Senate Bill No. 274–Senator Daly

CHAPTER.....

AN ACT relating to industrial insurance; revising requirements for the administration of certain insurance claims and the maintenance and accessibility of certain insurance records; removing the requirement that certain entities maintain a telephone service to accept collect calls from injured employees; revising the circumstances under which the Administrator of the Division of Industrial Relations of the Department of Business and Industry is authorized to remove a physician or chiropractic physician from a list or panel of physicians and chiropractic physicians who may provide certain services relating to the Nevada Industrial Insurance Act; requiring the Administrator to publish certain reports; authorizing certain physicians and chiropractic physicians to decline to perform certain evaluations; revising procedures for the selection of a physician or chiropractic physician to perform certain evaluations and examinations; revising provisions relating to independent medical examinations; revising provisions relating to benefits for a permanent partial disability; revising provisions relating to an appeal of certain determinations of the Administrator; revising procedures for the reimbursement of an insurer that pays for an increase in certain compensation or benefits; requiring the Administrator to post certain information on the Internet website of the Division; increasing the amount of certain penalties for certain violations of the Nevada Industrial Insurance Act or the Nevada Occupational Diseases Act; revising provisions relating to the imposition and payment of benefit penalties; revising certain requirements for certain investigations conducted by the Administrator; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law establishes the Nevada Industrial Insurance Act and the Nevada Occupational Diseases Act, which provide for the payment of compensation to employees who are injured or disabled as the result of an occupational injury or occupational disease. (Chapters 616A-616D and 617 of NRS)

Existing law requires certain insurers to maintain an office in this State that is operated by the insurer or its third-party administrator and to provide access to files relating to industrial insurance claims at that office. (NRS 616B.021, 616B.027) **Section 3** of this bill requires the insurer to make such files available for inspection and reproduction by electronic means or at an office operated by the insurer or its third-party administrator located in this State. **Section 3** also authorizes the insurer to keep physical records concerning a claim filed in this State at a location outside

this State if those records are made available for inspection and reproduction in certain electronic forms or at an office located in this State.

Section 4 of this bill permits an insurer to keep reproductions of certain files rather than original copies at an office in this State operated by the insurer or its third-party administrator. **Section 4** also removes the requirement that an insurer accept collect calls from injured employees.

Existing law requires a person who acts as a third-party administrator pursuant to the Nevada Industrial Insurance Act or the Nevada Occupational Diseases Act to administer claims arising under each plan of insurance that the person administers from one or more offices located in this State and maintain in those offices all records concerning those claims. (NRS 616B.503) **Section 5** of this bill removes that requirement. Instead, **section 2** of this bill establishes certain authorizations and requirements concerning the administration of claims arising under the Nevada Industrial Insurance Act or the Nevada Occupational Diseases Act. **Section 2** authorizes certain employees and third-party administrators of private carriers to administer such claims from a location outside this State and stipulates how records concerning such claims must be maintained. **Section 2** also authorizes certain other employees of a private carrier and certain third-party administrators to administer such claims only from one or more offices located in this State and requires that records relating to such claims be maintained at those offices. **Section 4** requires certain employees and third-party administrators who administer a claim from a location outside this State to make themselves available to communicate in real time with a claimant or a representative of the claimant at certain times.

Existing law requires the Commissioner of Insurance to take certain disciplinary action against a third-party administrator for certain violations. (NRS 616B.506) **Section 6** of this bill requires the Commissioner to also take such disciplinary action against a third-party administrator who violates the provisions of **section 2**.

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 of the Division of Industrial Relations of the Department of Business and Industry. 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 9** of this bill expands the circumstances under which a physician or chiropractic physician may be involuntarily removed from an insurer's list and requires the Administrator to adopt certain regulations. **Section 10** of this bill revises the reasons for which a physician or chiropractic physician may be removed from a panel and authorizes a physician or chiropractic physician who has been removed from a panel to reapply for inclusion under certain circumstances.

Existing law provides that an employee who is injured by an accident arising out of and in the course of employment is entitled to receive compensation under the Nevada Industrial Insurance Act for a permanent partial disability which is rated during an evaluation by certain physicians or chiropractic physicians. (NRS 616C.490) **Section 17** of this bill revises the methodology by which those physicians or chiropractic physicians are selected to perform such an evaluation and authorizes such a physician or chiropractic physician to decline to perform an evaluation under certain circumstances. **Sections 7 and 17** require the Administrator to prepare annual and quarterly reports relating to the frequency with which those physicians and chiropractic physicians perform such evaluations and certain other examinations.

Existing law authorizes an injured employee, subject to various requirements and restrictions, to obtain an independent medical examination concerning an injury

that is the subject of a claim filed pursuant to the Nevada Industrial Insurance Act. (NRS 616C.145) **Section 12** of this bill provides that such an injured employee is entitled to request such an independent examination for a permanent partial disability under certain circumstances. **Section 12** also identifies the method by which the rate of reimbursement relating to certain independent medical examinations must be determined and authorizes an insurer to recover the cost of certain examinations under certain circumstances.

Existing law sets forth the method by which a physician or chiropractic physician is selected under certain circumstances to determine the percentage of disability of an injured employee. (NRS 616C.100, 616C.330, 616C.360) **Sections 11, 15 and 16** of this bill require, with certain exceptions, that such physicians and chiropractic physicians be selected at random from a list maintained by the Administrator.

Existing law provides that a claimant under the Nevada Industrial Insurance Act may elect to receive payment for a permanent partial disability in a lump sum under certain circumstances. (NRS 616C.495) **Section 18** of this bill requires an insurer to use the actuarial annuity tables adopted by the Division that are in effect on the date on which the claimant elects payment in a lump sum to calculate the present value of the lump sum payable.

