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DEPARTMENT OF BUSINESS AND INDUSTRY
DIVISION OF INDUSTRIAL RELATIONS
WORKERS' COMPENSATION SECTION

Frequently Asked Questions Regarding Changes Related to SB 274 (2023) and Regulation R076-23 (adopted 10/9/24)

Updated 12/23/24

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Claims Office and Administration Requirements Changes

1. Who is required to have an office in Nevada?

NRS 616B.027 was amended as follows:
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.

NRS 616B.500 remains intact and states that an insurer may not enter into a contract with a third-party administrator unless the third-party administrator maintains an office in this State and has a certificate issued by the Commissioner of Insurance pursuant to NRS 683A.08524.

However, NRS 616B.503 was amended to remove the requirement that third-party administrators administer plans of insurance from one or more offices located in the state and maintain claim records in those offices.

Since NRS 616B.500 and NRS 616B.503 are not consistent with one another, the Division will continue to expect compliance with NRS 616B.500, which requires TPAs to have an office in Nevada.

2. How is "Office" defined?

NAC 616A.181 defines "Office" as a place of business located within the state operated and maintained by an insurer or third-party administrator and does not include the private residence of a person who works for the insurer or third-party administrator.

"Virtual" offices and locations providing mail services that are not operated and maintained by an insurer or third-party administrator are not considered offices for purposes of NRS 616B.021, NRS 616B.027 and NRS 616B.0275(2).

3. Who can administer claims outside Nevada?

NRS 616B.0275(1) and NAC 616B.013 allow an employee of a private carrier licensed as a company adjuster or a person acting as a TPA for a private carrier to administer claims from a location outside of the state.

NRS 616B.0275(2) and NAC 616B.013 require an employee of a private carrier that is not licensed as a company adjuster to administer claims only from an office located in Nevada. "Office" is defined in NAC 616A.181 as a place of business located within the state operated and maintained by an insurer or third-party administrator and does not include the private residence of a person who works for the insurer or third-party administrator.

NAC 616B.448(4) and NAC 616B.558(4) preclude self-insured employers and associations of self-insured employers, respectively, from administering programs of self-insurance from a location outside of the state.

4. Can the claim files be maintained outside Nevada?

NAC 616B.013(2) was amended to require all claim files to be administered in accordance with NRS 616B.0275 and be made available for inspection and reproduction in accordance with NRS 616B.021. For private carriers whose claims are administered pursuant to NRS 616B.0275(1) by an employee of the insurer that is licensed as a company adjuster or by a third-party administrator from a location in or outside of Nevada, claim records must be maintained at one or more offices located in Nevada or in an electronic format that produces an accurate reproduction of the original.

For private carriers whose claims are administered pursuant to NRS 616B.0275(2) by an employee of the insurer that is not licensed as a company adjuster or for self-insured employers and associations of self-insured employers, claim records must be maintained in an office in Nevada.

5. Do C-4 Forms, claim documents, and medical bills have to be mailed?

No. Regulation R076-23 amends NAC 616B.010(2) to allow all correspondence and other documents - including C-4 Forms, claim documents, and medical bills - to be mailed to the address of the insurer, third-party administrator or organization for managed care of one of its offices or provided by electronic means.

6. Can an entire claim file be maintained electronically or are hard copies required?

NRS 616B.021 and NAC 616B.013 allow insurers to make claim files available for inspection and reproduction either in physical hard copy form or by electronic means, given the following criteria:

a. An insurer shall make the files of claims available for inspection and reproduction:
   1) At an office operated by the insurer or its third-party administrator located in this State; or
   2) By electronic means.
b. The physical records in a file concerning a claim filed in this State may be kept at a location outside this State if all records in the file are made available for inspection and reproduction at an office operated by the insurer or its third-party administrator that is located in this State or by computer in a microphotographic, electronic or other similar format that produces an accurate reproduction of the original.

7. Does SB 274 change the timelines for providing copies of claim files?

The timelines for reproducing and availability for inspection have not changed. Per NRS 616B.021(2) and NAC 616B.010(1)(b), the records for open claims must be reproduced and available for inspection during regular business hours within 24 hours of the request. For closed claims, the records must be reproduced and available for inspection during regular business hours within 14 days of the request.

