NRS & NAC re: PPDs

NRS 616C.110 American Medical Association's *Guides to the Evaluation of Permanent Impairment*: Duty of Division to adopt *Guides* by regulation.

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

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

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

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

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

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

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

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

(Added to NRS by 1995, 2128; A 1999, 1777; 2003, 1671; 2009, 3032)

NAC 616C.002 Adoption by reference of American Medical Association's *Guides to the Evaluation of Permanent Impairment.* (NRS 616A.400, 616C.110)

1. For the purposes of NRS 616B.557, 616B.578, 616B.587, 616C.105, 616C.392, 616C.490 and 617.459, the Division hereby adopts by reference the *Guides to the Evaluation of Permanent Impairment*, Fifth Edition, published by the American Medical Association.

2. A copy of the publication may be obtained from the Order Department, American Medical Association, P.O. Box 930876, Atlanta, Georgia 31193-0876, by telephone at (800) 621-8335, or on the Internet at **www.amabookstore.com**, for the price of $139 for persons who are members of the Association, or $159 for persons who are not members of the Association.

3. The provisions of this section do not:

(a) Constitute a change of circumstances for the purposes of NRS 616C.390.

(b) Entitle an injured employee whose permanent partial disability was rated pursuant to NRS 616C.490 before October 1, 2003, to an increase in the compensation he or she receives for that disability.

(Added to NAC by Div. of Industrial Relations by R009-97, eff. 10-27-97; A by R060-03, 9-8-2003, eff. 10-1-2003; R108-09, 6-30-2010)

NAC 616C.021 Rating physician or chiropractor: Designation; qualifications; maintenance of designation; authority; review of rating evaluation by Administrator. (NRS 616A.400, 616C.490)

1. The designation of a rating physician or chiropractor pursuant to NRS 616C.490 must be in writing.

2. To qualify for designation, a physician or chiropractor must:

(a) Possess the qualifications required of a physician or chiropractor who is appointed to the panel of physicians and chiropractors established pursuant to NRS 616C.090 and NAC 616C.003.

(b) Demonstrate a special competence and interest in industrial health by:

(1) Completing:

(I) An appropriate level of training, as determined by the Administrator, related to industrial health from a nationally recognized program that provides training related to industrial health; or

(II) One year or more of experience concerning industrial health in private practice. The Administrator shall determine whether the experience in private practice concerning industrial health is sufficient to qualify for designation as a rating physician or chiropractor on a case-by-case basis.

(2) Except as otherwise provided in subsection 3, successfully completing a course on rating disabilities, in accordance with the most recent edition of the *Guide*, that is approved by the Administrator.

(3) Except as otherwise provided in subsection 3, passing an examination on evaluating disabilities and impairments that is administered by the American Board of Independent Medical Examiners or its successor organization, or by any other organization or company recognized by the Division.

(4) Except as otherwise provided in subsection 3, passing the Nevada Impairment Rating Skills Assessment Test which is administered by the American Academy of Expert Medical Evaluators or its successor organization and which examines the practical application of the rating of disabilities in accordance with the *Guide* with a score of 75 percent or higher.

(c) Demonstrate an understanding of:

(1) The regulations of the Division related to the evaluation of permanent partial disabilities; and

(2) The *Guide*.

3. The Administrator may exempt an ophthalmologist or psychiatrist who is authorized to practice in this State from the requirements set forth in subparagraphs 2, 3 and 4 of paragraph (b) of subsection 2 and authorize an ophthalmologist or psychiatrist to evaluate injured employees with impaired vision or brain function or mental or behavioral disorders according to his or her area of specialization.

4. In order to maintain designation as a rating physician or chiropractor, the physician or chiropractor must:

(a) Except as otherwise provided in subsection 5, perform ratings evaluations of permanent partial disabilities when selected pursuant to NRS 616C.490, except disabilities related to an employee's vision or brain function resulting from an industrial accident or occupational disease;

(b) Schedule and perform a rating evaluation within 30 days after receipt of a request from an insurer, a third-party administrator or an injured employee or his or her representative;

(c) Except as otherwise provided in subsection 5, serve without compensation for a period not to exceed 1 year on the panel to review ratings evaluations established pursuant to NAC 616C.023 upon the request of the Administrator;

(d) Except as otherwise provided in subsection 5 and after the date of designation as a rating physician or chiropractor, successfully complete biennially a course that is approved by the Administrator on rating disabilities, in accordance with the American Medical Association's *Guide*; and

(e) Except as otherwise provided in subsection 5, if the physician or chiropractor passed an examination concerning an edition of the *Guide* that is not the most recent edition adopted by the Administrator to become designated as a rating physician, pass the Nevada Impairment Rating Skills Assessment Test which is administered by the American Academy of Expert Medical Evaluators or its successor organization and which examines the practical application of the rating of disabilities in accordance with the *Guide* with a score of 75 percent or higher.

5. If an ophthalmologist or psychiatrist has been designated as a rating physician and wishes to maintain such designation, the Administrator may exempt the ophthalmologist or psychiatrist who is authorized to practice in this State from the requirements set forth in paragraphs (a), (c), (d) and (e) of subsection 4 and authorize the ophthalmologist or psychiatrist to continue to evaluate injured employees with impaired vision or brain function or mental or behavioral disorders according to his or her area of specialization.

6. A rating evaluation of a permanent partial disability may be performed by a chiropractor only if the injured employee's injury and treatment are related to his or her neuromusculoskeletal system.

7. A rating physician or chiropractor may not rate the disability of an injured employee if the physician or chiropractor has:

(a) Previously examined or treated the injured employee for the injury related to his or her claim for workers' compensation; or

(b) Reviewed the health care records of the injured employee and has made recommendations regarding the likelihood of the injured employee's ratable impairment.

8. A rating evaluation of a permanent partial disability performed by a rating physician or chiropractor is subject to review by the Administrator pursuant to the provisions of NAC 616C.023.

(Added to NAC by Dep't of Industrial Relations, eff. 8-30-91; A by Div. of Industrial Relations by R009-97, 10-27-97; R090-99, 10-28-99; R105-00, 1-18-2001, eff. 3-1-2001; R060-03, 9-8-2003, eff. 10-1-2003; R006-06, 6-1-2006; R108-09, 6-30-2010)

NRS 616C.105 Requirements for designation of chiropractor to rate permanent partial disabilities. The Administrator shall not designate a chiropractor to rate permanent partial disabilities unless the chiropractor has completed an advanced program of training in rating disabilities using the American Medical Association's *Guides to the Evaluation of Permanent Impairment* which is offered or approved by the Administrator.

(Added to NRS by 1991, 2392) — (Substituted in revision for NRS 616.5417)

NAC 616C.103 Rating evaluation of injured employee: Requirements; award of payment; appeal. (NRS 616A.400, 616C.490)

1. For purposes of determining whether an injured employee is stable and ratable and entitled to an evaluation to determine the extent of any permanent impairment pursuant to this section and NRS 616C.490, the Division interprets the term:

(a) "Stable" to include, without limitation, a written indication from a physician or chiropractor that the industrial injury or occupational disease of the injured employee:

(1) Is stationary, permanent or static; or

(2) Has reached maximum medical improvement.

(b) "Ratable" to include, without limitation, a written indication from a physician or chiropractor that the medical condition of the injured employee may have:

(1) Resulted in a loss of motion, sensation or strength in a body part of the injured employee;

(2) Resulted in a loss of or abnormality to a physiological or anatomical structure or bodily function of the injured employee; or

(3) Resulted in a mental or behavioral disorder as the result of a claim that has been accepted pursuant to NRS 616C.180.

2. If an insurer proposes that an injured employee agree to a rating physician or chiropractor chosen by the insurer, the insurer shall inform the injured employee in writing that the injured employee:

(a) Is not required to agree with the selection of that physician or chiropractor; and

(b) May request that the rating physician or chiropractor be selected in accordance with subsection 3 and NRS 616C.490.

3. An insurer shall comply with subsection 2 of NRS 616C.490, within the time prescribed in that subsection for the scheduling of an appointment, by:

(a) Requesting a physician or chiropractor from the list of qualified rating physicians and chiropractors designated by the Administrator to evaluate the injured employee and determine the extent of any permanent impairment or, if the injured employee and insurer have agreed to a rating physician or chiropractor pursuant to subsection 2 of NRS 616C.490, by submitting a completed form designated in NAC 616A.480 as D-35, Request for a Rotating Rating Physician or Chiropractor, to the Workers' Compensation Section within 30 days after the insurer has received the statement from a physician or chiropractor that the injured employee is ratable and stable;

(b) Mailing written notice to the injured employee of the date, time and place of the appointment for the rating evaluation; and

(c) At least 3 working days before the rating evaluation, providing to the assigned rating physician or chiropractor from the insurer's file concerning the injured employee's claim:

(1) All reports or other written information concerning the injured employee's claim produced by a physician, chiropractor, hospital or other provider of health care, including the statement from the treating physician or chiropractor that the injured employee is stable and ratable, surgical reports, diagnostic, laboratory and radiography reports and information concerning any preexisting condition relating to the injured employee's claim;

(2) Any evidence or documentation of any previous evaluations performed to determine the extent of any of the injured employee's disabilities and any previous injury, disease or condition of the injured employee that is relevant to the evaluation being performed;

(3) The form designated in NAC 616A.480 as C-4, Employee's Claim for Compensation/Report of Initial Treatment;

(4) The form designated in NAC 616A.480 as D-35, Request for a Rotating Rating Physician or Chiropractor; and

(5) The form designated in NAC 616A.480 as D-36, Request for Additional Medical Information and Medical Release.

4. An insurer shall pay for the cost of travel for an injured employee to attend a rating evaluation as required by NAC 616C.105.

5. Except as otherwise provided in subsection 7, if the rating physician or chiropractor finds that the injured employee has a ratable impairment, the insurer shall, within the time prescribed by NRS 616C.490, offer the injured employee the award to which he or she is entitled. The insurer shall make payment to the injured employee:

(a) Within 20 days; or

(b) If there is any child support obligation affecting the injured employee, within 35 days,

Ê after it receives the properly executed award papers from the injured employee or his or her representative.

6. If the rating physician or chiropractor determines that the permanent impairment may be apportioned pursuant to NAC 616C.490, the insurer shall advise the injured employee of the amount by which the rating was reduced and the reasons for the reduction.

7. If the insurer disagrees in good faith with the result of the rating evaluation, the insurer shall, within the time prescribed in NRS 616C.490:

(a) Offer the injured employee the portion of the award, in installments, which it does not dispute;

(b) Provide the injured employee with a copy of each rating evaluation performed of the injured employee; and

(c) Notify the injured employee of the specific reasons for the disagreement and the right of the injured employee to appeal. The notice must also set forth a detailed proposal for resolving the dispute that can be executed in 75 days, unless the insurer demonstrates good cause for why the proposed resolution will require more than 75 days.

8. The injured employee must receive a copy of the results of each rating evaluation performed of the injured employee before accepting an award for a permanent partial disability.

9. As used in this section, "award papers" means the following forms designated in NAC 616A.480, as appropriate:

(a) D-10(a), Election of Method of Payment of Compensation.

(b) D-10(b), Election of Method of Payment of Compensation for Disability Greater than 25 Percent.

(c) D-11, Reaffirmation/Retraction of Lump Sum Request.

(Added to NAC by Div. of Industrial Insurance Regulation, eff. 10-26-83; A 2-22-88; 9-7-88; 8-30-91; A by Div. of Industrial Relations by R009-97, 10-27-97; R006-97, 12-9-97; R090-99, 10-28-99; R090-99, 10-28-99, eff. 1-1-2000; R105-00, 1-18-2001, eff. 3-1-2001; R118-02, 9-7-2005; R108-09, 6-30-2010)

NAC 616C.105 Rating evaluation of injured employee: Payment for cost of travel. (NRS 616A.400, 616C.490)

1. An insurer who requests that an injured employee submit to a rating evaluation pursuant to NRS 616C.490 shall include with the notice required pursuant to subsection 3 of NAC 616C.103:

(a) Payment for the cost of travel for the injured employee;

(b) A receipt evidencing payment for the cost of travel for the injured employee; or

(c) Any combination thereof.

2. For the purpose of determining the cost of travel for the injured employee:

(a) The insurer shall pay for the cost of travel incurred by the injured employee if the injured employee is required to travel at least 20 miles one way from:

(1) His or her residence to the place where the rating evaluation will be conducted; or

(2) His or her place of employment to the place where the rating evaluation will be conducted if the injured employee is required to be examined during his or her regular working hours.

(b) Except as otherwise provided in this section, payment for the cost of travel must be computed at a rate equal to:

(1) The mileage allowance for state officers and employees who use their personal vehicles for the convenience of this State; or

(2) The cost of travel actually incurred by the injured employee, if the injured employee consents to payment at that rate and the cost of travel is not more than the amount to which the injured employee would otherwise be entitled pursuant to subparagraph (1).

(c) Except as otherwise provided in this section, if the injured employee is required to travel before 7:00 a.m. or between 11:30 a.m. and 1:30 p.m., or cannot return to his or her residence or place of employment before 7:00 p.m., the insurer shall pay the injured employee an allowance for meals equal to:

(1) The rate allowed for state officers and employees; or

(2) The cost actually incurred by the injured employee for meals, if the injured employee consents to payment at that rate and the cost is not more than the amount to which the injured employee would otherwise be entitled pursuant to subparagraph (1).

