IN THE SUPREME COURT OF THE STATE OF NEVADA

WILLIAM POREMBA,

Appellant,

v.

SOUTHERN NEVADA PAVING; AND S&C CLAIMS SERVICES, INC.,

Respondents.

Supreme Court No.: 66888

District Court No.: A-14-698184-J

RESPONDENTS' SOUTHERN NEVADA PAVING'S AND S & C CLAIMS SERVICES, INC.'S ANSWERING BRIEF

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I.

STATEMENT OF THE LEGAL ISSUES PRESENTED

1. What is the proper standard for review in this case?

2. Whether the District Court's Order properly affirmed the Appeals Officer's Order Granting Summary Judgment as Appellant had Not Established that His industrial insurance claim should be reopened?

II.

STATEMENT OF THE CASE

Appellant appealed from the November 8, 2012 denial of reopening of his worker's compensation claim. There was no medical evidence submitted to support the request for reopening as required by NRS 616C.390. (App. at 134).

The parties agreed to bypass the Hearing Officer on this issue and present the reopening issue directly to an Appeals Officer. (App. at 3-5.)

On or about March 26, 2013, Respondents, through Counsel, filed a Motion for Summary Judgment. (App. at 6-12.)

On April 17, 2013, the Appeals Officer issued an Order Denying the Motion for Summary Judgment. (App. at 191-192.)

The matter was subsequently argued before the Appeals Officer on January 29, 2014. Counsel for Respondents raised the Summary Judgment arguments made previously at this hearing.

The Appeals Officer issued an Order Granting Summary Judgment on February 25, 2014.

Appellant filed his Petition for Judicial Review on March 25, 2014, and an Amended Petition for Judicial Review on March 27, 2014.

Respondents filed a Notice of Intent to Participate on March 31, 2014.

On or about May 5, 2014, the Record on Appeal was submitted.

On June 18, 2014, Appellant submitted his Opening Brief.

On July 21, 2014, Respondents submitted their Answering Brief.

On August 25, 2014, Appellant submitted his Reply Brief.

District Court Judge Valorie J. Vega heard oral argument on the Petition for Judicial Review on September 29, 2014.

On October 22, 2014, the District Court denied the Petition for Judicial Review.

The Notice of Entry of Order was filed on October 23, 2014.

Subsequently, Appellant filed an appeal to the Nevada Supreme Court on November 10, 2014.

Appellant's Opening Brief was filed on March 27, 2015.

Respondents, through Counsel, now file their Answering Brief.

III.

STATEMENT OF FACTS

Appellant, WILLIAM POREMBA (hereinafter referred to as "Appellant"),

filed a Petition for Judicial Review of an Appeal Officer's Order Granting Summary Judgment against him in a contested workers' compensation claim.

Appellant appealed from the denial of reopening of his worker's compensation claim. There was no medical evidence submitted to supporting the reopening. (App. at 133-134).

By way of background, Appellant was involved in a vehicle-heavy equipment accident on or about July 22, 2005 while at work. He sought medical treatment and filled out a C-4 three days later on July 25, 2005. He was diagnosed with thoracic, cervical strains; a face contusion and a knee contusion. (App. at 18).

A follow-up appointment at Concentra on July 29, 2005 produced the same diagnosis. App. at 26-27).

Appellant treated on his own outside of worker's compensation arena on August 2, 2005. (App. at 28-29).

Appellant was informed by Respondent Insurer that he could not treat with non-preferred providers and could only have one treating physician. (App. at 30-32). Care was transferred to Dr. Angela Thomas. (App. at 33).

On August 12, 2005, the claim was accepted for cervical strain, lumbar strain and left knee sprain. (App. at 37). The accepted scope of the claim was never appealed by Appellant.

On August 12, 2005, Dr. Thomas documented that Appellant had a non-

industrial history of chronic low back pain. (App. at 38-40). Physical therapy was recommended.

Appellant and his counsel were informed of Respondent Insurer's lien against and third-party suit proceeds in August 2005. (App. at 41-42).

On November 7, 2005, Dr. LaTourette opined that Appellant would need knee surgery in the future. (App. at 56-57).

Respondent Insurer sent a claim closure letter on January 27, 2006. (App. at 60). The claim closed.