8. Do insurers have to accept collect calls from injured employees?

No. NRS 616B.021(1)(b) was amended to eliminate the requirement for insurers to accept collect calls.

9. What hours do private carriers or their TPAs who administer claims outside Nevada have to be available to claimants or claimants' representatives?

NRS 616B.027(3) requires an employee of a private carrier licensed as a company adjuster or a person acting as a third-party administrator for a private carrier and administering claims outside of Nevada to make himself or herself available to communicate in real time with a claimant or claimant's representative Monday through Friday, 9 a.m. to 5 p.m., local Nevada time, excluding legal holidays.

Treating Panel

10. What happens if a provider on the treating panel does not accept and treat injured employees?

NRS 616C.090 (8)(9), in part states, any interested person has the ability to submit a Complaint form, available on the DIR/WCS website, informing DIR/WCS of their belief that a physician or chiropractic physician does not accept and treat injured workers. An investigation will be conducted to determine whether the physician or chiropractic physician will remain on the panel.

Treating Provider Lists

11. Will the method for sending treating provider lists to the Workers' Compensation Section be changing?

Yes, instead of sending an email with treating provider lists, insurers, or TPAs will be required to submit treating provider lists via CARDS by October 1 of each year per NRS 616C.087 (6).

12. When will insurers be required to start submitting treating provider lists in CARDS?

The functionality for insurers to upload treating provider lists into CARDS will launch in Spring 2025, and lists will be due by October 1, 2025.

13. Will insurers and TPAs be able to upload treating provider lists into CARDS?

Yes, insurers and TPAs will be able to upload a CSV file into CARDS.

14. What information will be needed in the upload file?

(a) Name of the insurer or TPA
(b) Name and license number of the licensed adjuster or the name of the insurer's highest-ranking employee who is responsible for processing workers' compensation claims filed in this State, who is certifying the accuracy of the information submitted
(c) Provider identification number and name of each physician or chiropractic physician who is included on the list.
Once this information is uploaded, CARDS will automatically populate other information for each provider on the list, including address, specialties, and body parts treated.

15. Where will the provider identification number come from?

Per the new requirement set forth R076-23 Sec 6., the Administrator shall assign each physician or chiropractic physician appointed to the panel of physicians and chiropractic physicians a provider identification number. This number can be found on the Medical Providers webpage under Physicians and Chiropractors Detail CSV- for import/custom sorting.

16. How will treating provider addresses be kept up to date?

Once a treating provider has been added in CARDS, the address will be kept up to date based on information provided by the treating provider to WCS. No action will be needed by insurers or TPAs to update provider addresses.

17. Will training be provided on how to upload treating provider lists into CARDS?

The Workers' Compensation Section (WCS) will notify insurers and TPAs when the functionality goes live and provide scheduled training.

18. How will the public be able to search for a treating provider online?

(a) The WCS Treating Panel of Physicians and Chiropractors may be found on the Medical Providers webpage at https://dir.nv.gov/WCS/Medical_Providers/.
(b) Insurers' Treating Provider Lists may be found at:
    1) https://dir.nv.gov/WCS/Insurers%E2%80%99_Treating_Provider_Lists/. There is also a quick link on the WCS homepage at https://dir.nv.gov/WCS/home/ under Medical Providers on the bottom left.
    2) Once treating provider lists are live in CARDS in October 2025, the public will be able to go to: TreatingProvider - CARDS.

19. What happens if a treating provider is removed from DIR's treating panel? Is it automatically removed from an insurer's treating provider list?

The Workers' Compensation Section will notify all insurers, third-party administrators, and managed care organizations of a physician or chiropractic physician who has been suspended or removed from the panel and request they advise employers and employees that the physician or chiropractic physician is not authorized to treat cases workers' compensation cases for workers' compensation per NAC

616C.012. Once insurer treating provider lists are posted online in CARDS, providers that have been removed from DIR's treating panel will also be automatically removed from insurers' treating provider lists.

