the death would not have occurred except for the preexisting permanent physical impairment, any compensation paid is entitled to be reimbursed from the Subsequent Injury Account for Associations of Self-Insured Public or Private Employers.

2. An association of self-insured public or private employers shall notify the Board of any possible claim against the Subsequent Injury Account for Associations of Self-Insured Public or Private Employers pursuant to this section no later than 60 days after the date of the subsequent injury or the date the employer learns of the employee's false representation, whichever is later.

Sec. 5. Chapter 616C of NRS is hereby amended by adding thereto the provisions set forth as sections 6 to ~~[9,]~~ 9.7, inclusive, of this act.

Sec. 6. ~~*[1. The Legislature hereby declares that:*~~

~~*(a) The choice of industrial providers of health care is a substantive right and substantive benefit of an injured employee who has a claim under the Nevada Industrial Insurance Act or the Nevada Occupational Diseases Act.*~~

~~*(b) The injured employees of this State have a substantive right to an adequate choice of industrial providers of health care to treat their industrial injuries and occupational diseases.*~~

~~*2. Except as otherwise provided in this subsection and subsection 3:*~~

~~*(a) The panel maintained by the Administrator pursuant to section 7 of this act must not include an industrial provider of health care if the industrial provider of health care does not accept and treat injured employees for industrial injuries or occupational diseases; and*~~

~~*(b) An insurer's list of other industrial providers of health care from which an injured employee may choose pursuant to section 7 of this act must include not less than 12 providers of each of the following types from the panel of industrial providers of health care maintained by the Administrator pursuant to section 7 of this act:*~~

~~*(1) Persons licensed to practice dentistry, other than persons described in subparagraphs (2) and (3);*~~

~~*(2) Persons licensed to practice dentistry who specialize in orthodontia;*~~

~~*(3) Persons licensed to practice dentistry who specialize in oral and maxillofacial surgery;*~~

~~*(4) Registered nurses who hold a master's degree in the field of psychiatric nursing and are licensed to practice professional nursing;*~~

~~*(5) Optometrists;*~~

~~*(6) Speech-language pathologists;*~~

~~*(7) Audiologists;*~~

~~*(8) Licensed physical therapists;*~~

~~*(9) Podiatric physicians;*~~

~~*(10) Licensed psychologists;*~~

~~*(11) Licensed clinical professional counselors;*~~

~~*(12) Licensed clinical social workers; and*~~

~~*(13) Licensed clinical alcohol and drug counselors.*~~

~~*". If the panel of industrial providers of health care maintained by the Administrator pursuant to section 7 of this act contains fewer than 12 industrial providers of health care of a type identified in this subsection, all of the industrial providers of health care on the panel of that type must be included on the insurer's list.*~~

~~*3. For each county whose population is 100,000 or more, an insurer's list of industrial providers of health care must include for that county a number of industrial providers of health care that is not less than the number required by subsection 2 and that also maintain in that county:*~~

~~*(a) An active practice; and*~~

~~*(b) A physical office.*~~

~~*4. If an insurer fails to maintain a list of industrial providers of health care that complies with the requirements of subsections 2 and 3, an injured employee may choose another industrial provider of health care from the panel of industrial providers of health care maintained by the Administrator pursuant to section 7 of this act. If an industrial provider of health care is removed from an insurer's list pursuant to subsection 8 or 9, within 60 days after the date of removal, the insurer shall replace the industrial provider of health care on the list*~~

~~to maintain compliance with the requirements of subsections 2 and 3. If the insurer fails to do so, an injured employee may choose an industrial provider of health care from the panel of industrial providers of health care maintained by the Administrator pursuant to section 7 of this act.~~

~~5. Each insurer shall, not later than October 1 of each year, update the list of industrial providers of health care and file the list with the Administrator. The list must be certified by an adjuster who is licensed pursuant to chapter 684A of NRS. An insurer shall not at any time remove an industrial provider of health care from the insurer's list except as expressly authorized by subsection 8 or 9.~~

~~6. Upon receipt of a list of industrial providers of health care that is filed pursuant to subsection 5, the Administrator shall:~~

~~(a) Stamp the list as having been filed; and~~

~~(b) Indicate on the list the date on which it was filed.~~

~~7. The Administrator shall:~~

~~(a) Provide a copy of an insurer's list of industrial providers of health care to any member of the public who requests a copy; or~~

~~(b) Post a copy of each insurer's list of industrial providers of health care on an Internet website maintained by the Administrator and accessible to the public for viewing, printing or downloading.~~

~~8. At any time, an industrial provider of health care may request in writing that he or she be removed from an insurer's list of industrial providers of health care. The insurer must comply with the request and omit the industrial provider of health care from the next list which the insurer files with the Administrator.~~

~~9. An industrial provider of health care may not be involuntarily removed from an insurer's list of industrial providers of health care except for good cause. As used in this subsection, "good cause" means that one or more of the following circumstances apply:~~

~~(a) The industrial provider of health care has died or is disabled.~~

~~(b) The license of the industrial provider of health care has been revoked or suspended.~~

~~(c) The industrial provider of health care has been convicted of:~~

~~(1) A felony; or~~

~~(2) A crime for a violation of a provision of chapter 616D of NRS.~~

~~(d) The industrial provider of health care has been removed from the panel of industrial providers of health care maintained by the Administrator pursuant to section 7 of this act by the Administrator upon a finding that the industrial provider of health care:~~

~~(1) Has failed to comply with the standards for treatment of industrial injuries or occupational diseases as established by the Administrator; or~~

~~(2) Does not accept and treat injured employees under chapters 616A to 616D, inclusive, or chapter 617 of NRS.~~

~~10. Unless an industrial provider of health care is removed from an insurer's list of industrial providers of health care pursuant to subsection 9, an injured employee may continue to receive treatment from that industrial provider of health care even if:~~

~~(a) The employer of the injured employee changes insurers or administrators.~~

~~(b) The industrial provider of health care is no longer included in the applicable insurer's list of industrial providers of health care, so long as the industrial provider of health care agrees to continue to accept compensation for that treatment at the rates which:~~

~~(1) Were previously agreed upon when the industrial provider of health care was most recently included in the list; or~~

~~(2) Are newly negotiated but do not exceed the amounts provided under the fee schedule adopted by the Administrator.~~

~~11. The Administrator shall adopt regulations prescribing the form in which a list of industrial providers of health care created by an employer, insurer or third-party administrator pursuant to this section must be maintained. The Administrator shall require that any such list be in a format which is easily searchable, including, without limitation, an indexed database, a portable document format, a spreadsheet with data that may be filtered, a comma-separated values file or any other comparable format.]~~ **(Deleted by amendment.)**

Sec. 7. ~~[1. The Administrator shall establish, maintain and update not less frequently than annually on or before July 1 of each year, a panel of industrial providers of health care 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. The Administrator shall maintain the following information relating to each industrial provider of health care on the panel:~~

~~(a) The name of the industrial provider of health care.~~

~~(b) The title or degree of the industrial provider of health care.~~

~~(c) The legal name of the practice of the industrial provider of health care and the name under which the practice does business.~~

~~(d) The street address of the location of every office of the industrial provider of health care.~~

~~(e) The telephone number of every office of the industrial provider of health care.~~

~~(f) Every discipline and specialization practiced by the industrial provider of health care.~~

~~(g) Every condition and part of the body which the industrial provider of health care will treat.~~

~~2. Every employer whose insurer has not entered into a contract with an organization for managed care or with providers of health care pursuant to NRS 616B.527 shall maintain a list of those industrial providers of health care on the panel who are reasonably accessible to his or her employees.~~

~~3. 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 pursuant to NRS 616B.527 may choose an industrial provider of health care from the panel of industrial providers of health care. If the injured employee is not satisfied with the first industrial provider of health care he or she so chooses, the injured employee may make an alternative choice of industrial provider of health care from the panel if the choice is made within 90 days after his or her injury. The insurer shall notify the first industrial provider of health care in writing. The notice must be postmarked within 3 working days after the insurer receives knowledge of the change. The first industrial provider of health care must be reimbursed only for the services the industrial provider of health care 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 or by order of a hearing officer or appeals officer. A request for a change of industrial provider of health care must be granted or denied within 10 days after a written request for such a change is received from the injured employee. If the insurer takes no action on the request within 10 days, the request shall be deemed granted. Any request for a change of an industrial provider of health care must include the name of the new industrial provider of health care chosen by the injured employee. If the industrial provider of health care refers the injured employee to a specialist for treatment, the insurer shall~~

~~provide to the injured employee a list that includes the name of each industrial provider of health care with that specialization who is on the panel. Not later than 14 days after receiving the list, the injured employee shall select an industrial provider of health care from the list.~~