(d) If an injured employee is required to travel at least 50 miles one way from his or her residence or place of employment and is required to remain away from the residence or place of employment overnight, the insurer shall pay the injured employee:

(1) The per diem allowance authorized for state officers and employees; or

(2) The cost of travel actually incurred by the injured employee,

➥ whichever is less.

(e) If the injured employee receives the prior approval of the insurer requesting the rating evaluation, the insurer shall pay for the cost of travel by airplane if the time, distance, convenience or cost of travel justifies the injured employee's travel by airplane.

(f) If the injured employee moves outside this State or to a new location within this State after filing a claim for compensation, the insurer shall pay the cost of travel for the injured employee to attend the rating evaluation, not to exceed $1,000.

(g) A person who travels with an injured employee is not entitled to receive payment for the cost of travel to accompany the injured employee unless there is a medical necessity that prevents the injured employee from traveling alone. The treating physician or chiropractor of the injured employee shall provide a written explanation of the medical necessity.

(Added to NAC by Div. of Industrial Relations by R105-00, 1-18-2001, eff. 3-1-2001; A by R118-02, 9-7-2005)

NAC 616C.109 Presence of representative during rating evaluation. (NRS 616A.400, 616C.490)

1. If an injured employee, employer, insurer or third-party administrator is permitted by the rating physician or chiropractor to have his or her attorney or other representative present during a rating evaluation for a permanent partial disability, that party shall, in writing and at least 5 working days before the evaluation, notify each of the other persons described and the attorney or other representative of those persons of the intent to have his or her attorney or other representative attend the evaluation. The rating physician or chiropractor may request an attorney or representative to leave the examination room or may terminate the examination:

(a) If the attorney or representative disrupts the examination; or

(b) To protect the privacy of the injured employee.

2. Nothing in this section shall be deemed to limit the right conferred by subsection 4 of NRS 616C.140.

(Added to NAC by Dep't of Industrial Relations, eff. 8-30-91; A by Div. of Industrial Relations by R009-97, 10-27-97; R090-99, 10-28-99)

NAC 616C.148 Reports by rating physician or chiropractor. (NRS 616A.400, 616C.490) Unless good cause is shown:

1. A rating physician or chiropractor shall mail a report of an evaluation of an injured employee to the insurer within 14 days after the evaluation is completed. Unless good cause is shown, if an addendum is requested by the insurer, the rating physician or chiropractor shall mail the addendum to the insurer within 14 days after receiving the request.

2. If a rating evaluation is requested by an injured employee or a representative thereof, the rating physician or chiropractor shall mail a report of the evaluation to the injured employee or a representative within 14 days after the evaluation is completed. Unless good cause is shown, if an addendum is requested by the injured employee or a representative, the rating physician or chiropractor shall mail the addendum to the injured employee or a representative within 14 days after receiving the request.

(Added to NAC by Div. of Industrial Relations, eff. 11-10-93; A 3-5-96; R009-97, 10-27-97; R121-97, 12-10-97, eff. 1-1-98; R090-99, 10-28-99; R105-00, 1-18-2001, eff. 3-1-2001; R118-02, 9-7-2005)—(Substituted in revision for NAC 616C.212)

NRS 616C.100 Additional determination of percentage of disability permitted if cost paid by injured employee; authority of injured employee to seek reimbursement of cost; results of determination may be offered at hearing or conference.

1. If an injured employee disagrees with the percentage of disability determined by a physician or chiropractor, 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 chiropractor in rotation from the list of qualified physicians or chiropractors 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 chiropractor selected to make the second determination finds a higher percentage of disability than the first physician or chiropractor, 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.

(Added to NRS by 1991, 2398; A 1993, 736; 1995, 2148; 1999, 1777)

NRS 616C.485 Permanent partial disability: Loss of or permanent damage to teeth. The Administrator shall adopt, by regulation, a schedule which, in the judgment of the Administrator, is best calculated to compensate fairly and adequately an injured employee for the loss of, or permanent damage to, a tooth. The Administrator shall review the schedule at least once every 2 years to ensure the fairness and adequateness of the schedule.

[Part 64:168:1947; A 1951, 485] — (NRS A 1989, 333) — (Substituted in revision for NRS 616.595)

NRS 616C.490 Permanent partial disability: Compensation.

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. Within 30 days after receiving from a physician or chiropractor 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 chiropractor selected pursuant to this subsection to determine the extent of the employee's disability. Unless the insurer and the injured employee otherwise agree to a rating physician or chiropractor:

(a) The insurer shall select the rating physician or chiropractor from the list of qualified rating physicians and chiropractors 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.

(b) Rating physicians and chiropractors must be selected in rotation from the list of qualified physicians and chiropractors 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 chiropractor is currently an employee of the insurer making the selection, in which case the insurer must select the physician or chiropractor who is next on the list and who is not currently an employee of the insurer.

3. If an insurer contacts the treating physician or chiropractor to determine whether an injured employee has suffered a permanent disability, the insurer shall deliver to the treating physician or chiropractor 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.

4. At the request of the insurer, the injured employee shall, before an evaluation by a rating physician or chiropractor 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.

5. 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.

6. The rating physician or chiropractor 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.

7. 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.

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

9. Where there is a previous disability, as the loss of one eye, one hand, one foot, or any other previous permanent disability, the percentage of disability for a subsequent injury must be determined by computing the percentage of the entire disability and deducting therefrom the percentage of the previous disability as it existed at the time of the subsequent injury.

10. 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.

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

12. 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.

[63:168:1947; A 1949, 659; 1953, 292] — (NRS A 1959, 204; 1966, 46; 1967, 691; 1969, 475; 1971, 326; 1973, 531; 1975, 605; 1977, 1006; 1979, 1057; 1981, 1170, 1493, 1653; 1983, 428, 1295; 1985, 308, 374; 1987, 78; 1991, 493, 2423, 2424; 1993, 748, 1871; 1995, 579, 2156; 1999, 1791; 2001, 1898; 2009, 3036)

NRS 616C.495 Permanent partial disability: Payments in lump sum.

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, 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.

(Added to NRS by 1983, 430; A 1983, 646, 1296; 1987, 1465; 1989, 687, 1162, 2001, 2002; 1991, 493, 2425; 1993, 749, 1872; 1995, 579, 2157; 2001, 1899; 2003, 1675; 2005, 1493; 2007, 3357; 2015, 1141)

NAC 616C.460 Factors for determining percentage of permanent partial disability. (NRS 616A.400, 616C.490) In determining the percentage of permanent partial disability of an injured employee whose accident occurred before July 1, 1973, and whose disability has not been shown on any applicable statutory schedule, the insurer shall consider:

1. The following factors:

(a) The extent of the injured employee's physical impairment.

(b) The injured employee's age at the time of injury.

(c) The injured employee's occupation and number of years in the occupation.

(d) The loss of earning power caused by the injury.

(e) The incapacity for work as a result of the injury.

(f) The inability to find work as a result of the injury.

(g) Any previous disability.

2. The American Medical Association's *Guides to the Evaluation of Permanent Impairment.*

3. The "Nevada Schedule for Rating Permanent Disabilities," issued by the former Nevada Industrial Commission on July 1, 1971. That schedule is incorporated by reference into this section. A copy of that schedule may be obtained from the Division of Industrial Relations, 400 West King Street, Carson City, Nevada 89710, for the cost of the reproduction.

[Industrial Comm'n, No. 5.011, eff. 6-30-82]—(NAC A by Dep't of Industrial Relations, 10-26-83; A by Div. of Industrial Relations by R009-97, 10-27-97)

NAC 616C.463 Scope. (NRS 616A.400, 616C.490) The provisions of NAC 616C.463 to 616C.490, inclusive:

1. Apply to ratings of permanent partial disabilities which are determined on or after May 1, 1997.

2. May not be used as the only basis for a change of circumstances pursuant to NRS 616C.390 to require an increase of compensation for any ratings of permanent partial disability for injuries which occurred before May 1, 1997.

[Comm'r of Insurance & Industrial Comm'n, No. 41 § 11, eff. 5-13-82]—(NAC A by Dep't of Industrial Relations, 10-26-83; A by Div. of Industrial Relations by R009-97, 10-27-97)

NAC 616C.476 Rating physician or chiropractor: Performance of evaluation and calculation of entitlement to compensation. (NRS 616A.400, 616C.110, 616C.490)

1. A rating physician or chiropractor who performs an evaluation of a permanent partial disability shall evaluate the industrial injury or occupational disease of the injured employee as it exists at the time of the rating evaluation. The rating physician or chiropractor shall take into account any improvement or worsening of the industrial injury or occupational disease that has resulted from treatment of the industrial injury or occupational disease. The rating physician or chiropractor shall not consider any factor other than the degree of physical impairment of the whole person in calculating the entitlement to compensation.

2. In performing an evaluation of a permanent partial disability, a rating physician or chiropractor shall not use:

(a) Chapter 14, "Mental and Behavioral Disorders," of the *Guide*, unless the claim was accepted pursuant to NRS 616C.180; or

(b) Chapter 18, "Pain," of the *Guide*.

(Added to NAC by Div. of Industrial Relations by R009-97, eff. 10-27-97; A by R105-00, 1-18-2001, eff. 3-1-2001; R060-03, 9-8-2003, eff. 10-1-2003; R108-09, 6-30-2010)

NAC 616C.479 Rating physician: Form for evaluation of injury or disease caused by stress. (NRS 616A.400, 616C.110, 616C.490) When performing an evaluation of a permanent partial disability for a claim accepted pursuant to NRS 616C.180, a rating physician shall use the form designated in NAC 616A.480 as Form D-9(c), Permanent Partial Disability Worksheet for Stress Claims Pursuant to NRS 616C.180, to determine the percentage of impairment under Chapter 14, "Mental and Behavioral Disorders," of the *Guide*.

(Added to NAC by Div. of Industrial Relations by R108-09, eff. 6-30-2010)

NAC 616C.487 Limitation on percentage of impairment. (NRS 616A.400, 616C.490) The percentage of impairment in any specific rating or combination of ratings may not exceed 100 percent of the applicable extremity or of the whole person.

[Comm'r of Insurance & Industrial Comm'n, No. 41 § 8, eff. 5-13-82]—(NAC A by Div. of Industrial Relations by R009-97, 10-27-97; R108-09, 6-30-2010)

NAC 616C.490 Apportionment of impairments. (NRS 616A.400, 616C.490)

1. If any permanent impairment from which an employee is suffering following an accidental injury or the onset of an occupational disease is due in part to the injury or disease, and in part to a preexisting or intervening injury, disease or condition, the rating physician or chiropractor, except as otherwise provided in subsection 8, shall determine the portion of the impairment which is reasonably attributable to the injury or occupational disease and the portion which is reasonably attributable to the preexisting or intervening injury, disease or condition. The injured employee may receive compensation for that portion of his or her impairment which is reasonably attributable to the present industrial injury or occupational disease and may not receive compensation for that portion which is reasonably attributable to the preexisting or intervening injury, disease or condition. The injured employee is not entitled to receive compensation for his or her impairment if the percentage of impairment established for his or her preexisting or intervening injury, disease or condition is equal to or greater than the percentage of impairment established for the present industrial injury or occupational disease.

2. Except as otherwise provided in subsection 8, the rating of a permanent partial disability must be apportioned if there is a preexisting permanent impairment or intervening injury, disease or condition, whether it resulted from an industrial or nonindustrial injury, disease or condition.

3. A precise apportionment must be completed if a prior evaluation of the percentage of impairment is available and recorded for the preexisting impairment. The condition, organ or anatomical structure of the preexisting impairment must be identical with that subject to current evaluation. Sources of information upon which an apportionment may be based include, but are not limited to:

(a) Prior ratings of the insurer;

(b) Other ratings;

(c) Findings of the loss of range of motion;

(d) Information concerning previous surgeries; or

(e) For claims accepted pursuant to NRS 616C.180, other medical or psychological records regarding the prior mental or behavioral condition.

4. Except as otherwise provided in subsection 5, if a rating evaluation was completed in another state or using an edition of the American Medical Association's *Guides to the Evaluation of Permanent Impairment* other than the edition of the *Guides* as adopted by reference pursuant to NAC 616C.002 for a previous injury or disease involving a condition, organ or anatomical structure that is identical to the condition, organ or anatomical structure being evaluated for the present industrial injury or occupational disease, or if no previous rating evaluation was performed, the percentage of impairment for the previous injury or disease and the present industrial injury or occupational disease must be recalculated by using the *Guides*, as adopted by reference pursuant to NAC 616C.002. The apportionment must be determined by subtracting the percentage of impairment established for the previous injury or disease from the percentage of impairment established for the present industrial injury or occupational disease.

5. If precise information is not available, and the rating physician or chiropractor is unable to determine an apportionment using the *Guides* as set forth in subsection 4, an apportionment may be allowed if at least 50 percent of the total present impairment is due to a preexisting or intervening injury, disease or condition. The rating physician or chiropractor may base the apportionment upon X rays, historical records and diagnoses made by physicians or chiropractors or records of treatment which confirm the prior impairment.

6. If there are preexisting conditions, including, without limitation, degenerative arthritis, rheumatoid variants, congenital malformations or, for claims accepted under NRS 616C.180, mental or behavioral disorders, the apportionment must be supported by documentation concerning the scope and the nature of the impairment which existed before the industrial injury or the onset of disease.

7. A rating physician or chiropractor shall always explain the underlying basis of the apportionment as specifically as possible by citing pertinent data in the health care records or other records.