20. If removal of a provider from DIR's treating panel would make an insurer's list noncompliant, how long does an insurer have to make their treating provider list compliant?

Pursuant to Section 10 of R076-23, The insurer must submit an updated, compliant list within 60 days after the removal of the physician or chiropractic physician.

Assignment of Raters for Permanent Partial Disability (PPD) Evaluations

21. How did SB 274 change how rating physicians and chiropractic physicians are assigned for PPD ratings?

For ratings assigned pursuant to NRS 616C.092, NRS 616C.100, NRS 616C.145(5), NRS 616C.330, NRS 616C.360, and NRS 616C.490, the rating physician or chiropractic physician is selected at random from the list of qualified physicians and chiropractic physicians instead of by rotation. There is still an option to choose a rater by mutual agreement.

22. What are the geographic locations that impact the random assignment selection process?

Per new requirements set forth in R076-23 Sec. 8, there are three defined regions:

- The southern Nevada region consists of Clark, Lincoln, Nye and Esmerelda Counties.
- The northern Nevada region consists of Carson City and Lyon, Churchill, Storey, Douglas, Mineral and Washoe Counties.
- The rural Nevada region consists of Pershing, Humboldt, Elko, Lander, Eureka and White Pine Counties.

23. How are the geographic regions used to assign raters?

- If the injured employee resides in the southern Nevada region, the Medical Unit will assign a rater from the southern Nevada region.
- If the injured employee resides in the northern Nevada region, the Medical Unit will assign a rater from the northern Nevada region.
- If the injured employee resides in the rural Nevada region, the Medical Unit will assign a rater from the northern Nevada region or rural Nevada region.

24. What is the D-35 assignment process for out-of-state injured workers?

D-35 requests for injured workers who live out-of-state are assigned a rater randomly from any geographic region in Nevada. When submitting Form D-35 for random assignments, the submitter cannot choose a preferred Nevada region for out-of-state Injured Workers (IW). If a D-35 for random selection is received with a request to select a rater from a preferred region, the Workers' Compensation Section (WCS) will do a random assignment with no geographic preference.

25. When should Form D-35 be submitted?

Per NRS 616C.092, NRS 616C.100, NRS 616C.145(5), NRS 616C.330, NRS 616C.360, NRS 616C.490, Form D-35 is submitted to the medunit@dir.nv.gov to request the assignment of rating physician or chiropractic physician.

26. Should a D-35 be used to request an Independent Medical Examination (IME)?

Per NRS 616C.145(5), A D-35 should be submitted when requesting a rater assignment to perform an IME for the purpose of determining if there is a ratable impairment or a dispute to a previous rating.

27. How is a rater notified of an assignment?

Pursuant to new requirements set forth in R076-23 Sec. 8., the rater is notified via email from medunit@dir.nv.gov.

Declining a Rating Assignment

28. When can a rating assignment be declined?

Pursuant to NRS 616C.490(2)(b)(3), a rater may decline a random rating assignment if the rater believes he or she does not have the ability to rate the disability at issue. This option is not available for ratings assigned by mutual agreement.

29. How many days does a rater have to decline a random rating assignment?

Per new requirements set forth in R076-23 Sec. 7, the declining rater must notify the submitter/requester and medunit@dir.nv.gov via email. This must be done within 2 business days of the assignment.

30. What are my options when a rater declines a random assignment?

Per new requirements set forth in R076-23 Sec. 7**,** a new D-35 is submitted requesting another random assignment, or you may utilize the option for a mutual agreement. If the original submitter/requester has not utilized one of these options within 5 business days of the declination, a new D-35 random assignment will be processed by the WCS Medical Unit staff.

31. Is a new rater automatically assigned after a rater declines an assignment?

Per new requirements set forth in R076-23 Sec. 7, If the original submitter/requester has not submitted a new D-35 for processing within 5 business days of the declination, a new D-35 random assignment will be processed by the WCS Medical Unit staff.

32. What happens if a rater fails to notify the Administrator and the requestor of the decision to decline a rating?

Pursuant to NAC 616C.024(1)(g), failure to follow the correct procedure to decline a rating may result in, a warning, suspension, or removal from the Rating Panel of Physicians and Chiropractic Physicians.