On October 5, 2010, Respondent Insurer sought recovery of its worker's compensation lien. (App. at 61-63).

On November 3, 2010, Appellant sought to reopen his claim, more than one year after it closed. Appellant provided a one-page letter from Sudir Khenika, M.D., which did not have any medical records attached. The letter asks for reopening since the Appellant has had increased pain complaints. This is the PRIOR request for reopening and not the one that is the subject of this appeal. (App. at 66).

On November 8, 2010, Respondent Insurer denied reopening because Appellant had not proven that he has exhausted his third-party recovery on medical treatment, which he must do before Respondent Insurer would be responsible to pay for reopening and future medical treatment. (App. at 67).

In November 2010, Appellant returned to the Las Vegas Pain Institute for neck and low back pain. He was told to continue home exercises. (App. at 69-72).

Appellant received a settlement of $63,500.00 from a responsible third party who caused his accident. (App. at 74-76). According to Appellant's affidavit, he personally received $34,631.51 in settlement proceeds. That money has been exhausted prior to this reopening request but it has not been proven to be exhausted on medical treatment that would otherwise be part of the worker's compensation claim. (App. at 183-184). Appellant admits that he used that money to support his family and pay household bills.

Appellant previously appealed the denial of reopening of his claim. On March 7, 2011, the Hearing Officer properly denied the request for reopening. (App. at 107-111).

Appellant appealed to the Appeals Office. (App. at 118).

On May 6, 2011, Respondent Insurer filed a Motion for Summary Judgment regarding the appeal over the denial of reopening before a different Appeals Officer. (App. at 124-130).

On May 17, 2011, the Appeals Officer GRANTED Respondent Insurer's prior Motion for Summary Judgment. (App. at 131-132).

Appellant waited approximately a year and on November 8, 2012, his counsel sought reopening once again. Again, there is no new medical reporting to

support this request and again, Appellant has not proven that he has exhausted his third-party proceeds on medical treatment before asking Respondent Insurer to pay for more benefits under the worker's compensation claim.

On November 8, 2012, Respondent Insurer denied the request for reopening. (App. at 134).

Appellant appealed and the parties agreed to bypass the Hearing Officer hearing.

Respondent Insurer filed a Motion for Summary Judgment. It was opposed and Appeals Officer Shirley Lindsey denied the Motion. (App. at 191-192).

At the appeal hearing, Respondents' Counsel again raised the Motion for Summary Judgment which the Judge had previously denied. (App. at 319-320). A full hearing took place on the merits. Appellant testified that he received $34,631.51 in settlement proceeds from his third-party lawsuit. (App. at 345).

Appellant testified that he spent the $34,631.51 on some medical bills and he and his family lived off it; it paid for his house; it paid for his food. Appellant admits that he spent the money on expenses required to support his two children, one in college and one in middle school. (App. at 348).

It is undisputed that Appellant did not spend the entire $34,631.51 on medical expenses that would otherwise be part of his worker's compensation claim. (App. at 348).

In closing argument, Appellant argued that he may spend the $34,631.51 in settlement proceeds he received from the third-party lawsuit on paying his mortgage and putting food on the table for his family. (App. at 352). Appellant also argued that he "needs a home to live in to be able to recover. Particularly, he needs food and healthy diet to be able to recover" (Id.)

While all humans need food and shelter to stay alive, that is not the inquiry here. The issue before the Appeals Officer was whether Appellant spent his third-party settlement proceeds on medical treatment that would otherwise be the responsibility of the insurance company if his worker's compensation claim were to be reopened. It is undisputed that the money was spent on other things, such as paying his mortgage, on his family and on his own food and shelter needs. Appellant admits that he did not spend the $34,631.51 on medical care that would be the responsibility of the worker's compensation Insurer if the claim was reopened.

Respondents' Counsel made two arguments in closing: (1) that Appellant has not proven that he has exhausted his offset because he has not proven that he spent his third-party proceeds on medical care incurred after the date of settlement; and (2) even if we could reach the issue of reopening, Appellant has insufficient medical evidence to prove the need for more treatment on an industrial basis. (App. at 352-359). The medical records used to support reopening were years old

and had previously been rejected in a prior attempt to reopen. (App. at 357-358). There are no new medical reports since the last denial of reopening was made. The medical reports being relied upon are from 2009 and 2010.