~~4. An injured employee whose employer's insurer has entered into a contract with an organization for managed care or with providers of health care pursuant to NRS 616B.527 must choose an industrial provider of health care pursuant to the terms of that contract. If the injured employee is not satisfied with the first industrial provider of health care he or she so chooses, the injured employee may make an alternative choice of industrial provider of health care pursuant to the terms of the contract without the approval of the insurer if the choice is made within 90 days after his or her injury. Except as otherwise provided in this subsection, any further change is subject to the approval of the insurer or by order of a hearing officer or appeals officer. A request for a change of an industrial provider of health care must be granted or denied within 10 days after a written request for such a change is received from the injured employee. If the insurer takes no action on the request within 10 days, the request shall be deemed granted. If the injured employee, after choosing an industrial provider of health care, moves to a county which is not served by the organization for managed care or providers of health care named in the contract and the insurer determines that it is impractical for the injured employee to continue treatment with the industrial provider of health care, the injured employee must choose an industrial provider of health care who has agreed to the terms of that contract unless the insurer authorizes the injured employee to choose another industrial provider of health care. If the industrial provider of health care refers the injured employee to a specialist for treatment, the insurer shall provide to the injured employee a list that includes the name of each industrial provider of health care 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 pursuant to NRS 616B.527, as appropriate. Not later than 14 days after receiving the list, the injured employee shall select an industrial provider of health care. If the employee fails to select an industrial provider of health care, the insurer may select an industrial provider of health care with that specialization. If an industrial provider of health care with that specialization is not available pursuant to the terms of the contract, the organization for managed care or the provider of health care may select an industrial provider of health care with that specialization.~~

~~5. If the injured employee is not satisfied with the industrial provider of health care selected by himself or herself or by the insurer, the organization for managed care or the provider of health care pursuant to subsection 4, the injured employee may make an alternative choice of an industrial provider of health care pursuant to the terms of the contract. A change in the industrial provider of health care may be made at any time but is subject to the approval of the insurer or by order of a hearing officer or appeals officer. A request for a change of industrial provider of health care 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 an industrial provider of health care must include the name of the new industrial provider of health care chosen by the injured employee. If the insurer denies a request for a change in the industrial provider of health care 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.~~

~~6. 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 industrial provider of health care 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 industrial provider of health care or other person.~~

~~7. The Administrator may order necessary changes in a panel of industrial providers of health care and shall:~~

~~(a) Suspend or remove any industrial provider of health care from a panel for good cause shown in accordance with section 6 of this act; and~~

~~(b) Remove from being included on a panel any industrial provider of health care who does not accept and treat injured employees for industrial injuries or occupational diseases.~~

~~8. Any interested person may notify the Administrator, on a form prescribed by the Administrator, if the person believes that an industrial provider of health care does not accept and treat injured employees under chapters 616A to 616D, inclusive, or chapter 617 of NRS for industrial injuries or occupational diseases.~~

~~9. If the Administrator receives notice pursuant to subsection 8, the Administrator shall:~~

~~(a) Conduct an investigation to determine whether the industrial provider of health care may remain on the panel; and~~

~~(b) Publish or cause to be published on the Internet website of the Division not later than 90 days after receiving the notice the results of the investigation.~~

~~10. An industrial provider of health care who is removed from a panel pursuant to paragraph (b) of subsection 7 may request, on a form prescribed by the Administrator, to be reinstated on a panel if the industrial provider of health care demonstrates to the satisfaction of the Administrator that he or she accepts and treats injured employees.~~

~~11. An injured employee may receive treatment by more than one industrial provider of health care:~~

~~(a) If the insurer provides written authorization for such treatment; or~~

~~(b) By order of a hearing officer or appeals officer.~~

~~12. The Administrator shall design a form that notifies injured employees of their right pursuant to subsections 3, 4 and 5 to select an alternative industrial provider of health care and make the form available to insurers for distribution pursuant to subsection 2 of NRS 616C.050.]~~ **(Deleted by amendment.)**

Sec. 8. ~~[1. Upon a finding of good cause in accordance with subsection 2, a hearing officer or an appeals officer may order any needed examination, assessment or treatment by a physician, chiropractic physician or industrial provider of health care be conducted by any physician, chiropractic physician or industrial provider of health care who will accept the fee schedule adopted by the Administrator, whether the physician, chiropractic physician or industrial provider of health care is located in this State or another state.~~

~~2. For the purpose of subsection 1, good cause exists if a hearing officer or appeals officer finds, for the examination, assessment or treatment which is needed, that there is a lack of physicians, chiropractic physicians or industrial providers of health care available to provide the examination, assessment or treatment.]~~ **(Deleted by amendment.)**

Sec. 9. ~~[1. Not later than 5 business days before the date of a hearing before a hearing officer, the Administrator, employer, insurer or third party administrator, as applicable, shall:~~

~~(a) File with the Hearings Division of the Department of Administration the following documents, appropriately numbered and indexed:~~

~~(1) A brief statement of the reason for the determination of the insurer; and~~

~~(2) Copies of all documents in the file of the claimant which relate to the matter before the hearing officer; and~~

~~(b) Serve upon all other parties to the hearing the documents described in paragraph (a), by any means which ensure the documents are received contemporaneously with the filing submitted pursuant to paragraph (a).~~

~~2. The claimant may provide copies of any documents he or she will rely upon in a hearing to the hearing officer and any other parties at the time of the hearing.~~

~~3. Not later than 30 days after the date on which a notice of appeal is filed with an appeals officer, the Administrator, employer, insurer or third-party administrator, as applicable, shall:~~

~~(a) File with the appeals officer, appropriately indexed and in chronological order, a copy of all documents in the file of the claimant; and~~

~~(b) Serve upon all other parties to the appeal the documents described in paragraph (a), by any means which ensure the documents are received contemporaneously with the filing submitted pursuant to paragraph (a).~~

~~4. Before a hearing before an appeals officer, not later than 14 days before the date of the hearing for an appellant and not later than 7 days before the date of the hearing for a respondent, each party to the appeal shall:~~

~~(a) File with the appeals officer, the following documents with all pages separately numbered and including a comprehensive index:~~

~~(1) All documents the party intends to introduce as evidence at the hearing;~~

~~(2) A statement of the issues the party will raise or expects will be raised at the hearing;~~

~~(3) A list of witnesses the party expects to call, including a brief summary of the proposed testimony of each witness and a statement indicating whether any witness is expected to testify via telephone or through the use of audiovisual technology; and~~

~~(4) An estimate of the length of time required to present the case, including any rebuttal testimony and argument; and~~

~~(b) Serve upon all other parties the documents described in paragraph (a), by any means which ensure the documents are received contemporaneously with the filing submitted pursuant to paragraph (a).~~

~~5. Except as otherwise provided in this subsection, upon the objection of a party, an appeals officer shall exclude from the record and shall not rely upon any evidence or portion thereof which is not timely filed and served in accordance with the requirements of this section. An appeals officer may, for good cause shown and to avoid injustice to an injured employee, rely upon and allow untimely evidence to be entered into the record.~~] (Deleted by amendment.)

Sec. 9.3. *The Administrator may adopt regulations which authorize a treating physician or chiropractic physician to delegate certain routine follow-up care of an injured employee, as determined by the Administrator, to a physician assistant who is an employee of and under the supervision of the physician or chiropractic physician. The regulations must:*

1. Require informed consent from the injured employee before the delegation and provision of any such follow-up care; and

2. Be consistent with accepted standards of practice for a physician assistant in accordance with chapters 630 and 633 of NRS and the regulations adopted pursuant thereto.

Sec. 9.5. *1. The Administrator shall select a closed formulary which is nationally-recognized and evidence-based to be used by insurers in connection with claims made pursuant to chapters 616A to 616D, inclusive of NRS.*

2. An insurer shall use the formulary selected pursuant to subsection 1 for any drug that is prescribed or dispensed to an injured employee for outpatient services in connection with a claim made pursuant to chapters 616A to 617, inclusive, of NRS. An insurer is not required to use the formulary for prescription drugs that are prescribed or dispensed for emergency medical services or inpatient services.

3. In selecting the formulary pursuant to subsection 1, the Administrator shall consider:

(a) Whether the formulary focuses on medical treatment which is specific to industrial insurance;

(b) Whether the basis for the formulary is readily apparent and publicly available;

(c) Whether the formulary includes measures to assist in the management of opioid medications;

(d) The cost of implementation of the formulary and any associated costs after implementation of the formulary;

(e) Evidence-based guidelines for the treatment of injuries or diseases which are compensable pursuant to the provisions of chapters 616A to 617, inclusive, of NRS.

4. As soon as practicable after the Administrator selects a formulary pursuant to subsection 1, the Administrator must make available and update as necessary, on an Internet website maintained by the Administrator and accessible to the public, current information relating to the formulary selected pursuant to subsection 1.

Sec. 9.7. *1. If an insurer, pursuant to subsection 2 of section 9.5 of this act, is required to use the formulary selected pursuant that section, the insurer shall not provide reimbursement for any drug if the drug is listed but not approved, or omitted from, the formulary.*

2. If a physician or chiropractic physician believes the drug is medically necessary for an injured employee, the physician or chiropractic physician may submit a request to the insurer for authorization to prescribe to the injured employee a drug which is listed but not approved, or omitted from, the formulary selected pursuant to section 9.5 of this act.

3. If the insurer denies the request of a physician or chiropractic physician pursuant to subsection 2, the injured employee or his or her representative may appeal the determination of the insurer to a hearings officer in the manner provided by NRS 616C.315.