Existing law authorizes an insurer or employer who pays an annual increase in compensation for a permanent total disability to a claimant or dependent who is entitled to such compensation due to certain industrial injuries or disablements to obtain reimbursement from the Administrator and sets forth the procedure for obtaining such reimbursement. (NRS 616C.266) Similarly, existing law entitles an insurer who pays an increase in certain death benefits to be reimbursed annually for the amount of that increase and sets forth procedures for obtaining such reimbursement. (NRS 616C.268) **Sections 13 and 14** of this bill revise the procedures governing the issuance of such reimbursement to an insurer and impose various requirements on the Administrator with respect to such reimbursement.

Existing law requires the Administrator under certain circumstances to order an insurer, organization for managed care, health care provider, third-party administrator, employer or professional employer organization to pay a claimant a benefit penalty in an amount not less than $5,000 and not greater than $50,000 for refusing to process a claim for compensation or committing certain other violations of the Nevada Industrial Insurance Act or the Nevada Occupational Diseases Act. (NRS 616D.120) **Section 20** of this bill increases the amount of that benefit penalty to not less than $17,000 and not greater than $120,000. **Section 20** also extends from 10 days to 15 days the time in which a benefit penalty must be paid to a claimant after the Administrator determines the amount of the benefit penalty. **Section 19** of this bill requires the Administrator to publish, maintain and make available to the public on the Internet website of the Division certain information relating to benefit penalties imposed by the Administrator.

Existing law sets forth procedures by which a person may contest a decision of the Administrator to impose or refuse to impose a benefit penalty. Under existing law, a person who is aggrieved by a failure of the Administrator to respond to a written request for a determination within 90 days after the request is mailed to the Administrator may appeal the failure to respond by filing a request for a hearing within 100 days after the unanswered written request was mailed to the Administrator. (NRS 616D.140) **Section 22** of this bill revises those provisions to instead authorize a person who is aggrieved by the failure of the Administrator to respond to a complaint alleging that an insurer, organization for managed care, health care provider, third-party administrator, employer or professional employer organization has committed certain violations within 120 days after the

Administrator receives the complaint to appeal the failure to respond by filing a request for a hearing within 150 days after the receipt of the complaint. **Section 22** also: (1) requires a party who unsuccessfully appeals the imposition of a benefit penalty to pay a claimant double the amount of the benefit penalty initially imposed; (2) establishes certain requirements for when a benefit penalty must be paid; and (3) authorizes the Commissioner of Insurance to suspend a certification issued to an insurer, organization for managed care, health care provider, third-party administrator, employer or professional employer organization under certain circumstances.

Existing law requires the Administrator, upon receipt of a complaint or if the Administrator has reason to believe that certain provisions of the Nevada Industrial Insurance Act have been violated, to cause an investigation to be conducted and render a determination concerning those violations. (NRS 616D.130) **Section 21** of this bill broadens the circumstances under which the Administrator is required to cause an investigation to be conducted and requires the Administrator to: (1) provide the Commissioner and the suspected violator with a copy of the complaint or an explanation of the reason why the Administrator believes a violation has occurred and a copy of the determination rendered on the matter; and (2) include with the Administrator's determination any settlement agreement relating to the violation. **Section 21** also revises the time in which the Administrator must complete certain actions pursuant to the investigation.

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

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

Section 1. (Deleted by amendment.)

Sec. 2. Chapter 616B of NRS is hereby amended by adding thereto a new section to read as follows:

1. An employee of a private carrier who is licensed as a company adjuster pursuant to chapter 684A of NRS or a person who acts as a third-party administrator pursuant to chapters 616A to 616D, inclusive, or chapter 617 of NRS for a private carrier may administer claims arising under chapters 616A to 616D, inclusive, or chapter 617 of NRS from a location in or outside of this State. All records concerning a claim administered pursuant to this subsection must be maintained at one or more offices located in this State or by computer in a microphotographic, electronic or other similar format that produces an accurate reproduction of the original.

2. An employee of a private carrier who is not licensed as a company adjuster pursuant to chapter 684A of NRS or a person who acts as a third-party administrator pursuant to chapters 616A to 616D, inclusive, or chapter 617 of NRS for a self-insured employer or an association of self-insured public or private employers may administer claims arising under chapters 616A to

616D, inclusive, or chapter 617 of NRS only from one or more offices located in this State. All records concerning a claim administered pursuant to this subsection must be maintained in those offices.

3. The Commissioner may:

(a) Under exceptional circumstances, waive the requirements of subsections 1 and 2; and

(b) Adopt regulations to carry out the provisions of this section.

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

616B.021 1. An insurer shall ~~[provide access to]~~ ***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 ~~[its offices.]~~ ***this State; or***

(b) By electronic means.

2. The physical records in a file concerning a claim filed in this State may be kept at ~~[an office located]~~ ***a location*** outside this State if all records in the file are ~~[accessible]~~ ***made available for inspection and reproduction*** at ~~[offices]~~ ***an office operated by the insurer or its third-party administrator that is*** located in this State ~~[on]~~ ***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. NRS 616B.027 is hereby amended to read as follows:

616B.027 1. Every insurer shall:

(a) Provide an office in this State operated by the insurer or its third-party administrator in which:

(1) A complete file ***, or a reproduction of the complete file,*** of each claim is accessible, in accordance with the provisions of NRS 616B.021;

(2) Persons authorized to act for the insurer and, if necessary, licensed pursuant to chapter 683A of NRS, may receive information related to a claim and provide the services to an employer and his or her employees required by chapters 616A to 617, inclusive, of NRS; and

(3) An employee or his or her employer, upon request, is provided with information related to a claim filed by the employee or a copy or other reproduction of the information from the file for that claim, in accordance with the provisions of NRS 616B.021.

(b) Provide statewide toll-free telephone service to the office maintained pursuant to paragraph (a) **.** ~~[or accept collect calls from injured employees.]~~

2. Each private carrier shall provide:

(a) Adequate services to its insured employers in controlling losses; and

(b) Adequate information on the prevention of industrial accidents and occupational diseases.