Subsequently, on February 24, 2015, Appeals Officer Shirley Lindsey issued an Order Granting the Insurer's Motion for Summary Judgment. (App. at 298-299). The Appeals Officer issued the Order in lieu of issuing a Decision and Order with Findings of Fact and Conclusions of Law.

Regardless of the mechanism of the ruling, it is clear that the Appeals Officer considered all the evidence and testimony and did not believe that the Claimant proved a right to reopen his claim.

Appellant filed his Petition for Judicial Review of that Order on March 25, 2014. (App. at 362-367.)

On October 22, 2014, the District Court issued an Order Denying Petition for Judicial Review. (App. at 431-433.)

On November 10, 2014, Appellant filed his Notice of Appeal.

IV.

ARGUMENT

A.

Standard of Review

Judicial review of a final decision of an agency is governed by NRS 233B.135.

NRS 233B.135 Judicial review: Manner of conducting; burden of; standard for review.

1. Judicial review of a final decision of an agency must be:

(a) Conducted by the court without a jury; and

(b) Confined to the record.

In cases concerning alleged irregularities in procedure before an agency that are not shown in the record, the court may receive evidence concerning the irregularities.

2. The final decision of the agency shall be deemed reasonable and lawful until reversed or set aside in whole or in part by the court. The burden of proof is on the party attacking or resisting the decision to show that the final decision is invalid pursuant to subsection 3.

3. The court shall not substitute its judgment for that of the agency as to the weight of evidence on a question of fact. The court may remand or affirm the final decision or set it aside in whole or in part if substantial rights of the petitioner have been prejudiced because the final decision of the agency is:

(a) In violation of constitutional or statutory provisions;

(b) In excess of the statutory authority of the agency;

(c) Made upon unlawful procedure;

(d) Affected by other error of law;

(e) Clearly erroneous in view of the reliable, probative and substantial evidence on the whole record; or

(f) Arbitrary or capricious or characterized by abuse of discretion. (Emphasis added.)

The standard of review is whether there is substantial evidence to support the underlying decision. The reviewing court should limit its review of administrative decisions to determine if they are based upon substantial evidence. North Las Vegas v. Public Service Comm'n., 83 Nev. 278, 291, 429 P.2d 66 (1967); McCracken v. Fancy, 98 Nev. 30, 639 P.2d 552 (1982). Substantial evidence is that quantity and quality of evidence which a reasonable man would accept as adequate to support a

conclusion. See, Maxwell v. SIIS, 109 Nev. 327, 331, 849 P.2d 267, 270 (1993); and Horne v. State Indus. Ins. Sys., 113 Nev. 532, 537, 936 P.2d 839 (1997).

When reviewing administrative court decisions, this Court has held that, on factual determinations, the findings and ultimate decisions of an appeals officer are not to be disturbed unless they are clearly erroneous or otherwise amount to an abuse of discretion. Nevada Industrial Comm'n. v. Reese, 93 Nev. 115, 560 P.2d 1352 (1977). An administrative determination regarding a question of fact will not be set aside unless it is against the manifest weight of the evidence. Nevada Indus. Comm'n. v. Hildebrand, 100 Nev. 47, 51, 675 P.2d 401 (1984). A decision by an appeals officer that is based upon the credibility of the claimant and other witnesses is "not open to appellate review." Brocas v. Mirage Hotel & Casino, 109 Nev. 579, 585, 854 P.2d 862, 867 (1993).

While the Court is not required to give deference to pure legal questions determined by the agency, those conclusions of the agency which are closely related to the agency's view of the facts, are entitled to deference, and will not be disturbed if they are supported by substantial evidence. Jones v. Rosner, 102 Nev. 215, 217, 719 P.2d 805, 806 (1986). The Appeals Officer's Decision and Order was clearly erroneous in view of the reliable, probative and substantial evidence in the record.

NRS 616A.010(2) and (4) make it clear that Nevada no longer has liberal construction. Issues must be decided on their merits, and not according to the

common law principle that requires statutes governing workers' compensation to be liberally construed. This means workers' compensation statutes must not be interpreted or construed broadly or liberally in favor of any party.