Ineligibility to do a Rating Assignment

33. When is a rater ineligible to perform a rating?

Pursuant to NAC 616C.021(9) and (10), a rater is ineligible to perform a rating examination if:

a. The rater previously examined or treated the injured employee; or
b. The rater has reviewed the health care records of the injured employee for any purpose relating to his or her claim for workers' compensation and has made recommendations regarding the likelihood of the injured employee's ratable impairment; or
c. The rater previously provided a rating for the injured employee and the injured employee is requesting a second determination of the percentage of disability pursuant to NRS 616C.100 or 616C.145.

These provisions apply to both random assignments and mutual agreements.

34. How many days does a rater have to indicate they are ineligible to do a rating?

The rater must notify the submitter/requester and medunit@dir.nv.gov via email, this must be done within 2 business days of the assignment.

35. What are my options after a rater indicates they are ineligible to do a rating assignment?

You may submit new D-35 is submitted requesting another random assignment, or you may utilize the option for a mutual agreement. If the original submitter/requester has not utilized one of these options within 5 business days of a rater indicating they are ineligible to do a rating, a new D-35 random

assignment will be processed by the WCS Medical Unit staff.

36. Is a new rater automatically assigned after a rater indicates they are ineligible to do the rating?

If the original submitter/requester has not submitted a new D-35 within 5 business days of a rater indicating they are ineligible to do a rating, a new D-35 random assignment will be processed by the WCS Medical Unit staff.

Mutual Agreements

37. How do I select a rater by mutual agreement?

Pursuant to NRS 616C.145, NRS 616C.490, the injured worker and the insurer may agree to a specific rater chosen from the Rating Panel Provider List. The rater must be eligible to perform the Permanent Partial Disability (PPD) impairment rating for the type of injury documented. Complete the Mutual Agreement Portion of the D-35 to indicate which rater has been selected.

38. Do the parties need to check to ensure a rater is willing to do a rating by mutual agreement?

Yes, the rater must agree to accept the PPD rating assignment prior to the completed D-35 Mutual Agreement request is submitted to medunit@dir.nv.gov.

39. Can a rater decline a mutual agreement?

Ratings can only be declined for random assignments. However, a rater may indicate that they are ineligible to rate an assignment that was made by mutual agreement if one of the following applies:

a. The rater previously examined or treated the injured employee; or
b. The rater has reviewed the health care records of the injured employee for any purpose relating to his or her claim for workers' compensation and has made recommendations regarding the likelihood of the injured employee's ratable impairment; or
c. The rater previously provided a rating for the injured employee and the injured employee is requesting a second determination of the percentage of disability pursuant to NRS 616C.100 or 616C.145.

40. Can the parties choose to do a mutual agreement after a rater declines a random assignment?

Yes, if a rater declines a random assignment after two business days, a request can be submitted for a mutual agreement to medunit@dir.nv.gov.

In addition, if 30 days have passed since the random assignment and no appointment has been scheduled then a D-35 Mutual Agreement may be submitted to medunit@dir.nv.gov.

41. Can parties choose to do a mutual agreement after a random assignment has been made and has not been declined?

Pursuant to NRS 616C.490 (2)(b), a mutual agreement will not be processed if a previously requested random selection is active and the rating physician or chiropractic physician has not declined the rating assignment. Once a D-35 request has been completed for a random selection, it is considered an active assignment to the randomly selected rater, and a mutual agreement will not cancel the randomly assigned rating. The assigned rater has 30 days from the date of assignment to schedule the PPD evaluation with the injured worker. If 30 days have passed since the random assignment and no appointment is scheduled, a mutual agreement can be submitted to medunit@dir.nv.gov for processing.

Conducting Ratings

42. Who is responsible for making a rating appointment for an injured employee?

The rating physician or chiropractic physician must schedule a PPD evaluation within 30 days of assignment per NAC 616C.021 (4)(b).