Sec. 10. ~~[NRS 616C.040 is hereby amended to read as follows:~~

~~616C.040 1. Except as otherwise provided in this section, a treating physician, chiropractic physician, physician assistant or advanced practice registered nurse shall, within 3 working days after first providing treatment to an injured employee for a particular injury, complete and file a claim for compensation with the employer of the injured employee and the employer's insurer. If the employer is a self-insured employer, the treating physician, chiropractic physician, physician assistant or advanced practice registered nurse shall file the claim for compensation with the employer's third-party administrator. If the physician, chiropractic physician, physician assistant or advanced practice registered nurse~~

~~files the claim for compensation by electronic transmission, the physician, chiropractic physician, physician assistant or advanced practice registered nurse shall, upon request, mail to the insurer or third-party administrator the form prescribed by the Administrator for a claim for compensation that is signed by the injured employee and the physician, chiropractic physician, physician assistant or advanced practice registered nurse. The form must be mailed within 7 days after receiving such a request.~~

~~2. A physician, chiropractic physician, physician assistant or advanced practice registered nurse who has a duty to file a claim for compensation pursuant to subsection 1 may delegate the duty to a physician assistant or an advanced practice registered nurse at a medical facility~~ ~~**[.]** ***or an industrial provider of health care.***~~ ~~If the physician, chiropractic physician, physician assistant or advanced practice registered nurse delegates the duty to a physician assistant or an advanced practice registered nurse at a medical facility~~ ~~**[.]** ***or an industrial provider of health care:***~~

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

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

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

~~(2) An authorized representative of the medical facility~~ ~~**[.]** ***or the industrial provider of health care.***~~

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

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

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

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

~~(2) The physician assistant~~ ~~**,** **[**or**]** advanced practice registered nurse ***or the industrial provider of health care*** to whom the duty to file a claim for compensation is delegated pursuant to subsection 2.~~

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

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

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

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

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

~~(b) A physician assistant or advanced practice registered nurse at a medical facility~~ ~~***or an industrial provider of health care***~~ ~~if the duty to file the claim for compensation has been delegated to him or her pursuant to this section.~~~~**]**~~ **(Deleted by amendment.)**

Sec. 11. ~~[NRS 616C.045 is hereby amended to read as follows:~~

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

~~2. The report must:~~

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

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

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

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

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

~~4. The Administrator shall impose an administrative fine of not more than $1,000 on an employer for each violation of this section.~~**]** **(Deleted by amendment.)**

Sec. 12. ~~[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 the claimant's 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 chiropractic physician and an alternative treating physician or chiropractic physician ***, or an industrial provider of health care and an alternative industrial provider of health care, as applicable,*** in accordance with the provisions of NRS 616C.090~~ **[**~~;~~**]** ~~***or section 7 of this act;***~~

~~(3) Request the appointment of the Nevada Attorney for Injured Workers to represent the claimant 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 the claimant's injury or disease; or~~

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

~~(6) Receive services for rehabilitation if the claimant's injury prevents him or her 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 12 of NRS 616C.090 *or subsection 12 of section 7 of this act* that notifies injured employees of their right to select an alternative treating physician or chiropractic physician [.] *or industrial provider of health care.* The Administrator shall adopt regulations for the manner of compliance by an insurer with the other provisions of subsection 1.]~~ **(Deleted by amendment.)**

Sec. 13. ~~[NRS 616C.055 is hereby amended to read as follows:~~

~~616C.055 1. The insurer may not, in accepting responsibility for any charges, use fee schedules which unfairly discriminate among physicians and chiropractic physicians.~~

~~2. Except as otherwise provided in NRS 616C.087 [.] *or section 6 of this act,* if a physician , [or] chiropractic physician *or industrial provider of health care* is removed from the panel established pursuant to NRS 616C.090 *or section 7 of this act, as applicable,* or from participation in a plan for managed care established pursuant to NRS 616B.527, the physician , [or] chiropractic physician [.] *or industrial provider of health care,* as applicable, must not be paid for any services rendered to the injured employee after the date of the removal.]~~ **(Deleted by amendment.)**

Sec. 14. NRS 616C.087 is hereby amended to read as follows:

616C.087 1. The Legislature hereby declares that:

(a) The choice of a treating physician or chiropractic physician is a substantive right and substantive benefit of an injured employee who has a claim under the Nevada Industrial Insurance Act or the Nevada Occupational Diseases Act.

(b) The injured employees of this State have a substantive right to an adequate choice of physicians and chiropractic physicians to treat their industrial injuries and occupational diseases.

2. Except as otherwise provided in this subsection and subsections 3 and 4:

(a) The panel maintained by the Administrator pursuant to NRS 616C.090 must not include a physician or chiropractic physician in a discipline or specialization if the physician or chiropractic physician does not accept and treat injured employees for industrial injuries or occupational diseases in that discipline or specialization; and

(b) An insurer's list of physicians and chiropractic physicians from which an injured employee may choose pursuant to NRS 616C.090 must include not less than 12 physicians or chiropractic physicians, as applicable, in each of the following disciplines and specializations, without limitation, from the panel of physicians and chiropractic physicians maintained by the Administrator pursuant to NRS 616C.090:

(1) Orthopedic surgery on spines;
(2) Orthopedic surgery on shoulders;
(3) Orthopedic surgery on elbows;
(4) Orthopedic surgery on wrists;
(5) Orthopedic surgery on hands;
(6) Orthopedic surgery on hips;
(7) Orthopedic surgery on knees;
(8) Orthopedic surgery on ankles;
(9) Orthopedic surgery on feet;
(10) Neurosurgery;
(11) ~~[Neurology;~~
~~(12)]~~ Cardiology;

~~[(13)]~~ ***(12)*** Pulmonology;
~~[(14) Psychiatry;]~~
~~[(15)]~~ ***(13)*** Pain management;
~~[(16)]~~ ***(14)*** Occupational medicine;
~~[(17)]~~ ***(15)*** Physiatry or physical medicine;
~~[(18) General practice or family medicine;]~~ and
~~[(19)]~~ ***(16)*** Chiropractic medicine.

➥ If the panel of physicians and chiropractic physicians maintained by the Administrator pursuant to NRS 616C.090 contains fewer than 12 physicians or chiropractic physicians, as applicable, for a discipline or specialization specifically identified in this subsection, all of the physicians or chiropractic physicians, as applicable, on the panel for that discipline or specialization must be included on the insurer's list. ***The insurer shall ensure that any physician or chiropractic physician on the insurer's list accepts and treats patients in the discipline or specialization for which the physician or chiropractic physician is listed.***

3. For any other discipline or specialization not specifically identified in subsection 2, the insurer's list must include not fewer than 8 physicians or chiropractic physicians, as applicable, unless the panel of physicians and chiropractic physicians maintained by the Administrator pursuant to NRS 616C.090 contains fewer than 8 physicians or chiropractic physicians, as applicable, for that discipline or specialization, in which case all of the physicians or chiropractic physicians, as applicable, on the panel for that discipline or specialization must be included on the insurer's list. ***The insurer shall ensure that any physician or chiropractic physician on the insurer's list accepts and treats patients in the discipline or specialization for which the physician or chiropractic physician is listed.***

4. For each county whose population is 100,000 or more, an insurer's list of physicians and chiropractic physicians must include for that county a number of physicians and chiropractic physicians, as applicable, that is not less than the number required pursuant to subsections 2 and 3 and that also maintain in that county:

(a) An active practice; and

(b) A physical office.

5. If an insurer fails to maintain a list of physicians and chiropractic physicians that complies with the requirements of subsections 2, 3 and 4, ***including the requirement that each physician or chiropractic physician on the list accepts and treats patients in the discipline or specialization for which the physician or chiropractic physician is listed,*** an injured employee may choose a physician or chiropractic physician from the panel of physicians and chiropractic physicians maintained by the Administrator pursuant to NRS 616C.090. ***If a physician or chiropractic physician is removed from an insurer's list pursuant to subsection 9 or 10, within 60 days after the date of removal the insurer shall replace the physician or chiropractic physician on the list to maintain compliance with the requirements of subsections 2, 3 and 4. If the insurer fails to do so, an injured employee may choose a physician or chiropractic physician from the panel maintained by the Administrator pursuant to NRS 616C.090.***

6. ~~[Each]~~ ***Except as otherwise provided in this subsection, each*** insurer shall, ~~[not later than October 1,]~~ ***on or after December 1 and on or before December 31*** of each year, update the list of physicians and chiropractic physicians and file the list with the Administrator ~~[.]~~ ***in accordance with the provisions of subsection 12.*** The list must be certified by an adjuster who is licensed pursuant to chapter 684A of NRS. ***An insurer may update the list at additional times during the year for the purpose of replacing a physician or chiropractic physician pursuant to subsection***

5. An insurer shall not at any time remove any physician or chiropractic physician from the insurer's list except as expressly permitted by subsection 9 or 10. A third-party administrator may file a single list on behalf of more than one insurer for which the administrator provides services, if the list expressly indicates each insurer to which the list applies.