B.

APPELLANT HAS NOT ESTABLISHED ANY ERROR OF LAW

It is Appellant, not Respondents, who had the burden of proving his case by a preponderance of all the evidence. State Industrial Insurance System v. Hicks, 100 Nev. 567, 688 P.2d 324 (1984); Johnson v. State ex rel. Wyoming Worker's Compensation Div., 798 P.2d 323 (1990); Hagler v. Micron Technology, Inc., 118 Idaho 596, 798 P.2d 55 (1990).

In attempting to prove his case, Appellant had the burden of going beyond speculation and conjecture. That means that Appellant had to establish the work connection of his injuries, the causal relationship between the work related injury and his disability, the extent of his disability, and all facets of the claim by a preponderance of all the evidence. To prevail, Appellant had to present more evidence than an amount which would make his case and his opponent's "evenly balanced." Maxwell v. SIIS, 109 Nev. 327, 849 P.2d 267 (1993); SIIS v. Khweiss, 108 Nev. 123, 825 P.2d 218 (1992); SIIS v. Kelly, 99 Nev. 774, 671 P.2d 29 (1983); 3, A. Larson, The Law of Workmen's Compensation, § 80.33(a).

It is disingenuous for Appellant to argue that he had no idea that the Motion

for Summary Judgment would be reasserted during the appeal hearing. The arguments made in the Motion for Summary Judgment are the identical arguments that Respondents have been making to defeat reopening in this case since 2011. To say that Appellant did not expect to hear these arguments defies logic. Surely Appellant should have expected that Respondents were going to defend the denial of reopening. Respondents' brief was timely filed. Thus, this argument can be dismissed outright as is deserves no merit.

Secondly, the argument is made that since the Appeals Officer did not make Findings of Fact or Conclusions of law, this Court cannot adequately review her ruling. If that is true, then this Court should remand the matter to the Appeals Officer to make such findings. In workers' compensation cases in Nevada, the Appeals Officer is the trier of fact. The Appeals Officer is the only Judge who heard the live testimony. This Court may not re-weigh the evidence or rule on the credibility of the witnesses. If this Honorable Court finds that Findings of Fact and Conclusions of Law need to be generated, then a remand to the Appeals Officer is the proper remedy. This Court may not step in the shoes of the trier of fact here.

The arguments the Appellant appears to be making now were already made to the Appeals Officer through his counsel before he lost the appeal hearing. There is nothing new here, just an attempt to get another bite at the proverbial "apple" since the Appeals Officer did not agree with Appellant's arguments. That is

insufficient to warrant this Court reversing the District Court decision which upheld the Appeals Officer's Order Granting Summary Judgment.

B.

THE APPEALS OFFICER'S ORDER IS SUPPORTED BY SUBSTANTIAL AND PERSUASIVE EVIDENCE

Appellant's appeal must be denied as the Appeal Officer's Order is supported by substantial evidence. If the decision of the administrative agency on the appealed issue is supported by substantial factual evidence in the Record on Appeal, the District Court must affirm the Decision of the Agency as to that issue. Tighe v. Las Vegas Metro. Police Dep't, 110 Nev. 632, 877 P.2d 541 (1994). Here, the Order is supported by substantial and persuasive facts in the record.

Substantial evidence has been defined as that quantity and quality of evidence which a reasonable man could accept as adequate to support a conclusion. Tighe at 634; State Employment Sec. Dep't v. Hilton Hotels Corp., 102 Nev. 606, 608 at n.1, 729 P.2d 497 (1986). In addition, substantial evidence is not to be considered in isolation from opposing evidence, but evidence that survives whatever in the record fairly detracts from its weight. Universal Camera Corp. v. NLRB, 340 U.S. 474, 477, 488 (1951); Container Stevedoring Co. v. Director, OWCP, 935 F.2d 1544, 1546 (9th Cir. 1991).

The undisputed fact is that Appellant admits that he spent his third-party settlement funds on supporting his family and not solely on future medical

treatment, which he must do before he asks for any further compensation from the Insurer under his workers' compensation claim. He cannot spend his settlement proceeds on home loans and family expenses and expect that money to be credited toward Respondent Insurer's subrogation offset. That is what he has done here. EICON v. Chandler, 23 P.3d 255 (Nev. 2001) clearly stands for this proposition.