8. If no documentation exists pursuant to subsection 6 or 7, the impairment may not be apportioned.

[Comm'r of Insurance & Industrial Comm'n, No. 41 § 9, eff. 5-13-82]—(NAC A by Dep't of Industrial Relations, 10-26-83; 6-23-86; A by Div. of Industrial Insurance Regulation, 2-22-88; A by Div. of Industrial Relations by R009-97, 10-27-97; R105-00, 1-18-2001, eff. 3-1-2001; R108-09, 6-30-2010; **Amended in R136-14, Sec. 1, eff. 6-28-16**)

NAC 616C.496 Evaluation of disability from multiple accidents. (NRS 616A.400, 616C.490) If no factual measurement has been made of a disability that:

1. Involves the same anatomical structure or the same or a related condition or organ; and
2. Is attributable to the injury from the first accident,

Ê before a disability occurs as a result of the second accident, the total disability from both accidents must not be evaluated until both injuries are stabilized following the second accident.

[Industrial Comm'n, No. 5.041, eff. 6-30-82]—(NAC A by Dep't of Industrial Relations, 10-26-83; A by Div. of Industrial Relations by R105-00, 1-18-2001, eff. 3-1-2001)

NAC 616C.498 Eligibility to receive compensation in lump sum for injury incurred on or after July 1, 1995; installments. (NRS 616A.400, 616C.495) An employee injured on or after July 1, 1995, who incurs a permanent partial disability that:

1. Does not exceed 25 percent may elect to receive compensation in a lump sum.
2. Exceeds 25 percent may elect to receive compensation in a lump sum equal to the present value of an award for a disability of 25 percent. If the injured employee elects to receive

compensation in a lump sum pursuant to this subsection, the insurer shall pay in installments to the injured employee that portion of the injured employee's disability in excess of 25 percent.

(Added to NAC by Div. of Industrial Relations, eff. 5-10-96)

NAC 616C.499 Election to receive award in lump sum: Reaffirmation; payment; notice of waiver of rights. (NRS 616A.400, 616C.495)

1. If an injured employee elects to receive an award for a permanent partial disability in a lump sum, he or she must reaffirm the election within 20 days after receiving notification from the insurer pursuant to subsection 2 of NRS 616C.495 before the lump sum will be paid.

2. If an injured employee reaffirms the election within 20 days, the insurer shall make payment to the injured employee:

(a) Within 20 days; or

(b) If there is any child support obligation affecting the injured employee, within 35 days, Ê after the insurer receives the reaffirmation.

3. In offering an award for a permanent partial disability in a lump sum, the insurer shall notify the injured employee that acceptance of the award waives all of his or her rights regarding the claim, including the right to appeal, except the right to reopen the claim and to vocational rehabilitation services.

(Added to NAC by Div. of Industrial Insurance Regulation, eff. 2-22-88; A by Div. of Industrial Relations, 3-28-94; R009-97, 10-27-97)

NAC 616C.502 Factors for computing present value for lump-sum payment. (NRS 616A.400, 616C.495) The factors in the following table must be applied whenever present value is computed to make a lump-sum payment for an award for a permanent partial disability. The determination of the age of an injured employee must be made by subtracting the birthdate of the injured employee from the date of the request by the injured employee for a lump-sum payment. Only the month and year may be used in the determination.

DIVISION OF INDUSTRIAL RELATIONS

Factors to be Applied to Awards for Monthly
Permanent Partial Disability to Calculate Lump-Sum Settlements

MALES/FEMALES - BENEFITS TO AGE 70

1997 UNDIFFERENTIATED PENSION MORTALITY – 6% INTEREST

Age Years	Months 0	1	2	3	4	5	6	7	8	9	10	11
15	192.72	192.68	192.63	192.59	192.54	192.50	192.45	192.41	192.36	192.32	192.27	192.23
16	192.18	192.13	192.09	192.04	191.99	191.94	191.89	191.85	191.80	191.75	191.70	191.65
17	191.61	191.56	191.50	191.45	191.40	191.35	191.30	191.25	191.20	191.14	191.09	191.04
18	190.99	190.94	190.88	190.83	190.77	190.72	190.66	190.61	190.55	190.50	190.44	190.39
19	190.33	190.27	190.21	190.16	190.10	190.04	189.98	189.92	189.86	189.80	189.74	189.68
20	189.63	189.56	189.50	189.44	189.37	189.31	189.25	189.18	189.12	189.06	188.99	188.93
21	188.87	188.80	188.73	188.66	188.60	188.53	188.46	188.39	188.33	188.26	188.19	188.12
22	188.05	187.98	187.91	187.84	187.76	187.69	187.62	187.55	187.47	187.40	187.33	187.26
23	187.18	187.11	187.03	186.95	186.87	186.79	186.72	186.64	186.56	186.48	186.40	186.33
24	186.25	186.16	186.08	186.00	185.92	185.83	185.75	185.67	185.58	185.50	185.42	185.33
25	185.25	185.16	185.07	184.99	184.90	184.81	184.72	184.63	184.54	184.46	184.37	184.28
26	184.19	184.10	184.00	183.91	183.81	183.72	183.63	183.53	183.44	183.34	183.25	183.16

DIVISION OF INDUSTRIAL RELATIONS

Factors to be Applied to Awards for Monthly
Permanent Partial Disability to Calculate Lump-Sum Settlements

MALES/FEMALES - BENEFITS TO AGE 70

1997 UNDIFFERENTIATED PENSION MORTALITY – 6% INTEREST

Age Years	Months											
	0	1	2	3	4	5	6	7	8	9	10	11
27	183.06	182.96	182.86	182.76	182.66	182.56	182.46	182.36	182.26	182.16	182.06	181.96
28	181.86	181.75	181.64	181.54	181.43	181.32	181.22	181.11	181.00	180.90	180.79	180.68
29	180.58	180.46	180.35	180.24	180.12	180.01	179.90	179.79	179.67	179.56	179.45	179.33
30	179.22	179.10	178.98	178.86	178.74	178.62	178.50	178.38	178.27	178.15	178.03	177.91
31	177.79	177.66	177.54	177.41	177.28	177.16	177.03	176.90	176.78	176.65	176.52	176.40
32	176.27	176.14	176.01	175.87	175.74	175.60	175.47	175.34	175.20	175.07	174.94	174.90
33	174.67	174.53	174.39	174.25	174.11	173.96	173.82	173.68	173.54	173.40	173.26	173.12
34	172.98	172.83	172.68	172.53	172.38	172.23	172.08	171.94	171.79	171.64	171.49	171.34
35	171.19	171.04	170.88	170.72	170.57	170.41	170.26	170.10	169.94	169.79	169.63	169.48
36	169.32	169.16	168.99	168.83	168.66	168.50	168.33	168.17	168.01	167.84	167.68	167.51
37	167.35	167.18	167.01	166.83	166.66	166.49	166.32	166.14	165.97	165.80	165.63	165.45
38	165.28	165.10	164.92	164.74	164.56	164.38	164.20	164.02	163.83	163.65	163.47	163.29
39	163.11	162.92	162.73	162.54	162.35	162.16	161.97	161.78	161.59	161.40	161.21	161.02
40	160.83	160.63	160.43	160.23	160.03	159.83	159.64	159.44	159.24	159.04	158.84	158.64
41	158.44	158.23	158.02	157.81	157.60	157.39	157.19	156.98	156.77	156.56	156.35	156.14
42	155.93	155.71	155.49	155.27	155.06	154.84	154.62	154.40	154.18	153.96	153.74	153.52
43	153.30	153.07	152.84	152.62	152.39	152.16	151.93	151.70	151.47	151.24	151.01	150.78
44	150.55	150.31	150.07	149.83	149.59	149.35	149.11	148.87	148.63	148.39	148.15	147.91
45	147.67	147.42	147.17	146.91	146.66	146.41	146.16	145.91	145.66	145.41	145.15	144.90
46	144.65	144.39	144.12	143.86	143.60	143.34	143.07	142.81	142.55	142.28	142.02	141.76
47	141.49	141.22	140.94	140.67	140.39	140.12	139.84	139.57	139.29	139.02	138.74	138.47
48	138.19	137.91	137.62	137.33	137.04	136.76	136.47	136.18	135.90	135.61	135.32	135.03
49	134.75	134.45	134.14	133.84	133.54	133.24	132.94	132.64	132.34	132.04	131.74	131.44
50	131.14	130.82	130.51	130.19	129.88	129.56	129.25	128.94	128.62	128.31	127.99	127.68
51	127.36	127.03	126.70	126.38	126.05	125.72	125.39	125.06	124.73	124.40	124.07	123.74
52	123.41	123.07	122.72	122.38	122.04	121.69	121.35	121.00	120.66	120.32	119.97	119.63
53	119.28	118.92	118.56	118.20	117.84	117.48	117.12	116.76	116.40	116.04	115.68	115.32
54	114.96	114.58	114.20	113.83	113.45	113.07	112.69	112.31	111.94	111.56	111.18	110.80
55	110.43	110.03	109.63	109.24	108.84	108.44	108.05	107.65	107.25	106.86	106.46	106.06
56	105.67	105.25	104.83	104.41	104.00	103.58	103.16	102.75	102.33	101.91	101.50	101.08
57	100.66	100.23	99.79	99.35	98.91	98.47	98.03	97.60	97.16	96.72	96.28	95.84
58	95.40	94.94	94.48	94.02	93.56	93.10	92.64	92.18	91.71	91.25	90.79	90.33
59	89.87	89.38	88.90	88.41	87.92	87.44	86.95	86.46	85.98	85.49	85.00	84.52
60	84.03	83.52	83.00	82.49	81.98	81.46	80.95	80.43	79.92	79.41	78.89	78.38
61	77.86	77.32	76.78	76.23	75.69	75.15	74.60	74.06	73.51	72.97	72.43	71.88
62	71.34	70.76	70.18	69.61	69.03	68.45	67.88	67.30	66.72	66.15	65.57	64.99
63	64.42	63.80	63.19	62.58	61.97	61.35	60.74	60.13	59.51	58.90	58.29	57.67
64	57.06	56.41	55.75	55.10	54.45	53.79	53.14	52.49	51.83	51.18	50.53	49.87
65	49.22	48.52	47.82	47.12	46.42	45.72	45.02	44.32	43.62	42.92	42.22	41.53
66	40.83	40.08	39.32	38.57	37.82	37.07	36.32	35.57	34.82	34.07	33.32	32.56

DIVISION OF INDUSTRIAL RELATIONS

Factors to be Applied to Awards for Monthly
Permanent Partial Disability to Calculate Lump-Sum Settlements

MALES/FEMALES - BENEFITS TO AGE 70 — 1997 UNDIFFERENTIATED PENSION MORTALITY – 6% INTEREST

Age Years	Months											
	0	1	2	3	4	5	6	7	8	9	10	11
67	31.81	31.00	30.19	29.38	28.57	27.76	26.95	26.14	25.33	24.52	23.70	22.89
68	22.08	21.20	20.32	19.44	18.56	17.68	16.80	15.92	15.04	14.16	13.28	12.40
69	11.52	10.56	9.60	8.64	7.68	6.72	5.76	4.80	3.84	2.88	1.92	0.96

(Added to NAC by Dep't of Industrial Relations, eff. 6-29-84; A 11-12-85; 6-23-86; eff. 7-1-86; 8-31-87; A by Div. of Industrial Relations by R009-97, 10-27-97)

NAC 616C.505 Acceptance of award in installment payments. (NRS 616A.400) An injured employee may accept an award for a permanent partial disability in installment payments without prejudice to any right which he or she may have to an administrative or judicial review.

[Industrial Comm'n, No. 5.031, eff. 6-30-82]—(NAC A by Div. of Industrial Relations by R009-97, 10-27-97)

NAC 616C.508 Compensation for loss of or permanent damage to tooth. (NRS 616A.400, 616C.485, 616C.495)

1. An injured employee is entitled to receive the following compensation for the loss of or permanent damage to a tooth:

Incisor	$200
Cuspid	300
Bicuspid	300
Molar	400

2. An insurer or third-party administrator shall pay an injured employee for the loss of or permanent damage to a tooth within 30 days after he or she is notified by the treating dentist that the dental treatment related to the tooth has been completed.

