Assembly Bill No. 458–Committee
on Commerce and Labor

CHAPTER.....

AN ACT relating to industrial insurance; providing that certain phrases relating to a claim for compensation may be used interchangeably; authorizing an injured employee to obtain an independent medical examination under certain circumstances; setting forth the manner in which a vocational rehabilitation counselor is to be appointed; increasing the amount of medical benefits required to be paid during the first 12 months after a claim is opened; revising provisions relating to permanent partial disability; revising provisions concerning the payment in lump sum for a permanent partial disability; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Section 2 of this bill specifies that a physician or chiropractor may use interchangeably certain phrases that relate to a claim for compensation when determining the causation of an industrial injury or occupational disease.

Existing law authorizes a hearing officer or appeals officer to order an independent medical examination if such an examination is necessary to resolve a medical question concerning an injured employee's condition or to determine the necessity of treatment for which authorization for payment has been denied. In such situations, an injured employee may choose any physician or chiropractor, whether or not the physician or chiropractor is on the insurer's panel of providers of health care. (NRS 616C.330, 616C.360) **Section 3** of this bill sets forth that an injured employee is entitled to an independent medical examination for a claim for compensation that is open or when the closure of a claim is under dispute. **Section 3** further authorizes the injured employee to obtain an independent medical examination: (1) when a dispute arises from a determination issued by the insurer; (2) within 30 days after the injured employee receives a certain report generated by a medical examination; or (3) by leave of a hearing officer or appeals officer. **Section 3** additionally requires an injured employee to select a physician or chiropractor from the panel of physicians or chiropractors established by the Administrator of the Division of Industrial Relations of the Department of Business and Industry. **Section 3** further requires the insurer to: (1) pay for an independent medical examination; and (2) upon request, receive a copy of any report or other document that is generated as a result of the independent medical examination. **Section 3** additionally allows the injured employee to obtain only one independent medical examination per calendar year.

Existing law provides that the primary obligation of a vocational rehabilitation counselor is to the injured employee. (NRS 616C.547) Existing law authorizes an insurer or injured employee to request a vocational rehabilitation counselor to prepare a written assessment of the injured employee. (NRS 616C.550) Existing law requires the vocational rehabilitation counselor to develop a plan for a program of vocational rehabilitation for each eligible injured employee. (NRS 616C.555) **Section 4** of this bill provides for a vocational rehabilitation counselor to be appointed by the insurer and injured employee when a written

assessment is requested or when a plan for a program of vocational rehabilitation is required.

Existing law requires, where there is a previous disability, the percentage of disability for a subsequent injury to be determined by deducting from the entire disability of the person the percentage of previous disability as it existed at the time of the subsequent injury. (NRS 616C.490) The Division of Industrial Relations of the Department of Business and Industry previously implemented a regulation that required an apportionment to be made by subtracting the percentage of previous disability as it existed at the time of the previous disability from the percentage of present disability as it existed at the time of the present disability. (NAC 616C.490) The Nevada Supreme Court in *Pub. Agency Comp. Trust v. Blake*, 127 Nev. 863 (2011), found this regulation to be invalid since it was in conflict with the existing statute. **Section 8** of this bill incorporates the substance of the regulation at issue into existing law.

Existing law authorizes an insurer, after sending notice to the claimant, to close a claim if, during the first 12 months after a claim is opened, the medical benefits required to be paid for the claim are less than $300. Existing law further requires an insurer to send to a claimant who receives less than $300 in medical benefits within 6 months after the claim is opened a written notice that explains how the claim may be closed if, during the first 12 months after the claim is opened, the medical benefits required to be paid for the claim are less than $300. (NRS 616C.235) **Section 7.3** of this bill increases the amount of medical benefits required to be paid for the claim from $300 to $800.

Existing law sets forth that if an employee's claim is reopened, the employee is not entitled to vocational rehabilitation services or benefits for a temporary total disability if, before the claim was reopened, the employee retired for reasons unrelated to the injury for which the claim was originally made. (NRS 616C.390) **Section 7.7** of this bill defines the term "retired" for the purposes of these existing provisions.