The Nevada Supreme Court held in Chandler that: "An insurer is entitled to withhold payment of medical benefits for a work-related injury until an employee has exhausted any third-party settlement proceeds..." Id. at 258.

Here, Appellant testified that he received more than $34,000.00 in settlement proceeds which he has not proven that he has spent on his own future medical treatment. In Chandler, the insurer's lien was paid back and still benefits were denied until he exhausted the money he received from his third-party case. Here, the lien has not even been paid back. The facts in the present case are even stronger than those in the Chandler case.

Furthermore, NRS 616C.215 provides the following, in pertinent part:

> 2. When an employee receives an injury for which compensation is payable pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS and which was caused under circumstances creating a legal liability in some person, other than the employer or a person in the same employ, to pay damages in respect thereof:
>
> (a) The injured employee, or in case of death the dependents of the employee, may take proceedings against that person to recover damages, but **the amount of the compensation the injured employee or the**

> **dependents of the employee are entitled to receive pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS, including any future compensation, must be reduced by the amount of the damages recovered**, notwithstanding any act or omission of the employer or a person in the employ which was a direct or proximate cause of the employee's injury.
>
> (b) If the injured employee, or in case of death the dependents of the employee, receive compensation pursuant to the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS, the insurer, or in case of claims involving the Uninsured Employers' Claim Account or a subsequent injury account the Administrator, has a right of action against the person so liable to pay damages and is subrogated to the rights of the injured employee or of the employee's dependents to recover therefor.
>
> 5. In any case where the insurer or the Administrator is subrogated to the rights of the injured employee or of the employee's dependents as provided in subsection 2 or 3, the insurer or the Administrator has a lien upon the total proceeds of any recovery from some person other than the employer, whether the proceeds of such recovery are by way of judgment, settlement or otherwise. **The injured employee**, or in the case of his or her death the dependents of the employee, **are not entitled to double recovery for the same injury**...

(Emphasis added).

The future offset identified in subsection (2) can be asserted against the entirety of a Claimant's settlement, including a pain and suffering award, pursuant to Breen v. Caesars Palace, 715 P.2d 1070, 102 Nev. 79 (1986).

The language of the NRS 616C.215 is clear that all future workers' compensation benefits must be reduced by the amount of money a claimant receives from a third-party settlement. Until the point at which Appellant has accumulated $34,631.51 in benefit entitlement associated with his worker's compensation injuries, incurred since his third-party settlement, Appellant cannot receive any payments under the workers' compensation system.

Appellant's position is that he simply must exhaust his settlement proceeds on his living expenses, food, and home loans rather than exhausting the $34,631.51 solely on expenses related to his industrial injury. The notion is not supported by any case law in the Ninth Circuit.

In Tobin v. The Dept. of Labor and Industries, 145 Wn. App. 607, 613, 187 P.3d 780, 783 (Wn. Ct. App. 2008), the Washington Court of Appeals held that where the remaining balance of a settlement is paid to an employee, "the employee or beneficiary is not entitled to receive additional workers' compensation benefits until the additional benefits equal the remaining balance of the recovery paid to the employee or beneficiary." (Emphasis added).

The policy underlying future credits is that they shift responsibility for compensating injured employees from the no-fault employer to those who are legally and factually liable for the injury. *See,* Id. The Court clarified that the claimant cannot be paid compensation and damages by the employer and "yet retain the portion of damages which would include those same elements." *See,* Id.

In Associated Steel Workers, Ltd. v. Mullen, 2005 Haw. LEXIS 46 (Sup. Ct. Haw. 2005), the Hawaii Supreme Court held that the claimant's receipt of the remainder of the settlement was "subject to the requirement that [the claimant] **first exhaust all necessary future workers' compensation payments from that remainder** prior to requesting future compensatory payments from the

[insurer]...for the compensable injuries arising out of the same accident." (Emphasis added).

The Arizona Court of Appeals, in Polito v. Industrial Commission of Arizona, 171 Ariz. 46, 47, 828 P.2d 182, 183 (Ariz. Ct. App. 1992), held that a workers' compensation carrier is only responsible for paying the deficiency between the amount actually collected by the claimant from a third-party settlement and any medical benefits which are due under the industrial insurance statutes.