(Added to NAC by Div. of Industrial Insurance Regulation, eff. 8-30-91; A by Div. of Industrial Relations by R009-97, 10-27-97; R105-00, 1-18-2001, eff. 3-1-2001)

State of Nevada
Department of Business and Industry
DIVISION OF INDUSTRIAL RELATIONS
Workers' Compensation Section
400 West King Street, Suite 400
Carson City, Nevada 89703
(775) 684-7265 (telephone) (775) 687-6305 (fax)

REQUEST FOR A ROTATING RATING PHYSICIAN OR CHIROPRACTOR

Name of Requestor: _____ Date: _____

Address: _____ Phone: _____ FAX: _____

City: _____ State: _____ Zip: _____

Requestor is: _____ Insurer/Third-Party Administrator; _____Injured Employee;

_____*Injured Employee's Attorney or Representative; _____Other (Specify)

**Please provide a signed release or power of attorney*

Insurer/Third-Party Administrator/

Association of Self-Insured Employers Name: _____ Certificate #: _____

Self-Insured Employer's Name: _____ Certificate #: _____

Employer Name: _____

Injured Employee's Name: _____

Injured Employee's Address: _____

City: _____State: _____ Zip: _____

Social Security Number: ____-____-____ Claim Number: _____ Date of Injury: _____

INSURER'S INITIAL REQUEST

Stable & Ratable Received: _____Name(s) of Treating & Evaluating Doctor(s): _____

Body Part(s) Codes: _____ _____ _____

Body Part(s) to be evaluated _____ _____ _____

Diagnosis: _____

Name(s) of Doctor(s) who reviewed for possible PPD _____

If a specific specialty is ordered by a hearing or appeals officer, the decision must be attached

FOR ADDITIONAL RATING PHYSICIAN/CHIROPRACTOR REQUESTS ONLY

Date(s) of prior PPD Evaluation(s): _____ Prior Rating Doctor(s): _____

Name of Treating Physician(s)/Chiropractor(s): _____

Body Part(s) Codes: _____ _____ _____

Body Part(s) to be evaluated: _____ _____ _____

Diagnosis: _____

Reason for additional request: _____

If a specific specialty is ordered by a hearing or appeals officer, the decision must be attached

INSURER AND INJURED EMPLOYEE ASSIGNMENT/AGREEMENT OF RATER

Assigned or Agreed by: _____ Date of Assignment/Agreement: _____

Physician/Chiropractor Assigned or Mutually Agreed to: _____

Assigned Rating Physician/Chiropractor's Phone Number: _____

***Notice to requestor: Hard copy will not follow by mail.*

Compliance with NAC 616C.103 is required

PERMANENT PARTIAL DISABILITY AWARD CALCULATION WORK SHEET

Injured Employee:_____ DOB: _____ Sex:_____

SS #: _____ DOI: _____ Claim #: _____

*Average Monthly Wage: _____ *State Average Wage: _____ Date of Rating:_____

Date Award Offered:_____ Date Evaluation Report Received: _____

Body Basis - Verification

Description: _____ %

_____ % Total _____ % BB

Installment Calculation

* A.	_____ x	**.005 **.006 **.0054 x	_____ % BB	= $ _____	Year of Birth ***	Last TTD, TPD, or DOI
	Monthly Wage			Monthly Rate		
B.	_____ x 12			= $ _____	+ _____	+ 5 Yr.
	Monthly Rate			Annual Rate		
C.	_____ /365.25			= $ _____		
	Annual Rate			Daily Rate		

Installment Calculation

(1) Last Date TTD or TPD Paid: _____ First Payment Date: _____

(2) Time Covered by First Payment: (a)_____ through (b)**** _____

****** DOI/date of claim reopening or day after last TTD/TPD

(3) First Payment: $_____ + $_____ + $_____ = $ _____

( ) Day(s) ( ) Month(s) ( ) Year(s)

(4) Time Covered by Annual Payments: _____ through _____ = $ _____

**** ( ) Years

(5) Time Covered by Final Payment:_____ through _____

(6) Final Payment: $ _____ + $ _____ = $ _____

( ) Month(s) ( ) Day(s)

***** Monthly [ ] Annual [ ] Total of Installment Payments: $ _____

Minimum Lump Sum Calculation

.5% X _____% BB X _____ Monthly Wage from (A) above: $

Minimum Lump Sum Amount

Lump Sum Calculation of Disability Up To and Including 25%

(Use form D-9b for disability greater 25%)

(7)	Effective Date of Award (year, month following 2 b) Per NAC 616C.502	_____		_____
(8)	Date of Birth (year, month)	_____		_____
(9)	Injured Employee Age at Award Effective Date = (7) minus (8) (years, months)	_____		_____
(10)	Monthly Rate from (B)	$ _____		
(11)	Factor from Table for Present Value	X _____	= $	_____
(12)	Insert sum of (3). Add to sum of (11) only.		+ $	_____
(13)	Subtotal of (11) plus (12):		$	_____
(14)	Greater of (13) Full Lump Sum or Minimum Lump Sum:		$	_____
(15)	Minus any applicable award payments previously paid:		- $	_____
(16)	Net Amount Payable:		$	_____

* Use the Average Monthly Wage or the State Average Wage, whichever is lower. If the average monthly wage (AMW) for TTD on this claim is subject to the frozen 1993 rate, recalculate the AMW for PPD purposes.

** Use .005 for injuries sustained before 07/01/81. Use .006 for injuries sustained after 07/01/81, through 06/17/93. Use .0054 for injuries sustained on or after 06/18/93. Use .006 for injuries sustained on or after 1/1/00.

*** Per NRS 616C.490(7), age at which entitlement ceases.

**** This must reflect the end of the month prior to election of the award. Recalculation may be required to bring the award to present day value. If (2)(b) is December date, use caution on line (4) to assure correct number of years. (If subtracting dates, add one year)

***** Must pay monthly installments if monthly entitlement is $100 or more. May pay annual installments if monthly entitlement is less than $100.

******Use date of claim reopening if TTD/TPD benefits were not paid after the claim was reopened (2)(a).

PREPARED BY: _____ DATE: _____

CHECKED BY: _____ DATE: _____ D-9a (rev 1-12)

PERMANENT PARTIAL DISABILITY AWARD CALCULATION WORK SHEET
FOR DISABILITY OVER 25% BODY BASIS

see NRS 616C.495(1)(c)

Injured Employee:_____ DOB: _____ Sex:_____

SS #: _____ DOI: _____ Claim #: _____

*Average Monthly Wage: _____ *State Average Wage: _____ Date of Rating:_____

Date Award Offered:_____ Date Evaluation Report Received:_____

Body Basis - Verification

Description: _____ % Total _____ % BB

_____ % - 25% Lump Sum

Balance for installment calculation: _____ %

Installment Calculation

* A.	_____ x	**.005 **.006 **.0054 x	_____ % BB	= $ _____	Year of Birth ***	Last TTD, TPD, or DOI
	Monthly Wage			Monthly Rate		
B.	_____ x 12			= $ _____	+ _____	+ 5 Yr.
	Monthly Rate			Annual Rate		
C.	_____ / 365.25			= $ _____		
	Annual Rate			Daily Rate		

Transfer (1) through (3) from form D-9a to (1) through (3) on form D-9b

(1) Last Date TTD or TPD Paid: _____ First Payment Date: _____

(2) Time Covered by First Payment: (a)_____ through (b) ****_____

******DOI/date of claim reopening or day after last TTD/TPD

(3) First Payment: $_____ + $_____ + $_____ = $_____

( ) Day(s) ( ) Month(s) ( ) Year(s) (from Form D-9a)

(4) Time Covered by Annual Payments: _____ through _____ = $_____

**** ( ) Years

(5) Time Covered by Final Payment:_____ through _____

(6) Final Payment: $ _____ + $ _____ = $ _____

( ) Month(s) ( ) Day(s)

***** Monthly [ ] Annual [ ] Total of Installment Payments: (4) through (6) $ _____

Minimum Lump Sum Calculation

(Payable only if greater than total of installment on form D-9a)

.5% X _____% BB X _____ Monthly Wage from (A) above: $ _____

(Use Total Percent of Disability) Minimum Lump Sum Amount

D._____ X ** X 25 %BB = $ _____

Average Monthly Wage (from A above) Monthly Rate

(7) Effective Date of Award (year, month following 2 b) Per NAC 616C.502			_____
(8) Date of Birth (year, month)			_____
(9) Injured Employee's Age at Award Effective Date = (7) minus (8) (years, months)			_____
(10) Monthly Rate from D	$ _____		
(11) Factor from Table for Present Value	X _____ =		$ _____
(12) Insert sum of (3)	+		$ _____
(13) Subtotal of (11) plus (12):			$ _____
(14) Minus any applicable award payments previously paid:			$ _____
(15) Net Amount Payable:			$ _____

---

* Use the Average Monthly Wage or the State Average Wage, whichever is lower. If the average monthly wage (AMW) for TTD on this claim is subject to the frozen 1993 rate, recalculate the AMW for PPD purposes.

** Use .005 for injuries sustained before 07/01/81. Use .006 for injuries sustained after 07/01/81, through 06/17/93. Use .0054 for injuries sustained on or after 06/18/93. Use .006 for injuries sustained on or after 1/1/00.

*** Per NRS 616C.490(7), age at which entitlement ceases.

**** This must reflect the end of the month prior to election of the award. Recalculation may be required to bring the award to present day value. If (2)(b) is December date, use caution on line (4) to assure correct number of years. (If subtracting dates, add one year)

***** Must pay monthly installments if monthly entitlement is $100 or more. May pay annual installments if monthly entitlement is less than $100.

******Use date of claim reopening if TTD/TPD benefits were not paid after the claim was reopened. (2)(a).

PREPARED BY: _____ DATE: _____

CHECKED BY: _____ DATE: _____

NEVADA DIVISION OF INDUSTRIAL RELATIONS
Workers' Compensation Section

PERMANENT WORK-RELATED MENTAL IMPAIRMENT RATING REPORT WORK SHEET

Since the AMA *Guides to the Evaluation of Permanent Impairment*, 5th Edition, does not provide a quantified method for assigning permanent impairment percentages under Chapter 14, "Mental and Behavioral Disorders," the provider shall use this form when evaluating claims accepted pursuant to NRS 616C.180.

Patient Name: _____ Date of Service: _____
Claim No.: _____ Insurer: _____

SCORING INSTRUCTIONS:

1. This form should only be used to determine an impairment after the case has been found to meet all of the specific criteria for a Diagnostic and Statistical Manual of Mental Disorders, Fourth Ed. (DSM-IV) diagnosis.

2. The AMA *Guides to Permanent Impairment*, 5th Edition should be consulted for guidance in determining these ratings.

3. Determination of a rating of permanent mental or behavioral impairment shall be limited to mental or behavioral disorder impairments not likely to remit with further mental health treatment.

4. Impairment ratings based on chronic pain are not applicable within the mental/behavioral domain.

5. To obtain the final overall impairment rating:

   a. The elements to be rated are divided into four Areas of Function: Activities of Daily Living; Social Functioning; Thinking, Concentration and Judgment; and Adaptation to Stress.

   b. Assign a rating (0-6) to each subcategory of the areas of function based on patient self-report, other sources of information, and the physician's clinical assessment. (See Category Definitions on Page 5 of this form.) Given the heavy reliance on the patient's subjective report for information in some of the ratings, the physician should give careful consideration to any corroborating evidence that might be available.

   c. Average the two highest subcategory ratings within each Area of Function to obtain the overall category rating. For example, if the two highest scores are 2 and 5, the category score is 3.5.

   d. To calculate the overall impairment rating, average the two highest category ratings and then, if appropriate in the case, use clinical judgment to add or subtract up to 0.5 point from the result. If the score is modified in this fashion due to clinical judgment, ***justification for doing so must be documented***. Factors influencing the physician's discretion may include the following:

      i. Factors influencing the patient's believability, such as the presence of symptom magnification, or the presence or absence of corroborating information from psychological or neuropsychological testing;

      ii. The extent to which medication ameliorates the effects of the condition;

   e. Use the Category Conversion Table in these instructions to convert the final number to a percentage.

6. Include the DSM-IV diagnosis at the top of the worksheet.

The final determination must include ratings for all of the elements in each area of function, the category averages reached in each area of function, the overall average, the final assigned overall permanent impairment rating, and documentation for any divergence (± 0.5) from the calculated score.

CATEGORY CONVERSION TABLE	
Final Score	**Percentage**
0	0
0.25	0
0.5	1
0.75	1
1	**1**
1.25	2
1.5	3 to 4
1.75	5
2	**6 to 7**
2.25	8 to 9
2.5	10 to 12
2.75	13 to 15
3	**16 to 18**
3.25	19 to 21
3.5	22 to 23
3.75	24 to 25
4	**26 to 32**
4.25	33 to 38
4.5	39 to 44
4.75	45 to 50
5	**51 to 56**
5.25	57 to 62
5.5	63 to 68
5.75	69 to 75
6	**76 to 83**
6.25	84 to 91
6.5	92 to 100

7. If apportionment is applicable, complete a separate form calculating the pre-injury rating to be subtracted from the total current rating.

8. If there is a finding of no impairment, refer to Part V on the worksheet, if appropriate.

WORKSHEET

Patient Name _____ Date of Service: _____

Claim # _____ Insurer _____

NOTE: Determination of a rating of permanent mental or behavioral impairment shall be limited to mental or behavioral disorder impairments not likely to remit with further mental health treatment. Further, impairment ratings based on chronic pain are not applicable within the mental/behavioral domain, but are restricted to physical examination with evidence of anatomic or physiologic correlation and included within a physical impairment rating.