Existing law authorizes an award for a permanent partial disability to be paid in a lump sum. Existing law further provides how a lump sum amount is to be calculated and requires the tables used in this calculation to be reviewed annually by a consulting actuary. (NRS 616C.495) **Section 9** of this bill specifies the maximum amount of a lump sum that a person injured on or after July 1, 1995, and before January 1, 2016, on or after January 1, 2016, and before July 1, 2017, and on or after July 1, 2017, may elect to receive as his or her compensation. **Section 9** additionally requires the tables used to calculate the lump sum to be adjusted on July 1 of each year.

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

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

Section 1. Chapter 616C of NRS is hereby amended by adding thereto the provisions set forth as sections 2, 3 and 4 of this act.

Sec. 2. ***Certain phrases relating to a claim for compensation for an industrial injury or occupational disease and used by a physician or chiropractor when determining the causation of an***

industrial injury or occupational disease are deemed to be equivalent and may be used interchangeably. Those phrases are:

1. "Directly connect this injury or occupational disease as job incurred"; and

2. "A degree of reasonable medical probability that the condition in question was caused by the industrial injury."

Sec. 3. ***1. An injured employee may obtain an independent medical examination:***

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

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

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

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

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

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

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

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

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

5. If the dispute concerns the rating of a permanent disability, an independent medical examination may be conducted by a rating physician or chiropractor. The injured employee must select the next rating physician or chiropractor in rotation from the list of qualified physicians and chiropractors maintained by the Administrator pursuant to subsection 2 of NRS 616C.490, unless the insurer and the injured employee otherwise agree to a rating physician or chiropractor.

6. The insurer shall:

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

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

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

Sec. 4. ***Where a written assessment is requested pursuant to NRS 616C.550 or where a plan for a program of vocational rehabilitation is required pursuant to NRS 616C.555, a vocational rehabilitation counselor must be appointed as follows:***

1. The insurer and the injured employee or personal or legal representative of the injured employee shall agree on the selection of a vocational rehabilitation counselor;

2. If the insurer or injured employee or personal or legal representative of the injured employee are unable to agree on the appointment of a vocational rehabilitation counselor, the insurer shall submit a list of at least three vocational rehabilitation counselors to the injured employee or personal or legal representative of the injured employee;

3. The injured employee or personal or legal representative of the injured employee shall select a vocational rehabilitation counselor from the list provided by the insurer pursuant to subsection 2 within 7 days after receiving the list provided by the insurer pursuant to subsection 2;

4. The vocational rehabilitation counselor that is selected by the injured employee or personal or legal representative of the injured employee pursuant to subsection 1 or 3 must be assigned to provide all vocational rehabilitation services for the claim pursuant to this section and NRS 616C.530 to 616C.600, inclusive; and

5. After a vocational rehabilitation counselor is selected and assigned pursuant to this section, an injured employee or personal or legal representative of the injured employee may only rescind the selection of the vocational rehabilitation counselor with the consent of the insurer.

Secs. 5, 6 and 7. (Deleted by amendment.)

Sec. 7.3. NRS 616C.235 is hereby amended to read as follows:

616C.235 1. Except as otherwise provided in subsections 2, 3 and 4:

(a) When the insurer determines that a claim should be closed before all benefits to which the claimant may be entitled have been paid, the insurer shall send a written notice of its intention to close the claim to the claimant by first-class mail addressed to the last known address of the claimant and, if the insurer has been notified that the claimant is represented by an attorney, to the attorney for the claimant by first-class mail addressed to the last known address of the attorney. The notice must include, on a separate page, a statement describing the effects of closing a claim pursuant to this section and a statement that if the claimant does not agree with the determination, the claimant has a right to request a resolution of the dispute pursuant to NRS 616C.305 and 616C.315 to 616C.385, inclusive, including, without limitation, a statement which prominently displays the limit on the time that the claimant has to request a resolution of the dispute as set forth in NRS 616C.315. A suitable form for requesting a resolution of the dispute must be enclosed with the notice. The closure of a claim pursuant to this subsection is not effective unless notice is given as required by this subsection.

(b) If the insurer does not receive a request for the resolution of the dispute, it may close the claim.

(c) Notwithstanding the provisions of NRS 233B.125, if a hearing is conducted to resolve the dispute, the decision of the hearing officer may be served by first-class mail.