California is also in agreement, holding the following: "after payment of the employer's [or the insurance carrier's] lien, [it] shall be relieved from the obligation to pay further compensation to or on behalf of the employee...*up to the amount of the balance of the judgment*, if satisfied, *without any deduction*." See Dodds v. Stellar, 30 Cal 2d 496, 505, 183 P.2d 658, 664 (1947). (Emphasis added).

Similarly, in Employers Ins. Co of Nevada v. Chandler, 23 P.3d 255, 117 Nev. 421(2001), the Nevada Supreme Court did not allow the claimant to simply present evidence that he had spent his settlement proceeds on whatever he felt like spending it on. Rather, the Court held that the claimant could not undergo medical treatment within the workers' compensation system until he had spent his entire third-party settlement on industrially-related expenditures.

The entire point of the future offset provision is to prevent a double recovery. Double recovery means allowing an injured worker to be paid for his injury by a third party and also recover the same amount from the worker's compensation insurer.

In the present case, Appellant received in excess of $34,000.00 from the third party to compensate him for the injury he sustained in the car accident which occurred at work. Although that money may be "gone," it is undisputed that it was not entirely spent on medical care, disability benefits, or any other accident benefit that would have been covered under his worker's compensation claim. Rather, Appellant used it to pay his bills and support his family. He now argues that since the money is exhausted, he is entitled to receive accident benefits under his worker's compensation claim. This is the definition of a double recovery.

Appellant wants to be paid benefits under his workers' compensation claim when he did not use the $34,631.51 on benefits that would be covered under his workers' compensation claim. Obviously, if an individual is provided with medical care under a worker's compensation claim, that individual is not going to pay the same doctor for the bills paid under the worker's compensation claim. That would be double payment.

Double recovery is when an individual is provided money for the accident benefits and then asks that the same accident benefits be paid under the worker's

compensation claim (i.e. the worker gets the money for the accident benefits and asks the worker's compensation carrier to pay for the accident benefits – double recovery). That is exactly what Appellant is asking this Court to order and exactly what every Court mentioned above has rejected.

The money received from the third-party tortfeasor was compensation for Appellant's medical expenses and disability status (accident benefits), both of which were the responsibility of the wrongdoer, not the workers' compensation insurer. The money was not intended to be used to pay for a home loan or other voluntary purchases. Appellant cannot accept disability payments from the third-party tortfeasor and also accept them from the workers' compensation insurer. This is double recovery.

The idea that Appellant "spent the money" equates to exhaustion of the offset under NRS 616C.215 is not supported by law. There would be no purpose in having the offset if all an injured worker had to prove was that they 'spent' the money. The money must be used on items/treatment or accident benefits that would be covered under the workers' compensation claim. Any other interpretation of this law makes no logical sense.

Furthermore, even assuming arguendo that the merits of the reopening could be reached, Appellant has not met his burden of proof to prove reopening. He has a letter from his counsel and some old doctor letters from 2009 and 2010. The

letter from counsel purports of subjective complaints of pain. This falls well below the Appellant's legal burden of proof.

Appellant's own assertions prove that he cannot prevail. He admits that he recovered in excess of $34,000.00 in his third-party settlement. He claims that he has spent $14,000.00 in medical treatment relating to his industrial accident. First, this is not enough. He has to show that he spent ALL of the money he got in the third-party case and he has to prove that he spent it on medical treatment that Respondent Insurer would otherwise be liable for.

Secondly, he has to show that he **spent** this money AFTER he got it. Appellant's assertion that he is going to need a surgery in the future does NOT meet the requirement because he has not spent that money yet.

Finally, the bills that Appellant did produce to this court are almost exclusively for services incurred BEFORE the third-party settlement. These monies are not considered for the offset. The letter to Appellant regarding his settlement is dated September 25, 2009. Thus, any medical bill incurred BEFORE this date does not count for the offset. The bills prior to settlement were negotiated and known to his personal injury lawyers. The offset requires that the money was spent AFTER the settlement.