I. DSM-IV Diagnosis: Axis I: _____ Axis II: _____

Axis III: _____ Axis IV: _____

Axis V: _____

II. LEVELS OF PERMANENT MENTAL IMPAIRMENT

Category

0. No permanent impairment
1. Minimal Category of Permanent Impairment
2. Mild Category of Permanent Impairment
3. Moderate Category of Permanent Impairment
4. Marked Category of Permanent Impairment
5. Extreme Category of Permanent Impairment
6. Maximum Category of Permanent Impairment

III. AREAS OF FUNCTION[1] ***Rate only impairments due strictly to the psychiatric condition.***

1. Activities of Daily Living, *see* 14.3a, p. 361 of *Guides*, 5th ed. and Table 1-2, p. 4 (*Guides*, 5th ed.)

0 1 2 3 4 5 6	Self-care, personal hygiene (urinating, defecating, brushing teeth, combing hair, bathing, dressing oneself, eating)
0 1 2 3 4 5 6	Communication (writing, typing, seeing, hearing, speaking)
0 1 2 3 4 5 6	Physical activity (standing, sitting, reclining, walking, climbing stairs)
0 1 2 3 4 5 6	Sensory function (hearing, seeing, tactile feeling, tasting, smelling) NB: smell/taste 1%-5% WP, p. 262
0 1 2 3 4 5 6	Nonspecialized hand activities (grasping, lifting, tactile discrimination)
0 1 2 3 4 5 6	Travel (driving, riding, flying) i.e. impairments in driving, riding, flying which are generally a result of symptoms of affective or anxiety disorders
0 1 2 3	Sexual function (orgasm, ejaculation, lubrication, erection)
0 1 2 3 4 5 6	Sleep (restful, nocturnal sleep pattern)

Overall Category Rating: (average of 2 highest) _____

2. Social Functioning *see* 14.3b, p. 362 of *Guides*, 5th ed.

0 1 2 3 4 5 6	Interpersonal relationships
0 1 2 3 4 5 6	Communicates effectively with others
0 1 2 3 4 5 6	Participation in recreational activities (consider pre-injury activities of the patient)
0 1 2 3 4 5 6	Manage conflicts with others--negotiate, compromise

Overall Category Rating: (average of 2 highest) _____

[1] See attached Appendix for further description of all or part of the listed areas of function.

3. **Concentration, Persistence, and Pace** *see* 14.3c, p. 362 of *Guides*, 5th ed.

0 1 2 3 4 5 6	Ability to perform complex or varied tasks
0 1 2 3 4 5 6	Judgment
0 1 2 3 4 5 6	Problem solving
0 1 2 3 4 5 6	Ability to abstract or understand concepts
0 1 2 3 4 5 6	Memory, immediate and remote
0 1 2 3 4 5 6	Maintain attention, concentration on a specific task
0 1 2 3 4 5 6	Perform simple, routine, repetitive tasks
0 1 2 3 4 5 6	Comprehend/follow simple instructions

Overall Category Rating:
(average of 2 highest)

_____

4. **Deterioration or Decompensation in Complex or Worklike Settings** *see* 14.3d, p. 362 of *Guides*, 5th ed.

0 1 2 3 4 5 6	Set realistic short & long term goals
0 1 2 3 4 5 6	Perform activities (including work) on schedule
0 1 2 3 4 5 6	Adapt to job performance requirements

Overall Category Rating:
(average of 2 highest)

_____

IV. FINAL CALCULATIONS:

Average the two highest Area of Function ratings: _____ + _____ **divided by 2 =** _____

Add or subtract up to 0.5 from the completed calculation above, if appropriate, based on clinical judgment.
Justify this deviation below or attach a separate sheet:

_____

Using the Category Conversion Table on page 2 of this form, convert the final number to a percentage for the overall permanent impairment rating:

Overall Psychiatric Permanent Impairment

Rating _____%

OR

V. If this patient has ZERO impairment according to the above criteria and requires continuing medication for their DSM diagnosis, an impairment of 1-3% may be assigned _____%.

IF ZERO % PSYCHIATRIC RATING

***RATING*_____%**

VI. TOTAL IMPAIRMENT RATING (if applicable)

Total Whole Person *Physical* Impairment = _____%

Combined with psychiatric permanent impairment equals:

Total Whole Person Impairment (including psychiatric impairment)
_____%

Physician: _____ Date: _____
(Signature)

APPENDIX

1. Activities of Daily Living

Sexual Function: Scoring categories 4, 5 and 6 are not available because the maximum impairment allowed per the AMA *Guides* for total loss of sexual function is 20% (Table 13-21, p. 342 of the 5th edition of the *Guides*).

PERMANENT WORK-RELATED MENTAL IMPAIRMENT RATING
REPORT WORK SHEET
CATEGORY DEFINITION GUIDELINES

CATEGORY 0: 0% **No Permanent Impairment**

Mental symptoms arising from the work-related psychiatric diagnosis have been absent for the past month. ADLs are not affected. Functioning is at pre-injury baseline in social and work activities in all areas; no more than everyday problems.

CATEGORY 1: 1-5% **Minimal Category of Permanent Impairment**

Mental symptoms, arising from the work-related psychiatric diagnosis and not likely to remit despite medical treatment, minimally impair functioning.

CATEGORY 2: 6-15% **Mild Category of Permanent Impairment**

Mental symptoms, arising from the work-related psychiatric diagnosis are not likely to remit despite medical treatment, and are mildly impairing. ADLs are mildly disrupted. Functioning shows mild permanent impairment in social or work activities.

CATEGORY 3: 16-25% **Moderate Category of Permanent Impairment**

Mental symptoms, arising from the work-related psychiatric diagnosis and not likely to remit despite medical treatment, are moderately impairing. ADLs are moderately disrupted. Functioning shows moderate permanent impairment. Activities sometimes need direction or supervision.

CATEGORY 4: 26-50% **Marked Category of Permanent Impairment**

Mental symptoms, arising from the work-related psychiatric diagnosis and not likely to remit despite medical treatment, are seriously impairing. ADLs are seriously disrupted. Functioning shows serious difficulties in social or work activities.

CATEGORY 5: 51-75% **Extreme Category of Permanent Impairment**

Mental symptoms, arising from the work-related psychiatric diagnosis and not likely to remit despite medical treatment, are incapacitating. At times, ADLs require structuring. Functioning is quite poor, unsafe in work settings, at times requires hospitalization or full-time supervision. Most activities require directed care.

CATEGORY 6: 76-100% **Maximum Category of Permanent Impairment**

This impairment level precludes useful functioning in all areas. These individuals are generally appropriate for institutionalized settings, if available. All activities require directed care.

Injured Employee: _____ Date: _____
Claim No: _____ Date of Injury: _____
Employer: _____ Insurer: _____

ELECTION OF METHOD OF PAYMENT OF COMPENSATION

(Pursuant to NRS 616C.495)

NRS 616C.495(2) provides:

2. If the injured employee elects to receive his payment for a permanent partial disability in a lump sum, all of his benefits for compensation terminate. His acceptance of that payment constitutes a final settlement of all factual and legal issues in the case. By so accepting he waives all of his rights regarding the claim, including the right to appeal from the closure of the case or the percentage of his disability, except:

(a) His right to reopen his claim according to the provisions of NRS 616C.390; and

(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.

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.

I, _____ _____
(Name) (Social Security Number)
have been advised that I may elect to receive my permanent partial disability compensation on an installment basis or, if eligible, and I so elect, on a lump sum basis.

Should I elect to receive my compensation on an installment basis, payments will begin on _____ and terminate on _____ and will be paid at the *monthly/annual rate of $_____ for a total installment payment of $_____.

If I elect to receive my entitlement on a lump sum basis I will receive approximately $_____. This sum will vary depending on the date I elect to receive my lump sum payment. As provided by NRS 616C.495, if I elect to receive my payment for permanent partial disability in a lump sum, all of my benefits for compensation terminate.

My acceptance of the lump sum payment constitutes a final settlement of all factual and legal issues in this case, including but not limited to unresolved issues that are or could become the subject of pending litigation,. By so accepting, I waive all of my rights regarding the claim, including, but not limited to, the right to appeal from the closure of the case or the percentage of my disability, except:

(a) My right to request reopening in accordance with the provisions of NRS 616C.390; and

(b) Any counseling, training or other rehabilitation services provided by the insurer.

Further, I understand that I have twenty (20) days after this notice has been mailed or personally delivered to me, within which to retract or reaffirm my request for a lump sum. I also understand that I will not be paid a lump sum until I have reaffirmed this election in writing. I also understand that any lump sum I receive is subject to an offset based on any prior PPD payments I received before electing to accept a lump sum.

Check one to indicate method of payment desired and sign below.

1. [ ] On an installment basis as provided by NRS 616C.490.
2. [ ] A lump sum of approximately $ **_____ as calculated pursuant to NRS 616C.495.

DATE: _____ INJURED EMPLOYEE: _____

DATE: _____ WITNESS: _____

* Insurer: Designate whether monthly or annual rate.

** Amount depends on actual effective date (date elected).

Injured Employee: _____ Date: _____

Claim No: _____ Date of Injury: _____

Employer: _____ Insurer: _____

ELECTION OF METHOD OF PAYMENT OF COMPENSATION
FOR DISABILITY GREATER THAN 25%
(Pursuant to NRS 616C.495(1)(c))

I, _____ _____
(Name) (Social Security Number)

have been advised that I may elect to receive my permanent partial disability compensation on an installment basis or; on a lump sum basis of 25%, plus installment payments on the balance of _____% of my percentage of disability.

Should I elect to receive my compensation on an installment basis, payments will begin on _____ and terminate on _____ and will be paid at the *monthly/annual rate of $_____ for a total installment payment of $_____.

If I elect to receive my entitlement of 25% on a lump sum basis, I will receive approximately $_____. This will vary depending on the date I elect to receive my lump sum payment. According to NRS 616C.495(1)(c), if I elect to receive my payment for permanent partial disability in a lump sum, the balance of _____% will be paid on an installment basis. Payments will begin on _____ and terminate on _____ and will be paid at the *monthly/annual rate of $ _____, for a total of installment payments of $ _____ plus lump-sum payment of $ _____, for a total of $_____.

My acceptance of the lump sum payment constitutes a final settlement of all factual and legal issues regarding this claim. By so accepting, I waive all of my rights regarding the claim, including the right to appeal from the closure of the case or the percentage of my disability, except:

(a) My right to request reopening in accordance with the provisions of NRS 616C.390; and

(b) Any services for counseling, training or other rehabilitation services provided by the insurer.

Further, I realize that I have twenty (20) days after the mailing or personal delivery of this notice within which to retract or reaffirm my request for a lump sum. I also realize that I will not be paid a lump sum until I have reaffirmed this election in writing.

Check one to indicate method of payment desired and sign below.

1. [ ] On an installment basis as provided by NRS 616C.490.
2. [ ] A lump sum of approximately $ **_____, with the remaining installment balance of $_____ as calculated pursuant to NRS 616C.495.

DATE: _____ INJURED EMPLOYEE:_____

DATE: _____ WITNESS: _____

* Insurer: Designate whether monthly or annual rate.
** Amount depends on actual effective date (date elected).

Injured Employee: _____

Social Security No.: _____

Claim No.: _____

Employer: _____

Date of Injury: _____

REAFFIRMATION/RETRACTION OF LUMP SUM REQUEST

(Pursuant to NRS 616C.495(2) and NAC 616C.499(1))

NAC 616C.499(1) provides: If an injured employee elects to receive his award for a permanent partial disability in a lump sum, he must reaffirm his election within 20 days after receiving notification from the insurer pursuant to subsection 2 of NRS 616C.495 before the lump sum will be paid.

Please indicate whether you wish to reaffirm or retract your request for a lump sum payment by checking the appropriate box below. Your decision as indicated on this form constitutes your final election regarding the lump sum payment.

Failure to return this form or not checking one of the boxes may result in a delay in the processing of your award.

☐ I reaffirm the request for my lump sum payment. I understand that in doing so, I am waiving all of my rights regarding the claim, except my right to request reopening and vocational rehabilitation.

☐ I retract the request for my lump sum payment.

_____ _____

Signature of Injured Employee Date

_____ _____

Witness Date

SECOND REVISED PROPOSED REGULATION OF THE

ADMINISTRATOR OF THE DIVISION OF INDUSTRIAL RELATIONS

OF THE DEPARTMENT OF BUSINESS AND INDUSTRY

LCB File No. R059-15

March 24, 2016

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

AUTHORITY: §1, NRS 616A.400 and 616C.495, as amended by section 3 of Senate Bill No. 232, chapter 240, Statutes of Nevada 2015, at page 1141.

A REGULATION relating to industrial insurance; revising provisions concerning compensation of an injured employee who incurs a permanent partial disability; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law allows an injured employee who incurs a permanent partial disability to elect to receive compensation for that injury in a lump sum. The Administrator of the Division of Industrial Relations of the Department of Business and Industry is required to adopt regulations for determining the eligibility of such an employee who is injured on or after July 1, 1995, to receive all or a portion of his or her compensation in a lump sum. (NRS 616C.495, as amended by section 3 of Senate Bill No. 232, chapter 240, Statutes of Nevada 2015, at page 1141) Existing regulations allow such an employee who incurs a partial disability that: (1) does not exceed 25 percent to elect to receive compensation in a lump sum; and (2) exceeds 25 percent to elect to receive a portion of his or her compensation in a lump sum equal to the present value of an award for a disability of 25 percent. (NAC 616C.498) This regulation allows such an employee who is injured on or after July 1, 2015, but before January 1, 2016, who incurs a partial disability that exceeds 25 percent to elect to receive a portion of his or her compensation in a lump sum up to the present value of an award for a disability of 30 percent if the insurer offers to provide compensation in a lump sum of that amount. This regulation also allows such an employee injured on or after January 1, 2016, who incurs a partial disability that: (1) does not exceed 30 percent to elect to receive compensation in a lump sum; and (2) exceeds 30 percent to elect to receive a portion of his or her compensation in a lump sum equal to the present value of an award for a disability of 30 percent.

Section 1. NAC 616C.498 is hereby amended to read as follows:

616C.498 *1.* An employee injured on or after July 1, 1995, ***but before January 1, 2016,*** who incurs a permanent partial disability that:

~~[1.]~~ ***(a)*** Does not exceed 25 percent may elect to receive compensation in a lump sum.

