SENATE BILL NO. 232–COMMITTEE ON COMMERCE, LABOR AND ENERGY

MARCH 9, 2015

Referred to Committee on Commerce, Labor and Energy

SUMMARY—Makes various changes relating to workers' compensation. (BDR 53-987)

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

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

AN ACT relating to workers' compensation; providing to a workers' compensation insurer, organization for managed care, third-party administrator or employer certain subrogation rights regarding certain payments made for the treatment of an injured employee; revising provisions relating to the reopening of a workers' compensation claim; revising provisions relating to a lump-sum award to an employee for a permanent partial disability; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

This bill revises various provisions of the Nevada Industrial Insurance Act, which provides for the payment of compensation to employees who are injured or disabled as the result of an occupational injury. (Chapters 616A-616D of NRS)

Existing law provides that if an insurer, organization for managed care, third-party administrator or employer denies coverage for medical treatment or services related to an employee's injury, and the employee's health or casualty insurer pays for such treatment or services, the health or casualty insurer may seek reimbursement from the insurer, organization for managed care, third-party administrator or employer if a hearing officer or appeals officer ultimately determines that the treatment or services should have been covered by the insurer, organization for managed care, third-party administrator or employer. (NRS 616C.138) **Section 1** of this bill provides a reciprocal right to reimbursement in situations in which an insurer, organization for managed care, third-party administrator or employer appeals an order of a hearing officer, appeals officer or district court and the order is not stayed pending the appeal. In such situations, if the appeal is successful, the insurer, organization for managed care, third-party administrator or employer is entitled to seek reimbursement from the injured

employee's health or casualty insurer for payments made while the appeal was pending.

Existing law provides for the reopening of a workers' compensation claim under certain circumstances and conditions. (NRS 616C.390) Under these provisions, an employee has 1 year to file an application to reopen a claim if the employee was not off work as a result of the injury and did not receive benefits for a permanent partial disability. **Section 2** of this bill revises NRS 616C.390 to provide that an employee has 1 year to file an application to reopen a claim if the employee was not incapacitated from earning full wages for at least 5 consecutive days or 5 cumulative days within a 20-day period.

Existing law provides that an injured employee who suffers a permanent partial disability may elect to receive compensation for that injury in a lump sum. (NRS 616C.495) **Section 3** of this bill provides that an employee who has sustained more than one permanent partial disability may not receive compensation for any portion of an injury that is based on a combined permanent partial disability rating for all the employee's injuries that exceeds 100 percent.

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

Section 1. NRS 616C.138 is hereby amended to read as follows:

616C.138 1. Except as otherwise provided in this section, if a provider of health care provides treatment or other services that an injured employee alleges are related to an industrial injury or occupational disease and an insurer, an organization for managed care, a third-party administrator or an employer who provides accident benefits for injured employees pursuant to NRS 616C.265 denies authorization or responsibility for payment for the treatment or other services, the provider of health care is entitled to be paid for the treatment or other services as follows:

(a) If the treatment or other services will be paid by a health insurer which has a contract with the provider of health care under a health benefit plan that covers the injured employee, the provider of health care is entitled to be paid the amount that is allowed for the treatment or other services under that contract.

(b) If the treatment or other services will be paid by a health insurer which does not have a contract with the provider of health care as set forth in paragraph (a) or by a casualty insurer or the injured employee, the provider of health care is entitled to be paid not more than:

(1) The amount which is allowed for the treatment or other services set forth in the schedule of fees and charges established pursuant to NRS 616C.260; or

(2) If the insurer which denied authorization or responsibility for the payment has contracted with an organization for managed care or with providers of health care pursuant to NRS 616B.527, the

amount that is allowed for the treatment or other services under that contract.

2. The provisions of subsection 1:

(a) Apply only to treatment or other services provided by the provider of health care before the date on which the insurer, organization for managed care, third-party administrator or employer who provides accident benefits first denies authorization or responsibility for payments for the alleged industrial injury or occupational disease.

(b) Do not apply to a provider of health care that is a hospital as defined in NRS 439B.110. The provisions of this paragraph do not exempt the provider of health care from complying with the provisions of subsections 3 and ~~[4.]~~ ***7.***

3. If:

(a) The injured employee pays for the treatment or other services or a health or casualty insurer pays for the treatment or other services on behalf of the injured employee;

(b) The injured employee requests a hearing before a hearing officer or appeals officer regarding the denial of coverage; and

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

➥ the hearing officer or appeals officer shall order the insurer, organization for managed care, third-party administrator or employer who provides accident benefits to pay to the injured employee or the health or casualty insurer the amount which the injured employee or the health or casualty insurer paid that is allowed for the treatment or other services set forth in the schedule of fees and charges established pursuant to NRS 616C.260 or, if the insurer has contracted with an organization for managed care or with providers of health care pursuant to NRS 616B.527, the amount that is allowed for the treatment or other services under that contract.