3. An employee of a private carrier who is licensed as a company adjuster pursuant to chapter 684A of NRS or a person who acts as a third-party administrator pursuant to chapters 616A to 616D, inclusive, or chapter 617 of NRS for a private carrier who administers a claim arising under chapters 616A to 616D, inclusive, or chapter 617 of NRS from a location outside of this State pursuant to subsection 1 of section 2 of this act shall make himself or herself available to communicate in real time with the claimant or a representative of the claimant Monday through Friday, 9 a.m. to 5 p.m. local time in this State, excluding any day declared to be a legal holiday pursuant to NRS 236.015.

Sec. 5. NRS 616B.503 is hereby amended to read as follows:

616B.503 1. A person shall not act as a third-party administrator for an insurer without a certificate issued by the Commissioner pursuant to NRS 683A.08524.

2. A person who acts as a third-party administrator pursuant to chapters 616A to 616D, inclusive, or chapter 617 of NRS shall:

(a) ~~[Administer from one or more offices located in this State all of the claims arising under each plan of insurance that the person administers and maintain in those offices all of the records concerning those claims;~~

~~(b)]~~ Administer each plan of insurance directly, without subcontracting with another third-party administrator; and

~~[(c)]~~ ***(b)*** Upon the termination of the person's contract with an insurer, transfer forthwith to a certified third-party administrator chosen by the insurer all of the records in the person's possession concerning claims arising under the plan of insurance.

3. The Commissioner may, under exceptional circumstances, waive the requirements of subsection 2.

Sec. 6. NRS 616B.506 is hereby amended to read as follows:

616B.506 The Commissioner shall impose an administrative fine, not to exceed $1,000 for each violation, and may withdraw the certification of any third-party administrator who:

1. Fails to comply with regulations of the Commissioner regarding reports or other requirements necessary to carry out the purposes of chapters 616A to 616D, inclusive, or chapter 617 of NRS; or

2. Violates any provision of NRS 616B.503 ***, section 2 of this act*** or any regulation adopted by the Commissioner or the Administrator concerning the administration of the plan of insurance.

Sec. 7. Chapter 616C of NRS is hereby amended by adding thereto a new section to read as follows:

1. The Administrator shall, not later than 30 days after the end of each calendar quarter, publish and make publicly available on the Internet website of the Division a report containing:

(a) The name of each rating physician or chiropractic physician, listed in alphabetical order by last name, who conducted an examination or evaluation on an injured employee pursuant to NRS 616C.100, 616C.145, 616C.330, 616C.360 or 616C.490 in the immediately preceding calendar quarter; and

(b) For each rating physician or chiropractic physician identified pursuant to paragraph (a), the number of examinations or evaluations that were conducted by the rating physician or chiropractic physician as result of:

(1) The selection of the rating physician or chiropractic physician at random from the list of qualified physicians and

chiropractic physicians maintained by the Administrator pursuant to subsection 2 of NRS 616C.490; and

(2) An agreement by an insurer and an injured employee.

2. The Administrator shall retain an archive of each report published pursuant to subsection 1 which is accessible by the public.

Sec. 8. 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 in accordance with the provisions of NRS 616C.090;

(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 ~~[9]~~ ***12*** of NRS 616C.090 that notifies injured employees of their right to select an alternative treating physician or chiropractic physician. The Administrator shall adopt regulations for the manner of compliance by an insurer with the other provisions of subsection 1.

Sec. 9. 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 ~~[, an]~~ ***:***

(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:

~~[(a)]~~ ***(1)*** Orthopedic surgery on spines;
~~[(b)]~~ ***(2)*** Orthopedic surgery on shoulders;
~~[(c)]~~ ***(3)*** Orthopedic surgery on elbows;
~~[(d)]~~ ***(4)*** Orthopedic surgery on wrists;
~~[(e)]~~ ***(5)*** Orthopedic surgery on hands;
~~[(f)]~~ ***(6)*** Orthopedic surgery on hips;
~~[(g)]~~ ***(7)*** Orthopedic surgery on knees;
~~[(h)]~~ ***(8)*** Orthopedic surgery on ankles;
~~[(i)]~~ ***(9)*** Orthopedic surgery on feet;
~~[(j)]~~ ***(10)*** Neurosurgery;
~~[(k)]~~ ***(11)*** Neurology;
~~[(l)]~~ ***(12)*** Cardiology;
~~[(m)]~~ ***(13)*** Pulmonology;
~~[(n)]~~ ***(14)*** Psychiatry;
~~[(o)]~~ ***(15)*** Pain management;
~~[(p)]~~ ***(16)*** Occupational medicine;
~~[(q)]~~ ***(17)*** Physiatry or physical medicine;
~~[(r)]~~ ***(18)*** General practice or family medicine; and
~~[(s)]~~ ***(19)*** 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.

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.

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, 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.

6. Each insurer shall, not later than October 1 of each year, update the list of physicians and chiropractic physicians and file the list with the Administrator. The list must be certified by an adjuster who is licensed pursuant to chapter 684A of NRS.

7. Upon receipt of a list of physicians and chiropractic physicians that is filed pursuant to subsection 6, 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 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 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.

10. A physician or chiropractic physician may not be involuntarily removed from an insurer's list of physicians and chiropractic physicians except for good cause. As used in this subsection, "good cause" means that one or more of the following circumstances apply:

(a) The physician or chiropractic physician has died or is disabled.

(b) The license of the physician or chiropractic physician has been revoked or suspended.

(c) The physician or chiropractic physician has been convicted of:

(1) A felony; or

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

(d) 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 ~~[has]~~ ***:***

(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.

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 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. 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.

Sec. 10. NRS 616C.090 is hereby amended to read as follows:

616C.090 1. The Administrator shall establish, maintain and update not less frequently than annually on or before July 1 of each year, a panel of physicians and chiropractic physicians 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 physician and chiropractic physician on the panel:

(a) The name of the physician or chiropractic physician.

(b) The title or degree of the physician or chiropractic physician.

(c) The legal name of the practice of the physician or chiropractic physician and the name under which the practice does business.

(d) The street address of the location of every office of the physician or chiropractic physician.

(e) The telephone number of every office of the physician or chiropractic physician.