~~[2.]~~ ***(b)*** Exceeds 25 percent may ~~[elect]~~ ***:***

(1) Elect to receive compensation in a lump sum equal to the present value of an award for a disability of 25 percent. If the injured employee elects to receive compensation in a lump sum pursuant to this ~~[subsection,]~~ ***subparagraph,*** the insurer shall pay in installments to the injured employee that portion of the injured employee's disability in excess of 25 percent.

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

2. An employee injured on or after January 1, 2016, who incurs a permanent partial disability that:

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

(b) Exceeds 30 percent may elect to receive compensation in a lump sum equal to the present value of an award for a disability of 30 percent. If the injured employee elects to receive compensation in a lump sum pursuant to this paragraph, the insurer shall pay in installments to the injured employee that portion of the injured employee's disability in excess of 30 percent.

MARY BETH DICKINSON, Appellant, vs. AMERICAN MEDICAL RESPONSE, Respondent.

No. 48021

SUPREME COURT OF NEVADA

124 Nev. 460; *186 P.3d 878*; *2008 Nev. LEXIS 49*; *124 Nev. Adv. Rep. 44*

July 3, 2008, Filed

SUBSEQUENT HISTORY: Rehearing denied by *Dickinson v. Am. Med. Response, 2008 Nev. LEXIS 94 (Nev., Oct. 3, 2008)*

PRIOR HISTORY: [***1]

Appeal from a district court order denying a petition for judicial review in a workers' compensation matter. Eighth Judicial District Court, Clark County; Jessie Elizabeth Walsh, Judge.

DISPOSITION: Reversed and remanded with instructions.

COUNSEL: Clark & Richards and H. Douglas Clark, Las Vegas, for Appellant.

Lewis Brisbois Bisgaard & Smith, LLP, and J. Michael McGroarty, Las Vegas, for Respondent.

JUDGES: BEFORE HARDESTY, PARRAGUIRRE and DOUGLAS, JJ.

OPINION

[*461] [**879] PER CURIAM:

In this appeal, we address the use of equitable estoppel and waiver principles in administrative workers' compensation proceedings, as well as the appeals officer's duty to make factual findings in rendering a determination. We conclude that equitable estoppel and waiver principles may be applied in workers' compensation proceedings, and therefore, since those principles generally require a factual determination, the appeals officer has authority to and must consider them in the first instance. Further, we reiterate that, in resolving aspects of a contested case, including equitable estoppel or waiver, the appeals officer must support the determination with factual findings.

Fundamentally, this appeal challenges an appeals officer's decision that denied a [***2] workers' compensation claimant permanent partial disability (PPD) benefits for a cervical spine condition. The appeals officer's decision was based on two conclusions: first, that the claimant's failure to administratively challenge the exclusion of her neck condition from her accepted workers' compensation claim precluded payment for that condition, and second, that the claimant failed to demonstrate that her neck condition was caused by her industrial injury.

In [***3] considering the claimant's argument that her failure to administratively appeal should not preclude PPD benefits for her cervical spine condition because she continued to receive medical benefits for that condition, we conclude that the doctrines of equitable estoppel or waiver apply in workers' compensation proceedings, and thus, the appeals officer must determine whether those doctrines apply here. Further, with respect to the claimant's contention that substantial evidence does not support the appeals officer's refusal to recognize her cervical spine condition as industrial, we are unable to adequately review that issue because the appeals [*462] officer failed to provide the requisite factual findings supporting the determination.

Therefore, we reverse the district court's order denying judicial review of the appeals officer's decision and remand this matter so that the appeals officer may address and revisit these issues. Finally, we point out that the appeals officer's award of any PPD benefits on remand must accord with *NRS 616C.490(2)*'s rating physician selection requirements.

FACTS AND PROCEDURAL HISTORY

Appellant Mary Beth Dickinson suffered from a nonindustrial right neck and shoulder [***4] condition, which included cervical spine and nerve problems, since 1997. In late August 1998, Dickinson sustained an industrial injury to her right upper extremity and filed a claim for workers' compensation based upon a physician's diagnoses of causalgia and winging at the right scapula. [1] Although that physician also indicated that further diagnostic testing was appropriate, Dickinson's employer, respondent American Medical Response, accepted her claim for the right arm and shoulder. Dickinson did not administratively challenge the scope of claim acceptance at that time.

1 According to J.E. Schmidt, M.D., 1 & 6 *Attorneys' Dictionary of Medicine*, C-119 & W-32 (1999), "causalgia" is "[a] burning sensation or pain, especially in the palms and soles, caused by injury to the nerves which carry impulses from these parts," and "winged scapula" is "[a]n abnormal condition in which the scapula (shoulder blade), especially its medial border, extends away from the back of the chest wall."

Soon after the August 1998 accident, however, Dickinson also reported neck pain. On September 3, 1998, a medical report indicated that Dickinson had a work- or treatment-related worsening of a preexisting cervical [***5] disc herniation. A few days later, on September 8, 1998, a physician examined Dickinson's cervical spine, and in comparing a recent magnetic resonance image (MRI) to one taken previously, in March 1998, he noted significant changes; nevertheless, the physician reported that while the August 1998 industrial injury possibly caused the noted changes, causation was "much more difficult to prove." Additional testing and physical therapy were recommended.

In the following months, Dickinson was tested for and diagnosed with likely mild [**880] brachial plexus injury and possible mild cervical radiculopathy. [2] Medication was prescribed and physical therapy was recommended. Apparently, Dickinson underwent physical therapy during the fall and winter of 1998, discontinuing the physical therapy around February 1999.

2 The "brachial plexus" is "[a] large and important nerve structure situated partly in the neck and partly in the armpit," and "radiculopathy" is generally defined as "[a]ny disease of the roots of spinal nerves." J.E. Schmidt, M.D., 1 & 5 *Attorneys' Dictionary of Medicine*, B-174 & R-10.

[*463] Around that time, Dickinson ostensibly requested that her cervical spine condition be included in her workers' [***6] compensation claim. On March 16, 1999, however, American Medical Response's third-party administrator denied Dickinson's request. The administrator's letter stated that it would not pay for Dickinson's neck injuries as part of her claim because, in the September 8 medical report, her physician was unable to state, with a reasonable degree of medical probability, that her neck condition was related to the industrial injury. Dickinson did not administratively challenge the March 1999 letter.

In June 1999, Dickinson returned to her physician with complaints of upper right extremity tenderness, and physical therapy was again recommended. As part of the physical therapy that Dickenson underwent over the next several months, Dickinson's cervical issues were noted and attended to. Meanwhile, a September 30, 1999, neurology report indicated that Dickinson suffered a burning sensation that originated at the right scapula and radiated down her right arm. The diagnosis was "status post possible brachial plexus injury, work-related," as well as degenerative disc disease at the cervical spine. Although the neurologist indicated that it was unlikely that the condition shown on the MRIs contributed [***7] to Dickinson's symptoms, he also opined that the 1998 injury had "contributed significantly" to her current problems.

In December 1999, Dickinson's physician noted that she continued to suffer from neck and shoulder pains, and he recommended that physical therapy be reinstated. Apparently, the administrator authorized a limited number of physical therapy sessions. Thereafter, in March 2000, Dickinson reported to her physician with increased neck and shoulder pain, apparently due to increased work duties. Her physician noted that an MRI showed evidence of cervical radiculopathy and myelopathy, [3] and he stated that, although some timing issues existed, the injuries "historically" were related to Dickinson's work or her work-related injury's medical treatment.

3 "Myelopathy" denotes "[a]ny disease of the spinal cord." J.E. Schmidt, M.D., 4 *Attorneys' Dictionary of Medicine*, M-315.

In June 2000, a neurologist reviewed Dickinson's extensive medical history and concluded that the industrial accident had resulted in a right wrist, right upper extremity strain, a right arm and shoulder strain injury, and a right brachial traction injury. In addition, he opined that treatment of those injuries [***8] had exacerbated Dickinson's preexisting cervical degenerative disease; radicular symptoms were noted. Despite largely successful treatments, the neurologist stated, Dickinson continued to suffer from surgically addressable spinal steno-

sis, [4] which was caused by her preexisting cervical degenerative disease and complicated by her treatments.

> 4 Spinal "stenosis" refers to an abnormal narrowing of the spinal canal. *See* J.E. Schmidt, M.D., 5 *Attorneys' Dictionary of Medicine*, S-292.

[*464] During the following months, to treat any cervical radiculopathy, the third-party administrator apparently paid for Dickinson to have several right nerve root block injections. In April 2001, the administrator sent Dickinson for an independent medical examination with Dr. R. W. Patti, who suggested that many of Dickinson's current complaints were due to her preexisting injuries, that her condition was stable and ratable, and that apportionment was appropriate.

Consequently, the administrator scheduled Dickinson for a PPD evaluation with Dr. Larry J. Tarno for her "cervical injury," also instructing the rating physician to examine Dickinson's "right upper extremity, cervical" and to apportion any rating based on [***9] preexisting [**881] conditions. Dickinson was informed that her medical file would be submitted so that her cervical spine and right upper extremity could be rated. In September 2001, Dr. Tarno indicated that despite Dickinson's preexisting condition, her cervical spine problems suggested a work-related injury and, in any case, because those problems required more treatment, a PPD rating was inappropriate at that time. Dickinson thus continued to obtain diagnostic treatment and take medications, and she was advised to obtain a surgical opinion.

In December 2002, an administrative status report indicated that the administrator was awaiting an opinion from another physician regarding whether the cervical spine should be accepted as part of the industrial injury claim. A few days later, that physician listed as industrial, among other things, right cervical and shoulder strains, chronic complaints of neck pain, right shoulder pain, and numbness in her right fingers, right brachial plexus involvement with mild radiculopathy, and preexisting degenerative disc disease, indicating that Dickinson's disc herniation seemed to have improved and that no neural compromise was evident. As for nonindustrial [***10] conditions, he contradictorily listed chronic complaints of neck pain, right shoulder pain, and numbness in the right fingers.

In February 2003, the administrator scheduled Dickinson for another PPD evaluation of her right shoulder/cervical strain injury, this time with Dr. Maureen E. Mackey. Dickinson failed to appear for her evaluation, and therefore, her claim was closed. She administratively appealed.

While Dickinson's administrative appeal was pending, in December 2003, Dickinson attended a PPD evaluation with the originally scheduled physician, Dr. Mackey. The resulting PPD report connected her condition to a work-related worsening of her preexisting condition, diagnosing bilateral cervical radiculopathy and multilevel cervical herniated discs, as well as right shoulder strain. A 27-percent PPD rating was given, on a total body basis, based on 2-percent impairment to the right shoulder and 25-percent impairment to the cervical spine.

[*465] The appeals officer, however, determined that the December 2003 PPD evaluation was unauthorized and sent Dickinson for a third PPD evaluation, which was conducted by Dr. Tarno. The appeals officer asked Dr. Tarno to opine on the claim's scope and whether [***11] apportionment was appropriate. On May 12, 2004, Dr. Tarno rated Dickinson with 16-percent whole-person impairment--1-percent impairment of the right shoulder and 15-percent impairment of the cervical spine. He opined that the industrial injury was wholly responsible for the findings and current impairments. On April 27, 2005, pursuant to the appeals officer's interim order, Dr. Tarno again examined Dickinson; this time, he rated her with a 17-percent whole person impairment--2-percent impairment of the right shoulder and 15-percent impairment of the cervical spine, which he connected to the industrial injury.

Finally, the administrator asked a third rating physician, Dr. Richard Kudrewicz, to review Dr. Tarno's evaluation. Dr. Kudrewicz, disagreeing somewhat with Dr. Tarno's methodology, indicated that a 4-percent whole-person impairment rating would be appropriate for the injury to Dickinson's right shoulder, if Dickinson's cervical condition was excluded. With respect to her cervical condition, he noted that her injury's history was confusing and concluded that, if Dickinson did have bilateral radiculopathy, then Dr. Tarno was ultimately correct in his 15-percent impairment rating [***12] for Dickinson's cervical condition.

After reviewing these reports, the appeals officer reversed in part the hearing officer's decision, determining that Dickinson's claim should be closed with a 4-percent PPD award based on Dr. Kudrewicz's report. Specifically, the appeals officer determined that no PPD award with respect to the cervical spine was permitted because Dickinson had failed to administratively challenge both the claim acceptance letter and the March 1999 letter denying her request to include her neck condition as part of her claim. Nevertheless, the appeals officer went on to conclude that Dickinson had failed to meet her burden to show, by the preponderance of the evidence, that her claim should be expanded [**882] beyond the right shoulder. Dickinson petitioned for judi-

cial review, which the district court denied, and Dickinson then appealed.