Additionally, we must remember the procedural posture in this case, as it is telling. This Appellant previously appealed the denial of reopening of his claim in

2011. On March 7, 2011, the Hearing Officer properly denied the request for reopening. (App. at 107-111).

Appellant appealed and lost that appeal. The present request for reopening was based on the same old medical evidence that was insufficient in the last attempt to reopen. **On May 17, 2011, the prior Appeals Officer GRANTED the Insurer's Motion for Summary Judgment due to Appellant's failure to prove that reopening was warranted.** (App. at 131-132).

In this attempt to reopen, Appellant is relying on Dr. Khanka's report from October 22, 2010. This evidence has already been deemed insufficient by a prior Appeal Officer. Appellant needs a medical report that is at least newer than the last summary judgment order filed against him denying reopening.

The Affidavit filed by Appellant opposing the Motion for Summary Judgment supports Respondents' position. It proves that Appellant has not exhausted his third-party proceeds on medical treatment associated with this claim.

All of the foregoing is the substantial evidence used to rule in Respondents' favor in this case. The Appeals Officer reviewed the entirety of the record before her. She listened to testimony and argument during the lengthy appeal hearing. While the Appeals Officer ruled by Order, instead of by Decision and Order, that does not change the fact that her ruling to deny reopening is correct. Appellant is upset because the Appeals Officer ruled against him.

Appellant is asking this court to re-weigh the facts, which may not be done now. The Appeals Officer applied all the laws correctly. Therefore, the facts and the law support the denial of Appellant's appeal. North Las Vegas v. Public Service Common, 83 Nev. 278, 291, 429 P.2d 66 (1967); McCracken v. Fancy, 98 Nev. 30, 639 P.2d 552 (1982).

V.

CONCLUSION

Based upon the foregoing, Respondents respectfully contend that the Appeals Officer's Order contained no error of law, and that her decision was supported by undisputed credible and substantial evidence as well as binding case law.

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Wherefore, Respondents respectfully ask this Honorable Court to affirm the decision of the District Court which affirmed the Appeals Officer's Order Granting Summary Judgment.

DATED this 27 day of July, 2015.

Respectfully submitted,

LEWIS BRISBOIS BISGAARD & SMITH LLP

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CERTIFICATE OF COMPLIANCE

1. I hereby certify that this brief complies with the formatting requirements of NRAP 32(a)(4), the typeface requirements of NRAP 32(a)(5), and the type style requirements of NRAP 32(a)(6) because this brief has been prepared in a proportionally spaced typeface using Microsoft WORD software in 14 point Times New Roman font.

2 I further certify that this brief complies with the page limitations of NRAP 32(a)(7) because, excluding the parts of the brief exempted by NRAP 32(a)(7)(C), the document type volume limitation does not exceed 14,000 words [per WORD's word count utility, this document, including tables of content and authorities, addendums, footnotes.]

3. Finally, I hereby certify that I have read this appellate brief, and to the best of my knowledge, information, and belief, it is not frivolous or interposed for any improper purpose. I further certify that this brief complies with all applicable Nevada Rules of Appellate Procedure, in particular NRAP 28(e)(1), which requires every assertion in the brief regarding matters in the record to be supported by a reference to the page and volume number, if any, of the transcript or appendix where the matter relied on is to be found. I understand that I may be subject to sanctions in the event that the accompanying brief is not in conformity with the requirements of the Nevada Rules of Appellate Procedure.

Dated this 17 day of July, 2015.

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CERTIFICATE OF MAILING

Pursuant to Nevada Rules of Civil Procedure 5(b), I hereby certify that, on the 27 day of July, 2015, service of the foregoing **RESPONDENTS' SOUTHERN NEVADA PAVING'S AND S & C CLAIMS SERVICES, INC.'S ANSWERING BRIEF** was made this date by depositing a true copy of the same for mailing, first class mail, at Las Vegas, Nevada, addressed as follows:

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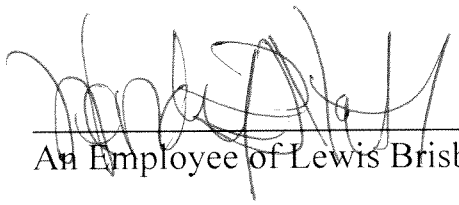

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