(f) Every discipline and specialization practiced by the physician or chiropractic physician.

(g) Every condition and part of the body which the physician or chiropractic physician 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 physicians and chiropractic physicians 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 a treating physician or chiropractic physician from the panel of physicians and chiropractic physicians. If the injured employee is not satisfied with the first physician or chiropractic physician he or she so chooses, the injured employee may make an alternative choice of physician or chiropractic physician from the panel if the choice is made within 90 days after his or her injury. The insurer shall notify the first physician or chiropractic physician in writing. The notice must be postmarked within 3 working days after the insurer receives knowledge of the change. The first physician or chiropractic physician must be reimbursed only for the services the physician or chiropractic physician, as applicable, 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 physician or chiropractic physician 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 physician or chiropractic physician must include the name of the new physician or chiropractic physician chosen by the injured employee. If the treating physician or chiropractic physician 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 physician or chiropractic physician with that specialization who is on the panel. Not later than 14 days after receiving the list, the injured employee shall select a physician or chiropractic physician 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 a treating physician or chiropractic physician pursuant to the terms of that contract. If the injured employee is not satisfied with the first physician or chiropractic physician he or she so chooses, the injured employee may make an alternative choice of physician or chiropractic physician 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 physician or chiropractic physician 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 a treating physician or chiropractic physician, 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 physician or chiropractic physician, the injured employee must choose a treating physician or chiropractic physician who has agreed to the terms of that contract unless the insurer authorizes the injured employee to choose another physician or chiropractic physician. If the treating physician or chiropractic physician 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 physician or chiropractic physician 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 a physician or chiropractic physician from the list. If the employee fails to select a physician or chiropractic physician, the insurer may select a physician or chiropractic physician with that specialization. If a physician or chiropractic physician 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 a physician or chiropractic physician with that specialization.

5. If the injured employee is not satisfied with the physician or chiropractic physician 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 physician or chiropractic physician pursuant to the terms of the contract. A change in the treating physician or chiropractic physician 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 physician or chiropractic physician must be granted or denied within 10 days after a written request for such a change is received from the injured employee. If no action is taken on the request within 10 days, the request shall be deemed granted. Any request for a change of physician or chiropractic physician must include the name of the new physician or chiropractic physician chosen by the injured employee. If the

insurer denies a request for a change in the treating physician or chiropractic physician 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 physician, chiropractic physician or other person selected by the injured employee in disregard of the provisions of this section or for any compensation for any aggravation of the injured employee's injury attributable to improper treatments by such physician, chiropractic physician or other person.

7. The Administrator may order necessary changes in a panel of physicians and chiropractic physicians and shall ~~[suspend]~~ ***:***

(a) Suspend or remove any physician or chiropractic physician from a panel for good cause shown in accordance with NRS 616C.087 ~~[.]~~ ***; and***

(b) Remove from being included on a panel as a practitioner of a discipline or specialization any physician or chiropractic physician who does not accept and treat injured employees for industrial injuries or occupational diseases in that discipline or specialization.

8. ***Any interested person may notify the Administrator, on a form prescribed by the Administrator, if the person believes that a physician or chiropractic physician does not accept and treat injured employees:***

(a) Under chapters 616A to 616D, inclusive, or chapter 617 of NRS for industrial injuries or occupational diseases; or

(b) For industrial injuries or occupational diseases in a discipline or specialization for which the physician or chiropractic physician is included on a panel of physicians and chiropractic physicians maintained by the Administrator pursuant to this section.

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

(a) Conduct an investigation to determine whether the physician or chiropractic physician may remain on the panel for a discipline or specialization; 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. A physician or chiropractic physician who is removed from a panel as a practitioner of a discipline or specialization pursuant to paragraph (b) of subsection 7 may request, on a form prescribed by the Administrator, to be reinstated on a panel for that discipline or specialization if the physician or chiropractic physician demonstrates to the satisfaction of the Administrator that he or she accepts and treats injured employees for that discipline or specialization.

11. An injured employee may receive treatment by more than one physician or chiropractic physician:

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

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

~~[9.]~~ ***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 treating physician or chiropractic physician and make the form available to insurers for distribution pursuant to subsection 2 of NRS 616C.050.

Sec. 11. NRS 616C.100 is hereby amended to read as follows:

616C.100 1. If an injured employee disagrees with the percentage of disability determined by a physician or chiropractic physician, the injured employee may obtain a second determination of the percentage of disability. If the employee wishes to obtain such a determination, the employee must select the ~~[next]~~ physician or chiropractic physician ~~[in rotation]~~ ***at random*** from the list of qualified physicians or chiropractic physicians maintained by the Administrator pursuant to subsection 2 of NRS 616C.490. If a second determination is obtained, the injured employee shall pay for the determination. If the physician or chiropractic physician selected to make the second determination finds a higher percentage of disability than the first physician or chiropractic physician, the injured employee may request a hearing officer or appeals officer to order the insurer to reimburse the employee pursuant to the provisions of NRS 616C.330 or 616C.360.

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

Sec. 12. NRS 616C.145 is hereby amended to read as follows:

616C.145 1. An injured employee may obtain an independent medical examination:

(a) Except as otherwise provided in subsections 2 and 3, whenever a dispute arises from a determination issued by the insurer regarding the approval of care, the direction of a treatment plan or the scope of the claim;

(b) Within 30 days after an injured employee receives any report generated pursuant to a medical examination requested by the insurer pursuant to NRS 616C.140; or

(c) At any time by leave of a hearing officer or appeals officer after the denial of any therapy or treatment.

2. An injured employee is entitled to an independent medical examination pursuant to paragraph (a) of subsection 1 only:

(a) For a claim for compensation that is open;

(b) When the closure of a claim for compensation is under dispute pursuant to NRS 616C.235; or

(c) When a hearing or appeal is pending pursuant to NRS 616C.330 or 616C.360.

3. An injured employee is entitled to only one independent medical examination per calendar year pursuant to paragraph (a) of subsection 1.