43. How far in advance does the injured worker need to be notified of an appointment?

Pursuant to NAC 616C.1162, if an insurer or employer requests that an injured employee who has filed a claim for compensation submit to a medical examination, the insurer or employer must notify the injured employee, in writing, of the time and place of the medical examination at least 21 days before the date of the medical examination, unless the parties agree to a date that is less than 21 days before the medical examination.

44. How long does a rater have to do a rating examination after the rating is assigned?

The rating physician or chiropractic physician must perform a PPD evaluation within 30 days of assignment per NAC 616C.021 (4)(b).

45. Can the timeline to complete a rating examination be extended?

Pursuant to NAC 616C.021(3)(b)(2), the timeline may be extended if the insurer or Third-Party Administrator (TPA) agrees with the injured employee or his or her representative to extend the period.

46. Can an attorney be present during a rating?

Yes, an attorney can be present during the rating exam. Per NRS 629.620(1)(b), a person compelled to submit to a mental or physical examination has a right to have an observer throughout the exam, which includes the person's attorney, health care provider, or other representative. No notice is required. NAC 616C.109(1) will be amended at a future date to indicate that there is not a notice requirement. In the meantime, the requirements in NRS 629.620(1)(b) supersede the language in NAC 616C. 109(1).

47. Under what conditions can a rater end an examination when an attorney is present?

Per NAC 616C.109 (1), the rating physician or chiropractic physician may suspend the examination if the attorney or representative disrupts or attempts to participate in the examination.

Requirements After a Rating is Complete

48. Where is the rater required to send the completed rating report?

The completed PPD report should be sent to the insurer and the Division of Industrial Relations (DIR) at ppdreports@dir.nv.gov.

49. After a rating is completed, is the insurer required to report the rating in CARDS through claims indexing (D-38)?

Insurers must update the claim in CARDS with the Permanent Impairment Percentage, the Rating Practitioner, and the Rating Completed Date within 30 days after the Rating Completed Date.

50. Where are reports posted showing the number of ratings assigned and the number of ratings reported as completed?

These reports are published on the WCS website at: Reports.

Qualifications of Raters

51. What are the new qualifications for raters effective October 9, 2024?

Pursuant to NAC 616.021, the following requirements are effective October 9, 2024.

a. Complete 3 years or more of experience concerning industrial health in private practice;
b. Successfully complete a course approved by the Administrator on rating disabilities, in accordance with the Guide;
c. Pass the Nevada Impairment Rating Skills Assessment Test (NIRSAT) with a score of 75% or higher;

1) MDs and DOs who have taken the NIRSAT can rate any type of injury or illness.
2) Chiropractic physicians who have taken the revised NIRSAT December 2023 or later can rate any type of injury or illness. Chiropractic physicians who took the NIRSAT prior to December 2023 may only rate neuromusculoskeletal injuries.
3) Ophthalmologists who have not taken the NIRSAT may only perform PPD evaluations involving injuries or disorders of the visual system.
4) Psychiatrists who have not taken the NIRSAT but who have successfully completed a course on Form D-9c, may only perform PPD evaluations involving mental impairments.

d. Only physicians and chiropractic physicians who have successfully completed a course on Form D-9c may perform PPD evaluations involving injuries or disorders rated using Form D-9c

52. Which courses are approved by the Administrator to become a rater pursuant to NAC 616C.021(2)(b)(2)?

a. The American Board of Independent Medical Examiners (ABIME) AMA Guides 5th Edition Course may be found at https://abime.org/.
b. The American Academy of Expert Medical Evaluators (AAEME) AMA Guides 5th Edition Course may be found at https://testing.wpirs.com/.

53. Which examination is required to become a rater pursuant to NAC 616C.021(2)(b)(3)?

The AAEME NIRSAT may be found at https://testing.wpirs.com/.

54. What class do raters need to take to rate stress injuries pursuant to NAC 616C.021(2)(b)(4)?

The course on Form D-9c is Nevada Impairment Rating of Stress Disorders, and it may be found at https://testing.wpirs.com/.

55. Do MDs and DOs need to retake the NIRSAT?

MDs and DOs who have already passed the MD/DO NIRSAT are not required to pass the revised test.