7. Upon receipt of a list of physicians and chiropractic physicians that is filed pursuant to subsection 6 ~~[.]~~ ***or a list of providers of mental health care that is submitted pursuant to NRS 616C.180,*** the Administrator shall:

(a) Stamp the list as having been filed; and

(b) Indicate on the list the date on which it was filed.

8. The Administrator shall:

(a) Provide a copy of an insurer's list of physicians and chiropractic physicians ***, and providers of mental health care pursuant to NRS 616C.180,*** to any member of the public who requests a copy; or

(b) Post a copy of each insurer's list of physicians and chiropractic physicians ***, and providers of mental health care pursuant to NRS 616C.180,*** on an Internet website maintained by the Administrator and accessible to the public for viewing, printing or downloading.

9. At any time, a physician or chiropractic physician may request in writing that he or she be removed from an insurer's list of physicians and chiropractic physicians. The insurer must comply with the request and omit the physician or chiropractic physician from the next list which the insurer files with the Administrator. ***If a physician or chiropractic physician chooses to cancel a contract between the physician or chiropractic physician and the insurer, employer or third-party administrator, the insurer may omit the physician or chiropractic physician from the next list which the insurer files with the Administrator.***

10. A physician or chiropractic physician may not be involuntarily removed from an insurer's list of physicians and chiropractic physicians except ~~[for]~~ ***:***

(a) For good cause. As used in this ~~[subsection,]~~ ***paragraph,*** "good cause" means that one or more of the following circumstances apply:

~~[(a)]~~ ***(1)*** The physician or chiropractic physician has died or is disabled.

~~[(b)]~~ ***(2)*** The license of the physician or chiropractic physician has been revoked or suspended.

~~[(c)]~~ ***(3)*** The physician or chiropractic physician has been convicted of:

~~[(1)]~~ ***(I)*** A felony; or

~~[(2)]~~ ***(II)*** A crime for a violation of a provision of chapter 616D of NRS.

~~[(d)]~~ ***(4)*** The physician or chiropractic physician has been removed from the panel of physicians and chiropractic physicians maintained by the Administrator pursuant to NRS 616C.090 by the Administrator upon a finding that the physician or chiropractic physician:

~~[(1)]~~ ***(I)*** Has failed to comply with the standards for treatment of industrial injuries or occupational diseases as established by the Administrator; or

~~[(2)]~~ ***(II)*** Does not accept and treat injured employees under chapters 616A to 616D, inclusive, or chapter 617 of NRS.

(b) Beginning on December 1, 2026, and every 3 calendar years thereafter, the insurer may audit the insurer's list, including, without limitation, for compliance with subsections 2, 3 and 4, and may remove any physician or chiropractic physician of the insurer's choosing from the list which the insurer is required to file not later than December 31 of that year pursuant to subsection 6.

11. Unless a physician or chiropractic physician, as applicable, is removed from an insurer's list of physicians and chiropractic physicians pursuant to

subsection 10, an injured employee may continue to receive treatment from that physician or chiropractic physician even if:

(a) The employer of the injured employee changes insurers or administrators.

(b) The physician or chiropractic physician is no longer included in the applicable insurer's list of physicians and chiropractic physicians, provided that the physician or chiropractic physician agrees to continue to accept compensation for that treatment at the rates which:

(1) Were previously agreed upon when the physician or chiropractic physician was most recently included in the list; or

(2) Are newly negotiated but do not exceed the amounts provided under the fee schedule adopted by the Administrator.

12. The Administrator shall adopt regulations prescribing ~~[the form]~~ ***a uniform format*** in which a list of physicians and chiropractic physicians created by an employer, insurer or third-party administrator pursuant to this section must be maintained ~~[.]~~ ***, which must be uniformly applicable to any person who creates such a list.*** The Administrator shall require that any such list be in a format which is easily searchable, including, without limitation, an indexed database, a portable document format, a spreadsheet with data that may be filtered, a comma-separated values file or any other comparable format. ***The Administrator shall not require submission of such a list through any specific proprietary software platform or particular electronic system. Submission of a list to the Administrator in the format determined by the Administrator shall be deemed to satisfy the requirements of subsection 6 to file such a list. Nothing in this subsection imposes any duty on the Administrator in receiving such a list other than those administrative duties described in subsections 7 and 8.***

Sec. 15. NRS 616C.110 is hereby amended to read as follows:

616C.110 1. For the purposes of NRS 616B.557, 616B.578, 616B.587 ~~[,]~~ ***and*** 616C.490 ***,*** ~~[and 617.459,]~~ not later than August 1, 2003, the Division shall adopt regulations incorporating the American Medical Association's Guides to the Evaluation of Permanent Impairment, Fifth Edition, by reference. The regulations:

(a) Must provide that the American Medical Association's Guides to the Evaluation of Permanent Impairment, Fifth Edition, must be applied to all examinations; and

(b) Must be applied to all examinations for a permanent partial disability that are conducted on or after the effective date of the regulations, regardless of the date of injury.

2. After adopting the regulations required pursuant to subsection 1, the Division may amend those regulations as it deems necessary, except that the amendments to those regulations:

(a) Must be consistent with the Fifth Edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment;

(b) Must not incorporate any contradictory matter from any other edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment; and

(c) Must not consider any factors other than the degree of physical impairment of the whole person in calculating the entitlement to compensation.

3. If the Fifth Edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment contains more than one method of determining the rating of an impairment, the Administrator shall designate by regulation the method from that edition which must be used to rate an impairment pursuant to NRS 616C.490.

Sec. 15.5. **NRS 616C.115 is hereby amended to read as follows:**

616C.115 1. Except as otherwise provided in subsection 2 ~~[,]~~ ***and sections 9.5 and 9.7 of this act,*** a physician or advanced practice registered nurse shall prescribe for an injured employee a generic drug in lieu of a drug with a brand name if the generic drug is biologically equivalent and has the same active ingredient or ingredients of the same strength, quantity and form of dosage as the drug with a brand name.

2. ~~[A]~~ ***Except as otherwise provided in sections 9.5 and 9.7 of this act, a*** physician or advanced practice registered nurse is not required to comply with the provisions of subsection 1 if:

(a) The physician or advanced practice registered nurse determines that the generic drug would not be beneficial to the health of the injured employee; or

(b) The generic drug is higher in cost than the drug with a brand name.

Sec. 16. NRS 616C.137 is hereby amended to read as follows:

616C.137 1. If an insurer, organization for managed care or employer who provides accident benefits for injured employees pursuant to NRS 616C.265 denies payment for some or all of the services itemized on a statement submitted by a provider of health care on the sole basis that those services were not related to the employee's industrial injury or occupational disease, the insurer, organization for managed care or employer shall, at the same time that it sends notification to the provider of health care of the denial, send a copy of the statement to the injured employee and notify the injured employee that it has denied payment. The notification sent to the injured employee must:

(a) State the relevant amount requested as payment in the statement, that the reason for denying payment is that the services were not related to the industrial injury or occupational disease and that, pursuant to subsection 2, the injured employee will be responsible for payment of the relevant amount if the injured employee does not, in a timely manner, appeal the denial pursuant to NRS ~~[616C.305 and]~~ 616C.315 to 616C.385, inclusive, or appeals but is not successful.

(b) Include an explanation of the injured employee's right to request a hearing to appeal the denial pursuant to NRS ~~[616C.305 and]~~ 616C.315 to 616C.385, inclusive, and a suitable form for requesting a hearing to appeal the denial.

2. An injured employee who does not, in a timely manner, appeal the denial of payment for the services rendered or who appeals the denial but is not successful is responsible for payment of the relevant charges on the itemized statement.

3. To succeed on appeal, the injured employee must show that the:

(a) Services provided were related to the employee's industrial injury or occupational disease; or

(b) Insurer, organization for managed care or employer who provides accident benefits for injured employees pursuant to NRS 616C.265 gave prior authorization for the services rendered and did not withdraw that prior authorization before the services of the provider of health care were rendered.

Sec. 17. NRS 616C.180 is hereby amended to read as follows:

616C.180 1. Except as otherwise provided in this section, an injury or disease sustained by an employee that is caused by stress is compensable pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS if it arose out of and in the course of his or her employment.

2. Except as otherwise provided in subsection 4, any ailment or disorder caused by any gradual mental stimulus, and any death or disability ensuing therefrom, shall be deemed not to be an injury or disease arising out of and in the course of employment.

3. Except as otherwise provided by subsections 4 and 5, an injury or disease caused by stress shall be deemed to arise out of and in the course of employment

only if the employee proves by clear and convincing medical ***, psychological*** or psychiatric evidence that:

(a) The employee has a mental injury caused by extreme stress in time of danger;

(b) The primary cause of the injury was an event that arose out of and during the course of his or her employment; and

(c) The stress was not caused by his or her layoff, the termination of his or her employment or any disciplinary action taken against him or her.

4. An injury or disease caused by stress shall be deemed to arise out of and in the course of employment if the employee is a first responder and proves by clear and convincing medical ***, psychological*** or psychiatric evidence that:

(a) The employee has a mental injury caused by extreme stress due to the employee directly witnessing:

(1) The death, or the aftermath of the death, of a person as a result of a violent event, including, without limitation, a homicide, suicide or mass casualty incident; or

(2) An injury, or the aftermath of an injury, that involves grievous bodily harm of a nature that shocks the conscience; and

(b) The primary cause of the mental injury was the employee witnessing an event or a series of events described in paragraph (a) during the course of his or her employment.