4. Except as otherwise provided in subsection 5, an independent medical examination must not involve treatment and must be conducted by a physician or chiropractic physician selected by the injured employee from the panel of physicians and chiropractic physicians established pursuant to subsection 1 of NRS 616C.090.

5. ~~[If the dispute concerns the rating of a permanent disability,]~~ ***An injured employee is entitled to request*** an independent medical examination ~~[may be conducted by a rating physician or chiropractic physician.]~~ ***pursuant to paragraph (a) of subsection 1 for a permanent partial disability to determine if the injured employee has a ratable impairment or, if the injured employee is seeking to dispute an initial rating determination, to obtain a second rating.*** The injured employee must select the ~~[next]~~ rating physician or chiropractic physician ~~[in rotation]~~ ***at random*** from the list of qualified physicians and chiropractic physicians maintained by the Administrator pursuant to subsection 2 of NRS 616C.490, unless the insurer and the injured employee otherwise agree to a rating physician or chiropractic physician. ***Nothing in this subsection shall be construed to prohibit an injured employee from obtaining a determination for a permanent partial disability pursuant to NRS 616C.100.***

6. The insurer shall:

(a) Pay the costs of any independent medical examination conducted pursuant to this section in accordance with ~~[NRS 616C.260;]~~ ***subsection 7;*** and

(b) Upon request, receive a copy of any report or other document that is generated as a result of the independent medical examination.

7. ***The rates of reimbursement for an independent medical examination conducted pursuant to this section must be:***

(a) For an independent medical examination other than an independent medical examination conducted pursuant to subsection 5, the rates applicable to independent medical examinations, as set forth in the schedule of fees established by the Administrator pursuant to NRS 616C.260.

(b) For an independent medical examination conducted pursuant to subsection 5, the rates applicable to a permanent partial disability, as set forth in the schedule of fees established by the Administrator pursuant to NRS 616C.260.

8. If an injured employee requests an independent medical examination pursuant to subsection 5 to obtain a second rating and the second rating does not result in a higher percentage of disability than the initial rating determination, the insurer may recover the cost of the independent medical examination, determined in accordance with the rates of reimbursement specified in paragraph (b) of subsection 7, from the amount of the award for permanent partial disability that the injured employee is entitled to be paid for that claim pursuant to NRS 616C.490.

9. The provisions of this section do not apply to an independent medical examination ordered by a hearing officer pursuant to subsection 3 of NRS 616C.330 or by an appeals officer pursuant to subsection 3 of NRS 616C.360.

Sec. 13. NRS 616C.266 is hereby amended to read as follows:

616C.266 1. An insurer, including an employer who provides accident benefits for injured employees pursuant to NRS 616C.265, who pays an annual increase in compensation for a permanent total disability to a claimant or a dependent of a claimant pursuant to subsection 2 of NRS 616C.473 is entitled to be reimbursed for the amount of that increase in accordance with this section if the insurer provides to the Administrator all of the following:

(a) The name of the claimant or dependent of a claimant to whom the insurer paid the increase in compensation.

(b) The claim number under which the compensation for a permanent total disability was paid to the claimant or dependent of a claimant.

(c) The date of the industrial injury or disablement from an occupational disease which resulted in the permanent total disability of the injured employee.

(d) The date on which the disability of the injured employee was determined or deemed to be total and permanent.

(e) The amount of the compensation for a permanent total disability to which the claimant or dependent of a claimant was entitled as of December 31, 2019.

(f) Proof of the insurer's payment of the increase in compensation for a permanent total disability.

(g) The amount of reimbursement requested by the insurer.

2. An insurer must provide the Administrator with the items required pursuant to subsection 1 not later than March 31 of each year to be eligible for reimbursement for payments of increases in compensation for permanent total disability which were made in the immediately preceding calendar year.

3. ~~[An]~~ ***If an*** insurer ~~[may not be reimbursed pursuant to this section unless the insurer's request for reimbursement is approved by]~~ ***complies with subsection 2,*** the Administrator ~~[.]~~ ***shall:***

(a) Not later than 60 days after the date on which the Administrator receives the information required by subsection 1, issue a written determination approving or rejecting the insurer's request for reimbursement. If the Administrator fails to issue the written determination within those 60 days, the request for reimbursement is deemed approved.

(b) Not later than July 1 of each year, provide the insurer with a detailed list of reimbursements approved or rejected by the Administrator.

4. ~~[If]~~ ***A person who is aggrieved by a written determination of*** the Administrator ~~[approves an insurer's request for reimbursement,]~~ ***pursuant to this section may appeal*** the ~~[Administrator must withdraw from the Uninsured Employers' Claim Account established pursuant to NRS 616A.430 an amount of the income realized from the investment of the assets in that Account that is necessary to reimburse]~~ ***determination by filing a request for a hearing before an appeals officer. The request must be filed not later than 30 days after*** the ~~[insurer or employer for]~~ ***date on which*** the ~~[cost]~~ ***insurer receives notice*** of the ~~[increase in compensation paid to claimants and dependents pursuant to subsection 2 of NRS 616C.473. If the income realized from the investment of the assets in the Account is insufficient to pay such reimbursement, the Administrator must pay the remainder of the reimbursement from the assessments levied by the Administrator pursuant to NRS 232.680.]~~ ***Administrator's determination.***

5. ***The Administrator shall, not later than May 31 of each year, mail to each insurer an invoice for any assessment levied by***

the Administrator pursuant to NRS 232.680 to be used to pay reimbursement pursuant to this section. Each insurer shall, not later than July 31 of each year, pay to the Department of Business and Industry the amount of the assessment.

6. The Administrator shall make every effort to collect from an insurer the amount of the assessment described in subsection 5. If the Administrator is not able to collect the amount of the assessment within 60 days after July 31, the Administrator shall notify the Commissioner that the insurer is delinquent. An insurer who fails or refuses to pay the amount of an assessment within 60 days after July 31 is, after notice and a hearing held pursuant to NRS 679B.310 to 679B.370, inclusive, subject to revocation of the insurer's certificate of authority to transact insurance in this State.