4. ***If:***

(a) A hearing officer, appeals officer or district court issues an order or otherwise renders a decision requiring an insurer, organization for managed care, third-party administrator or employer to pay for treatment or other services provided to an injured employee;

(b) The insurer, organization for managed care, third-party administrator or employer appeals the order or decision, but is unable to obtain a stay of the order or decision;

(c) Payment for the treatment or other services provided to the injured employee is made by the insurer, organization for managed care, third-party administrator or employer during the period between the date of the issuance of the order or decision and the date of the final resolution of the appeal; and

(d) The appeal is subsequently resolved in favor of the insurer, organization for managed care, third-party administrator or employer,

➥ the insurer, organization for managed care, third-party administrator or employer may recover from any health or casualty insurer of the injured employee an amount calculated pursuant to subsection 5. Any recovery from a health or casualty insurer pursuant to this subsection is subject to the exclusions and limitations of the policy of health or casualty insurance covering the injured employee that relate to the diseases set forth in NRS 617.453, 617.455 and 617.457.

5. An insurer, organization for managed care, third-party administrator or employer entitled to recover for an amount paid during the pendency of an appeal pursuant to subsection 4, may recover from a health or casualty insurer of the injured employee the lesser of:

(a) The amount actually paid by the insurer, organization for managed care, third-party administrator or employer during the period between the issuance of the order and the final resolution of the appeal;

(b) The amount established for the treatment or services provided to the injured employee pursuant to NRS 616C.260 or the usual fee charged by the provider of health care, whichever is less;

(c) The amount provided for the treatment or services provided to the injured employee on an in-network basis if there is a contract between the provider of health care and the health or casualty insurer of the injured employee and the treatment or services are covered under the terms of the policy of health or casualty insurance covering the employee; or

(d) The amount provided for the treatment or services provided to the injured employee on an out-of-network basis pursuant to the terms of the policy of health or casualty insurance covering the injured employee if there is not a contract between the provider of health care and the health or casualty insurer of the injured employee.

6. If an insurer, organization for managed care, third-party administrator or employer is entitled to recover for an amount paid during the pendency of an appeal pursuant to subsection 4, upon a final resolution of the appeal in favor of the insurer, organization for managed care, third-party administrator or

employer, the hearing officer, appeals officer or district court shall order the injured employee to provide to the insurer, organization for managed care, third-party administrator or employer:

(a) Any documentation in the possession of the injured employee related to any policy of health or casualty insurance which may have provided coverage to the injured employee for treatment or other services provided to the injured employee; and

(b) The identity and contact information of the insurer providing such health or casualty insurance.

7. If the injured employee or the health or casualty insurer paid the provider of health care any amount in excess of the amount that the provider would have been entitled to be paid pursuant to this section, the injured employee or the health or casualty insurer is entitled to recover the excess amount from the provider. Within 30 days after receiving notice of such an excess amount, the provider of health care shall reimburse the injured employee or the health or casualty insurer for the excess amount.

~~[5.]~~ ***8.*** As used in this section:

(a) "Casualty insurer" means any insurer or other organization providing coverage or benefits under a policy or contract of casualty insurance in the manner described in subsection 2 of NRS 681A.020.

(b) "Health benefit plan" means any type of policy, contract, agreement or plan providing health coverage or benefits in accordance with state or federal law.

(c) "Health insurer" means any insurer or other organization providing health coverage or benefits in accordance with state or federal law.

Sec. 2. NRS 616C.390 is hereby amended to read as follows:

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

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

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

(b) The primary cause of the change of circumstances is the injury for which the claim was originally made; and

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

2. After a claim has been closed, the insurer, upon receiving an application and for good cause shown, may authorize the reopening of the claim for medical investigation only. The application must be accompanied by a written request for treatment from the physician or chiropractor treating the claimant, certifying that the treatment is

indicated by a change in circumstances and is related to the industrial injury sustained by the claimant.

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

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

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

(b) There is clear and convincing evidence that the primary cause of the change of circumstances is the injury for which the claim was originally made.

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

(a) The claimant ~~[was not off work]~~ ***did not meet the minimum duration of incapacity as set forth in NRS 616C.400*** as a result of the injury; and

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

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

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

(a) Retired; or

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

➥ for reasons unrelated to the injury for which the claim was originally made.

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

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

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

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

Sec. 3. 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 ~~[25]~~ ***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 ~~[25]~~ ***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 ~~[25]~~ ***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 ~~[25]~~ ***30*** percent.

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

(e) 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. 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; and

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

➥ The claimant, when he or she demands payment in a lump sum, 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.

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

4. Except as otherwise provided in this subsection, the total lump-sum payment for disablement must not be less than one-half the product of the average monthly wage multiplied by the percentage of disability. If the claimant received compensation in installment payments for his 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.

5. The lump sum payable must be equal to the present value of the compensation awarded, less any advance payment or lump sum previously paid. The present value must be calculated using monthly payments in the amounts prescribed in subsection 7 of NRS 616C.490 and actuarial annuity tables adopted by the Division. The tables must be reviewed annually by a consulting actuary.

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

Sec. 4. This act becomes effective upon passage and approval for the purposes of adopting any regulations or performing any preparatory administrative tasks that are necessary to carry out the provisions of this act, and on January 1, 2016, for all other purposes.

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