5. An injury or disease caused by stress shall be deemed to arise out of and in the course of employment, and shall not be deemed the result of gradual mental stimulus, if the employee is employed by the State or any of its agencies or political subdivisions and proves by clear and convincing medical ***, psychological*** or psychiatric evidence that:

(a) The employee has a mental injury caused by extreme stress due to the employee responding to a mass casualty incident; and

(b) The primary cause of the injury was the employee responding to the mass casualty incident during the course of his or her employment.

6. An agency which employs a first responder, including, without limitation, a first responder who serves as a volunteer, shall provide educational training to the first responder related to the awareness, prevention, mitigation and treatment of mental health issues.

7. The provisions of this section do not apply to a person who is claiming compensation pursuant to NRS 617.457.

8. For the purposes of any claim arising out of this section:

(a) An insurer shall maintain a list of providers of mental health care who have agreed to accept and treat injured employees pursuant to this section, from which an injured employee has the right to choose a mental health care provider of his or her choice.

(b) For each county whose population is 100,000 or more, the list maintained pursuant to paragraph (a) must include not less than 12 providers of mental health care.

(c) Each insurer shall, between December 1 and December 31 of each year, update the list maintained pursuant to paragraph (a) and submit the list to the Administrator.

(d) If the list maintained pursuant to paragraph (a) contains a provider of mental health care that does not accept and treat patients pursuant to this section, an injured employee may choose any provider of mental health care who agrees to accept the schedule of fees and charges established pursuant to NRS 616C.260.

~~[8.]~~ ***9.*** As used in this section:

(a) "Directly witness" means to see or hear for oneself.

(b) "First responder" means:

(1) A salaried or volunteer firefighter;

(2) A police officer;

(3) An emergency dispatcher or call taker who is employed by a law enforcement or public safety agency in this State; or

(4) An emergency medical technician or paramedic who is employed by a public safety agency in this State.

(c) "Mass casualty incident" means an event that, for the purposes of emergency response or operations, is designated as a mass casualty incident by one or more governmental agencies that are responsible for public safety or for emergency response.

(d) "Provider of mental health care" means a psychiatrist, a licensed psychologist, a licensed clinical professional counselor or a licensed marriage and family therapist.

Sec. 18. NRS 616C.220 is hereby amended to read as follows:

616C.220 1. The Division shall designate one:

(a) Third-party administrator who has a valid certificate issued by the Commissioner pursuant to NRS 683A.085; or

(b) Insurer, other than a self-insured employer or association of self-insured public or private employers,

➥ to administer claims against the Uninsured Employers' Claim Account. The designation must be made pursuant to reasonable competitive bidding procedures established by the Administrator.

2. Except as otherwise provided in this subsection, an employee may receive compensation from the Uninsured Employers' Claim Account if:

(a) The employee was hired in this State or is regularly employed in this State;

(b) The employee suffers an accident or injury which arises out of and in the course of his or her employment:

(1) In this State; or

(2) While on temporary assignment outside the State for not more than 12 months;

(c) The employee files a claim for compensation with the Division; and

(d) The employee makes an irrevocable assignment to the Division of a right to be subrogated to the rights of the injured employee pursuant to NRS 616C.215.

➥ An employee who suffers an accident or injury while on temporary assignment outside the State is not eligible to receive compensation from the Uninsured Employers' Claim Account unless the employee has been denied workers' compensation in the state in which the accident or injury occurred.

3. If the Division receives a claim pursuant to subsection 2, the Division shall immediately notify the employer of the claim.

4. For the purposes of this section and NRS 616C.223, the employer has the burden of proving that the employer provided mandatory industrial insurance coverage for the employee or that the employer was not required to maintain industrial insurance for the employee.

5. Any employer who has failed to provide mandatory coverage required by the provisions of chapters 616A to 616D, inclusive, of NRS is liable for all payments made on behalf of the employer, including any benefits, administrative costs or attorney's fees paid from the Uninsured Employers' Claim Account or incurred by the Division.

6. The Division:

(a) May recover from the employer the payments made by the Division that are described in subsection 5 and any accrued interest by bringing a civil action or filing an application for the entry of summary judgment pursuant to NRS 616C.223

in a court of competent jurisdiction. For the purposes of this paragraph, the payments made by the Division that are described in subsection 5 are presumed to be:

(1) Justified by the circumstances of the claim;

(2) Made in accordance with applicable law; and

(3) Reasonable and necessary.

(b) In any civil action or application for the entry of summary judgment filed pursuant to NRS 616C.223 against the employer, is not required to prove that negligent conduct by the employer was the cause of the employee's injury.

(c) May enter into a contract with any person to assist in the collection of any liability of an uninsured employer.

(d) In lieu of a civil action or filing an application for the entry of summary judgment pursuant to NRS 616C.223, may enter into an agreement or settlement regarding the collection of any liability of an uninsured employer.

7. The Division shall:

(a) Determine whether the employer was insured within 30 days after receiving notice of the claim from the employee.

(b) Assign the claim to the third-party administrator or insurer designated pursuant to subsection 1 for administration and payment of compensation.

➥ Upon determining whether the claim is accepted or denied, the designated third-party administrator or insurer shall notify the injured employee, the named employer and the Division of its determination.

8. Upon demonstration of the:

(a) Costs incurred by the designated third-party administrator or insurer to administer the claim or pay compensation to the injured employee; or

(b) Amount that the designated third-party administrator or insurer will pay for administrative expenses or compensation to the injured employee and that such amounts are justified by the circumstances of the claim,

➥ the Division shall authorize payment from the Uninsured Employers' Claim Account.

9. Any party aggrieved by a determination made by the Division regarding the assignment of any claim made pursuant to this section may appeal that determination by filing a notice of appeal with an appeals officer within 30 days after the determination is rendered. The provisions of NRS 616C.345 to 616C.385, inclusive, apply to an appeal filed pursuant to this subsection.

10. Any party aggrieved by a determination to accept or to deny any claim made pursuant to this section or by a determination to pay or to deny the payment of compensation regarding any claim made pursuant to this section may appeal that determination, within 70 days after the determination is rendered, to the Hearings Division of the Department of Administration in the manner provided by NRS ~~[616C.305 and]~~ 616C.315.

11. All insurers shall bear a proportionate amount of a claim made pursuant to chapters 616A to 616D, inclusive, of NRS, and are entitled to a proportionate amount of any collection made pursuant to this section as an offset against future liabilities.

12. An uninsured employer is liable for the interest on any amount paid on his or her claims from the Uninsured Employers' Claim Account. The interest must be calculated at a rate equal to the prime rate at the largest bank in Nevada, as ascertained by the Commissioner of Financial Institutions, on January 1 or July 1, as the case may be, immediately preceding the date of the claim, plus 3 percent, compounded monthly, from the date the claim is paid from the account until payment is received by the Division from the employer.

13. Attorney's fees recoverable by the Division pursuant to this section must be:

(a) If a private attorney is retained by the Division, paid at the usual and customary rate for that attorney.

(b) If the attorney is an employee of the Division, paid at the rate established by regulations adopted by the Division.

➥ Any money collected must be deposited to the Uninsured Employers' Claim Account.

14. If the Division has not obtained a civil judgment or an entry of summary judgment pursuant to NRS 616C.223 and the Division assigns a debt that arises under this section to the State Controller for collection pursuant to NRS 353C.195, the State Controller may bring an action in his or her own name in a court of competent jurisdiction to recover any amount that the Division is authorized to recover pursuant to this section.

Sec. 19. 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, the claimant 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 $800, the insurer may close the claim at any time after the insurer 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 $800 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. 20. NRS 616C.295 is hereby amended to read as follows:

616C.295 1. The Chief of the Hearings Division shall adopt regulations establishing:

(a) A code of conduct for hearing officers who conduct hearings in contested cases for compensation under chapters 616A to 617, inclusive, of NRS; and

(b) A code of conduct for appeals officers who conduct hearings and appeals as required pursuant to chapters 616A to 617, inclusive, of NRS.

2. The codes of conduct established pursuant to subsection 1 must be designed to ensure fairness and impartiality, and to avoid the appearance of impropriety.

3. The Chief of the Hearings Division shall adopt regulations establishing:

(a) Standards for the initial training and continuing education of hearing officers who conduct hearings in contested cases for compensation under chapters 616A to 617, inclusive, of NRS; and

(b) Standards for the initial training and continuing education of appeals officers who conduct hearings and appeals as required pursuant to chapters 616A to 617, inclusive, of NRS.

4. The standards established pursuant to subsection 3 must, without limitation, include training and continuing education in:

(a) The provisions of chapters 616A to 617, inclusive, of NRS;

(b) Dispute resolution; and

(c) Mediation.

5. The Chief of the Hearings Division shall:

(a) Prescribe by regulation the qualifications required before a person may, pursuant to chapters 616A to 617, inclusive, of NRS, serve as a hearing officer.