7. The Administrator shall, not later than December 31 of each year, reimburse each insurer that has paid an annual increase in compensation for a permanent total disability pursuant to subsection 1.

8. In an insurer fails to pay the amount of the assessment described in subsection 5, the Administrator shall apportion to the insurers that have paid the amount of the assessment an amount of reimbursement calculated in the same manner in which the Administrator determines the assessment rate applied to those insurers pursuant to NRS 232.680. Upon receipt of the amount of the assessment that is paid after July 31, the Administrator shall pay to each insurer, the remaining amount of reimbursement to which the insurer is entitled.

9. An insurer may elect to apply any approved reimbursement under this section towards any current or future assessment levied by the Administrator pursuant to NRS 232.680.

Sec. 14. NRS 616C.268 is hereby amended to read as follows:

616C.268 1. An insurer, including, without limitation, an employer who provides accident benefits for injured employees pursuant to NRS 616C.265, who pays an increase in death benefits to a widow, widower, surviving child or surviving dependent parent pursuant to NRS 616C.508 is entitled to be reimbursed for the amount of that increase from the Fund for Workers' Compensation and Safety if the insurer provides to the Administrator all of the following:

(a) The name of the widow, widower, surviving child or surviving dependent parent to whom the insurer paid the increase in death benefits.

(b) The claim number under which death benefits were paid to the widow, widower, surviving child or surviving dependent parent.

(c) The date of the industrial injury or disablement from an occupational disease which resulted in the eligibility of the widow, widower, surviving child or surviving dependent parent for death benefits.

(d) The date of the death of the injured employee who is the:

(1) Spouse of the widow or widower;

(2) Parent of the surviving child; or

(3) Child of the surviving dependent parent.

(e) The amount of the death benefit to which the widow, widower, surviving child or surviving dependent parent was entitled as of December 31, 2019.

(f) Proof of the insurer's payment of the increase in death benefits.

(g) The amount of reimbursement requested by the insurer.

2. An insurer must provide the Administrator with the information required pursuant to subsection 1 not later than March 31 of each year to be eligible for reimbursement pursuant to this section for payments of increases in death benefits which were made in the immediately preceding calendar year.

3. ~~[An]~~ ***If an*** insurer ~~[may not be reimbursed pursuant to this section unless the insurer's request for reimbursement is approved by]~~ ***complies with subsection 2,*** the Administrator ~~[.]~~ ***shall:***

(a) Not later than 60 days after the date on which the Administrator receives the information required by subsection 1, issue a written determination approving or rejecting the insurer's request for reimbursement. If the Administrator fails to issue the written determination within those 60 days, the request for reimbursement is deemed approved.

(b) Not later than July 1 of each year, provide the insurer with a detailed list of reimbursements approved or rejected by the Administrator.

4. ***A person who is aggrieved by a written determination of the Administrator pursuant to this section may appeal the determination by filing a request for a hearing before an appeals officer. The request must be filed not later than 30 days after the date on which the insurer receives notice of the Administrator's determination.***

5. The Administrator shall, not later than May 31 of each year, mail to each insurer an invoice for any assessment levied by the Administrator pursuant to NRS 232.680 to be used to pay reimbursement pursuant to this section. Each insurer shall, not

later than July 31 of each year, pay to the Department of Business and Industry the amount of the assessment.

6. The Administrator shall make every effort to collect from an insurer the amount of the assessment described in subsection 5. If the Administrator is not able to collect the amount of the assessment within 60 days after July 31, the Administrator shall notify the Commissioner that the insurer is delinquent. An insurer who fails or refuses to pay the amount of an assessment within 60 days after July 31 is, after notice and a hearing held pursuant to NRS 679B.310 to 679B.370, inclusive, subject to revocation of the insurer's certificate of authority to transact insurance in this State.

7. The Administrator shall, not later than December 31 of each year, reimburse each insurer that has paid an annual increase in death benefits pursuant to subsection 1.

8. If an insurer fails to pay the amount of the assessment described in subsection 5, the Administrator shall apportion to the insurers that have paid the amount of the assessment an amount of reimbursement calculated in the same manner in which the Administrator determines the assessment rate applied to those insurers pursuant to NRS 232.680. Upon receipt of the amount of the assessment that is paid after July 31, the Administrator shall pay to each insurer the remaining amount of reimbursement to which the insurer is entitled.

9. An insurer may elect to apply any approved reimbursement made pursuant to this section towards any current or future assessment levied by the Administrator pursuant to NRS 232.680.

Sec. 15. NRS 616C.330 is hereby amended to read as follows:

616C.330 1. The hearing officer shall:

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

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

(c) Conduct hearings expeditiously and informally.

2. The notice must include a statement that the injured employee may be represented by a private attorney or seek

assistance and advice from the Nevada Attorney for Injured Workers.

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

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

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

6. The hearing officer shall order an insurer, organization for managed care or employer who provides accident benefits for injured employees pursuant to NRS 616C.265 to pay to the appropriate person the charges of a provider of health care if the conditions of NRS 616C.138 are satisfied.

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

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

(a) The hearing; or

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

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

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

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

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

Sec. 16. NRS 616C.360 is hereby amended to read as follows:

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

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

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

(a) Order an independent medical examination and refer the employee to a physician or chiropractic physician of his or her choice who has demonstrated special competence to treat the

particular medical condition of the employee, whether or not the physician or chiropractic physician is on the insurer's panel of providers of health care. If the medical question concerns the rating of a permanent disability, the appeals officer may refer the employee to a rating physician or chiropractic physician. The rating physician or chiropractic physician must be selected ~~[in rotation]~~ ***at random*** from the list of qualified physicians or chiropractic physicians maintained by the Administrator pursuant to subsection 2 of NRS 616C.490, unless the insurer and the injured employee otherwise agree to a rating physician or chiropractic physician. The insurer shall pay the costs of any examination requested by the appeals officer.