56. Can chiropractic physicians choose to just continue rating neuromusculoskeletal injuries?

Chiropractic physicians who have not passed the revised NIRSAT by January 1, 2024, may only perform PPD evaluations involving injuries or disorders rated using chapters 1, 2, 13, 15, 16, and 17 of the Guide.

Please note that this is only a temporary option as all chiropractic physicians must pass the revised NIRSAT by July 1, 2026.

57. What do chiropractic physicians need to do if they want to rate any type of injury or illness?

a. Pass the revised NIRSAT with a 75% or higher; and
b. Successfully complete a course on Form D-9c

Please note that all raters will need to meet these requirements by July 1, 2026.

58. Can ophthalmologists continue to be on the rating panel if they only want to rate eye injuries?

Ophthalmologists who have not passed the NIRSAT with a 75% or higher may only perform PPD evaluations involving an injury or disorder of the visual system.

Please note that this is only a temporary option as all ophthalmologists must pass the revised NIRSAT by July 1, 2026 to remain on the rating panel

59. What are the continuing education requirements for raters pursuant to NAC 616C.021(4)(d)?

Raters must successfully complete a course on rating disabilities, in accordance with the Guide, every

two years.

60. Which classes have been approved by the Administrator to meet the continuing education qualifications for raters?

a. The American Board of Independent Medical Examiners (ABIME) AMA Guides 5th Edition Course may be found at https://abime.org/.
b. The American Academy of Expert Medical Evaluators (AAEME) AMA Guides 5th Edition Course may be found at https://testing.wpirs.com/.
c. Designated courses offered during the Annual Nevada Workers' Compensation Educational Conference.

Proof of course completion and certificate must be sent to medpanels@dir.nv.gov.

61. What qualifications do all raters need to meet by July 1, 2026?

Effective July 1, 2026, all raters must meet the following requirements to remain on the rating panel:
a. Complete 3 years or more of experience concerning industrial health in private practice;
b. Successfully complete a course approved by the Administrator on rating disabilities, in accordance with the Guide;
c. Pass the Nevada Impairment Rating Skills Assessment Test (NIRSAT) with a score of 75% or higher (Please note that chiropractic physicians must pass the revised NIRSAT offered December 2023 or later); and
d. Successfully complete a course on Form D-9c.

COLA Reimbursements and Assessments Changes

62. What are the timelines related to COLA reimbursement requests?

NRS 616C.266 and NRS 616C.268 were amended to specify timelines related to requests for reimbursement by insurers, determinations relating to those requests, appeals of determinations, invoicing of assessments and reimbursement payments to insurers by the Administrator of DIR:

- An insurer must submit COLA reimbursement requests not later than March 31 of each year for payments made in the prior calendar year.
- An insurer who provides the required information related to a COLA reimbursement request will receive a written determination approving or rejecting the insurer's request for reimbursement within 60 days of receipt of the request. If a written determination is not rendered within the 60 days, the request for reimbursement is deemed approved.
- Not later than July 1 of each year, the insurer will be provided with a detailed list of reimbursements approved or rejected.
- A person who is aggrieved by a written determination of the Administrator related to the approval/denial of the reimbursement request may file a request for a hearing before an appeals officer within 30 days of receipt of the determination.
- Not later than May 31 of each year, the insurer will be provided an invoice for any assessment levied by the Administrator… to be used to pay reimbursement…
- Each insurer shall, not later than July 31 of each year, pay to the Department of Business and Industry the amount of the assessment.
- If the Administrator is not able to collect the amount of the assessment within 60 days of 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… subject to revocation of the insurer's certificate of authority to transact insurance in this State.
- Approved reimbursements will be issued no later than December 31 of each year. If the full assessments are not received, the Administrator shall apportion to the insurers that have paid the amount of the assessment an amount of reimbursement calculated pursuant to NRS 232.680.
- If assessment payments are received after July 31, insurers will be reimbursed the remaining amount to which they are entitled.

Benefit Penalty Changes – Effective for claims (C-4 Forms) filed on or after January 1, 2024.