(b) Provide for the expediting of the hearing of cases that involve the termination or denial of compensation.

(c) Maintain and make accessible to the public on the Internet website maintained by the Hearings Division, a calendar of all matters which are before hearing officers and appeals officers.

6. From the cases heard each year by hearing officers and appeals officers regarding claims for benefits by injured employees, the Chief of the Hearings Division shall prepare an annual report which itemizes, on the basis of each insurer and third-party administrator, the number of cases affirmed, reversed, remanded and resolved by other disposition involving that insurer or third-party administrator, including a breakdown of that information by the type of benefits denied by the insurer or third-party administrator.

7. As used in this section, "Chief of the Hearings Division" means the Chief of the Hearings Division of the Department of Administration.

Sec. 21. NRS 616C.315 is hereby amended to read as follows:

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

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

(a) The name of:

(1) The claimant;

(2) The employer; and

(3) The insurer or third-party administrator;

(b) The number of the claim; and

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

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

(a) A written determination of an insurer; or

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

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

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

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

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

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

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

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

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

Sec. 22. NRS 616C.320 is hereby amended to read as follows:

616C.320 If an employee of a self-insured employer, an employer who is a member of an association of self-insured public or private employers or an employer insured by a private carrier is dissatisfied with a decision of his or her employer, the association or the private carrier, the employee may seek to resolve the dispute pursuant to NRS ~~[~~616C.305 and~~]~~ 616C.315 to 616C.385, inclusive.

Sec. 23. NRS 616C.345 is hereby amended to read as follows:

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

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

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

(a) The name of:

(1) The claimant;

(2) The employer; and

(3) The insurer or third-party administrator;

(b) The number of the claim; and

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

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

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

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

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

~~5.~~ Except as otherwise provided in NRS 616C.380, the filing of a notice of appeal does not automatically stay the enforcement of the decision of a hearing officer . ~~or a determination rendered pursuant to NRS 616C.305.~~ The appeals officer may order a stay ~~, when appropriate,~~ ***in accordance with the requirements of subsection 5*** upon the ~~application~~ ***motion*** of a party. If ***a party files*** such ~~an application is submitted,~~ ***a motion,*** the decision is automatically stayed until a determination is made concerning the ~~application.~~ ***motion.*** A determination on the ~~application~~ ***motion*** must be made within 30 days after the filing of the ~~application.~~ ***motion.*** ~~***If a determination is not made within that period, the motion is automatically denied.***~~ If ~~***the motion is automatically denied or***~~ a stay is not granted by the officer after reviewing the ~~application,~~ ***motion,*** the decision must be complied with within 10 days after the date of the ~~***automatic denial or***~~ refusal to grant a stay . ~~***and the nonmoving party is entitled to reasonable attorney's fees and costs incurred as a result of the motion.***~~

5. An appeals officer shall not:

(a) Grant a motion to stay the enforcement of the decision of a hearing officer unless the appeals officer makes specific findings of fact and conclusions of law that the moving party seeking the stay has established ~~***, by clear and convincing evidence,***~~ ***that:***

(1) The moving party has a reasonable likelihood of success in the appeal on the factual merits or as a matter of law;

(2) The moving party will suffer irreparable harm if the stay is denied; and

(3) The nonmoving party will not suffer irreparable harm if the stay is granted.

(b) For the purpose of making findings and conclusions relating to irreparable harm pursuant to paragraph (a), consider the ability to recoup benefits and compensation provided by an industrial insurer to an injured employee during the pendency of the appeal.

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

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

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

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

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

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

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

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

9. The period specified in subsection 1 ~~,~~ ***or*** 2 ~~or 4~~ within which a notice of appeal or a notice of a contested claim must be filed may be extended for an additional 90 days if the person aggrieved shows by a preponderance of the

evidence that the person was diagnosed with a terminal illness or was informed of the death or diagnosis of a terminal illness of the person's spouse, parent or child.

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

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

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

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

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

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

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

Sec. 24. NRS 616C.370 is hereby amended to read as follows:

616C.370 1. No judicial proceedings may be instituted for compensation for an injury or death under chapters 616A to 616D, inclusive, of NRS unless:

(a) A claim for compensation is filed as provided in NRS 616C.020; and

(b) A final decision of an appeals officer has been rendered on such claim.

2. Judicial proceedings instituted for compensation for an injury or death, under chapters 616A to 616D, inclusive, of NRS are limited to judicial review of the decision of an appeals officer.

3. Notwithstanding any other provision of law:

(a) The following requirements, and no others, are mandatory and jurisdictional for a petition for judicial review of the final decision of an appeals officer:

(1) The petition must be filed within 30 days after the date of entry and service of the decision and order of the appeals officer; and

(2) A copy of the decision and order of the appeals officer must be attached to the petition.

(b) Other than the requirements of paragraph (a), a court may excuse any other defect in substance, form, venue or service of a petition for judicial review, and may permit any appropriate amendment or change of venue at any time before the final disposition of the petition.

4. The prevailing party in any judicial proceedings instituted for compensation for an injury or death under chapters 616A to 616D, inclusive, of

NRS shall cause a copy of the final decision issued by the court in the proceedings to be:

(a) Served upon the appeals officer whose final decision was appealed. The appeals officer shall include the copy of the final decision in the administrative record on the matter.

(b) For a prevailing party in the Court of Appeals or Supreme Court, filed in the district court whose final decision was appealed.

Sec. 25. NRS 616C.375 is hereby amended to read as follows:

616C.375 ***1.*** If an insurer, employer or claimant, or the representative of an insurer, employer or claimant, appeals the decision of an appeals officer, that decision is not stayed unless a stay is granted by the appeals officer or the district court within 30 days after the date on which the decision was rendered.

2. An appeals officer or district court shall not:

(a) Grant a motion to stay the enforcement of the decision of an appeals officer unless the appeals officer or district court makes specific findings of fact and conclusions of law that the moving party seeking the stay has established ~~***[,***~~ ~~***by clear and convincing evidence,]***~~ ***that:***

(1) The moving party has a reasonable likelihood of success in the appeal on the factual merits or as a matter of law;

(2) The moving party will suffer irreparable harm if the stay is denied; and

(3) The nonmoving party will not suffer irreparable harm if the stay is granted.

(b) For the purpose of making findings and conclusions relating to irreparable harm pursuant to paragraph (a), consider the ability to recoup benefits and compensation provided by an industrial insurer to an injured employee during the pendency of the appeal.

~~***[3. If the appeals officer or district court denies a motion to stay pursuant to this section, the nonmoving party is entitled to reasonable attorney's fees and costs incurred as a result of the motion.]***~~

Sec. 26. NRS 616C.390 is hereby amended to read as follows:

616C.390 Except as otherwise provided in NRS 616C.392:

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 cause of the change of circumstances is the injury for which the claim was originally made; and

(c) The application is accompanied by the certificate of a physician or a chiropractic physician 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 chiropractic physician treating the claimant, certifying that the treatment is indicated by a change in circumstances and is related to the industrial injury sustained 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 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 cause of the change of circumstances is the injury 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 did not meet the minimum duration of incapacity as set forth in NRS 616C.400 as a result of the injury; 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, the employee is not entitled to vocational rehabilitation services or benefits for a temporary total disability if, before the claim was reopened, the employee:

(a) Retired; or

(b) Otherwise voluntarily removed himself or herself from the workforce,

➥ for reasons unrelated to the injury 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 chiropractic physician.

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 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.

11. As used in this section:

(a) "Governmental program" means any program or plan under which a person receives payments from a public form of retirement. Such payments from a public form of retirement include, without limitation:

(1) Social security received as a result of the Social Security Act, as defined in NRS 287.120;

(2) Payments from the Public Employees' Retirement System, as established by NRS 286.110;

(3) Payments from the Retirees' Fund, as defined in NRS 287.04064;

(4) A disability retirement allowance, as defined in NRS 1A.040 and 286.031;

(5) A retirement allowance, as defined in NRS 218C.080; and

(6) A service retirement allowance, as defined in NRS 1A.080 and 286.080.

(b) "Retired" means a person who, on the date he or she filed for reopening a claim pursuant to this section:

(1) Is not employed or earning wages; and

(2) Receives benefits or payments for retirement from a:

(I) Pension or retirement plan;

(II) Governmental program; or

(III) Plan authorized by 26 U.S.C. § 401(a), 401(k), 403(b), 457 or 3121.

(c) "Wages" means any remuneration paid by an employer to an employee for the personal services of the employee, including, without limitation:

(1) Commissions and bonuses; and

(2) Remuneration payable in any medium other than cash.

Sec. 27. NRS 616C.500 is hereby amended to read as follows:

616C.500 1. Except as otherwise provided in subsection 2 and 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 accident arising out of and in the course of employment, is entitled to receive for a temporary partial disability the difference between the wage earned after the injury and the compensation which the injured person would be entitled to receive if temporarily totally disabled when the wage is less than the compensation, but for a period not to exceed 24 months during the period of disability.