DISCUSSION

This court, like the district court, reviews an appeals officer's decision for clear error or abuse of discretion. [5] Although we independently review an appeals officer's purely legal determinations, the appeals officer's fact-based legal conclusions are entitled to deference and will not be disturbed if they are supported by substantial [*466] [***13] evidence. [6] Substantial evidence is evidence that a reasonable person could accept as adequately supporting a conclusion. [7] We may not substitute our judgment for that of the appeals officer as to credibility determinations or the weight of the evidence on a question of fact. [8] Our review is limited to the record before the appeals officer. [9]

5 *Construction Indus. v. Chalue, 119 Nev. 348, 352, 74 P.3d 595, 597 (2003).*
6 *Ayala v. Caesars Palace, 119 Nev. 232, 235, 71 P.3d 490, 491 (2003).*
7 *Id. at 235, 71 P.3d at 491-92.*
8 *Grover C. Dils Med. Ctr. v. Menditto, 121 Nev. 278, 283-84, 112 P.3d 1093, 1097 (2005).*
9 *Id. at 284, 112 P.3d at 1097.*

On appeal, Dickinson argues that the appeals officer erroneously concluded that she waived her right to any PPD award based on her cervical spine condition by failing to challenge the claim acceptance and March 1999 letters because, despite the letters, the administrator continued to pay accident benefits related to that condition, and thus, she was not "aggrieved" by the administrator's letters. She also argues that the appeals officer's determination with respect to limiting the scope of her claim is not supported by substantial evidence and that the appeals [***14] officer improperly failed to rely solely on authorized rating physicians' evaluations in awarding PPD benefits.

Dickinson did not necessarily waive her right to cervical PPD benefits

Under *NRS 616C.315(3)*, any person who is aggrieved by an administrator's written determination has 70 days within which to administratively appeal that determination. In *Reno Sparks Visitors Authority v. Jackson*, [10] we recognized that the 70-day time frame was jurisdictional and mandatory and that, subject to narrow exceptions that do not apply here, the failure to timely file an administrative appeal operates as a final decision on the matter, which cannot be relitigated. [11]

10 *112 Nev. 62, 65-66, 910 P.2d 267, 269-70 (1996).*

11 *See also Browning v. Young Elec. Sign Co., 113 Nev. 420, 424, 936 P.2d 322, 325 (1997).*

Dickinson, however, asserts that she could not have administratively appealed because she was not aggrieved by the administrator's letters, since the administrator continued to allow her to treat for her neck condition. But Dickinson's argument is not truly about aggrievement--clearly, Dickinson was "aggrieved" by the letters to the extent that they purported to exclude a known industrial condition [***15] or denied her request to cover her cervical spine [*467] condition. [12] Rather, Dickinson is in essence asserting that American Medical Response is estopped from arguing, or has waived any argument, that she was not entitled to PPD benefits for her cervical condition because its administrator acted in a manner inconsistent with the information set [**883] forth in the letters. [13]

12 *Cf. Valley Bank of Nevada v. Ginsburg, 110 Nev. 440, 446, 874 P.2d 729, 734 (1994)* (explaining that a party is "aggrieved" for the purpose of appealing a district court's decision to this court under *NRAP 3A(a)* when the order substantially affects a personal or property right).

The record reveals that after the administrator declined to accept Dickinson's cervical spine condition based on the September 8 medical report, which contemplated the possibility that the cervical condition was industrial, several physicians rendered additional cervical diagnoses and connected those diagnoses to her industrial injury or the treatment of that injury. We make no determination regarding whether Dickinson's failure to administratively challenge the administrator's letter necessarily barred her from later seeking to include her cervical [***16] condition in her workers' compensation claim based on the additional medical reporting.

13 *See NRS 616B.324* (explaining that a self-insured employer's administrator is the employer's agent).

Equitable estoppel may be invoked against a party who claims a statutory right in administrative workers' compensation proceedings, when the invoking party has reasonably relied on the other party's words or conduct to her detriment. [14] Implied waiver applies in those types of proceedings when the other party's conduct clearly shows an intention to waive a right or when that party's neglect to insist upon the right prejudices the invoking party. [15]

14 *See Schmidt v. Beeson Plumbing and Heating, 869 P.2d 1170, 1175, 1175 n.7 (Alaska 1994)*; *Barrington v. Employment Sec. Com'n, 55 N.C. App. 638, 286 S.E.2d 576, 578 (N.C. Ct.*

App. 1982) ("It is well established that the doctrine of equitable estoppel may be applied in workers' compensation cases."); *Appleby v. Workers' Safety & Comp. Div., 2002 WY 84, 47 P.3d 613, 619 (Wyo. 2002)* (explaining that substantive legal issues like equitable estoppel may be determined by an administrative agency as part of a contested workers' compensation case and has been applied to prevent strict application [***17] of statutory limitations periods); *see generally Lentz v. McMahon, 49 Cal. 3d 393, 261 Cal. Rptr. 310, 777 P.2d 83, 88-91 (Cal. 1989)* (recognizing that administrative agencies routinely apply equitable estoppel in administrative hearings and that permitting them to do so is consistent with administrative remedy exhaustion requirements and separation of powers); *Matter of Harrison Living Trust, 121 Nev. 217, 223, 112 P.3d 1058, 1061-62 (2005)* (explaining the doctrine of equitable estoppel).

15 *See Schmidt, 869 P.2d at 1175, 1175 n.7*; *see also Hudson v. Horseshoe Club Operating Co., 112 Nev. 446, 457, 916 P.2d 786, 792 (1996)* (explaining that "[w]aiver occurs where a party knows of an existing right and either actually intends to relinquish the right or exhibits conduct so inconsistent with an intent to enforce the right as to induce a reasonable belief that the right has been relinquished").

[*468] Here, Dickinson asserts that she did not administratively challenge the administrator's letters declining to include her cervical spine condition within the scope of her workers' compensation claim because the administrator, contrary to the language of its letters, had paid for and continued to pay for her cervical treatment. She also [***18] contends that the administrator's post-March 1999 conduct in paying for the cervical treatments and in scheduling PPD evaluations of her neck in this matter constituted acceptance of her cervical condition as part of her industrial claim. Whether estoppel or waiver principles apply under these circumstances requires a factual determination, [16] however, and therefore, this matter must be resolved by the appeals officer in the first instance.

16 *See Harrison Living Trust, 121 Nev. at 222, 112 P.3d at 1061*; *Schmidt, 869 P.2d at 1175* (noting that the Alaska court "will uphold a Board decision as to whether to apply equitable principles if it is supported by substantial evidence").

Although the appeals officer noted that Dickinson's cervical spine was "subject to differential and rule out diagnostic enquiry or treated incidental to the industrial residuals, [but was] never [an] accepted body part[ ]," the record contains no indication that the medical evaluations and treatment were so limited. Accordingly, while treating a nonaccepted condition for the noted reasons is not necessarily improper, it nonetheless appears that Dickinson might have reasonably relied on the administrator's conduct [***19] as indicative of acceptance, invoking principles of equity.

The appeals officer improperly failed to provide explicit factual findings

With respect to the appeals officer's alternative determination that Dickinson failed to show, by a preponderance of the evidence, that her industrial claim should not be limited to the right shoulder, but instead should include her cervical spine condition, the appeals officer erroneously failed to make any findings regarding this conclusion.

Workers' compensation benefits are available to a claimant who shows, by a preponderance of the evidence, that her medical condition is industrial, in that it arose out of and in the course of employment. [17] Further, the resulting condition of an employee whose industrial injury aggravates, precipitates, or accelerates a preexisting, nonindustrial condition is deemed industrial, unless the insurer demonstrates that the industrial injury is not a "substantial contributing cause" of the claimant's resulting condition. [18] The insurer must accept a newly developed industrial [**884] condition even after the workers' compensation claim has been filed. [19]

17 *NRS 616C.150(1).*
18 *NRS 616C.175(1).*
19 *NRS 616C.160.*

[*469] Here, the record contains [***20] several medical reports indicating that, at least to some extent, Dickinson's current cervical condition was caused or substantially contributed to by the August 1998 injury. [20] While, as the appeals officer noted, some reports appear to dispute the extent to which Dickinson's current condition should be deemed industrial, the appeals officer made no other factual findings with respect to the industrial or nonindustrial nature of Dickinson's current cervical condition. Nor did the appeals officer indicate the statutory bases for her determination that Dickinson failed to meet her evidentiary burden. Accordingly, we are unable to adequately review this issue.

20 *See Imperial Palace v. Dawson, 102 Nev. 88, 90-91, 715 P.2d 1318, 1320 (1986)* (recognizing that a workers' compensation insurer is

responsible for covering any injury caused by the treatment of an industrial injury).

As set forth in Nevada's Administrative Procedure Act at *NRS 233B.125*, the appeals officer's final decision must include findings of fact and conclusions of law, separately stated. The factual findings must be based upon substantial evidence and, if rendered in statutory language, supported by a "concise and explicit [***21] statement of the underlying facts supporting the findings." [21] This requirement, we have recognized, is crucial to the administrative process, as factual findings not only help ensure that the administrative agency engages in reasoned decision making, but they also facilitate judicial review. [22] Through factual findings, the parties may make a fully informed decision as to whether to seek judicial review in the first place, and upon seeking such review, the courts are enabled to evaluate the administrative decision without intruding on the agency's fact-finding function. [23] This is particularly important in a case like this, where the record contains several medical reports, not addressed by the appeals officer, that appear to conflict with the appeals officer's conclusion.

21 *NRS 233B.125*.

22 *State, Bd. Psychological Exmr's. v. Norman, 100 Nev. 241, 244, 679 P.2d 1263, 1265 (1984)*.

23 *Id.*; *see also PSC v. Continental Tel. Co., 94 Nev. 345, 350, 580 P.2d 467, 470 (1978)* (presuming that an administrative agency's order was unreasonable because it offered "no explanation" with respect to a certain determination and thus did not comply with *NRS 233B.125*'s requirement to make findings of fact [***22] and conclusions of law to support particular findings).

Accordingly, as the appeals officer's order summarily states only that the preponderance of the evidence supports limiting the claim to the right shoulder (even though it was also accepted for the right arm), without further legal and factual explanation, we cannot adequately review the appeals officer's alternate determination. Consequently, we necessarily reverse the district court's order and remand this matter for further proceedings. If, on remand, the appeals officer determines that Dickinson may seek [*470] PPD benefits for her cervical condition, the appeals officer must then ascertain whether Dickinson has met her statutory burden to show that she is entitled to those benefits because her cervical condition is industrial. In so doing, the appeals officer should comply with *NRS 233B.125*'s requirement by explicitly stating the facts supporting the determination.

On remand, NRS 616C.490(2) must be followed

Finally, we take this opportunity to address one last issue. In her reply brief, Dickinson asserts that the appeals officer had no authority to determine whether her cervical spine condition should be accepted as part of her workers' [***23] compensation claim. The premises underlying this assertion are as follows. Dickinson's administrative appeal challenged the administrator's decision to close her claim based on her failure to appear for her PPD evaluation; therefore, the only issue before the appeals officer was whether her failure to appear warranted claim closure, not whether her cervical condition was part of her claim. Thus, once the appeals officer determined that Dickinson's failure to [**885] appear did not warrant claim closure without a PPD evaluation, she was automatically entitled to a PPD award based on the statutorily authorized PPD physicians' rating, which included her cervical condition, because the administrator had allowed her to treat her cervical condition under the claim and scheduled PPD evaluations for that condition.

Although we need not address this assertion because Dickinson first fully articulated it in her reply brief, [24] we note that Dickinson specifically asked the appeals officer to award her PPD benefits based on a rating that included her cervical condition. Therefore, whether Dickinson was entitled to PPD benefits for that cervical condition was necessarily raised, and addressed by the appeals [***24] officer, once it was suggested that Dickinson was entitled to PPD benefits despite failing to appear at the scheduled evaluation. [25]

24 *See Edwards v. Emperor's Garden Rest., 122 Nev. 317, 330 n.38, 122 Nev. 317, 130 P.3d 1280, 1288 n.38 (2006)* (noting that appellants bear the responsibility to present cogent arguments and relevant authority in support of their appellate concerns); *Weaver v. State, Dep't of Motor Vehicles, 121 Nev. 494, 502, 117 P.3d 193, 198-99 (2005)* (pointing out that this court need not consider arguments raised for the first time in the reply brief).

25 *See NRS 616C.360(2)* (providing that the appeals officer must consider any matter raised on its merits); *Diaz v. Golden Nugget, 103 Nev. 152, 155, 734 P.2d 720, 723 (1987)* ("[T]he hearing before the appeals officer is more akin to a hearing *de novo* than to an appeal.").

Nonetheless, in determining PPD benefits, the rating physician selection process set forth in *NRS 616C.490(2)* must be followed. [26] [*471] Here, the appeals officer relied on the record review completed by the third rating physician, Dr. Kudrewicz, even though Dr. Kudrewicz apparently was not selected according to statute. While we do not suggest that the appeals officer may [***25] never rely on an outside rating physician's record review, [27] nothing in the record here provides a basis for pro-

ceeding outside the statutory process. Further, we point out that Dr. Kudrewicz's report ostensibly conflicts with the properly selected rating physicians' reports regarding the percentage of cervical permanent disability. While we will not reweigh the evidence regarding a question of fact or whether a burden was met, we note the apparent inconsistency between the appeals officer's decision to assign "little weight" to the first, properly selected rating physician's report ostensibly merely because the physician's late evaluation was not authorized by the administrator, and the appeals officer's decision to rely on Dr. Kudrewicz's apparently statutorily unauthorized report. Any PPD award on remand should accord with *NRS 616C.490(2)*'s requirements.

26 *See Georgeff v. Sahara Hotel, 103 Nev. 485, 489, 745 P.2d 1142, 1145 (1987)* (applying former version of statute); *NRS 616C.360(3)(a)*; *see also NRS 616C.100(1)* (allowing *the claimant* to obtain a second PPD determination, from an *NRS 616C.490(2)*-selected rating physician, based on which compensation may be ordered).