63. Did the minimum and maximum benefit penalty amounts change?

Yes. NRS 616D.120(3)(a) and NAC 616D.411(1) and (3) were amended to increase the minimum benefit penalty amount from $5,000 to $17,000 and the maximum benefit penalty amount from $50,000 to $120,000. The $3,000 benefit penalty amount for lesser violations outlined in NRS 616D.(3)(b) did not change.

64. Did the additional amount awarded per point assessed change?

Yes. NAC 616D.411(3) was amended to increase the additional amount awarded per point assessed pursuant to that section from $2,250 to $8,500.

65. Did the time to pay a benefit penalty payment change?

Yes. NRS 616D.120(4) was amended to increase the time to pay a benefit penalty directly to the claimant from within 10 days of the determination date to within 15 days of the determination date.

66. Did the time to provide proof of payment of the benefit penalty change?

Yes. NRS 616D.120(4) was amended to increase the time to provide proof of payment to the Administrator of DIR increased from within 10 days of the determination date to within 15 days of the determination date, unless a stay has been granted.

67. Did the time for the Administrator of DIR to respond to a complaint filed pursuant to NRS 616D.130 change?

Yes. NRS 616D.130 was amended to extend the time for the Administrator to initiate and complete an investigation and render a determination to 120 days.

68. What happens if the Administrator fails to respond within 120 days of receiving a complaint pursuant to NRS 616D.130?

NRS 616D.140 was amended as follows:

- Removing jurisdiction from the Administrator of DIR after the expiration of the 120-day period after receipt of the complaint.
- Adding a provision for the complainant to request a hearing before an appeals officer the failure of the Administrator to respond to the complaint. The request must be filed within 150 days of the receipt of the complaint by the Administrator.

Form Changes and New Forms

69. Have changes been made to adopted forms?

Yes. The term “Chiropractor” was replaced in NRS 616 and 617 by “Chiropractic Physician” requiring the following forms to be modified to reflect the change:

- The D-39, Physician’s and Chiropractor’s Progress Report – Certification of Disability, has been renamed to the D-39, Physician’s and Chiropractic Physician’s Progress Report – Certification of Disability.
- The D-53, Alternative Choice of Physician or Chiropractor, has been renamed to the D-53, Alternative Choice of Physician or Chiropractic Physician.

NRS 616C.100, NRS 616C.330, NRS 616C.360 and NRS 616C.490 were amended and regulation R076-23 added new sections to NAC which change the method of assignment of a rating physician from “in rotation” to “at random” requiring the following form to be modified to reflect the change:

- The D-35, Request for a Rotating Physician or Chiropractor, has been renamed to the D-35, Request for Assignment of Rating Physician or Chiropractic Physician

NRS 616C.235 outlines the procedure for insurers to close a claim and the required notifications to the injured employee depending on the status of the claim. This statute was amended in 2009 and 2017,

updating the criteria for the various claim closure scenarios. Regulation R076-23 amends NAC 616A.480 by modifying the D-31, Notice of Intent to Close Claim and introducing three (3) new forms:

- The D-31, Notice of Intention to Close Claim, has been renumbered to D-31a, Notice of Intention to Close Claim and removes the reference to the injured worker not being entitled to a Permanent Partial Disability (PPD) award.
- D-31b, Notice of Circumstances Under Which a Claim May be Closed Under subsection 2 of NRS 616C.235
- D-31c, Notice of Intention to Close Claim of Less Than $800 in Medical Benefits in 12 Months - No Permanent Partial Disability Evaluation
- D-31d, Notice of Intention to Close Claim of Less Than $800 in Medical Benefits in 12 Months - Permanent Partial Disability Evaluation Scheduled

Effective Dates

70. When do the changes take effect?

Changes to Nevada Revised Statutes (NRS) related to SB 274 became effective January 1, 2024. The new benefit penalty provisions will apply to claims for which a C-4 Form is submitted on or after January 1, 2024.

Changes to Nevada Administrative Code (NAC) related to regulation R076-23 became effective upon adoption on October 9, 2024, with exception of the following:

- Changes related to benefit penalty amounts apply to claims for which a C-4 Form is submitted on or after January 1, 2024.
- Changes related to the qualification requirements for the Rating Panel become effective on October 9, 2024 and July 1, 2026.