2. Except as otherwise provided in NRS 616B.028 and 616B.029, an injured employee or his or her dependents are not entitled to accrue or be paid any benefits for a temporary partial disability during the time the employee is incarcerated. The injured employee or his or her dependents are entitled to receive such benefits if the injured employee is released from incarceration during the period of disability specified in subsection 1 and the injured employee is certified as temporarily partially disabled by a physician or chiropractic physician.

3. If ~~[a claim for the period of]~~ an injured employee makes a claim for temporary partial disability , ~~[is allowed,]~~ the first payment or a determination regarding 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.]~~ claim.

Sec. 28. 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 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 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]~~ ***Except as otherwise provided in subsections 3 and 4, 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)]~~ ***(d)*** Dispose of procedural requests or similar matters.

~~[(f)]~~ ***(e)*** Generally regulate and guide the course of a pending hearing or proceeding.

3. Appeals officers, upon motion and for good cause shown, in conducting hearings pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS or regulations adopted pursuant to those chapters, may grant discovery to any party by any methods available under the Nevada Rules of Civil Procedure ~~.~~ ***, except an appeals officer shall not grant discovery in the form of requests for admission under Rule 36. An appeals officer shall not deny an injured employee's reasonable request to conduct discovery. The scope of discovery must be:***

(a) Expressly limited to that which is necessary to the adjudication of the claim for compensation; and

(b) Otherwise governed by the standards for relevance and proportionality set forth in Rule 26(b) of the Nevada Rules of Civil Procedure.

4. A party seeking to conduct discovery pursuant to subsection 3 shall not serve a request for discovery on another party without the approval of the appeals officer. The party seeking discovery must file a motion for approval which includes, without limitation, a copy of the discovery request to be served, an identification of any witnesses sought to be deposed and a summary of the anticipated testimony of each such witness. Any party opposed to the motion to approve discovery may file an opposition within 5 days after the date of service of the motion. The moving party is not entitled to reply to any opposition.

Sec. 29. NRS 616D.090 is hereby amended to read as follows:

616D.090 1. In an investigation, the Administrator or a hearing officer may cause depositions of witnesses residing within or without the State to be taken in the manner prescribed by law and Nevada Rules of Civil Procedure for taking depositions in civil actions in courts of record.

2. ~~[After]~~ ***Except as otherwise provided in NRS 616D.050, after*** the initiation of a claim under the provisions of this chapter or chapter 616A, 616B, 616C or 617 of NRS, in which a claimant or other party is entitled to a hearing on the merits, any party to the proceeding may, in the manner prescribed by law and the Nevada Rules of Civil Procedure for taking written interrogatories and depositions in civil actions in courts of record:

(a) Serve upon any other party written interrogatories to be answered by the party served; or

(b) Take the testimony of any person, including a party, by deposition upon oral examination.

Sec. 30. 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, employer or professional employer organization 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 the claimant 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 the claimant 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 the claimant 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;

(h) Engaged in a pattern of untimely payments to injured employees; or

(i) Intentionally failed to comply with any provision of, or regulation adopted pursuant to, this chapter or chapter 616A, 616B, 616C or 617 of NRS , ~~*[; or*~~

~~*(j) Concealed, falsified or failed to provide any evidence or other document which is required to be filed before a hearing conducted pursuant to NRS 616C.330 or 616C.360 if such concealed, falsified or absent evidence would have been useful to an injured employee in seeking benefits or compensation 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, employer or professional employer organization 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 ***, clerical or ministerial*** violation, as defined by regulations adopted by the Division . ~~*[; or]*~~ ***The regulations must require, in the case of more***

than one minor, clerical or ministerial violation which is substantially similar across multiple claims and which does not create a financial impact to an injured employee, that such violations be combined into a single finding in a notice of correction.

(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 ***of the same section*** for which a notice of correction has been issued pursuant to paragraph (a); or

(2) Any other violation ***of the same section*** 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]~~ ***more*** than $375 for an initial violation, ***more than $750 for a second violation of the same section, more than $1,500 for a third violation of the same section*** or more than $3,000 ***per violation*** for any ~~[second]~~ ***fourth*** or subsequent violation ~~[.]~~ ***of the same section. If the Administrator determines that a person has fully complied with any plan of correction submitted pursuant to paragraph (c) or that the person has had no violations in the 3 years immediately preceding the date on which a fine is imposed pursuant to this paragraph, the fine must be in the amount for an initial 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, (h) or (i) ~~*[(g) to (j), inclusive,]*~~ of subsection 1 has occurred, the Administrator shall order the insurer, organization for managed care, health care provider, third-party administrator, employer or professional employer organization to pay to the claimant a benefit penalty:

(a) Except as otherwise provided in paragraph (b), in an amount that is not less than $17,000 and not greater than $120,000; or

(b) Of $3,000 if the violation involves a late payment of compensation or other relief to a claimant in an amount which is less than $500 or which is not more than 14 days late.

4. To determine the amount of the benefit penalty, the Administrator shall consider the degree of physical harm suffered by the injured employee or the dependents of the injured employee as a result of the violation of paragraph (a), (b), (c), (d), (e), ~~*[(g),]*~~ (h) ~~*[,]*~~ or (i) ~~*[or (j)]*~~ of subsection 1, the amount of compensation found to be due the claimant and the number of fines and benefit penalties, other than a benefit penalty described in paragraph (b) of subsection 3, previously imposed against the insurer, organization for managed care, health care provider, third-party administrator, employer or professional employer organization pursuant to this section. The Administrator shall also consider the degree of economic harm suffered by the injured employee or the dependents of the injured employee as a result of the violation of paragraph (a), (b), (c), (d), (e), ~~*[(g),]*~~ (h) ~~*[,]*~~ or (i) ~~*[or (j)]*~~ 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 the claimant within 15 days

after the date of the Administrator's determination. If the claimant is the injured employee and the claimant dies before the benefit penalty is paid to him or her, the benefit penalty must be paid to the estate of the claimant. Proof of the payment of the benefit penalty must be submitted to the Administrator within 15 days after the date of the Administrator's determination unless an appeal is filed pursuant to NRS 616D.140 and a stay has been granted. 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. To determine the amount of the benefit penalty in cases of multiple violations occurring within a certain period of time, the Administrator shall adopt regulations which take into consideration:

(a) The number of violations within a certain number of years for which a benefit penalty was imposed; and

(b) The number of claims handled by the insurer, organization for managed care, health care provider, third-party administrator, employer or professional employer organization in relation to the number of benefit penalties previously imposed within the period of time prescribed pursuant to paragraph (a).

5. 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.

6. 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.

7. 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.

8. 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.

9. If the Administrator determines that a vocational rehabilitation counselor has violated the provisions of NRS 616C.543, the Administrator may impose an administrative fine on the vocational rehabilitation counselor of not more than $250 for a first violation, $500 for a second violation and $1,000 for a third or subsequent violation.

10. The Administrator may make a claim against the bond required pursuant to NRS 683A.0857 for the payment of any administrative fine or benefit penalty imposed for a violation of the provisions of this section.

Sec. 31. NRS 617.401 is hereby amended to read as follows:

617.401 1. The Division shall designate one:

(a) Third-party administrator who has a valid certificate issued by the Commissioner pursuant to NRS 683A.085; or

(b) Insurer, other than a self-insured employer or association of self-insured public or private employers,

➥ to administer claims against the Uninsured Employers' Claim Account. The designation must be made pursuant to reasonable competitive bidding procedures established by the Administrator.

2. Except as otherwise provided in this subsection, an employee may receive compensation from the Uninsured Employers' Claim Account if:

(a) The employee was hired in this State or is regularly employed in this State;

(b) The employee contracts an occupational disease that arose out of and in the course of employment:

(1) In this State; or

(2) While on temporary assignment outside the State for not more than 12 months;

(c) The employee files a claim for compensation with the Division; and

(d) The employee makes an irrevocable assignment to the Division of a right to be subrogated to the rights of the employee pursuant to NRS 616C.215.

➥ An employee who contracts an occupational disease that arose out of and in the course of employment while on temporary assignment outside the State is not entitled to receive compensation from the Uninsured Employers' Claim Account unless the employee has been denied workers' compensation in the state in which the disease was contracted.

3. If the Division receives a claim pursuant to subsection 2, the Division shall immediately notify the employer of the claim.

4. For the purposes of this section and NRS 617.4015, the employer has the burden of proving that the employer provided mandatory coverage for occupational diseases for the employee or that the employer was not required to maintain industrial insurance for the employee.

5. Any employer who has failed to provide mandatory coverage required by the provisions of this chapter is liable for all payments made on behalf of the employer, including, but not limited to, any benefits, administrative costs or attorney's fees paid from the Uninsured Employers' Claim Account or incurred by the Division.

6. The Division:

(a) May recover from the employer the payments made by the Division that are described in subsection 5 and any accrued interest by bringing a civil action or filing an application for the entry of summary judgment pursuant to NRS 617.4015 in a court of competent jurisdiction. For the purposes of this paragraph, the payments made by the Division that are described in subsection 5 are presumed to be:

(1) Justified by the circumstances of the claim;

(2) Made in accordance with applicable law; and

(3) Reasonable and necessary.