2. If, during the first 12 months after a claim is opened, the medical benefits required to be paid for a claim are less than ~~[$300,]~~ ***$800,*** the insurer may close the claim at any time after the insurer sends, by first-class mail addressed to the last known address of the claimant, written notice that includes a statement which prominently displays that:

(a) The claim is being closed pursuant to this subsection;

(b) The injured employee may appeal the closure of the claim pursuant to the provisions of NRS 616C.305 and 616C.315 to 616C.385, inclusive; and

(c) If the injured employee does not appeal the closure of the claim or appeals the closure of the claim but is not successful, the claim cannot be reopened.

3. In addition to the notice described in subsection 2, an insurer shall send to each claimant who receives less than ~~[$300]~~ ***$800*** in medical benefits within 6 months after the claim is opened a written notice that explains the circumstances under which a claim may be closed pursuant to subsection 2. The written notice provided

pursuant to this subsection does not create any right to appeal the contents of that notice. The written notice must be:

(a) Sent by first-class mail addressed to the last known address of the claimant; and

(b) A document that is separate from any other document or form that is used by the insurer.

4. The closure of a claim pursuant to subsection 2 is not effective unless notice is given as required by subsections 2 and 3.

5. In addition to the requirements of this section, an insurer shall include in the written notice described in subsection 2:

(a) If an evaluation for a permanent partial disability has been scheduled pursuant to NRS 616C.490, a statement to that effect; or

(b) If an evaluation for a permanent partial disability will not be scheduled pursuant to NRS 616C.490, a statement explaining that the reason is because the insurer has determined there is no possibility of a permanent impairment of any kind.

Sec. 7.7. NRS 616C.390 is hereby amended to read as follows:

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

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

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

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

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

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

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

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

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

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

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

(a) The claimant did not meet the minimum duration of incapacity as set forth in NRS 616C.400 as a result of the injury; and

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

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

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

(a) Retired; or

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

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

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

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

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

10. The provisions of this section apply to any claim for which an application to reopen the claim or to increase or rearrange compensation is made pursuant to this section, regardless of the date of the injury or accident to the claimant. If a claim is reopened

pursuant to this section, the amount of any compensation or benefits provided must be determined in accordance with the provisions of NRS 616C.425.

11. As used in this section:

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

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

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

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

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

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

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

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

(1) Is not employed or earning wages; and

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

(I) Pension or retirement plan;

(II) Governmental program; or

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

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

(1) Commissions and bonuses; and

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

Sec. 8. NRS 616C.490 is hereby amended to read as follows:

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

2. 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]~~ ***Except as otherwise provided in subsection 10, if*** 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. ***If a rating evaluation was completed for a previous disability involving a condition, organ or anatomical structure that is identical to the condition, organ or anatomical structure being evaluated for the present disability, the percentage of disability for a subsequent injury must be determined by deducting the percentage of the previous disability from the percentage of the present disability, regardless of the edition of the American***

Medical Association's Guides to the Evaluation of Permanent Impairment as adopted by the Division pursuant to NRS 616C.110 used to determine the percentage of the previous disability. The compensation awarded for a permanent disability on a subsequent injury must be reduced only by the awarded or agreed upon percentage of disability actually received by the injured employee for the previous injury regardless of the percentage of the previous disability.

11. 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.]~~ ***12.*** 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.]~~ ***13.*** 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.

Sec. 9. NRS 616C.495 is hereby amended to read as follows:

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

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

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

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

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

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

(2) Exceeds 25 percent may:

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

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

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

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

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

(f) Any claimant injured on or after July 1, 2017, who incurs a disability that exceeds 30 percent may elect to receive his or her compensation in a lump sum equal to the present value of an award for a disability of up to 30 percent. If the claimant elects to receive compensation pursuant to this paragraph, the insurer shall pay in installments to the claimant that portion of the claimant's disability in excess of 30 percent.

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

2. If the claimant elects to receive his or her payment for a permanent partial disability in a lump sum pursuant to subsection 1, all of the claimant's benefits for compensation terminate. 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 ~~[.]~~ ***and must be adjusted accordingly on July 1 of each year by the Division using:***

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

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

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

Sec. 10. This act becomes effective on July 1, 2017.