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

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

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

6. The appeals officer shall order an insurer, organization for managed care or employer who provides accident benefits for injured employees pursuant to NRS 616C.265 to pay to the appropriate person the charges of a provider of health care if the conditions of NRS 616C.138 are satisfied.

7. Any party to the appeal or contested case or the appeals officer may order a transcript of the record of the hearing at any time before the seventh day after the hearing. The transcript must be

filed within 30 days after the date of the order unless the appeals officer otherwise orders.

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

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

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

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

(a) The date of the hearing; or

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

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

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

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

Sec. 17. NRS 616C.490 is hereby amended to read as follows:

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

2. Except as otherwise provided in subsection 3:

(a) Within 30 days after receiving from a physician or chiropractic physician a report indicating that the injured employee may have suffered a permanent disability and is stable and ratable, the insurer shall schedule an appointment with the rating physician or chiropractic physician selected pursuant to this subsection to determine the extent of the employee's disability.

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

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

(2) Rating physicians and chiropractic physicians must be selected ~~[in rotation]~~ ***at random*** from the list of qualified physicians and chiropractic physicians designated by the Administrator ~~[, according to their area of specialization and the order in which their names appear on the list]~~ unless the ~~[next]~~ physician or chiropractic physician ***who is selected*** is currently an employee of the insurer making the selection, in which case ~~[the insurer must select the]~~ ***another random selection must be made until a*** physician or chiropractic physician ~~[who is next on the list and]~~ who is not currently an employee of the insurer ~~[.]~~ ***is selected.***

(3) A rating physician or chiropractic physician selected pursuant to subparagraph (1) or (2) may decline the selection if he or she believes he or she does not have the ability to rate the disability at issue.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10. If there is a previous disability, the percentage of disability for a subsequent injury must be determined pursuant to NRS 616C.099.

11. In the event of a dispute over an award of compensation for permanent partial disability, the insurer shall commence making installment payments to the injured employee for that portion of the award that is not in dispute:

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

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

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

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

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

15. The Administrator shall prepare and publish on the Internet website of the Division an annual report which contains:

(a) The name of each rating physician or chiropractic physician who was selected in the immediately preceding year to conduct an evaluation to determine the extent of an employee's disability pursuant to this section; and

(b) For each rating physician or chiropractic physician identified pursuant to paragraph (a):

(1) The number of times the rating physician or chiropractic physician was selected to conduct an evaluation to determine the extent of an employee's disability; and

(2) The number of evaluations that the rating physician or chiropractic physician completed.

Sec. 18. NRS 616C.495 is hereby amended to read as follows:

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

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

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

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

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

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

(2) Exceeds 25 percent may:

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

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

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

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

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

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

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

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

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

(a) The right of the claimant to:

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

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

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

(c) The right of the claimant to receive a benefit penalty in accordance with NRS 616D.120; and

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

(1) The scope of the claim;

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

(3) The claimant's average monthly wage.

3. The claimant, when he or she demands payment in a lump sum pursuant to subsection 2, must be provided with a written notice which prominently displays a statement describing the effects of accepting payment in a lump sum of an entire permanent partial disability award, any portion of such an award or any uncontested

portion of such an award, and that the claimant has 20 days after the mailing or personal delivery of the notice within which to retract or reaffirm the demand, before payment may be made and the claimant's election becomes final.

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

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

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

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

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

7. ***To calculate the present value of a lump sum payable to a claimant, the insurer shall use the actuarial annuity tables adopted by the Division that are in effect on the date on which the claimant elects payment in a lump sum.***

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

Sec. 19. Chapter 616D of NRS is hereby amended by adding thereto a new section to read as follows:

1. If the Administrator orders an insurer, organization for managed care, health care provider, third-party administrator, employer or professional employer organization to pay a benefit

penalty pursuant to NRS 616D.120, the Administrator shall post on the Internet website of the Division:

(a) The full legal name of the insurer, organization for managed care, health care provider, third-party administrator, employer or professional employer organization;

(b) The amount of the benefit penalty imposed; and

(c) A brief description of the violation for which the benefit penalty was imposed.

2. The information required by subsection 1 must:

(a) Be published not more than 30 days after the date on which the time for taking an appeal on the order to impose the benefit penalty has elapsed or the date on which all appeals regarding the order have been exhausted and the order to impose the benefit penalty has been upheld, whichever is later.

(b) Remain posted on the Internet website of the Division for not less than 5 years after the date on which it is initially posted.

3. The Administrator shall establish and maintain on the Internet website of the Division a database which:

(a) Contains the information required by subsection 1;

(b) Is publicly accessible;

(c) Is searchable; and

(d) Is updated regularly.

Sec. 20. 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,

➥ 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 violation, as defined by regulations adopted by the Division; or

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

➥ The notice of correction must set forth with particularity the violation committed and the manner in which the violation may be corrected. The provisions of this section do not authorize the Administrator to modify or negate in any manner a determination or any portion of a determination made by a hearing officer, appeals officer or court of competent jurisdiction or a provision contained in a written settlement agreement or written stipulation.

(b) Impose an administrative fine for:

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

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

➥ The fine imposed must not be greater than $375 for an initial violation, or more than $3,000 for any second or subsequent violation.