(b) In any civil action or application for the entry of summary judgment filed pursuant to NRS 617.4015 against the employer, is not required to prove that negligent conduct by the employer was the cause of the occupational disease.

(c) May enter into a contract with any person to assist in the collection of any liability of an uninsured employer.

(d) In lieu of a civil action or filing an application for the entry of summary judgment pursuant to NRS 617.4015, may enter into an agreement or settlement regarding the collection of any liability of an uninsured employer.

7. The Division shall:

(a) Determine whether the employer was insured within 30 days after receiving the claim from the employee.

(b) Assign the claim to the third-party administrator or insurer designated pursuant to subsection 1 for administration and payment of compensation.

➥ Upon determining whether the claim is accepted or denied, the designated third-party administrator or insurer shall notify the injured employee, the named employer and the Division of its determination.

8. Upon demonstration of the:

(a) Costs incurred by the designated third-party administrator or insurer to administer the claim or pay compensation to the injured employee; or

(b) Amount that the designated third-party administrator or insurer will pay for administrative expenses or compensation to the injured employee and that such amounts are justified by the circumstances of the claim,

➥ the Division shall authorize payment from the Uninsured Employers' Claim Account.

9. Any party aggrieved by a determination made by the Division regarding the assignment of any claim made pursuant to this section may appeal that determination by filing a notice of appeal with an appeals officer within 30 days after the determination is rendered. The provisions of NRS 616C.345 to 616C.385, inclusive, apply to an appeal filed pursuant to this subsection.

10. Any party aggrieved by a determination to accept or to deny any claim made pursuant to this section or by a determination to pay or to deny the payment of compensation regarding any claim made pursuant to this section may appeal that determination, within 70 days after the determination is rendered, to the Hearings Division of the Department of Administration in the manner provided by NRS ~~[616C.305 and]~~ 616C.315.

11. All insurers shall bear a proportionate amount of a claim made pursuant to this chapter, and are entitled to a proportionate amount of any collection made pursuant to this section as an offset against future liabilities.

12. An uninsured employer is liable for the interest on any amount paid on his or her claims from the Uninsured Employers' Claim Account. The interest must be calculated at a rate equal to the prime rate at the largest bank in Nevada, as ascertained by the Commissioner of Financial Institutions, on January 1 or July 1, as the case may be, immediately preceding the date of the claim, plus 3 percent, compounded monthly, from the date the claim is paid from the Account until payment is received by the Division from the employer.

13. Attorney's fees recoverable by the Division pursuant to this section must be:

(a) If a private attorney is retained by the Division, paid at the usual and customary rate for that attorney.

(b) If the attorney is an employee of the Division, paid at the rate established by regulations adopted by the Division.

➥ Any money collected must be deposited to the Uninsured Employers' Claim Account.

14. If the Division has not obtained a civil judgment or an entry of summary judgment pursuant to NRS 617.4015 and the Division assigns a debt that arises under this section to the State Controller for collection pursuant to NRS 353C.195, the State Controller may bring an action in his or her own name in a court of competent jurisdiction to recover any amount that the Division is authorized to recover pursuant to this section.

Sec. 32. NRS 617.405 is hereby amended to read as follows:

617.405 1. No judicial proceedings may be instituted for benefits for an occupational disease under this chapter, unless:

(a) A claim is filed within the time limits prescribed in NRS 617.344; and

(b) A final decision by an appeals officer has been rendered on the claim.

2. Judicial proceedings instituted for benefits for an occupational disease under this chapter are limited to judicial review of that decision.

3. Notwithstanding any other provision of law:

(a) The following requirements, and no others, are mandatory and jurisdictional for a petition for judicial review of the final decision of an appeals officer:

(1) The petition must be filed within 30 days after the date of entry and service of the decision and order of the appeals officer; and

(2) A copy of the decision and order of the appeals officer must be attached to the petition.

(b) Other than the requirements of paragraph (a), a court may excuse any other defect in substance, form, venue or service of a petition for judicial review, and may permit any appropriate amendment or change of venue at any time before the final disposition of the petition.

4. The prevailing party in any judicial proceedings instituted for benefits for an occupational disease shall cause a copy of the final decision issued by the court in the proceedings to be:

(a) Served upon the appeals officer whose final decision was appealed. The appeals officer shall include the copy of the final decision in the administrative record on the matter.

(b) For a prevailing party in the Court of Appeals or Supreme Court, filed in the district court whose final decision was appealed.

Sec. 32.3. **1. Within 120 days after the effective date of this act, the Administrator of the Division of Industrial Relations of the Department of Business and Industry shall solicit public comments concerning the selection of a formulary required by section 9.5 of this act.**

2. The Administrator shall select the formulary required by section 9.5 of this act on or before July 1, 2027.

Sec. 32.7. **Notwithstanding the provisions of section 9.7 of this act, an insurer may, until January 1, 2028, provide reimbursement for a drug that is dispensed to an injured employee after July 1, 2027, if:**

1. The injured employee sustained the injury for which a claim was made pursuant to chapters 616A to 617, inclusive, of NRS, on or after January 1, 2027, and on or before July 1, 2027; and

2. The injured employee was originally prescribed the drug in connection with his or her claim on or after January 1, 2027, and on or before July 1, 2027.

Sec. 33. The amendatory provisions of this act apply to any claim pursuant to chapters 616A to 616D, inclusive, or 617 of NRS, which is open, filed or reopened on or after the effective date of this act.

Sec. 33.5. **The provisions of any administrative regulations which conflict with or are inconsistent with the provisions of this act are void, including, without limitation, the provisions of any administrative regulations which impose an assessment relating to the Subsequent Injury Account for Associations of Self-Insured Public or Private Employers pursuant to NRS 616B.575, as that section existed before the effective date of this act.**

Sec. 34. NRS **616B.410,** 616C.305 and 617.459 are hereby repealed.

Sec. 35. **1.** This **section and sections 1 to 4.1, inclusive, 4.3 to 9.5, inclusive, and 10 to 32.3, inclusive, 33, 33.5 and 34 of this** act ~~[becomes]~~ **become** effective upon passage and approval.

2. Section 4.2 of this act becomes effective:

(a) Upon passage and approval for the purpose of adopting any regulations and performing any other preparatory administrative tasks that are necessary to carry out the provisions of this act; and

(b) On January 1, 2026, for all other purposes.

3. Sections 9.7 and 32.7 of this act becomes effective:

(a) Upon passage and approval for the purpose of adopting any regulations and performing any other preparatory administrative tasks that are necessary to carry out the provisions of this act; and

(b) On July 1, 2027, for all other purposes.

TEXT OF REPEALED SECTIONS

616B.410 Annual audits; objection to assignment of standard industrial classification.

1. The Commissioner shall cause to be conducted at least annually an audit of each association of self-insured public or private employers in order to verify:

(a) The standard industrial classification of each member of the association;

(b) The individual experience of each member of the association;

(c) The payroll of each member of the association; and

(d) The assessment required to be paid by each member of the association.

2. The audit required by this section must be conducted by an auditor approved by the Commissioner.

3. A report of the audit must be filed with the Commissioner in a form required by the Commissioner.

4. The association or any member of the association may request a hearing before the Commissioner to object to any standard industrial classification assigned to a member of the association as a result of the audit. If the Commissioner determines that the assessment required to be paid by any member of the association is:

(a) Insufficient because of the standard industrial classification assigned to the member, the Commissioner shall order the association to collect from that member any amount required to recover the deficiency.

(b) Excessive because of the standard industrial classification assigned to the member, the Commissioner shall order the association to pay to the member the excess amount collected.

5. The expenses of any audit conducted pursuant to this section must be paid by the association.

616C.305 Procedure for appeal of final determination of organization for managed care which has contracted with insurer.

1. Except as otherwise provided in subsection 3, any person who is aggrieved by a final determination concerning accident benefits made by an organization for managed care which has contracted with an insurer must, within 14 days of the determination and before requesting a resolution of the dispute pursuant to NRS 616C.345 to 616C.385, inclusive, appeal that determination in accordance with the procedure for resolving complaints established by the organization for managed care.

2. The procedure for resolving complaints established by the organization for managed care must be informal and must include, but is not limited to, a review of

the appeal by a qualified physician or chiropractic physician who did not make or otherwise participate in making the determination.

3. If a person appeals a final determination pursuant to a procedure for resolving complaints established by an organization for managed care and the dispute is not resolved within 14 days after it is submitted, the person may request a resolution of the dispute pursuant to NRS 616C.345 to 616C.385, inclusive.

617.459 Determination of percentage of disability resulting from heart or lung diseases.

1. The percentage of disability resulting from an occupational disease of the heart or lungs must be determined jointly by the claimant's attending physician and the examining physician designated by the insurer, in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment as adopted and supplemented by the Division pursuant to NRS 616C.110.

2. If the claimant's attending physician and the designated examining physician do not agree upon the percentage of disability, they shall designate a physician specializing in the branch of medicine which pertains to the disease in question to make the determination. If they do not agree upon the designation of such a physician, each shall choose one physician so specializing, and two physicians so chosen shall choose a third specialist in that branch. The resulting panel of three physicians shall, by majority vote, 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.