27 *See, e.g., Georgeff, 103 Nev. 485, 745 P.2d 1142.*

CONCLUSION

Although [***26] Dickinson did not administratively appeal the administrator's letters excluding her cervical spine condition from her workers' compensation claim, the appeals officer must determine whether the doctrines of equitable estoppel and waiver apply to bar American Medical Response from asserting that Dickinson's failure to appeal precludes relief or from denying the industrial nature of that condition. Further, with respect to the appeals officer's alternative conclusion that Dickinson's cervical condition should not be included in her claim, the appeals officer's failure to make explicit factual findings supporting that conclusion prevents adequate review. Accordingly, we reverse the district court's order and remand this matter with instructions to the district court to remand this matter to the appeals officer for further proceedings consistent with this opinion. The appeals officer's decision on remand should comply with *NRS 233B.125* and *NRS 616C.490(2)*.

PUBLIC AGENCY COMPENSATION TRUST (PACT), Appellant, vs. DALE BLAKE, Respondent.

No. 54822

SUPREME COURT OF NEVADA

127 Nev. 863; 265 P.3d 694; 2011 Nev. LEXIS 94; 127 Nev. Adv. Rep. 77

November 23, 2011, Filed

PRIOR HISTORY: [***1]

Appeal from a district court order denying a petition for judicial review in a workers' compensation action. Eighth Judicial District Court, Clark County; James M. Bixler, Judge.

DISPOSITION: Reversed and remanded with instructions.

COUNSEL: Lynne & Associates and Jill M. Lynne, Las Vegas, for Appellant.

King, Gross & Sutcliffe, Ltd., and Ward M. Sutcliffe, Las Vegas, for Respondent.

JUDGES: Hardesty, J. We concur: Saitta, C.J., Parraguirre, J.

OPINION BY: HARDESTY

OPINION

[*864] BEFORE SAITTA, C.J., HARDESTY and PARRAGUIRRE, JJ.

[**695] By the Court, HARDESTY, J.:

In this appeal, we determine the proper method of apportioning permanent partial disability (PPD) benefits between prior and subsequent industrial injuries when the impairment ratings for those injuries were based on different editions of the applicable guide. PPD awards are based on the percentage of whole person impairment as determined by a rating physician, who makes the calculations using the edition of the American Medical Association [*865] Guides to the Evaluation of Permanent Impairment (AMA Guides) adopted by the Division of Industrial Relations. See *NRS 616C.490*; *NRS 616C.110*. Relying on a regulation that addresses the apportionment of PPD benefits, *NAC 616C.490(4)*, the appeals officer and [***2] the district court in this case concluded that respondent's prior impairment rating, which was calculated using an older version of the AMA Guides, should be deducted from his current impairment rating, which was calculated using the current edition of the AMA Guides. We disagree. The plain language of the governing statute, *NRS 616C.490(9)*, requires the rating physician to reconcile the different editions of the AMA Guides by first recalculating the percentage of the previous impairment rating using the current edition and then subtracting that recalculated percentage from the current level of impairment. Thus, we reverse.

PROCEDURAL HISTORY AND FACTS

Respondent Dale Blake injured his back on December 15, 2004, during the course and in the scope of his employment. Prior to this accident, Blake had suffered four other industrial accidents, in 1982, 1983, 1993, and 1995, resulting in injuries to his lower back. As of his last PPD determination in 1995, Blake received a PPD compensation based on a 14-percent whole person impairment rating using the second edition of the AMA Guides.

In 2003, the Legislature mandated the use of the fifth edition of the AMA Guides for calculating PPD awards. [***3] [1] Blake's most recent injury was evaluated under the fifth edition of the AMA Guides. That evaluation found that Blake suffered a 40-percent whole person impairment. Subtracting the 14-percent prior impairment rating from Blake's current 40-percent impairment, the rating physician determined that Blake's PPD

award for the 2004 injury should be calculated using a net 26-percent increase in impairment rating.

> 1 See *NAIW v. Nevada Self-Insurers Association, 126 Nev. 74, 77-78, 225 P.3d 1265, 1267 (2010)*, for a general discussion of the use of the fifth edition of the AMA Guides to evaluate impairment percentage or rating for injured workers.

After receiving the rating physician's evaluation, appellant Public Agency Compensation Trust (PACT), which was the insurer for Blake's employer when the 2004 accident occurred, expressed concern to the rating physician that the impairment rating for the prior evaluations were not comparable to the rating for the new evaluation because of the change in editions of the AMA Guides. In response, the physician submitted an addendum to his report indicating that he was unsure whether Blake's condition before the 2004 injury could be established. He stated [***4] that there was insufficient data to establish Blake's rating, but the fifth edition of the AMA Guides permits an estimation of impairment. On that [*866] basis, the doctor estimated that Blake's prior level of impairment was equal to a 23-percent level of impairment under the fifth edition of the AMA Guides. Subtracting the revised 23-percent impairment for the prior injuries from the 40-percent [**696] current impairment rating, the doctor determined that the PPD award should be apportioned to compensate him for 17-percent impairment for the 2004 injury. PACT then offered an award to Blake based on a net 17-percent rating of whole person impairment.

Blake administratively appealed, and an appeals officer ordered PACT to offer a PPD award to Blake based on the original net 26-percent impairment rating. PACT petitioned for judicial review pursuant to *NRS 233B.135*. The district court upheld the appeals officer's finding that the prior percentage of disability is deducted from the current disability percentage regardless of the edition of the AMA Guides used to calculate the prior disability determination. PACT now appeals.

DISCUSSION

We now determine the proper method of calculating PPD compensation for [***5] a subsequent work-related injury when the impairment rating for that injury is based on a different edition of the AMA Guides than were prior injuries. We conclude that *NRS 616C.490(9)* is plain and unambiguous and requires that the calculations for prior and subsequent injuries be reconciled by first using the current edition of the AMA Guides to determine both the percentage of the entire disability and the percentage of the previous disability, and then subtracting the latter number from the former to calculate the award for the current injury. We further conclude that to the extent that *NAC 616C.490* allows for computation of PPD compensation without reconciliation of the different editions of the AMA Guides, it impermissibly conflicts with *NRS 616C.490* and is invalid.

Standard of review

This court applies de novo review to questions of law, including issues of statutory interpretation. *State, DMV v. Taylor-Caldwell, 126 Nev. 132, 134, 229 P.3d 471, 472 (2010)*; *State, Dep't of Motor Vehicles v. Terracin, 125 Nev. 31, 34, 199 P.3d 835, 836-37 (2009)*. When a statute is clear and unambiguous, this court gives effect to the plain and ordinary meaning of the words and does not resort to [***6] the rules of construction. *Seput v. Lacayo, 122 Nev. 499, 502, 134 P.3d 733, 735 (2006)*, abrogated on other grounds by *Buzz Stew, LLC v. City of N. Las Vegas, 124 Nev. 224, 228 n.6, 181 P.3d 670, 672 n.6 (2008)*.

[*867] *NRS 616C.490(9)* is plain and unambiguous

NRS 616C.490(9) provides, in pertinent part, that

> [w]here there is a previous disability, . . . the percentage of disability for a subsequent injury must be determined by computing the percentage of the entire disability and deducting therefrom the percentage of the previous disability as it existed at the time of the subsequent injury.

(Emphasis added.)

Blake interprets *NRS 616C.490(9)* to permit the deduction of prior disability ratings without reconciling the calculation of the prior rating with any new edition of the AMA Guides. More specifically, Blake reads this provision as codifying a legislative determination that the calculation should be made using the percentage of impairment as it existed at the time of the subsequent injury. PACT, however, contends that a proper apportionment of prior and subsequent injuries under the statute requires the rating physician to recalculate the impairment rating for the prior disability under the [***7] same edition of the AMA Guides used to calculate the impairment rating for the current injury. The plain language of *NRS 616C.490(9)* demonstrates that PACT is correct.

NRS 616C.490(9) applies in situations where a worker with a prior permanent disability suffers a subsequent disability from an employment-related accident. *NRS 616C.490(9)* requires the percentage of prior impairment to be deducted from the percentage of current

impairment. However, there may be situations in which the prior impairment was determined under one standard and the new impairment under another because the American Medical Association periodically publishes new editions of the AMA Guides, and our Legislature has frequently [**697] amended the statute with respect to applying the AMA Guides. *NRS 616C.110* (requiring adoption of the fifth edition of the AMA Guides); see also 2009 Nev. Stat., ch. 500, § 3, at 3032-33; 2003 Nev. Stat., ch. 305, § 7, at 1671-72; 1999 Nev. Stat., ch. 388, § 53, at 1777. In such situations, the two determinations may not be comparable because updates to the AMA Guides can, as they did in this case, create different percentages of impairment rating for the prior disability.

However, the Legislature [***8] has made it clear that a previous disability must be calculated "as it existed at the time of the subsequent injury." *NRS 616C.490(9)*. This phrase refers to "previous disability," not "percentage," because "previous disability" is the antecedent immediately before it. See 2A Norman J. Singer and J.D. Shambie Singer, Sutherland Statutory Construction § 47:33 (7th ed. 2007) (referential and qualifying phrases generally apply to the last antecedent, meaning the last word to which the [*868] phrase can apply without impairing the sentence's meaning); see also *Thompsen v. Hancock, 49 Nev. 336, 341, 245 P. 941, 942 (1926)* ("It is a rule of construction that relative and qualifying words and phrases, grammatically and legally, where no contrary intention appears, refer solely to the last antecedent."). This interpretation is logical in light of the purpose of the workers' compensation scheme. Workers' compensation is meant to compensate for the actual impairment to the worker caused by an industrial injury. See *NAC 616C.490*. The purpose of each revision of the AMA Guides is to "update the diagnostic criteria and evaluation process used in impairment assessment, incorporating available scientific [***9] evidence and prevailing medical opinion." American Medical Association, Guides to the Evaluation of Permanent Impairment 1 (Linda Cocchiarella & Gunnar B.J. Anderson eds., 5th ed. 2000). Using a consistent method of accounting for impairment ensures that workers are fairly compensated for their disability.

Furthermore, this interpretation is consistent with the legislative intent of permitting only one award per injury. See *SIIS v. Bokelman, 113 Nev. 1116, 1123-24, 946 P.2d 179, 184 (1997)* (explaining that a similar statute regarding permanent total disability is intended to avoid duplicate recoveries); see also *Ransier v. SIIS, 104 Nev. 742, 744, 766 P.2d 274, 275 (1988)* ("When a worker's post-injury impairment is due to both the immediate injury and a pre-existing injury, compensation may only be paid for that portion of the impairment reasonably attributable to the current injury."). Also, *NRS 616C.425(1)* states "[t]he amount of compensation and benefits and the person or persons entitled thereto must be determined as of the date of the accident or injury to the employee, and their rights thereto become fixed as of that date." Reconciling the evaluation is necessary to prevent inconsistent [***10] accounting of the level of impairment.

Although *NRS 616C.490(9)* is plain and unambiguous, the appeals officer and the district court relied on the corresponding provision in the Nevada Administrative Code, *NAC 616C.490*, in determining that the impairment rating of Blake's prior disability should have been calculated under a prior edition of the AMA Guides. Accordingly, we now turn to a determination of whether *NAC 616C.490(4)* conflicts with its governing statute, *NRS 616C.490(9)*.

NAC 616C.490(4) impermissibly conflicts with *NRS 616C.490(9)*

To determine the meaning of an administrative regulation, we will generally defer to the "agency's interpretation of a statute that the agency is charged with enforcing." *State, Div. of Insurance v. State Farm, 116 Nev. 290, 293, 995 P.2d 482, 485 (2000)*. However, [*869] we will not defer to the agency's interpretation if, for instance, a regulation "conflicts with existing statutory provisions or exceeds the statutory authority of the agency." Id.; *Jerry's Nugget v. Keith, 111 Nev. 49, 54, 888 P.2d 921, 924 (1995)* ("administrative regulations cannot contradict the statute they are designed to implement").

NAC 616C.490(4) provides:

> If a rating evaluation was [***11] completed in this State for a previous industrial injury or occupational disease involving a condition, organ or anatomical structure that is identical [**698] to the condition, organ or anatomical structure being evaluated for the present industrial injury or occupational disease, an apportionment must be determined by subtracting the percentage of impairment established for the previous industrial injury or occupational disease from the percentage of impairment established for the present industrial injury or occupational disease, regardless of the edition of the [AMA Guides] used to determine the percentage of impairment for the previous industrial injury or occupational disease.

(Emphasis added.) *NAC 616C.490(4)* clearly contemplates the deduction of a previous disability percentage from the current disability percentage without requiring the prior disability percentage to be assessed "as it existed at the time of the subsequent injury." *NRS 616C.490*.

Because we conclude that *NRS 616C.490(9)* requires recomputation of the previous injury's percentage of disability, *NAC 616C.490(4)* is in direct conflict with the governing statute. Therefore, no deference to the agency's interpretation is due, [***12] and we conclude that *NAC 616C.490(4)* is invalid.

Because we conclude that the district court and the appeals officer erred in relying on *NAC 616C.490(4)* to determine the amount due and, therefore, the PPD award based on the 17-percent whole person impairment rating for the current injury was proper, we reverse the district court's order denying the petition for judicial review and remand this case to the district court with instructions to remand it to the appeals officer so that Blake's PPD compensation can be calculated using the 17-percent impairment difference. [2]

2 We have considered the parties' other arguments and conclude that they are without merit.

Hardesty, J.

Hardesty

We concur:

Saitta, C.J.
Saitta

Parraguirre, J.
Parraguirre