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

3. If the Administrator determines that a violation of any of the provisions of paragraphs (a) to (e), inclusive, (h) or (i) 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 ~~[$5,000]~~ ***$17,000*** and not greater than ~~[$50,000;]~~ ***$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), (h) or (i) 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), (h) or (i) 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 ~~[10]~~ ***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 ~~[10]~~ ***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. 21. NRS 616D.130 is hereby amended to read as follows:

616D.130 1. Upon receipt of a complaint for a violation of subsection 1 ***, 2 or 3*** of NRS 616D.120, or if the Administrator has reason to believe that such a violation has occurred, the Administrator shall ~~[cause]~~ ***:***

(a) Promptly provide a copy of the complaint, or an explanation of the reason the Administrator believes that a violation has occurred to ***:***

(1) The Commissioner; and

(2) The insurer, organization for managed care, health care provider, third-party administrator, employer or professional employer organization that allegedly committed the violation; and

(b) Cause to be conducted an investigation of the alleged violation. ~~[Except as otherwise provided in subsection 2, the]~~

2. The Administrator shall ~~[, within]~~ ***:***

(a) Within 30 days after ~~[initiating the]~~ ***receipt of a complaint, initiate an*** investigation ~~[:~~

~~(a) Render~~ ***;***

(b) Within 60 days after the date on which the investigation is initiated, complete the investigation; and

(c) Within 30 days after the investigation is completed, render a determination ~~.~~ ***and deliver a copy of the determination to:***

(1) The Commissioner; and

(2) The insurer, organization for managed care, health care provider, third-party administrator, employer or professional employer organization that was the subject of the investigation.

3. The determination ***rendered pursuant to subsection 2*** must include the Administrator's findings of fact ***, any settlement agreement on the matter*** and, if the Administrator determines that a violation has occurred, one or more of the following:

~~(1)~~ ***(a)*** The amount of any fine required to be paid pursuant to NRS 616D.120.

~~(2)~~ ***(b)*** The amount of any benefit penalty required to be paid to a claimant pursuant to NRS 616D.120.

~~(3)~~ ***(c)*** A plan of corrective action to be taken by the insurer, organization for managed care, health care provider, third-party administrator or employer, including the manner and time within which the violation must be corrected.

~~(4)~~ ***(d)*** A requirement that notice of the violation be given to the appropriate agency that regulates the activities of the violator.

~~(b) Notify the Commissioner if the Administrator determines that a violation was committed by a self-insured employer, association of self-insured public or private employers or third-party administrator.~~

~~2. Upon receipt of a complaint for any violation of paragraph (a), (b), (c) or (d) of subsection 1 of NRS 616D.120, or if the Administrator has reason to believe that such a violation has occurred, the Administrator shall complete the investigation required by subsection 1 within 60 days and, within 30 days after the completion of the investigation, render a determination and notify the Commissioner if the Administrator determines that a violation was committed by a self-insured employer, association of self-insured public or private employers or third-party administrator.~~

~~3.~~ ***4.*** If, based upon the Administrator's findings of fact, the Administrator determines that a violation has not occurred, the Administrator shall issue a determination to that effect.

Sec. 22. NRS 616D.140 is hereby amended to read as follows:

616D.140 1. If a person wishes to contest a decision of the Administrator to impose or refuse to impose a benefit penalty pursuant to NRS 616D.120, the person must file a notice of appeal

with an appeals officer in accordance with this section. The notice of appeal must set forth the reasons the proposed benefit penalty should or should not be imposed.

2. A person who is aggrieved by:

(a) A written determination of the Administrator; or

(b) The failure of the Administrator to respond within ~~[90]~~ ***120*** days to a ~~[written request mailed to]~~ ***complaint filed pursuant to NRS 616D.130 and received by*** the Administrator ~~[by]~~ ***from*** the person who is aggrieved,

➥ may appeal from the determination or failure to respond by filing a request for a hearing before an appeals officer. The request must be filed within 30 days after the date on which the notice of the Administrator's determination was mailed by the Administrator or within ~~[100]~~ ***150*** days after the date on which the unanswered ~~[written request was mailed to]~~ ***complaint was received by*** the Administrator, as applicable. The failure of the Administrator to respond ~~[to a written request for a determination]~~ within ~~[90]~~ ***120*** days after receipt of the ~~[request]~~ ***complaint*** shall be deemed by the appeals officer to be a denial ~~[of the request.]~~ ***of any allegation of a violation of subsection 1, 2 or 3 of NRS 616D.120 set forth in the complaint. After the expiration of the 120-day period after receipt of the complaint, the Administrator shall have no further jurisdiction to issue a determination concerning the complaint, and only the appeals officer shall have jurisdiction over the decision to impose or refuse to impose the benefit penalty.***

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

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

5. A benefit penalty imposed pursuant to NRS 616D.120 must be paid to the claimant on whose behalf it is imposed. If such a payment is not made within the period required by NRS 616D.120, the benefit penalty may be recovered in a civil action brought by the Administrator on behalf of the claimant in a court of competent jurisdiction in the county in which the claimant resides, in which the violation occurred or in which the person who is required to pay the benefit penalty has his or her principal place of business.

6. Any party aggrieved by a decision issued pursuant to this section by an appeals officer may appeal the decision directly to the district court.

7. If an appeals officer or district court renders a decision upholding the imposition of a benefit penalty, the insurer, organization for managed care, health care provider, third-party administrator, employer or professional employer organization upon which the benefit penalty is imposed shall, not later than 30 days after the date on which the decision is rendered, unless an appeal is filed and a stay has been granted, pay to the claimant the benefit penalty in an amount equal to twice the amount of the benefit penalty initially imposed.

8. If a claimant enters into a settlement agreement with an insurer, organization for managed care, health care provider, third-party administrator, employer or professional employer organization concerning the amount of a benefit penalty owed to the claimant, the insurer, organization for managed care, health care provider, third-party administrator, employer or professional employer organization shall pay directly to the claimant the amount agreed upon in the settlement agreement not later than 15 days after the date on which the settlement agreement is made.

9. If an insurer, organization for managed care, health care provider, third-party administrator, employer or professional employer organization fails to pay a benefit penalty to a claimant within the time limits imposed by this section or subsection 4 of NRS 616D.120, the Commissioner may suspend, pending an investigation or any other disciplinary action, any certificate issued by the Commissioner to the insurer, organization for managed care, health care provider, third-party administrator, employer or professional employer organization, as applicable.

Sec. 23. The amendatory provisions of sections 19 to 22, inclusive, of this act apply only with respect to claims which are filed on or after January 1, 2024.

Sec. 24. 1. This section and section 23 of this act become effective upon passage and approval.

2. Sections 1 to 22, inclusive, of this act become 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, 2024, for all other purposes.